

Middlesex University Research Repository

An open access repository of

Middlesex University research

<http://eprints.mdx.ac.uk>

Bourne, Frances Elizabeth (2014) Endings and beginnings: a thematic analysis of client and psychotherapist experience of an imposed change of psychotherapist. Other thesis, Middlesex University / Metanoia Institute.

Final accepted version (with author's formatting)

This version is available at: <http://eprints.mdx.ac.uk/13987/>

Copyright:

Middlesex University Research Repository makes the University's research available electronically.

Copyright and moral rights to this work are retained by the author and/or other copyright owners unless otherwise stated. The work is supplied on the understanding that any use for commercial gain is strictly forbidden. A copy may be downloaded for personal, non-commercial, research or study without prior permission and without charge.

Works, including theses and research projects, may not be reproduced in any format or medium, or extensive quotations taken from them, or their content changed in any way, without first obtaining permission in writing from the copyright holder(s). They may not be sold or exploited commercially in any format or medium without the prior written permission of the copyright holder(s).

Full bibliographic details must be given when referring to, or quoting from full items including the author's name, the title of the work, publication details where relevant (place, publisher, date), pagination, and for theses or dissertations the awarding institution, the degree type awarded, and the date of the award.

If you believe that any material held in the repository infringes copyright law, please contact the Repository Team at Middlesex University via the following email address:

eprints@mdx.ac.uk

The item will be removed from the repository while any claim is being investigated.

See also repository copyright: re-use policy: <http://eprints.mdx.ac.uk/policies.html#copy>

**Endings and Beginnings: A Thematic Analysis of Client
and Psychotherapist Experience of an Imposed Change of
Psychotherapist**

Frances Elizabeth Bourne

**Middlesex University and Metanoia Institute
Doctor in Counselling Psychology and Psychotherapy
by Professional Studies**

Submission January 2014

ACKNOWLEDGEMENTS

Thank you to the clients and therapists who worked with me on this project, generously giving their time and sharing their experiences of an imposed change of therapist.

ABSTRACT

This study explores a phenomenon that has over the years attracted little systematic investigation and has never been addressed from the dual perspectives of client and therapist in a working therapeutic dyad. This original contribution provides knowledge on how an imposed change of therapist can impact individuals, relational dynamics and therapeutic outcome.

The research took place in a substance misuse agency with four therapeutic dyads composed of client and replacement therapist. A thematic analysis of semi-structured interviews was used to capture individual client and therapist experiences of the phenomenon, then paired client and therapist interviews were analysed for dyad material.

The client experience of the imposed ending and change to a different therapist involved the activation of the attachment system and the possibility of change in substance use or the fear of relapse. For clients there was an accumulation of losses linked to the relationship with the departing therapist, the work done in that relationship and the hope of an outcome from that work. The experience of the therapist working with an imposed change client is documented in their approach to working as the replacement therapist and a presence in the relationship of the first therapist. In the four dyad accounts the findings from individuals are seen to shape the development and trajectory of this second relationship and therapy outcome.

From the findings, the importance of acknowledging and working with this phenomenon is discussed and recommendations are made for both practitioners and organisations to benefit client, therapist and organisation. The data not only fills a gap in knowledge but also opens the way for further investigation into the relationship that ended due to the therapist's departure and the phenomenon's impact in different clinical settings.

CONTENTS

1. INTRODUCTION	1
1.1 Defining the phenomenon	1
1.2 Background.....	2
1.3 Research context	3
1.4 Rationale.....	4
1.5 Aims and objectives	4
2. LITERATURE REVIEW.....	5
2.1 Problematic substance use.....	6
2.2 The therapeutic relationship	8
2.3 Beginning therapy	9
2.4 Ending therapy.....	9
2.5 Imposed change.....	12
2.6 Summary.....	18
3. METHODOLOGY	19
3.1 The framework	19
3.2 The researcher	20
3.3 The setting	21
3.4 The participants	22
3.5 Ethical considerations.	25
3.6 Contact and consent	30
3.7 Collecting experiences	30
3.8 Analysing experiences.....	32
3.9 Evaluation.....	35
4. FINDINGS.....	37
4.1 Introduction.....	37

4.2 Presentation of findings	37
4.3 Identifying the voices	38
4.4 Overview	39
4.5 Individual accounts	43
4.5.1 Dyad One – Client James	43
4.5.2 Dyad Two – Client Sidney	54
4.5.3 Dyad Three – Client Megan	64
4.5.4 Dyad Four – Client Kezia	74
5. DISCUSSION	84
5.1 The client experience and attachment	84
5.2 Client reoccurrence of symptoms.....	85
5.3 Client loss and change.....	85
5.4 Therapist experience and endings.....	91
5.5 Therapist beginning with imposed change clients	92
5.6 The Dyad	95
5.7 The Organisation.....	96
5.8 Contribution and recommendations	97
5.9 Challenges, limitations and future research	102
5.10 Conclusion	104
APPENDICES	105
Appendix 1 – Research diary extracts	106
Appendix 2 – Agency imposed change clients 01/07/05 to 07/07/08	109
Appendix 3 – Tier 3 service	110
Appendix 4 - Client therapy history with T1 and T2	111
Appendix 5 – Interview guides.....	112
Appendix 6 – Analytic trail	114

Appendix 7 – Atlas codes-primary documents table	122
Appendix 8 – External coder	127
Appendix 9 – Atlas Code Families	135
Appendix 10 – Codes to diagram themes	139
Appendix 11 – Participant check notes	140
REFERENCES.....	147

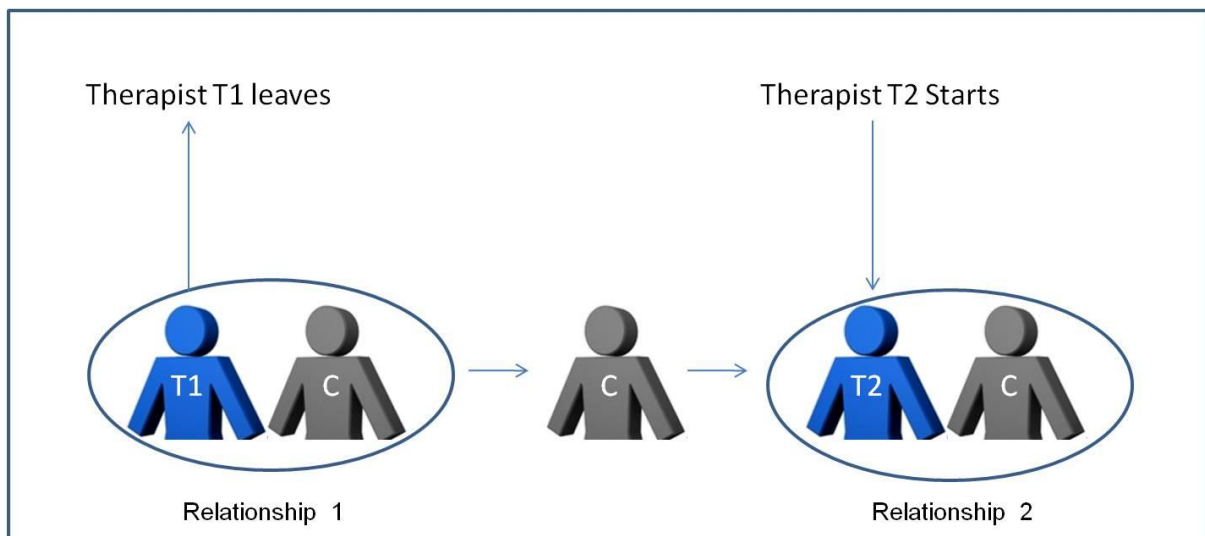
FIGURE 1 IMPOSED CHANGE OF THERAPIST	1
FIGURE 2 LITERATURE REVIEW CONCEPTUAL MAP	5
FIGURE 3 INTERVIEW TRIANGLE.....	26
FIGURE 4 FORMAT FOR FINDINGS	34
FIGURE 5 DIAGRAM OF IMPOSED CHANGE AND THEMES.....	40
TABLE 1 DATA SETS.....	19
TABLE 2 PARTICIPANT SEARCH RESULTS.....	23
TABLE 3 EVALUATION CRITERIA AND EVIDENCE	36
TABLE 4 CLIENT THEMES	41
TABLE 5 THERAPIST THEMES	42
TABLE 6 RECOMMENDATIONS FOR ORGANISATIONS AND THERAPISTS.....	99

1. INTRODUCTION

1.1 Defining the phenomenon

A clinical reality in the provision of individual psychological therapy is that therapists (here ‘therapist’ will cover all qualified and trainee counsellors, psychotherapists and psychologists) end therapy with a client for reasons that are not related to the therapeutic work, client need or client outcome. Therapists may change jobs, relocate, become ill or die and in settings where a proportion of the staff are trainees, there may be time limited placements or therapist rotations. All these events are therapist-led and external to the therapeutic process. Due to the nature of these endings, planned or unplanned, if therapy is to continue, clients are either reassigned to work with a different therapist or put on a waiting list. For this piece of work I am conceptualising this imposed therapist change process as being made up of the ending of one therapeutic relationship for non-therapeutic, therapist-led reasons, followed by the client starting work with another therapist, see Figure 1.

Figure 1 Imposed change of therapist



For me, this imposed change suggests that one or both members of the original therapeutic dyad consider the therapeutic work unfinished or that the desired outcome or goal of the work has not been achieved, hence the second therapeutic relationship.

1.2 Background

I initially recognised my interest in the phenomenon of imposed change of therapist when a colleague commented on the change in energy as I described clients who experienced an imposed therapist change at the substance misuse agency (the Agency) where I worked. When reflecting on the endings and beginnings these clients experienced, I found my 'biographical presence' (Smith 2004, p.45) in my own childhood experience of being part of a family who relocated every two years. I had to negotiate endings and beginnings at many schools and cope with interruptions to, and lack of continuity in my education as well as the making and ending of friendships. I believe my history has led me to privilege the unheard voice of an imposed therapist change client.

My first clinical placement as a trainee was at the Agency. Along with my training, my personal, integrative, developmentally guided, relational framework for the psychological therapy that I provide was shaped by working with clients at the Agency. My clinical orientation takes into account our biological, psychological and social selves. Clients who come for psychological therapy in all the settings I have worked in, present with issues that are complex combinations of all these and for some clients these issues incorporate problems with substance use. At the Agency, I experienced the diversity of client presentation in the type and amount of substance they used, their goals to reduce use or become abstinent and their motivation and readiness to work towards their goals. Beyond the common factor of problematic substance use, I have also appreciated the range of client psychological and emotional strengths and vulnerabilities, their different educational and socioeconomic status, personal beliefs, culture and family histories.

Working with an imposed change client in this first placement, I found my curiosity was stimulated by this client group who were not actively defined at the Agency or in the wider substance misuse field. This group of clients experienced an imposed change of therapist, in some cases more than one change of therapist, due to staff and placement turnover. What was it like for these clients? Do the changes in therapeutic relationship affect their length of stay in the service and their progress towards their hoped for outcome? For the Agency clients, could the change of therapist be handled differently or with more awareness to facilitate the best client outcome?

When I took on the role of replacement therapist I was guided by my external supervisor to enquire about the client's previous therapeutic work and ending. Work with an imposed change client was not marked in any way at the Agency. Starting out on this research I made the assumption that other therapists would be guided by supervision or past experience, in the handling of endings and in working with imposed change clients.

1.3 Research context

Beyond the definition that isolates the phenomenon for study, there are macro and micro environmental factors that will influence the process of imposed therapist change in any particular setting. The macro environment includes the social and cultural milieu of the setting and the external financial and evidence based determinants of the service it provides. Reading (2003) describes the addictions field as 'multi-disciplinary and subject to political and public pressures, with powerful influences (including legislation and selective provision of resources) being exerted at particular times'.

Changes in Government policy, such as the move to drug related crime reduction and the use of the criminal justice system to get drug users into treatment, continuously impact funding and service provision to substance misuse clients. Distinctions between clients, based on the substance they use developed from socio-political perspectives that have determined the current, international separation of legal alcohol misuse and illegal drug use treatment paths (Allamani, 2008). During this project there was a change of service provider at the Agency that heralded a change in attitude to the use of psychological therapy for clients. In this setting, the clients and therapists experienced the influence of service commissioning funding on the micro environment of the therapeutic relationship. Prior to this change the service was offered to clients regardless of the substance used and therapists were not obliged to adhere to any particular therapy regime. Following the change, employed therapists were renamed Key Workers; the time allowed for therapy was reduced to 12 weeks and clients whose problematic substance was alcohol (clients in this study) were excluded from individual psychological therapy. Later, therapy was only offered by volunteers and placements. This Agency imposed change provided an interesting parallel for me as researcher and therapist, alongside my study of the more intimate imposed change of therapist (Appendix 1 - Research diary extracts).

In the micro environment, in the meeting of two individuals in a therapeutic relationship there will be individual differences, the individual histories of client and therapist as well as the unique relationship they create together. In this study, as researcher, I am not an observer and I see myself representing both a macro and micro influence on the study. By investigating the phenomenon of imposed therapist change experienced by four dyads, I bring an influence from outside the phenomenon to bear on the description of each participant's experience within the micro environment of researcher and participant. Like each participant I come to the study with my own history and knowledge that has an impact on each part of the project.

1.4 Rationale

Having identified the phenomenon, I further refined the definition to a specific form of imposed change, a therapist-imposed change. For me the imposed change client group were invisible at the Agency and it was important to investigate their experience and any impact this had on the outcome of their engagement with the service, both for the client and service provision. Initially I set out to explore the client experience but extended the study to include the therapists and the therapeutic relationships involved. While still staying with my wish to privilege the client experience of the events that encompass an imposed change of therapist, I felt the inclusion of this second group would enrich the data by adding a second perspective on the event. It is also in keeping with my view of the importance of the therapeutic relationship.

The change from an individual to dual perspective exploration of the phenomenon shifted the methodology from Interpretative Phenomenal Analysis to a critical realist, contextual, thematic analysis. This change allowed a deeper investigation of the phenomenon by adding the relational dynamics of the therapeutic dyad to the individual experience of client and therapist.

1.5 Aims and objectives

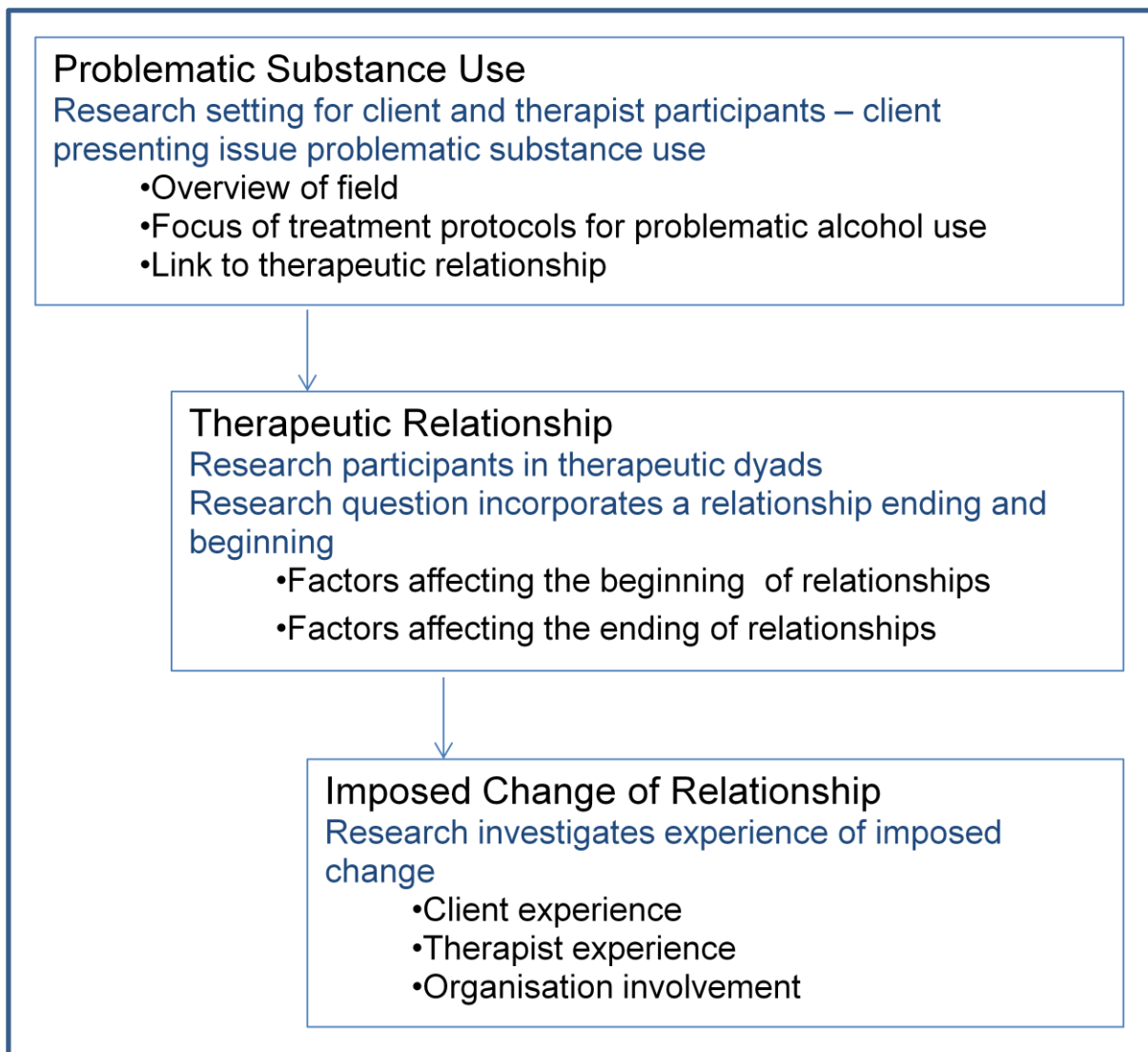
My aim was to record and analyse the client and therapist experience of the imposed change of therapist in an attempt to shed light on the following:

- *How the client experiences the imposed change of therapist*
- *How the therapist experiences the ending or beginning with the client*
- *How for the new dyad, the client and therapist experiences compare*
- *How the client and therapist perceive the imposed change as influencing the Care Programme journey and outcome of the client*

2. LITERATURE REVIEW

This research brings together themes from different areas of therapeutic enquiry. Literature concerning problematic substance use, the therapeutic relationship, the ending and beginning of therapy and imposed change of therapist are all considered (see Figure 2) as I put the phenomenon of imposed change of therapist, the research participants and myself as researcher in context.

Figure 2 Literature review conceptual map



2.1 Problematic substance use

There are a multiplicity of terms used in the literature to describe the problematic use of alcohol and drugs that have both professional and lay usage including addiction, substance abuse, substance misuse and substance dependence. There is also a medical, diagnostic based terminology with named disorders (DSM-IV-TR, 2000). The medical, professional and everyday terminology does not necessarily describe the same presenting issue or client population. The research participants in this study are drawn from two distinct groups, the Agency clients identified by their presenting issue of problematic alcohol use and the service provided to them, and the Agency therapists identified by their professional training and work with the Agency clients. Below I briefly consider theory and research in the addictions field.

‘Why am I the way I am?’

In attempting to answer this question posed by a client at the Agency, the addiction literature covers the biological, psychological and social processes involved over a life span. The incorporation of biopsychosocial thinking has shifted the earlier moral perspective (addiction as excess consumption) and the medical (disease/brain processes) model to multidimensional thinking that helps define a broader aetiology and the differences between individuals with problematic substance use.

The field is multidisciplinary with many researcher and practitioner perspectives on the how and why of problematic substance use and this informs the commissioning of research and service provision. Investigations pursue singular processes such as addiction genes (for example, Buckland, 2008); neuroscience that relates the neural positive reinforcement of substances to the activation of mechanisms that suppress distress and pain (such as Wise, 1988); or take in the complexity from a biopsychosocial perspective focusing on the adaptive considerations of a biological mechanism (mesolimbic dopamine system), psychological development (self-regulation and attachment) and social behaviour (Lende and Smith, 2002). Social context has also been a research focus investigating social networks and client support (Copello et al., 2002; Soye et al., 2006). For me, the genetics and neuroscience are a fascinating background to what a client is struggling with on a day to day basis. As a practitioner, I see evidence of the client’s psychological development and relationship history providing grist to the mill for therapeutic work as life outside therapy is present during sessions in the therapeutic dyad.

Theory, research and service provision

In keeping with my experience of working with clients with problematic substance use Leighton (2004, p.84) suggests that it would be ‘misleading to generalize about addiction’ and delineate a ‘Procrustean template’ but states that many clients have ‘suffered damage to

their relationships and have a history of highly unsatisfactory relationships in their primary family and possibly suffered considerable mistreatment, neglect or abandonment’.

Considering this generalization I find it unsurprising that there are theories that encompass the substance misuser’s capacity to cope with distress and difficulties with self-regulation (Flores, 2003; Khantzian & Albanese, 2008; Reading, 2002). A Self Psychology perspective using Kohut’s concept of narcissistic vulnerability (Chelton & Bonney, 1987; Weegman, 2002) and psychoanalytically orientated theories (Krystal, 1997; Wurmser, 1987) describe the use of a substance as a substitute for missing intrapsychic functions and problems with interpersonal relationships. Apart from the underpinnings of a therapeutic approach for working with problematic substance use, the breadth and scope of a client’s problems associated with substance use means service providers often have to offer service users acute support on a range of issues. The luxury of time to explore the determinants at a deeper psychological level is often not allowed as evidenced by the changes in provision that I experienced at the Agency. A National Treatment Agency report (Waingaratne et al., 2005) suggests that for substance misuse clients any form of psychological treatment leads to better treatment outcomes compared to no psychological treatment, but there is no consensus that one form of treatment is better for all clients than another.

Matching clients to treatment

In this field there have been concerted efforts to match clients to treatment protocols (Project MATCH Research Group, 1998; UK Alcohol Treatment Trial (UKATT) Research Team, 2001, 2005) despite the diversity of proposed predisposing, contributory and perpetuating factors in problematic substance use. This for me captures the divides between theory, practice and research.

In the UKATT publications (Orford, 2001; Orford et al., 2006; Orford et al., 2009a; Orford et al., 2009b) there has been, over time, an acknowledgement of the importance of ‘the formation of a good relationship with a helping person’ (Orford et al., 2009a, p.311) but the team still leaves as a priority, solving the ‘mystery’ of why diverse treatment types are equally effective, as if not allowing the ‘nonspecific factors’ of the relationship to be at the centre of carefully devised protocols.

I see service provision caught between the research evidence of treatments that work and practice based theories that inform the work of practitioners. From a meta-analysis, Imel et al., (2008, p. 541) discuss the place of ‘divergent theoretical bases’, and ‘researcher allegiance effect’ in the failure to discover outcome differences between treatment protocols. They suggest a research focus on ‘the complex interactions that occur between patients and therapists’ as researchers ‘typically ignore the therapist as a source of variability in clinical trials’. Norcross and Lambert (2011, p.3) pick their way round the unproductive nature of the

'false dichotomy of treatment versus relationship' as the 'empirical evidence' and 'therapist centrality' camps polarise the discipline. In a similar vein, Beutler et al., (2012, p.256) looking at common and specific factors suggest 'dismantling treatment models' and exploring how 'patient, treatment, relationship and matching variables interact'.

Nationally, research and funding for services appears to favour 'treatments', short term symptom reduction outcomes, with the holistic approach towards longer term change becoming a luxury. For me, work in the relationship allows the complexity and history of an individual to be considered in the client work as part of the presenting problem and other problems that arise in the context of the therapeutic relationship.

2.2 The therapeutic relationship

The acknowledgement of the 'good relationship' found in the qualitative data of the 'matching clients to treatment' literature discussed above has been a feature of the therapy literature for several decades (for example Luborsky et al., 1983; Luborsky et al., 1997; Norcross and Goldfried, 1992; Wampold et al., 1997). Lambert's 1992 review of the outcome literature identified key factors and estimated their influence on the variance in outcome suggesting that 30% was due to the therapeutic relationship.

Specifically with substance misuse clients, studies have linked the part played by the therapeutic relationship in client retention (Meier et al., 2005a) and outcome (Luborsky et al., 1985; Najavits and Weiss, 1994). While Meier et al., (2005b) looked more specifically at the client relationship history being instrumental in engagement and retention in the therapeutic relationship. A National Treatment Agency review of the effectiveness of treatment for alcohol problems (Heather et al., 2006) considering the 'how' rather than 'what' was delivered, concluded that therapist characteristics account for around 10 to 50% of the outcome variance and that building a therapeutic alliance is important.

While I am not interested here in defining parts of the relationship, or therapist and client characteristics in isolation; there is work in this area with substance misuse clients that has quantitatively researched the therapeutic relationship. Such research breaks down the complexity of the therapeutic relationship into investigation-sized pieces such as, the therapeutic alliance (Meier & Donmall, 2006), attachment styles (Meier et al., 2005b; Caspers et al., 2006), client and therapist factors (Meier et al., 2005b) and dynamic or interpersonal processes (McDonald et al., 2007). All of these I see, from my practitioner perspective, as contributing to establishing, understanding and maintaining a fruitful therapeutic relationship. Changes in themselves can be problematic as Flores (2004, p.2), whose work is informed by attachment theory, holds that disruptions in attachment to either the therapist or treatment programme leads to dropout and relapse.

2.3 Beginning therapy

In the psychotherapy literature the quality of the therapeutic alliance is cited as one of the most consistent predictors of therapy outcome, particularly the alliance in the initial stages of therapy (Horvath et al., 2011; Martin, Garske & Davis, 2000). In this study I am interested in beginnings, in the development of the second therapeutic relationship following an imposed ending.

Horvath et al., (2011) describe the alliance as a way of 'conceptualising what has been achieved' by the appropriate use of relationship elements such as empathy and creating a safe environment. The importance of therapeutic empathy on client improvement is supported by various findings (Orlinsky & Howard, 1986; Luborsky et al., 1988) and specifically in relation to 'problem drinkers' (Meier et al., 2005a; Miller et al., 1980, 1993). Akerman and Hilsenroth (2003) reviewed therapist activities and attributes that positively influenced the alliance. The activities included support, noting past therapy success, facilitating expression of affect and attending to the client's experience. Therapist attributes included being flexible, trustworthy, warm, interested and open.

The therapeutic relationship is about the interaction between two people and 'past and present interactions' for them both (Diamond and Marrone, 2003, p.27). The workings of individual 'inner worlds', of 'transference and projections' and therapist 'countertransference' (Harris, 2004a, p.193) that need to be considered when studying the workings of a particular dyad. Harris (2004a, p. 198) links clients leaving therapy prematurely with the failure to build an alliance and describes the use of attachment theory to 'ensure this alliance is fully developed by tailoring therapy style to attachment style'. Ruptures in the alliance are also part of the therapy along with repairs, and can herald both change and a stronger alliance (Safran et al., 1990; Safran & Muran, 1996).

Other work has looked at helpful and hindering events in psychotherapy (review by Timulak, 2010) highlighting differences between client and therapist views. Helpful for the client are interpersonal events such as therapist reassurance and in-session outcomes. Hindering events include client disappointment with the therapist or therapy, misunderstandings and repetition.

2.4 Ending therapy

Having defined an imposed change of therapist as being made up of an ending and beginning, I am going to look at the literature on ending therapy and imposed or forced endings before looking at endings that constitutes part of an imposed change. From psychotherapy process and practice, there are various terms for what may or may not represent the same scenario.

The use of 'termination' to describe the ending of therapy Schlesinger (2005, p. 4) suggests, conveys the mutually agreed bringing of therapy to a close with the 'opportunity to work through' and the client as a result, owning and taking away their achievements. This description conveys that for therapists ending is an active, working part of therapy with its own outcomes. Endings that are not mutually agreed come with different labels such as, 'imposed' or 'forced' ending. For a change of therapist the terms 'transfer' or 'reassignment' of the client are used.

Termination

'Few of our treatments meet the mythological, idealised model of termination that has inadvertently evolved', Golland (1997, p.266) suggests, adding, that each ending is actually an 'idiosyncratic activity that has some orientating principles, but much more ambiguity than clarity'. Wachtel (2002) compares psychoanalytic, experiential and cognitive behavioural approaches to termination. He comments on their similarities and the consensus between orientations, despite their different theoretical assumptions. Noting, the emphasis on unconscious conflicts and anxieties in psychoanalytic therapy, attention to the client's subjective experience in experiential therapy and the cognitive behavioural therapy emphasis on the goals of therapy.

The use of loss and mourning (Bowlby, 1979; Freud, 1917) to conceptualise the end of therapy is prevalent in the literature 'evolving' from the psychoanalytic field (Boyer and Hoffman, 1993; Marx & Gelso, 1987; Pearson, 1998). For Kenneth Frank (1999, 2009) this evolution continues as he marks his change to a relational view that can no longer use the 'rules of psychoanalytic termination'. These rules appear to have been the main stay of the termination literature with reviewers commenting on the lack of articles on something other than the mechanics of termination (Frank, G. 1999; Golland, 1997; Pearson, 1998) and the lack of investigation into the termination process (Roe et al., 2006).

While a lot of the writing on endings are drawn from clinical work 'replete with accounts of poignant reactions from clients and counsellors alike' (Pearson, 1998, p.56) they do build a picture of, and give a feel for, the endings of therapy as largely negative experiences. If loss is a theme in the therapy that will influence the importance the client attaches to the ending (Gould, 1978; Marx & Gelso, 1987) with previous losses being revived at ending for both client and therapist (Boyer and Hoffman, 1993). Pearson (1998) adds that there will be client ambivalence about ending, anxiety about maintaining the therapeutic gains, sadness related to separation and loss, pain associated with unresolved attachment, fears of abandonment and rejection, anger, confusion and denial of feelings.

Schlesinger (2005) suggests that some clients can only separate by devaluing the therapist. Stagnation and impasse can develop as issues are avoided by the client and the

therapist due to fear of separation. Messler Davies (2005), with her relational view of the 'deeply difficult process', captures for me the intersubjective 'unique synergy of historical moments, intense affect states, internal systems of meaning construction, and object relatedness' between therapist and client as she writes of one particular experience.

There is also research that suggests that such negative reactions are overstated (Fortune et al., 1992; Marx & Gelso, 1987; Quintana & Holahan, 1992), possibly as a result of the predominance of psychoanalytic based literature. More recently Roe et al., (2006) explored client feelings during termination related to their satisfaction with therapy and found that factors contributing to positive feelings were about termination as a practice of independence, a reflection of positive aspects of the therapeutic relationship and positive gains experienced in therapy. Loss of a meaningful relationship was the most frequently mentioned factor contributing to negative feelings during termination.

Imposed or forced ending

Writers on this subject note the sparsity of literature for such a frequently occurring phenomenon (Penn, 1990; Robb & Cameron, 1998) and again what there is has a predominantly psychoanalytic orientation. Pearson (1998) suggests that the tasks are like those for mutual termination but more challenging, with Bostic et al., (1996, p.347) deciding that forced terminations 'are a powerful experience for both patients and residents' also 'introducing a potent stressful event' into the therapeutic relationship. The majority of the literature is therapist accounts of forced endings, often with recommendations for the handling of these endings (Bostic et al., 1996; Dewald, 1965; Pearson, 1998).

The client response is variously described as: acting out, withdrawing and passive resignation (Dewald, 1965). As the client is about to be abandoned by the therapist toward whom they have developed some degree of trust Schlesinger (2005) suggests the response has complicated idiosyncratic reactions (consistent with their character structure). He lists common initial reactions such as, flight, withdrawal, regression, denial, projection and splitting, resignation and apathy. The list from Bostic et al., (1996) includes, vengeful self-defeating behaviour, the search for substitute transference objects, deprecation of therapy, increase symptoms, inducing guilt in the therapist, a quick finish or holding on to the therapist.

Unlike the other work in this area Kahn (1995) used semi-structured interviews with clients who had undergone a therapist imposed ending. Rather than the generalised responses and theory based therapist descriptions seen in the rest of the literature, three categories of experience were found in the interview material: termination as traumatic and emotionally unresolved at the time of interview; traumatic at the time but worked through and

unremarkable, successful events that evoked feelings of sadness but with no enduring negative effect.

2.5 Imposed change

Having looked at the therapeutic relationship, relationship beginnings and endings, what happens when the relationship is ended and the work is to be continued in a new relationship? It seems fundamental that therapists would consider this change and have access to clinical observations and research to inform them. However over the decades literature reviewers agree that there is a 'paucity of references dealing with this common problem' (Keith, 1966, p.185), 'the literature has little to say about it' (Scher, 1970, p.278), and the area has received 'sporadic attention' (Wapner, 1986, p.492). Schlesinger (2005, p.27) bemoans the fact that training institutions do not train therapists to handle the endings and beginnings of transfers and use an 'administrative mechanism' to pass 'unfinished patients' from one trainee to another. I found no research into imposed change of therapist with substance misuse clients (other than incidental use of transfers to study therapist success, McLellan et al., 1988) but a line in a National Treatment Agency review document (Heather et al., 2006) suggested that with a Stepped Care approach, the steps 'which may involve a change of practitioner, are natural steps for the service user'. In checking with the authors I established that this comment was drawn from unpublished data from an addiction unit Treatment Perception Questionnaire that found 'consistent unhappiness at changes of practitioner' (Raistrick, 2012) and that this had not been looked at in terms of outcomes for those clients. This one line was embedded, un-evidenced in a document that rated all the 'effectiveness' research it presented - a nugget on imposed change that had not been further investigated or published.

The body of work detailed below appears to have had little impact on policies, procedures and practices over the decades. I have divided the imposed change literature into the following areas: the numbers of transferred clients; descriptions of how the imposed change is experienced by client and therapist, the part played by the administration of the clinical setting and the success rate of transfers.

Numbers transferred

To quantify this common occurrence, Wapner et al., (1986) surveyed 45 American psychology training clinics and found transfer rates that varied from 6 -10% of cases to 21-50% of cases with a variety of approaches to transfer being used by clinics. Bostic et al., (1996) quote figures of 33% to 66% for client transfer to another therapist, but give no details of referral reason or therapy setting.

For this research my audit of the Agency therapy appointments diary for three years (Appendix 2 - Agency imposed change clients) showed 65% of clients whose therapists left the agency ended their therapy when the therapist left, while the remaining 35% were allocated to another therapist. Of the 65% who ended therapy, 11% returned for further therapy within three months of the ending. While the two published sources show a wide variation in the reported rate of transfer from 6% to 66% the papers highlight for me the complications around making comparisons between what might be very different events.

Client and therapist responses to imposed therapist change

Of the articles written on this subject the majority are based on therapist reports of both client and therapist feelings and behaviour (for example Keith, 1966; Pumpian-Mindlin, 1958). The academic research into therapist change deals only with an imposed change due to trainee therapist rotations and these again rely on therapist reports of client responses (for example Meyer & Tolman, 1963; Muller, 1986).

In keeping with the writing in this area I have grouped the responses for client and therapist in accordance with the ending and beginning phases of the imposed change process. While separating out individual responses, the relationships involved have not been entirely ignored in the literature. Flesch (1947, cited in Scher, 1970, p. 279), saw imposed therapist change as a triangular process. Scher (1970) takes up this theme of a three-sided awkwardness stemming from the real and imagined relationships between the participants. She urges that the relational dynamics of the process are considered, and that attending to the interpersonal nuances within the triangle that old and new therapist form with the client can facilitate the therapeutic process.

Ending – the client response

Based on clinical work, Scher (1970) describes the pain of desertion and abandonment for a client threatened with object loss and the classical anxiety that comes with separation, as a common response from clients on reassignment. She also suggests that if the relationship had been enjoyable and beneficial the client may experience sorrow, if it has been chaotic and painful they may feel relief and that with ambivalence comes guilt.

Keith (1966, p.186) designated the term 'transfer syndrome' to the cluster of client 'symptoms' that result from an inadequately understood therapist loss. He suggests these symptoms vary developmentally in the 'primarily unconscious ego-defensive manoeuvres which are attempting to alleviate anxiety resulting from the object loss' and so reflect the client's way of coping with loss generally. Both Scher and Keith couch the client experience in theoretical terms, the 'classical anxiety that comes with separation', the 'primarily unconscious ego-defensive manoeuvres', language characteristic of the psychoanalytic

termination literature. Keith (1966, p.188) identifies that clients display depressive equivalents such as somatic symptoms and loss of interest in session content. As part of the 'transfer syndrome' Keith (1966, p.188) moves from theoretical labelling of client responses to identifying certain behaviours such as requests for changes in appointment times or for advice on 'reality crises' as signs that the client feelings have not been worked through. Muller (1986, p. 265) notes that as well as the probability of a 'precipitous termination' increasing significantly when clients are transferred, symptoms related to the originally assessed disorder can reoccur and suicide has also followed client transfer.

Using a therapist survey Meyer and Tolman (1963, p. 243) investigated levels of client 'disturbance'. They looked at therapist ratings of patient closeness to the therapist and the interventions used; insight based or supportive. They found that when the relationship was rated as close and insight techniques were used, this led to greater patient 'disturbance' about the transfer and suggest that patients are stimulated to react by the intervention and therapist response (such as guilt) rather than automatically reacting to the transfer. Glenn (1971) also includes the therapist response. He lists common responses to the ending of therapy for both client and therapist as including the anxiety of separation, sadness, anger or frustration in their mutual helplessness, thereby equating the experiences of both parties at the time of the imposed end.

Reider (1953 cited in Scher, 1970, p. 278) is alone in describing a different response to imposed change for the patient who 'moves compliantly' from therapist to therapist 'making little distinction between them' with their primary tie to the 'omniscient, benevolent clinic', suggesting here a transference to the institution rather than a specific therapist.

Ending – the therapist response

Focusing on student therapist countertransference, Pumpian-Mindlin (1958) suggests that investment in the therapeutic process and client, the therapist's own termination anxiety and setting unrealistic therapeutic goals are part of their response to transferring a client. He also notes that the therapist can also displace their feelings about the ending onto the client or the organisation, seeing themselves as a pawn in the process. Schlesinger (2005) adds that therapists tend to put off telling the client they are leaving as well as being caught up in the administrative process.

Keith (1966, p.188) lists 'common manifestations' of departing therapists such as denying their importance to the client, their impact on the client and becoming preoccupied with the mechanics of transfer. He suggests that these are an attempt to avoid awareness of their own bereavement. In discussing the 'subtle defences' employed by clients, Keith (1966, p.187) outlines the effect of these on the departing therapist, where therapists have 'succumbed narcissistically to a patient's parting praises' without exploring 'the ambivalence

over the impending loss'. Additionally, if the therapist by gratifying the client wishes in the closing sessions (acting out the wish to be a good parent) 'unwittingly arouses excessive positive transference feelings and regressive urges within the patient' they set up the incoming therapist to be viewed as the 'bad' or 'frustrating parent'. While the unconscious aspects of the therapeutic relationship are made apparent in Keith's writing, the tone suggests concern for the therapist being the subject of 'subtle defences' and 'unwittingly' having an effect on the client. This concern in his writing highlights for me the difference between his identifying client transfer syndrome symptoms as developmental in origin and therapist manifestations as a response to the client.

Scher (1970, p.281) also picks up the departing therapist's loss, writing that they may feel 'adrift' like their client as well as 'exposed' to their peers in the records they leave and the comparisons the client may make with the new therapist.

I found no literature that described therapist experiences of handling the ending component of the therapist change but Chang (1977) suggests that clinicians deal with this on an intuitive basis with varying approaches. Wapner (1986, p.493) agrees that there appears to be 'no theoretical or empirical basis for handling different aspects of the transfer process'. Glenn (1971) sees the process as often oversimplified and that therapy should focus on the leave-taking of both client and therapist. Ideas on how the ending aspect could be handled both in the therapeutic relationship and at the organisational level have been suggested by Pumpian-Mindlin (1958), Chang (1977) and Robison et al., (1986). Picking up student transfers of long-term clients, Trimboli and Keenan (2010) make suggestions for supervisors 'attending to this critical juncture in treatment' but do not consider the second part of the transfer, the new therapist and transferred client.

Beginning – the client response

Scher (1970, p.280) looks at the feelings that may be aroused as the client engages with the new therapist suggesting 'fear of disapproval, distortion and misperception' as the client feels exposed under the 'intense scrutiny of a stranger' or may 'dread the different and unfamiliar personality of the new therapist'. Scher also states that the client may also feel disloyal to the former therapist if his 'health' improves, or he feels he has failed the 'rescuer', the new therapist if their condition deteriorates. Muller (1986, p. 274) recording trainee therapist experiences of imposed ending clients describes how clients 'need to act out by terminating treatment' and that therapists are on the receiving end of a client's 'displaced anger'. Where the client visits the new therapist before ending with the old, Weiss (1972) suggests they will degrade the new and idealise the departing therapist when back with them.

Using the concept of an 'institutional transference' (Reider, 1953 cited in Scher, 1970, p. 278) Bostic et al., (1996) suggest for such clients where therapists are seen as alike, they exhibit ritualistic appointment keeping, dependent relationships with therapists, concern for 'sameness' and attachment to the institution.

Seemingly alone in considering the therapeutic work, Glenn (1971) considers potential difficulties for a client resuming therapeutic work with the second therapist. I find it interesting that 'resumed' is the word of choice here as it suggests some continuity and discounts the ending and change that has occurred. Schlesinger (2005, p.91) writes about 'the convenient fiction that the treatment is merely being interrupted' being kinder to both the 'guilty departing therapist and the grieving patient'.

Outside the imposed ending literature but relevant to imposed change, Nielsen et al., (2009) studied therapist discontinuity where a client had an intake therapist and then therapy with another therapist. They found that discontinuity increased premature termination or led to an increased number of sessions. Discontinuity they suggest obliges clients to retell their problem, exposes clients to two different therapeutic styles and may confront the client with contradictory theoretical orientations and therapeutic techniques.

Beginning – the therapist response

A daunting prospect is what Schlesinger (2005) describes for the incoming therapist; being faced by an angry patient grieving the loss of his former therapist who may also be their colleague. For similar reasons Keith (1966, p.188) suggests therapists may not want to take 'old, uninteresting cases' to avoid facing the transferring client's hostility and bereavement. Alternatively, Keith (1966, p.188) explains the pleasure of a second therapist responding to a client's defensive criticism of their previous therapist, maybe fostering this with the fantasy that ventilating feelings will help establish the relationship without unmanageable hostility. With this therapist response, the client loses the opportunity to experience the grief of the loss that with 'skilful interpretation of the hostility' would 'bring to light tender feelings, genuine expressions of disappointment and yearnings for an enduring, close relationship'.

In the triangular relationship Scher (1970, p.282) sees the new therapist having to 'tolerate the scrutiny and comparison' by the client with some therapists feeling trapped (in organisational settings) into accepting the transfer client but not engaging fully in the relationship. She suggests that the 'adventure of exploration is missing' and much of the work will be done 'in the shadow of the former therapist' while weathering 'the indignity of being less important' to the client than the previous therapist. She adds that the new therapist's relationship with the departing therapist will colour the new therapeutic relationship, enhancing it if there was warmth and respect and making the client's mourning hard to endure if they disliked their colleague.

Taking up the theme of comparison Muller (1986, p.270) finds for one trainee 'the desire to differentiate herself in a concrete way from the previous therapist' and a view of the previous therapist as 'benevolent and effective' while feeling 'intrusive and inept' herself, imagining that 'something major went on in the former therapy' and the need to fit into the former therapist's 'shoes'. Muller pulls the case study material together utilising contextual information on the agency and supervision of the case that adds a new dimension to frame his discussion of the 'conscious and unconscious attitudes, communications and interventions of the therapist'. Muller (1986, p.267) proposes seven major factors that influence the therapist beginning work with a transfer client including the developmental level of the therapist (inexperienced having more difficulties), the client's actual experience in the previous therapy, the administrative context and the 'fishbowl' effect. While this study is still a one sided look at the relationship, it is more directly descriptive of the individual therapists involved.

The clinical setting

The clinical settings considered in the literature used here and the setting for this study, are organisation based and private practice has not been considered. Mention has been made already of the use of administrative procedures around transfer for example as a procedural defence (Keith, 1966) and so this organisational influence is apparent. In keeping with this are articles that concentrate on the handling of transfers. Wapner et al., (1986) found little consensus across the directors of 45 clinics about how to handle such transfers and few explicit policies or guidelines; fifteen out of the 45 had a specific policy for dealing with transfers, with some directors believing that transferring clients is 'not particularly problematic' (Wapner et al., 1986, p.494). They consider the countertransference issues raised by Pumpian-Mindlin (1958) as a possible explanation for the resistance they see to approaching the transfer process thoroughly. Muller (1986), along the same lines, comments on the unresolved and unpleasant emotions experienced by all those connected with the transfer situation.

The focus of the literature is placed with the individuals involved, for example, in describing therapist countertransference. For me, this captures the difficulties that gather around loss and grief and is the corollary of someone crossing the street rather than having to speak to a recently bereaved person, but like this one person crossing the street, it does not address a more collective, society or organisation based response. At the organisational level, understandings of the unconscious anxiety-containing function of organisations that offer therapy feels relevant as a background to this study (Hinshelwood, 1994; Rizq 2011). That therapists come to 'represent an unwanted, vulnerable and expendable aspect' of a service (Rizq, 2011, p.37) resonated with my experience at the Agency.

Defining success/failure and the success variables

Tantam and Klerman (1979) used client drop-out rate as the measure of failure of transfer in an out-patient setting when comparing the rates for transferred and non-transferred clients. They found that transferred clients had twice the drop-out rate.

From an analysis of the records of a Psychological Services Centre, Wapner et al., (1986) found one third of therapy transfers (due to the ending of a trainee therapist's practicum) were deemed failures. They compared the number of sessions held with the first therapist to those with the transfer therapist and the transfer therapist's report showing the client's premature termination of therapy. Their survey of other institutions showed a range from 31% up to 90% of transfer clients continuing treatment. Their definition of successful transfer in this survey was the client continuing treatment and working effectively on treatment goals and issues. Having looked at, for example, client level of functioning and number of sessions before transfer Wapner et al., (1986) concluded that, there was no evidence of a relationship between successful transfer and the client, therapist or treatment variables. There was a marginal relationship between successful transfer outcome following prior therapy, 76%, and success with no previous therapy, 54%.

2.6 Summary

I have brought together different areas of enquiry around problematic substance use, the therapeutic relationship and the beginning, ending and imposed change of a relationship. I have considered the differences in service provision for problematic substance use based on conceptualisations of the 'user' versus the 'problems of using' and nationally funded research imperatives to reduce the problems. I have found that national policy-determined service provision sometimes makes reference to the benefits of a therapeutic relationship but has not looked beyond the use of such a relationship to carry out evidence based protocols.

Where the therapeutic relationship has been investigated more fully, little attention has been paid to the client and therapist experience of this relationship ending and even less work has been done on imposed change. This leaves a gap in both research and practice based knowledge around imposed change and an understanding of the impact of imposed change for problematic substance user service providers. These service providers range from individual therapists in private practice to large national organisations that employ a range of different staff who engage therapeutically with clients. For all clients an improved understanding of the phenomenon of an imposed change of therapist and training within organisations on the management of endings and beginnings is needed to reduce the potential impact of imposed change.

3. METHODOLOGY

3.1 The framework

I set out to explore the client experience of an imposed change of therapist using Interpretive Phenomenological Analysis (Smith, 1996, 2009), an idiographic approach theoretically rooted in critical realism (Bhaskar, 1978) and the social cognition paradigm (Fiske & Taylor, 1991). The first two client interviews stimulated my curiosity about the therapist experience of the phenomenon as I heard clients describe missed sessions and what was involved for them in starting the second relationship. I changed the research question to include therapist experiences of the imposed change undergone by the client participants.

While IPA captures individual experience it is theoretically bound to a phenomenological epistemology. I wanted to find out how participant therapists made sense of their own and their client's imposed change experience and so needed to rethink my methodological framework as I included this second perspective on the imposed change. The therapist interviews also added a further line of enquiry when I noticed that certain aspects of the therapy were commented on by both parties giving me an insight into the therapeutic relationship.

The data to analyse following the change of research question comprised individual interviews for both client and therapist groups and a pairing of client and therapist interviews for each therapeutic dyad. Table 1. Shows the data and use of the data for the findings.

Table 1 Data sets

Data sets
1. Individual client or therapist interview <ul style="list-style-type: none">• Code for rich thematic description• Themes supported by data extracts• Participant accounts written using themes to retain individual complexity
2. All client interviews <ul style="list-style-type: none">• Group all client interviews• Themes supported by data extracts• Table of group themes
3. All therapist interviews <ul style="list-style-type: none">• Group all therapist interviews• Themes supported by data extracts• Table of group themes
4. Pairing of dyad client and therapist interview <ul style="list-style-type: none">• Interviews analysed for dyad themes• Themes supported by data extracts• Dyad account written to describe relationship dynamics

To accommodate the new data I changed from IPA to thematic analysis. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. Braun and Clarke (2006, p. 77) describe thematic analysis as offering a 'theoretically flexible approach' that 'should be considered as a method in its own right'. As thematic analysis is independent of theory and epistemology Braun and Clarke (2006, p.78) recommend that researchers make 'active choices about the particular form of analysis' and 'make their assumptions explicit'.

I chose to stay with a critical realist perspective seeing thematic analysis as a contextualist method. Hemsley (2013, p.93) describes using thematic analysis as a 'flexible framework that permitted analysis of the data through different epistemological lenses'. Here I took different views on parts of the data corpus choosing to analyse both individual interview transcripts and themes generated in interviews from the perspectives of the client and therapist in each dyad. This provided individual data on the experience across the two participant groups and also matching themes in the dyads. For the individual data I used an inductive approach, identifying themes in the data and for the dyad data an 'analyst-driven' (Braun & Clarke, 2006, p.84) deductive approach.

Having discarded IPA's phenomenological approach that fitted the original research question, I found that other qualitative methodologies for example Grounded Theory (Glaser and Strauss, 1967) that aims to generate theory did not match the capacity of thematic analysis to explore individual personal experience.

3.2 The researcher

I believe researcher and participant each bring their own history, knowledge and experience to the research relationship. As the sole researcher on this project, working in this active role, I saw the need for reflexivity and transparency at each stage, not just during the interpretative work and so kept a reflective diary starting with my first attempts to formulate a research question. Qualitative research is a dynamic process (Smith et al., 1999, p.218) that gives access to the 'participant's personal world' that is 'complicated by the researchers own conceptions' as they carry out the interpretive work required. Berg and Smith (1988, p. 31) use 'self-scrutiny' to describe what is required of researchers in providing 'the intellectual and emotional factors that inevitably influence the researcher's involvement and activity, and at the same time provide information about the dynamics of the individual or social system being studied.'

I am a white, middle-class, British woman, a UKCP registered Integrative Psychotherapist and Counselling Psychology doctoral student. My first clinical placement was at the Agency (later employed at the Agency) and I have also worked in NHS Primary

and Secondary Care, a charity trauma and bereavement service and private practice. I therefore have a history with the Agency and had a place within it. I was not separate from the culture, the context or the participants. My changing relationship to the Agency is documented in my research diary extracts (Appendix 1).

As a practitioner researcher my interest, knowledge and practice come from a combination of psychology, psychotherapy and substance misuse perspectives. I see 'without being influenced' as impossible but acknowledging the influence as not only possible but essential. As a therapist, my training and personal orientation have been shaped by an holistic, humanistic (Hycner, 1993; Rogers, 1961), developmentally guided (Bowlby, 1979; Schore, 1994, 2003; Siegel 1999; Stern 1985, 1998), relational framework (Object Relations, Balint 1968; Gomez, 1997; Winnicott 1960). As well as Self Psychology (Kohut 1977), unconscious communication, (Maroda 1991; Sandler, 1993) and Intersubjectivity, (Beebe and Lachman 1998; Benjamin 1990; Ogden 1989, 1994, 2004; Stolorow and Attwood 1992, 1997). I have been mindful of my 'direction' and tried to stay open to what was in the data I collected, recruiting an independent coder and acknowledging my 'theoretical position'.

3.3 The setting

This study took place in a substance misuse agency situated in a county town in England. The Agency provided a Tier 3 (Appendix 3), structured day service for clients who self-referred or were referred by their GP or other agencies such as the Community Mental Health Team, the Community Drug and Alcohol Team and the Probation Service. The Agency was embedded within the range of services prescribed by the National Treatment Agency and affected by changes in Government policy and service commissioning guidelines.

Clients varied in how their lives were affected by their substance use, from those who were in full time employment and only attended for therapy, to those who were unemployed, had their weekly therapy and attended the centre on a daily basis for group work and alternative therapies. Some clients who presented with mental health issues fitted dual-diagnosis criteria.

Clients could be in various stages of their 'addiction career' (Best et al., 2006, p.2), having several years, weeks, days or hours free of using their problematic substance. Some had been accessing the service for several years, some back temporarily during a challenging time, while others were just starting at the Agency. At the Agency, psychotherapy and counselling were provided by a diverse range of therapists who were not required to provide a specific model of therapy.

During the period of this project there was a change in service provider and service provision at the Agency. The participant interviews were carried out at this time of change but before the most extensive changes to the service (that included withdrawing therapy for alcohol users). The change of service provider added an interesting personal comparison for me between the therapist experience of imposed service change and the participant experience of imposed therapist change, prompting me to reflect on issues of power and choice. As a therapist I experienced the loss of the familiar regime and structure behind our work, along with the uncertainty of the new, impending changes (Appendix 1 - Research diary extracts).

3.4 The participants

Finding participants

During the development of my research question and proposal, I kept a note of all instances of therapist imposed change at the Agency. It was frustrating during the six month wait for Agency research approval to see potential participants come to the end of their therapy with a replacement therapist. I went through three years of appointment diaries (one diary covering a three month period was missing) to establish the occurrence of the phenomenon and to find current imposed change clients (Appendix 2 – Agency imposed change clients). I discussed my project with therapists at the Agency to raise awareness and to help me identify potential participants. When I drew up my first list of possible participants I realised, as therapists suggested names, that they were unclear as to who might be an imposed change client and also that I had not defined this clearly for myself. Consequently I added 'therapist leaving' to the imposed ending criteria. I contacted the Agency's other sites in the county but none had any imposed change clients. This may have been due to other sites having been established since the change of service provider and their use of different working practices. Clients not approached were those whose ending was due to their transfer from the rehabilitation unit and clients at a satellite service whose therapist died. At the point where Agency approval was granted my search had produced nine potential participants.

Widening the scope

Initially I set out to explore the client experience of imposed therapist change. However following the first two client interviews, I found the material left me wondering how the therapists viewed their client's experience, and how they had experienced and handled the phenomenon. I decided to interview all three parties involved in the imposed change: the client, their original therapist (T1) and the replacement therapist (T2). This added another

delay to the project as I amended my research question and proposal which then needed to be agreed by both Middlesex University and the Agency. Ultimately I was unable to get a full complement of T1 therapists so my study centred on the dyad of client and T2. While I was expanding the scope of the project the list of potential clients was contracting as prospective participant circumstances changed or were reviewed. Table 2 shows the clients and therapists considered and those who took part.

Table 2 Participant search results

No.	Ending Therapist	Client	Beginning Therapist	Notes
1	T1-James	James	T2-James	T1 not traced
2	T1-Sidney	Sidney	T2-Sidney	T1 interview arranged then DNA
3	T1-Kezia	Kezia	T2-Kezia	T1 interview not used, too few T1s
4	T1-Megan	Megan	T2-Megan	T1 interview not used, too few T1s
5	T1-Client 5	Client 5	T2- Client 5	T2 saw client as too vulnerable
6	T1-Joanna	Joanna	T2-Joanna	Client interviewed but did not fit criteria
7	T1-Client 7	Client 7	T2- Client 7	Client set to start with T2 then left service
8	T1-Client 8	Client 8	T2- Client 8	Client ending with T2 at time of approach
9	T1-Client 9	Client 9	T2- Client 9	Client did not fit imposed ending criteria
				Interviews used
				Interviews not used

Using paired client populations presented methodological challenges such as the interviewing of client and therapist from a therapeutic dyad (see 3.7) and capturing the dyad material in the write up (see 3.8). These challenges were addressed as they arose and necessitated a change in the methodological framework.

Participant numbers

As sole researcher my time and resources limited the number of participants I was able to include and the changes at the Agency meant the number of potential participants was finite. However, the qualitative nature of the data collected meant that while the depth of analysis required was time consuming, rich data was available on the experience I was exploring. Four client interviews gave me both the ‘individual’ and the ‘shared’, and exploration of the phenomenon was widened by including therapists and analysing individual participant pieces in their dyad context.

Client participants

I used purposive, criteria based sampling, where participants are judged to be typical of a population. Here, clients who had experienced an imposed change of therapist at the Agency.

I initially set four criteria for client participation based on ethical considerations and to achieve homogeneity within the group. I added a fifth as I started the search for participants, further defining the nature of the imposed ending.

1. A client currently in a one to one therapeutic relationship at the agency.
2. A relationship of at least 6 weeks duration and not due to end at the time of the interview (potentially half way through a 12 week contract).
3. The participant will not be one of my clients.
4. The participant has a substance use problem (still using or abstinent).
5. The imposed ending was due to the therapist leaving the agency.

While these criteria limited the number of potential participants, ethical considerations for participating clients were at the forefront of my thinking for this group (see 3.5).

As participation was by invitation I created a self-selection bias. The self-selecting clients were all 'alcohol only' clients. While not planned, this increased the homogeneity of the group addressing 'the complex relationship between personality profile and drug of choice' (Donovan et al., 1998, p. 41). Interviews from four white British clients are included in the findings. Two clients were male and two female and their ages ranged from 40 to over 60 years of age (Appendix 4 -Client therapy history with T1 and T2).

Therapist participants

The therapist group was determined by the client group. Participation for this group was also by invitation, the criteria for participation being,

1. The T2 (at the Agency) for a client in the study
2. The therapist has clinical supervision.

Four interviews from three therapists are included in the findings (one T2 was working with two of the clients). All therapists were white British; two were female and one male ranging in age from 25 to over 60 years of age. One was a trainee on placement and the other two were qualified therapists volunteering at the Agency (both were three years post-qualification). The trainee was a first year Counselling Psychology student who was required to use a Person Centred approach with clients (psychodynamic in the second year). The qualified therapists both cited using a Person Centred approach in their client work. One described integrating CBT, Gestalt and Existentialism in their therapeutic work and the other

included Transactional Analysis while also currently undertaking a Rational Emotive Behaviour Therapy course.

Unused interviews

I completed 12 interviews and analysed eight of these. Of the interviews not used three were T1 therapists and one a client. For this client, the participation criteria mismatch was not evident until the interview was underway. The unanalysed interviews helped me to clarify and refine the focus of this research and while the material from these interviews did not contribute directly to the findings, it did inform my thinking. I spoke to participants whose material was not used explaining their place in helping to shape the project and that they would be acknowledged in the final piece.

3.5 Ethical considerations.

Ethical approval was obtained from the Agency Service User Involvement Committee, the Metanoia Institute and the University of Middlesex. As a therapist, with professional (BPS, UKCP and BACP) ethical guidelines and a personal ethical commitment that are part of my practice, I consider ethical issues as ongoing, as a process and in need of continual review. I see this perspective of engaging with principles rather than regulations where 'thinking is not optional' (BPS, 2011, p.4) as pervading my research design and conduct with the SRA (2003, p.7) need for 'responsibility with accountability' as I consider the consequences of my actions upon others.

The research relationship

I was aware of the structural, culturally conferred power differential in my being part of the system in the privileged position of therapist, which would influence the research relationship with both participant populations. There was also my status as a doctoral researcher with its implied differences in educational background and knowledge. I had not met any of the clients before the interviews, avoiding the dual relationship (Hart, 1999) of being therapist and researcher to a participant, but I had met all the therapists. I gave information sheets to all participants setting out my relationship and that of the Agency to the project and I also covered this during the pre-interview consent process.

The Agency context and semi-structured nature of the interview had echoes of a therapeutic relationship, requiring trust as the participant's private experience was explored. I was a listener asking for personal, maybe emotive material to be divulged possibly placing the participants in a vulnerable role. Hollway and Jefferson (2000, p.85) suggest that relational dynamics such as understanding and respect have 'the capacity to transcend

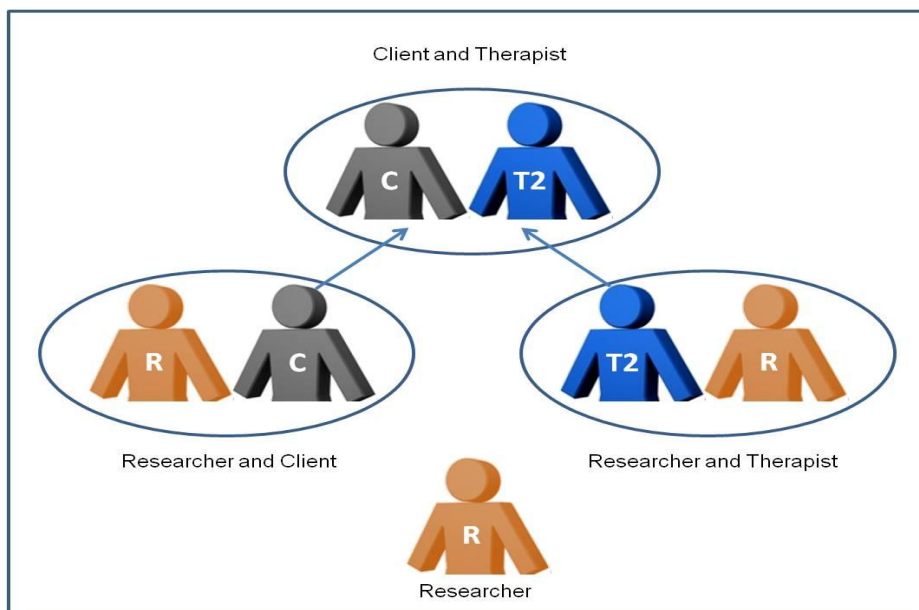
structural power differences'. While I see such relational dynamics as fundamental both personally and professionally, differences also need to be acknowledged.

For me, there was a tension between my exercise of power as a researcher following my interest in carrying out a project that I saw as empowering for participants. Also in my desire to respect each individual and be faithful to the participant voices and the potential impact the research could have on the participants. As researcher I defined the research relationships, directed the research process and selected and interpreted the data. While the participants were invited as the expert, the holder of knowledge for the project, and were involved in participant checks on the findings (giving them control over their contribution), their influence was otherwise limited to a choice to take part, take part and withdraw or not take part in the research.

Interview triangle

Before embarking on the methodological change to the dyad format, I considered my role and the appropriateness of the triangle created by myself, client and therapist (see Figure 3).

Figure 3 Interview triangle



Before the change in methodology (the addition of client's therapists to the study), all clients were aware that their anonymised material might be available to, and recognised by, their therapists. This awareness did not prevent the pre-change participants describing their lives, therapy and therapists. This openness felt at times akin to the interview being used as a conduit for messages to therapists. Knowing that dyad participants could read the words of their client or therapist had an influence on my writing. I wanted to write in a way that was

respectful to both without diluting the content and lose the impact of the phenomenon on both parties.

The change in methodology was shared with the pre-change interviewees and the consent process was repeated in light of the changes. No individual invited to take part declined, no participants withdrew from the study and any concerns expressed about the content of the findings during the participant checks were included in the final text. All participants showed a robust willingness to take part and keen interest in the subject matter. I was aware from the two pre-change interviews that the content would have an impact on the T2 interviews. I considered introducing a second interviewer for the therapists to avoid the triangular relationship and intra-dyad contamination of material. However, having started the interviews I was aware of the unspoken communication and relational feel of being with each interviewee that would be unavailable to me if I recruited a second interviewer. I chose to be part of the triangle, as a parallel to the phenomenon under investigation and, like the client, hold the two different relational experiences with my experiencing and this holding being an acknowledged influence on the data.

Participant payment

The Agency Service User Committee that authorised the research stipulated that service users receive some form of payment for their time. I decided to offer all participants a £20 gift voucher of their choice. All the clients and two of the therapists accepted this offer. The therapists who declined the voucher would have accepted had the Agency been providing the voucher. Payment of participants can be seen as a mark of respect for their time and a way of equalising the relationship, my money for their time. Alternatively, it could be seen as an exercise of power. In an attempt not to link the payment as an inducement to participate, I opted to leave mention of the payment until participants had shown an interest in taking part. The voucher was sent after the interview irrespective of whether the participant data was used for the project.

Confidentiality

The offer of confidentiality was a feature from the outset as I contacted potential participants directly rather than through the Agency. I also made provision to interview in an annexe at the Agency. As part of the consent procedure my professional, ethical obligation of disclosing threatened harm to self or other was included in discussion as the only foreseeable reason for me to break confidentiality. Confidentiality was an explicit item in the Information Sheet and Consent Form. During the consent process I set out the possibility that the research may be published and that it was my intention to protect their anonymity as far as possible by changing their names.

Clients chose pseudonyms known only to myself. Therapists were named 'T2-client pseudonym'. Data was not stored under their real names. Data protection criteria were used for the storage of data. Only participant agreed extracts have been disclosed from the interview data and participants had the option to withdraw their data from the project at any stage. I screened all transcripts and write-ups for deductive disclosure and participants were invited to check their part of the findings section.

An emerging ethical consideration came with the change to using both client and therapist as participants. While our confidentiality agreement restricted the availability of the interview transcript and disclosure of their identity, interviewing both client and therapist participants and combining their material meant that the participant dyads not only knew that each other were part of the study but that they would be able to read the other's contribution. I reminded clients and therapists that they would be able to recognise each other in the findings and that they were linked by the client pseudonyms.

I carried out the client checks first, reminding them that I had also interviewed their T2 therapist. I reminded them their therapist would recognise their material and asked if they were they still willing for their material to be used. All were adamant that their material should be part of the project even though the dyad material was not available for them to read at the time of their participant check (therapists needed to check their contribution before it was disclosed). The clients were offered a third meeting to read the dyad piece, none accepted (by the time of the participant checks all clients had ended with their T2). The therapists were also reminded of the possibility of the clients reading their material at the time of their checks. The therapists read the dyad account.

Risk of harm or distress

I used my nominated consultant (Agency clinical team lead) for a general discussion on potential risks to participants and sources of vulnerability within the client population at the Agency.

During the consent process participants were given the opportunity to explore the impact of participating in the research. I informed them of the nature of the project and the procedures involved in an attempt to protect them and help them protect themselves from harm or distress. I endeavoured to describe what the participant may not have anticipated in taking part, such as the personal nature of the interview, the recall of painful memories or that they may disclose more than they were comfortable with. All participants were told they could stop the research process and withdraw at any stage and that there was a support system in place outside of their current therapeutic relationship. I emphasised the acceptability and 'no penalty' nature of withdrawing at any stage as I felt that a participant without such information could feel exploited by the research process.

I was mindful both in the construction and conduct of the interviews of the distress the subject matter may cause participants. All participants however appeared able to talk about potentially distressing experiences in the interview environment and all seemed to value the chance to talk about their experience of the phenomenon. None of the participants reported or showed any signs of distress that needed action on my part and none of the participants requested support.

I considered each participant's ability to give informed consent. For example, I would have not proceeded with consent for any participant who appeared to be intoxicated. On an individual basis, each potential participant was considered in terms of vulnerabilities due to for example, their age, disability, physical or mental health, social, relational or financial circumstances.

Inclusion

There was no participant exclusion based on socio-educational status, ethnicity, gender, age, language, literacy or special needs. I did not have to make any provision for language, literacy or special needs for any participant. The participant criteria for inclusion were set to reduce risk and avoid harm; not working with my own clients, clients being in an ongoing therapeutic relationship and therapists in a supervisory relationship.

Consent and withdrawal

Consent was considered as ongoing rather than a one off decision made by the participant. There is some overlap here with the previous sections that outlined the research relationship, confidentiality and the risks of harm and distress. I tried to make all written information and discussion about the research as clear and as comprehensive as possible to facilitate the participant's decision making. Hollway and Jefferson (2000, p. 88) suggest that the decision to consent cannot be 'reduced to a conscious cognitive process but is a continuing emotional awareness that characterises every interaction'. In their experience consent decisions had less to do with the information they offered and more to do with the person's feelings about them. For me, this view of consent reinforced my awareness of the trust each participant was placing in me and my responsibility to use my 'power' as researcher ethically.

Support

I saw myself as having sufficient training and experience to respond sensitively and supportively if participants were distressed during the interview. As discussed above, support for participants had been built into the design. For clients, being in an ongoing therapeutic relationship of at least six weeks and with no imminent ending planned meant there would be support both immediately after the interview and beyond that. Alternatively,

there was the offer of support outside the therapeutic relationship through the Clinical Lead but this was not used. For therapists, support during and after the research period was in place in their regular and continuing clinical supervision. While I took every care to support the participants during the research process, I also discussed their responsibility to censure their disclosures and monitor their own willingness to take part.

For myself, I arranged supervision (along UKCP practice guidelines) and discussion time with the Agency consultant in case of unforeseen risks or ethical dilemmas during the project. As a professional courtesy I discussed with all the Agency therapists the nature of the research and their availability for support for participants while not naming participants or discussing their material.

3.6 Contact and consent

I contacted potential participants by telephone, explaining my interest in their experience of imposed therapist change and asked if I could send written information about the study, arranging a day and time to call back.

During the second telephone call, I arranged a time and place to meet. All the participants wanted to combine the consent and interview in one meeting. Before the interview, as well as discussing the project, I covered confidentiality, consent and withdrawal procedures, the independence of the project from service provision, the interview procedure, use of the findings and the payment of expenses (no participants claimed expenses). I also invited the participants to make their own assessment of their vulnerability. Support or a further interview was available for those who might decide not to take part but all who came to the interview completed the initial consent procedure.

Due to the change in project design two clients went through the consent process again following their first interview to ensure they were aware of the involvement of their T2. On completion of the Findings section I organised participant checks, meeting the participants for a second time.

3.7 Collecting experiences

I collected the participant experiences in individual participant-researcher audio-recorded semi-structured interviews. The interviews varied in length from 55 minutes to 70 minutes and were conducted in English as this was the first language of all involved.

Interview design

I used an interview guide (Appendix 5) as an aide memoire to collecting data that satisfied the aims and objectives of the study and to aid consistency between the interviews. Brocki

and Wearden (2006) suggest that there is often unacknowledged structuring of data prior to collection in IPA studies and I feel this applies to other qualitative methods. My guide design was developed from my practice based experience and definition of an imposed change as having an ending and beginning component. Another form of structuring was the provision of written and verbal information to participants on the research subject. While this pre-interview information will have influenced their thinking I found it did not inhibit them from introducing other material into the interview.

I treated the first interview with client James as a pilot interview. This interview produced richly descriptive material and neither James nor I had any difficulties with the research procedure. For these reasons I decided to treat the material from this interview as part of the main body of data. The pilot shaped the rest of the interviews in that I sought to maintain the balance between gathering data to answer the questions I posed while allowing the participant the space to describe their experience. In the pilot interview this space had generated unrequested, interesting material evoked by the research topic and circumstances. I found the unrequested material added context to each individual experience of imposed change and shaped the individual accounts I used for writing up the findings.

The interviews

As I see all relationships as being mutually influencing, I have recorded my influence as biographical material in sections 1 and 3.2. I shared with the participants my belief that the interview was a collaborative process, that they had the knowledge that I would record and interpret.

I found participants were at ease with expressing both positive and negative feelings about the Agency and their therapy despite the interviews taking place at the Agency and knowing that I was a psychotherapist working at the Agency.

I used a mostly non-directive style attempting to let each participant tell their own story. I noticed that my therapist training served me well to explore the participant's account and fitted the 'minimal probes' described by Smith and Osborn (2003, p.63) for semi-structured interviews. I did monitor my shaping; when I let participants follow a non-topic line, I linked it to the topic or redirected them back to the topic. I also reintroduced participant themes, inviting them to consider something again where it felt appropriate.

After each interview I noted my feelings and the process and content of the interview. Recording such research data is in keeping with my theoretical and practice based understanding of unconscious communication and intersubjectivity.

Interviews were arranged so that all clients then all therapists were interviewed.

Data collection/storage

Verbatim transcripts of the recordings were made. I used client chosen pseudonyms and therapist-client references for the transcribed data, storing them separately from the participant names and contact details.

3.8 Analysing experiences

Thematic analysis

I subjected the data to thematic analysis using thematic coding and then grouped the codes as I made sense of the connections between themes. Within this framework I developed my own routines to consecutively handle each interview transcript in a way that fitted with my response to the data and ways of processing complex information. I repeated each routine as detailed below until I felt satisfied that I had captured all the data relating to each individual experience of the phenomenon and had an appreciation of the individual experiencing it before moving on to look at other participant transcripts. I analysed all client interviews before analysing the therapist interviews.

Individual transcripts

Having been part of each interview and having listened to the recording several times, transcribed and checked the transcription against the recording; I was left with a live, participant presence when I then read each completed transcript. For each participant, I read and reread the transcript initially making notes on the left side of each page, underlining words, metaphors and linking passages with arrows, referring myself back to earlier parts of the transcript (see Appendix 6 – Analytic trail). The nature of the material evoked by the research topic made me aware of each participant's history, relational style and the impact the phenomenon had on them. This flavour of each individual felt in keeping with critical realism, that 'inner worlds cannot be understood without knowledge of their experience in the world, and whose experiences in the world cannot be understood without knowledge of the way in which their inner worlds allow them to experience the outer world' (Hollway and Jefferson, 2000, p.3). I then moved to listing (on the right of the page) emerging themes relating to the experience of imposed change, the individual experiencing the phenomenon and my understanding of these.

Annotating the first transcript made me aware of the volume of codes and quotes that could be generated from the eight transcripts. Each transcript went through the read/manually annotate routine, I then imported the transcripts into Atlas ti to give me the freedom to assign codes and collect quotes while the text location, storage and retrieval (case by case or codes across cases) was taken care of. The thematic analysis terminology

of of 'themes' is not used in Atlas ti and so supporting documents for this research taken from the Atlas ti stored data are headed up with 'code' and 'code family' equating to theme.

I found that alongside the tidy security of Atlas storage, I still needed the creative chaos of handling the data on paper in my lists and diagrams as new codes appeared, shaping my continually developing picture of the impact of the phenomenon. I experienced this part of the analysis, the immersion in the transcript detail, as simultaneously confusing (as the transcripts appeared to grow with the addition of codes) and intensely fascinating (as I examined small pieces of the whole). I coded the therapist transcripts with a prefix of XTB so that the two participant populations were identifiable in the list of codes (see Appendix 6 – Analytic trail; Appendix 7 - Atlas codes primary document table).

Checking for missed pieces

In focusing on extracting parts from the whole, and being immersed in small pieces of data, I felt at times that I had lost touch with the participant. I was concerned about what I was leaving out and of losing the shape of the whole transcript that represented the participant and our interview together. I wanted to keep the individual client experience while also finding similarities and differences between individuals. I reread each coded transcript noticing where I had, and had not, included parts of the text as quotes and where I had not allocated codes. When I was satisfied that I had captured all that felt relevant, I moved on to the next transcript. For each participant group (client or therapist), I also revisited each 'finished' transcript as later transcripts generated new codes. With the initial pre-Atlas right hand transcript annotation of emergent themes, I was aware of identifying individual and phenomenon themes and on reflection this helped me keep the 'whole' by descriptively grounding each individual when I was writing the Findings section.

External coder

To check the validity of the codes

- that codes were represented in the verbatim transcript
- to find new codes
- to safeguard against my bias distorting the process of code selection and application

I sent interview extracts to an external coder. The external coder (a practitioner researcher not connected to the Agency or working in the substance misuse field) had four sections of transcript, two from client interviews and two from therapist interviews to code 'cold'. I included one coded client and one coded therapist extract as a guide and for familiarisation. I also included a code list relevant to the extracts chosen. Appendix 6 shows two of the cold

coded extracts as part of the analytic trail. Appendix 8 contains the documents relating to the external coder and an analysis of the results of the coding.

Grouping codes

After completing all the transcripts in one participant group, my ‘thinking on paper’ in diagrams linking codes was transferred to the Atlas Code Family facility (themes). The code families provided the structure for the project findings. Refining the grouping and extraction of the final themes continued right through the writing up of the findings (Appendix 9 - Code Families; Appendix 10 Codes to diagram themes).

Writing up

In writing up the findings, analysis deepened as I chose quotes for each individual from the code families, setting them side by side for further interrogation. As this interrogation across cases developed, I was aware of wanting to keep the complexity of each individual case and the dyad material, rather than group the cases under theme headings. While the thematic analysis of transcripts was carried out across cases, in the findings, I have presented the themes within individual cases. Figure 4 shows how themes are linked to each participant with their illustrative quotes.

Figure 4 Format for Findings

Findings
Participant 1 Theme 1, Theme 2....
Participant 1 Theme 1, Theme 2....

I constructed individual accounts from the themes for client and therapist (see Findings - Table 4 Client themes, Table 5 Therapist themes).

I worked with two participant populations. Looking at the data for the two populations separately did not bring together the material that held the potential third perspective for interpretation. This ‘third’ was the intersubjective dimension in the workings of the therapeutic dyad, the dyadic dance as a response to the imposed change. The dyadic pairing is an important addition to research into imposed endings and I needed to hold the participants individuality to capture the dyad relationship. To present my view of the relational material within each dyad I wrote a piece taking extracts from the individual client and therapist accounts of each case. This format of individual and dyad accounts developed out of my interpretation of the data as both researcher of the phenomenon and a therapist with access to the client and therapist experience of their therapeutic relationship. The

themes are brought together under more traditional headings in the discussion section to crystallise the findings and set them in the context of theoretical concepts and earlier research.

The process of writing each individual account concluded when I felt a sense of coherence between my experience of the interview and participant and my written account portraying them and their experience of the imposed change. At this point I was satisfied that I had captured individual complexity as the context for individual experience of the phenomenon of imposed therapist change. The dyad piece also needed to feel coherent by representing both the individual accounts and the relationship.

Participant consultation

I asked participants to read the findings section containing their verbatim extracts from our first interview. From this interview I wanted to:

- check that there was no evidence of their identity in the writing
- check that they wanted this material to be used in the final report
- to outline to them general findings from the research so that they could put their experience in context.

(Appendix 11 – Participant check notes).

Consent timings meant that for the first group of checks (clients) the dyad account was not available. All clients were offered a meeting to read the dyad piece but were content to have read and commented on their own account. All therapists chose to read the dyad piece.

3.9 Evaluation

I was aware that for the findings of this study to be of value they would need to meet accepted criteria for the evaluation of qualitative research. To negotiate my way between what is expected in terms of this evaluation and what I felt were satisfactory checks on my work I used the Lincoln and Guba (1985) trinity of trustworthiness (including credibility and transferability), dependability and confirmability as my template from the outset. The following table (Table 3) charts the criteria and the supporting evidence.

Table 3 Evaluation criteria and evidence

Criteria	Evaluation tool	Section
Trustworthiness		
- credibility	Acknowledge context	1.3 Research context 3.3 The setting
	Acknowledge power differential	3.5. The research relationship
	Thick description of researcher	3.2 The researcher
	External coder	3.8 External coder
	Participant checks	3.8 Participant consultation
	Use of participant quotes	4. The Findings
- transferability	Thick description of setting	3.3 The setting
	Thick description of participants	3.4 The participants 4. The Findings
	Relevance to other contexts	5. Discussion
Dependability		
- Audit trail	Thick descriptions of setting, researcher and participants	3.2 The researcher 3.3 The setting 3.4 The participants
	Full descriptive methodology	3. Methodology
	Examples of transcript, coding and external coder check	Appendix 6 Appendix 8
	Research field notes	Reflexive presence in writing
	Detail of analysis with examples	3.8 Analysing experiences Appendix 6
	Example of extract journey to findings	Appendix 6
Confirmability		
- audit trail	As above	
- reflexivity		Reflexive presence in writing

4. FINDINGS

4.1 Introduction

The format for the presentation of these findings developed from my analysis of the transcripts and my psychotherapeutic framework that values both the individual and the therapeutic relationship. My challenge was to find a format that retained the individuality of each participant experience and captured elements of the client/therapist relationship found in the individual accounts of the imposed change experience.

4.2 Presentation of findings

I start with an overview of the findings with a diagram showing the imposed change process followed by tables of the themes that include quotes from all the participants. After the overview I move on to look at the themes for each individual experience in more depth. This fuller description of the individual accounts provides the context for the dyad piece. I describe below the four parts that I use to present the findings from each dyad: Part 1 Client, Part 2 Therapist (the detail in Parts 1 and 2 set the scene for the dyad findings), Part 3 Dyad, Part 4 Researcher synopsis.

Part 1 Client

The client interviews elicited unprompted detail of the client's life and current circumstances, affording me the privilege of a very personal picture of that individual. This openness may have been a consequence of the interview being in their therapy setting, or me being known to be a therapist at the Agency, as if clients were staying in the client role. I start each account with the client's reason for being at the Agency in terms of their understanding of their problematic use of alcohol. I then address the themes identified in the Figure 4 diagram for each client based on the description of their experience of the phenomenon, my experience of them and my knowledge of the full transcript. Table 3 lists extract examples for the themes across the client group.

Part 2 Therapist

The material from the therapist interviews was more concerned with professional rather than personal matters. Their accounts contain the experience of being the T2 in the imposed change process, their approach to therapy and their reflections on endings in therapy. As with the client interview material, the write up follows the themes in the Figure 4 diagram and my experience of each therapist with the background of the whole interview transcript shaping what is presented here. Table 4 lists extract examples for the themes across the therapist group.

Part 3 Dyad

My perspective on the client/therapist relationship emerged as a separate piece of writing from the interview material of client and therapist. In Part 3, I bring together client extracts that I saw as sharing common ground with extracts from the therapist interview.

Part 4 Researcher synopsis

In the synopsis I give a brief view from across parts 1 to 3 for each dyad.

4.3 Identifying the voices

My voice will be present as researcher (R in the extracts) and writer and I have used changes in font to indicate changes in person. References to T1 are the client's ending therapist, T2 is the client's beginning therapist taking part in this study.

Client words are in italics and indented. Clients are identified by their chosen pseudonym.

Therapist (T2) words are in a different font and further indented to the right. Therapists will be identified by T2-client name, to maintain the dyad link.

Graphic representation

When reading the text I have transcribed from the recorded interview, I see, hear and feel the interview again. While I am not able to convey all of this, as the spoken word becomes a written word on the page, the following are attempts to represent and convey as much as possible of that primary experience.

In the extracts:

- indicates the speaker pausing and the length approximately represents the time elapsed.
- Items within () are participant noises or gestures, my description of how the words were spoken, or notes in place of the participant words where verbatim transcription would break confidentiality or anonymity.

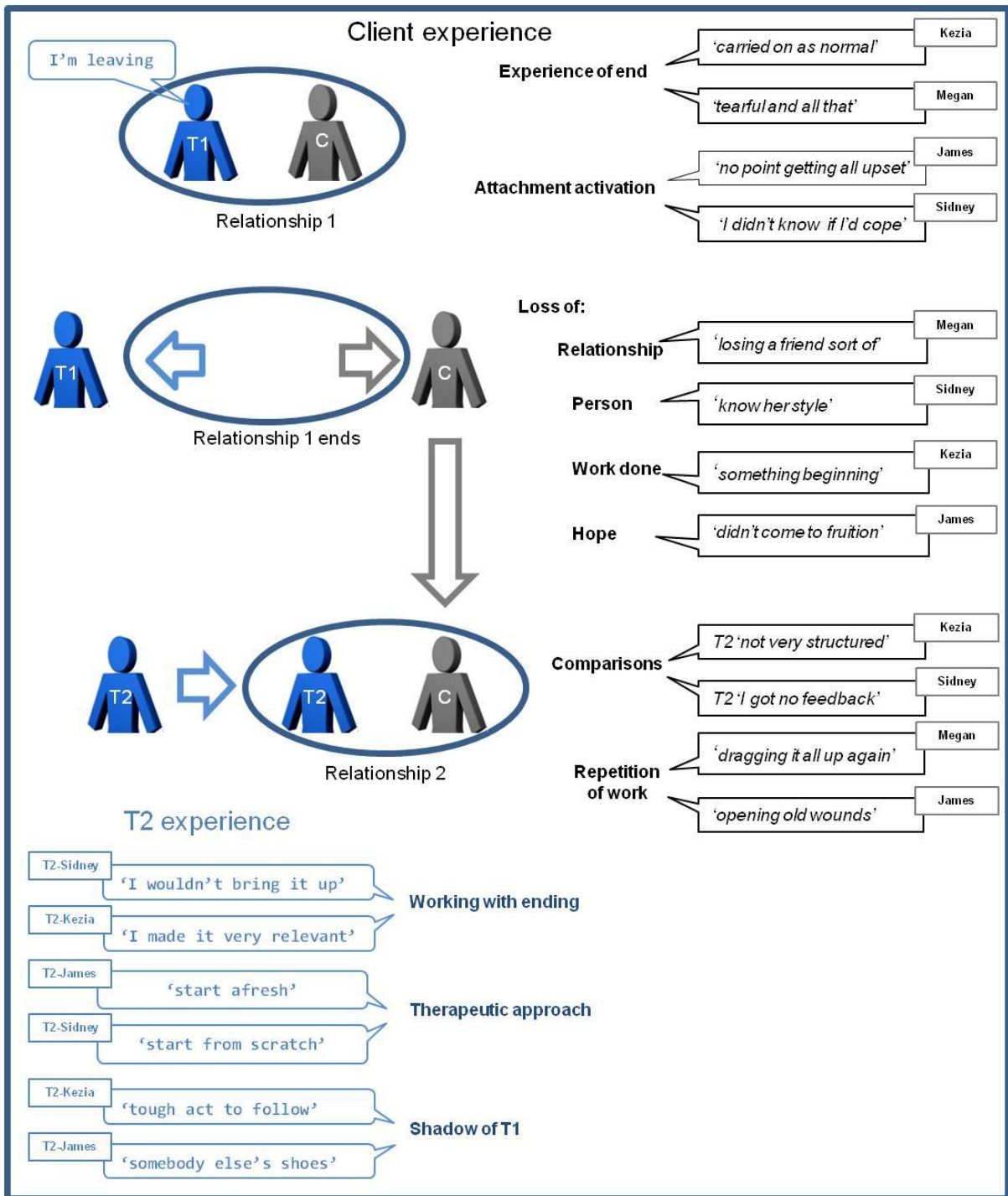
Participant checks

Participant comments on the write up are added at the end of each individual participant section. A fuller record of the comments can be found in Appendix 11.

4.4 Overview

Figure 4 below illustrates the main themes that emerged from the participant interviews. The figure captures the imposed change sequence of the ending between the client and original therapist (T1) and the beginning of the relationship between the client and replacement therapist (T2). For clients the ending involved: their experience of the end of the first relationship, attachment activation, losses around the relationship, the person, the work done and hope of an outcome. In starting with T2, themes of comparison making and repetition of work were evident for the client. The themes for therapists were: working with the client's ending with T1, the therapeutic approach they used with the client and the presence or 'shadow' of T1 in the work.

Figure 5 Diagram of imposed change and themes



Tables 4 and 5 below give quotes from each participant as examples of the themes shown diagrammatically in Figure 4

Table 4 Client themes

Client	James	Sidney	Megan	Kezia
			Same T1 for Megan and Kezia	
Experience of ending with T1	<i>'it wasn't traumatic'</i> T1 gives 'cuddle'	<i>'I thought this is the last time I'll see her...and um yeah I thought what's gonna happen..'</i>	<i>'tearful and all that'</i> <i>'it's a wrench'</i> <i>'sobby, you know sort of out of control'</i>	<i>'carried on as normal'</i> <i>'I gave her a hug'</i> <i>'initially I didn't feel too much'</i>
Attachment activation (at ending with T1 and beginning with T2)	<i>'don't stand watching the boat sail'</i> <i>'no point getting all upset'</i> Not <i>'put my head over the parapet'</i>	<i>'who can I trust'</i> <i>'I really panicked'</i> <i>'I didn't know if I'd cope'</i> Unresponsive T2 <i>'I got no feedback'</i>	<i>'emotional response'</i> <i>'nervous'</i> <i>'apprehensive'</i> <i>'it takes a while to build trust'</i>	<i>'delayed reactions'</i> <i>'anxiety' rather than 'grief'</i> <i>'c'est la vie'</i>
Loss of relationship and loss of person	<i>'something else going'</i> <i>'she was nice'</i> <i>'I got on pretty well with T1'</i> <i>'its very confusing...as soon as you get used to somebody...'</i>	<i>'like losing a friend'</i> <i>'I felt robbed'</i> <i>'she got to know YOU (loud emphasis), and you got to know her style.'</i>	<i>'losing a friend sort of'</i> <i>'get to know them'</i>	<i>'the best counsellor I have had'</i> <i>'losing contact, losing support'</i>
Loss of work done and repetition	<i>'like climbing a mountain'</i> <i>'starting all over again'</i> <i>'the same blummin story again'</i> <i>'opening old wounds'</i>	<i>'I didn't like raking up old memories'</i>	<i>'start all over again'</i> <i>'dragging it all up again'</i> <i>'draining'</i>	With T1 <i>'it was really good'</i> <i>'more structured'</i>
Loss of hope	<i>'didn't come to fruition'</i> with T1	With T2 <i>'got nothing out of him'</i> <i>'felt no different'</i>	<i>'getting somewhere'</i> with T1	<i>'something beginning'</i> with T1
			Same T2 for Sidney and Megan	
Comparison of T2 with T1	T1 <i>'more relaxed'</i> T2 <i>'not really up to speed'</i>	T2 <i>'typical man'</i> <i>'tougher and they haven't got no feelings'</i> <i>'no feedback'</i>	T2 does not <i>'talk back'</i> Therapists are all <i>'different'</i> T1 did <i>'more than just listening'</i>	T2 sessions <i>'not very structured'</i>
Suggestions	Get T2 <i>'up to date'</i> with <i>'some notes'</i> <i>'have two counsellors'</i> <i>Mr Nice Guy and Mr Blooming Bad Guy'</i>	Find <i>'own type of counsellor'</i>	T2 reads T1 reports to <i>'gain insight'</i>	

Table 5 Therapist themes

Therapist	T2-James	T2-Sidney	T2-Megan	T2-Kezia
		Same T2 for Sidney and Megan		
Therapeutic approach and working with T1 ending	<p>Person Centred. <i>'I deliberately did not read his notes'</i></p> <p>Not work with T1 ending. <i>'start afresh'</i> <i>'I have deliberately not asked anything about past sessions'</i></p> <p>View of T1 ending <i>'his experience was abandonment again'</i></p>	<p>Person Centred. <i>'I never read other peoples notes'</i></p> <p>Not work with T1 ending. <i>'starting from scratch'</i> <i>'the agenda is really the clients. ..so I wouldn't bring it up'</i></p>	<p>Person Centred .</p> <p>Not work with T1 ending. <i>'classic person Centred thing is that you start from scratch'</i></p> <p>View of T1 ending <i>'nothing devastating or, or frustrating'</i></p>	<p>Person Centred <i>'I found myself looking'</i> at notes</p> <p>Work with T1 ending <i>'I made it very relevant'</i> <i>'ask my client'</i></p> <p>View of T1 ending <i>'the counselling had been helping her'</i></p>
Experience of beginning with client	<i>'very, very, slow'</i> <i>'difficult to get to engage'</i> <i>'I knew it had to be patience, and building up a relationship'</i>	<i>'hard to hear what he said'</i>	<i>'dealing with her differently to other people'</i>	<i>'wanting to give her what she was missing'</i> <i>'try to focus'</i>
Shadow of T1	<i>'I'm not trying to step into somebody else's shoes'</i> <i>'wondering if I'm doing as well as'</i> <i>'it's about having confidence in your ability'</i>	<i>'I don't remember Sidney ever referring to his previous counsellor'</i>	<i>'whether I'm okay or not comparatively speaking'</i> <i>'interested about how T1 would be a counsellor'</i>	T1 <i>'had been sort of the best'</i> <i>'tough act to follow'</i>
On client endings	<i>'first one was very difficult'</i> <i>'be careful around the boundaries'</i> <i>'like saying goodbye to a friend'</i>	<i>'endings are more important to counsellors than clients'</i> <i>'ending difficult however you do it'</i> <i>'very few of my clients have planned ending'</i>	<i>'about letting go...it's not very easy'</i> <i>'I hate endings'</i> First client <i>'very, very sad losing'</i>	<i>'uncharted territory'</i> <i>'I think I would find it hard'</i>
Suggestions	<i>'next person...not brand new and inexperienced because there will be a lot of hurt and questioning'</i> <i>'assurance..you're not going to do the same'</i>			Not having the <i>'unspoken'</i> But <i>'is it right to ask'</i>

4.5 Individual accounts

Having presented an overview, the detail in the individual accounts within each dyad are set out below in their four part format. Each dyad is identified by the client name.

4.5.1 Dyad One – Client James

Part 1 Client James

James described his reason for being at the Agency,

'it's just that it was severe depression, er.....I was sinking a few beers but I've no problem with it..'

Experience of ending

The ending of his therapy with T1 was sudden in that he remembered there being little notice of the end,

'Err, about the next week I think.....or I think it was the same day I'm not sure, but it wasn't traumatic, it wasn't'.

When I asked how it had felt he said,

'It just felt, well there's something else going, you know'

This seemed a theme for the interview in his recounting the loss of several family relationships and his current circumstances of living alone. He also appeared to have experienced losses associated with moving into a different stage in his life.

In response to my enquiries about the ending with T1, James conveyed the nature of their farewell exchanges,

*'I said 'Good luck' you know, (brightly) give me a cuddle and that you know'
'it was fairly basic, she got the.... going to a better position..'*

The *'cuddle'* sounded like a warm recollection for James amidst his matter of fact description of the last session. The *'basic'* may have been a reference to the reason for T1 leaving as it seemed important to James that she was leaving to go to a better position, a good reason for a man I understood to have his own career history. For James, maybe their exchanges seemed *'basic'*, unless his *'not traumatic'* suggests the lack of expressed emotion around the ending.

Attachment activation

While there was little direct naming of his feelings around the phenomenon of imposed change this was counterbalanced by his extensive use of metaphor in our interview. I found this a rich, engaging and inviting source of expression that added depth to my perspective on his experience.

When talking about having little notice of the end with T1,

'Yeah, yeah....I phhh (exhales), if I say bye-bye to someone, I don't likeI don't stand watching the boat sail and all that. If they're on the boat and they're going away and that's it.'

'No point, no point getting all upset about itit's er.....no, I've always been like that, it's gonna end, it's gonna end, that's it, you know'

James seemed to welcome the short notice period of the ending with T1 as he suggests it is not his way to watch *'the boat sail'* and for me this rang with a note of resignation, he seemed powerless *'it's gonna end it's gonna end'* and there was *'no point getting all upset'* about *'something else going'*.

In starting with T2 James let me know about his hesitancy,

'I don't put myself.....put my head over the parapet let's put it like that, I'm not going to get shot down again like, you know what I mean, go so far and it's on my terms you know'

It sounded to me that James, in telling his story to T1 had unusually put his *'head over the parapet'* and trusted T1.

Loss of relationship and person

In the interview James remembered T1,

'Yes, I got on pretty well with T1'

'She was nice, she um,... (quieter voice) moved on.'

He also introduced the idea of the change being a loss of the familiar, a *'nice'* person he got on with and that loss led to confusion,

'I don't know it's very confusing'

R: confusing?

'Mmm as soon as you get used to somebody they.....(James changed to talking about appointment times).'

Loss of work done and repetition

Looking at his experience of beginning with T2, I heard in James' choice of metaphor his recognition of what his therapy with T1 had entailed and his having to repeat this work,

'but it's starting all over again you know. It's like climbing a mountain and then coming down the hill and starting again, you know.'

'I've already been there'

'all the same blummin story again'

Maybe climbing the *'mountain'* describes more than an amount of work or the time taken, but also alludes to the content of the work with T1. James uses *'open'* and *'old wounds'* to elaborate on his description of changing therapist, sounding angry at times,

'well it was like starting with T1. They want to know why you're here and what the circumstances are and this, you know and it's all ...sort of opening old wounds again'

'no it's just an open wound, the more you (T2) flaming go on about it that's why I have missed sessions'

James' experience of beginning with a new therapist sounded to me both frustrating in having to start again, tell the same story and upsetting, maybe painful in *'opening old wounds'*.

Loss of hope of an outcome

As the interview progressed I became aware of the way James often described what he said he did not feel,

'I'm not resentful because T1 moved on (describes T1's reason for leaving) the fact that I don't go forward it doesn't mean to say that I'm resentful or anything, it doesn't'

This contrast of T1's movement and his lack of movement encompassed for me his loss of hope that was both attributed to T1,

'perhaps T1 thought she was getting through you know, after (laughs), after a long time.'

and in his own suggestion,

'I'm not saying that if I'd been with T1 she'd have waved a magic wand and I'd be (gives details of how his life might be different) but, I dunno,...it didn't come to fruition because as I say she moved on, you know.'

In these extracts it seems that the loss of the work done and loss of hope are not to be expressed as resentment towards T1.

Comparisons

Indirect comparisons were made by James when he talked about T1's therapeutic style and their relationship,

'I mean I don't look back and regret not being with T1, but the only thing with T1 was, it was more relaxed....'

Linked with his experience of the impact of starting again he commented

'yeah until T2 got up to speed and that you know, even then she's not really up to speed'

James implied that T2 had taken some time getting to where he left off with T1. He adds to that a suggestion that T2 isn't there yet and this left me wondering if this is about matching up as well as catching up.

Suggestions

James was quick to respond when asked for suggestions

'well I would think, get them up to date on, well.....some notes and that but there again it's not as if they keep notes because it's between you and the counsellor but it means assuming that the counsellor leaves notes.'

So James would like the next therapist to know his story

'it's just one of them things, there's, there's no easy way out, unless you have two counsellors together and then that wouldn't be one-to-one then would it?'

and his take on having two counsellors is interesting,

'Yeah and then you'll get Mr Nice Guy and Mr Blooming Bad Guy, you know what I mean so you get different reactions.'

So for James therapists are different, they could be Mr Nice Guy or Mr Bad Guy. Maybe the imposed change process then can be likened to having two therapists with *'different reactions'* with a *'Nice Guy'*, *'Bad Guy'* feel. The essence of this metaphor for me, in the context of an interview about endings and beginnings is not only about difference but also where it is acceptable to put anger about the imposed change.

These suggestions from James would in practice minimise the sense of starting again for him and the repetition of the client story that he found difficult. They also highlight what impact the change of person and therapeutic style can have on an imposed change client.

Comments from James on reading his contribution

He reflected that he was in much the same place, being *'reticent to go forward'*. James was given notice that the therapy with T2 was going to end and he did not attend the final session, smiling he used the quote about the boat sailing.

Part 2 Therapist T2-James

Therapeutic approach

T2 described how her therapeutic orientation meant that she did not specifically work with the imposed ending experienced by James.

'I made a conscious decision as a Person Centred therapist that as I said to James, I deliberately did not read his notes because I didn't want to bring anything into our sessions....other than the.....just what he chose to bring in'

She shared with James that she had not read his previous therapist's notes but acknowledged to me that she did know something of James

'but I knew a little bit because.....um, his Keyworker had asked me to take him on board'

A client with a history at an agency may well present a dilemma for a therapist who does not want prior knowledge of their new client. In my experience even if there is no direct exchange of information, a client known to the setting will often trigger comments from other members of staff when work starts with that client. For T2, James was a new client, though not new to therapy or the Agency. Therapist T2 described how James introduced his work with T1 into their sessions,

'..and if it was okay with him I wanted to start afresh and that was what we did'

R: mmm.....and he didn't

'a couple of times he did hark back and say well, 'oh, when T1 did this I told her all that'

R: so..

'when T1 did this, and I'd said no, remember I'm not T1 this is fresh and then he was okay'

Both *'fresh'* and *'afresh'* are used by T2 with the client being described as fresh for her and she lets the client know that this is a new therapy experience, a fresh start. In doing so it appears that T2 needed to hear for herself what James had already shared with T1 but not how James had worked with it in his previous therapy.

Starting therapy and working with the T1 ending

In asking if James' previous therapy ending became part of their work I had expected to hear how T2 worked with the ending

R: and did that become part of what you did..

'no'

T2 described starting work with James

'I found him very difficult to get to engage'

and T2 gave her understanding of why this was

'you know...being quite private, keeping his feelings to himself'

'it was difficult to form a relationship with him, very difficult and a couple of times I felt really, 'now I'm taking it to supervision', because it was um, difficult to get beneath that, it felt like a (emphasized) plastic covering..... you could see through but you couldn't get through'

and how she would work with this,

'but I knew it had to be patience and, and building up a relationship'

Her suggestion was that the pace of the work was slow and it seemed James had added a further more tangible restriction,

'...but it has only been in the last two months that I have been able to get him to stay for the full session'

In the interview there was no suggestion of T2 having a description of the ending with T1 as told by James. It seems that her work with him was guided by her understanding of his experience of endings in general

'mmm.....I think he felt, you know he'd got issues with abandonment'

T2 talked about how this shaped her work with him alluding to the ending with T1

'his experience was abandonment again'

'it was not an abandonment, for whatever reason that's how he felt, you know. I felt it was important just to keep a link, a strong link there and one he would grow to depend on the therapeutic relationship'.

Shadow of T1

T2 described how she introduced herself to James with,

'I'm a different.....person'

and reminded him when he talked about the work he had already done previously,

'I'm not T1 this is fresh'

I asked about the presence of T1 for T2

'um, I wasn't worried about it because.....I knew it before I took him on, so anything I was concerned about I was able to work through but I can't say that I was'

So while the emphasis is the new therapy relationship, she mentions that if she had concerns she would have worked through them. A later remark about working with imposed change clients,

'I'm not trying to step into somebody else's shoes'

suggests to me that while not invited into the current therapy, there seems to be a T1 presence in the *'shoes'* metaphor. In our circling round various themes T2 and I come back to this presence,

'I could have allowed myself to be wondering if 'I'm doing as well as' and I deliberately had to put those issues to one side'

'...it's about having confidence in your ability'

So do the shoes represent some standard or a way of doing therapy? Does *'doing as well as'* lead to questioning your own ability?

'yes, there's always the er, um, the possibility of you know them saying 'my other counsellor did it like that' and he did once'

R: What was it like for you when he did say that

'perfectly fine because I said 'well I'm glad about that because it shows that we are different'.

Again, T2 stresses her difference from T1 when James mentions the previous therapist. Does being different mean a comparison can't be made, the *'shoes'* are different and so can't be compared? Does the previous therapist feature for the imposed change replacement therapist only when the client mentions the therapist and their work together, or are they a continuing presence? For T2 it seems that the previous therapist could be thought about before the work begins with the imposed change client. Thought about, with the possibility *'to work through'* any issues before, or during, the work and this can lead a therapist to reflect on their own *'ability'*.

Endings

All the therapists I interviewed talked about therapeutic endings and for T2

'the first one was very difficult for me, I found it was.....I had to sort of you know....be careful around the boundaries'

'there is still part of me that feels, you know.....it's like saying goodbye to a friend'

So endings are a difficult part of the work, having to *'be careful around the boundaries'* when saying *'goodbye to a friend'*. This links for me with T2's suggestion that a client brings *'a lot of hurt and questioning'* from their imposed ending and the framing of endings as painful.

Suggestions

For imposed ending clients in general, T2 suggests that is possibly best dealt with by an experienced therapist,

'...I do think that if there has been an abrupt ending for whatever reason then I think the next person who takes that on should ideally be someone who is not brand new and inexperienced because there will be a lot of hurt and questioning'

She also added,

'I think assurance, you know that you are in for the long journey, you're not going to do the same'

would be helpful for these clients. In the context of her experience with James, while she did not say that James openly expressed *'hurt and questioning'*, there is a sense, with her suggestion, that assurance is needed that *'you're not going to do the same'*, and that her work with James was guided by these thoughts.

Comments from T2-James on reading her contribution

T2 thought the *'plastic'* was about control, controlling the sessions. T2 agreed that my suggestion of James' anger at the repetition was correct. James leaving the sessions early was discussed in supervision and although her supervisor disagreed, T2 decided to *'let it happen'*. T2 confirmed that she had *'no desire to step into the shoes'* as she saw each therapist as unique but was not unhappy with the way I developed this theme.

Part 3 Dyad, James and therapist T2-James

T2's perspective on the development of their therapeutic relationship and their work highlighted for me two areas of correspondence with the account given by James.

The first area of correspondence the *'very, very slow'* description of their work given by T2 seemed to fit with the labelling in James's account of T2 not being *'up to speed'* and maybe this slow pace added to his sense of not getting anywhere. I think this area, that on the surface seems to be a matter of pace, began to make more sense as I pieced together T2's experience. For T2 it seems the pace of work that is possible with James revolves around his *'mistrusting'* and her work entailing *'patience'* and *'building up a relationship'*, as well as her image of James having an impenetrable *'plastic covering'*. While T2 links trust and the expression of emotions, she reasons that for James *'if you are a man you don't show your emotions'*. I can add to this what I gleaned from James' perspective on the imposed change in his aim not to *'put my head over the parapet'* and get *'shot down again'*.

A second area to explore is James' *'flaming'* and *'blummin'*, and my sense of his frustration at having to go back up the *'mountain'*, the upset or pain of having to open *'old wounds'* that came with *'starting again'*, telling the *'story'* again. From my perspective I can set this alongside T2's explanation how for her the therapy is a fresh start and when James would *'hark back'* she would remind him *'no, remember I'm not T1 this is fresh and then he was okay'*

R: was he saying he'd done it before?
*'no, not quite like that, but basically um.....
.....it was almost, well it didn't work last time
so....that sort of underneath feeling of what do you
want to know again for, what's the point'*

This questioning did stop,

*'only in the first few sessions but after that he
stopped completely and hasn't ever since really'*

So T2 did hear what I label as a loss of hope and the anger in *'what do you want to know again for, what's the point'*. It feels to me that this is played out in the dyad in James not wanting to tell the *'story'* again (bearing in mind the issues of trust and *'old wounds'*) and his *'missed sessions'* set against T2's position of not knowing the story as this is a *'fresh'* start.

In a later part of the interview T2 adds that James would say,

'right, that's it you've had your time now'.

It seemed that James was reducing his exposure to opening up those *'old wounds'*, exerting his power in limiting the time, having been powerless at the ending with T1.

The themes of loss, privacy, trust, difference, pace and time seems to coalesce in the dynamic with James not wanting to put his *'head over the parapet'* and restricting the time he allows T2 while T2 maintains her therapeutic approach that does not include his imposed ending and change experience.

Part 4 Researcher synopsis

James talked openly about his experience of the imposed change of therapist and the ending of other relationships in his life. Whether it was asking James about this specific ending, or that the discussion of the imposed change had primed me for attachment related themes, it felt like he was describing his current attachment status for me. He dismissed goodbyes and linguistically identified his denial of, or defence against, the affects associated with endings in his negative statements on trauma and resentment. He also gave examples of how he keeps people at a distance, of not trusting people and how he values emotional self-reliance and separateness. I see such affect minimisation or inhibition and dismissing of the importance of relationships as characteristic of individuals with a dismissing (avoidant) attachment style. Slade (2008) describes how affects, memories and cognitions relevant to attachment are overregulated and the talk of dismissing individuals is laced with negativity, hopelessness, anger and disappointment.

Yet it seemed that with T1 James had a warm relationship with someone he had placed trust in and had hope that he would benefit from this relationship. His powerful metaphor of not getting shot down again (having trusted T1 before she left) suggested to me that James would have started the relationship with T2 with a strategy characteristic of his attachment style, that is deactivating his attachment system (Mikulincer and Shaver, 2007) to defend against future emotional unavailability.

T2 experienced James as hard to engage, as private and so sets the pace and tone of the work based on her understanding of trust and abandonment being issues for him. Her description of the *'plastic covering'* suggests a barrier to working with emotional material and for James a way to avoid experiencing dysregulation (Harris, 2004b). James is faced with a new relationship and the reworking of painful issues that he suggests leads him to miss sessions, of a rupture, a disruption to the therapeutic relationship. T2 adds to this picture describing James taking control of the time she is allowed to work with him.

Their relationship is not determined by one party. The therapist also has intrapsychic representations of their own and we get a glimpse of the painful feelings experienced by T2 at endings that may influence how she works with imposed change clients. While T2 explored James' history of endings it did not include the therapeutic ending with T1 although it is suggested by T2 that such a client comes to therapy with *'hurt and questioning'*. James appears to work with the loss of T1 that is not addressed in the new relationship with an idealisation/devaluation comparison of his two therapists. He uses time as the marker (in *'not up to speed'*) as if displacing anger and disappointment of the ending with T1 onto T2, even offering a nice guy/bad guy metaphor for the difference that comes with the change of therapist.

For T2 it seems that comparison is inevitable, if not directly articulated by James, then unconsciously communicated (Robbins, 2000) and makes her question her ability as a therapist. While not invited in, T1 seemed to have a presence in this relationship.

4.5.2 Dyad Two – Client Sidney

Part 1 Client Sidney

Sidney was clear about his history of alcohol use,

'.. I will say I'm an alcoholic and I've been sober for, for about 35 years now'

his understanding of what alcohol meant to him,

'it isn't a drinking problem, it's a living problem'

'It does, I mean it never leaves yer, you get um, when your, your mind's racing you just want to get out of it, out of it, by drinking you get out of it (gives description) yeah, get away from worries'

and why he attended the Agency to maintain his sobriety

'no, it's very frightening (slows down) so that's why I come in really (to the Agency) I just don't want to go back there....'

Experience of ending

Sidney mentioned his feeling of panic when he heard T1 would be leaving,

'yeah, I really panicked you know, where can I go, who can I talk to?'

He remembered the details of the end in a fairly matter of fact way,

'yeah, yeah, she left for another job'

and the notice,

'I think it was about a month'

In the interview Sidney openly expressed his feelings to describe both his experience of the imposed change of therapist and other experiences in his life.

I heard much of the material Sidney introduced into the interview as references to loss and change around the ending of a long term personal relationship, of him missing the contact with that person, his living alone and his move into a different stage in his life.

Sidney took action to replace T1,

'yes I said 'is there any chance you can get me a new counsellor?'

'cos I thought, well, you gotta do something Sidney..'

and then

*'..I talked to **** about it, yeah that I do want somebody, there's such a lot going on in my life'*

'I didn't know if I'd cope, I did just about, I was hanging on then..'

Loss and change, *'a lot going on in my life'*, seemed pivotal in his request for *'somebody'* when he found out that T1 was leaving. Wondering *'if I'd cope'* and *'who can I talk to?'* when there is a *'lot going on'* made Sidney consider his sobriety and relapse.

'I thought this is the last time I'll see herand um, yeah and I thought what's gonna happen, what was I gonna do, cos I was thinking in advance of what was I gonna do'

Sidney openly expressed the concern he had of not coping if he was without a therapist. I got a real sense of his determination in setting about getting what he felt he needed in this and other areas of his life. He was aware of his need to maintain his sobriety through a difficult period in his life and for Sidney.

Attachment activation

Sidney's description of his experience of the ending with T1 is shown in the extracts above, feelings of panic and thinking around how he would manage without a counsellor at that time. That the counsellor was leaving left him wondering,

'who can I trust?'

He also knew what he was looking for in a counsellor,

'they care about you and you are in their thoughts'

The change he meets with therapist T2 does not provide what Sidney was looking for

'I felt he never listened properly.'

'he just said 'yes' and 'no' I got no feedback'.

Loss of relationship and person

'..like losing a friend'

'she got to know YOU (loud emphasis), and you got to know her style as well'

Sidney describes above the loss of the relationship he had with T1 and what sounds like a welcome familiarity that came with development of the therapeutic relationship. In the comparisons section below, Sidney's words deal with details of therapist style and relationship factors that were lost at the ending with T1. He explains that this is why he did not continue the therapy,

'well, I felt robbed so I stopped going'.

The imposed change of therapist had taken away a relationship and a person he trusted who listened, who would hold him *'in their thoughts'*.

Loss of work done and repetition

Sidney gave another reason for leaving therapy with T2,

'I didn't like raking up old memories'

He qualified that he had been able to go back over past events with other therapists describing one,

'I get the impression (voice softens and slows) she listens and cares.'

suggesting that it is about who these 'old memories' are raked up with rather than if they are raked up.

Loss of hope of an outcome

Sidney stopped going to his sessions with T2 as,

'I didn't get nothing out of him, so I just left'

'I ended it because I'd go out feeling no different, you know'

It seemed he had lost hope of getting what he wanted from the sessions. Sidney's loss of hope was also tied up with 'the person' of the therapist as he described that on ending with T2,

'it had an effect, because I thought who can I trust? Who can I go to?'

Comparisons

Unlike James, Sidney made explicit and sometimes angry comparisons between T2 with T1. In describing his therapists Sidney commented on age and gender as well as how he experienced them as therapists.

Comparison on the basis of gender is unsurprising as Sidney's female therapist leaves and he is allocated to a male therapist. He comments on T2,

'I suppose he's a typical man, you know because he's a typical man and a woman understands more'

'But a man, a man seems a, I don't know, men seem to be harder, a lot tougher and they haven't got no feelings'

In several places in the interview he tells of his experiences of getting into trouble with male teachers at school for his retaliation to bullying and also criticises a male GP so maybe these are his 'typical' men. It would be easy to use this alone to understand his relationship with T2 but it seemed there was something else happening as well,

'I got the impression he found me harder'

'I don't think he really understood what I was trying to get across, he sort of um, didn't really identify with what you were going through, you know, and I used to go home frustrated cos, um, I felt he never listened properly.'

With Sidney's requirement of therapy being about someone he could 'talk to' he openly expressed his frustration of experiencing T2 as not listening 'properly'.

So while Sidney 'got the impression he found me harder' maybe he himself found the change, the differences between his therapists hard too,

'...like talking to a door, you know he just said 'yes' and 'no' I got no feedback'

'Yeah, I couldn't relate to him really. He sort of did different things.' In the interview he told how T1 would contact him if he was unable to make his session

'my first counsellor used to ring me up if she knew I was sick...'

'it shows they, they're um, it shows they care and they're doing a, their job (quietly) they care about you, and you are in their thoughts'

T2 didn't,

'yeah, the second just didn't bother, you know.'

For Sidney, with the change of therapist came comparisons of the person and their style of therapy with a loss of what was familiar including therapist behaviour outside the therapeutic hour.

Suggestions

'Well I think it is about finding their own type of counsellor. I think you gotta have a sympathetic counsellor, yeah. But I believe you gotta care, say 'why did you do that?' say she's no fool she knows what's coming she can tell the lie between the truth yeah, no mucking about'

R: no mucking about?

'at the same time being a little bit sympathetic, but at the same time pointing out the true values of life.'

Sidney's suggestions revolve around getting the right person/therapeutic approach rather than concerns around the loss of work or repetition.

Comments from Sidney on reading his contribution

Sidney added some more of his childhood memories that supported my ideas on his 'typical man'. Sidney clarifies that a warm relationship had been taken away and replaced by a cold one that lacked the ideas and practical suggestions he was used to. Sidney confirmed that 'raking up' was about going back over things.

Part 2 Therapist T2-Sidney

Therapeutic approach

T2 talked about his approach when starting with clients who have undergone a therapist imposed ending.

'I never read other peoples notes, about what people have said before, in fact I don't even read assessments.'

He described his approach as Person Centred and his own interpretation of this

'Er, it's a bit, it's a pure way of working that is not intentional or done for that purpose, but er,I like, I like to have a view of a person in a way if I can but I don't like it to be a view that is somebody else's view'

he suggests that his view could be 'coloured' by what he heard about a client,

'I didn't have a clue about what he (Sidney) had dealt with before, we started afresh, I had no contact with his previous counsellor so I was really starting from scratch.'

Starting therapy and working with T1 ending

In the interview we revisited 'starting from scratch' and I asked if he works with the previous ending in such cases,

'(inhales deeply).....well, I suppose that, that some people, some counsellors might work with the fact that there had been a previous ending but that's not from, it's not part of, as I would see it the Person Centred way because the agenda is really the clients, er, so I wouldn't bring it up'

'..but I tend to regard everything as a completely new instance and relationship and I don't go back into it (the prior ending) unless the client wants to. So really I don't see any particular need to do so'

Shadow of T1

T2 did not know Sidney's T1 and while T2 would not introduce the topic of a previous imposed ending into the work of therapy I asked if Sidney had,

'I don't remember Sidney ever referring to his previous counsellor'.

T2 did talk about clients pointing out that therapists were different and the differences being what they might talk about and how therapists dealt with things.

Endings

Talking about client views on the end of a therapeutic relationship T2 said,

'..but sometimes perhaps it isn't as important as we think, think it is to the client. I think, I feel endings are more important to counsellors than clients. I mean how often does somebody ring up or not even ring up, and say they are not coming again (laughs) they don't want an ending session'

This extract combines T2's thoughts on endings for both client and therapist. In cases where there had not been an ending (here both T2 and I are using 'ending' as in, planned ending), he suggests for some clients, *'they don't want an ending session'*. T2 seems to be equating clients leaving therapy with or without letting their therapist know as either being about endings having less importance for the client than the therapist, or clients not wanting an ending session.

From the suggestion that *'endings are more important to counsellors than clients'* T2 expands,

'they will want to talk about the ending because they probably see as, ohhhh (sharp intake, like a tutting sound) very (emphasized) importantI tend not to lead the client....'

His mocking tone seems to reinforce for me his distinction as to who in the relationship holds the ending as something important or significant. While T2's experience is that some clients don't want an ending he introduces the idea that,

'very often, very often, I think the thing, the difficulty for clients, is when a long, long standing relationship.....it's, it's then people find the ending difficult however you do it'

With this there is a shift from the ending lacking importance for a client to one of the ending being *'difficult however you do it'* following a *'long standing relationship'*.

T2 described his experience of final sessions with clients,

'...very few of my clients have a planned ending, er, when they are...then I tend to have something that, review things and they tend to fizzle out somehow as though this last session.....doesn't need to be done...maybe twenty minutes is quite enough and then 'ah, okay so, well that's it then isn't it really (laughs).'

Again this has echoes for me of either a lack of importance, if the last session *'doesn't need to be done'* or of the ending being *'difficult however you do it'*.

T2 described his experience of the ending brought about by Sidney,

'Yeah, I mean my, my time ended with him, he just stopped coming
R: so you didn't have an ending
'no we didn't have an ending as such'
R: mmm, and what was that like for you?
*'I always find it frustrating when that happens..... ..
.....Mhhhh! (sounds frustrated).....and Sidney was, was not unreasonable about it.....as far as I can remember. It was a reasonably amicable sort of ending (very quiet) he recognised he wasn't going to keep coming and just stopped rather than muck you about'.*

Suggestions

None

Comments from T2-Sidney on reading his contribution

T2 expressed surprise on reading that Sidney had said he 'never listened properly'. When Sidney commented on being contacted when he missed sessions, T2 talked of finding this a difficult issue saying that he makes a judgement that does not mean he does not care or is a *'typical man'*. T2 spoke of *'not fathoming out'* what Sidney had wanted and wondering *'what he was running away from'*. T2 did *'not like the sound of'* my suggestion that I found a 'lack of importance' in his comments on therapeutic endings. His suggestion was that the ending session was more about intuition and *'letting go of dogma'*.

Part 3 Client Sidney and Therapist T2-Sidney

Looking at both the interviews there are themes that suggest rupture points that led to the unplanned ending of this particular dyad. T2 described how,

'..it's very hard to hear what he said all the time and ...I, I found with him that I let some things go which I couldn't hear otherwise I was asking every moment what he had said again which I thought was a bit too much'

' occasionally it seemed to be okay to say, to feel, well I missed a bit there but I don't think that bit was.....I'll ask the next time it sounds like I am really missing something (clears his throat)

R: mmm

'and it did get easier, but sometimes it was very, very hard'

R: hard to actually make out..

'yeah, hard to be with him to, to get the full drift of everything all the time'

While T2 is struggling, as it is *'very hard to hear what he said'*, *'to get the full drift'*, and found it *'hard to be with him'*, I heard in Sidney's interview his experience that T2 *'never listened properly'* (In my post interview notes I recorded that for both participants I struggled to hear what they said at times).

As well this physical, not hearing, not heard, *'missing something'* in their relationship, Sidney made many comments on how his therapists differed. T2 defined his training and practice as Person Centred and his style as one where,

'Mmm, I suppose I tend to let people talk more than I talk..'

This style of therapy would seem to fit with Sidney's quest following the *'panic'* on hearing that T1 was leaving *'where can I go, who can I talk to'*, as T2 offers *'to let people talk more than I talk..'* However Sidney's experience of T2 was *'I got no feedback'*. It is hard to know if this is the noting of a difference of style between therapists or a further complication that arose from the not hearing/not heard issue.

Therapist gender was an important theme in Sidney's interview. He commented on his relationship to various men in his life and labelled T2 as a *'typical man'* suggesting that *'a woman understands more'*. In discussing the different therapists he has worked with he suggested that he looks for someone who *'listens and cares'*. Sidney knows a therapist *'cares'* when they call him if he misses a session. T2 in contrast talked about his practice of not contacting clients. In talking about the end of therapy with Sidney, T2 mulls this over,

'Cos there's sometimes the debate about how far I should go to contact these people to keep them in the service'

'...I suppose it has changed a bit I used to do a lot more contacting people, I tend to now.....I tend to rely on people making their own decisions'

This practice maybe left Sidney feeling T2 did not care and contributed to his exit from therapy.

In talking generally about the client group at the Agency T2 commented,

'wellsome of the people we have, I think.....rely very much on coming here to be able to just talk to somebody....and.....I don't think they necessarily have the same.....they don't have the desire to be free of their addiction, that, that is the most important thing, it's more about complimenting their life in some way with something because very often we are the only people that they talk to...'

Sidney would seem to be one of these clients, wondering *'who can I talk to'* when his therapist leaves and so maybe he was *'coming here to be able to just talk to somebody'*. I am not sure what is being said here in terms of T2's work with this client group, maybe frustration as T2 suggested, a lack of desire *'to be free of their addiction'*? Is Sidney free of his addiction as he maintains his sobriety, continues with AA and after many years can still be fearful of a relapse? It sounds like the therapy ended with frustration on both sides and for me I feel I am left with *'missing pieces'*.

Part 4 Researcher synopsis

With this second client I was again aware of attachment related phenomena and processes. Sidney expressed his panic at hearing that his therapist was leaving and his fear of not coping without one that included struggling to maintain his sobriety. He described how he immediately set about finding a replacement therapist and the qualities he looked for; a robust therapist that listens and cares. For me, Sidney described the under regulated affect and proximity seeking behaviour associated with a preoccupied attachment style. Slade (1999) describes a preoccupied organisation as lacking the structures for regulating affect, feelings, memories and cognitions related to attachment that leads to a sense of being overwhelmed by them. Being unable to get adequate comfort from the symbolic proximity of an internalised attachment figure, a preoccupied attachment status leads to hyperactivation strategies to seek and retain a caregiver (Mikulincer and Shaver, 2007).

Once Sidney is allocated to T2 his experience is one of unmet requirements. There seem to be different strands contributing to the relationship difficulties (ie Sidney leaves therapy unannounced). Firstly, a powerful transference depicting the therapist as a *'typical man'* and T2's style of neutral responsiveness that Sidney sees as uncaring. Such neutrality is documented as evoking feelings of rejection and neglect for clients with a preoccupied attachment style and suggests a need for therapist awareness around attachment phenomena (Harris, 2004a). The countertransference that comes with an anxious client with a hyperactivated attachment system (Slade, 1999) who presents as needy, dependent and demanding may well have had an influence in this relationship.

Secondly, there seems to be a Real Relationship (Clarkson, 1995) issue of not hearing and not being heard. While T2 describes difficulty hearing Sidney there was no sense of this being addressed as a way to build the relationship or avoid a rupture (Safran & Muran, 1996). Sidney's anger is apparent in our interview with his unmet expectations and his comparison of T1 and T2 with T1 idealised and T2 devalued. In their work, T2 cites therapeutic orientation as the reason for not acknowledging or directly working with the imposed ending, change, and the losses this involved. It is hard to exclude T2's own confessed dislike of endings from the approach taken with this imposed change client.

Thirdly, there were differences in client and therapist understanding of the 'problem'. While Sidney describes himself as an 'alcoholic' T2 sees Sidney attending not to deal with an addiction but because he is lonely. While T2 may well have recognised that Sidney was lonely it means their relationship was based on a difference in their expectations of the therapeutic work they would do, as well as how Sidney defines himself.

4.5.3 Dyad Three – Client Megan

Part 1 Client Megan

Megan described herself in the following way

'I have suffered from depression and that as well andlack of confidence and thatalways been a little bit of lack of confidence but.....no, just.....it's not liking myself andyou drink on your troubles and'

and around her troubles she identified her attempts to cope

'..with the chaos in my head'.

Experience of ending

'yeah, at the end of the, yeah' (taps her sternum and demonstrates faster breathing)

R: your breathing goes up and you get..

'tearful and all of that'

R: mmm

'like it's a wrench sort of thingand that' (gestures hand moving up)

R: mmm, and the actual parting was really filled you up? You are showing me on your chest

'yeah and that sobby, you know sort of out of control'.

I found Megan's description of the last session with T1 very moving. The 'wrench' of the ending that prompted this powerful 'sobby', 'out of control' emotional reaction felt very real between us in that moment. During the interview she made many references to her emotional nature and how upsetting endings are for her. Having had several therapists, Megan included these endings in the interview by way of explanation that not all these endings provoked an emotional response.

Attachment activation

Megan's description of the ending with T1 that was painful and emotional can be linked together with her apprehension around change, and caution when starting new relationships

'I've never liked change..(detail of changes)..better the devil I know'.

On several occasions Megan used a building metaphor

'it takes a while to build trust'

'and you get attached to somebody, maybe a bit, and that trust builds up and everything'.

I returned to *'attached'* to ask how she would know when she is attached,

'cos I think um..... yeah cos I think I um, open up more'

R: mmm

'be dead honest, you know....not scared to cry and um....get emotional in front of them' .

In the comparisons section below difficulties in starting the relationship with T2 are evident in her descriptions.

Loss of relationship and person

The phrase Megan used to describe both the ending with T1 and some other therapist endings was,

'losing a friend sort of'.

She further defined what was lost,

'...again with T1 as well, it's upsetting cos you start getting familiar with people'

'yeah, you get to know them' .

While defining the relationship that was lost as a friendship, Megan describes a familiarity that sounds comforting and the building of trust being important. Getting to know the therapist could well encompass both the person, as a person, and their style or way of working,

'people work in different ways don't they?'

Loss of work done and repetition

Megan who had worked with several different therapists describes the repetition needed following an imposed change of therapist and the effect that it has on her,

'you've got to start.....start all over again'.

'...and starting again um, explaining like your whole life over and over again'.

'you change counsellor and although I've passed that stage.....I'm not explaining this very well,.....if I passed that, that, that stage, dragging it all up again'

'you need to go back over everything and I find it draining'.

Megan assumes that going back over everything is what is needed by the therapist and without questioning volunteers *'going over all the stuff again'*.

A suggestion of what prompted this is in her recounting of T2's words,

'say whatever you want, say what comes into your head' ,

as well as being left with an open space to fill with this new therapist who she had yet to become familiar with.

Loss of hope of an outcome

'...it would have been nice to have carried on with T1, it felt like I was getting somewhere'.

While Megan held some hope in her *'getting somewhere'* she adds her thought

'well what was that all for?'

when parting from T1.

This captured for me a loss attributed across all her therapeutic encounters in the loss of hope of finding what for her sounded like 'the' answer she sought,

'..but why are you like the way you are....and I've never found that out yet'.

Comparisons

Megan suggested that she was not showing her emotions yet with T2 (two months into the relationship),

'I am very reserved, and probably with T2 for the first few times..' .

Megan made comparisons about the content of sessions between T1 and T2 and described what she was doing with T2,

'my drinking's going up again so we talk about that at the minute'

'not.....um.....I don't know, maybe it's about my drinking cos I have to keep doing drinks diaries for CDAT and I bring them in to T2'.

Her being *'apprehensive'* and not *'opening up'* seemed to affect how Megan was with T2.

'yeah, yeah, um, yeah, I can get.....can get quite emotional some times. I haven't been.....lately, talking about things....um, but.....I did a lot with T1, I think because of the stuff that was going on then'.

She felt that not working with emotional issues might be because she had already handled difficult emotional issues with T1,

'I don't know whether T1 understood me a bit more, her being a female and my....men problems (laughs) and things like that'.

Here she uses gender but later recognised that with a previous male therapist she been able to *'open up to'* about her relationship problems, suggesting that maybe therapist gender is not the main issue.

Megan compared the approach of T1 with that of T2

'she'd talk back more'

'talk more rather than just listening, she'd give me ideas of things to do..... think aboutdifferent ways to think about things'

'...it'ssssssss, yeah he does talk back, it's not always just me talking, or not so much just me pouring out my heart'.

Having said that T2 talks less than T1, Megan seems to adjust the picture by saying that *'he does talk back'*, but somehow for me the *'not so much just me pouring out my heart'* left me with a sense Megan feeling on her own in the silence. This lack of *'talk back'* suggests that her expectations were not met from the start

'the first time, I sat here and I'm waiting for him to fire away with the questions'

'yeah, but I don't know whether that, cos he said.....in my first meeting he said 'say whatever you want, say what comes into your head' I think because he's aI can't remember the word.....'

'.....mmm, that must mean that I do the...and he picks out, picks out the bits and once he's got a, a picture of me and that, then he may start asking more questions'

Suggestions

Megan made a suggestion that she thought would be helpful in the imposed change process,

'I don't know, I don't know if they, do they read...through...the...like the last counsellor's reports?',

'..possibly because they'd get a little bit of insight into what you've gone through cos I can't always remember every little detail' .

Her suggestion supports the importance she attaches to *'what you've gone through'* when she says that *'I can't always remember every little detail'*. She sees a need for her to drag up *'certain things'* that mean she will *'get all emotional'* and feel drained. This sounds difficult and maybe painful for Megan and so she would welcome her new therapist having notes, *'a little bit of insight'* as to her history to help her out with this.

Comments from Megan on reading her contribution

Megan commented that she is easily led and talked about a fear of getting it wrong and when with T2 not being able to ask for what she wanted.

Part 2 Therapist T2-Megan

Therapeutic approach

The extracts below are from the second interview with this therapist as he is both T2-Sidney and T2-Megan.

'so I'm not sure that it's necessarily a good thing to have prior knowledge...the classic Person Centred thing is that you start from scratch'

While T2 described a Person Centred stance that was consistent across the two interviews and was about not reading the previous therapist's notes or directing the client to talk about their previous therapy and therapist, he also suggests flexibility in his work with Megan in

'dealing with her differently'

and working with her drink diaries.

Starting therapy and working with T1 ending

I asked what T2 knew of the imposed ending,

'yeah, umum, the ending was just an essential ending'

'ummmmm, it was nothing particularly, nothing devastating or, or frustrating er, I can't remember now what the things were...I know it was nothing untoward, just sort of mentioning 'en passant' sort of thing.'

It seemed that Megan had not told T2 how she experienced the ending with T1 or the differences she noted between T2 and T1. T2 is curious about Megan's work with T1 but dismisses it as irrelevant even though he is working differently with this client.

From the outset T2 commented on difference,

'something different about Megan, I'm not quite sure what it is.....possibly the fact there's there's been.....no particular signs of movement or progress (emphasized)I imagine from where she was'.

He suggests this lack of progress while acknowledging her time spent with T1,

'maybe six months or so...not that longbut the behaviour pattern seems to be.....I imagine, much the same'.

This perceived lack of progress leads T2 to state an interest in T1 and the work with Megan. T2 then dismisses this interest,

'I'm just interested in what she might have talked about'

'.....er, but in a way er....it's not relevant this is just my curiosityso I haven't looked back (at the notes).'

Being curious about what happened in Megan's previous therapy does not prompt T2 to work with the ending or the work with T1 as he works by starting from 'scratch'.

Shadow of T1

Early in the interview T2 mentioned his awareness of Megan having seen another therapist

'more conscious with her of the, of her seeing someone else before.....there is no particular reason I can think. She doesn't refer particularly to her previous counsellor'.

Through the interview his interest moved from Megan seeming different, to Megan's work with T1, to wondering about T1 and how he compared

'so it wasn't of any relevance particularly to the counselling.....but I have no feeling what so ever as to how the counselling was'

'.....or whether I'm okay or not comparatively speaking.....anything like that, she turns up so I presume it's alright'.

T2 reflects on what it is like for the client, suggesting that,

'I suppose on some occasions it must, it must (emphasized) be very difficult for the client, er moving from somebody they got on really well and they are forced to stop and offered something else, whereas this might not be working'

R: mmm

'so it's different and then the realisation that you know, things aren't the same, they are different and 'it's not what I want' (laughs) and sometimes maybe it's 'gosh this is worse than it was before'.

Although this is not directly related to T2's wondering 'whether I'm okay or not' it follows on from this and describing his curiosity of what went before. If for the client the new

therapy is *'not what I want'* and *'is worse than it was before'* the laugh is about the plight or exposure of the therapist here rather than the client. For me, this suggests a vulnerability around the difficulty for the therapist of providing what is not wanted or working, or seen as worse than the previous therapy.

Endings

*'I remember the first client I had I was very, very sad
Losing*

R: mmm, someone you had worked with and built up a relationship
with

*'.....
.....it's not about a sense of loss actually
.....I didn't particularly mind'*

R: you didn't?

'no'

R: but you felt sad

'(quietly) yes'

R: mmm

'(describes the reason for the ending for this client)'

R: you can experience a sense of loss

'yes I felt a sense of loss'.

*'yeah, so the endings are all different.....it's
probably me, it feels like (inaudible)'*

R: you feel more?

'I think I probably feel more.....'

R: about endings?

'yeah, (very quietly) I hate endings'.

T2 suggests that he as well as his clients find endings to long term relationships difficult.

Suggestions

None

Comments from T2-Megan on reading his contribution

T2 said that Megan had stopped attending and so being able to *'get somewhere'* did not happen with him. He thought it a fair observation that they worked on practical rather than emotional matters and was not sure there was any significant emotional content in their work. He said it is true that he hates all endings.

Part 3 Client Megan therapist T2-Megan

Both Megan and T2 commented on difference. T2 on how he was working differently with Megan compared to other Agency clients. On hearing Megan's difficulties with practical matters he offered to look at them with her,

'.....I'm finding that I am dealing with her differently to other people.....quite a lot differently..'

'yeah, maybe I'm sort of.....doing some key-working at times..... 'Let's have a look at drinks diaries, let's have a look at your finances', more paperwork'

Both Megan and T2 commented in interview about the change in Megan's drinking,

'(completing drinks diaries)...I suppose it did illustrate the point to me that her drinking has in the few er....weeks has increased quite a bit.....um, now that she is writing it down'

and he sees this collaboration as,

'helping her to move herself on a bit somehow'

The client and therapist accounts give a contrasting view on Megan's progress. She saw herself as *'getting somewhere'* with T1 while T2 suggests a lack of progress with Megan seeming *'much the same'* after her time with T1.

Megan notes the differences between her therapists in how they work and how she has engaged with and placed trust in each therapeutic relationship. She described her view that therapists *'work in different ways don't they'* and that in comparison to T2, T1 would *'talk more rather than just listening'*. In the therapeutic relationship with T2, she commented on not working with emotional issues, *'I don't think we have touched on that sort of side yet..'*. In terms of the therapeutic relationship T2 also suggests *'we are not fully there yet'*,

'Megan, I feel okay with but we still sort of...I'm still not quite...um.....you know getting on pretty well and I've got a feeling that, that um, she sees me as being okay, it just feels that way, but we are not there, we are not fully there yet, cos she's working very hard. I think we are building quite a relationship and we are actually going to be able to get somewhere, it feels like that, whether or not we will, it's a matter of time.'

T2 is hopeful *'to be able to get somewhere'*, while for Megan it is *'early days'* in their relationship, her being *'apprehensive'* to start with and waiting until *'that trust builds up'*. Is there a hint here of T2 wondering about his own acceptability as a therapist for someone who has had many therapists? For Megan the *'early days'* status of their relationship means some of the emotional content of her world has not come into their work, *'I don't think we have touched on that sort of side yet'*.

Part 4 Researcher synopsis

Megan described an emotional ending with a trusted therapist who she felt she was making progress with. She also explained her fears around change and starting with a new therapist. Following the ending with T1 and starting with T2 her drinking had increased. While Megan seemed ambivalent about starting another therapeutic relationship, her anxiety and apparent lack of structure to contain feelings, suggests a preoccupied attachment status (Mikulincer and Shaver, 2007) that led her to take up the interpersonal support offered at the Agency.

Her need to build a relationship and trust to feel attached to a therapist before emotional issues could be handled meant for her, work to date with T2 had concentrated on practical matters. T2 confirms that he is working differently with Megan. Slade (1999), comments on the countertransference for therapists of a preoccupied client's dysregulation and need for advice and support, (their hyperactivating cues). This leads therapists to try and organise and structure the client and in this dyad drink diaries (a 'reality crisis' Keith 1966, p.188) rather than emotional content was the work in hand.

In addition to Megan defining what she needs to be able to do the emotional work of therapy, she comments on the difference between T1 and T2. The loss of familiarity of T1 and the different style of T2, is for her about therapist contribution in the sessions. Therapeutic neutrality for a client with a preoccupied attachment style can trigger an experience of rejection or neglect, reinforcing the client's anxiety and a desire for approval (Slade, 1999). That a 'chronically anxious person' remains vigilant for even minor indications of attachment figure unresponsiveness, means that the attachment system remains hyperactivated (Mikulincer & Shaver, 2007, p.32) and neutral responsiveness is experienced as discomfort or distress (Harris, 2004a). I found both anxiety and desire for approval in Megan's 'going with the flow' as she tried to provide what is wanted both in her description of working with all her therapists and in our interview.

T2's curiosity about Megan's T1 seems very personal and was not a concern in other therapist interviews. T2 does check out his status in comparison to a client's other therapists as well as in a more general sense around change of therapist. While this T2 would consider talking to a prior therapist about their work with a client, he would not ask the client. Working

with the client agenda is the explanation that excludes questions about either the ending with T1 or the work done in that relationship. It is hard to ignore that this therapist who 'hates' endings makes assumptions that both Sidney and Megan are alright with their imposed change of therapist and the general comments on client attitudes to endings suggest that therapeutic endings do not matter.

Both Sidney and Megan found going over work done with previous therapists difficult, and both left this therapy before an ending with T2 having stayed for an ending with their T1.

4.5.4 Dyad Four – Client Kezia

Part 1 Client Kezia

Kezia firmly placed where alcohol fits in her life,

'but the drink is.....what shall I say.....sort of sheltering me at the moment, it's like I'll jeopardise things, I know I'll drink and I never will be able to get up'

'...if I go to bed and I'm sober, something always comes unbidden into my, or if I'm in the bath, unbidden into my head, from the past it could be anything, anything at all but.....it just creeps in. Mmm so there is lots but it's such.....a tangled mesh'

Kezia's alcohol consumption increased after ending with T1 and starting with T2.

Experience of ending

'It was alright, I gave her a hug (laughs). We just sort of carried on as normal. (Quietly) It's not necessarily helpful to talk about, you know, how you are feeling and going on, (louder) and I tend to have probably more delayed reactions to things' R: a delay..

'yes, initially I didn't feel too much and then I seem to remember afterwards something came up and I thought 'oh, I'm not doing very well without a counsellor or something'

Kezia described her experience of the ending with T1 in terms of carrying on as 'normal', wanting to avoid feelings and seeing her reactions to the ending as delayed. She had concerns about the potential and maybe imminent loss of current personal relationships due to illness and age as well as the limited time she would have with T2. She seemed preoccupied with a future that would involve loss of 'contact' and 'support'. For me, it suggested that the potential impact was of being without a therapist rather than a particular therapist, the loss of 'contact' and 'support' and the anxiety that this may provoke.

Attachment activation

'..the counsellors always say to you, well you know, 'how are you feeling it's nearly time that I'm going' and I often feel 'oh, should I be showing great signs of grief and all that'.....anxiety yes maybe..'

Kezia had said she 'didn't feel too much' at the ending with T1 and elaborates,

'well, I suppose there is a loss yeah, you know you've been seeing them a long time and er, you think you won't see them again and yes there is, sort of er,sadness, um....but I suppose I got used to it now that um,it's almost sort of, (brightly) oh, 'c'est la vie' you know'.

Her 'quite upset', 'sort of er,sadness', seem tentative and she asks herself if there should be signs of 'grief'. Does this fit with 'c'est la vie'? Is Kezia either de-sensitised due to the many endings she has experienced or describing attachment phenomena?

Loss of relationship and person

From her many experiences of ending with therapists, Kezia talked in general about these endings

'...I've been quite, sort of upset about it.....um....you know feeling that, um, I'm losingmmm, yeah, I'm losing the contact, losing support'

'but um,....on the whole um, you know some I've got on better with than others.'

The qualitative distinction in terms of the different therapeutic relationships she has experienced seemed to determine the feeling of loss, as if the level of sadness or anxiety depended on the perceived quality of the relationship that she was losing.

Loss of work done and repetition

'I was beginning to think, 'oh, it's beginning to'you know, maybe something beginning to.....come out of this when it had to be ended so.....yeah'.

Kezia is not specific about her sense of what might be coming out of her work with T1 but in making comparisons between her therapists said,

'we don't do very structured sessions (with T2). I think T1 tried to make it a bit more structured sometimes...'

Structure was what Kezia valued from T1. Structure that maybe went some way to holding the 'tangled mesh' that she tries to shelter from using alcohol.

Loss of hope of an outcome

'..why is it so impossible to um.....you know, why can't I.....turn things round so that I feel that I'm capable of doing things'

For me this linked to the 'something beginning' possibly provided by the structured sessions, but also to the fact that many therapeutic relationships had not got her to the point where she could 'turn things round'. The increase in her alcohol consumption was also highlighted as coinciding with the ending with T1.

Comparisons

In contrast to a sense of a continuing hopelessness, Kezia spoke about her experience of T1 as her therapist,

'...yeah, it was really good.....'

'...I would probably say yes, the best counsellor I have had has been T1.'

Although T2 was,

'very nice andquite helpful'.

She makes comparisons between her therapy with T1 and T2 citing T1's more structured sessions adding that with T2,

'..I guess I sort oflead it in a way, um'

It is unclear if it is the difference in therapist orientation or style that makes her feel that she leads the work. Again her metaphor of a *'tangled mesh'*, sheltering using alcohol and her possible reluctance to explore her feelings and issues from the past all seem to come together as I move backwards and forwards through the transcript trying to piece together Kezia's experience.

Suggestions

None

Comments from Kezia on reading her contribution

Kezia did not agree with my suggestion that 'any counsellor' rather than a particular one would do. She felt she had to *'make the best of who ever she gets'*. She added that the people who have made a difference for her are not always counsellors and cited the example of a GP. Kezia agreed that she likes structure and maybe needs more *'compartmentalisation'* in her life.

Part 2 Therapist T2-Kezia

Therapeutic approach

T2 described her approach to therapy as Person Centred and talked about what it was like having a client who had ended with another therapist at the Agency.

'..it was sort of almost tempting I suppose to get a picture of, of kind of, what was going on for her and um, I found myself sort of looking at a couple of the most previous, sort of sessions..(previous therapist notes) ..and I kind of just decided well, I don't want to look at too much, I'd like to start off fresh and just ask my client myself you know, how was it for her'

Here T2 is torn between finding out about the client and wanting like the other therapists in the study to 'start off fresh'.

Starting therapy and working with T1 ending

What did mark this therapist out as different from participating therapists was that following a discussion in supervision she purposefully enquired about Kezia's experience of ending with T1,

'I made it very relevant'

'what was good and um, what was.....sort of, what....yeah, what was helpful really'

'Is it right to ask or is it better that the client can just say for themselves? I'm not sure. I suppose for me another reason why it was good to ask how her previous was, because otherwise it is like something that exists that is kind of unspoken and not really talked about, yet it is, it does seem very relevant'.

This therapist also thought about what the client brings with them by way of the experience of having already been a client with another or many other therapists,

'um, I'd say that I think someone who has been in counselling before um...Learns, probably more how they want to use the session um, they are more aware of kind of how it works (examples) preconceived ideas they might have about counselling means that it could sort of be that they want to work in a way that, that the counsellor might feel very different, um...'

This reflection on a client's expectations when changing therapists was mirrored in her struggle to find a path between providing what Kezia wanted and how their work was going to proceed.

Shadow of T1

In choosing to ask about Kezia's previous therapy, this therapist then asks herself,

'..in making it so relevant did I bring about more of a comparison?'

The detail of that comparison is available to this therapist,

'that the previous counsellor that she'd had, had been sort of the best she felt out of all of them'

R: what was it like when she said that?

'(laughs) I did sort of feel, 'Ooo I've gotta tough act to follow' you know, not that it should be an act'.

She laughs, maybe in recognition of the impact of hearing about the 'best' counsellor but does not directly describe the 'Ooo', of how it felt, although a 'tough act' possibly implies a daunting task. Daunting as Kesia also describes,

'(with T1)...it had been at that point things had been going very well for her as well so...which suggests that the counselling had been helping her, she wasn't drinking, um,.....and a belief you know things were going better for her'

'yeah, I've got to live up to her expectations of, you know, and its wanting to provide a space for her and that it was really helpful..(describes the client)...taking that on and wanting to give her sort of what she was missing in a way'.

Endings

My asking T2 about her own experience of endings had its own relevance in this case; an ending was already part of her work with Kezia due to there being a limit to the number of sessions available. This would be her first planned ending with a client,

'I'm going into uncharted territory'.

When I ask about her feelings around being the one who was setting the end of the relationship

'..am I somehow abandoning her?'

*'..I feel as though she does need the ongoing support and it's quite hard for me, actually I find it quite hard just to say that it will just be the 12 weeks'
'So, me actually saying that...um...I think I do find it difficult although it's not rejection, it is me sort of saying well you know, well I can't see you any more'
R: how does that make you feel?
Um,I think it's kind of disappointing because as a counsellor I want to be able to help her in some way'.*

I asked about the disappointment,

'Yeah, I suppose...the disappointment...I think that is something I have to face, you know that there can't always be, sort of a quick solution um, and that's what counselling is about somewhat, just sort of being there to work through the issues with the client and um.....and knowing that, it does not make me a bad counsellor (laughs) just because um, she hasn't reached a point where she can stop drinking or where she has found out something that might help her...'

Here '*abandoning*' is used to imply an act on the part of T2, rather than Kezia experiencing the ending as abandonment, maybe linking the forthcoming event and her thinking that for Kezia '*there's going to be an ending for her, that she kind of fears that in a way*'.

While T2 wonders if she is abandoning Kezia by setting an ending to their contract she continues,

'and it could be that if I'm sort of strong enough to deal with the ending after the 12 weeks and that if I sort of show her that that's what's going to happen, maybe it could be a good thing for her'.

For herself,

'..whether she could face having that last session. But again I think I would find it hard um...',

and went on to talk about using supervision around the ending of therapy as she had when starting with this imposed change client.

Suggestions

T2 did not provide specific suggestions but does demonstrate some thinking around the implications of the impact of the ending on Kezia's presenting issue. Between ending with T1 and starting with T2 an event in her life is seen as the trigger for Kezia to start drinking again. T2 speculates,

'It could be suggested as well, that having lost that counselling relationship (coughs) was it then that she sort of turned to drink more because that wasn't there for her?'

Comments from T2-Kezia on reading her contribution

T2 suggested that she did *'find it difficult to believe that I am good enough as a counsellor working with Kezia'*. Kezia attended the last session and T2 did not feel that they had moved from a place of being stuck at the beginning.

Part 3 Client Kezia and therapist T2-Kezia

T2's thoughts on the way Kezia views her therapy seemed to fit with Kezia's own perception of her need for *'ongoing'* therapy,

'having a counsellor as opposed to perhaps wanting to reach a point where she just doesn't need one anymore'

'She seems to be coming back so I guess there must be something that's helpful but I'm not sure if it goes beyond that it's supportive, her being able to kind of um, share what she is going through'

I heard a note of resignation or maybe despondency in T2's *'something that's helpful but I'm not sure if it goes beyond that it's supportive'*.

Another fit with a common theme, but with differing perspectives was around the provision of a structure for the therapy work. In her interview Kezia's described how she found the sessions with T1 *'more structured'* implying that this was part of T1 being the *'best'*, of providing the *'something beginning'*. T2 having asked Kezia about her previous therapy experience found that,

'I sort of became aware thatwhat she had actually liked about the other counsellor and the things she was asking for ...it was hard to see that she really wanted those particular qualities or she wanted that in her sessions (talks about sessions) ..I needed to try and help her to focus in perhaps sometimes um'

'because she could go off on a tangent to a great extent, taking over the session'

'she said that her previous counsellor would, was very good at challenging her ..so it was like she was setting the agenda..'

'but it's like there is disparity or discrepancy between, kind of what she wants and what um... it's not necessarily easy to give her what it sounds like she wants'.

T2's focusing sounds like an attempt to provide structure to the session, but one that can be thwarted by *'a tangent'* and Kezia *'taking over the session'*, or as Kezia comments *'..I guess I sort oflead it in a way'*. T2 says,

'it is quite difficult to set a specific goal (gives examples) every session there's so many different issues that come out that it is quite difficult to pin point something (examples) it's like she just kind of needs the support'

T2 seems caught by the *'discrepancy'*; wanting to give Kezia *'what she was missing'*, structure, rather than *'the support'* that is all she seems able to provide when Kezia is *'taking over'*. For me Kezia's *'lead'* seems to take the form of her bringing her *'tangled mesh'*, her many concerns into the sessions.

Kezia talked of her inability to *'turn things round'* and T2 seems to have grasped this,

'I think a real sort of theme is um, her not being able to actually get on with doing the things that she'd like to do or that she'd want to do because they seem just like they're too much..'

'everything seems so big um, that she sort of doesn't even get started, and I think there's got to be some sort of element of ending as well but nothing ever ends because it doesn't really begin I suppose in a way'.

T2 looked at this in relation to their work together,

'so they both relate to each other, um...here it has begun I suppose and I've actually seen her, has begun, but in a way it is quite hard to get past the feeling of the beginning'

'...but I get the feeling that the idea in itself that there's going to be an ending for her, that she kind of fears that in a way, perhaps in her life as well'

In my search through Kezia's interview I also noted her preoccupation with the endings in her life. She seemed held back from starting and appeared ambivalent around endings so she and T2 seemed caught at the beginning even though their ending was in sight.

Part 4 Researcher synopsis

Kezia's concerns were rooted in the present. She suggested that the past had not been addressed in therapy and that she shelters from both the past and present in her use of alcohol. Her therapist, T2, seemed caught between Kezia's requirement for structure in the sessions and what Kezia would work with as she warded off her therapist by 'going off at a tangent'. I felt caught in the 'tangled mesh' in writing Kezia's account. It took more reading and reflection than the other pieces, was harder to pull together and I wondered where in 'story-making' and 'story-breaking' (Holmes, 2001, p.87) I would have set the therapeutic work with Kezia.

Kezia's preoccupation with potential personal endings and a history of many therapeutic endings combined with her 'delayed response' to ending when she recognised that she was not coping, held for me a mix of anxiety and avoidance. When finding anxiety and avoidance together Batholomew and Horowitz (1991) suggest a disorganised or fearful avoidant attachment style is present. This mixed attachment strategy, 'fearful avoidant' is characterised by 'a haphazard, confused and chaotic manner' and when under stress presents with either contradictory approach/ avoidance behaviours or 'paralyzed inaction or withdrawal' (p. 225). For me this description goes some way to capturing my sense of Kezia's anxiety that appears without expressed feelings.

T2 openly discussed her inexperience and use of supervision as she met new and challenging therapeutic events with Kezia. In the dyad, T2 addressed the imposed change and so had to consider T1 as described by Kezia. This comparison stimulated a response from T2 as she attempts to provide what Kezia says she wants. Slade (1999) discusses the countertransference therapists meet when working with different attachment styles. I saw in this relationship the need of the 'fearful' component of this style for structure and care taking, making T2 try hard to give Kezia what she wanted despite the confusion as to what this was.

The avoidant component can lead the therapist to feel shut out, helpless, with an unconscious response of 'forgetting to bring things to the patient's attention' and so 'colluding' with the client's inability to grapple with the exigencies of his or her emotional life' (Slade, 1999, p.588). I saw this in Kezia continuing to 'lead' the sessions. While the dyad itself seemed to be in a state of 'paralysed inaction', T2 is left with the sense of them still being at the beginning. Schlesinger (2005) discusses stagnation and impasse at the ending of a therapeutic relationship and Kezia's mention of the ending and T2 considering the possible abandonment of this client may be bringing the ending into what feels like the beginning of their work.

5. DISCUSSION

The experience of an imposed change of therapist is both individual and relational for the client and therapists involved. This discussion is structured firstly around individual experience, client and then therapist. Themes of individuality and loss come out of the client narratives and for therapists both personal and professional issues around working with imposed change clients and endings (as shown in Figure 5 in the Findings section). Secondly, I look beyond the individual to the therapeutic dyad and the organisational aspect of imposed change. In adding a view on organisational involvement, I hope to stimulate the thinking of therapists and organisations that are party to imposed change experiences for clients. I then conclude with recommendations for handling imposed therapist change.

5.1 The client experience and attachment

The literature suggests that endings (Dewald, 1965; Schlesinger, 2005; Roe et al., 2006) and imposed change of therapist endings (Keith, 1966; Scher, 1970; Glen, 1971) elicit a range of client responses and these can be conceptualised using differing terminology that places the origin of the response to the ending, in the individual's past.

The terminology I found most compelling when studying each client's response to the imposed change was from attachment processes and phenomena, the 'dynamic regulatory, defence and motivational systems' (Slade, 2008, p.89). I found that inviting the participants to engage with their experience of this particular ending and change evoked material related to other relationships, losses, separations and abandonments, stimulating 'preconscious activation' (Mikulincer and Shaver, 2007, p.33), an 'automatic heightening of access' to attachment related thoughts and behaviours.

The nature of the therapeutic relationship that develops between therapist and client will have many elements of an attachment relationship (Slade, 1999; Skourteli and Lennie, 2010) and Reading (2002) suggests that the working alliance allows the therapist to function as a temporary attachment figure, or as Richardson (2010) describes, a secondary care-giver. That T1 represented an attachment figure, or that the relationship was attachment based, was evidenced for me in the client's experience of the first therapy relationship as intimate and caring. The client's reflections upon his or her experience of the imposed change and other endings provided me with an insight into their particular way of regulating affective and interpersonal experience. In the Findings section I discussed client responses to the imposed change suggesting attachment styles and features of attachment system activation for each individual and the effect this had on the therapist and the therapeutic relationship.

For a therapist, attachment phenomena can suggest how the client will manage the imposed change process and the affect associated with it; in this study there is evidence of the impact of the ending on the client and on the second therapeutic relationship. Work with substance misuse client groups has linked individual attachment representations, emotional regulation and support seeking behaviour to the capacity to stay in treatment (Meier et al., 2005b; Caspers et al., 2006). In addition statistics (Wapner et al., 1986; Bostic et al., 1996) suggest that early client termination is not unusual following an imposed change and not specific to this client group. I see these factors influencing the client both engaging with and staying in therapy. This study shows how loss, change and attachment activation might influence the likelihood of an untimely ending of the second relationship.

5.2 Client reoccurrence of symptoms

A reoccurrence of 'symptoms' (Muller, 1986, p.265) during the imposed change process would include here the client's presenting issue relevant to the Agency, of problematic alcohol use. Each client had a view on their use of alcohol that is echoed in theoretical thinking, theories that link substance misuse with the capacity to cope with distress, and difficulties with affect regulation (Flores, 2003; Reading, 2002; Khantzian, 2003). Hyatt Williams (2002, p.9) suggests that being unable to contain and process painful states leads to the drug of choice becoming the relief for these painful states and that the therapist is then equated with the drug. Therefore at separation or during breaks, 'acting out' in the form of relapse or change in use occurs. The data from this study documented that for two of the client participants their alcohol consumption increased at the time of the imposed change and for another there was a fear of relapse. The clients described missing the departed therapist and needing a therapeutic relationship for coping, for affect regulation.

5.3 Client loss and change

The literature on imposed change of therapist gives us the clinician's view of the client response both in theoretical terms and with descriptions of the affect displayed such as sadness and anger (Keith, 1966; Scher, 1970) and client behaviours. From the termination literature Roe et al., (2006) identify the loss of a meaningful relationship as the most frequently mentioned factor contributing to negative feelings on termination.

In this study, the client's words provide detail of the losses that come with ending, the departing therapist T1 and the change to working with therapist T2. The losses are associated with the relationship, the therapy in terms of the work done and the hope linked to the therapeutic work.

The relationship

The clients provided glimpses of what was lost on ending with T1. These glimpses are seen both in the comments about T1 and the direct and indirect comparisons between T1 and T2. The loss of T1, the person, and the familiarity with both the person of the therapist and their style of therapy were evident.

The loss of the, nice, caring, understanding therapist seems to be about the person of the therapist, the 'real relationship' (Gelso and Carter, 1985, p.186) or 'the intimate person-to-person contact' with T1 (Frank, 2009, p.140) or as Roe et al., (2006) found, a meaningful relationship. While it is impossible from the data in this research to tease out therapist personal qualities from the therapy offered by that person, client Sidney's suggestion that *'they care about you, and you are in their thoughts'* captures for me the relationship between the container and contained (Bion, 1967) and the holding function (Winnicott, 1971) that can be part of the therapeutic relationship as provided by a particular therapist and experienced by their client. Sidney's need to be contained or held in this way becomes apparent as T1 leaves and Sidney describes how he *'panicked'*, wondering if he would cope. These suggestions of a need for regulation, containment and holding fit with both the substance misuse literature and an understanding of attachment styles, in the example given, a preoccupied style.

In picking out these losses, a picture emerges of what was valued and is now missing for these clients in terms of their experience of the person of the departing therapist and their therapeutic style. Scher (1970, p.280) suggests that the client may 'dread the different and unfamiliar personality of the new therapist'; one client did express such concerns but the comments were made after having spent time with T2. As well as the loss of the person of the therapist, there was also the loss of a familiar style of therapy, as clients described differences in the work with T1 and T2. It was not evident that the clients in this study experienced 'fear of disapproval, distortion and misperception' as suggested by Scher (1970, p.280), but may have felt exposed under the 'intense scrutiny of a stranger'. I found clients who were either learning a new way to be a client, or trying to guess what the new therapist wanted from them as if 'stranger' here was also about therapeutic style. Nielson et al., (2009) showed that even a difference in style between assessor and therapist has an impact on client engagement and length of therapy.

The losses experienced by the clients can be contextualised with reference to the attachment style defined by each narrative account. In the client material, I found examples of differences in behaviour between T1 and T2. The clients that I describe as having a preoccupied style both struggled with the neutral style (therapist not talking and not giving feedback) of their T2. Such neutrality can 'trigger experiences of rejection, neglect and abandonment' in 'preoccupied' clients (Slade, 1999, p. 589). These client experiences bring

together the intra-psychic, unconscious with the perceived interpersonal differences. Slade (2008) suggests that attachment phenomena can include behaviours that establish or disrupt contact and function. Whatever conceptual view is given to the unconscious component of the client experience, both client and therapist contribute to the establishment of the working alliance, with therapist empathic failures also disrupting contact at the start of the relationship (Frank, 2009).

Losses experienced by the client can be both intra-psychic and interpersonal as the bereavement associated with the ending combines with the change to a new therapist. A client's loss history and current support network can be critical in how they manage the intra-psychic demands of another relational loss. The absence of a support network or the presence of an unsupportive network is documented in the substance misuse literature (Copello et al., 2002). All the clients described other relationship losses and appeared to lack support networks to buffer changes in alcohol consumption or relapse that came with the loss of the departing therapist.

Managing loss and difference

The literature (based on therapist reports) suggests that both the ending and beginning therapist can be devalued (Keith, 1966) and that the ending therapist can be idealised (Weiss, 1972, although this was for clients who visited the replacement therapist prior to ending). In this study, idealising/devaluing was polarised with all the clients idealising the ending therapist and devaluing the new. In the literature, unconscious processes are used to explain the polarisation with Keith (1966, p.187) suggesting that a client's criticism of the ending therapist is defensive. Keith also suggests that for the client who views the replacement therapist as a 'bad' or 'frustrating parent', the ending therapist may have gratified client wishes, arousing 'excessive positive transference feelings and regressive urges within the patient'.

Thinking of the triangular nature of the two relationships in the imposed change process (Scher, 1970) lends possibilities for understanding how clients manage the loss and change involved and offers a way of viewing how some clients might organise their experience of objects T1 and T2, by splitting (Klein, 1946). During a period of disruption and anxiety, the use of splitting to protect against thoughts and feelings that threaten the individual can be seen as an unhealthy defence to create separation between T1 and T2. Schneider (2003) however suggests splitting creates a 'generative space' where contrasting elements can be brought together in imagination. For me, this space provides an opportunity, fertile ground for a T2 to work with therapist difference, with the change component of this phenomenon.

The differences to be managed are in addition to the loss of T1 and the consequent affect precipitated by the ending. The literature suggests that ending therapists deny their importance to the client and avoid their own bereavement by the preoccupation with the mechanics of transfer (Keith, 1966), and that organisations use the 'administrative mechanism' to avoid acknowledging the ending part of the imposed change process (Schlesinger, 2005). Having insufficient material from the T1 therapists means I am unable to determine the rationale used for choosing client transfer rather than ending therapy or any avoidance of the ending by the T1. If the ending is denied or avoided then presumably the mourning will be too. Frank (2009, p. 141) sees de-idealisation of the therapist (in the context of termination of therapy, not imposed change) as a necessary part of the process of mourning.

The use of the term transfer and the allocation of a client to a waiting list, both seem to imply some continuity for the client as if more therapy is the same as continuing therapy. This denial or avoidance does however deprive the client of a mourning process that could leave some 'inner source of persisting assuagement' (Reading, 2002 p.19), an internalisation of the departing therapist. It would also be interesting to explore the departing therapist's use of a transfer rather than an ending on a client by client basis especially for those who seem to fit Reider's (1953 cited in Scher, 1970) conceptualisation of an institutional transference.

For the incoming therapist Keith (1966) suggests that therapists will not take transfer cases in an attempt to avoid facing the client's hostility and bereavement over the loss of the departing therapist. So at both therapist points of the triangle, the ending is avoided. Potentially all parties in the client/ two therapist triangle can be unconsciously avoiding the bereavement and the difficulties of change and difference. While Pumpian-Mindlin (1958) describes how therapists can displace their feelings about ending onto the client or organisation, I suggest that the client also displaces unprocessed grief such as feelings of anger at being abandoned, onto the second therapist. Muller (1986, p.274) uses the term 'acting out' as shown by client termination of the therapy. From this research I see that a response such as client termination of the second therapeutic relationship can be multilayered involving the client's unprocessed grief, the struggle with change and difference around the loss, the client's attachment style and being met by therapist avoidance or denial.

Another feature of the client response to the imposed ending was that of acceptance, resignation or apathy, as they described this loss as inevitable alongside other losses they had experienced. This seemed to capture their lack of power to influence what was happening to them. The devaluation of T2 in this context can be seen as an attempt to weaken or hurt the 'object' while establishing a sense of control; reclaiming power as a means of reducing the experience of vulnerability and disappointment (Robbins, 2000).

Clients missing sessions or taking control of the length of sessions could also be viewed in this light. Clients also chose the ultimate sanction, 'precipitous termination' (Muller, 1986 p.265), one describing how '*I felt robbed so I stopped going*'. There are individual responses again with layers of possible explanations and formulations that are available to understand a client's experience of, and response to, imposed change and the part played by the two therapists in creating this shared experience. However, the lack of recognition of and no discussion about the phenomenon leaves therapists caught in the relational dynamics of the process and not attending to the 'interpersonal nuances within the triangle' (Scher, 1970 p. 286).

The work of therapy

Here the work of therapy includes both the client material that is shared and explored in the therapeutic relationship and the work to build and maintain the therapeutic alliance. An alliance being built on the remains of the previous relationship, on change and difference rather than a new piece of ground.

I found only one mention in the literature of the work done in the first therapeutic relationship, Glenn (1971) writes that the client may have difficulties resuming therapeutic work with the second therapist. 'Resuming' for me falls within the transfer vocabulary that excludes the ending of a prior relationship, the 'convenient fiction' of an 'interruption' (Schlesinger, 2005 p.91).

For the clients in this study, the second therapeutic relationship meant repetition, and this was hard work. The retelling of their past was difficult and sometimes painful, going over what they had done with T1 and in some cases with more than one therapist. There was no sense of a resumption of work for the clients but of being back at the beginning again. In keeping with the termination literature (Frank, 2009), the clients talked of the loss of the work they had done and loss of the progress they felt they had made with the departing therapist. Frank (2009 p. 139) writes of the 'vulnerability' of the gains made in therapy coming to the foreground at ending but here I do not have information from the departing therapists to identify if this was part of the ending process or something realised by clients once in the second relationship. I found that the work done with T1 was not seen as a completed piece of work and was either part of the loss of the relationship or was looked back on as futile or pointless. Maybe the nature of their presenting issue, problematic drinking and fears of relapse, or increased consumption around the time of the imposed ending added to that sense of futility.

I found that the clients were uncertain what therapy was for, as they cited different reasons/understandings of why they came to therapy. For three of the four clients, affect regulation in the relationship (coping, support) was the prime reason for attending. While the

transfer of the client in an organisation suggests unfinished work and equivalence of therapeutic relationships as work is resumed, the nature of what this means to the client seems either forgotten or not thought about.

One client assumed that repetition was required by the therapist, another was angry at being asked to provide their history again. The pain resulting from repetition seemed to add to comparison making. A client suggestion that came out of the interviews was that T2 should read the client notes to avoid this repetition. Outside the imposed change literature Nielsen et al., (2009) studied discontinuity at intake (where client assessment is not performed by the therapist) finding that a client having to retell their history can increase missed sessions, lead to the need for more sessions and increased likelihood of termination. So, discontinuity between assessment and therapy can have an impact without there being the ending of an established therapeutic relationship.

The hope of an outcome

As well as the therapy with T1 not being seen as a completed piece of work, in some way unacknowledged, lost or invalidated by the imposed ending there was also a sense from the client of futility or pointlessness about that therapy.

Their comments suggested that the therapy with T1 had held the hope of an outcome. Whether this loss of hope is part of the ending/grieving process, or that hope was part of that therapeutic work/relationship is unclear, but suggestions of the therapy 'getting somewhere' before ending were expressed. Again the 'vulnerability of the gains' of therapy (Frank, 2009 p.139) at ending are taken into the new relationship to be met by difference, uncertainty and the need to start again. There was no indication of whether the loss of hope came before or after they started work with T2. It may be that the differences between therapists and the sense of starting again, of repetition, highlighted unfinished work with T1.

The interview in this study did not explore the meaning for the client of being transferred, of needing more therapy when T1 left. The unilateral therapist decision to end the therapy, the transfer and the need for further therapeutic work may imply failure on the part of the client that then makes the hope of achieving an outcome less likely. Client expectations of their therapy varied from wanting an understanding of why they were like they were to the maintenance of sobriety. For me this raises issues that could be followed up in further research. Looking at the match between therapist and client expectations of the work, and if this is shared in the dyad. There were suggestions of a mismatch in some dyads as to the nature of the client's presenting issue and hence outcome. For example, in one dyad an 'alcoholic' working with a therapist who did not see the client as having a problem with addiction.

Beyond this basic joint understanding, Keith (1966, p.188) describes therapists seeing transferred clients as 'old uninteresting cases', in wanting to avoid the hostility and bereavement of the loss. I would suggest with 'old uninteresting cases' will also come some thinking around what can be achieved by way of an outcome, exacerbated by views on the frequency of relapse for this client population. In service provision for clients with problematic substance use the view of addiction as a 'chronic relapsing disorder' (Cunningham & McCambridge, 2012 p.6) allows certain client engagement, attrition and reengagement patterns to be the norm, with or without an imposed change of therapist. Such patterns following an imposed change of therapist could be dismissed from a 'chronic relapsing disorder' perspective.

5.4 Therapist experience and endings

While I have insufficient data on the T1 ending therapists to complete the imposed change triangle, the literature on therapists who impose endings on clients suggests they may experience a loss or feel 'adrift' (Scher, 1970 p.281), or suffer 'termination anxiety' (Pumpian-Mindlin, 1958). Glenn (1971) equates the client and therapist affect at ending and this is seen in the client comments in this study that indicate the emotional tone of their ending in physical contact with the departing therapist and reports of this therapist also being upset at the end. Frank (2009, p.149) discusses the benefit to a client of a mutual experience of letting go at ending so that mourning is not a 'one-sided affair'. Other writers have focused on the therapist's use of the 'administrative mechanism' (Schlesinger, 2005 p. 27) to avoid their leaving being an ending, denying their importance to the client (Keith, 1966) or simply delaying telling the client that they are leaving (Schlesinger, 2005). I am including the ending therapists here as I see the handling of the imposed ending having an impact on the next therapeutic relationship. Muller (1986, p.267) suggests that the type of ending can leave the second therapist feeling 'set up' and Keith (1966, p.187) frames this as the ending therapist 'unwittingly arouses excessive positive transference feelings and regressive urges within the patient'. I found no acknowledgement of this with the replacement therapists in this study.

The clients shed little light on any 'ending work' with T1. The ease with which I use the term 'ending' to mean a purposeful, worked towards termination of a therapeutic relationship led to my expectation of being able to explore the client experience of this work, assuming either that clients would notice or be told about it. Golland's (1997, p.266) view on termination, the 'mythological, idealised model' that in reality 'has more ambiguity than clarity' is maybe applicable across different therapeutic orientations and therapists within orientations. The shift for Frank (1999, 2009) to a more relational way of working within an

analytic frame, models for me the individuality of approach that comes with acceptance of grief and mourning around endings.

In their interviews the T2s talked about their experiences of ending therapeutic relationships with clients (not imposed endings) and these for me contextualised their response to their imposed change client. The concentration on professional issues in the T2 interviews meant I was unable to suggest attachment styles as I had done for the clients. I recorded the T2s feelings of 'sadness' of the difficulty of 'letting go' of clients they end with. Even when one had yet to experience an ending, there were thoughts of rejection or abandonment of the client. One therapist dismissed endings on behalf of clients suggesting it 'doesn't need to be done' and that the client does not want the ending session; that therapeutic endings are more about a counselling intervention or technique for the therapist. This therapist went on to talk about therapist investment (Pumpian-Mindlin, 1958) and validation of the work done, but then closed with a moving disclosure of their own feelings around ending. For me, this echoes Keith's (1966) suggestion that therapists deny the ending's importance to the client to avoid their own bereavement, but in this example rather than denying their importance to the client, it is the client's affect and need for an ending (as in a process linked to the termination of the relationship). Again terminology and technique meet the affective experience of ending and the use of a professional rationale for the relational experience of an ending.

5.5 Therapist beginning with imposed change clients

Above I discussed therapist experiences of ending with clients and the awareness of some for the potential 'abandonment' or 'rejection' involved and how they themselves are affected by endings. So did their own experiences of client endings shape or influence the way they worked with the imposed change clients? I had expected that one of the therapeutic tasks undertaken by the T2 therapists would be to work with the affect /experience of the imposed ending but found that only one offered this. Taking the therapist themes around beginning with the client, I am going to look first at the T2's therapeutic orientation and their approach to working with an imposed change client. I will then consider the position of the previous therapist T1, in the imposed change triangle alongside the client and T2.

Therapeutic approach and a fresh start

All the therapists identified themselves as using a Person Centred approach suggesting that this for them meant starting from 'scratch' or 'afresh', not reading notes, or having contact with the previous therapist. However, one did look at the previous therapist's notes and others had conversations within the Agency about the client. All the therapists knew about

the client's previous therapy and so presumably the fresh start was in some way contaminated.

This idea of a fresh start is interesting in the light of the client experiences that describe losses and repetition of the work done with T1. The fresh client and fresh work for the therapist is ongoing work for the client. For the client the change of therapist entails revisiting difficulties of the past either when the therapist asks for their history or they assume that the therapist requires this. From the client data, the Person Centred approach, of leaving the space open by working in a non-directive way, can it seem open up uncertainty for the client due to the difference in style between T1 and T2.

Is the need for a fresh start because the 'adventure of exploration is missing' (Scher, 1970 p.282), or that these are seen as 'old uninteresting cases' (Keith, 1966 p.188)? Having worked at the Agency I recognised that there was an expectation that some clients would remain in the service or reappear from time to time. Within the group of therapists at the Agency there were different understandings of problematic substance use that included a genetic or medical discourse that to my thinking limits the therapist's hope of change for the clients that stay in the service or reappear.

Working with imposed change

The therapists in the study all had a view on their client's prior imposed ending whether it represented for example '*abandonment*' or '*nothing devastating*' that either tallied or not with the expressed experience of the client. Only one therapist asked the client about the previous therapist and ending. The therapists who did not ask used a Person Centred rationale (although this was a retrospective attribution in response to my questioning) in that they would not direct a client.

Rogers (1961) provides the background for Person Centred therapists with his core conditions and a non-directive stance. There has however been much written about Rogers' own way of working, for example Bowen (1996, p. 89-90) describes Roger's use of a very directive style and she suggests some Rogerian therapists can be 'technique-bound'. I have noted each therapist description of their training background (3.4 The Participants page 22) and none identified themselves as working solely as a Person Centred therapist but all saw their approach to client work having a Person Centred base. Lister and Gardner (2006, p.435) looking at different perspectives on engagement found the client-focused approach saw techniques as 'unimportant' with an emphasis on empathy and the relationship prevailing. I was struck by the contradiction as therapists stated they did not choose what material the client works with but were actively requesting that the client repeat material that they saw as necessary for the therapy. The therapist that did include the prior ending and

therapeutic work did not want to have this as *'unspoken'* in their sessions and for me this displays congruence in speaking of their shared knowledge of the previous therapy ending.

I think the Person Centred rationale for not enquiring into previous therapeutic work and endings, as well as the therapist view of a fresh start, needs to be considered here in the light of the imposed ending. One therapist recognised that imposed change client's will come with *'hurt and questioning'* and yet appeared not allow such questioning in the sessions. The imposed ending literature suggests that for therapists it can be a daunting prospect (conscious or unconscious in origin) to be faced with an angry client grieving the loss of their departed therapist (Schlesinger, 2005). I suggest that this experience for therapists is also about facing their own experiences of loss following 'preconscious activation' (Mikulincer and Shaver, 2007, p.33) and it is not just the client experience that might be avoided, but also the therapist's response to the impact of the client's activated attachment system on the dynamics of the new relationship (Slade, 1999). The opportunity of a 'generative space' (Schneider, 2003) for the imposed change client to manage the change and difference will also be lost if it is only the client's life history that it entertained as acceptable content rather than the losses associated with the previous therapeutic relationship. Therapist modality was not of interest to me in terms of the research question but as the findings developed from initial transcript analysis through to writing up I became increasingly curious as to the contribution this made to the experience of the phenomenon for both parties in each dyad. As discussed earlier all therapists described taking a Person Centred approach but varied in either their interpretation of this or the use of it as a rationale for how they worked with imposed change clients. The therapist descriptions of how they approached the work turned out to be critical to the client experience of working with them as shown in the dyad material. While questions can be asked of therapists around their training and therapeutic work, it is challenging to try and clarify where their style of working comes from, an original training in one modality, an integration of original training and further trainings or maybe these in combination with the response to particular clients.

The Therapist and 'shadow' of T1

I discussed earlier the client's place in the triangular relationship and their management of the loss and changes involved. Scher (1970, p.282) suggests that for therapists the second relationship will be in the 'shadow of the former therapist', open to comparisons being made and with them having to weather the 'indignity of being less important' to the client.

Therapist interviews revealed differences between those who had attended to the previous therapy and therapist of the imposed change client, and those that had not. Having invited this information one felt the pull of a *'tough act to follow'* and the comparisons that ensued, real, or imagined. For those that did not enquire, I found the departed therapist

present in the metaphor of not stepping into '*somebody else's shoes*', voiced as client expectations and also in questioning of themselves as therapists, in comparison to the imagined previous therapy of the client. There was also evidence of active discouragement of the client including the former therapy and therapist in the work. This was achieved by, as Muller (1986, p.270) found, differentiating themselves 'in a concrete way from the previous therapist'. For one therapist there was also curiosity around, not only the work of T1, but also how that person would be as a therapist, ultimately wondering why the client showed, in their view, no improvement in their presenting issue. The presence, or shadow, whether derived from exploration or exclusion seemed like a force to undermine the replacement therapist who follows on from the departed idealised therapist. When discussing client idealisation/devaluation I suggested processes by way of explanation, attributing for example projective identification in the client's devaluation of the replacement therapist (Robbins, 2000) that might then call into question the therapists professional identity and their ability to do the work with this client.

Therapist use of supervision

The use of supervision was not a prominent feature in the interview material. I did not pick therapist supervision as a theme for the findings section when writing up the individual or dyad accounts. In writing the discussion however, the use of supervision did start to interest me. There appeared to be little use of supervision except for the trainee therapist who was encouraged by their supervisor to explore the previous therapeutic relationship with the client. Another therapist chose to ignore their supervisor's suggestion that missed sessions and the session time boundary should be worked with, and the third therapist did not see the work with this client particularly needing supervision time. One of Muller's (1986, p.267) seven factors that influence therapist's work with an imposed change client is the developmental level of the therapist and I would suggest here that an inexperienced therapist using supervision can counterbalance that influence by attending to the interpersonal nuances within the triangle (Scher, 1970).

Having an insight into each therapeutic relationship from interrogating the data to writing the dyad piece, I am surprised that features that I have identified as possible rupture, impasse or enactment were not sufficiently puzzling to take to supervision. This suggests that the significance of the ending and change is underplayed, much as I underplayed supervision in determining the main themes.

5.6 The Dyad

The dyad piece for each case brings together the separated out client and therapist themes discussed above. I found no research that brought together client and therapist interviews

although Muller (1986) considers the dyad as reported by the therapist. When writing up the individual pieces for client and therapist, areas of convergence and divergence around certain themes became apparent. Collating these in the Findings added another dimension to the understanding of experiences and behaviours found in the individual transcripts. In this study I was in researcher-participant relationships on either side of the dyad and alone as reflective researcher. I had a sense of another thirdness (Ogden, 1994) in my reverie on the dynamic, intersubjective field of each dyad. A thirdness that shaped the narrative accounts for each individual.

While this could be likened to the 'triadic intersubjective matrix' of supervision (Brown and Miller, 2002; Aron, 2006), my time with each participant placed me inside and outside the dyad as the individuals described the challenges of an imposed change of therapist. While Muller (1986) identifies client 'acting out' and others differentiate between client symptoms (Keith 1966) and therapist countertransference (Pumpian-Mindlin, 1958), I suggest that a relational perspective taking contributions from both parties rather than a list of expected client/therapist responses allowed access to the spoken and unspoken between client and therapist.

The dyad data allows us into the heart of the relationship to detect rupture, empathic failure and enactment; therapist responses to a previous therapist and the effect of activated or deactivated client attachment systems; client responses to loss and change; glimpses of client control around the therapeutic boundaries; and the background substance use discourse of client and therapist. All examples of the way the phenomenon exerts an influence on individual therapeutic relationships.

5.7 The Organisation

In the introduction, macro and micro environmental factors in the field of substance misuse service provision were considered. The examination here of individual experiences of an imposed change of therapist has provided more information on the micro environment of the relationship. I now want to look at influences outside the therapeutic dyad that will impact on an imposed change of therapist generally, and more specifically, in the context of this research.

Administrative mechanism

In the research setting there were no guidelines around therapist decision making whether to end or transfer a client when leaving the Agency, or for therapists starting with imposed change clients.

The literature covers the therapist's use of the 'administrative mechanism' (Schlesinger, 2005 p. 27) to avoid the therapist leaving being an ending, or as denial of the

their importance to the client. This mechanism does not appear to serve some clients well. Reider (1953) describes an institutional transference where clients miss the opportunity to be led to 'the final parting of therapist and patient' (Scher, 1970 p.286) to work on endings and the loss and mourning that may be pivotal work for the client. Scher (1970) calls for better communication between professionals to pinpoint such cases.

Social defence system

Going beyond the administrative mechanism that allows clients to be transferred without consideration of their care programme and the workings of a therapeutic relationship I want to draw on ideas of the social defence system (Hinshelwood, 1994) and the part played by institutions in allocating anxiety work, the containment of client vulnerability and dependence to therapists.

Having 'found' Hinshelwood during the period of change at the Agency and the Agency move away from providing psychotherapy for clients, an article by Rizq et al., in 2010 resonated with my experience at the Agency. In this article they describe the changes of role and function for therapists as Primary Care Trusts moved to well-being work (Improving Access to Psychological Therapies, IAPT) and discuss the political and financial imperatives. A Kleinian framework (Rizq et al., 2010, p. 44) is used that offers an explanation of changes that 'reduce to a minimum the possibilities for emotional engagement between patient and therapist'. I saw this at the Agency in a role change from therapist to Key Worker and the removal of funding for clients whose substance of choice was alcohol.

Both IAPT and some specific treatment protocols for substance misuse are designed to meet political and financial demands by having 'surefire' interventions (Edwards, 2006, p. 5) that exclude the containment function and leaves researchers trying to solve the 'mystery' of why diverse treatments types are equally effective (Orford et al., 2009a, p. 306).

5.8 Contribution and recommendations

This study explored a phenomenon that has over the years attracted little systematic investigation and has never been addressed from the dual perspectives of client and therapist in a working therapeutic dyad. Choosing this novel approach has meant the addition to the field of material on the relational dynamics following an imposed change.

This new material has value in providing information for working as the departing or replacement therapist in an imposed change relationship or as a supervisor of either therapist. Beyond this there is the potential for organisations to improve client retention, presenting issue management and outcome, alongside supporting client and therapist wellbeing. The participant voices in this study particularly need to be heard to maximise the

use of the ending and change for clients and to facilitate the best possible experience for all involved.

The findings of this study contradicted my assumption that replacement therapists would incorporate the ending and imposed change experienced by the client in their therapeutic work. My own experience as a trainee of working with an imposed change client was supported by a supervisor who recommended making the ending and the change explicit. Prior to this study I also assumed that clients who had experienced an ending would have some awareness that the ending had therapeutic significance as shown in their departing therapist's handling of the ending. This was not always the case.

As a therapist, this research has made me reflect on my relationship to endings. It has reinforced my view of the importance of allowing the work of ending to take place and has given me an insight into what a client faces when starting the second therapeutic relationship. While writing up this research I became an agency service manager and supervisor and am now even more mindful of all contact with potential and actual service users and the relationships formed. I have used the knowledge gained from this study in my workplace to introduce,

- the monitoring and recording of endings
- training on working with endings and change for both therapists and supervisors
- changes to the referral processing pathway to reduce the number of times a potential client has to repeat their story

In my experience trainee and trained therapists have had little training input on working with client endings and some have little awareness of the impact of the ending on themselves. I aim to manage client changes and endings to ensure that I incorporate a good learning experience for both the client and therapist involved.

Implementation of the findings

In considering the contribution this study makes, and the use I have made of it in my workplace, I have drawn up a list of recommendations. The recommendations capture the need for acknowledgement of the phenomenon by both therapists and organisations. The recommendations suggest actions to be taken and the rationale for implementing these actions. I have used the term practitioner rather than therapist to highlight the need for all those who develop relationships with clients to have awareness of the impact of an imposed change and have support with ways of working effectively with such a change.

Following on from the recommendations, I set out a framework for managing change of therapist and link these to the themes that emerged from the research material.

Recommendations

Table 6 summarises the recommendations in an attempt to provide a route to incorporating awareness of imposed therapist change in service provision or private practice. In an organisation there is a need for a comprehensive approach that provides policy and procedures to address this phenomenon. The policy needs to acknowledge the existence of the impact of an imposed practitioner change, needs to record and monitor all instances of imposed change (to ensure management/ supervision of the practitioners and support for the client) and needs to provide procedures for training practitioners in working with endings and imposed change. Both client and practitioner need support at the time of change and to be able to manage change with awareness of the possible consequences of the change. In this study setting, the consequences included fear of relapse, increased substance misuse, missed sessions and precipitous terminations.

Table 6 Recommendations for organisations and therapists

	Organisation	Practitioner
Acknowledgement	Existence of phenomenon 'transfer syndrome' and 'institutional transference' <ul style="list-style-type: none"> • Impact on client • Impact on practitioners • Impact in relation to client population and setting Numbers of imposed change cases	Existence of phenomenon, 'transfer syndrome' and 'institutional transference' <ul style="list-style-type: none"> • Impact on client • Impact on self • Impact in relation to client population and setting
Actions	Policy Procedures Monitoring Training	Awareness Search for literature and training Reflect on practice Use of supervision
Rationale	Client care Practitioner care Improved statistics <ul style="list-style-type: none"> • engagement and retention • outcomes Improve cost /benefit ratio and access to funding	Client care Self care Enhance practice for working with imposed change <ul style="list-style-type: none"> • endings • prior therapist ending • losses on imposed change • repetition of work • therapist difference and comparison

A framework for managing change of therapist

This framework builds on the actions listed in the table of recommendations for organisations. I have added boxes that contain findings-linked suggestions for working with an imposed change of therapist/practitioner.

Policy to contain

- Review of the findings on imposed change of practitioner
 - Rationale for policy and procedures
 - Aims and objectives
 - Procedures to achieve the aims and objectives
 1. Training
 2. Monitoring and recording
 3. Management of imposed change cases (line management/supervision)
1. Training to include
 - an outline of findings on the impact of imposed change and how to work in the ending or replacement relationship
 - the organisation's imposed change procedures
 - clarification of the roles of Line Manager/Supervisor (designated person) in procedures, monitoring, recording and support provision
 2. Monitoring and recording by designated person
 - establish method of recording, for example, using client database
 - practitioner to notify designated person of leaving date or in cases of a sudden ending or ending without notice, designated person to move to immediate case management for client
 - record ending type for client e.g. planned ending, imposed change, sudden ending
 - record replacement practitioner start date for client
 - monitor outcome forms/practitioner reports for impact of imposed change on client
 - record ending type for client and replacement practitioner
 - establish a review procedure for comparing case management, training and outcome of all cases so training and procedures can be monitored for suitability and effectiveness
 3. Management of imposed change cases

On notification of practitioner leaving, designated person provides time for discussion and support for the practitioner on

- giving prompt notice of ending to client
- discussion/decision making with client as to whether the departure will be an ending or imposed change for the client
- giving notice of waiting period/start date with replacement practitioner
- discussing with client arrangements for client support during a waiting period
- working with the imposed ending of the relationship and the work of ending

*For client and practitioner
Allow grief and mourning around losses at ending
Recognise gains to be taken from therapy
Work with attachment activation*

- working with the client experience of ending and feelings around starting with a new practitioner and any waiting period before starting the new relationship

*Work with attachment activation
Client reoccurrence of symptoms*

During a waiting period

- organise availability of support for the client

*Work with attachment activation
Client reoccurrence of symptoms*

On appointment of replacement practitioner, provide time for discussion and support for the practitioner on

- starting with an imposed change client

*For client
Open 'generative space'
Acknowledge previous ending, work done and repetition
Work with client attachment activation
Allow grief and mourning around the losses of ending
Recognise gains from previous therapy*

*For practitioner
'Shadow' of previous therapist and comparisons
Attachment style response to client activation*

- ongoing support of the client work
- handling of own ending with client

These guidelines do not specifically cover a sudden practitioner ending (due to death or illness for example) but could be adapted so the designated person intervenes to provide a practitioner to work with the absence of an ending and manage the imposed change. Ideally with this practitioner being the replacement.

5.9 Challenges, limitations and future research

Challenges

Adopting a novel approach to this study opened up a series of challenges both ethical and methodological. Having thought through the ethics of working with clients from a substance misuse agency, I had planned the support needed for client vulnerability and any change in substance use stemming from participation. It was important to me that collecting the added, unique data was not to be at the expense of any of the participant's wellbeing. My ethical considerations therefore were:

1. Working with a client and therapist in an ongoing relationship meant that the client was engaged at the Agency and had support available. Waiting until the relationship had ended may have left the client isolated and unsupported with issues that the interview brought up for them.
2. The anonymity outlined in the original design was compromised as client and therapist would be able to identify each other when reading the participant extracts so this was made explicit and consent checked.
3. As researcher I had to
 - Consider using a separate interviewer for the therapists
 - Organise to interview all clients before therapists
 - Maintain client confidentiality during the therapist interview
 - Have an awareness of the impact of the client material on the T2 interview
 - Acknowledge the impact of undertaking both interviews
 - During analysis hold both interviews as separate entities within each participant type
 - Be sensitive in my write up of the contributions from the two participant perspectives
 - Work to time constraints due to the changes at the Agency
 - Acknowledge the impact of the Agency changes on the participants and myself

Limitations

While the aims and objectives were largely met, how *'the client and therapist perceive the imposed change as influencing the Care Programme journey and outcome of the client'* was not fully explored in the initial interview and then was affected by changes at the Agency, as noted in the participant check interviews. A clearer delineation of outcomes without the Agency changes would I feel, have added weight to the data for service providers but immersion in the Agency change did give an interesting parallel which I think added a weight of its own.

The findings have given some insight into the impact on the presenting issue of this particular client group and the working of therapists with this client population. The small number of participants means that it cannot be assumed that similar findings would come from all clients and therapists in a similar or different setting. However, the emergence of common themes from the data suggests there could be wider applicability as well as the findings usefully stimulating thinking about the phenomenon. Similar studies with the same and different client and therapist/practitioner populations would help provide a better understanding. The participants in this study were not demographically diverse.

While a small number of participants took part in the study, having one of the therapists working with two of the client participants reduced the variety of therapist experience of the phenomenon. A fourth therapist would have added either contrasting or supporting information to the findings gained from the three therapists interviewed. While reducing the amount of individual therapist data the 'therapist in common' added new, unexpected dyad findings as both clients had a similar response to the therapist's approach to working with imposed change clients and style of therapy. This highlighted the meeting of client and therapist research themes (client; attachment activation and losses and therapist; approach to therapy and working with imposed change) with the non-directive stance and neutral style of the therapist having an impact on clients that I identified as having a preoccupied attachment style. Where modality or approach of therapist is critical to a research question or interpretation of research findings it seems that assumptions around equivalence of provision needs to be tempered by the relational dynamics in the dyad.

Future research

The findings of this study support the development of working practices around imposed change in all client work for both therapists and non-therapists. It would be interesting to research imposed endings in client/ non-therapist relationships. An organisation wide study, monitoring outcomes for imposed change clients before and after the introduction of new working practices for imposed change cases would further add to these findings.

Collecting experiences for all three parties involved in the imposed change, by extending the innovative dyad interviewing to triads, would be a valuable addition in completing the picture of the relationship triangle. This three-way interviewing would also give individual data for the instigator of the imposed change.

5.10 Conclusion

The qualitative participant data from this research has provided some illustrations of both client and therapist experience of a therapist imposed change, adding to knowledge in a neglected area of study. Such illustrations suggest that endings and beginnings have a relational complexity that have consequences for both the clients and therapists engaged in them, and that neglecting the detail of what happens can have an impact on both the relationship and client outcome. This research shows the importance of the need for practitioners and service providers to attend closely to an imposed change of therapist to promote the most beneficial outcome for all those involved.

APPENDICES

Appendix 1 – Research diary extracts

Entries relevant to change of service provider

18/08/06

New partnership. Possibly new negotiations to do having okayed research with CH will have to start again as 'partnership' is really a take-over!!!

04/09/07

Impact on me of change in organisation that comes with partnership, seen in staff and service users. Fear of loss (what currently available), fear that change represents less/worse/restrictions to practice/availability of service, clients will be offered less, therapists restricted, lose status, counselling devalued. In my contact with organisation expect to be dismissed, disregarded, of no interest.

New SP interested in user group feedback but is day to day stuff (biscuits) rather than individual treatment concerns.

Whole set up presents 'danger' to clients as they represent passport to qualification for placement staff with minimal monitoring/supervision. Charity relies on placements seeing some of most vulnerable clients.

10/09/07

My own version of 'life imitating art' as my therapist is in hospital, stimulates issues in me around endings/change, specifically 'no endings', potential for things left unfinished. My history, 1st therapist moved so imposed end of relationship, 2nd therapist ill (unknown from here) how would I have ended it? I have stayed with 1st sup as well, she commented on reading the personal part of the case study that she could see why I stayed. Still searching for continuity, avoiding relationship change and endings?

22/09/07

Fog around exact definition of 'sample'...focus on imposed change of therapist ie change as an intervention.

Felt my sense of injustice, client not considered, valued (my history!!) Seems parallel process of therapists re organisation of not being valued. Look at unconscious process in organisation, chaos of clients within staff and procedures.

Agency procedures woolly, what are clients allowed in terms of no. of sessions...setting of ending times? End of day 'debrief' for all has been stopped by new regime. Was a good place to share or 'leave' difficult pieces from day, staff v upset. Weekly supervision also to go.

11/12/07

Been through my own imposed therapist ending (again) this one very different to earlier. V painful, bought back other endings/deaths, is this because of illness connection and uncertainty of survival? V aware of feeling of impending state of being left alone as end approached, extent of attachment and dependency. During her illness also experienced feelings of aloneness. After last session sad feelings as I imagine her. Very good internalisation to take with me. Will not replace her. What is it like for clients who are transferred straight to another? Confusing? Does former lose place? Transference implications for client and therapist? At agency do not choose next therapist.

Flat & yet distressing place as the ending process took place over 3 weeks, my choice. Coincided with no news from NSP, fear of rejection, time slipping by, having a

learning/writing void and stuck feeling with added helplessness. On hearing back about timing, ok with delay and energy picked up with interest in project again. New inspiration. Need to reengage with Agency therapists as have become isolated.

17/01/08

As a child what were my experiences of imposed change?

Matter of fact, fact of life, within family.

Until 10 years old no memory of feeling sad at leaving. No memory of fear of the new, not allowed, not expected? Experienced bullying and did not tell. Experienced missing educational pieces and did not ask.

Three levels of assumptions

1. me as therapist (power) me as therapist who has ended due to my or agency reasons. How did I handle it? Look at own practice.
2. me as therapist with training and theory based in integrative/humanistic thinking and with relational, developmental stance
3. me as individual with history/culture

08/03/08

New Agency manager outlined the changes that are being introduced. She came over as strong and determined and in that sense 'held' the process of change, whereas earlier (beginning of NSP) change had been demanded but unsupported. How like client work, the need to hold and support the work. However felt irritated as I have known that the Agency has drifted into poorly monitored case work, on overload etc as NM described (new regime in charge for about year and now taking 'control') and like the others at Agency had a sense of helplessness that fell to moaning about it as the norm. The new management will be good but I do wonder about the emphasis on outcomes that measure success at a completed set of 12 weeks and boxes ticked on a form. I felt so bad all evening following this meeting have decided to speak to NM in support of the change and adding concerns especially around the referring out of non substance related issues. I have seen how these clients are moved out of all services until they are 'clean', old regime speciality was taking all. Also issue of long term clients and the Lt value of the outcomes measured vs continued work and also catering for the group that stay in the service..why do they stay? Can they be supported in a less expensive way see ref re diff types of client, those who work and move on and those who stay. What about those who give up and move out of the service, find life too difficult without the substance and need support to get at underlying issues?

16/04/08

Also in conversation with D & J re service changes. Lots proposed nothing gets done. New 12 week rule encourages collusion to maintain practice, mixed messages from management. A, who was at meeting where told can only do 12 weeks (stats based on retention time) said NTA/ commissioners now say based on outcome not retention time. Stats produce funding and so stats managed to show desired results. Funding follows heroin and crack users not alcohol!!

Staff unhappiness/ illness/ lot absence as change not managed well. Staff not held by new management, confusion re practices and procedures, delays in implementation causes problems in service provision, poor communication, poor interpersonal handling etc.

19/07/08

Current mumbblings re service. New locality manager appointed and visits. Feel of the service being unmanageable, no one tackled it successfully in 2 years.

History of old regime and many of staff part of old regime. Regime based on being available for all, no waiting list, long term therapy, clients staying in service, groups not structured

open to all. What is commissioning basis for contract for NSP? Open all hours no longer manageable by staff. History of setting makes it different from services under management of same provider, newly opened services in the county that start with different ethos, staff rules around what available for clients. Possibly different client groups. Old established service gets revolving door clients?

Struggle to get client participants partly due to poor record keeping at Agency (missing data from diary, old system) therapists not taking on board my project/me not communicating it well enough. Records not kept of clients who keep being transferred/ reengaging. Why not as they are an important use of Agency resources? Therapists not know that their client had had imposed ending!

3/08/08

In interviews am getting lot of angry feelings re running of agency. Lack of interest in progress of individual clients and those with therapists leaving are left to continue. Eg Kesia why has no one stopped to look at her 'career' as she seems stuck. What about an exit interview for therapist? What about monitoring of therapist cases? Used to happen. Therapists taking responsibility is one thing but Agency also needs to be accountable. Agency professes to be person centred but more like sausage machine.

30/09/08

Join the ranks of departing/soon to depart therapists!

Appendix 2 – Agency imposed change clients 01/07/05 to 07/07/08

Therapist leaving date	Therapist code no.	No. Clients at leaving date	No. Clients ending	Clients to transfer	Ending clients return < 3 mth
01/07/05	16	3	3		1
13/07/05	10	2	2		
25/07/05	7	4	1	2	
20/09/05	8	3	1	2	
24/10/05	19	4	4		
24/10/05	20	2	1	1	1
12/04/06	27	1		1	
21/04/06	2	4	3	1	1
27/04/06	5	1		1	
02/05/06	28	1	1		
28/06/06	18	5	5		
17/07/06	9	1	1		
31/08/06	15	1		1	
06/10/06	24	2	1	1	
2/11/06	12	3	2	1	1
23/11/06	23	3	3		1
13/12/06	18	1		1	
*	29	2		2	
	13	3	3		
	15	1	1		
	17	3	1	2	
	23	2	2		
	26	1	1		
	36	5	2	3	
21/01/08	39	2		2	
04/04/08	41	3	3		
04/04/08	42	3	2	1	
07/07/08	32	3	2	1	
Totals		69	45	24	5
% ending			65%	35%	
% of enders returning					11%

*Appointments diary missing for three month period. Pieced together therapists leaving and their clients from other sources; database and receptionist.

Appendix 3 – Tier 3 service

Agency status during 2003-2008.

Tier 3 is part of a National Framework set out by the National Treatment Agency in 2002. The framework describes the range of services that should be available in every drug action team in the country. Models of Care aims to establish a co-ordinated system of treatment. There are four treatment tiers.

- Tier 1 is concerned with screening and referral.
- Tier 2 provides specialist services including advice and information.
- Tier 3 works with other specialist services, solely for drug misusers in structured programmes of care. A Comprehensive assessment and care plan, a care co-ordinator.
Psychotherapeutic interventions and structured counselling
Motivational interventions
Methadone maintenance programmes
Community detoxification
Day programmes
- Tier 4 Clients with high level need, drug and alcohol, in-patient detoxification or stabilisation, residential rehabilitation units, residential crisis intervention centres.

Appendix 4 - Client therapy history with T1 and T2

Client	Therapy with T1	Between T1 & T2	Therapy with T2	Ending with T2
James	12 months	2 months	5 months	Stopped attending before planned ending
Sidney	6 months	2 months	3 months	Stopped attending sessions
Megan	6 months	3 months	5 months	Did not return to therapy after detox treatment
Kezia	6 months	3 months	3 months	Worked to planned ending

Appendix 5 – Interview guides

1. Client Interview Guide

Objectives

- How the client experiences the change of therapist.
- How the client perceives this change as influencing their care programme journey and outcome.

Interview Guide

Introduction

- Recap procedure, confidentiality and withdrawal option.
- General conversation, client's details.
- Client's summary of counselling at VH, check ongoing
- Explain 'imposed change', introduce therapeutic relationship that ended

Change/ Ending

- Client describes hearing about ending
- Preparation for the ending, what helped, what did not help?
- The last session
- Explore the affects of ending

Change/ Beginning

- Client describes starting with new therapist
- What helped, what did not help?
- Explore the affects of starting again

Closing Down

- Client summarizes impact of change
- Suggestions of what helped at the time of ending and starting again
- Suggestions of what could be done at ending and starting
- Any other comments

Ending

- Thank you
- Expenses payment arrangements
- Contact for follow up

2. Therapist Interview Guide

Objectives

- How the therapist experienced the ending/beginning
- How the therapist worked with the ending/beginning
- The therapist's perception of how the client experienced the change of therapist.
- How the therapist perceived the ending/beginning as influencing the client's Care Programme journey and outcome.

Interview Guide

Introduction

- Recap procedure, confidentiality and withdrawal option.
- General conversation, therapist details, training, orientation.

Ending or beginning

- Therapist describes ending/starting with client.
- Client's reaction to ending/beginning, issues raised
- Preparation for the ending/beginning, what helped, what did not help?
- The last session
- Explore the client affects of ending/starting.
- Therapist experience of end/beginning

Closing Down

- Therapist summarizes impact of change
- Suggestions of what helped at the time of ending and starting again
- Suggestions of what could be done at ending and starting
- Any other comments

Ending

- Thank you
- Expenses payment arrangements
- Contact for follow up

Appendix 6 – Analytic trail

1. Client James. Annotated typed transcript

	R: I'm er wondering how you did the ending with her you know	
no what? Better than him? Pavelin resigned T. self-disclosure. that's in	J: I just wished her well, she said 'I hope everything work out James' <u>that was it</u> but there was <u>no</u> , it was like a <u>fairly basic</u> , she got the, going to a better position, nearer ***** where she lived, so <u>that was it</u> you know	T. ENDING ENDING REASON FOR END
	R: It sounds like you didn't have much time to get used to the end	
	J: Ah, er	
	R: Just a week	
soon/quick avoid pain?	J: Well I'd <u>sooner</u> have it that way, you know.	T. ENDING
	R: it was easier was it to just have a short	
Reaction to all endings seen in this one that's it! THE END!	J: Yeah, yeah....I phhh, if I say ^{childlike} <u>bye bye</u> to someone I don't like.... I <u>don't stand watching the boat sail</u> and all that. If they're on <u>the boat and they're going away</u> and <u>that's it</u> . Say see you soon and <u>that's it</u>	T. ENDING OTHER ENDINGS REL. TO OTHERS ATTITUDE METAPHOR
	R: Something about that being the way for you to do it	
familiarity	J: Yeah, jut, if it's gonna happen it's gonna happen	ATTITUDE
	R: If it's gonna happen do it now	
	J: Yep	
	R: and not stand and	
NOT get upset - avoids business as usual company.	J: <u>No point</u> , no point getting all <u>upset</u> about it..pause.. it's er..No I've always been like that, it's gonna end it's gonna end, that's it, you know I don't know it's very er (pause)..... <u>confusing</u>	ATTITUDE AFFECT
	R: Confusing?	
Loss familiarity diverts away a person	J: Mmm as <u>soon</u> as you <u>get used to somebody</u> they, (changes track)	T. ENDING

2. Client James. Coded Atlas interview transcript

Date: 01/08/09 P 1: Interview C1 James.rtf Page: 1/1

129 R: *I'm er wondering how you did the ending with her you know*

130 J: I just wished her well, she said 'I hope everything work out James' that was it but there was no, it was like a fairly basic, she got the, going to a better position, nearer ***** where she lived, so that was it you know

131 R: *It sounds like you didn't have much time to get used to the end*

132 J: Ah, er

133 R: *Just a week*

134 J: Well I'd sooner have it that way, you know.

135 R: *it was easier was it to just have a short*

136 J: Yeah, yeah....I phhh, if I say bye bye to someone I don't like.... I don't stand watching the boat sail and all that. If they're on the boat and they're going away and that's it. Say see you soon and that's it

137 R: *Something about that being the way for you to do it*

138 J: Yeah, jut, if it's gonna happen it's gonna happen

139 R: *If it's gonna happen do it now*

140 J: Yep

141 R: *and not stand and*

142 J: No point, no point getting all upset about it..pause.. it's er..No I've always been like that, it's gonna end it's gonna end, that's it, you know I don't know it's very er (pause).....confusing

143 R: *Confusing?*

144 J: Mmm as soon as you get used to somebody

- basic~
- Ending therapist~
- Experience of ending with theraj
- Reason for ending~
- Attitude/belief~
- Avoids emotion~
- Avoids ending~
- Confusing~
- Experience of ending with ther
- Metaphor, analogy~
- Own terms~
- ME - 24/07/08 [3]
- Experience of ending with ther
- get used to somebody~

3. Client James. External coder check of Atlas interview transcript

* Not sure of difference between this code and 'Reason for ending' (James coding)

Date: 27/11/08

P 1: Interview C1 James.rtf

Page: 1/4

129	R: I'm er wondering how you did the ending with her you know	Experience of Ending with therapist Ending therapist
130	J: I just wished her well, she said 'I hope everything work out James' that was it but there was no, it was like a fairly basic, she got the, going to a better position, nearer ***** where she lived, so that was it you know	Gender of therapist Assumptions about therapist Ending-reason for * basic Angry Resentful
131	R: It sounds like you didn't have much time to get used to the end	Notice of ending
132	J: Ah, er	Defends therapist
133	R: Just a week	
134	J: Well I'd sooner have it that way, you know.	
135	R: it was easier was it to just have a short	Feeling re ending ✓ Experience of ending ✓ Avoids ending ✓ Metaphor/analogy ✓
136	J: Yeah, yeah....I phhh, if I say bye bye to someone I don't like.... I don't stand watching the boat sail and all that. If they're on the boat and they're going away and that's it. Say see you soon and that's it	
137	R: Something about that being the way for you to do it	
138	J: Yeah, jut, if it's gonna happen it's gonna happen	
139	R: If it's gonna happen do it now	Attitude/belief ✓
140	J: Yep	Resignation? Acceptance? Doesn't question? Passive?
141	R: and not stand and	
142	J: No point, no point getting all upset about it..pause.. it's er..No I've always been like that, it's gonna end it's gonna end, that's it, you	

Not code
Feeling Dismissed?
Ambivalence
Contradiction
(implicit?)

1. Client James. Quote trail Interview – Findings – Discussion

Interview Line 136

J: Yeah, yeah....I phhh, if I say bye bye to someone I don't like.... I don't stand watching the boat sail and all that. If they're on the boat and they're going away and that's it. Say see you soon and that's it

4.5.1 Dyad One – Client James

Part 1 Client James

When talking about having little notice of the end with T1,

'Yeah, yeah....I phhh (exhales), if I say bye-bye to someone, I don't likeI don't stand watching the boat sail and all that. If they're on the boat and they're going away and that's it.'

'No point, no point getting all upset about itit's er.....no, I've always been like that, it's gonna end it's gonna end, that's it, you know'

James seemed to welcome the short notice period of the ending with T1 as he suggests it is not his way to watch *'the boat sail'* and for me this rang with a note of resignation, he seemed powerless *'it's gonna end it's gonna end'* and there was *'no point getting all upset'* about *'something else going'*.

4.5.1 Dyad – Client James

Part 4 Researcher synopsis

He dismissed goodbyes and linguistically identified his denial of or defence against the affects associated with endings in his negative statements on trauma and resentment. He also gave examples of how he keeps people at a distance, of not trusting people and how he values emotional self-reliance and separateness. I see such affect minimisation or inhibition and dismissing of the importance of relationships as characteristic of individuals with a dismissing (avoidant) attachment style.

Discussion 5.1 The client experience and attachment

That T1 represented some form of an attachment figure or that the relationship was attachment based was evidenced for me in the client participant's experience of the first therapy relationship as intimate and caring. The client's reflections upon his or her experience of the imposed change and other endings provided me with an insight into their particular way of regulating affective and interpersonal experience. In my earlier discussion of their individual responses to the imposed change (Findings Section 4) I have suggested attachment styles and features of attachment system activation for each client participant and the effect this had on the therapist/therapeutic relationship.

5. Therapist T2-Kezia. Annotated typed transcript

R: Did anyone say this is a client that has seen someone else

TB3: No, um, there was another counsellor who mentioned 'oh, yes she's seen other counsellors' so that, yeah that made me aware of it but kind of left to think about it, yeah.

R: and what was it like for you

TB3: Um, I'd say that I think someone who has been in counselling before um..., learns probably more how they want to use the session um, they are more aware of kind of how it works and um in a way that could be a good thing, well not always a good thing because it means that they might have, the preconceived ideas they have about counselling means that it could sort of be that they want to work in a way that, that the counsellor might feel very different, um

R: mmm, and did you experience that when you started seeing Kesia, what was it like?

TB3: when I started seeing her....., she made it, I mean she said that her previous counsellor would, was very good at um, challenging her

R: mmm

TB3: particularly on sort of issues around drink and that...you know 'she would come in, she would respond to me and she challenged me' you know and so it was like she was kind of setting the agenda, this is what I have had

R: mmm

TB3: in particular that the previous counsellor that she'd had, had been sort of the best she felt out of all of them

R: what was that like for you when she said that

TB3: (laughs) I did sort of feel, 'Ooo I've gotta tough act to follow you know, not that it should be an act but

R: mmm

TB3: but I've got to kind of

R: it registered

TB3: yeah, I've got to 'live up to her expectations of, you know, and it's sort of wanting to provide a space for her and that it was really helpful. There was sort of, she hadn't wanted it to end and there were

Handwritten notes:

- How knew in planning + file
- Multi therapy
- Cl + prev. learns what want How it works ambiv/unsure
- expect.
- talk about previous agree w. cl details
- clear prev. Th.
- difference from prev. cl. quite some prev Th met.
- !!
- Cl comment → feeling
- met.
- expect. cl expect → Th behavior

6. Therapist T2-Kezia. Coded Atlas interview transcript

Date: 27/11/08

P 6: Interview A TB3.rtf

Page: 3/4

- 034 *R: and what was it like for you*
- 035 TB3: Um, I'd say that I think someone who has been in counselling before um...., learns probably more how they want to use the session um, they are more aware of kind of how it works and um in a way that could be a good thing, well not always a good thing because it means that they might have, the preconceived ideas they have about counselling means that it could sort of be that they want to work in a way that, that the counsellor might feel very different, um
- 036 *R: mmm, and did you experience that when you started seeing Kesia, what was it like?*
- 037 TB3: when I started seeing her....., she made it, I mean she said that her previous counsellor would, was very good at um, challenging her
- 038 *R: mmm*
- 039 TB3: particularly on sort of issues around drink and that...you know 'she would come in, she would respond to me and she challenged me' you know and so it was like she was kind of setting the agenda, this is what I have had
- 040 *R: mmm*
- 041
- 042 TB3: in particular that the previous counsellor that she'd had, had been sort of the best she felt out of all of them
- 043 *R: what was that like for you when she said that*
- 044 TB3: (laughs) I did sort of feel, 'Ooo I've gotta tough act to follow you know, not that it should be an act but
- 045 *R: mmm*
- 046 TB3: but I've got to kind of
- 047 *R: it registered*
- 048 TB3: yeah, I've got to live up to her expectations of, you know, and it's sort of wanting to provide a space for her and that it was really helpful. There
- X TB difference from previous therapist~
 - X TB experienced client~
 - X TB about client participant~
 - X TB client sets agenda~
 - X TB difference from previous therapist~
 - X TB experience of beginning~
 - X TB metaphor~
 - X TB researcher directs to client participant~
 - X TB uses same word/phrase as client~
 - X TB about client participant~
 - X TB client expectations~
 - X TB client remembers prev therapist~
 - X TB experience of beginning~
 - X TB laughs at own 'failing'~
 - X TB metaphor~
 - X TB therapist feeling re previous therapist~
 - X TB uses same word/phrase as client~
 - X TB about client participant~

7. Therapist T2-Kezia. External coder check of Atlas interview transcript

Date: 27/11/08

P 6: Interview A TB3.rtf

Page: 3/4

<p>034 R: and what was it like for you</p> <p>035 TB3: Um, I'd say that I think someone who has been in counselling before um...., learns probably more how they want to use the session um, they are more aware of kind of how it works and um in a way that could be a good thing, well not always a good thing because it means that they might have, the preconceived ideas they have about counselling means that it could sort of be that they want to work in a way that, that the counsellor might feel very different, um</p> <p>036 R: mmm, and did you experience that when you started seeing Kesia, what was it like?</p> <p>037 TB3: when I started seeing her....., she made it, I mean she said that her previous counsellor would, was very good at um, challenging her</p> <p>038 R: mmm</p> <p>039 TB3: particularly on sort of issues around drink and that...you know 'she would come in, she would respond to me and she challenged me' you know and so it was like she was kind of setting the agenda, this is what I have had</p> <p>040 R: mmm</p> <p>041</p> <p>042 TB3: in particular that the previous counsellor that she'd had, had been sort of the best she felt out of all of them</p> <p>043 R: what was that like for you when she said that</p> <p>044 TB3: (laughs) I did sort of feel, 'Ooo I've gotta tough act to follow you know, not that it should be an act but</p> <p>045 R: mmm</p> <p>046 TB3: but I've got to kind of</p> <p>047 R: it registered</p> <p>048 TB3: yeah, I've got to live up to her expectations of, you know, and it's sort of wanting to provide a space for her and that it was really helpful. There</p>	<p>- TB Experienced client ✓</p> <p>- TB About client participant ✓</p> <p>- TB Client experience ✓</p> <p>- TB Client expectations ✓</p> <p>- TB Discrepancy client agenda ✓</p> <p>- TB Differene from previous therapist ✓</p> <p>- TB Aware previous therapist ✓</p> <p>- TB Client remembers prev. therapist ✓</p> <p>- TB Client use of therapy ✓</p> <p>- TB Client alcohol use ✓</p> <p>- TB Client remembers prev. therapist ✓</p> <p>- TB Client sets agenda ✓</p> <p>- TB About client participant ✓</p> <p>- TB Aware previous therapist ✓</p> <p>- TB About client participant ✓</p> <p>- TB Therapist's feeling about previous therapist ✓</p> <p>- TB Therapist's own issues ✓</p> <p>- TB Handling beginning ✓</p>
---	--

Curious about therapist expectations

8. Therapist T2-Kezia. Quote trail Interview-Findings-Discussion

Interveiw Line 44

TB3: (laughs) I did sort of feel, 'Ooo I've gotta tough act to follow you know, not that it should be an act

4.5.4 Dyad Four – Client Kezia

Part 2 Therapist T2-Kezia

Shadow of T1

In choosing to ask about Kezia's previous therapy this therapist then questions

'..in making it so relevant did I bring about more of a comparison?'

The detail of that comparison is available to her

'that the previous counsellor that she'd had, had been sort of the best she felt out of all of them'

R: what was it like when she said that?

'(laughs) I did sort of feel, 'Ooo I've gotta tough act to follow' you know, not that it should be an act'

She laughs maybe in recognition of the impact of hearing about the 'best' counsellor but does not directly describe the 'Ooo', of how it felt, although a 'tough act' possibly implies a daunting task.

Discussion 5.5 Therapist beginning with imposed change clients

The Therapist and 'shadow' of T1

I discussed earlier the client's place in the triangular process and their management of the loss and change. Scher (1970, p.282) suggests that for therapists the second relationship will be in the 'shadow of the former therapist', open to comparisons being made and with them having to weather the 'indignity of being less important' to the client.

Therapist interviews revealed differences between those who had attended to the previous therapy and therapist of the imposed change client and those that had not. Having invited this information one felt the pull of a 'tough act to follow' and the comparisons that ensued real or imagined. For those that did not enquire I found the departed therapist present in the metaphor of not stepping into 'somebody else's shoes', voiced as client expectations and also in questioning of themselves as therapists in comparison to the imagined previous therapy of the client.

Appendix 7 – Atlas codes-primary documents table

Primary documents relate to

Client	Therapist
1 James	5 T2-James
2 Sidney	6 T2-Kezia
3 Kezia	7 T2-Sidney
4 Megan	8 T2-Megan

CODES-PRIMARY-DOCUMENTS-TABLE (CELL=Q-FREQ)

Report created by Super - 23/09/08 21:25:19

"HU: [C:\Documents and Settings\Frances B\My Documents\Scientific Software\ATLASTi\Te...\Client Interviews.hpr5]"

Code-Filter: All [249]

PD-Filter: All [8]

Quotation-Filter: All [502]

CODES	PRIMARY DOCS								Totals
	1	2	3	4	5	6	7	8	
	0	0	2	0	0	0	0	0	2
AA	0	10	1	4	0	0	0	0	15
Age	1	10	3	0	0	0	0	0	14
Alcohol	4	14	5	5	0	0	0	0	28
Alone	8	8	2	0	0	0	0	0	18
ambivalence	0	0	1	1	0	0	0	0	2
angry	6	0	2	0	0	0	0	0	8
Anxious	0	1	2	1	0	0	0	0	4
Assumptions about th	0	1	0	0	0	0	0	0	1
Attachment	0	0	1	2	0	0	0	0	3
Attitude/belief	14	5	2	0	0	0	0	0	21
Attunement	4	12	0	0	0	0	0	0	16
automatic	0	0	1	0	0	0	0	0	1
Avoids emotion	1	0	1	0	0	0	0	0	2
Avoids ending	1	0	0	0	0	0	0	0	1
basic	1	0	0	0	0	0	0	0	1
Beginning therapist	14	22	5	16	0	0	0	0	57
Building	2	0	0	5	0	0	0	0	7
can't get hold of	1	0	0	0	0	0	0	0	1
Care too much	0	0	0	1	0	0	0	0	1
change	0	0	0	2	0	0	0	0	2
client DNA/ no endin	0	0	0	0	0	0	1	0	1
Closure	0	0	0	1	0	0	0	0	1
Confidentiality	0	0	0	1	0	0	0	0	1
consistency	0	0	0	1	0	0	0	0	1
contradiction	0	0	2	0	0	0	0	0	2
Coping	2	2	0	0	0	0	0	0	4
defends therapist	3	2	0	2	0	0	0	0	7
delayed reaction	0	0	2	0	0	0	0	0	2
dependent on therapi	0	0	1	0	0	0	0	0	1
depersonalised thera	0	0	3	0	0	0	0	0	3
Depression	4	0	0	1	0	0	0	0	5
Disability	0	6	0	0	0	0	0	0	6
dismissed	0	0	4	0	0	0	0	0	4
Dismisses self	2	0	0	0	0	0	0	0	2
Dragging it up again	0	0	0	1	0	0	0	0	1

draining	0	0	0	3	0	0	0	0	3
Dreams	5	0	2	0	0	0	0	0	7
emotional	0	0	0	8	0	0	0	0	8
empathy	1	15	0	0	0	0	0	0	16
end product	3	0	0	0	0	0	0	0	3
Ending- reason for	1	0	0	0	0	0	0	0	1
Ending therapist	14	10	12	12	0	0	0	0	48
Experience of beginn	6	5	2	7	0	0	0	0	20
Experience of ending	8	10	10	5	0	0	0	0	33
Experience of other	0	9	3	3	0	0	0	0	15
Experience other the	0	0	4	7	0	0	0	0	11
family/network	5	5	2	6	0	0	0	0	18
feedback	0	0	1	0	0	0	0	0	1
feel incapable	0	0	1	0	0	0	0	0	1
feel silly	0	0	0	1	0	0	0	0	1
Feeling re ending	1	0	10	1	0	0	0	0	12
gender of therapist	0	5	1	3	0	0	0	0	9
get used to somebody	1	1	0	0	0	0	0	0	2
getting familiar	0	0	0	1	0	0	0	0	1
getting somewhere in	0	0	1	2	0	0	0	0	3
Got used to ending w	0	0	1	0	0	0	0	0	1
Head is chaos	0	0	0	2	0	0	0	0	2
held back	0	0	3	0	0	0	0	0	3
helpful/unhelpful	2	1	0	0	0	0	0	0	3
Home	6	0	0	0	0	0	0	0	6
hope	0	0	1	0	0	0	0	0	1
hopeless	0	0	1	0	0	0	0	0	1
illness discourse	0	0	12	0	0	0	0	0	12
jeopardise things	0	0	1	0	0	0	0	0	1
Keep sanity	0	1	0	0	0	0	0	0	1
length of therapy	3	0	0	0	0	0	0	0	3
locked in	2	0	0	0	0	0	0	0	2
looks to others	0	0	5	0	0	0	0	0	5
loosing a friend	0	1	0	3	0	0	0	0	4
Loss	1	0	1	1	0	0	0	0	3
Loss - other	7	11	1	3	0	0	0	0	22
lost in junk/mass	0	0	3	0	0	0	0	0	3
Lot going on	0	1	6	1	0	0	0	0	8
Magic wand	3	0	5	2	0	0	0	0	10
Medication	2	0	0	0	0	0	0	0	2
medication withdrawa	0	2	0	0	0	0	0	0	2
Metaphor, analogy	19	13	9	9	0	0	0	0	50
Mind racing	0	5	0	0	0	0	0	0	5
Missed sessions	1	0	0	3	0	0	0	0	4
moved on	0	0	0	7	0	0	0	0	7
Moving	6	0	0	0	0	0	0	0	6
multi-therapist clie	0	0	1	3	0	0	0	0	4
Negative phrasing	7	0	0	0	0	0	0	0	7
new is scary	0	0	0	2	0	0	0	0	2
New issues	0	0	1	0	0	0	0	0	1
no good	0	0	1	0	0	0	0	0	1
Non-endings	0	0	3	0	0	0	0	0	3
not remembered	0	0	0	2	0	0	0	0	2
notice of ending	1	1	1	2	0	0	0	0	5
Number of therapists	0	0	1	0	0	0	0	0	1
old wounds	3	0	0	0	0	0	0	0	3
ongoing	0	0	2	0	0	0	0	0	2
Open up	0	0	0	2	0	0	0	0	2
ORW (outreach worker	6	1	0	1	0	0	0	0	8
Other relationships	1	0	0	1	0	0	0	0	2
other therapeutic re	0	0	5	0	0	0	0	0	5

Own terms	5	0	0	0	0	0	0	0	5
painful	1	0	0	0	0	0	0	0	1
Panic	0	7	0	0	0	0	0	0	7
passive client	0	0	0	1	0	0	0	0	1
Past experi evoked	1	1	3	1	0	0	0	0	6
Past not talked abou	0	0	2	0	0	0	0	0	2
Physical contact at	1	0	1	0	0	0	0	0	2
physical description	0	0	0	1	0	0	0	0	1
Physician heal thyse	2	0	0	0	0	0	0	0	2
Practical matters	3	3	0	2	0	0	0	0	8
pressing you	3	0	0	0	0	0	0	0	3
Private	5	0	0	3	0	0	0	0	8
Proactive client	0	6	0	0	0	0	0	0	6
Problem finishing	0	0	1	0	0	0	0	0	1
Reason for ending	2	2	2	1	0	0	0	0	7
Referral	4	1	0	0	0	0	0	0	5
Regulation	1	13	2	1	0	0	0	0	17
Relapse	0	1	1	0	0	0	0	0	2
reliance	1	0	0	0	0	0	0	0	1
remember	0	2	1	0	0	0	0	0	3
repetition	6	3	0	7	0	0	0	0	16
researcher- change d	6	10	4	3	0	0	0	2	25
Researcher- particip	1	0	0	0	0	0	0	0	1
Researcher-miss	4	5	2	2	0	0	0	0	13
researcher lets esca	0	0	0	1	0	0	0	0	1
researcher scream	0	0	1	0	0	0	0	0	1
resentful	2	0	0	0	0	0	0	0	2
Robbed	0	2	0	0	0	0	0	0	2
Role of therapist no	1	1	0	0	0	0	0	0	2
Routine	2	1	0	0	0	0	0	0	3
Runner	0	7	0	0	0	0	0	0	7
Seeking	0	1	0	0	0	0	0	0	1
Self blame	4	0	0	2	0	0	0	0	6
Setting	1	0	4	0	0	0	0	0	5
Shame	0	0	0	1	0	0	0	0	1
silly	4	0	0	0	0	0	0	0	4
slow pace	1	0	0	0	0	0	0	0	1
Someone to myself	0	0	2	0	0	0	0	0	2
Sounding board	0	0	2	0	0	0	0	0	2
Start again	5	0	0	5	0	0	0	0	10
Status	3	7	0	0	0	0	0	0	10
story	4	0	0	2	0	0	0	0	6
structure	0	0	5	0	0	0	0	0	5
Stuck	13	0	5	2	0	0	0	0	20
Suggestions	3	2	0	1	0	0	0	0	6
Support	0	0	0	1	0	0	0	0	1
Talk to	1	2	3	0	0	0	0	0	6
Tangents	0	0	1	2	0	0	0	0	3
tearful	0	0	0	2	0	0	0	0	2
therapeutic ear	1	0	0	0	0	0	0	0	1
Therapist active	0	0	0	1	0	0	0	0	1
Therapist comparison	4	4	1	6	0	0	0	0	15
Therapist self-discl	2	0	1	0	0	0	0	0	3
Therapist training/e	0	6	0	1	0	0	0	0	7
Therapists not share	2	0	0	1	0	0	0	0	3
therapy	17	8	15	12	0	0	0	0	52
trust	1	1	0	2	0	0	0	0	4
Try to reach	1	0	0	0	0	0	0	0	1
unable to turn thing	0	0	2	0	0	0	0	0	2
uncertainty	1	7	2	0	0	0	0	0	10
Unknown	0	0	0	1	0	0	0	0	1

Unusual experience	2	0	0	0	0	0	0	0	2
up to speed	4	0	0	1	0	0	0	0	5
Up to speed client	0	0	0	1	0	0	0	0	1
Upsetting-ending	0	0	0	3	0	0	0	0	3
Use setting	0	9	0	0	0	0	0	0	9
Wait for next therap	0	3	3	0	0	0	0	0	6
wasting therapists t	0	0	1	0	0	0	0	0	1
X length of therapy	0	0	0	0	1	0	0	0	1
X TB work slowly	0	0	0	0	1	0	0	0	1
X TB Abandonment	0	0	0	0	3	1	0	0	4
X TB age/male discou	0	0	0	0	1	0	0	0	1
X TB asks client abo	0	0	0	0	0	2	0	0	2
X TB aware of prev t	0	0	0	0	0	1	0	1	2
X TB bad therapist	0	0	0	0	0	1	0	0	1
X TB breaks	0	0	0	0	0	1	0	0	1
X TB choosing client	0	0	0	0	0	0	2	0	2
X TB client's lack o	0	0	0	0	0	0	0	3	3
X TB client alcohol	0	0	0	0	1	6	0	2	9
X TB client backgrou	0	0	0	0	5	0	0	0	5
X TB client continui	0	0	0	0	0	2	0	0	2
X TB client disabili	0	0	0	0	0	0	2	0	2
X TB client does not	0	0	0	0	0	0	1	2	3
X TB client expectat	0	0	0	0	0	1	0	1	2
X TB Client experien	0	0	0	0	1	0	0	0	1
X TB client experien	0	0	0	0	6	3	1	0	10
X TB client fears en	0	0	0	0	0	1	0	0	1
X TB client loss	0	0	0	0	1	1	0	0	2
X TB client lot of s	0	0	0	0	0	0	0	1	1
X TB client pain	0	0	0	0	3	0	0	0	3
X TB client plastic	0	0	0	0	4	0	0	0	4
X TB client ready to	0	0	0	0	3	0	0	0	3
X TB client reliant	0	0	0	0	6	0	0	0	6
X TB client remember	0	0	0	0	2	3	1	1	7
X TB client sets age	0	0	0	0	0	2	0	0	2
X TB client stuck	0	0	0	0	1	1	0	3	5
X TB Client switches	0	0	0	0	1	0	0	0	1
X TB client trust	0	0	0	0	5	0	0	0	5
X TB client use of t	0	0	0	0	0	5	0	2	7
X TB clients droppin	0	0	0	0	0	0	4	0	4
X TB difference from	0	0	0	0	2	4	1	2	9
X TB difficult to ta	0	0	0	0	0	3	0	0	3
X TB disability disc	0	0	0	0	0	0	1	0	1
X TB discrepancy in	0	0	0	0	0	1	0	0	1
X TB encourages depe	0	0	0	0	3	0	0	0	3
X TB ending after LT	0	0	0	0	0	0	1	0	1
X TB endings importa	0	0	0	0	0	0	2	1	3
X TB endings unimpor	0	0	0	0	0	0	3	0	3
X TB experience of b	0	0	0	0	5	2	2	1	10
X TB experience of c	0	0	0	0	6	7	1	5	19
X TB experienced cli	0	0	0	0	0	1	0	0	1
X TB fresh start	0	0	0	0	0	1	1	0	2
X TB gap between the	0	0	0	0	0	0	1	0	1
X TB handling beginn	0	0	0	0	6	2	1	0	9
X TB key worker	0	0	0	0	3	0	0	0	3
X TB lack of goal	0	0	0	0	0	1	0	0	1
X TB lack of outcome	0	0	0	0	0	1	0	0	1
X TB laughs at own '	0	0	0	0	0	4	0	0	4
X TB long time to en	0	0	0	0	6	0	0	0	6
X TB making ending r	0	0	0	0	0	1	0	0	1
X TB metaphor	0	0	0	0	12	6	1	0	19
X TB not hearing cli	0	0	0	0	0	0	1	0	1

X TB not read notes	0	0	0	0	1	2	1	3	7
X TB on endings	0	0	0	0	1	0	1	0	2
X TB other beginning	0	0	0	0	1	0	3	1	5
X TB person centred	0	0	0	0	2	1	0	1	4
X TB previous therap	0	0	0	0	0	0	0	1	1
X TB rejection	0	0	0	0	1	0	0	0	1
X TB self-disclosure	0	0	0	0	0	0	1	0	1
X TB setting	0	0	0	0	1	5	5	0	11
X TB shuts down prev	0	0	0	0	1	0	0	0	1
X TB still at the be	0	0	0	0	0	1	0	0	1
X TB Substance misus	0	0	0	0	3	0	2	0	5
X TB suggestions	0	0	0	0	1	0	0	0	1
X TB Supervision	0	0	0	0	2	6	1	0	9
X TB therapist curio	0	0	0	0	0	0	0	4	4
X TB therapist curio	0	0	0	0	0	0	0	4	4
X TB therapist dismi	0	0	0	0	0	0	0	1	1
X TB therapist feeli	0	0	0	0	5	2	0	0	7
X TB therapist not a	0	0	0	0	0	0	2	2	4
X TB therapist not i	0	0	0	0	0	0	1	1	2
X TB therapist own i	0	0	0	0	3	0	0	3	6
X TB therapist respo	0	0	0	0	0	2	1	7	10
X TB therapist view	0	0	0	0	12	5	1	0	18
X TB therapists not	0	0	0	0	0	0	2	0	2
X TB this client dif	0	0	0	0	0	0	0	3	3
X TB time	0	0	0	0	7	1	0	0	8
X TB uses same word/	0	0	0	0	3	12	1	3	19
X TB variance to cli	0	0	0	0	1	0	0	0	1
X TB what client cho	0	0	0	0	2	0	0	0	2
X TB what therapist	0	0	0	0	0	0	0	3	3
X therapist training	0	0	0	0	4	4	3	2	13

Totals	308	305	220	217	139	106	53	66	1414

Appendix 8 – External coder

1. Letter to External Coder

29/11/08

Dear *****

Endings and Beginnings: An Interpretative Phenomenological Analysis of Client and Psychotherapist Experience of an Imposed Change of Psychotherapist

Thank you for agreeing to read and code the enclosed samples of the data from my study. It would be useful if you can add all your thoughts on the data, the coding and any observations or reflections that arise when carrying out the procedure.

For this study there were two groups of participant, clients at the setting and the beginning therapists of those clients. I have identified the therapists involved as the ending therapist, the therapist who left the setting and the beginning therapist who the client worked with following the imposed ending.

Enclosed are both client and therapist coded extracts for familiarisation with the material and codes, as well as an extract to code for that participant and one other from each group.

Client Participant James a coded extract, lines 94-118

Client Participant James an extract for coding, lines 129-160

Client Participant Sidney an extract for coding, lines 19-57

Therapist Participant TB1 a coded extract, lines 13-58

Therapist Participant TB1 and extract for coding, lines 111-126

Therapist Participant TB3 an extract for coding, lines 14-54

I have marked areas that are most densely coded from my analysis of the extracts.

Also enclosed are a list of codes and a list of the codes and their descriptions. The Therapist Participant codes are all prefixed by an X.

The Client Participant codes are a mixture of those that relate to the phenomenon in question, that of imposed change and the codes that are more specific to individual experience. For example,

Phenomenon code	Experience of beginning with therapist
	Experience of ending with therapist
Individual code	Delayed reaction
	Old wounds

For the beginning therapist there are also general and specific codes for example,

Phenomenon code	Client experience of beginning
	Handling beginning
Individual code	Work slowly
	Making ending relevant

There are also specific researcher codes where I have tried to track my influence on the participant and interview.

If you have any queries regarding any of the enclosed please give me a call otherwise I will look forward to receiving the coded extracts and your comments.

Many thanks

Best wishes

Frances Bourne

2. External coder results, comparison and researcher notes

In the tabulated results below, column A records agreement between researcher and external coder as '1'. I have added back phenomenon codes or where there is direct use of the code word or phrase in the text 1*. Suggested additional codes and comments by the coder are recorded in blue. Notes follow each extract table.

Extract 1 Client James

Line no.	Researcher Codes Used	A	Ext. Coder Codes/Comments	Note
129-130	Basic	1	Basic	
	Ending therapist	1	Ending therapist	
	Exp of ending with therapist	1	Exp of ending with therapist	
	Reason for ending	1	Reason for ending	
			Gender of therapist	1
			Assumptions about therapist	2
			Angry, resentful	3
			Feeling dismissed	4
131-144	Attitude/belief	1	Attitude/belief	
	Avoids emotion			
	Avoids ending	1	Avoids ending	
	Confusing	1	Confusing	
	Exp of ending with therapist	1	Exp of ending with therapist	
	Metaphor/analogy	1	Metaphor/analogy	
	Own terms	1	Own terms	
	Get used to somebody	1	Get used to somebody	
	Private			
	Notice of ending	1*	Notice of ending	5
			Ambivalence	6
			Resigned, does not question	6
	Feeling re ending	1*	Feeling re ending	7
			Adjustment/adaptation	8
145-146	Exp of beginning with therapist	1*		
	Resentful	1		6
			Adjustment/adaptation	8
148-152	Magic wand	1	Magic wand	
	Metaphor/analogy	1	Metaphor/analogy	
	Not getting any easier	1*	Not getting any easier	9
155-158	Attitude/belief			
	Beginning therapist	1*		
	Ending therapist	1	Ending therapist	
	Magic wand	1		
	Moving	1*		
	Negative phrasing			
	Reason for ending	1	Reason for ending	
	Resentful	1	Resentful	
	Stuck			
	Metaphor/analogy	1	Metaphor/analogy	
	Therapist comparison	1	Therapist comparison	
		1	Defends therapist	10
			Use of humour	11
159-160	Beginning therapist	1*		
	Ending therapist	1*		
	Up to speed	1	Up to speed	
		30/33		

Notes Extract 1 Client James

1. The code 'Gender of therapist' was used here by the external coder in response to the client using the word 'she' rather than the therapist gender being of relevance to the client participant. On reflection the description for the code is not clear but the external coder does not continue to code each mention of 'she'.
2. 'Assumptions about therapist' was in this case incorrect as the therapist had disclosed this information.
3. From my own experience of the interview I did not hear anger or resentment towards the ending therapist and so did not code for these in this section. I code resentment later in the text both in the guise of a Negative Phrasing code and as heard in the interview. This is also picked up in the findings write up.
4. I had not created a code 'Feeling Dismissed', but can appreciate that the participant words at this point could convey this feeling and will consider this in the findings section.
5. Notice of ending does fit here and is added to the Researcher coding.
6. The coder uses 'Defends Therapist' when the participant describes how he would rather have short notice of the ending as was imposed on him by the therapist. I viewed this from having the whole interview and the picture that built up of him avoiding all endings. A note by the coder here ties in with this in that she introduces 'Ambivalence Contradiction (implicit?)', ambivalence in the resentment that cannot be directed towards the idealised therapist is picked up in the findings. Likewise the 'Resignation? Acceptance ? Doesn't question?' and 'Passive?' listed by the coder are considered in the findings.
7. 'Feeling re ending' is valid here and added to the Researcher coding.
8. Here the coder notes 'Adjustment' and 'Adaptation' as the participant describes how the session time with T2 is less convenient than that with T1. In the dyad piece for this participant issues around a power struggle, anger and difficulty with the change emerge in writing up rather than the original coding.
9. 'Not getting any easier' does fit here and is added to the Researcher codes.
10. 'Use of humour' suggested as a specific category is picked up by us both in the metaphor used. The feeling behind the metaphor / use of humour are picked up in the write up.

Extract 2 Client Sidney

Line no.	Researcher Codes Used	A	Ext Coder Codes/Comments	Note
19	Assumptions about therapist	1	Assumptions about therapist	
	Attunement	1	Attunement	
	Empathy			1
	Ending therapist	1	Ending therapist	
	Therapist training/experience	1*		2
			Gender of therapist	3
21	Attunement	1	Attunement	
	Beginning therapist	1	Beginning therapist	
	Empathy			1
	Gender of therapist	1	Gender of therapist	
	Metaphor/analogy	1	Metaphor/analogy	
	Age	1	Age	
23-25	Runner			
	Reason for ending	1	Unsure of code, DNA?	4
	Attunement			1
	Empathy			1
	Exp of other therapist	1	Exp of other therapist	
	Multi therapist client	1	Multi therapist client	
			Multi-ending?	5
27-31	Reason for ending	1	Reason for ending	
	Attunement			1
	Beginning therapist	1	Beginning therapist	
	Empathy			1
	Ending therapist	1*	Ending therapist	6
			Gender of therapist	3
33-37	Beginning therapist	1*		
	Alone	1*		7
	Coping	1	Coping	
	Exp of ending with therapist	1*		
	Loss-other	1*		8
	Mind racing			
	Panic	1	Panic	
	Practical matters			
	Talk to	1	Talk to	
41	Loss-other			
	Home	1	Home	
44-51	Exp of ending with therapist	1	Exp of ending with therapist	
	Uncertainty			
	Panic	1	Panic	
	Seeking			
	Talk to	1	Talk to	
	Alcohol	1	Alcohol	
	Alone	1*		6
			Not sure which loss referred to	9
	28/40			

Notes Extract 2 Client Sidney

1. Where I have used the codes 'Attunement' and 'Empathy' they have not been used by the coder in 6 of 8 instances. My use of the word for the codes could be confusing as the description is for presence or absence of either. (Attunement – suggestion that participant does or does not experience attunement with other. Empathy – client experience describes empathic/unempathic therapist response). These two codes were introduced during the analysis of this participant's text as they seemed to describe in many cases what he wanted but was not getting. Being one word codes I hoped to pick up both positive and negative experiences to contrast with each case and across cases.
2. The client specifically refers to the therapist's experience.
3. 'Gender of therapist' as for extract 1, lack of clarity for code description.
4. The External Coder comments that she is unsure of the code, suggesting DNA or non-ending. I have used the general 'reason for ending' code to capture all descriptions of the reason for ending.
5. The coder note asks if this is a multi-ending client when the interviewee refers to leaving. The coder is correct as this participant did end with T2 and had more than one ending. I had not coded for these lines but it is addressed in the write up.
6. Agree with coder that the phenomenon code belongs here.
7. The participant refers to living alone.
8. 'Loss-other' (a loss other than of therapist) is referred to by the participant.
9. The coder adds no codes for lines 52-57 but a note that she is unsure whether the participant is referring to his wife or his therapist. She also suggests that the participant is using the researcher as a therapist.

Extract 3 Therapist T2-James

Line no.	Researcher Codes Used	A	Ext Coder Codes/Comments	Note
111-116	About client participant	1	About client participant	
	Client plastic cover	1	Client plastic cover	
	Experience of beginning	1	Experience of beginning	
	Experience of client	1*		
	Long time to engage	1	Long time to engage	
	Metaphor/analogy	1*		
	Therapist view of the work	1	Therapist view of the work	
	Time	1	Time	
	Supervision	1	Supervision	
	Client trust	1	Client trust	
			Encourages relationship	1
	Work slowly	1	Work slowly	
			Client difficult to reach	2
119-120	Handling beginning	1*		
	About client participant	1	About client participant	
121-126	About client participant	1	About client participant	
	Client pain			
	Client ready to make new start			
	Long time to engage	1	Long time to engage	
	Therapist view of the work	1*		3
	Time	1	Time	
	Client experience	1	Client experience	
	Client trust	1	Client trust	
	Client use of therapy	1*	Client use of therapy	
			Impt of devel of relationship is this the same as encourages?	4
			Humour	5
		20/22		

Extract 3 notes Therapist T2-James

1. Code 'Encourages relationship' - encourages client dependence on relationship, does not fit for me in the text at this point.
2. 'Client difficult to reach' was captured for me in the 'Client plastic cover' and so I did not create a new code here.
3. The Therapist participant does talk about the work with this client.
4. Coder questions if Encourages relationship is the same as her suggestion of the importance of the development of the relationship. I had subsumed all the relationship development under 'Handling the beginning'.
5. New code Humour suggested which fits with the therapist's description of her response to the client and maybe gives an indication of their relationship but I felt this was not a key part of what was developing from the data. I had used the code 'Therapist view of the work here' for this section.

Extract 4 Therapist T2-Kesia

Line no.	Researcher Codes Used	A	Ext Coder Codes/Comments	Note
16-19	Asks client about prev therapist	1	Asks client about prev therapist	
	Fresh start	1	Fresh start	
	Handling beginning	1	Handling beginning	
	Setting	1	Setting	
	Aware of prev therapist	1	Aware of prev therapist	
	About client participant	1	About client participant	
			Ambiv. About read/not read	1
20-21	Difference from prev therapist	1	Difference from prev therapist	
			Therapist expectation beginning	2
24-25	Asks client about prev therapist	1*		
	Supervision	1	Supervision	
	Handling beginning	1	Handling beginning	
			Client experience of ending	3
26-27	Supervision	1	Supervision	
32-33	Aware of previous therapist	1	Aware of previous therapist	
	About client participant	1	About client participant	
34-35	Difference from prev therapist	1	Difference from prev therapist	
	Experienced client	1	Experienced client	
			About client participant	4
			Client expectations	4
			Discrepancies in client agenda	4
			Client experience	4
36-39	About client participant	1	About client participant	
	Client sets agenda	1	Client sets agenda	
	Difference from prev therapist			
	Experience of beginning			
	Metaphor/analogy			
	Researcher directs			
	Uses same word/phrase as client			
	Client remembers pre therapist	1	Client remembers pre therapist	
			Client alcohol use	5
			Aware previous therapist	6
			Client use of therapy	7
			Therapist expectations?	8
42-48	About client participant	1	About client participant	
	Client expectations			
	Client remembers prev therapist			
	Experience of beginning	1	Handling beginning	
	Laughs at own 'falling'			
	Metaphor/analogy			
	Therapist feeling re prev therapist	1	Therapist feeling prev therapist	
	Uses same word/phrase as client			
			Therapist own issues?	8
			Aware prev therapist	6
	About client participant	1	About client participant	
49-51	Client experience of ending	1	Client experience of ending	
	Therapist resp to client ending			
	Client experience	1	Client experience	
	Therapist view of work	1	Therapist view of work	
			Expectation to meet client needs?	8
52-54	About client participant			
	Client alcohol use	1*		
	Client sets agenda			
	Discrepancies in client agenda			
	Experience of client			
	Therapist feeling prev therapist			
	Therapist view of work	1*	Client use of therapy	
	Aware of prev therapist	1	Aware of previous therapist	
	Client expectations	1	Client expectations	
	Client remembers prev therapist	1	Client remembers prev therapist	
			Therapist meeting client needs?	8
		30/46		

Notes Extract 4 Therapist T2-Kezia

1. The coder questions the ambivalence of the therapist around reading/not reading client notes and this is reported in the findings section.
2. This also relates to the reading of client notes as 1.
3. The 'Client experience of ending' code relates to what the therapist has heard or thinks about the client ending with T1. Here the therapist is talking about asking or not asking the client about the ending and that fitted into my code of 'handling the beginning'.
4. Here the therapist is talking generally about clients who have had another therapist not specifically about this imposed change client.
5. The code 'Client alcohol use' was to capture use of alcohol rather than therapeutic interventions.
6. 'Aware previous therapist' is the therapist's own awareness rather than that reported by the client.
7. Here the External Coder codes the therapist report of how the client describes work with the previous therapist. While this code was not used this is picked up in the write up.
8. The coder notes that she is curious about the therapist expectations next to the extract where the therapist tells how the client has told her that her the previous therapist was the best she had worked with and makes two further comments on this and meeting client needs. This is picked up in 'Client expectations' and addressed in the write up. 'Therapist expectations' was not a code but could have been. Therapist expectations are picked up across the cases in the write up via other codes.

Table of Researcher/ External Coder Results

	Extract 1	Extract 2	Extract 3	Extract 4
No. Researcher codes	33	40	22	46
No. External coder agreed codes	30	28	20	30
% Agreed codes	90	70	90	65
No. of notes	11	9	5	8

From the external coding exercise I learnt a lot about my coding and my implicit understanding of the codes based on having allocated them and having all the data from all cases available. I feel that in future I would aim for greater clarity in the code descriptions and their use. I am satisfied that although the overall agreement on coding averaged out at 79% and the difference across extracts was in some cases wide I had picked up all the External Coder comments and suggestions in writing up the Findings across the cases. While the intimacy of being a lone researcher with a small number of participants allows in-depth knowledge of each case the views and coding of the External Coder was invaluable in giving a different perspective that made me consider both my coding and immersion in the transcripts. The External Coder often picked up individual participant items that I gathered together in the process of moving between phenomenon codes and the individual narrative format of the findings and then back again to the phenomenon in the discussion. I felt I had chosen a robust External Coder who freely added comments and codes.

Appendix 9 – Atlas Code Families

Code Families

HU: Client Interviews
File: [C:\Documents and Settings\Frances B\My Documents\Scientific Software\ATLAS\Te...\Client Interviews.hpr5]
Edited by: Super
Date/Time: 29/12/11 19:25:34

Code Family: Client 'frame of mind'
Created: 30/08/09 11:36:13 (Super)
Codes (4): [Depression] [Head is chaos] [lost in junk/mass] [Mind racing]
Quotation(s): 15

Code Family: Client communication
Created: 30/08/09 10:48:58 (Super)
Codes (3): [Dreams] [Metaphor, analogy] [Negative phrasing]
Quotation(s): 62

Code Family: Client compares therapists
Created: 30/08/09 10:40:25 (Super)
Codes (1): [Therapist comparison]
Quotation(s): 16

Code Family: Client describes TB, beginning therapist
Created: 30/08/09 10:38:56 (Super)
Codes (4): [Assumptions about therapist] [Beginning therapist] [Therapist training/experience] [up to speed]
Quotation(s): 63

Code Family: Client describes TE, ending therapist
Created: 30/08/09 10:36:22 (Super)
Codes (6): [Assumptions about therapist] [Ending therapist] [reliance] [Therapist self-disclosure] [Therapist training/experience] [Unusual experience]
Quotation(s): 55

Code Family: Client discourse
Created: 30/08/09 10:51:11 (Super)
Codes (3): [AA] [Age] [illness]
Quotation(s): 39

Code Family: Client experience of beginning
Created: 09/09/08 15:29:47 (Super)
Codes (47): [Beginning therapist] [Building] [client DNA/ no ending] [defends therapist] [dependent on therapist] [depersonalised therapist] [draining] [end product] [Experience of beginning with therapist] [feedback] [gender of therapist] [helpful/unhelpful] [locked in] [looks to others] [Lot going on] [Magic wand] [Missed sessions] [moved on] [new is scary] [New issues] [old wounds] [ongoing] [Open up] [Own terms] [Practical matters] [pressing you] [Private] [Regulation] [reliance] [repetition] [Role of therapist not person] [Runner] [Seeking] [Self blame] [Someone to myself] [Start again] [story] [structure] [Stuck] [Suggestions] [Support] [Talk to] [Therapist comparison] [Therapist training/experience] [trust] [uncertainty] [up to speed]
Quotation(s): 185

Code Family: Client experience of ending

Created: 09/09/08 15:01:33 (Super)

Codes (30): [Avoids ending] [Closure] [defends therapist] [delayed reaction] [emotional] [Ending- reason for] [Ending therapist] [Experience of ending with therapist] [Feeling re ending] [get used to somebody] [getting familiar] [getting somewhere in therapy] [Got used to ending with therapists] [helpful/unhelpful] [losing a friend] [Loss] [not remembered] [notice of ending] [painful] [Panic] [passive client] [Physical contact at end] [physical description of end feeling] [Proactive client] [Problem finishing] [Reason for ending] [resentful] [tearful] [Upsetting-ending] [wasting therapists time]

Quotation(s): 103

Code Family: Client experience of other therapists

Created: 30/08/09 10:41:14 (Super)

Codes (4): [Experience of other therapist] [multi-therapist client] [Number of therapists] [other therapeutic relationship]

Quotation(s): 23

Code Family: Client place of alcohol in life

Created: 30/08/09 10:53:05 (Super)

Codes (1): [Alcohol]

Quotation(s): 28

Code Family: Client reference to setting

Created: 30/08/09 10:45:36 (Super)

Codes (3): [Referral] [Setting] [Use setting]

Quotation(s): 19

Code Family: Client suggestions

Created: 30/08/09 10:43:32 (Super)

Codes (2): [helpful/unhelpful] [Suggestions]

Quotation(s): 9

Code Family: Client therapy practical matters

Created: 30/08/09 10:47:33 (Super)

Codes (4): [length of therapy] [notice of ending] [Referral] [Wait for next therapist]

Quotation(s): 19

Code Family: Client view of therapy

Created: 30/08/09 10:32:25 (Super)

Codes (9): [end product] [Magic wand] [ongoing] [remember] [Role of therapist not person] [Someone to myself] [structure] [Talk to] [therapy]

Quotation(s): 67

Code Family: Client, other relationships

Created: 30/08/09 10:50:13 (Super)

Codes (3): [family/network] [ORW (outreach worker)] [Other relationships]

Quotation(s): 26

Code Family: James, individual codes

Created: 30/08/09 11:02:49 (Super)

Codes (26): [Alone] [basic] [can't get hold of] [Confusing] [Depression] [end product] [feel silly] [Home] [Magic wand] [Medication] [Missed sessions] [moved on] [Moving] [Negative phrasing] [old wounds] [Own terms] [Physical contact at end] [Physician heal thyself] [pressing you] [Private] [reliance] [repetition] [resentful] [Routine] [Start again] [story]

Quotation(s): 95

Code Family: Kezia, individual codes

Created: 30/08/09 11:17:55 (Super)

Codes (25): [ambivalence] [automatic] [contradiction] [delayed reaction] [dependent on therapist] [depersonalised therapist] [Dismisses self] [feel incapable] [getting somewhere in therapy] [Got used to ending with therapists] [hopeless] [illness] [jeopardise things] [looks to others] [lost in junk/mess] [multi-therapist client] [New issues] [no good] [Number of therapists] [other therapeutic relationship] [Someone to myself] [Sounding board] [structure] [unable to turn things round] [wasting therapists time]

Quotation(s): 46

Code Family: Megan, individual codes

Created: 30/08/09 11:13:52 (Super)

Codes (24): [Anxious] [Attachment] [change] [Closure] [Confidentiality] [consistency] [defends therapist] [Dragging it up again] [draining] [emotional] [feel silly] [get used to somebody] [getting familiar] [getting somewhere in therapy] [Head is chaos] [losing a friend] [Loss - other] [Lot going on] [new is scary] [passive client] [physical description of end feeling] [Practical matters] [tearful] [Upsetting-ending]

Quotation(s): 67

Code Family: Researcher checks

Created: 30/08/09 11:00:09 (Super)

Codes (4): [researcher- change direction] [Researcher- participant links back to miss] [researcher lets escape/avoids] [X TB researcher directs to client participant]

Quotation(s): 35

Code Family: Researcher codes

Created: 30/08/09 10:54:17 (Super)

Codes (21): [ambivalence] [angry] [Attitude/belief] [Attunement] [Avoids emotion] [Avoids ending] [contradiction] [depersonalised therapist] [Dismisses self] [empathy] [Loss] [Loss - other] [Metaphor, analogy] [Negative phrasing] [passive client] [Past experi evoked] [Proactive client] [Regulation] [Status] [Stuck] [Therapist active]

Quotation(s): 155

Code Family: Sidney, individual codes

Created: 30/08/09 11:09:00 (Super)

Codes (23): [AA] [Assumptions about therapist] [Attunement] [client DNA/ no ending] [Coping] [Disability] [empathy] [gender of therapist] [losing a friend] [Loss - other] [Lot going on] [medication withdrawal] [Mind racing] [Panic] [Proactive client] [Regulation] [Relapse] [remember] [Robbed] [Runner] [Talk to] [Use setting] [Wait for next therapist]

Quotation(s): 125

Code Family: Therapist & discourse

Created: 30/08/09 12:21:12 (Super)

Codes (2): [X TB disability discourse] [X TB Substance misuse discourse]

Quotation(s): 6

Code Family: Therapist about client James

Created: 30/08/09 12:00:47 (Super)

Codes (16): [X TB about client participant] [X TB work slowly] [X TB Abandonment] [X TB age/male discourse] [X TB client alcohol use] [X TB Client experience] [X TB client loss] [X TB client pain] [X TB client plastic cover] [X TB client ready to make new start] [X TB client reliant] [X TB client stuck] [X TB Client switches off] [X TB client trust] [X TB experience of client] [X TB long time to engage]

Quotation(s): 69

Code Family: Therapist and client's previous ending

Created: 30/08/09 11:55:50 (Super)

Codes (13): [X TB asks client about prev therapist] [X TB bad therapist] [X TB client does not talk prev therapist] [X TB client experience of ending] [X TB client remembers prev therapist] [X TB difference from previous therapist] [X TB making ending relevant] [X TB previous therapist/therapy not relevant] [X TB therapist curious about prev therapist] [X TB therapist dismisses curiosity] [X TB therapist feeling re previous therapist] [X TB therapist not aware prev ending] [X TB therapist not introduce ending]

Quotation(s): 38

Code Family: Therapist and client Kezia

Created: 30/08/09 12:11:51 (Super)

Codes (23): [X TB about client participant] [X TB Abandonment] [X TB asks client about prev therapist] [X TB bad therapist] [X TB breaks] [X TB client alcohol use] [X TB client continuing need] [X TB client expectations] [X TB client experience of ending] [X TB client fears ending] [X TB client remembers prev therapist] [X TB client sets agenda] [X TB client use of therapy] [X TB difficult to tackle this ending] [X TB discrepancy in client agenda &] [X TB experience of client] [X TB still at the beginning] [X TB Supervision] [X TB therapist feeling re previous therapist] [X TB therapist view of the work] [X TB uses same word/phrase as client] [X TB what client chose contradiction] [X TB what therapist offers]

Quotation(s): 83

Code Family: Therapist and client Megan

Created: 30/08/09 12:08:24 (Super)

Codes (9): [X TB about client participant] [X TB aware of prev therapist] [X TB client's lack of prev progress] [X TB client alcohol use] [X TB client lot of stress/issues] [X TB difference from previous therapist] [X TB therapist curious about prev therapist] [X TB therapist dismisses curiosity] [X TB therapist feeling re previous therapist]

Quotation(s): 77

Code Family: Therapist and client Sidney

Created: 30/08/09 12:04:22 (Super)

Codes (7): [X TB about client participant] [X TB client background] [X TB client disability] [X TB client use of therapy] [X TB disability discourse] [X TB not hearing client] [X TB self-disclosure]

Quotation(s): 68

Code Family: Therapist and setting

Created: 30/08/09 12:19:22 (Super)

Codes (2): [X TB key worker] [X TB setting]

Quotation(s): 14

Code Family: Therapist experience of beginning

Created: 30/08/09 11:43:36 (Super)

Codes (10): [X TB asks client about prev therapist] [X TB Client experience] [X TB experience of beginning] [X TB fresh start] [X TB gap between therapists] [X TB handling beginning] [X TB long time to engage] [X TB not read notes] [X TB other beginning clients] [X TB person centred approach]

Quotation(s): 39

Code Family: Therapists on endings

Created: 30/08/09 12:27:56 (Super)

Codes (9): [X TB difficult to tackle this ending] [X TB ending after LT therapy] [X TB endings important to therapists] [X TB endings unimportant to client] [X TB making ending relevant] [X TB on endings] [X TB therapist not aware prev ending] [X TB therapist response to client ending] [X TB therapists not bad at endings]

Quotation(s): 23

Code Family: Therapists on therapy

Created: 30/08/09 12:16:08 (Super)

Codes (16): [X length of therapy] [X TB client expectations] [X TB client use of therapy] [X TB clients dropping out] [X TB ending after LT therapy] [X TB endings important to therapists] [X TB endings unimportant to client] [X TB lack of goal] [X TB lack of outcome] [X TB on endings] [X TB Supervision] [X TB therapist own issues] [X TB therapist view of the work] [X TB time] [X TB what therapist offers] [X therapist training/experience]

Quotation(s): 68

Appendix 10 – Codes to diagram themes

Codes	Code Families	Diagram Themes
Total 247	Total 31	Total 11
30 codes	Client experience of ending	Experience of end
30 codes 47 codes 16 codes	Client experience of ending Client experience of beginning Client other relationships	Attachment activation
30 codes 47 codes 1 code 6 codes 4 codes	Client experience of ending Client experience of beginning Client compares therapists Client describes T1 Client describes T2	Losses <ul style="list-style-type: none"> ○ Relationship ○ Person ○ Work done ○ Hope
1 code 6 codes 4 codes	Client compares therapists Client describes T1 Client describes T2	Comparisons
47 codes	Client experience of beginning	Repetition
13 codes	Therapist and client's previous ending	Working with ending
10 codes 16 codes	Therapist experience of beginning Therapists on therapy	Therapeutic approach
13 codes	Therapist and client's previous ending	Shadow of T1

Appendix 11 – Participant check notes

These notes were taken using a fuller version of the findings write up and so may comment on parts not included in the final shorter piece. I have included all the comments as I feel it adds to the 'thick description' of participants as required for evaluation of the research see Table 2 in the Methodology section.

1. Participant second interview preparation.

I talked about consent and withdrawal and then described how I had written up the findings (the individual narrative format) and what I expected to get out of the combination of all the participant experiences. I explained that their words from the taped interview were in a different font, that I was R and who T1 and T2 were.

I had two copies of their section of the draft findings and I asked the participants how they would like to go through their piece, to read it to themselves or for me to read it aloud. I invited them to comment as they, or we, went through it and explained that I would make notes of their comments on my copy. I noted noises, smiles etc inviting them to talk about the part they were reading at that time. I also asked them to check that nothing I had written would identify them to a reader. For all participants I read my notes back to them at the end letting them know that these would be added to the text.

For clients I took a new consent form and information sheet as I had changed the title since they signed the original one. Knowing that these clients no longer had therapy available at the Agency I was monitoring the effect on them of the material I presented to them and checked that they still had an information sheet with the contact numbers on. I let them know that some of their quotes would be seen by the therapists but was checking their part first. I suggested that at a second meeting once the therapists had checked their contributions then the clients could read their contributions alongside those of the therapists. None of them wanted to do this. As therapists were offered both their individual and dyad piece to read I added an explanation of the structure of the dyad and individual pieces, that contained their words and the some of the client words.

2. Participant Check notes

Below are the notes made at the participant check interviews that ranged in time from nine months to one year after the initial interview. Participant comments were added to the end of their piece in the findings.

2.1 Interview notes for James

James chose to read the section himself, mostly in silence and then said he was content that I had *'got it right'*.

- He commented with a smile *'I sound quite complex don't I?'*
- When he finished reading he reflected on what was happening for him now (ten months after the first interview) and what was written up from our original interview. He seemed surprised to find himself in much the same place, *'reticent to go forward'* with reference to a planned trip, commenting that in going he would feel *'exposed'* again an echo he heard in my writing. He was keen for what I had done to reach a wider audience and said he was pleased to have taken part.

- James was no longer having therapy, he explained that T2 had given him notice of their ending date during a session and he had called her the following week to say that he would not be attending anymore sessions. Smiling he used his quote from my writing about the boat sailing.

2.2 Interview notes for T2-James

From the outset T2 wanted to talk about the changes and ending brought about by the Agency. T2 talked with great feeling about the loss of the service, the whole service of individual, group work and drop-in for the client group and the unprofessional way it had been handled. T2 said they still felt angry 9 months after the event. While the Agency had over a period of time been changing the service provision at the site, for example with no more long term contracts, the actual end of working at that site was relatively sudden leaving therapists only a few weeks to tell their clients that they had to end. T2 felt forced to break the contract with James having offered him the opportunity to do long term work.

- On reading the dyad section of the findings T2 said she could not remember exactly what she had meant by *'breaking away'* but recalled the work she did with James around other endings in his life and felt it related to how the therapy ending felt for him.
- T2 felt that the *'perspex'* of *'plastic'* was about control, James wanting to control their sessions.
- T2 felt my suggestion of his anger was correct.
- T2 added to the extract on James leaving sessions early. This was discussed in supervision where there had been a disagreement on the course of action. It was T2's decision to *'let it happen'*. T2 described the stance with James as one of being very careful, slow and tentative with challenges.
- For the individual piece T2 asked for clarification on the *'boat sails'* reference and I explained the metaphor for James' behaviour at endings. T2 talked of disappointment that James had called before their last session to cancel. T2 went on to talk about being angry not just disappointed, initially thinking it had only been anger with the Agency but felt that it was also anger with him. T2 thought the *'boat sails'* captured her sense of his not wanting the ending session, avoiding it.
- *'reconfirm the past'* related to awareness of his history, of previous endings and not wanting to repeat his experience. T2 felt that this did happen as the Agency closed the service. In my writing I had originally linked *'reconfirm the past'* to their therapy, to her seeing each client as new and not asking about the previous ending. As my interpretation was incorrect I removed it.
- T2's own metaphor of *'somebody else's shoes'* produced a change of energy in responding to the extract and a need to add that it was not just about *'not trying to step into'* those shoes, there was *'no desire to step into the shoes'*. T2 said just as each client is unique so is each therapist. Initially I was ready to delete my interpretation but T2 went on to say they were happy with the rest of the piece and how I had developed this theme and so it was left intact.

2.3 Interview notes for Sidney

Sidney chose for me to read his findings section. As we went through I paused after each of my summary points and checked that I had correctly represented his experience. He agreed that I had.

- For the paragraphs that covered his personal history, for example where I had included his school experiences with reference to his *'typical'* men he provided me with extra detail about his family life that added weight to the argument I had presented. I have not added this detail to the findings.
- I checked out *'robbed'* and Sidney confirmed that what he had taken away from him was a warm relationship replaced by a cold one that lacked the ideas and practical suggestions he was used to.
- I also checked out *'raking up memories'* and he confirmed that it was about going back over things again.
- At the end he reiterated that his requirement for a counsellor is that, they listen, they are a strong person, are down to earth and honest with him.

Sidney was happy that his anonymity was maintained in the writing.

The Agency service had ended between the first interview and the participant check. Sidney was no longer having therapy but he felt well prepared by his final counsellor (the one after T2) for their ending and *'going it alone'*.

2.4 Interview notes for T2-Sidney

- T2 expressed surprise when he read that Sidney's experience was that he, T2 *'never listened properly'* even though he had read the earlier paragraph stating that he thought he had *'missed'* bits.
- He read out my comment that I had struggled to hear both of them and commented that he also had difficulty hearing his words in a recording of his voice.

I felt uncomfortable knowing T2 was reading my words containing Sidney's quote that T2 is a *'typical man'* but T2 made no direct comment.

- T2 commented on still finding contacting clients who don't turn up a difficult issue. He suggested that he had to judge when it was appropriate and that did not mean that he did not care. He does not believe he should in any way force people to attend and unless he was to ask clients he would not know what his calling or not calling meant to them but he considered asking them as not Person Centred.
- The extract relating to the client group and individuals wanting or not wanting to be *'free of their addiction'* prompted him to clarify that he did not understand Sidney as addicted to anything, he did not see their work as about addiction but about Sidney being a lonely person. Sidney's AA membership he saw as Sidney finding a place to fit in rather than being about an addiction.

T2 also commented here about the change at the Agency from a focus on people to being only about addiction, a change he did not like.

- I asked T2 about his audible sigh. It was about *'not fathoming out what Sidney had wanted'* and he listed the things happening in Sidney's life at the time he saw him. He also wondered aloud *'what was he running away from?'*
- While he still held to the *'starting from scratch'* Person Centred approach he suggested that he had changed in other ways since the interview, in that he found himself being more directive (that at times felt *'mean'*) and behaving more intuitively with clients, that he saw as his *'growing up'* as a therapist. He views this as retaining his Person Centred concepts but being more challenging. He still sees no need to introduce the subject of a previous ending unless he has a sense that it needs to be talked about.
- He clarified that *'isn't as important as we think'* as a less *'definitive statement'* and being about him having more investment in the relationship than the client.

- He did not agree with my assumption about him equating clients leaving therapy with the importance or not of an ending or them not wanting an ending. He said he was often surprised when clients left and he has to adjust his thinking about that client and the work.

He thought that he could see how it would be for a client if the reverse happened and they were told it was the last session *'out of the blue'*, like my imposed ending participants. Not knowing what happened to clients when they did just stop coming was also an issue for him.

- He smiled at my suggesting of a mocking tone and he said it was *'tongue in cheek'*.
- When I reintroduce the idea of a lack of importance about endings T2 was uncertain how it sounded. While he felt there needs to be some sort of ending it does not have to be a full session, he said he feels the need for intuition and *'letting go of dogma'*.
- To the extract where he suggests clients *'have a lot of power'* he added that they are not aware of this and that he feels sometimes that they are not even aware of you as a human being.

2.5 Interview notes for Megan

I was shocked by the change in Megan realising that I had not seen her face properly at our first meeting due to her cap being pulled down. She was bright, talkative and very thin, letting me know straight away that she was 10 months without a drink. She went through a one month detox while seeing T2 and that when she came out had not gone back. Currently she has a support worker to help with practical matters. She told me of more endings and upsets with changes of CDAT worker and her floating support worker.

- On reading the first extract she explained that she was emotional because of letting go, the final closure, because a relationship was ending. That the therapist had been *'part of your life'* and they *'knew so much about you'*.
- She commented on her use of the term *'depression'* as she had recently seen a doctor who had questioned her long term use of antidepressants and suggested that it was anxiety that she experienced. She felt this fitted better with her feelings and her OCD.
- My question as to what *'that'* might be about was a puzzle for her too as she could not remember what she had originally meant but felt my explanation made sense.
- When she read what she had said about what she might be looking for in therapy she reflected on whether alcohol or her own nature made her the way she is.
- In several places she introduced issues that I covered later on in her account that felt confirming for me in that I had picked out her important themes and for her she saw it as a sign of her own *'thinking ability'*. For example she mentioned building trust 15 lines before I introduced it in my writing.
- Reading of my suggestion of her apprehension about starting with T2 elicited agreement and she commented on, the unknown, not knowing what to expect and fearing the worst all the time.
- Throughout her reading she criticised the yeahs, ums and ers that she saw as a symptom of her lack of intelligence and ability to express herself.
- The nature of the work with T2 prompted her to reflect on her thinking of therapy as an interview where you have to be your best, when really you do not need to do that in therapy. She also commented that with some therapists she did not feel judged and so was more comfortable.
- She nodded and said that gender was not an issue.
- In the time that has elapsed since she had therapy with T1 she has wondered if childhood issues are at the root of her problems as other children had the same experiences as her but did not end up drinking. She now favours the idea that being hard on herself has contributed to how she is.

- She agreed that she and T2 had dealt with practical matters rather than emotional.
- On the lack of *'talk back'* she experienced with T2 she now wonders if it was the wrong sort of help for her. She had to speak first and that for her is difficult as she needs someone else to start things off. Also once started she can go off at tangents and maybe that is boring for people. She thinks now that she would benefit from life skills work rather than counselling. Decision making is still a big problem for her and takes a lot of time and energy along with the demands she places on herself related to her OCD.
- Going with the flow struck a chord with her and she reframed it as her being easily led. She is aware she does not challenge, does not have opinions and if she does, does not voice them. She fears people would not understand what she was trying to say, or think she was wrong. She related this to her therapy with T2 and what she might have wanted from working with him if she had been able to say.
- In the final part of the piece I suggest that Megan retelling her story is a response to her assumption that that is what the therapist wants to hear and she commented *'That's me, I tell people what I think they want to hear'*. That made me think as I sat there with her!
- Overall she was surprised how much had come out of the initial interview with me as she thought she had said nothing worthwhile and I reminded her that she had during that interview been concerned that she had nothing to say.

2.6 Interview notes for T2-Megan

- Knowing what happened would colour T2's view, would be non Person Centred. Also working at the Agency you would often hear about clients and other therapist's work.
- Having read *'sees me as being okay'* and my suggestion that there was a hint of T2 *'wondering about his own acceptability'* he clarified that this was about himself and not in relation to any previous therapists a client may have had. He went on to say that in the end Megan stopped coming and so being able to *'get somewhere'* did not happen with him.
- The *'emotional content'* that I suggested had not come into their work he felt was a fair observation and reflecting said he was not sure there was any significant emotional content in what they did.
- T2 said he did not dismiss his concerns with T1 as irrelevant but put his curiosity to one side.
- He asked me to remove a line that suggested that he dismissed his curiosity as of no relevance to his work with Megan.
- T2 added that as well as the possibility of work with a new therapist being *'worse'* than it was before it could also be better in some cases.
- T2 nodded when reading the final extract saying that it is true, he does hate all endings.

2.7 Interview notes for Kezia

Kezia gave me an update on what had happened since our initial interview. She had completed a hospital based detox 5 months ago and up until recently had been *'dry'* relapsing briefly but had then managed to resume an alcohol free life. Her partner had died 3 months ago. She has had no contact with the Agency since finishing her sessions with T2 (10 months ago) as they no longer had provision for *'alcohol clients'*. Her detox was arranged through another organisation. She had not had therapy but was waiting to hear from another agency about starting counselling. Following the death of her partner she had contacted a bereavement support organisation but they felt their service was not suitable for her due to her history of problematic alcohol use and depression.

Kezia seemed stronger and more articulate than at our first meeting but before reading the section commented that she was interested to see if anything had changed for her since our first interview as she now felt she knew what she needed help with, that being her very low self esteem that *'held her back'*.

- She queried my interpretation that it was being without a counsellor rather than being without T1, but decided on balance it did represent that period even though she had found T1 very good.
- Kezia tutting commented on the *'ums'* and *'you knows'* in her quotes.
- Kezia thought the quotes about her drinking were appropriate and said the unbidden thoughts came regularly but were mostly about her partner and his death.
- She was unsure of the meaning of 'diagnosis payload' but once I had explained she felt it was a good description.
- The quote *'a bit of a failed perfectionist'* made her laugh commenting that she still feels that if she got on and got things done then *'what would I do?'* and that *'I don't know where to start let alone finish'* that tied in with my later interpretations.
- The next discussion point was her quote *'sounding board'* my suggestion of inert does not fit her use of the term. She sees a sounding board as something that you get a response from and she went on to add that where I write that this can be 'any counsellor' is not how she feels. She explained that she has had to *'make the best of whoever she gets'* and has often been *'left wondering if there is any help for me?'* She started talking about a GP who had had a significant effect on her progress and well being (*'she was magic'*) and I recognised this person from our first interview. I explained that I remembered her telling me about this person but had not selected that part of the interview. I asked her to say what it was about this doctor that made a difference. She was unsure as she only saw her once a month but suggested it was about this person sharing and being interested in her, meaning she did not just feel like a subject (I found this an interesting comment from a research participant). She also said that she had originally *'not been impressed by the doctor'* and wondered if her lack of expectations made a difference, suggesting that *'expectations'* were very much a part of her upbringing alongside being *'let down'*. I offered to put the doctor back into her section in recognition of her importance to both Kezia and my understanding of the many helping relationships she has experienced.
- She read to the end and said *'yes, I like structure, I loved learning foreign languages, learning how new languages worked rather the conversation side....maybe I need more compartmentalisation in my life.'*

The last words I wrote were of her saying *'this low self esteem renders me useless, I feel useless'* and yet I experienced her in this second interview as active as interested in what she read, at one point correcting a spelling mistake I had not noticed!

2.8 Interview notes for T2-Kezia

This check was done by email with T2 annotating the findings sections with her comments.

- Where I suggest hearing a note of resignation or maybe despondency. T2 writes *There is probably an element of me finding it difficult to believe that I am good enough as a counsellor working with Kezia and my lack of knowing whether Kezia finds this helpful in progressing in her life. The fact that she comes back suggests to me that there is something about therapy with me that does bring her to come back.*
- While she decides not to have the *'unspoken'* T2 comments *I wasn't quite sure what you meant by this? Was it that I didn't talk to Kezia further about my concerns about being good enough compared to T1? I*

suppose what I meant was that I didn't leave it unspoken by asking Kezia about her previous counselling experience.

While this was my meaning I obviously had not made it clear.

- T2 comments where I pick up her laugh at this point in the transcript.
Yes, I think this is accurate, I think an issue for me is being good enough and providing the client with what they need. The comparison appears to be about me needing to live up to what the Kezia wants and be a good counsellor as opposed to Kezia making this comparison. I tend to laugh and overemphasise things in order to cover up worry or discomfort with something.
- About the discomfort that can come with client expectations and a colleague's apparent success.
I think this makes a lot of sense, it seems as though I'm really the one setting up the comparison really and subsequently this causes me discomfort.
- You raise an interesting point about abandonment, that it is more my worry that I will abandon Kezia, than it is the way she would have experienced it. In the end she did attend our last session together, however in many ways I didn't feel we had moved on from the beginning.

REFERENCES

Ackerman, S. J., & Hilsenroth, M. J., 2003. A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, 23, pp.1-33.

Allamani, A., 2008. Views and models about addiction: Differences between treatments for alcohol-dependent people and for illicit drug consumers in Italy. *Sunstance Use and Misuse*, 43 (12 & 13), pp. 1704-1728.

American Psychiatric Association, 2000. *Diagnostic and statistical manual of mental disorders (4th ed. Text Revision)*. Washington: American Psychiatric Association.

Aron, L., 2006. Impasse and the third: Clinical implications of intersubjectivity theory. *The International Journal of Psychoanalysis* 87 (2), pp. 349-368.

BACP, 2004. *Ethical Guidelines for researching counselling and psychotherapy*. Rugby: British Association for Counselling and Psychotherapy, http://www.bacp.co.uk/admin/structure/files/pdf/e_g.pdf
[Accessed 13 September 2006]

BPS, 2011. *Code of Human Research Ethics*. Leicester: British Psychological Society.
http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics
[Accessed 15 November 2011]

Balint, M., 1968. *The Basic Fault: Therapeutic Aspects of Regression*. Illinois: Northwestern University Press.

Batholomew, K., & Horowitz, L. M., 1991. Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61, pp. 226-244.

Beebe, B., and Lachmann, F. M., 1998. Co-Constructing Inner and Relational Processes: Self and Mutual Regulation in Infant Research and Adult Treatment. *Psychoanalytic Psychology*, 11, pp. 480-516.

Benjamin, J., 1990. Recognition and Destruction: An Outline of Intersubjectivity, in S.A. Mitchell and L. Aron, (eds.), 1999. *Relational Psychoanalysis: the emergence of a Tradition*. New Jersey: The Analytic Press, pp.181-210.

Berg, D. N., & Smith, K. K., 1988. *The Self in Social Enquiry: Researching Methods*. Newbury Park, CA, Sage.

Best, D., Day, E., & Morgan, B., 2006. *Addiction careers and the natural history of change*. London: National Treatment Agency for Substance Misuse.
Available at: http://nta.nhs.uk/uploads/nta_addiction_careers_2006_pdf
[Accessed 12 September 2007]

Beutler, L. E., Forrester, B., Gallagher-Thompson, D., Thompson, L., & Joseph, B., 2012. Common, specific and treatment fit variables in psychotherapy outcome. *Journal of Psychotherapy Integration* 22 (3), pp. 255-281.

Bhaskar, R., 1978. *A Realist Theory of Science*. West Sussex: Harvester Press.

Bion, H., 1967. *Second Thoughts. Select Papers on Psychoanalysis*. London: Heinemann.

Bostic, J. Q., Shadid, L. G., & Blotcky, M. J., 1996. Our time is up: Forced terminations during psychotherapy training. *American Journal of Psychotherapy*, 50 (3), pp. 347-359.

Bowen, M. V., 1996. The Myth of Nondirectiveness: The Case of Jill. In B. A. Farber, D. D. Brink and P. M. Raskin (eds), *The Psychotherapy of Carl Rogers: Cases and Commentary*. New York: Guildford Press, pp.74-94.

Bowlby, J., 1979. *The making and breaking of affectional bonds*. London: Tavistock Publications Ltd.

Boyer, S. P. & Hoffman, M. A., 1993. Counselor affective reactions to termination: Impact of counsellor loss history and perceived client sensitivity to loss. *Journal of Counseling Psychology*, 40 (3), pp. 271-277.

Braun, V., & Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, pp 77-101.

Brocki, J. M., & Wearden, A. J., 2006. A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, 21 (1), pp. 87-108

Brown, L. J., & Miller, M., 2002. The Triadic Intersubjective Matrix in Supervision: The Use of Disclosure to Work Through Painful Affects. *International Journal of Psychoanalysis* 83, pp. 811-823.

Buckland, P.R., 2008. Will we ever find the genes for addiction? *Addiction* 103 (11), pp. 1768-1776.

Caspers, K. M., Yucuis, R., Troutman, B., & Spinks, R., 2006. Attachment as an organizer of behaviour: implications for substance abuse problems and willingness to seek treatment. *Substance Abuse Treatment Prevention and Policy* 1(32).

Available at <http://www.sunstanceabusepolicy.com/content/1/1/32>

[Accessed 20 May 2007]

Chang, A. F., (1977). The handling of therapists' premature termination in Psychotherapy. *Psychology* 14, pp.18-23.

Chelton, G.L., & Bonney, W.C., 1987. Addiction, Affects and Selfobject Theory. *Psychotherapy* 24 (1), pp. 40-46.

Clarkson, P., 1995. *The Therapeutic Relationship*. London: Whurr Publishers Ltd.

Copello, A., Orford, J., Hodgson, R., Tober, G., & Barrett, C., 2002. Social Behaviour and network therapy: Basic principles and early experiences. *Addictive Behaviours* 27, pp. 345-366.

Cunningham, J.A., & McCambridge, J., 2012. Is alcohol dependence best viewed as a chronic relapsing disorder? *Addiction* 107 (1), pp. 6-12.

DeWald, P. A. (1965). Reactions to the forced termination of therapy. *Psychiatric Quarterly* 39 (1) pp.102-126.

Diamond, N., & Marrone, M., 2003. *Attachment and Intersubjectivity*. London: Whurr Publishers.

Donovan, J.M., Soldz, S., Kelley, H.F., & Penk, W.E., (1998). Four Addictions: The MMPI and Discriminant Function Analysis. *Journal of Addictive Diseases*, 17 (2), pp. 41-53.

Edwards, G., (2006). On making friends, building alliances and avoiding the boring: An interview with Professor Griffith Edwards. *Scanbites, quarterly newsletter of the Specialist Clinical Addiction Network*. 3 (3) www.scan.uk.net.
[Access date 30 May 2007].

Fiske, S. T., & Taylor, S. E., 1991. *Social Cognition*. 2nd Edition. New York, McGraw-Hill.

Flesch, R., 1947. Treatment Considerations in the Reassignment of Clients. *Family Service Association of America*, New York.
Cited in Scher, 1970.

Flores, P. J., 2003. *Addiction as an attachment disorder*. New Jersey: Jason Aronson.

- Flores, P. J., 2004. Addiction as an attachment disorder: implications for group psychotherapy. In B. Reading & M. Weegman (eds.), *Group Psychotherapy and Addiction*. London: Whurr Publishers Ltd, pp.1-18.
- Fortune, A. E., Pearlingi, B., & Rochelle, C. D., 1992. Reactions to termination of individual treatment. *Social Work* 37, pp.171-178.
- Frank, G., 1999. Termination Revisited. *Psychoanalytic Psychology* 16 (1), pp.119-129.
- Frank, K. A., 1999. *Psychoanalytic Participation: Action, Interaction and Integration*. New Jersey: The Analytic Press.
- Frank, K. A., 2009. Endings With Options. *Psychoanalytic Inquiry*, 29, pp.136-156.
- Freud, S., 1963. Analytic therapy. In J Strachey (ed. & translation), *The standard edition of the complete psychological works of Sigmund Freud* (original work published 1917). London: Hogarth Press, pp. 448-463.
- Gelso, C.J., & Carter, J.A., 1985. The relationship in counselling and psychotherapy: Components, consequences and theoretical antecedents. *The Counselling Psychologist*, 13 (2), pp. 155-253.
- Glaser, B. G., & Strauss A. L., 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago: Aldine Publishing Company.
- Glen, M. L., 1971. Separation anxiety: When the therapist leaves the patient. *American Journal of Psychotherapy* 25, pp. 437-446.
- Golland, J. H., 1997. Not an Endgame: Terminations in Psychoanalysis. *Psychoanalytic Psychology* 14 (2) pp. 259-270.
- Gomez, L., 1997. *An Introduction to Object Relations*. London: Free Association Books.
- Gould, R. P., 1978. Students' experience with the termination phase of individual treatment. *Smith College Studies in Social Work*, 48, pp. 235-269.
- Harris, T., 2004a. Chef or chemist? Practicing psychotherapy within the attachment paradigm. *Attachment & Human Development* 6(2), pp. 191-207.
- Harris, T., 2004b. Implications of Attachment Theory for Working in Psychoanalytic Psychotherapy. *International Forum for Psychoanalysis* 13, pp. 147-156.
- Hart, N., 1999. Research as therapy, therapy as research: Ethical dilemmas in new-paradigm research. *British Journal of Guidance and Counselling*, 27 (2) pp. 205-214.

Heather, N., Raistrick, D., & Godfrey, C., 2006. *A summary of the Review of the Effectiveness of Treatment for Alcohol Problems*. National Treatment Agency
Available at
http://www.nta.nhs.uk/uploads/nta_review_of_the_effectiveness_of_treatment_for_alcohol_problems_summary_2006_alcohol3.pdf
[Accessed 12 September 2007]

Hemsley, C., 2013. A thematic analytic exploration of how counselling psychologists in the UK experience and position themselves in relation to the NICE guidelines. *Counselling Psychology Review*, 28 (2), pp. 91-105.

Hinshelwood, R. D., 1994. The relevance of psychotherapy. *Psychoanalytic Psychotherapy* 8, pp. 283-294
Available at
<http://www.essex.ac.uk/centres/psycho/hinshpub/relevance.htm>
[Accessed 7 September 2007]

Hollway, W., & Jefferson T., 2000. *Doing qualitative research differently: free association, narrative and the interview method*. London: Sage Publications.

Holmes, J., 2001. *The search for a secure base: attachment theory and psychotherapy*. Hove: Brunner-Routledge.

Horvath, A.O., Del Re, AC., Fluckiger, C., & Symonds, D., 2011. Alliance in individual psychotherapy. In J. C. Norcross (ed.), 2011. *Psychotherapy relationships that work: Evidence-based responsiveness 2nd edition*. New York: Oxford University Press, pp. 25-69.

Hyatt Williams, A., 2002. The application of Bowlby's attachment theory to the psychotherapy of the addictions. In M. Weegmann & R. Cohen (eds.). *The Psychodynamics of Addiction*. London:Whurr Publishers, pp. 3-12.

Hycner, R., 1993. *Between person and person: Toward a dialogical psychotherapy*. New York: The Gestalt Journal Press.

Imel, Z. E., Wampold, B. L., & Miller, S. D., 2008. Distinctions without a difference: Direct comparisons of psychotherapies for alcohol use disorders. *Psychology of Addictive Behaviours*, 22, pp. 533-543.

Kahn, A. M., 1995. Therapist-initiated terminations of psychotherapy: The impact on clients. *Dissertation Abstracts International: Section B: The Sciences and Engineering* 55 (8-B), p. 3591. Abstract only.

Keith, C., 1996. Multiple Transfers of Psychotherapy Patients. *Archives of General Psychiatry* 14 (2), pp.185-189.

Khantzian, E. J., 2003. Understanding addictive vulnerability: An evolving psychodynamic perspective. *Neuro-Psychoanalysis*, 5 (1), pp. 5-21.

Khantzian, E. J., & Albanese, M. J., 2008. *Addiction as self-medication: Finding hope behind the pain*. Maryland: Rowman & Littlefield Publishing Inc.

Klein, M., 1946. *Envy and Gratitude and Other Works 1946-1963*. London: Vintage (1997).

Kohut, H., 1977. *The Restoration of the Self*. New York: International Universities Press.

Krystal, H., 1997. Self-representation and the capacity for self-care. In D.L. Yalisove (ed). *Essential papers on addiction*. New York: New York University Press, pp.109-146.

Lambert, M.,(1992). Implications of outcome research for psychotherapy integration. In J. Norcross & J. Goldstein (eds.), *Handbook of psychotherapy integration*. New York: Basic Books, pp. 94-129

Lende, D. H., & Smith, E. O., 2002. Evolution meets biopsychosociality: an analysis of addictive behaviour. *Addiction* 97, pp. 447-458.

Leighton, T., 2004. Interpersonal group therapy in intensive treatment. In M. Weegman & B. Reading (eds). *Group Psychotherapy and Addiction*. London: Whurr Publishers, pp. 81-98

Lincoln, Y. S., & Guba, E. G.,1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lister, M. ,& Gardner, D., 2006. Engaging hard to engage clients: A Q methodological study involving clinical psychologists. *Psychology and Psychotherapy: Theory, Research and Practice*, 79 (3), pp. 419-443.

Luborsky, L., Crits-Christoph, P., Alexander, L., Margolis, M., & Cohen, M., 1983. Two helping alliance methods of predicting outcomes of psychotherapy. *Journal of Nervous and mental Disease*, 171, pp. 480-491.

Luborsky, L., McLellan, A.T., Woody, G., O'Brien, C., & Auerbach, A., 1985. Therapist success and its determinants. *Archives of General Psychiatry*, 42, pp. 602-611.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A.,1988. *Who will benefit from psychotherapy? Predicting therapeutic outcomes*. New York: Basic Books.

Luborsky, L., McLellan, A.T., Diguier, L., Woody, G., Seligman, D., 1997. The psychotherapist matters: Comparison of outcomes across twenty-two therapists and seven patient samples. *Clinical Psychology: Science and Practice*, 4 (1), pp. 53-65.

- McDonald, J., Cartwright, A., & Brown, G., 2007. A quantitative and qualitative exploration of client-therapist interaction and engagement in treatment in an alcohol service. *Psychology and Psychotherapy: Theory, Research and Practice*, 80 (2), pp. 247-267.
- McLellan, T. A., Woody, G.E., Luborsky, L., & Goehl, L., 1988. Is the counselor an 'active ingredient' in substance abuse rehabilitation? : An examination of treatment success among four counselors. *Journal of Nervous & Mental Disease* 176 (7), pp. 423-430.
- Maroda, K., 1991. *The Power of Countertransference*. Chichester:Wiley.
- Martin, D., Garkse, J.P., & Davis, M.K., 2000. Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, 68, pp. 438-450.
- Marx, J. A., & Gelso, C. J., 1987. Termination of individual counseling in a university counselling center. *Journal of Counseling Psychology* 34 (1), pp. 3-9.
- Meier, P.S., Barrowclough, C., & Donmall, M. C., 2005a. The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction*, 100 (3), pp. 304-316.
- Meier, P.S., Donmall, M. C., Barrowclough, C., McElduff, P., & Heller, R.F., 2005b. Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction*, 100 (4), pp. 500-511.
- Meier, P.S., Donmall, M. C., 2006. Differences in client and therapist views of the working alliance in drug treatment. *Journal of Substance Use*, 11 (1), pp. 73-80.
- Messler Davies, J., 2005. Transformations of desire and despair reflections on the termination process from a relational perspective. *Psychoanalytic Dialogues* 15 (6), pp. 779-805.
- Meyer, M. M., & Tolman, R.S., 1963. The Reactions of Patients to Enforced Changes of Therapists. *Journal of Clinical Psychology* 19, pp. 241-243.
- Mikulincer, M., & Shaver, P. R., 2007. *Attachment in Adulthood: Structure, Dynamics, and Change*. New York: The Guildford Press.
- Miller, W.R., Taylor, C.A., & West, J.C., 1980. Focused versus broad spectrum behaviour therapy for problem drinkers. *Journal of Consulting and Clinical Psychology*, 48, pp. 590-601.
- Miller, W.R., Benefield, R.G., & Tonigan, J.S., 1993. Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology*, 61, pp. 455-461.

Muller, R., 1986. The Trainee and the Transfer Case: Why is this Case Different from All Other Cases? *American Journal of Psychotherapy*, (2), pp. 265-276.

Najavits, L.M., & Weiss, R. D., 1994. Variations in therapist effectiveness in the treatment of patients with substance use disorders: An empirical review. *Addiction*, 89, pp. 679-688.

Nielsen, S. L., Okiishi, J., Nielsen, D. L., Hawkins, E. J., Harman, C. S., Pederson, T., Worthen, V. E., Isakson, R. L., Lambert, M. J., Lawson, J., Whipple, J. L., Gleave, R. L., Hansen, N. B., Dougher, K. M., Smart, D. W., Rice, M. L., Chapman, R. K. & Jackson, A. P., 2009. Termination, Appointment Use, and Outcome Patterns Associated with Intake Therapist Discontinuity. *Professional Psychology: Research & Practice* 40 (3), pp. 272-278.

Norcross, J. C., & Goldfield, M. R., 1992. *Handbook of Psychotherapy Integration*. New York: Basic Books.

Norcross, J. C., & Lambert, M. J., 2011. Evidence based therapy relationship. In J. C. Norcross (ed.), 2011. *Psychotherapy relationships that work: Evidence-based responsiveness 2nd edition*. New York: Oxford University Press, pp. 3-21.

Ogden, T.H., 1989. *The Primitive Edge of Experience*. New Jersey: Jason Aronson.

Ogden, T.H., 1994. The Analytic Third: Working with Intersubjective Clinical Facts. In S.A. Mitchell and L. Aron, (eds.), 1999. *Relational Psychoanalysis: the emergence of a Tradition*. New Jersey: The Analytic Press, pp. 459-492.

Ogden, T.H., 2004. The Analytic Third: Implications for psychoanalytic theory and technique. *Psychoanalytic Quarterly*, 73, pp.167-195.

Orford, J., 2001. Addiction as excessive appetite. *Addiction*, 96(1), pp. 15-31.

Orford, J., Hodgson, R., Copello, A., John, B., Smith, M., Black, R., Fryer, K., Handforth, L., Alwyn, T., Kerr, C., Thistlethwaite, G. ,& Slegg, G., 2006. The clients' perspective on change during treatment for an alcohol problem: qualitative analysis of follow-up interviews in the UK Alcohol Treatment Trial. *Addiction*, 101 (1), pp. 60-68.

Orford, J., Hodgson, R., Copello, A., Krishnan, M., De Magdariaga, M., & Coulton, S., 2009a. What Was Useful About That Session? Clients' and Therapists' Comments after Sessions in the UK Alcohol Treatment Trial. *Alcohol & Alcoholism*, 44 (3), pp. 306-313.

Orford, J., Hodgson, R., Copello, A., Wilson, S. & Slegg, G., 2009b. To what factors do clients attribute change? Content analysis of follow-up interviews in the UK Alcohol Treatment Trial. *Journal Of Substance Abuse Treatment*, 36, pp. 49-58.

Orlinsky, D.E., & Howard, K.I., 1986. Process and outcome in psychotherapy. In S.L. Garfield & A.E. Bergin (eds). *Handbook of psychotherapy and behaviour change*. 3rd Edition. New York: Wiley.

Pearson, Q. M., 1998. Terminating before counselling has ended: Counseling implications and strategies for counsellor relocation. *Journal of Mental Health Counseling* 20 (1), pp. 55-63.

Penn, L. S., 1990. When the therapist must leave: Forced termination of psychodynamic therapy. *Professional Psychology: Research and Practice* 21 (5), pp. 379-384.

Project MATCH Research Group, 1998. Therapist effects in three treatments for alcohol problems. *Psychotherapy Research*, 8 (4), pp. 455-474.

Pumpian-Mindlin, E., 1958. Comments on Techniques of Termination and Transfer in a Clinic Setting. *American Journal of Psychotherapy*, 12, pp. 455-464.

Quintana, S. M., & Holahan, W., 1992. Termination in short-term counselling: Comparison of successful and unsuccessful cases. *Journal of Counselling Psychology*, 39, pp. 299-305.

Raistrick, D., 2012. A summary of the Review of the Effectiveness of Treatment for Alcohol Problems, clarification of findings. [Email] Personal communication 12 March 2012.

Reading, B., 2002. The application of Bowlby's attachment theory to the psychotherapy of the addictions. In M. Wegmann, & R. Cohen (eds.) *The Psychodynamics of Addiction*. London: Whurr Publishers, pp.13-30.

Reading, B., 2003. Is it necessary or advisable to undertake specialist training in order to work effectively with clients having addictive problems? In B. Reading & M. Jacobs (eds). *Addiction: Questions & Answers for counsellors and therapists*. London: Whurr Publishers, pp. 82-83.

Reider, N., 1953. A Type of Transference to Institutions. *Bulletin Menninger Clinic*, 17:58. Cited in Scher, 1970.

Richardson, S., 2010. Reaching for relationship: Exploring the use of an attachment paradigm in the assessment and repair of the dissociative internal world. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis*, 4, pp. 7-25.

Rizq, R., 2011. IAPT, Anxiety and Envy: A psychoanalytic view of NHS Primary Care mental health services today. *British Journal of Psychotherapy*, 27(1), pp.37-55.

Robb, M., & Cameron, P.M., 1998. Supervision of termination in psychotherapy. *Canadian Journal of Psychiatry*, 43, pp. 397-402.

- Robbins, B., 2000. Under Attack: Devaluation and the Challenge of Tolerating the Transference. *Journal of Psychotherapy, Practice and Research*, 9, pp. 136-141.
- Robison, F. F., Hutchinson, R. L., Barrick, A. L., & Uhl, A. N., 1986. Reassessing Clients: Practices used by counselling centres. *Journal of Counseling Psychology*, 33 (4), pp. 465-468.
- Roe, D., Dekel, R., Harel, G., Fennig, S., & Fennig, S., 2006. Clients' feelings during termination of psychodynamically oriented psychotherapy. *Bulletin of the Menninger Clinic*, 70 (1), pp. 68-81.
- Rogers, C.R., 1961. *On Becoming a Person: A therapist's view of psychotherapy*. London: Constable.
- Safran, J. D., Crocker, P., McMains, S., & Murray, P., 1990. The therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy: Theory, Research and Practice*, 27, pp. 154-165.
- Safran, J. D., & Muran, J. C., 1996. The resolutions of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology*, 64 (3), pp. 447-458.
- Sandler, J., 1993. On communicating from patient to analyst: Not everything is projective identification. *International Journal of Psychoanalysis*, 74 pp. 1097-1107.
- Scher, M., 1970. The process of changing therapists. *American Journal of Psychotherapy*, 25 (2), pp. 278-286.
- Schlesinger, H. J., 2005. *Endings and Beginnings: On the Technique of Terminating Psychotherapy and Psychoanalysis*. New Jersey: The Analytic Press.
- Schneider, J. A., 2003. Working with pathological and healthy forms of splitting: A case study. *Bulletin of the Menninger Clinic*, 67, pp. 32-49.
- Schore, A. N., 1994. *Affect Regulation and the Origin of the Self*. New Jersey: Lawrence Erlbaum Associates.
- Schore, A.N., 2003. *Affect Regulation and the Repair of the Self*. New York : W.W.Norton.
- Siegel, D. J., 1999. *The Developing Mind*. New York: The Guildford Press.
- Skourteli, M. C., & Lennie, C., 2010. The therapeutic relationship from an attachment theory perspective. *Counselling Psychology Review*, 26 (1), pp. 20-33.
- Slade, A., 1999. Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (eds), *Handbook of Attachment: Theory, Research and Clinical Applications*. New York: The Guildford Press, pp. 575-594.

Slade, A., 2008. The Move from Categories to Process: Attachment Phenomena and Clinical Evaluation. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis* 2(1), pp. 89-105.

Smith, J.A., 1996. Beyond the divide between cognition and discourse: using interpretative phenomenological analysis in health psychology. *Psychology and Health*, 11, pp. 261-271.

Smith, J. A., 2004. Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology*, 1, pp. 39-54.

Smith, J. A., Jarman, M., & Osborn, M., 1999. Doing Interpretative Phenomenological Analysis. In M.P. Murray & K. Chamberlain (eds). *Qualitative Health Psychology: Theories and Methods*. London: Sage Publications, pp. 218-239.

Smith, J.A., & Osborn, M., 2003. Interpretative phenomenological analysis. In: J. A. Smith (ed). *Qualitative Psychology: A practical guide to research methods*. London: Sage Publications, pp. 51-80.

Smith, J.A., Flowers, P., & Larkin, M., 2009. *Interpretative Phenomenological Analysis: Theory, Method and Research*. London: Sage Publications.

Soyez, V., De Leon, G., Broekaert, E. & Rosseel, Y., 2006. The impact of a social network intervention on retention in Belgian therapeutic communities: a quasi-experimental study. *Addiction*, 101, pp. 1027-1034.

SRA (2003) Social Research Association: Ethical Guidelines.
Available at www.the-sra.org.uk
[Accessed 21 November 2006]

Stern, D. N., 1985. Affect Attunement. In J. D. Call., E. Galenson. & R. L. Tyson (eds.). *Frontiers of Infant Psychiatry, Vol 2*. New York: Basic Books.

Stern, D.N., 1998. *The Interpersonal World of the Infant*. London: Karnac.

Stolorow, R. D., & Atwood, G. E., 1992. *Contexts of being: The intersubjective foundations of psychological life*. New Jersey: Analytic Press.

Stolorow, R. D. and Atwood, G. E., 1997. Deconstructing the myth of the neutral analyst. *Journal of the American Psychoanalytic Association*, 45, pp. 1231-1239.

Tantum, D. & Klerman, G., 1979. Patient transfers from one clinician to another and dropping out of out-patient treatment. *Social Psychiatry*, 14, pp. 107-113.

Timulak, L., 2010. Significant events in psychotherapy: An update of research findings. *Psychology and Psychotherapy: Theory, research and Practice*, 83 (4), pp. 421-447.

Trimboli, F., & Keenan, C. W., 2010. Supervising student-therapists: Suggestions for the transfer of long-term psychotherapy patients. *Psychoanalytic Psychology*, 27 (3), pp. 319-319.

UKATT Research Team, 2001. United Kingdom alcohol treatment trial: hypotheses, design and methods. *Alcohol and Alcoholism*, 36 (1), pp. 11-21.

UKATT Research Team, 2005. Effectiveness of treatment for alcohol problems: findings of the randomised UK alcohol treatment trial (UKATT). *British Medical Journal*, 331, pp. 541-58.

Wachtel, P. L., 2002. Termination of therapy: An effort at integration. *Journal of Psychotherapy Integration*, 12 (3), pp. 373-383.

Wampold, B. E., Mondin, G.W., Moody, M., Stich, F., Benson, K. & Ahn, H., 1997. A meta-analysis of outcome studies comparing bona fide psychotherapies: Empirically, All must have prizes. *Psychological Bulletin*, 122 (3), pp. 203-215.

Wanigaratne, S., Davis, P., Pryce, K., & Brotchie, J., 2005. *The effectiveness of psychological therapies on drug misusing clients*. London: National Treatment for Substance Misuse Agency.

Available at: http://drugslibrary.stir.ac.uk/documents/rb11_final_pdf
[Accessed 15 October 2007]

Wapner, J. H., Klein, J. G., Friedlander, M. L., & Andrasik, F. J., (1986). Transferring psychotherapy clients: State of the art. *Professional Psychology: Research and Practice* 17 (6), pp. 492-496.

Weegman, M., 2002. The Vulnerable self: Heinz Kohut and the addictions. In M. Weegmann & R. Cohen (eds.) *The Psychodynamics of Addiction*. London: Whurr Publishers, pp.31-49.

Weiss, S. S., 1972. Some thoughts and clinical vignettes on translocation of an analytic practice. *International Journal of Psychoanalysis*, 53, pp. 505-513.

Winnicott, D., 1960. The theory of the parent-infant relationship. In *The maturational Processes and the facilitating Environment*. London: Karnac Books.

Winnicott, D. W., 1971. *Playing and Reality*. London: Routledge.

Wise, R., 1988. The Neurobiology of Craving: Implications for the Understanding and Treatment of Addiction. *Journal of Abnormal Psychology*, 97 (2), pp. 118-132.

Wurmser, L., 1987. Flight from conscience: experiences with the psychoanalytic treatment of compulsive drug abusers. *Journal of Substance Abuse Treatment*, 2, pp. 227-258.

