Broadening the Focus: Counselling Psychology and Mental Health in the Field of Substance Misuse

Anna-Maria Plessa

Supervised by Dr Susan Strauss

Portfolio submitted in fulfilment of the requirements for the Professional Doctorate in Counselling Psychology (DPsych)

Department of Psychology

City University of London

June 2020

TABLE OF CONTENTS

City, University of London
Northampton Square
London
EC1V 0HB
United Kingdom

T +44 (0)20 7040 5060

THE FOLLOWING PARTS OF THIS THESIS HAS BEEN REDACTED FOR COPYRIGHT AND DATA PROTECTION REASONS:

Section C: Client study.....
sECTION D: Publishable article.....

SECTION C: PROFESSIONAL PRACTICE – CLIENT STUDY

REMOVED

'The importance of the therapeutic relationship in cognitive-behavioural therapy with an adult survivor of childhood sexual abuse and co-existing substance use problems: A client study'

Part A: Introduction to the Case

Rationale for choosing this particular case

Theoretical orientation: Cognitive-Behavioural Therapy

The context of the work and referral details

Client biographical details and presenting problem

Assessment and Formulation of the presenting problem

Negotiated contract and therapeutic aims for psychological therapy

Part B: The Development of Therapy

The pattern of therapy

Key content issues and main techniques/interventions used

The therapeutic process, difficulties encountered and addressed in the work (including the use of supervision)

Part C: Therapy Review and Evaluation

Evaluation of the work, professional and personal learnings

References

Appendices

Appendix 1: Genogram of family members and important relationship symbols as discussed by John during our sessions

Appendix 2: Diagrammatic CBT formulation of John's difficulties

Appendix 3: Placement Supervisor's Confirmation of Client's Consent to Record Sessions and Use this Case for Academic Assignments.

ACKNOWLEDGEMENTS

The completion of this portfolio would not have been possible without the contribution and support of many people.

I extend my heartfelt thanks to my research supervisor, Dr Susan Strauss, who has so generously, enthusiastically and patiently supported me throughout this process. I am deeply grateful for all the time she gave me, her wise counsel and stimulating input, all of which helped me navigate through the ups and downs of the thesis journey! It has been a privilege and a pleasure to be your supervisee, Susan.

I would also like to express my sincere gratitude to the participants of this study, without whom the research component of the thesis would not have been possible. I am very thankful to all of them for trusting me so openly and generously with deeply personal experiences of therapeutic change, and giving me permission to print their material. I hope this research will enable your voices to be heard!

Special thanks go to Dr George Christo who has been an inspiring clinical supervisor and a mentor. He also helped me to obtain ethical approval from the drug and alcohol service in which I carried out this research.

Last but definitely not least, my love and thanks are extended to my family and close friends who have supported me through this long process of completing my training. Producing this portfolio has been an interesting but challenging journey, which would not have been possible without their consistent encouragement and caring presence. Although they all know who they are, I feel obliged to mention my grandmother, Mary, my parents, Marianna and Gianni, my sisters, Christiana and Penny, as well as my beloved doggie, Chloe – for seeing my messiest parts and still choosing to love me. Finally, I would like to dedicate this portfolio to the loving memory of my grandfather, Demetrios D. Plessas, whom I lost in the very early stages of the research project.

DECLARATION OF POWERS OF DISCRETION

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole or in part without reference to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgement.

THE FOLLOWING PARTS OF THIS THESIS HAVE BEEN REDACTED FOR DATA PROTECTION REASONS:

Section C: Professional Practice – Client Study
pp. 269-296

SECTION A: PREFACE

This doctoral portfolio represents the culmination of my training in Counselling Psychology, on the interlaced levels of theory, practice and research, as well as the journey of personal growth and self-discovery I have undergone throughout this process.

This preface aims to provide an overview of each of the three pieces of work that comprise the current portfolio. They are all focused on the relevance of psychotherapeutic work with individuals affected by harmful use of psychoactive substances, inclusive of alcohol and illicit drugs controlled under the Misuse of Drugs Act 1971 (Advisory Council on the Misuse of Drugs, 2009). This represents an important topic for me as in the course of my therapeutic work with this client group I noticed that this is a rather complex therapeutic area, marked by a wealth of comorbid mental health challenges and elevated dropout rates. At the same time, however, maybe because of this complexity, it is also an area that tends not to receive a lot of attention within the mainstream psychotherapy literature, and this has resulted in insufficient understanding about the therapeutic processes and factors that facilitate meaningful healing in this field of practice (Kellogg & Tatarsky, 2012). Additionally, in recent years, the discipline of Counselling Psychology has been accused of lacking presence in the field of substance misuse, and calls have been made to increase its contribution to the scholarly literature in this area, as substance misuse remains a pervasive public health problem, which more often than not co-occurs with other mental health concerns (Martin, Burrow-Sanchez, Iwamoto, Glidden-Tracey & Vaughan, 2016).

Hence, these are the reasons why I decided to construct my portfolio around the interconnected topics of psychotherapy and substance misuse. In this manner, the overarching theme, or common thread, that runs throughout the body of this work is the notion of '*broadening*', for I believe it captures well the way both myself and the individuals whose experiences are documented therein have gradually grown and expanded in the process of attempting to bring the worlds of psychotherapy and substance misuse closer together – each from their own perspective. In this sense, I also hope that this portfolio offers an opportunity to *broaden* the presence of Counselling

Psychology in the field of substance misuse, by building new understandings for practitioners[1] and clients alike.

The reader of this portfolio will find the following three sections that constitute its component parts. An overview of each of these sections will also be provided below.

1. The Doctoral Research

The doctoral research forms the first section of the portfolio and consists of an original piece of qualitative research that aims to explore in-depth pertinent psychosocial factors implicated in the process of therapeutic change from the perspective of individuals who have found psychotherapy helpful in assisting their recovery from substance misuse. The study utilises semi-structured interview data gathered from a mixed-gender clinical sample of 12 adult participants who were self-identified as former substance misusers and had completed a course of individual psychotherapy at a London-based drug and alcohol service. A constructivist version of grounded theory (Charmaz, 2014) was used to inform the processes of data collection and analysis. This particular methodology was chosen because it enables a researcher to construct an explanatory model of participants' formulation and experience of therapeutic change, whilst at the same time it acknowledges that the results of such an analysis are constructed through ongoing interactions between the researcher and what is being researched. In this manner, the end-product of a constructivist grounded theory study is seen as one possible interpretative portrayal, rather than a universal or unidimensional 'truth', about the phenomenon under consideration. The theoretical model that emerged from the current analysis represented participants' experiences of therapeutic change as an overall process of 'broadening', which reflected the influence of attachment and existentially-informed factors on the successful resolution of substance use problems. These findings are discussed in light of theoretical insights gained as well as extant empirical literature, whilst implications for future research and the discipline of Counselling Psychology are also considered.

[1] The terms 'practitioner', 'psychologist', 'counselling psychologist', 'therapist', 'psychotherapist', 'counsellor' and 'clinician' will be used interchangeably throughout this portfolio.

Overall, the experience of conducting qualitative research, although riddled with complexity, self-doubt and emotional turmoil, has been an enormously rewarding one which has greatly honed and enhanced my ability to work independently as a researcher. This is shown through active and reflective engagement in the processes of elucidating the ontological and epistemological assumptions of the research design employed, conducting data collection and analysis, linking findings to existing literature and discussing the implications of the outcomes of my study.

2. The Client Study

This section presents an example of my clinical work in the form of a client study. The focus here is on the professional practice of counselling psychology through the presentation of a piece of work that is intended to demonstrate my clinical competence in a particular therapeutic model (in this case, cognitive-behaviour therapy) and, thereby, to show how sound theoretical knowledge has been applied to practice.

The study is a written summary of the main aspects of the collaborative work between me and a male client who was referred to the psychology service that was part of a multidisciplinary, community-based drug and alcohol agency in Greater London. At the time of referral, the client had been six months abstinent from illicit drug use and felt that in order to maintain his recovery he needed a space to explore the longstanding impact of his childhood sexual abuse, so as to resolve persistent feelings of low mood and anxiety, as well as a pervasive sense of low self-esteem. The client's difficulties were formulated within the cognitive-behavioural therapy model, and the therapeutic interventions employed focused upon broadening the client's repertoire of adaptive coping skills for the downregulation of his negative mood and associated psychological difficulties, which appeared to be characteristic of complex post-abuse trauma (e.g., intrusive memories and flashbacks of the sexual abuse, avoidance of internal and external reminders of the abuse, negative self-worth and self-blame for the traumatic event, suicidal ideation, interpersonal hypervigilance and sleep disturbance).

In addition to demonstrating competence in the practical application of the cognitive-behavioural therapeutic approach, this piece of work highlights my belief that it is the quality of the therapeutic relationship between the client and therapist which forms the basis on which psychological theories and therapeutic techniques are embedded. In this

sense, this client study is also intended to show the reader the way I used clinical supervision and continued personal reflection in order to establish and maintain a purposeful therapeutic alliance, especially in light of challenges that were presented by the client's well-ingrained perceptions of interpersonal relationships as potential sources of hurt, danger or betrayal.

Overall, this particular client study was chosen as I consider it a good example of how the use of a collaborative case formulation can facilitate a shared understanding of a client's difficulties, and assist in professional and ethical treatment planning through the selection of appropriate therapeutic interventions. Additionally, the work with this client contributed to the broadening of my clinical skills when working with adult survivors of childhood sexual abuse, and highlighted my growth as a counselling psychologist who emphasises the quality of the therapeutic relationship as a critical factor to the process of integrating theoretical concepts with clinical practice, and personal and professional awareness.

3. The Journal Article

The third and final section of the portfolio presents a subset of results from the doctoral research. The findings presented focus on attachment-related themes that comprise the main grounded theory category that has been labelled as 'therapist-client engagement', due to their direct implications for psychological practice. This piece of work is presented as a journal article with the aim of being published in the peer-reviewed journal *'Psychology and Psychotherapy: Theory, Research and Practice'*. The article has been formatted according to this particular journal's guidelines, and this journal was deliberately chosen as it appeals to a wide range of psychologists and allied professionals (e.g., counselling, clinical, health and forensic psychologists, counsellors and psychotherapists) who may be interested in accessing findings from this study while working in a therapeutic capacity with individuals affected by substance use problems. The purpose of this paper is to explore and theorise about therapeutic change-promoting factors and processes from an attachment theory perspective and as experienced by clients who have found individual psychotherapy sessions helpful in their recovery from substance use problems. In this manner, it is hoped that the dissemination of my research findings through the publication of this article will inform

the clinical practice of psychologists and psychotherapists in the field of substance misuse, and stimulate greater clinical and research interest in the value of incorporating attachment-informed constructs for the treatment of substance use problems.

Preface Conclusion

In conclusion, the three different sections that comprise this portfolio represent different aspects of my own personal and professional journey of 'broadening' and developing as a counselling psychologist and as a qualitative researcher, over the course of my training and beyond. I believe that each section of the portfolio is relevant, in content, to the practice of counselling psychologists in the field of substance misuse, as well as to the ethos of the discipline of counselling psychology in general. The experience of completing this doctoral portfolio has been equally challenging and satisfying, and it is my hope that the pieces of work included therein will succeed in evidencing my acquisition of knowledge, skills and competencies necessary to make the transition from trainee to chartered counselling psychologist.

References

Advisory Council on the Misuse of Drugs (2009). *Pathways to problems: A follow-up report on the implementation of recommendations from pathways to problems*. London: Home Office.

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd ed.). London: Sage.

Kellogg, S. H., & Tatarsky, A. (2012). Re-envisioning addiction treatment: A six-point plan. *Alcoholism Treatment Quarterly*, *30*(1), 109-128.

Martin, J. L., Burrow-Sanchez, J. J., Iwamoto, D. K., Glidden-Tracey, C. E., & Vaughan, E. L. (2016). Counseling psychology and substance use: Implications for training, practice and research. *The Counseling Psychologist*, 1-26.

SECTION B: DOCTORAL RESEARCH

'How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change: A constructivist grounded theory analysis'

ABSTRACT

The purpose of the present study is to explore the process of therapeutic change from the perspective of individuals who have found psychotherapy helpful in assisting their recovery from substance misuse. Based upon the premise that substance misuse psychotherapy research has been criticised for lacking a qualitative focus that encompasses the client's view and subjective perceptions of change in the process of recovery (Miller, 2016), this research utilised a constructivist version of Grounded Theory (Charmaz, 2014) to analyse data collected from individual, semi-structured interviews with 12 participants (six male, six female; age range: 30 to 65 years) who had recently completed a course of psychotherapy at a London-based drug and alcohol service. Detailed analysis of the interview transcripts resulted in the construction of a theoretical model which consisted of four main categories: 'addressing the substance relationship', 'therapist-client engagement', 'becoming one's own therapist' and 'ultimate therapeutic change outcome'. These categories and their properties (i.e., more focused subcategories) were identified as representing key psychosocial processes involved in participants' experiences of therapeutic change and recovery from substance misuse over time. A core connecting category, termed 'Broadening', was also identified as applying to all therapeutic change dimensions that were extracted from participants' accounts. These findings are discussed in light of relevant theoretical and research literature in order to provide explanatory support for the constructed grounded theory model as well as contribute new insights which may be useful to future research and practice in this field of inquiry. Last but not least, this study also aims to respond to recent calls to increase the presence of the profession of Counselling Psychology in the field of substance misuse through engagement in relevant areas of research and practice (Martin, Burrow-Sanchez, Iwamoto, Glidden-Tracey & Vaughan, 2016).

CHAPTER 1: INTRODUCTION

1.1 Chapter Overview

This chapter aims to address the significance of substance misuse as a pervasive public health problem, and the value of psychosocial therapies as important recovery pathways in the process of overcoming substance use problems. Although substantial quantitative evidence, reviewed in this chapter, indicates the effectiveness of psychotherapy in improving substance misuse outcomes, these studies lack information on the psychosocial processes of change as experienced from the client's perspective. Moreover, the chapter reviews recent research which indicates that clients who experience problematic substance use tend to disagree with recovery-related indicators embedded in professionally-constructed, standardised outcome measures, frequently used to evaluate client change following participation in psychosocial therapies. Additionally, to date, very limited qualitative research exists on clients' subjective experience of therapeutic change in the context of psychotherapy for substance misuse. As a result, little is known as to how psychotherapies for substance misuse facilitate positive changes from the client's perspective. Finally, the contribution of client-focused, qualitative research is also made with respect to the discipline of Counselling Psychology.

1.2 Substance Misuse: Scope, Prevalence, Impact and Therapeutic Response

Substance misuse refers to the harmful use of psychoactive substances[2], inclusive of alcohol and illicit drugs controlled under the 1971 Misuse of Drugs Act (National Institute for Health and Care Excellence, NICE, 2016). Alcohol and drug use is judged to be harmful on the basis of the consequences with which these behaviours tend to be associated. In this sense, substance misuse can be construed as a socially constructed term, commonly employed in the context of drug and alcohol healthcare services to refer to the negative impact the use of certain substances can have on a person's life, including their physical and mental health, relationships, work, education, finances,

[2] 'Psychoactive substances' refer to a class of substances, both licit and illicit, which when taken into the living organism have the potential to affect or modify its mental processes (i.e., cognition and affect). The word 'psychotropic' is also frequently used as an alternative and equivalent term (Teesson, Hall, Proudfoot & Degenhardt, 2011). In effect, we could say that the chemical properties of these substances have in common a function of artificially changing the subjective experience of the self (Sussman & Sussman, 2011).

and/or offending behaviour (NICE, 2016). In this sense, the term 'substance misuse'[3] (or 'substance use problems') will be used in this thesis to indicate that the focus is on the problematic use of substances, rather than substance use per se.

Substance misuse affects us all. It is a major public health concern with wide-reaching consequences at individual, familial and societal levels throughout most of the world (Peacock et al., 2018).

In the United Kingdom (UK), for those aged 15 to 49 years, the misuse of alcohol is the number one risk factor attributable to early mortality and ill health (e.g., injuries, mental distress, suicide, cognitive decline, hypertension, cardiovascular and liver disease), whilst for all ages it is the fifth most important (Public Health England, PHE, 2016). Alcohol-related harms are also associated with adverse social and economic consequences, including interpersonal relationship problems, loss of earnings and unemployment, as well as problems with the law (PHE, 2016). The harm caused by alcohol is dose-dependent and thereby determined by intake levels (i.e., units per week) at both the individual and population level. Increasing alcohol risk is determined by consumption of more than 14 units/week for both genders, whereas higher risk is defined as over 50 units/week for males and over 35 units/week for females (PHE, 2016). Based on these benchmarks, UK household surveys (which tend to underestimate population-level consumption) have estimated that over 10 million adults are consuming more than 14 units/week, with 8.5 million drinking at increasing risk and 1.9 million at higher risk levels. Overall, the combination of increasing and higher risk consumption accounts for about 25% of the UK population, with only approximately 6% receiving relevant treatment (Dunne et al., 2018).

In terms of illicit drug use prevalence, according to the latest findings from the annual Crime Survey for England and Wales (CSEW), it is estimated that in 2018/19 around 9.4% of people aged between 16 to 59 years (i.e., about 3.2 million people) had taken a drug that belongs to Class A, B or C, whilst a third of these people (30.3%) were classed as 'frequent drug users', meaning that they had used an illicit substance more

[3] Substance misuse exists along a continuum of severity. The word 'addiction' (or 'dependence') is also frequently used, in both academic and everyday discourses, to denote that a person has become 'given over' or overwhelmingly involved with the activity of using certain substances, to the extent that other components of life have been forced to the periphery (Sussman & Sussman, 2011). The meaning of the word addiction, however, is not restricted to problematic substance use, and may equally apply to other behaviours that have the potential to become excessive (e.g., gambling, shopping, eating, exercising, sex, etc.; Orford, 2001). I have chosen to use the term 'substance misuse' throughout this text.

than once a month in the last year (Home Office, 2019). Cannabis was found to be the most commonly used drug, accounting for 7.6% of the population surveyed, and cocaine the second, accounting for 2.9%. Opiates accounted for 0.1%. Illicit drug misuse is also associated with increased morbidity and mortality risks, owning to neurological impairments, respiratory and cardiovascular dysfunctions, blood-borne viral infections, as well as prominent mental distress and suicidal ideation (Teesson et al., 2011). Moreover, in recent years the number of drug misuse deaths is the highest on record (PHE, 2017). Additionally, in cases of health-related harm, for both licit and illicit substance misuse, tobacco smoking rates are estimated to be substantially higher than those of the general population (PHE, 2017).

The total annual cost to society from substance misuse is estimated to be £21 billion for alcohol and £15 billion for illicit drugs (PHE, 2017). These fiscal costs are associated with the burden of healthcare, welfare and criminality, whilst not counting for the additional emotional distress, family breakdown and co-occurring mental health problems that affect both those who misuse substances and their associates. Indeed, mental health distress appears to be highly comorbid with substance misuse, estimated at up to 70% for those who cite illicit drug misuse upon presentation to healthcare services and 86% for those who present with alcohol misuse, with males making up 69% of the entire treatment population (NICE, 2016; PHE, 2017). Such co-occurrence between substance use and psychological/psychosocial problems calls for integrated care within mental health and substance misuse treatment services in the process of helping people work toward meaningful recovery outcomes (Mee-Lee, McLellan & Miller, 2010; Miller, 2016; NICE, 2016). In this sense, psychosocial therapies are considered essential components – either as standalone practices or in combination with pharmacological interventions – to any comprehensive substance misuse treatment programme, and especially for substances (e.g., cannabis and cocaine) where effective pharmacological treatments are currently lacking (Jhanjee, 2014). The relevance and impact of psychosocial therapies within the field of substance misuse treatment will be discussed in more detail later in this chapter.

1.3 Substance Misuse Recovery[4]: What do clients say?

Overall, the information cited in the previous section provides a powerful argument for putting recovery from substance misuse at the heart of current policy, research and practice efforts, especially in light of evidence indicating that every £1 spent on beneficial substance misuse treatment saves £2.50 in costs to society (PHE, 2017).

Recovery, however, remains a vague and contested concept in the field of substance misuse, where it has recently been criticised (e.g., Borkman, Stunz & Kaskutas, 2016; Neale et al., 2014) for being narrowly equated with medical-informed notions of abstinence, reduction in substance use and/or remission from a cluster of behavioural, physical and psychosocial symptoms (e.g., craving, diminished self-control, tolerance, withdrawal, psychosocial impairment) indicative of what has been termed as 'substance use disorder' by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). Such perspectives on recovery appear to view substance misuse as something that resides solely within the individual, being essentially caused and maintained by the chemical effects of certain substances on neural brain regions of the central nervous system (e.g., over-activation of the mesolimbic dopamine reward system and progressive decrease in inhibitory control by prefrontal cortical areas; Everitt, 2014). Consequently, it is assumed that therapeutic outcomes should mainly focus on basic quantitative indicators weighted toward reduced problematic substance use, as well as global changes in individuals' health, wellbeing and social functioning (e.g., improvement in broad areas of physical and mental health, (re)building relationships, stable housing, employment and income management, responsible citizenship and participation in community life; ACMD[5], 2013; Betty Ford Institute, 2007; Laudet, 2007). Although such broad recovery outcomes are certainly of benefit in the process of overcoming substance misuse, the dominance of this way of thinking about substance misuse recovery has its roots in professionally-driven discourses, which have subsequently led to the construction of standardised outcome measures that target clients' experiences of recovery via quantitative assessment of differences in pre-post treatment scores within a set of pre-

[4] Even though the concept of 'recovery' is a core feature of national and international policy and practice in the field of substance misuse (Dar et al., 2015; Groshkova & Best, 2011), at present there is no clear consensus on its meaning. Consequently, in this thesis, I am using the word 'recovery' as an umbrella term to refer to positive changes in the context of overcoming problematic substance use.

[5] Advisory Council on the Misuse of Drugs

determined response items related to substance use problems (e.g., the Treatment Outcomes Profile (TOP); Marsden et al., 2008) and general psychological distress (e.g., the Clinical Outcomes Routine Evaluation – Outcome Measurement (CORE-OM); Evans, Connell, Barkham, Mellor-Clark & Audin, 2002). Measuring recovery outcomes in such a strictly nomothetic and 'objective' manner may be deemed important to the current commissioning and funding of drug and alcohol services that operate within UK's Payment by Results (PbR) scheme and which, therefore, need to demonstrate particular criteria of effectiveness in supporting individuals' recovery from substance misuse (Erens, Roland & Knapp, 2011). On the other hand, such gross quantification of recovery experiences, based upon expert-driven, standardised methods of assessment, has the effect of reducing clients' (or service users') participation in substance misuse treatment evaluation to the state of passive providers of numerical data, and thereby ignores their own views and privileged insights into what is essentially a deeply personal and subjective process of change (Lee & Zerai, 2010; Orford, 2008).

Indeed, in recent years, it has been increasingly acknowledged that the client's experiential perspective is missing from dominant discourses and recovery pathways from substance misuse (Alves, Sales & Ashworth, 2017; Borkman et al., 2016; Moskalewicz, 2010; Neale et al., 2015; Rance & Treloar, 2015). Moreover, recent research that has sought individuals' perspectives on the meaning of recovery from substance misuse has revealed gaps in dominant recovery discourses, as well as differences between professional-constructed outcome assessment tools and clients' views of therapeutic changes involved in addressing problematic substance use.

For instance, in the UK, Neale et al. (2015) ran focus groups (N = 44, 16 women, 28 men, age range: 21 to 62 years) with individuals who were currently misusing Class A drugs and/or alcohol, service users attending residential detoxification/rehabilitation, as well as people who defined themselves as ex-drug or alcohol users, and asked their opinions on 76 indicators of recovery commonly used by service providers, working across psychosocial therapies and residential treatment, in evaluating treatment outcomes. Qualitative data analysis revealed participants' frustration with what they thought was vague, ambiguous and inappropriate language to describe their experiences of recovery (e.g., recovery indicator phrased as "behaving morally", was questioned by participants asking "whose morals?", p. 31), whilst the majority challenged

professionals' focus on substance misuse recovery as a rational process of behaviour change, stating instead that recovery involved emotional changes that entailed the recognition and management of negative feelings, rather than the absence of depression, shame, guilt and boredom. Overall, participants seemed disappointed with these recovery indicators – which are actually embedded in popularly used outcome measures – stating that service providers "had no idea of their experiences" (p. 31) and expected them to "become superhuman" (p. 29) by achieving more than those who do not misuse substances. The researchers concluded that recovery-related perceptions, goals and aspirations of people who experience drug and alcohol problems differ from professionals' views of their treatment needs. They further argued that despite prominent stigmatising attitudes – both within the general public and healthcare sectors – toward people who experience problems related to substance use, these individuals are able to articulate their views clearly and have valuable insights to offer when engaged in discussions about the personal meaning recovery has for them and the therapeutic processes involved in working towards it. It was, therefore, recommended that future research should focus on exploring and communicating the lived experiences of substance misuse recovery, from the point of view of the principal protagonists – the people who use drug and alcohol services – so that weaknesses in dominant, professionally-privileged discourses can be highlighted and the client's viewpoint taken seriously and incorporated into improving current policy and quality of service delivery.

In another study conducted in Portugal, Alves et al. (2017) recruited 93 newcomer clients (57% male, mean age = 43 years) from three outpatient drug and alcohol services and one inpatient therapeutic community, and asked them to engage in a brief, semi-structured interview in order to reflect on personal concerns that led them to seek professional help. Participants' responses were analysed thematically, leading to the identification of 54 client-reported domains of concern. Subsequently, the researchers explored the thematic content of items embedded in 42 outcome assessment tools (e.g., CORE-OM, TOP, Addiction Severity Index, Leeds Dependence Questionnaire, Maudsley Addiction Profile, the WHO Quality of Life, etc.) frequently used in substance misuse treatment settings in Europe, so that they could compare the domains covered by these standardised instruments with the main concerns reported by the 93 participants. By using factor analysis and 'Multiple Correspondence Analysis', 31

domains were identified across the 42 measures, with ‘substance misuse’ (67%) and ‘general psychological health’ (40%) representing the commonest. Additionally, the majority of the measures were deemed similar to each other, suggesting a repetitive understanding of substance use problems. Thematic comparison analysis and content matching between the 31 domains covered by standardised measures and the 54 domains of client-reported concerns, revealed that 26% of client-generated domains (n = 14) did not feature in any of the 42 outcome measures. Among the unmatched client-reported domains were topics pertaining to ‘personal development’, ‘understanding self’, ‘existence/existential’, ‘future’, ‘time’, ‘outlook on life’, ‘moving on’, ‘guilt’, and ‘dependence on other people’. On the other hand, client-reported domains of concern frequently represented by outcome measures tended to focus on broad areas of interpersonal relationships, substance misuse, communication and social problems. Only 10% of standardised outcome measures contained half or more of client-reported domains of concern. The overarching conclusion was that the majority of expert-driven measures fail to capture the diversity of client-reported concerns, and thereby overlook aspects of recovery regarded meaningful and relevant to individuals seeking professional help for problems that co-exist with substance misuse. Consequently, it was suggested that there is a disparity of views between client and professional perspectives on the meaning of therapeutic improvement in the process of substance misuse recovery. It was recommended that future research should focus on increasing client involvement in healthcare provision, through active exploration of their subjective perceptions, personal experiences and views on particular therapeutic changes involved in achieving meaningful recovery outcomes. In this manner, our understanding of how therapeutic interventions work can be advanced, whilst the scope of future outcome measurement can be informed and broadened. Finally, the researchers recommended that future research in this area should also gather and explore, through a bottom-up and idiographic approach, clients’ personalised views on change post-treatment, so that a more complete and dynamic picture of meaningful recovery may be obtained.

1.4 Substance Misuse and Psychosocial Therapies: The Importance of the Client Factor

Substance misuse constitutes a complex, multifaceted phenomenon, which more often than not co-occurs with various psychological and social problems. Indeed, Miller (2016) has noted that "In a career of treating [substance use problems] one may encounter the entire DSM" (p. 100) and "[…] effective treatments […] address far more than substance use" (p. 106). For this reason, psychosocial therapies are considered essential components of treatment-assisted recovery pathways from substance misuse (Jhanjie, 2014). Psychosocial therapies refer to a broad range of evidence-based[6] psychological or psychotherapeutic interventions, anchored in varied theoretical traditions and technical operations, including, but not limited to, cognitive-behavioural therapy (CBT), relapse prevention (RP), motivational interviewing (MI), psychodynamic therapy, social behaviour and network therapy (SBNT) and twelve-step facilitation (TSF) approaches (see Galanter & Kleber, 2010; Witkiewitz, Steckler, Gavrishova, Jensen & Wilder, 2012, for extensive reviews). These approaches are all aimed at eliciting positive changes in clients' substance use behaviour and maladaptive cognitive, emotional and relational patterns, whilst also being mindful of the fact that any type of human behaviour occurs in a social context since human existence is essentially 'peopled with others' (Hersch, 2015, p. 118). The terms 'psychosocial therapy', 'psychological therapy' and 'psychotherapy' can be used interchangeably to refer to a professional interpersonal encounter that is: (a) planned and bounded by culture, place and time; (b) anchored in psychological principles; (c) taking place between a trained therapist and a client seeking help for a particular concern(s); and (d) intended by the therapist to be of necessary quality, appropriateness and conditions (endogenous and exogenous) remedial for the client's concerns (see Wampold & Imel, 2015). Bruce Wampold also uses the term "bona fide psychotherapy" to describe the essence of such an activity (Wampold, 2015).

Research into the efficacy and effectiveness of psychosocial therapies for substance misuse has its roots in the medical or 'natural science' tradition (Strawbridge, 2016) of understanding and treating human problems, meaning that it prioritises objective,

[6] Miller & Moyers (2015, p. 404) state that because the bar for a psychosocial therapy to be nominated as 'evidence-based' is 'set so low', requiring only one positive, well-designed randomised controlled trial, over 330 different psychosocial interventions for substance misuse are currently listed as evidence-based.

observable, measurement-oriented and professionally-led ways of generating human knowledge claims, which tend to exclude relevant lay knowledge and subjective client perspectives on therapeutic change factors, in favour of randomised controlled trial (RCT) evidence and a nomothetic understanding of issues pertaining to substance misuse and its treatment (Miller, 2016; Miller & Moyers, 2015; Neale & Strang, 2015; Orford, 2008). However, this dominant treatment research paradigm, with its strong commitment to positivist and modernist epistemological and methodological assumptions, seems to have reached an impasse, as a large volume of empirically sound alcohol and drug treatment RCTs, from either individual studies or meta-analyses, have consistently failed to find significant differences in efficacy and effectiveness among various brands of evidence-based psychotherapies, anchored in distinct theoretical rationales and prescribed techniques (e.g., Davis et al., 2015; De Crescenzo et al., 2018; De Giorgi et al., 2018; Dutra et al., 2008; Imel, Wampold, Miller & Fleming, 2008).

For instance, Project MATCH (Project MATCH Research Group, 1997) in the United States, a landmark multi-site, longitudinal, comparative RCT, which involved 1,726 adult outpatient (n = 952, 72% male) and inpatient/aftercare (n = 774, 80% male) clients with alcohol use problems, being randomly assigned to either manual-based CBT, TSF or Motivational Enhancement Therapy (MET; i.e., a longer-term variant of MI) delivered over 12 weeks, failed to find evidence of differential efficacy among these three conceptually and methodologically different psychotherapies. Instead, it was concluded that all three therapies yielded virtually identical, positive outcomes across three years of follow-up, on each of the primary dependent variables, including drinking frequency and intensity, as measured by Form-90. Additionally, in terms of theoretically-derived interactions (e.g., responsiveness to CBT would be predicted by degree of cognitive problems; TSF would be more effective among clients with social networks supportive of drinking; clients with low levels of readiness to change and/or high in anger would show better outcomes in MET due to its focus on increasing motivation to change whilst being deliberately non-confrontational), the only significant result that was detected was that outpatient clients whose psychological distress was relatively low had more abstinent days in TSF than in CBT, thereby not supporting the argument that contrasting psychotherapies work via different mechanisms or specific ingredients of change. Overall, although Project MATCH has been criticised for not including a control condition, excluding people who misused

illicit drugs, and recruiting primarily male clients, given the size of the trial, along with a range of reliable and valid measures employed to test the efficacy of the three psychotherapies, and thereby adequate statistical power to detect differential effects, such results are unlikely to have been due to a Type II error (Mee-Lee et al., 2010). In the UK, Project MATCH was followed up by the UK Alcohol Treatment Trial (UKATT; UKATT Research Team, 2005), a rigorous, pragmatic, multicentre RCT with 742 clients (74% male, 96% Caucasian, mean age = 42 years), whose primary purpose was to compare the clinical effectiveness and cost-effectiveness of three sessions of MET and eight sessions of SBNT, both delivered over 12 weeks, for the treatment of alcohol use problems. Consistent with Project MATCH, no differences between the two psychotherapies were found at three- and 12-month follow-up, either on primary outcome measures related to alcohol consumption, or on secondary measures associated with health-related quality of life and general psychological distress. Additionally, no hypothesised client-treatment matching effects were observed, supporting Project MATCH's conclusions (UKATT, 2007). Moreover, Imel and colleagues' (2008) state-of-the-art meta-analysis, which included all published RCTs to date (k = 30, N = 3,503 clients) that directly compared at least two different bona fide psychotherapies for alcohol use problems, concluded that competing and theoretically distinct bona fide therapies were equally effective. Finally, robust meta-analyses of comparative RCTs have also been conducted to test whether differences in efficacy and effectiveness exist among psychosocial therapies for illicit drug misuse (e.g., cannabis, cocaine, heroin, polysubstance use), with results confirming equivalent, positive effects on both primary (i.e., frequency and severity of use) and secondary (i.e., psychosocial functioning) outcomes (e.g., Davis et al., 2015; De Crescenzo et al., 2018; Dutra et al., 2008).

In the wider psychotherapy literature, this general finding of uniform efficacy of conceptually different evidence-based psychotherapies has been termed as the 'outcome equivalence paradox' or the 'Dodo Bird Verdict'[7], in an attempt to acknowledge the equivalent contribution of different theoretical traditions and, more importantly, the significance of 'common factors' across different models of

[7] The 'Dodo Bird' metaphor (Rosenzweig, 1936) is taken from Lewis Carroll's (1865/2010) novel "Alice's Adventures in Wonderland", wherein at the end of a race intended to dry the animals that had been soaked by Alice's tears, the Dodo announced "*Everybody* has won, and *all* must have prizes." (p.27, italics in original).

therapeutic practice in the process of facilitating positive change outcomes (see Wampold & Imel, 2015, for an extensive review). In this manner, the RCT results from the substance misuse psychotherapy literature are consistent with the preponderance of general psychotherapy research, where robust meta-analytic investigations of over 500 RCTs for all major DSM diagnoses have consistently demonstrated that whilst psychotherapy is an exceptionally effective healing practice that produces a large effect size of 0.80[8] in comparison to no treatment (e.g., waitlist control), head-to-head comparisons of competing bona fide psychotherapies fail to indicate that any one type of therapy is superior or inferior to any other (Wampold & Imel, 2015).

As a result, it has been concluded that the prevailing medical and 'technological' model of psychotherapy for substance misuse, whereby specific theory-based techniques or active ingredients are held responsible for the benefits of a particular therapeutic approach, contributes to an oversimplification of psychotherapy effects by ignoring and devaluing a wealth of variables and factors (both intra- and extratherapeutic), which are non-randomly distributed and cut across empirically supported therapies associated with positive change outcomes (Black & Chung, 2014; Gaume, Heather, Tober & McCambridge, 2018; Miller & Moyers, 2015). Consequently, it has been argued that continued overreliance on the deeply positivist and modernist epistemological and methodological grounds on which traditional research on the evaluation of substance misuse psychosocial therapy is based, is unlikely to provide us with findings useful to clinical practice, other than decontextualized, statistical confidence in the efficacy and effectiveness of bona fide psychotherapies (Miller, 2016).

Thus, in recent years, it has been suggested that a paradigm shift is needed in the way substance misuse psychotherapy research is carried out, by looking beyond the therapeutic rationale of particular orientations, as a guide to mechanisms responsible for positive client change, and toward non-randomly assigned, cross-cutting, or 'common', therapeutic factors. Although these factors have been shown in meta-analyses of RCT studies to account for substantially larger variability in outcomes than

[8] This means that the average person who completes a course of psychotherapy is better off than approximately 80% of people who want, or need to, but do not currently engage in psychotherapy. In short, even though not everyone benefits and dropouts have been recognised as a significant problem in the delivery of mental health services, and especially when substance misuse issues are involved (Brorson, Arnevik, Rand-Hendriksen & Duckert, 2013; Swift & Greenberg, 2012), we can have confidence that psychotherapy works. The question is how.

that associated with specific intervention models, they have received scant attention in the substance misuse treatment literature (Miller & Moyers, 2015). To date, the common factors that have been shown in quantitative studies to be associated with better substance use outcomes across different therapeutic models are those related to: (a) the therapist (e.g., allegiance to or heightened belief in particular therapeutic models or techniques, personal dispositions and facilitative interpersonal, relational skills of genuine expressiveness, empathy, warmth, affect modulation; Barkham, Lutz, Lambert & Saxon, 2017; Gaume et al., 2018; Moyers & Miller, 2013; Saarnio, 2011; Wolff & Hayes, 2009); (b) the client (i.e., both internal and external resources clients bring to the therapeutic encounter, such as readiness for change, hope, self-efficacy, therapy-related expectancies, experience of and contribution to the therapeutic bond, quality of participation in the therapeutic process, as well as extratherapeutic factors related to social support networks, socioeconomic status and life events; Buckingham, Frings & Albery, 2013; Frankl, Philips & Wennberg, 2014; Kelly & Greene, 2014); and (c) the therapeutic alliance, which although transactional in nature and better predicted by clients', rather than therapists', evaluations (Kan, Henderson, von Sternberg &Wang, 2014; Marcus, Kashy, Wintersteen & Diamond, 2011), its relationship to beneficial outcomes has been found to be statistically moderated more by the therapist's, rather than client's, variability in capacity (i.e., therapist's actions or characteristics) to forge a collaborative bond with the client (Artoski & Saarnio, 2012; Baldwin, Wampold & Imel, 2007; Davis, Ancris & Ashby, 2015; Del Re, Fluckiger, Hovarth, Symonds & Wampold, 2012).

Overall, the field has explicitly acknowledged that such common factors are inherently "interdependent, fluid and dynamic" (Duncan, Miller, Wampold & Hubble, 2010, p. 34), meaning that psychotherapy is a reciprocal process, continuously influenced and changed by the ongoing interactions between therapist, client, relational and contextual factors. At the same time, it has also been noted that client factors (i.e., both internal and external resources) contribute much more to outcome variance than those associated with psychotherapy itself (e.g., therapist and alliance factors). Thus, according to Wampold & Imel (2015) the large effect size of 0.80 that is generally attributed to the effects of psychotherapy versus no treatment, accounts for around 14 percent of the variability in client change outcomes relative to not receiving therapy (which is much higher compared to pharmacological interventions versus placebos).

This, in turn, means that around 86 percent of the variance in therapeutic change, although inclusive of unexplained and error variance, can be attributed to client and extra-therapeutic factors that occur beyond therapy but still influence its effects and outcomes, implying that the client factor might offer the best explanation for the Dodo Bird Verdict (Bohart & Wade, 2013). The overarching conclusion that can, therefore, be drawn by pondering the meaning of these figures is that psychotherapy is not a treatment administered to a client, but a process in which the client is actively engaged, and which cannot be understood without standing back from our own beliefs and assumptions about what happens both inside and outside therapy that contributes to meaningful change and relief from distress, as experienced from the client's own perspective. This, in turn, means that one way in which the dominant substance misuse psychotherapy research paradigm could be shifted, in an attempt to better understand how psychosocial therapies work and thereby generate findings useful to clinical practice, might be via exploring the qualitative ground on which measurable outcomes are produced from the point of view of clients who have found psychotherapy helpful in assisting their recovery from substance misuse. Unfortunately, as argued below, it is in this respect that the substance misuse field seems to have neglected to adequately explore the client factor in relation to therapeutic process and outcome, especially in light of recent quantitative research, in the broader field of psychotherapy, showing that integrating client feedback systems to track progress and tailor services to clients' needs enhances improvement outcomes (e.g., Lambert, 2015; Mikeal, Gillapsy, Scoles & Murphy, 2016).

The failure (or resistance) of the substance misuse field to move away from its traditional 'natural science' model of inquiry – with study designs that rely on pre-posttreatment standardised assessment tools as the predominant way for investigating 'how' therapy works – and adopt a more postmodern, idiographic, 'human science' framework (Strawbridge, 2016) of inquiring about and understanding the subjective views of clients on therapeutic factors involved in overcoming problematic substance use, can be seen in qualitative meta-analyses that have synthesised the findings of research on clients' varying experiences in psychotherapy in order to identify common factors clients experience at the heart of the therapeutic endeavour.

Levitt, Poerville and Surance (2016) have conducted the largest and most comprehensive qualitative meta-analysis to date, which used grounded theory methods

to review 109 studies (published in English-language, peer-reviewed journals between 1988 and 2013) on adult client experiences in individual psychotherapy and generate process-relevant principles for practice. The central theme that emerged from the analysis was the phenomenon of "being known and cared for" (p. 821) by the therapist, as this led to clients becoming curious about their own experiences, and thereby committed to engage in identifying and altering patterns of thinking, feeling, behaving and relating that were tied to previously unrecognised needs. Besides the significance of these findings in enriching our knowledge of the clients' perspective on the process of therapy, what is perhaps even more striking and relevant to this thesis, is sobering observation that, out of the 109 studies reviewed, only one explored the perspective of clients who had found psychotherapy helpful in their recovery from substance misuse. This study was conducted by Edwards and Loeb (2011) and will be reviewed in the following section. Such gross underrepresentation of substance misusers' therapeutic experiences reflects a noticeable dearth of qualitative research into therapeutic experiences of change from the point of view of clients affected by substance use problems.

1.5 Client Perspectives on Therapeutic Changes in Relation to Psychosocial Therapies for Substance Misuse

We now turn our attention to the limited literature that exists on clients' individualised perspectives on the value of psychotherapy and factors involved in assisting their recovery from substance misuse.

My own review of the literature[9] identified the following two qualitative studies which sought to investigate clients' subjective experience of therapeutic change during and following psychotherapy for substance misuse, and thereby stood out as notable exceptions to the general trend of using quantitative, standardised, 'objective' and

[9] The literature reviewed was obtained from searches on online databases of PsycINFO and PsycARTICLES as well as ResearchGate.net. Search terms used included combinations of 'substance misuse', 'substance abuse', substance use disorders', 'alcohol', 'drug use', 'illicit drugs', 'addiction', 'psychotherapy', 'counselling', 'client/patient change experiences/perspectives', 'qualitative research', 'phenomenological', 'grounded theory', 'narrative', 'discourse analysis'. My aim was to identify qualitative research specifically on psychotherapy (not exclusively focusing on other forms of treatment, such as detoxification, rehabilitation, occupational therapy, 12-step fellowships, acupuncture, physical exercise), in which the findings were derived from clients' own reports, rather than from researchers creating a set of predetermined codes on which to map client experiences.

decontextualized approaches to inquiry in this area. Moreover, the rationale for focusing on the following two studies was further guided by my decision to exclude qualitative studies on client recovery narratives which lacked information in relation to psychological therapies received and how these were helpful (e.g., Christensen & Elmeland, 2015; Hansen, Ganley & Carlucci, 2008; Rodriguez & Smith, 2014), as well as qualitative research on substance-using client experiences within particular therapeutic modalities (e.g., Moerman & McLeod, 2006), which tended to conceptualise change as synonymous with distinct orientations, and thereby ignored the influence of common, cross-cutting psychosocial factors operating both inside and outside the therapeutic context.

As part of the three- and 12-month follow-up points of the UKATT, discussed in the previous section, Orford and colleagues conducted brief (i.e., approximately 20-minute-long), semi-structured interviews with a subsample of clients (n = 397) in order to explore the factors to which they attributed positive changes to their drinking (Orford et al., 2006a). The authors were interested in client explanations that attributed change to both intra- and extratherapeutic factors. Data was analysed according to grounded theory principles (Glaser & Strauss, 1967), leading to the development of a client-informed model of change that was composed of eight main categories and their interrelationships. At the core of the model lay a triad of interrelated therapeutic processes, labelled as 'thinking differently', 'acting differently' and 'support from family and friends', to which clients attributed psychotherapy-facilitated changes. 'Thinking differently' was facilitated by client perceptions of therapists as empathic, understanding and supportive, and entailed focusing on the downside and future consequences of alcohol misuse in an honest manner, developing self-efficacy in caring about oneself, and adopting a more positive outlook on life. 'Acting differently' was focused on positive changes in drinking behaviour through the development of self-control strategies, such as deliberate scheduling of non-alcohol-related activities and moving away from stressful environments. 'Family and friend support' in the service of effecting positive changes in one's drinking was enabled through the role of therapy in facilitating improved communication patterns between clients and their support networks. All of the above changes were perceived by clients as being embedded within a broader extra-therapeutic, change-promoting system, which included support from general medical practitioners in helping clients realise the nature of their problems and

making appropriate referrals, the take-up of additional help in the form of detoxification, prescribed medication, employment, education and family support, as well as involvement in mutual-aid groups. Finally, meaningful change was attributed to clients' own efforts in seeking and accepting professional help. According to clients, the process of help-seeking was propelled by what the researchers termed as a 'catalyst system' that involved a set of processes deemed responsible for change. An invariant element contained in this catalyst system, which prompted clients to seek and accept professional-assisted help, instead of engaging in unaided self-change or mutual-help organisations (e.g., Alcoholics Anonymous), was deemed to be their own realisation that problems pertaining to health and family issues were deeply connected to excessive alcohol use and worsening, or accumulating, to the point at which their significance could no longer be denied and pro-active action was inevitable (see also, Orford et al., 2006b). Orford et al. (2006a) concluded that the change-promoting value of the psychotherapies on which the UKATT focused (i.e., MET and SBNT) was qualitatively equivalent and embedded within a broader, multifarious system of change-enhancing factors. Consequently, it was suggested that psychosocial therapy providers expand their theories of how meaningful change happens in the real world of clients who seek their services, by transcending the dodo bird/differential effectiveness dichotomy that is narrowly focused on the psychotherapy system itself, and examining, instead, cross-cutting intra- and extra-therapeutic change-promoting factors, as experienced by clients themselves.

Orford et al. (2006a) should be commended for complementing the quantitative findings of the UKATT with the inclusion of clients' perspectives on their own change processes, both inside and outside the therapy room. On the other hand, the role of this qualitative component has been explicitly acknowledged as being secondary to the trial's primary focus on comparative psychotherapy outcome research, and thereby its emphasis on the 'medical' and 'technological' model of psychotherapy, which tends to view this process as a 'drug' (Stiles & Shapiro, 1994) supplied via the particular techniques of an active, all-knowing professional to a passive recipient (Orford, 2008). It is likely that, for this reason, this study may have not received the attention it deserves in the wider qualitative field of research on clients' experiences of psychotherapy as, for example, it was not detected by Levitt et al. (2016) in their review (see previous section). Furthermore, although the sample size (N = 397) of the study seems quite

impressive by qualitative research standards, at the same time it might have been too large to allow the researchers to explore in more depth the whys and hows of clients' subjective processes and experiences of change. Finally, although the authors did not provide specific information on the number of men and women that comprised the qualitative sample, the fact that males made up 74% of the total UKATT sample, might mean that women's voices and experiences of therapeutic change may not be well represented by the qualitative component of the study. Additionally, we know nothing about the subjective experiences of change for individuals who face problems related primarily to illicit drug misuse and find psychotherapy helpful in their process of recovery, as the focus of the UKATT was solely on alcohol misuse.

Edwards and Loeb (2011) focused on the subjective experiences of therapeutic change from the point of view of six (four males, two females; age range: 36 to 49 years) illicit drug misusers (substances were not specified) who had been engaged in individual counselling[10] sessions, for a minimum of six months, at a specialist agency in Scotland. The researchers were interested in finding out the difference counselling had made to the lives of these participants, and, in line with Orford et al. (2006a), it was explicitly acknowledged that counselling existed within a broader substance misuse treatment system which also included access to other services, such as housing and/or employment support, as well as substitute prescriptions (e.g., methadone). In this manner, Edwards and Loeb (2011) used a qualitative methodology, which involved conducting 60 to 90-minute-long individual, semi-structured interviews with participants recruited from the counselling service of the agency the researchers were themselves working in, with other clients. Qualitative data from the interviews were subjected to grounded theory analysis in order to examine their multiple meanings and develop codes that were ultimately brought together into four discrete, but interlinked, categories, based on the underlying patterns identified by researchers as relevant to describing the process under consideration (i.e., participants' experience of change through counselling). The researchers stated that all participants reported 'experiencing

[10] Although Edwards & Loeb (2011) do not specify particular counselling approaches that were used, within the broader therapeutic field it has been acknowledged that the differences or boundaries, if any, between the activities of what is known as 'counselling' and 'psychotherapy' are rather unclear and opaque (e.g., see Woolfe 2011, 2016). Even Carl Rogers (1942) himself, who has been credited with coining the word 'counselling', noted that "[…] the most intensive and successful counseling is indistinguishable from intensive and successful psychotherapy" (p. 4). Consequently, the terms 'counselling' and 'psychotherapy' may be used interchangeably.

considerable change through counselling' (p. 107). The four main categories that were developed to account for participants' subjective processes of change were termed as: (a) 'Change from self-destruction to intrapersonal gains and caring for oneself'; (b) 'Change from isolation to interpersonal gains'; (c) 'Change from 'losing it' to an improved quality of life'; and (d) 'Change from having low expectations of counselling to perceiving the relationship with the counsellor positively'. Particular change-promoting factors that were embedded within these categories, and highlighted by participants as especially important in facilitating positive outcomes, were the therapeutic relationship, whose impact was influenced by clients' positive perceptions of counsellors' personalities (e.g., being sincere, caring and 'cheery') and professional skills (e.g., attentive listening, honest feedback and commitment to help), as well as clients' own engagement in the therapeutic processes of setting their own agenda inside the sessions and working toward goals supportive of recovery (e.g., becoming less violent toward others, more able to relate in a respectful and assertive manner, asking for help instead of isolating, attempting return to work, exercising, caring about one's needs and the direction of one's life). Edwards and Loeb (2011) concluded that findings were in line with a 'common factors' approach to therapeutic change, and highlighted the importance of 'client factors' in facilitating positive change outcomes.

A particular strength of the above study is the opportunity it gave to the voices of a typically stigmatised and marginalised group of individuals (e.g., see Lang & Rosenberg, 2017) to be heard, and their insights into their own processes of therapeutic change to be privileged over and above those of professionals working in this field. On the other hand, potential shortcomings of this research included a relatively small sample size for grounded theory purposes (McLeod, 2011), as well as recruitment of participants who were still attending counselling on the premises of the research site and informed about the study through their own counsellors. Although participation was voluntary and kept confidential from participants' therapists, such methodological arrangements are likely to have introduced demand characteristics, with participants being inclined to focus more on what they perceived as positive aspects of therapy-facilitated change processes, and refrain from providing more critical reflections on potential limitations of therapy-assisted pathways of recovery. Finally, the researchers' grounded theory analysis appeared to have remained at a more descriptive, rather than interpretative and explanatory level (Charmaz, 2014), resulting in a presentation and

discussion of findings that were not based on or concerned with making explicit links to existing theoretical perspectives in the field, and thereby failing to suggest possibilities in which our current ways of understanding and responding to clients with substance use problems may be improved or expanded.

1.6 Substance Misuse Psychotherapy Research and Counselling Psychology: Bridging the Gap

As an academic and professional field of activity, counselling psychology in the UK emerged post-1980 to represent the union between the science of psychology and the therapeutic practices of counselling and psychotherapy, as these activities had originally developed outside the psychology profession (Strawbridge & Woolfe, 2010). In this way, the discipline of counselling psychology, as a growing body of knowledge and form of practice, is firmly rooted within the broad arena of therapeutic helping that is concerned with understanding and alleviating various forms of human distress and mental health suffering (Woolfe, 2016). One of the things, however, that differentiates counselling psychology from its proximity to other therapeutic approaches (e.g., mainstream clinical psychology and psychiatry) is its commitment to actualise the underlying ethos and philosophy of humanistic values, which turn the spotlight on the understanding of human beings' subjective and intersubjective experiencing, and thereby question and challenge traditional emphases on medicalization, nomothetic classification and normative constructed discourses with reference to the conception, treatment and measurement of mental distress (Cooper, 2009; Douglas, 2010; Hemsley, 2013; James, 2013; Strawbridge, 2016; Woolfe, 2012, 2016). In this manner, counselling psychology espouses a paradigmatic shift away from the prevailing natural science model of psychology, and situates itself within the postmodern, social justice and human science tradition, as a framework for understanding and inquiring about the complex and multifaceted realms of human consciousness, subjective experience, meaning and agency, whilst at the same time acknowledging that the production of such knowledge is inevitably value-laden and embedded within particular perspectives. Consequently, counselling psychology's research foci are epistemologically compatible with qualitative research methods that have the potential to privilege the everyday language of psychotherapy clients and their subjective experiences of change,

over and above dominant professional discourses and notions of specific diagnostic and treatment protocols, currently favoured by NICE guidelines and based upon RCT outcomes that do not consider the clinical realities captured by practice-based evidence, and thereby reduce people down to general and abstract numbers which equate therapeutic change with symptom reduction (Cooper, 2010; Fairfax, 2013).

That being said, in recent years there have been concerns among counselling psychologists nationally and internationally, with regard to the focus and direction of the discipline's research. For instance, following a critical narrative review of the literature on the relationship between psychotherapy research and practice (as reflected in *The Counseling Psychologist* and *Counselling Psychology Review*), Henton (2012) identified major gaps between counselling psychology's rhetoric of mutuality in the interrelated activities of therapy research and practice, and counselling psychologists' focus on explorations of trainee and therapist experiences, or discussions of professional and theoretical topics, at the expense of producing more bottom-up, client-focused and clinically-relevant research that explores the complexity of therapeutic process-outcome factors. Given that provision of psychotherapy is one of the main activities that characterise the applied profession of counselling psychology, Henton, along with other colleagues, has been concerned that the scarcity of counselling-related and practice-based research in the discipline's flagship journals 'cannot be good news for our identity' (Litchtenberg, 2011; Murdock, 2011; Scheel, Berman, Friedlander, Conoley, Duan & Whiston, 2011, p. 687).

Moreover, counselling psychology's scarcity of research on client-focused therapeutic processes and outcomes has nowhere been more noticeable than in the area of substance misuse, where the discipline has recently been accused of lacking presence and overlooking the opportunity to make important contributions (Martin et al., 2016). For instance, Martin et al. (2016), in reviewing counselling psychology research in relation to substance misuse over the past 20 years, found less than 15 articles published in *The Counseling Psychologist* and the *Journal of Counseling Psychology* together. The authors argued that because substance misuse has not traditionally been a focus for counselling psychologists' training and practical experience – despite high rates of co-occurrence with other mental health concerns practitioners frequently work with – these limitations extend to research as well, and altogether risk placing the discipline at a disadvantage to meet the needs of the current healthcare marketplace which calls for

increased integration between mental health and substance misuse services. Moreover, given counselling psychology's commitment to a social justice framework for both research and practice, where great emphasis is placed upon seeking to elicit and empower the voices, needs and experiences of typically marginalised and stigmatised populations, minimal training in and research on the pathways of substance misuse development and recovery are significant missteps that have the unfortunate potential of taking on the same attitudinal stigma and discriminatory practices of the larger societal culture toward people with substance use problems (Martin et al., 2016). In this respect, carrying out qualitative research on client factors and therapeutic processes involved in creating positive outcomes, is in line with the humanistic philosophy of counselling psychology, and a promising strategy for improving public perceptions of both the resilience of individuals with substance use problems and the benefits of psychotherapeutic practices in aiding their recovery potential. For these reasons, Martin et al. (2016) have recently urged counselling psychologists to increase their presence in the field of substance misuse recovery through relevant training and research-informed practice. The current research aims to be a step in the right direction.

1.7 Rationale for Current Research

It seems that, from a research perspective, the time has come for a new agenda and paradigmatic shift in how we study the processes and outcomes of psychotherapies for substance misuse. In particular, a welcome trend in this field is the growing appreciation for clients' individualised perspective on therapeutic process and outcome of change, as this is frequently secondary, with greater emphasis and reliance on objective measures and quantitative outcome studies as principal ways of investigating therapeutic change and guiding treatment planning. In this manner, the value of research with a qualitative focus has been recognised as a much-needed complement to conventional hypothetico-deductive, measurement-oriented and expert-led ways of scientific knowledge production in this area of inquiry. To this end, the current research aims to contribute to the existing qualitative literature in this field, by extending the understanding of change-promoting factors and processes, as experienced by clients who have found psychotherapy helpful in their recovery from substance misuse. The way the current study aims to meet this objective is by conducting in-depth, individual

interviews with adult clients who have recently completed a course of individual psychotherapy at a London-based drug and alcohol service, and inquiring about their subjective experiences of change across empirically-supported therapeutic modalities. The ultimate aim is to identify common factors and processes of therapeutic change from the client's side of the interaction, so as to generate a theoretical explanation in relation to the investigated phenomenon.

It is anticipated that qualitative exploration of how clients view the therapeutic change process may sensitise, reframe and inform the clinical work of counselling psychologists and allied professionals in the field of substance misuse, by bringing to light both intra- and extratherapeutic change-promoting factors, involved in clients' experience and conceptualisation of meaningful change. In this respect, the aim of this research is not to provide unequivocal answers or determine 'the truth' of clients' experiences, but rather to collect a range of rich, experiential accounts which describe and interpret the nature and process of change from the client's perspective and in a clinically useful manner. Findings of this study may also hold the potential to meaningfully contribute to current notions and client-informed understandings of recovery in the field of substance misuse, which may prove useful to future research, policy and service delivery efforts.

The following chapter turns its attention to the methodological considerations and epistemological rationale for the chosen method of inquiry.

CHAPTER 2: METHODOLOGY

2.1 Chapter Overview[11]

The right choice of methodology enables a researcher to answer their research question in a way that is rigorous and compatible with the ontological and epistemological assumptions of the study (Willig, 2013). This chapter outlines the rationale for choosing an appropriate methodological approach to my research inquiry and the research paradigm within which this study is situated. In this manner, consideration is given to associated philosophical assumptions which clarify my ontological and epistemological positioning within the study, as well as my underlying values, beliefs and motivations as a trainee counselling psychologist and researcher. Additionally, the chapter describes the research design of the study in terms of my chosen method for data collection and analysis. The research design also includes a thorough description of the procedural steps of the study, which range from sampling considerations and methods of participant recruitment to issues of quality assurance and criteria for evaluating the rigour of my study and its findings. Last but not least, the chapter covers careful consideration of ethical issues pertaining to my study, whilst the importance of reflexivity is highlighted throughout with the inclusion of relevant annotated sections.

2.2 Research Design

The present study utilised an exploratory qualitative research design in which data were collected from individual, semi-structured interviews carried out with 12 participants[12] recruited from a drug and alcohol service in London. The data were collected and analysed using the guiding principles and practices of Constructivist Grounded Theory (Charmaz, 2014).

2.3 Research Question

As advocated by grounded theory scholars (e.g., Nolas, 2011), the question addressed in the current research was developed and clarified over time alongside the collection

[11] In keeping with the principles of my chosen methodology, this chapter is written mostly in the first person in order to address the reader directly, as well as illustrate the unfolding nature of the research process in a reflexive manner (Josselson, 2017).

[12] Published guidelines for recommended sample size in grounded theory research tend to vary from 8 to 20 informants (McLeod, 2011).

and analysis of participant data (see Box 1, below). In this manner, the proposed research question is:

'How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?'

The central aim of this study was to capture the process of therapeutic change as grounded in the lived realities of the people concerned, so as to arrive at a theoretical account that could be used to inform policy and practice in relation to client perceptions about the place and value of psychotherapy in the field of substance misuse. Consequently, the choice of my methodologies was based on the above research question as well as the context in which it was asked and conceptualised.

Box 1: Reflections on the Context and Development of the Research Question

As it was mentioned in the previous chapter, my research aimed to meet the call of deepening our understanding of therapeutic change in the context of substance misuse, by privileging and bringing to the forefront client perspectives on the experience of this phenomenon. In order to do this, I was influenced by my review of previous literature and studies conducted in the area of therapeutic client change, as well as my own experiences of engaging in psychological therapy with individuals affected by substance misuse. These influences resulted in developing my own assumptions about the investigated phenomenon, which, in turn, coloured the way I initially phrased my research question and defined the limits of what could be 'found' (Willig, 2013, p.10). In this manner, my original research question was posed as '*How do people affected by drug and alcohol use experience the process of therapeutic psychological change?'* and made the following assumptions.

First, based upon a humanistic lens of understanding human nature, which focuses on self-awareness and agency (Strawbridge, 2016), my research question was interested in capturing the lived experience of therapeutic change by eliciting a first-person, 'subjective' perspective of that 'experience'. In this sense, a characterising property of experiential states is that they have intentionality, meaning that experiences are subjective judgements about something, or contain reference to something (beim Graben, 2014; Frie, 2003). In this case, the something of 'experience' my research

question focused on was 'therapeutic change' in the context of substance misuse, which was further conceptualised as something more than merely abstinence or reduction in substance use. In this way, I inserted the word 'psychological' which primed me to consider therapeutic change as a complex interaction of behavioural, cognitive and affective transformations, which together could point toward the development of inner capacities and resources that allow people to live their lives with a greater sense of satisfaction, freedom and possibility (Shedler, 2010; Sperry & Carlson, 2014). In this manner, the word 'process' was also added in order to consider from participants' points of view the 'how' of their experiencing of change over time, and with reference to factors or activities that occurred in therapy and facilitated subjectively significant, memorable or curative outcomes (Cooper & McLeod, 2015). At this point, it should also be noted that my research was interested in obtaining retrospective accounts of change, elicited after completion of individual psychotherapy sessions that were conducted as part of a holistic treatment programme for substance misuse (see 'Research Procedures' below). Being aware that retrospective interviews can raise concerns about recall and interpretation of past events (Knight, Richert & Brownfield, 2012), another assumption that was implicitly embedded in my research question – and thereby influenced my selection of research paradigm (see below) – was that subjective meanings and interpretations held by individuals who had experience of the investigated phenomenon were given priority over the uncovering of objective knowledge and impartial truths about the understanding of therapeutic change.

Thus, whilst my previous knowledge and experiences influenced the identification of the original research inquiry, through the process of undertaking the current research I was led to reconsider the phrasing of the proposed research question, in a way that seemed to resonate better with my intersubjective understanding of participants' meanings in relation to the studied topic. For instance, through comparative analysis of participants' accounts, I noticed that interviewees tended to perceive their experiences of therapeutic change as psychosocial, rather than purely psychological, phenomena, which were marked by both intra- and interpersonal transformations, occurring within as well as outside the therapeutic context (see 'Findings' and 'Discussion' chapters). This observation led me to remove the word 'psychological' from the research question, concluding that it was already subsumed under the phrase 'therapeutic change'. Additionally, further exploration of research interviews, repeatedly brought to my

attention that interviewees who had sought psychotherapy as a method of addressing and resolving substance use problems, tended to use the words 'change' and 'recovery' interchangeably. This indicated to me they likely needed to highlight that experiences of therapeutic change in this context were closely associated with perceptions of recovery from a lifestyle and 'way of being' that was dominated by the effects of harmful substance use.

Originally, I had hesitated to use the word 'recovery' in my research question due to widespread concerns within the substance misuse field that there is yet no consensus on the meaning of the term (Scott, Pope, Quick, Aitken & Parkinson, 2018), as well as observations that 'recovery' references can unwittingly narrow the focus to substance use abstinence and thereby result in perceptions of stigma and discrimination in terms of who is and who is not in recovery (Kaskutas, Witbrodt & Grella, 2015). However, as my research did not intend to develop objective definitions of constructs, such as 'recovery', but rather to privilege individualised experiences of meaningful change, I decided to honour the terms and language used by participants to refer to those experiences and thereby included the word 'recovery' in the final wording of my research inquiry.

In this way, my final research question was put forth as: *'How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?'*

2.4 Research Paradigm – Constructivist-Interpretivist

The researcher's choice of paradigm of inquiry influences their work by guiding how they think and act during the research process (Lincoln, Lynham & Guba, 2018). As my study sought to explore, describe and interpret, rather than quantify, measure and control, participants' experiences of therapeutic change in a context-specific setting, my research question was open-ended and informed by a qualitative approach to scientific inquiry, which was anchored within a constructivist-interpretivist research paradigm (Ponterotto, 2005), and influenced by symbolic interactionist (Blumer, 1969) and pragmatist principles (James, 1907; Mead, 1934) in order to arrive at a theoretical account that would be of practical use and relevance to its audience. Charmaz (2014) describes constructionism as the study of what people at a particular point of time

believe to be real, which can then be used to inform how they construct their views and actions. In this manner, interpretivism is seen as the understanding of the world through the eyes of other people (e.g., research participants), whilst at the same time acknowledging that the person(s) who is doing the interpretation (e.g., researcher) also brings the influence of their own beliefs, assumptions and experiences in the process of reflecting and making sense of how others construct their world.

In choosing the constructivist-interpretivist research paradigm, or philosophical worldview, to situate my study within, I was further guided by consideration of the following parameters incorporated within philosophy of science, which help to elucidate researchers' assumptions about the nature of their research for the purpose of systematic quest for knowledge (Howard & Myers, 1991).

- The researcher's beliefs or assumptions about the nature of reality (i.e., **ontology**);
- The researcher's stance towards the acquisition of knowledge, and thereby the relationship between the 'knower', or research participant, and the 'would-be knower', or researcher (i.e., **epistemology**);
- The researcher's beliefs about the role and place of their values in the scientific research process (i.e., **axiology**);
- The language employed to present the research procedures and results (i.e., **rhetorical structure**); and
- The methodological processes and procedures (i.e., the **research method**(s) or guiding principles employed in the process of finding out whatever a researcher thinks can be known), emanating from researcher's ontological, epistemological and axiological position.

In this manner, my decision to anchor my qualitative inquiry within the constructivist-interpretivist paradigm was informed by the following philosophical assumptions, which set the context for my research design and guided the selection of appropriate research tools, participants and methods used in the study.

2.4.1 Ontological Perspective of Constructivism-Interpretivism

Being concerned with the researcher's beliefs and assumptions about the form and nature of reality, ontology is the study of being, asking "What is the form and nature of reality, and what can be known about that reality?" (Ponterorro, 2005, p. 130).

The constructivist-interpretivist paradigm acknowledges the existence of multiple, apprehendable and equally valid constructed realities, mediated by available historical, cultural and linguistic structures individuals interact with in the process of creating knowledge of themselves, the world and others (Burr, 2015; Schwandt, 1994; Sexton & Griffin, 1997). In this way, a relativist ontological position is assumed, indicating that the nature of reality is subjectively constructed in the mind of the individual, rather than being an external entity, and depends upon the context of the situation in which it is created.

Thus, by posing the question *'How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?'* I acknowledge that I started from the premise that reality is subjective, contextual and transactional, arising out of research participants' own experiences and perceptions, the social environment, and the dynamic interaction between participant and researcher which also includes the latter's pre-existing ideas. The result of this complexity is that multiple meanings and interpretations may interact to give rise to multiple realities.

2.4.2 Epistemological Perspective of Constructivism-Interpretivism

The researcher's epistemology is defined by their ontology, as ontological assumptions and beliefs about the nature and form of reality influence epistemological claims as to how knowledge of this reality may be gained (Willig, 2012). In this manner, epistemology is concerned with "what and how can we know?" reflecting thereby the relationship between the 'knower' (i.e., research participant) and the 'would-be knower' (i.e., researcher).

By drawing upon the aforementioned ontological assumptions, the constructivist-interpretivist paradigm advocates the adoption of a transactional and subjectivist epistemological stance to knowledge generation, according to which reality is socially constructed, with meaning captured and brought to the surface by deep reflection and interactive researcher-participant dialogue (Charon, 2010; Schwandt, 2000). This

hermeneutical approach to knowledge generation aims, in turn, to focus scientific inquiry upon 'idiographic' and 'emic' goals, leading to the study of human experience that is subjective and unique to an individual and their sociocultural context, rather than universal and generalizable (Denzin & Lincoln, 2018).

Moreover, this epistemological position assumes not only that through intense interaction and dialogue between research participant and researcher deeper insights into the former's 'lived experience' are facilitated and constructed, but also that because of this dynamic dialogic interaction both the researcher and research participant will be changed in some way (Bott, 2010). In this manner, I entered this research study anticipating that participants' sharing of personal experiences of therapeutic change and recovery from harmful substance use would have a cognitive and emotional impact upon me, by offering insights that could enhance my therapeutic ability to work with and relate to the needs of people affected by substance misuse. In return, I hoped that as a result of our interaction, participants would experience the interviews as rewarding opportunities to reflect on and make deeper sense of their therapeutic gains.

2.4.3 Axiological Perspective of Constructivism-Interpretivism

In line with the aforementioned ontological and epistemological perspectives, the researcher who anchors their study and research question within this paradigm cannot ignore or eliminate the way their own value biases can influence and shape the research process and its outcomes (Ponterotto, 2005). For this reason, researchers should strive to acknowledge, describe, monitor and 'bracket' their values, whilst recognizing the impossibility of eliminating them. This is because, based upon the underlying epistemological assumptions, for the dynamic and close interpersonal contact required between researcher and research participants for facilitation and construction of meanings of the studied phenomenon, the researcher's own value biases are seen as 'sensitizing concepts' (Charmaz, 2014), or means of enhancing rapport and dialogue with participants. It is because of this particular axiological perspective that constructivist-interpretivist researchers are expected to keep a reflexive journal (see Appendix 1), in which they can note and ponder the emotional and cognitive impact the research process (e.g., interviews with participants, analysis of transcripts, etc.) has on them and the generation of outcomes.

2.4.4 Rhetorical Structure within the Constructivist-Interpretivist Research Paradigm

Based on the ontological, epistemological and axiological underpinnings of the constructivist-interpretivist paradigm, the rhetoric or language employed to report and present the procedures and results of such research, tends to be in the first person and communicated in an open and personalised manner, comprehensively noting the researcher's own experience, expectations, values and biases, as well as the impact the research process has had on their emotional and intellectual life (Josselson, 2017). Additionally, the rhetoric of research situated within this paradigm, privileges the voice and experience of participants through the selection and presentation of detailed representative quotations (Fassinger, 2005), which also aim to provide the reader with evidence to inspect whether the researcher's interpretations are grounded in participants' narratives (Morrow, 2005).

2.5 Personal and Epistemological Reflexivity (*see also Box 1, above*)

Having outlined the basic philosophical assumptions embedded within the constructivist-interpretivist research paradigm, it appears that a distinctive feature of qualitative inquiry that focuses on understanding subjective realities – as presented in participants' own language and contextualised within social constructs that shape them – is the respective acknowledgement and acceptance of the subjectivity of the researcher, which offers the opportunity to co-construct meaning 'at the intersection of the two subjectivities' (Stolorow & Atwood, 1989, p.364) and from a reflexive-interpretivist stance (Morrow, 2007). In this manner, the qualitative researcher, far from being a neutral and impartial investigator, is seen as a real person, whose own experiences, values, beliefs, interests and motivations for conducting a study, play a direct and intimate role in shaping the research process and outcomes (Willig, 2013). For this reason, it is important for qualitative researchers, and the rigour or trustworthiness of their study, to 'own their perspective' through active engagement in transparent reflexivity, which, in turn, allows readers to get a feel of where the researcher is coming from as they assess the study's findings and gauge whether alternative interpretations have been duly considered (Kasket, 2012).

The following account reflects on how my own interests, experiences and value biases may have contributed to the investigated phenomenon, from the initial construction and development of the research question, all the way through the findings and outcomes of this study.

The genesis of this study has its roots in my professional practice, meaning that I have inevitably approached the phenomenon of interest with preconceptions and assumptions I attempted to recognise and 'bracket' through reflexive writing, research supervision and discussions with colleagues (Fischer, 2009). As a member of the counselling psychology profession I have a special interest in what clients experience during therapy and how this process helps them to transform or find meaning and relief from their distress. My motivation to explore client perceptions of therapeutic change grew out over the preceding years of working in a drug and alcohol service and providing individual psychotherapy as part of a holistic treatment programme for people affected by substance use problems. As part of my work there was to collect quantitative data on psychotherapy outcomes (e.g., pre-post CORE-OM and HADS[13] scores), I found myself wanting to understand more than what was presented in the numbers, in terms of how psychotherapy was helping (or not helping) those clients to achieve meaningful changes. Moreover, through the process of engaging in psychological therapy with substance-using clients I became acutely aware that this population was characterised by high complexity of comorbid mental health challenges, and that the pain underlying much substance use had interpersonal roots. These experiences sparked further my interest in the conceptualisation and treatment of substance use problems within a mental health framework, speculating that the connection between therapist and client could be of vital importance for meaningful change and recovery. At the same time, I was also aware of very high dropout rates in the psychology service of the agency I was practising, a trend that I found out was also reflected in national and international statistics for client groups who misuse psychoactive substances (Brorson et al., 2013). These observations disappointed me and made me, at times, question the value and place of psychological therapy in the area of substance use.

[13] Hospital Anxiety and Depression Scale (Zigmond & Snaith, 1983)

Turning to available literature, in an attempt to further support my confidence in psychotherapeutic work with this population, resulted in additional confusion and disappointment by bringing to my attention a longstanding resistance within the addiction treatment field to the use of insights of psychology, championing and basing treatment, instead, mainly on the beliefs and practices of mutual-aid organisations (Kellogg & Tatarsky, 2012). What's more, there seemed to be greater resistance to and consequent dearth of existing research focusing on the accounts of substance misusers who had found psychotherapy helpful in assisting their recovery (Vanderplasschen, Naert, Laener & De Maeyer, 2015). It was as a result of these realisations that I decided to undertake this research and attempt to give a public face to substance users' perceptions of therapeutic change and recovery.

Although my academic readings and professional experiences of psychological therapy with individuals affected by substance misuse resulted in developing my own assumptions and perceptions about the investigated phenomenon, I was also coming from a perspective of not having been personally or interpersonally (i.e., in my close relationships) affected by substance use problems. This meant that my membership status in relation to the participant group and studied topic had to be negotiated as a position between an insider and outsider perspective (Dwyer & Buckle, 2009), which could allow me flexibility to reflexively move more or less inside or outside the investigated phenomenon, as suggested by the needs of different research phases. For instance, during the early stages of data collection and analysis I consciously endeavoured to stand outside the phenomenon of therapeutic change by noting and bracketing off assumptions and expectations formed by my own knowledge and experiences of therapeutic work with a similar population (e.g., the importance of the therapeutic alliance, client internal resources and extratherapeutic factors). On the other hand, there were times during interviews and analysis where I was able to draw upon my experiential and academic learnings in a manner that allowed me to probe further into participants' experiences or make a particular hypothesis of the data. This permitted me, in turn, to reveal aspects of the investigated phenomenon that may not have been possible to come to light had I assumed a more distant and disengaged perspective.

To aid further my reflexivity, I also kept a reflexive journal throughout the interview and analysis processes, in which I noted my emotional and cognitive reactions to the

research process, important ideas that came to mind as I encountered participants and listened to their experiences, as well as general field notes. Excerpts from these reflections can be found in Appendix 1.

In terms of reflecting on and attempting to identify the epistemological foundations that underpinned my research – suggesting thereby an appropriate method of inquiry – I considered carefully, as recommended by Willig (2012), the assumptions I made about the social and psychological world I studied, the kind of knowledge my research aimed to create, and my role as a researcher in the research process and outcomes.

In this manner, I came to acknowledge that in choosing to pursue this research topic and construct my research question the way I did (see Box 1) , I was influenced by the humanistic, postmodern and constructivist underpinnings of my training in counselling psychology, which place great emphasis on: (1) appreciating the uniqueness and 'otherness' of each person (or research participant in this case); (2) prioritising individuals' subjective and intersubjective experiencing (i.e., alluding to the constructivist-interpretivist ontological belief that reality is subjective, contextual and transactional); (3) creating, rather than discovering, meaning between the 'knower' and the 'would-be knower'; as well as (4) an orientation towards empowering people (see Cooper, 2009; Hansen, 2004; Strawbridge, 2016). Taken together, these value bases mean that the interpretative, interactionist and political elements of my training in counselling psychology have influenced the choices I made and assumptions I held with regard to this research. This means, in turn, that in the current research I was coming from a position of aiming to reflect upon and understand how an individual experiences and makes sense of their world (Meriam, 2009), so that I could generate a clear and effective representation of participants' construction of meanings regarding their experiences of therapeutic change in the process of recovering from harmful substance use.

On the other hand, with reference to my role in the research process and knowledge generated, I also acknowledged that I saw myself as an active agent and co-constructor, rather than an objective and detached observer, in the process of understanding participants' perception of reality and making meaning of the phenomenon under consideration. In this way, a relativist and social constructionist epistemological stance was adopted in relation to the nature and status of the data I collected and analysed,

meaning that any knowledge claims or 'discoveries' arising out of this research were seen as one possible interpretative portrayal, rather than an exact and universal picture, of the studied world (Burr, 2015; Charmaz, 2014). That being said, it is also important to note that whilst relativism accepts that the researcher and research participants bring their own sense of reality and pre-existing ideas to phenomena which are essentially contextual and standpoint-dependent, at the same time multiple realities are not necessarily completely unique and incomparable to one another, since through the medium of mutual language and symbolic understandings, shared versions of knowledge can be negotiated and constructed between people (Blumer, 1969; Charon, 2010). In this manner, my dual identity as a trainee counselling psychology researcher and practitioner was also philosophically related in this research by acknowledging that, whilst I did not expect my understanding of another person's (i.e., client's or research participant's) experience to ever be exact, I still thought that it was possible to be close enough so that it could render a useful interpretation of it.

Based on the above points of reflexivity, I believe that my position in the current research lends itself best to a relativist ontology and a relativist-constructivist epistemology by: (1) acknowledging the existence of multiple standpoints of 'reality' (both those of research participants and researcher); (2) seeing knowledge as socially constructed within a real world that exists (i.e., the reality of the research situation, which includes who and what is in this situation or affects it from the outside) but is never separate from the viewer and the viewed, who may see that world from multiple standpoints, and whose views may conflict not only with each other but also among themselves (Flew, 1989); and (3) accepting that 'truth' is subject to interpretation and influenced by the context in which it is situated. In this manner, and in keeping with the principles and philosophical assumptions of my chosen method (see below), I believe that my study's worth and the knowledge it generates would ultimately be judged by how helpful it would prove to its participants and other people with similar experiences, as well as those engaged in supporting their efforts at therapeutic change and recovery.

2.6 The Chosen Research Method – Constructivist Grounded Theory

In seeking a research methodology that would provide an appropriate fit with the aforementioned ontological, epistemological, axiological and rhetorical perspectives that underlie the constructivist-interpretivist paradigm and suit the nature of the research question, aims and objectives of my study, after exploring a number of different qualitative methods (see 'methodological reflexivity' below), I was led to choose a constructivist approach to grounded theory methodology, which is known as Constructivist Grounded Theory (CGT; Charmaz, 2014).

As a research methodology, grounded theory (GT) begins with broad, exploratory and action-oriented questions, which identify the phenomenon to be studied. Indeed, the emphasis on actions and processes which characterize and drive GT inquiries means that as a research methodology GT is underpinned by the assumption that people are purposeful agents engaged in action that results in or is in response to a process of change. In this manner, the aim of GT studies and the research methods that underpin them is to explicate and shed light on basic social and psychological processes that underlie people's actions and behaviours in relation to the phenomenon in question (Bryant & Charmaz, 2007; Corbin & Strauss, 2008; Dey, 2007; Tweed & Charmaz, 2012). In order to do this, GT uses a consistent set of inductively-driven strategies for data collection and analysis, aimed to develop 'middle-range' theory from the bottom up, by engaging in progressively more abstract levels of comparative data analysis and thereby providing the researcher and intended audience with an explanatory framework with which to understand the investigated phenomenon (Charmaz & Henwood, 2013; Henwood & Pidgeon, 2006).

Since its creation through the seminal work of Barney Glaser and Anselm Strauss (1967), as a revolutionary, qualitative alternative to the hegemony of the quantitative research paradigm in social sciences and the resultant arbitrary division between theory and research, GT has gradually shifted from a more realist to a more relativist epistemology, in response to the postmodern, constructivist and interpretative turn which challenged its original positivist and postpositivist approach to knowledge generation (Clarke, 2009; Mills, Boner & Francis, 2006; Morse, Stern, Corbin, Bowers, Charmaz & Clarke, 2009; Norton, 1999). It is because of the explicit acknowledgement of this relativist epistemological shift in the methodological procedures and

applications of GT that the paradigmatic home of CGT is seen to be best aligned with the constructivist-interpretivist research paradigm (Fassinger, 2005).

According to Charmaz (2014), CGT represents a contemporary revision of Glaser and Strauss's (1967) original conception of classic GT, which provided the first explicit set of guidelines for conducting systematic, rigorous, inductive and comparative qualitative research aimed at contextualised, mid-range, rather than grand, theory generation of studied phenomena. Although Glaser and Strauss (1967) never explicitly declared their ontological and epistemological standpoints, close examination of their texts and research practices has revealed that they were approaching GT work from an epistemological perspective of positivism and postpositivism, which stressed belief in an 'external' reality, researcher objectivity and neutrality (Hallberg, 2006; Melia, 1987). This was evident in the request for removal of personal, professional and literature-based preconceptions during data collection and analysis, the 'discovery' of knowledge, concepts, categories and hypotheses inherent in the data, as well as a strong focus on the verification of findings throughout the course of a GT project (this latter objectivist and postpositivist feature was especially evident in Strauss and Corbin's 1990 and 1998 development and reformulation of GT following the former's separation from Glaser).

In contrast to the aforementioned positivist and postpositivist epistemological underpinnings of Glaser and Strauss' original formulation and subsequent reformulations of GT, CGT, in line with constructivism (Gergen, 2001), the philosophical roots of Symbolic Interactionism (Blumer, 1969) and pragmatism (Bryant, 2002, 2009; James, 1907; Mead, 1934), assumes the relativism of multiple social realities, knowledge of which is mutually created by the viewer and the viewed through a process of intrapersonal and interpersonal interactions which facilitate interpretative understandings of viewers' meanings. This, in turn, means that, whilst Glaser and Strauss's objectivist formulations of GT viewed its products as the 'discovery' of categories inherent in the data and observed or unearthed in an external world by a neutral researcher, CGT, as developed and articulated by Kathy Charmaz's extensive body of work (Charmaz, 1983, 1995, 2000, 2004, 2005, 2006, 2007, 2008, 2009, 2011, 2014), views the data and knowledge derived from grounded theories as products of emergent processes that occur and are co-constructed through an ongoing interaction between the researcher and research participants. Thus, the more recently

developed constructivist underpinnings of GT assume a fundamentally interactive and interpretative method of inquiry which focuses on meaning, action and processes, by taking into account research contexts and participants' and researchers' positions, perspectives and interactions. In this manner, the result or end-product of a CGT study is presented as a story or narrative which reflects the viewer's (researcher's) interpretative understanding of how the viewed (participant) creates his/her understanding and meaning of reality within a particular time, culture and context. An implication of the relativist-constructivist epistemology that underpins CGT is, therefore, that the results of such an analysis are seen as one way of interpreting the data at hand, rather than a universal or unidimensional 'truth' about the investigated phenomenon (Charmaz, 2014).

Overall, I believe Charmaz's GT approach resonates well with the epistemological, ontological and axiological perspectives I have assumed in conducting this research, as whilst it remains faithful to the core components of GT methodology – which I believe fit my research question and aims of the study – it explicitly acknowledges that the resulting 'theory' is an interpretation, influenced by the researcher's interactions with participants as well as their personal and professional values, beliefs and studied contexts.

2.6.1 Methodological Reflexivity

In reflecting upon the methodological choices I made as a researcher in the execution of this study, and thereby how I helped to 'shape' the results of my research in a particular way, I believe that my research method was instrumental in 'shaping' the kind of knowledge I generated through my study. This, in turn, means that, had I chosen to use other methods, my research might have produced different insights (Kasket, 2012).

Before deciding on the use of CGT I also considered, and subsequently rejected, the potentialities offered by interpretative phenomenological analysis (IPA) and narrative methodology. It should be noted that quantitative research methods were immediately rejected since the research question of the current study is exploratory and open-ended in nature, interested in eliciting participants' lived experiences and meanings of the investigated phenomenon. In this way, I did not intend to find out how much, but why

and how people affected by substance misuse experience the process of therapeutic change, so that a conceptual understanding of this phenomenon could be generated and serve as a useful balance to the continuing emphasis on quantitative outcome studies for the evaluation of client change in this field (Neale & Strang, 2015). The decision to employ a qualitative approach was, therefore, related to the nature of the research question and the study's aims.

In terms of the potential usefulness and suitability of IPA in answering the research question, I decided against it after realising that, although IPA is compatible with the ontological, epistemological and axiological stance of the constructivist-interpretivist paradigm, it is best suited for the recruitment of a homogeneous sample (e.g., heroin users only) as it is designed to describe and interpret nuanced experiential features and meanings ascribed to a particular phenomenon (Langdridge, 2007). Moreover, IPA's objective is on illuminating the subjective 'feel' of a particular experience, rather than lifting the analysis from detailed interpretative description to a more explanatory framework of psychosocial processes involved in the phenomenon under consideration (Smith, Flowers & Larkin, 2009). For these reasons, I considered the aims of IPA incompatible with the objectives of my research question – at least in the way it was formulated and the kind of knowledge it sought to generate.

Finally, I explored the possibility of using a narrative methodology, which can also be ontologically, epistemologically and axiologically compatible with the constructivist-interpretivist-research paradigm, but, again, rejected it in favour of CGT on the grounds that, although the meanings of participants' narratives or stories about their experiences are fluid and contextual, narrative methodology tends to focus the analysis on particular linguistic and temporal aspects of stories at the time of narration, rather than looking for particular autobiographical and psychosocial processes involved in theorising about the experience of particular phenomena (Bonsmann, 2010).

Overall, after considering different qualitative research methods, for the reasons cited above, I felt that CGT was particularly fitting for the nature of my research question and the objectives of my study.

2.7 Research Procedures

2.7.1 Study Context Overview

The study was conducted at an outpatient, publicly funded community drug and alcohol service in Greater London, which served a mixed-gender and culturally diverse treatment-seeking population, living mostly on low declared incomes. The service operated from a harm minimisation model and consisted of a multidisciplinary team, comprising substance misuse keyworkers, physicians, nurses, psychologists and psychiatrists. Referrals were accepted from any source (self-referrals included) and a comprehensive array of services was provided, including individualised assessment of treatment needs, one-to-one key-working, group-based psychosocial and relapse prevention support, individual psychological therapy, vocational training and employment assistance, alternative therapies (e.g., acupuncture), substitute prescribing (e.g., methadone), testing for blood borne viruses (e.g., hepatitis, HIV) as well as referral to inpatient detoxification and rehabilitation.

The psychology service (whose users formed the targeted population for this study) supported most psychotherapeutic styles and interventions, including cognitive-behavioural, person-centred, solution-focused, motivational interviewing, twelve-step facilitation and relapse prevention practices. In this respect, it is important to note that there are no unique psychotherapeutic models or techniques used with substance users which are not also used with non-substance users (DiClemente, 2015). Individual psychological therapy was mainly provided by master's- and doctoral-level psychotherapy trainees, under weekly supervision of a consultant psychologist, for a minimum duration of 12 weekly fifty-minute sessions, which could be extended up to one year according to individual needs. The service's philosophy behind the 12-week recommendation for minimum commitment to psychological therapy was based on research suggesting that at least three months are likely to be needed for substance users to complete a course of individual therapy in non-residential settings (e.g. Kellogg & Tatarsky, 2012; Teesson et al., 2011).

2.7.2 Participants

The participant sample consisted of 12 adult individuals (six females, six males), aged between 30 and 65 years old (mean age = 47.83) and affected by diverse substance use

problems, ranging from 'alcohol alone' (n = 6) to 'cannabis alone' (n = 1), 'cocaine alone' (n = 2), 'heroin alone' (n =1), 'alcohol+cannabis+cocaine' (n =1) and 'heroin+crack cocaine+alcohol' (n =1). Their self-reported abstinence periods away from harmful substance use at the time of the study ranged from 1.5 to 32 months, whilst one participant reported being stabilised on an opiate substitute (methadone) dose and three engaging in controlled/moderate use of alcohol. All participants were UK residents and representative of broad socioeconomic and cultural backgrounds, as conferred by their educational/occupational status and self-identified ethnicities. They had all completed individual psychotherapies in the past six months within the agency's psychology service (range = 12-50 sessions, mean = 28 sessions). Moreover, the researcher ensured that all participants had completed their course of psychological therapy at least one month, but not greater than six months, prior to taking part in the study, in order to allow them time to disengage from the therapeutic encounter and assess their experience of change, but also to ensure that details of their experiences remained relatively fresh and accessible. The mean length of time following completion of individual psychological therapy was 2.3 months (range = 1-6 months).

In terms of sample heterogeneity, the differences between participants' characteristics, as noted above and in Table 1 below, are considered a strength in grounded theory approaches, as the aim is for researchers to seek diverse sources of information so that results as rich and encompassing as possible can be developed (Einstein, 2015; Glaser & Strauss, 1967).

The inclusion and exclusion criteria for the sample were as follows:

Inclusion criteria

- Male and female participants aged 18 or over;
- Having been affected by drug and/or alcohol problems;
- Having completed a minimum of 12 sessions of psychological therapy in the past six months, provided at the drug and alcohol service by a relevant practitioner other than the researcher;
- Not currently being in psychological therapy;
- Being able to give informed consent to take part in the study (BPS[14], 2014);

[14] British Psychological Society

- Speaking English fluently so that a clear experiential account of the phenomenon in question could be provided during the research interview; and
- Being free of any non-prescribed drug and/or alcohol use on the day of the research interview in order to ensure abstinence from physically dependent and/or excessive use of psychoactive substances (McKeganey, Bloor, Robertson, Neale & MacDougall, 2006), and thereby participants' ability to provide a clear and coherent account of their experience of therapeutic change (Willig, 2013). As the drug and alcohol service from which participants were recruited was not an inpatient rehabilitation or detoxification service – meaning that service users were not required to have achieved a certain period of complete drug and/or alcohol abstinence as part of attending clinical interventions – this criterion was assessed by trusting participants' own account of drug and/or alcohol abstinence on the day of the research interview. At the same time, the researcher was also mindful of participants' behaviour and affect during the research process, prepared to suggest terminating the study in case she sensed a participant was not presenting and conducting themselves in a stable manner. This did not prove necessary, although two interviews had to be discontinued and data discarded due to noticeable memory retrieval problems in one case and disclosure of imminent risk to self in another (see 'exclusion criteria' and 'interview procedure' sections below).

Exclusion criteria

People who were actively suicidal, had noticeable symptoms indicative of cognitive impairment, had limited ability to communicate in English, and/or were unable to abstain from non-prescribed drug and/or alcohol use on the day of the research interview were excluded from the study on the grounds that these characteristics can substantially compromise the applicability and usefulness of qualitative methods aimed at generating rich narrative data (Willig, 2013).

Table 1. Demographic details of participants

Participant Number *	**Gender**	**Age** (in years)	**Ethnicity/ Nationality**	**Educational Status** (i.e., highest qualification obtained)	**Occupational Status**	**Primary Drug of Concern**	**Time elapsed since last use**	**Number of psychological therapy sessions completed**	**Time passed since therapy termination**	**Therapist's Theoretical Orientation** (if known)
P1	M**	52	White - British	A-Level	Employed as Teaching Assistant	Alcohol	3 months	24 sessions	2 months	Integrative
P2	F***	53	White - British	University Degree	Currently Unemployed	Alcohol	3.5 months	15 sessions	6 months	Cognitive-behavioural/ Mixed
P3	M	30	German	University Degree	Employed as Personal Assistant	Cocaine	6 months	25 sessions	3 months	Person-centred
P4	F	47	Italian	University Degree	Currently Unemployed	Cannabis	4 months	25 sessions	6 months	Humanistic/ Person-centred
P5	F	65	White - British	Professional Diploma	Currently Unemployed	Alcohol	4 days Controlled Use (2 glasses of wine)	17 sessions	1 month	Cognitive-behavioural/ Mixed
P6	M	38	Indian	Professional Diploma	Employed as IT Technician	Cocaine	5 months	12 sessions	3 months	Humanistic/ Integrative
P7	M	59	Greek-Cypriot	PhD	Employed as Programme Designer	Alcohol	2 days Controlled Use (half glass of wine with food)	15 sessions	1 month	Unknown – focus on feelings and assertiveness

P8	M	53	Irish	Primary education	Volunteering in peer-mentoring (addictions field)	Alcohol in combina-tion with cannabis and cocaine	2 days Controlled Use (2 beers) 1 year re. last cannabis and cocaine use	45 sessions	1 month	Humanistic/ Person-centred
P9	M	53	Irish	A-level	Volunteering in gardening project (addictions field)	Heroin	32 months Currently on methadone mainte-nance (18 ml)	48 sessions	2 months	Cognitive-behavioural
P10	F	39	White - British	GCSE	Currently Unemployed –waiting to begin voluntary work at church	Alcohol	1.5 months	12 sessions	1 month	Unknown – focus on communication skills
P11	F	44	White – British	GCSE	Volunteering in peer-mentoring (addictions field)	Crack cocaine; Heroin; Alcohol	13 months	50 sessions	1 month	Humanistic/ Integrative
P12	F	41	Chinese	University Degree	Employed as Interior Designer	Alcohol	12 months	48 sessions	1 month	Humanistic/ Integrative

**Participant demographic data are presented in the chronological order that interviews were conducted*

*** M refers to 'male' gender*; **** F refers to 'female' gender*

2.7.3 Sampling Considerations and Participant Recruitment

In keeping with suggestions regarding the nature and size of samples normally required for the purpose of producing a technically sound and effective GT project (e.g., Bowen, 2008; Flick, 2009; McLeod, 2011), participant selection and recruitment in this study was flexible and informed by their knowledge and experience of the phenomenon in question. This meant that, in this study, the researcher entered into a process of 'purposive sampling' by recruiting participants who were relevant and involved in the phenomenon under investigation. Once preliminary analysis of the initial interview transcripts was underway, the researcher implemented an 'abbreviated version of theoretical sampling' (see Willig, 2013, and section on 'Analytic Strategy' below). This meant that, although the researcher mostly worked within the confines of the original dataset which led to the final construction of the current CGT model (see Findings chapter) after all interviews had been completed, she also took care to meaningfully adapt the original interview schedule as the study progressed (see next section). In this manner, the researcher continued recruiting participants until most of the analytic concepts that had emerged from initial coding of the data provided by earlier participants, were deemed to have reached sufficient saturation for generating a theoretical explanatory framework which could be used to understand and make sense of the studied phenomenon.

The rationale for engaging in purposeful and abbreviated theoretical, rather than random and representative, sampling was underpinned by the philosophical assumptions embedded within qualitative and GT research, according to which generalizability of the findings obtained by qualitative research projects is less important than the collection of rich and thick descriptions that allow a shared understanding of participants' views and experiences of the studied topic (Howitt, 2013; Kirk & Miller, 1986).

Following ethical clearance to conduct this research project, recruitment for the study began by on-site advertisement and eventually proceeded through word of mouth. In this manner, the sample was self-selecting and recruited by means of flyers (coloured yellow to attract attention) and information sheets, displayed together in the reception areas of the drug and alcohol service (see Appendices 2 and 3 for copies of recruitment flyer and participant information sheet, respectively). These materials aimed to provide a fair

description of the nature and purpose of the research as well as explicate the criteria for eligible participation, thereby allowing prospective participants to make an informed decision about taking part. Interested participants were asked to voluntarily enter their contact details in the appropriate spaces indicated in the recruitment flyer and take this form to the receptionist of the service, who placed it in a confidential envelope and handed it to the researcher.

Moreover, due to the nature of this population, being generally hard to reach and featuring a rather high drop-out rate from psychology services, both at this particular agency and in general (Brorson et al., 2013), I was advised by the recruitment site to compensate eligible participants for their time and contribution to the study by explicitly stating on flyers and information leaflets that a £10 gift certificate to a local grocery store would be obtained for participation. This aspect of recruitment was carefully thought out due to the potential of attracting people interested in exploiting a paying study rather than really committed to the objectives of the research. Following further consultation with my academic supervisor, as well as review of previous research suggesting that cash can be a trigger for people who have a history of substance misuse (e.g., Hall & Queener, 2007), I decided that researcher funding of a modest gift certificate was an appropriate incentive for participation and consistent with other research programmes conducted in this field (Vanderplasschen et al., 2015).

Thus, following receipt of completed recruitment letters that indicated an interest in taking part, I made brief telephone contact with each participant in order to ensure they fulfilled the study's criteria and were comfortable with the nature and purpose of the research prior to agreeing a meeting date and time. The brief telephone conversation was used as a means of establishing rapport and gauging suitability to participate by asking screening questions, such as:

- How did you decide to participate in this study?
- For how long were you in psychological therapy?
- How long has it been since you finished with this therapy?
- How long have you been abstinent from any dependent or excessive use of drugs and/or alcohol?

- How would you describe your emotional adjustment at present? – responses to this question also led into assessing risk more explicitly by inquiring whether participants have ever had any thoughts of harming themselves or someone else.

Following this screening telephone contact, I agreed with each participant a mutually convenient date and time to meet in order to take part in an individual audio-recorded research interview, which was conducted in one of the service's interview rooms and lasted for an average of one hour.

2.7.4 Data Collection Techniques

This study made use of individual, face-to-face interviews conducted at a community drug and alcohol service, which was the researcher's previous clinical placement site. The interviews were semi-structured and lasted between 32 and 100 minutes (mean interview duration = 65.91 minutes), in order to collect rich qualitative data from people who had been affected by substance misuse and completed a minimum of 12 psychological therapy sessions as part of their treatment.

The interview schedule that was used to guide this process and facilitate participant disclosure in relation to the studied phenomenon can be found in Appendix 4. This was constructed by the researcher following relevant background reading on the topic of client change (e.g., Elliott, 2008, 2010, 2012; Sperry & Carlson, 2014), which provided certain 'sensitizing concepts' (Charmaz, 2014) I drew upon to generate some initial ideas of interest and particular types of open-ended and reflective questions to ask participants (e.g., exploration of intra- and extra-therapeutic change-promoting factors and processes; perceived sense of agency in relation to reported changes).

In accordance with good practice guidelines (e.g., Smith, 1995), before the interview schedule was used with actual participants it was first piloted with my clinical placement supervisor – a senior consultant psychologist with extensive knowledge and experience in the area of substance misuse – in order to ensure the interview would elicit information to

help answer the research question, and to check the overall flow, sequence and wording of questions.

Piloting of the interview highlighted the need for further prompts to expand upon some of the questions and also resulted in the addition of a specific question on the potential impact of therapist effects on participants' process of change (Appendix 4, question #8), in light of research highlighting the significance of therapist variability in effectiveness and treatment outcomes (e.g., Baldwin & Imel, 2013). Additionally, the process of piloting allowed me a degree of technical rehearsal via practice of interviewing techniques and style, whilst it also provided some insight into the timing of the interview. As participant recruitment progressed and sampling became more theoretical in nature, the interview schedule was slightly modified and informed by themes and concepts that arose from preceding interviews and data analysis (see highlighted sections in Appendix 4).

Furthermore, prior to the interview questions, all participants were asked to complete a brief and anonymous demographic data questionnaire (Appendix 5), in order to obtain relevant background information that was used to describe the characteristics of the sample (see Table 1 above).

2.7.5 The Interview Procedure

Following telephone confirmation of participation in the research, a suitable date and time to meet and conduct the interview was arranged with each participant. At that point, I liaised with receptionist staff to ensure a private room was booked at the agency for the interviews to take place. In this manner, the location and context of interviewing permitted participants (as well as the researcher) to feel safe and comfortable in familiar surroundings, possibly encouraging them to open up more (Brinkmann & Kvale, 2018).

Prior to starting each interview, time was allocated to revisit and discuss the information sheet I had created to explain my research and to answer participants' questions about any aspect of the study, including disclosure of information about my own role in the service, educational background and work experience, as well as my motivation for this research. It should be noted that, not only I had not worked in a therapeutic capacity with any of the participants I recruited, but also by the time I began conducting this research I had already

completed my placement at this service and thereby no longer had contact with other practitioners involved in participants' care. Explicit mention of this, I believe, was important in encouraging participants to perceive me as sufficiently separate to the services they had been using and thereby feel safe to enter into open and honest dialogue about their experiences of therapeutic change (Pope, 1991). Additionally, not having encountered any of the participants in the role of therapist safeguarded against the potential of contaminating my analysis as I attempted to approach fresh material from a perspective of unfamiliarity.

Once participants indicated they had understood the nature and purpose of the research and were comfortable with what was required of them, I asked them to read and sign a consent form (Appendix 6) in order to allow me to proceed with the collection of data. Although hard copies of signed consent forms were retained by each participant and myself, all participants were assured that consent to take part in no way would bind them to the research, and were reminded they were free to withdraw from the study at any time without giving a reason and with no penalty, reassuring them that the research was separate from their current and/or future care needs in the service. They were further assured that, although it was anticipated that the research would inform psychological service provision within the field of substance misuse, under no circumstances would interview transcripts be shared with service providers, and any subsequent publication of results, in written or oral form, would ensure participant anonymity and removal of potential identifiers through the use of codes and pseudonyms.

Each participant was, then, asked to complete an anonymous questionnaire which collected relevant background data (Appendix 5). Having the researcher present during this process permitted participants to ask further questions and/or request clarifications deemed necessary.

A semi-structured interview was subsequently held, allowing each participant flexibility to conclude when they felt they had reached a natural stopping point. All interviews were audio-recorded on two devices to avoid data loss through technical failure. The decision to record interviews not only ensured that no verbal and non-verbal material was missed, but also allowed me to focus on the process of interviewing and rapport building, without being distracted by the need to take copious notes.

To put participants at ease and build rapport, initial questions were of a general nature (e.g., "Can you give me a sense of what brought you to therapy?"). As each interview progressed I used open-ended prompts and referred to the interview schedule in order to facilitate deeper exploration of emerging themes and elicit rich descriptive data about participants' experience of therapeutic change. During the interview, I frequently reminded participants that I was not looking for right or wrong answers, and any questions I posed were designed to act as triggers to encourage them to talk about their subjective experiences of change, in their own words and in a way that felt comfortable to them. Moreover, in the spirit of conducting CGT research, I aimed to democratise researcher-participant relationship imbalances by adopting an informal conversational style and a 'narrator-listener', rather than 'interviewee-interviewer', approach, emphasising from beginning to end that participants were the experts of their experiences and my role was to listen to what they had to share (Alex & Hammarstorm, 2008). In this manner, I was mindful to use uncomplicated, jargon-free language (Smith, 2008) and, where possible, adopted participants' own use of language in reflecting on their experiences and checking whether I had understood the content of their responses. Paying attention to the particular terms and vocabulary chosen by participants to convey their experiences was also deemed important in eliciting descriptions of individualised meanings and being provided with a rich source of 'in-vivo' codes that could be used during the analytic process (Charmaz, 2009).

During interviews, a few participants felt emotionally vulnerable as they revisited some painful memories and experiences they attached to the development and period of substance use problems. Moreover, several of them disclosed feeling suicidal during the active period of substance misuse and whilst in the beginning phases of psychological therapy. Even though ethical reviews of my proposed study had concluded that taking part in the interviews was not anticipated to cause psychological harm, I acknowledged that the research topic could be emotive and in cases that I sensed any signs indicative of participant distress (e.g., tears) I suggested taking a break or stopping the interview at any time they wished. Additionally, following completion of each interview, a debrief, non-recorded, session was offered to discuss participants' experience of the research and check whether the interview or any other aspect of the study had raised any potential concerns or adverse effects. During debriefing, participants were encouraged to ask further questions and

handed a written list of organisations that could offer further support if needed (Appendix 7). Furthermore, the location of research within the premises of the drug and alcohol service meant that connection to relevant sources of support was immediately available if deemed necessary. All participants also had access to my professional contact details, as well as those of my research supervisor, and were encouraged to use these in case they needed to discuss any issues they became aware of following the conclusion of their participation or wanted to pull out of the study and have their data destroyed.

Although no expressions of concern or withdrawals occurred in this study, two participants who were recruited in the beginning stages of the research had to be excluded for the following reasons.

Initially, guided by previous retrospective psychotherapy research (e.g., Levitt, Butler & Hill, 2006), the length of time since completion of psychological therapy was set to one year prior to the interview. In this way, a male participant who was in his 60s and had been affected by alcohol misuse, expressed interest in taking part in the study, having completed a course of therapy in the past twelve months. Soon after the interview began, however, it transpired that he was really struggling to talk about his experience of therapeutic change in a clear and detailed manner. Less than 15 minutes into the interview, and after having gone through all of the open-ended questions and prompts embedded in the interview guide in an attempt to facilitate exploration of his personal experiences, he kept repeating that all he could remember was *"a general feeling of feeling better"* and *"being nicer to my wife"*. Based on the inflexibility of his responses and apparent inability to elaborate on his experiences in a spontaneous manner, my clinical judgement was that he was likely experiencing cognitive difficulties in the areas of memory encoding and/or retrieval (see Christo, 1998). Consequently, I decided not to risk frustrating him by repeating open-ended questions he was unable to answer. Instead, I acknowledged that likely a lot of time had passed since the completion of his therapy sessions, rendering those memories inaccessible. He agreed with my suggestion and we mutually decided to end the interview at that point. I thanked him for his participation, handed him the £10 voucher and decided to revise the recruitment criteria of my study, by limiting the timeframe between therapy completion and research interview to six months in order to avoid running into similar difficulties with

other participants. In fact, I had already interviewed a participant who had completed psychotherapy six months prior to our meeting and she had not seemed to struggle with noticeable memory difficulties in reflecting on her experiences. Subsequent participant recruitment confirmed that the six-month time limit seemed suitable for the purpose of my research.

One more participant also had to be excluded from the study and her data discarded due to disclosure of imminent suicide risk during the interview. This was the second person I recruited and she had completed psychological therapy twelve months ago. She was in her 50s, and even though she seemed able to reflect on and assess her experience of therapeutic change, halfway through the interview she mentioned she was planning to end her life by overdosing on her medications. I remember feeling very alarmed by this revelation and sensing that she was really meaning what she was saying. At the same time, I also felt a sense of hope, thinking that, if she decided to meet and talk with me so openly about the upcoming possibility of seriously harming herself, maybe she was ambivalent about dying and indirectly trying to ask for further help and support. I therefore acknowledged her distress and informed her that as a psychologist I had a duty of care towards her welfare, which meant that her own safety came before my research (Levinas, 1995). Consequently, the interview had to be discontinued at that point and standard ethical practices followed by liaising with the service manager in the presence of the participant and reporting her needs. A care plan was subsequently agreed upon between the service manager and the participant, according to which a doctor's appointment was booked to have her medication reviewed and an immediate re-referral to the psychology service was made. Although this was certainly a challenging experience, it also taught me to be more explicit in terms of assessing risk and ensuring eligibility to take part in the study by habitually inquiring during telephone screening whether prospective participants were currently experiencing any thoughts of harming themselves.

The interview procedure was concluded by asking each of the 12 participants who completed the research whether they wished to receive a transcript of their interview in order to check the accuracy of its contents and ensure the anonymity of their responses in subsequent publication of interview material. Additionally, they were offered the option to

be sent a copy of summarised results once the research and academic evaluation processes had been completed. The sharing of interview transcripts and findings is advocated in the field of qualitative research on the grounds that people should have access to information on themselves (Tracy, 2010). Thus, participants who responded in the affirmative provided me with their personal details and were sent a copy of their interview transcript, stripped of any identifiable information.

2.7.5.1 Reflections on the Interview Process

Overall, I found the interviews stimulating and important learning experiences. All participants provided positive feedback on the process and expressed appreciation for the project. Although some of them voiced uncertainty as to whether their responses were helpful in addressing the aims of my research, I experienced all of them engaging with a sense of interest and openness, which greatly contributed to the richness of the data. Even though interview experiences varied, some feeling more emotionally charged and others more rational and articulate, I felt that by drawing upon core counselling skills of warmth, empathy and genuineness I was able to establish comfortable and collaborative relationships with all participants. I also attempted to use the interview schedule flexibly, guided by participants' pace and specific styles of conversation. In this manner, I found myself being more active in my interviewing style, employing further explorative questions at times I experienced participants having difficulty expressing their thoughts. At the same time I encouraged them to proceed at their own pace so that the unexpected could be embraced when it occurred (Brinkmann & Kvale, 2015). Such flexibility in interviewing enabled me to strike a balance between my need to gather information pertinent to the aims of the research and participants' freedom to report their personal experiences of change in their own terms. Moreover, based on contextual-constructivist epistemological claims (Ponterotto, 2005), such reciprocal interaction between myself and research participants not only was deemed essential for deeper meanings to emerge in relation to the studied phenomenon, but pointed to the co-construction of findings by both researcher and participants' contributions to the understanding and interpretation of the meaning of their experiences of therapeutic change. To the extent the research relationship bore fruit, both parties contributed to generation, meaning and interpretation of the data.

2.7.6 Analytic Strategy – *guided by Charmaz's (2014) set of flexible GT principles*

Shortly after each interview had been audio-recorded, it was transferred to a password protected computer file, using Windows Media Player, and transcribed by the researcher verbatim into a Microsoft Word Document. Following transcription, each interview was read whilst listening again to a playback of the audio recording in order to check for accuracy and become more familiar with the data. Before beginning to analyse an interview transcript, each participant was given a unique code (e.g., P1) so as to ensure anonymity, whilst all identifiable names contained in the transcript were masked and/or replaced with pseudonyms.

The lines of the text were then numbered throughout and fracturing of the data began, initially by coding data line-by-line and using 'gerunds' (i.e., verbs as nouns) on the margins of the right side of the transcript in order to attach short and, where possible, in vivo labels that served to preserve action by stating what participants were doing as they were engaging with their experience. This initial level of coding allowed complete immersion in and interaction with the data, providing me with an insider's view and intimate familiarity with the phenomenon under consideration. Additionally, whilst engaging in the process of coding data line-by-line, I endeavoured to apply what Henwood and Pidgeon (2006, p.350) describe as 'theoretical agnosticism', meaning that, although I was aware of previous research conducted in the field, I attempted to approach participants' accounts with an open mind and a critical stance. In this manner, initial coding helped me to ensure that my analysis was grounded in the data and that subsequent higher-level categories and relational statements emerged from the transcripts.

Following initial coding, I began moving from a descriptive to a more interpretative level of analysis by reviewing each coded transcript and looking for the most frequent and significant codes used by participants to describe the feelings, meanings and assumptions attached to their experiences in relation to the studied topic. GT analysis at this level is termed focused (or selective) coding. This process was instrumental in beginning to raise into tentative and more abstract categories what I considered to be the most frequent and significant codes in the data, which were relevant to the research question and could

therefore be used to guide subsequent interviews and inform the process of theoretical saturation (see below).

On the other hand, the process of analysis was not linear as throughout different levels of coding I also engaged in constant comparative analysis, both within and across transcripts, in order to compare participants' experiences (both within and amongst themselves) for similarities and differences, and, thereby, capture the full complexity, depth and diversity presented within the studied dataset and emerging categories. Continuous application of GT's constant comparative and negative case analysis methods was instrumental in establishing the properties and relationships between categories, providing thereby clues as to which categories could be merged due to significant similarities or split for differences. Since the analytic focus in the current study – as well as a potential limitation of it (see Discussion chapter) – was on positive changes, rather than lack of improvement or hindering experiences, negative case analysis was approached by looking at participant experiences which did not fit or were at odds with particular analytic concepts embedded within a main category. For reasons of space, as well as in order to increase the transparency of the analytic strategies employed, selected examples of negative case analysis in relation to the components and properties of a particular CGT category can be found in Appendix 13.

Additionally, in applying the method of constant comparison, I was greatly assisted by drawing upon Glaser's (1978, p.74) set of coding families (known as the 6 C's), in terms of interrogating the data at hand and searching for commonalities of meaning, which could eventually raise the level of abstraction of categories to a more theoretical and hierarchical structure, providing thereby further evidence to support or challenge emerging categories. In this manner, engagement in more sophisticated, theoretical coding (Charmaz, 2006, pp.63-66) was progressively facilitated and led to final stage categories, defined at the highest level of abstraction by their ability to integrate and subsume lower level categories grounded in codes and concepts emerging from the studied data. In this way, data collection and analysis continued until each of the emerging categories (together with relevant transcript extracts) were deemed to have achieved sufficient theoretical saturation so as to capture and account for the bulk of the available data. I also acknowledged that any

perception of saturation was inevitably transient since new information could continue to emerge in a never-ending manner (Dey, 1999). In this manner, I felt that provisional saturation and theoretical completeness occurred when no further insights were triggered for me by the data (as advocated by Charmaz, 2008) and I was able to account for "as much variation in a pattern of behavior with as few concepts as possible thereby maximizing parsimony and scope" (Glaser, 1978, p.93). At this point, it is also important to note that in the process of achieving sufficient theoretical saturation after all interviews had been completed, as well as generating a theoretical model that bore usefulness and relevance to future research and practice pertaining to the phenomenon under investigation, I attempted to establish linkages between lower- and higher-order analytic categories by drawing upon relevant existing theoretical concepts (e.g., attachment- and existentially-informed notions; see Findings chapter), which enabled me to blend in a meaningful manner the processes of interpretation and explanation. Consequently, it should be acknowledged that such an approach to theoretical saturation and the overall interpretative phase of the analysis in relation to the studied dataset, was underpinned by the application of a sensitive mixture of both 'empathic' and 'suspicious' types of interpretation (see Willig, 2013). These analytic strategies are explicitly displayed in the following chapter which focuses upon the presentation and analysis of the study's findings.

Additionally, throughout the processes of data collection and analysis I engaged in frequent memo-writing in relation to the constructed codes and categories. This enabled me to capture emerging hypotheses, identify gaps or questions about the data to be followed up in subsequent interviews, justify the labels chosen for my categories and the relationships between them, and, overall, facilitate theory building and write-up of the project. Moreover, the process of ordering my memos, whilst in the final stages of analysis, assisted me to create inductive, deductive and abductive arguments with regard to my decision to identify a core connecting category, which could be used to explain the relationship between the categories constructed and linked to it, and thereby inform the construction of an explanatory framework with which to understand the range of variability of the phenomenon of therapeutic change in the field of substance misuse (see Findings chapter).

2.7.6.1 Reflections on Data Analysis

As a novice qualitative researcher, with rather limited prior knowledge of and practical experience with GT methods, I found the concurrent processes of data collection and analysis quite challenging to implement in a thorough and consistent manner across all interviews and within the time constraints imposed by the scheduling of certain research meetings. This meant that at times I was unable to transcribe and analyse through open coding each interview before the next one took place, as would be advocated by the creators of the approach (Glaser & Strauss, 1967). In order to compensate for this methodological shortcoming, I took care to always reflect on the content and insights sparked by preceding interviews so as to inform the facilitation of subsequent ones and amend the interview schedule in a meaningful manner. This practice is also supported by Rennie (2000) who advocates using GT interviews as a mode of inquiry that enables the researcher to get a sense of each participant's narrative and develop an encompassing understanding of its meanings before the act of transcribing takes place. Whilst acknowledging and implementing the usefulness of Rennie's recommendations on occasions I found it impossible to carry out concurrent interview transcription and analysis, I also noted that successful engagement in the parallel processes of transcription and analysis did result in deepening further my understanding of the text and generating more elaborative and clarifying questions I could use to facilitate subsequent data collection. On reflection, I believe that conducting second interviews with the participants would have allowed the opportunity for further validation of my analytic claims to take place on the levels of open and focused coding. On the other hand, every effort was made to keep my analysis transparent through the use of reflexive writing, memoing and diagramming as audit trails that documented my thoughts, hypotheses and influences behind the generation of analytical categories through which the findings of this study could be viewed. In this manner, while going through the process of analysis, I spent many hours interacting with and dwelling in the data, actively aiming for the deepest possible penetration of participants' accounts, through the use of empathy, self-reflection and selection of the most telling excerpts in which participants' voices could speak forth. In this sense, whilst acknowledging that my adoption of a constructivist-interpretivist epistemology essentially meant that the development of 'experience-near' theory from data analysis depends on the

researcher's view (Fassinger, 2005, p.165), I also strove to generate and name analytical categories in a manner that respected participants' meanings and remained as grounded as possible in their original experiences.

2.8 Quality Assurance Criteria

Qualitative research methods are deemed too diverse for the establishment of common procedures and standards of validity or trustworthiness (Meyrick, 2006). This observation has led qualitative scholars to argue that evaluative criteria for demonstrating the qualitative goodness of a research study should reflect the paradigmatic underpinnings within which a particular investigation is anchored (Madill, Jordan & Shirley, 2000; Morrow, 2007). Thus, in the process of appraising the value of my emerging findings it is important to acknowledge that CGT embraces the influence of researchers' subjectivity in co-constructing the meaning and interpretation of participants' data (Morrow, 2005). Additionally, in ensuring the rigour, quality and trustworthiness of my study I have drawn upon Charmaz's (2006) criteria of 'credibility', 'originality', 'resonance' and 'usefulness' in relation to the constructed categories and explanatory framework of the studied phenomenon. These concepts are further considered and expanded in the Discussion chapter of the thesis, wherein the current study will be evaluated.

2.9 Ethical Considerations

Although a procedural account of ethical working is embedded within preceding sections, the purpose of this section is to provide explicit acknowledgement of the situational and relational ethical issues involved in the design of the study.

Approval for the research was granted by both the Senate Research Ethics Committee of City, University of London (see Appendices 8 and 9 for a complete 'Ethics Application Form' and 'Ethics Approval Letter', respectively) and the Medicines Management Committee of the drug and alcohol service from which the participant sample derived (see Appendix 10 for a complete research application form and approval confirmation).

Additionally, the project was conducted in accordance with the BPS (2014, 2018) and HCPC[15] (2012) Codes of Ethics and Conduct, and the principles of the Data Protection Act (Great Britain, 1998). This meant that, in executing the study, the researcher ensured participants' right to autonomy and freedom to make their own choices and decisions were preserved by providing them with thorough and accurate information about the nature, value and procedures of the research prior to their participation (Appendix 3). Moreover, on the day of the scheduled research interview and before any process of data collection took place, all participants were asked to read and sign a consent form (Appendix 6). In this manner, they indicated they had indeed been provided with adequate and comprehensible information about the nature, procedures and outcomes of the study, and were aware of the confidentiality and anonymity of their responses, as well as the fact that participation was voluntary and that they had a right to withdraw without giving a reason at any stage of the project and up to six months following participation. All consent forms, interview transcripts and other information pertaining to participants were stripped of personal identifiers and secured in a locked filing cabinet at the researcher's home. Additionally, audio recordings of interviews were kept within a home safe, whilst electronic records of transcribed data were secured on a password protected computer. All such materials will be safely destroyed five years following the completion of this research, as advocated by BPS guidelines.

Participant distress during interviews was acknowledged by the researcher as a potential ethical consideration in light of the nature of the studied topic. For instance, in the process of disclosing and reflecting back regarding difficult experiences participants addressed through psychological therapy, it was anticipated that some emotional discomfort might ensue. On occasions where participants exhibited signs of distress during the interview, time was taken to re-confirm whether they were comfortable to continue with the research. Additionally, at the end of the interview, wherein both verbal and written debriefing took place, all participants were invited to explore whether involvement in the study had resulted in the experience of unforeseen distress, and reminded they could contact either the researcher or research supervisor in case they wanted to raise concerns or express

[15] Health and Care Professions Council

dissatisfaction that arose after participation. Moreover, whether or not requested, all participants were provided with contact details of accessible psychotherapeutic services in case additional support was needed (Appendix 7), allowing thereby a degree of privacy on whether they wanted to make use of these resources. It should also be noted that the location of research within a drug and alcohol service premises meant that connection to relevant support was immediately available if deemed necessary.

Care was also taken to ensure participants did not enter a dual relationship with the researcher, by recruiting and interviewing service users to whom psychology services had not been provided by myself (Pope, 1991). On the other hand, it was acknowledged that prior to the commencement of this research I was working as a trainee counselling psychologist for over a year in the same service participants were recruited from. This circumstance led to having a degree of familiarity with a couple of participants who took part in the study and were aware of my previous role at the service. As a result, care was taken both during telephone screening and research meeting to inform all participants that I had already terminated my practice at the service and that the study I was conducting was separate from the services they were using. Explicit acknowledgement of those issues was deemed important in facilitating participants to feel safe to talk to me openly about their experiences of therapeutic change. At the same time, it was thought advantageous, in terms of building trust and rapport, that as a researcher I was familiar with the setting and nature of work participants had been involved with. Moreover, recruitment and data collection within premises of a drug and alcohol service that was familiar to both participants and researcher helped to ensure the safety of both parties in case a situation of risk arose.

Additionally, in terms of safeguarding both the participants' and researcher's welfare, the researcher in collaboration with the drug and alcohol service's manager carried out a thorough risk assessment in order to ensure that all potential hazards contained within the research site had been identified and adequately controlled (see Appendix 11).

Finally, in terms of self-care, I was mindful of the potential to be affected by the content of the research topic in the process of immersing myself in aspects of participants' experiences and attempting to reach an intersubjective understanding. To that end, I took time to debrief myself following interviews by acknowledging and documenting in my

reflexive journal the thoughts and feelings interactions with participants activated in me. Additionally, appropriate use of research supervision and personal therapy enabled me to reflect further on and separate what belonged to me and what belonged to the data, nurturing thereby my emotional resilience and harnessing the intrusion of my subjectivity.

Overall, in accordance with good practice guidelines for conducting research with human participants, it was deemed that potential ethical implications of the current study and appropriate responses to these were sufficiently considered for both the participants and the researcher (see Abrahams, 2007; Miller, Birch, Mauthner & Jessop, 2012; Robson, Cook, Hunt, Alred & Robson, 2000).

The next chapter presents the application of CGT in the analysis of the data and development of a theoretical framework in relation to participants' experiences of therapeutic change in the process of recovering from harmful substance use.

CHAPTER 3: FINDINGS

3.1 Introduction and Overview of Findings

This chapter provides a grounded theory analysis of the narrative accounts of 12 former substance misuse psychotherapy clients who participated in individual interviews aimed at addressing the current research question. To increase transparency of the analysis, selected parts from a coded interview transcript and an accompanying memo are provided in Appendix 12.

Overall, a high degree of convergence was noted between participants' accounts and led to the construction of four main categories following grounded theory analysis of the data: "addressing the substance relationship", "therapist-client engagement", "becoming one's own therapist" and "ultimate therapeutic change outcome". These main categories were identified as representing key dimensions of therapeutic change and recovery from harmful alcohol and illicit drug use, as experienced by research participants in a chronological order and over the course of their treatment journeys. In this way, the unfolding of the findings can be seen as representing a "story", developed through the "inductive analysis of the data" (Charmaz, 2006, p. 187), with respect to participants' subjective experience of therapeutic change. Moreover, the components and properties of these four main categories have been further explored and analysed through the development of more focused subcategories, based on interviewees' constructed meanings to explain the processes and factors involved in successful change and resolution of substance use problems. Finally, a core connecting category, termed "Broadening", has been identified as applying to all therapeutic change and recovery dimensions extracted from participants' narratives.

Figure 1 below displays a graphic illustration of the constructed theoretical model, incorporating the four main categories, subcategories and core connecting category. The latter is deliberately placed at the centre of the model in order to demonstrate its fundamental role in connecting and cutting through all other themes incorporated in the model.

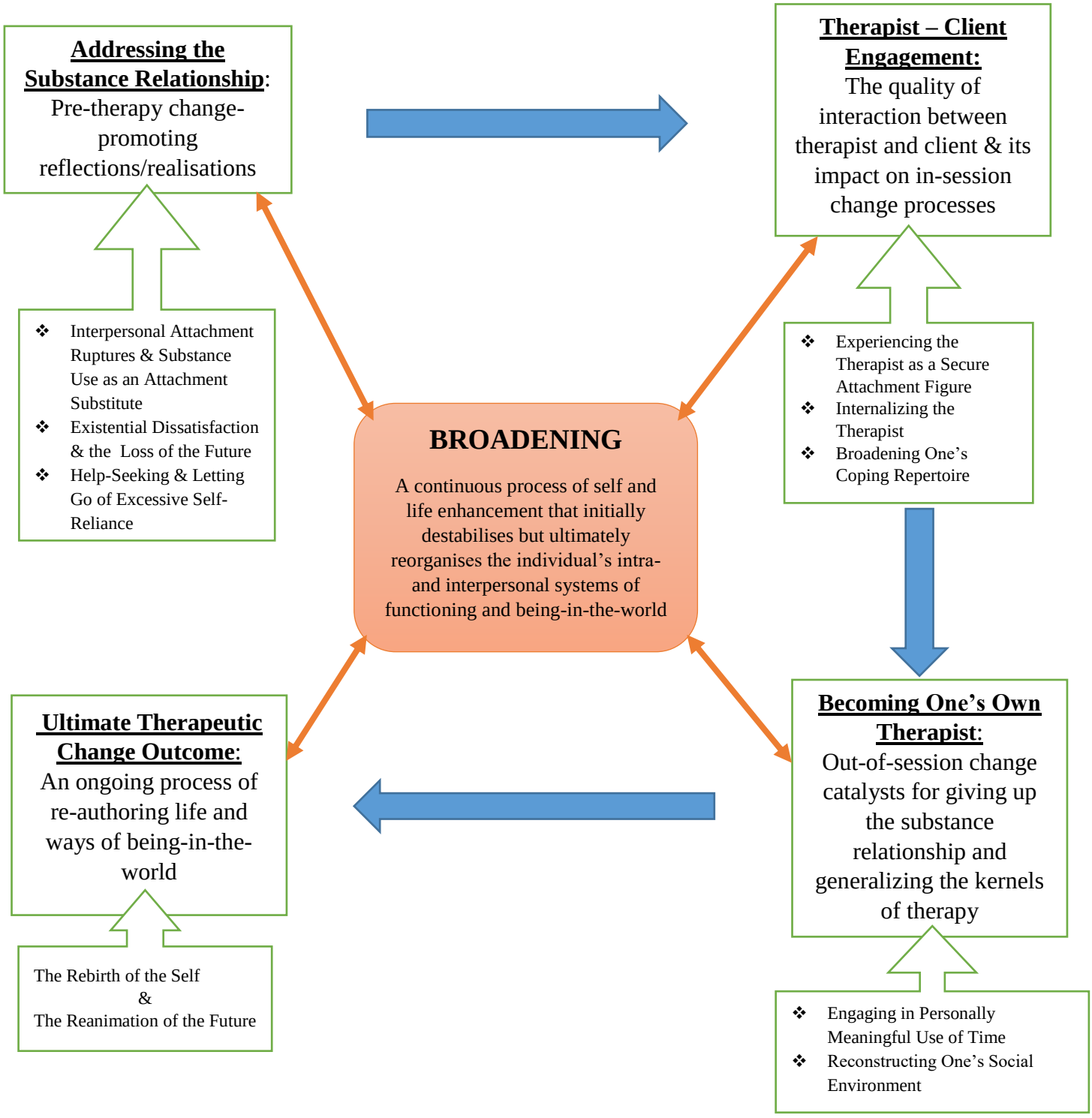


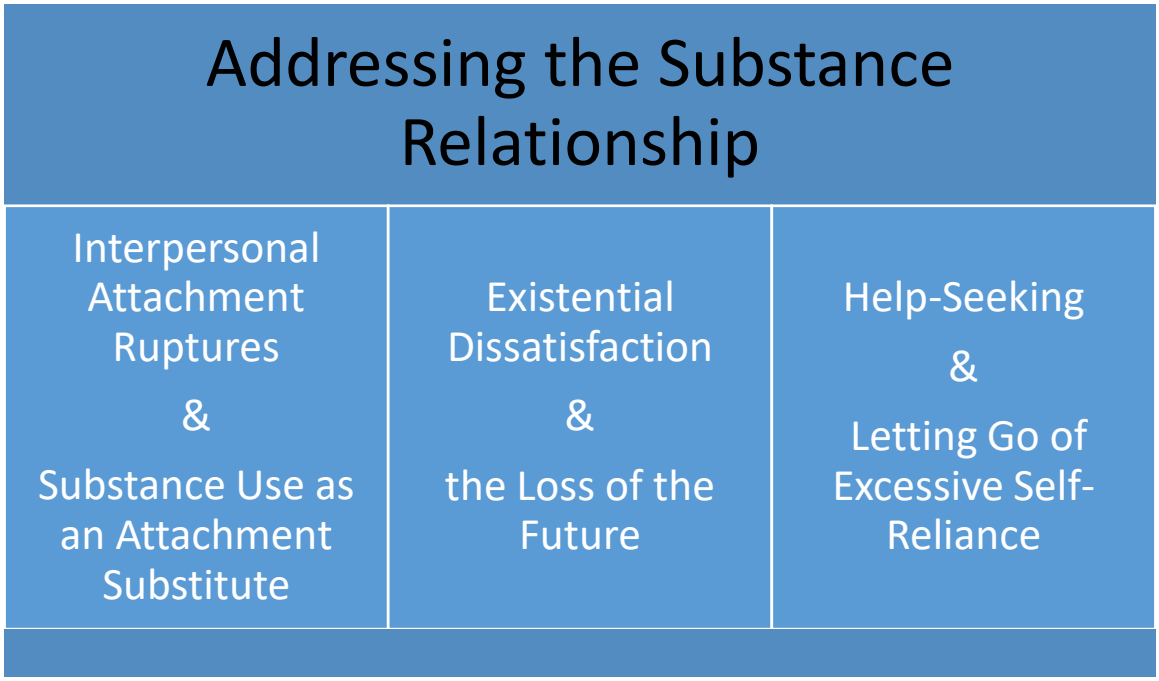
Figure 1: CGT model illustrating researcher's theory of participants' experience of therapeutic change – *the model consists of one core category, labelled "Broadening" and organized around four main categories, which together, in a hierarchical order, represent common change processes and pathways involved in the resolution of substance use problems*.

In the following sections of this chapter, each of the main categories and subcategories, and the core connecting category, are presented and analysed. Additionally, the findings are illustrated by the inclusion of relevant excerpts from transcript data in order to privilege the authenticity of participants' voices and provide a balance between the researcher's narrative and the raw data. Moreover, the process of integrating participants' in vivo perceptions of their experiences with my own analysis and interpretation aims to reflect and highlight the essential aspects of intersubjectivity and social interactionism which characterise the constructivist version of grounded theory (see Methodology chapter).

Throughout the analysis every attempt has been made to represent the views of all participants who took part in the research, and, in order to avoid unintentional bias towards a specific participant, a variety of illustrative interview quotes are incorporated within each main category and its constituent components. Additionally, due to space restrictions, a table is provided in Appendix 14 in order to illustrate which participants were represented within each category. Finally, to safeguard participants' identity, all transcript data has been anonymised and potentially identifying examples or references removed from interview quotations. For this reason, participants and interview extracts are represented by codes (i.e., P1-P12) followed by the relevant page and line numbers of the quoted transcript.

3.2 Presentation and Analysis of the Findings

3.2.1 Main Category #1: ADDRESSING THE SUBSTANCE RELATIONSHIP



"For many years I had a wonderful relationship with alcohol. One of my best friends...it was a love affair. (...)[16] *a love affair that turned bad. It became like Richard Burton and Elizabeth Taylor(...). Deeply in love with each other but couldn't live with each other and couldn't live without each other. (...) The other way of calling it was like Butch Cassidy and the Sundance Kid. (...)We were a team. And we worked for many, many years. (...) But eventually the relationship changed. The alcohol became a dominant part in that relationship."* (P1, 9.215-228)

As illustrated by the aforementioned interview extract, this category presents findings that focus upon participants' subjective experiences and processes involved in the development and maintenance of substance use as a powerful attachment substitute, as well as factors and processes in disengaging from this failed relationship.

[16] This symbol indicates removal of interim dialogue

3.2.1.1 SUBCATEGORY: Interpersonal Attachment Ruptures and Substance Use as an Attachment Substitute

In the beginning of the interviews participants were asked about the reason(s) they sought psychological therapy in the process of dealing with substance use problems. In responding to this question, the majority connected their engagement in harmful substance use to affect regulation difficulties and lack of self-esteem, occurring within an interpersonal context characterised by painful early and later life attachment wounds.

For instance, P1 (52-year-old male) identified as a major trigger to the development of his alcohol dependency his experience of traumatic separation from his father during childhood, insufficient maternal affect regulation and the resultant negative impact on his internal sense of self-worth and lovability.

"I suffer very badly for many, many years a self-loathing, lack of confidence. Although people say I'm a very confident person (…) inside I'm not. Just a mask I've put on (…) it stems back to when my father died when I was six. He took his own life. (…) And I used to have it in my mind that he did it because he didn't love me. (…) I didn't matter. (…)I'm not worth anything because (…) my dad can't be bothered to be around, why would anyone else bother to be?" (P1, 1-2.1-35)
"I really (…) hated me. I didn't like me at all. When in fact (…) I didn't really know me at all. I was always craving for acceptance. (…) I'd speak to my mum sometimes (…). And she just couldn't understand it. (…) And I didn't know how to deal at all with emotions (…). I was very good at masking my emotions." (P1, 3-4.72-103)
"(…) and alcohol does give you the numbness. (…) for a few precious hours…you just don't think or care about anything. (…) For many years I had a wonderful relationship with alcohol." (P1, 8-9.203-215)

In the above excerpts, P1 appears to attribute his motivation toward problematic alcohol use to a primary sense of longstanding and hidden psychological suffering, understood on the background of poor attachment to his father, as well as his mother, who by failing to respond to his needs for comfort, understanding and approval (i.e., indicating a lack of mentalization[17]) did not manage to provide him with a more constructive affect regulation system following his father's suicide. This, in turn, appears to have impacted negatively on

[17] See Fonagy & Allison (2014)

his own representation of self and ability to engage in interpersonal relatedness in a self-assured and honest manner.

Instead of learning how to make sense of, accept and regulate his emotional experience (a key determinant of the construction of self and self-organisation[18]) within the natural milieu of secure and close human relationships, P1 gravitated toward more self-reliant methods of coping with and modifying his cognitive and affective landscape. This appears to have resulted in a profound sense of self-estrangement and self-deprecation, as by relying on instrumental alcohol administration for an artificial alteration of his mood and experience of self, he was essentially engaging in a strategic act of self-deception (or 'being in bad faith', as Sartre, 1943/2003, would put it) that was disrupting the naturally-occurring ambiguous tension of human existence. In this manner, his alcohol addiction can be seen as a form of lying and 'untruth'[19], both on an intra- and interpersonal level, whilst at the same time desiring love and acceptance. It can therefore be said that P1's experiences of loss and rupture in important attachment relationships created deficits in his capacity for self and emotional regulation, and resulted in the transference of unmet attachment needs to a substance-soothing substitute that served as a replacement for love.

A similar commentary can be used to analyse and make sense of P10's (39-year-old female) experience of lack of close and secure attachment relationships in developing a robust sense of self-worth and engaging in meaningful interpersonal connectedness. In this way, her reliance on alcohol seems to reflect an alternative attachment relationship and misguided attempt at self-repair.

"I was going through a very difficult time (...) because of the alcohol (...) I think a lot of it went back from when I was a kid. (...) just being left to my own devices (...) mum and dad didn't really put me in the right direction (...)" (P10, 1.1-8)

"I just didn't feel that I was worth anything or anybody wanted or needed me (...) I was always doing things for people (...) even though inside I was breaking (...) I was just putting on this face, 'It's okay'. (...) I was just trying to buy people's friendship (...). (...) and nobody was helping me except the alcohol, which wasn't helping me in the long run. (...) My depression and anxiety was through the roof." (P10, 1-2.15-37)

[18] See Greenberg (2006)

[19] See Kemp (2009) on substance addiction as a form of 'untruth' relating.

Again, similar patterns of subjectively experienced early and later life deficits in intimacy, protection and self-regulation seem to be indicated in the data and connected to vulnerability in the development of attachment to harmful substance use as a more safe refuge for relieving hidden psychological suffering and compensating for an alienated sense of intra- and interpersonal relating. However, the effect of substance-assisted regulation of P10's being-in-the-world[20] seems to be short-lived, paradoxically, resulting in further affect dysregulation and interpersonal disengagement.

Additionally, P10's account gives a strong impression of her experiencing a social struggle to belong and be of emotional value to others. In order to ensure her social fitness, P10, like P1, seems to be operating at a 'presentational level of self'[21] during her interpersonal exchanges, concealing, thereby, her actual feelings of vulnerability and strategically projecting a self-image deemed appropriate. From this it can be further hypothesised that, her excessive engagement in people-pleasing patterns of relating, as an attempt to compensate for her sense of lack of self-worth and interpersonal significance, is another indication of P10's unmet emotional needs from her parents, which were translated into emotional neediness towards peers as another source of finding intimacy and reassurance. However, such excessive displays of emotional neediness to others may have alienated them, as indicated by their lack of reciprocity in tending to her needs, and thereby created another layer of reduced social functioning and negative self-perception regarding her ability to be loved and respected. As a result, negative feelings about her social standing can be seen as another factor in P10's motivation to shift the painful urge for relational closeness toward a neutral object, the alcohol, and thereby develop a secondary attachment strategy of avoidance in relation to affect regulation and interpersonal intimacy.

Similar insights into the interaction between crucial attachment ruptures, profound affect dysregulation and subsequent maladaptive attachment transition to alcohol and other drugs were also voiced by P8 (53-year-old male):

[20] 'Being-in-the-world' is an existential construct, reflecting the phenomenological reality that human beings are not existing as encapsulated psyches but as an engaged unity of self and world (Heidegger, 1927/1996).

[21] See Mearns & Cooper (2017)

"I didn't have the most pleasant of upbringings as a child (…). My family is pretty much divided (…) I lost my father (…) my sister took her own life. (…) we didn't do that communication with my family. And that would frustrate me. And my reaction to it would be to go and get a bottle of whisky." (P8, 1.15-23)
"(…) I didn't have anyone in my life (…) I'd self-ostracise (…) become very reclusive. (…)I was afraid of the whole world (…) I didn't feel that I was capable to communicate (…) and also the embarrassment of it." (P8, 2-3.40-53)
"And (…) one of the difficult things is how to cope (…) with the time that you've lost, and what you've done to yourself (…) it's easier not to wake up to that but (…) continue in the cycle of abuse (…) because it takes an enormous amount of courage to face the unknown." (P8, 3.69-78)

In these excerpts P8 seems to perceive a strong link between his motivation toward substance-assisted affect regulation and unmet emotional and communication needs within his family environment. Traumatic early and later life experiences of interpersonal loss and separation, in combination with rather poor, if non-existent, emotional support from significant others, are offered by P8 as powerful precipitating factors of vulnerability to the development and maintenance of avoidant and self-reliant strategies for the alteration of the subjective experience of self and strong emotional discomfort.

The repetitive experience of lacking a facilitative and nurturing environment, in which he could learn how to balance painful affect release with affect containment, seems to have contributed to the formation of P8's belief that others could not be relied upon to soothe and protect him. It can, therefore, be hypothesised that the development of such insecure internal representations of the function of interpersonal relationships led to overwhelming feelings of helplessness which P8 attempted to defend against by establishing a secondary attachment to chemicals and acting as if he was not living in a community. Such a shift in his attachment strategies served, in turn, both as an obstacle and substitute for interpersonal closeness.

So great appeared to be P8's need to protect himself from relational vulnerability that he even imposed upon himself a social death penalty by choosing to become a recluse and avoid inter-human contact at all costs. Moreover, intentional engagement in such profound interpersonal disconnection appears to have exacerbated P8's negative and inadequate representation of self in relation to others, which, in turn, led to the experience of a deep sense of personal shame that further reinforced the downward spiral of harmful substance use and breakdown of intra- and interpersonal trust.

In this way, P8's misguided attempts to cope with and medicate away his experiences of attachment trauma and thwarted belongingness can be seen as representing a form of pseudo-autonomy which ultimately results in the infliction of self-violence and self-annihilation. These latter processes and end-products that spring from attachment to substance-assisted self-regulation can be posited to account for P8's vocalised experience of lost, unlived, unused time, which ultimately constitutes a form of 'existential guilt'[22] that arises from his awareness of his own transgressions against himself and untapped possibilities of being-in-the-world.

Furthermore, as P8 sincerely acknowledges in the last excerpt, the realisation of lost time and awakening of existential guilt can act as a change-blocking factor, in that reflection upon one's wastage of already limited lifetime can be very painful and avoided by continuing to act in a self-deceptive manner. This could be another indication of how maladaptive attachment to substances represents an existential form of lying and untruth, or being in bad faith (cf. P1 and P10 above). On the other hand, P8 seems to leave space for the possibility of the experience of existential guilt to act as a change-promoting factor, as long as one plucks up the courage to accept responsibility for the thwart of one's growth, let go of substance-cultivated self-deception, and atone for the past by revitalizing the future and the remainder of one's life (see findings in following subcategories).

In concluding the analysis of the findings embedded in this subcategory, subjective experiences indicative of a longstanding and poorly functioning attachment system, with resultant insecurity in internal representation of self and others, and subsequent transition of the original attachment bond to a welcome security offered by substance use, were consistent themes featured in the accounts of the majority of interviewees. Due to space restrictions, however, it is not possible to include at this point further interview excerpts relating to substance use as an attachment alternative to close relationships. As mentioned above, Appendix 14 contains additional quotes which the reader may wish to refer to.

[22] See Yalom (1980)

3.2.1.2 SUBCATEGORY: Existential Dissatisfaction and the Loss of the Future

In the previous section the development and maintenance of problematic substance use appeared to originate from a source of '*primary psychological suffering*' rooted in deficiencies in self and affect regulation. In this way, it was conceived as representing a form of self-treatment to alleviate this suffering by seeking solace in the substance relationship.

On the other hand, this section's findings focus upon the ways reliance on and preoccupation with the substance relationship can lead to '*secondary psychological suffering*' by rendering one's life and existence in the world deeply meaningless and unbearable. This profound experience of secondary suffering seems, in turn, to propel sufferers to abandon overly self-reliant and narrow modes of being-in-the-world by surrendering to external, inter-human assistance provided by recovery-orientated services. The processes of 'help-seeking and letting go of excessive self-reliance' are further developed and discussed in the last subcategory of this conceptual cluster. The current subcategory focuses on the experience of profound existential dissatisfaction and the temporal disruptions associated with extended reliance on the substance relationship.

"I had two suicide attempts. (...) I seriously did want to die. I just thought everyone would be better off without me around. (...) that's how badly it got." (P1, 7-8.179-185)
"I was such a pessimist. When you talk about, is the glass half full or the glass half empty, mine was half empty and I'd drill a hole in the bottom (...)." (P1, 16.399-402)
"(...) it [alcohol] *just helps you to forget anything. (...) it's just a short term fix, unless you stay in a constant state of inebriation, which at times I did."* (P1, 22.557-560)
"(...) a realisation that this…this wasn't a life. I was existing. I wasn't living. I was existing badly." (P1, 37.868-870)

In the above excerpts, P1 (52-year-old male) eloquently paints a picture of the depths of despair and existential vacuum chronic alcohol addiction, as a way of 'fixing' one's being-in-the-world, can lead to. There appears to be a collapse of future time perception (see Kemp, 2018), which, in combination with an extremely negative internal representation of his sense of self in relation to others, leads P1 to experience an overpowering sense of hopelessness, meaninglessness and dread over his existence. The way he then attempts to

respond to these deeply painful existential challenges is by engaging in acts of self-violence (i.e., suicide attempts, inebriation) which represent the annihilation of his perception of time by blocking consideration of the future.

Thus, P1 seems to live a suffering and narrow relation to time, feeling cemented and trapped in an endless, painful and empty 'now', completely devoid of any sense of meaning and purpose over the moving-forward of his being. Being extensively frozen and stuck in 'being' rather than 'becoming'[23], the only activity that seems to provide P1 with a sense of meaning, however futile and short-lived that might be, is spending time consuming alcohol in an attempt to extend the forgetfulness of all aspects of his existence – physical, social, emotional, temporal. In other words, this phantasy of self and affect regulation, so seductively promoted by engagement in the substance relationship, facilitates the experience of an absent presence, which eventually leads P1 to conclude that not only he is not living, but he is existing in a rather dissatisfied manner and form.

Furthermore, P1 uses a metaphor of drilling a hole in the bottom of a half empty glass as a way of expressing the depth of his pessimism and, by extension, his unchanging and closed perception of the future. By the same token, we could draw upon a cosmological analogy and liken the flavour of his existential dissatisfaction and seductive attraction to alcohol to the black holes in the universe, from which energy and matter are unable to escape and thereby they deaden everything they absorb.

"(…) when I was in a very low peak, before [therapy], *I would drink two bottles of wine a day (…) and I was afraid of people coming around to see the state the flat was in. (…) very embarrassed and I would panic if anyone came to the door. (…) I did get into a bad position financially (…) I got into arrears with my rent and I was facing eviction…"* (P5, 2.18-26)

"(…) I used to wake up in the morning wishing I was dead. That would be my first thought when I woke up." (P5, 3.38-40)

P5 (65-year-old female) also appears to be describing an existence and way of being-in-the-world that is rather narrow, dominated by and trapped in the 'safe' refuge provided by the substance relationship. She seems to be actively avoiding human contact, acting as if she is denying the social nature of her existence, whilst at the same time her interpersonal

[23] See Rogers (1961)

isolation seems to be motivated and reinforced by prominent feelings of personal shame (alluding to sensitivity to interpersonal rejection) that accompany the practical consequences of being preoccupied with the alcohol relationship and neglecting to tend to other aspects of her existence (i.e., personal hygiene, living conditions). Moreover, she alludes to the neglect of the material aspect of her existence, which can further imply that during the period of active addiction money has value only insofar as it can be exchanged for substances to be consumed and spend time with. Ultimately, she seems to reach her subjective sense of existential despair that leads to the foreclosure of the future and results in suicidal ideation.

"(…) my life was just so meaningless. (…) I just didn't see 'what' – 'why'. (…) I had suicidal thoughts but (…) I was so lazy [laughs] *that I couldn't even be bothered to carry it out (…). (…) I was so unmotivated with everything. The only thing I was motivated was where to get the alcohol and when to drink it."* (P12, 13.320-328)
"(…) I don't think I got to the worst point though, compared to a lot of people I guess. But I guess it's all individual for me." (P12, 15.66-68)

P12 (41-year-old female) describes her own experience of living a life devoid of a satisfying sense of meaning, purpose and future movement. She connects her sense of existential dissatisfaction to experiences of suicidal ideation, saying that she was too *"lazy"* to even act on suicidal thoughts. If we interpret the word 'lazy' to mean 'bored', then boredom can be conceptualised as a sense of temporal stuckness in an extended and unsatisfying 'now', combined with a difficulty to envisage the future and act in a more positive manner towards that vision. In this sense, the temporal flavour of her existential suffering can account for both her overpowering motivation to engage in impulsive (i.e., lack of future consideration) alcohol consumption and her subjective experience of eventually hitting her personal bottom that propelled her to let go of overly self-reliant, substance-assisted self-regulation.

"I just felt bad the majority of the day (...) just stayed indoors, curtains shut, blinds down, hiding away from everybody (...). (...) 'What's the point if I get up in the morning, I'm just going to buy booze (...) I'm not doing much, I'm just sitting here, it's not living, (...) I'm just existing, I'm just here'." (P10, 2-3.31-45)
"(...) it'd just be like, 'I'll just drink, just drink, just drink' – it could be 10:00 in the morning and I'd think, 'Can't go to the shop now, it's too early', 'It's 10:30 now, no still too early'(...). It's like clock watching." (P10, 10.225-229)

P10 (39-year-old female) gives her own account of being cocooned and having retreated from the world. She seems to opt for a distance from her surroundings, choosing to have very little interaction with other human beings, and only insofar as this contact promises the procurement of alcohol. She is interpersonally alienated and seems to be using alcohol as a way of facilitating further escape and withdrawal from the world, which likely at this point has become unmanageable. She evidences an extreme degree of self-sufficiency, acting as if she is not part of a community and not needing others.

Paradoxically, the very same thing (i.e., alcohol) that once promised to help her regulate her existence seems now to have resulted in a profound exacerbation of her emotional suffering and complete takeover of her life. Indeed, she gives the impression of being held hostage by alcohol, which has now even begun dictating the passage of time – a very slow passage of time that likely makes the present feel like it is going to endure forever.

Her description of profound isolated inactivity, and a sedentary lifestyle dominated by alcohol consumption, naturally seems to call time into reflection. In this way, she appears to be mired in an ongoing and suffering 'now', forever awaiting a future-limited reunion with the substance relationship.

As she comes to realise that her relation to time revolves around the procurement and consumption of alcohol, she seems to connect this with a profound sense of existential stagnation and an essentially unlived life that fails to project forwards in time. In this way, P10 seems preoccupied with surviving a static, timeless present and a future that does not seem to approach fast enough in order to be meaningful.

"I didn't really have much hope, you know. I didn't care about the future. I didn't really want the future. (...)I'd stay indoors and I'd just lie down and heroin would come out. (...)I didn't want to answer the phone or speak to anyone." (P9, 10-11.308-320)

P9 (53-year-old male) also connects his experience of heroin addiction to an existence characterised by a blockage of the future and concomitant cessation of forward movement. Heroin is used and related to as a replacement for inter-human contact as well as a tool for miring his being in the now and closing off the future. With the future lived as closed and actively avoided, P9 seems to be stuck in a one-sided dimension of 'being', unable to reach and make contact with the future-orientated and multifaceted possibilities of 'becoming'.

"(...) I was wasting my life, wasting my time, wasting my potential. (...) I've seen my friends, married, kids, houses, moving forward, good jobs (...) making the most out of life, experiencing new things which I wouldn't do." (P6, 6.114-119)

P6 (38-year-old male) also evidences existential dissatisfaction with the way he experiences his being-in-the-world as well as a cessation of forward movement (i.e., a loss or blockage of the future). By engaging in a fruitful process of social comparison, he seems to become aware of his transgressions against himself (an indication of experiencing existential guilt) with regard to multiple missed life opportunities and an overall unwise use of limited lifetime. These realisations seem, in turn, to provide him with a powerful impetus to initiate a therapeutic and prospectively-focused process of change, aimed at renewing and transforming his way of being-in-the-world. Overall, we can suggest that P6's actual 'existential cravings'[24] have begun to overpower his substance cravings.

In conclusion, the findings analysed above seem to suggest that the experiential processes of existential dissatisfaction and loss/blockage of the future are characterised by a rather narrow and individualistic way of being-in-the-world, which focuses upon the procurement and consumption of self-soothing substances and eventually leads to a paralyzing sense of hopelessness, meaninglessness and a now-orientated perception of time. Subjective experiences of suffering along the dimensions of these existential challenges can thereby

[24] See Kemp (2018)

be construed as experiences of profound psychological distress, which if of sufficient magnitude can eventually give rise to an overwhelming sense of helplessness/powerlessness. It is at this point that an individualised experience of 'hitting rock bottom'[25] occurs and the original, interpersonal proximity-seeking, attachment system opens up, propelling the person to relinquish excessively self-reliant coping efforts and reach out to (or be willing to be reached by) relevant sources of help and support. The following subcategory focuses on the experiential dimensions of these latter processes.

3.2.1.3 SUBCATEGORY: Help-Seeking and Letting Go of Excessive Self-Reliance

By this stage participants' existential circumstances appear to have become unbearable and for many there seems to be a realisation that too much has been lost due to their strong attachment to the substance(s) of their choice. At this point the only thing left to lose appears to be life itself – and most precisely an unlived life and trapped existence in the depths of the substance relationship. As a result, many interviewees seem to be facing a 'boundary situation'[26] whereby they feel powerless and defeated over the dominance of substances in dictating their way of being. This state of being seems to be subjectively experienced as an individualised sense of 'rock bottom', where the truth about the negative consequences of reliance on substances for self and affect regulation can no longer be denied. As exemplified by the following interview extracts, it is at this place where positive change has the potential to begin through the processes of admitting powerlessness over one's ability to cope with their suffering alone and instead seeking external, inter-human assistance.

"Denial, denial, denial. 'Oh, no, no, no. I'm fine. (…) I can deal with this myself'. And I came in [XXXX drug and alcohol service] *after the second one* [suicide attempt]. *I was a beaten man at that point."* (P1, 10-11.255-258)

[25] A popular phrase used within the literature of twelve-step fellowships to describe an experience that has the potential to mark the beginning of change and recovery from addictions (see Chen, 2010).
[26] In existential thinking, a 'boundary situation' refers to experiences of conscious confrontation with the limits of one's existential situation (Fuchs,2013; Yalom, 1980)

"(…) this is the second time I tried to kill myself, and I suddenly thought, 'This is not right' (…) '(…) I need to accept that and take whatever's on offer' (…) a big step forward." (P1, 19-20.488-503)

"It was the biggest and hardest thing of them all. To admit I needed help. 'I've got a problem (…) it's affecting everyone around me (…) and it's just got to stop (…) I'm only 52. I've got (…) a lot of living to do'. And the way I was going I wasn't gonna see 55." (P1, 38.890-898)

In the above excerpts, P1 (52-year-old male) seems to experience such intense and profound existential suffering which eventually serves as a key change-instigating factor that initiates treatment motivation and abandonment of overly self-reliant efforts of coping. Being confronted with his second experience of a 'boundary situation' (i.e., his confrontation with his personal death via suicide) appears to provide him with a possibility of becoming aware of the limits of his existence and this confrontation serves, in turn, as a powerful factor in letting go of denial (i.e., self-deception about self-reliance) and acknowledging defeat and powerlessness over his current ways of coping. A sudden change in his awareness about the negative consequences (both intra- and interpersonal) of extreme self-reliance seems to occur as a response to enduring stress and suffering, causing the original, interpersonal proximity-seeking, attachment system, that was until now held hostage by alcohol, to open up in order to resolve this crisis. This, in turn, instigates a process of reaching out to interpersonal sources of help and support.

In effect, P1's experience of initiating a change in his attachment to alcohol illustrates the paradox involved in the parallel experiences of self-surrender and self-empowerment[27]. This means that he essentially gives up the subconscious solipsism and grandiose belief in his omnipotent self-perception. Moreover, through the act of surrendering himself to interpersonal sources of help, P1 empowers himself to begin a process of positive change and healing. In this way, P1's narrative speaks of the dynamic tensions involved in developing strength through accepting powerlessness.

Finally, in P1's experience of initial change we can also see that the processes of help-seeking and letting go of excessive self-reliance seem to result in a re-animation of the future zone of lived time, as he comes to realise that he still has *"a lot of living to do"* and thereby begins projecting himself forward in time.

[27] See Medina (2014)

"It was the initial shock. I was trying to stop using cocaine on my own for over a year. My fiancé at the time didn't know that I was an addict. She found out and split up with me and I think it was just a jolt to the system about losing her I guess and trying to make a change, realising that I couldn't do it on my own and I needed some help. So I contacted XXXX drug and alcohol service who set me up with a key worker. (…) my key working sessions came to an end (…) I wasn't getting anything more out of them. So I asked to see a therapist to go deeper into my addiction problems." (P6, 1.1-9)

For P6 (38-year-old male) the parallel processes of letting go of self-reliance and engaging in interpersonal help-seeking also feature in his initiation of change and recovery from cocaine use. In his case, the resolution of excessive self-reliance and seeking outside help seems to be precipitated by a painful life experience of loss and separation from his fiancé, which was possibly perceived as hitting his subjective bottom place where the negative consequences of his cocaine attachment could no longer be denied, and his personal limits had to be acknowledged.

In this manner, P6, like P1, admits to a felt sense of personal powerlessness and defeat over the emotional tug of war between himself and the substance relationship. Moreover, similar to P1, P6's original, interpersonal proximity-seeking, attachment system appears to open up while being confronted with his personal experience of powerlessness, leading him to surrender himself to the need for help and assistance from a power outside of himself. In this way, initial attempts at therapeutic change and disengagement from problematic substance use can be construed as an outcome of humility, honesty and acceptance of one's personal limitations.

Finally, P6's narrative highlights the importance of multidisciplinary working within the field of substance use recovery as well as the value of psychological therapy in the process of addressing and disengaging from the depths of the substance relationship.

"(…) I felt cheated in life, even angry. (…) like, 'Oh my God I need to do something about it. It's like I have a disability. (…) I can't do this' (…) And, I had this emotion of like, '(…) I've wasted a good part of my life because of this' (…)." (P7, 3.40-45)

"(…) I think the overwhelming motivating factor was that it was killing me. It was like some sort of suicide, some kind of a slow death (…) I know people have died on the streets (…) people who

are really sick (…) and I can see myself in them. (…) It's only when you see. Because in them I saw my future self and I thought, 'I'm not going to be like that'." (P7, 17-18.377-388)

P7 (59-year-old male), much like P1 and P6, seems to be eventually confronted with his own boundary situation and personal experience of hitting bottom, which act as catalysts in initiating change by letting go of self-perceptions of invincibility and instead seeking external assistance in disengaging from alcohol attachment.

Moreover, in P7's narrative the experience of existential guilt and anger for having thwarted his potential and wasted valuable lifetime features prominently and seems to act as a change-promoting factor, enabling him to accept the crushing responsibility of having allowed alcohol to dominate his life, and to atone for this by altering his future relationship to it. At this point, it would be reasonable to speculate, in the same way Kazantzakis (1958) did while writing a continuation of Homer's Odyssey, that the person who feels s/he has not lived is the one who is most terrified of dying. In this way, the experience of guilt and anger for the crime of the unlived/unused life P7 has committed against himself seems to act as another boundary situation that poignantly brings to his awareness the temporal limits of his existence and has, therefore, the power to result in a major shift in the way he chooses to live in the world. As Yalom (1980) compellingly wrote, "Though the physicality of death destroys an individual, the *idea* of death can save him." (p.159, *italics* in original). Moreover, by admitting powerlessness over his alcohol use and being willing to surrender himself to therapeutic support, P7 seems to begin moving away from a temporal orientation to the immediate, short-term present, and projects himself forwards in time by considering the long-term outcome of his consumption. In this way, as part of his initial process of effecting a positive change in his relationship to alcohol, P7 appears to begin re-animating the future and thereby the untapped possibilities of life itself. Arguably, such a present-future shift in his temporal perception can also be posited to account for a sense of openness and hope in his abandonment of excessive self-reliance and concomitant help-seeking behaviour.

"(…) I was at the end of my tether and I just thought I'll try anything now, so let's try this [therapy]. *(…) the therapist, had a lot to do with me getting detox. (…) getting rehab and getting clean (…) and then coming out and carrying on with the therapy."* (P11, 2-3.20-46)

P11 (44-year-old female) appears to be genuinely exhausted by her longstanding efforts of excessive self-reliance promoted by polysubstance-assisted regulation of her being. Becoming aware of having reached 'the end of her tether' seems to provide her with a powerful boundary situation and personal experience of hitting bottom that results in subsequent admission of powerlessness over her current ways of coping. These experiences appear, in turn, to be the motivating forces for her willingness to reach out to others for help in overcoming her substance use problems.

Similar to the previous participants, P11's narrative also illustrates the paradox of self-surrender and self-empowerment as she is essentially attempting to renew her sense of personal strength and resilience via accepting powerlessness over her own ability to treat her suffering with mood-altering substances.

Moreover, P11's excerpt, similar to that of P6, and P12 below, highlights the importance of engaging with multiple sources of help and support during the process of overcoming problematic substance use. Possibly due to the longstanding and multifaceted nature of her substance use problems, in order for P11 to be able to become properly attached to psychological therapy, she first needed to become completely detached from her addiction to substances by entering a rehabilitation centre.

"I was suffering from very severe depression and I was drinking really heavily. And my GP was concerned, so he pushed me into getting help with XXXX drug and alcohol service. (…) So, when I came in here, my key worker (…) said, 'Look, I think you need to see a therapist for it'." (P12, 1.1-7)

"I wanted help with the depression. (…) stop drinking (…) take care of myself (…) go back to work (…) having a closure or forgiveness or peace with all the past relationships and traumas." (P12, 3.91-101)

In contrast to the previous participants who spoke of self-referral to drug and alcohol treatment services following their realisation of hitting personal bottom, P12 (41-year-old female), although also caught in a downward spiral of loss of control over her alcohol use,

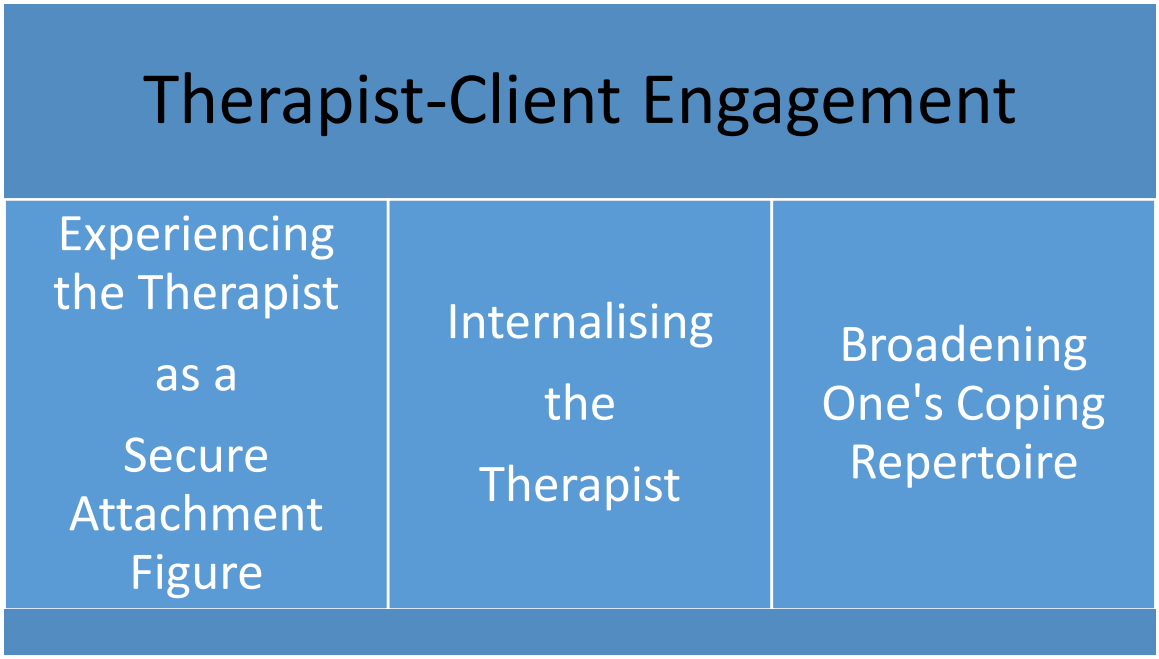
appears to need the help and support of her general medical practitioner (GP) in better acknowledging her problems and receiving guidance to appropriate recovery facilities. Thus, even though she does not seem to have reached a point where her existential suffering has become of sufficient magnitude to propel her to openly admit to personal powerlessness, she does seem to respond positively to being reached by her GP to consider the possibility of letting go of excessive self-reliance and surrender herself to relevant treatment.

The GP's recommendation for formal substance use treatment must have evoked positive expectations and stimulated sufficient hope to enable her to go through the referral process and accept external assistance. Such a referral pathway to substance use treatment highlights, then, the important influence of healthcare professionals in motivating substance-misusing clients' help-seeking behaviours and thereby facilitating abandonment of excessive self-reliant methods for self and affect regulation.

Moreover, as in P6 and P11's excerpts, P12's narrative stresses the importance of multidisciplinary work and collaboration within the field of substance use recovery. The excerpt reveals that following P12's referral to the drug and alcohol service it was her keyworker who initially sensed an underlying psychological issue in her alcohol use and referred her to appropriate psychotherapeutic support. Additionally, P12 reveals an intrinsic sense of motivation and willingness to overcome both her emotional and alcohol use problems, which can, therefore, account for her receptivity to engage in psychological therapy and address the intra- and interpersonal difficulties that were contributing to the maintenance of heavy alcohol use.

The findings embedded within the following main category focus upon the psychotherapeutic processes and dynamics involved in effecting positive change and recovery outcomes within the psychological therapy room.

3.2.2 Main Category #2: THERAPIST-CLIENT ENGAGEMENT



"The therapist provided me with a space and ability to explore. (…) my contribution was the effort I made for that to happen. (…) it was a synergy." (P3, 20.459-463)

"(…) I had this determination to stop but I was not equipped to do it. And he helped me equip myself." (P6, 8.188-189)

"I'm very appreciative and very grateful to the whole process. (…) I feel much better, I'm equipped now (…) I can rise to quite a few challenges (…) than I certainly could without it." (P8, 44.1445-1459)

"If it wasn't because of the therapy, I don't think I'd be able to stop drinking – because the drinking was to help me cope with the pain (…)." (P12, 4.120-122)

As illustrated by the aforementioned interview excerpts, the findings embedded in this category focus upon the importance of the psychotherapeutic relationship, as an interactional phenomenon, in the resolution of problematic substance use. If dependence on psychoactive substances is construed as representing an interpersonal attachment deficit and consequent self-affect dysregulation – as it was argued based on the previous category's findings – then change and recovery seem to require repair of such insecure

attachment patterns and subsequent development of alternative sources of self-affect regulation. In this manner, the findings presented and analysed here point to important dimensions and processes involved in fostering attachment reparation and broadening participants' abilities to overcome intra- and interpersonal experiential avoidance.

3.2.2.1 SUBCATEGORY: Experiencing the Therapist as a Secure Attachment Figure

The primary psychotherapeutic process portrayed in the following interview excerpts is participants' experience of the therapist as a close, secure and soothing attachment figure, which, in turn, results in reappraising and updating internal representations of self and others. In this manner, healthier mental states and more constructive intra- and interpersonal behaviours can be promoted and achieved.

"Knowing my therapist, I think, gave me more confidence (…) that I wasn't a bad person." (P2, 5.152-154)
"I was very surprised because she was very young. (…) but (…) really good at what she did (…). Her tone of voice was very gentle. (…) she made me feel she wasn't judging me. (…) if I'm trying to go back to work is because she did give me the, I think, motivation to think that I could do it." (P2, 7-8.194-230)
"You feel warm. (…) You can just feel that feeling. (…) I think it was just the way she showed her empathy. (…) the way she explained things and made me see more sense about things." (P2, 14-15.395-423)
"(…) because we had this sort of rapport (…) I could tell her sort of things that I've never really told anyone. (…) she was very unique (…) her maturity (…) her intelligence (…) just trying to make me see that things could improve (…)." (P2, 17-18.512-541)

P2 (53-year-old female) describes how her progressive attachment and secure relationship to her therapist resulted in a positive re-evaluation of her internal sense of self and broadening of her problem-solving skills, which, in turn, instilled in her a newfound sense of hope, self-efficacy and self-empowerment (e.g., "*see that things could improve"*). Feeling soothed and reassured by the therapist's warm presence, as a result of the latter's gentle tone of voice, ability to empathise with and non-judgmentally accept P2's

'otherness'[28], as well as capacity to act as a resource for guidance and understanding (e.g., *"explained things and made me see more sense about things"*), P2 appears to be using the perceived safety and warmth of the therapeutic alliance as a 'secure base'[29] from which she can explore novel or frightening experiences (e.g., going back to work) and thereby develop trust in her potential to expand her ways of being.

Moreover, P2's experience of the powerful impact of these specific relational components enables her to overcome her initial alarming observation about the potential negative influence of certain social distance factors (i.e., in this case the noticeable age difference between the therapist and the client), which can separate the worlds of the client and the practitioner and thereby limit empathy and understanding. Instead, P2's experience of a safe and secure attachment to her therapist seems to translate into a strong sense of trust in her therapist's credibility in helping and comforting her (e.g., *"her maturity, her intelligence"*), which, in turn, enables her to let go of relational engagement at the presentational level of self and risk experimenting with more honest and intimate forms of interpersonal connectedness (e.g., *"I could tell her sort of things that I've never really told anyone"*). Overall, P2's experience of a safe and secure attachment to her therapist seems to reflect how she used the therapeutic bond in order to effect positive changes on both conscious and subconscious levels.

"(…) she definitely made me feel so safe to talk about things and just literally say things I never said to anyone. (…) just by letting me talk, she helped me to really know myself (…) and like myself (…). You feel you're not judged, because my biggest fear before was others. Because, you know, drugs is not something we reveal. (…) she helped me to kind of not to hate who I am. (…) she just kept like, I think with this sort of positive regard. (…) you knew she was very present. (…) and this warmth in her eyes, it was very kind of assuring. (…) how attentive she was listening. (…) she would remember things (…) I was really, really amazed." (P3, 3-5.46-111)

"(…) the further she let me be myself, I became much more empathetic and aware of other people's kind of thoughts and experiences." (P3, 10.227-229)

"I don't think I'd ever be the same person, like a year ago. (…) I don't need as much of approval from outside. And I do struggle with low moods and sometimes, even suicidal thoughts. But (…) I learned to…that time could pass and I'm worthy of living. (…) I think she gave me hope." (P3, 11.238-245)

[28] See Cooper (2009) on the humanistic ethic of unconditional positive regard as a reflection of valuing a person's uniqueness and otherness.

[29] Bowlby (1988)

P3 (30-year-old male) appears to be transformed as a result of his positive experience of the therapist's perceived presence and relational qualities. Similar to P2, P3's experience of therapist-offered relational conditions of genuine warmth, attentive listening, consistent positive regard and affirmation of his unique and separate existence (i.e., 'otherness'), appears to underlie the development of a strong sense of safety in the therapeutic relationship, which is subsequently employed as a secure base from which to explore and reflect upon his internal landscape.

Moreover, P3 makes explicit an important point about the value and significance attached to the therapist's ability to relate to substance-using clients in a non-judgemental and affirming manner (i.e., "*You feel you're not judged, because my biggest fear before was others. Because (…) drugs is not something we reveal*"). Such as lying, hiding and 'untruth'[30] forms of interpersonal relating tend to be at the core of the relationships people with problematic substance use form with others – mostly due to psychic tensions between a natural desire for interpersonal love and prominent feelings of shame, distrust and perceived stigma attached to substance use behaviours – the therapist's ability to honour and validate the client in all his otherness appears to be key in P3's experience of establishing a safe attachment relationship that leads to honest self-revelation and un-hiddenness.

Additionally, the implicit element of genuine caregiving that seems to underlie and run through all of the positive relational qualities P3 attributes to his experience of the therapist, appears to result in subsequent positive shifts in P3's attitudes toward both his intra- and interpersonal forms of relating (e.g., liking himself, not needing as much approval from outside, becoming more aware of and empathic towards other people's thoughts and experiences). Thus, it appears that being given permission to talk and listen to himself ("*by letting me talk*"), within an interpersonal atmosphere of safety, acceptance and containment, enables P3 to begin reflecting both upon his own mental states and those of other people that populate his world. In other words, as a result of his safe attachment to the therapist, P3 is helped to engage in a process of mentalization which encourages him to contemplate both his own mind and that of others, and thereby facilitate more satisfying forms of intra- and interpersonal connectedness.

[30] Kemp (2009)

Finally, as P3 learns to utilize reflective functioning and thinks about his thoughts, feelings, behaviours, desires and motivations, it appears that he also learns to inhibit his immediate reactions (e.g., low moods, suicidal thoughts, substance cravings) and thereby develop more effective self-affect regulation skills, such as becoming aware of the continuous flow of his existence and projecting himself forwards in time (e.g., *"time could pass and I'm worthy of living"*).

Overall, it appears that, as a result of experiencing a secure relationship with his therapist, P3 feels empowered to relate to himself and others in a similar way to how he related within the therapeutic encounter.

"(…) my therapist – just someone that would listen. (…)I've got family and I've got my girlfriend. And they would listen, but I guess he was listening without judging kind of thing. Just the way he reacts compared to the way other people react. (…) his body language (…) I think in some sessions I was actually just trying to observe him [laughs]. *(…) the way he spoke (…) the tone of his voice. (…) I never felt defensive speaking to him. I talked about personal feelings and relationships and work. (…) I just felt like I could talk to him about everything."* (P6, 6-7.122-143)

P6's (38-year-old male) excerpt seems to illustrate how one's experience of social relationships can be both the problem and the solution. It appears that in P6's case a vital ingredient in the formation of a secure and close attachment to the therapist is the latter's ability to refrain from judging and evaluating the former's experience. This, in turn, means that if the therapist is to serve as a secure attachment figure and safe base from which to explore one's world, s/he must be welcoming, honouring and attentively tuning into the client's otherness. Indeed, this distinctive characteristic of the therapist seems to set him apart, in P6's mind, from his relational experience with significant other people in his social world, and in this way contributes to the formation of a strong sense of trust and safety to explore honestly and anew all vital aspects of his life (i.e., "*I just felt like I could talk to him about everything."*).

Like P2, P6 nominates the therapist's tone of voice as an important soothing quality that contributes to his experience of safety within the therapeutic encounter, whilst he also points to his own sense of alertness and sensitivity to the interpersonal climate of therapy, possibly as a way of gauging his level of comfort and security in this particular context (i.e., "*in some sessions I was actually just trying to observe him"*). Overall, P6's excerpt

highlights, again, the importance of therapists' acceptance of the client as a separate person in the process of facilitating honest disclosures and safe forays into the exploration and reconstruction of vital intra- and interpersonal areas.

"(...) the fact that she could recall things that I told. (...) she had me in her mind (...) she was interested (...) trying to help me. Somebody loves me." (P12, 23-24.591-596)
"(...) she'd always nod and smile like, 'Okay' (...). And then she would be quite quick at maybe saying things in response to it [to P12's disclosures] *that makes me realise that she's not judgemental. (...) she was genuinely in it and not judgemental so that she could ask questions or say something which I knew that she wasn't struggling sort of thing with it."* (P12, 27.660-669)

P12 (41-year-old female) also appears to have experienced a strong, close and caring therapeutic bond between herself and her therapist. In particular, the therapist's active and attentive listening skills, as demonstrated by her ability to retain and relay important client communications, let P12 know that she has made a difference to the experiential field of the therapist and matters to her. This experience leads her, in turn, to conclude that she's being held in her therapist's mind, thought about, cared for and worthy of the therapist's interest, and much more, in her words, the therapist's love! At this point we can speculate that the experience of being worthy of someone else's genuine interest can do wonders for one's self-esteem, and thereby result in a positive reconstruction of one's internal representation of self in relation to others.

Moreover, P12, like all previous participants, considers her therapist's perceived lack of judgement an important relational component in the formation of a secure and close attachment bond. Based on her perception of the therapist's genuine and soothing non-verbal expressions (e.g., "*she'd always nod and smile like, 'Okay'"*), as well as the therapist's ability to participate in the therapeutic encounter in a real and spontaneous manner, P12 appears to feel accepted, well-tracked and received by the therapist. At this point we can also speculate that the experience of participating in a two-person relational encounter characterised by a natural flow, proximity, immediacy and spontaneity likely resulted in P12 experiencing the therapist as a fellow traveller along the path to positive change and recovery and, thereby, decreased her sense of loneliness in the painful process of reversing her current state of affairs.

"(…) I found myself in the therapy sessions and feeling really quite comfortable. (…) I was quite introvert when I first started with the therapy (…) I used to (…) blush very badly (…) I would sweat and I would rain. (…) And those symptoms (…) gradually reduced. (…) I would make eye contact (…) became more lucid (…) more capable of free-flowing speech patterns (…). I think just by talking (…) I was practicing communicating with persons. (…) that is key in understanding yourself (…). That makes you feel like a person." (P8, 16-18.515-557)
"(…) the last thing a person in that situation (…) wants is coldness. They've already got coldness, you know. We live in coldness, you know. We're freezing here, you know. We want warmth." (P8, 21.721-726)

In this excerpt P8 (53-year-old male) reveals prominent symptoms indicative of intense interpersonal fear and sense of personal danger when exposed to social interactions. It is, therefore, noteworthy to hear him state that through the progressive development of a comfortable sense of intimacy with his therapist he was able to feel more confident and secure in his ability to engage in meaningful inter-human contact. In this way, P8 seems to be using the therapeutic encounter as a safe base from which to explore and experiment with more spontaneous and intimate ways of communicating and relating to others as well as to himself. This experience has, in turn, the effect of reanimating his sense of personhood (i.e., *"That makes you feel like a person."*) and connection to other human beings, and, thereby, possibly results in a decreased sense of aloneness in the world. Indeed, it is striking to notice P8's heartfelt expression about the absence of interpersonal warmth from his life (i.e., "*We live in coldness, you know. We're freezing here, you know. We want warmth."*) and his yearning to participate in a close and meaningful relationship greater than himself.

Moreover, in recounting the therapeutic encounter, P8 makes an important – and often overlooked – point about the place of laughter within the therapeutic relationship as well as the intrapersonal process of healing:

"(…) and an important thing (…) in a therapy environment (…) is laughter. (…) Because (…) once I find myself laughing at something (…) I realized how long it had been since I had been, you know, jovial (…). (…) and what's more, laughing, laughter, really helps establish trust and a confidence bond (…). (…) for me to allow myself to be spontaneous was a big sign (…) I'm returning to myself. (…) and having the ability to reflect on your own actions with laughter is a positive step. (…) you become lighter (…) you stop beating yourself up and slow down (…)." (P8, 29-30.1045-1087)

P8 initially describes the shared use of laughter within the therapeutic encounter as a specific relational component that promotes the development of *"trust and a confidence*

bond", possibly by allowing both parties to relate in a genuine and spontaneous manner, and thereby establish a climate of ease, mutuality and egalitarianism. In this way, there appears to be a specific bonding function that is facilitated by the constructive use of laughter within the therapy milieu and which possibly encourages less defensive and more creative psychotherapeutic explorations[31].

Additionally, P8 talks about the therapeutic benefits of laughter on his sense of self and reappraisal of upsetting experiences. Specifically, he likens his ability to laugh with a return to himself and a regaining of his spontaneity. Here, we can theorize that P8's adoption of a more playful and humorous attitude allows him to bring into the therapeutic relationship his whole personality and thereby re-discover parts of himself he has, hitherto, lost or forgotten to get in touch with.

Finally, P8 asserts that the deliberate use of laughter and humour provides him with a means to lighten up and reflect upon his perceived mistakes in a less threatening and more compassionate light which, in turn, fosters a greater sense of self-acceptance. In this way, P8's use of laughter can be seen as a powerful emotional and cognitive antidote against his tendency to engage in self-criticism and self-deprecation.

Overall, it seems that the constructive use of laughter and humour, within the context of a secure therapeutic relationship, can serve as another means of reconstructing internal representations of self and others.

"Just given me the chance to say what I wanted to say, and…and not judgin' (…) If you feel someone's judging you, straightway, you can back up. (…) It's body language and…it's not what he said (…) It's what he meant. (…) It allows you to open up a bit more. Or explore…explore further." (P9, 21-24.569-627)

Similar to the findings embedded in the previous excerpts, P9 (53-year-old male) considers his therapist's lack of judgement and unconditional positive regard as a fundamental relational component, or highly attractive quality, in the development of a secure attachment to the therapist which, in turn, can be used as a safe base from which to openly and non-defensively explore his world. It is also evident that P9's perception of his

[31] See Winnicott (1971) on the therapeutic significance of playing (literally or figuratively) within the psychotherapeutic space and time.

therapist's non-verbal demeanour and implicit way of being with him leads him to develop positive beliefs about the therapist's intentions toward him, which, in turn, facilitate further interpersonal safety and concomitant release of pent-up experiences.

Furthermore, and in contrast to previous participants, P9 refers to his experience of two different types of therapist self-disclosure (TSD), which appear to act as additional relational components that deepen and advance his attachment to the therapist and, thereby, his sense of comfort and safety within the encounter:

"(…) because he's Irish as well, so I know he understands the background I come from. (…) and when talkin' about my father, he's disclosed a couple of things about his father that was related in a similar sort of way, which then brings you closer. (…) So that allows you to open up easier (…)." (P9, 25.634-643)

"(…) there's a couple of times of him where he was sort of really concerned about me – the thing I was talking about. (…) and he even said that to me. Well, he was obviously thinking what he can do to help me. And I was sitting there thinking, well just by having this session is helping me. Out there I've always been on my own and looked after me-self." (P9, 28.705-714)

First, P9 describes the use and impact of a particular extra-therapy TSD[32] that conveys similarity between himself and the therapist in regard to their shared cultural and paternal experiences. In this way, his therapist's transparency (i.e., willingness to be known) about his own difficult paternal experiences outside the therapy room seems to both humanize the therapist (i.e., reducing the power differential and asymmetrical nature of the encounter) and advance the therapeutic relationship by adding extra layers of authenticity, empathy, mutuality and universality. The end product of such sharing and exchange of client-therapist experiences appears to be greater trust, proximity and openness in P9's involvement in the therapeutic work.

Subsequently, P9 recounts another powerful instance of immediate, intra-therapy TSD[33] which also gives a glimpse into his experience of the therapist as a close and protective attachment figure that fosters greater self -affect regulation. In particular, by openly voicing his sincere feelings of care and concern toward P9, his therapist seems to wisely transfer

[32] See Levitt, Minami, Greenspan, Puckett, Henretty, Reich & Berman (2016) on the different types of TSD.
[33] As above

the focus of the encounter from the intrapersonal to the interpersonal realm of self-affect regulation and this, in turn, appears to allow P9 to feel held and contained within the therapeutic relationship (i.e., *"And I was sitting there thinking, well just by having this session is helping me. Out there I've always been on my own and looked after me-self."*). In this way, it can be said that P9 is enabled to use the therapist and the therapeutic encounter as a 'safe haven'[34] and space to recognize, express, reflect upon and tolerate painful affective states he has hitherto defended against through avoidance and secondary attachment strategies linked to problematic substance use.

3.2.2.2 SUBCATEGORY: Internalising the Therapist

The extent of participants' secure attachment to their therapists can also be captured in the processes of assimilating and accommodating in one's mind the therapist's perspective, in a manner that seems indicative of having internalised the attachment to the therapist. As illustrated below, internalising the therapist seems to be an important psychological factor associated with effecting positive changes in self and affect regulation skills and thereby promoting further disengagement from the substance relationship.

The following participants provided explicit references that indicated the development and positive influence of such an internalised attachment to their therapists.

"I started thinking sometimes, I noticed it was so weird, I would think of her (...). For example, when I was in the shower and I knew I had to go and see her. (...) I use my showers for reflection time as well. (...) Now I just think what she would say. (...) because I knew she cares and I knew there wouldn't be judgement. (...) she would always ask me, '(...) how you feel?' She…amazing reflection on how. (...) she picked up very nicely on how I felt. Because sometimes, you're just confused and you don't know what to say. But she did it quite well." (P3, 12-13.271-299)

P3 (30-year-old male) describes a metacognitive process – which initially felt strange or perhaps unexpected – of thinking about his therapist, outside the therapeutic hour, as part of engaging in self-reflection. Moreover, following the termination of his therapy, P3 reveals that he continues to hold in his own mind his therapist's positive regard and caring

[34] Bowlby (1988)

manner of relating and communicating with him, in an attempt to relive the encounter and recreate the therapist's perspective.

Furthermore, in thinking about his therapist, P3 appears to specifically yearn for the therapist's ability to accurately and sensitively explore, acknowledge and validate his emotional world and thereby enable him to self-soothe. In this way, we can say that P3 acts as if he carries a little voice of his therapist inside his head, which continues to assist him with the processes of self-affect regulation by asking him questions about his internal states and offering him supportive comments and reassuring words.

Consequently, it looks like P3 has internalised the soothing and positive manner in which his therapist related to him, and this internal representation of the therapeutic relationship has now the potential to transform his own self-relational stance into a more reflective, empathic and affirming one.

Finally, implicit in P3's narrative appears to be a flavour of nostalgia or 'separation distress'[35] he likely feels from being apart from his therapist, as well as a sense of gratitude and thankfulness for the benefits he has received as a result of the therapist's way of being. In this way, we can hypothesise that the experiences of separation distress and gratitude toward the therapist can be facilitative conditions for the internalisation of the therapeutic encounter and possibly its transference to other important relationships – both intra- and interpersonal ones.

"(…) when I did relapse (…) it was mainly because of anger and not being able to express myself, not feeling that I was being understood. (…)I think I was trying to punish my girlfriend in a way. (…) like, 'You're not understanding me. Fuck you. I'm going to go and do some drugs'. (…) At that time, I really wanted to see him. I just thought he'd help me calm myself and just say things like, 'Hold on a minute. What are you doing?' (…) 'Is it really worth it?' But I could not see him and I realised myself. I think the training that he's given me (…) helped me to realise myself." (P6, 9.203-215)

P6's excerpt (38-year-old male) also evidences a 'take in' of the therapist and in particular the therapist's metacognitive and mentalization skills, in the process of self-affect regulation, as important safeguards against substance use relapse.

[35] Bowlby (1988)

In my view, P6's account demonstrates how a positive internal representation of the relationship with the therapist, and thereby all the corrective cognitive, emotional, relational and behavioural experiences embedded wherein, can act as a buffer against problematic substance use by preventing an occasional lapse escalating into a full-blown relapse. In this way, P6 initially describes how his experience within an interpersonal context characterised by misunderstanding and misattunement in relation to his internal states led to uncontained feelings of anger and subsequent impulsive retaliation via harmful substance use and experiential avoidance. Later on, as P6 engages in metacognition and reflects upon his instrumental use of drugs, he appears to be reminded of the comforting voice of his therapist which helps him to slow down, contemplate and understand his own mental states so that he can recognize himself as an intentional agent and make an informed choice about whether to use drugs in the service of self-affect repair. Thus, holding the therapist in his mind seems to buffer against P6 feeling psychologically alone with his anger, which could have resulted in continued, reflex-like drug use and thereby a full-blown relapse. In this way, it is as though the therapist is with him and exerts an active and positive influence on his mind and otherwise destructive behaviours. In this sense, P6's internalisation of the attachment to the therapist has the potential to act as a protective factor in his continued change and recovery.

Similar to P3, P6's account of the internalisation of his therapist also appears to occur against a background of nostalgia and gratitude toward the therapist as a secure attachment figure, endowed with particular skills to enhance his resilience and thought-action repertoire.

"I valued my therapist and her opinion. (…) it would resonate so that when I got home and (…) the danger signs came about then I could (…) reflect on what was said to me (…) so that would help in some of my decision-making (…) So, you know, 'I'm frustrated (…). So, I'm going to go to the shop and (…) buy such and such' [substances]. *And then I would (…) sort of catch myself and what the conversation was in there* [in therapy] *(…) and how much progress I've made (…) just sort of follow these different things (…)."* (P8, 38.1286-1301)

P8 (53-year-old male) seems to explicitly link the internalisation of his therapist to his sense of gratitude and appreciation for the therapist's interest in promoting his well-being and furthering the recovery process.

Moreover, the therapist is seen as credible and her perspective appears to *"resonate"* with P8's goals for change and recovery, denoting thereby a strong therapeutic alliance[36]. In this way, when P8 is alone and becomes aware of possible *"danger signs"* and cues to relapse, such as the experience of uncomfortable negative affective states, he seems able to inhibit his immediate, impulsive reactions toward substance use and experiential avoidance by reflectively holding in his mind therapeutic conversations that have the power to positively influence his *"decision-making"* in the interest of continued change and recovery.
Similar to P3 and P6 above, it can therefore be said that P8's newfound intrapersonal relationship to self-affect regulation, especially during difficult times and painful affective states, has emerged as the internalisation of the therapeutic encounter. In other words, the way P8 has experienced his therapist relating to him has started to become the way he now relates to himself.

3.2.2.3 SUBCATEGORY: Broadening One's Coping Repertoire

The findings presented and analysed in the first and second subcategories of this conceptual cluster appear to have in common a sense of participants' subjective experiences having been recognized and adequately understood by their therapists. This is the process that has been termed and referred to as 'mentalization' in the previous sections. In this section, it appears that therapeutic experiences of mentalization have led to the formation of 'epistemic trust'[37] which, in turn, empowers participants to recognize themselves as intentional agents and thereby generate new and more flexible ways of coping with their intra- and interpersonal experiences.

Three participants spoke explicitly about broadening their affect regulation skills in the process of disengaging from problematic substance use.

"[before therapy] *I didn't know how to deal at all with emotions (...). I was very good at masking my emotions."* (P1, 23.577-579)

[36] Fluckiger, Del Re, Wampold, Symons & Horvath (2012)
[37] 'Epistemic trust' refers to a person's willingness to consider new knowledge and skills gained within secure social encounters, in the service of effecting positive changes in intra- and interpersonal relationships (see Fonagy & Allison, 2014).

Before embarking on a course of psychological therapy, P1 (52-year-old male) alludes to longstanding experiences of poor emotion regulation, emotional avoidance and possibly alexithymia (i.e., difficulty in identifying, naming and expressing emotions). We already know from his previous excerpts that his customary method of coping with, 'masking' and burying difficult or unwanted emotions was the harmful and inflexible use of alcohol.

Later on during the interview, he reports – as a result of participating in psychological therapy – a process of improving and broadening his intrapersonal affect regulation skills, which has helped him to respond flexibly to aversive emotional states via accessing alternatives to alcohol for the tolerance and downregulation of his negative mood.

"(…) having a more understanding of…and not being ashamed of the way I feel. (…) once you've accepted the way you feel, think about well, how can I change the way I feel…and work on it." (P1, 40.932-943)
"Shame, guilt…loathing. All those horrible things that just sit in the biggest dark. (…) it's too easy to try and block it away. You have to open your mind for those. (…) The brain said 'Oh yeah, we know what this is now'. '(…) you know when you get this feeling, what can happen. We need to do something about it'. Whether it be talk to somebody, get out and do something, change where I am." (P1, 41-42.957-979)

In the above excerpts, P1 appears to describe the underlying dimensions of developing healthier and more flexible emotion regulation skills. Specifically, he talks about gaining awareness, clarity and acceptance of previously hidden affect, so that he can embrace the way he feels and subsequently use his emotional cues to respond adaptively to the tolerance and downregulation of emotional distress (e.g., *"talk to somebody, get out and do something, change where I am."*). Thus, the broadening of P1's emotion regulation skills appears to include recovery from alexithymia, development of emotional intelligence, use of reflective functioning (i.e., mentalizing) and engagement in goal-directed behaviour (i.e., substance use avoidance) to stabilize his mood. Overall, P1's excerpts underscore the importance of knowing one's emotions in well-being and recovery from harmful substance use.

"I just realised I'm connecting with myself (…) say, 'Oh, this is how I feel and that's okay.' (…) Just validate feelings. And then with some feelings I question (…) why am I feeling this way, because some of them were very new or (…) so suppressed (…). [e.g.] *Anger. Why am I feeling angry? Because before it was anger was bad. (…). Or shy (…) Insecure. Sad. (…) that helps you to change. (…) it gives you an opportunity to respond to it in a different way (…). Then you just feel like you're smarter. (…) denying your feelings is not for you anymore. Just learned that. (…) you get in such trouble (…) deny closeness (…) deny yourself (…) build no more relationships."* (P3, 16-20.384-456)

Similar to P1, P3 (30-year-old male) alludes to having developed more robust affect regulation skills which, in turn, enable him to know and connect with himself more authentically, and thereby recognize his sense of agency and self-efficacy in modulating his mood without the use of substances. P3, like P1, also appears to conceptualise the construct of emotion regulation as a multidimensional one, involving mindful awareness and acceptance of previously hidden negative affect, as well as linking emotional discoveries to actions that have the potential to assist with mood improvement in a constructive manner. Finally, as a result of broadening his affect regulation skills, P3 seems to realise that improvements in his intra- and interpersonal psychological health and wellbeing rest upon decreasing experiential avoidance of negative affect and increasing emotional intelligence.

"(…) she [the therapist] *seemed to have identified my area of problem, like 'where are your emotions?' (…) and I thought, 'Oh my God, they're bottled up inside me and they're killing me.' And then, when I began expressing* [emotions] *or just being assertive, then it just felt better. (…) It felt like an incredible release (…)."* (P7, 15.319-324)
"Change seems to have happened when I began looking for my emotions. 'What are my emotions?' That is when I thought, 'Oh my God, that's the big problem. That is what's killing me. That's what's making me an alcoholic.' And, that is where the big change happened". (P7, 16.337-343)

While in active alcohol addiction, P7 (59-year-old male) also appears to be engaging in emotional suppression and thereby avoidant and inflexible responding in relation to his internal experiences. As a result of feeling mentalized by his therapist, he seems to experience epistemic trust and openness to explore and make genuine contact with his hitherto hidden or *"bottled up"* affect. Such affective experiencing seems, in turn, to enable P7 to feel liberated and broaden his affect regulation skills, by using his newfound emotional awareness as a means of facilitating more genuine and transparent intra- and

interpersonal encounters (i.e., he talks about expressing his emotions and being assertive). Finally, by becoming an emotion detective (i.e., *"I began looking for my emotions"*) and allowing himself to feel his feelings, he also seems to feel empowered in his ability to effect a positive change in his harmful use of alcohol.

In addition to experiencing improvements in affect regulation skills, the following two participants also spoke about the processes involved in broadening their interpersonal communication and relatedness skills as part of effecting positive changes in their patterns of harmful substance use.

"A lot of communication problems (...) I had in the past. And speaking to the therapist I think I'm able to express myself better and listen. (...) Because I used to have a tendency. (...) I used to get angry very easily. I don't anymore. I kind of take a few deep breaths and let myself calm down before I say something or do something. In the past, (...) would be, 'Fuck it. I don't care. I'm pissed off. I'm going to go and do some drugs.' Now, it's more like take a step back and try and put myself in the other person's shoes so I can relate to them more easily. For me it's important because it's helping me with my relationships. And it's also keeping me calm." (P6, 2.27-44)

By referring to his past experience of abundant communication problems, P6 (38-year-old male) seems to allude to deep-rooted mentalization problems, whereby one fails to be adequately understood by another and this, in turn, leads to the breakdown of meaningful interpersonal connectedness and concomitant affect dysregulation, thus an attachment rupture.

It appears that following the corrective relational experience of being sensitively responded to by his therapist, P6's own capacity to mentalize is restored, leading him to become aware of his tendency to respond inflexibly to interpersonal misattunements, guided by overwhelming feelings of anger which motivate subsequent harmful drug use as an attempt to numb from distressing thoughts and emotions. Thus, by contemplating and engaging with his own mental states, P6 is able to consider himself as an active agent in broadening both his intra- and interpersonal emotion regulation and relatedness skills. In this way, he is able to self-soothe and downregulate the intensity of his anger via active use of controlled, deep breathing skills, which, in turn, allow space for the development of improved understanding of social situations via further mentalization and perspective-taking (i.e., *"try and put myself in the other person's shoes so I can relate to them more easily"*). Overall, this broadening of P6's coping repertoire appears to result in noticeable

improvement of his intra- and interpersonal competence and thereby a positive shift in the quality of his attachment relationships.

"(...) I think that's what happens in psychology, in therapy. I find that it's so amazing how you can look at it in so many ways. (...) I kind of sort of learned the technique from the therapist (...). (...) we could talk about all the previous bad relationships. Like my mother (...). And I thought, 'Okay. (...) she is a human as well'. And I put myself in her shoes. If I was the mother (...) done certain mistakes that I would make as well. So, yeah, you can forgive her for that. So, you look at it that way. And (...) I managed to slowly talk to my mum again. (...) just tell her how I feel. And then she got to understand it. And she apologised (...). And (...) through that, (...) I realised, again, that's how you don't realise sometimes when you've hurt someone, you know, that it wasn't intentional." (P12, 5.130-157)

Similar to P6, P12 (41-year-old female) describes how the therapeutic broadening of her interpersonal relatedness and communication skills, through the process of mentalization (e.g., "*I put myself in her shoes"*), resulted in increased accuracy of her social understanding and promoted subsequent attachment reparation.

Present in P12's account appears to be, again, the experience of epistemic trust within the therapeutic relationship, which enables P12 to learn from her therapist new and more flexible ways of seeing and interacting with her particular social world. In this manner, the therapeutic situation seems to have enhanced P12's capacity to mentalize and thereby update her existing knowledge and internal representation of both herself and significant others, in such a way as to begin approaching social interactions in a more benign and empathic manner.

Importantly, by transferring the mentalization skills P12 learned within the therapeutic encounter to her own social world, she seems able to assertively and empathically confront her mother in order to transparently share with her the way she feels about potential ruptures in their relationship, as well as contemplate and engage with her mother's mental states. This experience enables P12, in turn, to modify her cognitive structures for interpreting her mother's behaviour (e.g., *"I realised (...) that it wasn't intentional"*) in a way that allows her to develop greater mental flexibility and tolerance for ambiguity so that she can both forgive her mother and feel sensitively responded to (e.g., "*she apologised"*).

Overall, P12's excerpt seems to illustrate the broadening of one's capacity to understand social encounters through increased mentalization, which, in turn, has the potential to challenge and restructure interpersonal relationship schemata, and thereby foster corrective attachment experiences that reduce one's mental and psychic pain (i.e., emotion regulation).

Finally, P8 (53-year-old male) was one of the participants who spoke about the broadening of his temporal horizons as a way of coping with his intense sense of existential guilt and missed life opportunities.

"(…) the hardest time when we recover – for me is what I lost; I have no children, I have no family and I lost that portion of my life. (…) facing up to this realisation is the biggest fear in my experience. (…) the waste of time (…). I remember speaking with my therapist about that specific thing and she spoke a lot about how old I was and (…) how much time I potentially have left and (…) what could be achieved and done within that time. (…) so focusing more on the present and future rather than – [the] *past."* (P8, 38-40.1314-1332)

In the above excerpt, P8 appears to link his recovery from substance misuse to a crushing realisation that his personal history contains important periods of lost time, especially with respect to undeveloped intimate interpersonal bonds of belongingness. In order to make better sense of P8's account, it is important at this stage to remind ourselves of the now-orientated temporal dimension of active addiction, during which the future tends to be lived as closed and all vital aspects of one's existence are totalized around the need for substances (see findings within main category #1). In this way, P8 seems to liken his emergence from substance dependence to a difficult process of waking up to a life in which time has passed without having been lived or made use of in a meaningful manner, as the previous prioritisation of the substance relationship relegated all other potentially rewarding relationships and events incapable of assuming enough importance to exert a formative and prospectively-focused influence on his life.

Being naturally impossible to will backward, P8 is now confronted with the painful task – and potential relapse trigger – to face up to his current life situation and transgressions against himself, which seem to have truncated the meaning of his one and only life. Thus, in attempting to accept and deal with the devastating sense of guilt and sorrow that likely

emanate from his conscious reflection upon the loss of valuable life possibilities, P8 is encouraged within the therapeutic relationship to use the therapist's brain to modulate his own, by reorienting his temporal focus to the present and future possibilities of his being-in-the-world. In this manner, P8 appears to be provided with an opportunity to broaden his temporal horizons and use this as a coping skill which can allow him to atone for the past crime of *"the waste of time"* by reconceptualising and altering the remainder of his life. Moreover, implicit in the process of broadening his temporal horizons and nurturing the present- and future-orientated nature of his being, seems to be the fostering of another important existential coping skill, that of self-forgiveness – not as an attempt to relinquish accountability, but rather as a means of releasing resentment, hatred and hostility toward the self.

Overall, the findings analysed in this category seem to suggest that the making of keys, which unlock people's capacity to grow and widen their ways of seeing themselves and the world around them, is the work of psychological therapy that is based upon the quality of interaction between the therapist and the client. In this manner, therapy can encourage and prepare clients to develop trust in their abilities to effect positive changes in their being-in-the-world. However, responsibility for effecting positive and lasting changes needs to also be taken beyond the therapeutic setting, in the person's living environment, so that people can become their own therapists. In this manner, the following category presents findings which illuminate the processes involved in continuing the work of positive change and recovery outside the therapy room.

3.2.3 Main Category #3: BECOMING ONE'S OWN THERAPIST

"There is no point in walking out the door and not putting into practice what you've learned." (P1, 15.370-371)

"(...) there is not, 'Okay you do twelve weeks with a therapist and then you go out, goodbye, you're cured'. This doesn't work." (P8, 36.1263-1265)

As briefly illustrated by the excerpts above, the process of positive change and recovery from harmful substance use tends to remain vulnerable and incomplete outside the therapeutic setting, unless psychotherapy participants invest energy in the assumption of responsibility for re-authoring their ways of being and interacting with their particular worlds. In this manner, the findings embedded in this category concern themselves with vital factors and processes involved in effecting self-directed changes that generalise the kernels of therapy and facilitate improvements in participants' wellbeing and quality of life – in ways that support but also go beyond the mere behavioural change from substance misuse to abstinence or harm minimisation.

3.2.3.1 SUBCATEGORY: Engaging in Personally Meaningful Use of Time

This subcategory presents findings pertaining to participants' agential efforts to actively change and restructure their being-in-the-world by planning and engaging in activities that provide positive alternatives to substance use and foster a meaningful relation to lived time.

It appears that disengagement from harmful substance use results in a noticeable experience of a void in participants' sense of lived time and a concomitant question of how to live life without substances. In responding to these challenges, participants seem to realise that time is a human activity that needs to be managed and structured in a disciplined and future-orientated manner via the adoption of simple practices and routines, which hold the potential to reanimate interest in caring for oneself and aid societal reintegration.

The following excerpts illustrate the ways different participants were able to exercise a perceived sense of mastery over their change and recovery efforts by engaging in activities that provided them with a renewed sense of meaning and purpose, and thereby increased their sense of wellbeing and life satisfaction.

"(…) I started going to the gym, exercising. (…) looking after my health, eating better, sleeping better (…) looking after my finances. (…) most of my time was spent doing drugs. All of a sudden that time was there. (…) I had time to fill (…). (…) I started filling it with positive things. (…) I was thinking about other things, when my next holiday is going to be (…)." (P6, 4.65-81)
"Eventually, I started to learn how to enjoy time by myself. (…) I started to read books. I went home and just relaxed, had a bath, hot bath (…) I started to actually like my own company (…)." (P6, 5.103-104)

In the process of disengaging from harmful substance use, P6 (38-year-old male) seems to realise that his previous drug use was where his relation to lived time was mostly situated (i.e., *"most of my time was spent doing drugs"*). By using what appears to be a 'container' metaphor of lived time (i.e., *"I had time to fill"*), P6 appears to recognise that time is his possession, and he therefore has freedom and responsibility in how he chooses to inhabit it. In this way, P6 realises that time is a human activity and begins to re-author his daily routine by introducing activities and behaviours which are non-drug-related and can result in healthy and rewarding consequences. For instance, he is engaging in regular physical exercise, which likely provides him with a natural way to improve his physiological and

psychological wellbeing; performing daily acts of self-care (e.g., *"looking after my health, eating better, sleeping better"*); attending to the material aspect of his existence (e.g., *"looking after my finances"*); developing a positive orientation toward the future by planning upcoming holidays; and overall fostering an improved sense of intrapersonal relating via activities which provide constructive means of self-regulation (e.g., reading books, taking hot baths).

Overall, we can argue that by restructuring his daily rituals around meaningful and rewarding acts of self-care, P6 likely experiences a sense of control and self-efficacy over the maintenance of his positive change efforts, whilst at the same time he enables the rhythms of everyday life and social (i.e., collective) lived time to be slowly reintegrated and allow a gradual re-adaptation into society.

"(…) when I stopped drinking I was like, 'Oh my god, what do I do?' (…) Suddenly, I was like, 'There's too much time.' I was quite scared of it. (…) So I did fill my time and did everything I could. I went to the gym (…) started to clean the house to make it look nice (…) planning down I'm going to go on holidays. And then slowly that became self-care (…) I'd be more interested in brushing my teeth, having a shower (…) organising my wardrobe (…) cooking, reading. (…) having more interest in things." (P12, 8.212-232)

P12 (41-year-old female), similar to P6, also seems to be dealing with the challenge of free time and facing the crucial question of how to live her time without drinking. In this way, once harmful alcohol use is given up, P12 appears to experience a noticeable shift in her temporal perspectives associated with a threatening expansion of her sense of lived and experienced time. Eventually, like P6, she is able to acknowledge that time is a human activity that needs to be planned and organised around simple practices that can give meaning, value and interest in the things of the world (e.g., gym, clothes, food, books, recreation). Furthermore, by performing activities of daily life, such as cleaning the house, cooking, reading, exercising, attending to personal hygiene, P12 is enabled to rediscover an interest in caring for herself and the direction of her life. Additionally, engaging in a more purposeful use of her time helps P12 to keep herself meaningfully busy and off drinking and thereby strengthens her internal locus of control for effecting positive changes. Overall, we can hypothesise, again, that the establishment of a personally meaningful routine, and use of time grounded in activities alternative to alcohol, aids P12's

gradual re-adaptation to social and biological rhythms of daily life and thereby facilitates her societal reintegration.

"I've started getting more organised and started going to the gym. (...) I'd left my flat get very run-down. (...) now I'm managing to keep it clean and keep myself clean. I prepare my meals, do the laundry (...). So, I manage (...) coping better day-to-day." (P5, 5.92-97)
"(...) started looking after my skin again. (...) when I was drinking I'd just fall into bed at night, but now I'm sort of cleaning and putting on creams and moisturisers. (...) just sticking to my skincare regime, so that's one change, quite an important one really." (P5, 7.123-127)

P5 (65-year-old female), like P6 and P12, also acknowledges the management and structuring of her time around daily rituals and acts of self-care as vital strategies for taking on an active role in her own therapeutic process and acquiring improved skills of effective living. Moreover, by taking responsibility to re-author her lifestyle in a more disciplined and prospectively-focused manner (e.g., exercising, keeping self and flat clean, tending to nutrition and skincare needs), P5 seems to rediscover in very simple practices a broadening of her world and an improved quality of her life.

"(...) the crucial thing for me was…I regained structure in my life and without structure, I don't think (...) I would've responded as well as I have (...). (...) So I started to have these sorts of different dates within the week and that was something to aim for. (...) to stay sober for (...). (...) For example, I did a short course called 'Breaking Free Online' (...) and then I did some work in teaching other people how to utilise it. So that gave me more structure, more responsibility and therefore more self-esteem." (P8, 7-8.195-227)

P8 (53-year-old male) also describes the value structure and routine added to his sense of wellbeing and positive change efforts. However, compared to the previous participants, he seems to talk more about the benefits he derived from engaging in regular acts of service, rather than acts of self-care. In this manner, P8 takes active steps to plan his weekly lived time by participating in meaningful social activities and prosocial behaviours (e.g., *"different dates within the week"*). For instance, in the excerpt above, he describes engaging in relevant education and vocational skills training which, in turn, enables him to be of service to other people via peer-mentoring practices. In this way, P8 seems able to build a relatively stable and prospectively-focused structure and routine, which not only

supports the overarching goal of refraining from harmful substance use, but also provides him with a renewed sense of purpose, significance and self-worth, by encouraging him to feel that he has a meaningful and productive role in society.

"I get up and I do things, I do training (…) I keep myself busy (…). Everyday things (…) if there's an appointment, getting to it (…). (…) I'm always doing stuff now, I'm not busy just staying in, drinking and doing drugs. I'm busy actually doing things." (P11, 5-6.121-130)

P11 (44-year-old female) also reports imposing a meaningful everyday structure and routine that supports her recovery maintenance and encourages re-adaptation to and re-synchronisation with the social rhythms of lived time. Similar to P8, she talks about the value of being productive and keeping her self occupied by participating in society. For example, she takes responsibility to schedule and keep interpersonal appointments, which likely help her reduce time spent in isolated inactivity as a potential relapse trigger, whilst she also pursues vocational skills training that has the potential to make her feel like a valued member of society and thereby renew her sense of purpose and meaning in life.

Overall, the findings reviewed within this subcategory point to the significance of planning and performing everyday acts of self-care and service as important intrapersonal strategies that nurture participants' willpower and efficacy in effecting and maintaining positive change efforts, promoting, thereby, their agency in functioning as their own therapists.

The following subcategory continues in the direction of taking responsibility to become one's own therapist by focusing upon findings which reveal factors involved in restructuring one's social environment and personal support networks, in ways that promote one's adaptive strivings and ensure a positive impact of interpersonal connectedness on human behaviour and wellbeing.

3.2.3.2 SUBCATEGORY: Reconstructing One's Social Environment

This subcategory presents findings that illustrate the crucial role social connections play in the pathways into and out of harmful substance use. Although social support and interpersonal connectedness are generally regarded as positive characteristics of mental health, participants' accounts reveal that these are more complex and multidimensional constructs in relation to substance use behaviour. In particular, the findings show that participants' social networks can either facilitate continued substance misuse or promote recovery-related self-efficacy, and for this reason they need to be restructured in ways that foster substance use avoidance and ensure a positive influence of interpersonal belongingness.

The following participants provided explicit references in relation to the importance of actively changing the composition of their social networks by distancing themselves from interpersonal connections associated with substance-using behaviour.

"I cut out all my friends that I used to have. (...) I wanted to be around a different set of people (...). So I started socialising more with work colleagues rather than old friends (...)." (P6, 5.88-92)

P6 (38-year-old male) alludes to the complexity and importance of his interpersonal interactions in the process of overcoming problematic substance use. Specifically, he talks about drastically ending all of his friendships that were supportive of continued substance use – thereby serving as powerful craving and relapse triggers – and becoming interpersonally connected to work colleagues, who likely served as a social group whose norms opposed problematic substance use and thereby supported his positive change and recovery efforts. Although not explicitly verbalised, we can further hypothesise that implicit in P6's transitioning from a social network supportive of substance use to one supportive of recovery, is the facilitation of a shift in his social identity and perception of himself as someone in recovery, or a non-substance user, capable of engaging in behaviours that support an improved sense of wellbeing and quality of life.

"(...) I have lost contact with all my old friends, like anyone who's using. My brother still uses every day, so I don't even speak to my brother anymore. (...) That housing estate was a massive trigger. (...) So I got off of that estate, moved out of XXXX district altogether, which was a big using area for me." (P9, 11.323-335)

Similar to P6, P9 (53-year-old male) talks about breaking ties with previous substance-using social groups, including his connection to his own brother. Moreover, he stresses the importance of exercising control over substance-related cues and temptations by physically moving away from an area associated with substance use availability, and relocating to a trigger-free environment. In this way, P9's excerpt seems to illustrate problematic substance use as a socially, rather than solely individually, mediated phenomenon, and thereby places importance on the influence of the social context in which an individual is changing and recovering. Finally, as with P6, we can again speculate that P9's radical changes in the composition of his social network and living environment can diminish the salience and relevance of a substance-user identity and foster the development of a social identity associated with beliefs and behaviours that promote continued recovery maintenance.

"(...) I did lose all of my friends because of the alcohol – that was me, I had to say, 'Alright, everybody leave me alone'. (...) they were bad news, they said they were friends but they weren't. Because if they were friends they would be helping me and they wouldn't have been coming to my flat saying, 'here's another bottle of wine'." (P10, 5-6.123-135)

P10 (39-year-old female) also refers to the impact of social connections on substance use behaviour and highlights the importance of creating physical and psychological distance from friends supportive of continued alcohol use. In this way, removing from her social network friends associated with drinking seems to act as a strategy that fosters both the avoidance of alcohol use temptations and the separation of herself from a social identity associated with harmful substance use.

"A lot of things have changed. I think it made me realise that I've come out different but everyone else around me is still the same. (...) doing the same things (...). (...)I had to get rid of a lot of my old friends and not see them anymore (...)." (P11, 8.84-91)

As a result of engaging in therapeutic work to overcome substance use problems, P11 (44-year-old female) seems to experience a noticeable change in her perception of herself, which, in turn, leads her to engage in a reflective process of social comparison and evaluative differentiation between herself and her previous group memberships. In this way, it appears that the changes P11 has experienced as a result of her efforts to disengage from harmful substance use have resulted in decreased social identification with substance-using friends, and thereby fostered her conscious decision to eliminate them from her current social network, whose norms likely oppose continued substance-using attitudes and behaviours. Thus, in the process of reconstructing her social environment P11, like the previous participants, also seems to renegotiate her social identity in a way that identifies her more with the values and beliefs of people in recovery or non-using.

In addition to moving away from social networks populated by people who encourage continued engagement in harmful substance use, several participants spoke about the importance of moving toward and becoming more connected to social support groups whose norms of belonging are antithetical to substance-using behaviour.

The adaptive changes in interpersonal connectedness the following participants reported fostering had to do with repairing or rebuilding relationships with family members negatively affected by previous substance use, as well as forming new social support networks composed of peers supportive of positive change and recovery maintenance.

"(...) I didn't really have a good relationship with my mum and dad due to communication. (...) And since therapy and since not doing the drugs, it's a lot different. I spend a lot of time now seeing them. I'm just talking about how their day went and things like that which I never used to do." (P6, 3.45-40)

P6 (38-year-old male) reports improving his attachment to and communication with his parents, and thereby strengthening his sense of belonging within his nuclear family support

system. Moreover, his extra-therapeutic experiences of improved relational interactions with his family seem to have occurred as a vital extension of the positive and supportive modes of relating that he experienced within the therapeutic encounter and was able to transfer to his own social world.

"My daughter says to me now (...) 'Mum, can I do your hair?' (...) We wouldn't have done this like, three months ago (...). Well, we do actually sit and talk now. Before we would grunt at each other (...). (...) she's been like, 'Oh, we'll go out for dinner tonight, shall we?' (...) Doing mother and daughter things, things that I should've done years ago, but the alcohol was (...) more of a friend than my family (...)." (P10, 6-7.137-156)

Similar to P6, P10 (39-year-old female) also describes establishing a closer and more meaningful interpersonal connection with her daughter, which likely enhances her sense of belonging to a valued family support system that provides her with increased purpose and meaning to sustain her positive change efforts. Specifically, her excerpt reveals how disengagement from problematic alcohol use allows her to rebuild more adaptive and intimate modes of relating to and interacting with her daughter, which, in turn, result in strengthening their attachment bond in a way that exerts a positive influence on P10's social functioning and recovery maintenance.

"[the therapist] *encouraged me to go to AA*[38]*, which I have done. (...) I found that it helped me and I found a women's group which was better (...). (...) they are all nice women there (...) supportive to each other."* (P5, 10.206-214)

P5 (65-year-old female), on the other hand, speaks about the value of forming ties with paraprofessional, mutual-aid groups whose norms and values fit with her change and recovery aims. In this way, by heeding her therapist's suggestion to attend AA meetings, P5 seems to be provided with a valuable extra-therapeutic opportunity to reconstruct and broaden her social support network in ways that enhance her motivation and efficacy to abstain from harmful alcohol use, as well as nurture the development of a social identity associated with sobriety-related attitudes and behaviours. Overall, it appears that P5's

[38] Alcoholics Anonymous

exposure to and connection with other women in recovery offers important windows of opportunity for positive transformation, instilling of hope, resilience and a constructive influence on her sense of interpersonal belongingness.

"(…) before if something happened (…) my thought was, '(…) I'll just get a drink to take the edge off'. (…) If something happens now I normally ring someone up or I'll pop down and see someone. Or if I'm feeling down, I share it now and let people know instead of bottling it up and then sitting on my own and isolating." (P11, 5.108-117)

P11 (44-year-old female) actively seeks and draws upon informal interpersonal sources of support through her connections to non-substance-using social networks. In this way, her reliance on supportive peers and friends, perceived as valued and appropriate to sustain the maintenance of her change, appears to enable her to utilise constructive coping strategies to approach, rather than avoid, her personal difficulties. For instance, in the above excerpt, P11 describes the value of sharing with supportive others her negative feelings and upsetting experiences as a means of achieving an improved sense of self-affect regulation, rather than engaging in social and experiential avoidance that can promote destructive self-soothing behaviours. In this manner, the identification and involvement of informal helping agents, who know how to get through life without engaging in harmful substance use, seem to act as a curative factor of protective social influence that enhances P11's mastery in sustaining her recovery.

On the other hand, an anthropocentric perspective on the extra-therapeutic benefits of drawing upon constructive sources of social support can blind us to the role of pets as unique attachment figures and alternative sources of social support. In this way, I found it quite interesting, and initially unexpected, that a few female participants also spoke about the value of pets in supporting their change and recovery efforts outside the therapeutic setting.

Upon reflection, however, it is also likely that, due to being a pet owner myself, these findings further attracted my attention and decision to focus upon them in more detail. My personal experiences with pets have taught me that they can be vital members of one's support network and exert a positive influence on individuals' sense of belongingness and

wellbeing (provided they are adequately treated). The data indicated that the following participants shared similar beliefs, albeit in the context of positive change and recovery from harmful substance use.

"(…) I had the support of my cats. That helped a lot. (…) They made me happy (…) the responsibility of taking care of them. (…) It's what happened to…to keep me going." (P4, 20-21.417-425)

During the interview, P4 (47-year-old female) was one of the participants who spoke of interpersonal betrayal and inadequate social support outside the therapeutic environment. It was in this context that she subsequently mentioned how her strong attachment to her cats provided her with a valuable source of emotional and social support, as well as meaning and purpose to persevere in the direction of positive change and recovery from problematic substance use.

As revealed by the data contained in P4's excerpt, it appears that the safe and rewarding relational interactions with her cats have the potential to compensate for her unmet attachment and companionship needs, serve as happiness and life reinforcements, and provide her with everyday opportunities to engage in prosocial acts by tending to their needs. In this way, we can argue that P4's strong bond with her cats supports her change efforts outside the therapeutic setting by encouraging corrective attachment experiences, which convince her that she is lovable and worthy of love, and providing her with a sense of purpose and responsibility that enriches her feelings of personal significance and self-esteem.

"(…) some of my triggers might possibly be down to isolation. (…) I look after a person's dog (…). So, I was there for the weekend, and they left a bottle of wine and I didn't finish it. (…) because I just had the dog for company, I didn't need it." (P5, 14.287-294)

P5 (65-year-old female) appears to be aware that social isolation can trigger problematic alcohol use as an attachment substitute, and describes how interacting with and caring for a dog can act as a viable relapse prevention strategy by meeting her psychosocial needs for belongingness and companionship. Moreover, we can speculate that the strong dependency and care-taking needs of dogs (much stronger, in my experience, compared to other

companion animals), in combination with their innate ability to serve as highly responsive companions, enhance P5's positive changes in self-perception and relatedness skills by enabling her to experience herself as a caring, responsive, reliable and protective attachment figure.

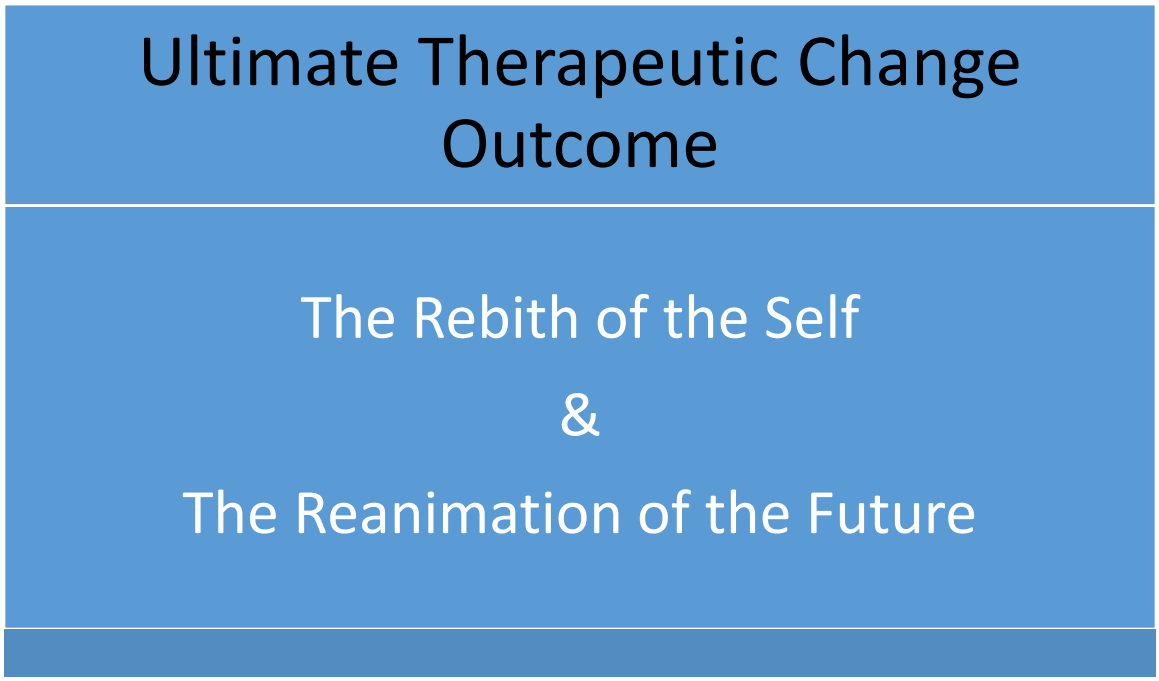
"I've got a (...) dog, but before I was 'Just go in the garden'. But now we've been going out for walks (...)." (P10, 4.72-74)
"(...) it's nice going out because I can have dog walkers as well that I can walk around the field with (...)." (P10, 5.92-94)

Compared to P4 and P5 above, P10's (39-year-old female) excerpt seems to add another dimension to the beneficial role of pets as attachment-enhancing and supportive figures. By resuming care-taking responsibilities for her dog, P10 seems to be offered not only with increased physical activity benefits of walking the dog, but also with opportunities to broaden her social network with likeminded people (i.e., other dog walkers). In this way, it can be argued that P10's ventures with her dog into the broader community have the potential to serve as an effective catalyst for satisfying social interaction and interpersonal relatedness with other members of her community, extending, thereby, the human-pet bond to human-human bonds.

In conclusion, the findings embedded in this category point to participants' deliberate deployment of psychosocial strategies which ensure that the extra-therapeutic nourishment of their change and recovery efforts is contextualised within an environment that fosters their sense of self-efficacy in becoming their own therapist, as well as an emerging sense of self as non-using or in recovery.

The last main category builds upon the findings presented in the previous categories and concludes the mapping of participants' experience of therapeutic change by drawing upon accounts that refer to an ultimate outcome of rebirth and the rediscovery of the future.

3.2.4 Main Category #4: ULTIMATE THERAPEUTIC CHANGE OUTCOME



As participants disengage from the substance relationship and begin rebuilding their lives by effecting constructive changes in their intra- and interpersonal ways of being-in-the-world, they ultimately seem to experience powerful personal transformations, linked to a sense of rebirth and a regaining of interest in the unfolding of the future. These experiences are conceived as the ultimate therapeutic outcome that follows successful psychological therapy for the resolution of substance use problems.

The following excerpts illustrate the ways participants' experiences of rebirth and a concomitant focus on the future-orientated dimension of their being allow them to transcend their past ways of being-in-the-world, realise that they are the authors of their own lives, and thereby meet themselves as individuals who are in an ongoing process of becoming and care about the moving forward of their being.

"I've been given a second chance (...) just a completely different philosophy to life and a different way of thinking. Consequence is the future looks better. More hopeful. There's things I can look forward to (...). It's a much nicer feeling (...). It used to scare me. (...) it's an ongoing process. (...) You're constantly moving forward." (P1, 21.531-542)

P1 (52-year-old male) describes having developed a brand new and refreshing attitude and "*philosophy to life*", which is accompanied by transformative and more adaptive ways of thinking that allow a broadening of his temporal horizons, and thereby a hopeful orientation to the future possibilities and potentialities of his being. In this manner, his previous fear of the future as an ambiguous and changeable temporal horizon – and consequent blockage of it through harmful substance use – seems to have been replaced by an increased awareness of the continuous flow of his existence, and thereby an emerging sense of personal freedom and agency in choosing how he wants to live his life. It is in this context that P1 appears to experience an opportunity of *"a second chance"* at life which allows him to make a fresh start and better choices in the ongoing process of becoming and moving forward into the future.

"(...) I'm acting more grown up (...) I find this guy thinking more about the future rather than the present. (...) it's like you've just been born. And you've got to learn how to function." (P6, 9.196-201)

P6 (38-year-old male) also acknowledges a significant shift in his temporal perspective, which is associated with an increased and reflective focus upon the future dimension and possibilities of his being, as well as a reduced emphasis on enjoying the present moment of his existence in a way that might lead to impulsive behaviours (e.g., substance misuse) and a lack of consideration of future consequences. This broadening of P6's temporal horizons and the associated rediscovery of the future zone of lived time allows him, in turn, to realise that he has grown and matured in his ways of thinking and acting. Moreover, P6 explicitly likens his newfound relation to the future to an experience of giving birth to a new sense of self that has the potential to become more than he was, by being free to choose and learn different ways of functioning in the world.

"I've managed to reduce my alcohol consumption down to normal levels (…). I feel a lot better (…) orientating myself towards work (…) feeling healthier. (…) I can see myself and I look better, I have a better posture, I speak better. (…) I love myself now. I care about myself (…). I want to live my life and I want to have a good life and I have realised that too much alcohol is killing me (…). So I'm doing this because I really care about myself." (P7, 7-8.159-174)

P7 (59-year-old male) appears to link his successful reduction of alcohol, within safe limits of consumption, to positive transformations in his sense of physical and mental competence, as well as the re-establishment of meaningful occupational activity, which is likely incompatible with a temporal way of being that is dominated by hazardous drinking. In this way, P7 seems to experience an invigorating and newfound sense of self-care and self-love, which, in turn, is expressed as a regaining of interest in the flow of his existence and desire to *"have a good life"*, by envisioning his future and choosing to act in a positive and healthy manner towards that vision (i.e., maintaining safe alcohol use). In this context, we can therefore argue that P7, similar to P1 and P6, experiences a sense of personal and social rebirth, which motivates him to re-orient himself to the careful anticipation and consideration of the future possibilities of his being-in-the-world.

"The goal was (…) to try and recover and better myself. (…) I used to hate the thoughts of getting old. (…) But now I'm actually embracing getting old, which is a really big change for me (…). (…) Embracing myself…and exploring and been keen to learn more about myself (…) and it's a learning process all the time." (P9, 32-33.801-817)

P9 (53-year-old male) also seems to describe his ultimate recovery from harmful substance use alongside the enrichment and expansion of his sense of self that is conceived as being in flux and an ongoing process of becoming. In this manner, P9's 'now' sense of temporality that appeared to be dominant during the active phase of substance misuse and foreclosed the future as a possibility (i.e., *"I used to hate the thoughts of getting old"*), seems to have been replaced by a reanimation of the future-orientated dimension of his being, and thereby the rebirth of some new aspect of his sense of self. By being able to give birth to and embrace the dimension of his being that is naturally forward-moving (e.g., *"I'm actually embracing getting old"*), we can argue that P9's capacity for meaningful and purposeful forward movement is restored, motivating him to continue exploring and actualising the unknowable and unfinalizable potentialities of his being-in-the-world.

"(…) physically looking better. And also emotionally and mentally (…). (…)It's like I have new glasses. Like all the time I had old glasses and it was the wrong prescription. Everything looked so bright. (…) suddenly I thought 'Have I grown taller as well?' Because I don't remember the floor being that far down. And I think now, maybe I was walking around like this [leans over] *all the time."* (P12, 9-10.242-251)

"(…) it's a journey that I have to carry on on my own. And it will be ongoing. I don't think there is such a thing as 100%, you know, perfect, normal (…). I think it's all part of (…) the growth, isn't it?" (P12, 31.753-759)

P12 (41-year-old female) also acknowledges positive transformations in her physical, emotional and mental health status following psychological therapy and successful resolution of her substance use problems. Her account of therapeutic change outcomes appears to be dominated by the use of insightful metaphorical images and stories that celebrate her accomplishments and allude to vivid experiences of rebirth and forward movement.

For instance, P12 employs a metaphor of *"new glasses"* in her attempt to separate herself from an old way of being-in-the-world, as well as to bring forth the possibility of seeing the world and its potentialities in new and more refreshing ways that were previously not experienced. Additionally, she conveys a vivid sense of personal growth, maturation and expansion through the use of metaphorical language that reveals transformative bodily experiences of being (e.g., growing taller). In this way, we can say that, in the process of transcending her previous confines and limited/narrow ways of being, P12 has managed to become more than she was and thereby give birth to new aspects of herself.

Finally, P12 offers a *"journey"* metaphor, which seems to impart the idea of having travelled a long distance and accrued valuable knowledge and experience over the temporal course of psychological therapy, as well as her commitment to carry forward this learning by engaging in an ongoing, future-orientated process of growing and becoming. In this manner, P12 seems to accept herself as an unfinalizable and imperfect human being who is incessantly developing, growing and transcending herself whilst engaging with the ongoing project of living and moving toward possibility.

The study's findings are concluded with the presentation and brief discussion of a core connecting category, termed "Broadening" and identified as applying to all therapeutic change and recovery dimensions that were presented and analysed within the previous main categories and subthemes.

3.2.5 Core Connecting Category: BROADENING

This core category represents the central finding from the analysis. The study's findings suggested that the concept of therapeutic change and recovery from problematic substance use is experienced as a multifaceted and ongoing process of self and life enhancement that involves broadening and re-organisation of intra- and interpersonal ways of being-in-the-world.

All participants in this study described how the active period of substance use problems was characterised by marked narrowness and withdrawal from the world of things and human beings that populate one's life space. The effect of such a restricted way-of-being is that the meaning of life and use of time are totalised around the immediate procurement and use of substances which provide short-term, self-reliant methods of artificial self-affect regulation. The impact of such profound retreat into oneself is to deaden the horizon of possible lived experiences, temporalize existence around an ever-present 'now', lose sight of the open and changeable quality of the future zone of lived time, become uncoupled from conventional societal activities and rhythms of life, and eventually obliterate one's sense of esteem and agency in coping constructively with being-in-the-world.

As a result, it appears that positive change and recovery efforts require the destabilization of these narrow and inflexible patterns of being, via the creation and adoption of broadened cognitive, behavioural, emotional and relational repertoires. In this manner, the data indicated that through the safe mentalizing environment afforded by the therapeutic relationship and therapists' sensitive responsiveness, participants were able to tolerate a disruption in their former intra- and interpersonal patterns of functioning, and begin experimenting with new cognitive, affective, experiential and temporal ways of being, both inside and outside the therapeutic setting. Thus, over time, an ongoing process of intra- and interpersonal broadening in participants' functioning was observed and marked by improved self-regulation skills, via reaching out toward activities that promote a meaningful relation to the things of the world and experience of time (e.g., work, recreation, self-care), as well as utilizing recovery-promoting sources of social support embedded in one's natural environment.

The following chapter reviews the findings of the four main categories and the core connecting category in order to relate them to existing theory and identify areas where new understandings or directions for future research and practice can be suggested. Additionally, a critique of the current research is made and followed by conclusions and final points of reflexivity.

CHAPTER 4: DISCUSSION

4.1 Chapter Overview

This final chapter reviews and develops further the four main categories and the core connecting category by linking findings to existing theory and highlighting the insights gained and areas in need of further research. The strengths and limitations of this study are also appraised in light of the way the research has met appropriate standards of quality assurance, whilst the applicability of the findings to the discipline of Counselling Psychology is explicitly considered. The chapter concludes with some final reflections on the author's research journey.

4.2 Synthesising and Integrating Findings with Existing Literature

The following sections consider the way the study's findings have answered the central research question by reviewing the main outcomes of the analysis and relating them to existing theory and research in the field.

4.2.1 Addressing the Substance Relationship

The findings in this category suggested that substance misuse is subjectively experienced as being closely connected to affect regulation difficulties and a pervasive, negative sense of self, with both of these psychological difficulties operating on a background of rather weak or poor attachment representations (e.g., P1, P8, P10 spoke about growing up feeling psychologically alone or uncared for, with noticeable absence of meaningful communication between themselves and significant others concerning emotional problems and understanding of the self). Given that the evolutionary function of secure attachment relationships is associated with the expression, recognition and regulation of overwhelming experience, in order for individuals to develop an internal representation of self as capable of understanding and tolerating their thoughts and feelings, and a representation of others as safe and reliable sources of knowledge about how to navigate one's environment, we can argue that the absence of these characteristics may put individuals at risk of developing

a secondary, maladaptive attachment transition to psychoactive[39] substances, and substitute them for intimate relationships in the service of self-soothing and regulating their affective landscape (Flores, 2011; Tronnier, 2015). To further back up the argument of substance use as a powerful attachment substitute for self-affect regulation, we should remind ourselves of the psychological aspects of and personal meanings participants in this study attributed to substance use, calling it 'a friend' (e.g., P1, P10), 'a lover' (P1), and an aid in coping with feelings of inadequacy and emotional 'pain' that failed to find assuagement elsewhere (P6, P8, P10, P12). These findings seem to concur with those of other theorists and researchers in the field. For instance, informed by clinical observations and psychoanalytic ideas in ego psychology and object relations, the psychodynamic psychiatrist, Edward Khantzian (2013) has argued that substance misuse arises due to a lack of capacity for self-care and thereby represents an attempt to 'self-medicate' a range of painful or intolerable feelings. Relevant quantitative research has confirmed Khanztian's observations, showing that the misuse of alcohol, stimulants and opiates is associated with the management of emotional pain, dysphoria and anxiety in the service of achieving emotional stability (McKernan et al., 2015; Suh, Ruffins, Robins, Albanese & Khantzian, 2008). In line with Khanztian but also aiming to extend his formulations, Dodes (2009, 2017) has utilised case study methods to claim that substance addiction is precipitated by developmentally-based attachment and empathic failures which have left a person with an overwhelming sense of helplessness in their ability to control their affective life. This experience gives, in turn, rise to an ever-present narcissistic injury (i.e., shame and rage) that calls for 'reversal of powerlessness' and reassertion of one's potency with respect to self-affect repair through the use of psychoactive chemicals. Additionally, limited quantitative evidence in the field has pointed to significant associations between insecure attachment patterns, avoidance of interpersonal closeness and intimacy, poor affect regulation and self-esteem, as well as an increased degree of alexithymia in men and women who misuse psychoactive substances versus those who do not (Cruise & Becerra,

[39] As it was noted in the Introduction chapter, 'psychoactive substances' refer to chemicals which when taken into the living organism can reliably – albeit problematically – alter its mental structure (i.e., cognition and affect).

2018; De Rick, Vanheule & Verrhaeghe, 2009; Thorberg & Lyvers, 2010; Wyrzykowska, Glogowska & Mickiewicz, 2014).

In this manner, and as it was also suggested by this study's findings, the transformative power of substances for dealing with uncontained emotional discomfort and compensating for a negative and inadequate sense of self, appears to motivate individuals to gravitate toward an extreme degree of self-reliance, not only as a way of coping, but rather as a way of being-in-the-world, whereby they protect themselves from relational vulnerability by acting as though they do not need interpersonal closeness and, instead, become more and more withdrawn, isolated and alienated from the world (Fletcher, Nutton & Brend, 2015). As present findings indicated, such a narrow and restricted way of being-in-the-world, due to underlying vulnerability and emotional unpreparedness to cope with one's relational nature, not only leads one to mistake the natural process of growth in autonomy with total self-reliance, but eventually gives rise to profound existential suffering that affects all aspects of one's physical, emotional, temporal, spatial and social existence. In this sense, during the period of severe substance misuse, participants in this study described 'existing' (rather than 'living') with very little breadth in their lives, and in a world that was robbed of meaning, other than that attached to the procurement and consumption of substances. The effect of such a truncated, dull and devalued way of being-in-the-world was that it eventually led participants to feel condemned to live in the present – not a mindful, meaningful present, but rather a sense of temporality that was experienced as an empty, static, meaningless and ever-present 'now' – and begin contemplating – some even actively attempting – to put an end to this dreadful, unbearable and unspeakable suffering by flirting with death wishes and thereby the ultimate obliteration of being-in-time and moving toward possibility. Moreover, while being preoccupied with substances and retreated from the world, several participants also spoke of lingering feelings of 'existential guilt/regret' (Cole, 2016; Yalom, 1980) for having bypassed their own life without living up to their potentialities (e.g., P6, P7, P8). The experience of being confronted with an internal court regrading one's transgressions against their potentialities and untapped life opportunities, appeared to add to participants' existential distress and sense of despair in relation to the future.

Although limited empirical research exists on substance misusers' experience of lived time (see Hilte, 2019) – and to my knowledge there are no studies that have explored substance misusers' experiences of existential guilt – the above findings appear to be in line with a recent Polish study that sought to qualitatively explore the disturbances of lived time in individuals with multiple substance dependencies (e.g., alcohol, cannabis, stimulants, opiates) who had just entered a therapeutic community. In this study, Moskalewicz (2016) recruited seven men and three women (median age = 27.5 years) and interviewed them about their inner experience/perception of time and how they imagined their future. Phenomenological lived time analysis indicated that common themes of 'severely shortened time horizons', preoccupation with negative past memories related to both childhood and experiences with substances, as well as a sense of present time passing too slowly to become connected to a meaningful future, were running throughout interviews and associated with an impaired planning capacity, coupled with prominent feelings of boredom and an overwhelming need to accelerate the passage of time. Moskalewicz concluded that recovery from substance misuse needs to focus on the temporal aspects of addiction and resynchronise clients with mainstream, collective temporality. The researcher further recommended that post-treatment studies on substance misuse check whether therapeutic interventions are associated with changes in clients' experience of lived time.

Finally, the findings in this category showed that protracted attempts at excessive self-reliance and associated existential suffering, as described above, eventually gave rise to an overwhelming sense of powerlessness that was subjectively experienced as 'hitting bottom' and being confronted with the limits of one's existential situation (e.g., P1, P6, P7, P11). It appeared to be at this point that a sense of imminent and inescapable threat triggered attachment-related behaviours (Holmes, 2011) that led participants to give up omnipotent perceptions of self-reliance as a viable path to self-affect regulation, accept powerlessness, and begin the process of change by seeking professional recovery, which also included psychotherapeutic input. The underlying factors embedded in this process of help-seeking appear to link both to empirically-based aspects of Bowlby's (1988) attachment theory and the ideas of the founders of 12-step programmes, which claim that the beginning of therapeutic change and recovery from addictions is marked by a symbolic

death of self-sufficiency and humble surrendering to external, inter-human assistance (Chen, 2010; Jordan, 2019; Medina, 2014). Furthermore, this finding echoes Orford and colleagues' (2006a; 2006b) research on a powerful catalyst system that propels individuals with substance misuse to seek professional help when they reach a point at which their problems have accumulated to such an extent that their importance can no longer be denied. Based on my findings, I would further argue that perhaps even more important than the realisation of accumulating problems is the willingness to let go of excessive self-reliance, in order to lay the foundation to begin appreciating that human beings take their strength from being intimately connected to trusted others. In other words, "secure attachment liberates" (Schindler & Broning, 2015, p. 305).

4.2.2 Therapist-Client Engagement

What featured strongly in this category was that the process of therapeutic change and recovery from substance misuse appeared to occur through the development and gradual internalisation of a secure attachment relationship between study participants and their therapists. Participants' experience of the therapist as a secure and helpful attachment figure seemed to be facilitated by the latter's ability to sensitively and accurately tune into their subjectivity (i.e., 'otherness'[40]) and thereby enable them to 'feel felt' and recognised as valued, separate and intentional agents of their own mental states (Allison & Fonagy, 2016; Fonagy, Campbell & Luyten, 2017). Perceived perception of therapist-offered relational conditions of genuine warmth, transparency, attentive listening, consistent positive regard and affirmation of the uniqueness of each client-participant, appeared to be facilitated via therapist use of gentle caregiving, ostensive communication cues, such as eye contact, soothing tone of voice, lack of judgement and contingent empathic responding (Fonagy et al., 2017). Participants' felt experiences of these in-session, client-therapist interactions appeared to result in optimal regulation of their attachment system and thereby the formation of an interpersonally close and safe environment that could be used as a 'safe haven' and 'secure base' from which they could start exploring their own and other people's minds (Bowlby, 1988; Cozolino, 2016). In this manner, within the context of a

[40] Cooper, 2009

close, secure and mentalizing therapeutic relationship, participants appeared to be able to develop the ability to utilize reflective functioning, become (re)acquainted with their emotional self, address attachment failures, update internal representations of self and others, and cultivate alternative, more constructive strategies for affect regulation and interpersonal communication.

These findings appear to be in line with recent developments in interpersonal neurobiology, which argue that due to a built-in, biological human need to be understood, empathic relational experiences in psychotherapy powerfully impact the development of psychic structure and emergent sense of self via intersubjective, right-brain-to-right-brain attachment communications, by which new neural pathways are developed in the process of strengthening clients' capacity to regulate internal aspects of arousal and thereby reduce impulsive reliance on external means of affect regulation, such as the use of psychoactive substances (Schore, 2014; Tronnier, 2015). In this manner, attachment, or relational, trauma that had been imprinted into nonverbal, right cortical-subcortical systems and impeded a person's ability to self-regulate under psychological stress, can gradually be addressed and repaired in ways that correspond with healthier left-to-right brain neural integration, and thereby improved self-reflection and associated capacity for secure attachment relations (Schore, 2014).

Additionally, the importance of explicitly targeting in therapy substance-using clients' intra- and interpersonal regulatory capacities, as indicated by their abilities to adequately reflect on and understand themselves and others as agents of intentional mental states, has been highlighted by recent quantitative research whose findings suggest that, even after cessation of substance misuse, individuals with histories of alcohol, cannabis, cocaine and/or opiate dependence tend to perform worse than controls on tasks designed to measure the cognitive and affective aspects of mentalizing (e.g., False Belief trials, Reading the Mind in the Eyes Test, Interpersonal Reactivity Index) (Bora & Zorlu, 2016; Gandolphe et al., 2018; Sanvicente-Vieira et al., 2017). Such mentalizing deficits have, in turn, been posited to account for continued problems in the areas of affect-regulation, empathic processing and social cognition, especially under conditions of heightened emotional arousal, which may, in turn, contribute to ongoing difficulties in (re)establishing and

maintaining recovery-promoting interpersonal relationships as well as preventing future relapse episodes. Consequently, it has been suggested that therapeutic interventions which focus on the development of new models of minds for self and others, via the balanced integration of the emotional and cognitive aspects of mentalizing, may constitute important treatment targets that have the potential to facilitate long-term recovery.

Moreover, findings from this study suggested that what appeared to be of further significance and added value was participants' descriptions of how learning to mentalize within the context of a secure psychotherapy attachment, engendered a sense of 'epistemic trust' (Duschunsky, Collver & Carel, 2019), whereby the experience of having their subjectivity and agentic nature being understood within the therapeutic encounter, opened them up to transfer this knowledge about mental states into their own living environments and use it as a guide to begin trusting the social world, again, as a learning place about themselves in relation to others. In this manner, participants, such as P1, P3, P6, P7, P8 and P12, described how holding in mind what they had learnt in therapy enabled them to learn from experience beyond the therapeutic relationship by increasing their capacity to mentalize in the service of effecting positive changes in their intra- and interpersonal functioning (e.g., mindful self-affect regulation and relapse prevention, perspective-taking, assertiveness, attachment reparation, increased sense of self-esteem and reduced experience of mental pain). The ultimate outcomes of these intra- and interpersonal changes appeared to be a perceived sense of mastery and expansion of participants' thought-action repertoire, as well as replacement, or reduced function, of pre-therapy insecure attachment patterns (e.g., intra- and interpersonal anxiety and avoidance) with the gradual formation and internalisation of secure attachment representations.

Overall, these findings appear to be in line with a 'common factors' approach to psychotherapy – as discussed in the Introduction chapter – whereby the centrality of the therapeutic alliance – inclusive of therapist facilitative relational factors and client experiences of genuine care, support, hope and self-efficacy – has been shown in quantitative studies of substance misuse to account for a greater proportion of therapeutic outcome compared to theory-specific interventions (Davis et al., 2015; Kan et al., 2014), whilst it also features strongly in clients' subjective experiences of change-promoting

factors (Edwards & Loeb, 2011). On the other hand, although the aforementioned literature defines the therapeutic alliance as the location of a significant part of the change process, it appears to fail to specify the potential mechanism(s) by which the alliance might exert its change-promoting influences. In this sense, findings from this research appear to suggest that the healing power or potency of the therapeutic relationship, both inside and outside the therapy room, is connected to the optimal regulation of clients' attachment system through the processes of increased mentalizing and epistemic trust. In this way, the therapeutic relationship, in individual psychotherapy, can be seen as an analogue of secure caregiving attachment – akin to the way Bowlby (1988) originally described attachment aspects of healthy child-caregiver relationships – that has the potential to foster robust mentalizing skills and thereby generate an agentic and healthy sense of self in relation to others (i.e., development of new internal working models for self-regulation and interpersonal behaviour), which can eventually rekindle clients' wish to learn about their intra- and interpersonal worlds beyond the therapeutic setting (i.e., epistemic trust) so that they can find more fulfilling ways of being-in-the-world. These therapeutic implications are also in line with clinical observations in the field of substance misuse, which argue that problematic substance-using behaviour is a manifestation of longstanding, unmet attachment needs that have left an individual vulnerable to the development of a negative, inadequate sense of self, affect dysregulation and mistrust in the potential of close interpersonal relationships to act as reliable sources of knowledge and support in times of distress (Cihan, Winstead, Laulis & Feit, 2014; Fletcher et al., 2015; Flores, 2011).

Thus, in the current research an attempt has been made, based upon participants' narratives, to integrate the meta-theoretical concepts of 'attachment', 'mentalization' and 'epistemic trust' in order to stress the importance that, besides the significance of the therapeutic relationship in meeting substance-using clients where they hurt the most (i.e., in the need of a reliable holding relationship) and providing them with corrective mentalizing experiences, what seems to be of greater benefit is the extent to which clients' experiences in therapy of feeling thought about and sensitively responded to makes them feel safe enough to begin thinking about themselves in relation to their particular social world, so that they can learn to be their own secure attachment figures and effect positive changes in their social-emotional functioning. This is the process that Allison and Fonagy (2014) have

termed ‘epistemic trust’ (or trust in new knowledge gained within secure attachment encounters, such as the therapeutic relationship) and consider essential to lasting change and improvement in the parallel processes of growth in autonomy, competence and relatedness. In this sense, although a significant part of the work of change might be accomplished in the process of building a secure psychotherapy attachment and learning to mentalize in the clinical setting – a process that inevitably occurs in all bona fide psychotherapies, whether broadly labelled as CBT, humanistic-experiential or psychodynamic (see Bateman & Fonagy, 2012) – unless clients develop epistemic trust in therapeutic knowledge as personally relevant and generalizable beyond the consulting room, meaningful change is unlikely to be experienced in one’s own living environment. As exemplified by findings embedded in this and the following category, the outcomes of this research appear consistent with Allison and Fonagy’s (2014) assertions about the importance of epistemic trust as a common factor in the therapeutic process of change. At the same time it should be noted that the notion of ‘epistemic trust’ remains a theoretical and clinically-informed construct, in need of further development in terms of elucidating particular factors and dimensions that may prove useful in future assessment and measurement of therapeutic change outcomes in particular client groups (Schroder-Pfeifer, Talia, Volkert & Taubner, 2018).

4.2.3 Becoming One’s Own Therapist

Findings in this category appeared to support the aforementioned hypothesis that robust mentalizing within the context of a secure therapeutic attachment relationship is not enough in itself to bring about personally meaningful and transformative change. Instead, in recounting the process of therapeutic change, participants also used several examples stemming from their everyday lives outside of therapy in an attempt to explicate the relevance of extra-therapeutic factors that enabled them to generalise the kernels of therapy-facilitated changes and improve their quality of life.

Facilitative and self-directed change patterns that appeared to co-evolve with the experience of secure attachment in psychotherapy were found to be related to participants’ assumption of responsibility in actively reconstructing their temporal and social aspects of

being-in-the-world, in ways that seemed to nurture their agency in functioning as their own therapists.

As it was indicated by findings embedded in the first main category of the CGT model, before entering therapy participants (e.g., P1, P5, P9, P10, P12) were becoming painfully aware of living a narrow and suffering relationship to lived time, which was greatly weighted towards a static and empty sense of 'now' with most of life's meaning being totalised around the activities of obtaining and consuming psychoactive substances. A major implication of this way of being-in-the-world was participants' sense of being trapped in an existence devoid of personal development (since this is fundamentally related to the lived experience of the 'future' as an open temporal horizon; Cooper, 2015), which seemed to be closely linked to lingering feelings of 'existential guilt' (Cole, 2016), as well as a lack of temporal synchrony with the social and biological rhythms of everyday life, which likely served to exacerbate participants' sense of isolation and estrangement from the rest of the world. In this manner, gateways to therapeutic broadening outside the consulting room entailed participants' agentic efforts to change their perceptions of lived time and thereby, gradually, readapt to and reintegrate the rhythms of collective, everyday life by engaging in planned rituals of self-care (e.g., sleeping, eating, exercising, recreation and personal hygiene habits) as well as purposeful acts of service (e.g., working, volunteering, studying). Careful planning and execution of these activities seemed to have the effect of broadening participants' temporal horizons of possible lived experiences and thereby the range of meanings that could be attributed to the things of the world individuals interact with. In this manner, the world and one's existence in it were no longer lived as narrow and controlled entities, but actively engaged with in a purposeful, meaningful and hopeful manner that added to participants' perceived sense of significance and self-worth (e.g., P6, P5, P8, P11, P12). These findings appear to support Alves and colleagues' (2017) research, as reviewed in the Introduction chapter, which stated that individuals who enter psychosocial therapies for substance misuse want to address issues pertaining to 'existence', 'future', 'time', 'guilt' and 'personal development' as part of achieving meaningful change and recovery. As Alves et al. (2017) concluded, these issues are not currently covered by standard outcome measures clinicians routinely use to assess recovery from substance misuse, whilst other theorists and researchers in the field have argued that

the temporal aspects of substance misuse and its recovery remain poorly understood and under-researched, despite clinical observations pointing to these areas as vital components of relapse prevention work (Hilte, 2019; Kemp, 2018; Moskalewicz, 2016).

While therapeutically addressing their temporal aspects of being-in-the-world participants also engaged in a parallel process of reconstructing their social aspects of being-in-the-world (or 'being-with-others'; Hersch, 2015) in a way that ensured a positive impact of interpersonal connectedness on their wellbeing and adaptive strivings. For instance, P5, P6, P9, P10 and P11 described a parallel process of deliberately pulling themselves away from social contexts and networks associated with increased availability and permission of continued substance misuse, and toward interpersonal attachment ties and support groups whose norms of belonging were antithetical to substance misuse and supportive of continued recovery maintenance (e.g., parents, children, work colleagues, non-using friends and recovering peers). Based upon these findings, it was further hypothesised that one of the therapeutic benefits of transitioning from social networks supportive of substance misuse to those supportive of recovery could be a renegotiation of participants' implicit sense of social identity, in a manner that likely served to diminish the salience of attitudes and behaviours associated with harmful substance use and foster an emerging sense of self as someone in recovery, or a non-substance user, capable of engaging in intra- and interpersonal practices that support an improved sense of wellbeing.

This hypothesis appears to be supported by recent quantitative, cross-sectional research that has explored the impact of social network and social identity changes on perceived quality of life and recovery from substance misuse. For instance, Bathish, Best, Savic, Beckwith, Mackenzie and Lubman (2017) recruited 573 individuals who were mainly born in Australia, UK and New Zealand (54.6% female, 45% male, 0.4% 'other sex'; age range: 15 to 76 with a median age of 43 years) and asked them to complete an online survey about their experiences of recovery from alcohol, cannabis, opiates and stimulant addiction. As part of the survey, participants were also asked to indicate on Likert-type measures their social network variables (i.e., number of important people, proportion of substance misusers and people in recovery, and presence of diverse group memberships) as well as the extent to which they identified with 'other people in recovery' and 'other people who

use alcohol and drugs' (i.e., a measure of social identity preference). Finally, participants rated on an 11-point scale their overall quality of life in the past four weeks. On average, participants reported having experienced problematic substance use for a total of 18.6 years, with most of them having recovered through professional help and 12-step programmes. Results indicated that transition from substance addiction to recovery was marked by an increase in social connectedness (versus social isolation) which was characterised by transitioning from a social network populated with alcohol and drug misusers to one composed mainly of people in recovery as well as diverse group memberships (e.g., family, work, friendships). These factors were also associated with an increased preference for a 'recovery identity', evidencing thereby reduced social identification with people who misuse substances. Overall, these changes in social identity and support network composition accounted for 14% of the variance in participants' quality of life outcomes, a figure that was greater than the proportion of variance attributed to age, gender and substance use variables (i.e., total number of years participants had misused alcohol and other drugs, and total number of years they had been abstinent or in recovery). The researchers concluded that recovery from substance addiction could be conceptualised as a socially-mediated process that entailed social network and social identity changes, which, together, drove broader improvements in people's wellbeing. Consequently, Bathish et al. (2017) urged practitioners and researchers in the field of substance misuse to pay attention to the influence of the social context in which individuals are changing and recovering, since such contextual factors are likely good candidates to be leveraged during therapeutic interventions. This suggestion is also in line with the theory and practice of SBNT – as noted in the Introduction chapter – which is based upon the belief that a supportive social network (e.g., family members, friends, co-workers) is a key component in successful treatments of substance misuse (UKATT Research Team, 2005).

As argued above, findings from the current research seem to support Bathish and colleagues' (2017) assertions of recovery from substance misuse as a psychosocial process of therapeutic change that involves a confluence of both intrapersonal and social factors. Moreover, present findings appear to add to the potential of diverse sources of group membership as change-promoting factors embedded in one's natural environment, by including the therapeutic role of pets as unique attachment-enhancing and supportive

figures. In this sense, a few participants (e.g., P4, P5, P10) emphasized the impact of human-pet bonds on their process of therapeutic change, by commenting on the positive psychological (e.g., sense of happiness, purpose, resilience), physical (e.g., increased activity), social (e.g., sense of belongingness, companionship, opportunity to interact with other pet owners) and relapse prevention (e.g., reduced drinking) benefits they derived from their regular interactions with pets (cats and dogs). Although the therapeutic role of pets in mental health is a topic that remains relatively under-researched in the clinical literature (Hajar, 2015; Walsh, 2009) and almost untouched in the area of substance misuse treatment (Einstein, 2015), emerging quantitative research evidence suggests that for individuals who are often isolated, lacking in social support or undergoing significant changes in their interpersonal relationships – characteristics that were also found to apply to this study's sample – higher attachment levels to pets (as indicated by relevant self-report measures) are associated with lower degrees of loneliness and depressive symptoms, improved self-care, a more physically active lifestyle, improved nonverbal communication skills and increased contact with nature (Giaquinto & Valentini, 2009; Smolkovic, Fajfar & Mlinaric, 2012). These findings have been explained by drawing upon theoretical connections between the qualities of human-pet bonds and secure interpersonal relationships, such as the capacity of cats and dogs to fulfil attachment needs of proximity-seeking, tactile reassurance and physical comfort that facilitate the expression of repressed emotions, unconditional love and acceptance, as well as uplifting and rewarding playful interactions. Given the aforementioned links that were drawn between current findings and the consequences of unmet attachment needs as psychosocial factors that correlate with vulnerability in the development of substance misuse, the present study suggests that the value of pets as therapeutic adjuncts – at least for some people – in the process of recovery from substance misuse merits further investigation in future research.

Overall, the findings embedded in this category point to important client and extra-therapeutic factors in relation to enhanced self-regulatory competencies and improved relational interactions, which seem to have occurred as a vital extension of the capacity of the therapeutic relationship to create the potential for continued learning about oneself and others outside the treatment context (i.e., epistemic trust). In other words, participants' felt experiences of having been adequately understood and sensitively responded to in therapy

(i.e., mentalization in the context of secure client-therapist attachment) appear to have created a corrective emotional, cognitive and relational experience of growth in both autonomy and connectedness, which has, over time, been internalised in the form of both conscious and unconscious mental representations of self in relation to others (i.e., updated internal working models of self and others) that contribute to adaptive self-regulation strategies and psychosocial functioning outside therapy (Fonagy & Allison, 2014). In this manner, the potency of the therapeutic alliance can be explained by the development of 'epistemic trust' that enables social learning and allows individuals to benefit from their particular environment, through recruitment of effective sources of social support and avoidance of or disengagement from maladaptive relationships, so that they can learn to be their own secure attachment figures, capable of meeting the interrelated basic human needs of connection, competence and autonomy. Based upon these findings, it can therefore be argued that a significant proportion of therapeutic change is likely due to transformations in the way individuals use their social environment and not just to what happens inside therapy. This argument is in line with quantitative research that has highlighted the importance of client and extra-therapeutic factors in facilitating positive change outcomes (Bohart & Tallman, 2010; Bohart & Wade, 2013). It therefore seems important for psychotherapists to understand that effective therapeutic change depends as much on ensuring that clients' social environments exert a benevolent impact on their efforts to change, as on ensuring a similar emotional and relational undertone within the therapeutic context. In this way, clients' experience of feeling recognised, cared for and sensitively responded to as agentic beings within the therapeutic encounter is likely to empower them to begin feeling safe enough to think about themselves in relation to their particular social world by selecting their extra-therapeutic environment in a more positive and resilient manner.

4.2.4 The Rebirth of the Self and the Reanimation of the Future

Findings captured by this category are considered to represent a conclusion to what came before and was reviewed in previous categories of the CGT model. This is why in the Findings chapter this category was preceded by the heading "Ultimate Therapeutic Change

Outcome". In this sense, participants in this study appeared to link the ultimate outcome of their therapeutic journey, toward disengaging from substance misuse and reconstructing their intra- and interpersonal ways of being-in-the-world, to a powerful experience of rebirth and a regaining of interest in the unfolding of the future and the moving forward of their being.

One way in which these findings can be integrated with existing literature in the field is by linking them to the 12-step worldview, which argues that the process of recovery involves a symbolic death, whereby an individual admits to personal powerlessness and surrenders themselves to 'stronger and wiser' interpersonal sources of support, so that they can gradually learn how to navigate life without misusing substances and thereby reclaim a healthy sense of relationally-oriented autonomy that can be likened to an experience of self-transcendence, rebirth or redemption of a self that was lost to addiction (Medina, 2014; Pagano, White, Kelly, Stout & Tonigan, 2013). Although these change-promoting processes seem to be partly reflected in the findings of the current study and thereby provide support for therapeutic models based upon the philosophy of 12-step programmes (e.g., TSF), perhaps we could further argue that participants' experience of a newfound relationship to themselves and life itself might be an outcome of intra- and extra-therapeutic factors that fostered the capacity for healthy interpersonal attachments, which led to improved self-regulatory functions and thereby "*a second chance*" (P1 in this category) for participants to achieve a more robust emerging self that was subjectively experienced as being future-oriented and open to exploring its potentialities (Holmes, 2011; Tronnier, 2015). In this sense, we could perhaps draw parallels between the contemporary concepts of 'attachment', 'mentalizing' and 'epistemic trust' (as explored in previous sections), and Mead's (1934) sociological-constructivist understanding of the self as the product of the multiplicity of relationships a person has with others and which arises from introspection following participation in social interactions (in this case both within and outside the therapeutic relationship). This, in turn, means that a person's sense of self may be viewed as being in a constant state of emergent transformation while individuals actively engage with the world and reflectively define the situation they are in (Charon, 2010). In this manner, the dominant mode of human experience may be existentially located toward the future and a sense of self as "always in a process of becoming, always

developing in time, and […] never to be defined at static points" (May, 1958, p. 66). Perhaps this is why the existential philosophical tradition argues that the self is more about experience than essence, being continuously created and re-created via increased openness in 'being-in-the-world' and 'being-with-others', as opposed to simply existing alongside these parameters (Hersch, 2015).

4.2.5 'Broadening' as the Core Connecting Category

Overall, the findings of this study suggest that the process of therapeutic change and recovery from substance misuse is progressively experienced as a multifaceted and ongoing process of 'broadening' that occurs both within the individual and the particular social world in which he or she is situated. In this manner, a dialectic between the experiential processes of 'narrowing' and 'broadening' was observed in participants' accounts, whereby the active period of substance use problems seemed to be characterised by a pervasive sense of negativity, mistrust, avoidance and withdrawal from one's inner and outer environment, through the adoption of a lifestyle and way of being that was overly isolated, individualistic and controlled by the use of chemicals that provided reliable, albeit destructive, artificial and temporary, self-affect repair. Based upon the temporal standpoint from which such descriptions were drawn, these accounts appeared to be far removed from stereotypical portrayals of alcohol and drug misusers as overly hedonistic, pleasure-seeking subjects, who carelessly and ruthlessly indulge in temporary pursuits of immediate gratification aimed at disrupting the maintenance of dominant social order structures (Holt & Treloar, 2008; Taipale, 2017). Instead, participant accounts in relation to prolonged substance misuse appeared to be organised around the common themes of persistent psychological and existential suffering which had resulted in profound retreat into oneself and a sense of temporality (i.e., subjective perception of one's being-in-time) that was experienced as a period of lost time (i.e., existential guilt), coupled with an extended, static present that was failing to meaningfully project into an open and changeable future of possible lived experiences. Consequently, the experiential texture of this way of being-in-the-world was accompanied by participant experiences of emotional evaluations that were equally negative, unpleasant, pervasive and debilitating.

According to evolutionary-based accounts with regard to the function of emotions, the experience of negative emotions has the effect of constraining one's arena of attention so that individuals can focus their efforts on responding to immediate threats in the environment and thereby ensure their survival (Power & Dalgleish, 2015). Although modern life poses relatively few situations that call for immediate and quick action to perceived threat, we could perhaps argue – based upon current findings – that persistent experience of intense suffering (i.e., negative emotionality), in the context of a rather narrow, avoidant and constricted sense of being-in-the-world, might be a key factor in instigating a powerful motivation for change, growth and recovery from substance misuse, insofar as it leads to recognition of one's personal limitations (i.e., powerlessness) and acceptance of relevant assistance outside of oneself (i.e., help-seeking and attachment-related behaviours). In this manner, a therapeutic process of intra- and interpersonal 'broadening' may be gradually set in motion as individuals are re-opening their potential to feel sensitively responded to (e.g., through psychotherapeutic secure attachment and mentalizing experiences) and thus open themselves up to reflect on their experiences and behaviours, reinterpret their situations, contemplate new ideas and develop alternative solutions to their problems (i.e., improved cognitive, affective and behavioural mentalizing). Repeated engagement in these therapeutic pathways to broadening is likely to generate gradual destabilization of formerly narrow and inflexible patterns of being-in-the-world via the creation and adoption of more flexible and enhanced cognitive, emotional, behavioural and relational repertoires, which can free individuals from being victims of poorly regulated mental states and subsequent malfunctioning coping strategies (e.g., substance misuse and experiential avoidance). In this way, a newfound sense of optimism, agency, regulatory competence and resilience can become part of a person's self-experience and empower them to begin influencing and selecting their extra-therapeutic environment and relational experiences in a more positive and mindful manner (i.e., epistemic trust in learning from social experience).

In this way, perhaps the closest existing theoretical framework for understanding participants' experiences of key change-promoting processes, as described in previous sections and captured in the core category, might be related to the 'broaden-and-build theory of positive emotions' (Fredrickson, 2004). According to this theory, the process of

effective relationship-building, beginning with the therapeutic relationship and gradually extending to one's social environment, engenders positive emotional evaluations as important sources of information about individuals' intra- and interpersonal experience, which – compared to the narrowing function of overwhelming negative emotions – serve to expand the range of possible thoughts and actions that come to one's mind. For instance, in the context of a strong therapeutic alliance, research suggests that clients tend to experience positive emotions related to curiosity and interest in their mental states, which, in turn, motivate them to deepen their subjective awareness in relation to the functioning of their inner world and thereby begin building new understandings, alternative solutions and behaviours to endure difficult life tasks and facilitate positive change outcomes (Fitzpatrick & Stalikas, 2008). Additionally, in-session experiences of constructive use of humour and laughter (denoting an underlying positive emotion) have been linked to client development of increased self-acceptance and a movement from constricted to broadened views and beliefs about oneself (Fitzpatrick & Stalikas, 2008). Indeed, these findings appear entirely consistent with current participant experiences of the therapeutic relationship (see Findings chapter). In this manner, it has been argued that repeated client experiences of broaden-and-build cycles may represent a common factor of therapeutic change process that cuts through all major theories and particular change-promoting techniques (e.g., insight in psychodynamic, experiential learning in humanistic, schema reframing and new courses of action in cognitive-behavioural, and narrative reconstruction in constructivist paradigms) that are associated with clients' views of themselves as agentic and resilient beings, capable of coping and armoured with resources to address their concerns inside and outside the therapeutic milieu (Fitzpatrick & Stalikas, 2008). Although further research is needed on the role of positive emotions as potential mechanisms of therapeutic broadening, as well as on the types of therapeutic tasks in which the experience of such emotions may play a particularly salient role in replacing more narrowed ways of being, I have overall been left with an impression that a sense of a positive, upward broaden-and-build spiral was echoed throughout current participant experiences of therapeutic change.

4.3 Evaluation of the study

The aim of this study was to explore and gain an understanding of the experience of therapeutic change from the perspective of former substance misusers who had found psychotherapy helpful in assisting their recovery, so that an explanatory theoretical model could be developed and used to inform theory, research and practice in this field.

Overall, I believe the research study has achieved its aims and contributed to a deeper understanding of participants' experiences of therapeutic change in the process of overcoming problematic substance use. In this section, the merits and limitations of the current study, alongside potential avenues for improvement in future research, will be considered in relation to Charmaz's (2006) evaluative criteria for judging the 'qualitative goodness' of CGT studies. As noted in the Methodology chapter, these criteria are referred to as 'credibility', 'originality', 'resonance' and 'usefulness'.

In terms of '*credibility*', the trustworthiness and plausibility of current findings and interpretative analyses are based upon thick descriptions and in-depth explorations of qualitative data derived from a sample of 12 participants who had intimate familiarity with the phenomenon under consideration. In the Findings chapter, the categories constructed have covered a wide range of empirical observations from the overall dataset and been grounded in examples of the data (i.e., illustrative quotes) in order to enable readers to appraise the analytic procedures and consider alternative meanings in conjunction with particular categories and subcategories. Additionally, transcript codings, category syntheses and interpretative analyses have been triangulated through systematic submission of relevant drafts to my research supervisor, who has reviewed and provided feedback on all stages of the analysis – a credibility check that has further added to the trustworthiness of presented findings (Tracy, 2010). Moreover, the finding of saturation and construction of a core connecting category may act as another indication that the current analysis was thorough and continued to the point that new data did not spark further insights into the investigated phenomenon.

Regarding credibility limitations, although a sample size of 12 is deemed acceptable for a GT study that aims to achieve saturation of categories (McLeod, 2011), a larger sample might have added to the breadth and understanding of the phenomenon, and, thereby, lent

greater transferability to current findings. Additionally, the credibility of the study is restricted to a single interview for each participant, with the focus being on positive changes rather than lack of improvement or hindering experiences. Had more interviews been conducted, there would have been opportunities for participants themselves to validate, challenge and further elaborate on emergent themes and perspectives, and this is a potential limitation that follow-up studies may want to address. That being said, it should be noted that some qualitative researchers worry that the use of multiple interviews may make participants feel they have given a 'wrong answer' in the initial interview and attempt to correct it at follow-up (Flowers, 2008). Furthermore, although this research focused on a diverse sample in terms of gender, age, substances and therapeutic orientations (see Methodology), with no apparent experiential differences of the therapeutic change process being noted in the narrative accounts of different participants, the credibility of current findings is limited to participants who were drawn from the same drug and alcohol service. Consequently, future studies may benefit from recruiting participants from across the UK in order to eliminate potential geographical biases. Moreover, participants self-selected for this study, meaning that the findings may have been skewed in favour of the recruitment of a sample that consisted of more high-functioning, intrinsically motivated and psychologically-minded treatment-completers, who had engaged in an intentional, rather than imposed, change process and had thereby invested considerable time and effort in benefitting from psychosocial therapy and overcoming substance misuse. Even though these characteristics might be seen as common factors and active ingredients of therapeutic change itself (DiClemente, 2015), the self-selection factor in this research may not permit transferability of current findings to other types of change and client groups, such as individuals who are trying to change without psychotherapeutic input or those detained in prison or forensic settings where they are required to suspend certain behaviours without necessarily engaging in a process of intentional change (Sandbrook, Clark & Cocksedge, 2015). Additionally, since most of the participants who volunteered to take part were mature adults (30 to 65 years old, with a mean age of 47.8), it might be useful in future research to compare current findings with those of a younger sample in order to further explore particular psychosocial factors implicated in the development and resolution of substance misuse (e.g., existential frustration, attachment and mentalizing difficulties). In

this manner, proactive therapeutic interventions, aimed at preventing the escalation of substance use problems, may be better informed and implemented, in contrast to current practice where alcohol and drug services tend to react to older adults with well-established patterns of substance misuse (Schindler & Broning, 2015).

In relation to '*originality*', the current study has attempted to explore and offer client-informed insights in relation to a worthy topic, which in the field of substance misuse has previously been examined mostly quantitatively and in a clinician- or researcher-informed manner. Given that psychotherapy research is no longer concerned with efficacy, but rather with how effective change occurs, findings from the current research may sensitise practitioners to substance-using clients' inner processes, needs and experiences of therapeutic change in the wider context within which psychosocial therapies are set. For instance, while constructing categories and developing the emergent theory of therapeutic change in a manner such that the titles would be fresh and inclusive of the meanings and emotional connotations that featured strongly in the transcripts, I was struck by how rarely participants discussed symptomatic change and particular therapeutic interventions, and how much they attributed change to contextual and relational factors occurring within and outside the therapeutic setting. In this sense, the hierarchical organisation of codes and categories, which is central to theory building in GT studies, suggested that the process of therapeutic change is to a large extent self-directed, relationally-oriented and grounded in key dimensions of human experience, which, in my view, have been relatively neglected by traditional approaches to psychotherapy in this field, despite being part of the universal human condition and thereby significant in organising our psychological thinking about the context in which substance misuse and recovery may take place. For instance, common themes related to the presence and significance of existential guilt and temporality, as both change-blocking and change-promoting factors, in participants pre-therapy and extra-therapy experiences of change, appear to be largely overlooked, lost or absent from researchers' explorations of change and recovery from substance misuse. Additionally, although much research has been devoted to the exploration of the therapeutic alliance-outcome link in relation to substance use, findings from this research may qualitatively refine the nature of this relationship by showing that a strong therapeutic alliance is not only underpinned by clients' conscious perception of collaborating with therapists, but the

ability of the therapeutic relationship to function as a secure attachment bond clients can use to safely explore their own and other people's mental states, both inside and outside the consulting room. I, therefore, believe that the existential- and attachment-informed perspectives, which the findings of this research have drawn upon to better understand client experiences of substance misuse and recovery, may provide a new conceptual rendering of common change processes in this field of inquiry. Although I cannot claim on the basis of current findings that particular existential and attachment-related concepts I have focused on in preceding sections are universal or causal pathways into and out of harmful substance use, problems in these areas and perceived therapeutic changes in the same domains appeared present across diverse accounts of the present sample. Perhaps future research in substance misusers' experiences of therapeutic change could explore these areas further by using quantitative measures, such as the Existential Concerns Questionnaire (van Bruggen et al., 2017), Zimbardo Time-Perspective Inventory (Zimbardo & Boyd, 1999), Revised Adult Attachment Scale (Teixeira, Ferreira & Howat-Rodrigues, 2019), Client Attachment to Therapist Scale (Mallinckrodt, Gantt & Coble, 1995) and Reflective Functioning Questionnaire (Fonagy et al., 2016), in order to assess pre- to post-treatment changes in these domains and theorise accordingly.

In terms of '*resonance*', it should be noted that qualitative research aims to provide an account that is valid and relevant, rather than completely exhaustive or wholly representative (Willig, 2013). In this sense, every effort has been made to construct categories in a manner that portrays the breadth of the studied experience within the wider pre-treatment, intra-treatment and extra-treatment systems in which the process of change was embedded, by drawing upon and constantly comparing what I considered to be common themes across collective accounts of participants' experiences of therapeutic change. Although initially the phenomenon of therapeutic change seemed a broad and loosely defined area to investigate and do justice to, I endeavoured to approach it with an open mind and make as few assumptions as possible about its parameters. In this sense, I was gradually able to appreciate that despite the complex variety of individual experiences, both within and across participant accounts, consistent application of CGT analytic practices did enable common themes to emerge and be defined in a manner that attended both to the breadth and depth of their ideas and implications. Although this was at times an

unwieldy process, which required sheer stamina and a clear paper trail so as not to be drowned in what initially seemed to be a sea of detail and diverse strands in participant accounts, the more I persevered with the recursive cycles of coding and constant comparative analysis, the more I was able to relax into the process of moving between and across participant accounts, make sense of data noise and eventually decide what should be included or left out in the process of constructing my categories and organising them in a hierarchical manner. Drafts were written along the way and shared with my supervisor who offered valuable feedback that led to revisions of original interpretations and construction of categories until the analysis, as a whole, had achieved satisfactory resonance and thereby the potential to meaningfully affect interested readers in a manner that could invite transferability of current findings (Tracy, 2010). That being said, in keeping with the epistemological implications of the chosen constructivist approach, the GT analysis and model developed have been offered with the awareness that these findings are not the only possible interpretation of current data, but instead are one possible interpretative understanding that is based upon rigorous analysis of participants' interviews (Charmaz, 2014). Moreover, although I feel that the main theoretical framework I have constructed is sound, grounded within the data and close to participants' voices, I also need to acknowledge that saturation of categories cannot be permanent but only temporary, and thereby open to modification by future work that may expand upon their properties and dimensions through further theoretical sampling (Dey, 1999). For instance, the category pertaining to the process of reconstructing one's social environment could benefit from further research on potential factors involved in changing or broadening one's sense of social identity, as well as additional inquiry about the potential role of pets as therapeutic adjuncts to relapse prevention and self-affect regulation. Additionally, it should be noted that therapeutic change can also happen below the level of consciousness (Levitt et al., 2016). In this respect, potential ways of increasing resonance between research findings and participant experiences of therapeutic change might be by taking a multi-method approach in future research, whereby grounded theory methods could be combined with visual representations of subjective experiences of change and recovery from substance misuse. Given that the visual may paradoxically communicate that which cannot be made visible, the use of drawings in conjunction with interviews that also explore the meanings

participants contribute to their visual work, may enable studied individuals to express emotions, meanings and experiences they find difficult, elusive or painful to articulate in words (Reavey, 2020; Rose, 2016). In this manner, our understanding of the subjective experience of the therapeutic change process may be broadened and enriched in ways not possible with verbal accounts or visual material alone. Moreover, the act of complementing retrospective interview accounts with naturally occurring visual data may not only help generate additional insights and research questions to be followed up by future work, but it may also provide a better balance between client perspectives' on therapeutic change that may have been partly influenced by their therapists' theoretical frameworks on the one hand and their own idiosyncratic theories of change on the other (Knight, Richert & Brownfield, 2012).

Lastly, in relation to '*usefulness*' I believe that from a research perspective the current study has contributed toward shifting the dominant hypothetico-deductive, measurement-oriented, expert-led and technological paradigm of carrying out scientific treatment research within the substance misuse field, by looking at the process of therapeutic change from the client's side of the interaction and privileging their insights into their own change processes, both inside and outside the therapeutic setting. In this manner, not only has this study enabled the voices of what has been described in the literature as a typically challenging, hard-to-reach (or perhaps hard-to-engage), stigmatised and marginalised client group (Rance & Treloar, 2015; van Boekel, Brouwers, van Weegel & Garretsen, 2013) to be heard and honoured, but the findings generated may hold the potential to form new conceptualisations of both intra- and extra-therapeutic change-promoting factors, and thereby expand the explanation of the Dodo Bird Verdict in relation to lack of main effect differences between contrasting forms of psychotherapy. In this sense, findings of this study, as reflected in the analytic categories, have suggested potentially useful experiential processes of both intra- and extra-therapeutic changes (e.g., existential- and attachment-related), which may spark further research into the workings of these factors and lead to a new depth of understanding of common change processes and their interaction with particular therapeutic interventions or orientation-specific factors. In this way, findings emanating from this and future research on clients' experiences of therapeutic change may facilitate subsequent quantitative studies by providing background information that

contributes to the construction of outcome measures which assess what appears to be important to clients themselves in the process of recovery from harmful substance use. Moreover, since present findings have shed light on both clients' agentic contributions to therapeutic change and the way these interact with or are influenced by therapists' contributions, the insights offered by this study may also be used to orient other clients to make better use of their intra- and extra-therapeutic experiences in the process of recovering or disengaging from substance misuse. This is why in the Methodology chapter I suggested that, ultimately, my study's worth and the knowledge it generates would be decided by how useful it would prove to its participants, other people with similar experiences, as well as those engaged in supporting their efforts at therapeutic change and recovery. At present, this suggestion remains untested.

Finally, in this thesis, perhaps the most important means of evaluating the usefulness of the outcomes of this research might be by considering their applicability to the discipline of counselling psychology. The following section will focus on this particular area.

4.4 Application to Counselling Psychology

As a qualitative research study grounded in participants' subjective experiences of the therapeutic change process, the current study is epistemologically compatible with the humanistic-valuing base philosophy that underpins both the research and practice foci of counselling psychology, whereby great emphasis is placed upon "the personal, subjective experience of the client […] over and above notions of diagnosis and treatment" (Corrie, 2010, p.46). Moreover, given that practice and research in the field of substance misuse have not traditionally been a focus for counselling psychologists (Martin et al., 2016), the type of knowledge generated by current findings may have the potential to alert us to the lived experiences of individuals who struggle with substance use problems and have found psychotherapy helpful in assisting their recovery. In this manner, and because substance misuse can be a complicating factor in therapy, where it tends to be associated with high case complexity, relapse, early dropout and increased psychological distress on the part of professionals who work with this client group (Brorson et al., 2013; Reyre et al., 2017), the most pertinent implications and recommendations for increasing our theoretical

understanding and engaging in practices that promote the retention and resilience of these clients can be drawn from participants' own accounts of therapeutic experience and the change process.

In this sense, findings of this research have demonstrated that subjective expressions of therapeutic change in participants' lives during recovery go far beyond the primary concern of achieving abstinence from substance misuse or minimising its symptomatic harms. Instead, it might be useful for practitioners (whether in a therapeutic, supervisory and/or research capacity) to collaborate with clients in the process of obtaining a more in-depth understanding with regard to the interplay between substance misuse, attachment organisation, self-affect regulation and reflective functioning, as reflected in the processes of development, maintenance and recovery from addiction to psychoactive chemicals. In this manner, potential underlying factors that pertain to the symptoms of substance misuse, and which can be meaningfully addressed within the context of psychotherapy, may be viewed through a contemporary attachment theory lens, whereby problematic substance use is likely to represent a faulty activation of attachment strategies as a means of self-regulation (or self-medication) in the absence of satisfying interpersonal relationships and a well-developed ability to use flexible modes of mentalizing when faced with stressors (Tronnier, 2015). This, in turn, means that therapeutic practice may benefit from aiming to improve clients' reflective functioning through the creation of a secure attachment relationship – as discussed in previous sections – which can serve as an effective indicator of trustworthiness in the therapist's benevolent intentions toward the client and thereby facilitate the transmission of pertinent (including model-specific) knowledge and wisdom the therapist has acquired through training (Fonagy et al., 2017). In this sense, the therapeutic relationship may function as an intra- and interpersonal communication and learning context that has the potential to rekindle clients' epistemic openness to social learning in the form of relevant and generalizable therapeutic interventions (e.g., mentalizing about thoughts, emotions and motivations behind substance use, and learning more resilient self-regulation and interpersonal communication skills). Thus, beginning with the therapeutic relationship, clients may gradually alter their internal representations of themselves and others in ways that promote an increased sense of agency in dealing

constructively with one's inner experience and result in effective interpersonal relationship-recruiting beyond the therapeutic context.

Overall, the aforementioned clinical and practice implications that emanated from findings of this research suggest an attachment-informed approach to the centrality and potency of the therapeutic relationship, which may be transferred across different therapeutic models and ideological perspectives, and thereby bridge the gaps between science and practice in this field of inquiry (Fletcher et al., 2015). Focusing upon the functions of the relational foundations of the therapeutic alliance is consistent with the humanistic, non-pathologising values and postmodern characteristics of counselling psychology's approach to research and practice, whereby no single theoretical modality is given particular preference and, instead, emphasis is placed on the significance of common factors across models of therapy, with the quality of the therapeutic relationship being considered a paradigmatic cross-cutting factor in successful therapeutic encounters (Woolfe, 2016). In this sense, the view of the therapeutic alliance as a vital mechanism for integrating attachment-related aspects into the treatment of substance use problems seems to also raise implications for the therapist's own capacity for reflective functioning, in terms of understanding and empathising with a client as an intentional, agentive being, as well as the therapist's attachment orientation and thereby their ability to establish a close and supportive relational encounter that has the potential to foster attachment security, so that clients may begin rewriting historical internal representations of attachment relationships and associated self-regulation strategies (Cologon, Schweitzer, King & Nolte, 2017). Given that therapist variability has been found in large-scale, naturalistic studies to explain approximately 8% of outcome variance in the wider field of psychotherapy, with therapist factors such as age, gender, theoretical orientation, trainee and professional status bearing no substantial impact on client outcomes (Barkham et al., 2017), it might be useful for the discipline of counselling psychology, which places the therapist's reflective use of self at the heart of the therapeutic process (Woolfe, 2016), to explore whether the future training, recruitment and supervision of therapists in the field of substance misuse might benefit from raising therapists' awareness of the way their own attachment and mentalization patterns may affect client changes in self-regulation and relating to others.

For instance, it has been proposed that therapists with 'secure' or 'earned secure' (i.e., having resolved traumatic attachment experiences) attachment representations may attain better client outcomes, than those who are more insecurely attached, due to their ability to provide effective counter-complimentary responses to clients' negative relational expectations and thereby better manage emergent transferential and counter-transferential interactions within the therapeutic dyad (Mallinckrodt & Jeong, 2015). Additionally, it has been argued that attachment security can be predicted by mentalizing capacity (Oppenheim & Koren-Karie, 2013). This means that therapists' capacity to empathically tune in, understand and communicate the cognitive and affective meanings that underpin clients' mental states may enable clients to begin imbuing the therapeutic encounter with secure base properties, and, thereby, facilitate an emerging sense of trust in a reflective interpersonal space that can be used to become intimate with oneself as an intentional agent, rather than a victim of circumstances, who has the capacity to regulate and direct their behaviour (Holmes, 2011). In other words, the greater the therapists' capacity for reflective functioning, the greater the likelihood to facilitate growth in clients' reflective skills and thereby increased capacity for self-regulation and decreased reliance on impulsive, non-mentalizing behaviours (e.g., substance misuse). Research has found that compared to therapists with higher levels of reflective function, therapists with low levels of reflective function (regardless of theoretical orientation) tend to be insecurely-attached and restrict themselves to more observable or behavioural aspects of therapeutic work, as they become overwhelmed by clients' underlying difficulties in managing strong feelings and processing issues (Cologon et al., 2017).

It should be noted that the aforementioned propositions have been offered on the basis of research that has mainly utilised the Adult Attachment Interview (Main & Goldwyn, 1998) and Reflective-Functioning Scale (Fonagy, Target, Steele & Steele, 1998) to assess and classify therapists' attachment style and levels of mentalization in a categorical, positivist, 'objective' and potentially monolithic manner. Perhaps future counselling psychology research in this area could utilise a phenomenological and hermeneutic epistemology (e.g., IPA) in order to explore the personal meanings of therapists' subjective experiences of early- and later-life attachment relationships, and their impact on current ways of mentalizing and relating to their clients. In this manner, our understanding of the

therapeutic process and potential training needs of therapists within the context of attachment and reflective function may be further enhanced.

Finally, given counselling psychology's focus on a more whole person approach (Woolfe, 2016), therapeutic work in this field should also be mindful of and inquire about clients' potential existential needs and costs they may have incurred as a result of organising their lives around the use of particular substances. In particular, findings of this research suggest that prolonged engagement in substance misuse is likely to be accompanied by a suffering relationship to one's sense of temporality, whereby there might be a subjective experience of an unlived past and a fear or loss of the future. Consequently, paying attention to clients' perception of lived-time may contribute to a more holistic understanding of the impact of substance misuse on crucial aspects of human experience and elucidate important material to work on in therapy and in the process of recovery. For instance, conceptualising substance use problems in terms of clients' sense of temporality may deepen our understanding of their sense of self, particular emotional states, attitude toward personal goals, and relatedness to the world and others (Kemp, 2018). These ideas have been further discussed in preceding sections.

4.5 Concluding Reflections

Completing this research project has been an arduous but immensely rewarding experience both on a personal and professional level of development. I feel that the research process as a whole, from data collection to analysis and integration of findings with existing literature, has greatly enhanced, broadened and deepened my understanding of how the process of therapeutic change and recovery from substance misuse may be experienced from the client's perspective, and these insights have, in turn, made me want to strive to do better while working in a therapeutic capacity.

In reviewing my journey through the project, and thereby the way I have influenced and been influenced by the research process, what has really struck me is the growing awareness of how my own subjectivity and fore-understandings were further uncovered, challenged and transformed through the dialogic nature of the interview process, analytic

interactions with perspectives contained in the transcribed material and consistent engagement in reflexive writing. Although my own therapeutic work provided the impetus and inspiration to conduct this study as a thought-provoking extension of my clinical training and an opportunity to deepen my understanding of the therapeutic change process from the perspective of substance users who had been working towards it, the qualitative methodology I employed helped me clarify where I stood and what influences were behind the way I co-constructed and interpreted the findings along the research journey. In this respect, I found that through the processes of micro-coding, recursive constant comparison and systematic memoing I was able to keep the emergent theory grounded within the original dataset, whilst at the same time drawing upon relevant knowledge and experience from my training in a broad range of theoretical and psychotherapeutic perspectives in order to render the main outcomes of the study useful to therapeutic theory, research and practice. It was in this manner that the unfolding of the research process, gradually, guided me to document and reflect deeply on the nature of attachment relationships, mentalization and existential challenges that may be implicated in the development, maintenance and resolution of substance use problems. In other words, careful listening to the 'otherness' within the dataset let me gradually become increasingly aware of the 'me-ness' in relation to the phenomenon under consideration (Binder, Holgersen & Moltu, 2012). In this way, I was able to appreciate that there are multiple realities which coexist within "an inquiry process that creates knowledge through interpreted constructions" (Annells, 1996, p. 385), which emerge out of the dynamic interplay between the experiences of the participants, the presumptions of the researcher and the medium of shared language and symbolic understandings that belong to a particular time and culture and life histories we inhabit (Charon, 2010).

Overall, undergoing this research journey has been a truly enriching and transformative experience which has enhanced my professional confidence and helped me establish a more well-rounded identity as a reflective practitioner-researcher counselling psychologist. I feel that the findings and insights generated by this research have pragmatic applications to the discipline of counselling psychology in the field of substance misuse, and it is my sincere hope that the grounded theory model I have constructed will prove helpful in

supporting the therapeutic change process of individuals affected by substance use problems as well as inspire other researchers to develop further work in this area of inquiry.

REFERENCES

Abrahams, H. (2007). Ethics in counselling research fieldwork. *Counselling and Psychotherapy Research, 7*(4), 240-244.

ACMD. (2013). *What recovery outcomes does the evidence tell us we can expect? Second report of the Recovery Committee*. London: Advisory Council on the Misuse of Drugs.

Alex, L. & Hammarstorm, A. (2008). Shift in power during the interview situation: Methodological reflections inspired by Foucault and Bourdieu. *Nursing Inquiry, 15*(2), 169-176.

Allison, E., & Fonagy, P. (2016). When is truth relevant? *The Psychoanalytic Quarterly, 2,* 275-303.

Alves, P. C. G., Sales, C. M.D., & Ashworth, M. (2017). Does substance misuse treatment outcome assessment reflect the personal concerns of patients? A scoping review of measures recommended in Europe. *Drug and Alcohol Dependence, 179,* 299-308.

American Psychiatric Association (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Association.

Annells, M. (1996). Grounded theory method: Philosophical perspectives, paradigm of inquiry and postmodernism. *Qualitative Health Research, 6*(3), 370-393.

Artkoski, T., & Saarnio, P. (2012). Therapist effects in substance abuse treatment: A naturalistic study. *Journal of Substance Use, 17*(5-6), 456-467.

Baldwin, S. A., & Imel, Z. E. (2013). Therapist effects: Findings and methods. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behavior change* (6th ed., pp. 258-297). Hoboken, NJ: Wiley.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology, 75,* 842-852.

Barkham, M., Lutz, W., Lambert, M. J., & Saxon, D. (2017). Therapist effects, effective therapists, and the law of variability. In L. G. Castonguay & C.E. Hill (Eds.), *How and why are some therapists better than others? Understanding therapist effects* (pp. 13-36). Washington, DC: American Psychological Association.

Bateman, A., & Fonagy, P. (2012). *Handbook of mentalizing in mental health practice*. Washington, DC: American Psychiatric Association.

Bathish, R., Best, D., Savic, M., Beckwith, M., Mackenzie, J., & Lubman, D. I. (2017). "Is it me or should my friends take the credit?" The role of social networks and social identity in recovery from addiction. *Journal of Applied Social Psychology, 47,* 35-46.

beim Graben, P. (2014). Contextual emergence of intentionality. *Journal of Consciousness Studies, 21*, 75-96.

Betty Ford Institute (2007). What is recovery? A working definition from the Betty Ford Institute. The Betty Ford Institute Consensus Panel. *Journal of Substance Abuse Treatment, 33*, 221-228.

Binder, P. E., Holgersen, H., & Moltu, C. (2012). Staying close and reflexive: An exploratory and reflexive approach to qualitative research on psychotherapy. *Nordic Psychology, 64*(2), 103-117.

Black, J. J., & Chung, T. (2014). Mechanisms of change in adolescent substance use treatment: How does treatment work? *Substance Abuse, 35*, 344-351.

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. London: University of California Press.

Bohart, A., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83-111). Washington, DC: American Psychological Association.

Bohart, A. C., & Wade, A. G. (2013). The client in psychotherapy. In M. J. Lambert (Ed.), *Bergin and Garfield's handbook of psychotherapy and behaviour change* (6th ed., pp. 219-257). Hoboken, NJ: Wiley.

Bonsmann, C. (2010). What do clients say about therapy? *Counselling Psychology Review, 25*(4), 31-45.

Bora, E., & Zorlu, N. (2016). Social cognition in alcohol use disorder: A meta-analysis. *Addiction, 112*, 40-48.

Borkman, T. J., Stunz, A., & Kaskutas, L. A. (2016). Developing an experiential definition of recovery: Participatory research with recovering substance abusers from multiple pathways. *Substance Use & Misuse, 51*(9), 1116-1129.

Bott, E. (2010). Favourites and others: Reflexivity and the shaping of subjectivities and data in qualitative research. *Qualitative Research, 10*(2), 159-173.

Bowen, G. A. (2008). Naturalistic inquiry and the saturation concept: A research note. *Qualitative Research, 8*(1), 137-152.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London: Routledge.

Brinkmann, S., & Kvale, S. (2015). *Interviews: Learning the craft of qualitative research interviewing, 3rd ed*. London: Sage.

Brinkmann, S., & Kvale, S. (2018). *Doing interviews: The Sage qualitative research kit* (2nd ed.). London: Sage.

British Psychological Society (2014). *Code of human research ethics*. Leicester: Author.

British Psychological Society (2018). *Code of ethics and conduct*. Leicester: Author.

Brorson, H. H., Arnevik, E. A., Rand-Hendriksen, K., & Duckret, F. (2013). Drop-out from addiction treatment: A systematic review of risk factors. *Clinical Psychology Review, 33*, 1010-1024.

Brown, P., & Levinson, S. (1987). *Politeness: Some universals in language usage*. Cambridge: Cambridge University Press.

Bryant, A. (2002). Re-grounding grounded theory. *The Journal of Information Technology Theory and Application*, *4*, 25-42.

Bryant, A. (2009). Grounded theory and pragmatism: The curious case of Anselm Strauss. *Qualitative Social Research*, *10*(3), 1-38.

Bryant, A., & Charmaz, K. (2007). *The Sage handbook of grounded theory*. London: Sage Publications.

Buckingham, S. A., Frings, D., & Albery, I. P. (2013). Group membership and social identity in addiction recovery. *Psychology of Addictive Behaviors, 27*(4), 1132-1140.

Burr, V. (2015). *Social constructionism, 3rd ed*. East Sussex: Routledge.

Can, G., & Tanriverdi, D. (2015). Social functioning and internalized stigma in individuals diagnosed with substance use disorder. *Archives of Psychiatric Nursing, 29*, 441-446.

Carroll, L. (2010). *Alice's Adventures in wonderland*. London: Penguin Books. (Original work published 1865)

Charmaz, K. (1983). The grounded theory method: An explication and interpretation. In R. M. Emerson (Ed.), *Contemporary field research* (pp. 109-126). Boston: Little Brown.

Charmaz, K. (1995). Grounded theory. In J. A. Smith, R. Harre, & L. V. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 27-49). London: Sage.

Charmaz, K. (2000). Grounded theory: Objectivist and constructivist methods. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 509-535). Thousand Oaks, CA: Sage Publications.

Charmaz, K. (2004). Premises, principles, and practices in qualitative research: Revisiting the foundations. *Qualitative Health Research*, *14*(7), 976-993.

Charmaz, K. (2005). Grounded theory in the 21st century: Applications for advancing social justice studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 507-535). Thousand Oaks, CA: Sage Publications.

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis*. London: Sage.

Charmaz, K. (2007). Constructionism and grounded theory. In J. S. Holstein & J. Gubrium (Eds.), *Handbook of constructionist research* (pp. 397-412). New York: Guilford.

Charmaz, K. (2008). Grounded theory. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 81-110). London: Sage publications.

Charmaz, K. (2009). Shifting the grounds: Constructivist grounded theory methods. In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke (Eds.), *Developing grounded theory: The second generation* (pp. 127-193). New York: Routledge.

Charmaz, K. (2011). A constructivist grounded theory analysis of losing and regaining a valued self. In F. J. Wertz, K. Charmaz, L. M. McMullen, R. Josselson, R. Anderson, & E. McSpadden (Eds.), *Five ways of doing qualitative analysis: Phenomenological psychology, grounded theory, discourse analysis, narrative research, and intuitive inquiry* (pp. 165-204). New York: The Guilford Press.

Charmaz, K. (2014). *Constructing grounded theory: A practical guide through qualitative analysis* (2nd ed.). London: Sage.

Charmaz, K., & Henwood, K. (2013). Grounded theory. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research in psychology* (pp. 240-259). London: Sage.

Charon, J. M. (2010). *Symbolic interactionism: An introduction, an interpretation, an integration* (10th ed.). Boston: Prentice Hall.

Chen, G. (2010). The meaning of suffering in drug addiction and recovery from the perspective of existentialism, Buddhism and 12-step progam. *Journal of Psychoactive Drugs*, *42*(3), 363-375.

Christensen, A. S., & Elmeland, K. (2015). Former heavy drinkers' multiple narratives of recovery. *Nordic Studies on Alcohol and Drugs, 32*, 245-257.

Christo, G. (1998). The role of neuropsychology in substance misuse treatment. *Journal of Substance Misuse, 3*, 61-66.

Cihan, A., Winstead, D. A., Laulis, J., & Feit, M. D. (2014). Attachment theory and substance abuse: Etiological links. *Journal of Human Behavior in the Social Environment*, *24*, 531-537.

Clarke, A. E. (2003). Situational analyses: Grounded theory mapping after the postmodern turn. *Symbolic Interaction, 26*(4), 553-576.

Clarke, A. E. (2005). *Situational analysis: Grounded theory after the postmodern turn*. Thousand Oaks, CA: Sage.

Clarke, A. E. (2009). From grounded theory to situational analysis: What's new? Why? How? In J. M. Morse, P. N. Stern, J. Corbin, B. Bowers, K. Charmaz, & A. E. Clarke

(Eds.), *Developing grounded theory: The second generation* (pp. 194-235). New York: Routledge.

Cloud, W., & Granfield, R. (2008). Conceptualizing recovery capital: expansion of a theoretical construct. *Substance Use & Misuse, 43*(12-13), 1971-86.

Cole, G. (2016). Existential dissonance: A dimension of inauthenticity. *The Humanistic Psychologist*, *44*(3), 296-302.

Cologon, J., Schweitzer, R. D., King, R., & Nolte, T. (2017). Therapist reflective functioning, therapist attachment style and therapist effectiveness. *Administration & Policy in Mental Health and Mental Health Services Research*, *44*, 614-625.

Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, *24*(3&4), 119-129.

Cooper, M. (2010). The challenge of counselling and psychotherapy research. *Counselling and Psychotherapy Research*, *10*(3), 183-191.

Cooper, M. (2015). *Existential psychotherapy and counselling: Contributions to pluralistic practice*. London: Sage.

Cooper, M., & McLeod, J. (2015). *Client helpfulness interview studies: A guide to exploring client perceptions of change in counselling and psychotherapy*. (Working paper). Retrieved October 7th, 2019 from:
https://www.researchgate.net/profile/Mick_Cooper

Corbin, J. M., & Strauss, A. L. (2008). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (3rd ed.). Los Angeles, CA: Sage.

Corrie, S. (2010). What's evidence? In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp. 44-61). London: Sage.

Cozolino, L. (2016). *Why therapy works: Using our minds to change our brains*. New York: Norton.

Cruise, K. E., & Becerra, R. (2018). Alexithymia and problematic alcohol use: A critical update. *Addictive Behaviors*, *77*, 232-246.

Cummings, A. L., Hallberg, E. T. & Slemon, A. G. (1994). Templates of client change in short-term counseling. *Journal of Counseling Psychology*, *41*(4), 464-472.

Cutcliffe, J. R. (2000). Methodological issues in grounded theory. *Journal of Advanced Nursing, 31*(6), 1476-1484.

Dar, K., Ashby, F., Dhandayudham, A., Faizal, M., Glasper, A., Horsburgh, T., Radley, G., & Alam, F. (2015). Challenges and recommendations for the UK drug treatment system: Findings from a UK expert meeting. *Journal of Substance Use*, *20*(2), 151-153.

Davis, T. A., Ancris, J. R., & Ashby, J. S. (2015). Therapist effects, working alliance, and African American women substance users. *Cultural Diversity and Ethnic Minority Psychology, 21*(1), 126-135.

Davis, M. L., Powers, M. B., Handelsman, P., Medina, J. L., Zvolensky, M., & Smits, J. A. J. (2015). Behavioral therapies for treatment-seeking cannabis users: A meta-analysis of randomized controlled trials. *Evaluation & the Health Professions*, *38*(1), 94-114.

De Crescenzo, F., Ciabattini, M., D'Alo, G. L., De Giorgi, R., Del Giovane, C., Cassar, C., Janiri, L., Clark, N., Ostacher, M. J., & Cipriani, A. (2018). Comparative efficacy and acceptability of psychosocial interventions for individuals with cocaine and amphetamine addiction: A systematic review and network meta-analysis. *PLOS Medicine, 15*(12), 1-24.

De Giorgi, R., Cassar, C., D'Alo, G. L., Ciabattini, M., Minozzi, S., Economou, A., Tambelli, R., Lucchese, F., Saulle, R., Amato, L., Janiri, L., & De Crescenzo, F. (2018). Psychosocial interventions in stimulant use disorders: a systematic review and quantitative synthesis of randomized controlled trials. *Rivista di Psichiatria*, *53*(5), 1-23.

De Rick, A., Vanheule, S., & Verrhaeghe, P. (2009).Alcohol addiction and the attachment system: An empirical study of attachment style, alexithymia, and psychiatric disorders in alcoholic inpatients. *Substance use & Misuse, 44*, 99-114.

Del Re, A. C., Fluckiger, C., Hovarth, A. O., Symonds D., & Wampold, B. E. (2012). Therapist effects in the therapeutic alliance-outcome relationship: A restricted-maximum likelihood meta-analysis. *Clinical Psychology Review, 32*, 642-649.

Denzin, N. K. & Lincoln, Y. S. (2018). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (5th ed., pp. 1-25). Thousand Oaks, CA: Sage Publications.

Dey, I. (1999). *Grounding grounded theory: Guidelines for qualitative inquiry*. Bingley: Emerald Group Publishing.

Dey, I. (2007). Grounded theory. In C. Seale, G. Gobo, J. F. Gubrium, & D. Silverman (Eds.), *Qualitative research practice* (pp. 80-93). London: Sage.

DiClemente, C. C. (2015). Change is a process not a product: Reflections on pieces to the puzzle. *Substance Use & Misuse, 50,* 1225-1228.

Dodes, L. M. (2009). Addiction as a psychological symptom. *Psychodynamic Practice, 15*, 381-393.

Dodes, L. M., & Dodes, J. (2017). The case study method in psychodynamic psychology: Focus on addiction. *Clinical Social Work Journal, 45*, 215–226.

Douglas, B. (2010). Disorder and its discontents. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp. 23-43). London: Sage.

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. A. (2010). *The heart and soul of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association.

Dunne, J., Kimergard, A., Brown, J., Beard, E., Buykx, P., Michie, S., & Drummond, C. (2018). Attempts to reduce alcohol intake and treatment needs among people with probable alcohol dependence in England: A general population survey. *Addiction, 113*(8), 1430-1438.

Duschunsky, R., Collver, J., & Carel, H. (2019). "Trust comes from a sense of feeling one's self understood by another mind": An interview with Peter Fonagy. *Psychoanalytic Psychology, 36*(3), 224-227.

Dutra, L., Stathopoulou, G., Basden, S. L., Leyro, T. M., Powers, M. B., & Otto, M. W. (2008). A meta-analytic review of psychosocial interventions for substance use disorders. *American Journal of Psychiatry, 165*(2), 179-187.

Dwyer, S. C., & Buckle, J. L. (2009). The space between: On being an insider-outsider in qualitative research. *International Journal of Qualitative Methods, 8*(1), 54-63.

Edwards, J. & Loeb, S. (2011). What difference does counselling make? The perceptions of drug-using clients on low incomes. *Counselling and Psychotherapy Research, 11*(2), 105-111.

Einstein, S-S. (2015). Substance use and misuse fifty years later: Ongoing flaws and unfinished business. *Substance Use & Misuse, 50*, 917-938.

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research, 18*(3), 239-242.

Elliott, R. (2010). Psychotherapy change process research: Realizing the promise. *Psychotherapy Research, 20*(2), 123-135.

Elliott, R. (2012). Qualitative methods for studying psychotherapy change processes. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 69-81). West Sussex: Wiley-Blackwell.

Elliot, R., Fischer, C., T. & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*, 215-229.

Elliott, R., Slatick, E., & Urman, M. (2001). Qualitative change process research on psychotherapy: Alternate strategies. In J. Frommer & D. Rennie (Eds), *Qualitative psychotherapy research: Methods and methodology* (pp. 69-111). Lengerich, Germany: Pabst Science.

Erens, B., Roland, M., & Knapp, M. (2011). *Payment by Results (PbR) Drug and Alcohol Recovery Pilot Programme: A note of advice to the Department of Health (DH) on the proposed evaluation*. London: Policy Research Unit in Policy Innovation Research.

Evans, C., Connell, J., Barkham, M., Mellor-Clark, J., & Audin, K. (2002). Towards a standardised brief outcome measure: Psychometric properties and utility of the CORE-OM. *The British Journal of Psychiatry, 180,* 51-60.

Everitt, B. J. (2014). Neural and psychological mechanisms underlying compulsive drug seeking habits and drug memories – indications for novel treatments of addiction. *European Journal of Neuroscience, 40,* 2163-2182.

Fairfax, H. (2013). Where will counselling psychology be in the next 30 years? From a conference to premiership. *Counselling Psychology Review, 28*(3), 81-87.

Fassinger, R. E. (2005). Paradigms, praxis, problems, and promise: Grounded theory in counseling psychology research. *Journal of Counseling Psychology, 52*(2), 156-166.

Fischer, C. T. (2009). Bracketing in qualitative research: Conceptual and practical matters. *Psychotherapy Research, 19*(4-5), 583-590.

Fitzpatrick, M. R., & Stalikas, A. (2008). Positive emotions as generators of therapeutic change. *Journal of Psychotherapy Integration, 18*(2), 137-154.

Fletcher, K., Nutton, J., & Brend, D. (2015). Attachment, a matter of substance: The potential of attachment theory in the treatment of addictions. *Clinical Social Work Journal, 43,* 109-117.

Flew, A. (1989). *An introduction to Western philosophy*. London: Thames & Hudson.

Flick, U. (2009). *An introduction to qualitative research* (4th ed.). London: Sage.

Flores, P. (2011). *Addiction as an attachment disorder*. Oxford: Jason Aronson.

Flowers, P. (2008). Temporal tales: The use of multiple interviews with the same participant. *Qualitative Methods in Psychology, 5,* 24-27.

Fluckiger, C., Del Re, A. C., Wampold, B. E., Symons, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59*(1), 10-17.

Fonagy, P., & Allison, E. (2014). The role of mentalizing and epistemic trust in the therapeutic relationship. *Psychotherapy, 51*(3), 372-380.

Fonagy, P., Campbell, C., & Luyten, P. (2017). Mentalizing. In S. N. Gold (Ed.), *APA handbook of trauma psychology: Vol 1. Foundations in knowledge* (pp. 373-388). Washington, DC: American Psychological Association.

Fonagy, P., Luyten, P., Moulton-Perkins, A., Lee, Y. W., Warren, F., Howard, S., Ghinai, R., Fearon, P., & Lowyck, B. (2016). Development and validation of a self-report measure of mentalizing: The Reflective Functioning Questionnaire. *PLOS ONE, 11*(7):e0158678. doi: 10.1371/journal.pone.0158678

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998). *Reflective-functioning manual, version 5.0, for application to Adult Attachment Interviews*. London: University College London.

Frankl, M., Philips, B., & Wennberg, P. (2014). Psychotherapy role expectations and experiences: Discrepancy and therapeutic alliance among patients with substance use disorders. *Psychology and Psychotherapy: Theory, Research and Practice, 87,* 411-424.

Fredrickson, B. L. (2004). The broaden-and-build theory of positive emotions. *Philosophical Transactions of the Royal Society of London, Series B: Biological Sciences*, *359*(1449), 1367–1377.

Frie, R. (2003). *Understanding experience: Psychotherapy and postmodernism*. East Sussex: Routledge.

Fuchs, T. (2013). Existential vulnerability: Toward a psychopathology of limit situations. *Psychopathology*, *46*(5), 301-308.

Galanter, M., & Kleber, H. D. (2010). *Psychotherapy for the treatment of Substance Abuse*. Washington, DC: American Psychiatric Publishing.

Gandolphe, M-C., Lecluyse, B., Triquet, C., Brunelle, E., Duparcq, J-P., & Nandrino, J-L. (2018). Mind reading abilities in opiate-dependent patients: An exploratory study. *Comprehensive Psychiatry, 83,* 46-52.

Gaume, J., Heather, N., Tober, G., & McCambridge, J. (2018). A mediation analysis of treatment processes in the UK Alcohol Treatment Trial. *Journal of Consulting and Clinical Psychology, 86*(4), 321-329.

Gergen, K. J. (2001). Psychological science in a postmodern context. *American Psychologist, 56,* 803-813.

Giaquinto, S., & Valentini, F. (2009). Is there a scientific basis for pet therapy? *Disability and Rehabilitation*, *31*(7), 595-598.

Glaser, B. G. (1978). *Theoretical sensitivity*. Mill Valley, CA: The Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. New York: Aldine de Gruyter.

Goffman, I. (1967). *Interaction ritual*. New York: Anchor Books.

Great Britain (1998). *Data Protection Act*. London: Stationery Office.

Greenberg, L. S. (2006). Emotion-focused therapy: A synopsis. *Journal of Contemporary Psychotherapy, 36*(2), 87-93.

Groshkova T., & Best, D. (2011). The evolution of UK evidence base for substance misuse recovery. *Journal of Groups in Addiction & Recovery, 6,* 20-37.

Hajar, R. (2015). Animal-assisted therapy: The therapeutic value of pets. *Heart Views*, *2*(16), 70-71.

Hall, D. H., & Queener, J. E. (2007). Self-medication hypothesis of substance use: Testing Khantzian's updated theory. *Journal of Psychoactive Drugs*, *39*(2), 151-158.

Hallberg, L. R-M. (2006). The "core category" of grounded theory: Making constant comparisons. *International Journal of Qualitative Studies in Health and Well-being, 1*, 141-148.

Hansen, J. T. (2004). Thoughts on knowing: Epistemic implications of counseling practice. *Journal of Counseling & Development*, *82*, 131-138.

Hansen, M., Ganley, B., & Carlucci, C. (2008). Journeys from addiction to recovery. *Research and Theory for Nursing Practice: An International Journal*, *22*(4), 256-272.

Health and Care Professions Council (2012). *Guidance on conduct and ethics for students*. London: Author.

Heidegger, M. (1927/1996). *Being and time* (J. Stambaugh Trans.). New York: SUNY Press.

Hemsley, C. (2013). An enquiry into how counselling psychology is construed as a profession within discipline-oriented publications. *Counselling Psychology Review*, *28*(1), 8-23.

Henton, I. (2012). Practice-based research and counselling psychology: A critical review and proposal. *Counselling Psychology Review*, *27*(3), 11-28.

Henwood, K., & Pidgeon, N. (2006). Grounded theory. In G. M. Breakwell, S. Hammond, C. Fife-Schaw, & J. A. Smith (Eds.), *Research methods in psychology* (3rd ed., pp. 342-364). London: Sage Publications.

Hersch, E. L. (2015). What an existential ontology can offer psychotherapists. *Philosophy, Psychiatry & Psychology*, *22*(2), 107-119.

Hilte, M. (2019). Psychoactive drugs and the management of time. *Sociologisk Forskning*, *56*(2), 111-124.

Holmes, J. (2011). Attachment in the consulting room: Towards a theory of therapeutic change. *European Journal of Psychotherapy and Counselling*, *13*(2), 97-114.

Holt, M., & Treloar, C. (2008). Pleasure and drugs. *International Journal of Drug Policy*, *19*, 349-352.

Home Office (2019). *Drugs misuse: Findings from the 2018/19 Crime Survey for England and Wales*. Retrieved December 9th, 2019 from: https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2018-to-2019-csew

Howard, G. S., & Myers, P. R. (1991). Philosophy of science and counseling research. In C. E. Watkins & L. J. Schneider (Eds.), *Research in counseling* (pp. 33-47). New Jersey: Lawrence Erlbaum Associates.

Howitt, D. (2013). *Introduction to qualitative methods in psychology* (2nd ed.). Harlow: Pearson.

Imel, Z. E., Wampold, B. E., Miller, S. D., & Fleming, R. R. (2008). Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviors*, *22*(4), 533-543.

James, P. E. (2013). Counselling psychology in the UK: A 30-year passage. *Counselling Psychology Review*, *28*(3), 75-80.

James, W. (1907). *Pragmatism, a new name for some old ways of thinking: Popular lectures on philosophy*. New York: Longmans, Green & Company.

Jhanjee, S. (2014). Evidence-based psychosocial interventions in substance use. *Indian Journal of Psychological Medicine*, *36*(2), 112-118.

Jordan, J. A. (2019). Alcoholics Anonymous: A vehicle for achieving capacity for attachment relationships and adaptive affect regulation. *Journal of Social Work Practice in the Addictions*, *19*(3), 201-222.

Josselson, R. (2017). Editor's note. *Qualitative Psychology*, *4*(2), 119.

Kan, L. Y., Henderson, C. E., von Sternberg, K., & Wang, W. (2014). Does change in alliance impact alcohol treatment outcomes? *Substance Abuse*, *35*, 37-44.

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, *27*(2), 64-73.

Kaskutas, L. A., Witbrodt, J. & Grella, C. E. (2015). Recovery definitions: Do they change? *Drugs and Alcohol Dependence*, *154*, 85-92.

Kazantzakis, N. (1958). *The Odyssey: A modern sequel* (K. Friar Trans.). New York: Simon & Schuster.

Kellogg, S. H., & Tatarsky, A. (2012). Re-envisioning addiction treatment: A six-point plan. *Alcoholism Treatment Quarterly*, *30*(1), 109-128.

Kelly, J. F., & Greene, M. C. (2014). When there's a will there's a way: A longitudinal investigation of the interplay between recovery motivation and self-efficacy in predicting treatment outcome. *Psychology of Addictive Behaviors*, *28*(3), 928-934.

Kemp, R. (2009). Relating to the other: Truth and untruth in addiction. *European Journal of Psychotherapy and Counselling*, *11*(4), 355-368.

Kemp, R. (2018). Addiction as a temporal disorder: interoception, self, meaning. *Phenomenology and Cognitive Sciences*, 1–15. https://doi.org/10.1007/s11097-018-9578-7

Khantzian, E. J. (2013). Addiction as a self-regulation disorder and the role of self-medication. *Addiction*, *108*, 668-669.

Kirk, J., & Miller, M. L. (1986). *Reliability and validity in qualitative research*. London: Sage Publications.

Kirschenbaum, H., & Henderson, V. L. (1989). *The Carl Rogers reader: Selections from the lifetime work of America's preeminent psychologist, author of On becoming a person and A way of being*. New York: Houghton Mifflin.

Knight, T. A., Richert, A. J. & Brownfield, C. R. (2012). Conceiving change: Lay accounts of the human change process. *Journal of Psychotherapy Integration, 22*(3), 229-254.

Lambert, M. J. (2015). Progress feedback and the OQ-system: The past and the future. *Psychotherapy, 52*, 381-390.

Lang, B., & Rosenberg, H. (2017). Public perceptions of behavioral and substance addictions. *Psychology of Addictive Behaviors, 31*(1), 79-84.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Harlow: Pearson.

Laudet, A. B. (2007). What does recovery mean to you? Lessons from the recovery experience for research and practice. *Journal of Substance Abuse Treatment, 33*, 243-256.

Lee, H. S., & Zerai, A. (2010). "Everyone deserves services on matter what": Defining success in harm-reduction-based substance user treatment. *Substance Use & Misuse, 45*, 2411-2427.

Levinas, E. (1995). *Ethics and infinity: Conversations with Philippe Nemo*. Pittsburgh: Duquesne University Press.

Levitt, H., Butler, M., & Hill, T. (2006). What clients find helpful in psychotherapy: Developing principles for facilitating moment-to-moment change. *Journal of Counseling Psychology, 53*(3), 314-324.

Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly, 29*(1), 7-28.

Levitt, H. M., Poerville, A., & Surance, F. I. (2016). A qualitative meta-analysis examining clients' experiences of psychotherapy: A new agenda. *Psychological Bulletin, 142*(8), 801-830.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2018). Paradigmatic controversies, contradictions, and emerging confluences, revisited. In N. K. Denzin & Y. S. Lincoln

(Eds.), *The Sage handbook of qualitative research* (5th ed., pp. 108-149). Thousand Oaks, CA: Sage Publications.

Litchtenberg, J. W. (2011). Declining counseling research in counseling psychology journals: Is the sky falling? *The Counseling Psychologist*, *39*(5), 693-700.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contexualist and radical constructionist epistemologies. *British Journal of Psychology*, *91*, 1-20.

Main, M., & Goldwyn, R. (1998). *Adult Attachment scoring and classification system*. Berkley, CA: University of California.

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology*, *42*, 307-317.

Mallinckrodt, B., & Jeong, J. (2015). Meta-analysis of client attachment to therapist: Associations with working alliance and client pretherapy attachment. *Psychotherapy*, *52*(1), 134-139.

Marcus, D. K., Kashy, D. A., Wintersteen, M. B., & Diamond, G. S., (2011). The therapeutic alliance in adolescent substance abuse treatment: A one-with-many analysis. *Journal of Counseling Psychology*, *58*, 449-455.

Marsden, J., Farell, M., Bradbury, C., Dale-Perera, A., Eastwood, B., Roxburgh, M., & Taylor, S. (2008). Development of the treatment outcomes profile. *Addiction*, *103*, 1450-1460.

Martin, J. L., Burrow-Sanchez, J. J., Iwamoto, D. K., Glidden-Tracey, C. E., & Vaughan, E. L. (2016). Counseling psychology and substance use: Implications for training, practice and research. *The Counseling Psychologist*, 1-26.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*(4), 370-396.

May, R. (1958). Contributions of existential psychotherapy. In R. May, E. Angel, & H. Ellenberger (Eds.), *Existence: A new dimension in psychiatry and psychology* (pp. 37-91). New York: Basic Books.

McKeganey, N., Bloor, M., Robertson, M., Neale, J., & MacDougall, J. (2006). Abstinence and drug abuse treatment: Results from the Drug Outcome Research in Scotland study. *Drugs: Education, Prevention, and Policy*, *13*, 537-550.

McKernan, L. C., Nash, M. R., Gottdiener, W. H., Anderson, S. E., Lambert, W. E., & Carr, E. R. (2015). Further evidence of self-medication: Personality factors influencing drug choice in substance use disorders. *Psychodynamic Psychiatry*, *43*(2), 243-276.

McLeod, J. (2011). *Qualitative research in counselling psychology* (2nd ed.). London: Sage Publications.

Mead, G. H. (1934). *Mind, self and society*. Chicago: University of Chicago Press.

Mearns, D., & Cooper, M. (2017). *Working at relational depth in counselling and psychotherapy* (2nd ed.). London: Sage.

Medina, M. (2014). The paradox of self-surrender and self-empowerment: An investigation of the individual's understanding of the higher power in Alcoholics Anonymous. *Counselling Psychology Review*, *29*(3), 28-42.

Mee-Lee, D., McLellan, A. T., & Miller, S. D. (2010). What works in substance abuse and dependence treatment. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 393-417). Washington, DC: American Psychological Association.

Melia, K. M. (1987). Rediscovering Glaser. *Qualitative Health Research*, *6*(3), 368-378.

Meriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: John Wiley and Son.

Meyrick, J. (2006). What is good qualitative research? A first step towards a comprehensive approach to judging rigour/quality. *Journal of Health Psychology*, *11*(5), 799-808.

Mikeal, C. W., Gillapsy, J. A., Scoles, M. T., & Murphy, J. J. (2016). A dismantling study of the partners for change outcome management system. *Journal of Counseling Psychology*, *63*(6), 704-709.

Miller, W. R. (2016). Sacred cows and greener pastures: Reflections from 40 years in addiction research. *Alcoholism Treatment Quarterly*, *34*(1), 92-115.

Miller, T., Birch, M., Mauthner, M., & Jessop, J. (2012). *Ethics in qualitative research* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Miller, W. R., & Moyers, T. B. (2015). The forest and the trees: Relational and specific factors in addiction treatment. *Addiction*, *110*(3), 401-413.

Mills, J., Boner, A., & Francis, K. (2006). The development of constructivist grounded theory. *International Journal of Qualitative Methods*, *1*(5), 1-10.

Moerman, M., & McLeod, J. (2006). Person-centered counseling for alcohol-related problems: The client's experience of self in the therapeutic relationship. *Person-Centered & Experiential Psychotherapies*, *5*, 21-35.

Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, *35*(2), 209-235.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, *52*(2), 250-260.

Morse, J. M., Stern, P. N., Corbin, J., Bowers, B., Charmaz, K., & Clarke, A. E. (2009). *Developing grounded theory: The second generation*. New York: Routledge.

Moskalewicz, M. (2016). Lived time disturbances of drug addiction therapy newcomers: A qualitative, field phenomenology case study at Monar-Markot Center in Poland. *International Journal of Mental Health & Addiction*, *14*, 1023-1038.

Moyers, T. B., & Miller, W. R. (2013). Is low therapist empathy toxic? *Psychology of Addictive Behaviors*, *27*(3), 878-884.

Murdock, N. L. (2011). The ghosts of counseling psychology: Is counseling research really dead? *The Counseling Psychologist*, *39*(5), 715-718.

National Institute for Health and Care Excellence (2016). *Coexisting severe mental illness and substance misuse: Community health and social care services*. NICE guideline [NG58]. Retrieved January 17th, 2020 from: https://www.nice.org.uk/guidance/ng58

Neale, J., Finch, E., Marsden, J., Mitcheson, M., Rose, D., Strang, J., Tompkins, C., Wheeler, C., & Wykes, T. (2014). How should we measure addiction recovery? Analysis of service provider perspectives using online Delphi groups. *Drugs: Education, Prevention and Policy*, *21*(4), 310-323.

Neale, J., & Strang, J. (2015). Philosophical ruminations on measurement: Methodological orientations of patient reported outcome measures (PROMs). *Journal of Mental Health*, *24*(3), 123-125.

Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Wykes, T., & Strang, J. (2015). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. *Drugs Education, Prevention and Policy*, *22*(1), 26-34.

Nolas, S-M. (2011). Grounded theory approaches. In N. Frost (Ed.), *Qualitative research methods in psychology: Combining approaches* (pp. 16-43). Maidenhead: McGraw Hill/Open University Press.

Norton, L. (1999). The philosophical bases of grounded theory and their implications for research practice. *Nurse Researcher*, *7*(1), 31-43.

Oppenheim, D., & Koren-Karie, N. (2013). The insightfulness assessment: Measuring the internal processes underlying maternal sensitivity. *Attachment and Human Development*, *15*, 545-561.

Orford, J. (2001). Conceptualizing addiction: Addiction as excessive appetite. *Addiction*, *96*, 15-31.

Orford, J. (2008). Asking the right questions in the right way: the need for a shift in research on psychological treatments for addiction. *Addiction*, *103*(6), 875-885.

Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., Fryer, K., Handforth, L., Alwyn, T., Kerr, C., Thistlethwaite, G., & Slegg, G. on behalf of the UKATT Research Team (2006a). The client's perspective on change during treatment for an alcohol problem: Qualitative analysis of follow-up interviews in the UK Alcohol Treatment Trial. *Addiction*, *101*, 60-68.

Orford, J., Kerr, C., Copello, A., Hodgson, R., Alwyn, T., Black, R., Smith, M., Thistlethwaite, G., Westwood, A., & Slegg, G. (2006b). Why people enter treatment for alcohol problems: Findings from UKATT pre-treatment interviews. *Journal of Substance Use*, *11*(3), 161-176.

Pagano, M. E., White, W. L., Kelly, J. F., Stout, R. L., & Tonigan, J. S. (2013). The 10-year course of Alcoholics Anonymous participation and long-term outcomes: A follow-up study of outpatient subjects of Project MATCH. *Substance Abuse*, *34*, 51-59.

Parker, I. (2005). *Qualitative psychology: Introducing radical research*. Berkshire: Open University Press.

Peacock, A., Leung, J., Larney, S., Colledge, S., Hickman, M., Rehm, J., Giovino, G. A., West, R., Hali, W., Griffiths, P., Ali, R., Gowing, L., Mardsen, J., Ferrari, A. J., Grebely, J., Farell, M., & Degenhardt, L. (2018). Global statistics on alcohol, tobacco and illicit drug use: 2017 status report. *Addiction*, *113*, 1905-1926.

Ponterotto, J. G. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Consulting Psychology*, *52*(2), 126-136.

Ponterotto, J. G. (2006). Integrating qualitative research requirements into professional psychology training programs in North America: Rationale and curriculum model. *Qualitative Research in Psychology*, *2*, 97-116.

Pope, K. S. (1991). Dual relationships in psychotherapy. *Ethics and Behaviour*, *1*, 21-34.

Power, M., & Dalgleish, T. (2015). *Cognition and emotion: From order to disorder* (3rd. ed.). New York: Psychology Press.

Project MATCH Research Group (1997). Matching alcoholism treatments to client heterogeneity: Project MATCH posttreatment drinking outcomes. *Journal of Studies on Alcohol*, *58*, 7-29.

Public Health England (2016). *The public health burden of alcohol and the effectiveness and cost-effectiveness of alcohol control policies: An evidence review*. London: PHE Publications (gateway number: 2016490).

Public Health England (2017). *Adult substance misuse statistics from the National Drug Treatment Monitoring System (NDTMS)*. London: PHE Publications (gateway number: 2017542).

Rance J., & Treloar, C. (2015). "We are people too": Consumer participation and the potential transformation of therapeutic relations within drug treatment. *International Journal of Drug Policy*, *26*, 30-36.

Reavey, P. (2020). *A handbook of visual methods in psychology: Using and interpreting images in qualitative research* (2nd ed.). East Sussex: Routledge.

Rennie, D. L. (1994). Clients' deference in psychotherapy. *Journal of Counseling Psychology*, *41*(4), 427-437.

Rennie, D. L. (2000). Grounded theory methodology as methodological hermeneutics: Reconciling realism and relativism. *Theory and Psychology*, *10*(4), 481-502.

Rennie, D. L. (2001). The client as a self-aware agent in counselling and psychotherapy. *Counselling and Psychotherapy Research*, *1*(2), 82-89.

Reyre, A., Jeannin, R., Largueche, M., Moro, M. R., Baubet, T., & Taieb, O. (2017). Overcoming professionals' challenging experiences to promote a trustful therapeutic alliance in addiction treatment: A qualitative study. *Drug and Alcohol Dependence*, *174*, 30-38.

Robson, M., Cook, P., Hunt, K., Alred, G., & Robson, D. (2000). Towards ethical decision making in counselling research. *British Journal of Guidance and Counselling*, *28*(4), 533-547.

Rodriguez, L., & Smith, J. A. (2014). 'Finding your own place': An interpretative phenomenological analysis of young men's experience of early recovery from addiction. *International Journal of Mental Health & Addiction*, *12*, 477-490.

Rogers, C. (1942). *Counseling and psychotherapy*. Boston: Houghton Mifflin Company.

Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. London: Constable.

Rose, G. (2016). *Visual methodologies: An introduction to researching with visual materials* (4th ed.). London: Sage.

Rosenzweig, S. (1936). Some implicit and common factors in diverse forms of psychotherapy. *American Journal of Orthopsychiatry*, *6*, 412-415.

Saarnio, P. (2011). Therapists' big five personality traits and interpersonal functioning in the substance abuse field: A cluster-analytic study. *Journal of Substance Use*, *16*(5), 348-358.

Sandbrook, J., Clark, T., & Cocksedge, K. A. (2015). Addressing substance misuse in medium secure settings in the UK and Ireland – a survey of current practice. *Journal of forensic practice*, *17*(3), 192-203.

Sanvicente-Vieira, B., Romani-Sponchiado, A., Kluwe-Schiavon, B., Brietzke, E., Brasil-Araujo, R., & Grassi-Oliveira, R. (2017). Theory of mind in substance users: A systematic minireview. *Substance Use & Misuse*, *52*(1), 127-133.

Sartre, J-P. (1943/2003). *Being and nothingness* (H. Barnes Trans.). London: Routledge.

Scheel, M. J., Berman, M., Friedlander, M. L., Conoley, C. W., Duan, C., & Whiston, S. C. (2011). What happened to the counseling in counseling psychology research? *The Counseling Psychologist*, *39*(5), 673-692.

Schindler, A., & Broning, S. (2015). A review on attachment and adolescent substance abuse: Empirical evidence and implications for prevention and treatment. *Substance Abuse*, *36*, 304-313.

Schore, A. N. (2014). The right brain is dominant in psychotherapy. *Psychotherapy*, *51*(3), 388-397.

Schroder-Pfeifer, P., Talia, A., Volkert, J., & Taubner, S. (2018). Developing an assessment of epistemic trust: a research protocol. *Research in Psychotherapy: Psychology, Process and Outcome*, *21*, 123-131.

Schwandt, T. A. (1994). Constructivist, interpretative approaches to human inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 118-137). Thousand Oaks, CA: Sage Publications.

Schwandt, T. A. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics and social constructionism. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 189-213). Thousand Oaks, CA: Sage Publications.

Scott, A. L., Pope, K., Quick, D., Aitken, B., & Parkinson, A. (2018). What does "recovery" from mental illness and addiction mean? Perspectives from child protection social workers and from parents living with mental distress. *Children and Youth Services Review*, *87*, 95-102.

Sexton, T. L., & Griffin, B. L. (1997). *Constructivist thinking in counseling practice, research and training*. New York: Teachers College Press.

Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American Psychologist*, *65*(2), 98-109.

Smith, J. A. (2008). *Qualitative psychology: A practical guide to research methods* (2nd ed.). London: Sage.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In J. A. Smith, R. Harre, & L. V. Langenhove (Eds.), *Rethinking methods in psychology* (pp. 9-26). London: Sage.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.

Smolkovic, I., Fajfar, M., & Mlinaric, V. (2012). Attachment to pets and interpersonal relationships. *Journal of European Psychology Students*, *3*, 15-23.

Sperry, L., & Carlson, J. (2014). *How master therapists work: Effecting change from the first through the last session and beyond*. New York: Routledge.

Stiles, W. B., & Shapiro, D. A. (1994). Disabuse of the drug metaphor: psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology*, *62*(5), 942-948.

Stolorow, R. D., & Atwood, G. E. (1989). The unconscious and unconscious fantasy: An intersubjective-developmental perspective. *Psychoanalytic Inquiry*, *9*, 362-374.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage Publications.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage Publications.

Strawbridge, S. (2016). Science, craft and professional values. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *Handbook of counselling psychology* (4th ed., pp. 20-37). London: Sage.

Strawbridge, S., & Woolfe, R. (2010). Counselling psychology: Origins, developments and challenges. In R. Woolfe, S. Strawbridge, B. Douglas, & W. Dryden (Eds.), *Handbook of counselling psychology* (3rd ed., pp. 3-22). London: Sage.

Suh, J. J., Ruffins, S., Robins, C. E., Albanese, M. J., & Khantzian, E. J. (2008). Self-medication hypothesis: Connecting affective experience and drug choice. *Psychoanalytic Psychology*, *25*(3), 518-532.

Sussman, S., & Sussman, A. N. (2011). Considering the definition of addiction. *International Journal of Environmental Research and Public Health*, *8*, 4025-4038.

Swift, J. K., & Greenberg, R. P. (2012). Premature discontinuation in adult psychotherapy: A meta-analysis. *Journal of Consulting and Clinical Psychology*, *80*, 547-559.

Taipale, J. (2017). Controlling the uncontrollable: Self-regulation and the dynamics of addiction. *The Scandinavian Psychoanalytic Review*, *40*(1), 29-42.

Teesson, M., Hall, W., Proudfoot, H., & Degenhardt, L. (2011). *Addictions: Clinical psychology, 2nd ed*. East Sussex: Psychology Press.

Teixeira, R. C. R., Ferreira, J. H. B. P., & Howat-Rodrigues, A. B. C. (2019). Collins and Read Revised Attachment Scale (RAAS): Validity evidences. *Porto Alegre*, *50*(2), 1-11.

Thorberg, F. A., & Lyvers, M. (2010). Attachment in relation to affect regulation and interpersonal functioning among substance use disorder in-patients. *Addiction Research and Theory*, *18*(4), 464-478.

Tracy, S. J. (2010). Qualitative quality: Eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry*, *16*(10), 837-851.

Tronnier, C. D. (2015). Harnessing attachment in addiction treatment: Regulation theory and the self-medication hypothesis. *Journal of Social Work Practice in the Addictions*, *15*(3), 233-251.

Tweed, A., & Charmaz, K. (2012). Grounded theory methods for mental health practitioners. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy* (pp. 131-146). West Sussex: Wiley-Blackwell.

UKATT Research Team (2005). Effectiveness of treatment for alcohol problems: Findings of the randomised United Kingdom Alcohol Treatment Trial (UKATT). *BMJ, 331*, 541-544.

UKATT Research Team (2007). UK Alcohol Treatment Trial: Client-treatment matching effects. *Addiction*, *103*, 228-238.

van Boekel, L. C., Brouwers, E. P. M., van Weegel, J., & Garretsen, H. F. L. (2013). Stigma among health professionals toward patients with substance use disorders and its consequences for healthcare delivery: Systematic review. *Drug and Alcohol Dependence*, *131*, 23-35.

van Bruggen, V., Klooster, T. P., Westerhof, G., Vos, J., de Kleine, E., Bohlmeijer, E., & Glas, G. (2017). The Existential Concerns Questionnaire (ECQ): Development and initial validation of a new existential anxiety scale in a nonclinical and clinical sample. *Journal of Clinical Psychology*, *73*(12), 1692-1703.

Vanderplasschen, W., Naert, J., Laener, F. V., & De Maeyer, J. (2015). Treatment satisfaction and quality of support in outpatient substitution treatment: Opiate users' experiences and perspectives. *Drugs: Education, Prevention and Policy*, *22*(3), 272-280.

Walsh, F. (2009). Human-animal bonds I: The relational significance of companion animals. *Family Process*, *48*(4), 462-480.

Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, *14*(3), 270-277.

Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). NY: Routledge.

White, W. L. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment*, *33*, 229-241.

Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (Ed.), *APA Handbook of research methods in psychology: Vol.1. Foundations, planning, measures and psychometrics* (pp. 1-17). USA: APA.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). Maidenhead: McGraw Hill/Open University Press.

Winnicott, D. W. (1971). *Playing and reality*. London: Tavistock Publications.

Witkiewitz, K., Steckler, G., Gavrishova, A., Jensen, J., & Wilder, M. (2012). Psychotherapies for addiction: Empirically supported interventions for the addiction syndrome. In H. J. Shaffer, D. A. LaPlante, & S. E. Nelson (Eds), *APA addiction syndrome handbook, Vol.2. Recovery, prevention and other issues* (pp. 87-103). Washington, DC: American Psychological Association.

Wolff, M. C., & Hayes, J. A. (2009). Therapist variables: Predictors of process in the treatment of alcohol and other drug problems. *Alcoholism Treatment Quarterly*, *27*, 51-65.

Woolfe, R. (2011). Mapping training routes into working as a therapist. In R. Bor & M. Watts (Eds.), *The trainee handbook: A guide for counselling and psychotherapy trainees* (3rd ed., pp. 17-32). London: Sage.

Woolfe, R. (2012). Risorgimento: A history of counselling psychology in Britain. *Counselling Psychology Review*, *27*(4), 72-78.

Woolfe, R. (2016). Mapping the world of helping: The place of counselling psychology. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket, & V. Galbraith (Eds.), *Handbook of counselling psychology* (4th ed., pp. 5-19). London: Sage.

Wyrzykowska, E., Glogowska, K., & Mickiewicz, K. (2014). Attachment relationships among alcohol dependent persons. *Alkoholizm i Narkomania*, *27*(2), 145-161.

Yalom, I. D. (1980). *Existential psychotherapy*. New York: Basic Books.

Zigmond, A.S., & Snaith, R. P. (1983). The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scandinavica*, *67*, 361–370.

Zimbardo, P. G., & Boyd, J. N. (1999). Putting time in perspective: A valid, reliable, individual-differences metric. *Journal of Personality and Social Psychology*, *77*(6), 1271-1288.

APPENDICES

Appendix 1: Excerpts from Reflective Journal

14/12/16

So far I have completed 4 interviews (actually had to exclude another 2 participants due to disclosures of imminent suicide risk and memory recall/retrieval problems, respectively, which rendered the interview process unsuitable and infeasible). Even though I feel that I'm still in the very early stages of coding and analysing what seems to already look like a big mountain of data (!), I am glad that the 4 participants I have interviewed thus far seemed to be quite interested in reflecting on and sharing with me in an open, coherent and insightful manner their experience and process of therapeutic change and recovery from harmful substance use.

I noticed there were times, however, during the interview process that I experienced a couple of participants becoming emotionally distressed and vulnerable as they revisited some painful memories and events they associated with the development of their substance use problems and which they tried to process and work through their psychological therapies. These interview experiences presented a few challenges for me as I noticed in myself a natural instinct and inclination to try to contain those participants' emotional distress during the interview, by engaging in a more empathic and psychotherapeutic role, which at times felt like the beginning stages of fostering a therapeutic connection with them. Even though it appeared that those participants did feel well contained during the interview, as they were able to balance the release of painful affect with affect containment and thereby carry on with the process of interviewing, I cannot help but wonder whether I unintentionally breached the boundaries of what is strictly considered to be the role of a 'researcher-interviewer' and stepped into 'practitioner-interviewer' shoes.

I am aware that as a counselling psychologist in-training, who has also had personal experience of engaging in psychotherapeutic work with substance misuse clients, my inclination is to try and develop a holding and trusting environment with people I would like to let me into the private realms of their experiences. The personal qualities that I draw upon in my attempt to foster such an encounter are usually those of empathy, warmth, attentive listening and consistent positive regard, and I have noticed that I also rely upon those same qualities whilst trying to foster a connection with research participants and keep them well contained during the interview process. On the other hand, this awareness leaves me wondering about the potential differences and dividing lines between me as a researcher-interviewer and practitioner-interviewer, especially during difficult and emotionally charged research interview moments. I believe that consulting with my supervisor on this issue might help me develop a more balanced perspective between being caring and considerate with research participants who might at times become emotionally vulnerable during the interviews, but without overly diverting from psychotherapy researcher to practitioner stance.

15/04/17

Today marks the completion of my 8th interview and I have noticed that certain themes are reoccurring and emerging strongly in the data. For instance, it is becoming more and more clear to me that the majority of participants I have interviewed thus far seem to be conceptualising of the development and maintenance of harmful substance use as an important relationship that is employed in the service of soothing and disconnecting from subjectively painful emotional experiences contextualized on the background of early and later life interpersonal relationship failures. In this manner, participants' attachment to harmful substances seems to serve as a substitute for the function of interpersonal relationships to promote self and affect repair. I have labelled this process as *"substance use as a relationship substitute"* and I think that I now have sufficient data that permit me to raise this process to a focused code which will enable me to sift through large amounts of data that can be subsumed under this theme. Moreover, making analytic sense of substance use as a relationship substitute, and categorizing certain batches of data accordingly, seems to reasonably lead to attachment theory considerations and constructs both in the development and therapeutic resolution of substance use problems. This also seems to be indicated by data that speak to participants' experiences of helpful therapist and therapeutic alliance factors in assisting their process of change and recovery (e.g., developing more positive internal representations of self and others as well as more constructive intra- and interpersonal relatedness skills that assist in self and affect regulation).

On the other hand, I endeavour to remain open to the processes of coding and categorizing data at an increased level of abstraction, bearing in mind that focused coding is not a linear process all the time and acquisition of new data from subsequent interviewees may prompt me to study earlier data afresh or suggest greater variations, and even negative cases, within already established codes and categories.

29/01/18

I have now began organising further my data by doing some clustering so that I can produce a visual, preliminary map of my work to date which can assist me with the construction of higher order categories and thereby the production of a descriptive and explanatory grounded theory model.

The central idea or therapeutic change process that has emerged so far from my reading and analysis of the data is that of *"broadening"* (vs. narrowing), which I have now posited to account for participants' active movement away from the dominance of the substance relationship and toward the re-authoring and re-organisation of vital intra and interpersonal aspects of their existence or being-in-the-world.

Engaging in the parallel processes of analysing and clustering what I consider to be important/significant data, set me thinking about how my own perspective on the processes and outcomes of therapeutic change and recovery from substance use problems has changed since I embarked on this research. For instance, I seem to have become much more

aware of substance misuse clients' confrontation with and attempts to resolve central existential challenges related to *existential guilt* and *experience of lived time* as part of the broadening process of therapeutic change and recovery. In this manner, I feel a little embarrassed in myself that during my own psychotherapeutic work experience with this population I never really gave much thought to the significance of these existential issues and their potential to act as both therapeutic change-blocking and change-promoting factors. Moreover, searching for and exploring relevant literature sources on these issues, in relation to substance use problems and their recovery, also revealed noticeable gaps and a dearth of psychological-psychotherapeutic research and practice attention to these factors. Consequently, I have made a note for my discussion section to raise the research and practice implications of these existential themes for counselling psychologists who work in the substance addiction field. Indeed, based on my reading and analysis of the data so far, I feel that substance using clients' grapple with these existential issues and challenges seems to currently lurk in the background of psychotherapeutic research and practice consideration. I therefore feel that a potential contribution of my research would be to make these issues more explicit and move them into the foreground.

Appendix 2: Recruitment Flyer

Department of Psychology City University of London

PARTICIPANTS NEEDED FOR
RESEARCH IN THE EXPERIENCE OF THERAPEUTIC CHANGE

We are looking for volunteers to take part in a study exploring the experience of therapeutic change from the perspective of XXXX service users who have been affected by drug and/or alcohol problems. **Eligible participants** must have **completed in the past 6 months a minimum of 12 psychological therapy sessions** with a XXXX practitioner other than **Anna-Maria Plessa** who is conducting this study, not currently being in psychological therapy, being aged 18 or over, and abstinent from the use of any non-prescribed drugs and/or alcohol on the day of their participation.

You would be asked to: attend an interview with the researcher, Anna-Maria Plessa, lasting for around 1 hour and complete an anonymous demographic form.

If you have read the information leaflet and are interested in taking part, or would like some more information, please complete your details below and take this form to the service's receptionist, who will place it in a confidential envelope and hand it to the researcher, **Anna-Maria Plessa**, who will, in turn, contact you soon.

Name (just first name if you prefer): …….....

Contact telephone number(s): …….....

Preference for time call (circle one):

Any time
Morning
Afternoon
Evening

As a thank you for your time, you will receive a £10 Tesco voucher.

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University of London [*Ethics Approval Code: PSYETH (P/F) 15/16 167*] as well as The Westminster Drug Project's Ethics Committee.

Appendix 3: Participant Information Sheet

Participant Information Sheet

Title of study: *How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?*

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

This project is part of a doctoral thesis in Counselling Psychology at City University of London. It is an investigation into the way people affected by drug and/or alcohol problems experience the nature of therapeutic change from their own perspective.

Why have I been invited?

The reason you have been informed about this study is because you are aged 18 or over and have recently completed a minimum of 12 psychological therapy sessions at XXXX Drug & Alcohol Service with a relevant practitioner other than Anna-Maria Plessa, who is conducting this study.

Do I have to take part?

Participation in this project is completely voluntary, and you can choose not to participate in part or all of the project, without this affecting the standard of care and any treatment you receive (or plan to receive in the future) at XXXX Drug & Alcohol Service. You can withdraw at any stage of the project, up until the final write-up of the doctoral thesis (i.e., six months following your participation), without being penalized or disadvantaged in any way, as stated above.

It really is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form, given to you by the researcher, Anna-Maria Plessa, when you arrange a meeting with her at XXXX Drug & Alcohol Service. As mentioned above, if you decide to take part and sign the consent form, you are still free to withdraw at any time until the final write-up of the thesis (i.e., six months following your participation) and without giving a reason.

What will happen if I take part?

- Your participation will involve completing a brief and anonymous demographic form and attending an interview at XXXX Drug & Alcohol Service with the researcher, Anna-Maria Plessa. The interview will last approximately one hour.
- The participant and the researcher will meet once for an interview conducted in one of the rooms at XXXX Drug & Alcohol Service.
- The research method employed in this project is a qualitative semi-structured interview, in which the researcher will be asking you some questions to enable you to talk about your experience of therapeutic change in a way that feels comfortable to you. Given your consent, the interview will be audio-recorded so that it can be later transcribed and analysed for the project (the researcher will also provide you with a written copy of your transcript following the interview, which you can review for accuracy of the data you have provided and keep for your records). Recording the interview will allow the researcher to focus on the interview process itself without being distracted by the need to write copious notes and without impacting on rapport building, as well as ensuring that no spoken material is missed.
- The research will take place on the premises of XXXX Drug & Alcohol Service at a convenient date and time for you, the participant.
- The individual data and responses you will provide in the process of answering the interview questions will not be shared with any other organization, nor will they be shared with XXXX Drug & Alcohol Service or the person who informed you about this research.

What do I have to do?

If you are interested in taking part in this study, all you have to do is **fill in your contact details in the spaces provided in the recruitment flyer**, **hand it in to the service's receptionist at the front desk**, who will place it in a confidential envelope and give it to the researcher, Anna-Maria Plessa, who will, in turn, contact you soon.
Following this initial contact, if you agree to participate, an interview at XXXX Drug & Alcohol Service will be arranged at a time that suits best your schedule.

What are the possible disadvantages and risks of taking part?

Your participation is not expected to involve any risks of mental or physical harm any greater than those involved in your daily life, but nonetheless you will be debriefed fully at the end of the interview. The researcher will ask you how you found it to participate and will provide some information about where you can get support should any difficult issues arise as a result of the interview. All the material you provide will be anonymous and your name will be changed so that it will not be recognized by anyone else. Should you wish to have a summary of the results when the research is finished, the researcher can arrange for you to receive one.

What are the possible benefits of taking part?

It is hoped that this research will provide **an opportunity for the voice of the client to be heard and privileged** over and above that of the therapist in terms of what appears to be important in the experience of therapeutic change for people affected by drug and/or alcohol problems. This information may in turn inform the work of counselling and psychological therapy practitioners working in the field of substance addictions by increasing their awareness of what matters most to clients who use these services in the process of moving forward. Moreover, the insights brought to light by this research may also be used to orient other clients to make better use and sense of their psychological therapy experience and the process of change.

Additionally, research has shown that the use of qualitative methods of collecting data, such as interviewing, promotes reflexivity, self-awareness and empowerment of the parties involved in such research endeavours, by giving people voice to tell their stories in their own words. This sharing can be cathartic, rewarding and therapeutic in itself.

Finally, as a thank you for your time and participation, you will also receive a £10 Tesco voucher. This will be given to you by the researcher, Anna-Maria Plessa, on the day you attend the research interview.

What will happen when the research study stops?

When the research study stops and a written report is completed data will be retained for 5 years for publication purposes as recommended by the British Psychological Society's (BPS) guidelines. Following this period of time, interview recordings will be permanently deleted and interview transcripts will be shredded.

Will my taking part in the study be kept confidential?

- Only the researcher will have access to the information obtained before anonymising the data. After the data has been sufficiently anonymised so that no individual details can be identifiable, the research supervisor may have access only to the written interview transcripts as part of the process of supervising the researcher's project. This means that the digital audio recordings will not be heard by any other person other than the researcher, Anna-Maria Plessa.
- Each participant will be given a unique participant number (e.g. P01) in order to ensure anonymity. Recorded interviews will be transferred from a digital voice recorder to a password protected computer file. Each interview will be transcribed using Windows Media Player into a Microsoft Word document. During transcription any identifiable names will be removed and replaced with pseudonyms, whilst lines of the text will be numbered throughout. Interview transcripts will be stored in a locked cabinet at the researcher's home.
- Confidentiality will be maintained throughout the research. Confidentiality may be breached only in case participants disclose risks of harming themselves or other people. In this case, the research supervisor and XXXX Drug & Alcohol Service's director will be informed so that the participant's safety and security can be ensured.
- As mentioned above, the digital audio recordings and written interview transcripts will be stored under secure conditions and destroyed at the appropriate conclusion

of their use. Audio recordings will be permanently deleted and transcripts shredded 5 years after the conclusion of the research.

What will happen to the results of the research study?

The results of this research will be anonymous and every participant will be given a pseudonym in any written material arising from the study so that their identity will not be attached to the information they provide. The key that lists the participant's identity and pseudonym will be kept securely and separately from the research data in a locked file. This will be destroyed 5 years after the research is completed. Additionally, the purpose of the research is to examine groups of people and not one particular individual.

The results of this research may be published in psychological journals or otherwise reported to scientific bodies within a period of 5 years following the completion of the research, but none of the participants involved in the study will be identified in any such publications or reports.

Moreover, as mentioned previously, the individual data and responses participants will provide in the process of answering the interview questions will not be shared with any other organisation or any practitioners working at XXXX Drug & Alcohol Service.

If any of the participants would like to receive a copy of the results of the research for their own interest, the researcher will arrange for them to receive a summary of results when the report is finished.

What will happen if I don't want to carry on with the study?

As mentioned before, if you agree to participate and subsequently decide that you no longer wish to carry on with the study, **you are free to withdraw your consent without an explanation or penalty at any time up until the final write-up of the doctoral thesis** (i.e., six months following your participation). Should you decide to withdraw your consent and participation before the final write-up of the thesis, any data or recordings related to you will be immediately destroyed.

What if there is a problem?

If you have any problems, concerns or questions about this study, you should ask to speak to a member of the research team. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: *"How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?"*

You could also write to the Secretary at:

[redacted]
Secretary to Senate Research Ethics Committee
Research Office, E214
City University of London
Northampton Square
London
EC1V 0HB
Email: [redacted]

City University of London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

Who has reviewed the study?

This study has been approved by City University of London, Psychology Department Research Ethics Committee, **Ethics Approval Code: PSYETH (P/F) 15/16 167** as well as by the Ethics Committee of XXXX Drug & Alcohol Service.

Further information and contact details

I hope this information is enough to give you some idea of whether you would like to participate in this research. Your participation will be invaluable and much appreciated. Should you have any further questions that you would like answered, please contact me at: Anna-Maria Plessa, [redacted]

Additionally, the contact details of my supervisor, Dr Susan Strauss, are as follows: Department of Psychology, School of Social Sciences, City University, Northampton Square, London, EC1V 0HB. [redacted]

Thank you for your interest and taking the time to read this information leaflet.

Appendix 4: Interview Guide

Interview Schedule

In this interview I would like us to explore any changes you may have noticed over the course of psychological therapy and how you think these changes came about. The main purpose of this interview is to allow you to share with me about the experience of change from your point of view and in your own words, in a way that feels comfortable to you. This information will help me to understand better how psychological therapy works for people affected by drug and/or alcohol use so please provide me with as much detail as possible. First…

1. Can you give me a sense of what brought you to psychological therapy?
   Inquire about quality of interpersonal relationships and potential meaning of substances as an important relationship?
   Inquire about existential/life satisfaction and experience of lived time – including death wishes, suicidal ideation, suicide attempts
   Inquire about perceptions of and potential perceived changes in self-reliance

2. What was your aim when you came to psychological therapy? *OR*: What did you aim to change when you first came in?
   Inquire about potential changes in negative self-perception/appraisal, destructive self-affect regulation skills, interpersonal connectedness/relationships (if not mentioned)

3. How do you think that you/your life has changed over the course of this therapeutic process? *OR*: What changes, if any, have you noticed in yourself over the course of therapy?
   Prompt: for example, are you feeling, thinking or acting differently from the way you did before?
   Inquire about positive changes in self-perception and intrapersonal relatedness, changes in impulsive responding
   Inquire about lifestyle changes
   Inquire about changes in the experience of lived time and temporal perspective (e.g., learning how to live time without the use of substances, becoming more prospectively focused, thinking about the future, planning and structuring everyday activities, self-care practices etc.)
   Inquire about changes in interpersonal relationships and ways of interacting with others

4. How did this change/these changes happen? *OR:* How did you know change had occurred? Prompt: what would other people who know you say?
   Look for intra- and interpersonal broadening and building resilient coping skills – e.g., self-affect regulation, interpersonal relatedness skills, temporal changes

5. What did you first notice when change began?
   Inquire about temporal changes, having more structure in one's life, self-care practices, interpersonal relatedness (if not already mentioned)
6. How would you describe the processes that took place while you were changing? In other words, can you give me a sense of how that change/these changes occurred?
   Explore (further) intra- and interpersonal experiences of broadening and being-in-the-world (if not already mentioned)

7. In general, what do you think might have brought these changes about?
   Prompt for things both inside and outside of therapy
   Inquire about potential contribution of therapeutic relationship inside and outside the therapy context
   Inquire about self-initiated changes outside the therapeutic setting – *Becoming own therapist??*
   Inquire about changes to and expansion of personal and social support networks
   Inquire about potential therapeutic role of pets

8. Was there anything in particular that your therapist did or say to facilitate (or influence) this process of change?
   Inquire about the quality of therapeutic relationship/attachment, therapist effects and relational attitudes/qualities (if not already mentioned)
   Inquire about potential instances and impact of therapist self-disclosure(s)
   Inquire about in-session emotion exploration and affective experiencing, learning more effective communication and assertiveness skills of interpersonal relatedness (e.g., transparent emotional expression, empathy and perspective-taking/mentalizing)
9. Can you think of any instances that change didn't occur? Follow-up question: What was different in these times that change didn't occur?
   Inquire about both intra- and extra-therapy factors – e.g., continued harmful use of substances, experiential avoidance, difficult interpersonal experiences, reduced physical/social recovery capital

10. Was there anything else that you wanted to change over the course of therapy, but didn't, and why do you think that is? (N.B. this is a double question, but can be broken down into two distinct ones to avoid participant confusion)
    Inquire about experience of change/personal growth as an ongoing process

11. Do you have anything else that you want to tell me in relation to your experience of change or how it happened?
    OR Was there anything that wasn't asked about that feels significant about your experience of change? (i.e., time for participants to add further comments)
12. How did you find the interview?

Appendix 5: Demographic Data Questionnaire

Demographics form

BACKGROUND INFORMATION

To begin, I would like to obtain some basic information about you, such as your age, education and occupation. The reason for this is so that we can provide some general details about the group being studied in the report of the project. The information you provide me will not be used to identify you in any way, and your name will not be used at any point in the report. Nevertheless, if you don't want to answer some of the questions, please don't feel that you have to.

Thank you for your cooperation.

1. What is your gender? _____

2. How old are you?
   _____ years

3. What is your highest educational qualification?

   (*Please tick the appropriate answer*)

   None _____

   GCSE/O-Level/CSE _____

   A-Level _____

   Diploma _____

   Degree _____

   Postgraduate degree/diploma _____

4. What is your current occupation, or if you are no longer working, what was your last occupation? (Please write below)

---

5. How would you describe your ethnicity/nationality?

6. What was your drug of choice?

7. When was the last time you used it? _____ Days/ Weeks/ Months/ Years

   (please indicate as appropriate)

8. How long were you in psychological therapy for? _____ Weeks

   _____ Months

   _____ Years

9. How many sessions of psychological therapy have you had?

   _____ Sessions

10. How long ago did your psychological therapy end? _____ Weeks

    _____ Months

    _____ Years

11. Are you aware of the type of therapy you received (e.g., cognitive-behavioural, person-centred, gestalt, psychodynamic, integrative)?

    If yes, can you please write your therapist's orientation in the space provided below?

Appendix 6: Participant Consent Form

Title of Study: ***How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?***

Ethics approval code: PSYETH (P/F) 15/16 167

		Please initial box
1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be audiotaped • completing an anonymous questionnaire asking me about basic demographic/background information	
2.	This information will be held and processed for the following purpose(s): To answer the research question posed by the study I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation, nor will they be shared with the service or service practitioner who informed me of this research. AND I understand that the results of this research will be anonymous and I will be given a pseudonym in any written material so that my identity will not be attached to the information I contribute. The key that lists my identity will be kept securely and separately from the research data in a locked file. It will be destroyed 5 years after the research is completed. In addition, I understand that the purpose of the research is to examine groups of people and not one particular individual. AND	

	I understand that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research. AND I understand that the results of this research may be published in psychological journals or otherwise reported to scientific bodies, but that I will not be identified in any such publication or report.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project, up until the final write-up of the doctoral thesis (i.e., six months following my participation), without being penalized or disadvantaged in any way. I understand that if I withdraw my consent and participation before the final write-up of the thesis, my data, including any recordings, will be immediately and permanently destroyed.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

When completed, 1 copy for participant; 1 copy for researcher file.

Note to researcher: to ensure anonymity, consent forms should NOT include participant numbers and should be stored separately from data.

Appendix 7: Debrief Form

How psychotherapy clients in recovery from harmful substance use experience the process of therapeutic change?

DEBRIEF INFORMATION FOR PARTICIPANTS

Thank you for taking part in this research project! Your help is much appreciated!

The purpose of the research is to gain a more in depth understanding of how people affected by drug and/or alcohol use experience the nature of therapeutic change as it gradually unfolds to them. Your contribution and your views and thoughts on this subject have therefore been invaluable and are much appreciated.

It is hoped that the study will increase our understanding of the internal processes and experiences involved in therapeutic change from the perspective of people who have undergone this process themselves and have no professional background or theoretical framework with which to structure their account of how clinically meaningful change comes about, the way therapists and psychologists do. This may in turn inform the work of psychological therapy practitioners working in the field of drug and alcohol addiction by increasing their awareness of what matters most to people who use their services in the process of moving forward. Moreover, the insights brought to light by this research may also be used to orient other clients to make better use and sense of their psychological therapy experience and the process of change.

If you have any questions regarding the research, or wish to withdraw your consent or participation at any time, up until the final write-up of the doctoral thesis (i.e., six months following your participation), you may contact me directly at [redacted] . Alternatively, my telephone number is [redacted]

The contact details of my research supervisor, [redacted], are as follows: Department of Psychology, School of Social Sciences, City University, Northampton Square, London, EC1V 0HB. Telephone: [redacted] . You may contact my supervisor should you have any queries or issues regarding the research or conduct of the interview, for example, which you do not wish to share with me.

If you wish to receive a copy of the results of the research for your interest, please give me your postal address and I will send you a summary of results when the research is finished.

At the end of the interview I asked you how you had found it to take part in the research and how you were feeling after the interview. If as a result of participating you have experienced or are experiencing any difficult feelings, such as sadness, emotional distress or uncomfortable feelings about yourself, for example, I have provided below some details of organisations that you can contact in order to get some support. I hope that these might

be useful if issues have come up for you during or after the interview that you would like to talk to someone about.

The Samaritans:	Provides confidential emotional support 24 hours/day and 365 days/year to people experiencing feelings of distress or despair. Tel: 0845 790 90 90 OR 116 123 (free from any phone) Website: www.samaritans.org.uk
SupportLine	Provides confidential crisis telephone counselling to children, young people and adults. It maintains an extensive information system which contains details of other agencies and support groups throughout the UK and can refer callers to a specific agency when required. Tel: 01708 765200 Website: www.supportline.org.uk
Benenden	24/7 stress counselling helpline Tel: **0800 414 8247** **Website:** www.benenden.co.uk/health/cover/healthcare/247-stress-counselling-helpline
Waterloo Community Counselling	Provides individual, couple and group counselling to adults faced with emotional issues, such as anxiety, depression and low self-esteem. It also includes a multi-ethnic counselling service where your cultural background is taken into consideration. Tel: 0207 928 3462 Website: http://www.waterloocc.co.uk Open: 9:30am – 5:30pm

You could also go to your **GP** or contact the **British Psychological Society (BPS)** for information regarding finding a psychologist.

The British Psychological Society
St Andrews House
48 Princess Road East
Leicester
LE1 7DR

Tel: +44 (0)116 254 9568
Fax: +44 (0)116 227 1314
Email: enquiries@bps.org.uk
Website: www.bps.org.uk

Office Opening Hours
Monday to Friday, 9am – 5pm

Alternatively, you may also wish to contact the **British Association for Counselling and Psychotherapy (BACP)** for information regarding finding a counsellor.

BACP House
15 St John's Business Park
Lutterworth
Leicestershire
LE17 4HB

Tel: 01455 883300
Open: Monday to Friday, 9am – 5pm
Website: www.bacp.co.uk

Ethics approval code: *PSYETH (P/F) 15/16 167*

Appendix 8: Ethics Application Form

CITY UNIVERSITY LONDON

Psychology Department Standard Ethics Application Form:

Undergraduate, Taught Masters and Professional Doctorate Students

This form should be completed in full. Please ensure you include the accompanying documentation listed in question 19.

Does your research involve any of the following? ***For each item, please place a 'x' in the appropriate column***	**Yes**	**No**
Persons under the age of 18		X
Vulnerable adults (e.g. with psychological difficulties)		X
Use of deception		X
Questions about potentially sensitive topics	X	
Potential for 'labelling' by the researcher or participant (e.g. 'I am stupid')		X
Potential for psychological stress, anxiety, humiliation or pain	X	
Questions about illegal activities		X
Invasive interventions that would not normally be encountered in everyday life (e.g. vigorous exercise, administration of drugs)		X
Potential for adverse impact on employment or social standing		X
The collection of human tissue, blood or other biological samples		X
Access to potentially sensitive data via a third party (e.g. employee data)		X
Access to personal records or confidential information		X
Anything else that means it has more than a minimal risk of physical or psychological harm, discomfort or stress to participants.		X

If you answered 'no' to all the above questions your application may be eligible for light touch review. You should send your application to your supervisor who will approve it and send it to a second reviewer. Once the second reviewer has approved your application they will submit it to psychology.ethics@city.ac.uk and you will be issued with an ethics approval code. You cannot start your research until you have received this code.

If you answered 'yes' to any of the questions, your application is NOT eligible for light touch review and will need to be reviewed at the next Psychology Department Research Ethics Committee meeting**.** You should send your application to your supervisor who will approve it and send it to psychology.ethics@city.ac.uk. The committee meetings take place on the first Wednesday of every month (with the exception of August). Your application should be submitted at least 2 weeks in advance of the meeting you would like it considered at. We aim to send you a response within 7 days. Note that you may be asked to revise and resubmit your application so should ensure you allow for sufficient time when scheduling your research. Once your application has been approved you will be issued with an ethics approval code. You cannot start your research until you have received this code.

Which of the following describes the main applicant? ***Please place a 'x' in the appropriate space***	
Undergraduate student	
Taught postgraduate student	
Professional doctorate student	X
Research student	
Staff (applying for own research)	
Staff (applying for research conducted as part of a lab class)	

1. Name of applicant(s).

Anna-Maria Plessa

N.B. This application has been previously approved (on 1st April 2015), but I am now coming back to the committee because, following relevant discussions and agreement with my research supervisor at City, [redacted], I have now changed the focus of my research question, making it specific to the process of therapeutic change as experienced by people affected by drug and alcohol problems, and have also changed my methodology to grounded theory as this will enable me to better answer my research question.

2. Email(s).

[redacted]

3. Project title.

How do people affected by drug and alcohol use experience the process of therapeutic psychological change? A qualitative exploration of the experience of therapeutic change from the client's perspective

4. Provide a lay summary of the background and aims of the research. (No more than 400 words.)

A welcome trend in the counselling and psychotherapy literature is the growing appreciation for clients' individualized perspective on therapeutic outcome and the process of change (e.g. see Cooper & McLeod., 2011; Elliott, 2012; Knight, Richert & Brownfield, 2012), as this provides a useful balance to the continuing emphasis on quantitative outcome studies typically used to evaluate client change and guide treatment planning on a theoretical and practical level. In particular, addiction research has been criticised for lacking a qualitative focus that encompasses the client's view

and subjective perceptions of change in the process of recovery (e.g., Neal, Finch, Marsden, Mitcheson, Rose, Strang, Tompkins, Wheeler & Wykes, 2014; Ronel, Elisha, Tumor & Chen, 2013).

To this end, this study aims to meet the call to deepen our understanding of change from the client's perspective by interviewing 12-15 psychological therapy clients who have completed a minimum of 12 sessions at a community drug and alcohol service about their subjective experience of the process of therapeutic change. The interviews are proposed to be analysed by using grounded theory methods (Charmaz, 2014) in order to provide an in-depth understanding of people's subjective experiences of change following psychological therapy.

Finding out how clients understand and construe the process and experience of change responds to the call for qualitative approaches to this line of inquiry and aspect of therapy in a way that privileges the client's perspective and gets close enough to the lived experience of how change occurs and the way it looks from the other chair. Moreover, understanding how clients think about and experience change may sensitize and inform the clinical work of counselling psychologists working in the field of addictions by increasing their awareness of clients' internal and covert processes involved in the process and conceptualisation of change and thereby aid in the reconstruction of therapeutic practice and principles involved in engaging productively with and promoting meaningful client change. Finally, by bringing to light experiences that psychologists may rarely consider in formal training, or which may not be easily observable within sessions, the findings of qualitative research, like the one proposed here, can facilitate subsequent quantitative studies (Neal & Strang, 2015) by providing background information that contributes to the construction of outcome measures for addictions therapy which assess what appears to be important to clients in the process of change. In this way, evaluations of therapy by counselling psychologists, psychotherapeutic counsellors and potentially insurance companies and other mental health providers, may benefit from the development of broader ways to define outcome which contribute to the evidence-based practice of the profession and bridge researcher, clinician and client points of view about key change events and processes involved in the recovery from drug and alcohol addictions.

5. Provide a summary of the design and methodology.

The decision to employ a qualitative approach relates to the nature of the research question and the aims of objectives of the current research. As my research question is interested in exploration and seeks to produce knowledge and an explanatory framework that aims to understand, describe and further illuminate the meaning of therapeutic change, whilst also focusing on the 'processes' involved in generating such change, a qualitative study conducted from a grounded theory perspective is proposed for the current project. Moreover, grounded theory is compatible with a range of epistemological perspectives and can therefore be used in a flexible way that suits both the research design and the researcher's epistemological beliefs (Chamberlain, 1999). To this end, Charmaz's (2014) social constructionist version of grounded theory is

proposed to be employed for the purposes of analysing semi-structured interviews and informing further data collection.

The main purpose of grounded theory is to generate a theoretical explanation from the data collected which can be tested against subsequent data collection, in case the full version of the approach is used. In this respect an analytical approach whereby data collection and analysis are closed related and conducted simultaneously will be employed as this will allow for data collection and participant selection to be shaped by ongoing analysis in order to refine the emerging concepts, themes and theory.

Coding (open, focused, theoretical and constant comparative forms) will be used to analyse data as it constitutes the most basic and fundamental process in grounded theory that links data with emerging theory in a way that allows to both describe what is happening and identify meaning (Charmaz, 2014; Willing, 2013). Initially, once the interviews have been transferred from a digital voice recorder to a password-protected computer and transcribed into a Microsoft Word document, data will be coded line-by-line by attaching labels to sort and compare interview extracts and this will be a continual process in order to make sense of the emerging findings and move from lower-level and more descriptive to higher-level and more analytic categories. Memo writing, referring to memos about codes and comparisons between emerging categories, will also be made throughout the analysis in order to capture emerging hypotheses and facilitate the theory building and write up of the analysis, as well as to define and record relationships between categories. Further data collection will also be conducted in order to develop more focused codes and advanced memos. In this way, coding will also become more focused on meaning rather than merely describing and summarising statements and thereby lead to the construction of analytical categories which can eventually progress into more detailed and theoretical categories as the depth of the analysis progresses. Any gaps or questions identified about the data will also be documented in order to follow up and clarify in subsequent interviews. Moreover, throughout the coding process both negative case analysis and comparative analysis will be used in order to identify instances that do not fit and compare participants' experiences for similarities and differences, respectively. In this way, the full complexity of the data can be captured, whilst categories can be later merged in case there are significant similarities between them or spilt for differences within the data category. It is further anticipated that the analysis of the data will also identify a core category, which will explain the relationships between the categories that will be constructed. As the core category emerges, subcategories will be linked to it, and eventually links will be made between all categories in order to inform theory generation. Subsequent data collection and analysis will continue in order to allow the researcher to further elaborate and refine categories until nothing new appears from the data, which will signal the saturation of existing categories (Charmaz, 2014). This also demonstrates that although initially grounded theory uses an inductive process, as analysis progresses it eventually moves to a more deductive approach (Willig, 2013).

6. Provide details of all the methods of data collection you will employ (e.g., questionnaires, reaction times, skin conductance, audio-recorded interviews).

Brief demographic form to obtain information on participants' age, gender, ethnicity educational and professional background as well as type and duration of psychological therapy received. The reason for this is to gather some general details about the characteristics of the group being studied.

Audio-recorded interview using a digital recorder – current interview schedule is comprised of 12 questions

7. Is there any possibility of a participant disclosing any issues of concern during the course of the research? (e.g. emotional, psychological, health or educational.) Is there any possibility of the researcher identifying such issues? If so, please describe the procedures that are in place for the appropriate referral of the participant.

Given the nature of the topic being investigated, it is possible that during the course of the interviews some emotional distress may be experienced as participants revisit painful experiences or aspects of their lives they sought therapy for. For this reason, details of accessible counselling services will be provided to each participant at the end of the research conversation wherein both verbal and written debriefing will take place (please see debrief sheet appended). Moreover, in case a participant discloses any such issues of concern the researcher will immediately liaise with the research supervisor and inform her about any such occurrences so that the participant's safety and security can be ensured.

8. Location of data collection. (If any part of your research takes place outside England/Wales please also describe how you have identified and complied with all local requirements concerning ethical approval and research governance.)

For the purposes of ensuring both researcher and participant security, it is proposed that potential participants will be recruited from and interviewed on the premises of the Westminster Drug Project (a.k.a. 'WDP'), a community drug and alcohol service which is located in the area of Barnet (42a Hendon Lane, Finchley, N3 1TT) – an interview room will be booked at the service upon arranging an upcoming interview.

9. Details of participants (e.g. age, gender, exclusion/inclusion criteria). Please justify any exclusion criteria.

The inclusion criteria for participants to take part in the research will be:

- **Aged 18 or over;**
- **Ability to give informed consent to take part (BPS, 2014);**
- **Subjective experience of therapeutic change during the course of psychological treatment provided by a relevant practitioner other than the researcher;**
- **Being free of any non-prescribed drug and/or alcohol use on the day of the research interview in order to ensure abstinence from physically dependent and/or excessive use of drugs and/or alcohol (e.g., McKeganey, Bloor, Robertson, Neale & MacDougall, 2006), and thereby participants' ability to provide a clear and accurate experiential account of their experience of psychological change (Willig, 2013). Moreover, as WDP is not an inpatient drug rehabilitation or detoxification service, meaning that clients attending treatment services there are not required to be or have achieved a certain period of drug and/or alcohol abstinence, this criterion will be assessed by trusting participants' own account of complete drug and/or alcohol abstinence on the day of the research interview, whilst also being mindful of their behaviour and affect during the interview and thereby prepared to suggest terminating the interview in case I sense that a participant is not presenting and conducting themselves in a stable manner.**
- **English fluency so that a clear experiential account can be provided during the research interview (Willig, 2013).**

People who are actively suicidal, diagnosed with a psychotic or substance disorder, as well as those with a limited ability to communicate in English, will be excluded from the study as these characteristics can compromise the applicability of qualitative methods (Willig, 2013).

In terms of assessing risk and ensuring that potential participants meet the study's participation criteria, the researcher, as mentioned below in section 10 below, prior to meeting potential participants who give their informed consent to participate will have a brief telephone contact with them during which she will assess their eligibility to take part in the study on the basis of meeting the participation criteria as described above. More specifically, the brief telephone conversation between potential participants and researcher will be used as a means of establishing rapport and gauging suitability to participate by asking screening questions, such as:

- **How did you decide to participate in this study?**
- **How long were you in therapy for?**
- **How long has it been since you finished therapy?**
- **How long have you been abstinent from any dependent or excessive use of drugs and/or alcohol?**
- **How would you describe your emotional adjustment at present? – responses to this question will then lead into assessing risk more explicitly by inquiring whether participants have ever had any thoughts of harming themselves**

10. How will participants be selected and recruited? Who will select and recruit participants?

Following ethical approval by City University Research Ethics Committee, as well as the Research Ethics Committee of WDP, adult client-participants, who have recently completed a minimum of 12 psychological therapy sessions will be recruited by means of flyers and participant information sheets displayed together throughout the WDP drug and alcohol service in Barnet (please see attached documents of the recruitment flyer and participant information sheet). These materials which aim to provide prospective participants with a fair description of the nature and purpose of the research as well as explicate the criteria for eligible participation (see 'inclusion and exclusion criteria' in section 9 above). Interested participants will be asked to voluntary enter their contact details in the appropriate spaces indicated in the recruitment flyer and then take this form to the receptionist of the service who will place it in a confidential envelope and hand it to the researcher. The researcher will, then, make brief telephone contact with each participant in order to ensure that they fulfil the participation criteria and are comfortable with the nature and purpose of the study. Following this brief screening telephone contact, the researcher will agree with each eligible participant a mutually convenient date and time for them to meet at the service and take part in an individual and audio-recorded research interview, which will be conducted in one of the service's interview rooms and last for around one hour. In this way, prospective client-participants can be given control over accepting or refusing to receive an invitation about taking part in this project.

11. Provide details of any incentives participants will receive for taking part.

An opportunity to tell and articulate in their own words their story of how psychological therapy facilitates meaningful change so that their voice can be heard and privileged in a way that will sensitise practitioners in the field of addictions to clients' internal and covert processes involved in the process of effecting therapeutic change.

12. Will informed consent be obtained from all participants? If not, please provide a justification. (Note that a copy of your consent form should be included with your application, see question 19.)

Yes, informed consent will be obtained from all participants throughout the research process.

13. How will you brief and debrief participants? (Note that copies of your information sheet and debrief should be included with your application, see question 19.)

Participants will be briefed by means of receiving a participant information sheet that explains the nature, aims and process of the research in a lay and transparent manner.

Also, at the end of the interview, the researcher will ask each participant how she or he found it to participate and will provide them with some information about where they can get support should any difficult issues arise as a result of the interview. All the data participants provide in this study will be sufficiently anonymised and their name will be changed so that it will not be recognized by anyone else. Should participants wish to have a copy of summarised results when the study is finished and has passed examination, the researcher will arrange for them to receive one.

14. What potential risks to the participants do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

Participation in this research is not expected to involve any risks of mental or physical harm any greater than those involved in the participants' everyday life, and all possible safeguards will be taken to minimize any potential risks.

For instance, because of the nature of the topic being investigated, it is possible that during the course of the interviews some emotional distress may be experienced as participants revisit painful experiences or aspects of their lives they sought therapy for. For this reason, details of accessible counselling services will be provided to each participant at the end of the research conversation wherein both verbal and written debriefing will take place (please see attached debrief sheet).

15. What potential risks to the researchers do you foresee, and how do you propose to deal with these risks? These should include both ethical and health and safety risks.

The researcher's personal safety and welfare will be protected by interviewing potential participants on the premises of the community drug and alcohol service in the area of Barnet (i.e. booking an interview room at the service prior to an interview taking place). Furthermore, because the researcher will be in room alone with prospective participants for the individual interviews, the receptionist at the front desk of the building will be informed in advance of scheduled interviews and a system for making contact before and after interviewing participants will be agreed (e.g., using work mobile phone or the

phone placed in the room). Additionally, the researcher will position herself by the door in the interview room and carry a panic button in case a participant exhibits unexpected aggressive or otherwise dangerous behaviours/impulses.

Finally, making appropriate use of personal counselling and research supervision will safeguard against signs of unanticipated psychological distress experienced by the researcher as a result of conducting this research.

16. What methods will you use to ensure participants' confidentiality and anonymity? (Please note that consent forms should always be kept in a separate folder to data and should NOT include participant numbers.)

Please place an 'X' in all appropriate spaces

Complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification.)	
Anonymised sample or data (i.e. an *irreversible* process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates.)	
De-identified samples or data (i.e. a *reversible* process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location.)	**x**
Participants being referred to by pseudonym in any publication arising from the research	**X**
Any other method of protecting the privacy of participants (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only.) ***Please provide further details below.***	**X**

Direct quotations will be used with participants' permission in the final report and any publications arising from the research.

17. Which of the following methods of data storage will you employ?

Please place an 'X' in all appropriate spaces

Data will be kept in a locked filing cabinet	**X**
Data and identifiers will be kept in separate, locked filing cabinets	**X**
Access to computer files will be available by password only	**X**
Hard data storage at City University London	
Hard data storage at another site. *Please provide further details below.*	

Interviews will be recorded using a digital voice recorder and then transferred to a password protected computer file on the researcher's private computer. Following this,

the recorded interviews will be permanently deleted from the digital recording device. During transcription of each interview, identifiable names will be removed and replaced with a unique participant number (e.g., P01). Transcribed interviews will be stored in a Microsoft Word document on the researcher's password protected computer, whilst hard copies of the transcribed interviews, which may be needed for the purposes of data analysis, will be kept in a locked filing cabinet at the researcher's home in London.

18. Who will have access to the data?

Please place an 'X' in the appropriate space

Only researchers named in this application form	**X**
People other than those named in this application form. *Please provide further details below of who will have access and for what purpose.*	

19. Attachments checklist. *Please ensure you have referred to the Psychology Department templates when producing these items. These can be found in the Research Ethics page on Moodle.

Please place an 'X' in all appropriate spaces

	Attached	Not applicable
***Text for study advertisement**	**X**	
***Participant information sheet**	**X**	
***Participant consent form**	**X**	
Questionnaires to be employed		
Debrief	**X**	
Others (please specify, e.g. topic guide for interview, confirmation letter from external organisation) - Interview schedule & Brief Demographic form (both attached)	**X**	

20. Information for insurance purposes.

(a) Please provide a <u>brief</u> abstract describing the project

A welcome trend in the counselling and psychotherapy literature is the growing appreciation for clients' individualized perspective on therapeutic outcome and the process of change (e.g. see Cooper & McLeod., 2011; Elliott, 2012; Knight, Richert & Brownfield, 2012), as this provides a useful balance to the continuing emphasis on quantitative outcome studies typically used to evaluate client change and guide treatment planning on a theoretical and practical level. In particular, addiction research has been criticised for lacking a qualitative focus that encompasses the client's view and subjective perceptions of change in the process of recovery (e.g., Neal, Finch, Marsden, Mitcheson, Rose, Strang, Tompkins, Wheeler & Wykes, 2014; Ronel, Elisha, Tumor & Chen, 2013).

To this end, this study aims to meet the call to deepen our understanding of change from the client's perspective by interviewing 12-15 psychological therapy clients who have completed a minimum of 12 sessions at a community drug and alcohol service about their subjective experience of the process of therapeutic change. The interviews are proposed to be analysed by using grounded theory methods (Charmaz, 2014) in order to provide an in-depth understanding of people's subjective experiences of change following psychological therapy.

Please place an 'X' in all appropriate spaces

(b) Does the research involve any of the following:	**Yes**	**No**
Children under the age of 5 years?		**X**
Pregnant women?		**X**
Clinical trials / intervention testing?		**X**
Over 5,000 participants?		**X**
(c) Is any part of the research taking place outside of the UK?		**X**

If you have answered 'no' to all the above questions, please go to section 21.

If you have answered 'yes' to any of the above questions you will need to check that the university's insurance will cover your research. You should do this by submitting this application to [redacted] before applying for ethics approval. Please initial below to confirm that you have done this.

I have received confirmation that this research will be covered by the university's insurance.

Name …… Date…….

21. Information for reporting purposes.

Please place an 'X' in all appropriate spaces

(a) Does the research involve any of the following:	**Yes**	**No**
Persons under the age of 18 years?		**X**
Vulnerable adults?	**x**	
Participant recruitment outside England and Wales?		**X**
(b) Has the research received external funding?		**X**

22. Declarations by applicant(s)

Please confirm each of the statements below by placing an 'X' in the appropriate space

I certify that to the best of my knowledge the information given above, together with accompanying information, is complete and correct.	**X**
I accept the responsibility for the conduct of the procedures set out in the attached application.	**X**
I have attempted to identify all risks related to the research that may arise in conducting the project.	**X**

I understand that **no** research work involving human participants or data can commence until ethical approval has been given.		**X**
	Signature (Please type name)	**Date**
Student(s)	**Anna-Maria Plessa**	**22 January 2016**
Supervisor	[redacted]	**15 February 2016**

Reviewer Feedback Form

Name of reviewer(s).			
Committee			
Email(s).			
Psychology.ethics@city.ac.uk			
Does this application require any revisions or further information?			
Please place an 'X' the appropriate space			
No Reviewer(s) should sign the application and return to psychology.ethics@city.ac.uk, ccing to the supervisor.		**Yes** Reviewer(s) should provide further details below and email directly to the student and supervisor.	x
Revisions / further information required To be completed by the reviewer(s). PLEASE DO NOT DELETE ANY PREVIOUS COMMENTS.			
Date: 3rd March 2016 Comments: 1. Section 8. Please include the name and location of the drug and alcohol service where the work will be conducted. 2. Section 9. Please provide further justification for the inclusion criteria of a 2-week abstinence period. (As opposed to a longer period.) 3. Section 17. Please indicate where the hard data will be stored. <u>Information sheet</u> 4. Please remove the second full stop after 'WDP'.			

Applicant response to reviewer comments

To be completed by the applicant. Please address the points raised above and explain how you have done this in the space below. You should then email the entire application (including attachments), with tracked changes directly back to the reviewer(s), ccing to your supervisor.

Applicant's response to reviewer comments:

Having reviewed the Committee's feedback and comments, I have addressed each of the 4 points raised above in the following way:

1. Section 8. The full name and exact location of the drug and alcohol service where the research will be conducted is now clearly stated in Section 8 (please see the relevant highlighted section in the application form).

2. Section 9: Given the variety of ways in which abstinence can be defined (e.g., see McKeganey, Bloor, Robertson, Neale & MacDougall, 2006), this inclusion criterion has now been changed to eligible participants being completely free from the use of any non-prescribed drugs and/or alcohol on the day of their participation to the research interview in order to ensure abstinence from physically dependent and/or excessive use of drugs and/or alcohol, and thereby participants' ability to provide a clear and accurate experiential account of their experience of psychological change (please see the relevant highlighted section in the application form).

3. Section 17. I have explained both how and where the hard data will be stored (please see the relevant highlighted space in the application form).

<u>Information sheet</u>

4. The second full stop after 'WDP' has now been removed (please see highlighted modification in the relevant document).

Reviewer signature(s)

To be completed upon FINAL approval of all materials.

	Signature (Please type name)	**Date**
Supervisor		
Second reviewer		

Appendix 9: Ethics Approval Letter

Psychology Research Ethics Committee

School of Arts and Social Sciences

City University London

London EC1R 0JD

2nd June 2016

Dear Anna-Maria Plessa and [redacted]

Reference: PSYETH (P/F) 15/16 167

Project title: How do people affected by drug and alcohol use experience the process of therapeutic psychological change? A qualitative exploration of the experience of therapeutic change from the client's perspective

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted] in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

[redacted] [redacted]

[redacted] [redacted]
[redacted] [redacted]

Appendix 10: Recruitment Site Research Request Form and Approval Confirmation

Life transformed.

5. Research Audit Request Form

About You

[redacted]

Please attach the following information with your application.

A copy of your Research/Audit Project Briefing Document	✓
Copies of all questionnaires/tools to be used during the project	✓
Copies of the Consent Form to be signed by Participants	✓
Ethics Committee Approval Documentation	✓

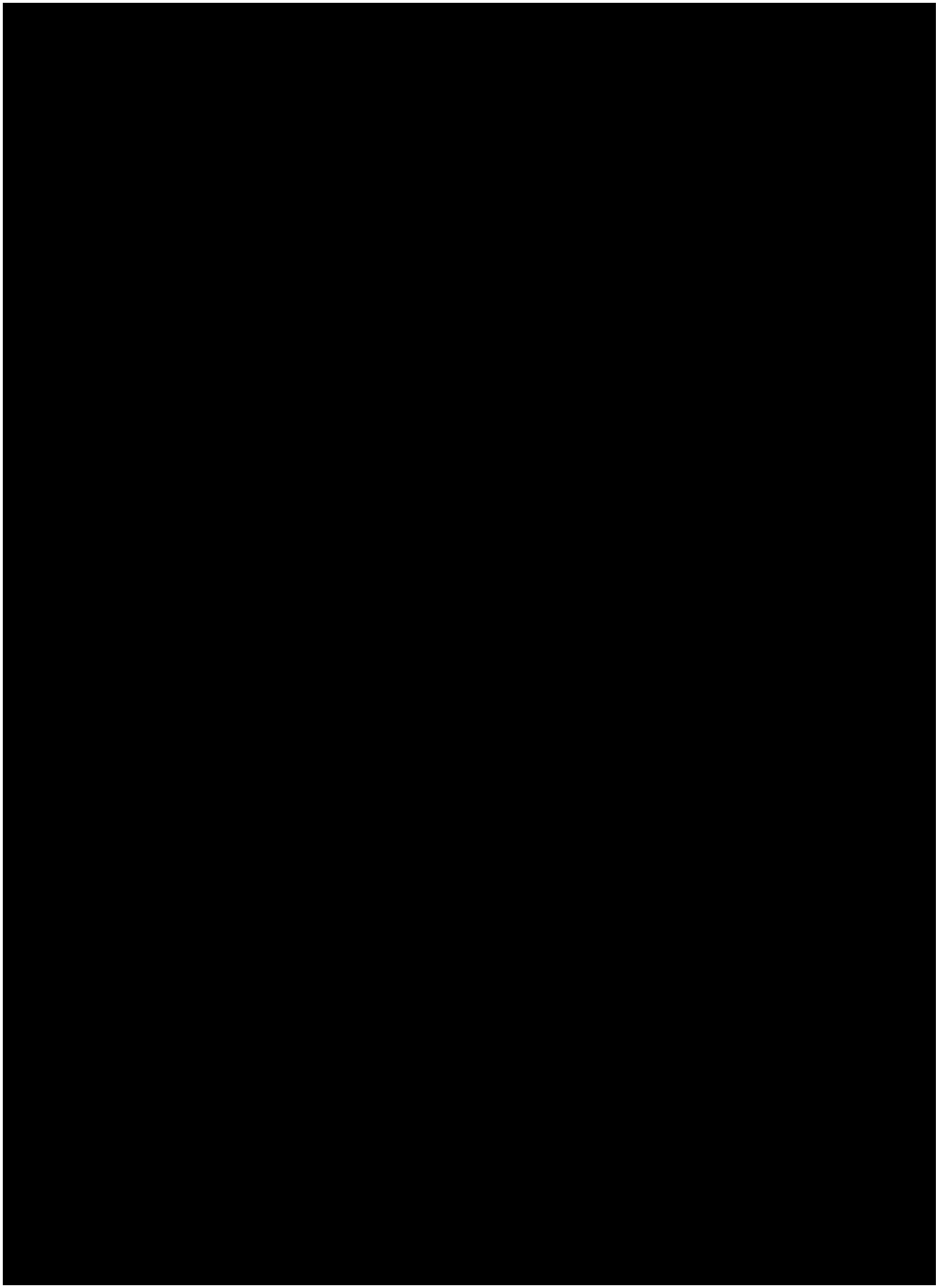
For office Use Only

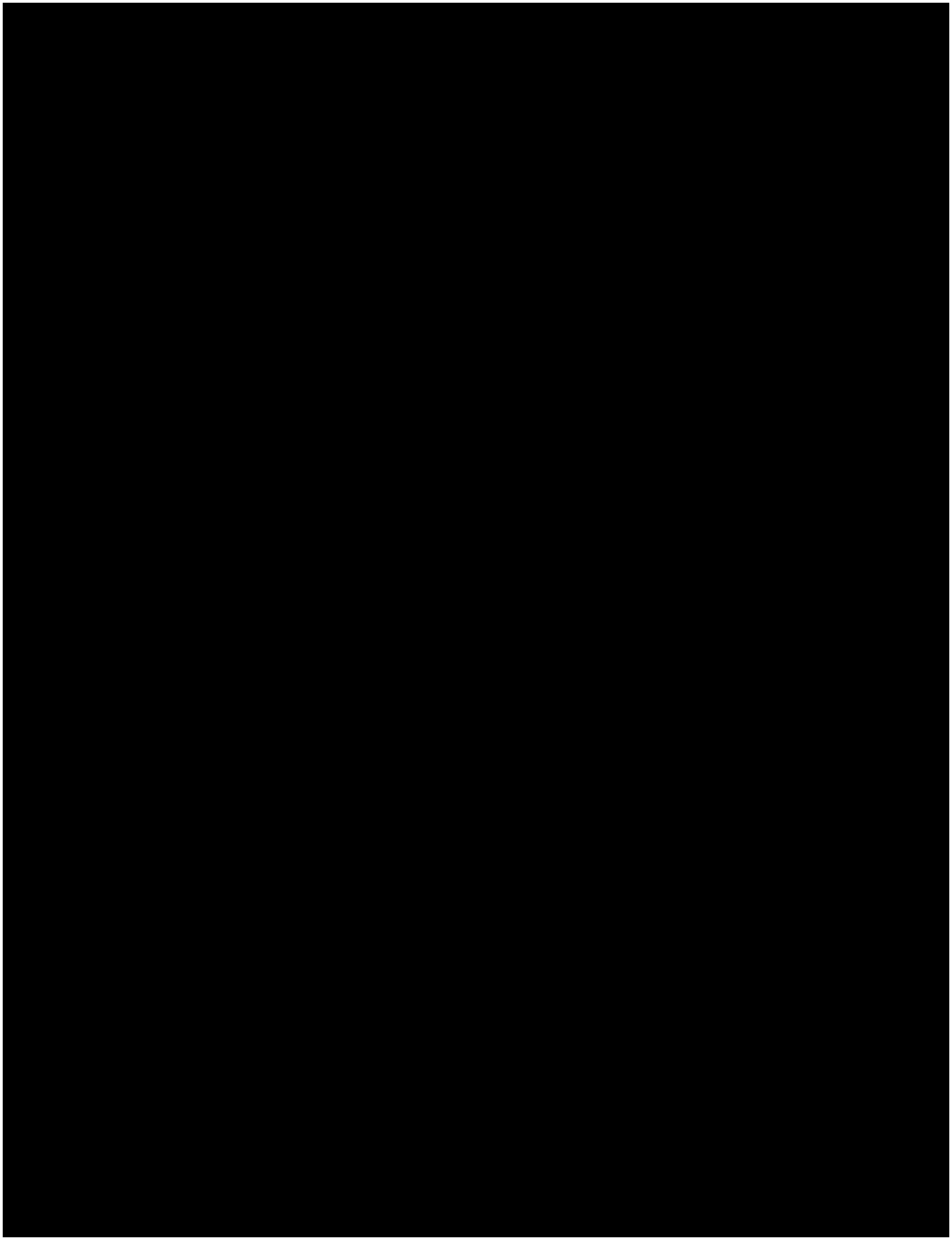
Reviewed by Medicines Management Group	Yes	No
Research/Audit approved to be completed in WDP services	Yes	No
Date of approval		
Applicant advised of decision	Yes	No

Equality Impact Assessment

Measures	Compliant?	
1. Is it likely that the policy **could** have a positive or negative impact on the minority ethnic groups? What evidence either presumed or otherwise) do you have for this?	Y	N
2. Is it likely that the policy **could** have a positive or negative impact due to gender (including pregnancy and maternity)? What evidence (either presumed or otherwise) do you have for this?	Y	N
3. Is it likely that the policy **could** have a positive or negative impact due to disability? What evidence (either presumed or otherwise) do you have for this?	Y	N
4. Is it likely that the policy **could** have a positive or negative impact on people due to their sexual orientation? What evidence (either presumed or otherwise) do you have for this?	Y	N
5. Is it likely that the policy **could** have a positive or negative impact on people due to their age? What evidence (either presumed or otherwise) do you have for this?	Y	N
10. Is it likely that the policy **could** have a positive or negative impact on people due to their religious belief (or none)? What evidence (either presumed or otherwise) do you have for this?	Y	N
11. Is it likely that the policy **could** have a positive or negative impact on people with dependants/caring responsibilities? What evidence (either presumed or otherwise) do you have for this?	Y	N
12. Is it likely that the policy **could** have a positive or negative impact on people due to them being transgender or transsexual? What evidence (either presumed or otherwise) do you have for this?	Y	N
13. Is it likely that the policy **could** have a positive or negative impact in people due to their marital or civil partnership status? What evidence (either presumed or otherwise) do you have for this?	Y	N
14. Can any adverse impact be justified on the grounds for a particular group? (For example, the policy may be deliberately designed to promote equality for disabled people but may run the risk of this being at the expense of non-disabled people which is permissible under law).	Y	N

[redacted]





Appendix 11: Risk Assessment Form

Psychology Department Risk Assessment Form

Please note that it is the responsibility of the PI or supervisor to ensure that risks have been assessed appropriately.

Date of assessment: 11 January 2016

Assessor(s): Anna-Maria Plessa, WDP[41] Service Administrator, Project Manager & Service Manager

Activity: Individual Interviews with WDP Service Users

Date of next review (if applicable): 9 September 2016

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date &** **Person responsible**	**Completed**
Fire Risk	Physical, Chemical & Biological Risks/Harm – e.g., slips, trips, chocking, death	All occupants in the building, including staff, managers, visitors, clients	Following WDP Protocol Procedures learned at induction (e.g., fully functional fire alarm with smoke detectors; fire evacuation exits are	High level of risk but Adequately Controlled	Adequately controlled at present	9 September 2015 WDP Service Manager	Yes a

[41] WDP stands for Westminster Drug Project

		or service users, volunteers	displayed and clearly indicated throughout the building by appropriate signs and with emergency lighting; copies of evacuation policy are available for visitors and service users; distances to fire exits are short; all staff members are aware when a disabled client is on the premises and have a responsibility to evacuate a disabled client to safety; no smoking on the premises; flammable substances are locked away; floor surfaces on escape routes are always free from tripping and slipping hazards; the fire alarm system is satisfactory, in working order and can be raised without anyone being placed at risk; there is sufficient fire-fighting equipment of the correct type; automatic smoke detectors are of the appropriate type; there is sufficient artificial lighting in the building for all occupants to see their				

			way out safely when there is not enough natural light (even though the building also benefits from natural light)				
Substances Hazardous to Health (e.g., cleaning products, spray office solvents, correction fluids, printer cartridges /toner, batteries, fluorescent lightbulbs)	Physical & Chemical Risks/I Harm – e.g., potential skin, eye, throat and abdominal infections through ingestion, inhalation or absorption	Any vulnerable person allowed access to such substances and products	Hazardous substances and products are kept in locked cupboards and clearly labelled; only people who have been adequately trained and risk assessed are allowed access to such substances (e.g., cleaners, office staff, printer and photocopier users, service administrator, engineers who change and dispose fluorescent bulbs); visitors and service users are not allowed access to substances hazardous to health; batteries and electrical/electronic items are recycled appropriately	Medium level of risk and adequately controlled at present	Adequately controlled at present	9 September 2015 WDP Service Manager	Yes
Health and	Physical, Biological & Psychological Risks/Harm – e.g., scalding if hot water	Anyone in the building who may be exposed	"Hot Water" signage on water dispensers; the kettle is not taken outside of the kitchen and is used	Medium to Low level of risk	Adequately controlled at present	9 September 2015 WDP Service Manager	Yes

Safety Risk (e.g., risks associated with hot water dispensers, kettle use, filing cabinets, clutter, electric wires, clinical waste, spillages, food hygiene and violent behaviour)	dispensers are used improperly or inattentively; risks associated with boiling water, steam and earthed electrical appliances; open drawers can create trip hazards, whilst overloaded drawers may cause cabinets to topple over; unattended clutter may cause trips and falls as well as fire risk; loose electric wires can pose a tripping hazard; walking through spillages can cause slips and falls; risk of distress or physical injury in the event of witnessing or coming into contact with aggressive service users; risk of bacterial infection by coming in contact with clinical or biohazard waste	to such health and safety risks	appropriately for its purpose according to manufacturer's instructions; the kitchen is a staff-only area; staff are aware that drawers need to be kept closed at all times and not to be kept overfull – regular archiving is also undertaken in order to reduce the volume of paper and free cabinet space; offices and common areas are always kept tidy and free of clutter; electric wires are kept out of the way by plugging appliances (e.g., computers, laminator) in such a way that cables are not running at the front of desks; all service users or clients are subject to a risk assessment process and a risk management plan is in place for dealing with high-risk clients; also, clients presenting under the influence of drugs or alcohol are asked to come back at a later date; all visitors must give their				

			name on the intercom before being allowed into the building; practitioners and managers are trained as appropriate to manage incidents involving aggressive and/or violent behaviour; staff are used to and carry response and panic alarms as appropriate; clinical and biohazard waste are always promptly taken to appropriate biohazard bins/sharp boxes; tissues and waste bins are available in all rooms of the building and near every work station for people to use when sneezing etc.; washroom facilities are available for staff and clients/visitors and include antibacterial soap and paper towels; antibacterial hand gel is available for both clients/visitors and staff in common areas and offices; disinfecting wipes are available for phones; keyboards, furniture and door handles; staff are aware to both pick up and				

			report spillages immediately as well as to use appropriate signage if necessary; disposable cups, spoons and plates are available for use in client areas – staff are aware that no food is to be left in service user areas, other than group food (during group break only) and milk				
Researcher's Safety Risk during individual interviews	Physical &/or Psychological Risk/Harm	Researcher while being alone in room with prospective participants for individual interviews	Receptionist at the front desk of the building informed in advance of scheduled interviews and a system for making contact before and after interviewing participants will be agreed (e.g., using work mobile phone or the phone placed in the room); Researcher to position herself by the door in the interview room and carry a panic button in case a participant exhibits unexpected aggressive or otherwise dangerous behaviours/impulses.	Medium to Low level of risk	Adequately controlled at present	9 September 2015 WDP Service Manager	Yes

Manual Handling of Loads	Physical Risk/Harm	Only Staff involved in the manual handling of loads	Staff involved in the manual handling of loads are aware of manual handling safety guidance for lifting and carrying loads (safe lifting guide); staff are responsible for ensuring that the hallway and floors are free of obstruction and clutter at all times in order to minimise the risk of trips and falls; heavier items are not to be stored at high levels, whilst all items are stored in a stable way and cupboard doors are kept closed at all times in order to minimise the risk of falling objects.	Low level of risk	Adequately controlled at present	9 September 2015 WDP Service Manager	Yes

Appendix 12: Sample of initial, focused and theoretical coding and accompanied memo

The following table presents selected parts from a coded interview transcript in order to make the processes of initial, focused and theoretical coding more transparent.

Coding key for table:
R: Researcher
P6: Participant #6

Additionally, the parallel processes of coding and analysing P6's transcript led to the generation of the following memo in an attempt to analyse further the processes involved in the emerging code I have labelled as 'internalising the therapist'.

When and how do psychotherapy substance using clients experience a therapeutic process which is indicative of having internalised their therapist? – MEMO 3 (9.03.17)

Having completed 6 interviews and progressed further toward the development of more focused codes, I have begun noticing that another property which seems to characterise the quality of the therapeutic engagement is that of thinking about the therapist outside the therapeutic setting, in a manner that exerts a positive influence on the process of continued change and recovery.
For instance, P3 (participant #3) provided explicit comments on thinking about his therapist outside the therapeutic hour as well as after the termination of the therapeutic relationship, in an attempt to relive the encounter and recreate the therapist's perspective on reflecting and understanding his mental and emotional states.
Within the scientific realm of counselling and clinical psychology this process is labelled as "mentalization" (Fonagy & Allison, 2014) and I have therefore concluded thus far that P3 had internalised the therapist's mentalizing ability. Moreover, based on P3's relevant transcript excerpts, it has transpired that certain factors which appear to facilitate this 'take in' of the therapist are those of having trust in the therapist's ability to accurately sense and mirror one's subjective experiences; missing the therapist, which can also be labelled as "separation distress" following Bowlby's (1988) attachment theory constructs; as well as an explicit attitude of thankfulness or gratitude toward the therapist's consistent empathic and affirming manner of relating to the client.

Now, P6 seems to have also provided his own perspective on having internalised his therapist's mentalizing ability following a cocaine lapse he experienced after the end of the therapeutic relationship. Compared to P3 who talked about holding the therapist in his mind both during and after the end of therapeutic relationship for the purposes of continued self-affect regulation, but without making any specific references to particular events that triggered this process, in P6's case it appears that the experience of going through a difficult time of lapsing activated a strong nostalgia for and subsequent active recreation of the therapist's mentalizing abilities for self-refection and understanding of painful affects and interpersonal experiences that led him to use. In this manner, the experience of actively internalising the therapist seemed to be mediated by trust in the therapist's mentalizing ability to exert a protective influence on P6's continued recovery and guard against continuous, reflex-like use and a full-blown relapse. *[N.B. A relevant literature search revealed that trust in another person's mentalizing skills for the understanding of one's own and others' behaviour in terms of mental states, can be labelled in psychological terms as "epistemic trust" (Wilson & Sperber, 2012)]*

In this way, what appears to emerge is that the experience of internalising the therapist is mediated by a strongly felt sense of trust in the therapist's mentalizing skills, which cannot only aid in continued self-affect regulation (as in P3's case), but also in preventing the escalation of otherwise destructive behaviours and thereby getting the client back on the road to continued change and recovery.

In upcoming interviews I will therefore continue probing about potential experiences of having internalised one's therapist in an attempt to tease out further the processes and dimensions involved in the development and activation of this change-promoting factor.

TRANSCRIPT	INITIAL CODING	FOCUSED CODING	THEORETICAL CODING
R: Can you give me a sense of what brought you to psychological therapy? P6: It was the initial shock. I was trying to stop using cocaine on my own for over a year. My fiancé at the time didn't know that I was an addict. She found out and split up with me and I think it was just a joke to the system about losing her I guess and trying to make a change, realising that I couldn't do it on my own and I needed some help. So I've contacted XXXX Drug & Alcohol Service who set me up with a key worker. And then from there, I think my key working sessions came to an end naturally. I wasn't getting anything more out of them. So I asked to see a therapist to go deeper into my addiction problems.	Experiencing a shock *(rock bottom? boundary situation?)* Trying to stop cocaine use on his own Hiding cocaine use from fiancé *(untruth relating)* Being discovered as "an addict" and abandoned by fiancé Realising he is unable to stop using on his own and needs external help Contacting Drug & Alcohol Service and being set up with key worker Completing key working sessions Requesting to see a therapist in order to engage in deeper exploration of addiction problems	Sudden change in awareness Being self-reliant Interpersonal Attachment Rupture Letting go of Self-Reliance & Help-Seeking	Addressing the Substance Relationship
P6: Yeah, well what contributed [to making the decision to seek psychological help] was I guess my realisation that I was wasting my life, wasting my time, wasting my potential. I haven't gone anywhere.	Realising the damage done to the prospects of himself through extended drug use	Experiencing Existential Dissatisfaction & Loss of the Future	Addressing the Substance Relationship

I've seen my friends, married, kids, houses, moving forward, good jobs, enjoying life actually, living, enjoying life, making the most out of life, experiencing new things which I wouldn't do.	Engaging in a process of social comparison and evaluative differentiation to assess and realise the negative impact and consequences drug use has had on possible lived experiences and the moving forward of his being-in-the-world	(including implications of experiencing existential guilt)	
R: Okay. So how was your therapist helpful? P6: Just someone that would listen I think. I really needed someone that would listen. I had, I've got family and I've got my girlfriend. And they would listen, but I guess he was listening without judging kind of thing. R: How did you know that? How did you know that he was listening with a non-judgemental mind? P6: Just the way he reacts compared to the way other people react. R: How would you know that? Would it be something about, like, his facial expression, body language, what he would say? P6: I think a combination of all of it definitely, his body language. So I, everyone watches TV and they see like	Valuing therapist's listening skills Needing somebody to listen to him Comparing family's and girlfriend's listening ability to that of therapist Being aware of therapist's ability to listen to his experiences without judging them Comparing therapist's in-session relational reactions/stance to those of other people in his social world Paying attention to therapist's body language and evaluating the non-verbal aspects of the therapist's relational	Experiencing the therapist as a secure attachment figure (Emphasis on Relational Skill of Unconditional Positive Regard & Welcoming of 'Otherness')	Therapist-Client Engagement

things, little things about body language, the way if you're doing this, you're closing up and stuff like that. So I think in some sessions I was actually just trying to observe him. [Laughs] It was the overall job so yeah. Definitely body language and definitely the way he spoke, when he spoke the tone of his voice. And I never felt defensive speaking to him. And I never felt like I couldn't talk to him. There was a few times where I went off subject a lot, quite a lot of times. I just went off subject, didn't have to do with drugs. I talked about personal feelings and relationships and work and like, and yeah. I just felt like I could talk to him about everything. And I don't feel that I could talk to people that are close to me. I don't feel that I could talk to them about everything or....I've tried and I do get angry with them. I think it's the judgement, their opinion and their judgement which my therapist didn't have.	behaviours based on interpersonal experiences witnessed on TV programs Observing/scrutinizing therapist's non-verbal relational behaviour Assessing therapist's relational effectiveness as a whole, including non-verbal, linguistic and paralinguistic interactional aspects of communication Opening up to the therapist in a non-defensive, honest manner Feeling able to confide in therapist at all times and about all vital and intimate aspects of his life experiences – including, drugs, personal feelings, relationships, work Confiding in therapist and disclosing experiences he does not feel comfortable to share with significant others in his social world Refraining from engaging in intimate disclosures with significant others in his life due to their perceived judgement *(alluding to sensitivity to interpersonal rejection)*	Experiencing the therapist as a secure attachment figure (Emphasis on proximity and using therapist as a 'secure base' from which to explore and reflect on one's intra- and interpersonal landscape)	Therapist-Client Engagement
P6: And he helped me equip myself. He helped me see different ways of handling situations which I wasn't equipped to know before.	Being helped by therapist to equip self Broadening/widening his ways of coping with, handling and responding to personally relevant situations	Broadening one's coping repertoire	Therapist-Client Engagement

I really wasn't equipped on anything before because I was an addict for about 20 odd years. Before when I used to run into problems, I used to always turn to drugs and trying to escape them but they don't go away. They're there. And I'm just delaying them so to speak. But the way I've been handling problems now is slightly different, not running away from them and I think it's the therapy that's helped me do that. Like, a lot of communication problems as well which I had in the past. And speaking to the therapist I think I'm able to express myself better and listen. [Listen to] other people yeah. Because I used to have a tendency. I guess I used to get angry very easily. I don't anymore. I kind of take a few deep breaths and let myself calm down before I say something or do something. In the past, doing something would be, "Fuck it. I don't care. I'm pissed off. I'm going to go and do some drugs." Now, it's more like take a step back and try and put	Being an addict for 20 years deprived himself from learning effective living skills and building constructive ways of coping with his being-in-the-world Finding solace in drugs as a short-term strategy for avoiding and escaping problems *(experiential avoidance)* Realising that problems persist and are just pushed by drug use to avoid them Being helped in therapy to reverse the pattern of problem avoidance and develop more constructive problem-solving skills Experiencing interpersonal communication difficulties/ruptures Speaking to and interacting with the therapist enabled him to build more effective self-expression and interpersonal listening skills Inhibiting low frustration tolerance pattern/tendency to get easily upset which can result in impulsive drug use as a self-soothing strategy Using controlled, deep breathing relaxation skills to self-soothe and allow space to self-reflect and mentalize with	Giving up the substance relationship & Developing more constructive problem-solving skills Interpersonal Attachment Ruptures *(alluding to lack of mentalization)* Substance use as an attachment substitute for self-affect regulation Broadening one's coping repertoire (Alluding to in-session mentalization and epistemic trust processes in developing more constructive intra-	Therapist-Client Engagement

myself in the other person's shoes so I can relate to them more easily. For me it's important because it's helping me with my relationships. And it's also keeping me calm.	other people's mental states so he can improve his interpersonal relatedness skills Acknowledging that engagement in the above intra- and interpersonal coping skills results in the experience of more satisfying attachment relationships and improved self-affect regulation	and interpersonal regulation skills in his particular social world)	
P6: I mean when I did relapse in November, it was mainly because of anger and not being able to express myself not feeling that I was being understood. And there was anger. I think I did it more not because I wanted to do it, not because I was craving it. Just because I was angry. I think I was trying to punish my girlfriend in a way. I think that sounds a bit weird but I was just like, "You're not understanding me. Fuck you. I'm going to go and do some drugs." Not because I wanted to do it, but because I was being a bit spiteful. At that time, I really wanted to see him. I just thought he'd help me calm myself and just say things like, "Hold on a minute. What are you doing?" kind of thing. "Is it really worth it?" But I couldn't see him and I realised myself.	Relapsing due to feelings of anger triggered by his inability to express himself and have his subjectivity adequately understood by others Experiencing intense feelings of anger which motivated drug use as a way of retaliating against girlfriend's perceived lack of understanding. Acting impulsively and engaging in experiential intra- and interpersonal avoidance via drug use in order to punish his girlfriend for failing to understand his experience Experiencing an intense desire to see the therapist Thinking about the therapist's soothing qualities and self-reflective questions in relation to his drug using behaviour	Interpersonal Attachment Rupture & Substance use as an attachment substitute for self-affect regulation/repair Internalising the Therapist (experiencing the therapist as a 'safe haven' and soothing attachment figure that can promote his reflective functioning and mentalization skills;	Therapist-Client Engagement

But I think the training that he's given me or the advice he's given me helped me to realise myself.	Being unable to see the therapist but able to realise by himself Having internalised and holding in his mind the training and advice received by the therapist during the temporal course of their encounter enabled him to realise himself	evidencing "epistemic trust" in therapist's mentalizing skills)	
R: And what, if anything, did you first notice when change began for you? P6: So I started going to the gym, exercising. I started looking after my health, eating better, sleeping better and then I started looking after my finances. So I'm 38 years old, for 36 years of my life, I never actually made a spreadsheet to say this is money coming in and money going out. I started doing things like that. So, and the spreadsheet also helped me to see the situation currently as well as forward plan again. It was mainly doing things differently so my, most of my time was spent doing drugs. All of a sudden that time was there. I had time basically. I had time to fill so. I was filling it with drugs and then I started filling it with positive things so.	Building up a gym routine Engaging in daily rituals of self-care acts Taking care of finances Developing a prospectively-focused interest in his material existence and utilizing spreadsheets to monitor his savings and expenditures Becoming prospectively focused Realising his experience of lived time was revolving around the consumption of drugs Experiencing a sudden expansion in his sense of lived time upon stopping drug use and responding to this temporal challenge via the introduction and planning of positive, drug-alternative, activities in order to fill the gap his previous drug use left in his experience of lived time	Engaging in a Personally Meaningful Routine and Use of Time Engaging in a Personally Meaningful Routine and Use of Time Learning how to live (being-in-time) without substances	Becoming own Therapist Becoming own Therapist

So all I used to think about was how I can get my next drugs, things like that before. And that stopped happening, I wasn't thinking about that. I was thinking about other things, when my next holiday is going to be, things like that.	Being cognitively dominated by the acquisition and consumption of drugs Experiencing/Noticing an absence of drug-intrusive thoughts Disengaging from drug-intrusive thoughts by shifting his cognitive and temporal focus on planning and anticipating to engage in alternative recreational activities, such as holidays		
P6: So I stopped doing drugs and I cut out all my friends that I used to have. So I feel like I'm a very extrovert type of guy. I wanted to be around people but I wanted to be around a different set of people, not people that I used to be around. So I started socialising more with work colleagues rather than old friends, older friends.	Stopping drug use and ending all previous friendships associated with harmful substance using behaviour Recognising self as extroverted Having a desire to be around other people and socialise, but choosing to pursue different social group memberships Making a choice to socialise with work colleagues and distance himself from old friends associated with his drug using days	Reconstructing one's Social Environment Reconstructing one's Social Environment Changing the composition of one's social network	Becoming own Therapist Becoming own Therapist
P6: That's like I'm acting more grown up, less childish. Well, now, it's like I find this guy thinking more about the future, rather than the present so.	Acknowledging the experience of personal growth and maturation in his current ways of acting Recognising a shift in his temporal perspectives whereby his cognitive consideration of the future zone of lived	The Rebirth of the Self & Reanimation of the Future	Ultimate Therapeutic Change Outcome

In a way it's like you've been just born. And you've got to learn how to function.	time is prioritised over the immediate (and possibly impulsive) experience of the present Likening his experience of personal positive changes and transformations to a process of giving birth to a new sense of self that has responsibility to nurture and author his ways of being and functioning in the world		

Appendix 13: Examples of Negative Case Analysis

The following interview excerpts and embedded analytic commentary are presented here as examples of negative case analysis in relation to the second main category of the CGT model (see Findings Chapter), which has been labelled "Therapist-Client Engagement" and its particular properties (i.e., more focused subcategories).

SUBCATEGORY: Experiencing the Therapist as a Secure Attachment Figure

Although all of the participants interviewed expressed positive beliefs about their therapists, certain parts in P4's narrative stood out as a notable exception to the overall trend of experiencing the therapist and his or her intentions towards the client as benevolent and focused on promoting the latter's well-being. The main contributing variable that appeared to account for this effect – as voiced by P4 – was the therapist's frequent use of inappropriate or irrelevant instances of self-disclosure. This particular phenomenon is presented and analysed here as an example of a 'negative case' that did not fit with the overall patterns observed in the rest of the data.

Negative Case analysis:

"(...) at a certain point, I mean, I didn't know what kind of therapy it was. (...) I really liked him. (...) It was very much like a friend however (...). (...) more [than] *like this is a professional. (...) I mean sometimes he talked. (...) and I think maybe once it wasn't (...) very appropriate. (...) you know, it's not the kind of comparison that you can make I think with a client. (...) because we...we touched on (...) my relationship being...being gay. (...) And just coming back to me and he said (...) 'I've had girlfriends since I was seven years old'. And I thought, 'What's his point?' (...) Quite irrelevant. (...) 'How would you compare yourself?' You're a straight guy (...). (...) And also another self-disclosure that I did not make much sense of it and it upset me. (...) I was to be told that he was opening his own practice. (...) the clients would have to pay, like, so much money (...). (...) 'Why are you saying this to me? (...) I think that actually he said that stuff to me to see my reaction. And my reaction is* [was] *like, (...) 'Hey, congratulations'. What can I say? (...) I congratulate you for your success. (...) I get shocked. So I'm not able to say anything."* (P4, 31-32.647-702)

While analyzing P4's (47 year-old-female) evident negativity and skepticism toward the therapist and his approach, it feels to me important to contextualize these experiences within the benefits[42] P4 perceived that she gained from therapy as a whole and thereby be mindful of possible tensions between negative appraisals of the therapist and the gratitude implicitly felt toward the therapist.

In stark contrast to P9's experience of the therapeutic effect of therapist self-disclosures (TSDs) in fertilising the client-therapist attachment and deepening the interpersonal bond, P4 reports a rather different and disturbing experience in relation to the use and impact of TSDs. It appears that P4's experience of extra-therapy TSDs which are (a) dissimilar to her experience (i.e., there are marked cultural differences between P4 and her therapist in terms of gender and sexual orientation), (b) therapist-focused and (c) characterised by content that steps out of the ordinary therapeutic discourse (also termed 'aside disclosures'[43] – e.g., therapist opening own practice) signal a break from the therapeutic encounter and leave P4 confused – even suspicious – as to the therapist's intentions and rationale for disclosing, as well as the difference between a professional relationship and a friendship.

Thus, P4 seems baffled and dismisses her therapist's disclosure of dissimilarity in their respective sexual orientations as 'irrelevant', and possibly more appropriate within a friendship rather than professional context, whilst she finds his aside disclosure about the upcoming opening and fees of his private practice as 'upsetting' and equally meaningless. As a result, instead of furthering the attachment bond, proximity and closeness to therapist, P4 seems to become acutely aware of the social distance factors that separate her world from the therapist's world, and thereby limit empathy and understanding (cf. P2 in this subcategory on bridging social distance factors between the client and the therapist), as well as skeptical about the therapist's rationale in drawing her awareness to their subcultural differences. At this point it should also be noted that P4, as all of the participants in this sample, was receiving subsidized therapy, and more importantly during the

[42] *"I was very scared that I wasn't able to finish my last module at Uni. So that was one of the priorities, to have a therapist that could keep me contained enough to manage to go through my last module and finish my degree."* (P4, 1.11-15) *"And he* [the therapist] *helped me* [to finish her degree], *because otherwise I wouldn't have managed to… regain that type of, like, comfortable feeling with all the anger (…)."* (P4, 15.295-297)

[43] See Levitt et al. (2016)

interview she revealed that she was struggling with a very low physical/financial recovery capital, which likely invoked conflictual feelings of envy and indebtedness upon hearing about the therapist's private practice fees.

Overall, in analysing P4's except what I find even more striking than the apparent negative impact of her therapist's disclosures on the therapeutic alliance, is P4's own in-session reactions to the perceived inappropriateness of these TSDs. Although P4 appears to be ostensibly concerned and irritated by the therapist's misguided disclosures, she also reveals an evident reluctance to openly confront the therapist about his perceived limitations. Instead, her negative reactions toward the therapist's disclosures are withheld (e.g., *"I get shocked. So I'm not able to say anything."*) and only privately experienced as distressful, whilst she seems to be engaging in a subtle attack of passive-aggressive metacommunication (e.g., *"And my reaction is like (...)'Hey, congratulations'. (...) I congratulate you for your success."*), as an indirect way of commenting on how the therapist's communications are affecting her, as well as potentially reducing the therapist's perceived power and authority. We could further hypothesise that by sending out passive-aggressive signals P4 is possibly hoping that her therapist will pick up the underlying message of her communications and reveal the rationale or intentions behind his disclosures so that she can come to understand his frame of reference and thereby their interaction can be repaired. However, as P4 seems to find that her passive-aggressive cues are missed by the therapist, she ends up silently tolerating the therapist's perceived faults as well as her resentment towards the therapist's behaviour.

Such reluctance to openly confront or challenge the therapist during moments of negative feeling about the latter's performance has been termed in the empirical literature as 'negative politeness'[44], 'face-work'[45] or 'unexpressed deference'[46]. These terms denote that important relationship encounters tend to continue in the face of perceived doubts and dissatisfactions via people's ability to maintain and enhance both their own and the other person's self-esteem (i.e., 'saving face').

[44] Brown & Levinson (1987)
[45] Goffman (1967)
[46] Rennie (1994)

Thus, in P4's case we can speculate that her concern about the therapist's manners is being kept subtly covert due to a combination of a variety of conflictual factors, such as: the asymmetry of the therapeutic relationship, wherein the therapist is usually considered to be more expert and powerful than the client in terms of knowledge, skills and judgement; worries that upfront client confrontation might hurt the therapist's feelings and jeopardise the therapeutic relationship which has also been helpful and positive; a sense of acceptance or tolerance for therapist's limitations and imperfections, especially when viewed in the context of other positively evaluated therapist's aspects; as well as a feeling of indebtedness to the therapist as therapy has been subsidized and the therapist has been generally interested in the client's welfare. Notwithstanding all these potential factors, unspoken client deference or negative politeness in the face of perplexing therapist behaviours raises implications for the quality of the therapeutic relationship, as well as practitioners' conduct of psychotherapy, and thereby constitutes an important area of professional practice.

SUBCATEGORY: Broadening One's Coping Repertoire

Negative Case analysis:

"(...) when I felt unwell, again, after the exam [college exam] *(...) it was the trigger of not having a home again. (...) Very practical things. I mean, I was very scared. (...) I was completely without a place. (...) And I had just finished my exam (...) and my therapist was saying like (...) 'You should be happy. You managed to do that'. (...) I mean, I don't have money, I cannot work (...). (....) I don't think that this is (...) the work of the therapist to take care of this stuff. But he was making things a bit too easy, like (...) it's fine when no, it's not. It was not fine at all."* (P4, 29-30.600-643)

In contrast to the previous participants who appeared to have received the experience of their subjectivity being adequately understood by their therapists and thereby developed epistemic trust in the therapist's attempts to empower them to broaden their intra- and interpersonal coping repertoire, P4 (44 year-old-female), as the above excerpt reveals, seems not to feel sufficiently mentalized by her therapist (e.g., *"he was making things a bit too easy"*). As a result, she evidences difficulty in trusting and internalising her therapist's attempts to update and enhance her internal sense of self-esteem and self-efficacy by

drawing attention upon her recent personal accomplishments (e.g., passing her college examinations; *"You should be happy. You managed to do that"*).

It appears that due to struggling with very serious financial and housing problems (i.e., a very low physical recovery capital[47]), P4 experiences her very basic and vital needs related to personal survival to be threatened and unmet (e.g., *"I was completely without a place", "I don't have money"*) and as a result is not able to heed her therapist's communications to attend to higher-order needs related to esteem and personal accomplishment[48]. Even though she acknowledges that it's not a therapist's job to resolve a client's material existence, she seems to feel poorly mentalized by her therapist for not acknowledging the way her pressing needs for personal survival exceed and thereby interfere with her current ability to broaden her self-esteem and self-agency needs.

[47] See Cloud & Granfield (2008)

[48] See Maslow's (1943) hierarchy of needs

Appendix 14: Table with Analytic Categories and Illustrative Quotes

The following table illustrates which participants were represented within each category of the reported grounded theory model.

Main Category #1: ADDRESSING THE SUBSTANCE RELATIONSHIP	
SUBCATEGORY: Interpersonal Attachment Ruptures and Substance Use as an Attachment Substitute	*"I suffer very badly for many, many years a self-loathing, lack of confidence. Although people say I'm a very confident person (…) inside I'm not. Just a mask I've put on (…)*[49] *it stems back to when my father died when I was six. He took his own life. (…) And I used to have it in my mind that he did it because he didn't love me. (…) I didn't matter. (…)I'm not worth anything because (…) my dad can't be bothered to be around, why would anyone else bother to be?"* (P1, 1-2.1-35) *"I really (…) hated me. I didn't like me at all. When in fact (…) I didn't really know me at all. I was always craving for acceptance. (…) I'd speak to my mum sometimes (…). And she just couldn't understand it. (…) And I didn't know how to deal at all with emotions (…). I was very good at masking my emotions."* (P1, 3-4.72-103) *"(…) and alcohol does give you the numbness. (…) for a few precious hours…you just don't think or care about anything. (…) For many years I had a wonderful relationship with alcohol. One of my best friends...it was a love affair. (…)a love affair that turned bad. It became like Richard Burton and Elizabeth Taylor (…). Deeply in love with each other but couldn't live with each other and couldn't live without each other. (…) The other way of calling it was like Butch Cassidy and the Sundance Kid. (…)We were a team. And we worked for many, many years. (…) But eventually the relationship changed. The alcohol became a dominant part in that relationship."* (P1, 8-9.203-228)
	"(…) my mum had passed away. (…) all of a sudden I was drinking a lot, you know, and I was very angry… (…) basically all my life, whenever there's been a crisis, been obviously loads of other times, but in any type or crisis situation, the first thing I turn to is alcohol, and that's it you know. And it's just sort of I don't know, I've been like that, you know what I mean, it's hideous, you know. (…) if I meet rejection or certain things, if things don't go the way I sort of think they would go, then that could be enough to turn me straight back to drink, if you get what I mean." (P2, 1-3.2-72)
	"I was using both alcohol and cannabis, cannabis more, more cannabis really just to kinda suppress because I had…this type of anger, this you

[49] This symbol indicates removal of interim dialogue

	know… what I wasn't able to, to, you know, I just completely shut down." (P4, 1. 6-9) *"(…) I was so… angry for what they did to me… I felt misunderstood. (…) I just couldn't cope anymore with people… I was completely isolated and just taking everything…* [referring to substances] *(...) I had to take all the pain that my mom went through. And I didn't have any support whatsoever."* (P4, 2-3. 48-67) *"(…) my self-esteem got completely trashed."* (P4, 6. 118) *"(…) I had a lot of problems when I was growing up. (…) I felt completely alone (…) I felt completely isolated and not...and I did not even want to see anyone. (…)I was completely isolated and not seeing anyone... (…) and I think human beings, in general, need... to be able to be connected to other human being*[s]*. And I couldn't. And I didn't want it."* (P4, 7-8, 124-158)
	"I was suffering from alcoholism and depression (…) I've had a tendency to depression throughout my life, as long as I can remember (…) I mean, I do have low esteem. I guess what… as a child I never really liked myself very much and that's made it quite hard to form relationships (…) that's what's started it for me because I was very shy. And I was about 16 when I went to a party and I had a cider –they were serving cider- and I felt so much better, like I could talk to people. In fact on one occasion, I was in the pub with some friends and one of them said, "Oh, are you your normal self now, P5?" Because I had a few drinks and I was able to talk and join in the conversation (…) and my father was a heavy smoker and would drink hard. It was never said that he was an alcoholic, but I think he was. He would go out and drink at lunch time and come back and go to bed and sleep and then he'd go out and get a drink again in the evening. So I think he, well, he had a problem to say at least." (P5, 1-14.2-282)
	"(…) when I used to run into problems, I used to always turn to drugs [meaning cocaine and alcohol use] *and trying to escape them but they don't go away. They're there. (…) So I didn't really have a good relationship with my mum and dad due to communication. (…) I don't think I'm a very emotional person. I don't think anyone in my family is very emotional, so things like hugging and kissing and things like that, we don't really do."* (P6, 2-5.21-108)
	"(…) I had an alcohol problem which I suspected was related to a psychological problem. (…) the problem began in my very early years. I grew up to be not an assertive person and consequently I have suffered stress which has led to alcohol. (…) When I got stressed due to conflict [meaning interpersonal conflict] *(…) I thought that a little bit of wine, I thought was just okay. So I didn't think much of it in the beginning, but it eventually got to me. (…) it eventually got out of hand. (…) I fell back on wine due to conflict and stress and that is when it became a really big problem."* (P7, 1-7.1-147)

	"I didn't have the most pleasant of upbringings as a child (…). My family is pretty much divided (…) I lost my father (…) my sister took her own life. (…) we didn't do that communication with my family. And that would frustrate me. And my reaction to it would be to go and get a bottle of whisky." (P8, 1.15-23) *"(…) I didn't have anyone in my life (…) I'd self-ostracise (…) become very reclusive. (…)I was afraid of the whole world (…) I didn't feel that I was capable to communicate (…) and also the embarrassment of it."* (P8, 2-3.40-53) *"And (…) one of the difficult things is how to cope (…) with the time that you've lost, and what you've done to yourself (…) it's easier not to wake up to that but (…) continue in the cycle of abuse (…) because it takes an enormous amount of courage to face the unknown.*" (P8, 3.69-78)
	"I was going through a very difficult time (…) because of the alcohol (…) I think a lot of it went back from when I was a kid. (…) just being left to my own devices (…) mum and dad didn't really put me in the right direction (…)" (P10, 1.1-8) *"I just didn't feel that I was worth anything or anybody wanted or needed me (…) I was always doing things for people (…) even though inside I was breaking (…) I was just putting on this face, 'It's okay'. (…) I was just trying to buy people's friendship (…). (…) and nobody was helping me except the alcohol, which wasn't helping me in the long run. (…) My depression and anxiety was through the roof."* (P10, 1-2.15-37) *"The alcohol was more of a friend than my family or my kids"* (P10, 7.155-156)
	"(…) my addiction [referring to crack cocaine, heroin and alcohol use] *and I've had a lot of bereavement, because I've lost my two sisters and my brother through substances. I just didn't seem to stop* [using] *after that happened and, so I presumed that was….Well, that* [the bereavements] *was 20 years ago, so yeah. I thought if I dealt with the bereavements then I would stop. (…) Also, my mum really and my ex-partner. So a lot of the same stuff that was there from before. It wasn't just addiction and bereavement, they were also part of when I first came here."* (P11, 1-4.1-92)
	"I was suffering from very severe depression and I was drinking really heavily. (…) just getting the key work on alcohol, it just didn't work for me. (…) I think it was a long time coming. But then I think maybe the last couple of years just before the diagnosis of depression, it was the trauma of it all when the relationship broke down and all that from a very abusive relationship and then also a very brief relationship that didn't work out. And then, after that, there were issues with my family also. (…) I didn't think I'd be able to stop drinking because the drinking was to help me cope with the pain, sort of thing (…) all the previous bad relationships. Like my mother for example, she was…." (P12, 1-5. 1-121)

SUBCATEGORY: Existential Dissatisfaction and the Loss of the Future	*"I had two suicide attempts. (…) I seriously did want to die. I just thought everyone would be better off without me around. (…) that's how badly it got."* (P1, 7-8.179-185) *"I was such a pessimist. When you talk about, is the glass half full or the glass half empty, mine was half empty and I'd drill a hole in the bottom (…)."* (P1, 16.399-402) *"(…) it* [alcohol] *just helps you to forget anything. (…) it's just a short term fix, unless you stay in a constant state of inebriation, which at times I did."* (P1, 22.557-560) *"(…) a realisation that this…this wasn't a life. I was existing. I wasn't living. I was existing badly."* (P1, 37.868-870)
	"Well, I was unhappy, disappointed. (…) I thought, 'No, I can't live with this'. (…) I didn't really think much about the future; the future didn't really hold anything. (…) I didn't really think there was any sort of future or anything really that much to look forward to really." (P2, 3.84-91)
	"I was in constantly low moods (…) I had suicidal thoughts (…) feeling quite hopeless and helpless (…) I didn't have any specific kind of aim for, 'This is what I want to achieve'. (…) Like either kill myself or do drugs or kind of just thought 'Oh! Who cares?'" (P3, 2.17-26)
	"(…) when I was in a very low peak, before [therapy], *I would drink two bottles of wine a day (…) and I was afraid of people coming around to see the state the flat was in. (…) very embarrassed and I would panic if anyone came to the door. (…) I did get into a bad position financially (…) I got into arrears with my rent and I was facing eviction…"* (P5, 2.18-26) *"(…) I used to wake up in the morning wishing I was dead. That would be my first thought when I woke up."* (P5, 3.38-40)
	"(…) I was wasting my life, wasting my time, wasting my potential. (…) I've seen my friends, married, kids, houses, moving forward, good jobs (…) making the most out of life, experiencing new things which I wouldn't do." (P6, 6.114-119)
	"(…) I had a bit of depression. Unwillingness to do anything. I was feeling very low actually. (…) and I was not in a good state of health. (…) I was going downhill – I was going downhill. (…) it was killing me. It was like some sort of suicide, some kind of slow death, you know." (P7, 7.159-168)
	"(…) the moods were incredibly low (…) I don't think I had any hopes at that stage – I didn't really have a lot of optimism. I felt quite numb at the time and everything was 'I can't'. Mentally I was dying… [feeling] *suicidal, isolated, etc., etc."* (P8, 6.186-193)
	"I didn't really have much hope, you know. I didn't care about the future. I didn't really want the future. (…)I'd stay indoors and I'd just lie down and

	heroin would come out. (…)I didn't want to answer the phone or speak to anyone." (P9, 10-11.308-320)
	"I just felt bad the majority of the day (…) just stayed indoors, curtains shut, blinds down, hiding away from everybody (…). (…) 'What's the point if I get up in the morning, I'm just going to buy booze (…) I'm not doing much, I'm just sitting here, it's not living, (…) I'm just existing, I'm just here'." (P10, 2-3.31-45) *"(…) it'd just be like, 'I'll just drink, just drink, just drink' – it could be 10:00 in the morning and I'd think, 'Can't go to the shop now, it's too early', 'It's 10:30 now, no still too early'(…). It's like clock watching."* (P10, 10.225-229)
	"I was hopeless. (…) I would self-harm (…). But that wasn't suicide – that was just release of the pain and the frustration." (P11, 3.49-52)
	"(…) my life was just so meaningless. (…) I just didn't see 'what' – 'why'. (…) I had suicidal thoughts but (…) I was so lazy [laughs] *that I couldn't even be bothered to carry it out (…). (…) I was so unmotivated with everything. The only thing I was motivated was where to get the alcohol and when to drink it."* (P12, 13.320-328) *"(…) I don't think I got to the worst point though, compared to a lot of people I guess. But I guess it's all individual for me."* (P12, 15.66-68)
SUBCATEGORY: Help-Seeking and Letting Go of Excessive Self-Reliance	*"Denial, denial, denial. 'Oh, no, no, no. I'm fine. (…) I can deal with this myself'. And I came in* [XXXX drug and alcohol service] *after the second one* [suicide attempt]*. I was a beaten man at that point."* (P1, 10-11.255-258) *"(…) this is the second time I tried to kill myself, and I suddenly thought, 'This is not right' (…) '(…) I need to accept that and take whatever's on offer' (…) a big step forward."* (P1, 19-20.488-503) *"It was the biggest and hardest thing of them all. To admit I needed help. 'I've got a problem (…) it's affecting everyone around me (…) and it's just got to stop (…) I'm only 52. I've got (…) a lot of living to do'. And the way I was going I wasn't gonna see 55."* (P1, 38.890-898)
	"(…) even I'd kind of cut down on drugs (…) I would still experience very low moods. And I think that was the reason why I thought I need additional support" (P3, 1.1-3)
	"I mean I knew that there was like, I mean like a lot of distress in everything and… I suppose I just wanted someone to keep it contained… (…) I remember the first time I arrived in here [referring to XXXX drug and alcohol service] *and I looked at the building. (…) It looked warm. It looked welcoming and everyone was kind."* (P4, 2.34-41)
	"It [referring to XXXX drug and alcohol service] *was recommended by my doctor because I was suffering from alcoholism and depression and she recommended me here."* (P5, 1.5-6)

	"It was the initial shock. I was trying to stop using cocaine on my own for over a year. My fiancé at the time didn't know that I was an addict. She found out and split up with me and I think it was just a jolt to the system about losing her I guess and trying to make a change, realising that I couldn't do it on my own and I needed some help. So I contacted XXXX drug and alcohol service who set me up with a key worker. (…) my key working sessions came to an end (…) I wasn't getting anything more out of them. So I asked to see a therapist to go deeper into my addiction problems." (P6, 1.1-9)
	"(…) I felt cheated in life, even angry. (…) like, 'Oh my God I need to do something about it. It's like I have a disability. (…) I can't do this' (…) And, I had this emotion of like, '(…) I've wasted a good part of my life because of this' (…)." (P7, 3.40-45) *"(…) I think the overwhelming motivating factor was that it was killing me. It was like some sort of suicide, some kind of a slow death (…) I know people have died on the streets (…) people who are really sick (…) and I can see myself in them. (…) It's only when you see. Because in them I saw my future self and I thought, 'I'm not going to be like that'."* (P7, 17-18.377-388)
	"It's timing. (…) The person themselves decline. The patient – whatever you are, I refer to them as – has to be in an area mentally where they want, you know… I had come to sort of dead end, you know. I had been in a dead end a long time but it was going to be, you know, something very negatively serious - seriously negative was going to happen to me. (…) I mean, you know, I was in areas of you know suicidal et cetera and so on and you know, and those kind of thoughts and started to really see it as a…really as an escape, but you know. It sounds considering a reality off, that, which is not a good place to be." (P8, 26.952-966)
	"I mean, I needed to do it for me, because otherwise, I would've just gone downhill even more. Yeah, I've had to have a big kick at the back side I suppose like, 'Come on. Deal with this now. There's no excuse for you to be sitting indoors, not doing anything, and letting things just go on and on and on in your head, and not do something about it'. Because sitting in by myself all day was making me go even more mad, because I wouldn't do anything, I was just sitting, laying, not moving, just feeling more and more…nothing… (…) Yeah, because I was just sitting around and doing nothing, so I think… Because I could see myself deteriorating, nothing was moving forward. I was still where I was last year, I still was at this year, and I thought, 'No, come on'." (P10, 7-8.192-211)
	"(…) I was at the end of my tether and I just thought I'll try anything now, so let's try this [therapy]. *(…) the therapist, had a lot to do with me getting detox. (…) getting rehab and getting clean (…) and then coming out and carrying on with the therapy."* (P11, 2-3.20-46)
	"I was suffering from very severe depression and I was drinking really heavily. And my GP was concerned, so he pushed me into getting help with XXXX drug and alcohol service. (…) So, when I came in here, my key

	worker (…) said, 'Look, I think you need to see a therapist for it'." (P12, 1.1-7) *"I wanted help with the depression. (…) stop drinking (…) take care of myself (…) go back to work (…) having a closure or forgiveness or peace with all the past relationships and traumas."* (P12, 3.91-101)
Main Category #2: THERAPIST-CLIENT ENGAGEMENT	
SUBCATEGORY: Experiencing the Therapist as a Secure Attachment Figure	*"I learned a lot with my therapist about myself. (…) the counselling was more like…it was just like a good sounding board for me. (…) I was never good at talking about myself. And that's what helped. The counselling helps a lot. You know, I could talk about myself. And that was…could be painful at times. Very painful. There was…sometimes there was quite a few tears in there. And she just…she…I don't know. I can't put it in words really. I don't know, it's just I felt comfortable. And I think that's really important. (…) You need…you need to feel comfortable to be able to… She was very calm. And she seemed to care about what I was going through. You know, gave me time to talk. And saying, you know, 'You're doing well, you're moving forward, you're learning'. It's encouraging. And, you know…and kind of understanding where I was and why I was feeling, you know… (…) You don't feel like a freak anymore. (…) It was a massive relief. (…) It's okay to feel the way I feel. It's not I'm a loony…or there's something crazy about me. And it was… yeah, it was just like a weight…weight off your shoulders really. (…) and then coming to an understanding why I was behaving the way I was. Or accepting what…that's probably a better word. Accepting why I was behaving the way I was."* (P1, 28-29.678-704)
	"Knowing my therapist, I think, gave me more confidence (…) that I wasn't a bad person." (P2, 5.152-154) *"I was very surprised because she was very young. (…) but (…) really good at what she did (…). Her tone of voice was very gentle. (…) she made me feel she wasn't judging me. (…) if I'm trying to go back to work is because she did give me the, I think, motivation to think that I could do it."* (P2, 7-8.194-230) *"You feel warm. (…) You can just feel that feeling. (…) I think it was just the way she showed her empathy. (…) the way she explained things and made me see more sense about things."* (P2, 14-15.395-423) *"(…) because we had this sort of rapport (…) I could tell her sort of things that I've never really told anyone. (…) she was very unique (…) her maturity (…) her intelligence (…) just trying to make me see that things could improve (…)."* (P2, 17-18.512-541)
	"(…) she definitely made me feel so safe to talk about things and just literally say things I never said to anyone. (…) just by letting me talk, she helped me to really know myself (…) and like myself (…). You feel you're not judged, because my biggest fear before was others. Because, you know,

	drugs is not something we reveal. (…) she helped me to kind of not to hate who I am. (…) she just kept like, I think with this sort of positive regard. (…) you knew she was very present. (…) and this warmth in her eyes, it was very kind of assuring. (…) how attentive she was listening. (…) she would remember things (…) I was really, really amazed." (P3, 3-5.46-111) *"(…) the further she let me be myself, I became much more empathetic and aware of other people's kind of thoughts and experiences."* (P3, 10.227-229) *"I don't think I'd ever be the same person, like a year ago. (…) I don't need as much of approval from outside. And I do struggle with low moods and sometimes, even suicidal thoughts. But (…) I learned to…that time could pass and I'm worthy of living. (…) I think she gave me hope."* (P3, 11.238-245)
	"And he [the therapist] *helped me, because otherwise I wouldn't have managed to… regain that type of, like, comfortable feeling with all the anger (…). And then also a sense of security (…) because he's a man and I felt like, okay, I can have the support of a man here. (…) It was important because I felt like, I mean it's a man and he's on my side. At least one man that is on my side."* (P4, 15.295-303)
	"(…) whatever I told her [the therapist] *she wouldn't be judgmental, so. Well, she didn't criticise. So, I felt that she wasn't judgemental. I didn't have any fear of that happening. That was just something I was aware of."* (P5, 3.71-75)
	"(…) my therapist – just someone that would listen. (…)I've got family and I've got my girlfriend. And they would listen, but I guess he was listening without judging kind of thing. Just the way he reacts compared to the way other people react. (…) his body language (…) I think in some sessions I was actually just trying to observe him [laughs]. *(…) the way he spoke (…) the tone of his voice. (…) I never felt defensive speaking to him. I talked about personal feelings and relationships and work. (…) I just felt like I could talk to him about everything."* (P6, 6-7.122-143)
	"Well, in the beginning, she [the therapist] *managed to break the ice very quickly. She was very friendly and established a good relationship, established a very good working relationship and she managed to draw out a lot of things that I would have not normally discussed with other people. (…) she established a very good working relationship.(…) Well, I think it's probably her demeanour, the way she behaves and speaks (…). She's a very nice, friendly lady. She makes you feel comfortable, and when you feel comfortable, then you're more likely to…speak. To open up. (…) she struck me as a very friendly lady who shows genuine interest and I felt very comfortable with her. In fact, the first thing which I realised when I met her, I thought, "Gosh, she's half my age!" Do you know what I mean?(…) I immediately overruled that because I have experienced that it's not age, it's what people say (…) and she seemed to be a very keen listener and also she seems to really take note of what you say and question it and, you know. So, I thought, 'My God, you know, she's working on it! She's working on*

	my problems'. (…) because she did instantly recall things that I'd said a long time before. I was like, 'My God, you remember that? Oh my God!' you know. (…)the effect was to draw me out even more because I was not just dealing with just a person who just says yes; I was dealing with somebody who's actually listening and working on the…on what I'm saying. (…) I would then just drop my boundaries and I would just tell a lot of things that I wouldn't have said to anybody else." (P7, 8-10.179-241)
	"(…) I found myself in the therapy sessions and feeling really quite comfortable. (…) I was quite introvert when I first started with the therapy (…) I used to (…) blush very badly (…) I would sweat and I would rain. (…) And those symptoms (…) gradually reduced. (…) I would make eye contact (…) became more lucid (…) more capable of free-flowing speech patterns (…). I think just by talking (…) I was practicing communicating with persons. (…) that is key in understanding yourself (…). That makes you feel like a person." (P8, 16-18.515-557) *"(…) the last thing a person in that situation (…) wants is coldness. They've already got coldness, you know. We live in coldness, you know. We're freezing here, you know. We want warmth."* (P8, 21.721-726) *"(…) and an important thing (…) in a therapy environment (…) is laughter. (…) Because (…) once I find myself laughing at something (…) I realized how long it had been since I had been, you know, jovial (…). (…) and what's more, laughing, laughter, really helps establish trust and a confidence bond (…). (…) for me to allow myself to be spontaneous was a big sign (…) I'm returning to myself. (…) and having the ability to reflect on your own actions with laughter is a positive step. (…) you become lighter (…) you stop beating yourself up and slow down (…)."* (P8, 29-30.1045-1087)
	"Just given me the chance to say what I wanted to say, and…and not judgin' (…) If you feel someone's judging you, straightway, you can back up. (…) It's body language and…it's not what he said (…) It's what he meant. (…) It allows you to open up a bit more. Or explore…explore further." (P9, 21-24.569-627) *"(…) because he's Irish as well, so I know he understands the background I come from. (…) and when talkin' about my father, he's disclosed a couple of things about his father that was related in a similar sort of way, which then brings you closer. (…) So that allows you to open up easier (…)."* (P9, 25.634-643) *"(…) there's a couple of times of him where he was sort of really concerned about me – the thing I was talking about. (…) and he even said that to me. Well, he was obviously thinking what he can do to help me. And I was sitting there thinking, well just by having this session is helping me. Out there I've always been on my own and looked after me-self."* (P9, 28.705-714)

	"I got on with my therapist, she was great! (…) She spoke like a mum. (…) I just feel a lot better in myself from all the counselling and coming here." (P10, 12.348-361)
	"He [the therapist] *took my corner (…) I think he just believed in me and I felt that he believed in me and he could see underneath all of the barriers and stuff I've built up, he knew that. I don't know, he'd seen something and he stood by me. That's how I felt. (…)When I was speaking it was like he was listening, instead of keyworkers, who sort of, you come out and then you think they didn't hear a word I said there. (…)I mean, you know when someone's hearing what you're saying. (…) He just listened. Because I think I had to talk, I had to get things off of me, so he listened. And he let me speak in my own time, he didn't…. (…) he was very non-judgmental. (…) I never felt uneasy saying something or being… I never felt I had to mask anything up. (…) I never felt like he'd been thinking 'God, she does all that'. (…) I'm really grateful, really. Grateful to have done the counselling and having the support (…) And having him there as sort of a constant while I was getting used to everything was really, it really meant a lot."* (P11, 10-12.233-291)
	"(…) the fact that she could recall things that I told. (…) she had me in her mind (…) she was interested (…) trying to help me. Somebody loves me." (P12, 23-24.591-596) *"(…) she'd always nod and smile like, 'Okay' (…). And then she would be quite quick at maybe saying things in response to it* [to P12's disclosures] *that makes me realise that she's not judgemental. (…) she was genuinely in it and not judgemental so that she could ask questions or say something which I knew that she wasn't struggling sort of thing with it."* (P12, 27.660-669)
SUBCATEGORY: Internalising the Therapist	*"I started thinking sometimes, I noticed it was so weird, I would think of her (…). For example, when I was in the shower and I knew I had to go and see her. (…) I use my showers for reflection time as well. (…) Now I just think what she would say. (…) because I knew she cares and I knew there wouldn't be judgement. (…) she would always ask me, '(…) how you feel?' She…amazing reflection on how. (…) she picked up very nicely on how I felt. Because sometimes, you're just confused and you don't know what to say. But she did it quite well."* (P3, 12-13.271-299)
	"(…) when I did relapse (…) it was mainly because of anger and not being able to express myself, not feeling that I was being understood. (…)I think I was trying to punish my girlfriend in a way. (…) like, 'You're not understanding me. Fuck you. I'm going to go and do some drugs'. (…) At that time, I really wanted to see him. I just thought he'd help me calm myself and just say things like, 'Hold on a minute. What are you doing?' (…) 'Is it really worth it?' But I could not see him and I realised myself. I think the

	training that he's given me (...) helped me to realise myself." (P6, 9.203-215)
	"[referring to the impact of the therapeutic relationship outside the therapy room] *And then, I just sat down and thought. I sat down and thought, 'Oh my God, why did she* [the therapist] *ask me this?' Really, I did my best."* (P7, 14.300-302)
	"I valued my therapist and her opinion. (...) it would resonate so that when I got home and (...) the danger signs came about then I could (...) reflect on what was said to me (...) so that would help in some of my decision-making (...) So, you know, 'I'm frustrated (...). So, I'm going to go to the shop and (...) buy such and such' [substances]*. And then I would (...) sort of catch myself and what the conversation was in there* [in therapy] *(...) and how much progress I've made (...) just sort of follow these different things (...)."* (P8, 38.1286-1301)
	"(...) and thinking before you do things, you know, reflecting (...) and thinking about advice and comments [as explored and discussed in therapy]*."* (P11, 6.134-137)
	"I would remember the things that she [the therapist] *said would be…that I need to be kind to myself. Yeah, because I was bashing myself up. Yeah, be kind, you know. So like take it easy, slowly, it takes time, be patient, don't beat myself up. That sort of thing, yeah. (...) I think it slowly sort of dripped into my head. Because at first I think it was still very much like, 'No, I need to solve this. I need to get rid of these problems. I need to….' And slowly, begin thinking that, yeah, I do need to give myself time. Be patient. Take it easy. Be kind to myself. What's the point of beating myself up? (...)You have to look at all the good things as well and reflect on that. (...) So it's like things started to feel better. And then I thought, 'Yeah, she is right. So she is helping me in the right way.' So, then, trust the person who's helping you in the right way. (...). She was very much about exercising and trying to do mindfulness, meditation – that's what she always encouraged me to do…yeah, and going outside, seeing people (...) breathing and just sitting in the moment, that sort of thing, yeah. And letting things pass. That, she'd always say like clouds, just letting it pass. Just watching it and not judging."* (P12, 24-25.613-652)
SUBCATEGORY: Broadening One's Coping Repertoire	*"*[before therapy] *I didn't know how to deal at all with emotions (...). I was very good at masking my emotions."* (P1, 23.577-579) *"(...) having a more understanding of…and not being ashamed of the way I feel. (...) once you've accepted the way you feel, think about well, how can I change the way I feel…and work on it."* (P1, 40.932-943) *"Shame, guilt…loathing. All those horrible things that just sit in the biggest dark. (...) it's too easy to try and block it away. You have to open your mind for those. (...) The brain said 'Oh yeah, we know what this is now'. '(...) you know when you get this feeling, what can happen. We need to do*

	something about it'. Whether it be talk to somebody, get out and do something, change where I am." (P1, 41-42.957-979)
	"Well if I'm trying to go back to work is because she [the therapist] *did give me the, I think, motivation to think that I could do it. (…) the therapy helped me to gradually start to believe I could do things. I think she somehow made me feel more that I could believe in myself a bit more, I believe in my abilities a bit more (…) I started to get this confidence back (…) I just became motivated again and I… But I had to work hard to do it (…) I had to do research (…) and contact people and all these type of stuff. So, I had to do quite a lot."* (P2, 8.229-241)
	"I just realised I'm connecting with myself (…) say, 'Oh, this is how I feel and that's okay.' (…) Just validate feelings. And then with some feelings I question (…) why am I feeling this way, because some of them were very new or (…) so suppressed (…). [e.g.] *Anger. Why am I feeling angry? Because before it was anger was bad. (…). Or shy (…) Insecure. Sad. (…) that helps you to change. (…) it gives you an opportunity to respond to it in a different way (…). Then you just feel like you're smarter. (…) denying your feelings is not for you anymore. Just learned that. (…) you get in such trouble (…) deny closeness (…) deny yourself (…) build no more relationships."* (P3, 16-20.384-456)
	"(…) therapy helped me to see that I had different options to deal with it. And he [the therapist] *was just helping…he helped me a lot to think (…) And he helped me because otherwise I wouldn't have managed to… regain that type of, like, comfortable feeling with all the anger and this limbo stuff"* (P4, 15.290-298) *"So the feelings were not so overwhelming. The intensity had gone down. (…) Less anger, more acceptance. And thinking, 'Okay, I can deal with it'. (…) And that would help me to keep calm, keep like contained."* (P4, 16.315-324)
	"A lot of communication problems (…) I had in the past. And speaking to the therapist I think I'm able to express myself better and listen. (…) Because I used to have a tendency. (…) I used to get angry very easily. I don't anymore. I kind of take a few deep breaths and let myself calm down before I say something or do something. In the past, (…) would be, 'Fuck it. I don't care. I'm pissed off. I'm going to go and do some drugs.' Now, it's more like take a step back and try and put myself in the other person's shoes so I can relate to them more easily. For me it's important because it's helping me with my relationships. And it's also keeping me calm." (P6, 2.27-44)
	"(…) she [the therapist] *seemed to have identified my area of problem, like 'where are your emotions?' (…) and I thought, 'Oh my God, they're bottled up inside me and they're killing me.' And then, when I began expressing* [emotions] *or just being assertive, then it just felt better. (…) It felt like an incredible release (…)."* (P7, 15.319-324)

	"Change seems to have happened when I began looking for my emotions. 'What are my emotions?' That is when I thought, 'Oh my God, that's the big problem. That is what's killing me. That's what's making me an alcoholic.' And, that is where the big change happened". (P7, 16.337-343)
	"(…) the hardest time when we recover – for me is what I lost; I have no children, I have no family and I lost that portion of my life. (…) facing up to this realisation is the biggest fear in my experience. (…) the waste of time (…). I remember speaking with my therapist about that specific thing and she spoke a lot about how old I was and (…) how much time I potentially have left and (…) what could be achieved and done within that time. (…) so focusing more on the present and future rather than – [the] *past."* (P8, 38-40.1314-1332)
	"I've always been sort of probably scared to have a good look at myself. Whereas the counselling has allowed me to do that without pushing me at the same time. Letting me go at my own pace and then just start to see reasons why I did certain things through my life. In particular around relationships (…) retrain my brain to be more positive rather than negative (…) I've managed to change my whole way of thinking, especially around violence and fighting with other guys (…) trying to rewire my brain, pretty much. (…) I used to get aggressive (…) Verbally first, and if they didn't back off, then I'd get physical and I'd sort of go from naught to 100 in a split-second. I used to have quite a temper. So now even if someone does get a bit...I know now to just switch off, give myself a few seconds before I say anything. But then when I do respond, make sure there's no threats involved or... I just talk differently now. Not that first response, which goes back to my default setting, which is aggression, fighting, violence. I would give myself time to slow things down. Just think things through a little bit before I act. I use a more measured approach nowadays. I'm a bit more measured in how I react. (…) Doing a little bit of meditating at home. Just try and get into that sort of neutral space in my head where I can think clearer. (…) keeping like a daily diary, a journal. Especially with the depression, I can go back and read like how it was last year, and I can see the changes, which helps. To write it down gets it from spinning around in your head. It gets out clearly. It's out on paper, and then when I look back through it, I can see the progress gradually. I might notice it...not notice it from week to week, but now when I look back last month or three months or six months, I can see a steady process. (…) And even in what I'm writin,' I can see a change as well. [it is] *More positive. And it's more about a feeling. It's not like 'I think like this'. It's more like 'I feel that this is a…or I feel that…' So there is a change. A year ago I probably wouldn't have even said I feel. I would have just wrote I'm really pissed off today. Whereas now, it'd be more like 'I feel a bit down today. I can later do something'. Or 'I feel annoyed, or irritated'. I never used to write, like, 'feel'. (…) and enough people have noticed it in me as well, have noticed a change in me. My family and everything. I'm smiling a lot more. I don't get annoyed like I used to or lose my temper. I've stopped killing things as in hunting* [laughs] *(…) and it's taken time to learn…to change. I mean, I might be two steps forward and*

	one step back, or three steps back and two forward. But I'm gradually, gradually…" (P9, 4-8.102-227)
	"I could just see things more clearly. And I just had a lot of realisations because of seeing things clearly that I couldn't see before with the drugs. (…) Because when you're in addiction you're in a dark place, so everything's the worst. (…) looking at the past before and how I dealt with things towards how I deal with them now, or how I think of them differently. (…) like before if something happened I'd think, my thought was, 'Do you know what, I'll just get a drink to take the edge, take it off'. And now it's the last thing I want to do, do you know what I mean? If something happens now I normally ring someone up or I'll pop down and see someone. Or if I'm feeling down, I share it now and let people know instead of bottling it up and then sitting on my own and isolating. (…) I just feel like I'm more in control and I've got a choice about it." (P11, 4-5.103-127)
	"(…) I think that's what happens in psychology, in therapy. I find that it's so amazing how you can look at it in so many ways. (…) I kind of sort of learned the technique from the therapist (…). (…) we could talk about all the previous bad relationships. Like my mother (…). And I thought, 'Okay. (…) she is a human as well'. And I put myself in her shoes. If I was the mother (…) done certain mistakes that I would make as well. So, yeah, you can forgive her for that. So, you look at it that way. And (…) I managed to slowly talk to my mum again. (…) just tell her how I feel. And then she got to understand it. And she apologised (…). And (…) through that, (…) I realised, again, that's how you don't realise sometimes when you've hurt someone, you know, that it wasn't intentional." (P12, 5.130-157)
Main Category #3: BECOMING ONE'S OWN THERAPIST	
SUBCATEGORY: Engaging in Personally Meaningful Use of Time	*"(…) my time is valuable (…) she* [the therapist] *helped me to explore my career (…) I got a job during that time* [while in therapy] *(…) I did structure my day, did yoga and things like that (…) And then towards the end of therapy I would be more kind of grounded. More balanced."* (P3, 26.598-604)
	"I've started getting more organised and started going to the gym. (…) I'd left my flat get very run-down. (…) now I'm managing to keep it clean and keep myself clean. I prepare my meals, do the laundry (…). So, I manage (…) coping better day-to-day." (P5, 5.92-97) *"(…) started looking after my skin again. (…) when I was drinking I'd just fall into bed at night, but now I'm sort of cleaning and putting on creams and moisturisers. (…) just sticking to my skincare regime, so that's one change, quite an important one really."* (P5, 7.123-127)
	"(…) I started going to the gym, exercising. (…) looking after my health, eating better, sleeping better (…) looking after my finances. (…) most of

	my time was spent doing drugs. All of a sudden that time was there. (…) I had time to fill (…). (…) I started filling it with positive things. (…) I was thinking about other things, when my next holiday is going to be (…).” (P6, 4.65-81) *“Eventually, I started to learn how to enjoy time by myself. (…) I started to read books. I went home and just relaxed, had a bath, hot bath (…) I started to actually like my own company (…).”* (P6, 5.103-104)
	“I get up early, exercise, go to work. If you drink too much in the evening the next day is gone” (P7, 18.395-397)
	“(…) the crucial thing for me was…I regained structure in my life and without structure, I don’t think (…) I would’ve responded as well as I have (…). (…) So I started to have these sorts of different dates within the week and that was something to aim for. (…) to stay sober for (…). (…) For example, I did a short course called ‘Breaking Free Online’ (…) and then I did some work in teaching other people how to utilise it. So that gave me more structure, more responsibility and therefore more self-esteem.” (P8, 7-8.195-227)
	“I try to give myself some sort of a structure to my day. (…) like the gardening project (…) even at home I do have things…little coping mechanisms. Like I said, the music and the reading, the writing, meditation and everything helps me. (…) Like, I try and play a little guitar and I can write songs (…) do a little bit of exercise, and it makes me feel better mentally as well. Once I’ve done some exercise I feel tired for a good reason, rather than aching. And that, in turn, helps me to sleep better as well. (…) But I still can’t…don’t want to be stuck at home all the time. So, it’s good…if I’ve got commitments…if I’ve made a commitment…even if I don’t feel great that day (…) but if I’ve made a commitment to someone, I’ll make sure I get myself ready and get there.” (P9, 13-14.368-394)
	“(…) having something to get up for in the morning, even if I don’t have to get up and do anything. (…) like I said, the dog, the job centre because now I have to go back to work, and I’ve also offered myself to this voluntary place in the church. (…) because I’ve got all this time on my hands, why can’t I do voluntary here, voluntary there, just to get me out and doing different things. (…) and actually going out and doing something for myself has made me feel a bit more, ‘You can do it actually’.” (P10, 8-9.176-191)
	“I get up and I do things, I do training (…) I keep myself busy (…). Everyday things (…) if there’s an appointment, getting to it (…). (…) I’m always doing stuff now, I’m not busy just staying in, drinking and doing drugs. I’m busy actually doing things.” (P11, 5-6.121-130)
	“(…) when I stopped drinking I was like, ‘Oh my god, what do I do?’ (…) Suddenly, I was like, ‘There’s too much time.’ I was quite scared of it. (…) So I did fill my time and did everything I could. I went to the gym (…) started to clean the house to make it look nice (…) planning down I’m going to go on holidays. And then slowly that became self-care (…) I’d be more interested in brushing my teeth, having a shower (…) organising my

	wardrobe (…) cooking, reading. (…) having more interest in things." (P12, 8.212-232)
SUBCATEGORY: Reconstructing One's Social Environment	*"(…)I've always been very good at helping other people. I just…don't…I didn't like being helped and I didn't like helping myself. (…) accepting that, you know, okay, if you're prepared to give up your time and effort in…in support for other people, you shouldn't get uptight receiving it. Which I admit I used to get very. (…), so I keep in touch with...with people I was in...in XXXX drug and alcohol rehabilitation service with, so I've...I've got a support network. There's people I can phone up and speak to if I'm having a bad day. (…) I can still be prone, if I'm not careful, to let those negative vibes... but I can, from what I've learned here and through therapy, you know, I recognise the signs. I can recognise the signs, I can recognise the triggers. And it's almost a physical feeling, you know. Oh, I know that feeling in the pit of my stomach. This is not good, and recognise it and then acting on it, you know, rather than letting it get out of control."* (P1, 12-13.292-336)
	"(…) my older brother (…) gave me encouragement and he sent me cards. And he was…I can't remember what his exact words was but they were like, 'Well done,' or something like that – he did give me a lot of encouragement. To go for it sort of thing, to go for whatever my goals, what I could do, you know, and stuff, you know." (P2, 17.484-501)
	"(…) I had the support of my cats. That helped a lot. (…) They made me happy (…) the responsibility of taking care of them. (…) It's what happened to…to keep me going." (P4, 20-21.417-425)
	"[the therapist] *encouraged me to go to AA*[50]*, which I have done. (…) I found that it helped me and I found a women's group which was better (…). (…) they are all nice women there (…) supportive to each other."* (P5, 10.206-214) *"(…) some of my triggers might possibly be down to isolation. (…) I look after a person's dog (…). So, I was there for the weekend, and they left a bottle of wine and I didn't finish it. (…) because I just had the dog for company, I didn't need it."* (P5, 14.287-294)
	"I cut out all my friends that I used to have. (…) I wanted to be around a different set of people (…). So I started socialising more with work colleagues rather than old friends (…)." (P6, 5.88-92) *"(…) I didn't really have a good relationship with my mum and dad due to communication. (…) And since therapy and since not doing the drugs, it's a lot different. I spend a lot of time now seeing them. I'm just talking about*

[50] Alcoholics Anonymous

	how their day went and things like that which I never used to do." (P6, 3.45-40)
	"I really wanted to change my pattern of behaviour [regarding his social connections]*. (…) I've actually began doing things differently. I began not allowing, you know, stressful influences. I began, you know, being more assertive, saying no. And, I began feeling better that I could do this. (…) In effect I was allowing outside influences to kill me. I got into some bitter conflicts. (…)the verbal sort, but complicated, and also I allowed people to unload their problems into my life so I found myself very, very stressed and I thought to myself, all these people are actually causing me to drink alcohol and alcohol is killing me; in effect these people are killing me. So, I have to really stand up for myself, be more assertive, make sure this never happens again, and I'm working on it. So, what can I say? I'm working on it. I'm not saying that I'm doing it right yet, but I'm working on it. (…) It* [his sense of self-esteem] *began changing very drastically when I began actually practising my assertiveness. That is when I really felt my self-esteem going up."* (P7, 5-6.89-116)
	"(…) the more time I spent in a normal situation with people, as opposed to being locked away by myself, just with my own thoughts and on negativity… the more interaction I received, XXXX Recovery Service became my family. And so this is when I started to, you know, put my fingers into different pies, and, so to speak, as in doing different things, like volunteering, doing the p.m. XXXX training course (…)" (P8, 23-24.856-863)
	"(…) I have lost contact with all my old friends, like anyone who's using. My brother still uses every day, so I don't even speak to my brother anymore. (…) That housing estate was a massive trigger. (…) So I got off of that estate, moved out of XXXX district altogether, which was a big using area for me." (P9, 11.323-335)
	"(…) I did lose all of my friends because of the alcohol – that was me, I had to say, 'Alright, everybody leave me alone'. (…) they were bad news, they said they were friends but they weren't. Because if they were friends they would be helping me and they wouldn't have been coming to my flat saying, 'here's another bottle of wine'." (P10, 5-6.123-135) *"My daughter says to me now (…) 'Mum, can I do your hair?' (…) We wouldn't have done this like, three months ago (…). Well, we do actually sit and talk now. Before we would grunt at each other (…). (…) she's been like, 'Oh, we'll go out for dinner tonight, shall we?' (…) Doing mother and daughter things, things that I should've done years ago, but the alcohol was (…) more of a friend than my family (…)."* (P10, 6-7.137-156) *"I've got a (…) dog, but before I was 'Just go in the garden'. But now we've been going out for walks (…)."* (P10, 4.72-74)

	"(…) it's nice going out because I can have dog walkers as well that I can walk around the field with (…)." (P10, 5.92-94)
	"A lot of things have changed. I think it made me realise that I've come out different but everyone else around me is still the same. (…) doing the same things (…). (…)I had to get rid of a lot of my old friends and not see them anymore (…)." (P11, 8.84-91) *"(…) before if something happened (…) my thought was, '(…) I'll just get a drink to take the edge off'. (…) If something happens now I normally ring someone up or I'll pop down and see someone. Or if I'm feeling down, I share it now and let people know instead of bottling it up and then sitting on my own and isolating."* (P11, 5.108-117)
	"(…) I resolved issues with my mum. That was the first one to get resolved. (…)I sort of realised from the therapy that I could try and approach [a] *very difficult subject without being accusing or aggressive… or, you know, you can try and put your point across without, you know… and being very mindful of the person's feelings but not to the point where you shut up and don't say anything just because you're afraid of how that person might feel…or, you know, that sort of little things that I've learned through therapy."* (P12, 18-19.447-457)
Main Category #4: ULTIMATE THERAPEUTIC CHANGE OUTCOME	
The Rebirth of the Self and the Reanimation of the Future	*"I've been given a second chance (…) just a completely different philosophy to life and a different way of thinking. Consequence is the future looks better. More hopeful. There's things I can look forward to (…). It's a much nicer feeling (…). It used to scare me. (…) it's an ongoing process. (…) You're constantly moving forward."* (P1, 21.531-542)
	"I'm more cheerful, making jokes (…) have things to look forward to (…) I'm thinking 'Well, there is a chance, something can happen here'." (P2, 5.128-133)
	"(…) I don't think I let myself do anything. I was so restrained kind of… So tied up. I don't know how I could live like that. (…) I don't think I'd ever be the same person, like a year ago. [I am] *Much more self-content.(…) so, it's kind of…I think she* [the therapist] *gave me hope"* (P3, 11.238-243)
	"(…) I'm acting more grown up (…) I find this guy thinking more about the future rather than the present. (…) it's like you've just been born. And you've got to learn how to function." (P6, 9.196-201)
	"I've managed to reduce my alcohol consumption down to normal levels (…). I feel a lot better (…) orientating myself towards work (…) feeling healthier. (…) I can see myself and I look better, I have a better posture, I

	speak better. (…) I love myself now. I care about myself (…). I want to live my life and I want to have a good life and I have realised that too much alcohol is killing me (…). So I'm doing this because I really care about myself." (P7, 7-8.159-174)
	"(…) it's down with the structure, down with some of the people I've met here, the methods that I've been exposed to, and the self-awareness, the self- pride as well. (…) I'm very appreciative and very grateful to the whole process. (…) I feel much better, I'm equipped now (…) I can rise to quite a few challenges (…) than I certainly could without it [without therapy]*."* (P8, 44.1445-1459)
	"The goal was (…) to try and recover and better myself. (…) I used to hate the thoughts of getting old. (…) But now I'm actually embracing getting old, which is a really big change for me (…). (…) Embracing myself…and exploring and been keen to learn more about myself (…) and it's a learning process all the time." (P9, 32-33.801-817)
	"(…) physically looking better. And also emotionally and mentally (…). (…)It's like I have new glasses. Like all the time I had old glasses and it was the wrong prescription. Everything looked so bright. (…) suddenly I thought 'Have I grown taller as well?' Because I don't remember the floor being that far down. And I think now, maybe I was walking around like this [leans over] *all the time."* (P12, 9-10.242-251) *"(…) it's a journey that I have to carry on on my own. And it will be ongoing. I don't think there is such a thing as 100%, you know, perfect, normal (…). I think it's all part of (…) the growth, isn't it?"* (P12, 31.753-759)

This content has been removed for copyright protection reasons

SECTION D: JOURNAL ARTICLE