A GROUNDED THEORY EXPLORATION INTO THE EXPERIENCES OF RECOVERING ALCOHOLIC COUNSELLORS WORKING WITH ALCOHOLIC CLIENTS

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Abstract

Many counsellors have shared trauma experience with their clients. However, there seemed to be mixed views on how this shared experience might impact on the client and therapist. Some researchers propose that shared experience offers symbiotic healing for the client and therapist, whilst other authors propose the shared wounds are detrimental to therapy process. Despite these conflicts little seems to be known about how the counsellor experiences and views the shared relationship with the client (Doukas & Cullen, 2011; Rowan & Jacobs, 2003; Wosket, 1999). This qualitative grounded theory study investigated the views and experiences of 10 Recovering Alcoholic Counsellors (RAC) who work with alcoholic clients.

The findings of the current study suggested that therapy with the alcoholic client related to the therapist managing their own recovery from alcoholism, which involved processes of building a self-identity, identifying with the client and fearing relapse. The alcoholic identity was maintained and actively used in the therapy work with the client, despite the RAC claiming long term recovery. Identifying with the client appeared to activate shame and increase a fear of relapse for the RAC. These processes appeared to affect a potential dependency on the client work. These factors were reflected to be influenced by AA philosophies, which also affected a bias towards certain therapy interventions. Potential over-identification appeared evident in protective empathic enmeshment and hostile countertransference reactions. This included a possible and concerning coercive interpretation of affording tough-love to clients, potentially causing abuse to the alcoholic client.

Positive reflexive practice, self-awareness and compassionate practice were also evident. Feeling deep empathy in the shared experience was suggestive of empathic enmeshment and possible symbiotic healing processes taking place. Other benefits and issues of the shared experience are explored and discussed further. Recommendations are suggested to increase safe therapy practice for counsellors working with alcoholic clients and future research direction has been proposed.

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Contents

Abstract i
Acknowledgements ii
CHAPTER ONE 1
1. Introduction 1
1.1. The Development of the Wounded Healer Concept 2
1.2. Wounded Healer Therapists 4
1.3. Therapist's Identification with the Client 5
1.4. Therapist's Reactions to the Client 6
1.5. Matching Client-Therapist Dyads on Similarities 10
1.6. The Recovering Alcoholic Counsellor (RAC) 12
1.7. Research Directed at RACs Working with Alcoholic Clients 13
1.8. The RAC's Vulnerability to Relapse 16
1.9. Impact of Alcohol on the Human Body 17
1.10. Developmental Issues and Impact for Treatment 19
1.11. Shame 20
1.12. The Client's Defences 21
1.13. Recovery from Alcoholism 23
1.14. Alcoholics Anonymous as a Treatment for Alcoholism 26
1.15. Dependency and Co-dependency 28
1.16. Identity 29
1.17. Summary and Study Rationale 30
CHAPTER TWO 33
2. Methodology and Method 33
2.1. Aim of the Study 33
2.1.1. Research question 34
2.2. Methodology 34
2.2.1. Qualitative research 34
2.2.2. Researcher's beliefs and views 35
2.2.3. Epistemological positioning 37
2.2.4. Symbolic-Interactionism Epistemology 38
2.2.5. Methodology 40
2.2.6. Grounded Theory Methodology 40
2.2.7. Alternative methodology considered 44
2.3. Method 47
2.3.1. Participants 47
2.3.2. Materials 50
2.3.3. Practical considerations 50
2.3.3.1. Interview guide 50
2.3.3.2. Interviews 51
2.3.3.3. Ethical consideration 51
2.3.3.4. Rigour and trustworthiness within the GT 52
2.3.4. Procedure 52
CHAPTER THREE 54
3. Results 54
3.1. Levels of Interpretation 55

3.2. Grounded Theory Model 55
3.3. Core-category: Therapist Managing their own Recovery 63
3.3.1. Category: Therapist building a self-identity 63
3.3.1.1. Finding purpose and direction 64
3.3.1.2. Being influenced by an anonymous fellowship 65
3.3.1.3. Believing in a higher-power 67
3.3.1.4. Making sense of the past 69
3.3.1.5. Finding autonomy from the alcoholic identity 70
3.3.1.6. Avoiding transference of dependency 71
3.3.1.7. Separating the addict identity from the person 72
3.3.2. Category: Therapist identifying with the client 75
3.3.2.1. Sharing recovery identity with the client 76
3.3.2.2. Believing in enhanced skills in the shared experience 79
3.3.2.3. Knowing the client's behaviour, thinking and feelings 82
3.3.2.4. Affording tough-love to clients 84
3.3.2.5. Wanting to reduce negative feelings 88
3.3.2.6. Feeling deep empathy with the client 89
3.3.2.7. Managing problems in the shared experience with the client 91
3.3.3. Category: Therapist fearing relapse 95
3.3.3.1. Client acting as a deterrent for relapse 96
3.3.3.2. Always thinking about relapse 98
3.3.3.3. Wanting to give back 99
3.3.3.4. Developing through the work with the client 101
3.3.3.5. Loving the client work 102
3.3.3.6. Adopting the addict identity to access recovery 105
CHAPTER FOUR 108
4. Discussion 108
4.1. Summary of Findings 109
4.2. Critical Evaluation of Method 121
4.3. Relevance to Counselling Psychology 125
4.4. Further Research 131
References 133
APPENDICES 173
Appendix 1 174
Appendix 2 176
Appendix 3 177
Appendix 4 178
Appendix 5 179
Appendix 6 181
Appendix 7a 182
Appendix 7b 184
Appendix 8 186
Appendix 9 187
Appendix 10a 190
Appendix 10b 195
Appendix 10c 196
Appendix 10d 197
Appendix 10e 200
Appendix 11 201
Appendix 12 203
Appendix 13 206

Appendix 14 207
Appendix 15 212
Appendix 16 214
Appendix 17 215
Appendix 18 217
Appendix 19 218

CHAPTER ONE

1. Introduction

It is suggested that many therapists enter their profession as a result of past trauma experiences (Jackson, 2001; Stolorow & Atwood, 1979). Historical literature evidences that a helper who has endured a past trauma similar to someone else's suffering, can offer additional healing qualities to the sufferer (Conti-O'Hare, 1998; Jackson, 2001; Jung, 1961). However, some authors' caution that the therapist's past wounds may potentially interfere with the process of therapy and be detrimental to the client's progress towards problem resolution (Doukas & Cullen, 2011; Jung, 1966; White, 2000b). Despite these conflicting views, little seems to be known from the perspective of the therapist, about how the counsellor views and experiences the client when there is a shared trauma experience with the client (Doukas & Cullen, 2011; Rowan & Jacobs, 2003; Wosket, 1999).

The Recovering Alcoholic Counsellor (RAC) is recognised in the literature (Conti-O'Hare, 1998; Skuja, 1981; White, 2000b). The RAC is reported to have the most similarities to the alcoholic client of all the matched client-therapist dyads, which makes them a rich source of information to be explored (Lawson, 1982). This study will investigate the views and experiences of RAC on working with alcoholic clients. It is believed that carrying out this study will uncover additional insight and information useful for counselling practice, psychological understanding and future research.

1.1. The Development of the Wounded Healer Concept

Historical literature appears to promote the belief that someone who has experienced a trauma offers additional healing qualities to those suffering (Jackson, 2001). These helpers are traditionally known as 'wounded healers' (Conti-O'Hare, 1998; Jackson, 2001; Jung, 1951). This belief also implies that potentially individuals without this prior wounding are less skilled to help others. Significant wounded healers are evidenced within Greek mythology, the Bible and within early psychology and psychotherapy literature (Dunne, 2000; Jackson, 2001; Conti-O'Hare, 1998, 2002).

In Greek Mythology Chiron is recognised as a great wounded healer (Conti-O'Hare, 2002; Jackson, 2001; Sedgwick, 1999). Chiron was a Greek God, who through being rejected at birth by his parents received a psychological wounding and later endured a physical wounding with a poisonous arrow to his leg. Chiron's great healing powers as a physician were attributed to these psychological and physical wounds (Conti-O'Hare, 2002; Jackson, 2001; Sedgwick, 1999).

Within the Bible the prophetic references of the Old Testament in Isaiah 53 reflected Jesus as a wounded healer (Jackson, 2001). Jesus was persecuted and suffered for his belief in God and because of this experience he was believed to understand and offer healing to the persecuted and suffering masses. This belief is evidenced in the New Testament within the Book of Hebrews (4:14-16) (New International Version, 2010) and 2 Corinthians (1:3-7) (New International Version, 2010).

There are also many pastoral accounts of ministers who came to their profession as a result of suffering, with a view to heal others (Jackson, 2001; Conti-O'Hare, 1998, 2002). The Reverend George Trosse (1631-1713) became a clergyman following mental illness (Jackson, 2001; Trosse, 1714, 1974). Anton T. Boisen (1876-1965) suffered psychosis and became a hospital minister (Jackson, 2001). William James in 1902 applauded Boisen for connecting religion to psychological illness (Jackson, 2001), as well as identifying that many clergy choose the profession of helping as a result of their own wounding (Muse & Chase, 1993).

This claim links to more recent authors who proposed that individuals enter the helping professions as a result of past wounding (Conti-O'Hare, 1998; Groesbeck, 1975; Guy, 1987; Henry, 1966; Leiper & Kent, 2001; Moring, 1997; Sherman, 1996). It was also reported by James Hillman in 1967 that wounded healers appeared to be healing their own inner child through their work (Jackson, 2001). This statement also parallels more recent studies that proposed a number of professionals enter the field of counselling in order to resolve their own personal and past issues (Ford, 1963; Goldberg, 1993; Guy, 1987; Leiper & Kent, 2001; Moring, 1997) or through dysfunctional motivations in the form of neurotic needs, emotional limitation and defensive patterns (Sussman, 1992), as well as a means for getting a dependency need met for themselves (White, 2000b).

Henri Nouwen (1932-1996), a Priest and Clinical Psychologist, was reportedly the first to propose that in order for the minister to appreciate another's suffering, they first need to understand their own pain (Jackson, 2001; White, 2000b). This belief

seems reminiscent of an earlier caution by Freud in 1910, who stressed it was important for the therapist to have resolved personal issues prior to working with clients, as this might ultimately redirect the focus of therapy to the therapist and hinder the client's progress (Groesbeck & Taylor, 1977; Guy, 1987).

1.2. Wounded Healer Therapists

Several influential and professional clinicians are reported to be wounded healers, including Freud, Ferenczi, Frankl, Jung and Reich, who were reportedly attracted to the healing profession as a result of their own suffering (Stolorow & Atwood, 1979). Jung, whose parents were ministers (Dunne, 2000), directly promoted the therapeutic power of the wounded healer and also suggested that only through the therapist's own experience of suffering can the ability to heal be attained (Dunne, 2000). This healing ability is thought to be enabled through the therapist's vulnerability to the client's pain (Dunne, 2000; Wheeler, 2007).

Jung suggested that the wounded healer professional counsellor related their wounding to the client through unconscious transference (Sedgwick, 1999). Jung stressed the importance for the therapist to bring their own unconscious into conscious awareness (Dunne, 2000; Sedgwick, 1999). In consciously utilising this process the therapist tunes into both their own past suffering and the client's suffering, resulting in a joint process of change for both client and therapist (Dunne, 2000; Sedgwick, 1999).

This process is endorsed by several authors (Guggenbuhl-Graig, 1979; Hopenwassen, 2008; Wolgien & Coady, 1997) and is considered useful in regulating the client's emotions (Kohut, 1971, 1977; Winnicott, 1967). This connection is also reminiscent of Rowan & Jacobs (2003) transpersonal level of empathy, where client and therapist offers the client "sympathetic resonance" for healing (Rowan & Jacobs, 2003,p.80); and 'empathic resonance' suggested by Racker (1972).

Jung cautioned that only the clinician who has carried out personal healing can be effective as a clinician (Dunne, 2000). Jung also proposed that the wounded healer clinician needs to be particularly aware of the 'shadow' (Dunne, 2000). The 'shadow' is reported to encompass positive and negative aspects of the unconscious human psyche, including repressed memories and felt shame (Dunne, 2000). Jung stressed that if ignored the negative part will inevitably cause manifestation within or be projected outwards onto others and cause problems within the consciousness. In addition, the positive and meaningful part will be unharnessed (Dunne, 2000). Whilst acknowledging and becoming acquainted with the shadow (unconscious) will present problems, for example, not wanting to accept negative aspects of the self, the process of becoming self-aware is believed to bring new energy, honesty, authenticity and new depth of self (Dunne, 2000).

1.3. Therapist's Identification with the Client

Whilst Freud (1912) cautioned not to give personal information to the client, Jung (1913) promoted the merits of the client identifying with the therapist. Sedgwick (1999) suggested that Jung believed this identification enabled the client to enter the

therapist's world to ascertain and adopt the therapist's coping strategies. Sedgwick (1999) also proposed that this identification enabled the client to judge the integrity of the therapist, which enabled trust. This process seems reminiscent of Rogers' (1951) core conditions of empathy, unconditional positive regard and genuineness.

Whilst these are important theories for counselling practice there seems to be limited research that directly explores the impact of identification in the shared experience with the client, especially from the perspective of the therapist (Doukas & Cullen, 2011; Rowan & Jacobs, 2003; Wosket, 1999). There are studies that explore identification within the context of person centred and psychodynamic theories relating to empathy, countertransference, transference and projections (Ehrenberg, 1995; Racker, 1972; Rogers, 1951; Watkins, 1985; Zimberg et al., 1985). The literature that matches client-therapist dyads, based on similarities, also offers some insight into identification in the shared experience (Chang & Berk, 2009; Flicker et al., 2008; Squarez-Morales et al., 2010; Wintersteen et al., 2005). This study will now focus attention on these domains of knowledge.

1.4. Therapist's Reactions to the Client

Psychodynamic theory proposes that within the therapeutic relationship the therapist will experience an emotional reaction in response to identification with the client's, transference, projections and behaviours and these therapist's reactions are called countertransference (Ehrenberg, 1995; Racker, 1972; Watkins, 1985; Zimberg et al., 1985). Transference refers to the positive and negative feelings unconsciously transmitted from the client to the therapist within the therapeutic relationship

(Lemma-Wright, 2004). Projective identification relates more specifically to the client's unconscious intolerable thoughts and feelings, resultant from past rejection and/or trauma, which are externalised onto the therapist in the therapeutic encounter (Klein, 1946; Lemma-Wright, 2004).

In therapy, countertransference reactions of the therapist are reported to provide useful information about the client's interpersonal patterns (Lemma-Wright, 2004; Racker, 1972). Racker (1972) proposed that the therapist's identification with the client and self-awareness of the countertransference reactions can provide a deep empathic resonance to the client. Racker (1972) also suggested that this process facilitated the client in learning self-acceptance of difficult feelings and thoughts. Empathy is considered different to countertransference, as it is bi-directional identification and sharing of the experience with the client (Watkins, 1985). Empathic resonance also involves entering the client's inner world, yet remaining self-aware of what belongs to whom in the encounter (Rogers, 1980).

These empathic identifications between client and therapist are reported to afford positive change for the client (Festinger, 1954), a positive therapeutic alliance (Simons et al., 1970; Sue, 1998) and a stronger therapeutic alliance (Ackerman & Hilsenroth, 2003; Boston & Mount, 2006), which facilitates growth in rapport and trust (Marrow, 1977). Having a shared experience with the client also increases the therapist's understanding and relatedness to the client's experience (Ackerman & Hilsenroth, 2003; Boston & Mount, 2006) resulting in deepened therapeutic relationship (Barglow, 2005; Jenning & Skovholt, 1999).

However, problems may occur for the therapist within empathic resonance with the client and caution is necessary, since distortion of ownership through a process of over-identification in the shared experience may occur (Rogers, 1980; Rowan & Jacobs, 2003). This process results in distortion of ownership of what feelings belong to the client and what belongs to the therapist, which may be causal to over-empathising and collusion with the client (Rowan & Jacobs, 2003).

In a similar process, a client's defence behaviour may invoke intolerable identification in the form of countertransference reactions for the therapist (Racker, 1972). For example, the client's apparent resistance to therapy may lead the client to transfer feelings of lack of control and helplessness to the therapist. This may result in a countertransference reaction for the therapist of feeling a lack of control and helplessness with the client (Leiper & Kent, 2001; Moring, 1997). This reaction may escalate into a power struggle between therapist and client and result in an impromptu end of therapy (Cohen, 2006; Zimberg et al., 1985).

A client adopting the role of 'victim' may also invite the therapist to relate to the client as frail and childlike (Guggenbuhl-Graig, 1979). The therapist may respond by adopting the role of being over-protective and attempt to rescue the client from difficult feelings or refrain from exploring difficult issues (Gabbard & Wilkinson, 1994; Watkins, 1985; Weegman & Cohen, 2006). This process may ultimately end in mutual blame at the certain failure of therapy (Watkins, 1985).

When similarities between client and therapist are increased through additional sharing of identification, for example, race or gender role, countertransference

reactions and vulnerability to over-identification with the client are thought to be further increased (Leiper & Kent, 2001; Watkins, 1985; Wilson & Lindy, 1994, White, 2000b). These over-identification countertransference reactions may result in colluding with the client towards the positive or reassurance (Watkins, 1985). They may also lead to the opposite, masochism and therapy sabotage or setting up situations where the client takes advantage, for example, non-payment of sessions (Leiper & Kent, 2001; Watkins, 1985).

When there is identification with a trauma, for example, alcoholism or abuse, the countertransference reactions are amplified (McAdam, 2010). Over-identification may bias therapy treatment towards the therapist's own experience of recovery (Skuja, 1981; White, 2000b). Unresolved issues of internalised blame or excluding behaviours of the therapist may present through a state of hate towards the client (Allport, 1954). An example of this process is evident in the 1933 work of Ferenczi (1873-1933), who consciously adopted the loving parent position with clients, but felt anger and hate towards them. On examination, it was concluded that these were countertransference reactions from Ferenczi's own traumatic childhood (Gabbard & Wilkinson, 1994; Leiper & Kent, 2001). Watkins (1985) also proposed a similar reaction of hostile countertransference, being the result of the therapist's past internalised victimisation experience.

It seems that both positive and negative outcomes for the client are possible in the shared experience with the client. However, the negative outcome of abusing the client is of concern. In order to gain some additional insight into these processes the

literature that matches client-therapist dyads based on similarities, including race, gender and ethnicity, may offer additional information.

1.5. Matching Client-Therapist Dyads on Similarities

Studies that match client and therapist based on similarities appear to suggest that some similarities can positively impact on the client's progress in therapy, whilst others do not affect any change (Chang & Berk, 2009; Flicker et al., 2008; Squarez-Morales et al., 2010; Wintersteen et al., 2005). The predictive elements of which similarities are beneficial is unclear, since too many variables are reported to interfere with the outcomes (Dougherty, 1976; Karlsson, 2005; Sue, 2003). It is also reported that, due to the lack of universal measures used on all dimensions across these studies, the findings cannot be generalised (Docherty, 1976; Karlsson, 2005; Sue, 2003).

Squarez-Morales et al., (2010) studied individuals presenting with substance misuse and matched client-therapist dyads based on Hispanic cultural characteristics. It was concluded that a client-therapist dyad matched for ethnicity and language increased the benefit for therapy outcomes. However, no benefit was observed for matching birthplace or level of acculturation (Squarez-Morales et al., 2010). The authors reported several confounding variables that limited the study, including individual therapist qualities.

Flicker et al., (2008) also carried out ethnic matching with clients presenting with substance misuse. Flicker et al., (2008) focused on Hispanic and Anglo client-

therapist dyads. It was concluded that matching Hispanic client-therapist dyads reported better treatment outcome, but this did not occur for matching Anglo client-therapist dyads. Limitations of the study were unmeasured individual differences within cultural background, as well as therapist competencies.

Wintersteen et al., (2005) focused on racial differences and gender. It was reported that matches on racial similarities indicated better retention rates. Female client-therapist dyads rated higher therapeutic alliance to male client-therapist dyads, whereas male client-therapist dyads reported better retention rates to female client-therapist dyads. This study also stated that therapists reported a belief that the clients would feel a stronger alliance when matched on similarity. Limitations of the study related to individual racial and gender differences, which may have confounded the outcome (Wintersteen et al., 2005).

In a qualitative study by Chang & Berk (2009) focus was given to the client's experiences of 'cross-racial therapy'. Client and therapist were matched based on race and gender. It was concluded that cultural awareness was more important than sharing similarities. It was also suggested that the therapist's personality characteristics, therapy technique, addressing the client's core needs and the therapeutic relationship were as important to therapy success as similarities. There was also a correlation between the therapist's self-disclosure of personal history and treatment satisfaction. It was suggested that the client knowing the therapist had a shared experience effected higher client therapy satisfaction (Chang & Berk, 2009).

The authors identified several limitations to this study, including minority differences that were not measured and language expression lost through the interviews being conducted in English (Chang & Berk, 2009). This qualitative study appeared to offer additional information that might not have been afforded in a quantitative study. However, limitations were the use of subjective client accounts and no account for the therapists' views and experiences of the client.

These last two studies explored race and gender, but the outcomes were very different, which supports the claim that many studies cannot be generalised (Docherty, 1976; Karlsson, 2005; Sue, 2003). Several of the studies identified that individual characteristics of the therapist affected the data outcome (Chang & Berk, 2009; Flicker et al., 2008; Mollersen et al., 2009; Squarez-Morales et al., 2010) but only one study reported data from the therapist's perspective (Wintersteen et al., 2005). It seems that a qualitative study from the perspective of the therapist on the shared experience with the client could offer additional insight to the matched client-therapist literature.

1.6. The Recovering Alcoholic Counsellor (RAC)

As already stated, Lawson (1982) suggested that RACs have the most similarities to their clients of all the shared client-therapist dyad backgrounds. This makes an RAC a great resource to gain insight into the shared experience with the client. A RAC works with clients who present with alcoholism. These counsellors previously had a dependency on alcohol consumption and have attained alcoholism recovery through abstinence (Argeriou & Manohar, 1978; Lawson, 1982; Skuja, 1981; Shipko & Stout,

1992; White, 2000a, 2000b). The RAC has attained recognised qualifications through attending subsequent professional training to become a counsellor (White, 2000b) and it is expected that they have simultaneously worked through and resolved their difficulties that led them to use alcohol (Carringan et al., 2008; Weegman & Cohen, 2006; White, 2000b).

It is reported that there are many RACs working in the field of alcoholism (Conti-O'Hare, 1998; Milne-Glasser, 2007; Skuja, 1981; White, 2000b) and some organisations have an unspecified preference to employ RACs, for example, The Living Room (Stevenage, Hertfordshire). Some only employ RACs, for example, Trust the Process (TTP) Counselling (who have rehabilitation centres in Cheshire and Bedfordshire). This preference implies a perceived difference or additional quality inherent to the therapist's shared experience with the client, which is not applicable to Non-Alcoholic Counsellors (NAC).

1.7. Research Directed at RACs Working with Alcoholic Clients

There are several studies focused on the efficacy of RACs against NACs (Argeriou & Manolhar, 1978; Blum & Roman, 1985; Kirk, et al., 1986; Lawson, 1982; Shipko & Stout, 1992; Skuja, 1981). Existence of these studies further implies a belief in differences between RACs and NACs. However, these studies discovered minimal differences; they were subjective reports by clients and were predominantly quantitative.

In a quantitative study by Lawson (1982) ‘level of regard’, ‘empathy’, ‘unconditional relationship’ and ‘congruence’ were rated for RACs and NACs by alcoholic clients. It was found that clients rated RACs higher on all measures and these scores were higher when the counsellors were older than the client (Lawson, 1982). The limitations of the study included a small sample size and subjective reports from clients. A recovery concept for the RACs was not offered and the views and experiences of the RAC were not recorded.

Skuja (1981) considered efficacy of RACs and NACs and measured ‘diagnostic judgement’, ‘choice of treatment method’ and ‘goals utilising quantitative methodology’ using questionnaires. Skuja (1981) concluded that whilst no differences were found between the attitudes of RACs and NACs, the RACs demonstrated a lack of openness and an intervention bias. Skuja (1981) proposed that this bias related to NACs being more challenging to conventional treatment methods. Limitations included no RACs’ recovery concept and limited measurements.

In a slightly different quantitative study, Blum & Roman (1985) focused on job performance and attitudes between non-qualified recovered-alcoholics and NACs who counselled alcoholics. They reported no differences on client outcomes, but the RACs reported more job satisfaction than their academic colleagues (Blum & Roman, 1985). The increased satisfaction was correlated to a “sense of calling” or “mission” and a “higher concern about the job even when away from it” (Blum & Roman, 1985,p.367). These reasons sound like personal investment in the client work and perhaps relate to the motivations to be a wounded healer (Ford, 1963;

Goldberg, 1993; Guy, 1987; Leiper & Kent, 2001; Moring, 1997). The authors claimed that the reasons behind the sense of satisfaction was “beyond the scope” of the study and would need further investigation (Blum & Roman, 1985,p.376).

Further quantitative studies found no differences between RACs and NACs. Kirk et al., (1986) measured perceived empathy between RACs and NACs. Rosenberg, et al., (1976) focused on efficacy between NACs and RACs. Martin (1972) considered personality characteristics and suggested that a better predictor of the alcoholic counsellor’s ability might be the objective criteria in the treatment setting. Shipko & Stout (1992) measured ‘empathy’, as well as ‘ability to be non-judgemental’ and ‘flexibility’ and proposed that counsellors’ training background confounded the variables. All of these studies measured the subjective views of the client. None of these studies offered a recovery concept or considered the views and experiences of the therapist.

White (2000b) suggested that being in recovery from addiction does not qualify or disqualify an individual from being an addiction counsellor and it is important not to idealise the pain of addiction. Doukas & Cullen (2011) proposed that existing studies focused on RACs were few and outdated, and counselling practice would benefit from qualitative studies that explored new understanding from the perspective of the RAC. Several authors have suggested that an underestimated problem for the RAC is relapse to alcohol consumption (Doukas & Cullen, 2011; Kinney, 1983).

1.8. The RAC's Vulnerability to Relapse

A vulnerability of the RAC working with the alcoholic clients is relapse to alcohol consumption, despite previous recovery (Doukas & Cullen, 2011; Kinney, 1983; Nerenberg, 2009; White, 2000b). A therapist relapsing can be detrimental to the client's progress in therapy, as not only will they have a change of therapist, any hope in the recovery process may be destroyed (Doukas & Cullen, 2011; Nerenberg, 2009; White, 2000b). Whilst it is reported that relapse amongst RACs is rare (White, 2000b), several authors propose that occurrences of relapse might be underestimated, due to lack of policy for employing those in recovery (Doukas & Cullen, 2011; Kinney, 1983).

Kinney (1983) identified that relapse is a problem for many RACs and this is impacted by the lack of treatment agency policy for employing RACs and managing relapses when they occur. Kinney (1983) carried out a telephone survey of graduates following completion of an alcoholism counselling training course. Out of thirty-five, twenty-four were RACs, all with at least two years abstinence, but it was found that nine of them reported to have relapsed since qualifying and seven had undergone inpatient treatment (Kinney, 1983). Despite this survey being small in number the high numbers of relapses were of concern (Kinney, 1983).

In a qualitative study by Doukas & Cullen (2011) focus was given to relapse amongst RACs working at two addiction treatment agencies. Doukas & Cullen (2011) identified that both agencies had insufficient policy for employment screening RACs

and lacked policy for managing relapse. The authors concluded that literature was limited on RACs and additional studies were needed (Doukas & Cullen (2011).

Other authors have suggested that over-identification and over-involvement with the client work are implicated in the cause of relapse (Lawson et al., 1984; Mann, 1973). These processes are also correlated to secondary or vicarious traumatisation (McCann & Pearlman, 1990; McElroy & McElroy, 1991; Sexton, 1999) and burn-out, a state of exhaustion and impassiveness (McCann & Pearlman, 1990).

In order to appreciate how the RAC and their similarities to their client impact on the therapy, this study will now offer a basic understanding of the alcoholism presentation and present relevant literature exploring recovery from alcoholism, since recovery from alcoholism is the goal, for both counsellor and client.

1.9. Impact of Alcohol on the Human Body

Fundamental to the alcoholic client's overwhelming drive to consume alcohol are psychosocial, physical and biological constructs that impact on the individual's health and wellbeing (Weegmann & Cohen, 2006). These result from consuming regular and high levels of alcohol over a period of time, which may lead to alcohol dependency and alcoholism (Conte, et al., 2008; Nerenberg, 2009; Weegmann & Cohen, 2006). The American Psychiatric Association's (2000) Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) offers a classification, which incorporates two types of alcoholism diagnoses. These are 'alcohol abuse' and

'alcohol dependency' (see appendix 1). This paper will focus on alcohol dependency.

Individuals who are dependent on alcohol may also be vulnerable to mental health issues (Marmorstein, 2010), poverty (Neufelda et al., 2005) and relationship problems (Weegmann & Cohen, 2006, DeZulueta, 2006), and the addiction can be secondary to psychiatric disorders or personality disorders (Carey et al., 2000; Zimberg et al., 1985). Furthermore, many alcoholics find themselves deeply enmeshed within the culture of alcohol consumption, which can contribute to problems with reduction or abstaining from alcohol (Leiper & Kent, 2001; White, 2007).

Alcohol dependency has also been linked to a genetic predisposition (Sanja et al., 2009), as well as classical conditioning processes (Berridge & Robinson, 1998; Pavlov, 1927). Regular consumption of alcohol can cause impaired cognitive and memory functions (Conte, et al., 2008; Julien, 2001), as well as physical damage, including, liver function, heart failure, epilepsy and ultimately death (Dawson, 2000; Robson, 1999). The threat of these outcomes is often very distressing for the individual and concerning for the wider society (White, 2007). Collectively all of these factors add complexity to the client's formulation of problems that the therapist needs to appreciate.

1.10. Developmental Issues and Impact for Treatment

Adding further complexity to the alcoholic's presentation is the original motivation for the individual to consume excessive amounts of alcohol over time. These motivations may include social, cultural, career related, bereavement and trauma issues (Frost & Clayton, 1977; Guthrie et al., 1995; Peele, 1999; Zimberg, 1985). Zimberg (1985) proposed that many alcoholics have experienced childhood rejection, overprotection or premature responsibility. These experiences may also lead to feeling worthless and inadequate, which are feelings that often get suppressed and relate to an innate need to be nurtured and accepted (Zimberg, 1985). This process affects a dependent need which cannot be met in everyday reality. Consequently, the individual compensates for the resultant anxiety with a drive for control, achievement and power, which can be experienced through alcohol consumption (Bowen, 1978; Wilsnack, 1976; Zimberg, 1985).

For many individuals alcohol provides a temporary feeling of power and supremacy that may lead to a superior self-image (McClelland et al., 1972) and affect a reward process (Berridge & Robinson, 1998; Pavlov, 1927). However, problems may occur once the alcohol wears off, as the individual may experience a sense of failure when faced with a less than perfect reality and unmet needs (Zimberg, 1985). These factors together with the intoxicating effects of alcohol consumption often create a negative spiral of failure causing the individual to consume more alcohol, which is a process that may result in psychological and physical dependency (Zimberg, 1985).

1.11. Shame

Some authors might add that the negative spiral of failure involving alcohol consumption may be related to the emotion of shame for some individuals (Burggraf, 1995; Miller & Tangney, 1994; Stern, 1999; Tangney et al., 1995). Shame refers to difficult feelings that result from lost respect, as a result of inappropriate behaviour by others, or as a result of perceived negative behaviour of the individual who feels the shame (Neufeldt & Guralnick, 1988). These feelings may lead to internalised self-blame (Feiring & Taska, 2005; Harper & Arias, 2004). Shame is often found active to the underlying cause for alcoholism, as well as to the stigmatisation of the addict's behaviour and addict identity (Gray, 2009).

Shame has been described as excruciating and unbearable, leading the individual to believe they are defective or damaged, which they attempt to suppress and hide from others (Lewis, 1971; Lindsay-Hartz et al., 1995). As a result of this process, these individuals may present to others a 'false-self', which is a concept identified by Winnicott (1960b/1976). Alcohol or drugs may become a means to escape the painful feelings, which is a process that may lead to substance dependency (Dearing et al., 2005; Gray, 2009). The individual will also present a set of defences to protect the suppressed and damaged-self from being uncovered by others (Burggraf, 1995; Stern, 1999). These defences may also present when the alcohol consumption is challenged (Zimberg, 1985).

1.12. The Client's Defences

For the alcoholic, alcohol becomes integral to daily function. This makes escaping from the harmful effects especially difficult for some individuals (Cohen, 2006; Zimberg et al., 1985). Challenging alcohol consumption may be necessary when health is in jeopardy, but the individual may present defences to functionally maintain the alcohol consumption (Zimberg, 1985). For the counsellor working with an alcoholic client wanting to reduce or give up alcohol consumption, this adds further challenges to the work, which may induce negative countertransference reactions for the therapist and cause impasse in the therapeutic relationship (Cohen, 2006; Zimberg et al., 1985).

Two typical defence behaviours are ambivalence and avoidance of responsibility. Ambivalence is where the client verbalises a desire to gain abstinence from alcohol consumption, but at the same time does not want to give it up (Cohen, 2006). This can be very frustrating and challenging for the therapist and involve countertransference reactions (Cohen, 2006). The second defence is avoidance of responsibility and this involves the client blaming others for their drinking behaviour, or actively circumnavigating responsibility (Cohen, 2006; Zimberg et al., 1985).

The avoidance defence might include denial, which is often used when the client is directly challenged about their drinking behaviour (Cohen, 1995; Zimberg, 1985). This defence might be particularly demanding for the therapist and requires a careful balanced approach. Too much emphasis on alcohol consumption can result in the

therapy work being dependant on the drinking behaviour (Mearns & Cooper, 2006). Ignoring it could be seen as incompetent practice (Mearns, 2004d; Mearns & Cooper, 2006). Not enough importance given to the drinking behaviour may suggest to the client that it is not important (Leiper & Kent, 2001).

At the same time, the way in which the therapist challenges the drinking behaviour also presents problems, since this is linked to the client's resistance to the therapy process (Beutler et al., 1991; Karno, 2005; Miller et al., 1993). For example, if the therapist demands that the client drinks less alcohol (direct approach) this may result in the client drinking more alcohol, or ending therapy altogether (Beutler et al., 1991; Karno, 2005; Miller et al., 1993). The resultant denial defence may include the client 'acting out' or 'splitting', which refers to the client setting up a situation in order to drink alcohol, whilst simultaneously externalising the responsibility (Cohen, 2006; Klein, 1957; Zimberg et al., 1985). These issues emphasise the delicate balance and sensitivity that the therapist needs to apply with the alcoholic client.

Further complications may result from interpersonal difficulties (Cohen, 2006; Mearns, 2003a; Zimberg et al., 1985). These might include a lack of awareness of others and a tendency towards narcissism, resulting in lateness for appointments or crossing boundaries of therapy, for example, not wanting to end therapy sessions on time (Cohen, 2006). Interpersonal difficulties and defence behaviours can severely interfere with the therapist attaining relational-depth with this client group. However, relational-depth is necessary to affect client change towards the goal of recovery from alcoholism (Mearns & Cooper, 2006; Weegman & Cohen, 2006).

1.13. Recovery from Alcoholism

There is much evidence to suggest that recovery from the suffering of alcoholism is attainable for many individuals (Betty Ford Institute, 2007; Galanter, 2007; Laudet, 2007; Vaillant, 2005; White, 2007). However, there seemed to be confusion within the literature about what recovery from alcoholism entails (Betty Ford Institute, 2007, 2009; Galanter, 2007; Laudet, 2007; Vaillant, 2005; White, 2007). In order for a client and therapist to work towards a goal of recovery from alcoholism, it seems necessary to clarify what 'recovery from alcoholism' represents and how this might be achieved.

Some authors have suggested that recovery from alcoholism is possible by reducing alcohol consumption from an unhealthy quantity to a healthy limit (Dawson et al., 2005). The Department of Health (1995) recommends a maximum daily limit of alcohol for a female as 2-3 units and for a male as 3-4 units. Recovery by reduction is reported to be dependent on several factors and these include personal vulnerability, problem severity and problem complexity (Miller & Munoz, 2005; Larimer & Kilmer, 2000; Sobell et al., 1996). However, many authors claim that moderating alcohol consumption is not possible for an alcoholic and recovery is only achieved through abstinence from alcohol consumption (Betty Ford Institute, 2007; Galanter, 2007; Laudet, 2007, Vaillant, 1988, 2003, 2005; White, 2007).

Some experts in the field of addiction (alcohol and drugs) proposed that confusion on the recovery concept has previously been a problem for treatment and research (Betty Ford Institute, 2007; Galanter, 2007; Laudet, 2007; White, 2007). Other authors offer clarification and definition of the recovery concept utilising reviews of

the literature and empirical research (Betty Ford Institute, 2007; Laudet, 2007). Focus was given, to the individual and included spiritual recovery (Betty Ford Institute, 2007; Galanter, 2007), and systemic networks of the alcoholic , society as a whole, incorporating political issues relating to funding treatments and formulating a universal recovery concept for future research (White, 2007). It was concluded that total abstinence from alcohol consumption was necessary for recovery to be attained (Betty Ford Institute, 2007, 2009; Galanter, 2007; Laudet, 2007; White, 2007) and to be in recovery the individual needs to have fitted into a diagnostic category (Betty Ford Institute, 2007).

Dawson et al., (2005) would potentially disagree with these claims. Dawson et al., (2005) reported that despite fitting a diagnostic category, a third of alcoholics who find enduring recovery do so through reduced alcohol consumption. This suggests that two thirds find recovery from abstinence. Whilst it is tempting to suggest that all RACs need to be abstinent from alcohol consumption to work with alcoholic clients, this might be difficult to enforce, since alcoholism is usually based on self-reports (Midanik, 1982; Rehm et al., 1999) making it difficult to manage.

Enforcing abstinence for all therapists working with alcoholic clients would be unreasonable, as this would include NACs. It would however, be reasonable to expect all counsellors not to be intoxicated (or have bad hangovers) when working with clients. Managing RACs' alcoholism is the responsibility of the person and perhaps recovery is different for everyone, but without a clear recovery concept, there is no foundation or understanding. This is perhaps why many alcohol treatment agencies lack employment policies defining alcohol use (Mann, 1973;

Wright & Wright, 1993). This may also suggest that some RACs are not abstinent from alcohol consumption and practicing.

The Betty Ford Institute (2007) and Laudet (2007) proposed that the process of recovery was an ongoing state that involved personal change, as well as enabling a new functional and rewarding life. The Betty Ford Institute (2007) offered the following definition:

> "Recovery from substance dependence is a voluntarily maintained lifestyle, comprised of sobriety, personal health and c itizenship." (Betty Ford Institute, 2007,p.222).

This definition seems idealistic and it could be argued that these elements are not achieved by many non-addicts. It also negates to offer a method of recovery from alcoholism, however, it does offer focus for a goal of recovery. The Betty Ford Institute (2007) also proposed three stages of abstinent recovery duration, early 1-11 months; sustained 1-5 years and stable abstinence of 5 years or more . These figures were reported to derive from 'expert' experience and some studies, which were not referenced. Potentially, stable recovery could offer criteria to employ RACs to work for treatment agencies reducing the risk of relapse.

There are two reported ways to achieve recovery from alcoholism and these are without treatment (Cunningham et al., 2000) and with treatment. Treatments include individual counselling, group therapy and the self-help group Alcoholics Anonymous

(AA) (Conti-O'Hare, 1998, 2002; Galanter, 2007; Project MATCH Research Group, 1997; Vaillant, 2005; White, 2000b).

Since all the participants of the current study reported attending the self-help group AA in the early stages of their recovery, this study will briefly explore AA as a recovery treatment. However, Kalb et al., (1976) stressed that 'paraprofessionals' (untrained helpers, for example; AA members) are not professionals and they have very different motivations to those who are professionally trained therapists. Therapy encourages the client to gain their own self-awareness, whereas 'paraprofessionals' engage in a process of mutual gain (Kalb et al., 1976).

1.14. Alcoholics Anonymous as a Treatment for Alcoholism

AA is a self-help group and a popular first choice when considering alcoholism recovery for many (Groh et al., 2008; Kelly et al., 2010; Montgomery et al., 1995). It has a reported two million members worldwide in 150 countries (Alcoholics Anonymous World Service, 2001, 2002). It offers a 12-step programme based on spirituality (see appendix 2) and is proposed as an empirical model for recovery from alcoholism (Galanter, 2007). Jung is also reported to have influenced the underlying philosophy of AA through communication with the cofounder Bill Wilson in 1934 (Dunne, 2000).

The AA programme is based on alcoholics taking a central function of healing each other, in wounded healer roles (Jackson, 2001). The programme encourages newer AA members to ask an experienced member to be a sponsor. The AA sponsor

becomes a mentor and source of support to guide the newer member through the 12-step programme, utilising their own experience of recovery to aid recovery for the newer member (Jackson, 2001; Vaillant, 2005).

AA is also recognised for being a good means of building new social networks not involving alcohol consumption (Kelly, 2003, Kelly et al., 2010; Moos & Moos, 2004; Project Match Research Group, 1997). This is important since social networks involving alcohol consumption are found to increase the risk of relapse (Schutte et al. 2001; Weisner et al. 2003). Attendance at AA meetings is reported to have a moderate effect on drinking behaviour and functioning (Emrick et al., 1993). Some studies reported positive outcomes for achieving and maintaining recovery, in addition to professional treatments (Gossop et al., 2007; Kelly et al., 2010; Moos & Moos, 2004; Project MATCH Research Group, 1997). However, Fortney et al., (1998) argued that any positive outcomes from AA could be a reflection of those individuals already motivated to change, since AA studies are based on self-selection.

AA has been criticised for inconsistency and ambiguity (Groh et al., 2008) with a drop-out rate reported at approximately 75%-80% (Alcoholics Anonymous, 1990; Pettinati et al., 1982). Galanter (2007) acknowledged that recovery through a spiritual means was limited, since it was a difficult concept to measure. It is proposed as the only means for recovery in the AA Big Book (Alcoholics Anonymous World Service, 2002). The AA Big Book being a reference book of inspiration for AA members. Other authors have suggested potential harm from attending AA, which

included, setting the alcoholics up for failure, since only a small percentage of people attain recovery (Cain, 1963; Shute, 1997).

Vaillant (2005) argued that AA offers a treatment plan that is equivalent if not better than alternative alcoholism treatments. Valliant (2005) claimed that AA provides a 'substitute dependency', which is fundamental to attaining abstinence from alcohol consumption. This process appears to transfer the problem to something less harmful. Vaillant (2005) proposed that psychotherapy is not an effective treatment for alcoholism and the placebo effect of being accepted for therapy was as effective as the treatment. Vaillant (2005) explained that due to the permanent neurological changes this prevents any cognition or medication treatments from being effective. This seems to ignore the vast literature reporting alternative means for recovery from alcoholism and addiction, as already discussed (Bieracki, 1986; Cunningham et al., 2000; Dawson et al., 2005).

1.15. Dependency and Co-dependency

Vaillant (2005) proposed four elements necessary to enable abstinence and recovery from alcoholism and these were identified by Stall & Biernacki (1986) and Vaillant (1988) and included 'external supervision', 'substitute dependency', 'new romantic relationship' and 'increased spirituality'. Three of which are factors inherent within the AA programme of recovery (Vaillant, 2005). These elements might be suggestive of a process of co-dependency on AA members, as a means for recovery.

Co-dependency is recognised in the addiction treatment literature as hindering the recovery process for the addict (Asher, 1992; Krestan & Bepko, 1990; Weegmann, 2006). This is because the co-dependent is considered instrumental to enabling and maintaining the alcoholic to functionally consume alcohol (Harkness & Cotrell, 1997; Weegmann, 2006). Co-dependency is sometimes defined as a "relationship addiction" (Weegman, 2006,p.155). A co-dependent is also described as someone who lacks personal expression, externalises focus outside of themselves and derives a sense of purpose through others (Fischer et al., 1992; Harkness & Cotrell, 1997).

Several authors may argue that the label of 'co-dependency' is socially constructed to alleviate shame and displace responsibility of the negative behaviours associated with addiction (Asher, 1992; Krestan & Bepko, 1990; Weegman, 2006). The definition of 'co-dependency' appears to be describing an issue with identity. Identity is considered to be a product of how we perceive ourselves through the interactions with others, which was first proposed by Charles Cooley in 1902 (Charon, 1979).

1.16. Identity

Wallace (1985) proposed that identity is significant in the recovery process of alcoholism, due to the alcoholic's experiences of conflict between self-beliefs and behaviour when intoxicated on alcohol. Identity is also believed to facilitate change in the process of recovery from 'addict identity' to 'non-addict identity' (Biernacki, 1986; Kellogg, 1993; Kellogg & Kreek, 2005; McIntosh & McKeganey, 2000, 2001).

Biernacki (1986) carried out a qualitative study on 101 heroin addicts who had found recovery without treatment. Biernacki (1986) concluded that the addict identity was

pivotal in the recovery process. However, Biernacki (1986) also reported that some heroin addicts, who had refused to adopt the addict label, reported finding abstinence and recovery much easier (Biernacki, 1986). This suggested that perhaps adopting the addict identity may hinder the recovery process for some. McIntosh & McKeganey (2000, 2001) advanced Biernacki (1986) study and claimed that it was the process of 'repairing a spoiled identity' that was pivotal in the process of achieving recovery from addictions. These studies suggest that identity is a powerful entity towards the process of recovery for alcoholic clients.

1.17. Summary and Study Rationale

In summary, it seems that a person who has a past trauma wound may offer additional healing qualities to someone who is suffering (Hoppenwassen, 2008; Jackson, 2001). However, caution is needed as the wounds of the helper may be detrimental to the therapeutic process for the client (Freud, 1912; Racker, 1972; Rogers, 1951; Watkins, 1985; Zimberg, 1985).

Literature matching client-therapist dyads based on similarity identified some client benefits to the shared experiences, but these findings were unclear due to confounding variables and lack of consistency with measures (Dougherty, 1976; Karlsson, 2005; Sue, 2003). The RAC is reported to have the most similarities of all the matched client-therapist dyads, which makes them an excellent resource to explore this concept (Lawson, 1982). Past studies investigating the RAC are reported to be outdated and poorly designed (Doukas & Cullen, 2011), as well as predominately quantitative. There is an identified need for qualitative studies to

explore the effects of identification with the client from the perspective of the therapist (Rowan & Jacobs, 2003; Wosket, 1999).

Whilst, RAC's past alcoholism and ongoing goal for recovery is complicated, the alcoholism presentation of the client and same recovery goal increases the similarities between this client-therapist dyad. This also minimises the number of confounding variables. The recovery literature identified that five years abstinence from alcohol consumption is considered stable recovery (Betty Ford Institute, 2007) and this offers an anchor for this study and provides a universal measure for future research. Kinney (1983) might argue that the number of years abstinent from alcohol is not a good enough indicator to predict stable recovery and other factors should be taken into account. These would include, the therapist's self-worth being related to helping the client, the client being used to put right the past and the therapist's ability for self-reflection. However, measuring these factors would be difficult for the current study, as they are intrusive (Doukas & Cullen, 2010), but these factors will be kept in mind within the outcome of this current study.

The shared experience between RAC and alcoholic client is suggestive of a number of possible relational processes and actions. These included possible dependency/co-dependency and identity issues that might offer insight and understanding into other shared experiences in the client-therapist dyad. This amplifies the need to employ a sensitive, flexible and thorough epistemological position and methodology that will uncover subtle nuances and allow for thorough exploration and theory generation that is grounded in the data. It is proposed that a qualitative study exploring the views and experiences of RACs working with alcoholic

clients will provide useful insight and information for counselling practice, psychological understanding and future research direction.

CHAPTER TWO

2. Methodology and Method

2.1. Aim of the Study

The aim of this study is to develop and provide a theory about how RACs view and experience their clients in the shared experience, including what they see as important and significant within their clinical work. This emergent theory will appreciate the subtle nuances of the underlying social processes of what is occurring for the RAC in the relationship with the client utilising theoretical sensitivity (Glaser, 1978). The data will be enabled through the researcher's interpretation, which will be part of the process and the data will incorporate existing literature to support and enhance the emergent theory.

It is believed that this theory will offer in-depth insight and information that will be helpful towards resolve and the prevention of potential problems that may occur within a shared experience between counsellor and client. This will potentially offer new information to enhance safe practice and aid progression for the client within the therapeutic relationship. It is expected that this theory will be useful for the continual development and improvement of counselling practice, psychological understanding and it will generate information for future research direction.

2.1.1. Research question

What are the views and experiences of Recovering Alcoholic Counsellors (RAC) when working with alcoholic clients?

2.2. Methodology

2.2.1. Qualitative research

In order to achieve the study's aim, a research design needs to be chosen that captures in-depth understanding of actions and processes communicated by the participants about their complex lived experiences. It will also require a process that allows for the data to be co-constructed between the participant and researcher, and interpreted by the researcher (Henwood, 1996).

Whilst quantitative research is known for being credible to scientific enquiry with regards to rigor, replicable design, large data-sets and generalising the data, it lacks appreciation for individuals in their social context. It also lacks appreciation for historical backgrounds and it fails to appreciate concepts, such as personal meaning (Guba & Lincoln, 2004). Whereas, qualitative research offers a design affording description and interpretation of specific phenomenon, providing insight and theory generation from the perspective of the respondent, including meanings, actions and processes in the lived experiences of the participants. Since this explanation better fits the current study's aims, this study falls within the realms of qualitative research.

In order to choose the best possible methodology for the study, it is necessary to clarify the epistemological positioning first (Creswell, 2009; Henwood & Pidgeon, 2006). Epistemology refers to the appreciation of what can be known and what type of knowledge is required, incorporating the researcher/knower's relationship (Creswell, 2009). This can be established by clarifying the study's aims, as well as identifying the researcher's experience and beliefs, as these factors influence the choice of research methodology (Creswell, 2009; Mills et al., 2006; Yeh & Inman, 2007).

A major criticism of qualitative studies is that the data is open to the opinion and bias of the researcher throughout the process, including data collection, analysis and write-up of the study (Creswell, 2009; Goulding, 1998; Mills et al.,2006; Padget, 1998; Yeh & Inman, 2007). However, it is acknowledged that any bias can be reduced if the researcher is transparent with their experiences, beliefs and views (Creswell, 2009; Goulding, 1998; Mills et al.,2006; Padget, 1998; Yeh & Inman, 2007).

2.2.2. Researcher's beliefs and views

My related experiences relevant to the study included secondary personal experience with alcohol problems. This was through a marriage to an alcoholic for 8 years, some 13 years ago. At the end of the relationship I attended Alanon for an eighteen month period[1]. In addition, I have worked with alcohol and drug problems in a counselling role since 2005. I believe these experiences will help me appreciate

[1] Alanon is affiliated with Alcoholics anonymous (AA) and is focused at supporting family and friends of alcoholics. As part of the tradition Alanon members go into AA meetings once a month, where they hear the alcoholic's perspective in their battle with alcoholism.

some of the terminology related to addiction and recovery, as well as acceptance of the participants enabling the interviews to take place.

The original inspiration for this study derived from some research that I carried out, that was focused on therapists working with alcoholic clients. I noticed when carrying out this research that there was a belief of differences between RACs and NACs in therapeutic practice. Then in my counselling placement with alcoholic clients, I found some clients unique in being curious about my experience in their problem. I did not experience this curiosity with non-alcoholic clients. These involvements suggested to me a perceived difference through experience, which further increased my curiosity and led me to want to know more about the shared experience with the client.

In reviewing the literature, I was surprised to learn that I fall within the realms of a wounded healer, unconsciously drawn to the counselling profession as a result of my secondary experience of alcoholism. This is reported to be the case for many professionals in helping careers (Conti-O'Hare, 1998; Groesbeck, 1975; Guy, 1987; Henry, 1966; Leiper & Kent, 2001; Moring, 1997; Sherman, 1996) and I believe this further endorses a study investigating the shared experience with the client. Not only will learning more about this concept be helpful to my own therapeutic practice, I believe that other practitioners might also benefit from the additional knowledge. I am mindful that because of this personal interest in the study I need to remain reflexive throughout the process of research to ensure that I do not make assumptions of implied participant meanings as a result of my own experiences.

My philosophical world view is that knowledge is created by an individual's interpretation. This is obtained through language and action and its meaning is co-constructed between two people (Charon, 1979; Hayes & Oppenheim, 1997; Mead, 1934; Pidgeon & Henwood, 1997). This view falls within socially constructivist epistemology. I recognise that I am also influenced by my upbringing, cultural setting, experiences and more recently counselling training. These include the principles of Cognitive Behavioural Therapy (Beck et al., 1979; Beck, 1995; Safran, 1990; Sanders & Wills, 2005) and psychodynamic practices (Bateman, et al., 2007; Gerhardt, 2008).

2.2.3. Epistemological positioning

In considering an appropriate epistemological positioning for this study it is necessary to explore the options available. On a spectrum, epistemological vantage points fall between positivist at one end and social construction at the other end. The positivist position is generally defined as a belief in 'an objective world' and an occurrence determines the perception of it, suggesting a relationship between objects and how they are interpreted (Willig, 2006). Positivists aim to discover the uncomplicated 'objective truth' about this world (Erwin, 1999; Hansen, 2006; Willig, 2006) with a purpose to ultimately predict and control phenomenon (Ponterotto, 2005).

One significant aspect of positivists' aims is that the researcher must be 'objective', which means being completely separate and detached from the subject or object being researched. The theory behind this is to ensure that the research outcome is

unbiased and the accounts are impartial and pure (Reason, 2003; Willig, 2006). This positioning does not fit with my personal beliefs as a researcher, nor does it fit with the aim of the current study. It is expected that the participants will each have individual views of their client work, which will be influenced by different cultural and historical backgrounds.

On the other end of the scale is 'Social Constructivism', which is reported to be a popular epistemology position (Ponterotto, 2005). However, pure social constructivism would involve a field study, for example, the 1920s work of Margaret Mead and the Salmoan Islanders. Since this is neither practical nor relevant for this study, I metaphorically position the epistemological position to fall between the half-way point and the extreme constructivist view.

2.2.4. Symbolic-Interactionism Epistemology

One epistemology in this position is symbolic-interactionism. Symbolic-interactionism is attributed to the work of Charles Cooley (1864-1929), an American Socialist, and George Herbert Mead (1931-1983) an American Psychologist. Cooley is famous for the term 'looking glass self', which refers to an individual's 'self-identity' and how they see themselves as being a product of their relationship with others (Charon, 1979). Mead was reported responsible for proposing symbolism as the major aspect of human demeanour, identified through the medium of language (Charon, 1979). It is proposed that meanings come from social interactions and are symbolic, due to the interpretations associated with the various forms of language,

including gestures and significance of objects. These interpretations change and reorganise in light of altering situations (Charon, 1979; Schwandt, 1994).

Symbolic-interactionism considers that individuals develop subjective knowledge and meanings of their experiences, directed at objects and things in a given context (Charon, 1979; Charmaz, 2006). These meanings are transient and co-constructed with others, through interactions, discussion and influenced by historical and cultural norms (Creswell, 2009; Hansen, 2006; Schwandt, 1994).

Symbolic-interactionism as the epistemological position for the current study would offer several benefits to the study. It would offer insight into the RAC's internal interaction with themselves in their own struggle with alcoholism recovery. It would appreciate the therapy work in the present. It would offer understanding of subtle nuances within the interaction and identity in the shared experience with the client (Charon, 1979). Symbolic-interactionism also matches this study's research aims, as well as the beliefs and views of the researcher.

Detail of insight and information was found lacking in the previous studies explored, which were mainly expressed from a quantitative research design and positivist vantage point. Individuals' views and experiences are a complex concept to measure, which perhaps contributes to the acknowledged lack of knowledge exploring this shared experience (Wosket, 1999). A study using symbolic-interactionism epistemology would also afford an element of triangulation to previous studies, as well as offering in-depth appreciation of the complex processes encountered by the counsellors in the shared experience of alcoholism with the client

(Denzil, 1970). For all of the aforementioned reasons this study will adopt symbolic-interactionism as the epistemology to explore the views and experiences of the RACs in the shared experience of alcoholism with the client. The next step is to consider a suitable methodology.

2.2.5. Methodology

In considering a suitable methodology several factors need to be considered. These include a methodology to compliment symbolic-interactionism epistemology, a methodology that enables the researcher to be active in co-constructing and interpreting the participant's information, and a methodology that incorporates an inductive and deductive methodological process (Charmaz, 2006). The methodology would also need to be sensitive, thorough and grounded in the data. It would need to capture the participant's meanings, actions and processes, together with the researcher's interpretation, experiences and background (Creswell, 2009; Schwandt, 1994). The methodology would need to be reflexive to ensure that the participants' accounts were a reflection of the shared identification with the client and not imposed by the researcher's own beliefs.

2.2.6. Grounded Theory Methodology

One methodology that is considered to work well using symbolic-interactionism epistemology and offers an inductive and deductive process, as well as reflexivity is Grounded Theory (GT) (Charmaz, 2006). GT is a systematic methodology that generates a theory from the data (Charmaz, 2006; Glaser & Strauss, 1967). The

founders of symbolic-interactionism, Cooley and Mead have a relationship to the methodology Grounded Theory (GT) since Strauss (a founder of GT) studied under Mead when carrying out his doctoral thesis at the University of Chicago. It is proposed that Mead's influence on Strauss is reflected in the pragmatist philosophy underpinning of Strauss' work (Charmaz, 2006; Glaser & Strauss, 1967). This influence is evident in the open ended questions of GT and the belief that individuals are active in their worlds and influenced by external society (Charmaz, 2006; Glaser & Strauss, 1967).

The original paper by Glaser & Strauss (1967) introducing GT was considered a challenge at the time, since historically there was reliance on verification of theories and outcomes utilising quantitative research design (Charmaz, 2006; Goulding, 1998; Rennie, 2001). Glaser & Strauss (1967) offered a positivist qualitative methodology considered useful and recognized for its rigour (Charmaz, 2006). GT also encouraged new theory generation, instead of theory substantiation and provided a new perspective adhering to scientific procedures (Bryant & Charmaz, 2010; Charmaz, 1983; Goulding, 1998; Glaser & Strauss, 1967). This introduction revolutionised traditional research design (Charmaz, 2006).

Later, Glaser and Strauss went separate ways evolving GT within different epistemological frameworks. Strauss teamed up with a colleague Corbin (Strauss & Corbin, 1990, 1998) claiming a 'relativist pragmatists' epistemology to GT, embedding their research in history (Mills et al., 2006). Glaser remained in a positivist epistemological framework; proposing GT to be a comparative method of

discovery and relying on direct but arguably, constricted empiricism, whilst maintaining a basic social process (Charmaz, 2006; Glaser, 1992).

GT enables exploration of the individual's experiences, as co-constructed and interpreted by the researcher. Flexibility and the potential for in-depth insight into raw data are also enabled (Charmaz, 2006). GT is open to the subtle nuances of meaning, allowing codes and the derivation of conceptual categories to emerge from the data (Glaser, 1999). The GT processes are improved by continuous reflexivity using explicit documentation of the researcher's thoughts, feelings and ideas throughout the methodological procedure, actively recognising the researcher in the process. This process affords rigour, plausibility and application, enabling the reader to evaluate the impact of biases and preconceptions on the data collection and interpretation of the results (Charmaz, 2006; Bryant & Charmaz, 2010; McLeod, 2005).

In GT the researcher actively facilitates the analysis, whilst maintaining interpretive activity at bay until a later stage (Dallos & Vetere, 2005). The researcher's closeness to the data enhances accuracy of interpretation of the participant's meanings and utilises the researcher's subjective cognitive processes (Fonagy et al., 2002) and meta-reflection (Semerari et al, 2003) capturing the participant's intended meanings. These actions and processes are thought to be simultaneous (Luca, 2011). These are all qualities needed in the current study.

In recent years, variants of GT methodologies have evolved, including Rennie (1998a, 1998b, 1999, 2001) and Charmaz (2006) and these GTs are considered for

the current study. Rennie (1998a, 1998b, 1999, 2001) uses a positivist hermeneutics philosophy (McLeod, 2005). This claims a "theory of operation of understanding in its relation to the interpretation of text, which includes acknowledging the influence of individual's experiences, history and culture" (Ricoeur, 1978). Rennie (1998a, 1998b, 1999, 2001) uses hypotheses in the analysis to read meanings into what is said. However, hypotheses might be prone to researcher biases through suggestion and may potentially miss important nuances within the data. This process could lead to descriptive outcomes, which is a criticism of GT (Worren et al., 2002). This version of GT is from a positivist perspective, believing in an objective researcher, which is not useful for the current study.

Charmaz (2006) offers a version of GT using symbolic-interactionism epistemology, and given the theoretical origin of GT this seems to be a natural epistemological positioning for GT. This version of GT claims a method of 'principles and practices' and does not fit participant's answers into a predefined framework (Charmaz, 2006). The role of the researcher is acknowledged in the construction and interpretation of the data and likewise during the interaction with the participants and during data collection (Charmaz, 2006). It is expected that using Charmaz (2006) version of GT with symbolic-interactionism epistemology will offer additional sensitisation to the emerging concepts and categories, which are key components of GT (McLeod, 2005).

It is also anticipated that my experience in the arena of alcohol addiction will enable additional meanings and familiarisation with associated jargon, as well as understanding of the related theory and empirical work. This additional knowledge is

expected to increase theoretical sensitivity, which will contribute towards responsive interviews and increase engagement of an analytic mind to explore the emerging concepts (Charmaz, 1995, 2003). Dey (1993,p.63-64) claimed it is important for the researcher to begin a grounded theory study with an “open mind, not an empty head”.

The existing research explored was predominantly from a quantitative vantage point and positivist epistemological positioning. It is considered that a study utilising Charmaz (2006) version of GT from a symbolic-interactionism epistemology will afford an element of triangulation to previous research that has explored RACs and the shared experience with the client (Denzin, 1970). Having several vantage points exploring a similar concept is thought to afford a better appreciation of the concept being investigated. A GT study may offer some clarity with regards to the discord and ambiguity reported in the current literature and gain new insight into the shared experience with the client from the perspective of the therapist. It is expected that this study using GT methodology will provide a foundation that can be built on by further research. This study will use Charmaz (2006) version of GT.

2.2.7. Alternative methodology considered

Another methodology that utilises symbolic-interactionist epistemology and considered for this study was Interpretative Phenomenological Analysis (IPA) (Smith, 1997; Smith, 2004). IPA has similar outcome claims to GT, which are unravelling and explaining processes, including meanings. IPA claims a concise and methodical strategy to bring forth ‘themes’ and uncover the fundamental nature of a

phenomenon (Willg, 2006). However, there are some difference between GT and IPA.

One difference is IPA has a preference towards minimal participants and single case studies, claiming this offers greater depth of data (Smith, 2004). A significant benefit of GT over IPA is the use of evolving interviews until no further questions emerge from the data to the point of theory saturation (Charmaz, 2006). This involves as many participants as needed and therefore GT offers additional flexibility towards a complete appreciation of the concept being explored (Charmaz, 2006; Glaser & Strauss, 1967). This GT process also offers a degree of 'replicability' (Riley, 1996), which is another criticism of qualitative methodology (Morgan, 1996).

Due to the lack of qualitative understanding of the therapist's shared experience with the client and the complexity of the relational experience, including possible subtle nuances of identity, dependency and identification with the client, it is considered this study will require a methodology that offers a generated theory, together with sensitivity and flexibility to explore questions that emerge from meanings, processes and actions identified in the process. GT offers a complete process, to the development of an emergent theory grounded in the data.

GT methodology breaks down and reassembling the data, engaging in theoretical sensitively, utilising the co-construction of meaning with the researcher to understand underlying processes and what the participants see as being significant and important (Glaser, 1978). GT explores the data until all emergent questions have been investigated and 'theory saturation' has been reached. This detail is not

afforded by IPA. It is considered that GT's process will enable additional flexibility and sensitivity to explore the complexity of the participants' views and experiences in the shared experience with the client. GT also meets all the aims of the study. It is considered that Charmaz (2006) version of GT will be the most appropriate methodology on this occasion.

2.3. Method

2.3.1. Participants

Inclusion criteria

There were two criteria for the study. The first criteria required participants to report being at least five years abstinent from alcohol consumption following a problem with alcohol dependency. Five years was defined in the literature as stable recovery from alcohol dependency (Betty Ford Institute, 2007). Whilst Betty Ford Institute do not reference studies to identify five years, Dawson et al., (2005) offered empirical evidence to confirm that after five years alcohol dependents demonstrated increased rates of maintained recovery.

The second criteria required the participants to have been practicing counselling for a minimum of two years since qualifying. The literature was inconclusive on what constitutes competence as a therapist post qualification (Beutler, 2007; Crits-Christoph, et al., 1991). Keisler (1996) claimed that experience is not temporal. External supervisors needed to have had at least two years post qualification experience before students could use them to support their client work whilst training on the Counselling Psychology Doctoral Programme (University of East London, School of Psychology, 2009-2010,p.39). It was considered by the researcher that this rule evidenced a minimum competency and adequate experience as a practitioner to provide knowledge useful for the current study.

There were 10 participants that met the inclusion criterion. All of the participants and their relevant data are included in Table 1. They have been given pseudonyms to protect identity. These names are alphabetical to reflect order. Charmaz (2006) proposed that the order of interviews is important in GT, since questions that emerge from the data are explored in subsequent interviews.

Of the 10 participants, 5 were female and 5 were male, ages ranged between 32 years and 70 years (mean (*M*) = 52.9, standard deviation (*SD)* = 7.3). The number of years abstinent from alcohol ranged between 9 years and 17 years (*M* = 12.3, *SD* = 1.64). The number of years counselling in the field of alcohol problems ranged between 4 years and 15 years (*M* = 8.6, *SD* = 2.9). In addition, 7 of the 10 participants reported being active AA members. All the participants reported being paid for their client work and worked with clients presenting with alcohol problems.

Table 1: Demographic details of the participants

Participant	Age	Gender	Years Abstinent	Discipline Qualification	Years Practicing
Andy	62	M	13	Person centred/ Integrative Diploma	11
Betty	70	F	13	Integrative/ Humanistic Diploma	9
Carol	45	F	13	Integrative Diploma	7
Denis	32	M	13	Integrative Foundation degree	4
Edward	55	M	13	Humanistic Advance diploma	6
Fiona	57	F	12	Person centred Diploma	9
Gordon	57	M	9	Psychodynamic Diploma	4
Harriet	50	F	9	Psychotherapy Advance diploma	4
Ian	52	M	17	Psychosynthesis Post diploma	15
Jan	49	F	11	Psychosynthesis Post-degree	10

The participants were recruited from two charities located in Surrey and Hertfordshire, which worked with alcohol and addiction problems. Two of the participants were personal contacts through previous placements. One of the charities only employed RACs and it was the charity's policy to self-disclose this experience to the clients at the assessment stage. The principle of this employment policy and self-disclosure was never formally defined.

The charity organisations were contacted and sent information about the study and their members were invited to take part on a voluntary basis. The charities gave written acknowledgement for their members to participate in the study (see appendix 3 for letter wording). The original letters have been omitted to maintain confidentiality. Individual interviews were organised with the participants when they made contact with the researcher. At this stage an information sheet was given to them (see appendix 4). Before the start of the interview the study's aims were explained verbally and another copy of the information sheet was issued to the participant to ensure they were fully aware of the study's intentions and their involvement.

Each participant was asked to sign a consent form (see appendix 5) and the study was further explained verbally. It was also made clear at this point that the participant could withdraw from the study at any time. The participants were informed that the information remained confidential and transcripts were anonymised. At the end of the interview the participants were thanked for their participation and asked if there were problems, as a result of the interview process.

A debrief form was given with the researchers contact details and telephone numbers for additional support should subsequent problems occur related to the interview (see appendix 6).

Interviews took place between December 2008 and October 2009. They were held in a location of the participant's choice. Seven of the participants chose the dedicated counselling rooms at the charity where they worked and three chose their private homes.

2.3.2. Materials

An Olympus digital voice recorder DS-2200 was used to record the interviews. This was then transferred to a password encoded Laptop owned by the researcher.

2.3.3. Practical considerations

2.3.3.1. Interview guide

A semi-structured Interview Guide was used to assist the structure of the interviews (see appendix 7a and 7b). This guide changed during the process of the interviews to direct questions that emerged from the data (Charmaz, 2006). More than the necessary questions were recorded on the guide to cover several directions of conversation and prompt the researcher should the conversation not flow. Charmaz (2006) suggested that novice researchers can increase confidence and a better focus on the participant's narrative using an interview guide with questions and prompts.

The participants were encouraged to lead the focus of the interview to ensure that organic material was shared about the participant's experiences with their clients (Padget, 1998). Basic demographic questions on the guide were asked at the beginning of the interview, which aimed to put the participant at ease, as well as gain background information (Padget, 1998). Relevant open questions were asked during the body of the interview, in line with the participant's narrative (Charmaz, 2006). This enabled a natural flow and depth of answers for richer data collection. The final question on the guide was used to bring the session to a positive close.

2.3.3.2. Interviews

The interview lengths ranged from 49 minutes to 84 minutes (*M* = 61.6 minutes; *SD* = 7.3 minutes). There were no reported problems from the participants as a result of the interviews. All of the participants indicated that they would like to see the outcome of the research. The recordings were all transcribed in full using Microsoft Word. Line numbering was used to help with the analysis.

2.3.3.3. Ethical consideration

Ethical approval from the University of East London was granted for this study, dated 15th August, 2008 (see appendix 8). In addition, as already stated, letters of acknowledgement from both agencies used to recruit participants were obtained, confirming that they were fully aware of the research and gave authorisation to use their counsellors for this research (see appendix 3).

Throughout the interviews vigilance was afforded towards the welfare of the participants and as already stated, verbal and written debriefing was given with appropriate contact details, should a problems arise as a result of the interviews (see appendix 6). The participants did not report any problems during or at the end of the interviews. The researcher was not made aware by the participants or partaking charities of problems following the interviews.

2.3.3.4. Rigour and trustworthiness within the GT

Details of rigour and trustworthiness can be found in appendix 9.

2.3.4. Procedure

The procedure, including stages of the analysis are shown in Table 2 for ease of reference. A more detailed account of these stages can be found in appendix 10a.

Table 2: Table to show procedure and stages of analysis

Stage	**Details**
Interviews	Data gathering through semi-structured interviews and fully transcribed with line numbers ready for analysis.
Initial coding	Line-by-line summaries of information. These entries were made in the right-hand margin of the transcript (see appendix 10a,p.191). A focus was given to applying gerunds to the data to identify action within the codes (Charmaz, 2006; Glaser, 1978). Memos were written during this process (see appendix 10b).
Focus coding	Using an iterative process to bring the initial codes to concise meanings. Attention to frequency and relevance to the research questions was given. Focus code summaries were made in the left-hand margin of the transcripts (see appendix 10a,p.192). The interviews were cut up into their meaningful focus codes and stuck onto index cards for visual reference (Rennie, 1994).
Conceptual Coding	'Freewriting' (see appendix 10c) was used to free up cognitions, together with the visual aid of focus codes on the index card. These were sorted and allocated to relevant A3 sheets representing the hierarchy of categories (see appendix 10d). A process of continually moving between the transcripts, codes and memos, as well as writing substantial memos (see appendix 10e). This process helped to bring the conceptual elements of the coding together for understanding and relationships. This process resulted in the emerging theory.
Sampling	Additional interviews were conducted to supply fresh data, with participants who met the criteria of the study. A constant comparison process was applied to all interviews. As additional ideas emerged from the data further participants were sought.
Theory saturation	Interviews ceased at Interview 10(Ian), when no additional information or new theoretical ideas emerged from the data. Theory saturation was reached and theoretical coverage of the research area was considered adequate.

CHAPTER THREE

3. Results

The interviews yielded rich and descriptive data that expressed the views and experiences of the RACs in their shared experience with the alcoholic client. 'Therapist managing their own recovery' was the core category that emerged from the data. This reflected the underlying process and meaning of the participants in their client work. This core category was made up of three categories, which were inter-related with one another and these were: 'therapist building a self-identity'; 'therapist identifying with the client' and 'therapist fearing relapse'.

'Therapist building a self-identity' related to the participants' perspective and understanding of who they were as individuals. It reflected their building and making sense of their identity, since achieving abstinence from alcohol and previously as an alcoholic. The alcoholic identity was influenced by AA practice and enforced by the other two categories. The maintained alcoholic identity was actively used in the therapy work with the client.

In the category 'therapist identifying with the client' related to the similarities recognised through the shared experience of alcoholism with the client. This identification appeared to activate several processes and actions for the participants. These appeared to be within the participants' conscious and unconscious

awareness, which varied between participants and resulted in perceived negative or positive outcomes for the client work.

'Fearing relapse' was a category that related to an underlying process, which was enhanced through identification with the client, which acted to reinforce the alcoholic identity and increased the participants fearing relapse. This process appeared to affect a possible co-dependency on the client for some participants.

3.1. Levels of Interpretation

A unique dynamic of the participants was a reflection of their thinking from several perspectives, which included an interpretation as therapist, as an ex-client and observations of their client's experiences. The first interpretation, as therapist, referred to their role as a professional RAC working in the field of alcohol problems. The second layer of interpretation was afforded by the participants' experience as a client struggling with alcoholism, recalling their lived experience and embarking on the journey of recovery. The final interpretation arose from the participant's observation of the client's experience, including behaviour and opinions.

3.2. Grounded Theory Model

The theory grounded in the data became salient through the process of inductive and deductive analysis, where the categories and the underlying processes emerged from the data. This was enabled through a number of actions, including the construction of memos and constant comparison to the original transcripts and

codes. The process of cutting out the individual focus codes, which were then assembled on A3 sheets according to patterns, helped to order the emergent categories. This process offered a visual platform to contemplate category hierarchy, relationship and membership. This process was modelled on one proposed by Rennie (1994). The process of 'freewriting' and memo writing was also found useful to clarify and reinforce category membership.

A focus was given to utilising gerunds throughout coding, which aided closeness to the data, as well as identifying the participants' actions and underlying processes (Charmaz, 2006; Glaser, 1978). This process was also found to encourage the emergence of the GT and hierarchical order of the categories (Rennie, 1994) including, core categories, categories and sub-categories from the data. This visual aid also helped to identify underlying processes, the participant intended meanings, patterns and links between and within the categories and sub-categories.

Exploring the emergent findings in relation to current research also helped to enhance the inductive reasoning and offered additional insight into the emergent patterns within the developing theory. Further understanding and insight continued and the model became increasingly evident and strengthened, evolving right up to and during the write-up stage of the study.

As already stated, the core category that emerged from the data was 'therapist managing their own recovery'. Within this there were 3 categories and 20 sub-categories. Each category will now be outlined.

The first category was ‘therapist building a self-identity’, which contained 2 sub-categories that also belonged to another category. ‘Adopting the addict identity to access recovery’ was also considered to belong to category ‘therapist fearing relapse’. ‘Sharing addict identity with the client’ also belonged to category, ‘therapist identifying with the client’. There were 7 further sub-categories that belonged to this category alone, ‘finding purpose and direction’, ‘being influenced by an anonymous fellowship’, believing in a higher-power’, making sense of the past’, ‘finding autonomy from the alcoholic identity’, ‘avoiding transference of dependency’ and ‘separating addict identity from person’.

The second category was ‘therapist’s identifying with the client’ and contained 2 sub-categories that also belonged to an additional category. ‘Sharing addict identity with the client’ also belonged to category ‘therapist building a self-identity. ‘Client acting as a deterrent for relapse’ also belonged to category ‘therapist fearing relapse’. There were 6 further sub-categories that belonged to this category alone; ‘believing in enhanced skills in shared experience’, ‘knowing alcoholic’s thoughts, feelings and behaviour’, ‘affording tough-love to the client’, ‘wanting to reduce negative feelings’, ‘feeling deep empathy with the client’ and ‘managing problems in shared identity’.

The third category was ‘therapist fearing relapse’, which contained two sub-categories that also belonged to alternative categories. ‘Adopting the addict identity to access recovery’ also belonged to category ‘therapist building a self-identity’. ‘Client acting as a deterrent for relapse’ also belonged to category ‘therapist fearing relapse’. There were four further sub-categories that belonged to this category

alone, ‘always thinking about relapse’, wanting to give back’, ‘developing through the work with the client’ and ‘loving the client work’. These results are shown in Table 3.

Table 3: Results; core category, categories and sub-categories

Core Category	Categories	Sub-categories
Therapist managing their own recovery	Therapist building a self-identity	Finding purpose and direction
		Being influenced by an anonymous fellowship
		Believing in a higher-power
		Making sense of the past
		Finding autonomy from the alcoholic identity
		Avoiding transference of dependency
		Separating addict identity from person
		Sharing addict identity with the client
	Therapist identifying with the Client	Believing in enhanced skills in shared experience
		Knowing alcoholic's thoughts, feelings and behaviour
		Affording tough-love to the client
		Wanting to reduce negative feelings
		Feeling deep empathy with the client
		Managing problems in shared identity
		Client acting as a deterrent for relapse
	Therapist fearing relapse	Always thinking about relapse
		Wanting to give back
		Developing through the work with the client
		Loving the client work
		Adopting the addict identity to access recovery
	Therapist building a self-identity	

Therapist managing their own recovery

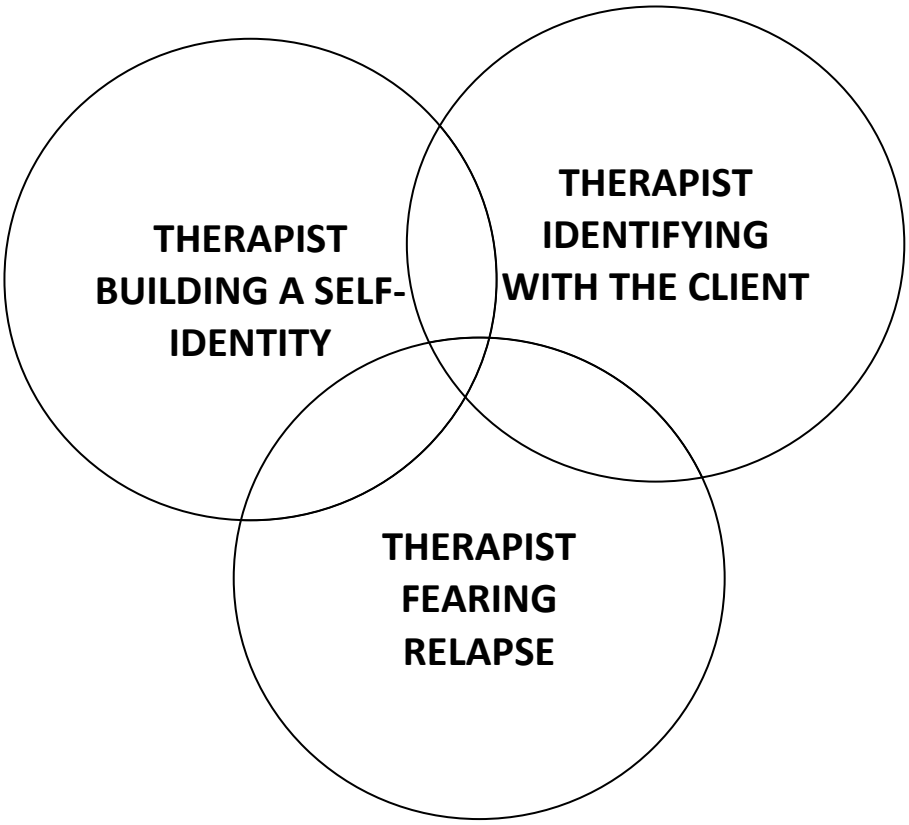

Figure 1: Model showing the core category 'Therapist managing their own recovery' and the relationship between the three categories 'therapist building a self-identity', 'therapist identifying with the client' and 'therapist fearing relapse'.

The model shown in Figure 1 represents the core category 'therapist managing their own recovery' and the relationship between the three categories. 'Therapist building a self-identity' has an overlapping relationship with 'therapist identifying with the client', which has an overlapping relationship with 'therapist fearing relapse'. 'Therapist fearing relapse' has an overlapping relationship with 'therapist building self-identity'.

Therapist managing their own recovery

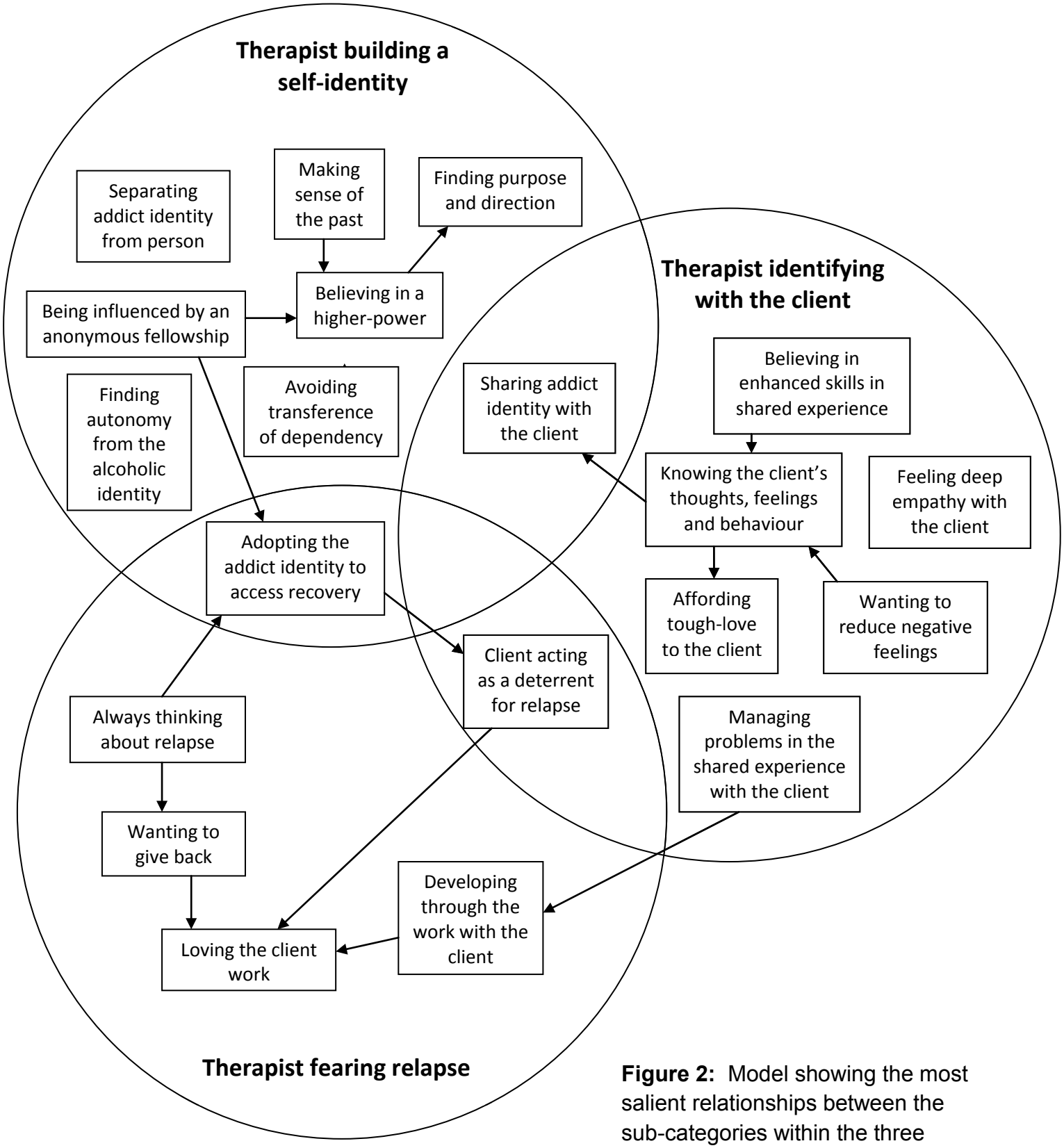

Figure 2: Model showing the most salient relationships between the sub-categories within the three categories of the core category.

The model shown in Figure 2 reflects the most salient relationship between the sub-categories within the categories as follows. Within the category of 'therapist building a self-identity' the sub-category connections were as follows; 'adopting the addict identity' connected to 'client acting as a deterrent for relapse'. 'Sharing addict identity with the client' was influenced by 'knowing the client's thoughts, feelings and behaviour'. 'Finding purpose and direction' was influenced by an anonymous fellowship', which related to 'believing in a higher-power and 'adopting the addict identity to access recovery'. It was also considered that 'believing in a higher-power' might also stand separate from 'being influenced by an anonymous fellowship' for some individuals. 'Believing in a high-power' had a connection to 'finding purpose and direction'. 'Making sense of the past' also appeared related to 'believing in a higher-power'. 'Finding autonomy from the alcoholic identity', 'avoiding transference of dependency' and 'separating addict identity from person' stood alone.

Within the category 'therapist identifying with the client' the sub-category connections were as follows; 'sharing addict identity with client' was influenced by 'knowing the client's thoughts, feelings and behaviour'. 'Client acting as a deterrent for relapse' was linked to 'loving the client work'. 'Believing in enhanced skills in shared experience' connected to 'knowing the client's thoughts, feelings and behaviour'. 'Knowing alcoholic's thoughts, feelings and behaviour' connected to 'sharing addict identity with the client' and 'affording tough-love to the client'. 'Wanting to reduce negative feelings' was connected to 'knowing the client's thoughts, feelings and behaviour'. 'Managing problems in the shared experience with the client' connected to 'developing through the work with the client'. 'Feeling deep empathy with the client' stood alone.

Within the category ‘therapist fearing relapse’ the sub-category connections were as follows; ‘adopting the addict identity to access recovery’ connected to ‘client acting as a deterrent for relapse’ which connected to ‘loving the client work’. ‘Wanting to give back’ also connected to ‘loving the client work’. ‘Developing through the work with the client’ connected to ‘loving the client work’. ‘Always thinking about relapse’ connected to ‘adopting the addict identity to access recovery’; ‘Loving the client work’ stood alone.

3.3. Core-category: Therapist Managing their own Recovery

The core category was ‘therapist managing their own recovery’. This reflected the overall content of the participant’s accounts and was directly referenced by some of the participants. Within the core category there were 3 categories and 20 sub-categories. The categories were ‘therapist building a self-identity’, ‘therapist identifying with the client’ and ‘therapist fearing relapse’. These will now be presented in more detail.

3.3.1. Category: Therapist building a self-identity

The participants described a process of ‘building a self-identity’ in their recovery from alcoholism. This involved ‘finding purpose and direction’, ‘being influenced by an anonymous fellowship’, ‘believing in a higher power’, ‘making sense of the past’, ‘finding autonomy from the alcoholic identity’, ‘avoiding transference of dependency’

and ‘separating the addict identity from the person’. Another sub-category fell within the realms of this category and the category ‘therapist identifying with the client’, which was sub-category ‘sharing addict identity with the client’. These sub-categories will now be presented.

3.3.1.1. Finding purpose and direction

The participants spoke about finding purpose and direction after giving up alcohol, which was relevant for them and their clients. The demographic information showed that all the participants became counsellors following their abstinence from alcohol consumption. The time between finding abstinence to counselling practice ranged between 1 – 9 years (*M* = 4.3, *SD* = 1.9). This suggested that the therapists were all wounded healers. The narratives recalled journeys of self discovery including, reintegration into society, exploring courses and careers, making choices and discovering personal strengths and limitations. The narratives seemed reflective of the Betty Ford Institute (2007,p.222) description of recovery, involving “a voluntarily maintained lifestyle”, “sobriety”, “personal health” and “citizenship.”

The participants’ accounts of finding purpose and direction appeared to support some findings in Biernacki’s (1986) study that focused on Heroin addicts who found recovery without treatment. Biernacki (1986) identified a process of ‘transformation’ of identity on three levels, returning to a prior identity, building onto an existing identity, or building a completely new self-identity. These levels of transformation appeared evident within the transcripts of this study. However, in Biernacki’s (1986) study the participants underwent a change of identity from addict to non-addict. In

the current study the participants expressed their alcoholic identity in the present and past tense interchangeably, which implied they retained their addict identity. Mead (1934) might argue that these accounts were evidence of a transient identity adapting to others within a situational context.

3.3.1.2. Being influenced by an anonymous fellowship

All of the participants reflected being influenced by an anonymous fellowship, which was AA. All of the participants reported to having attended AA during the early stages of recovery and 7 participants reported to still attend regularly. The participants described AA as a fellowship that provided a safe place, a sense of belonging through shared identification, normalisation, acceptance and a means for redemption. Some participants claimed that AA had nurtured them from giving up alcohol, as well as during a period of growing up. Some spoke about personal development. Others reported to have found new social connections and life-long friends offering them ongoing support.

Galanter & Kaskutas (2008) reported that AA builds on friendships formed within the meetings. The participants suggested that another benefit of attending AA meetings was being presented with evidence of alcoholism and recovery at different stages. This was reflected as important because it offered a deterrent of what could happen if alcohol consumption continued. It also evidenced that recovery was possible. Vaillant (2005) proposed that AA has inherent mechanisms of action that help prevent relapse. Additional participant explanations can be found in appendix 11.

Andy spoke about being influenced by the AA fellowship philosophy. He explained its impact on his life, including personal development, building a social network and influencing the way he thinks. Andy's account supports studies that propose positive outcomes for achieving and maintaining recovery in AA, in addition to professional treatments (Gossop et al., 2007; Kelly et al., 2010; Moos & Moos, 2005; Project MATCH Research Group, 1997).

> "I think AA is a wonderful way of picking up on great social life outside of alcohol and there some wonderful people in there, there are some raving lunatics in there as well, but some great people as well… ...a strong part of my life is AA and I did the 12 step programme and did quite a bit of 'big book' study as they call it, so (I: yea) I am very aware of it and it's in my life (I: it is yea) yes, it's a way of life (I: yea) and this is where that positive thinking comes from." (Andy;920-937)

Andy also explained that AA meeting attendance was not his choice in the early days of recovery. It had been a compulsory condition of the primary and secondary residential treatment centres that he attended. Moos & Moos (2005) suggested that compulsory attendance to AA is a common requirement for many centres, as it is believed to increase the chances of sustained recovery. Andy's account indicates a conflict of hating the meetings initially and through being made to go, he eventually gained benefit. This supports Moos & Moos (2005) claim of sustained recovery, since Andy reported 13 years abstinence and recovery from alcoholism.

> "They say 90 meetings for 90 days; I was doing 9 meetings a week at one point. (I: so was that before or after the primary care, secondary

care) after. (I: after) I hated it when I was in primary care (laughs) I absolutely loafed it in my secondary." (Andy;882-887)

3.3.1.3. Believing in a higher-power

Many of the participants spoke about 'believing in a higher-power' and reflected this as helpful for attaining recovery. Believing in a higher-power was referenced by the participants as a power greater than anything physically living and one that was responsible for mapping out their life path prior to it happening. This implied that no matter how a person thinks, feel or behaves it is out of their control. The participants also spoke about believing in a higher-power in conjunction with making sense of the past trauma as an alcoholic.

Believing in a higher-power was reflected as an archetypal concept, as well as incorporated in AA philosophy, evident in steps 2, 3, 5, 6 and 11 of the 12-step programme (see appendix 2). The archetypal unconscious memory was a concept introduced by Jung (Dunne, 2000). However, Jung was also involved in the inception of AA and perhaps this narrative reflects his influence (Dunne, 2000). Jung proposed that all humans share an unconscious memory of historical concepts and desires, which is communicated to the conscious mind through dreams and imagery (Dunne, 2000). Essentially the participants were reflecting that believing in a higher-power was an inevitable outcome for everyone needing support in crisis.

Fiona suggested that her compulsion to drink alcohol was lifted when she got an AA sponsor and implied it was through something beyond her control. Vaillant (2005)

proposed the AA sponsor offers the supervision element towards relapse prevention. It might be that AA was also adopted as a substitute dependency to alcohol for Fiona (Vaillant, 2005).

> "So then I started to go to AA, I still didn't get recovery straight away, I still relapsed occasionally, but then suddenly, I got a sponsor ... went through the steps and you know, I am now twelve years in recovery. They say in AA the compulsion to drink was lifted. That was what happened, it wasn't anything to do with me, it had to be a power outside of me that lifted the compulsion to drink..." (Fiona;257-266)

Ian speaks about his belief that the higher power is an archetypal concept and how he had observed clients who had no relationship to AA, appearing to sub-consciously seek support from a power outside and greater than them. Ian justified how this pattern of behaviour is unrelated to the philosophy of AA or religion. Ian's account appeared to support Jung's archetypal memory theory.

> "I think there is a kind of archetype of recovery, that you don't just have to learn it bit by bit, what I notice is, like I was talking to somebody yesterday, no details about him as a client, but he was saying I don't believe in this 'god' stuff if I believe in myself and what I say to myself at the end of the day, to myself is, thank you for keeping me clean and sober for another day and bla bla bla" and I said "do you know that sounds exactly like the prayers I hear people saying to a higher power or whatever" and he said "well this was to me" and he hasn't been to AA, so it's almost like, where did he get that phraseology from… ...I kind of see it as archetypal the link is not out there the link is in here [gestures with hands to the heart]." (Ian; 488-501).

3.3.1.4. Making sense of the past

Several participants spoke about making sense of their past and in particular the trauma of alcoholism. They expressed a need to understand what had happened and to utilise this knowledge to a positive aim. McIntosh & McKeganey (2000, 2001) suggested that 'repairing a spoiled identity' is pivotal in the process of achieving recovery from addictions. Some participants expressed comfort in being able to utilise their negative experience for a positive aim, as this meant all the years drinking was not wasted time. It was also reflected that believing in a 'bigger plan' for the past trauma helped to reduce the pain of the past (linked to believing in a higher-power). Other participant explanations for making sense of the past appeared to be about personal resolve.

Gordon explains that he would 'like' to believe in the bigger plan, as it helps to take away the pain of his trauma, which suggested he was not convinced of this belief. This account appears to be less about Gordon repairing a spoiled identity, but more about a belief that by making sense of his past this will offer resolve for his related feelings.

> "You start off in life, you are going to rule the world and you are going to tear away at it, so perhaps I am doing what I meant to have done (laughs)(I: So a predefined path, so you needed to go through that to be) Yes everything, yes that is how I like to think of it now, it took away the pain from the past (Gordon; 679-684).

Fiona reflected on making sense of her past by using the experience towards a positive aim in working with alcoholic clients. She reflected on her son's expressed admiration, which implied her having repaired a spoiled identity (McIntosh & McKeganey, 2001). Fiona related her experience to someone who had been disabled and reflected a difference, which might be suggestive of shame and feeling she had a choice in her alcoholism. The reference to someone disabled may have represented how she felt in her active alcoholism. Fiona's narrative suggested that she considered 'luck' involved in her ability to use her past positively implying it was not in her control.

> "It makes all that awful stuff worthwhile, I've turned a really negative into a positive, you know that is how my boys see it, you have turned that negative experience into a positive, you know and they can't believe that I am twelve years sober and doing what I am doing. So it's like, if you turn it around you know, those negative. I suppose it's like if someone is in a wheelchair and they use that to encourage other people then they can see a positive somewhere inside of them. It's not a reason, I would not say it is a reason, because that is a different thing, but they can either use it as a negative or use it as a positive, you know and I am lucky enough, you know I have managed to use it as a positive." (Fiona;648-656)

3.3.1.5. Finding autonomy from the alcoholic identity

Some participants reflected the importance of finding autonomy from the addict identity when outside of work. Some spoke of AA no longer being helpful after time, claiming it as repetitive and negative. Rogers (1951) suggested that autonomy is important, as it enables individuals to achieve independence. Erikson (1963)

proposed autonomy as a developmental stage that enabled a sense of self. This autonomy was reflected by some participants' as a process to enable connection with themselves, others and the outside world. Gray (2009) proposed that shame inhibits empathic connection to self and others, which might implicate shame associated with the alcoholic identity as an underlying process.

Betty reflected her delight in finding autonomy from the alcoholic identity in a new environment after moving home. The bottle of champagne symbolised her autonomy from the alcoholic identity with her new neighbours. Betty's expressed pleasure in finding autonomy from the alcoholic identity may relate to being free from feelings of shame regarding the alcoholic identity. Gray (2009) proposed that shame was underlying to the stigmatisation associated with the alcoholic identity.

> "I was so excited and thrilled because I moved here and I got some people from the village shop to help me and I was given a bottle of champagne and it sat on that mantelpiece as we moved everything in… …I said it's the biggest prize I've ever had, because they don't know." (Betty; 403-406)

3.3.1.6. Avoiding transference of dependency

This sub-category reflected the participants' references to 'avoiding transference of dependency' to something else. Several participants spoke about a tendency of transferring their dependency to something else, after giving up alcohol. It was described as 'obsessions' by some, which included relationships, food, shopping and AA. The participants said it was important to be vigilant with themselves and with

their clients to avoid this from happening. Kushner et al., (2000) claimed that those with substance dependency have increased risk of Obsessive Compulsive Disorder (OCD).

Just before this extract Carol reflected that AA was helpful to her in the earlier years, but over time it had become less helpful. Carol explained that this was because she was "hearing the same things over again", which had left her feeling "stuck". In the extract Carol proposed that AA had become another dependency and this was no longer helpful. This further supports Vaillant (2005) who claimed that AA provides a substitute dependency to alcohol. Carol reflected on the importance of mixing with different groups of people to enable progress in her recovery. Whilst Carol appeared to be reflecting the need for autonomy and independence from the alcoholic identity (Erikson, 1963; Rogers, 1951), she also reflected avoiding transference of dependency.

> "I got addicted to meetings, I got addicted to just going around with AA people, I needed to mix with other people, so I am all for people going, because all the more help they get the better, so you know, there comes a time when you have to move on." (Carol;242-244)

3.3.1.7. Separating the addict identity from the person

This sub-category reflected several participants' explanations of a belief that the 'addict' is a separate identity within them. It was proposed that separating the addict identity from the person enabled the person to be built up and the addict part

weakened, however it will always be there. This explanation incorporates the belief that the addiction is ongoing (Betty Ford Institute, 2007; Laudet, 2007).

Some participants described the addict part as being a devil or a gremlin and the person as an angel. This explanation seemed to be a metaphor, which is something that Jung is recognised for using in his work (Dunne, 2000). This action may have represented separating the shameful alcoholic identity from a potentially good unspoiled person. This symbolic action perhaps relates to repairing a spoilt identity (McIntosh & McKeganey, 2001).

Ian explained how he separated the addict identity from the person and spoke about the concept of having a devil and an angel on opposite shoulders. Ian reflects on a small experiment that he carried out where people who had not experienced alcoholism did not recognise this concept. This suggested a perceived difference inherent in the alcoholic identity. Ian reflected on how he uses the metaphor successfully in his work.

> "When I am working that every single person I have ever talked to who has got an addiction problem knows what it is like immediately and will often describe it to have a little devil on one shoulder and a little angel on the other, with them in the middle, almost watching a tennis match, thinking... …We will kind of work on what that little gremlin or imp or monkey or devil is saying to them, so they can kind of separate it from their own voice and get to know what that voice is about and begin to dialogue with it instead of thinking they are it" (Ian;333-360)

Gordon explained his belief of separating the addict from the person in terms of personalities. Gordon reflected on shame in his narrative, perhaps implying it is implicated in the addict identity. Gordon used imagery and metaphors in his explanation. The image included a victim (the person) who is scared and good, but being attacked by the addict, who is bad. Gordon appeared to reflect himself as a hero taking control of the situation, separating the bad addict from the good person. Gordon punishes the addict by feeding the person making them big, which by default starves the addict making it small. Gordon's explanation does not kill-off the addict, as he only speaks about making him smaller, thus the addict remains ongoing. Jung claimed that metaphors are more legitimate than science to accurately communicate information (Dunne, 2000, p.72).

> "So we are trying to get 'it' smaller and 'them' bigger, because when they come in, it is all 'it'. It is scary, it has got them and what we do is we separate and we work on that, making the 'it' smaller and 'them' bigger." (Gordon;395-397).

In summary of the category 'therapist building a self-identity', the participants reflected finding purpose and direction following abstinence from alcohol. The stories incorporated journeys of self-discovery, growing up and building up careers and self-worth towards a better future, which was ongoing. The participants reflected on being influenced by AA, which enabled them new social connections and a sense of belonging. AA was also reflected as a way of thinking and perhaps a substitute dependency to alcohol for some. It was a place where participants were presented with a choice of alcoholism or recovery.

The participants also reflected on believing in a higher-power and whilst AA was implicated, some participants proposed this belief was innately inherent for everyone. Believing in a higher-power appeared to offer meaning and escape from shameful feelings, believing that lives are predefined. Making sense of the past appeared closely linked to believing in a higher-power for some. This involved wanting to believe that their past was resultant of something meaningful and not wasted time. Some participants expressed wanting to make sense of the past to relieve pain of the past, whilst others wanted to make positive use of the knowledge learnt, which perhaps repaired a spoiled identity.

Finding autonomy from the alcoholic identity was expressed by some participants, claiming a need to escape the addict identity, but also retaining it for client work and their own ongoing battle with recovery. Several participants spoke about the usefulness of separating the addict identity from the person and used metaphors to explain the concept. All of these actions seemed to represent escaping or externalising the addict identity.

3.3.2. Category: Therapist identifying with the client

The next category was 'therapist identifying with the client'. Casement (1991) proposed that the therapist identifying with the client provides useful information towards understanding the client and reducing anxiety of the unknown in the therapy room. In the current study, identifying with the client included 8 sub-categories 'believing in enhanced skills', knowing the client's thoughts, feelings and behaviour', 'affording tough-love to clients' and 'feeling deep empathy with the client', 'managing

problems in the shared identity'. Two of the sub-categories fell within this category together with another category. The first was 'sharing addict identity with the client', which also fell into category 'therapist building a self-identity'. The second was 'client acting as a deterrent for relapse', which also fell into category 'therapist fearing relapse'. Each sub-category will now be presented.

3.3.2.1. Sharing recovery identity with the client

This sub-category was considered to fall within two categories: 'therapist building a self-identity' and 'therapist identifying with the client'. This dual membership was because the addict identity was actively used in this action, which appeared triggered by identifying with the client in the shared experience. It was however, the charity work ethic to self-disclose the alcoholic identity for some of the participants.

The participants reflected that they self-disclosed their alcoholic identities to the clients for three functions, justifying competence in the client's problem, bringing about equality of power and providing evidence that recovery was possible. In relation to justifying competence to the client, Gallant & Mallott (1985) suggested that it is important for the client to know that the therapist is competent, as it enables trust in the therapy process. The client feeling equality of power was considered by the participants to reduce their fear and help them relax. The participants claimed that providing evidence that recovery was possible, affected hope. Perry et al., (2007) emphasised it was important for the clinician to offer hope to the client in the recovery process. Additional participant explanations can be found in appendix 12.

Gordon used the analogy of repairing a car by a specialist to convey that he was a specialist in the client's problem. This may suggest that Gordon wanted the client to admire him, which Cohen (2006) proposed sometimes happens with helping professionals working in addictions. Evidence of a possible over-identification protective countertransference was reflected in Gordon's stating "I always self-disclose" indicating that he assumed that all clients benefited from this action based on his own experience. It could be argued that Gordon was offering his client compassion, recognising the client's suffering and offering kindness and awareness by wanting to help to relieve this discomfort (Gilbert, 2009; Shainberg, 1993).

> "I will always self-disclose, I say "I am a recovering alcoholic, I have been there and ten years ago I was living rough in the park, you know, and I know I am not here to judge you or whatever; I am just here to help you, because I am not doing that now". So it is a great, you know. I look at the analogy of, I wouldn't take a car that was broke, if I owned a Renault car and it was broke and it was a new one worth a lot of money, I would take it to a Renault garage, because I know they know the car." (Gordon;341-350)

Andy reflected on his motivation of sharing his alcoholic identity with the client, in order to equal the power within the therapeutic relationship. This may have reflected that the communication with the client was bidirectional identification in an empathic communication (Watkins, 1985). Rowan & Jacobs (2003) suggested that only through openly sharing can empathy be activated in the therapeutic relationship. Self-disclosure is openly sharing, but there is no way of knowing whether the client experienced empathy without asking them. Andy acknowledged a belief that all alcoholic clients are vulnerable when coming to therapy, referring to his own experience as evidence. This implied his action of sharing was about relieving the

client's difficult emotions and possibly his own too, suggesting an over-identification protective or avoidance countertransference reaction within Andy (Gabbard & Wilkinson, 1994; Watkins, 1985; Weegman & Cohen, 2006; Wilson & Lindy, 1994).

> "If you are sat there as the drunk looking at somebody over here, who is well dressed and very comfortable and you could have painted a picture of them, in their nice big car and in their comfortable home with lots of money, you know, the picture is there and it makes them feel very small. They are on the verge, either on the verge or they have lost everything, there is nothing there you know and sometimes I say to them, look I might sit here and I might look like that and you might think it is all right for me, but actually at one time all I had was a bag of clothes and nothing else." (Andy;484-492)

Carol explained her belief for sharing identity with the client as providing evidence that the recovery is possible, in order to enable trust and faith in the therapy process. Self-disclosure being used for the benefit of the client is endorsed by several authors (Goldberg, 2004; Myers & Hayes, 2006; Nerenberg, 2009). Carol demonstrated self-awareness of potential problems when sharing her identity, including changing therapy focus to the therapist, which was the caution of Freud in 1910 (Groesbeck & Taylor, 1977; Guy, 1987). Hill & Knox (2002) also stressed self-disclosure as destructive to the therapeutic alliance if not carried out in a conscious manner.

Carol's self-awareness of problems may have also indicated a possible negative reactivity or respondent bias (Lincoln & Guba, 1985). This may relate to wanting to be positively appraised as a therapist (Wosket, 1999). In relation to sharing the addict identity and seeing clients progress Carol stated she felt compassion and love for the client work, which implied a correlation between sharing her identity and

loving the client work. This process perhaps suggested a reward cycle in operation (Berridge & Robinson, 1998; Pavlov, 1927).

> "I will say to a client "I understand I have been there too and you can get sober." I don't tell them all ...You know if it is appropriate I tell them, you know it helps them move on … I think it gives them trust and faith, you know, you can change. … So we have had people here who have been helped and in counselling they say, "well you have been there haven't you, so how do you feel now", so I say how I feel and I say to them "really it's not about me is it, it's about you, but if it helps you to know how I am feeling", then I am going to tell them, you know I just love them, with compassion, I just want to help them and help them to help themselves." (Carol;198-215)

3.3.2.2. Believing in enhanced skills in the shared experience

Many of the participants reflected on a belief that that the shared experience of alcoholism with the client enabled additional helping skills. Proverb type phrases or maxims were used to communicate this belief and these were reflected as not otherwise available without a shared experience. This belief was also evident in the wounded healer literature explored earlier. For example, Jesus' suffering meant he understood others' suffering (Jackson, 2001) and Trosse used the identification with his own suffering to help others in his job as pastor (Trosse, 1714, 1974).

The participants explained that additional skills included being able to quickly recognise the client's defence behaviour that leads to relapse, including behaviours of denial, acting out and splitting, as described by Klein (1957), as well as recognition of fear. Some of the participants justified this implied superiority stating

that they did not perceive they were better therapists. This justification may suggest a respondent bias, as some of the participants knew that I was an NAC and may not want to offend me. An additional participant explanation can be found in appendix 13.

As previously mentioned, White (2000b) proposed that it was important not to glamorise the RAC's past experience and it was the therapist's relational skills that were more valuable for the client's progress. Watkins (1985) also proposed that identification based on similarities between client and therapist can lead the therapist to become overly enmeshed in the client's internal world activating over-identification countertransference reactions.

Jan reflected on the maxim "you can't kid a kidder" to demonstrate a general belief that the shared experience with a client implied additional skill for spotting someone lying. Jan reflected her disagreement with this belief and emphasised how she does not agree with challenging clients with negatives, implying she had witnessed some RAC therapists doing this with clients through believing in additional skills through the shared experience. Jan emphasised the powerful use of sharing positives with the client, drawing from her own experience. Shainberg (1993) suggested that negativity with the client hinders personal development and Watkins (1985) proposed that negativity of the therapist increases probability of therapy termination by the client. Gilbert (2009) proposed that reflecting an individual's strengths was helpful towards wellbeing. Jan's reflection implied that she was feeling frustrated at other therapists' negative practice.

> "It's like (name) says "you can't kid a kidder" and that is the thing isn't' it? You can't kid a kidder." It works in the negative way, but it also works in a positive way and I think we spot the good in people as well. I think we spot the good in people, when they can't feel everything themselves. That for me is what has helped me more than the challenge, so I think that is why the treatment centres, you have got to have people at different ends of the spectrum haven't you, because that challenge wouldn't have helped me, as much as you are OK (I: yea yea), it's somewhere in you that is OK would have helped me more You can't kid a kidder." (Jan;639-646)

Denis reflected AA philosophy to explain the origin of his belief in the shared experience, "you can never really understand it unless you have been there". Denis justified that he did not believe this necessarily meant that counsellors without this experience were less skilled and claimed that he believed that his shared experience with the client enabled him additional therapy tools. This comment may have been the result of a respondent bias, having the knowledge that I was a NAC.

> "I mean with AA they say that you can never really understand it unless you have been there and I do believe that. I don't believe that means that someone without an addiction can't help you (I: ok). It's like I believe that I can help people who have had experiences, which I haven't had myself, because I don't think it's just about that I think there is more to it, than having just been through it, I don't consider myself to be a better counsellor just because I have been through it, but I just consider it more of a tool to be able to help me with someone, it's just another tool to be able to use." (Denis/552-563)

3.3.2.3. Knowing the client's behaviour, thinking and feelings

Some of the participants expressed knowing the client's behaviour, thinking and feelings, which was described as an 'intuitive' knowledge, suggesting that it felt instinctive to them. Knowing the client's behaviour, thinking and feelings was reflected from the participant's identification with the client and was considered similar to the previous sub-category. However, this sub-category reflected 'knowing' the client, whereas the previous sub-category reflected a belief of additional therapeutic skills as a result of the shared experience.

The belief that the therapist knows what's best for the client is also indicative of over-identification countertransference reactions (Watkins, 1985; Wilson & Lindy, 1994). It is proposed that a therapist staying with 'not knowing' with a client enables them to find self-awareness (Bion, 1974; Shainberg, 1993).

Edward explained how he and his RAC colleagues would know and predict the client's behaviour towards relapse in the group therapy setting. Edward reflected this ability as an "instinct" resulting from the shared experience with the client. Halewood & Tribe (2003) suggested that counsellors who claim the ability to read their clients thoughts, feelings and behaviours might be demonstrating narcissistic tendencies. The counsellor's belief of knowing the client might relate to the presentation of a 'false-self' (Winnicott,1960b/1976) and influence of an 'imposter phenomenon' (Langford & Clance, 1993). Edward also spoke about how he believed this process reduced the possibility of the client lying to the RAC. The last

few words of this extract implied an authoritarian stance, which Rogers (1951) claimed worked well, but ultimately led to a dependent individual.

> "I don't believe the addict can con another addict to the same level. I can spot somebody who, because we do it, we all do it in there we just know if somebody has relapsed, we just know if somebody is sometimes is about to relapse. We just have the, there is an instinct for it and I think that comes from our own using, our own addiction and they won't get away with it as much..." (Edward;428-432)

Fiona further explained how she believed the RAC cannot be lied to by the client and how her identification with the client enabled her to spot the client's addictive behaviour and thinking. This reflection may have suggested a focus of therapy on the alcohol consumption and a reluctance to explore deeper issues with the client, which may indicate an avoidance countertransference. Wilson & Lindy (1994) proposed an avoidance countertransference may result in enmeshment and excessive advocacy with the client. Fiona implied that knowing the client was only available to RACs, which perhaps suggested a feeling of superiority (McClelland et al., 1972).

> "Because an addict gets so used to lying and cheating and covering up that they will come in here with all that going on, unless you have been there and you know about the manipulating, lying and cheating yourself then you probably wouldn't be able to spot it quite so much, you know." (Fiona;411-414)

3.3.2.4. Affording tough-love to clients

Affording tough-love to clients was described as a necessary action to directly challenge the client on their perceived defence behaviour, which was believed to lead to relapse. Many of the participants expressed concern about their observation of 'other RACs' affording tough-love to clients in a bullying and abusive way. This suggested that perhaps the participants considered their own practice as positive and not bullying or abusive.

Similar findings, where clinicians claimed to observe 'others' carrying out 'bad practice', which no one claims to be doing, was reported in a study investigating the clinical practice of nurses (Huggett, 2001). This might represent black and white thinking or splitting, 'good therapist' verses 'bad therapist' (Klein, 1957). It may also be suggestive of a projective identification, externalising shame (Klein, 1946; Lemma-Wright, 2004) and lack of self-reflection, which has been related to RAC relapse (Kinney, 1983). The observed accounts may also have been suggestive of over-identification countertransference reactions, perhaps related to internalised blame or excluding behaviour due to earlier victimisation, which Allport (1954) proposed was present for many 'recovered' addicts who train as counsellors.

The participants offered different interpretations of what affording tough-love to clients entailed, ranging from reflexive to bullying and abusive practice (see appendix 14). The participants also reflected that affording tough-love to clients derived from

AA practice, which implied that it was not an empirically recognised therapeutic intervention.

Some participants reflected an attitude of knowing what was best for the client when justifying affording tough-love. Having this belief was a caution of the International Therapeutic Community (White, 2010,p.11) who claimed it led to abusive "tough type tactics" (reflected as tough-love) by counsellors. The belief of 'knowing what was best for the client' was attributed to the demise of the American treatment centre 'Synanon', which developed into a 'cult' (disbanded in 1989) (Deitch & Zweben, 1981; White, 2010). Further participant explanations of affording tough-love to clients can be found in appendix 15.

Edward spoke about his belief in what was best for the client and proposed that affording tough-love was a useful intervention with addicts. Edward reflected that collusion did not help the client and reiterated his belief that 'tough-love' worked. This justification implied black and white thinking with no middle ground or recognition for reflexive practice. This may also be indicative of 'splitting' as defined by Klein (1957). This action may suggest a hostile countertransference reaction through fear of being infected by the client's behaviour (Watkins, 1985). It may also increase the possibility of relapse, which several authors' caution may happen (Doukas & Cullen, 2011; Nerenberg, 2009; Rodriguez de la Sierra, 2006).

> "I have mentioned about not just walking alongside the clients because I give quite a lot of tough-love and I think clients need that sometimes. I think some clients when they get to a certain stage,

> addicts, if you are too alongside them, then it doesn't work, so I think tough-love works." (Edward; 581-584)

On Edward's introduction of affording tough-love to clients, he was asked what he meant by 'tough-love'. Edward explained that the choice of this intervention was based on his own experience as an addict. White (2000b) proposed that an over-identification countertransference reaction of the therapist may cause the therapist to bias the treatment based on their own experience. An experience bias with RACs was also observed by Skuja (1981). In Edward's narrative he claimed to use questioning to challenge the client's behaviour. Socratic questioning is considered to be a useful tool to appreciate the client's underlying problems (Padesky, 1993). However, Edward reflected that he would confront the client with denial. This might have been an accurate interpretation, but curious questioning enables the client to find their own self-awareness, which is considered more helpful than the therapist's interpretation (Casement, 1991; Shainberg, 1993).

> "That is challenge them, if they act out or, it's not just if they act out, if they act out physically or if they act out mentally… …I will just say "I think you are avoiding or saying you don't know, I don't believe you don't know, I think you do know, you are just in denial, or you are avoiding completely" and I will challenge them straight away, so tough-love and clients need to know that they are acting out." (Edward;587-595)

Fiona offered an example of affording 'tough-love' to a client and stated a belief that clients were more likely to take 'tough-love' from a RAC than a NAC, indicating compliance to the therapist. Fiona also evidenced her beliefs by justifying that 'tough-love' worked within the AA fellowship. This implied that affording 'tough-love'

to clients is not an intervention derived from professional therapeutic education. Kalb et al., (1976) emphasised that AA has different motivations and aims to professional therapy. AA is a mutual support group, whereas professional therapy is focused on the client.

Fiona reflected on a belief that "addicts challenge other addicts". Reigle & Dowd (2004) in a quantitative study investigating AA affiliation found that members were more likely to adopt a confrontation 'tough-love' approach in order to enforce abstinence from alcohol. This involved a 'tough-minded' and 'antagonistic attitude' towards others (Reigle & Dowd, 2004). Shainberg (1983) suggested that the good therapist will facilitate the client to go inside themselves to consider new possibility through reflection and questioning. It is believed that this leads to new ways of thinking for the client and activates new energy (Shainberg, 1983). Fiona's account appeared more reflexive than hostility.

> "Clients will say something like, well I had a c lient the other day saying that "well, I don't drink very often, I only drink, you know, sort of every couple of months ... I say "what happened last time you had a drink", "well actually I had a drink and I had a fight with my husband and the Police were called and Social Services were called, but that is normal isn't it? ... well actually if you didn't have that drink, that wouldn't have happened and you wouldn't be her e ... Addicts challenge other addicts a lot more ... we know that tough-love and challenging work for us in AA and with our sponsors, so we sort of bring that experience with us." (Fiona;341-351)

3.3.2.5. Wanting to reduce negative feelings

Several of the participants reflected wanting to reduce negative feelings, for both themselves and the client. This appeared related to 'knowing the client's thoughts, feelings and behaviour' and it was an independent reflection in relation to the participant's own feelings when identifying with the client in the shared experience. Some of these accounts may have been evidence of over-identification countertransference reactions of the client (Watkins, 1985).

Denis explained how he resolved his negative feelings of frustration by being hard on the client. This extract suggested a hostile over-identification countertransference reaction with the client (Watkins, 1986). Rodriguez de la Sierra (2010) said that many substance abuse treatment centres use coercive practice with clients. As already stated, Rogers (1959) cautioned that whilst the authoritarian approach does work well, it leads to a dependent client.

> "I think I get frustrated if someone comes in every week and does not make changes. Then I think, well, because I know that I tried and I know that maybe they didn't want to be there or maybe they just came in, just to please someone. That can frustrate me and I will be hard on them, I will say "look, you know, why are you coming if you are not prepared to do anything?" you know, that is really the main frustration and then if they don't turn up, obviously but I get used to that, I've got used to that." (Denis, 228-233)

3.3.2.6. Feeling deep empathy with the client

Empathy refers to the bidirectional sharing and merging with another person's pain or pleasure as they feel it, but maintaining knowledge of what belongs to the other person (Rogers, 1959; Watkins, 1985). Rowan & Jacobs (2003) proposed three levels of empathy experienced by the therapist; Instrumental, Authentic Self and Transpersonal Self. The Instrumental referred to a trained and mechanical way of connecting with the client. The Authentic Self reflected a deep level of empathy, where there is personal involvement and openness with the client. The Transpersonal level is a level where there is a merging and spiritual connection involving heart and soul between therapist and client (Rowan & Jacobs, 2003).

The participants reflected on experiencing deep and spiritual levels of empathy with the alcoholic clients, corresponding to the transpersonal empathy level (Rowan & Jacobs, 2003). The participants also reflected that they believed empathy developed quickly with alcoholic clients. This depth of empathy was attributed to the shared alcoholism experience with the client. Samuels (1985) proposed that the past wounds of a wounded healer assist empathy. However, Samuels (1985) also cautioned potential over-identification through the shared experience with the client. Knowing the client's behaviours, thoughts and feelings was reported by some participants alongside their reference to empathy, which may suggest these experiences of 'knowing the client' were related to the experience of empathy (Rowan, 1993). Additional participant explanations can be found in appendix 16.

Carol described empathy felt with alcoholic clients as ‘special’ and experienced at a greater depth in comparison with clients without the shared experience. Carol reflected on how the shared goal enabled her to know how the client felt, which led to a deeper bond. This account may reflect Rowan & Jacobs’ (2003) transpersonal level of empathy, where the client and therapist enter a state of ‘resonance’ with each other where they are in ‘attunement’ involving a temporary merging of internal worlds (Rowan & Jacobs, 2003). Hopenwasser (2008) proposed a similar relational dynamic, where the therapist attained ‘attunement’ through shared wounding with the client, which was described as an optimal state to enable healing for both therapist and client.

> “The thing is there is a special empathy with clients who have the same alcohol problems as you, because you know, I know where they are coming from, it’s like a goal, there is a bond there, the same one, there is empathy with clients who I don’t know anything about their problem, you build up a relationship, so you go with the bond, and it is just, but I think you work different....so it is different, like a deeper bond.” (Carol;601-605)

Edward portrayed a heart-felt connection with the client as a spiritual bond. He described that he understands the client from his heart, as well as his head. He explained what he believed the client feels from this experience, which included trust, connection to others, a feeling of being at home and not judged. He reflected that clients acknowledged a belief that the counsellor works from their heart and not just books. Shainberg (1993) suggested that the therapist working from the heart opens up new possibilities and energy for the client to explore their problem from the inside. Chopra (1991) also proposed that it is necessary to work from both the mind

and the heart when healing. Edward referred to a “spiritual bond”, which seemed reflective of Rowan & Jacobs (2003) transpersonal empathy level. At this spiritual level a ‘sympathetic resonance’ may occur between therapist and client, described as several perspectives occupying one space, whilst at the same time the therapist remains self-aware (Rowan & Jacobs, 2003).

> “A lot of it, the empathy, the understanding is done in the head ... and what I think that works here, works for me, that I just don’t understand from my head, I understand it from the heart as well [puts his hand on his chest] ... they pick up on that and that means that it is that bit of the trust, the connection, them feeling at home, them feeling part of, them not feeling judged ... I think it is because the clients have said as well, if it was a counsellor, who was just coming from their head, from their books, that wouldn’t happen. It’s because they have that, I call it a spiritual bond ... there is another dimension where there is a connection.” (Edward;384-404).

3.3.2.7. Managing problems in the shared experience with the client

Many of the participants reflected on managing problems in the shared experience with the client. These problems appeared to be about countertransference issues. As already described in the introduction chapter countertransference reactions relate to feelings felt by the therapist in response to the transference or projective identifications from the client (Lemma-Wright, 2004; Watkins, 1985).

The participants reflected positive management of problems experienced with the client and positive use of countertransference reactions. They reported that whilst

the countertransference reactions were uncomfortable at the beginning of professional practice, these were not a problem now. That information gained through the countertransference reactions provided material for the participant to work on for personal development. The participants reported that they had developed positive strategies for issues, including use of supervision and personal therapy. The participants also pointed out that countertransference reactions could be about anything and were not necessarily about their past alcoholism.

However, the positive experiences reflected by the participants did not reflect the literature, where alcoholics are reported to be provocative and challenging due to transference and projective identification, characterised by a dependency need on the therapist (Weegmann & Cohen, 2006; Zimberg et al., 1985). Common challenges that might present include hostility, manipulation and testing the therapist, together with a superior attitude (Rodriguez de la Sierra, 2006; Zimberg, 1985). These were not reflected by the participants. It might be that RACs are immune to these challenges and they were expert in dealing with countertransference reactions.

These narratives could also represent two of four possible levels of competency, as prescribed in the 'learning cycle' and these could be 'conscious competence' or 'unconscious incompetence' (Dubin, 1962; Howell, 1982; Gordon Training International, 2012). The other two levels are 'unconscious competence' and 'conscious incompetence' (Dubin, 1962; Howell, 1982; Gordon Training International, 2012). It is claimed that we are all located in the learning cycle somewhere, which is an ever-changing/developing process (Dubin, 1962; Howell, 1982; Gordon Training International, 2012). Alternatively, the participants' positive accounts may

reflect them projecting a professional identity (Wosket, 1999), perhaps related to respondent bias (Lincoln & Guba, 1985). Additional participant explanations can be found in appendix 17.

Harriet spoke about her experience of countertransference within the therapeutic relationship. Harriet explained that her professional training had helped her to recognise and deal with negative countertransference reactions and by noticing the transference and projected identification from the client she could appreciate the client's pain. Harriet denied countertransference being a problem. Watkins (1985) suggested that when there is identification with the client and optimal distance is maintained, this enables understanding and relatedness to the client. Harriet's account reflected a distance from the client "I keep it as theirs" and she appeared to use transference information to recognise the client's pain.

> "I keep it as theirs as well, whatever they are going to share, I keep it as theirs. You know feelings come up for me, you know I can feel their pain sometimes, you know that projected identification when you can feel their pain, but not to the point where it has affected me and I need to go home and put something out for myself… …I learnt that in my counselling courses how to deal with that, you can't afford to take it on board, you know you are feeling it, which means that they are obviously in a lot of pain and most people who walk in here are anyway, in that painful place, where they have been on t hat cycle, you know lost out." (Harriet;512-521).

Betty reflected on her experience of negative countertransference reactions, which she described as painful at the beginning of her counselling career. Betty explained how she had managed the countertransference reactions and benefited from using

them for personal development, as well as managed these reactions in the present day. Betty reflected self-awareness and positive management of countertransference reactions in her therapy work with clients (Watkins, 1985).

> "When I first started counselling ... the countertransference I had was really very painful, because some point, if at the time, they did this significant others, so I would be talking to somebody's mother about their son or daughter, and I found it very hard because the guilt... …not saying anything to them, then coming out and going to see my supervisor ... I've got used to it now, so it doesn't worry me so much, but to begin with I found it hard." (Betty;539-552)

In summary of the category, 'therapist identifying with the client', the sub-category 'sharing the addict identity with the client' appeared to be related to possible over-identification countertransference reactions, which protected the client, and at the same time avoided negative feelings for the client and also the participant in the shared experience. There also seemed to be indication of a respondent bias, protecting the participants' professional identity.

Believing in enhanced skills in the shared experience was reflected as a generally accepted belief, which may relate to the wounded healer concept. Knowing the client's thoughts, feelings and behaviour appeared to correlate with a belief of superiority that was problematic and related to affording tough-love to the clients. The description of what it meant ranged from hostile and bullying over-identification countertransference reactions to reflective practice. This suggested some confusion to what this intervention entailed. It was a concept reflected to derive from AA philosophy, suggesting that it was not an empirically tested therapeutic tool.

Feeling deep empathy with the client appeared to involve enmeshment with the client at a spiritual level of empathy (Rowan & Jacobs, 2003) and a feeling of being connected to self and client. The accounts were suggestive of a possible symbiotic healing for both client and therapist. Managing problems in the shared experience with the client reflected positive management of countertransference reactions with client, which may have indicated lack of openness or evidenced a respondent bias.

3.3.3. Category: Therapist fearing relapse

Within the transcripts the participants' actions and processes were underlined by a process of fearing relapse to alcoholism. Some of the participant's narratives included their own stories or that of clients, of near death experiences and attempted suicides in order to escape alcoholism. Fearing relapse also appeared to be exacerbated through the beliefs inherent to the addict identity and the associated conditional beliefs derived from AA affiliation. The clients were reflected as a constant reminder of the fate of alcoholism, which the participants' stressed they did not want back. The fear also appeared to influence a possible co-dependency on the client, derived from the belief that they needed to help the alcoholic to maintain their own recovery from alcoholism.

Sub-categories that related to 'therapist fearing relapse' included 'client acting as a deterrent for relapse', 'always thinking about relapse', wanting to give back' and 'learning from the client'.

3.3.3.1. Client acting as a deterrent for relapse

The ‘client acting as a deterrent for relapse’ represented the participants’ reflection that the client contact acted as a constant reminder of a potential negative future, if they were to return to alcohol consumption. The participants were very clear that this was not a fate they wanted back. The participants’ fearing relapse appeared to be amplified through the client contact. The participants’ claimed this was also a process active within AA meetings and it was necessary to help alcoholics in order to maintain their own recovery.

However, Kinney (1983) cautioned that therapists who become over-involved with their clients are more vulnerable to relapse. This process suggested a potential co-dependency on the client to regulate their abstinence from alcohol as a result of fearing relapse. This potential perpetual cycle seemed reminiscent to the failure cycle of alcoholism, as discussed in the introduction (Zimberg, 1985). It might be that the dependency on alcohol has been replaced by the client work, as positive feelings of self-worth are achieved in the therapeutic relationship with the client (being the helper and managing one’s own recovery) and the feeling of failure being replaced by activated shame and fearing relapse, which is perpetuated by the constant reminder through identifying with the client, including a perceived shameful past and fate, if they were to return to alcohol.

Fiona reflected how the ‘client acting as a deterrent for relapse’ helped maintain her recovery. The trigger for Fiona in this extract was her own identification around the client caring for her children whilst drunk. This appeared to affect a fear of relapse

for Fiona reminding her of painful memories and a potential fate if she were to return to alcohol consumption. Fiona reflected that she found this reminder helpful towards maintaining her own recovery. This may imply that therapy focus for Fiona was on her own maintenance of recovery, which was the previously mentioned caution of Freud in 1910 (Groesbeck & Taylor, 1977; Guy, 1987).

> "Well it is the same as it works in AA, because, especially as, we get new comers coming in all the time… …it just reminds me of what it can be like. … They [the clients] almost mirror, you can have this back [name] any time you like, here you are, and it is like something I don't won't back, so that helps my recovery." (Fiona; 625-631)

Betty spoke about a client, who as a result of a relapse ended up in a wheelchair and ended a successful career. Betty understandably seemed very upset about her client. Betty demonstrated her fear of relapse in her recall of this client and how easy it is to lose everything from one drink. This client may have acted as a deterrent for alcohol consumption. Betty seemed very involved with her client; however, Betty claimed to have 13 years abstinence from alcohol consumption. This defies Kinney (1983) claim that involvement with the client is related to a vulnerability to relapse.

> "I was so concerned… …she had a drink when she came home and jumped out of the bedroom window and she has got a broken neck, she will never walk again… …she is in a wheelchair and it is absolutely heart breaking what this disease can do and that was just from one drink" (Betty; 265-268)

3.3.3.2. Always thinking about relapse

The participants spoke directly about their fear of relapse using examples and personal experience. The fear of relapse appeared underlying to the participants' everyday function. There does not seem to be any literature focused directly on the fear of relapse for RACs, however, Vaillant et al., (1996) carried out a follow-up study of 100 alcoholics 8 years after treatment and reported that 25% had maintained 3 years and above abstinent recovery, but 29% had died from alcohol related problems. Based on these figures the fear of relapse seems justified. Kinney (1983) identified that relapse rates amongst RACs was a problem and agencies need to be cautious when employing them with emphasis on their motivation to work with this client group. Doukas & Cullen (2011) reported that relapse amongst RACs was under-estimated and identified a lack of studies exploring RAC relapse.

Andy reflected on his belief that alcoholism goes into remission once abstinence is attained. This reflection related to his views of controlled drinking of alcohol. He said that he did not believe this was possible, as the fear of relapse is always there. Andy also said that he believed that if he was to return to alcohol consumption the effects would be worse each time. This hypothesis is supported by neurological research that proposes a process of sensitisation in relation to alcohol tolerance, resulting in the brain believing it needed alcohol (Darbra et al., 2002). Andy was speaking from personal experience, as he later revealed that he had once relapsed following a period of abstinence (Andy; 946).

> "I have a belief it goes into remission, because if you start again then you go back to it just as bad as it were before. I don't believe if you have gone down that route you can start suddenly being a controlled drinker as such or a social drinker because you have always got to think about it. (I: ok) You can't just say to yourself, I will go out and have a drink tonight I am going to come home again, like normal people do" (Andy; 43-49).

Harriet spoke about a fear of relapse, in relation to alcohol and the behaviours, as well as thinking, associated with the alcoholic identity (Solberg, 1983). Harriet also reflected on a fear of burn-out, which is a state of exhaustion and impassiveness (McCann & Pearlman, 1990). Harriet explained that she takes care of herself ensuring a balance between her family, herself and work to reduce the chances of a relapse. Doukas & Cullen (2011) propose that burn-out is a possible consequence for RACs and it is important for the employers to adequately support RACs in their work, in order to reduce the risk of relapse and burn-out.

> "The other thing is you have to be careful with addictions as well is if I don't look after myself I know where that can take me, it can take me back to being, I don't know, dry drunk, someone who has stopped drinking but not looking after themselves, not changing, so yes, addicts have to be careful of burn out, you know." (Harriet; 83-86)

3.3.3.3. Wanting to give back

The participants spoke about 'wanting to give back'. The meaning of this statement ranged from, wanting to give back being a condition in order to maintain their own recovery, through to, wanting to help the client because it gave them a chance to put

right all the past wrongs. The former related to fearing relapse, whereas the later seemed related to identity. The former explanation may also relate to a dependency on the client, indicating that focus of therapy was about the therapist and not the client, which was Freud's caution (Groesbeck & Taylor, 1977; Guy, 1987), as already discussed.

However, wanting to give back is also the 7th life stage as a mid-adult (25-64 years), which was identified by Erikson (1950). This stage reflects a stage of 'generativity v stagnation' (Erikson, 1950). Of the participants 9 out of the 10 were within this age range. It might be that the participants' reflection of wanting to give back signifies this life-stage.

Fiona stated that her belief derived from AA affiliation and working with alcoholics was necessary to retain recovery. This implied Harriet was dependent on the client to maintain her own recovery. Kinney (1983) proposed that some alcoholics pursue the career of counsellor in order to avoid relapse to alcohol consumption. At the same time, the alcoholic client is thought to be a trigger for RAC relapse (Doukas & Cullen, 2011; Kinney, 1983; Nerenburg, 2009).

> "I don't want it back, so that helps my recovery and it's like in AA it's you know, we firmly believe you have got to give it away to keep it, ok (I: ok), so in a way I am giving away to keep it, that's the philosophy and that's the philosophy in the group as well, you know." (Fiona; 631-634)

Gordon explained his wanting to give back through his work. Gordon's description of past behaviour sounded like narcissism, as he implied a lack of awareness of others and striving for control and achievement (Bowen, 1978; Wilsnack, 1976; Zimberg, 1985). His account appeared to relate to repairing his previous spoiled identity (McIntosh & McKeganey, 2001). Gordon's explanation could equally represent feelings of compassion (Gilbert, 2009). Gordon also reflected a passion for his work. This expressed passion might be explained by Maslow's (1943) 'hierarchy of needs'. Gordon's expressed a sense of achievement, which is a need within esteem and comes before ultimately attaining self-actualisation (Maslow, 1943). Gordon's expressed pleasure could represent these needs being met through the client work.

> "It gives me a sense of purpose, I often wondered, when I was about thirty odd, because I done that, I was very good at using people and acquiring things, because that is what the world tells me that is what successful people do and I was good at it, but something wasn't working somewhere because I needed more people to use and more things to acquire (I: yea) and it still didn't fix that, the stuff that was inside of me, so I see my job now, I am helping people and I am not acquiring things, you know and t here is a l ot more meaning to that....that fills me up, like I have never been filled up before..." (Gordon;650-660)

3.3.3.4. Developing through the work with the client

The participants reflected on the clients as a source for learning. Some reflected the clients as 'gifts' as they provided a lot of material towards their personal development. This was also spoken in relation to loving the client work, suggesting

that the therapist was getting a need met in their therapeutic encounter with the client.

Carol spoke about a long term client who she felt had made a lot of progress and how she felt that working with this client had helped her with her own recovery, in learning and personal development. Casement (1991) proposed that the therapist can learn from the client in the therapeutic relationship. Carol described a potential symbiotic relationship with the client, where there is mutual benefit for therapist and client. Jung proposed that the therapist tunes into their own past suffering alongside the client's suffering, which results in a joint process of positive change (Dunne, 2000; Sedgwick, 1999). Carol also reflected the client as a deterrent for relapse and her fearing relapse, which was evidenced in repeating her wish not to go back to alcoholism three times.

> "Sometimes you work with a client and you learn stuff from them about yourself and it builds you up (I: so do you think that has helped you in your recovery as well doing this kind of work?) Yes because it has shown me where I can end up, where I can go back to (I: so a reminder) I don't want to go back to there (I: no, no) you know and I am helping someone else to go up, it is also helping me to go up" (Carol; 544-557).

3.3.3.5. Loving the client work

All of the participants expressed loving the client work and some were emotional recalling what it meant to them. This suggested that the work was more than just a job. As reflected in the introduction, Blum & Roman, 1985) reported that RACs

reported more job satisfaction. These were correlated to a "sense of calling" or "mission" and a "higher concern about the job even when away from it" (Blum & Roman, 1985,p.367). These factors appeared to be reflected in the participants' accounts. However, these were also factors identified by Kinney (1983) that related to relapse for the RAC.

Ian spoke about his personal 'mission' to battle against alcoholism and that his job was a means of achieving this aim. He related his work to giving back to society, in the form of redemption, giving back what he had taken out when an active alcoholic. This also reflected the previous sub-category of 'wanting to give back'. Later in Ian's transcript he spoke about his love for his work and throughout he reflected on a personal battle against the demon of alcoholism, which he felt was a battle he would continually fight for the good. Wanting to redeem the past through the client was identified by Kinney (1983), as a precursor towards relapse. However, Ian reported 17 years of abstinence, which defies Kinney's (1983) claim.

> "In my day job I have felt a sense of mission about the alcohol clients, so I have kind of wanted to work in that area, so yea just a sense of mission or that it is important to me to be helpful in that area. Possibly there is a sense of redemption of having been a problem to people when I was a drinker, so I think it is partly about wanting to kind of make amends to the world and society for having been a bit of a waste of space in the past by kind of supporting other people and helping families who have got alcoholics." (Ian; 79-86)

Ian reflected on his love for the work, when reflecting on a question asked by a client about what helped him not to drink alcohol. Ian reflected that it was his job that

really helped his recovery and expressed his thoughts and feelings in relation to the client work.

> "Really it is doing the job I do and I am very aware of that and it is enlightened self interest for me and I get paid for doing it and also it is not an advertisement for drinking and also it is fascinating, it is endlessly fascinating, I love it, it is so interesting and very very stimulating and for me." (Ian; 686-691)

Fiona reflected that she felt her work was "amazing", offering her a sense of achievement as well as feeling she was doing the right thing for her. This implied that personal dependency needs were being met through the client work (Zimberg, 1985). Fiona's reflection supported Blum & Roman (1985) suggested that RACs reported more job satisfaction, than someone without the alcoholism history. Her claim of 'doing the right thing' also implied compliance to a rule and not doing the wrong thing, which implied a belief in a negative consequence.

> "I think it is amazing that I have ended up doing what I am doing, because it's a sense of achievement you know and I feel that I am doing the right thing, which is really important." (Fiona;685-687)

Jan reflected on how she felt about her client work. Her account also implied that she did not see people get well in previous places where she has worked.

> "I really love the work, I love the work and particularly now where I work because I really see people get well." (Jan 95-96)

3.3.3.6. Adopting the addict identity to access recovery

This sub-category appeared to fall into the realms of two categories, ‘therapist building a self-identity’ and ‘therapist fearing relapse’. The participants reflected a belief that they needed to adopt the addict identity in order to access recovery, which was a belief reflected to derive from AA affiliation. The acceptance of the alcoholic identity seemed to be reflected in step-1 of the 12-step programme (see appendix 2). The action of sharing the alcoholic identity with the client was reflected to help the client attain recovery. However, fearing relapse appeared underlying to adopting and using the addict identity, which seemed apparent for the participants and this belief was extended to the client.

In the following narrative, Ian had been speaking about AA and how AA uses the alcoholic identity as a motivation for recovery. Believing in an alternative future as part of the recovery is considered helpful for attaining recovery (McIntosh & McKeganey, 2001). The process included the new comer to AA being presented with a choice of two directions, one which entail a process of rejection and potential death or acceptance and potential recovery. However, there is a condition to attaining recovery and this is to adopt the alcoholic identity. It was established earlier in the sub-category ‘finding purpose and direction’ that individuals coming for help with alcoholism are terrified. The process being described by Ian appears to be based on fearing relapse and since alcohol kills this fear is very real. However, this environment negates that there are several methods of recovery from alcoholism (Biernacki, 1986; Dawson et al., 2005; Miller & Munoz, 2005; Larimer & Kilmer,

2000; Sobell et al., 1996). Adopting the addict identity has been indicated to hinder the recovery process for some (Biernacki, 1986).

> "Two years and ten years and so on and you can kind of look ahead at people still drinking and see what might be in store for you or you can look in recovery and see what is in store for you and you can think "do I want to be like them" (I: oh ok) and that is why one would actively help people to identify with the people and identify with, find themselves as alcoholics, that is why it is so important to go to meetings and say "I am an alcoholic" (I: oh right ok) otherwise you are not buying into this identifiable" (Ian; 457-462)

In summary of the category 'therapist fearing relapse' reflected a process where the 'client is a deterrent for relapse', but at the same time acts to amplify the fear of relapse. This perhaps increases the need to work with the alcoholic client. The process also seemed related to a consequence of the therapist always thinking about relapse, which seemed to be underlying to daily function. 'Wanting to give back', which appeared to range from wanting to repair a spoiled identity, to a belief that they must help alcoholics in order to retain their own recovery. This was a condition reflected to derive from AA affiliation. Learning from the client related to ongoing personal development and learning about the recovery process through the interaction with the client.

All of the participants expressed 'loving the client work' and some spoke with emotion. 'Loving the client work' reflected their feelings about the client work, implying their role as a therapist was more than just a job. This feeling was related by the participants to feeling a sense of achievement, a sense of mission, a means

for redemption, condition to maintain their own recovery, gratitude for their lives and an altruistic deed. This need may also represent Erikson's (1950) 7th life stage within mid-adult (25-64). Adopting the addict identity to access recovery appeared to relate to fearing relapse. The participants indicated that adopting the addict identity to access recovery was necessary and related to AA philosophy. This was mentioned by some participants in relation to repairing a spoiled identity and achieving redemption, which may have been about circumnavigating shame associated with the addict identity.

CHAPTER FOUR

4. Discussion

The grounded theory that emerged from the data is shown in Figures 1 and 2 (see pages 60 and 61). The theory grounded in the data has been presented in the results chapter with a detailed list of the core category, categories and sub-categories in Table 3 (see page 59). A core category was identified, which was the 'therapist managing their own recovery'. This encompassed three categories 'therapist building a self-identity', 'therapist identifying with the client' and 'therapist fearing relapse' and 20 sub-categories. The categories were seen as inter-related and dependant on each other.

The aim of this study was to develop and provide a theory about how RACs view and experience their clients in the shared experience, including what they see as important and significant within their clinical work. This emergent theory was to appreciate the subtle nuances of the underlying social processes of what is occurring for the RAC in the relationship with the client utilising theoretical sensitivity (Glaser, 1978). The data was enabled through the researcher's interpretation, which was part of the process and the data was to incorporate existing literature to support and enhance the emergent theory.

It was believed that this theory will offer in-depth insight and information that will be helpful towards resolve and the prevention of potential problems that may occur within a shared experience between counsellor and client. This will potentially offer new information to enhance safe practice and aid progression for the client within the therapeutic relationship. It is expected that this theory will be useful for the continual development and improvement of counselling practice, psychological understanding and it will generate information for future research direction.

The research question was as follows:

> 'What are the views and experiences of Recovering Alcoholic Counsellors (RAC) when working with alcoholic clients?'

This paper will now present the more pertinent findings of this study that are unique to the participants and relevant to Counselling Psychology Practice.

4.1. Summary of Findings

This study identified a number of possible issues through the shared experience with the client. It seemed that working with alcoholic clients acted to increase a fear of relapse for the RAC. This appeared to perpetuate a possible dependency on the client work, in a belief that working with the alcoholic client helped to manage their own recovery from alcoholism. At the same time, the shared relationship appeared to reinforce the ongoing alcoholic identity, activating shame and reinforcing the fear

of relapse. AA philosophies and beliefs appeared to influence these processes, as well as causing bias to therapy interventions used with the client.

Evidence of possible over-identification hostile countertransference reactions and protective empathic enmeshment were reflected by the participants in this study. The countertransference processes perhaps resulted in trauma and abuse to some alcoholic clients. The over-identification processes also appeared to suggest that therapy remained focused on the surface management of alcohol consumption, for both therapist and client in the shared experience. The participants reflected several adaptive techniques to externalise and manage negative emotions. There was also evidence of positive reflexive practice and compassionate practice by some RACs, as well as a possible symbiosis healing experience through empathic enmeshment, which would need verification from the clients to validate.

Perhaps the most concerning finding from this study was the potential bullying and abusive practice by some RACs in the action of affording tough-love to clients. This coercive practice was related to a belief of knowing the client's thoughts, feelings and behaviour and was claimed to prevent relapse. However, coercive practice with addicted individuals is a recognised and accepted practice by many institutions (Gray, 2009; Rodriguez de la Sierra, 2009). Some might argue that affording tough-love to clients is an essential action that potentially saves lives, since alcohol kills (Gray, 2009). In the current study, using coercive practice was justified by some, because it worked in AA.

Some participants' reflections of affording tough-love to clients appeared to be about the clinician's needs for managing their own difficult emotions and not about the client's needs. Participants spoke about affording tough-love to clients as a result of feeling frustrated with clients who remained victim to alcoholism and who were ambivalent or unwilling to engage in the therapeutic process. These accounts perhaps related to the participants' own victimisation experiences of coercive therapeutic practice when trying to attain abstinence from alcohol (Gabbard & Wilkinson, 1994; Leiper & Kent, 2001). These explanations were suggestive of hostile over-identification countertransference reactions, as outlined in the introduction (Guggenbuhl-Graig, 1979; Hahn, 2004; Leiper & Kent, 2001; Moring, 1997; Watkins, 1985). This also suggested that the client work was about the therapist, which was the caution of Freud in 1910 and discussed earlier (Groesbeck & Taylor, 1977; Guy, 1987).

Affording tough-love to clients may also imply an over-inflated ego-state, which perhaps related to a personal co-dependency on the client through fear of relapse and at the same time fearing contamination from the client (Kinney, 1983; Moring, 1997). Rogers (1959) said that whilst the authoritarian stance by the therapist is effective, it also leads to a dependent person. The potential action of projecting the RACs' own issues onto the client, as a result of shameful identification in the shared experience, seems reminiscent of the hypothesis that a 'co-dependent' is a social construct to externalise responsibility of shameful behaviour (Asher, 1992; Krestan & Bepko, 1990; Weegman, 2006). Some authors might add that hostile over-identification countertransference could result with any therapist who has

experienced a past trauma of victimisation (Allpport, 1954; Hahn, 2004; White, 2000b).

Whilst many alcoholic treatment professionals may claim that coercive practice is necessary (Rodriguez de las Sierra, 2009), coercive practice has been cautioned to increase shame, hinder empathic connection and abuse the client (Gray, 2009; Hahn, 2004; Tangney & Dearing, 2004). This claim seems to suggest that the coercive behaviour increases in a perpetual cycle of negative emotions and responsive behaviour. As discussed in the introduction, shame is implicated in the cause of alcohol dependency for some and embedded in the stigmatisation of the alcoholic identity (Gray, 2009; Potter-Efron, 1989; Tangney & Dearing, 2004).

Some participants reported recognising shame in relation to coercive practice, proposing this practice as unhelpful in motivating the client to change. Whilst some might proposed that guilt is a better emotion to motivate someone out of alcohol use, since shame internally escalates to self-destruction (Parker & Thomas, 2009; Tangney & Dearing, 2004), Potter-Efron (1989) reported that guilt and shame are difficult emotions to separate and professionals struggle with recognising the difference, causing inadvertent abuse to the client in the process.

The participants in the current study seemed to identify resourceful and alternative ways of separating from the shameful alcoholic identity. These included a process of utilising metaphors and analogies, for example, angel (the good self) and devil (shameful addict identity) and imaginary battles focused on reducing the size and power of the addict identity. They reflected that these interventions were helpful, for

their own understanding and for working with clients. The belief in a higher power and a predefined life path may have externalised blame for past perceived negative actions. The participants' observations of 'other' professionals carrying out 'bad practice' with clients, may have also been evidence of them circumnavigated any perceived negative practice of their own and reinforcing their practice as 'good' (Huggett, 2001).

Jung might propose that these behaviours related to the therapist rejecting or projecting onto the client the negative shadow part of themselves (Dunne, 2000). Jung might also say that not enough unconscious had been brought into conscious awareness for the therapist and further development was necessary (Dunne, 2000; Sedgwick, 1999). These interventions may imply that therapy focus was directed at the therapist building a positive self-identity through the client (Festinger, 1954; Mead, 1934).

Managing shame also appeared in the participants' accounts of 'wanting to give back', which for some resembled repairing a spoiled identity (Goffman, 1963; McIntosh & Keganey, 2001). Erikson (1950) might argue that wanting to give back was evidence of the 7th life stage, as a mid-adult. These findings also seemed indicative of the motivations to be a wounded healer, as discussed in the introduction (Ford, 1963; Goldberg, 1993; Guy, 1987; Leiper & Kent, 2001; Moring, 1997). Goffman (1963) suggested that individuals seek acceptance and respect and will repair a stigmatised identity to achieve this aim. As previously discussed, AA was reported to be an environment where the alcoholic identity is positively reflected (Cain, 1991). The participants spoke about feeling unaccepted in the wider

community and felt acceptance and a sense of belonging within AA. These positive attributes were also achieved through the client work, which appeared to offer positive reinforcement.

Further evidence of externalising negative emotions was in the participants' reflected motivations for sharing the alcoholic identity with the client. This appeared to be about rescuing the client from negative feelings in over-identification protective or avoidance empathic enmeshment (Rogers, 1980; Rowan & Jacobs, 2003; Watkins, 1985; Wilson & Lindy, 1994). These narratives also appeared in relation to the belief of knowing the client's thoughts, feeling and behaviour and they were linked to the participants' own experiences. It might be that the focus of therapy remained on the drinking behaviour, since deeper negative feelings appeared to be avoided (Mearns & Cooper, 2006).

The action of sharing may have also been about the participants' positive reinforcement. Chang & Berk (2009) reported that the client knowing the therapist has a shared identity to them increases client's perception of satisfaction with the therapy. The participants claimed that a function for sharing their alcoholic identity was to demonstrate their competence in the client's problem, in order to cultivate the client's trust in therapy (Gallant & Mallott, 1985).

It is also interesting that alcohol has remained a constant dependency for the participants', albeit in a different context, previously, consumption for survival and now, financial income for survival. This perhaps implies an ongoing dependency to alcohol. Some alcoholics are forced to go to AA meetings as part of their treatment,

which may imply compliance and dependency (Cain, 1991; Moos & Moos, 2005). Vaillant (2005) stated that AA provided an alternative safe dependency to alcohol that reduced the chances of relapse. It might be that the dependency aspect of the alcoholic identity is transferred for both therapist and client through the use of coercive practice.

In contrast, adopting an attitude of curiosity with the client is related to empowering the client towards self-discovery, self-awareness and independence (Bion, 1974; Casement, 1991; Stainberg, 1993). The lack of reported issues when participants' were asked about countertransference reactions may have suggested avoidance to exploring deeper painful issues with clients. However, this might also relate to excellent management of countertransference reactions or it could relate to a researcher bias, with participants filtering information in fear of losing professional status (Langford & Clance (1993; Wosket, 1999). This potential avoidance may also indicate a lack of openness. Lorr et al., (1992) suggested that dependency is associated with a lack of openness**.** Negative countertransference reactions have also been linked to a lack of openness (Casement, 1991; Rogers, 1959; Shainberg, 1993).

Openness of the therapist is associated with congruence, which is one of Rogers' (1961; 1995) core conditions for successful therapy. Reigle & Dowd (2004) also found that AA members scored low on openness and all the participants in the current study reported being influenced by AA philosophies. AA influence was reflected by the participants as influential in their choice of interventions, which indicates bias, for example, sharing the alcoholic identity with the client to reduce

negative feelings or reprimanding the client for possible behaviour leading to relapse. Lack of RAC openness, together with therapy intervention bias, was identified in a study comparing RACs and NACs by Skuja's (1981).

It seems that some AA philosophies hinder the RAC in their therapeutic judgement as a professional. Some RACs may represent professional AA sponsors, as a result of self-disclosing their alcoholic identity to the client. As mentioned in the introduction, Kalb et al., (1976) proposed that the paraprofessionals were motivated by mutual gain, whereas the professional counsellor helps the client gain their own self awareness. The participants indicated mutual gain in the shared experience with the client. Several participants said that their AA involvement after time became unhelpful and this may relate to them becoming independent. This independence may also imply transference of dependency from AA to the client work.

The maintained alcoholic identity and possible dependency on the client work seemed to relate to the conditional beliefs derived from AA philosophy. These included, adopting the alcoholic identity to access recovery, the client acting as a deterrent for relapse and helping alcoholics as necessary in order to maintain recovery. As stated in the introduction, there are several ways to gain recovery from alcoholism (Cunningham et al., 2000; Dawson et al., 2005). Galanter (2007) identified that a limit of AA affiliation was its claim to being the only means of recovery. This together with the conditional beliefs seemed to reinforce an underlying process of fearing relapse.

As previously discussed, relapse for RACs is reported to be an underestimated problem, which was due to a lack of policy, by treatment agencies, for employing RACs and managing relapse when it occurred (Dougas & Cullen, 2011; Kinney, 1983). The therapist relapsing is detrimental to the client's progress in therapy (Dougas & Cullen, 2011; Kinney, 1983; Nerenberg, 2009). Kinney's (1983) suggested measures to reduce relapse when employing RACs. These included, self-worth related to wanting to help the client, redemption as a motivation and having the ability to distinguish their own feelings from the client's feelings (self-awareness). All of these factors were evident in the current study, with some indicating poor therapy practice, as well as causing potential abuse to clients. However, all of the participants in the current study claimed long-term stable recovery from alcoholism. This effectively challenges these measures as being indication for relapse.

Interestingly, similar elements were found for job satisfaction for unqualified RACs by Blum & Roman (1985) who compared unqualified RACs and NACs on job performance and attitude. They proposed "sense of calling" or "mission" and a "higher concern about the job even when away from it", as factors correlated to their job satisfaction (Blum & Roman, 1986, p.367). High levels of job satisfaction were reported by all the participants in the current study. The participants reported loving and feeling passionate about their client work and feeling compassion towards their clients. It was reflected by some to be their life and they intended to do it until they were physically unable.

The participants in the current study described the client work as a means to utilise their past negative experience to positive aims, a means for redemption and they claimed the work ultimately maintained their own recovery from alcoholism. They also reflected that their client work enabled them to meet the conditional beliefs that protected them from relapse, as prescribed through AA affiliation. However, these claims also seemed reminiscent to some of the description of co-dependency given in the introduction. Co-dependency describes someone who lacks personal expression, externalises focus outside of themselves and derives a sense of purpose through others (Fischer et al., 1992; Harkness & Cotrell, 1997).

It may be that some participants of the current study were describing dependency needs being met through the client work. This may suggest that the measures offered by Kinney (1983) may be predictive of co-dependency on the client and poor practice, rather than relapse. Other authors might propose that the alcoholism recovery, vulnerability to relapse and effective therapy practice could more accurately be measured on the level of independence or openness (Casement, 1991; Lorr et al., 1992; Rogers, 1959; Shainberg, 1993).

However, it could also be argued that some participants in the current study were reflecting compassionate practice with the clients and their narratives were not reflective of over-identification countertransference reactions or empathic enmeshment, co-dependency on the client or fearing relapse. The participants described feelings of deep empathy with the clients. They explained that this was a feeling from their heart and not just intellect. Some participants implied a deep

awareness of the client's suffering and when identifying with the client wanting to reduce their negative feelings. Gilbert (2009) defined compassion as follows:

> "Its essence is a basic kindness, with a dee p awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it." (Gilbert, 2009,p.xiii)

Some participants spoke about feeling compassion, relating it to feeling connected with the others, the client and themselves. Gilbert (2009) proposed that possible traumatic events or too fast-a-pace of life with fear of failure can cause 'shameful feelings' that inhibits connection with the natural self-soothing emotion regulator. As already discussed, this process was also reflected by several authors in relation to shame inhibiting empathy (Tangney & Dearing, 2004; Potter-Efron, 1989). Safran & Muran (2003) suggested an authentic interpersonal contact needs to exist before the client will engage in therapy. The participants spoke about feeling quick and deep connection with the clients.

Gilbert (2009) proposed two innate systems that regulate emotions; one that is related to the drive for pleasure, enhancing quality of life and contentment and the second is a soothing system that enables calmness, contentment and well-being. These are associated with being valued by others, feeling connected and feeling socially safe. The participants reported feeling these elements within AA membership and wanting this for their clients. Gilbert (2009) proposed that an individual can be connected to their self-soothing regulator through the introduction of compassion.

Feeling deep empathy with the client may also be suggestive of a positive therapeutic symbiosis, which was identified by Searles in 1958. Searles (1979) proposed that whilst the therapist brings benefit to the client, the client also brings benefit for the therapist and this process was also related to a motivation for the therapist to work with the client (Young, 2010). Others authors promote that additional healing can occur in the shared experience with the client (Guggenbuhl-Graig, 1979; Hopenwasser, 2008; Jung, 1951; Rowan & Jacobs, 2003; Rogers, 1980). This may suggest a symbiosis benefit in operation in the current study, since the participants reflected receiving benefit from the client and they had observed client success. However, this possible outcome cannot be claimed without confirmation from the client that they experienced benefit from the therapy.

The participants also reflected their feelings in relation to spiritual connection. Miller (1985) linked spirituality as an asset to be cultivated to inspire hope within the recovery process. Spirituality was a concept mentioned in the introduction in relation to recovery and AA affiliation (Galanter, 2007). Galanter (2007) proposed that spirituality offers meaning and purpose. The participants reflected finding purpose and direction in their client work in relation to building a self-identity. The RACs' self-identity appeared challenged by potential shame activated when identifying with the client in the shared experience of alcoholism. The client also acting as a deterrent and means for the RAC to give back, increased an underlying process of fearing relapse. This process amplified a potential co-dependency on the client for managing their own recovery, which appeared to be the central motivation in the client work in the shared experience.

4.2. Critical Evaluation of Method

The methodology employed for this study was Grounded theory. Within the stages of analysis there was a tendency to impose psychological terminology onto the code labels as a result of my previous knowledge in the field of psychology (see appendix 18). This previous knowledge was also necessary to carry out the research. This was considered to be a minor problem in the analysis, which was easily managed by writing continuous memos and by referring back to the original transcripts and codes.

An issue with the analysis was the sample, which was heterogeneous. On reflection this has limited the findings, which would have benefited from a more purposive sample. For example, in relation to the sub-category of 'knowing the client's thoughts, feelings and behaviour', if there had been additional interviews carried out with NACs this would have given additional insight into whether this belief derived from the shared experience or was it one held by other therapists. These additional interviews could have also identified whether having the shared experience with the client impeded or enhanced therapeutic process.

On reflection some of the questions in the interview guide (see appendix 7a and 7b) could have been structured better to reflect the research questions more succinctly paying more attention to avoiding leading questions. Question 4 regarding theoretical appreciation of addiction seemed superfluous to the research question. Questions 5 and 6 in retrospect were leading, suggesting an expected outcome. For the majority of the interviews the questions were not adhered to exactly, but the

guide was used as a prompt to direct the researcher, as recommended by Charmaz (2006). The interview guide was considered a useful aid in keeping the interviews focused on the views and experiences of the participants when working with alcoholic clients (Charmaz, 2006).

More care and focus with the structure of the interview guide questions would be afforded if the study was repeated and fewer questions would ensure neutrality and focus towards the research question. The initial questions appeared to open the flow of conversation and provided some useful information about the participants' motivations to become RACs. The final question also yielded some interesting comments about the love for the client work.

Possible reactivity, respondent bias and research biases were reflected in the results. These reactions will have affected the participants' sharing of views and experiences (Padget, 1998). These accounts are also co-constructed in the narrative between researcher and participant, affected by the history and differences between these individuals (Charon, 2004). The findings are further limited by subjectivity of the researcher (Morrow, 2005). This subjectivity is also dependant on how the interview is managed by the researcher (Morrow, 2005). These limitations were control for as much as possible.

McLeod (1979) suggested that the quality of the data shared is related to the relational connection between the researcher and participant. Breakwell et al., (2006) proposed that participants are more likely to share their experiences if they perceive the interviewer to be similar. My presence in the arena of alcoholism and

knowing some of the participants suggests similarity, which may have contributed to the interviews being allowed to take place. This may have also contributed to a reduction in the respondent bias, putting the participants at ease and sharing more information than they would have with another interviewer (Padget, 1998).

At the same time, a familiarity may have led the participant to withhold information. This may relate to the participant not wanting to be viewed negatively. My role of researcher may also cause the participants to feel vulnerable, through a fear of being devalued (Kernberg, 1975; Kohut, 1977). Rennie (2001) claimed that interviews as a means to gather data are limited to what information the participant choices to share. Deutscher (1973) reported that people often do something different to what they say, which suggests that information gained through the interview process is limited.

To increase information sharing and reduce biases during the interviews several precautions were taken. These included, an awareness of biases, a curious attitude (Padget, 1998) receptiveness of researcher (Knapik, 2006), clear questioning (Hilton, 1995) and adopting a systemic approach (Cecchin, 1987). It might have been possible to reduce the effects of familiarity by employing another researcher to carry out some of the interviews. However, employing another researcher to interview would defer from continuity of the interpretations, adding another complexity to the data analysis.

Reflecting on my role as the researcher I found it difficult to remain balanced when reporting the findings. There appeared to be a researcher bias, towards protecting

the participants (Padget, 1998). This may have mirrored the protective defence presented by the participants, which is a process reported by Searles (1955) and found in the supervisory role of counsellors (Eckstein & Wallerstein, 1972; Doehrman, 1976; Sachs & Shapiro, 1976). This might be related to familiarity with some of the participants. Reflexivity in memos throughout this study enabled some of these processes to be identified, which adds additional insight and information to the data and findings for the study.

GT has been criticised for neglecting to address risk in studies, which was attributed to a lack of researcher reflexivity (Olesen, 2010). This research study has addressed this criticism. One issue of risk identified related to the consent forms (see appendix 5). There was a comment on the consent form that suggested "there were no known risks to partaking in this study for the participants" in retrospect this was incorrect. It is recommended that if this research were to be repeated, this reference to risk needs to be reworded to reflect the possibility of discomfort. Risk was also directly addressed in the debrief form, which the participant took away from the interview. This offered contact details, as well as external support numbers, should problems arise following the interview (see appendix 6).

As already stated, reflexivity was used throughout this study. At the end of the study a final reflexive account is given. This reflexivity explores my thoughts and feelings as a researcher, in relation to carrying out the study and towards my learning (see appendix 19). This offers further information and insight to the data.

Care and consideration was given to ethical issues during the process of this study. The action taken included, an introduction sheet given to the participants to inform them about the study, consent forms incorporating confidentiality and debrief forms, offering support numbers. All of this information was verbalised to the client for clarity. The only concerns that occurred during the interviews were the participants' reference to people and places. In order to protect the identity of the participants, all identifiable names and places have been replaced by '(name)'. In concluding, this study enabled in-depth appreciation of the participant's experiences and views working in the shared experience of alcoholism with the client. It is proposed that the epistemological positioning and methodology choice enabled subtly of identity and meanings that would not have otherwise been possible. It is considered that grounded theory methodology from a symbolic-interactionism epidemiology was the correct methodology to use for this study.

4.3. Relevance to Counselling Psychology

The participants' views and experiences suggested that the therapy work was about maintaining their own recovery. Many of the participants reflected positive practice with openness and reflexivity on their work. However, there appeared to be several issues inherent and related to the shared alcoholism experience. AA affiliation and alcoholic identity identified some conditional beliefs that appeared to relate to fearing relapse and potentially maintained the alcoholic identity, affecting a self-perpetuating dependency cycle between client and RAC.

The action of sharing the alcoholic identity appeared to facilitate this cycle and implicated potential protective over-identification countertransference reactions (Gabbard & Wilkinson, 1994; Watkins, 1985; Wilson & Lindy, 1994) and protective defences (Zimberg, 1985) that rescued both client and RAC from negative feelings and dealing with deeper issues. The practice of knowing the client's thoughts, feelings and behaviours and affording tough-love to clients was concerning practice and appeared linked to possible hostile over-identification countertransference reactions, potentially abusing clients (Hahn, 2004; Watkins, 1985). In order to reduce these problems some recommendations will now be suggested to ensure the welfare of the client and RACs and improve therapy practice.

It is recommended that a series of five training sessions take place for RACs. The first session of the five will cover the psycho-education of addiction, including an overview of current neurological research. This may remind RACs of the complexity of the presentation, indicating individual differences. This training will also incorporate the importance and benefits of adopting a curious and 'not knowing' therapeutic approach with clients. It would also be beneficial to provide an example of 'affording tough-love to clients' to show how it might replicate past abuse for the client.

A second training session will focus on the different ways that alcoholics can find recovery from alcoholism. This session needs to include a critical appraisal of each approach including AA, considering the benefits and limitations of membership and identify the differences to therapeutic practice. This session will also incorporate current research and a link to openness. It is expected that this will reinforce RACs'

knowledge and understanding, reducing bias to interventions based on personal experience.

In a third training session will focus on the management and maintenance of alcoholism. This might take the form of a workshop offering the RACs opportunity to learn from each other, about how they manage their own alcoholism recovery, as well as the client work. This session will incorporate the wounded healer concept and consider the relationship between AA and role as RAC. This session will also recognise and normalise that potentially all therapists are wounded healers, albeit from life (Nerenberg, 2009). It is expected that this will reduce any protective defences and reduce any perceptions of difference with NACs.

A fourth training session, and perhaps the most important of the series, will focus on possible relational dynamics that might occur in the shared experience. These will include positive and negative transference, countertransference and potential projections. It will be important to include the impact of over-identification countertransference reactions and how protective defences can occur and impact on the therapeutic relationship. It may be that some therapists are familiar with these aspects of counselling practice, so it would be important to establish knowledge and offer it as a refresher tutorial if necessary. This would help to remind the therapist of their impact on the therapeutic relationship and increase reflexivity of therapy practice.

In a fifth training session focus will be on compassionate practice (Gilbert, 2009). This would also incorporate information on empathy and reflexivity. Within this

session the intervention ‘affording tough-love to clients’ might be used as an example that could block the emotional regulator, to demonstrate how unhelpful this way of thinking can be in the therapeutic relationship. The session would introduce the theory behind the practice and potential benefits it could offer to the therapeutic relationship in the shared experience. This session might also incorporate some exercises to practice mindfulness and relaxation techniques.

It is proposed that the training session be followed up with a series of personal therapy sessions. These personal therapy sessions would ideally be carried out a few days after each training session to help the participant to process any new information. Bartlett (1932) introduced the idea that information is constantly being readjusted within a person’s schema. These therapy sessions will offer the opportunity for RACs to explore their resultant thoughts, feelings and behaviours in relation to the self, others and the world (Beck, 1995).

It is expected that these training courses and personal therapy sessions will help increase insight and understanding and reduce biases and protective defences, as well as any reliance on the alcoholic identity. It is hoped that these sessions will offer new and clear interpretation of ‘affording tough-love to clients’, to mean reflexivity and compassionate practice. If there is limited funding then it is proposed that at minimum training session 4 be prioritised and employed. It is also proposed that basic measures, quantitative (including level of openness and motivation to work with client group), as well as qualitative feedback from the trainees, are taken before the commencement of training and again on its conclusion. This will evaluate the

effectiveness of the training and identify areas where the training programme could be improved.

In addition to the proposed additional training, it is recommended that regular supervision is offered. It is suggested that individual supervision is offered at a minimum of 1 supervision session to 6 individual therapy sessions with clients, or 1 supervision session to 8 group therapy sessions. It is also recommended that additional supervision sessions are offered if the RAC requests it, to deal with difficult relational experiences.

It may also be useful for RACs to form reflective peer supervision groups, as an adjunct to their individual supervision sessions. This will provide additional support and give them the opportunity to learn from each other, keeping new learnt skills in mind and active. It is advisable that the supervisor has attended additional training in supervisory skills, to ensure they offer the RAC constructive support and reflexivity, as well as being familiar and practiced at utilising information from parallel processes (Searles, 1955).

These recommendations for supervision are suggested to reduce possible negative relational processes that may occur for RACs working with this client group. It is hoped that taking these measures will increase RACs' self-awareness and reduce the risk to relapse (Doukas & Cullen, 2011; Kinney, 1983; Nerenberg, 2009; White, 2000b), vicarious trauma, secondary trauma (McCann & Pearlman, 1990; McElroy & McElroy, 1991; Sexton, 1999) as well as burn out (McCann & Pearlman, 1990).

In addition to the training, personal therapy sessions and extra supervision sessions, there are some immediate recommendations for RACs to incorporate into their client work to improve therapeutic experience for both client and therapist. These measures are designed to reduce negative effects from superiority and belief in knowing what is best for the client.

It is recommended that RACs consciously adopt a curious practice with clients when interpreting client's thoughts, feelings and behaviours. This action will reduce the possibility of getting interpretations wrong, avoiding potential replication of past trauma and abuse (Hahn, 2004). It is expected that by checking interpretations with clients, this will increase understanding between client and therapist and will offer the client self-awareness and independence (Bion, 1974; Casement, 1991; Shainberg, 1993). It is also recommended that RACs reflect their interpretations in supervision, in order to identify any potential countertransference reactions in the therapeutic relationship.

It is expected that the training, personal therapy and supervision, together with additional techniques will help to reduce negative relational reactions that may occur for the counsellor in the shared experience of alcoholism with the client. It will also enhance therapy skills, offering additional self-awareness and personal development.

4.4. Further Research

It is recommended that a members' check is carried out, by asking the participants to read the dissertation for their agreement or disagreement on the findings. This will offer additional strength and validity to the study (Lincoln & Guba, 1985; McLeod, 2005). Charmaz (2006) also suggested that a member's check can sometimes uncover additional knowledge otherwise missed. However, it is envisaged that a member's check might be problematic, as the participants might not want to accept the suggestion of any negative practice (Bloor, 1997). Wosket (1999) claimed that therapists do not want to appear inefficient or devalued at their professions.

The literature used in this study has been predominantly from a psychodynamic therapeutic theory discipline. This might be because the majority of the literature found and explored was skewed towards this discipline, which might be for various reasons, including a belief that early trauma is related to alcoholism (Mirsal, et al., 2004). Psychodynamic theories are focused on development issues and childhood trauma (Gomez, 1997). It is proposed that another study be carried out consciously focused outside of a therapy vantage point or within a different therapy discipline, for example, Cognitive Behavioural Therapy. It is expected that this would offer triangulation to the findings from this study and further insight into the views and experiences of the RAC working with alcoholic clients.

It is recommended that another GT study is carried out with alcoholic clients during and after therapy treatment with the RAC. The focus of this study needs to address

their views and experiences of the therapy in the shared experience of alcoholism with the counsellor. This will enable another perspective of triangulation to the findings from this current study, together with insight and information about the usefulness of the interventions employed by the RACs. It is suggested that a study exploring the same research question is carried out with NACs and NAC clients. In the piece of work that led to this study there appeared to be a difference between how RACs and NACs worked with alcoholic clients, for example, NACs do not share their non-addict status with the client. It would be interesting to find out what the views and experiences of NACs working with alcoholic clients and compare the results with the current study.

The research study could be extended to explore the views and experiences of recovering counsellors who work in alternative addiction fields, for example, drugs, eating disorders, sex, obsessive compulsive disorder and gambling. This will ascertain whether the processes found in this study are unique to these counsellors or whether these findings are found in alternative arenas. It maybe that additional insight is uncovered, which could further advance work with addictions and potentially extend to mental health issues. Through learning more about counsellors' views and experiences in the shared experience it is expected to improve the therapeutic experience and outcome for the client.

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APPENDICES

Appendix 1 174
Appendix 2 176
Appendix 3 177
Appendix 4 178
Appendix 5 179
Appendix 6 181
Appendix 7a 182
Appendix 7b 184
Appendix 8 186
Appendix 9 187
Appendix 10a 190
Appendix 10b 195
Appendix 10c 196
Appendix 10d 197
Appendix 10e 200
Appendix 11 201
Appendix 12 203
Appendix 13 206
Appendix 14 207
Appendix 15 212
Appendix 16 214
Appendix 17 215
Appendix 18 217
Appendix 19 218

Appendix 1

DSM-IV-TR Diagnostic Criteria for Alcohol Abuse and Dependence

ALCOHOL ABUSE
(A) A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by at least one of the following occurring within a 12-month period:

- Recurrent use of alcohol resulting in a failure to fulfil major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to alcohol use; alcohol-related absences, suspensions, or expulsions from school; neglect of children or household)
- Recurrent alcohol use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by alcohol use)
- Recurrent alcohol-related legal problems (e.g., arrests for alcohol-related disorderly conduct)
- Continued alcohol use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of alcohol (e.g., arguments with spouse about consequences of intoxication).
- (B) Never met criteria for alcohol dependence.

ALCOHOL DEPENDENCE
(A) A maladaptive pattern of drinking, leading to clinically significant impairment or distress, as manifested by three or more of the following occurring at any time in the same 12-month period:

- Need for markedly increased amounts of alcohol to achieve intoxication or desired effect; or markedly diminished effect with continued use of the same amount of alcohol
- The characteristic withdrawal syndrome for alcohol; or drinking (or using a closely related substance) to relieve or avoid withdrawal symptoms
- Drinking in larger amounts or over a longer period than intended.
- Persistent desire or one or more unsuccessful efforts to cut down or control drinking
- Important social, occupational, or recreational activities given up or reduced because of drinking
- A great deal of time spent in activities necessary to obtain, to use, or to recover from the effects of drinking

- Continued drinking despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by drinking.
- (B) No duration criterion separately specified, but several dependence criteria must occur repeatedly as specified by duration qualifiers associated with criteria (e.g., “persistent,” “continued”).

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Appendix 2

AA (Alcoholics Anonymous) Twelve Steps

“The heart of the suggested program of personal recovery is contained in Twelve Steps describing the experience of the earliest members of the Society:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

Newcomers are not asked to accept or follow these Twelve Steps in their entirety if they feel unwilling or unable to do so.”
Alcoholics Anonymous UK, 2010. *The General Service Board of Alcoholics Anonymous (Great Britain) Ltd.*
Available at:
http://www.alcoholics-anonymous.org.uk/geninfo/05steps.htm.
[Accessed 26 March 2010].

Appendix 3

Acknowledgement letter from drug and alcohol charities

Harmonie
The Drive
Copthorne
West Sussex
RH10 3JX

17th July 2009

Dear Ruth

Further to our recent conversation, I confirm that (name of organisation) is aware that you are a Student on a Counselling Psychologist Doctorate programme studying at the University of East London, Stratford.

As part of this course we understand that you are carrying out some research in the field of alcohol addiction. The aim of this research is to appreciate the perspective of the Recovering Alcoholic Counsellor working with this client group and involves interviewing counsellors with this personal experience.

The (name) Management Team is aware of the counsellors that fit the criteria of the proposed study. We understand that some counsellors working for (name of organisation) have agreed to be interviewed for this research study and we give our full permission for these interviews to be carried out. We understand that the results will be published albeit in an anonymised form or similar in a doctorial thesis and it maybe that this study is also subsequently published in a journal. We have assessed the ethical implications of this study and we feel happy that every precaution has been taken to minimise distress to those interviewed. We also give permission for interviews, if required, to be carried out in our counselling rooms at the (name of organisation) office in (place name), subject to availability. In addition, we appreciate that the identity of those interviewed will be kept between you and the interviewee, however, if the interviewee wishes to discuss this with colleagues that will be at their discretion.

We are happy for this research to proceed and we look forward to reading a copy of the research when it is complete.

Yours sincerely

Appendix 4

Information Sheet

This study is being conducted by a Doctorate Programme student from the Psychology Department at the University of East London. The research is an exploration into the views and experiences of recovering alcoholic counsellors on how useful they perceive their past personal experiences to be when working with clients presenting with alcohol problems. The interviews will be conducted by the researcher and will last for approximately 1 hour. Throughout the interview you will be asked questions about your experience and views and you are encouraged to talk freely and provide as much detail as you feel comfortable. You are free to withdraw from the interview at any time if you wish and without explanation.

The interview will be audio-taped for the purpose of data analysis. The data you provide will be kept securely at the home of the researcher and only accessible to the researcher and research supervisor. The data you provide will also remain anonymous and confidential and your name will not be recorded on the transcript.

This study will be written up in the form of a thesis and extracts may be used in journal articles or conference publications.

Please keep in mind that it is your right to ask the researcher to terminate the study and destroy the data obtained by you at any point during the study even before the interview is complete. Also if you feel uncomfortable with any of the questions you have the right to refuse to answer and ask to move on to the next question.

If you have any questions throughout the interview, please do not hesitate to ask.

Contact details for any further queries or information are:

Student Researcher	Contacts
Ruth Henderson	Telephone: 07808 946491
E-mail:	ruthah@hotmail.co.uk

Address:
Counselling Psychology Doctorate Programme
Psychology Department
Green Building
University of East London
Stratford Campus
Romford Road
London
E15 4LZ

Appendix 5

Informed Consent form

Introduction

You are being invited to participate in a research study titled:

Does personal experience of the client's difficulties matter in psychological therapy?

This study is being conducted by Ruth Henderson under the supervision of Dr Helen Murphy from the School of Psychology at the University of East London.

Volunteer status and confidentiality

Your participation in this study is completely voluntary and confidentiality is assured in all published and written data resulting from the study. You have the right to refuse to answer particular questions. You may elect to withdraw from this study at any time and the information we have collected from you will be destroyed. If you decide to participate the information you provide will be used only for the completion of this study.

Purpose

This study is focused on attaining an in-depth and meaningful understanding of therapists' perspective of working with personal experience in the client's problems and using this in-sight to inform Counselling Psychology to the benefit of the client.

This study will be written up in the form of a thesis and extracts may be used in journal articles or conference publications.

Procedure

A semi Structured Interview

Time Commitment

Your participation in this study will take approximately 60 minutes.

Risks

There are no known risks to participating in this research.

Benefits

There is likely no direct benefit to you for participating in this study, but it will help us and others to further understanding in how personal experience interplays in the therapy processes.

Payment:

You will not be paid for participating in the study.

Ethical clearance:

This study has received ethical clearance from the School of Psychology Ethics Committee at the University of East London.

For Further Information

Any questions that you may have about this study can be answered by

Ruth Henderson: email: Ruthah@hotmail.co.uk
Mobile phone: 07808 946491

Before You Sign This Document

By signing below, you are agreeing to participate in a research study. Be sure that any questions have been answered to your satisfaction and that you have a thorough understanding of the study. If you have further questions that come up later, please feel free to ask the researcher. If you agree to participate in this study, a copy of this document will be given to you.

Participant's Signature:

Date:

Print name:

Researcher's Signature:

Date:

Appendix 6

Debriefing Form

This form should be used in addition to a personal debriefing which would normally be given to participants after they have acted as research participants.

Purpose of research

This study is focused on attaining an in-depth and meaningful understanding of therapists' perspective of working with personal experience in the client's problems and using this in-sight to inform Counselling Psychology to the benefit of the client.

Procedure

The data has been attained by way of a semi structured interview.

If you have any questions or concerns about this study, you are encouraged to call

Ruth Henderson: email: Ruthah@hotmail.co.uk
Mobile phone: 07808 946491

In addition, if you were upset, disturbed or distressed by participation in this study or found out information about yourself that is upsetting, disturbing, or distressing, we encourage you to make contact with one the
following agencies or individuals:

AA 08457 697555 or 0207 3523001
Narcotics Anonymous 02077300009
CareLine 020 8514 1177
Samaritans 08457 90 90 90
SADAS 01483 590150

In the event you would like to read more about these and related topics, here are several articles that you might find interesting.

Jackson, S.W. (2001). The Wounded Healer. *Bulleting History Med.* 75(1): 1-36

Wosket, V. (2003). *The therapeutic use of self; Counselling Practice, research and supervision*. NY. Routledge.

Appendix 7a

Interview guide – JULY 2009

INTERVIEW TO INVESTIGATE THE BELIEFS AND EXPERIENCES OF THE THERAPISTS WORKING IN THE AREA OF ALCOHOL PROBLEMS AND WHETHER HAVING EXPERIENCE OF THE CLIENT'S ISSUES INFLUENCES THE THERAPEUTIC ALLIANCE

Intro to the research project
Consent form

1. Demographic background
   Age
   Psychotherapy discipline
   Training
   Length of time counseling
   Length of time counseling in alcohol addiction
   How many clients are you seeing weekly at the moment?
   - **How many of those have purely alcohol issues?**

2. Can you tell me how it has come about that you work with alcohol addiction?
Was there a particular reason why you were attracted to this area?

3. Can you say what you consider is a positive outcome for your clients?
   Drink reduction?
   Abstinence?
   Other?

4. Could we explore the theoretical ideas that are important to you on how people become addicted to alcohol?
   Could you please elaborate?
   Do you think it is the same for everybody?
Can you see a particular theoretical model predominating in your work?
How do you feel about a neurological element to dependency?

5. How does your personal experience of alcohol dependency help you with your client work?
   Have you had any problems with this?
   (If yes, how did you overcome your problems?)

6. Do you disclose that you have had experience of alcohol problems?
   How does this help you with your client work?
   Have you had any problems with this?

7. How do you perceive 'success' for an individual with alcohol problems?
   Is there a specific intervention you use?
8. Have you seen many of your clients overcome their alcohol problems?
   Which intervention has been most effective?

9. On reflecting on your work, how do you feel about working with alcohol problems?

Debriefing

Appendix 7b

Interview guide – SEPTEMBER 2009

INTERVIEW TO INVESTIGATE THE BELIEFS AND EXPERIENCES OF THE THERAPISTS WORKING IN THE AREA OF ALCOHOL PROBLEMS AND WHETHER HAVING EXPERIENCE OF THE CLIENT'S ISSUES INFLUENCES THE THERAPEUTIC ALLIANCE

Intro to the research project
Consent form

1. Demographic background
   Age
   Psychotherapy discipline
   Training
   Length of time counseling
   Length of time counseling in alcohol addiction
   How many clients are you seeing weekly at the moment?
   - **How many of those have purely alcohol issues?**

2. Can you tell me how it has come about that you work with alcohol addiction?
Was there a particular reason why you were attracted to this area?
How many years abstinent?

3. Can you say what you consider is a positive outcome for your clients?
   Drink reduction?
   Abstinence?
   Other?

4. Could we explore the theoretical ideas that are important to you on how people become addicted to alcohol?
   Could you please elaborate?
   Do you think it is the same for everybody?
Can you see a particular theoretical model predominating in your work?
How do you feel about a neurological element to dependency?

5. How does your personal experience of alcohol dependency help you with your client work?
   Have you had any problems with this?
   (If yes, how did you overcome your problems?)
   Do you feel a deeper bond with the client?
   What do you think the client gains?

6. Do you disclose that you have had experience of alcohol problems?
How does this help you with your client work?
Have you had any problems with this?
Do you think the language you use lets the client know your experience?

7. Other interviewees say that working with alcohol problems helps with their own recovery
What do you think about this?
Lost time not wasted?

8. How do you perceive 'success' for an individual with alcohol problems?
Is there a specific intervention you use?

9. Have you seen many of your clients overcome their alcohol problems?
Which intervention has been most effective?

10. On reflecting on your work, how do you feel about working with alcohol problems?

Debriefing

Appendix 8

University of East London Ethical Committee approval

University of East London

Dr Cristian Tileaga
School of Psychology
Stratford

ETH/08/44

15th August 2008

Dear Dr Tileaga,

Application to the Research Ethics Committee: A Grounded Theory Exploration of the Views and Experiences of Recovered Alcoholic Counsellors and Non Alcoholic Counsellors on Working with Alcoholic Clients (R Henderson)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Vince Onye-Kwelu
Administrative Officer for Research
o.vincent@uel.ac.uk
02082237071

Research Ethics Committee: ETH/08/44/0

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:.....Date: .....

Please Print Name:

Appendix 9

Rigour and trustworthiness within the GT

Throughout the GT close attention was given to maximise accurate knowledge sharing, achieving rigour and trustworthiness of the study (Lincoln & Guba, 1985; Padget, 1998). The criteria included reflexivity, supervision, transferability and the possibility of an audit trail in the future (Lincoln and Guba, 1985).

Lincoln and Guba (1985) proposed several problems that might occur during interviewing, including reactivity, respondent's bias and researcher biases. Issues that were considered included the researcher's presence affecting the participant's sharing of information, causing a reactivity of some kind, for example, uncertainty of the researcher's intentions. In order to reduce negative reactivity active listening and a curious attitude were adopted (Knapik, 2006; Padget, 1998).

It was considered that those participants familiar with the researcher might feel unable to speak about personal information, or they might try to impress by elaborating on their experience in a respondent bias. To reduce these effects confidentiality was emphasised, use of consent forms and emotional sensitivity were employed to help the participant's feel safe and comfortable encouraging openness and honesty. Clear questioning was used to avoid participants guessing what the researcher wanted to hear (Hilton, 1995).

It was also considered that as the researcher I might feel compelled to protect the participants from exploring personal issues identified, for fear of offending, in a researcher bias. In order to reduce these effects the researcher remained mindful of the potential biases (Padget, 1998), as well as adopting a systemic approach, through encouraging elaboration of meanings to minimize researcher objectivity and assumptions (Cecchin, 1987). Carrying out all of these measures was also considered helpful in reducing the researcher's clinical skills from interfering with the interview process (Dallos and Vetere, 2005).

During the analysis stage, the systematic and rigorous procedure was continued to realise the concepts leading to the categories and sub-category codes. A great deal of time, patience and analytic skill was employed to ensure maximum benefit from the iterative process. These measures also ensured that the findings and interpretations were authentic and credible, reducing potential threat to trustworthiness (Lincoln and Guba, 1985). Care was also taken to maintain the social constructionist cannon of multiple truths throughout the research process to avoid GT falling within a positivist epistemological framework, which is sometimes reported (Golafshani, 2003).

In order to further reduce researcher bias in the analysis, additional precautions were taken. These included the researcher remaining reflective throughout the study by remaining in contact by telephone, emails and face-to-face meetings with the research supervisor. Regular contact was also maintained with fellow colleagues carrying out GT studies. These measures also helped to maintain grounding in the data (Charmaz, 1990).

To increase transferability of the current study's conclusions to additional applications a comprehensive explanation of each stage of analysis is given, together with details of inclusion criteria and a rich description of the phenomena being investigated (Lincoln and Guba, 1985; Riley, 1996). This action will also enable an audit trail to be carried out in the future (Lincoln and Guba, 1985).

Golafshani, N. (2003). Understanding reliability and validity in Qualitative research. *The Qualitative Report,* 8, 597-607.

Appendix 10a

Procedure of analysis

Interviews

The data was gathered by interviews to provide accurate accounts of the participants' views and experiences of alcoholism with the client (Breakwell et al., 2006). Interviews are considered a good method to explore participants' meaning and experience (Charmaz, 2006; Dallos & Vetere, 2005).

Initial codes

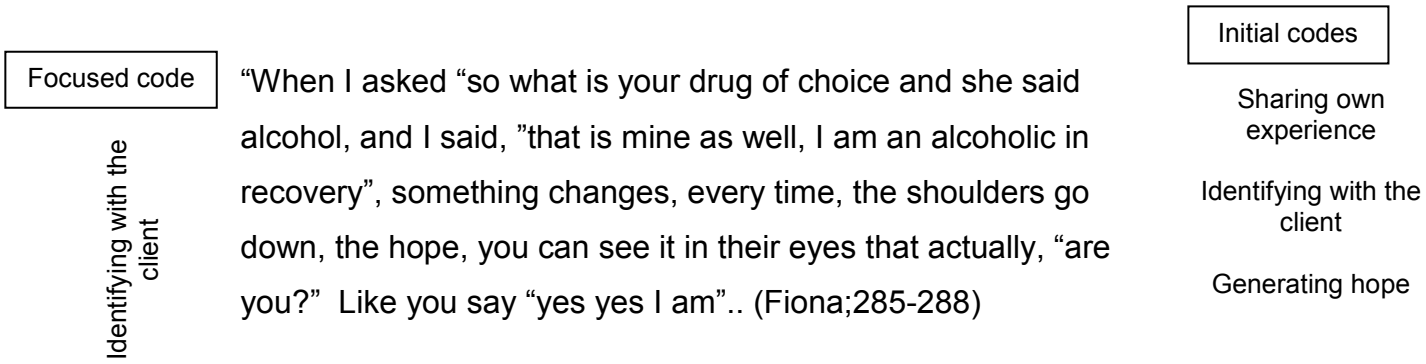
The first step of analysis was carried out for the whole of each transcript to extract meaning from the data (Charmaz, 2006). The initial coding was carried out line-by-line keeping close to the participant's words, identifying meaningful data through reading and abstracting information. This information was summarised and labelled in notes in the right-hand margin (Charmaz, 2006). Charmaz (2006) proposed that this process elucidate the phenomena being studied. During this stage several key questions were asked of the data, including, what was the study's aim, what does the data imply, from whose perspective is it and what is the theoretical concept (Charmaz, 2006). Charmaz (2006) claimed that these initial codes form the framework of the emerging theory (Charmaz, 2006). An example of initial codes follows.

Meaningful data in a transcript	Initial codes
"When I asked "so what is your drug of choice and she said alcohol, and I said, "that is mine as well, I am an alcoholic in recovery", something changes, every time, the shoulders go down, the hope, you can see it in their eyes that actually, "are you?" Like you say "yes yes I am".. (Fiona;285-288)	Sharing own experience Identifying with the client Generating hope

Reflexive memos were also written throughout the process of coding recording the researcher's thoughts and questions that emerged during this process (Charmaz, 2006). See appendix 10b for an example of an early memo. The initial codes were each cut into strips and stuck onto index cards. The purpose of this was to offer an additional visual aid towards the contractual level of coding and ensure certainty of relevance of sub-category codes. Particular focus was also given to applying 'gerunds', which is reported to help maintain closeness to the data and encapsulate processes and actions within the data (Charmaz, 2006; Glaser, 1978).

Sub-category codes

The second stage, sub-category codes involved working back through the transcript, line by line, utilising the initial codes and memos for analytic sense (Charmaz, 2006). Adherence to the frequency and significant meaning to the research questions was considered, whilst working towards a concise categorisation of the data (Charmaz, 2006). Additional summaries of the data crystallise the content and act to intensify participant's meanings. These sub-category codes were recorded in the left-hand margin of the transcripts. An example of sub-category codes is as follows:



The initial codes, which were previously cut from the interviews and stuck onto index cards, were collected together in the relevant sub-category codes, ready as a visual aid for the conceptual coding stage. This was a process modelled on a process suggested by Rennie (1994). This process is also claimed to help with ordering the conceptual hierarchy, as well as relationships between categories (Rennie, 1994)

Conceptual coding

This next stage of the analysis brings the sub-category codes into conceptual coding status. This refines the level of coding and helps to identify the relationship between the sub-category codes, as well as present higher order sub-categories and category status (Charmaz, 2006). In order to bring the sub-category codes to a conceptual level two processes were employed before writing up the findings. These were 'freewriting' (Charmaz, 2006) and a visual aid of cutting-up codes and sticking them onto index cards and from observed patterns correspondingly putting them onto A3 sheets representing the emerging hierarchical category and sub-categories (Rennie, 1994). This process included continually referring back into the full transcripts to ensure correct meanings, utilising 'freewriting' and the A3 sheets, bringing conceptual elements of the coding together for understanding and relationships. See appendix 10c for an example of 'freewriting' and appendix 10d for an example of codes collected on the A3 sheets.

'Freewriting' is a process that is considered to free up thoughts and flow of ideas away from preconceptions and old habits. The idea is to write whatever comes to mind with regards to the data: taking no time for grammar, spelling or punctuation. This enables new ideas and a natural voice (Charmaz, 2006). See appendix 10c for an example of 'freewriting'.

The collection of index cards on each of the A3 sheets were an aid for memo writing. The index cards and A3 sheets were used as a prewriting technique to help move the data onto the next conceptual level. Prewriting techniques are considered useful at this stage of analysis (Charmaz, 2006). This technique was found to be very helpful for the current study, providing a visual description of relationships between codes and illuminated higher level codes.

During this stage, memo-writing was intensified to bring the sub-category codes to conceptual categories and remaining grounded in the participants' accounts. This enabled emergence of ideas for writing up (Charmaz, 2006). Whilst memos had been written throughout all stages of analysis, these memos are more substantial, reasoned and sharp (Charmaz, 2006). Constant reference to the transcripts, interim memos, initial codes, sub-category codes were made throughout this process, which is considered intrinsic to the process (Charmaz, 2006; Lempert, 2010). This final process is reflected as the art of GT theory grounded in the data (Clarke, 2003, 2005; Strauss, 1987; Strauss and Corbin, 1998). See appendix 10e for an example of these memos.

Sampling

During the process of analysis sampling took place where participants were recruited to take part in the study based on the qualities being investigated. This study is focused on the views and experiences of the RACs in the shared experience of alcoholism with the client. Counsellors who shared the experience of alcoholism with their clients were sought and interviewed. Morse (2010) suggested that a good qualitative sample must be selected, in order to study the variations in meanings within the group under investigation.

Sampling using criteria provides direction for data collection, detailed memo-writing that effectively purifies the categories (Charmaz, 2006). As new questions emerge, new directions were explored through additional interviews to yield fresh data for exploration. Simultaneously, previous interviews were revisited to establish if less salient references can be linked to the new ideas (Charmaz, 2006).

Theory saturation

The sampling process continued until no new information came from the data. This included theoretical ideas and additional properties of the categories (Charmaz, 2006). It was found for interviews 9(Ian) and 10(Jan) that no fresh information or questions emerged from the data and at this point it was considered that theory saturation had been reached. No further interviews were conducted.

Clark, A. E. (2003). *Disciplining reproduction; modernity, American life sciences and the problems of sex.* Berkely, CA: University of California Press.

Lempert, L. B. (2010). *Asking questions of the data: memo writing in the grounded theory tradition.* In A. Bryant, & C. Charmaz. (2010).*The Sage handbook of grounded theory.* London: Sage.

Morse, J. M. (2010). *Sampling in grounded theory.* In: A. Bryant. & C. Charmaz. *The Sage Handbook of Grounded Theory.* London. Sage.

Appendix 10b

Sample of Early Memos – from initial coding (03/12/2009)

Edward
Memo 1 – line 46: transferring dependency
Alcoholics often change addictions if alcohol taken away. Seems often food is an alternative for a lot of people. Other interviews seem to concur with this observation of the counsellor.

Memo 2 – line 80 – exploring purpose and direction
RAC initially thinks counselling nice easy number, this was apparent in interview 2 as well.

Memo 3 – 124 – maintaining own recovery through clients
Big part of recovery process is working with addicts, also found same in other interviews.

Memo 4 – 132 – finding purpose and direction
Responsibility seems important in recovery process – counselling is a responsibility in a way as you are helping someone with their problems.

Memo 5 – 143 – feeling deep meaning in job
Recalled his experience of identity and satisfaction when working with addicts, emotional in saying this which suggests a deep meaning, got hope back, addicts need hope.

Memo 6 – 158 – sharing identity with the client

- *Reducing negative emotions*
- *Seeing hope*
- *Evidencing recovery is possible*

Sharing identity appeared to offer clients physical relieve from distressing feelings. It was reflected by the participant to offer hope for the client. Recognising – realisation for client, most clients do not believe it is possible to stop, the therapist provides evidence to the contrary of this belief.

Memo 7 – General reflection - identifying with the client and using self-disclosure
It occurs to me there appears to be two areas, what alcoholics need to aid recovery counsellors on continuum of recovery with client. Perhaps need to go into wounded healer literature. Counsellors gain a sense of self-worth providing evidence to clients. Counsellor offers skills in helping alcoholic, which builds trust and hope, maybe helping through stuck object relations stages.

Memo 9 – 200 – sharing identity with client
Counsellor discloses at point when speak of client's addiction choices. It seems to be an exchange for honesty – reference to Rogers and core conditions.

Appendix 10c

Example of 'freewriting' 05/03/2010

Self-disclosure

This seemed to form a large part of how therapists explained their work. They claim was that it was delivered when the client was stuck there was also discussion of possible problems when getting over confident and biases with self-disclosure, however a quick recovery when realising error. This participant spoke about working when tired so this is perhaps a caution for individuals working in substance misuse. The self-disclosure seemed to bring the relationship on equal terms releasing shame, guilt and fear of judgements. The process is reported to enable the client to be honest and open with the therapist. There seemed to be a normalising process in action the therapist report that there are visible signs of relief from the client, eyes, shoulders, which could be associated as a place someone might hold tension. They also reported the eyes as also being a place where they saw signs of relief. The therapist claimed that the s.d. is used as a tool in therapy where the client is locked in belief that there is no alternative to taking alcohol as life does not exist beyond this, particularly social life. By introducing evidence this is reported to instil hope. The participant draws on their own experience when going into recovery that this is how they felt. This seems important and differ3ent to how another therapist could work not having this knowledge of how an addict thinks, operates is reporting to be similar. Links to addiction as a cognitive process, which needs to be goggled for literature. They suggest that the mind unconsciously plans to get alcohol, no wonder it is a neurological process – attached to the mesolimbic pathway for survival. By the client knowing that the therapist is an RAC this gives them more credibility in being listened to and know what they are talking about. Addicts are masters in lying manipulation and it seems this very strong desire is almost out of their control – linked to addiction behaviour. This reflecting back via clocking their behaviour and bringing this to consciousness seems helpful in enabling the person within to take control and choice. This links to the splitting or the idea that the addict is or can be separated from the person, as a therapist working with alcohol problems I have heard clients describing their being a separate person within that takes the leads to the drinking and the drinking enables this person to come alive and achieve. The participants also spoke of their language use and conversations also gave away their past experience in subtle ways. They said that their honesty also encouraged the client to be honest. They report two benefits of s.d. as evidence and life after alcohol, social life and it can be done and can get life family back also reassure it is possible to recover so 3 fold. Their argument is alcoholics only see alcoholics so no life outside this culture. The therapist also reflected that they would only use s.d. in interest of client and whilst using it select information that is relevant and think might be useful. Also reflected that may use info outside of alcoholism if necessary.

Appendix 10d

Example of A3 sheets (sub-category codes) with index cards (initial codes)

Within sub-category - therapist identifying with the client

A3 sheet representing sub-category code: affording tough-love to the client
Index card of focus codes

- Dishing out a lot of tough-love to clients (Fiona; 430)
- Reflecting the client's denial is tough-love (Fiona; 426-429)
- Having to give clients tough-love to stop them drinking (Harriet; 352-363)
- Affording tough-love to clients to avoid transferring dependency to religion (Harriet; 461-464)
- Having to be tough on clients (Andy; 530-539)
- Being hostile with clients (Andy 535)
- Knowing that tough-love works in AA and using it with clients (Fiona; 387-399)
- Believing addicts need to be challenged (Edward; 456-465)
- Believing that addicts need to be challenged (Edward; 479-488)
- Affording a lot of tough-love to clients (Edward; 581-585)
- Needing to be confrontational with addicts (Andy 349-353)
- Needing to confront addicts (Edward; 11-19)
- Affording tough-love to clients (Gordon; 292-297)
- Needing to use tough-love with positive focus (Jan; 559-569)
- Hearing tough-love used with aggression by other therapists (Jan; 559-569)
- Challenging the client through reflecting behaviour (Carol; 304-311)
- Challenging the client's deviant behaviour by affording tough-love (Edward; 581-584).
- Reflecting on the good behaviour more helpful (Jan; 642-645)
- Affording tough-love as clients need to know they are acting out (Edward; 594)
- Feeling frustrated by clients ambivalence leads to being harsh (Denis; 90-96)
- Being tough on clients helps them get motivated (Denis; 90-96)
- Feeling frustrated with client so hard on client (Denis; 228-236)
- Not affording to be lenient on client as limited therapy sessions (Denis; 242-243)
- Having to make an impact on the client by shocking client with challenge (Denis; 262-266)
- Offering tough-love without rescuing the client (Gordon; 300-309)
- Affording tough-love to clients is gently challenging their negative behaviour (Gordon; 314-322)
- Using reflection of the unhelpful process to the client (Jan; 337-342)
- Hearing hostility in other therapists (Jan; 475-480)
- Hearing hostility in other therapists (Jan; 495-500)
- Experiencing hostile recovering therapists in alternative work places (Jan; 530-535)
- Addicts challenge other addicts a lot more (Fiona348-350)
- Affording tough-love works in AA so we use it with clients (350-356)

- Knowing when to confront the client about their behaviour (Gordon; 449-465)
- Affording tough-love is about setting boundaries with clients (Ian; 601-607)
- Affording tough-love in a bullying manner encourages compliance and re-abuse (Ian; 608-613)
- Not bullying clients encourages exploration of what client needs (Ian; 628-630)
- Observing others using tough-love in an aggressive way (Ian; 589-593)

A3 sheet representing sub-category code: sharing addict identity with the client

Index cards of initial codes

- Sharing negative experiences encourages clients to be open (Fiona; 581-593)
- Sharing experience offers hope (Fiona 412-415)
- Sharing recovering identity gives trust in recovery (Carol; 208-214)
- Sharing recovery evidences recovery is possible (Harriet; 638-637)
- Sharing recovery identity evidences life without alcohol (Andy; 453-461)
- Evidencing recovery offers client hope (Edward; 157-168)
- Seeing recovered alcoholics evidences reward of abstinence (Andy; 102-110)
- Seeing recovered alcoholics evidences recovery possible (Andy; 382-396)
- Sharing recovery helps client get recovery (Andy; 465-470)
- Meeting recovered alcoholics evidences recovery possible (Edward; 174-185)
- Sharing experience reassures client recovery possible (Andy; 492-494)
- Sharing alcoholic experience offers client hope and understanding (Edward; 212-222)
- Sharing own experience (Fiona:286)
- Identifying with the client (Fiona: 286)
- Generating hope (Fiona: 287)
- Offering the client hope through sharing the alcoholic identity (Fiona; 393-400)
- Self disclosing to demonstrate recovery possible (Denis; 97-102)
- Going to AA offers evidence recovery possible and offers hope (Denis; 111-115)
- Sharing identity when frustrated client not changing to offer evidence (Denis; 349-354)
- Sharing identity offers hope in recovery to client (Denis521-533)
- Sharing identity offers evidence recovery possible (Denis; 543-548)
- Offering self as evidence recovery possible (Gordon; 181-184)
- Offering the client hope in the recovery process (Gordon; 378-381)
- Identifying with the therapist gives the client hope (Jan; 653-657)
- Sharing identity offers the client hope for recovery (Jan; 162)
- Evidencing recovery possible offers hope (Jan; 209-213)
- Sharing identity in AA evidencing recovery possible (Ian; 432-442)
- AA offering evidence of choice between alcoholism and recovery (Ian; 454-462)
- Sharing experience reduces client fear (Fiona; 281-283)
- Sharing experience equals power dynamic/reduces clients shame (Fiona; 284-293)
- Sharing experiences indicates expertise and understanding in problem (Fiona 287-300)

- Evidencing recovery possible enables the clients trust (Edward; 174-182)
- Sharing experience reduces client's shame (Fiona: 501-512)
- Sharing experience evidences same negative identity (Fiona; 526-534)
- Recognising from own experience clients feel ashamed (Betty; 444-456)
- Reducing the client's fear by sharing shameful experience (Betty; 829-846)
- Sharing alcoholic identity reduces fear and enables trust (Harriet; 389-396)
- Sharing alcoholic identity helps client to feel understood (Harriet; 405-408)
- Sharing alcoholic identity reduces shame (Gordon; 347-350)
- Sharing alcoholic identity reduces shame (Andy; 484-487)
- Believing that another alcoholic will not judge, as shares shame (Betty; 227-230)
- Clients feeling relieved when discovering therapist is in recovery (Andy; 366-370)
- Frightened clients slowly revealing/testing therapist with shame (Edward; 553-565)
- Sharing therapist's identity puts client's fear at ease (Edward; 195-210)
- Clients more trusting of RAC with shame (Edward; 570-578)
- Sharing alcoholic identity reduces client shame (Edward; 544-551)
- Feeling compassion for self and client in reducing shame (Jan; 269-287)
- Reducing shame and guilt by self-disclosing (Gordon; 382-385)
- Sharing alcohol identity helps client feel understood (Jan; 178-188)
- Self disclosing own shame reduces shame for client (Jan; 386; 399)
- Reassuring clients that counsellor shares alcoholism experience (Ian; 415-422)
- Self-disclosing identity to demonstrate expertise in client's problem (Gordon; 354-362)
- Sharing identity to show understanding to the client (Andy; 371-373)
- Self-disclosing to offer a message to the clients (Edward; 223-225)
- Offering evidence of competence in clients problem (Denis; 137-144)
- Using self disclosure of qualifications and shared experience to communicate competence (Jan; 367-377)
- Sharing identity to offer advice to manage problems in alcoholism (Ian; 378-385)
- Qualifying own experience of alcoholism as well as working experience as evidence of competence for working as a RAC (Ian; 783-878)

Appendix 10e

Example of substantial memo

Sharing identity with client - *Evidence recovery was possible*
Recovery was a frightening prospect for the clients. There was a strong belief that recovery was not possible and if they gave up alcohol life would cease, they would not survive. The intensity of this belief/block in thinking stopped them from acting, but in the other direction there was continued ill health and death and they had nearly lost everything, material and family. The client's did not trust anybody and was intensely frightened.

The act of self-disclosure let the client know that they the therapists were living proof that recovery was possible. There seemed to be several levels of impact of this knowledge. The big one seemed to be the prospect and indisputable 'evidence that recovery was possible'. Here was somebody who was like them, with the label of alcoholism. They had said they lived in the park, with no belongings, no family who would have anything to do with them. They had been reliant on alcohol to keep them safe and free of worry or painful memories or reality. People crossed the road to get away from them; they were useless, hopeless and disgusting. It was reflected that alcoholics in the real world do not come into contact with people who are not alcoholics. If they are drunk all the time, then they probably do not relate to others, if they cross the road to avoid them. Only other alcoholics would speak to them as the fear of the unexpected behaviour would not be there. There was this person in front of them clean, nicely dressed and well, is this what recovery means?

The process of self-disclosing seemed to have some stages,

1. Took away some of the fear that there was no life without alcohol
2. Perhaps things could get better for an alcoholic
3. This person is describing how I feel, they seem to know
4. Maybe I can get what they have got and be clean, nicely dressed and well again.

The person in front of the client seems to be living proof that there can be a life without alcohol, and a good life that can be built up again. This person seems to have done it; maybe I can do it too. They have got themselves sober and they are happy. I want to know more about how to do this, so perhaps curiosity to know more is also present as a result of the evidence. It seems to break down the blocks of thinking that recovery is possible.

Appendix 11

Sub-category: Therapist building a self-identity
Sub-category code: Being influenced by an anonymous fellowship

Ian explained how he experienced being influenced by AA. He described a sense of belonging and acceptance. Festinger (1954) proposed that individuals identify with others who are perceived similar to themselves and the response and evaluation of others within this group results in the self-concept of the individual. Ian reflected that alcoholics are not accepted in society and AA provided a place where they felt accepted. Coley (co-founder of symbolic-interactionism) stated that self-identity is a product of the relationships with others. In the wider society 'alcoholism' is reflected on as a shameful identity (Gray, 2009). Whereas AA is claimed to be an environment where the social identity of an alcoholic is positively framed (Cain, 1991) and provides unlimited accepting social support (Vaillant, 2005). Ian seems to be supporting this process.

> "I think one of the things that people get from an AA meeting is a feeling that they have landed on the right planet and people are OK and I am a person and I fit in, instead of feeling the odd one out, where a lot of alcoholics do feel the odd one out in most situations they think differently or seem to think different, or are perhaps less mature, if I am honest, less adult less able to manage frustration." (Ian;258-262)

Gordon described AA as a safe place that enabled him to metaphorically 'grow-up'. Fairbairn (1994a) proposed that a relationship can facilitate individuals to gain mature independence. It might be that for Gordon the AA members represented 'role models' in this process (Steinberg and Morris, 2001). Gordon said he was vulnerable "I was scared, terrified". This emotional state may imply that Gordon was going through the critical development stage of adolescence when identity is formed (Erikson, 1968).

> "I was very violent and stuff, do you know what I mean, I was scared, terrified and the fellowship has held me and I went to AA consistently through, it was my life for a long while and I grew up within that." (Gordon;184-187).

Edward speaks about his past dependency on AA for his recovery and how these needs are now met working with alcoholic clients. This implied that he is now dependent on the client work. Edward expresses several benefits from the client work that help him manage his own recovery. This may indicate possible dependency needs being met. Benefits included developing through the client work, the client acting as a deterrent for relapse. Edward also reflected on the satisfaction he feels when the clients appear to get well, which he expresses alongside his own journey of recovery. This may indicate that the client reminds him of his own accomplishments in managing recovery. Edward is emotion in his recall and later in

the transcript expresses a belief that he will always work with alcoholic clients (Edward;538-539).

> "I mean when I came here I was going to probably about five meetings a week and I was doing various service issues in AA, like running a group, treasurer and other inter groups and what's happened since then I have stopped, I only go to two or three meetings a week now, because a lot of my recovery is done here [work]. I've learned more about the recovery programme, more about myself, more about how I operate, about how addicts work since I've been working here, so I am doing recovery every day. Every day I work here I am doing recovery stuff for myself and the client's are just gifts (I: so when you are with them you obviously gaining a lot, as well as them gaining) Yea, a simple thing, because I can identify with their struggle as well, but also because when I see them walking in, just about dying, you know you see them walking in, their faces completely blank, their eyes have no life about them at all and that reminds me of when I first went to AA and within a short period of time, you see a smile come on their face and you see a little spark come in their eye and that just makes my day, it's emotional." (Edward; 131-144)

Fairbairn, W. R. D. (1994a). 'Schizoid Factors in the Personality'. In *Psychoanalytic Studies in the Personality* (original publication 1940). London and New York: Routledge.

Steinberg, L. & Morris, A. S. (2001). Adolescent development. In S. T. Fiske, D. L. Schacter, & C. Zahn-Waxler (Eds.), *Annual Review of Psychology* 52, 83–110.

Appendix 12

Sub-category: Therapist building a self-identity and Therapist identifying with the client

Sub-category code: Sharing addict identity with the client

Andy reflected on the impact of self-disclosing the shared identity with the client, as a function to equal the power within the therapeutic relationship, based on his own experience as the alcoholic in therapy. Andy indicated that he recognised how the client was feeling. This may have reflected bidirectional identification with the client in an empathic communication (Watkins, 1985). Rowan and Jacobs (2003) suggested that only through openly sharing can empathy be activated in the therapeutic relationship and self-disclosing one's identity is openly sharing. However, there is no way of knowing whether the client experienced empathy without asking them. Andy also proposed that alcoholic clients are vulnerable when they come to therapy; "they have lost everything, there is nothing there you know." Andy's narrative implies an over-protective countertransference reaction, rescuing the client from difficult emotions through self-disclosing the alcoholic identity (Gabbard and Wilkinson, 1994; Watkins, 1985; Weegman and Cohen, 2006).

> "If you are sat there as the drunk looking at somebody over here, who is well dressed and very comfortable and you could have painted a picture of them, in their nice big car and in their comfortable home with lots of money, you know, the picture is there and it makes them feel very small. They are on the verge, either on the verge or they have lost everything, there is nothing there you know and sometimes I say to them, look I might sit here and I might look like that and you might think it is all right for me, but actually at one time all I had was a bag of clothes and nothing else." (Andy;826-837)

Gordon explained his belief that self-disclosing the shared alcoholic identity would positively impact the client by offering equality of power (Nerenberg, 2009; White, 2000b). Gordon suggested that the client feels "bad", which might indicate an empathic connection (Watkins, 1985), or compassion in recognising the client's pain and helping the client learn another perspective to the pain (Gilbert, 2009; Shainberg, 1993). Gordon's explanation could also imply over-identification countertransference reaction to rescue the client from difficult feelings.

> "Initially, when I take a client for an assessment I will say I am an alcoholic drug addict like you and automatically all the barriers come down, because then they are not the different one and you are not the fella sitting here who knows everything. (I: right) Immediately, they are not bad, because if they are bad you are bad, because you are the same as them." (Gordon;396-400)

Edward suggested that informing the client of the shared identity provided evidence that recovery is possible, which enabled trust and a sense of feeling safe to be

honest (Nerenberg, 2009). Shainberg (1993) proposed that the therapist needs to create a connection to the client that is within a spiritual and psychological framework in order for healing to take place. This process of connection may be enabled through Edward's action of sharing his identity. Edward claimed a belief that the shared experience enabled a quicker process of engagement with the client. This belief also suggested that this quick process is unique to RACs, as it is based on the shared experience. This may also imply that Edward felt a sense of superiority with a vulnerable client (Gelder et al., 1983; Zimberg, 1985) and represent a reward to the therapist with a sense of power. This might relate to motivations for choosing the wounded healer role, which is a process that may redirect focus of therapy to the therapist (Groesbeck and Taylor, 1977; Guy, 1987).

> "They can see, look it does work and sometimes that just builds on, the same feeling they get when they talk to us and that sense of trust, I think that, I don't know why, well I sort of know why, but clients, I've had clients come in here and within five minutes tell me things about themselves and abo ut their life that they wouldn't probably share to another counsellor that wasn't an addi ct, for months ... but for an addict who walks in here, who has probably been completely dishonest and untruthful for years, because they have to have their addiction, emm, to be able to just start off to being a little bit honest, is massive." (Edward;285-299)

Betty reflected on her own experience as the client and how the knowledge of the therapist's shared identity left her feeling safe and not judged, enabling her to speak freely. Nerenberg (2009) suggested that the RAC's self-disclosure can be very helpful in allowing the client to feel accepted and not judged. This narrative also suggested that Betty believed that all clients feel the same as she did when coming to therapy and in need of protecting. Betty's narrative implied that function of self-disclosure related to equality of power to enable the client trust and acceptance of the therapy process. Betty's account may also indicate a protective over-identification countertransference reaction (Watkins, 1985).

> "I would rather talk to another alcoholic, because I don't think they are looking at me or judging me, so I can say what I like, because they have been there they know the score." (Betty;253-256)

Andy explained how he experienced deep empathy with clients and described it as a quick process. Andy attributed these factors to the shared experience with the client and working with alcoholics for fourteen years. His empathy was reflected alongside knowing the client's behaviour, thoughts and feelings, which may suggest that this knowing came from an empathic resonance with the client. Rowan and Jacob (2003) suggested that in order to facilitate empathy there needed to be a sharing at some level.

> "So that puts me at an advantage, you know being able to see being able to read their faces figuring out and understand the feelings that they are having and the empathy side of it, you know, I do get true empathy, which I think it takes quite a long time for the counsellor who hasn't got that experience to get. I can almost do it at the first

meeting ... I know what buttons to hit and I know what to say at the right time, you know and it's not a skill it is just the fact that I am lucky enough to know and to have been there and been able to do that and have also fourteen years experience of working with drunks [laughs]" (Andy;496-508)

Gelder, X., Gath, D. & Mayou, R. (1983). *Oxford textbook of psychiatry* 3rd. ed. Oxford, UK: Oxford University Press. In Halewood, A. and Tribe, R. What is the prevalence of narcissistic injury among trainee counselling psychologists? *Psychology and psychotherapy: theory, research and practice.* (2003). 76, 87-102.

Appendix 13

Sub-category: Therapist identifying with the client
Sub-category code: Believing in enhanced skills in shared experience

Ian acknowledged the general belief that a shared identification with the client resulted in a better understanding of the client, but Ian also stated his uncertainty in this way of thinking. This may be the result of a respondent bias or a genuine reflection. This would need to be checked with Ian for confirmation.

> "I think there is certainly a culture that believes that only an alcoholic can understand another alcoholic, you often hear about it in treatment centres and people who come out of treatment centres. I am not sure I agree with it." (Ian;222-224)

Appendix 14

List of different interpretations of affording tough-love to clients

Headings with quotes from transcripts and high-lighted to emphasise different interpretation of tough-love

Hostile countertransference reaction as a result of "knowing what is best for client", authoritarian approach

"I have mentioned about not just walking alongside the clients because I give quite a lot of tough-love and I think clients need that sometimes. I think some clients when they get to a certain stage, addicts, if you are too alongside them, then it doesn't work, so I think tough love works. (I: so what is tough love?) That is challenge them, if they act out or, it's not just if they act out, if they act out physically or if they act out mentally. I will give you an example, I will always know if a client, an addict is avoiding something, because if I ask them a question and they come out within a milli second and say I don't know, I know that is an addict avoiding, because I am an addict and that is what I would do, you know. I would say" I don't know" and if an addict does that now I will think avoiding, so I will just ask more questions or I will just say I think you are avoiding or saying you don't know I don't believe you don't know, I think you do know, you are just in denial, or you are avoiding completely and I will challenge them straight away, so tough love and clients need to know that they are acting out." (Edward;581-595)

Hostile countertransference reaction of therapist, bullying, authoritarian approach, reflexive counsellor recognising relational dynamic

"But I need to be on my toes all the time, because sometimes I can get a bit blasé and over confident. I am only human and I need sometimes a smack in the face to bring me down to earth, so come on 'Andy' (pseudo-name) you have got to think, it is not that simple and every single person that sits in that chair opposite you is different…(I: so it brings you back?) The slap in the face, normally the client will say something (I: right) and it hurts, you know, in the sense of [breaths in deeply] I always say to myself, thank you, I needed that, because if it hurts it means that I am not doing it properly… …One of my problems, one of the difficult problems I have is the only time I get to counsel is late evening. (I: oh right ok) when they catch me, they get me after having done eight hours work, so I come in and I only pick on fairly hard drinkers that I work with (I: Oh do you) Oh yes, because I am pretty tough on them at that time of night, I can tell you (I: ok) I am very blunt and I am very short and very to

the point (I: ok) but they like it (I: yea) they keep coming back anyway, so they must get something from it." (Andy;513-539)

Maybe indicative of hostile countertransference reaction in a group setting?

"The group is very powerful anyway, you know because they just support each other all of the time, but groups work much better with addicts as well, because again, the group dynamic is that someone will spot someone in denial and I don't have to do the work, they come in straight away and you know, I can hear denial here, and they explain what they mean and it's like, the other person, sometimes they get annoyed about it, but at the end of the day they have to listen, it's called tough-love, really, we dish out a lot of tough love." (Fiona; 424-430)

Suggestive of authoritarian approach in a group environment

"You can't be too empathic because you have to start giving them tough-love. If you give an addict too much empathy they will never stop drinking, or taking drugs, do you know what I mean. There is no happy happy stuff. But it is really weird because the tough-love, is aimed with that sort of bond, because sometimes we think like, how can I put it. It's not like I will get you by hook or by crook, like with your mates or something, we work our tough-love in a way around the group will go, oh yea and the group will come in a give them, what they are seeing, because really 80% of their recovery is done by the group anyway (I: yea). They are facilitators aren't they as such, so it is more important for our clients to have a bond than it is with the counsellors." (Harriet; 354-363)

Related to own experience, refers to challenging, may be related to own past victimisation. Participant seems self-conscious of challenging behaviour.

"I learned that from other people who challenged me. Woke the real me up and it's like having your own supervisor, do you understand that, I become my own supervisor. It's like the real (name) in me was like a little child and I acted out childishly and I thought childishly and stuff like that, but I have grown up, and I challenge the addict, whenever he wakes up or starts to get a bit of life in him, I challenge him and I tell him to go away, so I think it is part of my job, to sometimes be their challenger, so I challenge them so that they will learn to challenge themselves. (I: yea that makes sense) so I tend to be the one who, that's just my sort of belief and I tend to be the one who is quite challenging. I don't know whether they will tell you that or not, but I am, but that is part of my make up as well, but I have to be careful about that because sometimes, that is turned on me and I don't feel good about myself if I upset anybody. It's a bit risky, you know if I take the risk to challenge somebody and there is a risk that they might be upset and then I don't

feel good, because I am a bit of a people pleaser as well. So, but part of my recovery is I have to challenge, I have to take that risk because I think that sometimes, on that day at that particular time might be the one thing that is going to work (I: yea) because addicts love somebody who goes "ah there, there". (I: yea I don't think that works, very often, occasionally it does." (Edward;473-493)

Raised concern at hostile countertransference reaction of therapist bullying, abusive
Setting conditions and boundaries for therapy with client, as affording tough-love to client

"I must admit I really hate confrontational, like people who feel that tough love is about telling other people what to do or what not to do, I really don't believe in that, I don't ever confront people, I don't confront people except with their strengths ... I don't bully people because it just frightens people away ... it doesn't help to make them become resourceful ... I will be very straight with people and I will say my opinion, that sort of thing (I: right ok yea) but I am not telling them off or telling them what to do and I will set boundaries and I will say "you have come here drunk and I have asked you not to before and you have come back and I have offered them a morning appointment. You have to come back here not drinking because, you know we can't do this work unless you aren't and I say "you know it is really boring for people who are repeating themselves, you are not sure whether to punch me or hug me and you might be disclosing things, which you wouldn't want to", so I am very straight forward to people, but not in a bullying way, just kind of trying to make it really clear about what works and what doesn't and for me tough-love is self-protection, it's not about telling other people what to do, tough-love is when you set a boundary for yourself and I say I can't help you unless you do this. It's not about you have got to do this or you, but I am trying to help you and what I need you to do is to get here without having a drink so we can work together and I say I am sure you can do that, so I have made your appointment for half past eight tomorrow (laughs) in the morning (I: yea). I never think there is a role for bullying people because it encourages is compliance and often it is re-enacting very similar situations from the past when people have had abusive childhoods and I wouldn't want to do that, I would get quite angry about that and I do get the kind of people who have been rejected by them (laughs) you know, it's not good. I don't swear at my clients, for instance, I don't shout at my clients; that would never happen." (Ian;388-613)

Raised concern, observation of hostile countertransference bullying abusive practice by others, using own experience to justify how it would not be helpful to client
Counsellor offering reflexive practice

"I have trouble, I have said this, I have trouble with the phrase 'tough love' because love can be strong and love can be powerful, but it's never abusive or it's not love, so like I can say to somebody, I suppose I can say to somebody "do you know what when you are speaking like that" I bring it back to myself "there is a part of me that feels angry, there is a part of me that feels sad, because I think I hear you setting yourself up to go and have a drink" now that, I feel when I talk like that it is lovingly said, that it is said with kindly eyes and the person might not hear it that way, they might hear, you know. If I said [speaks loudly] "you are going to have a drink today, I can hear it in your voice, you might as well piss off now", now if I said that, that is not the way I work, because that would have never helped me." (Jan; 464-473)

Reflexive practice, reference to some RACs "trampling all over people"

"I always try and do it gently, by saying "I can see why you have done that, but what happened there, oh yea this happened didn't it, is that what you wanted?" see "because I tried that and this happened, but when I done this, then this happened, so how do you think you could have done it differently" (I: right yea) so slightly more directives than if I was counselling them in a long term one to one session, you know. Just take your time. I can't be client led in there because we would all be going out for a drink, you know what I mean, so it's a tough one, but I won't collude with the illness, I will collude with the solution, but I won't collude with the illness, so that is my idea of tough love, it's not me marching in and trampling all over people, it's not my experience I don't think that will work." (Gordon; 314-322)

Further explanation by Gordon, representative of challenging the client, suggestive of subservient client implying counsellor as superior or authority

"I don't want to rescue them, which means that sometimes I have to give them 'tough-love, which means that I really don't believe you are taking responsibility for yourself on this one. ....so you have to be careful, you have to make sure you are doing it out of love and you are not doing it out of, because you want to be right and stuff like that, but if done right I think tough-love is really good and I found you get a lot of respect back from the client. They do, they go thanks and I know you are not going to let me do things that are going to hurt me." (Gordon;295-306)

Reflective practice
Tough-love connected to AA practice

"Clients will say something like, well I had a client the other day saying that "well, I don't drink very often, I only drink, you know, sort of every couple of months ... I say "what happened last time you had a drink", "well actually I had a drink and I had a fight with my husband and the Police were called and Social Services were called, but that is normal isn't it ..."well actually if you didn't have that drink, that wouldn't have happened and you wouldn't be here ... Addicts challenge other addicts a lot more ... we know that tough love and challenging work for us in AA and with our sponsors, so we sort of bring that experience with us. (Fiona;341-351)

Appendix 15

Sub-category: Therapist identifying with the client
Sub-category code: Affording tough-love to clients

Jan explained her thoughts about affording tough-love to clients, using her own experience as an alcoholic. Jan's comments implied that she had observed 'tough-love' being used in an abusive manner and reflected concerns about the effectiveness of this style of intervention. Rodriguez de la Sierra (2006) also identified that working with an addict can be frustrating for a therapist and it required endurance and expertise to resist reacting in a hostile and rejecting way to the dependent client. Jan's view reflected that of several authors, that reflecting warmth and genuineness is helpful towards client progress (Gilbert, 2009; Rogers, 1951; Shainberg, 1993; White, 2000b)

> "I have trouble, I have said this, I have trouble with the phrase 'tough-love' because love can be strong and love can be powerful, but it's never abusive or it's not love, so like I can say to somebody, I suppose I can say to somebody "do you know what when you are speaking like that" I bring it back to myself "there is a part of me that feels angry, there is a part of me that feels sad, because I think I hear you setting yourself up to go and have a drink." Now that, I feel when I talk like that it is lovingly said, that it is said with kindly eyes and the person might not hear it that way, they might hear, you know. If I said [speaks loudly] "you are going to have a drink today, I can hear it in your voice, you might as well piss off now", now if I said that, that is not the way I work, because that would have never helped me." (Jan; 464-473)

Gordon spoke about when and how he employed 'tough-love' with clients and what it meant to him. Gordon reflected an awareness of wanting to rescue the client, which seemed indicative of an over-protective countertransference (Watkins, 1985). Gordon also suggested that he was mindful of how he reflected the unhelpful behaviour back to the client. Shainberg (1993) suggested that the good therapist will facilitate the client to go inside themselves to consider new possibilities through reflection and questioning, which seemed to be what Gordon was describing. This process is believed to lead to new ways of thinking for the client and activates new energy (Shainberg, 1993). Gordon also spoke about the interaction being positively received by the client, suggesting that Gordon listened to the client's feedback. Duncan et al., (2004) suggested it is important for the therapist to have client feedback, as this helps the therapist tailor the therapeutic practice to meet the client's needs.

> "I don't want to rescue them, which means that sometimes I have to give them 'tough-love, which means that I really don't believe you are taking responsibility for yourself on this one. ....so you have to be careful, you have to make sure you are doing it out of love and you are not doing out of, because you want to be right and stuff like that,

> but if done right I think tough-love is really good and I found you get a lot of respect back from the client. They do, they go thanks and I know you are not going to let me do things that are going to hurt me." (Gordon;295-306)

Duncan, B. L., Miller, S. D. & Sparks, J. A. (2004). The heroic client: a revolutionary way to improve effectiveness (Revised). San Francisco: Jossey Bass.

Appendix 16

Sub-category: Therapist identifying with the client
Sub-category code: Feeling deep empathy with the client

On exploring the concept of a spiritual connection, Jan reflected her thoughts about what this meant to her. She explained that she was cut off through her addictions, including her love for alcohol and it was only through giving these up that she was able to connect with others. Gray (2009) suggested that shame interfered with being able to connect, inhibiting empathy. Jan suggested that it was only as a result of being able to feel compassion in her relationship towards herself that she was able to offer this experience to others. This appears to reflect what Gilbert (2009) spoke about in relation to feeling shame. This experience may also reflect Jung's claim that in order for a therapist to be effective they need to be further in the 'individuation process' (bringing unconscious to consciousness) than the client (Dunne, 2000). This perhaps translates into Jan being further along in the recovery process than her client.

> "I know from putting down drugs of choice for myself, that something in me has started to come alive and it is the part of me that cares passionately and deeply about relationships and other people. That part of me that loves, that ability to love and to think when I have been trapped in my love of food, or starving, or body shape or my love of alcohol it has cut me off, so in that sense it cuts me off. I guess my lived experience of spirituality is that it comes through people and it is not an abstract ... So coming into recovery I started to get some compassion for myself that maybe I wasn't such a bad person and a shameful bag of shit, you know. Perhaps there were some good things about me and maybe I did some bad things in my drinking ... but I wasn't bad, so it was the idea that there was something in me that was OK. So once I started to feel that, I started to feel it for the other people..." (Jan;218-236)

Appendix 17

Sub-category: Therapist identifying with the client
Sub-category code: Managing problems in the shared experience with the client

When directly asked about countertransference reactions the participants reflected upon self-awareness and positive management of the clients' transference and projective identifications. The participants also described benefit by learning and personal development from their work with the client. One of the participants reflected being regulated by the client. These accounts do not match the literature that proposed alcoholic clients as challenging the therapist (Rodriguez de la Sierra, 2006; Zimberg, 1985). This might have reflected a respondent bias, where the participant might be reluctant to share negative experiences of practice through fear of being devalued. Wosket (1999) suggested that it might be difficult to gain a full appreciation of the professional wounded healer's practice through their fear of being negatively appraised.

Carol reflected on an experience of countertransference early in her counselling career and how she dealt with it using supervision. Carol indicated how she utilised her own experience of therapy to inform her of potential risks when reflecting back information to the client. Carol reported how having self-awareness of the countertransference reaction led to a successful outcome with the client and additional learning and benefit for herself through the therapeutic experience. Casement (1991) proposed that the therapist can learn from the client in the therapeutic relationship.

> "I didn't say anything to the client, but you know I wasn't sure where to go with it, because it was so, it was such a lot though, you know, I don't really know where to go with this because it was touching on my stuff ... I said to the client "you know this is a lot to deal with, I can work with you, but it will take time". I was thinking there is a lot of pain there. I said you need to trust, you can't because there needs to be a lot of trust here, she said I do trust you, I said we need to work more slowly and she just came up with so much, it was like she wanted to tell someone... … I know what it is like, I have done it myself. I had a counsellor tell me to slow down and when she said that I thought oh she doesn't want to know ... I left ... she doesn't believe me, so I never went back… …She [the client] worked really hard you know ... we worked for nearly a year....she was brilliant and it helped me as well ... because it helped me with my own stuff, even though I have worked with my stuff, it helped me, I don't know if that is selfish, but sometimes you work with a client and you learn stuff from them about yourself and it builds you up." (Carol;561-599)

Andy reflected an impasse in the therapeutic relationship after he saw clients when he was physically and mentally tired. This included an attitude of "blasé and over confident" and he described himself as being "blunt" and "short" with the clients.

Andy's explanation indicated honesty, vulnerability as a therapist and self-awareness. However, his explanation also implied an over-identification countertransference reaction with feelings of anger and frustration perhaps at the ambivalence of the client to find abstinence from alcohol (Gabbard and Wilkinson, 1994; Leiper and Kent, 2001; Moring, 1997). Alternatively, this description could be a sadistic or sado-masochistic hostility countertransference response to a masochistic client with low self-esteem (Rodriguez de la Sierra, 2006; Watkins, 1985). Andy seemed to be saying that he was regulated by the clients' reactions.

> "But I need to be on my toes all the time, because sometimes I can get a bit blasé and over confident. I am only human and I need sometimes a smack in the face to bring me down to earth, so come on 'Andy' (pseudo-name) you have got to think, it is not that simple and every single person that sits in that chair opposite you is different…(I: so it brings you back?) The slap in the face, normally the client will say something (I: right) and it hurts, you know, in the sense of [breaths in deeply] I always say to myself, thank you, I needed that, because if it hurts it means that I am not doing it properly… …One of my problems, one of the difficult problems I have is the only time I get to counsel is late evening. (I: oh right ok) when they catch me, they get me after having done eight hours work, so I come in and I only pick on fairly hard drinkers that I work with (I: Oh do you) Oh yes, because I am pretty tough on them at that time of night, I can tell you (I: ok) I am very blunt and I am very short and very to the point (I: ok) but they like it (I: yea) they keep coming back anyway, so they must get something from it." (Andy;857-918)

Appendix 18

Struggle with psychological terminology and code labels

Memo – 20th March, 2010

In comparing the diagrams and original codes all of the participants seem to speak about an 'emotional intelligence' in the clients experiences. All of them reported to having this preconceived understanding and appreciation for the client's current and future behaviour, emotion and way of thinking. On consulting the original transcripts none of the participants speak use the term emotional or intelligence and this alerts me to an imposing my psychological knowledge onto the participant's codes.

Sample of codes

Identifying with the client [Fiona]388 – emotional intelligence
(Code dated 19/02/2010)
Knowing the effects of the alcoholic behaviour on others due to experiencing it, enables a reflection of consequences and outcomes positive and negative

Identifying with the client [Fiona]348 – emotional intelligence
Easier for addicts to challenge addicts, because client knows RAC knows

Identifying with the client [Denis]141 – emotional intelligence
(Code dated 21/01/2010)
How could you possibly know what it is like to be in a situation unless you have been there?

Building a self-identity [Betty] 931 – emotional intelligence
Owning triggers enabled control, so know this for clients.

After some consideration and a look back through the original codes all these codes contain "knowing". This seems to be a more accurate label for this message coming from the data.

Appendix 19

Final Reflections

I feel that I have learnt a great deal towards my personal and professional development in carrying out this study. I enjoyed carrying out the interviews and felt connected to the participants. During the interviews I resisted the role of counsellor through remaining self-aware of the purpose of the study, using the interview guide to remain focused as a researcher. The analysis was more difficult than anticipated and I struggled to remain objective and critical of the participants' narratives. I felt a positive bias towards the participants' that I initially struggled to recognise. I also struggled to report negative aspects within the data.

Only through reflection were these biases and feelings of protection towards the participants apparent. This was aided by making corrections to the dissertation and attending some additional training to learn supervising skills. This prompted me to recognise that these protective feelings represented a parallel processes (Searles, 1955), which may have been mirroring or reflection of the participant's and client relational dynamics (Eckstein and Wallerstein, 1972; Caligor, 1981; Doehrman, 1976; Sachs and shapiro, 1976).

During the interviews I felt empathic enmeshment in the participant's worlds feeling their pain and struggle with alcoholism. I found their stories inspiring. I felt complete admiration for the participants' in their lives as alcoholics. I was struck by their honesty, extreme circumstances, heroism and strength. I felt honoured to have these stories shared with me. I felt reminded of the AA meetings I had sat in on and stories of struggle and endurance. On reflection I can appreciate the strength and power of the collaboration of the AA members in supporting one another through the process of sharing their stories.

My protective feelings towards the participants may have also related to my professional identification with this client group and a sense of loyalty. Interpreting negative elements of practice felt like a betrayal of trust. The participants had put

their trust in me with very personal and sensitive information about their struggle with alcoholism and reflection of this in their client work. This also represented a conflict between the role as a researcher and my role as a counselling psychologist. As a therapist we are trained to keep our client's narratives confidential, in research I am recording personal details. This process felt uncomfortable.

Another issue that may have impacted my tendency towards being positive was the participants' request to read the dissertation upon completion. This was a strong influence, as I did and do not want to offend my participants. This reaction may also be something that I need to address in my own personal therapy, as it may link to some unhelpful beliefs about people pleasing and wanting to be evaluated positively by others.

During the interviews I also experienced reactivity to the participant's belief that having a personal experience in alcoholism meant that they were better prepared to work with alcoholics. Whilst I recognised there is some accuracy in this belief, with regards to attaining knowledge, I also believe that knowledge can be acquired through curiosity and learning. Not every helping role can have experience in the clients problem to be helpful, for example, General Practitioners or cancer nurses. This may have been a belief that I had projected or transferred to the participant's during the interviews, causing a respondent bias. It was interesting that within the transcripts, in relation to this belief many of the participants adjusted their statements to suggest that they did not believe this statement or reframed it as an additional therapy tool. These responses may have been evidence of my projections.

The process of the study also reminded me of my own personal experience of alcoholism, having been married to an alcoholic and I was reminded of the defences and chaos from the perspective of the alcoholic. During the study I realised that I was a wounded healer, drawn to the helping profession through my experience. I wondered about my motivations to work as a counsellor. I found myself reflecting on my own experience of counselling during the end of my marriage. I was struck by how counselling gave me additional perspectives and awareness of choices. I found that this experience of counselling was powerful and I found my curiosity ignited with a want to experience and learn more about myself and others. This also reminded

me on how vulnerable clients can be hanging on every word of the counsellor. This helped me gain perspective on my protecting the participants and how important it was to translate the participant's views as accurately as I could.

I have felt completely enmeshed and engaged with the data, with odd insights coming to me at odd times and places, even now it is finished. I have emergent questions about the alternative means of recovery from alcoholism and how much of the problem is located in the alcoholic identity and AA philosophy. Perhaps the alcoholic identity maintains the belief in ongoing recovery. Labels are powerful. I notice if I am told I am kind, then I find myself being kind. The identity of alcoholic was reflected as permanent by the literature and by the participants. Upon reading Biernacki (1986) book regarding recovery for heroin addicts, I am still stuck with those addicts who had not adopted the addict identity and reported recovery much easier. It appears that perhaps some of the problem with alcoholism is in the alcoholic identity.

I also find it fascinating that the participants continued to maintain alcohol in their lives through their client work. It is as though these individuals are metaphorically continuing to consume the alcohol through their client work. This leaves me curious and pondering. I anticipate that these questions will continue and this curiosity will be ongoing. I wonder if there are individuals who were previously dependent on alcohol and do not have alcohol in their lives.

Having carried out this study I appreciate some of Jung's work, including the shadow and quest for uncovering the unconscious in the personal actualisation, as well as the cautions about countertransference reactions. I am reminded how important it is as a professional to continue to work on myself, questioning my motivations and remaining open and curious with the client. I recognise that I am vulnerable to countertransference reactions, becoming enmeshed within the client's world. I am also vulnerable to defences and collusion with the client. Like other professionals I want to be viewed as competent, it seems like a balancing act to get it right. These seem like issues that would be applicable to all therapists. I have enjoyed the experience of writing this research and I have particularly enjoyed learning so much about myself and others in the process.