A PORTFOLIO OF ACADEMIC, THERAPEUTIC PRACTICE AND RESEARCH WORK

including an investigation of

MULTIPLE CARD SORT PROCEDURE AS AN ASSESSMENT TECHNIQUE USED BY COUNSELLING PSYCHOLOGISTS

and

THE ROLE OF PERCEIVED SOCIAL SUPPORT IN THE PROCESS OF THERAPEUTIC CHANGE IN ADDICTION TREATMENT

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Introduction

This portfolio represents a selection of pieces of work carried out in the course of the studies for the Psych D in Psychotherapeutic and Counselling Psychology at the University of Surrey from September 1995 to September 1998. It has been divided into three representative dossiers. The first dossier incorporates essays which reflect on the theoretical underpinnings of the discipline. The second dossier pertains to issues concerning therapeutic practice and reflections on my professional development. The third dossier consists of the research work carried out during the three years of studies in this course. Therefore, the pieces of work selected for this portfolio constitute examples of academic, practical and research work which I would hope present a fair and adequate case for the whole process undergone to become a Psychotherapeutic and Counselling Psychologist.
Introduction to the Academic Dossier

The academic dossier of the portfolio comprises of five essays. Three of these focus on the discussion of different issues pertaining to models of psychotherapy. In the first essay the extent to which lifespan developmental models aid an understanding of the development and dynamics of sexual and emotional relationships is discussed with specific reference to appropriate interventions emanating from them. The second essay looks at the role that an effective therapeutic alliance plays in the use of cognitive approaches in therapy. The third essay explores the extent to which cognitive-analytic therapy integrates the issues over which cognitive and psychodynamic approaches have fractionated.

Essays four and five pertain to issues in counselling psychology practice, which emerged out of readings, discussions, and experiences on placements. Essay four deals with the specific contributions of counseling psychologists in therapeutic services, and essay five is concerned with the evaluation of the viability of motivational interviewing approach in dealing with ambivalence in clients.
To what extent lifespan developmental models help you understand the development and dynamics of sexual and emotional relationships and frame appropriate interventions for clients experiencing relationship problems?

Developmental psychology in its course towards understanding, describing and explaining the development of human personality and behaviour across the lifespan has been pervasively influenced by the normative-crisis model of development. This model advocates that there is a built-in "ground plan" in human development and that a series of crises appropriate to particular phases of life need to be resolved for healthy subsequent development (Papalia & Olds 1986; Schultz 1990; Whitbourne & Weinstock 1979). With specific reference to the development and dynamics of sexual and emotional relationships, this model views the reference point of evolution during young adulthood when the individual becomes physiologically capable of sexual relationships, emotionally capable of serious involvement with another adult, and socially expected to "settle down" and find a partner. The major advocate of this position is E. Erikson (1968) followed by D. Levinson (1978) and G. Vaillant (1977) - who have expanded on his work and conducted research on his theoretical framework. The latter are the ones who have identified such explicit sequences of age-related social and emotional changes throughout the human lifespan. Other major theorists in the field of psychology are not excluded but their contribution on this issue are more implicit and less researched.

E. Erikson (1968) views intimacy (the establishment of a close relationship with another person - sexual partner, friend, spouse - that is mutually satisfying) as the central theme of young adulthood which, however, is dependent on identity growth during adolescence. The growth of identity in adolescence permits mature acceptance of differences among people, eventually heightening one's own sense of identity. Therefore, although identity remains a major issue throughout adult life, intimacy is affected by the extent to which identity has been consolidated in adolescence and goes beyond the exclusive or destructive relationships that mostly occur at this stage. The
abilities and virtues young adults have developed allow them to explore the world of sexual and emotional relationships from the perspective of shared commitment and honest communication which adds to the quality of such relationships and advances mutuality, which is viewed as the cornerstone in their healthy development. People who have developed a healthy sense of identity are willing to risk temporary loss of self in such emotionally demanding situations as coitus and orgasm, in the kinds of very close friendships that call for personal sacrifices and compromises, and in other situations requiring self-abandon. Erikson (1968) points out that young adults are faced with the difficulty of being able to merge their identity with someone else's without fear of losing something of themselves in the process. This requires a firm sense of self based on realistic self-knowledge and a reasonable degree of self-acceptance (Masters, Johnson & Kolodny 1995; Morris 1990; Papalia & Olds 1986; Stevens-Long & Commons 1992; Whitbourne & Weinstock 1979).

People unable to function in this way submerge in a state of isolation and self-absorption; they avoid close contacts with others and may even come to reject or aggress against those whom they see as threatening to their own selves. Such people prefer being alone out of fear of intimacy; a common complaint of persons presenting themselves in therapeutic services especially so in college/university counselling centres (Duck 1984; Masters, Johnson & Kolodny 1995; Morris 1990; Schultz 1990). According to Erikson, "utopia of genitality" (Papalia & Olds 1986, p.399) cannot occur until young adulthood. This refers to mutual orgasm in a loving heterosexual relationship in which trust is shared and the cycles of work, procreation and recreation are regulated as contrasted to the domination of adolescents' sex lives either by the search for their own identity or by "phallic or vaginal strivings which make of sex life a kind of genital combat" (p. 399; Masters, Johnson & Kolodny 1995).
Just as intimacy is the central theme of young adulthood, love is its major virtue and strength deriving from the satisfactory resolution of the Intimacy vs. Isolation crisis. Erikson writes that young adults must test the extremes in order to find a deep commitment, to develop a sense of choice, and to experience loyalty. The basic strength that grows out of the positive adaptive ways of testing the extremes is love; a mutual devotion in a shared identity; the finding and fusing of oneself with another person which is continuously reaffirmed throughout a person's life (Schultz 1990; Stevens-Long & Commons 1992).

Erikson's (1968) developmental model with respect to sexual and emotional relationships has been criticised in terms of being too narrow-minded to include within the realm of healthy development homosexuals, single people and non-parents, since he emphasises heterosexual relationships that culminate in mutual orgasm and lead to procreation of the species.

Inspired by Erikson are two longitudinal studies by G. Vaillant (1977) and D. Levinson (1978) (in Papalia & Olds 1986) with an eye to identifying specific stages of development. Both studies have been successful in supporting Erikson's developmental progression during adult life. With specific reference to the development of sexual and emotional relationships, Levinson's (1978) findings include the importance of young adulthood being the crucial point of reference for their establishment, within a life structure framework that includes both internal and external aspects, by incorporating not only the notion of commitment and mutuality but also the notion of tentativeness of direction and choice. Vaillant's (1977) findings on the other hand are pertinent to our discussion to the extent to which they have proposed an intermediate stage between intimacy and generativity: consolidation stage. This is when a person may turn away from an established intimate relationship to focus their full attention on career concerns. If the two intimates are at different points in this sequence - with one still wanting to work on intimacy and the other on career, miscommunication problems may appear that - according to Vaillant - may yield clues
for the number of intimate relationships that run into trouble at about the seventh year (Papalia & Olds 1986; Stevens-Long & Commons 1992; Whitbourne & Weinstock 1979).

These studies have been criticised on the basis of their sample which comprised of small groups of white middle to upper class males born in the 1920's or 30's. Thus findings must have been influenced by societal events that apply to their cohort but would not affect people born earlier or later and feed into the expectation that there exists a common age-related pattern of development universally without any reference to the individual's personality and background history. Therefore, it has been asserted that it is misleading to look at any aspect of adult development as a series of discrete stages, since so many of the same issues come back over and over again for both reflection and action throughout adulthood.

S. Freud (in Schultz 1990) has also briefly contributed to the understanding of the development and dynamics of sexual and emotional relationships from a theoretical perspective that emphasises the concept of sexual tension as their driving force. He has briefly commented on formation of intimate relationships as an event that occurs late in the genital stage of development. He has asserted that a committed relationship with a person of the opposite sex acts as a sublimation mechanism of the sexual energy pressing for expression which during young adulthood becomes fully satisfied as opposed to adolescence, when a relationship is formed because the expression of sexuality within the family runs counter to the universal taboos on incest. Freud views an intimate and loving relationship in young adulthood as the normal and fully successful reduction of the sexual conflict and tension during adolescence (Schultz 1990).

E. Fromm (1947) has proposed a similar developmental construct to Erikson's intimacy; he called it productive love and defined it as involving care, responsibility, respect and knowledge. According to Fromm (1947), productive love is the ideal way through which individuals achieve relatedness; that is, the need to maintain contact with other people
since their former instinctive relationship with nature has been lost. In early adulthood productive love takes the form of erotic love which is directed toward fusion and oneness with a member of the opposite sex; or brotherly love when directed to a member of the same sex. Within this context, the individual is concerned with another's growth and happiness, responds to others' needs and respects and knows the loved one as s/he really is (Schultz 1990).

Fromm (1947) contended that failure to satisfy the need for relatedness through erotic or brotherly love results in a condition of irrationality that he called narcissism. Since narcissistic individuals perceive everything from their own point of view, they cannot relate to other people or the outside world and as a consequence have no objective contact with reality (Schultz, 1990).

Some of the same thoughts as Erikson's and Fromm's were echoed and expanded in the work of a contemporary writer, Robert White (in Stevens-Long & Commons 1992). Writing on the 'freeing of personal relationships" (p. 136), White contended that young adults begin to respond to people as individuals, free of much of the egocentrism and anxiety characteristic of adolescence. Adults can make allowances which create room for warmth, respect and intimacy.

The view of the development and dynamics of sexual and emotional relationships (intimate relationships) advocated by the theorists discussed thus far appears to entail an inherent limitation in that it fails to take into account the variety of cultural, social, personal and situational contexts that heavily influence relationship development and dynamics. Differences that exist from one society to another and within subgroups of a given society, variations among adults in their life patterns and personality development and sex differences - that constitute the basis on which the nature of intimate relationships is developed - seem to have not been touched upon in their attempt to describe the "average" patterns. Lifespan developmental models - to the extent that they have attempted to understand and explain the development and dynamics of intimate relationships - have treated them as characterising a certain stage or phase of
development (young adulthood) rather than treating the issue from a process framework which would make more justice to the complexity of the development and dynamics of intimate relationships. Although the stage model of development is seen as an epigenetic one where previous developmental issues (crises) resulting from the interaction of biological, psychological and social forces characteristic of a period in the life cycle, exert a predominant influence on the consequent development and dynamics of intimate relationships, they are still viewed as discrete, age-related segments of the life span. The notion of process might be incorporated to the extent that their inadequate resolution causes them to coexist and become heightened in response to events which stimulate their reappearance in later stages (Nelson-Jones 1982; Papalia & Olds 1986; Whitbourne & Weinstock 1979).

Nevertheless, having acknowledged the limitations of the lifespan developmental models in relation to the understanding of the development and dynamics of intimate relationships, it is important to keep in mind that their major contribution in the study of sexual and emotional relationships centres around their prediction that it is a critical issue in young adulthood whose satisfactory outcome largely depends on previously accumulated strengths, virtues or inadequacies. It has been evident that all theorists touch on the same concerns pertaining to the development and dynamics of sexual and emotional relationships: intimacy, commitment, caring and fidelity. Young adults are faced with the task of making important life choices in the realm of personal relationships and moving from the relatively untested ambitions of adolescence to a personal maturity shaped by the realities of the world in which they live. Social networks provide the setting in which individuals struggle to find significance for themselves through relating to others. Developing the capacity for intimacy is a central task and a majoradjustive challenge since it is the first time that it becomes possible for the individual to engage in a truly intimate relationship with another person, to love another person for their real qualities and not just for the personal satisfactions that can be obtained from the relationship (Ivey, Ivey & Simek-Downing 1987; Stevens-Long & Commons 1992; Whitebourne & Weinstock 1979).
In light of the writings on the development and dynamics of sexual and emotional relationships, first R.J. Havighurst (in Stevens-Long & Commons 1992) and later Egan & Cowan (in Ivey, Ivey & Simek-Downing 1987) have expanded on these models by identifying general areas of work with clients experiencing relationship problems with reference to the task of intimacy-building and maintenance in young adulthood. These interventions which have been termed "developmental resources" are centred around the development of skills for interpersonal negotiation, conflict resolution, role discrimination and integration, and communication.

These interventions have been developed out of the key factors in the development and maintenance of intimacy that grow out of the work of the theorists discussed earlier. These key factors which have been further refined by C. Rogers (1961) entail mutuality and sharing, and communication within a context where the individual needs to be encouraged and helped to develop the ability to discover and accept his/her own self, break down artificial pretenses with others, have an open approach to experiences and encourage the growth of the other person involved in the relationship; in other words to move toward developing a firm sense of self based on realistic self knowledge which will in turn allow a breakdown of expectations that may not be based upon a true choice on the part of the individuals involved in the relationship once they have examined and clarified the roles each of them have relative to the other (Duck 1984; Masters, Johnson & Kolodny 1995 ; Stevens-Long & Commons 1992; Whitbourne & Weinstock 1979).

Thus discrimination and integration with respect to these roles and expectations is considered an appropriate intervention. Discrimination implies the serious consideration of all possibilities, an understanding of the antecedents and consequences of new forms, and deliberate, conscious selection of the form best suited to the self. Discrimination suggests a welcoming of the opportunity to exercise choice and yet an awareness that not all possible choices are equally appropriate. Once this schema has been identified, then skills on self-disclosure and effective communication and expression of thoughts and feelings are required for their integration (coping with change) to be achieved on an interpersonal level.
In a similar vein, E. Hatfield (in Nelson-Jones 1982) has outlined the areas of work with clients experiencing relationship problems with interventions aiming at a) reaching an acceptance of self and taking pleasure in the diversity between oneself and one's partner; b) reaching an acceptance of the partner's individuality and separate self; c) expressing oneself and self-disclosing so that partners have the opportunity to get to know each other; and d) being prepared to deal with one's partner's reactions to one's honesty and expressiveness and to work through negative reactions. Within this context, interventions focus on helping clients to reduce aversive communication, enhance helpful communication, increase positive behaviours and improve their abilities at negotiation and problem solving (Nelson-Jones 1982; Masters, Johnson & Kolodny 1995; Stevens-Long & Commons 1992).

Reparative work on sexual relationships also involves effective verbal and non-verbal communication and self-disclosing, although approaches to sexual relationship concerns range from enhancing unsatisfactory relationships to remedying specific sexual dysfunctions. Our approach in this discussion is pertinent to the former context where interventions may involve focused exploration of the ways in which clients think about sex, their body image, and their fears about their own and their partner's performance (Nelson-Jones 1982; Masters, Johnson & Kolodny 1995).

On an intrapersonal level, individuals that present with relationship problems may be habitually poor at creating relationships that involve trust and openness because of fear of intimacy. In such cases where the "relationship" is not itself the problem but rather it is one of its constituents that appears to resist commitment and closeness, appropriate therapeutic interventions entail work on identity and self-image issues within a therapeutic framework that attempts to repair traumatic relationships during childhood in order to overcome such self-handicapping blights prior to addressing interpersonal issues. The appropriateness of these interventions has been based on research findings (Orlofsky et al 1973; Marcia 1980; Waterman 1982; Brodzinsky, Gormly & Ambron 1986 in Morris, 1990) that have associated fear of intimacy and inability to form intimate relationships with lack of a firm sense of identity, negative self-image and
perception that resides in deep-seated anxiety and inadequacy from relationships during the formative years (Duck 1984; Masters, Johnson & Kolodny 1995).

Finally and most importantly, the aforementioned interventions for clients experiencing relationship problems are to be most effective when seen within the context of the individual's goals of life, needs for access to other coping styles and issues of self-definition. Effective reparative work is largely dependent on identifying and focusing on the items that are of greatest concern to the client and working within the client's worldview and frame of reference with regard to the problem (Duck 1984; Ivey, Ivey & Simek-Downing 1987; Morris 1990).

It has been evident throughout the present discussion that the lifespan developmental models that have approached an understanding and explanation of the development of sexual and emotional relationships have invaluably contributed to framing appropriate interventions for clients experiencing relationship problems despite their limitations. The value of these models appears to lie on their having constituted a reference point for developing appropriate interventions within the realm of relationships. Their limitations have contributed to enhance our knowledge on the appropriateness of interventions and it is through their inadequacies - that spring out of their novel insight - that our knowledge becomes expanded.
REFERENCES


What role does an effective therapeutic alliance play in the use of cognitive approaches in therapy?

The undertaking of the task to comment on the role that an effective therapeutic alliance plays in the use of cognitive approaches to therapy involves the attempt to identify the elements that constitute an effective therapeutic alliance and explore their impact on ameliorating the efficiency and effectiveness with which the techniques of cognitive approaches propose to deal with clients' identified difficulties and problems in the course of therapy. However, before delving into the actual parameters of such a discussion, it is deemed pertinent to orientate this discussion with a brief reference to the "historical" context of cognitive therapies in which the notion of therapeutic alliance has been traced and developed.

Until quite recently, most of the writings on cognitive therapy, although they have never been explicitly dismissive of the role that therapeutic alliance played in the scheme of things, have still underplayed its importance as opposed to the emphasis they cast on the technical aspects of therapy. Mahoney and Gabriel (1987) seem to argue that what gave rise to this attitude was the prevalence of the "rationalist" cognitive therapies which conceptualised learning and knowing in primarily passive ways with a corresponding neglect of the role of activity in learning and a neglect of the organisation of behaviour. Within this framework the therapeutic alliance has been notable by its absence and this absence has therefore fuelled the stereotypical common criticisms of cognitive therapy from the psychotherapeutic world about the former's application of techniques in a mechanical manner devoid of any attention to the individual's sensitivities and its neglect of transference and countertransference issues in the therapeutic relationship (Wills & Sanders 1997).

However, as the "constructivist" cognitive therapies started gaining prevalence in the world of cognitive approaches more attention is paid to restructuring deeper level schemata, to affective arousal techniques in therapy and to the transference relationship (Young 1987). In fact, Mahoney and Gabriel (1987) agree with Young in that the ground breaking schema theory and the developments of cognitive therapy in the Beck tradition gave rise to a more positive attitude towards emotion by emphasising the need for emotional experience and behavioural change in therapy.
and by valuing the therapeutic alliance as a safe learning situation (also see Scott & Dryden 1996).

It can thus be argued that in the last two decades a shift has been noticed in the cognitive psychotherapy universe from the traditional outlook that the technical aspects of cognitive therapy are the active ingredients and the therapeutic alliance is necessary but not sufficient for therapeutic change, to a more integrated view of the therapeutic alliance itself as assuming the more central role of an active ingredient in cognitive work. This shift has therefore influenced the role that the therapeutic alliance now plays in the conceptualisation of clients' difficulties and in the facilitation of the therapeutic process (Ryle 1993; Wills & Sanders 1997). In that sense, it can be argued that the above described journey has contributed to the achievement of a more realistic and effective balance between beliefs and procedures in the way cognitive therapies consider the application of their techniques.

The above argument is supported by the research evidence in cognitive therapy which suggests that the quality of the therapeutic alliance is central to the outcome of cognitive therapy. More specifically, Horvarth (1995), Raue & Goldfried (1994), Wright & Davies (1994), Burns & Nolen-Hoeksema (1992), DeRubeis and Feeley (1990), and Persons (1989) have all carried out studies looking at the relative contribution of non-specific, relationship factors versus technical factors in cognitive therapy. They all report that both are of equal importance for determining therapeutic effectiveness but, everything else being equal, they stress the significant contribution of a positive therapeutic alliance to the outcome of cognitive therapy.

At this point, it is considered important to clarify the meaning of the term therapeutic alliance within the cognitive approaches since it has been mentioned thus far as if the term's use is a clearly demarcated one. What needs to be clarified is the distinction between therapeutic alliance and the extent to which the use of the term, as intended by cognitive theorists and therapists, incorporates the elements of the transference-countertransference relationship. Clarkson (1996) asserts that the term therapeutic or working alliance, as viewed by cognitive behavioural practitioners, refers to "the part of the client-psychologist relationship that enables the client and
psychologist to work together even when the client experiences strong desires to
the contrary” (p.265). Harry Stack Sullivan defines therapeutic alliance as “two
people, both with problems in living, who agree to work together to study these
problems, with the hope that the therapist has fewer problems than the patient”
of what the term means by contending that is this situation in which “the patient
supplies raw data (reports on thoughts and behaviours......) while the therapist
provides structure and expertise on how to solve problems. The emphasis is on
working on problems rather than on correcting defects or changing personality.
[......] As therapy progresses, the patient is encouraged to take a more active
stance” (p.175).

It is therefore obvious that the meaning of the term therapeutic alliance in cognitive
approaches involves the notion of an exchange of expertise between therapist and
client within the framework of a relationship that fosters these conditions which are
necessary for engaging clients’ willingness and motivation to actively and
constructively deal with their difficulties aided by the efficient presence of the
therapist both as an individual and a professional.

Such conceptualisation of the therapeutic alliance in cognitive approaches begs one
of the undisputed roles of therapeutic alliance in the use of these approaches;
namely, the establishment of collaboration and collaborative empiricism (Wills &
Sanders 1997). The therapeutic alliance is perceived as the basis for advancing a
collaborative model of working which in itself enhances a sense of equality between
the client and the therapist. Both are considered as experts in their own right
exchanging elements of their expertise to reach a successful resolution of the
client’s difficulties. Therefore, in the cognitive approaches the collaborative element
inherent in the notion of therapeutic alliance allows the therapist to have an honest,
clear and explicit exchange with the client as to what is in her mind, avoiding any
hidden agendas, unconscious communications or implicit efforts to direct the
session one way or another without the client’s consent and knowledge. In this way
clients feel included and valued in a process that they have an equal share in the
decision making about the way and the plan the therapist proposes to help them
deal with their difficulties and an informed agreement to this. Thus, the role of
therapeutic alliance in the use of cognitive approaches lies in its contribution to the
development of reciprocity in the work that is carried out, where both the client and the therapist have an active role and both learn empirically from each other's perspectives. One could argue that it is in the absence or minimisation of the concept of therapeutic alliance that the sense of power imbalance, inferiority, shame and defensiveness lurk to "medicalise" the process of therapy, turning it into a context where the therapist is seen as the absolute expert and the client as merely a "complex" of problems that need to be dealt with.

Thus far into our discussion, though, there are still two questions that have been addressed but remain unanswered. One revolves around the identification of these conditions that contribute to the development of therapeutic alliance. The second centres around the inclusion of elements of the traditional transference-countertransference relationship in therapeutic alliance.

As far as the first question is concerned, it is obviously argued that the core conditions we are talking about in therapeutic alliance are the ones that apply to all therapies; namely, accurate empathy, understanding, genuineness, respect, congruence and unconditional, non-possessive positive regard (Wills & Sanders 1997). These core conditions are interwoven with the discussion of collaboration and constitute the basis on which therapeutic alliance and hence collaboration are built. This essentially means that the therapist enters the consulting room being authentic, honest and open to the fact that her work pertains to the meeting of two individuals first and foremost so that the professional and the client can thereafter meet in a non-intimidating and mutually respectful manner that will foster the clients' ability to trust the therapist and share their inner world without any fears or reservations about identifying and challenging their strange and illogical thoughts. From this perspective the role of the core conditions on which therapeutic alliance is negotiated and developed becomes explicit and undisputed leading to a more efficient and effective use of the technical tools of cognitive therapy. Within such an encounter the therapist can be seen as a trustworthy, reliable and impartial individual whose input is not threatening the client but rather constitutes an important forum in which the client feels safe to evaluate and restructure their view of themselves and the world and their assumptions about the future, and practice alternatives or new behaviours. In this way and as the therapist integrates her mastery of the cognitive techniques into the context of the relationship, the extent to
which these techniques can be used constructively and ingeniously by the client is maximised.

An important point that needs to be emphasised in this discussion is the unstated but obvious fact that, unlike in other approaches, in cognitive approaches the therapeutic alliance and the techniques and tools of cognitive therapy are interdependent on each other. That is, one is not sufficient for therapeutic change without the other and neither of them is overemphasised in and of itself assuming disproportionate importance on the expense of the other. Having said that, it means that the role of therapeutic alliance in the use of cognitive therapies is flexible and adaptive in that its use is commensurate to the conceptualisation of clients’ needs in order to maximise its helpfulness to the individual client by being sensitive to the modification of the core conditions if required. This decreases the probability that particular clients might feel threatened or overwhelmed by the therapist focusing too much on the relationship part of the therapy which might reserve adverse effects by using it to confirm rather than challenge and reconstruct their thoughts and beliefs (Wills & Sanders 1997).

The final part of this discussion will centre around the issue of those elements of the therapeutic alliance that involve transference and countertransference notions as conceptualised and used in cognitive therapies. Transference and countertransference issues are not alien concepts in cognitive therapy where the therapeutic alliance has grown to be recognised as a quality that continually fluctuates and which can be actively used in therapy to work on clients’ interpersonal schemata (Safran & Segal 1990).

Transference in the therapeutic alliance is used as valuable information to help understand and conceptualise the client’s difficulties. Transference in cognitive therapy is conceptualised as these situations in which the client may engage in a variety of schema-driven behaviours where the core beliefs and assumptions of the client are very likely to be mirrored, and the mechanisms by which the client confirms these assumptions can be illustrated in vivo (Wills & Sanders 1997) and thus provide important evidence and clues for the therapist into clients’ worldview that could be used to assess and reflect their consequent beliefs.
A pertinent example for purposes of illustration comes to mind. A client that I see in an inpatient drug dependence unit was, at the early stages of therapy, consistently not doing her homework. Every time that homework was brought up she would always find a legitimate excuse for not being able to do it. It later transpired that her behaviour was driven by her core beliefs of “worthlessness”. She held the assumption about herself that after all she has done in her life she does not deserve to be helped to put her life together and did not feel it was worth making the effort for herself. At the same token though she was also testing me out in the sense that she expected that I would soon be fed up with her not conforming and not wanting to help herself that I would confirm the belief about her worthlessness by giving our sessions up since she believed I would eventually come to think she did not deserve to be helped, thus perpetuating her beliefs. The fact that I accepted her behaviour without becoming punitive or demanding and that I did not give her up but discussed my concerns with her gave her good evidence to evaluate her beliefs about herself and the behaviour of others towards her and motivation to work on modifying them through homework amongst other tools. Transference can therefore be an integral part of the process of disconfirming the client’s assumptions leading to therapeutic progress, so long as the disconfirmation is accepted and integrated by the client allowing schema modification.

Countertransference, on the other hand, is also viewed in the context of cognitive therapy as a valuable means of gaining a deeper understanding of the therapeutic process and providing information that could be essential in working out the most therapeutic responses since it inevitably activates the therapist’s schemata, assumptions and experiences within the context of the interaction with the client’s problems. These can be used “in the service of therapy rather than allowing them to become obstacles in therapy” (Safran & Segal 1990 p.41).

Another pertinent example comes to mind. Another client that I see in the same context came across as forceful and inflexible in the way that he put his thoughts and beliefs across. He appeared to only superficially listen to other points of view or counterarguments being put across, each time rephrasing his points with more conviction and urgency. It was for me an almost intangible feeling of dread before the sessions, when I would find myself overwhelmed and trodden upon, almost completely deskillied to the extent that I felt an eerie sense of intimidation and anger.
toward this man who it felt as if he was ripping my abilities apart without however appearing the least threatening either in the tone of his voice or his posture. He described how often he found himself having heated arguments with other residents for no apparent reason and how they had fed back to him that he was intimidating when he could not see how he could come across like that. When he was talking I was thinking to myself that it was only natural that other people responded this way since he could not let go of invading their space and imposing his beliefs on them in a manner that communicated to them that if they did not agree with him they were in trouble. Although I realised it was not appropriate for me to feed back this to him, we looked at his feelings of mistrust towards other people, his all-or-nothing thinking patterns, the way that he puts his thoughts across and identified his tactic of intimidating them by making them feel useless, frustrated and angered linked to the assumption “I can only feel safe and adequate if they feel defeated and powerless: otherwise they will either criticise me or harm me in some other way and if they get angry then I am not to blame”. As soon as the assumptions were identified and discussed his interaction with other residents was improved and he even reported forming friendships with very few people he came to trust. Therefore, countertransference images that the therapist has about herself in the therapeutic relationship can provide important clues as to the client’s conceptualisations and if handled appropriately can move the client forward. All these of course imply that the therapist has a sufficient knowledge of her own assumptions, schemata and rules and is flexible and accepting enough to acknowledge them so that they will not interfere with her ability to identify or work with particular client issues or difficulties that will present themselves in the therapeutic relationship. In that sense, it has been evident that cognitive therapies are beginning to pay more attention to explicit means of examining and working with the therapist’s own psychological make-up as a useful adjunct for therapeutic effectiveness.

In conclusion, it is hoped that this paper has made an adequate case for the role that therapeutic alliance can play in the use of cognitive therapies. Although it could be argued by some that the focus of attention in the cognitive psychotherapy universe remains on beliefs rather than on processes, it is believed that there is ample evidence of the shift towards a more explicit use of the therapeutic alliance as an active ingredient in the service of therapy that aids to promote collaboration, to understand and conceptualise clients’ difficulties, to directly challenge
dysfunctional schemata and modify them instead of maintaining or avoiding them, and to provide a testing ground for challenging and restructuring beliefs and assumptions. It is in all these that the capacity of the therapeutic alliance to facilitate a corrective experience within the therapeutic encounter lies. And in that sense it can be conceptualised as central to the process of change within the framework of the cognitive therapies.
REFERENCES


Cognitive- Analytic Therapy: Integrating where cognitive and psychodynamic approaches have fractionated?

Integrationism has been a recent preoccupation in the psychotherapeutic universe primarily due to the failure of research evidence to point to an overall exclusive virtue for any one psychotherapeutic approach. Since no single approach has shown to hold a demonstrable monopoly of effective technique, the narrow orthodoxies of competing schools become all the more meaningless and incoherent within the context of the psychotherapeutic discourse which seems to be striving for a shared language or an overarching paradigm on which to build a coherent picture of the process of development and change. In light of this, the argument for integrationism, as opposed to purity of form and model, constitutes a valid and urgent focus of practice and research in the realm of psychotherapies.

Cognitive-Analytic Therapy (CAT) has in recent years been put forth as a demonstrably viable approach (Brockman et al 1987) toward bridging the gap between unidimensionally orthodox insights. It would appear that CAT proposes a therapeutic intervention that is more needs-led than theoretically driven in the sense that it enjoys a more comprehensive theoretical framework in which various specific techniques can be accommodated to provide a structured, collaborative and insightful venture in which the wide spectrum of the human entity can be addressed.

Ryle (1993), in his account of the development of CAT, describes how this approach originated with the realisation that psychoanalysis, despite its dominant clinical influence and use of an in-depth theoretical understanding of the link between infantile development, personality structure and relationship patterns and the crucial importance of the therapeutic relationship, falls short of the efficacy of outcome that many cognitive and behavioural therapies have clearly demonstrated. This was mainly attributed to the lack of a more structured, “tangible” intervention within the psychoanalytic paradigm. Ryle also disagrees with the necessity of hypothesising mental “energies” or “instincts” to account for these processes. However, this did not resolve the impasse that was created by an equally valid realisation that although cognitive and behavioural therapies possessed what psychoanalysis lacked, they in turn fell short of an understanding of more subtle, unconscious processes in the therapeutic relationship and of an acknowledgement of the fundamental contribution
of unconscious mental processes to thought, feeling and action. CAT was conceptualised as an approach that could compensate for the limitations of those basic generic models of therapy through the interweaving and cross-application of the more methodical, descriptive and structured techniques of cognitive and behavioural approaches an a basic analytic technique. Ryle (1978) suggests that if models of mental processes derived from cognitive psychology were applied to psychoanalysis and behaviourism, it would establish a restatement of these theories into a common language for psychotherapy.

Within this context, CAT is argued to be an integrated model of therapy that draws on psychoanalytic techniques (Klein and Object Relations theory), cognitive therapy (Beck), and personal construct theory (Kelly). It is a time limited therapy (16 sessions average) aiming at reducing the client’s psychological distress and building up self-esteem (Beard 1989). Although psychoanalytic ideas are central to CAT, it would, at face value, appear to resemble more an offshoot of cognitive psychology primarily due to the unfamiliar forms in which psychoanalytic ideas are blended into the cognitive framework. It would seem that the most accurate way to describe the cognitive-analytic approach is to view it as a restatement of object relations into cognitive terms through a comprehensive and complex multifactorial representation and account of interpersonal and intrapersonal behaviour.

Ryle (1993) recognises the particular power that object relations theory encompasses in its understanding of human interaction as linked with a model of development and personality structure. He states that in order to “anticipate the consequences of our own role behaviour we must predict the reciprocal role behaviour of the other, and in perceiving the consequences of our role behaviour we must evaluate the responding role of the other” (p.98). It therefore follows that the satisfactory development and maintenance of a relationship requires the need to understand two role procedures and the ability to match them correctly. He terms these procedures for organising relationships reciprocal role procedures and states the obvious preoccupation of object relations theory with these procedures, though in a developmental perspective that seeks to explain both individual personality and the patterning of interpersonal behaviour through the understanding of the formation of these procedures from the same early infantile experience.
In CAT, however, such emotional and interpersonal processes of human functioning, despite retaining an adherence to a developmental and unconscious milieu along with all the obvious and important implications that this has on the transference-countertransference relationship between client and therapist, are translated cognitively. Such a translation rests on the premise of cognitive behavioural theory that the way individuals perceive, interpret, select, order, evaluate and modify their experience, knowledge and action in the world is organised through hierarchical systems of schemata and constructs (Kelly 1955). Hence in CAT, the cognitive behavioural theory of human functioning is utilised to construct an information processing model of conscious and unconscious experience and actions, called Procedural Sequence Model (PSM) which represents the theoretical base for CAT. Within this model both active and focused cognitive behavioural techniques (i.e. self-monitoring of moods, symptoms, states of mind, clear establishment and monitoring of goals and homework tasks) and psychoanalytic techniques (i.e. transference, countertransference, conflict and defence) are an integral part of CAT.

The Procedural Sequence Model is an integrated model of mental and behavioural processes involved in the organisation of aim-directed activity, including affective and defensive procedures. Any procedure/aim may be conscious or unconscious, rationally or irrationally based. Higher level procedures generate a number of lower level procedures, and change in any one of these stages of procedural sequence will inevitably effect the other procedures involved in the sequence. Ryle (1984) argues that this enables one to understand the often indistinguishable outcomes achieved by very different therapeutic inputs. It seems that in this way Ryle attempts to account for the effectiveness of a wide range of psychotherapies which would appear otherwise incompatible. Cognitive management and/or psychodynamic exploration may all be used to challenge different aspects of this procedural sequence which is circular, involving constant evaluation, anticipation and modification.

At this point, it is important to stress that in practice the "conflict" between cognitive and analytical components of CAT is not great, since human actions or human behaviour includes emotions (e.g. pain), feelings (e.g. feeling "dumped on"), and cognitions (e.g. taking in information, conscious thought processes). As human
beings we function at different levels and the following example might serve to more
clearly conceptualise the above discussion of PSM and demonstrate the integrative
stance of CAT. Thus a simple example would be as follows: We get up on the
morning and carry out a series of rituals (bathroom, dress, breakfast). Many of these
rituals are carried out semi-automatically as if we are "programmed by practice". If
we want to change the programme one morning we need to learn how to do things
differently. But if one morning we have a row with our partner, this will cut across
our morning rituals and affect the sequence of our actions (e.g. forget something
important; drop something) because the strong emotions (e.g. anger: an
unconscious reliving of "put downs" by a parent in childhood) are fuelling our
feelings which in turn are affecting our behaviour. In this example, the way the
cognitive and analytic elements or levels are working together becomes more
explicit.

Whilst cognitive therapy focuses on re-learning and changing an automatic
emotional response to a rational conscious process, psychoanalytic therapy focuses
on how past events in childhood unconsciously affect our relationship with self and
others. In CAT the therapist needs to be aware of all these different levels as
underpinning action and behaviour in order to gain a better understanding of the
client. Ryle (1993) in relevant terms states: "only if by analytic is implied an
unyielding transference-centred interpretative mode is the cognitive component
intrusive" (p.220)

CAT's most distinctive feature is its emphasis on an active, collaborative partnership
with the client and an explicit sharing of focus of therapy with the client in written
form. Client and therapist work together on identifying the client's target problems.
Both explore why these target problems exist, why they don't change, and why they
are enacted time and time again (target problem procedures). A summary of the
target problems and target problem procedures is given to the client in the form of
a personal letter s/he can take away. There is no hidden agenda in CAT. In
contrast, it uses a diagram to track clients' past and present relationships with other
people. The client gives the information and the therapist drafts a diagram called
Sequential Diagrammatic Reformulation (SDR) in an attempt to identify client's
principle "states of mind" (typical mood, defensive organisation, sense of self and
the sense of the other) and represent the shifts and relationship between them in
the form of a "map". The client is given a copy of the diagram and s/he has something tangible to refer to which is argued to be particularly useful in the session with issues of transference that may arise.

In approaching a conclusion, it is deemed warranted by the discussion of CAT thus far to suggest that CAT presents the psychotherapeutic world with both a theoretical and practical challenge in the way it approaches the conceptualisation and application of therapeutic intervention through an integrative outlook. Ryle (1993) appears to suggest that CAT aims to compensate for the general failure of the cognitive therapies to consider the self in detail (especially with regard to subtle, unconscious processes) and acknowledge the availability of a cognitive account to describe phenomena described as defences in psychoanalysis, which has left cognitive therapies prey to the trap of superficial simplification of mental structure, psychic structure and emotion.

On the other hand, CAT - despite its incorporation of the key psychoanalytic understandings of how infantile experience shapes adult personality, the recognition of how far the mental processes which control our lives takes place outside our awareness, the frequently contradictory and conflicted nature of our desires and our ways of protecting ourselves of this fact, and the frequent recapitulation in the transference of elements of the individual's life problems - claims that it has revised and restated psychoanalytic theory in a way that these understandings are emphasised and challenged within the important framework of structured, tangible and focused action and high-level self-reflection. This appears to render the application of important and clinically useful psychoanalytic ideas more widely applicable, more effective and more relevant to the needs of the ordinary population of neurotic and personality-disordered patients than the purely psychoanalytic approaches.

Rather than aspiring to participate in the long-term remaking of the personality or restructure the way in which individuals think and behave, CAT seems to aim at aiding the beginning of the process of change by removing self-defeating blocks to growth through the client's active participation in the task of self-description and self-observation. The conceptualisation of the individual that emerges from this synthesis meets CAT's constructivist roots in its belief that individuals can actively
construct their own reality without rejecting, as Kelly did, principles derived from psychoanalysis and behaviourism.

Overall, it would only be fair to this new approach, still in its very formative years, to commend its efforts to integrate where other approaches have originally chosen the paths of fragmentation. It can be argued that it certainly appears a promising and appealing move toward the bridging of ideological, theoretical and technical differences of the most influential models in the psychotherapeutic universe in a constructive and respectful way. For this it deserves both our attention and our tolerance.
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The specific contribution of the counselling psychologist in therapeutic services.

Given that Counselling Psychology has very recently developed as a branch of professional psychology - achieving full professional status in 1992 (Woolfe 1996) - and is increasingly permeating into the therapeutic services, this is deemed an appropriate time to review its contribution to these services and its potential for initiating and shaping changes and advancements to the provision of such services. This task though is not easy considering that we are dealing with a discipline which is still in its infancy and - much to its strength - its development is dynamic and formative, under constant scrutiny and continuing inquiry.

Thus, for our purposes it is deemed that the establishment of a framework regarding the features, predicaments, philosophy and values that demarcate - to the extent possible - the field of counselling psychology and the work of its “disciples” along with consideration to the needs and premises of the function of therapeutic services, are of unequivocal importance in our attempt to outline the specific contributions of a counselling psychologist to the therapeutic services.

Counselling Psychology has been defined “as the application of psychological knowledge to the practice of counselling” (Woolfe 1996, p. 4) aiming at developing “a model of psychological enquiry which is appropriate for, and does justice to, the interpersonal, multidimensional, complex nature of relationships between people as they meet and negotiate the terms on which they can understand themselves and their words, particularly in forms of meeting such as psychological counselling” (Wilkinson et al 1997, p. 80). It is thus obvious that counselling psychology as a new discipline introduces the need and the challenge of an informed practice that marries content knowledge (sophisticated understanding of psychological theory and knowledge in negotiating an understanding of clients’ issues) with knowledge of process (the dynamics of the therapeutic relationship) (Williams & Irving 1995). It is on the mastery of this interplay that the development of counselling psychology is based, evolves, and asserts its right for role differentiation, along with placing a high value on understanding as a worthy objective; an understanding in whose achievement the counselling psychologist's own subjectivity and ethos play a
prominent role in engaging the other person collaboratively and in a way that is empowering.

It is within this framework which incubates a broad, flexible, diverse, rigorous, collaborative, and complex multivariate rather than monolithic approach to the conceptualisation and operationalisation of clients' difficulties and presenting problems that the work of counselling psychologists is informed and performed. Thus, it enables them to view and work with the full-spectrum of individuals' behaviour “with applications anywhere within the field of human life, across the continua of adjustment and development, through the range of associational groupings and throughout the life span” (Farrell 1996, p. 587) since the central focus is on “the uniqueness of individuals and the importance of their phenomenological world articulated within a professional relationship” (p. 587) and the use of this relationship to facilitate change and negotiate some resolution. Emphasis, thus, is on development of potential; on prevention rather than cure, on well-being rather than responding to sickness and pathology per se, and on a developmental approach to mental health, in contrast to the medical model that largely still informs the practice of other disciplines within the field, such as clinical psychology (Woolfe 1996; Watkins et al 1988).

Such process however requires a practice that is informed by psychological knowledge that guides the understanding of development and its vicissitudes along with a critical understanding of research on therapeutic approaches and on clients' subjective introduction of substantive issues, and an active involvement in the therapeutic process on the part of the counselling psychologist. These predicaments inevitably put the counselling psychologist in a position that advances the skilful integration of theory, research, and practice as viewed through the scientist-practitioner or practitioner-scholar perspective (Farrell 1996; Rennie 1994; Watkins et al 1988) and requires reflexivity in practice which is dependent upon the counselling psychologist setting a lead in continuing to work on an ongoing basis at increasing the level of awareness and understanding of their own psychological process and implicit theories through personal development work and the experience of being a client themselves (Wilkinson et al 1997; Woolfe 1996) as well as in continuing to work at developing professionally through initiating and facilitating continuing professional education (Wilkinson et al 1997; Farrell 1996).
Such rigorous and flexible practice, therefore, is based on and informed by - amongst everything else the ability to use both integratively and separately according to the assessment of individual needs different approaches (e.g. psychoanalytic, cognitive behavioural, systemic, humanistic or existential) and theories of psychological knowledge, without confusing theoretical viewpoints, theoretical levels and conflating theories deriving from incompatible assumptions - and evaluate the effectiveness and efficiency of their applications within a set core of values translatable into the internalisation of the full understanding of such issues as professional responsibility and liability, confidentiality, record keeping, risk assessment, boundaries, limits of competence and dual relationships (Wilkinson et al 1997; Farrell 1996).

It is hoped that this brief account of the potential that the role of the counselling psychologist can fulfil - through rigorous and comprehensive training - within the scheme of things in the field of academic and applied professional psychology has mapped a clear structure of how counselling psychologists aim at bridging the gap between tradition and innovation in the field of psychology. The breadth and depth of their training allows them to work in a remedial, developmental/educational, and preventive capacity, develop a broad repertoire of skills that is transferable and versatile across work settings and client populations, and promote a more articulated "scientific" basis for counselling through providing a pioneer paradigm for the integration of theory, research and practice that transcends the existing artificial dualism on these aspects and serves to integrate rather than fragment human action.

Having outlined what the role of a counselling psychologist entails and what the provision of services that he/she can offer and enhance comprises of, it would only be timely to explore how these are of specific contributing value to the therapeutic services. The reference to therapeutic services in this text applies to such services provided in NHS settings where the author has had recent exposure to and experience of.

Kosviner (1994) in an overview of "Psychotherapies within the NHS" points to the evolving and changing nature of the therapeutic services provided in the NHS which has developed to require the offer of a broad range of psychotherapies so that the
responsiveness and flexibility to individual needs be closest to the use of all resources in the field with optimal efficiency and effectiveness. She stresses the importance of the breadth and depth of understanding that comes from years of professional training and the integration of each approach as a cornerstone on which NHS therapeutic services need to establish a broad and flexible range of psychotherapies within a co-ordinated service, since services are often uncoordinated, unevenly distributed and poorly integrated with other psychiatric and psychological services. She argues that the co-ordination and integration of such resources require people with a broad appreciation and understanding of all aspects of services in the psychotherapies, not just one model or modality of psychotherapy.

Within this context the specific contribution of the counselling psychologist is twofold in that - given the breadth, depth and emphasis on the integrative paradigm of his/her professional training and knowledge - he/she can act as a manager/co-ordinator/organisational supervisor of therapeutic services and through his/her participation in departmental meetings and staff meetings (including social workers, community psychiatric nurses, psychiatrists and clinical psychologists) is able to offer a different challenging and constructive perspective with regard to the assessment and treatment planning of the presented cases due to his/her ability to combine or change psychological approaches as appropriate while remaining rigorous in their application; thus opening an important arena to encourage dialogue and add a counselling psychology perspective into the mix.

In this way, the counselling psychologist contributes to the efficiency of the provision of therapeutic services by inspiring an integrative paradigm that aids communication between different professionals and offers a more holistic view of the modalities that can be employed in clients' treatment, advancing the collaboration and co-operation of separate specialities that if left to their own devices can stir confusion, anxiety and conflict within the therapeutic services and engender detachment from the dynamic process of change within the organisational structure that provides the therapeutic services. Thus, the counselling psychologist, drawing on his/her knowledge and experience of an integrative approach that retains a quality which is informed by the principles underlying these different approaches, can contribute to the innovation and development of therapeutic services in a way that "incompatible
procedures are not mixed to brew an *inherently contradictory or meaningless eclectic cocktail* (Kosviner 1994, p.294, my italics).

In a discussion where efficiency and effectiveness of therapeutic services is an integral part of a process of monitoring and evaluating the provision of such services - especially in NHS settings where there is pressing need to provide more and better services within available resources - the importance of practitioners that also hold the capacity to design and carry out research sensitive to the variables being assessed is immediate and crucial. Thus, the training of the counselling psychologist within the scientist-practitioner model provides him/her with the capability of yet another very specific and essential contribution in the therapeutic services; namely the undertaking of the task to deal appropriately and accordingly with issues that require systematic audits of services (i.e. service relevance, equity, accessibility, acceptability, effectiveness and efficiency) as well as issues that are related to the elements of the therapeutic relationship per se and advance practitioners' knowledge on its dynamics and outcome substantiated by empirical research findings and sound psychological theories. Such an attitude pledges allegiance to the conclusion of the publication by The Department Of Health (1992) in which the need for the mental health professionals practising within the NHS to stay grounded in an empiricism sensitive to the complexities of the service which they provide and adequately monitor and research their services, was stressed.

Another yet core contribution of the counselling psychologist in the therapeutic services - which in itself also yields direct and close relevance to issues of efficiency in these services - is that of the key importance of assessment in NHS settings where appropriate and effective allocation of referrals is crucial for the viability of the services. Using Kosviner's (1994) words in relation to assessment in NHS settings:

"It [assessment] should be informed by an understanding of the range of different psychological therapies and their applicability to different types of difficulties and in different settings - whether in individual, group, couple or family therapies. Ideally, the assessment process should be informed by a broad understanding of human development and of the range of psychological approaches which can help in any particular case; it should be dispassionate and not biased toward any particular therapeutic orientation; it should be flexible and tailored to individual needs, and helpful in empowering people to make informed choices about which
psychotherapeutic approach may best suit them. It should also be able [........] to adjust psychological treatments to the individual rather than the other way round."
(p.293, my italics)

Bearing in mind the points that were raised when introducing the framework and philosophy within which counselling psychologists practice, it appears needless to point out the obvious match between the counselling psychology mentality of practice and the above predicaments, which effortlessly leads our thinking to the specific contribution of the counselling psychologist as appropriately qualified to fulfil a consulting role in assessing the most suitable form of psychotherapy in any individual case with apparent implications for the essential skills in differential assessment for the psychotherapies required in National Health Service provision.

Within this context, the emphasis that the discipline of counselling psychology casts on continuing personal and professional development implies, first of all, a firm commitment to ongoing search for emotional robustness and interpersonal confidence in the face of psychological distress through personal therapy, which accentuates and solidifies the practitioners' responsibility and ethical liability toward the service and the clients and entails an informed awareness of personal issues, limitations and boundaries. This is deemed very important by the present author for the provision of therapeutic services- especially within the NHS - where the danger of taking on an overload lurks around very insidiously and knowledge of one's own limits constitutes in itself an issue of efficiency and cost-effectiveness (burn-outs are more cost-effective and mounting to inefficiency than monitoring one's own work load and ability to practice with integrity and at a pace tailored to his/her own thresholds of psychological tolerance at any one time).

Secondly the aforementioned emphasis on continuing professional development renders the counselling psychologist able of both providing such opportunities in the settings he/she is employed and improving his/her own practice - and hence the provision of therapeutic services - through active involvement in and attendance of CPD programmes.

In conclusion, it is apparent in what ways the counselling psychologist can contribute to the provision of therapeutic services although the discussion could go
on into unravelling the subtle intricacies that render the counselling psychologist a valued member in the society of mental health professionals. However, in this author’s mind the most valued contribution of the counselling psychologist - which in itself poses a challenge to him/her - is his/her plight to modify in important ways the models and approaches he/she makes use of in terms of the changed socio-cultural context in which we now live so that the provision of therapeutic services will become attuned to the era to whose aid they have been called. Through the interweaving of professionalism, theory, practice, and research, the counselling psychologist could rise to standards of contribution that would include fruitful fertilisation, enhanced diversity and delight in increased choices in the therapeutic services themselves and an enrichment of their creative and discriminating capacities (to lend but a few terms from Clarkson, 1995).
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AMBIVALENCE: THE DILEMMA OF CHANGE
An Evaluation of the Viability of Motivational Interviewing in Dealing with Ambivalence.

As a training counselling psychologist with a special and active interest in the field of addiction, I have become aware of the existence of a degree of separation between the specialised therapeutic work with substance problems and the generalist worlds of practice. One influence towards separation derives from the fact that the system that delivers care for people with drug or alcohol problems is physically separate from the facilities that deal with the generality of therapeutic work. The loss that can result from the decay of communication is likely to effect both sides of the divide; practitioners working with alcohol and drug problems have skills and rich experience that can profitably be shared with the wider therapeutic community. In complimentary fashion, generalist practitioners can contribute in enhancing the specialists' updating in their awareness of generic developments. The general intention of this exchange is to initiate and assist the bridging between practice in substance misuse and the generalist mainland by inviting an active professional involvement in reflection on an issue that appears to transcend what lies within the boundaries of addictive behaviour; namely, the issue of ambivalence in clients.

It is argued that it is widespread knowledge among practitioners that the outcome of any therapy does not depend exclusively on the use of appropriate treatment strategies but equally as much on how persistently and conscientiously the client carries them through (Davidson 1996). This implies that the degree of engagement that clients show toward the therapeutic encounter constitutes a crucial factor in long-term success. Thus, motivation becomes of decisive importance for entering into, continuing and adhering to a change process.

The discussion then is bound to focus on ambivalence as the predominant underlying reason of motivational problems in therapeutic encounters. Ambivalence is a normal and common component of many psychological problems. In addictive behaviours, though, it is a central phenomenon (Miller & Rollnick 1991). As such, the exposure of the generalist practitioners to the meaning of ambivalence and their acquaintance with how specialist practitioners in substance misuse deal with the presentation of ambivalence in the clients they encounter could prove invaluably
useful when faced with the difficulty of ambivalent clients or clients who have primary or secondary substance misuse issues.

By virtue of ambivalence being a rather universal difficulty encountered by the majority of practitioners, it is deemed important to first of all briefly discuss how ambivalence is conceptualised and understood by psychological theories. The understanding of ambivalence has a long history in both the psychoanalytic and cognitive behavioural literature. Bleuler first used the word ambivalence in 1911 when he defined three types. Voluntary ambivalence is a conscious conflict about doing one thing versus something else. Intellectual ambivalence is a simultaneous interpretation of experience in positive and negative ways. Emotional ambivalence specifically refers to the feelings of love and hate directed at the same object. Freud (1913) built on the idea of emotional ambivalence as a precursor of defences like splitting and reaction formation.

Cognitive behavioural theorists, on the other hand, have developed ideas broadly in line with Bleuler’s (1911) conception of voluntary ambivalence when describing approach-avoidance conflicts (the type of conflict when the person is both attracted to and repelled by a single object). Sincoff (1990) has subsequently defined ambivalence as overlapping approach avoidance tendencies, manifested behaviourally, cognitively or affectively and directed towards a given person or experience. Therefore, consequently, ambivalence can result in personal distress, and more importantly perhaps the inability to make important life decisions. Janis and Mann (1977) have argued that resolution can come about when the losses arising from the behaviour in question exceed the gains, thus prompting an individual to seek out new solutions. As suggested by research evidence (Abelson & Levi 1985), this process may be hindered by information overload, lack of emphasis on the essential information, over-emphasis on non-essential information, and poor integration of information from various sources.

It is obvious then that the latter model views ambivalence as leaning heavily on logic and information processing, probably at the expense of self-reflection and subjective meaning of the decisions. Despite, this though, its major strength lies in its contribution to the acknowledgement that ambivalence is more of a situational variable or a state rather than a trait arising from either a uniquely pathological
personality or from disordered character defence mechanisms (i.e. denial, rationalisation or projection) (Davidson 1996). It is the psychoanalytic literature that implies that ambivalence is symptomatic of more deeply rooted conflicts, which should be dealt with before indecision can be resolved. Thus, psychoanalytic literature seems to contend that ambivalence - or lack of integration - is a relatively enduring characteristic associated with various forms of psychopathology. This of course does not mean that even cognitive therapists, who do not pathologise ambivalence, should ignore the importance of exploring the dangers and threats to self that conflict resolution may involve. It would appear that an integration of the more resilient components of the two theories would constitute the most effective and viable approach in dealing with ambivalent clients.

In recent years, new approaches that centre around the management of ambivalence, and the confrontation of denial, in the context of addiction treatment have shifted their emphasis on ambivalence as a state of mind in which a person has coexisting but conflicting feelings about something. In addictive behaviours, the person is usually ambivalent about engaging in the behaviour in question versus resisting it. It is inherent in this stance that the presence of such motivational conflict is not a personality problem and those who deny the need for change are not inherently lacking in motivation. Rather than a "bad sign", this is regarded as normal, acceptable and understandable. Subsequently then denial is viewed as a by-product of traditional confrontative interventions, and, thus, of a therapist-client dialogue that is consumed by a preoccupation of attacking the perceived "denial" monster (Davidson 1996; Miller & Rollnick 1991).

The most acclaimed of those approaches which is considered to be a particularly useful tool in helping people with substance misuse problems, who are still ambivalent or even resistant to change, is motivational interviewing. It was developed by Miller and Rollnick in the early part of the eighties. This approach grew out of the realisation - through research evidence (Leake & King 1977; Newcomb & Harlow 1986) - that it seems not only unhelpful but at times also a hindrance to change to think of a person as "poorly motivated", since such an attitude may foster expectancy of poor prognosis in the client, as convincingly demonstrated by Leake & King. Motivational interviewing therefore took up the challenge of discovering how practitioners can help strengthen the individual's
motivation for change, and thus it could be regarded as a set of ambivalence resolution strategies which are more persuasive than coercive, and more supportive than argumentative.

Motivational interviewing is a misnomer in the sense that it is not based on contemporary theories of the psychology of motivation. It is essentially a derivation of Rogerian client-centred counselling, and the central role of the therapist is to facilitate decision-making through clarification, advice, accurate feedback and appropriate empathy (Davidson 1996). That is, it combines the properties of cognitive behavioural techniques and the core premises of humanistic psychology by drawing on the understanding of the elements of the individual's motivational conflicts and relative importance that he/she assigns to them. In this sense though motivational interviewing is more task-focused and directive than traditional client-centred counselling in that the therapist will offer advice and actively attempt to create discrepancy or dissonance, rather than passively follow the client. Rollnick et al (1992) assert that the goal of motivational interviewing is to explore ambivalence and conflicts, and to encourage clients to express their concerns and arguments about change in order to increase the client's intrinsic motivation, so that change arises from within rather than being imposed from without. It could thus be argued that motivational interviewing has adapted the psychology of self-actualisation to the treatment of addictions.

The application of motivational interviewing is based on five therapeutic principles which constitute the foundation for the understanding and working through of ambivalence until the individual moves closer to determination and decision making. These are described below and are as follows:

1. **Expressing empathy**

Empathic warmth and reflective listening are essential and defining characteristics of motivational interviewing, since they enhance self-esteem, the person's general self regard. By utilising these techniques, the therapist seeks to understand the client's feelings and perspectives without judging, criticising or blaming. It is important though to note that such acceptance does not mean agreement, approval or collusion with the client's view. It primarily serves to create an environment of acceptance and respect that aids the development of therapeutic alliance and
supports the client's self-esteem; thus advancing these important conditions of change. These conditions are further enhanced by the acceptance of ambivalence as a normal part of human experience and change rather than as a pathological trait or pernicious defensiveness. Instead the client's situation is understood as one of being “stuck” through understandable psychological principles (Miller & Rollnick 1991; Davidson 1996).

2. Developing discrepancy
Using reflective listening and empathic warmth does not mean following the clients wherever they happen to wander. It is important in motivational interviewing to develop, make use of, increase and amplify (in the client's mind) a discrepancy between present behaviour and broader goals, until it overrides attachment to the present behaviour. This involves clarifying important goals for the client, and exploring the consequences of his or her present behaviour which conflict with those goals. It is essential that this process occurs within the client, rather than relying primarily for its implementation on external motivators (e.g. pressure from the spouse, threat of unemployment, or court imposed contingencies). When successfully done, motivational interviewing changes the client's perceptions of discrepancy without creating a feeling of being pressured or coerced (Miller & Rollnick 1991; Davidson 1996).

3. Avoiding argumentation
Direct argumentation tends to evoke reactance from people and is likely to elicit opposition and defensiveness which is counterindicative to implementation of change. For this reason, it is central in motivational interviewing to avoid arguments and head-to-head confrontations that evoke client resistance. Trying to force a client to accept the label of an alcoholic or a drug addict - on which some practitioners place great importance - can be countertherapeutic. Confronting clients with being "in denial" or "resistant" or "addicted" is more likely to increase their resistance than to instil motivation for change. Motivational interviewing advocates that the therapist start with the clients where they are, and alter their self-perceptions not by arguing about labels, but through substantially effective means (Miller & Rollnick 1991; Davidson 1996).
4. Rolling with resistance
Such effective means in motivational interviewing can be witnessed when clients are invited to consider new information and are offered new perspectives through reframing and turning a question or problem back to them. Rolling with resistance includes involving the client actively in the process of problem solving, since the client is regarded as a capable individual with important insights and ideas for the solution of their own problems (Miller & Rollnick 1991; Davidson 1996).

5. Supporting self-efficacy
Self-efficacy refers to a person's belief in his or her ability to carry out and succeed with a specific task or challenge. Motivational interviewing aims at increasing the client's perceptions of his or her capability to cope with obstacles and to succeed in change. Such efficacy can be bolstered by emphasising personal responsibility but without imposing undue pressure on the client. Contact with former clients as models can be helpful in this regard. Additionally or alternatively therapists can also use accounts of the numbers of people who have succeeded in changing, or specific success stories. The underlying assumption is that unless the person perceives any hope for change, no effort will be made (Miller & Rollnick 1991; Davidson 1996).

Overall, motivational interviewing moves towards the practical implementation of these principles through the use of such tools as effective advice, the elicitation of self-motivational statements in many ways ranging from evocative questions to paradoxical injunction, the provision of accurate feedback - perhaps through the use of objective tests -, the discussion of alternative treatment goals, the removal of practical barriers to facilitate the treatment process and the working through of decisional benefits and costs with emphasis on the positive incentives (Miller & Rollnick 1991; Davidson 1996)

There have been a number of controlled trials that examine the efficacy of this type of intervention for people with substance misuse problems. Like all outcome research though the results give us a mixed picture where only marginal differences in long-term outcome have been reported. Specifically, Valle (1981), Luborsky et al (1985), Miller & Baca (1993), and Rollnick et al (1992) have found some evidence of better long-term outcome in people who receive motivational interviewing therapy. In
contrast, Kuchipudi et al (1990) and Baker et al (1993) found no significant improvement or difference in people who were exposed to motivational interviewing interventions.

On balance it would appear likely that motivational interviewing strategies act in some way to assist clients to resolve ambivalence. However, it is obvious that further work is required to disentangle the array of elements that constitute motivational interviewing and to ascertain which of these are the best predictors of future success. Overall, it would appear that motivational interviewing is worth such effort and it may be that the most convincing arguments lie in contrasting motivational interviewing with traditional approaches that have been widely used specifically in the treatment of addictions and also more generally. It would therefore be interesting to contrast motivational interviewing with three other treatment approaches for purposes of conciseness. Three styles that vary in the position they hold in the continuum from specialist to generalist approaches were selected so that the broader applicability and practical utility of motivational interviewing could be discussed. These are: the confrontation-of-denial approach, the skills-training approach, and the nondirective approach.

In the confrontation-of-denial approach heavy emphasis is placed on the acceptance of the self as having a problem, which can ultimately lead to the interpretation that the acceptance of a diagnosis on the part of the individual is essential for change. It thus transpires that personality is pathologised in a way that reduces personal choice, judgement and control over one's behaviour. This is directly opposite to the emphasis of motivational interviewing on personal choice and responsibility for deciding future behaviour by viewing the emphasis on the acceptance of labels as unnecessary for change to occur. Furthermore, the former approach seems to advocate that the therapist needs to present perceived evidence of the problems in an attempt to convince the client to accept the aforementioned diagnosis. When this is resisted, resistance is consequently viewed as the person being "in denial" of reality which in itself is then regarded as requiring the use of direct confrontation in order to be dealt with. This in turn justifies the handling of resistance with argumentation and correction. Motivational interviewing, in contrast, allows the therapist to focus on eliciting the client's own concerns without excluding objective evaluation. Within this framework, resistance is rather viewed as an
interpersonal behaviour pattern influenced by the therapist's behaviour and is therefore met more flexibly with reflection (Miller & Rollnick 1991; Davidson 1996).

In overall terms, in the confrontation-of-denial approach the goals of treatment and the strategies of change are largely prescribed for the client by the therapist whereas in motivational interviewing they are negotiated between client and therapist. This generic difference seems to stem from a more fundamental distinction in the two approaches where the former views the client "in denial" and incapable of making sound decisions and the latter contends how vital the client's involvement in and acceptance of goals are for intrinsic motivation for change.

The second approach that motivational interviewing will be contrasted to is the skills-training approach which is heir to a rather pure cognitive-behavioural stance. Skills-training approach assumes that the client is motivated, thus placing emphasis on teaching the person how to change by identifying and modifying maladaptive cognitions and prescribing coping strategies. Motivational interviewing, on the other hand, does not make assumptions of this kind and employs specific principles and strategies for building client motivation and commitment (the why) to change, by exploring and reflecting client perceptions without labelling or corrections, and by eliciting possible change strategies from the client (Miller & Rollnick 1991; Davidson 1996).

Overall, it seems obvious how the skills-training approach is often highly prescriptive, offering specific directions, instructions and assignments, unlike motivational interviewing which leaves the responsibility for change methods with the client and precludes the use of training, modelling, teaching, or practising.

Finally, the third approach that motivational interviewing is to be contrasted to is the nondirective approach which is mostly employed by generalist practitioners. Although motivational interviewing incorporates many of the insights and strategies described by C. Rogers, it differs significantly from a classic "Rogerian" style as well as other nondirective (i.e. existential) approaches. While traditional nondirective approaches allow the client to determine the content and direction of therapy by avoiding the injection of the therapist's own advice and feedback, motivational interviewing systematically directs the client toward motivation for change by
injecting the therapist's own advice and feedback not indiscriminately but where appropriate. Within the nondirective framework empathic response is used noncontingently, whereas in motivational interviewing is used selectively to reinforce certain points while de-emphasising others (Miller & Rollnick 1991; Davidson 1996).

Overall then, it appears to be clear that the underlying difference between the two approaches, although one is the offspring of the other, is the emphasis or de-emphasis on a well-defined focus. That is, in motivational interviewing the therapist, rather than passively following the client's own offerings, is often working actively to create and amplify the client's discomfort and discrepancy in order to enhance motivation for change.

Apart from addictive behaviours, motivational interviewing is being applied to a variety of equally sensitive and challenging fields such as the treatment of sex offenders, HIV risk reduction, working with disruptive young people and even in couples therapy. Its numerous applications bear witness to the flexible, diverse, sensitive and dynamic quality of its principles and properties as far as dealing with the dilemma of ambivalence encountered in the therapeutic relationship is concerned. It is argued here that the potential of motivational interviewing lies in what James Baldwin asserted in "Notes of a Native Son": that not everything that is faced can be changed; but nothing can be changed until it is faced. Motivational interviewing is about helping people to face the ambivalence that entraps them into repetitive cycles of self-defeating or self-destructive behaviour; it is only then that there is a choice to change because people's own motivations and resources are freed up.
REFERENCES


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Introduction to the Therapeutic Practice Dossier

Throughout the course of training I have completed three placements. The first was in a private addictions centre where work based on the Minnesota and action-counselling models was undertaken. The second one was at a CMHT/NHS Trust and the third one was shared between a drug addiction unit of a large NHS hospital and a community substance misuse team. On average two to two and a half days per week were spent in these settings, representing over 450 hours of direct group and individual work with clients.

Included in this dossier are:

- Short descriptions of the placements.
- Summaries of four client studies, the originals of which are not included in this public document.
- A discussion of process issues derived from two process reports, also not included.
- A brief overview of the three years of experience.

Confidential files with further details on the above are included in a separate appendix. This, together of log books of my therapeutic work, are kept at the psychology department at the University of Surrey.

N.B.: In order to safeguard clients' anonymity, initials, names and other identifying details have been either changed or omitted.
Placement 1: Private Addictions Centre

This private addictions centre was a 14-bed residential unit for individuals with substance abuse problems although the great majority of admissions involved individuals who presented with alcohol dependency. Its treatment programme was based on the Minnesota model (a twelve-step based programme). This advocated the disease concept of chemical dependency through aiming at total abstinence from all mood and mind altering substances. The objectives of treatment were pursued through a highly structured programme that relied on group processes and imparting of information but was flexible enough to accommodate individual treatment issues and needs in weekly individual keyworking sessions. Therefore, individual psychological therapy was of a brief, short-term nature (6-8 weeks) where the action-counselling model was of prevalence with contributions from psychodynamic and cognitive-behavioural models.

The centre had an in-depth assessment procedure for admission purposes, and provided, as part of its services, a starters group for individuals on the waiting list, a detoxification regime, and a family group, couples counselling, family therapy and aftercare facilities for the clients who successfully completed the programme and their families. Sessions of art therapy were also incorporated into the treatment programme. The centre had an exclusion criterion for admission which pertained to individual with mental health problems or a dual or multiple diagnoses.

The staff team was comprised of a consultant psychiatrist, a counselling psychologist (director of the centre), a senior counsellor, three qualified counsellors and an art therapist specialised in addictions treatment, a number of trainee counsellors as well as a number of night staff and an administrator. The style of individual supervision was primarily psychodynamic with some input from cognitive-behavioural model. Peer supervision was also available once a week.

The referral system was quite extensive involving self-referrals, referrals from family, relatives and friends, and referrals from a variety of services including social services, court service, medical services and other addiction agencies.
I worked quite independently within the team, although the amount of independence progressively increased as time went by. I was involved in all aspects of treatment and was also liaising with social services, probation officers, funding officers and secondary care facilities. This placement took effect in October 1995 and ended in August 1996.
Placement 2: Community Mental Health Team in NHS Therapeutic Services

The CMHT provided a variety of services to people with psychological and mental health problems. The service was part of the wider area’s major hospital and comprised of a team of consultant psychiatrists, registrars to the psychiatrists, a number of community psychiatric nurses with different specialisations (e.g. elderly, learning disabilities), a senior clinical psychologist trained in individual and group psychoanalytic therapy (the director of the services), and a cognitive behavioural clinical psychologist.

The referral system was extensive and served the general population which presented a high incidence of mental health problems. It involved referrals from GPs who had contractual agreements with the services, psychotherapists around the area, CPNs and other psychologists employed by the trust as well as the consultant psychiatrists and their associates. Presenting problems covered a wide range, including depression, anxiety and panic attacks, phobias, relationship problems, childhood abuse, and mental health issues.

Supervision was conducted exclusively within the psychoanalytic model and was on a one-to-one basis. The length of individual work varied from a minimum of 6 sessions to a maximum of 10 months (the duration of the placement). For some of my individual clients, I had to liaise with support agencies to co-ordinate treatment plans. The placement took effect in September 1996 and lasted until August 1997.

I worked totally independently with input only from my supervisor. In addition to my individual case load, I was co-therapist in a short-term psychoanalytic group (30 sessions) which I run with a qualified group analyst. Both of us received supervision from an independent psychoanalytic practitioner.
Placement 3: National Addiction Inpatient Treatment Unit in NHS Services and Community Drug Team

This placement was shared between an inpatient unit and a community team. Both settings were part of an NHS trust’s addiction services. The inpatient unit specialised in working with people with drug dependence problems who had complex needs and aimed at helping these individuals realise their optimum level of functioning, free from drug dependence. The services were led by an eminent consultant psychiatrist who was Professor in the Psychiatry of Addictive Behaviours.

The inpatient team comprised of consultant psychiatrists, a consultant clinical psychologist, trainee counselling psychologists, specialised psychiatric nurses, medical practitioners, pharmacists, and occupational therapists. This team aimed at diagnosing and treating the wide range of medical and psychiatric disorders, psychological, behavioural and psychosocial problems which may accompany drug dependence, as well as assessing and treating the addiction itself.

The service specifically provided for individuals who presented with severe drug dependence problems, repeated unsuccessful treatment in other settings, chaotic drug use, co-morbidity of dependence with psychiatric or physical illness, and associated severe psychosocial difficulties. Referrals were accepted from specialist drug misuse services. Self-referrals and referrals from GPs and other generic services were made first to their local drug services which in turn referred those individuals to the unit.

The unit comprised of the Acute and the Recovery programmes occurring in two separate wards. The Acute programme provided multidisciplinary in-depth assessment, stabilisation or detoxification from drugs and treatment of concomitant problems and disorders which normally lasted for up to one week after the completion of detoxification/stabilisation. The Recovery programme was designed to offer relapse prevention services within a specialised inpatient setting through an intensive programme. The intensive treatment and recovery programmes were planned on a basis of a six weeks stay and were predominantly informed by cognitive-behavioural approaches to the treatment of addiction, the relapse
prevention model, the revolving door model of change and motivational interviewing techniques. These interventions followed a developmental sequence for each client (i.e. the client's programme took account of their progress and led toward preparation for re-entry into the community. Clients who needed to stay longer than six weeks were reassessed and an additional programme was devised, up to a maximum stay of six months.

The placement in the above described unit took effect in October 1997 and ended on May 22, 1998 due to extended bereavement leave. However, I went in on July 9 to have an ending session with my individual clients.

The community drug team comprised of a number of mental health professionals specialised in working with drug addiction from a harm minimisation and reduction perspective. The team was committed to helping those individuals who presented with the motivation and willingness to control and ultimately reduce or stop their illicit and/or prescribed drug use. It acted as a methadone authorising and/or dispensing clinic combined with a maintenance and/or reducing regime for those who presented with problematic use of prescribed medication. The team comprised of a consultant psychiatrist, four clinical specialist nurses, three care managers/social workers, a GP, an assistant psychologist and a counselling psychologist who practised within the CBT framework. The role of the counselling psychologist in the team primarily involved the use of motivational interviewing techniques as well as more specific cognitive behavioural strategies to help individuals examine their attitudes and beliefs, talk about the pressures and attractions that brought them to and sustain them in drug use, and provide them with the support that allow users to find out alternative ways of acting and reacting in the world and make decisions about drug use. Referrals to the counselling psychologist came from the clinical nurses working in the team. Other than that the team received self-referrals and referrals from GPs, other generic services and other specialist misuse services.

The placement in the community drug team took effect in January 1998 and lasted until May 22, 1998 for the reason already mentioned in conjunction with the addictions unit placement. However, I went in on July 2 to have ending sessions with my clients.
I worked independently in both settings where the style of supervision was cognitive-behavioural. In the inpatient unit, I run one CBT group, and two relapse prevention groups along with my individual case load. In addition I was involved in designing tools to evaluate group outcome, offered relaxation sessions and contributed to the design of an anger management group.
Summary of the first client study

Ms A. (31) was seen for individual psychological therapy as part of her eight week in-patient treatment in an addictions centre (for a brief description of the setting see pp. 50-51). She was a divorced female, living alone and unemployed for the last year. She was at the time in a relationship with her ex-employer which she described as problem-ridden due to reported difficulties between him and her parents.

Ms A. presented with a primary addiction on a particular brand of over-the-counter painkillers with a composition of aspirin, paracetamol and caffeine and a secondary dependence on alcohol. At the time of her admission she was taking more than twelve tablets of these painkillers, more than four units of alcohol, and was on 20 mg of Prozac daily. She maintained that her life had become unmanageable since she had become increasingly unable to work and her significant relationships (with partner, parents and siblings) were strained due to her compulsive-obsessive behaviour.

Ms A. described marked ideas of reference and non-psychotic behaviour that she was talked about by everyone wherever she went and reported their existence for the last two years. She appeared very reserved, timid, and shy and experienced difficulty settling into the therapeutic group. The volume of her voice was almost inaudible when talking (especially about her parents) and she was apparently experiencing high levels of stress and anxiety as a result of her phobic and obsessive preoccupation with others’ presence. This impacted adversely on her concentration and subsequently on her ability to examine her own feelings and behaviour.

These summaries may be incomplete and lacking in detail due to constraints imposed by conciseness and confidentiality issues.
Ms A. was the oldest of three daughters born to the same parents. She had few memories of childhood other than feeling smothered and overprotected. She described her mother as "an anxious, possessive, dependent but critical" individual and her father as a kind man who could at the same time be "very critical and rigid". She later described a confusing situation of inconsistency and unpredictability at home as a child and reported constant invasion of her privacy by her parents who would become judgmental, rejecting and emotionally unavailable at non-compliance with their rigid and Christian way of life and of what is proper and acceptable.

Ms A. reported a long-standing medical history of migraines since the age of seven when she was first given pain medication. She left school at sixteen and attended a secretarial college. In her mid teens she started using codeine-based medication and began to use alcohol solidly from about the age of nineteen when she met her ex-husband. Their difficult marriage and separation a few years later resulted to an increase in her migraines and her alcohol consumption as well as her use of XTC, LSD and cannabis.

Ms A's presenting problem of dependence on painkillers and alcohol seemed to have been a compensatory strategy for coping with a considerable amount of stress and high levels of anxiety which appear to have become of debilitating nature as a consequence of her obsessional ideation. It would appear as though such obsessional ideation might have been a psychological symptom and/or defence developed early on to sustain a basic sense of safety, security and control amidst a barrage of unpredictability, inconsistency, secrecy, rigidity, overprotectiveness, unexpressed emotion and critical attitude by the familial environment.

In light of this, it appeared that attachment took an insecure form in the parental relationship where both parties were still tied up in a symbiotic relationship that fed itself by the parents' apparent overprotectiveness and interference in Ms A's life. Such patterns probably left her with feelings of worthlessness, powerlessness, low self-esteem and sense of self-efficacy that seemed to become a self-fulfilling prophecy manifested in her inability to adequately and effectively cope at work, social situations and relationships. It would further appear that her migraines might have intensified due to the inner conflict and unexpressed anger about the ambivalence she experienced over issues of separation from her parents. Alcohol
and painkillers could have well been used to medicate the unpleasant concomitants residing with these unresolved issues.

Initially, therapeutic work centred around Ms A’s obsessive thinking patterns and unrealistic beliefs about others’ behaviour, her difficulty with relationships and her reluctance to become emotionally intimate. Issues around her feelings of constant anxiety, stress and worry were addressed along with her manifested inability to express herself. The largest bulk of the therapeutic work focused on Ms A’s low self-esteem and sense of self-efficacy, her lack of confidence, her inability to be assertive and consequent people-pleasing and attention-seeking behaviours and her relationship with her parents and partner.

Due to the nature of Ms A’s difficulties the development of a trusting relationship was of paramount importance for the therapeutic work to be productive and meaningful. It was not until the therapist dealt successfully with Ms A’s tests of trust that such a relationship could be developed and consolidated. At the end of therapy she had begun to make sense of her life situation, discover and build on her competencies, and learn to accept and express herself and her feelings. These developments helped her pursue and achieve setting boundaries in her relationship with her parents and partner and evaluating and making her own decisions about her life in spite of her parents’ and/or partner’s interference.
Summary of the second client study

Ms A. (27) was a single female, living with her parents. She was the youngest of four; two sisters and a brother. She had graduated with a first class degree in French and Drama and was looking for a job as a freelance director/writer although she had developed doubts about her suitability for this profession. She had recently broken up with her partner because of the difficulties she was experiencing.

Ms A. was referred for assessment for psychotherapy to deal with "generalised anxiety". She presented her difficulties as centring around her anxiety and panic attacks. She talked about a "disintegrated state of being" which she described as if "existing in two plains: one of a high achiever, confident and competent, and another of panic, fear and anxiety about her expectation that people would be hostile to her if she let them down". She maintained that this "hindered her progress as a human being", and wanted to be able to manage her emotions and behave in a way that would be acceptable to her, since she viewed some segments of her current behaviour as destructive.

Ms A. was quite plain looking and dressed in a rather casual manner that seemed to denote at first glance an unobtrusive but pensive presence. She came across as articulate, intelligent, eloquent, introspective and insightful with a strong willingness, determination and ability to explore and understand her difficulties. She reported a long history of suicidal ideation and depression (since the age of ten) which was accompanied by two parasuicidal gestures when she was 22.

Ms A. was born to a Greek mother and English father; a reader in the Anglican church. She described her childhood and situation at home as "bizarre", although she was not able to clarify what she meant. She described her father as an "evil" man who was "emotionally violent" to all of them and made unkind and critical comments. She described her mother in a rather contradictory manner. Initially mother was described as "perfect", who - although viewed by client as more intelligent, active and competent than father - was rather dependent and submissive to him and also very controlling both of herself and her feelings, and her children. Mother was also described as very anxious smothering and unpredictable in her reactions to affective responses from Ms A. when she was young. At the age
of seven, Ms A, started having night terrors and experienced her first
depersonalisation experience when she felt she was unreal. This seemed to have
coincided with the deterioration of her parents' relationship following her father's
"breakdown".

It seemed that the "absent presence" of an anxious and unpredictable mother and
the "paranoid" rigidity, psychological intimidation and angry outbursts on the part of
the father impacted adversely on Ms A's formative years, resulting to the withdrawal
of opportunity to develop a coherent and cohesive sense of self and to the need to
disavow her own feelings and needs in order to maintain some sense of sanity,
constancy and equilibrium (even if distorted) amidst such emotional turmoil of
ingrained helplessness and fear. As a result of these processes it appeared that Ms
A. developed a sense of self that oscillated between the extremes of detachment
and dependency.

It appeared probable that her panic and anxiety was a manifestation of the inner
conflict between these two polarities and the confused and ambivalent sense of
attachment which brought about a sense of insecurity and distrust both within her
and in relation to others. It was possible that her early preoccupation with suicide
was stemming from the trauma of feeling unnoticed and "unheld". It was
hypothesised that the disintegrated state of being she described was a direct
outcome of the above conflicts where she felt she had to be strong, competent, and
independent to counteract feelings of shame, helplessness and fear of inherent
pathology. On the other hand though she appeared to long for merging to give her a
sense of her presence as well as security, coherence and cohesiveness although
this was in itself perceived as dangerous and confusing due to the fear of losing
herself into another person who she could not trust to be consistent and caring
being pronounced.

Ms A. and I worked together for eleven sessions. In the first few sessions work with
Ms A. concentrated mainly on exploring the split between the parental dyad, the
unconscious processes that had led to it and how it had impacted on the
development of her presenting problems. This initial exploration furthered to
incorporate and analysis of her major defence, namely intellectualisation which in
itself constituted a split between cognitive and emotional insight, and her experience
of her relationship with her mother and her idealisation. This exploration resulted to Ms A. gaining an awareness of her need for and fear of dependency and "authentic human contact" and of her dismissive response patterns both toward herself and others as a means of protecting herself from the pain of shame and pathology.

In the remaining few sessions, our work shifted as a result of the natural progression of deconstruction and reconstruction of the relationship with mother. It centred around the upsurging feelings of anger, grief and loss as mother was demystified, and the polarisation and splitting started decompensating.

Her panic and anxiety attacks lessened both in frequency and intensity and she started taking risks of exposing her vulnerability in small but firm steps outside the consulting room. At the end of therapy, Ms A's move toward a more congruent and integrated sense of self and presence became obvious. She became more able to express how she felt by containing the fear that such response would drive people away and came to accept the end of our work as a starting point rather than an end point. She became able to reach out to her siblings and to start working on her relationship with them. She resumed her relationship with her partner and left home to live on her own. Finally she grew to make decisions about the course of her professional life by initiating the construction of a more stable, confident, and flexible framework of her experience of herself in this profession.
Summary of the third client study

Ms N. (27) was a single unemployed female living with her mother. She introduced her presenting problem in a largely somatised manner, stating that she felt "tired and drained" and experienced disturbed sleeping patterns, intense headaches, poor concentration, and a confused state of mind which pointed to depressive symptomatology. She also experienced frequent panic and anxiety attacks. She maintained she felt she could not trust anyone, yet she was influenced by others to the extent that she felt she had lost her sense of her own self as well as feeling "torn apart". Ms N stated that she would like psychological therapy to help her find out who she is, to understand herself and to become empowered to claim her space.

Ms N. appeared to have a pleasant manner and was, in appearance, attractive and well-dressed. However, she presented a split image in the sessions where her physical appearance and her mood fluctuated between control/coping ability and helplessness/anxiety, probably manifesting the inner conflict between who she "ought" to be or was expected of her to be and feel and how she really felt within. This was perceived as a manifestation of the incongruence between her "ideal" and "real" self. She made minimal use of words associated with feelings and disproportionately large use of cognitive and superordinate statements (i.e. "I think..." or "I should/ought to...").

Ms N. was born in ...... (country of origin). Her mother was married to a very influential local personality and had a son with him. After finding out that her husband was bisexual, she had two affairs out of which Ms N's second half-brother and herself were born. Shortly after Ms N was born, her mother left her husband, took the children and moved to England where Ms N was brought up. She never knew her father who was described by her mother as an "abusive alcoholic".

Ms N. met her stepfather when she was seven and described him as an overpowering and distant figure, dismissive of her feelings and exclusively interested in his career. She maintained that he imposed on her the expectation to be "in control of herself". She was educated in a Convent school and left without
completing her A levels. She felt that she had let her family down who expected better from her.

She had a history of depression that manifested itself two years after her eldest brother (who she had looked up to as a substitute father figure) left the country to return to ....... (country of origin). At around the same time, she started drinking heavily and was encouraged by her mother to got to .... (country of origin) where her eldest brother and stepfather could help her. While in the country, she was gang raped after getting drunk in a local pub. The incident was hushed up because of the social status of the family and as a consequence she came back to England feeling hurt, rejected and humiliated.

Ms N. described her relationship with her mother (apparently the only constant figure in her life) as good although she experienced her as unavailable, absent and intrusive. Ms N. reported that she had on numerous occasions told her that men are weak and not to be trusted and that Ms N needed to be strong and self-reliant to get through life on her own.

Ms N. formed her first relationship at age eighteen. This was short-lived because she was frightened that she might “lose herself” in it because she was very fond of her boyfriend. Ever since she had had numerous short-term relationships most of which during the time she was drinking.

It appeared that Ms N. had numerous losses and traumas in her developmental history which occurred in an almost insulated matriarchal environment, devoid of emotionally reliable parental figures and ridden by unvented feelings, dismissed needs, conflict, anxiety, unrealistic expectations and distorted attitudes toward life. Such an environment probably fostered the development of a fragile sense of self torn between an imposed but overwhelming need to be in control, strong, proper and self-reliant and a pervasive vulnerability to feelings of shame, guilt, rejection, abandonment, worthlessness and anger for having any needs. These factors in combination with the cumulative losses and traumas sustained apparently depleted Ms N’s ability to cope precipitating her depressive symptomatology and giving rise to pronounced features of anxiety and panic attacks. Following this inability, possibly came her extreme preoccupation with engaging in desperate efforts to find solutions
and appear in control which might have in turn precipitated such physiological responses as headaches, poor concentration, tiredness, and confusion.

Therapeutic work with Ms N. lasted for ten months. During the course of therapy Ms N's assumptions about herself, their origins and how they influenced the way she felt and behaved were explored. The focus was on enhancing her undermined ability to identify, acknowledge and express her feelings and on reaching some level of integration for her fragmented sense of self into a less rigid structure so as to restore her ability to cope with life in a constructive rather than self-destructive way. At the end of therapy although she had started to risk making small changes in her life (i.e. publishing her poems, enrolling in a university course for writing and poetry), become more in tune with her feelings and the way she responded to them and more assertive with people, evaluate the significant relationships in her life, and her headaches and panic attacks had considerably diminished in frequency, she failed to attend the ultimate session.
Summary of the fourth client study

Mrs K. (49) was separated from her husband and in a relationship with another man. She had a 25 year old daughter from her marriage. She appeared to be engaging in a way that suggested a strong need for attachment to others. She came across as willing and motivated to regain a sense of control over her life but it seemed that this was compromised by a sense of confusion as to where her priorities lay.

Mrs K. presented with a problem of a long standing dependence on prescribed anti-anxiolytic medication. Mrs K described her difficulties as emanating from her tendency to “keep things inside” and her perception of herself as “a strong person that needs to cope with anything”. She reported that throughout her life she has been feeling as if she is “the extension of other people’s selves”. She reported a moderate number of depressive symptoms, a heightened difficulty in making decisions, and a lessened sense of satisfaction with her sense of self-efficacy. She also reported symptoms of generalised anxiety. She had a score of moderate depression (26) on BDI and a score of moderate/severe anxiety (23) on BAI that were given to her during the assessment.

Mrs K. was first prescribed anti-anxiolytics in 1990 by her GP in (country of residence) to help her with menopausal symptoms. It was at around that time that she started experiencing heightened levels of anxiety and panic attacks. It appeared that such manifestations of a largely compromised coping ability coincided with her increasing sense of powerlessness, helplessness, loneliness and dissatisfaction in her marriage which seemed to be related to her ex-husband’s increasing “verbal and emotional abuse” and her very limited social network system over there.

Mrs K. was brought up by her grandmother since her mother had her out of wedlock and was unable to support her. She never knew her father. At around 17 she met her ex-husband, got married and later moved to (country of residence) with him where she stayed until their separation. She had a basic education and had never been employed in her life since her husband was a very wealthy man. Mrs K’s daughter left (country of residence) and moved to England a few years ago to study.
Mrs K. was an only child. She described her grandmother as very caring and affectionate. As far as her mother was concerned, she sufficed in saying that they got on and they were still in contact. Mrs K. described her ex-husband as a serious man who was totally immersed in his businesses and treated her as non-existent. Although she perceived her current partner as understanding and supportive, she described a few difficulties in their relationship that appeared to foster an emerging sense of doubt, ambivalence and distrust concerning his commitment to the relationship. This seemed to have had an adverse effect on her sense of self-esteem and self-worth that seemed to aggravate her depression and anxiety. Mrs K. also described a turbulent relationship with her daughter. She reported that she felt at a loss as to how to approach her and establish a meaningful relationship with her.

It seemed that although Mrs K. formed a reliable and adequately fulfilling relationship with her grandmother, the knowledge of the unavailability of both parents had probably left her believing that she is undeserving and hard to cope with. Such beliefs had probably activated the construction of her self-perception as strong and invulnerable at the face of hardships as compensatory mechanisms for the maintenance of some sense of self-efficacy and self-esteem. It also appeared that she had led a rather sheltered life moving from one relationship to another (from grandmother to mother to ex-husband to current partner) since this probably provided her with some sense of worth that could, at face value, disconfirm deep-seated assumptions that people find it unmanageable to be with her, and therefore lessen her anxiety that she is unlovable.

To this effect, it appeared that she put up with a frequent barrage of disapproval, criticism and neglect in her marriage which must have progressively weakened her sense of personal strength and raised her anxiety and panic levels as her own self image began to be dissonant with the reality of her experience. In light of this, prescribed medication reserved the advantage of helping her sustain her self-concept as strong and resourceful while at the same time enhancing the dissonance with her core beliefs (i.e. "I am unlovable, unworthy, undesirable, a burden to people") and feeding all the more into her feelings of hopelessness, helplessness, anger and depression for her perceived inability to assert herself. Thus, it seemed that the heightened vulnerability following the series of events that took place within the last year (relating primarily to relationship breakdowns) and the major task of
adjusting to a completely new lifestyle once she came back to England relentlessly fed into her drug dependency which in itself started becoming unmanageable.

Given Mrs K's low frustration tolerance for anxiety and depression, her damaged sense of self-esteem and self-efficacy and her difficulty with asserting herself, we agreed to work towards anxiety management, improving problem-solving and decision making skills, and helping her acquire assertiveness skills.

A good part of our work also involved an examination and evaluation of her relationship with her daughter and partner that aimed toward further development of problem-solving and assertiveness skills to improve her sense of self-efficacy so as to be better able to manage depression and anxiety triggered by these sources. Finally, we briefly engaged in some CBT work on panic attacks.

Mrs K. progressed satisfactorily during therapy. Her BDI and BAI scores were reduced to 16 by the end of therapy which was unfortunately forced prematurely due to the therapist taking extended bereavement leave. At the end of therapy she was able to ascertain herself in her relationship with partner and start amending her relationship with daughter as well as reducing her dosage.
A discussion of the process of psychological therapy

Through the trials and tribulations of a still short and initiating journey which I have perceived as a “rite of passage”, what has made a particular impact on my personal and professional reality is my perception of the almost inextricable way in which the development of the therapeutic relationship is linked to the therapist’s personal qualities, worldview and limitations, and the way these elements relate with the knowledge of, familiarity and comfort with the model(s) of theory and therapy that inform her practice.

Therefore, my aim is to attempt to present and discuss how the way that I have experienced the above interactions has influenced my therapeutic encounters by using one process report from my second year and one from my third year of placement for purposes of illustration.

My second year placement in a CMHT was orientated toward a psychodynamic framework of practice which as a consequence was the one that informed my practice. Despite my study and familiarity with the psychodynamic paradigm throughout the course of my training as a psychologist and later as a counselling psychologist, I found its applications quite anxiety-provoking and experienced apprehensiveness in relation to them.

This I believe was a result of my personal limitations and anxieties about making mistakes or “not getting it right” for the client from early on. Therefore, I found a rather “prescriptive” nature in, what I perceived as, the heavy reliance of the psychodynamic paradigm on the therapist’s interpretative attitude as informed by critical incidents during early development. I experienced it as helpful at the time in alleviating my anxieties. That is, I started by relying too much on theoretical knowledge and its technical skills despite being far from being an informed expert on them. In the process this appeared to compromise the asset of my attunement and intuitive capacities which appeared to be thwarted under the weight of what I felt as my responsibility to heal, educate, guide and/or help clients.

I believe that the therapeutic relationship can find a solid foundation to develop in the offering of empathy, unconditional positive regard, warmth and understanding.
directed from the therapist to the client but its effectiveness stretches beyond this to a constant exchange between the therapist's and the client's experiences, feelings and their attempts to tune to each other. By tuning in to the client's experiences, unverbalised meanings and the emotional content that lies beneath the expressed thoughts or spoken words (what could be termed as "inner listening"). The therapist needs to move beyond systematic thinking and away from the workings of explicit understanding and articulated thought and to encounter the client in an intuitive way for the therapeutic relationship to make an impact on the therapeutic work. It is the extent to which the therapist has developed the capacity to tolerate a temporary state of confusion and hold in abeyance knowledge and skills that a genuine communication can - amongst everything else - be of therapeutic value and effect.

It is my experience that if this is not the case then the therapist can relate to what the client brings in a "reactive" rather than a "responsive" way (Lomas 1994) keeping therefore the client at bay because of her own uncontained anxiety which usually finds haven in theoretical assumptions and biases. In this way the therapeutic process can be stifled since the therapist is functioning in a "borrowed" and "mechanised" manner that stifles the therapeutic interaction and dialogue instead of intuitively synthesising elements of theory and techniques and adapting her personal style of relationship to the uniqueness of the client. It does not leave much space for the client to learn to observe and question herself, to become more aware of the changing character of people, interactions and life in general.

A relevant illustration of the above argument is the therapeutic encounter that was tape recorded for one of my second year process reports. This was a female client I saw for very brief psychodynamic therapy (6 sessions). She was 27 and referred by her GP on grounds of depression that seemed to present itself after she was diagnosed with a life long medical condition, known as sacro-iliatis or in lay terms a particular form of arthritis. The cause is unknown and treatment is uncertain. It transpired that her mild depressive symptomatology was of a transient nature due to the number of losses she had suffered within the 1 1/2 years after her diagnosis and her increased vulnerability and dependence as a consequence of her illness. It also appeared from very early on that the major source of anxiety and frustration in her life related to her relationship with her mother which could be described as an
ambivalent one as a result of certain traumatic experiences when the client was very young.

Throughout the course of therapy the development of the therapeutic relationship had been successful in the sense that a good enough atmosphere of trust, safety and understanding had been established between us that allowed the client to motivate herself to reach a clarification and understanding of her current difficulties and find ways to deal with them. The tape recorded session pertained to her experience of opening up to her mother about their relationship and what was experienced as an adverse impact of such action-taking on the existing relationship.

There was an emotionally laden session with painful feelings which originated in the client's construction of her experience as damaging to the relationship with the mother. During this session because of my anxiety to help the client work through this very stressful experience for her, I resorted to largely relating in a reactive rather than a responsive way. My anxiety originated from my countertransference feelings of being protective towards her which also had a basis on my own issues around my own relationship with mother. Therefore, although I listened very carefully to her story telling, my interventions were from early on perhaps too long, too interpretative, too explanatory and too laden with my own meaning-making to facilitate an emphasis on the client's experience of her world view and its clarification by her own person.

I realised that by taking, what I would term as, an "intellectualised" stance that resonated in my own processes of dealing with pain, I contributed to depriving the client from going beyond the surface meaning into a more personalised emotional meaning. This occurred as she responded to my interventions in a descriptive and factual manner as if she could sense that I would not be able to tolerate "the burden" of her emotional pain. She had probably intuitively witnessed my struggle that demonstrated itself in my heavy reliance on interpretative interventions rather than process questions.

In terms of such interaction, it appeared that the client did not experience my personal style but instead one that was rather cramped by a theoretical technique.
In my anxiety to contain her pain, in a similar manner to the way I contain mine, it appeared that for quite a while in the session I was in doubt of and ambivalent about trusting my own intuitive capacities and building on my own style of being with people. Instead it seemed that I suppressed it and replaced it with a formula for behaviour imposed from without; a "borrowed" relational style informed by one aspect of a model that I felt comfortable within.

It was however later on in the session that, when I started allowing myself to respond to the client as a person seriously affected by her words, actions and unspoken behaviour, the client's capacity to believe that she has a firm place in the world and can actively effect change was encouraged and affirmed. I believe that the decisive moment for that change was when my internal supervisor still struggling with my defences sensed a dead end in the flow of interaction. It was the moment when the client started talking about the problems of other people that she relates to. Following this change in the quality of the interaction, it appeared that the client felt increasingly held which allowed her to focus on the emotional meaning of her experience in a "cathartic" manner (i.e. she cried, experienced what she termed her feeling of emptiness and went into silences apparently getting in touch with her deepest concerns) whilst still maintaining her optimism about her newly found empowerment.

In my third year of placement where a rather orthodox cognitive behavioural orientation is practised, I work - amongst other settings - at a NHS rehabilitation ward (i.e. clients have an in-patient status) for individuals who have a primary diagnosis of addictive drug use. My third year focused process report pertained to a tape recorded session with my first client on the ward in the very early days of my new placement.

In this illustration it appears that my anxiety had taken the opposite form. That is, having heavily worked with the therapeutic relationship in my previous year of psychodynamic training and having witnessed its therapeutic value through personal pains and struggles, I started out being anxious about how I could incorporate it within a cognitive-behavioural framework which seemed to be placing a lot of emphasis on structured exercises and techniques. This I think also colluded with my initially biased attitude towards a model of therapy which I had in the past
viewed as mechanistic and had a lot of times questioned myself as to the extent to which I would be able to become a skilful practitioner of.

It was under this state of confusion, agitation and uncertainty about how to balance the more surface level cognitive work on negative thoughts and dysfunctional assumptions and the intuitive, deeper level work on the client-therapist interaction, that I entered my first therapeutic encounter in my new placement. The male client that I started seeing for individual CBT work, primarily on anger management, low self-esteem and a damaged sense of self-efficacy, was 51. He had been using a number of drugs since the age of 13 but he was an exclusive user of crack-cocaine for the last 14 years of his life. Throughout his life he had had numerous short-lived relationships which as he stated lasted for up to nine months and a brief marriage that fitted the same pattern. He had described a very damaged relationship with his dead mother who he had experienced from early on as dependent on him in a "hostile" manner, "manipulative", and "controlling" and towards who he said he reserved a lot of unresolved anger and resentment since he thought he had never been good enough for her and despite his attempts to give her as much as he could he was always being rejected.

When this tape recording took place, I was still searching within myself to find a way to bridge what I perceived as a gap between the issues I mentioned above in a constructive manner. I was still feeling very unsure of myself but my knowledge that a reliance on the technical aspects of the model of therapy would not be the solution I was looking for was adding to my anxiety and confusion, especially with this client who came across as verbally forceful and held his ideas and thoughts about the world, others and the future with great conviction, and did not appear to take very well to a CBT way of working.

The particular session began with a barrage of descriptions about the happenings in a very recent NA meeting where he identified with the reaction of a woman who, he stated, reflected his behaviour in extreme ways, his difficulty with finding "middle ground", and his beliefs about other people and their behaviour. In this initial part, I was too careful to not fall into the trap and the struggle of making my responses too explanatory to clarify his worldview. Instead my interventions pertained to short open-ended process questions that put the emphasis of clarification on his part. In
that respect, I felt that my interventions were "responsive" instead of "reactive" since I felt able to contain my anxiety and confusion and give the initiative of creativity to the client instead of "usurping" his capacity to do so, as in the previous example.

Such interaction proved to be rather successful since the client appeared to use this space to make his own comments on how the beliefs and thoughts he holds and the way that behaves with people as a result of these had originated in the way that he had related to his mother and the messages he got from this interaction. From this point on, I believe I made the mistake - due to the anxiety and confusion in incorporating CBT strategies in my work with him - to shift the focus on attempts to probe him to pinpoint the faulty thinking in his beliefs and assumptions and generate alternative ways of behaving after having briefly established how his current way of behaving affected his lifestyle. The mistake was evident in my failure to take into account the feelings that had been stirred up by his recounting of his relationship with his mother, focusing instead on cognitive restructuring techniques.

This, I feel, resulted in the client feeling angry with me for what I think he might have perceived as an attempt on my part to change the way he behaves instead of understanding the way he felt. This manifested itself in his going into a long monologue about how well he treats women who have disappointed him with their behaviour, how he tests them to see if they are worth keeping, how he perceives other people in relationships as opponents and how irritated he feels with people who want to keep their distance from him and are not immediate and forthcoming with him.

This interaction took quite a while before it sank in, since I was more preoccupied at a conscious level with dealing with the faulty assumptions and negative automatic thoughts that related to his narrative. I must admit that in the session I never became fully aware of this level of the interaction but I believe that it was close to the end of the session that I realised that my CBT interventions were getting us nowhere and attended to uncovering the real face of those who were present with their absence in the room with us: namely the deep sadness and pain that fuelled the client's underlying rigidity and anger in the session.
This experience was very revealing for me and making use of it in consequent sessions made a marked difference for the therapeutic relationship that shaped the rest of our therapeutic encounter.

I feel that I have since gone through a painstaking journey with the help of my personal therapy and supervision to develop and consolidate a personal style of therapeutic interaction that attends equally to the relationship and the model of therapy and empowers my internal supervisor to embrace my personal limitations, anxieties and biases in such a way that will prevent me from falling prey to them on the expense of my work with my clients.
References

This is a reading list that has informed the writing of this paper.


Sage Publications.

Sage Publications.
A brief overview of a three year practice experience as a counselling psychologist in training

*Understanding begins with the sensibility:*  
we must have the experience before we attempt to explore  
the sources of the work itself.

*T. S. Eliot*

Throughout the three years of my training as a counselling psychologist, I have practised in a variety of settings where diverse therapeutic orientations are practised and diverse populations are served. I feel that these experiences have informed my professional development. I have gradually grown to maturity as a counselling psychologist through this exposure to the processes of dealing with issues that I have encountered and been challenged by in the course of my placements. This overview aims at highlighting and describing these processes, the questioning and evaluation that has contributed to shaping my identity as a counselling psychologist and my personal style as a practitioner.

My first year placement was at a private addictions centre within a multidisciplinary team dealing primarily with alcohol addiction and intermittently with other drug addictions. This team comprised of a counselling psychologist, addictions counsellors, trainee counsellors and a consultant psychiatrist. It offered a detoxification programme followed by a therapeutic programme under a six-week in-patient status. The therapeutic programme was based on the Minnesota model of treatment; a model that has been developed in accordance with the ideology and mode of operation of the Twelve Step philosophy of treatment for addictions. However, due to the complex nature of addictive disorders, the programme had incorporated and integrated into its entity aspects of systemic and family therapy, psychodynamic and cognitive-behavioural models of therapy to suit needs of individual clients.
In this sense, I found a great vantage point in witnessing and being involved in an integrative way of practising that this setting advocated. This experience constituted a milestone in the development of professional awareness and judgement since it sensitised me in appreciating as well as evaluating the way in which different models and techniques can be brought together to enrich what would otherwise appear as an exclusive treatment model so as to respect and respond to varied individual needs. At the same token, however, finding myself in a specialised setting that required the complex and demanding task of assimilating the knowledge and applications of different therapeutic models in a coherent whole, presented me with difficulties and challenges that were considerable particularly as a novice practitioner.

In the first year of my training, my principle goal and endeavour was to develop and enhance basic therapeutic skills and acquire insight in the theory and aetiology of addiction. I felt that this was at times interfered with by my frustration, confusion and sense of helplessness at the challenges that this particular client group brings into the therapeutic alliance due to their oftentimes chaotic, unstable and unpredictable way of relating to others which is more often than not shadowed and pronounced by feelings of mistrust, ambivalence, dependency, shame, guilt etc. As I embarked on grasping a comprehensive understanding of addiction, I also found myself overwhelmed by this task that was becoming all the more complex given that the primary presenting problem of substance abuse was also associated with such underlying but equally urgent problems as depression, anxieties, phobias, sexual abuse, aggression, post-traumatic stress disorder etc. In addition, the brevity of the therapeutic contracts made such an effort even more strenuous.

In such a challenging and demanding setting, one of the issues that stood out for me was working within a team. My experience taught me that a team can provide a forum where support, insight, assistance in evaluating one's own practice, enrichment by differing perceptions and conceptualisations of difficulties and how to deal with them can be enhanced. Nonetheless, I also realised that a team reserves an equal potential of scapegoating any of its members to account for another member's stress, anxiety, limitations and conflicts in their practice. I experienced both sides in the team that I worked for the first year of my placement. As a novice and inexperienced trainee I greatly valued the advantages of working not in isolation.
but as part of a team. It was through my openness and willingness to expose myself
to the team and make the best out of its vantage points that I was gradually able to
consolidate a sense of self-confidence, assert my growing abilities as a therapist,
and expand my horizons as far as treatment options are concerned.

Despite such an advantageous effect though, I also witnessed the scapegoating
potential that can be engendered within a team. It is my experience that this
happens when members let themselves fall prey to the parallel processes that are
entailed in their therapeutic work and fail to contain them by personal reflection on
his/her own values, prejudices and limitations. This appears to result in identification
with clients' issues that then can become a threatening challenge to the team's
cohesion and discursive capacities.

I encountered such an experience towards the end of my first year placement. It
involved a trainee counsellor with who I was co-keyworking a client. This trainee
was a recovering alcoholic with strong ties and adherence to the AA philosophy. In
collaboration with my supervisor I adopted some strategies and techniques with the
client that to the understanding of the trainee run counter to AA treatment principles.
Although I discussed the rationale of these interventions with the trainee and
explained their usefulness for the client's therapeutic progress, the trainee had great
difficulty accepting such integration of models and strongly objected to it at every
opportunity given maintaining that lack of adherence to AA principles should not be
allowed in such a treatment programme on ethical grounds. To my understanding
this reaction might have resonated in this person's own conflicts and unresolved
issues around the identity as an alcoholic and AA member that apparently clouded
therapeutic judgement. This temporarily resulted to the creation of a split in the
therapeutic dyad that colluded with the nature of client's difficulties. The issue was
finally resolved constructively but at the time felt an enormous challenge on my
evolving professional identity since it entailed an unwarranted attack on my
therapeutic judgement and interventions in my absence. Fortunately, the more
experienced members of the team and my supervisor who had closely worked with
me on that particular case and the appropriate interventions helped me work
through this conflict. The impact of this event on my personal and professional
development was also dealt within the space of my personal therapy.
Through this process, I came to appreciate and recognise the constructive input from related professions and the insurmountable importance of co-operation and joint effort for the best interest of the client. It has also taught me how unsettling and distressing the fixation and blind adherence to a single circumscribed therapeutic mode can be. In addition, it has made me aware of how counterproductive the lack of an inquisitive attitude towards one's personal worldview can be for the team and the clients at large.

As I moved on to my second year placement, the setting changed radically. Although I was considered part of a CMHT, I found myself considerably more isolated from my profession since the team included numerous CPNs and only my supervisor and another clinical psychologist who was working within an orthodox CBT model. During this year of placement, my orientation was exclusively psychodynamic with primarily longer term contracts than the limited six-week ones I had been used to. Due to practising within such a limited time structure in my previous placement, I had developed a disciplined attitude as far as the focus and content of the sessions was concerned.

In my new placement I had to adjust to the challenges of sparing my disciplined attitude, remaining within the circumscribed framework of a particular model of therapy, and practice in a considerably more isolated environment where the opportunities to liaise with a variety of fellow health and mental health professionals apart from my supervisor were limited and at times non-existent.

These challenges constituted a further developmental milestone in my professional development. I was presented with the opportunity to practice in a more independent way within which I was given more autonomy to use my clinical judgement in making decisions about the suitability of referrals, applying my assessment skills to detect the underlying issues within the presenting problems, setting appropriate contracts and liaising with different services within the Trust to recruit alternative treatment options (not necessarily psychological ones), where appropriate and necessary.

It was due to the nature of the setting and my supervision that I became sensitised to the importance of the therapeutic relationship in the therapeutic process and
outcome. I also became acutely aware of ethical and professional dilemmas within the course of clinical practice. Last but not least, I developed skills in becoming increasingly more attuned to following the client's pace and time my interventions according to this rather than the constraints of time or the discipline to a particular focus or demand of the setting.

In hindsight, I feel that it was during the second year of my training that I consciously and actively embarked upon a process of consolidating my personal therapeutic style despite the lack of integration of approaches. I believe that it was within the safety of the boundaries of the journey towards becoming a competent psychodynamic practitioner that I was given ample opportunity to appraise my own stance in the therapeutic process. This is what sets a solid foundation for further embarking on, maturely reflecting upon and applying an integrative model of practice. Without this, it seems to me that an attempt for integrative practice may become chaotic and unwarranted due to the frustration and confusion around the practitioner's search for her own meanings in this process.

This journey of developmental challenges and painstaking efforts towards their resolution came to fruition in the final year of my placement. I again practised in addictions services, this time in an NHS acute detoxification ward, therapeutic ward and community drug team. The medical model was prevalent (by virtue of the setting being part of the wider Psychiatry of Addictive Disorders department) and the psychological orientation was cognitive-behavioural. This presented me with the challenging but fruitful opportunity of synthesising elements of theories and techniques and adapt my personal style to the uniqueness of each client.

Within this framework, my primary concern was to find a way to apply the insight on the dynamics of the therapeutic relationship in the therapeutic process without disregarding the specific needs of individual clients. Throughout my experience of working in the addictions field, I became aware that more often than not the addiction itself, although usually presenting as primary, can be viewed as a dysfunctional compensatory strategy for a variety of underlying difficulties that have their origin in different developmental stages of the life span. However, due to its chaotic, unpredictable and unstable nature, it is usually the case that it has to be dealt in a structured and clearly boundaried and focused holding environment
before any underlying predisposing factors can be worked with. This of course largely depends on the severity of the addictive problem and the personality characteristics of individuals clients. In my third year placement setting both these variables rated on the severe end of the continuum in that the client group comprised of individuals with severe polydrug use and more often that not with a dual or multiple diagnosis of some sort of psychotic symptomatology.

This being the case, I was from the very beginning very aware of the appropriateness of the CBT model in this context and with this client group. However, I felt that the skilful and timely integration of interventions derived from the nature and the development of the therapeutic relationship would be of benefit to the clients. Such strategy would shift the emphasis from a directive, guided application of technical aspects of the model to a more tentative and open-ended way of communication. Such communication encourages clients to recognise and understand the ways in which they restrict themselves and how this comes about. This can be successfully achieved through their exposure to reflection on the interaction that takes place within the therapeutic relationship, without in the meanwhile sacrificing the structured nature of the therapeutic environment that is paramount for containing and managing the addiction. In such a relational way, clients can be helped to extract important information about the difficulties they experience which can instigate raised levels of self-knowledge, and to motivate themselves to collaborate with the therapist in finding and practising alternative ways of coping and behaving rather than relying on the therapist to provide them with such alternatives.

I realised that as a result of such an inquisitive process I was gradually more able to reach a firm consolidation of my own "integration process" and an identity as a counselling psychologist. This was born out of the ever increasing awareness that the most important factors in the impact of a therapeutic encounter are an intuitive understanding of others, a preparedness to engage them with hope, openness and flexibility, and a capacity to influence which is based on encouragement and genuineness rather than assumption of command and expertise. I have come to the conclusion that it is around these factors that my ability to make an informed decision, as to why and how I can apply an integrative approach with a given client
with a uniquely individual pattern of relating and presenting set of difficulties, has grown and been enriched throughout the course of my training.

Supervision, personal therapy and a variety of classes and workshops attended throughout my training have invaluably contributed as safeguards against an erosion of spontaneity, a dampening of creativity and a feeble conformity to circumscribed ways of practising. These, I feel, had at times threatened my professional development as a consequence of confusion, anxiety, conflicts, and pressures experienced in my status as a trainee both inside and outside the placements. I feel I have walked through a lot of paths since I first joined this course. Not all of them were either easy or successful, but all of them enriched me with experience, insight and deepened understanding both of myself as a professional and an individual, and those who seek a therapeutic encounter. It is due to all these that I can today ascertain myself as a counselling psychologist bearing an affirmative stance towards integration of theory and practice by creatively and respectfully bridging gaps between theories, models of therapy, techniques and therapeutic relationships rather than engaging in a polemic dialogue about the "survival of the fittest" or purest model.
Introduction to the Research Dossier

The research dossier of the portfolio contains three pieces of work. The first, 'Social support as a mediator of therapeutic change in the treatment of addiction', is a literature review carried out during the first year. The second project, 'A scientist-practitioner approach to psychological assessment: An evaluation of multiple card sort procedure as an assessment technique used by counselling psychologists', was a piece of work that can be viewed as a pilot study not only in itself but also for the third project, 'Perceived social support and addiction treatment: Understanding its role in the process of therapeutic change. Implications for practitioners, researchers and programme evaluators.', where multiple card sorting procedure is mainly employed to explore processes and issues involved in addiction treatment as well as in research and evaluation of treatment programmes.
Social Support as a Mediator of Therapeutic Change in the Treatment of Addiction.

Abstract

The purpose of this review was to examine how social support is related to therapeutic change within the context of treatment of chemically dependent individuals. The concept of social support was discussed from both a theoretical and methodological perspective and theoretical links to establish its significance as an integral part to be embodied within the treatment context of chemical dependence were provided. Within this population, recent literature has provided promising evidence relating social support with improved treatment outcome. This article synthesised and reviewed what is to date known about the effects of social support on the psychological well-being of chemically dependent people in treatment, highlighting the implications of this body of knowledge for therapeutic interventions. Despite the reasonably consistent findings, there appeared to be a distinct absence of a process model of change as related to the subjective inner experience of social support in the current research paradigm and a discussion of the interactive effects, social support bears on such a process model of change was advanced.
I. Introduction

Addiction has over the last three decades revealed its high prevalence as a psychological disorder with multiple adverse psychiatric implications along the spectrum of all age groups for both genders, although with an established higher incidence among men (Galanter 1993; Myers et al 1984; Regier et al 1984). Addictive disorders have been also estimated to have an onerous political and socio-economic cost to the European and American society - where their occurrence has attracted the interest and attention of scientific research - in health care, lost productivity, and law enforcement amongst others. Thus, the ensuing recognition of the severity of substance abuse problems has been gradually contributed to the recognition of addiction disorders amongst national priorities in the US and a host of European countries, including Great Britain (Galanter 1993; Godfrey 1994; Kirke 1995).

Social support has become of growing interest in research in the last two decades due to its gradual recognition as a positive influence on physical and psychological well-being. A sizeable amount of research that appears to show a positive relationship between social support and the rehabilitation process in chronic illness as well as the process of recovery from acute illness has been published. The facilitative impact of social support on rehabilitation from chronic illness or disability suggests that this same effect should apply to those who suffer from addiction, as will be discussed later (Oyabu & Garland 1987). However, relatively few studies have been conducted with a primary focus on the relationship between social support and addiction treatment outcome.

Many researchers in the field of addiction have been increasingly concerned about poor treatment outcome - manifested in the turn of the research focus to issues surrounding relapse and aftercare rather than primary treatment per se (Bromet & Moos 1977; Billings & Moos 1983; Longabaugh et al 1993; Monti et al 1994; Jarvis 1994). Thus, the current research regimen necessitates an urgent need to evaluate the effectiveness of existing treatment approaches, to research the potential for alternative or enhanced ones and to look at the processes of change within the therapeutic context of addiction treatment.
Within this frame of reference, social support - which has been shown to yield one of the more persuasive findings in terms of its importance to the recovery from and rehabilitative process of addiction treatment (McKay & Maisto 1993) - needs to be more intensively and comprehensively researched as one of the promising factors of mediating lasting therapeutic changes in treatment. However, since research seems to be focused on the impact of social support on treatment outcome rather than on processes of change that facilitate outcome (Booth et al 1992; Sayre et al 1992; Cronkite & Moos 1983), the need to explore social support as a facilitator of the process of change during treatment is growing. Harald and Klingemann (1995) point to the necessity of research to pay more attention to the intermediate psychosocial processes that lead to changes in the outcome variables to enhance clinicians' understanding of the conditions that advance or hinder therapeutic changes and thus ameliorate the effectiveness of their interventions.
II. Theoretical rationale for social support and its “healing” potency on psychological well-being.

The ideas of a number of important authors of the psychological discipline who subscribe to different orientations and approaches lend a theoretical foundation for the premise that social support, due to the potent, diverse psychosocial properties that it engulfs and fosters (e.g. sense of belonging and personal worth and esteem, sharing and identification, acceptance, modelling etc.), is a significant factor to account for positive mental health and psychological treatment outcome.

Part of the seminal work and conceptualisations of several of the pioneers of psychological theory and later scholars appear to have been devoted to social support and/or some of its components as to the importance they bear on the human psyche and to the process of psychological treatment.

Freud explored and commented on the process of identification as a contributing factor to the formation of the ego and the superego in the sense that an individual - by identifying after someone who possesses a desired quality, or seems to be more successful at gratifying needs, or appears omnipotent to the individual - reduces their own tension and anxiety by modelling the identified behaviours (Freud 1962; Fenichel 1972). This process has been deemed important to this topic because it is through social involvement which fosters support through acceptance, positive regard and belonging that this process becomes feasible and can lend itself to building (or rebuilding) the ego and superego; an essential reparative process for the emotionally, mentally, psychologically and socially depleted chemically dependent individual (Machel 1992). Within the psychodynamic school of thought, Khantzian (1985) formulated the self-medication hypothesis of addictive disorders which predicts that painful affect may lead to chemical use as a response to painful feelings. Thus, social support due to its mediating effects on stress and negative mood states may act as a compensatory mechanism for coping with negative affective states and for aiding psychological treatment of chemical dependence (Goehl et al 1993).

Jung pointed to the physical law of entropy as a principle that enhances the perpetual tendency of the constituents of the psyche toward a balance or
equilibrium - as far as psychic energy is concerned - that produces harmony, relaxation and contentment (Schultz 1990). Thus, if (for example) two desires or beliefs differ greatly in psychic value or intensity, energy will flow from the more strongly held to the weaker; a concept which shows the possibility of two personalities coming into close contact affecting one another. Based on the notion of entropy, Jung approved of social support and peer grouping as a possible positive influence in the treatment process of addiction whereby a process of transference would occur with a social group of people who strive toward recovery for themselves or want recovery for others (Machel 1992).

Adler (1939) formulated that individuals have an innate potential to unite with other people through social involvement in order to overcome personal feelings of inferiority, a condition common to all people ("To be a human being means to feel oneself inferior", p.96). Adler contended that through belonging to and being supported by a social context, the individual is encouraged to attempt to master life's problems which provides them with motivation to strive, to grow, to progress, to succeed.

Fromm's (1941) neopsychoanalytic approach - much along Adler's line of thought - postulated that the struggle of human beings toward individual freedom has come to the expense of the natural and social ties that have been the most important providers of a sense of security and belonging. As a result human beings have become beset by doubts about the meaning of life and by feelings of personal insignificance which prevents them from developing their full potentialities and enjoy their individual freedom. Thus, in 1968 he wrote about the necessity of attempting to become reunited with other people through social involvement - that entails affiliation, stability and security with mutual support, acceptance and respect - as an approach that leads to finding meaning and belonging in life and reduces the anxiety of alienation, loneliness and insignificance.

Rogers (1961) perceived the process of treatment or therapy as involving interpersonal relationships where the people involved are reciprocally able to satisfy and contain the individual's pervasive need for acceptance, love, and approval from others. He contended that the positive self-regard - which is fostered by a supportive, unconditionally accepting environment - comes as a result of the
feedback we receive from others which not only contributes to developing and
refining one's own self-concept but aids the internalisation of others' attitudes into
this self-concept until gradually positive regard comes from within oneself rather
than from others. Thus, it appears that Rogers viewed the process of treatment or
therapy as entailing forms of social support in order to have a positive outcome.

Maslow (1970) made a point that safety needs, belonging and love needs and
esteem needs are basic human needs whose absence can foster conflict due to a
lessening of self-esteem, may be a precipitant of emotional disturbance, and may
induce inability to realise and fulfil one's own potentialities and capabilities.
Therefore, he perceived of treatment as helping an individual to approach self-
actualisation by enhancing the satisfaction of these needs which are apparent
offshoots of socially supportive relationships.

Bandura (Schultz 1990) - one of the pioneer theorists of the social-learning
approach - wrote about a sense of self-efficacy as one of the most important
aspects of the self which determines the ability to cope with the demands of
everyday life and whose low level may be a precipitant of depression, self-
disparagement and feelings of worthlessness, potentially leading to emotional
misery and chemical abuse. Self-efficacy refers to one's sense of self-esteem and
self-worth, a feeling of adequacy and efficiency in dealing with life. Judgements of
self efficacy are based on four sources of information: (1) performance attainment,
prior success experiences that demonstrate a person's capacities; (2) vicarious
experiences, seeing similar people perform successfully; (3) verbal persuasion,
being told that one has the requisite ability to achieve; and (4) physiological arousal,
one's internal level of calmness and fear. Using these sources of information,
Bandura has found that it is possible to increase a person's self-efficacy since the
goal of treatment or therapy is to achieve and maintain one's optimal level of self-
efficacy. Thus, one's level of self-efficacy appears to be closely associated with the
perceived quality of one's social network. It also seems that what Bandura defined
as modelling and reinforcing behaviours that enhance one's sense of self-efficacy is
conceptually similar to certain forms and processes of social support [i.e.
reassurance of worth, esteem support] (Goehl et al 1993; Davidson 1994; Brewin
1995).
By reviewing the aforementioned conceptualisations that focus on how different theorists - who embrace different working frameworks and approaches in the ways they view the development of psychological well-being or disturbance - view the function and impact of social networks on the process of psychological treatment or therapy, it becomes evident that they have placed importance of a varied extent on its influence on the development, functioning, and proper balance of the human personality.
III. Justification of the importance of the role of social support in treating the chemically dependent.

The idea that there is a natural progression over time in the degree of dependence in relation to any substance dates back to Jellinek's (1952) addiction study which concluded that addiction is a progressive disease with an inexorable progression towards abstinence or death. Ever since, attempts of replication of this study have been largely unsuccessful and have been attributed by Vaillant (1983) to the large rate of death among chronic addicts and the difficulty in finding later or end-stage addicts since they do not seek treatment. To date the notion of the natural progression of dependence has been inadequately researched and careful examination and analysis of change within this framework is a challenge for the future (Smart 1994; Durand 1994).

Although we cannot talk in definitive terms about the process of change under which chemical dependency develops, a large bulk of research has been devoted to the identification of the personality characteristics of addicts, especially so of the alcoholics, and the progressive deterioration in the social and psychological dimension of their lives in the last four decades (Edwards 1994; Smart 1994; Cox 1979). These research findings warrant the liberty to discuss how psychosocial qualities of an individual deteriorate during the variable length of chemical use and suggest how social support can play a facilitative role in implementing therapeutic changes under these premises.

It is a common belief across the spectrum of influential psychological approaches that chemical abuse is motivated and recruited by one's need to seek relief from their depressed feelings of self-worth. Studies that have utilised self reports and self-evaluations to study alcoholics' self-concepts, and studies that have used the Minnesota Multiphasic Personality Inventory to study personality configurations of alcoholics have consistently demonstrated that alcoholics evaluate themselves unfavourably whether they are being compared with normative samples or with other psychiatric diagnostic categories and do not perceive themselves as being in control of the influences of their life circumstances. In addition to manifesting a low self-esteem they rate themselves as being depressed and anxious (Cox 1979; Schuckit et al 1994) and drug addicts in specific have reported significantly high
levels of life events stress and are significantly low on uplifts (day-to-day positive life experience) and social support (emotional, instrumental, informational and appraisal support) (Dubey 1993). However, with time the continuous chemical abuse has been found to exacerbate the low self-concept and the anxious and depressed feelings (Cox 1979). The same studies have reported a split between the real self (addict) and the ideal self (recovering addict) in alcoholics which seems to enhance their difficulty in voluntarily controlling their chemical use (Cox 1979; Durand 1994).

Research evidence on social networks and psychopathology among substance abusers (Westermeyer 1988) suggests that they experience isolation and decreased support as their drug dependence worsens, implying a process in which chemically dependent people become gradually alienated both as their own self-loathing increases and as they progressively become more involved with their drug of choice and lose contact with potential sources of support. It appears that substance abusers gradually place human relationships secondary to the primary relationship with the drug of their choice (Sayre et al 1992) and exhibit psychopathic deviation with poor life-adjustment and ego weakness as research findings based on the use of either the MMPI or 16PF or the California Psychological Inventory have shown (Cox 1979; Edwards 1994).

Edwards (1994) and Smart (1994) pointed to the increase of "humiliating experiences" such as homelessness, divorce, ridicule or rejection by a friend, embarrassment in front of children or other relatives or the prison sentence as being some of the most obvious externals of social deterioration of the chemically dependent individual. However, Edwards (1994) emphasised the more subtle aspects in the social domain that need to be taken into account, relating to the exclusion from normal society, social amplification of problems and resultant difficulty in finding a way back to normality.

Thus, chemically dependent people become socially stigmatised due to what is perceived by societal norms as character blemishes and the social difficulties they experience become gradually augmented leading to feelings of shame and guilt that further distort their self-concept. As a result of these attributions their sense of self-efficacy and social competence beliefs deteriorates and leads them to a self-imposed isolation from society (Brewin 1994; Durand 1994). Billings and Moos (1983) and Smart (1994) cite research findings that suggest that chemically
dependent people relapse due to negative emotional states (i.e. anger or depression), conflict, argument or unpleasant social exchanges with others, and pressures from other people - whether direct or not - to use the drug of their choice.

It thus becomes evident that addiction treatment needs to focus on socially and personally reparative and reconstructive therapeutic work with chemically dependent people, with a central goal to increase their ability to cope with various potentially stressful internal states and/or external situations without relapsing by enhancing their sense of self-esteem, self-efficacy and self-awareness while promoting social involvement and investment within a cohesive and supportive social environment (Galanter 1993; McKay & Maisto 1993). The extent to which these treatment goals can be facilitated by the sources and functions of social support will be discussed in the following section.
IV. The role of social support in the treatment and rehabilitation of chemically dependent people.

A. The concept of social support.

Interest in the concept of social support is relatively new in psychology and its value lies in its links with more traditional areas of interest (i.e. depression, anxiety, stress, chemical dependency). A review of the conceptualisation of social support by Lloyd (1994) shows that there has been little consensus among members of the scientific community with regard to a precise definition of social support. The idea of social support has been described alternately as rich and subtle or as diffuse and vague since social support encompasses a multitude of activities, relationships and subjective appraisals and its conceptualisation has followed a path from the probable multidimensional nature of social support to the controversy regarding the subjective versus objective measures of social support to an interest in identifying the most salient aspects of social support.

Cobb (Lloyd 1994; Oyabu & Garland 1987) defined social support as information that one belongs to a socially coherent community and that one is loved and esteemed leading to enhancement of self-esteem and self-identity in the social network. This definition seems to be limited to emotional aspects of support. Following Cobb, Kaplan et al (Lloyd 1994; Oyabu & Garland 1987) defined social support in terms of the degree to which an individual's basic social needs (i.e. affection, esteem, belonging, identity and security) are fulfilled through interaction with significant others which appears to be a more general conceptualisation of social support. In the following years Kahn (Oyabu & Garland 1987) defined social support as interpersonal transactions in affect, affirmation and aid which ultimately captured the multidimensionality of the concept which was further developed in theory by Veiel (1985).

It thus appears that social support refers to the various resources provided by one's interpersonal ties which protect people form the harmful effects of stress and enhance overall subjective well-being (Goehl et al 1993). Such an all-encompassing conceptualisation is so vague that begs for a proposition of broad categorical classifications of the concepts commonly included under the social support rubric. A
broad categorical proposition consists of two classes of support concepts that determine to a certain extent the direction of social support operationalisation in research: a) Social networks which refer to the objective structure of social relationships - the existence, quantity and type of relationships, and b) Perceived social support which refers to the individual's subjective perception or cognitive appraisal of availability functions and adequacy of or satisfaction with social relationships.

B. How social support exerts its effects on psychological treatment outcome.

Thoits (1986) has pointed to social support as provider of coping assistance that accepts and contains the individual's feelings of efficiency thus bolstering self-esteem and a sense of environmental mastery. Cohen and Wills (1985) suggested that social support exerts a generalised beneficent effect on psychological well-being by providing the individual with regular positive experiences and a set of stable, socially rewarding roles in the community or protects the individual from the pathogenic influences of stress through intervening between the stressful event and the stress reaction by attenuating the appraisal process. They differentiated among four types of support that mediate this effect: esteem support (feedback that one is valued and esteemed), informational support (information or teaching a skill which can provide solution to a problem and can help one in evaluating personal performance), social companionship and instrumental support (provision of goods and services that help solve practical problems) (Lloyd 1995; Orford 1992).

Weiss (1969) in his analysis of the specific role that relationships play in adulthood, especially among those who had experienced a major disruption in their lives such as chemical dependence can be thought of, proposed that people need particular provisions from relationships, and that the aggregate amount of provisions does not compensate for experiencing a deficit in some other provision. Weiss identified the following social support functions that he considered essential for psychological adjustment: (a) Attachment, that is feelings of intimacy, peace and security, whose absence leads to emotional isolation and profound loneliness; (b) Social Integration, a sense of belonging to a group with whom one shares common interests, whose lack induces social isolation and boredom; (c) Reliable Alliance, which refers to knowing that one can count on receiving assistance in times of need whose
absence is experienced as vulnerability; (d) Guidance, having relationships with people who can provide knowledge, advice and expertise, whose inadequate provision leads a person to become anxious and uncertain; (e) Reassurance of Worth, a sense of competence and esteem; whose lack of provision results to low self-regard and (f) Opportunity for Nurturance, being responsible for the care of others which makes a person perceive life as meaningful (Manchini & Blieszner 1992)

Thus the direct psychological benefits of social support manifest themselves in the enhancement of one's ability to define certain stressors as being less overwhelming, to openly express fears and frustrations which decrease ruminations and obsessive thinking about stressors, to assume a more realistic stance toward life, and to find more meaning in life and feel more in control of external events leading to bolstering feelings of self-worth and esteem (Longabaugh et al 1993; Zuckerman & Antoni 1995; Lloyd 1995).

The appropriateness of the aforementioned frameworks and functions of social interactions for explaining the association between social interaction and psychological well-being and for substantiating the potential mediating effect of the provision and incorporation of social support in the treatment of addiction seems evident when posed against the evidence about the psychosocial state of an addict in treatment. These mechanisms of action of social support as a psychosocial variable and their resultant psychological benefits also appear to be consistent with the theoretical approaches discussed at the beginning of the chapter.
V. The process of change in addiction treatment and the role of social support.

It was discussed in the Introduction section how research focus is urged to direct its efforts toward unravelling the conditions and processes under which change is achieved and maintained or not. It is the view of this author that change in research has until now been treated as a discrete variable rather than a continuous one. It is deemed of utmost importance to include in a discussion of change the notion that change is not a single event but a process which entails transitional stages amongst which intermittent movement backwards and forward occurs until change could be perceived as consolidated. Thus a process of change represents a type of activity that is initiated or experienced by an individual in modifying affect, behaviour, cognitions, or relationships (Prochaska & Di Clemente 1988).

It appears that the idea that stages in the process of change can be identified and operationalised straddles various fields of psychology amongst which the field of addictive behaviour especially due to the pronounced relapse rates after treatment. Therapeutic change, however, has attracted the interest of psychology in the recent years and Kelly's (1955) constructive view of change is one of the most clearly enunciated and has constituted the basis of many contemporary ideas on the processes and stages of personal change.

Personal construct theorists believe that construing is an ongoing process of continuous revision of one's view of the world and consequently one's behaviour. The core construct system is central to a person's identity and maintenance of a sense of self. When this is challenged and change is expected, threat and anxiety on the face of these challenges is experienced. These feelings, according to Kelly, are indicators that revision of core construct is necessary since they point to a recognition that events that confront an individual lie outside the range of convenience in their construct system. In 1970, Kelly proposed three processes of transition that characterise the change cycle: the Circumspection (review of various options); Pre-emption (focus on a particular issue at a time); and Control (making choices). He also described the Experience cycle which acts as a consolidating factor of longer term and more general change. Its stages entail Anticipation (a prediction is made), Pre-encounter (acting on the prediction), Confirmation or
Disconfirmation (personal assessment), and Constructive revision stage (reconstruction following evaluation of experiences).

The notion of transitional stages and dispositional states that Kelly introduced have had considerable impact on current thinking in the process of change in addiction (Davidson 1995). The most well-known and comprehensive model of change within addictions is that of Prochaska and Di Clemente (1984). The model was originally developed in a comparative study of self-change and therapy-change successful ex-smokers, employing a sample of almost 1000 subjects and the authors argue that its applicability has been demonstrated across a variety of behaviours including psychic distress and alcohol and cocaine use (Prochaska & Di Clemente 1988; Prochaska et al 1992).

This model treats stages and processes of change on five levels that include a symptom/situational one, a maladaptive cognitions one, a current interpersonal conflicts one, a family/system conflicts one, and an intrapersonal conflicts one (Prochaska & Di Clemente 1988). The authors call attention to the fact that systems of psychological therapy have traditionally attribute psychological problems primarily to one or two of these levels and have focused their interventions according to this orientation. They though contend that these levels are not separate from one another but are rather complementary in the sense that change in one level is likely to produce changes at the other levels. They thus urge toward a more integrative orientation that will incorporate enough flexibility to view the stages and processes of change from a holistic approach that incorporate interventions at all levels.

Prochaska and Di Clemente (1988) have identified four stages of change and ten processes or catalysts of change that they have attempted to match. Table I shows their attempt to integrate these elements.
During precontemplation, people do not feel impelled to do much about their addictive behaviour probably due to ambivalence, denial or selective exposure to information (social network primarily consisting of other addicts) and at least eight of the catalysts of change are used but minimally (Prochaska & Di Clemente 1988; Davidson 1995). In this stage a supportive network (i.e. family and friends concerned with the adverse effects of the individual’s addictive problem) may provide information about the problem and may establish contingencies that require that the person seek help, even though the person does not see their addictive behaviour as problematic (McCraday 1988).
As people become aware that a problem exists with their addictive behaviour, they enter the contemplation stage which is characterised by conflict and dissonance since it involves an affective and cognitive assessment of which values people will try to actualise, to act on, and make real, and thus a change in their sense of self (Prochaska & Di Clemente 1988; Davidson 1994). At this stage, the social network will provide support by continuing to give further information and feedback as well as continuing enforcement of contingencies for behaviour change (McCrady 1988).

During the action stage, when a commitment is made, people need to believe that they have the autonomy to change their lives in key ways and enhance their sense of self-efficacy. Due to its particularly stressful nature, addicts in treatment are in particular need of support and understanding from helping relationships (Prochaska & Di Clemente 1988; Davidson 1994). A supportive social network can provide attachment and reassurance of worth support and especially the family can be involved in treatment to change problems that are present in the system (McCrady 1988).

During the maintenance stage, when new behaviour is strengthened, an open assessment of existing alternatives to stress-inducing situations without resorting to self-defeating defences and pathological patterns of response is important (Prochaska & Di Clemente 1988; Davidson 1994). At this stage social integration support and opportunity for nurturance support are deemed most effective to reinforce the individual’s sense of self adequacy and resocialise the person to activities not related to using substances. It is thus obvious how the stages and processes of change have a powerful ally in the sources and functions of social support to be established and maintained.
VI. Review of research findings linking social support with psychological improvements in addiction treatment and subsequent therapeutic implications.

Clinical and theoretical literature reviewed suggests that social support may attenuate the negative emotional reactions that an individual may have to life stresses by helping a person to feel cared for, loved and valued, by providing feedback to the individual about his/her beliefs or values and a sense of belonging and a feeling of being connected to other people (McCrady 1988).

Since addiction can be viewed as a potentially controllable stressor with a detrimental effect on the psychosocial well-being of the chemically dependent, it transpires that social support through its sources and functions should enhance the addict's ability to cope with the stressor (i.e. overcoming his/her addictive problems).

Research evidence seems to suggest that strong social support networks (e.g. family members, friends, spouses, children, co-workers, supervisors) may be critical in addicts' attempts to deal with their addiction, although relatively few studies have been conducted with a primary focus on the relationship of social support to addiction treatment outcome to date (Booth et al 1992; Johnsen & Herringer 1993).

Quite recent research findings suggest that the following aspects of social support are frequently related to improved treatment outcome, including: perceived availability of reassurance of worth and attachment support (Booth et al 1992) and of greater social support viewed in more holistic dimensions (McLellan et al 1983), a general sense of feeling supported (Rosenberg 1983; Longabaugh et al 1993), perceived amount of social involvement and closeness to treatment peers (Machel 1992), supportive involvement of family and significant others during treatment (Nace 1982; Gordon & Zrull 1991; Sobell et al 1991; Sayre et al 1992), a sense of cohesiveness (absence of conflict) and encouragement for expressiveness by family and significant others (Billings & Moos 1983), frequency of use of supportive networks, i.e. attendance at AA, aftercare meetings (Johnsen & Herringer 1993), abstinent quality of peer network frequently used (Gordon & Zrull 1991; Kirke 1995), and spousal support (Sobell et al 1991).
In addition, Booth et al (1992) - in a study examining the relationship between perceived lack of social support and depression among men during alcoholism treatment - concluded that perceived lack of social support from family and friends has a strong independent association with symptoms of depression among this group. This study confirmed similar findings reported by Rhoads (1983) and Judson and Goldstein (1983) in studies conducted to explore reasons for relapse among heroin addicts. It appears that identifying support deficits that might be remedied with family, significant others or friend conjoint therapy and enhancing the client's ability to develop significant social relationships are important considerations for designing therapeutic interventions.

Although many studies point to a mediating effect of social support on treatment outcome, there is a very small number of studies which have provided negating evidence. Oyabu & Garland (1987) weighted the importance of the amount of social support available and the participatory involvement of social network in the treatment of alcoholics and found that any hypothesised mediating effect of social support on the improved psychosocial well-being of the subjects (self-esteem, level of depression and coping efforts) was negligible.

Goehl et al (1993) - in their study assessing the impact of social ties (measured by perceived availability of tangible, belonging, appraisal and self-esteem support) on treatment outcome among a population of methadone maintenance patients - found that despite the fact that social support was strongly positively correlated with positive affect and weakly inversely correlated with stress, it was not correlated with drug use outcome. Despite the neutral finding of the study as far as the self-medication model is concerned, the study's additional findings regarding substance using peer networks (positive correlation between SU peer network and continued drug use) address the possibility that a social network may harm treatment outcome if its members exert a negative influence that is supportive to continued use. This finding is consistent with Kirke's (1995) findings concerning substance abuse within peer networks among teenagers and appear to support the validity of the social learning model of substance use. Following these research findings comes the need to identify supportive others who are not substance users for effective therapeutic outcome. Therapeutic interventions could focus on reducing the deleterious impact of such relationships by pointing emphasis on the risk attached to drug-using
network and on empowering the client to take responsibility for distancing him/herself from such threatening environmental cues. It is suggested that clients might benefit from interpersonal skills learning to cope effectively with the overtures of other drug users (Monti et al 1994) and/or be encouraged to get involved with such supportive abstinent social networks as AA (Galanter 1993).

Longabaugh et al's (1993) study - conducted to determine whether the relationship between alcohol involvement and alcohol-specific social support is moderated by a person's social involvement - turned attention to individual characteristics and differences of substance abusers on the mediating impact of social support. They reported different findings for "high investors" and "low investors" (determined by the level of importance and value people attribute to social support). It was demonstrated that for high investors the support they experience positively influences their abstinence status, whereas for low investors, not only support was unrelated to abstinence status, but was predictive of subsequent substance use. The latter finding seems to be of great clinical importance and research interest, but would need to be replicated for its validity to be confirmed. The clinical implications according to the researchers involve optimal treatment approach matching where relationship enhancement techniques and methods are more effective for high investors while extended individually focused cognitive behavioural therapy is best suited for low investors.

It appears that the above finding comes into conflict with Sayre et al's (1992) findings. In their study that examined shifts in patients' views of support when their families were invited to participate in a family outreach programme, their findings indicated that when social support was not available by family members (refusal to participate), addicts in treatment invoked support by intensifying their relationships with other addicts in the residential unit. It could be speculated that the differences in sample (outpatients versus inpatients and drug addicts versus alcoholics correspondingly) might, to an extent, account for what seems to be conflicting information due to the qualitative difference of stigma attached and the differential opportunities provided by the environmental context. The clinical implications brought forward from this study involve the attempt of therapists to develop addiction rehabilitation techniques based on expertise of family therapy and couples
therapy - as research evidence (Sobell et al 1991) already mentioned has indicated - and carefully planned interventions within this modal approach.

Thus it seems that the research literature is not as enthusiastic as the clinical and theoretical literature on the impact of social support on psychosocial status improvement in addiction treatment. The evidence reviewed revealed the potential of social support as a mediator of therapeutic change but caution is still advisable as far as unquestioned reliance on the role of social support is concerned for a variety of reasons.

Research studies employ more men than women and more alcoholics than drug addicts in their samples possibly due to the latter's lower visibility. The measures of social support used differ according to the researchers' aims and definition of social support and the sample sizes are relatively small; facts that limit comparability and generalisation, although there seems to be an upsurge in the research interest in perceived measures in the recent years.

In addition due to the timing of the support assessment (pre or post), the studies have failed to clearly establish that social support plays an etiological role in treatment outcome (Booth et al 1992). Cohen and Wills (1985) have pointed to the need for more sophisticated research in the area of social support that will be based upon more precise theorising about the function of support, along with a thorough assessment of support deriving from a variety of sources including both family and work sources as well as others.

Finally, it has become evident that research studies lack significantly in addressing intrapersonal, subjective psychological variables that influence the chemically dependent's perception of social support, and in exploring and applying a process perspective on change rather than an outcome one. There is a clear need to pay more attention to the subjective maps chemically dependent people in treatment hold about support and to the inner processes of change in these individuals in treatment in an attempt to amalgamate the two toward describing the process of therapeutic change as related to social support and developing a more comprehensive rather than simplistic insight on the role of social support in
therapeutic changes during addiction treatment that will make justice to the intricate complexity of both social support and therapeutic changes.
VII. A commentary on therapeutic implications.

Being in psychological therapy can in itself be a powerful, non-specific experience of emotional, esteem and instrumental support, irrespective of what specific techniques are used, what skills are taught, or what novel knowledge takes place. At the same time though, Parry (1995) contends that "Therapists focus on the individual's development, learning, behaviour, emotional responses, perceptions and thoughts. They see people in the social vacuum of the consulting room, plucked from their usual social environment, building a picture of the patient's interpersonal processes and social world from self-report" (p. 279). Thus it appears that there is a need for therapists in the field of addiction to work synergistically with social and community approaches to deliver an effective form of therapy and to ensure that these are ecologically valid in order to increase the willingness or ability of clients and empower them to access support from others.
VIII. Recommendations for further research.

The guidelines, that the still pioneer research work on social support and addiction treatment has offered to the scientific community to date, suggest an impelling need for more research that will incorporate a methodological attempt to view change as a process within the subjective experience of the individual subject in relation to social support while at the same time identifying the components of this process (Oyabu & Garland 1987; McKay & Maisto 1993). The fit between the subjects' subjective expectations and their actual experiences of support and how the extent of this fit, as mediated - if so - by personality characteristics, impacts on the role that social support plays in treatment change is an important concern that further research awaits to deal with more comprehensively (Oyabu & Garland 1987; Booth et al 1992; Orford 1992). Thus additional research is needed to shed more light on determining which individuals might profit from what type of social support and on how to better facilitate the process of linking chemically dependent people to forms of social support that are conducive to maintaining alcohol and drug-free living (McKay & Maisto 1993).
REFERENCES


A Scientist-Practitioner Approach to Psychological Assessment: An Evaluation of Multiple Card Sort Procedure as an assessment technique used by Counselling Psychologists.

Abstract

This paper presented a relatively novel methodological approach (Multiple Card Sort Procedure) for modelling its specific contribution to the assessment process from the perspective of advancing a viable application of the scientist-practitioner model in counselling psychologists’ work. It was argued that existing assessment techniques, ranging from standardised questionnaires and psychological tests to interviews, are inherently biased by the interplay of a variety of therapist and client variables present in the therapeutic process with obvious constraints for unbiased, collaborative treatment decisions and evaluation procedures. There was also an array of questions as to their provision for adequately and convincingly enhancing those scientific elements that could promote the integration of a sound research aspect into practice. In light of this, it was proposed that MCSP has the potential to bring together in an assimilative manner both the systematic scientific element and the practitioner's collaborative elements with clients if successfully incorporated as a technique for assessment purposes as a starting point. It was further argued that the fact that it permits the elicitation of in-depth qualitative information which is still structured enough for quantitative systematic analysis testifies to its appropriateness and usefulness. The exploration of an idiographic assessment of aggression through the investigation of aggressive fantasies (using Multiple Scalogram Analysis and Procrustean Individual Differences Scaling Procedure analysis of data gathered from 20 general population respondents) was chosen to illustrate and add with a demonstration of applications to the discussion of the above arguments.
I. INTRODUCTION

There has been increasing preoccupation with the disparity of views in the assessment models appropriate to the counselling psychology context (Clarkson 1996; Woolfe 1996). Since psychological assessment is of great importance for diagnostic and treatment planning, it is argued that counselling psychologists should strive to conduct their assessment activities in ways that ensure the greatest degree of accuracy and accountability informed by their adherence to a scientist-practitioner approach (Spengler, Strohmer, Dixon & Shivy 1995).

There has been much debate over assessment procedures within the counselling psychology context as well as an emphasis on the advantageous contributions of a scientist-practitioner stance for the discipline (Spengler et al 1995; Clarkson 1996). However, despite this literature, the scientist-practitioner approach has never been properly integrated within the assessment framework. It would appear that counselling psychologists are more preoccupied with advancing the scientist-practitioner approach in relation to therapeutic process, and they often neglect to take into account that assessment is the foundation of therapeutic process. If there is a convincing way of arguing for a more integrative perspective - one where the roles of scientist and practitioner are not separated but instead can be fused into a more holistic role - it is through exploring the compatibility between the scientist-practitioner approach and psychological assessment.

Research suggests that therapist's judgements and hypotheses during assessment may be compromised by a high degree of inferential errors (Morey & Ochoa 1989; Spengler et al 1995; Garb 1996). One suggested cause is that therapists rely on comparing clients to either stereotypes (as constructed through standardised, structured psychological tests) or prototypes (as constructed through unstructured tests such as projective tests) (Haynes 1993). There is also research evidence to suggest that even such typical assessment formats as interview or questionnaire administration (interviews less so than questionnaires) are likely to lead therapist's to misguided inferences due to biases introduced by the client's unwillingness to disclose personally sensitive information, his/her perception of sensitivity of inventory items and the type of emotional experience associated with the formats used (Gallant 1985; Locke & Gilbert 1995). These biases can be further
strengthened by the absence of scientific models to guide all decisions therapists must make (Spengler 1995). It has also been observed that therapists' decision making is often constrained by adherence to one therapeutic model irrespective of the individual requirements of the client (Persons 1991).

However, it does need to be acknowledged that the non-linear, dynamic, bi-directional, unstable and sometimes apparently chaotic nature of behaviour and relationships present significant challenges to the counselling psychologist in the assessment procedure. It is important for counselling psychologists to ask themselves how can judgement accuracy in the assessment process be, if not determined, then facilitated in a profession that deals with subjective data derived from the human experience? Spengler et al (1995) were also intrigued by the same question and proposed the need for counselling psychologists to incorporate the attitudes of the scientist in their practice. This involves systematically operationalising assessment methods and invoking tentative and self-correcting procedures on a client-by-client basis. This should serve to incorporate clinical judgement debiasing techniques into their assessment strategies (also see Persons 1991; Nezu & Nezu 1993).

The suggestion of the employment of a scientific approach does not imply lack of respect, support, empathy or caring - qualities that constitute a positive therapeutic relationship; nor does it mean that it would circumvent agreement between the counselling psychologist about the tasks and goals of psychological therapy, aspects that characterise a positive working alliance (Spengler et al 1995).

Thus far in the assessment literature the need to integrate assessment with the scientist-practitioner approach has been dealt with by advancing problem-solving or scientific reasoning models (see Nezu & Nezu 1993; Spengler et al 1995; Garb 1996). However, such attempts appear to be unconvincing because there is inadequate explicit demonstration of how these models enable counselling psychologists to work collaboratively with the client in seeking to understand the client's inner reality and construal of life experiences.

One promising approach to addressing these needs and requirements involves the use of the Multiple Card Sort Procedure (MCSP). This study attempts to explore one
potential interface between this idiographic model of enquiry and therapeutic assessment. Multiple Card Sort Procedure (developed by Canter et al 1985) is a relatively novel idiographic approach used to access individual classification systems (attitudes, values, beliefs, representations and knowledge). We do not propose that the in-depth psychotherapeutic interview could ever be replaced by MCSP. What we propose is that this methodological approach, if it can be successfully incorporated among the techniques that the counselling psychologist employs for assessment purposes, can provide a valuable tool. This is because it permits the elicitation of in depth qualitative information which is still structured enough for quantitative systematic analysis (Tanner & Hammond 1996). It has the potential to bring together in an assimilative manner both the systematic scientific element and the practitioner's collaborative elements with the client.

MCSP is similar in principal to the widely-used Repertory Grid (Kelly 1955). Its rationale was initially grounded on the premises of Kelly's (1955) personal construct theory. However, MCSP has been advanced to challenge and test Kelly's assumption of the bipolarity of constructs. The assumption according to which MCSP functions is that "the ability to function in the world relates closely to the ability to form categories and to construct systems of classification by which nonidentical stimuli can be treated as equivalent. [...] Thus, an understanding of the categories people use and how they assign concepts to those categories is one of the central clues to the understanding of human behaviour." (Canter et al 1985, p. 79).

The main advantage of MCSP, which we believe renders it an ideal adjunct to assessment procedures, is that it allows a flexible exploration of conceptual systems either at the individual or group level since it does not presuppose or impose a view of the likely structure and content of the therapist's conceptual system on the client or impose a response format. MSCP involves working directly with individuals on their own terms, respecting their ability to formulate ways of thinking about the world and their experience of it (constructing personal meanings). This should enable the counselling psychologist to explore the organisation of the issues surrounding the presenting difficulties and problems without undue cognitive or affective strain. Such processes result in an account of what is salient to an individual together with an indication of its affectivity which would be an invaluable
tool for aiding the professional understanding of the meanings utilised by clients. In addition, MCSP constitutes a salient starting point for understanding the clients' actions in the world (Canter et al 1985; Wilson & Canter 1993; Hammond 1995; Tanner & Hammond 1996).

It is clear that the main feature of MCSP that is most compatible with the counselling psychology working framework is that it allows the exploration of both the nature and the organisation of concepts about any issue while maintaining the freedom and open-ended qualities that minimise the danger of forcing the client to fit an assessment's a priori structure. This is a particular weakness of currently available standardised inventories for psychological assessment used predominantly by clinical psychologists. In this way MCSP facilitates the development of a context which is flexible enough to accommodate and fit the client's structure and meaning of the world, yet still providing for systematic analysis of individual clients or groups.

The therapeutic implications of the above conceptualisations and suggestions rely on the development of an assessment technique that will foster a collaborative relationship between the counselling psychologist and the client through which therapeutic outcome can be maximised. This is important because the client is actively involved in negotiating the focus of therapeutic intervention without feeling anxiety about being invaded or intruded upon by an expert figure and allows the counselling psychologist to develop meaningful hypotheses from the juxtaposition of elements within the client's idiographic space. At the same time the technique retains the capacity for systematic operationalisation of the assessment issues (in line with the scientist-practitioner approach). The MCSP also allows the counselling psychologist to provide accessible feedback to the client, generating a discursive exploration of the client's difficulties in terms of the dimensions of meaning s/he employs to make sense of them and the world rather than the counselling psychologist attempting to compound these dimensions of meaning onto his/her predetermined dimensions (Canter et al 1985; Hammond 1995). Such a process gives space for invoking tentative and self-correcting methods for making justice to the crucial role assessment activities play in the iterative process of developing, implementing, monitoring, and evaluating a treatment plan developed collaboratively with each psychotherapy client (Hunsley 1996).
The relevance of MCSP to counselling psychology becomes even more explicit when one considers how useful this approach can be with more sensitive and complex/covert issues (i.e. aggression, sexual and/or physical abuse, addictive behaviour etc.) or blurred areas (i.e. underlying psychopathology) that may impinge on the therapeutic process. It is incumbent on counselling psychologists who seek to advance a new paradigm to ensure that their therapeutic work is sensitive to the complexities of contemporary clinical practice; especially so if we take into consideration Watkins et al.'s (1995) assertion that the basic practice of psychological assessment among clinical psychologists has changed little in the past 30 years.

The present study attempts to illustrate the potential of the MCSP approach by exploring an idiographic assessment of aggression through the exploration of aggressive fantasies. This decision was based on a twofold consideration. Most fantasies in general are considered to be a purely private affair. Their private nature reflects the sense that fantasies are imbued with personal meaning and thus retain the potential of revealing a great deal about oneself as they contain important clues about how one is feeling, what they wish for and what they fear which is latent and covert (Klinger 1971; Lemma-Wright 1995). Aggressive fantasies in particular though are considered possibly the most covert ones in the spectrum due to the strong and heavy psychosocial control and rules for the limiting, modifying, controlling and binding anger and aggressive impulses since they cannot be accommodated in an individual's life within a community in their original form and strength and they thus have to be reduced in quantity and changed in quality (Klinger 1971; Freud 1972). For these reasons, it was deemed that the employment of a MCSP with aggressive fantasies, due to their sensitive, complex, covert nature and confused definition, would best serve the purpose of demonstrating the potential of MCSP while remaining faithful to the counselling psychology paradigm.

Fantasy is a process central to normal human functioning since it may provide an alternative perspective on reality which can help individuals to overcome past hurts and disappointments or current conflicts and anxieties, finding new fulfilsments and satisfactions. On the other hand, it also may serve a defensive function by offering an escape from reality which may be manipulated, in fantasy, to suit one's needs. Fantasy themes therefore reflect not only the positive incentives for which people
strive but also the negative incentives they wish to avoid (Klinger 1971; Fonagy et al 1993; Lemma-Wright 1995).

Because the content of fantasy usually reflects current concerns and regnant subselves, fantasy processes constitute a continuous cycling of response elements that are most likely to be relevant to the individual's present life situations. In the course of fantasy, a person works over, recombines and sometimes reorganises the information often creatively. In that sense, fantasy carries an important burden of self-organisation in the individual's overall adaptive mission (thus the association in literature between fantasy and self-concept) [Klinger 1971; Fonagy et al 1993; Lemma-Wright 1995].

As far as aggressive fantasies are concerned in particular, it has been hypothesised that individuals who inhibit their anger and aggression as disapproved activities are more likely than others to portray in their fantasies the ill consequences of the activity, especially internal self-punishment and loss of love. There is fairly consistent research evidence to support that individuals who experience frustrated aggression incorporate both positive and negative incentives of their conflict into their fantasies, yielding something more that unadorned wish fulfilment (Klinger 1971).

Fonagy et al (1993) assert that both healthy and pathological aggression involve the intent to harm (in reality or fantasy), and tend to be accompanied by unpleasant affects such as anger, fear, resentment or frustration. Freud (1972) had already expanded on this when she precluded that the aim of aggression ranges from discharge, avoidance of rising tension, removal of upset and displeasure, upkeep of homeostasis to destruction for its own sake. Berkowitz (1962) suggested that such aggressive drives can be ventilated symbolically through fantasy which brings about vicarious catharsis.

However, aggressive fantasies have been only scarcely researched either through projective tests (i.e. TAT) or highly controlled experiments and primarily in relation to the patterns of effects of anger on fantasy rather than aggressive fantasies per se. Evidence though suggests that the effects of situations, roles and inferentially, of incentives seem to govern the process of hostility itself, not merely its expression in
fantasy; and also that an individual's experience of anger itself seems to depend on whether retaliation is socially appropriate (Klinger 1971).

Buie et al (1983) assert that no other commonality can be found among aggressive behaviours (which could very well extend to include symbolic aggressive behaviours, namely fantasies) but in their motivational aspects; neither their behavioural characteristics nor their affective concomitants. They though stress the need for a more precise and clinically useful delineation of the nature of aggression.

The current study explores the potential enhancement of a scientist-practitioner model of psychological assessment through the incorporation of a MCSP in the assessment process. The fundamental research question is whether a normative structure of the nature of aggression can be delineated from aggressive fantasies while at the same time providing insight into the way aggression is conceptualised and interpreted by the individual (that is, yielding in depth idiosyncratic information) using aggressive fantasies as the units of analysis. In order to facilitate the selection of fantasy materials an a-priori structure was imposed. This is a tentative model and is utilised primarily to aid in stimuli generation.
II. METHODOLOGY

Respondents
The study employed respondents from the general population. Recruitment was voluntary and each respondent signed a consent form (see Appendix A). Overall there were 20 respondents that participated in the study. None of the individuals approached refused to participate in the study. There were 11 males and 9 females. The age range varied from 21 to 50 (Mean: 30.70 S.D.: 7.57). The sample consisted of respondents with varied nationality; namely 11 British, 6 Greek, 1 Brazilian, 1 Icelandic and 1 Namibian, all living in England. Each interview took between 45 minutes and one and a half hours to complete.

Choice of Sorting Elements
The sorting elements refer to the different structure of aggressive fantasies used in the multiple card sort procedure. For the purpose of this exercise the elements were provided for each respondent. An experimental set of aggressive fantasies of approximately 150 words (see Appendix B) was constructed using a predefined facet structure identified by the researchers and is presented in figure 1. The predefined facet structure was identified through content analysis of a number of aggressive fantasies that individuals who were approached volunteered to provide. These volunteers were not recruited as respondents. A set of sixteen aggressive fantasies was produced which were then typed onto separate cards.

Procedure
Each respondent was presented with 16 cards each bearing a separate aggressive fantasy. Respondents were then first asked to sort the cards according to a) the similarity of the fantasies to their own, and b) the degree of appeal that each fantasy had for them (fixed sorts). Following this, the respondents were asked to sort the cards using one construct criterion at a time until all constructs they could generate had been exhausted. This “free sort” technique was adopted since it was felt that the category headings respondents used would provide useful idiosyncratic information about aggression cognitions.
Analysis

The MCSP data from each respondent was analysed using Multiple Scalogram Analysis (MSA). The MSA is particularly useful, for as well as providing an "overall" plot of the elements in 2-dimensional space, it also provides "item plots" for each construct (Wilson 1995). These indicate, for each construct, which category the elements were assigned to, thereby retaining all of the qualitative information concerning why elements are similar or different. It is therefore possible to demonstrate not only the structure of the individual's representation, but also why it is structured as it is. It is then possible to draw conclusions about the relationship of the constructs to one another.

The resulting co-ordinates were entered into a Procrustean Individual Differences Scaling analysis (PINDIS). The PINDIS procedure involves applying to the data one of 5 scaling models, of differing complexity, in order to form an estimated joint normative space (Hammond 1995). The individual configurations are transformed, in order to fit as closely as possible to a centroid plot (an "average" of all the respondents configurations). From this, it is possible to identify the degree to which (if at all) the individual's configurations share a common structure.

This means that each respondent has their own (idiographic) solution but also a measure of normative fit. That is, idiographic data is treated in such a way that the richness of information is used but at the same time a meaningful set of normative generalisations may or may not be available. Therefore, the respondents might share a common representational field but also each may be oriented in a uniquely way to it (Doise et al 1993).
III. RESULTS

a) Emergence of themes

The free sorts that individual respondents used as their constructs were content analysed to explore whether there were any common themes that could be extracted and to what extent these common themes fitted the facet structure on which the sorting elements were based.

A qualitative analysis of all the idiographic representations found that the major sorting themes used were content/outcome, severity and form of harm or damage inflicted and the form in which aggression was expressed in the fantasies.

Content/Outcome. This was the most frequent sort among respondents who identified the following elements under this construct; the most pronounced element was social humiliation in the eyes of a third party. The second element in order of frequency in the sorts was overt or covert sexual activity. Coming next was the identification of the element of self-harm. Finally, the elements of revenge and destructiveness for its own sake were identified by only a marginal percentage of the respondents.

Form of harm or damage. Respondents identified the elements of either psychological or physical harm or damage and were particularly sensitive to the degree of extremity/violence/danger that they felt was reflected in each vignette in ordinal form ranging from high to low.

Form in which aggression was expressed. Respondents also sorted out the set of aggressive fantasies according to whether the expression of aggression in the vignettes was physical or verbal.

Following these four themes - in order of frequency of appearance - were the themes of justification/intentionality of the narrated response and direction of aggression under which three sub-elements were identified; namely they felt that the recipient/target of aggression was either an outgroup, or strangers, or familiar people.
Finally there was only a marginal percentage of the respondents that identified the themes of satisfaction (amount of satisfaction gained from aggressing against a selected target), gender (whether the aggressive fantasies were more likely to be male, female or of both sexes), and humour.

In summary, the majority of respondents view, perceive and understand aggressive behaviour in terms of its content, severity and mode of harm/damage, and modality of its expression as the fundamental premises on which they would respond in the context of interpreting and making sense of theirs as well as others’ aggression.

This thematic analysis bears a rather close fit to the predefined structure identified by the researchers. This fit relates to the elicitation by the respondents of the same facets that were initially identified by the researchers as modality of aggressive expression (verbal and physical; Facet A), modality of damage (psychological and physical; Facet B), and modality of content (revenge, self harm, sexual, outgroup; Facet C). As far as the first two modalities are concerned, it appeared that there was an identical fit. However, regarding the modality of content, although it was identified by the respondents as a construct, there seemed to be some discrepancy in the elements that made up this construct in the researcher’s minds and in the respondents’ minds. Namely, the respondents clearly identified the sexual and self harm elements while they only marginally identified the element of revenge to bear any significance in terms of generalisation. Finally, the outgroup element was identified but not as a content element; rather as an element that explains the construct of the direction of aggression.

b) Idiographic Solutions/Analyses

In order to examine each idiographic representation of aggression the data derived from each respondent’s classification were analysed using MSA. Due to the need for conciseness and for purposes of demonstration, only two examples of idiographic analysis are presented below (a complete set of co-ordinates is available from the author). These are examples of two idiographic analyses in which the aggressive fantasies are positioned in Euclidean space according to their similarities during the sorting process. The actual cognitive representations are interpretable from the manner that the regions map onto the sorting categories. The content of
the cards plotted in these analyses are summarised in Table 1. A fuller account of the content of each card is given in Appendix B.

--- Table 1 about here ---

Idiographic Analysis I

This female respondent completed six sorts in total.

--- Figure 2 about here ---

From the sort headings it is possible to gain a superficial idea of the individual's representation. A salient feature seems to revolve around "harmfulness" which is suggested by sorts three and five (see figure 2). To an extent this is substantiated in the overall visual profile of the aggressive fantasies (see figure 3) which points to a rather clear demarcation between fantasies in terms of the damage that was inflicted. However, although this respondent's profile identified the facet of modality of damage, the underpinning elements did not concern the form the damage took but rather its severity. It is noteworthy that there is a noticeable isolation of fantasies that have a distinct, overt and explicit sexual theme.

--- Figure 3 about here ---

A deeper understanding of the way the individual conceptualised aggression can be achieved by examining the criteria used to sort the aggressive fantasies in conjunction with the visual profile of the aggressive fantasies. In this way it is possible to identify how the individual differentiates between the different aggressive fantasies and gain an understanding of how the representation of aggression is constructed. In this particular case, it is possible to identify five distinct regions; Most to least harmful fantasies (both in physical and psychological terms which are not distinguished where death is perceived as the ultimate harm), Level of impulse, Similarity and Appeal.

Thus the dominant facets in this respondent's representation are concerned with the outcome of the aggressive act, implulsiveness and the likelihood of that person acting on her aggression (e.g. severity of harm/fatality, intentionality, activating
potential). The relationship between the different facets within the individual's representation can also be identified. Most notable is the fact that the most impulsive the enactment of aggression is perceived to be, the most harmful the outcome is viewed. Further, the most the respondent regards that she may act on impulse, the more likely it is that expression of anger and aggression will be inhibited by her. Overall, then, it seems that the superordinate facet within this individual's representation of aggression is concerned with control over her anger and aggressive impulses in due consideration of the psychosocial implications involved in terms of damage and harm inflicted directly or indirectly, physically or psychologically. Thus, it appears that the more control the individual has over her feelings of anger, the safer she feels within herself.

In light of this, it would appear that it is difficult for this individual to respond healthily to and ventilate feelings of anger and aggression, possibly because of the fear that she will not be able to control them and thus prove to be destructive both for herself (since she might feel that she has lost her sense of control) and others. Therefore, it might be worthwhile that this interpretation could be discussed with the individual in terms of whether this is an accurate reflection of her stance toward anger and aggression and - if it is - work with the fear of losing control, so that a sense of empowerment and balance, without relinquishing the experience of such feelings, can be promoted.

*Idiographic Analysis II*

This male respondent completed five sorts in total.

---- *Figure 4 about here* ----

Clearly from the sort headings (see Figure 4), it is evident that this respondent is primarily concerned with the consequences of aggression and the target (direction) of aggression. From the visual profile of the aggressive fantasies (see Figure 5) in conjunction with a consideration of the sorts four regions were differentiated; Social humiliation involving strangers or people with who there is remote acquaintance, Embarrassment involving work relations, Mild physical harm, Severe physical harm (including death).
It appears that this respondent has a very basic representation of aggression, the dominant theme concerning the severity of damage inflicted ranging from psychological to physical. Another important facet is to who aggression is channelled. This latter facet seems to be related to the perceived severity of damage. That is, severe damage is perceived as likely to occur when the situation involves strangers or remote acquaintances, although it is clearly not condoned by the respondent who clusters such aggressive fantasies both as dissimilar to his own and as some that he would have never even considered implementing in contrast with the fantasies that he perceived as socially humiliating and embarrassing.

It would thus seem that in this respondent’s mind, feelings of anger and aggression can be harmlessly (i.e. in psychological form of embarrassment) ventilated regardless of the status of the target which suggests that he is able to express such feelings in a way that he feels comfortable with. However, it is implied that he perceives severe harm as being targeted and likely to be implemented only to strangers to the aggressor.

Moving to a Normative Interpretation

Procrustean Individual Differences Scaling Procedure

A PINDIS analysis was carried out on all 20 co-ordinate solutions (see Appendix C for a technical description of Procrustean Individual Differences Scaling analyses). This resulted in a model fit represented in Table 2. Here we see that the most parsimonious model is the vector model. The centroid solution for this model is presented in Figure 6. This model is an estimation of the normative representation that maximises distributive agreement between all the idiographic representations. The vector model suggests that the individuals share a common point of view, as seen in their common origin, but that they differ in the centrality with which they view the different aggressive fantasies.
It would therefore appear, from the plot of the weighted centroid configuration, that the aggressive fantasies are largely and primarily ordered by severity of harm/damage where there is a fairly clear distinction between psychological harm and physical harm (psychological harm being perceived as the least severe form of damage). It would also though seem that to a lesser extent but equally important, they are ordered by their content where there is a less clear but attainable distinction between sexual, outgroup, self harm and revenge themes. The consideration of the co-occurrence of these constructs explains the emergent marginal positioning of some fantasies as apparent in the centroid plot.

As evident in figure 6, the centroid plot strongly implies the existence of a highly ordered facet by severity of harm/damage where movement is clearly ordered from fatal harm (death) to mild psychological harm (humiliation/embarrassment). Another implication of the centroid plot is the emergence of a possible thematic order. There is fairly clear evidence of clusters of thematic groupings (self-harm, sexual, revenge, outgroup) which can be superimposed on the harm facets. What is interesting and worthwhile to note is that these thematic groupings appear to be interrelated to the distinctly ordered facets of harm in terms of, what appears to be, an ordered movement from self-harm to harming others (outgroup).

In light of this, it seems that there exists a basic normative structure around which individual perceptions and interpretations rotate. This normative structure confirms - to an extent - the researchers' suggested structure of aggressive fantasies since it appears that the facet of modality of expression of aggression and the facet of modality of content emerged as fairly distinct regions in the weighted centroid configuration.

However, it is noticeable and important that the most salient feature, according to which our normative structure holds, revolves around the severity of damage/harm which in itself suggests a strong link between the perception and interpretation of aggression primarily in terms of its social appropriateness (Klinger 1971) which possibly determines the degree to which anger and aggression in their original form and strength are limited, modified, and controlled in quantity and changed in quality
(Freud 1972). The normative structure that emerged suggests that these processes might be interdependent on the incentives that contextual and situational variables present for the individual (in contrast to Klinger 1971 and to an extent in agreement with Buie's (1983) findings of the importance of motivational aspects), which of course though are in turn dependent upon the individual's interpretation by him/her according to his/her idiosyncratic construal of life experiences (as already illustrated through the analysis of idiosyncratic information).

In addition, the normative structure that emerged in conjunction with the themes of intentionality and satisfaction that were identified from the qualitative analysis of the individual profiles suggest that there may be some consensus with Fonagy et al's (1993) assertions about the intention of harm that aggressive activities involve. The issue of emotional catharsis (Freud 1972; Berkowitz 1962) also seems to bear some importance in the way some of the respondents perceived and interpreted the aggressive fantasies in terms of their function for the individual.

Although this study is only a limited, small-scale one conducted, primarily for the purpose of illustration of the viability of the use of MCSP in an assessment context and we acknowledge the need for further investigation of normative aggressive cognitions, it would appear that the salient feature of severity of damage/harm in terms of the normative structure suggests that there is a commonality within aggressive behaviour in the way that respondents perceive its behavioural characteristics as opposed to Buie's (1983) assertion. Evidence for a commonality in terms of the affective concomitants of aggressive behaviour appears to be too idiosyncratic and marginal to have any normative implications for this study. The latter statement also holds for any indication about the functions of aggressive behaviour.

Finally, it seems noteworthy to mention that PINDIS analysis also provided a joint person plot (see Figure 7) which did not yield any interpretable patterns in the way that respondents perceive anger and aggression in terms of their nationality or age. However, its structure suggests that there might be a differentiation in the respondents' representation of anger and aggression according to their gender; that is, it is implied that there may exist a difference in the way that males and females perceive (and therefore express) anger and aggression. In addition though there
appears to be allowance for a joint space indicating that there may also be some convergence in the way certain males and females perceive and express anger and aggression (still always bearing in mind idiosyncratic construal which accounts for non-linear demarcation). These intriguing findings are believed to be of considerable heuristic value. However, it is beyond the scope of this study to further investigate and clarify them.

----- Figure 7 about here -----

This discussion of the representation and structure of aggression as illustrated by the study of aggressive fantasies was incorporated in this section of the paper, since it was not the major task undertaken. In this way, we are allowed to focus on a discussion and overview of the above illustration in terms of the primary undertaking of this study; namely, to demonstrate whether MCSP is a viable method to be used as a technique in an assessment context in order to advance and promote a sound scientist-practitioner approach to psychological assessment for counselling psychologists.
IV. DISCUSSION/OVERVIEW

On exploring the idiographic representations and constructs of aggressive fantasies a marked idiosyncrasy was found suggesting substantial individual variation in the way that individual respondents perceived and interpreted aggression. This implies evidence of widespread interpersonal variation in construal and cognitive complexity as far as aggressive feelings and behaviour are concerned. Beyond cognitive complexity though (as illustrated through the presentation of individual cases), there was clear evidence about how - with the use of MCSP - a counselling psychologist can reach an in-depth understanding of a client's unique interpretation of a sensitive, implicit and covert issue without undue prompting.

As part of the process of MCSP an MSA analysis is required. This can be readily done using a computer and takes only minutes to produce a plot. In light of this process, the counselling psychologist can feed back to the client his/her understanding (based on the client's view of his/her situation) of the way that the client perceives and responds to central issues and difficulties in his/her life, thus enabling a collaborative dialogue with the client which is free from biases, stereotypes or prototypes. This also gives ample incentive and opportunity to the counselling psychologist to evaluate his/her own stance toward the client along with critically thinking about interventions, and test his/her hypothesis opposite idiosyncratic but salient and concrete information.

It seems evident from the illustrations provided in the above section that MCSP can be used in a way that allows the client to propose his/her own terms without being compounded into categories, scale positions or theoretical stances and philosophies; that is, s/he is granted parity with our professional dimensions. This facilitates a conversation between therapist and client as equals, peers, people who are striving to understand each other rather than being caught up in a mimicry of the scientist measuring the object. Such a discursive relationship is more likely to aid the client to achieve insight into his/her own modes of interpreting his/her situation.

At the same time, however, that such richness of information is used discursively within the context of psychological assessment, a search for systematisation and commonality can be facilitated as demonstrated through PINDIS without though
adding to the continual over-simplification of our ways of construing people and to a
cornet with trivia that the urge to quantify and categorise thoughts, feelings and
behaviours in test terms has led to. This introduces an element of scientific
research, that is not ridden by presumptions, in the very heart of practice and makes
it possible for the counselling psychologist to soundly adopt a scientist-practitioner
attitude by moving from individual interpretations to a more normative and
generalisable model for planning larger scale interventions and preventive
programmes.

It is proposed here that the scientist-practitioner paradigm that is incumbent in the
working stance of counselling psychology can be promissingly served through the
use of MCSP in assessment since the existing false dichotomy between the
activities of research and practice can be bridged. It is our view that MCSP
facilitates the interaction of these strands in a synergetic capacity where the unique
lenses of the scientist and the practitioner merge in a fused and holistic way.
Perhaps the most important implication is to encourage practising and training
counselling psychologists to infuse practice with research in a manner that will both
enhance their therapeutic work but also render them credit for systematic, scientific
research work without having to sacrifice potentially valuable sources of time,
energy and financial resources.

It is also important to note that one of the strengths of MCSP as an assessment tool
is that, due to its nature, it transcends the boundaries of language, literacy,
education, intelligence, articulation, age, pathology, culture, race without
relinquishing the active participation of qualities that constitute a positive therapeutic
relationship in its process.

A final point that needs to be clarified in this discussion is that, although the present
study provided the respondents with a given set of elements to use as stimuli
because of its specific aims, the MCSP is so flexible that allows the clients to select
their own elements according to what they feel that the nature of their difficulties
pertains to. This means that there are no restrictions on the response format. Thus
there is no need on the part of counselling psychologists to impose the sorting
elements on clients who can choose the elements on their own terms and according
to their own construal of their situation.
It must be stressed that this study can only be perceived as a pilot study for the potential of MCSP as an assessment tool and that further exploration is needed to reveal even more about this potential. Further investigation is required where respondents will be fed back with the information derived from their idiosyncratic profiles so that we can have a working example of such an interface. However, we would like to believe that this study has succeeded in raising valuable issues for consideration by counselling psychologists in terms of the dilemma they are faced with in their applied discipline between science and practice, research and therapeutic work, and has in addition proposed a viable tool whose implications for the above considerations are worthwhile to pursue.

A psychology that participates in the human enterprise must perceive that the guidelines channelizing a person's processes are drawn by the person himself - that they are therefore personal constructs, and may be redrawn and revalidated by the user to construct anew his thought and his behaviour. They are not the residue of biographical incidents, nor are they projected facsimilies of reality. They are, instead, the axes of reference man contrives to put his psychological space in order and to plot his varying courses of action.

With such personal constructs a man can make his entrance into the world of reality by acting with initiative and ingenuity. Failing to erect them he can only repeat concretely what has been "reinforced", in the circular manner that psychological journals - themselves deliberately acting, I fear, as products of their own concrete satisfactions - describe. It is difficult to see how a psychology so addicted to its reinforcements can ever participate imaginatively in the mounting behavioural ventures of the coming generation. (Kelly 1969, p. 36)
REFERENCES


Dear participant,

My name is Effie Kavatha and I am a Doctorate student at the psychology department of the University Of Surrey. I am currently in the process of conducting my doctoral dissertation under the supervision of the department.

My interest is in exploring the relationship between the emotion of anger and aggression as its demonstrable counterpart. Your co-operation in this project would be greatly appreciated. It will involve reading a few cards containing people's aggressive fantasies and then sorting them into categories of your own choice. It is anticipated to last for approximately half an hour.

Please sign the consent form below if you agree to participate in this study. This is standard procedure. I would like to ensure you that anonymity and confidentiality will be safeguarded at all occasions. Should you become uncomfortable at any stage of this process, please feel free to not continue with it.

I understand the purpose of this study and I agree to the anonymous use of my responses.

Signature
Date
APPENDIX B

#1. Verbal Psychological Revenge

My manager is a horrible person. He treats me as if I am his slave, and threatens me with the loss of my job if I ever complain. As he is powerful in the company I know I have to do as he says. One day I notice that his tie has been caught up in his trouser zip. I wait until he is in a meeting with other senior executives and I go up to him and say "Sir, your tie would look better round your neck than protruding from your trousers, unless you are trying to draw attention to that part of your body that is even more useless than your head. Incidentally I am resigning immediately." Everyone laughs at him and he is obviously very embarrassed.

#2. Verbal Physical Sexual

I am in a very crowded pub and a middle aged man starts rubbing himself up against me. He begins to breathe heavily and I can feel that he is very sexually excited. Eventually he has an orgasm. I finally manage to pull away from him and I shout out, 'Look at this old pervert he has just come in his pants!' Everyone, looks at him and he goes bright red, clutches his chest and falls down dead with a heart attack.

#3. Verbal Psychological Sexual

I am being pestered by a young man in the street who keeps grabbing my breasts and rubbing himself up against me. An old couple walk towards us and he suddenly stops what he is doing. I realise they are his parents. As they come into close proximity I suddenly shout at him to take his disgusting hands off me and go fuck himself if his pathetic penis allows him to even do this. His parents are shocked and he looks like he wishes the ground would swallow him up.

#4. Physical Physical Self-Harm

One of my neighbours hates me and one day he poisons my pet dog. When I find it in my back garden he is leaning over the fence laughing at me. I am raging with anger and pain. I go out and buy a gun and go round to his house. When he opens the door I shoot him. As he falls to the ground I shoot myself.
#5. Physical Psychological Self-Harm

I discover that my partner is having an affair with another woman and I am devastated. Later I meet him in the street. I go over and slap and scratch his face. While he is trying to explain, I run toward the road and throw myself in front of the coming car as I hear him shouting "Please don't...Oh God".

#6. Verbal Physical Self-Harm

I am driving on a country road in a hurry and suddenly six people in a van appear in front of me blocking the road. They are all larking about and won't let me pass. After about 10 minutes I shout abuse at them but they ignore me so I drive my car straight into their van.

#7. Verbal Psychological Self-Harm

My partner has been complaining about everything I do which never seems to be good enough. One night he brings his boss round for dinner. I make a point of telling his boss what an inadequate person I am and how my partner has such a lot to put up with. I can see that my partner is very embarrassed and wishes I would shut up but I continue until his boss leaves.

#8. Physical Physical Revenge

I am out with my partner in a pub. Another woman comes up to him and starts fondling him and chatting him up. I tell her he is with me and she says that she cannot see what he is doing with such an ugly old boot as me. My partner is embarrassed and I am furious. Later I see her go to the toilet which is upstairs. I follow her and when she comes out I shove her down the stairs. She ends up in hospital with a broken rib and bruises.

#9. Physical Psychological Revenge

I have gone out shopping in a posh store. The saleswoman is obviously very disdainful of me and keeps making disparaging remarks about my figure and my ability to afford the clothes in the shop. I feel quite humiliated. Just then Princess Diana enters the shop. The saleswoman spots her and walks towards her obsequiously. I "accidentally" catch the back of her skirt with my umbrella. It rips and falls to the floor in front of Princess Diana. The saleswoman has very dirty knickers on and she is totally humiliated and runs out of the shop crying.
#10. Verbal Physical Revenge

I meet someone at a dinner party. He keeps on making smart remarks in which I am the butt of his jokes. I become extremely embarrassed and annoyed. I wait until he is eating and has his mouth full and then I loudly declare to everyone what an idiot he is. He gulps and starts choking and going blue. I leave the room as he falls to the floor coughing and gasping like a fish out of water.

#11. Physical Physical Sexual

I am attacked by a man who I have known for a couple of months. He tries to rape me at knife point and tells me that he has done this to lots of other women. I kick him, he falls and bangs his head. While he is dazed I grab his knife and cut off his balls. I run away leaving him screaming and writhing on the ground.

#12. Physical Psychological Sexual

I am confronted by my boss at an office party. He grabs my hands trying to put them on his penis. I am outraged and he is so drunk it is easy to shove him away. He falls to the ground comatose. I call up a friend who is a tattooist who comes over and tattoo's 'Sad Pervert' on my boss's penis while he is unconscious. We go off laughing thinking about how he will explain that to his wife.

#13. Verbal Psychological Outgroup

I am with some friends at a pub when a crowd of drunken football hooligans walk in. They start abusing us saying we are stuck-up, middle-class parasites. We single out the most vociferous one and tell him that we recognise him as one of the students in our Flower Arranging evening class and ask him how is his friend, Clarence. His friends don't know whether to believe us or not and they start to tease him. They all become rather confused. The ringleader goes bright red and they leave the pub.

#14. Verbal Physical Outgroup

I am on holiday with some friends and we find it difficult to get a sunbathing spot because the German tourists in our hotel keep booking the best places by putting their towels on the loungers the evening before. One morning my friend and I go down to the pool and throw off the towels on a couple of the best loungers and settle down. An hour later two elderly Germans come over and say that these are their loungers. We retort 'Well tough titty we are not moving!'. They are so startled they step back and fall into the pool.
#15. Physical Psychological Outgroup

I am in the train when a group of loutish youths get on. They are extremely noisy and make obscene comments at some of the people. When the train is slowing down for the next station the other passengers and I jump on them and remove their trousers. We throw them out at the next station and as the train pulls out we all laugh at them standing around embarrassed and humiliated on the platform.

#16. Physical Physical Outgroup

I am standing in the street with a few friends when a gang of five men with shaved heads and tattoos all over surrounds us and ask us for our money. We are not enough to fight with all of them and we give them our wallets. Then one of them pulls my golden chain off my neck. Unknown to them I have a gun. I pull it out and shoot one of them between the eyes. The rest of them start running but I manage to hit one at the back and another one at the leg. My friends around cheer at me.
APPENDIX C

PINDIS ANALYSES

The PINDIS analyses used in this study are not widely employed in the psychological literature. This appendix attempts to provide a brief summary of the technique. A more detailed technical account of these techniques can be found in Lingoes & Borg (1978) and Commandeur (1992).

The starting point of a PINDIS analysis is a number \( n \) of \( m \) dimensional co-ordinate matrices involving \( k \) variables. The principal aim is to identify a spatial arrangement of the \( k \) variables which is common to all matrices.

At a very simple level this involves the rotation and translation of the given matrices towards some form of centroid (or mean) configuration. This procedure is known as Generalised Procrustean Analysis (GPA) and involves no reparamatisation of the variables.

The results of this GPA analysis provide a common (or centroid) configuration as well as the degree of fit for each given configuration. The model applied with GPA is a fully normative model because it assumes that each configuration is identical except for rotation indeterminacy. In other words, the procedure provides a centroid configuration in which the relative distances between the variables in \( m \)-space are fixed.

PINDIS offers the potential for relaxing the rigid rotational assumption of GPA by applying other models of increasing idiography. These are described in Lingoes & Borg (1978). Simply put PINDIS offers 4 extra models on top of the GPA. The 1st allows the dimensions of the centroid configuration to be rescaled to maximise fit. This means that the relative distances may be distorted slightly by algebraic “stretching”. The second model allows the dimensions of each given configuration to be “stretched” in order to maximise fit. These two models are known as the dimension weighting models.

A further model is to allow the origin of the centroid configuration to move in order to maximise fit. This changes the length of the Euclidean vectors representing the distance of the variable from the origin. The 5th model does the same for all given configurations. These latter models are known as the vector weighting models.

In order to estimate the fit of the given configurations to the centroid, a variety of techniques are available. The simplest of these is to identify the correlation of the given configuration vectors with those of the centroid. The mean of the correlates ponds an index of overall fit which can be legitimately interpreted as a reliability coefficient.

It is clear that the reliability of the models is monotonic with the order of the models. Thus, the GPA model will always have a poorer fit than the dimension weighting models which in turn will have a poorer fit that the vector weighting models. The order of the models is also the order of idiography. GPA is normative and the individual configuration vector weighting model is fully idiographic.
The aim of a PINDIS analysis is to identify the best fitting model given the constraint that it should be optimally normative.

These techniques require a computer programme to apply because the estimation of the parameters is carried out by an iterative process. Prof. James Lingoes has written a programme using a Least Squares method. However, the programme used for this analysis was written by Dr Sean Hammond and uses an alternating Least Squares algorithm following the recommendations of Commandeur (1992).
Figure 1

A Proposed Facet Structure for Aggressive Fantasies*

<table>
<thead>
<tr>
<th>Facet A (Modality of Aggressive Expression)</th>
<th>Facet B (Modality of Damage)</th>
<th>Facet C (Modality of Content)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Verbal</td>
<td>1. Psychological</td>
<td>1. Revenge</td>
</tr>
<tr>
<td>2. Physical</td>
<td>2. Physical</td>
<td>2. Self Harm</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Sexual</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Outgroup</td>
</tr>
</tbody>
</table>

*This structure was drawn up following a content analysis of aggressive fantasies supplied by volunteers
<table>
<thead>
<tr>
<th>Number in Plot</th>
<th>Facet involved</th>
<th>Structuple</th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>Verbal Psychological Revenge</td>
<td>(a1b1c1)</td>
</tr>
<tr>
<td>2</td>
<td>Verbal Physical Sexual</td>
<td>(a1b2c3)</td>
</tr>
<tr>
<td>3</td>
<td>Verbal Psychological Sexual</td>
<td>(a1b1c3)</td>
</tr>
<tr>
<td>4</td>
<td>Physical Physical Self-Harm</td>
<td>(a2b2c2)</td>
</tr>
<tr>
<td>5</td>
<td>Physical Psychological Self-Harm</td>
<td>(a2b1c2)</td>
</tr>
<tr>
<td>6</td>
<td>Verbal Physical Self-Harm</td>
<td>(a1b2c2)</td>
</tr>
<tr>
<td>7</td>
<td>Verbal Psychological Self-Harm</td>
<td>(a1b1c2)</td>
</tr>
<tr>
<td>8</td>
<td>Physical Physical Revenge</td>
<td>(a2b2c1)</td>
</tr>
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<td>9</td>
<td>Physical Psychological Revenge</td>
<td>(a2b1c1)</td>
</tr>
<tr>
<td>10</td>
<td>Verbal Physical Revenge</td>
<td>(a1b2c1)</td>
</tr>
<tr>
<td>11</td>
<td>Physical Physical Sexual</td>
<td>(a2b2c3)</td>
</tr>
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<td>12</td>
<td>Physical Psychological Sexual</td>
<td>(a2b1c3)</td>
</tr>
<tr>
<td>13</td>
<td>Verbal Psychological Outgroup</td>
<td>(a1b1c4)</td>
</tr>
<tr>
<td>14</td>
<td>Verbal Physical Outgroup</td>
<td>(a1b2c4)</td>
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<td>15</td>
<td>Physical Psychological Outgroup</td>
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</tr>
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<td>16</td>
<td>Physical Physical Outgroup</td>
<td>(a2b2c4)</td>
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</table>
Sorts for idiographic analysis I

<table>
<thead>
<tr>
<th>Similarity</th>
<th>Appeal</th>
<th>Harm (physical &amp; mental)</th>
<th>Recipient deserved outcome</th>
<th>Death</th>
<th>Level of impulse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most similar</td>
<td>Most appealing</td>
<td>Least harmful</td>
<td>Yes</td>
<td>Yes</td>
<td>Most impulsive</td>
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<tr>
<td>Fairly similar</td>
<td>Moderately appealing</td>
<td>Moderately harmful</td>
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<td>No</td>
<td>Moderately impulsive</td>
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<tr>
<td>Moderately similar</td>
<td>Least appealing</td>
<td>Most harmful</td>
<td></td>
<td></td>
<td>Least impulsive</td>
</tr>
<tr>
<td>Least similar</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</table>
**Figure 3**

**MSA Solution for Case I on the 16 Aggressive Fantasies**

<table>
<thead>
<tr>
<th>Mild psychological damage</th>
<th>14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Least impulsive</td>
<td>13</td>
</tr>
<tr>
<td>Most appealing</td>
<td>10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe physical damage</th>
<th>11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately impulsive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderate psychological/physical damage</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderately impulsive</td>
<td>12</td>
</tr>
<tr>
<td>Moderately appealing</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fatal physical damage: Death</th>
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</thead>
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<td>Most impulsive</td>
<td>1</td>
</tr>
<tr>
<td>Least appealing</td>
<td>3</td>
</tr>
<tr>
<td>Least similar</td>
<td>2</td>
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</table>

Explicit sexual theme
Moderately appealing
### Figure 4

**Sorts for idiographic analysis II**

<table>
<thead>
<tr>
<th>Similarity</th>
<th>Appeal</th>
<th>Outcome</th>
<th>Direction</th>
<th>Performed</th>
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<td>Would do</td>
<td>Social humiliation</td>
<td>Strangers</td>
<td>Has done some variant</td>
</tr>
<tr>
<td>Very dissimilar</td>
<td>Would like to do but wouldn't</td>
<td>Up-front assertiveness</td>
<td>Acquaintance</td>
<td>Has never done</td>
</tr>
<tr>
<td>Similar</td>
<td>Wouldn't consider</td>
<td>Some form of physical violence</td>
<td>Partners</td>
<td></td>
</tr>
<tr>
<td>Dissimilar</td>
<td></td>
<td>Physical harm to self and others</td>
<td>Employer/Employee</td>
<td></td>
</tr>
</tbody>
</table>
Figure 5

MSA Solution for Case II on the 16 Aggressive Fantasies

Social humiliation directed to strangers, acquaintances or partner

Embarassment involving employer

Moderate physical harm directed to strangers or acquaintances

Severe physical harm including death directed to strangers or acquaintances
Table 2: Summary Table of the Communalities for PINDIS Transformations.

<table>
<thead>
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<th></th>
<th></th>
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<td>0.80</td>
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</tbody>
</table>

* 0.00 means that particular PINDIS transformation was not used.
Figure 6

PINDIS ANALYSIS

Weighted Centroid Configuration ($Z^*$)

<table>
<thead>
<tr>
<th>Self-harm</th>
<th>Sexual</th>
<th>Revenge</th>
<th>Outgroup</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>11</td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>5</td>
<td></td>
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<td>8</td>
<td>12</td>
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<td>3</td>
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<td>14</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>13</td>
</tr>
</tbody>
</table>

Death: Fatal physical harm

Severe physical harm

Moderate harm

Mild psychological harm
Figure 7

Pindis Analysis: Joint Person Plot
Perceived social support and addiction treatment: Understanding its role in the process of therapeutic change. Implications for practitioners, researchers and programme evaluators.

Abstract

This study assessed the role of perceived social support both in treatment outcome and in the process of therapeutic change in the treatment of individuals who present with substance abuse problems, so as to enhance the understanding of subjective inner processes of change for this population. The study employed the administration of a standardised questionnaire (Social Provision Scale) to investigate the relationship between perceived social support and treatment outcome and identify salient elements of support that impact significantly on treatment effect. It also employed a versatile method (Multiple Card Sort Procedure) to produce individual-level and social network data, examine the interaction of the individual and the structural over time both qualitatively and systematically and examine changes in both and their interaction over time in the same manner, so as to examine how changes in the meaning people attribute to supportive relationships can be facilitated in treatment and what impact they exert on treatment outcome and efficacy. Twenty participants were recruited from an in-patient treatment centre and twelve of them completed treatment. A Reliability Analysis was carried out for the SPS yielding coefficients from 0.51 to 0.83. The questionnaire data were analysed using the non-parametric Wilcoxon Matched-Pairs Signed Ranks test whose results indicated that the most significant changes over time occurred for attachment support, reliable alliance support and reassurance of worth support. Consequently, these elements were considered as representing the most salient functions of perceived social support. The MCSP data were analysed using Multiple Scalogram Analysis and Procrustean Individual Differences Scaling Procedure analysis. The results illustrated the process of and reasons for change throughout treatment for the individual whose case was used as an example. The implications of the study and its results for practitioners, researchers and programme evaluators were discussed.
I. INTRODUCTION

Within the last two decades, the concept of social support has manifested growing research interest due to the gradual recognition of its influential impact on physical and psychological well-being (Brugha 1995; Zuckerman & Antoni 1995; House et al 1988; Oyabu & Garland 1987). A sizeable amount of research has been published, highlighting the elements and functions of social support that seem to promote the rehabilitation process in chronic illness and psychiatric disorders (Brugha 1995). The facilitative potential that social support appears to exert on the rehabilitation process from chronic illness and psychiatric disorders suggests that this same effect should, at least theoretically, apply to those who present with substance abuse problems (Oyabu & Garland 1987).

Given this assumption, relatively few studies have cast primary focus on the relationship between social support and addiction treatment outcome. The vast majority of contemporary research in the field focuses on issues surrounding relapse and aftercare rather than treatment per se (Jarvis 1994; Monti et al 1994; Longabaugh et al 1993; Bromet & Moos 1977; Billings & Moos 1983; Bromet & Moos 1977). Although some attention has been paid to the impact of social support on addiction treatment outcome (Booth et al 1992a; Sayre et al 1992; Cronkite & Moos 1983), yielding one of the more persuasive findings for its importance to rehabilitation from addictive disorders according to McKay & Maisto (1993), relatively little attention if any at all has been directed to understanding how this effect occurs.

It would however appear that such negligence on the part of the research community might have been instigated by the existing limited consensus, reported by Lloyd (1994), among the scientific community with regard to a precise working definition of social support. He argued that over time discussion regarding the conceptualisation of social support has moved from the realisation of its multidimensional nature, to the controversy concerning subjective versus objective measures, to an interest in identifying its most salient aspects. Goehl et al (1993) after briefly reviewing the historical evolution around issues of definition concluded that social support apparently refers to the various resources (emotional, social,
practical) provided by one's interpersonal ties which protect people from the harmful effects of stress and enhance overall subjective well-being.

This all-encompassing definition though is still vague enough to beg for specificity for research purposes. Thus there are two broad categorical definitions of social support that appear in the research literature: a) Social network support which refers to the objective structure of social relationships - the existence, quantity and type of relationship, and b) Perceived social support which refers to the individual's subjective perception or cognitive appraisal of availability, functions and adequacy of or satisfaction with social relationships. Which is to be employed each time heavily depends on the nature of the research purpose. However, since the former is more easily quantifiable, less vulnerable to scientific criticism and scrutiny and more conducive to employment for outcome related studies, it is more often than not the obvious choice.

Despite such operationalisational difficulties, the importance of social support for psychological well-being has been well enough grounded to stir a legitimate pursuit of its most salient aspects, as an eligible alternative towards definitional consensus. Thoits (1986) has pointed to social support as provider of coping assistance that accepts and contains the individual's feelings of efficiency, thus bolstering self-esteem and enhancing a sense of environmental mastery. Cohen & Wills (1985) suggested that social support exerts a generalised beneficent effect on psychological well-being by providing the individual with regular positive experiences and a set of stable, socially rewarding roles in the community. Furthermore, they have more specifically argued that social support protects the individual from the pathogenic influences of stress through intervening between the stressful event and the stress reaction by attenuating the appraisal process. Cohen & Wills differentiated among four types of support that mediate this effect: esteem support (feedback that one is valued and esteemed), informational support (information or teaching a skill which can provide solution to a problem and can help one in evaluating personal performance), social companionship, and instrumental support (provision of goods and services that help solve practical problems) (Lloyd 1995; Orford 1992).
Weiss (1969) in his analysis of the specific role that relationships play in adulthood, especially among those who had experienced a major disruption in their lives such as chemical dependence can be thought of at a developmental level, proposed that people need particular provisions from relationships. He emphasised that the aggregate amount of provisions does not compensate for a deficit in some other provision. Weiss identified the following social functions that he considered essential for psychological adjustment and well-being: (a) Attachment, that is feelings of intimacy, peace and security, whose absence leads to emotional isolation and profound loneliness; (b) Social Integration, a sense of belonging to a group with whom one shares common interests, whose lack induces social isolation and boredom; (c) Reliable Alliance, which refers to knowing that one can count on receiving assistance in times of need whose absence is experienced as vulnerability; (d) Guidance, having relationships with people who can provide knowledge, advice and expertise, whose inadequate provision leads a person to become anxious and uncertain; (e) Reassurance of Worth, a sense of competence and esteem whose lack of provision results to low self-regard, and (f) Opportunity for Nurturance, that is being responsible for the care of others which makes a person perceive life as meaningful (Mancini & Blieszner 1992).

Thus the direct psychological benefits of social support manifest themselves in the enhancement of one’s ability to define certain stressors as being less overwhelming, to openly express fears and frustrations which decrease ruminations and obsessive thinking about stressors, to assume a more realistic stance toward life, and to find more meaning in life and feel more in control of external events leading to bolstering feelings of self-worth and esteem (Zuckerman & Antoni 1995; Lloyd 1995; Longabaugh et al 1993).

Social support may attenuate the negative emotional reactions that an individual may have to a life stresses by helping a person to feel cared for, loved and valued, by providing feedback to the individual about his/her beliefs or values. a sense of belonging and a feeling of being connected to other people (McCraday 1988). Since addiction can be viewed as a potentially controllable stressor with a detrimental effect on the psychological and physical well-being of the chemically dependent, it transpires that social support through its sources and functions reserves the
potential of enhancing the addict’s ability to cope with the stressor (i.e. overcoming his/her addictive problems).

Research evidence seems to suggest that strong social support networks (e.g. family members, friends, spouse, children, co-workers, supervisors) may be of critical importance to addicts’ attempts to deal with their addiction (Johnsen & Herringer 1993; Booth et al 1992a). Quite recent research findings suggest that the following aspects of social are frequently related to improved treatment outcome, including: perceived availability of reassurance of worth and attachment support (Booth et al 1992a) and of greater social support viewed in more holistic dimensions (McLellan et al 1983), a general sense of feeling supported (Longabaugh et al 1993; Rosenberg 1983), perceived amount of social involvement and closeness to treatment peers (Machel 1992), supportive involvement of family and significant others during treatment (Sayre et al 1992; Sobell et al 1991; Gordon & Zrull 1991; Nace 1982), a sense of cohesiveness and encouragement of expression by family and significant others (Billings & Moos 1983), frequency of use of supportive networks i.e. attendance at AA, aftercare meetings (Johnsen & Herringer 1993), abstinent quality of peer network (Kirke 1995; Gordon & Zrull 1991), and spousal support (Sobell et al 1991).

In addition, Booth et al (1992b), in a study examining the relationship between perceived lack of social support and depression among alcoholic men in treatment, concluded that perceived lack of social support from family and friends has a strong independent association with symptoms of depression among this group. This study confirmed similar findings reported by Rhoads (1983) and Judson & Goldstein (1983) in studies conducted to explore reason for relapse among heroin addicts.

Although the majority of studies suggest that social support facilitates positive treatment outcome, there is a small number of studies which have provided contradictory evidence. Oyabu & Garland (1987) weighted the importance of the amount of social support available and the participatory involvement of social network in the treatment of alcoholics. They concluded that any hypothesised impact of social support on the improved psychosocial well-being (self-esteem, level of depression and coping efforts) of the participants was negligible.
Goehl et al (1993) conducted a study assessing the impact of social ties (measured by perceived availability of tangible, belonging, appraisal and self-esteem support) on treatment outcome among a population of people on a methadone maintenance programme. They found that despite the fact that social support was strongly positively correlated with positive affect and weakly inversely correlated with stress, it was not correlated with drug use outcome. Furthermore this study's additional findings regarding substance using peer networks (positive correlation between SU peer network and continued drug use) address the possibility that a social network may harm treatment outcome if its members exert a negative influence that is supportive to continued use.

This finding is consistent with Kirke's (1995) findings concerning substance abuse within peer networks among teenagers. These findings (based on individual-level, self-reported data) confirmed that there was an association between the teenagers' self-reported ever use of drugs and their peers' self-reported ever use of drugs. This study demonstrated a considerable impact of a social network that provides social support for drug use on diffusing drug use within that peer community. The present author believes that this does not raise any questions about the potential of social support to influence one's course of action and decision-making. Rather it raises concern about the source(s) and the qualities and aspects that the provision of support can assume.

Despite the overall encouraging and promising research evidence of the beneficial impact of social support on the implementation of positive changes in the psychosocial status of individuals treated for addiction problems, the underlying process, that effectuates -if so- these changes, has yet to be comprehensively addressed in the research literature.

Despite that there seems to be an upsurge in the research interest in perceived measures in the recent years, Harald & Klingemann (1995) point to the necessity and urgency that research on substance abuse pay more attention to the intermediate psychosocial processes that lead to changes in the outcome variables. This would serve for filling in the gaps in therapists' understanding of the conditions that advance or hinder the process of therapeutic changes and thus ameliorate the effectiveness of their interventions. The discipline of counselling psychology
proclaims a fundamental commitment to enhancing such research interests that bear direct links to practice issues, psychosocial development and interventions, and process as well as outcome measures.

It is apparent that research studies are flawed in two important areas. On the one hand they have been inadequate in addressing intrapersonal, subjective psychological variables that influence chemically dependent people's perception of social support. On the other hand, they appear to be treating therapeutic change as a discrete rather than a continuous variable. That is, they tend to operationalise change as a single event (outcome) rather than a process which entails transitional stages, intermittent movement in perceptions, attitudes, affects and interactions.

There appears to be a clear need to pay more attention to the subjective maps chemically dependent people in treatment hold about supportive relationships, and the inner processes of change as far as the sources, functions and aspects of these relationships are concerned, since there is enough evidence that achievement and maintenance of a chemically free lifestyle is largely incumbent upon them. Gaining a more comprehensive rather than simplistic insight on the role of social support in therapeutic change during addiction treatment is necessitated to make justice to the intricate complexity of both variables.

Therefore, an approach that would allow for a more comprehensive understanding of the complexity of perceived social support and treatment effects, and would facilitate our understanding of subjective inner processes of change in individuals in treatment needs to be employed (McKay & Maisto 1993). To this effect, however, a method that can be used to produce individual-level and social network data, to examine the interaction of the individual and the structural, and to examine changes in both and in their interaction over time is sought for (Kirke 1995).

One promising approach to addressing these needs and requirements involves the use of Multiple Card Sort Procedure (MCSP). MCSP (Canter et al 1985) is a relatively novel idiographic approach used to access individual classification systems (attitudes, values, beliefs, representations and knowledge) which has seen some use (Wilson & Canter 1993; Canter et al 1985). It is similar in principal to the widely-used Repertory Grid (Kelly 1955). Its rationale was initially grounded on the
premises of Kelly's (1955) personal construct theory. However, MCSP has been advanced to challenge and test Kelly's assumption of the bipolarity of constructs. The assumption according to which MCSP functions is that “the ability to function in the world relates closely to the ability to form categories and to construct systems of classification by which nonidentical stimuli can be treated as equivalent. [.....] Thus, an understanding of the categories people use and how they assign concepts to those categories is one of the central clues to the understanding of human behaviour.” (Canter et al 1985, p.79).

The main advantage of MCSP is that it allows a flexible exploration of conceptual systems either at the individual or group level (Canter et al 1985), and permits the elicitation of in-depth qualitative information, which by virtue of maintaining a strong objective structure is still structured enough for quantitative systematic analysis (Tanner & Hammond 1996; Hammond 1995). MCSP, in addition to retaining a focus on subjective, personal and unique construction of meaning, has the potential of demonstrating patterns of change and allowing the development of meaningful hypotheses by examining the structure of the idiographic profiles of the same individual over time, and clarifying the intermediate processes that have instigated these changes from the juxtaposition of elements within the person's idiographic space and the study of the categories/constructs the person has attributed to the elements s/he has employed (idiosyncratic information).

Through the use of this highly sensitive and flexible but structured and systematic method, the present study seeks to explore and describe how -if so- individuals' perception of social support changes over time during treatment and to what extent -if any- such changes in the meaning individuals attribute to supportive relationships have any impact on treatment outcome and efficacy. In the course of this exploratory process, the present author also hopes to identify any salient aspects of social support which might bear some significance on the individual's overall treatment effect. In addition to these aims, this study also attempts to further the investigation on whether MCSP is warranted as an effective and versatile tool for mapping a client's progress throughout treatment so as to draw on decisions about the appropriateness of therapeutic interventions and evaluate the effectiveness of the ongoing therapeutic work.
This being the case, it is deemed pertinent to note that in the course of this endeavour, a pilot study was conducted (Kavatha & Hammond 1997) to serve as a basis for exploring the suitability of MCSP for aiding the assessment of clients' psychological needs within the therapeutic encounter. It is argued that the above study constitutes a stepping stone for furthering the aims and goals of the present one.

In summary, the primary aim of the study is to examine the utility of the MCSP in assessing social support in the therapeutic context. The particular question addressed is how might the technique improve on current methods of evaluating and monitoring change through the therapeutic process.
II. METHODOLOGY

About The Participants
The study employed participants from the in-patient population of St. Joseph's Centre for Addiction, Holy Cross Hospital. Recruitment was voluntary and each participant signed a consent form (see Appendix) after having been informed in detail about the procedure that was to be followed. Overall there were 20 participants; 10 males and 10 females. 12 of them presented with primary alcohol addiction, 4 with primary drug addiction, and another 4 with drug and alcohol addiction. Of the 20 participants only 12 (60%) completed treatment whilst the remaining 8 (40%) failed to complete treatment and were discharged prematurely. Of those 8 (4 males and 4 females), 6 discharged themselves prior to completion of treatment and 2 were discharged by the centre, one (male) on grounds of consuming alcohol during treatment and one (female) was discharged to a psychiatric hospital after suffering a psychotic breakdown during treatment. A more detailed account pertaining to the participants' demographic data will be presented in the results section.

The Setting
The St. Joseph’s Centre for Addiction is part of The Holy Cross Hospital. It offers a comprehensive treatment programme for chemically dependent people which involves a period of detoxification in the hospital (duration according to individual circumstances) followed by a six-week in-patient therapeutic programme at the centre itself. This programme is based on the Minnesota Model. That is, it centres around the Twelve-Step philosophy for the treatment of addiction. The programme though is designed in a well-rounded manner to integrate individual therapeutic work, cognitive behavioural therapy, systemic and family therapy, couples therapy, educational seminars on health and psychological issues and aftercare both for the patients and their families. In this way, it is carefully planned to provide for the needs of individual patients. The team of staff is comprised by a consultant psychiatrist, a counselling psychologist, a senior counsellor, and a number of counsellors and trainee counsellors all specialised in addictions treatment. It is worth noting that the centre's policy excludes from admission individuals with a dual
diagnosis. That is, people presenting with mental health disorders in addition to their chemical dependency do not fulfil the centre’s admission criteria.

Procedure
A detailed proposal of the present study was submitted to the management and ethical committee of the Holy Cross Hospital for approval two years ago. Confidentiality arrangements were clearly and explicitly emphasised in that, although the staff team was requested to help with recruitment activities, they would have no access to the data and information provided by the participants. They were also ensured that participants would be informed that parts of or all the data provided would appear in the final written version of this study and that the steps taken to guard confidentiality and anonymity would be explicitly conveyed.

Therefore, as specified and before signing the informed consent form (see Appendix A), participants were informed that the centre’s staff would have no access to the information given unless they so wished and the researcher had their written permission for so doing. They were also informed that the information provided might appear in the final written version of this study which would be public. They were ensured that their names would not be revealed anywhere and that they would be referred to as “male or female participant”. As far as their idiographic profiles are concerned, they were reassured that all names would be withheld and their profiles would consist of words that denote relationships (i.e. Friend, Mother, Sister etc.) so as to safeguard against any possibility of recognition by the people who were aware of their participation in the study.

The multiple card sorting tasks were conducted individually with participants using a limited set of preconditions. Participants were required to go through this process on three occasions during the length of their treatment: once during the first week of their admission; once during the third week of their admission; and once a day prior to their discharge. Each interview took between 45 minutes and one and a half hours to complete. On the first occasion participants were presented with a set of blank cards and were asked to write on them the names of people (optional) they considered significant in their lives and specify their relationship to them. They were also asked to include themselves in one of the cards. Following this, they were asked to complete two fixed sorts. In the first they were asked to sort the cards
according to who of these people abuse any substances or not. In the second they were asked to sort the cards according to how supportive they felt people represented on the cards had been to them. Then, the free sorts were introduced. Participants were asked to generate as many categories as they could about the attributes and characteristics that the people represented on the cards had and appealed to the participant or not, and sort the cards accordingly. Finally, they were asked to generate as many categories as they could about the ways in which they thought that the people represented on the cards had been supportive to them or not. At the end of the first interview, the researched asked permission to keep the cards in a safe place and bring them back for each subsequent interview. Therefore, the same set of cards was used in all three occasions and the same card sorting procedure was followed.

Furthermore, participants were informed that they would have the opportunity to have the three idiographic profiles shown and explained to them during the last meeting in order to be able to comment on and give their own interpretations to the outcome structures. To this effect a portable computer was introduced in the last meeting to generate the idiographic profile based on the ultimate sorting procedure. Participants were then also given the opportunity to feed back on the experience they had with the tasks throughout the course of our meetings.

Use Of Standardised Measures: Questionnaire

The Social Provisions Scale (Russell & Cutrona 1984; Cutrona & Russell 1987), a 24-item and 6 subscale measure of perceived social support was also administered twice during this process. Participants were asked to fill in this questionnaire once during the first interview and once during the last one. The administration of this standardised measuring instrument was intended to serve both as a validating instrument and as a means of statistically assessing outcome differences to be juxtaposed to the MCSP data.

The Social Provisions Scale (SPS; see Appendix B) is a 24-item rating Likert scale with two positively and two negatively worded items for each social provision, measuring the perceived availability of the following social provisions: the assisted-related ones; namely Guidance (refers to advice and/or information) and Reliable Alliance (refers to others who can be counted on for tangible assistance), and the
nonassistance related social provisions; namely, Reassurance of Worth (refers to feeling esteemed and valued by others), Opportunity for Nurturance (refers to providing assistance to others), Attachment (refers to a strong emotional bond with at least one other person), and Social Integration (refers to having other people who share your interests). This scale is based on a theory of relationship functions proposed by R. Weiss's (1974) and an operationalisation of those functions by Russell et al (1984). Its goal is to understand the processes through which interpersonal relationships enhance or sustain well-being in the context of stress (Booth et al 1992b). The SPS can be used to calculate a total score for perceived social support, as well as scores for the six separate provisions.

Russell & Cutrona (1984) reported internal consistency (coefficient alpha) for each of the subscales ranging from .76 to .84 in a sample of older adults and from .61 to .76 in a sample of teachers. A confirmatory factor analysis (Cutrona & Russell 1987) based on a combined data set of college students (N = 1,183), public school teachers (N = 303), and nurses (N = 306) resulted in a goodness-of-fit index of .86 for the subscales.

Mancini & Blieszner (1992) conducted a further confirmatory factor analysis of SPS based on a population of older adults (N = 494). They reported that the CFA revealed a pattern in the data that corresponds to the theoretical definition of relational provisions. They also reported that convergent validity was supported by significant correlations between the SPS and respondents' morale, frequency of contact with friends, feelings of closeness with an adult child, relationship control, and relationship conflict. Discriminant validity was as well supported by nonsignificant correlations between the SPS and the Eysenck Lie Scale.

The SPS has been previously used by Booth et al (1992a) and Booth et al (1992b) in two separate studies both of which were based on a population of alcoholics. They have argued that SPS is reliable when administered to groups of alcoholics with coefficient alphas of .86 for total support score and .52 to .85 for the six subscales.
Analyses
Reliability analysis was conducted on the SPS to explore further its use in research on a population of chemically dependent people. The quantitative data obtained from scoring the SPS scale were analysed using the non-parametric Wilcoxon Matched-Pairs Signed-Ranks test. This non-parametric method was chosen due to the small size of the sample, to find whether there were any significant differences over time both for total support scores and for scores of each of the six subscales. It was thus deemed methodologically more sound to apply the Wilcoxon test on the questionnaires' scores rather than calculating t-test values for paired scores.

The MCSP data from each participant were analysed using Multiple Scalogram Analysis (MSA). The MSA is particularly useful, for as well as providing an "overall" plot of the elements in two-dimensional space, it also provides "item plots" for each construct/category (Wilson 1995). These indicate, for each construct, which category the elements were assigned to, thereby retaining all of the qualitative information concerning why elements are similar or different. It is therefore possible to demonstrate not only the structure of the individual's representation, but also why it is structured as it is. It is then possible to draw conclusions about the relationship of the constructs to one another.

The resulting co-ordinates for each participant's set of three different MSAs were entered - separately for each participant - into a Procrustean Individual Differences Scaling analysis (PINDIS; for a technical description of PINDIS see pages 142-143) (Lingoes & Borg 1978). The PINDIS procedure involves applying to the data one of five scaling models, of differing complexity, in order to form an estimated joint normative space (Hammond 1995). The three individual configurations for each participant are transformed in order to fit as closely as possible to a centroid plot (an "average" of all three of each participant's configurations). A "goodness of fit" index is derived enabling inspection of the degree to which each configuration had to be "forced" to fit the centroid configuration. From this, it is possible to identify the degree to which (if at all) each participant's three configurations share a common structure.
III. RESULTS

a) Demographic Description of Sample
Complete demographic data (see Appendix C) were available for all of the 20 participants that took part in the study. The most important demographic characteristics of the participants are summarised in Table 1. In brief, average age was 37.1 years, participants were all British and predominantly single (35%); 30% of them were divorced and the rest either married or living with a sexual partner. 80% of the participants were currently unemployed and the rest either employed full-time or retired. Two thirds had acquired A levels or had college/university education and the remaining third was predominantly educated at a basic level. 65% of the participants reported the existence of at least another chemically dependent individual in the family. 60% of them stated that they had two or more previous treatment episodes and 70% claimed to have had attended AA and/or NA meetings prior to their admission for treatment. 60% of the participants reported that there would be at least one family member or significant other to attend the centre's family programme. One half were self-referred, 20% referred by family or friends and the rest by courts, social services, other D&A services, or medical staff. Finally, participants had a mean of 11.4 years of duration of their addiction and they on average started abusing substances at the age of 17.

--- Table 1 about here ---

b) Questionnaire (Social Provisions Scale)
The results of the reliability analysis are presented in detail in Table 2. It appears that the overall scale is reliable when administered to a group of chemically dependent people in treatment with a co-efficient alpha of 0.83 for total support score. Co-efficient alphas for the six subscales ranged from 0.51 to 0.83. These results are similar to the reliability results that Booth et al (1992a) and Booth et al (1992b) obtained for groups of alcoholics in treatment. However, two of the six subscales, namely Opportunity for Nurturance (OFN) and Social Integration (SI) failed to yield high enough alpha values so as to be considered soundly reliable for use as a measure, since it was deemed that 0.60 would be a reasonably sound cut-off point. It would thus appear that the most reliable of the subscales was Attachment (ATT), followed by Reliable Alliance (RA), Reassurance of Worth (RW), and Guidance (GUI) which was the weakest of the reliable subscales.
Having established that the overall Social Provisions scale as well as four of its subscales yield reliabilities that are adequate to further the instruments' appropriate use in the study, the Wilcoxon Matched-Pairs Signed-Ranks test was deemed appropriate to investigate whether the total scores and the scores of the four reliable subscales presented any significant differences over time. The results of the Wilcoxon test are presented in detail in Table 3. The scores of four of the subscales along with the scores of the total scale were found to be significantly different between the first and second time of their administration. It is noteworthy that differences in scores on the Guidance subscale which was found marginally reliable were not significant. On the contrary, no difference whatsoever was found. However, scores on the Social Integration (SI) subscale changed not only significantly but also considerably over time. This significant result though was disregarded since the subscale yielded a low reliability value that disqualified it as a reliable measuring tool. These results indicate that, throughout the course of their treatment, participants' perception of the availability of aggregate support, RA, ATT and RW support changed considerably. It therefore appears that the structure and quality of treatment they received contributed to feeling more support was available. Moreover specifically it would seem that the quality of their relationships in terms of attachment, reliable alliance and reassurance of worth was considerably improved.

These results are consistent and in agreement with findings reported by Booth et al (1992a) and McLellan et al (1983) about significant changes in attachment support, reassurance of worth support and aggregate support in the duration of treatment that impact beneficially on treatment outcome.

Finally, two individual demographic variables, namely attendance of AA/NA meetings and significant others' involvement in the family programme, were analysed using Mann-Whitney tests for Independent Samples in order to determine whether there were any significant relationships between them and change over time on total support scores and subscale scores. These two variables were isolated because of their inclusion in the operationalisation of social support in the research.
literature as subjective measurements whose impact bears links to positive treatment outcome. None of them, however, were found to be significantly related to over time change on SPS's total and subscale scores.

c) Idiographic Measurements: MCSP
As apparent as it may have been that the perception of the availability of social support functions changed significantly during the course of treatment by the results presented above, the process that facilitated the emergence of such changes still remains unaccounted for. To this effect, the analysis of the MCSP data is deemed invaluable for shedding light onto the processes underlying these changes and the constructs/elements that were separately perceived by each individual as advancing this process during their treatment.

In order to examine each idiographic representation of social support, the data derived from each respondent's classifications throughout the course of their treatment were analysed using MSA. Due to the need for conciseness, despite the voluminous qualitative data derived from each participant's idiographic profiles, only one example of idiographic analysis will be presented below. It is neither assumed nor advocated that this is an either representative or normative case example of the process of change that is sought to be examined. Although it was selected at random, it is argued that it can be significantly indicative of the workings of the process in question since it represents one of the cases that pose the most challenges and the poorest prognosis when found in treatment; that is, an individual whose social support structure initially centres mostly around other chemically dependent people.

However, before proceeding into these analyses, it is deemed important to provide a brief account of the aggregate experience that participants' reported about the use of MCSP as a tool for gaining an in-depth understanding of the way they perceive social support and how this might change over time and influence their interactions, own self-perception, and intention and ability to maintain a drug-free lifestyle as facilitated by treatment provisions. This account is also significant in establishing the suitability and viability of the tool as providing an accurate enough reflection of individuals' subjective view of their world and circumstances, and stance towards the issues implicated.
i) Feedback from the participants

General feedback on the MCSP was provided by 12 of the 20 participants that took part in the study; those that completed treatment. All of them reported that they enjoyed doing the sorting tasks because they experienced them as interesting, productive and challenging, as opposed to the dull and unrewarding experience of filling in a questionnaire. What they found most rewarding about this experience was the opportunity to involve themselves in a process that they found meaningful in the sense that they could relate personally to a task whose evolvement they could shape themselves. They all reported that they did not feel threatened by issues of disclosure to someone they were not familiar with, because they realised that the tasks did not require of them to divulge sensitive information about themselves or to explain the way they felt and acted on a face-to-face interview with a stranger who had nothing to do with their treatment. Most participants reported that they felt a sense of control over what was disclosed by them. This being the case they felt neither overwhelmed nor intimidated by undue cognitive or affective strain. They stressed that this allowed them to feel more relaxed and engage pleasantly in performing the tasks.

All participants reported that they were quite surprised by the fair amount of accuracy with which the idiographic profiles reflected their “journey” during treatment both in interpersonal and intrapersonal terms, when presented with all three profiles at the last meeting. Most of them expressed interest in finding out how the mere act of sorting cards can yield such insight into their personal and interactional development through time. They all found the feedback they were presented with very useful. Most of them reported that though they intuitively knew of the issues at hand and their progress over time, such a tangible account of their development not only encouraged and inspired them further, but in some cases also brought them face to face with underlying issues that they felt had to be consciously aware of and sensitised toward for the sake of their recovery.

Some of the participants stressed how it would have been more helpful if they had been shown each plot separately at every meeting. This was because they felt that the evidence of underlying issues in such a format would have been too “compelling to ignore, deny or defend against”. They argued that the mere verbal communication of and confrontation with these issues by staff and/or other group
members could not be as powerful as the presentation and discussion of the plot since in the former case lots of excuses on their part could be supported by the volatile nature of these relationships. In contrast, they claimed that information coming out of a profile would much more difficult to argue against due to its more objective nature. There were a couple of participants though who cautioned against such proposed use because they claimed that as far as they were concerned it might have been too overwhelming, too distressing, too much to handle at the very beginning of treatment when they reported feeling more vulnerable, less forthcoming and more guarded.

Some of the participants though found the experience rather tedious at some points. This occurred especially with participants who had a large number of cards/elements. As a result of this, some of the elements were consistently clustered together and when repeatedly asked to differentiate between them, these participants reported experiencing mild distress. Overall, however, participants reported that the feedback they received in the form of the emergent profiles was helpful for gaining a transparent, more comprehensive and well-rounded picture of their situation that gave them “food for thought and reflection” and opportunity for evaluation or re-evaluation of their life circumstances.

**ii) Idiographic Analyses: An example**

In this example of a series of idiographic analyses, the support sources (i.e. significant others and self) are positioned in Euclidean space according to their similarities during the sorting process, enabling visual analysis of the qualitative structure of the individual’s categorisations. The relative distances between the points indicate the degree of similarity or difference in how the individual views each significant other. The actual cognitive representations are interpretable from the manner that the regions map onto the sorting categories/constructs.

*1st week in treatment: Idiographic Analysis I*

This male participant completed nine sorts in total (see Table 4) and had a total of 25 sorting elements.

-----  Table 4 about here  -----
It is possible to gain a superficial idea of the individual's cognitive representation of social support from the sort headings. A salient feature seems to revolve around the nature of the relationship he has with the significant others he nominated as suggested by sorts one and nine (see Table 4). This is to a large extent substantiated in the overall visual profile of the way he perceives his ties with significant others as emerging through his social support constructs (see Figure 1a).

Figure 1a and 1b about here

This profile points to a rather clear demarcation between significant people in his life in terms of the type of social relationship he bears to them. It is noteworthy that he places himself with his addict friends who are actively using. This indicated a still perceived close bond with this particular culture or network, possibly because of his familiarity with the structures of this network.

As illustrated in this emergent first profile, the participant quite clearly perceives marked distinctions among him and his addict friends, the rest of the group members of the therapeutic community, and members of staff and close relatives. There appears to be an almost ordered movement where the participant perceives himself closest to addict friends, less close to fellow group members and least close to members of staff and very close relatives who have hardly any links whatsoever to drug networks/culture. It would seem that the underpinning reasons for this structure lie in the effect that the superimposition of the plots of the constructs of unwarranted pressure and understanding have on the overall profile (see Figure 1b). That is, the participant appears to perceive his addict friends as much more understanding of himself and his drug problems than any of the other people involved in his treatment and/or his life at this point in time. He also perceives these friends along with fellow group members as the least likely to urgently pressure him into "sorting himself out" before he feels ready to embark on this journey. This further explains why he has distanced himself so much from staff members and close relatives.

Nonetheless, the above finding seems to be rather controversial since through further examination of the criteria used by the participant to sort the significant others in his life, a completely opposite pattern arises. That is, by superimposing the
plot of the construct of support (see Figure 1b) onto the overall profile, it transpires
that the people he perceives as most supportive are the ones who he also perceives
as least understanding and more likely to put pressure on him to sort his life out,
and therefore clusters in distant groupings away from himself and his addict friends.
Through further superimposition of other clearly regioned constructs (see Figure
1b), it becomes apparent that this pattern becomes more coherent when viewed in
light of the participant's perception of these people as honest and reliable
(constructs five and eleven), which seem to constitute the most salient aspects of
his perception of the functions of social support.

Still though, there appears to be a distinct gap between the participant's cognitive
and affective representation of the meaning of support, as suggested by the above
seemingly contradictory evidence. It would seem that at this early stage of
treatment, he feels rather confused with regard to his perception of the differing but
equally important qualities of the social network he seriously considers exiting and
the one he feels he has to begin relating to. Although he is able to cognitively
appreciate the salient and dependable elements of support the new network
presents him with, he seems still affectively tied with the people he has formed a
bond based on identification and shared self-perceptions.

iii) About change: Idiographic Analyses II and III

    The Second Interview: 3rd week in treatment

In the second interview, the participant completed seven sorts in total (see Table 5).

    Table 5 about here

Clearly, as the visual profile of significant others suggests (see Figure 2a), a marked
change in how the participant perceives his relationships in terms of the support
they provide him with can be observed. There appears to be a rather clear
demarcation of regions again according to the social relationship he bears to his
nominated significant others.

    Figure 2 about here
However, this time round the participant clusters himself closely to his keyworker and another member of staff, whereas it seems that he has considerably distanced himself from his addict friends and to a much lesser extent from his fellow group members and close relatives. It is noticeable how he has grown to develop closer ties with staff members and gradually disentangle himself from the influence of the drug culture his addict friends represent. This becomes all the more clearer if the criteria used to sort these people (see Figure 2b) are more closely examined in conjunction with the overall visual profile. It then transpires that staff members, fellow group members and close relatives are perceived as much more supportive than addict friends. What appears to define the meaning of support from these people for the participant this time round is the construct of trust (sort four), despite any personality characteristics (sorts five and six) which did not yield clearly demarcated regions.

It would therefore appear that at this stage of his treatment (third week), when the participant has familiarised himself with the people that constitute his immediate community in the treatment centre and when the need for opening up becomes urgent for his personal development and therapeutic advancement, he came to perceive trust as of paramount importance in order to feel supported to proceed with his endeavour of maintaining a drug-free lifestyle. It appears that he began to realise its implications for his treatment and his perceptions seem to have shifted according to these predicaments, finding his keyworker and another staff member as the safest and most forthcoming and dependable aids for his goal.

The Third Interview: One day prior to discharge

The above pattern of change seems to have moved toward consolidating itself as suggested by the evidence of the last interview, a day before his discharge. The participant completed seven sorts in total (see Table 6).

---  Table 6 about here  ---

The overall visual profile (see Figure 3a) demonstrates a particularly clear demarcation of regions depending once again on the nature of social relationship the participant holds with the people he nominated on the cards. Staff members,
fellow group members and relatives have been clustered together as opposed to another cluster that comprises only of his addict friends.

-------- Figure 3a and 3b about here --------

It appears from the regioning of individual construct plots that he perceives the former grouping as supportive and the latter as completely non-supportive, since in the plot of construct four (see Figure 3b) he puts them down as offering him no form of support whatsoever. The clear demarcation according to his perception of support is explained further by the examination of the plots of the rest of the criteria he used to sort people (see Figure 3b). This examination shows that the most salient features of the people he perceives as supportive are a willingness to listen to him, a pleasant nature and an honest approach toward him (constructs three, four and five), as opposed to the non-supportive people (i.e. his addict friends) who lack the willingness to listen to him, are "sly, moody or intimidated by others", and dishonest with him.

It is, however, noticeable that this profile is shaped in a half-circled manner with the participant positioned almost in the middle of this half-circle. It would appear that the participant has re-positioned himself in between the two clusters which seems to denote that he perceives no allegiance to either cluster but rather points to a perceived state of transition on his part. This is supported by his positioning himself in either region in different construct plots (i.e. with addict friends in plots of constructs three, four, five and six, being mainly around personality elements). This seems to make sense considering the fact that he is about to enter a stressful and possibly frightening transitional period by leaving the safety, security and reassurance of the treatment centre to face life in its totality without drugs. In addition, this very event constitutes a plausible explanation for the fact that the participant seems to have distanced staff members, keyworker, and fellow group members, and instead to have brought forward family members. This may be so since it would appear that upon his departure from the treatment centre staff members and keyworker will become less available sources of support than his family or friends will be.
It would therefore appear that although the participant still perceives certain similarities between himself and his addict friends, within the duration of his treatment and through the provision of the elements of support that the treatment programme capitalised on and which have been identified by the MSAs, he became increasingly sensitised and able to reflect upon and evaluate the quality of the relationships that he perceives as significant and influential to his recovery. In this way, it seems that he grew to develop a skill in distinguishing between the ones that have the potential to prove constructive and beneficial to his goal of maintaining a drug-free lifestyle and those that might prove detrimental. Such a treatment outcome is considered to be of major importance in the field of addictions since it serves to independently aid relapse prevention and consequently ameliorate a good prognosis.

Finally, it is worth noting that the results and hypotheses emerging from the participant’s MSAs were convey to and discussed with him at the end of the last interview. The participant testified to their accuracy and reported that he felt he gained further insight into his own progress and the issues surrounding it through this discussion. He concluded by noting that he would have found it invaluable for raising his awareness and aiding in the therapeutic work on these issues, if this discussion had taken place after each interview.

d) Procrustean Individual Differences Scaling Procedure (PINDIS)

As Hammond (1995) argues much is to be gained by the focus of MCSP on the individual in both a therapeutic and research context, since the data collected on “the individual’s own idiosyncratic use of language and the meaning they ascribe to stimuli is explicitly examined” (p. 2-3). He though adds that the approach becomes problematic when the generalisation of findings is desired because the idiographic focus tends to preclude statistically sound systematic comparison between meaningful perceptual and cognitive profiles.

The PINDIS analysis treats idiographic data in such a way that the richness of the information is used but that a meaningful set of normative generalisations may also be available (Hammond 1995). That is, it goes some way to combining idiographic and normative approaches in interpreting the data obtained. The PINDIS analysis can also be applied to several card sorts completed by the same individual on
different occasions. By plotting each configuration into a "common space", it is possible to make direct comparisons of any changes that occur as a result of treatment intervention. Therefore, since it was deemed imperative that a method that could provide a reliable generalised representation of the particular participant's (and for that matter of all the rest of them) perception of his significant others as well as validation of the change that was independently observed taking place over time, the Procrustean Individual Differences Scaling Procedure seemed ideal for this purpose.

The resulting co-ordinates for this participant's set of three different MSA configurations were entered into a PINDIS programme written by Hammond (1995). The models used for the analysis are ordered in degree of parsimony and thus, idiosyncrasy. The basic GPA model (0 model) is most parsimonious since the unknown parameters are fewest while model 4, the idiosyncratic vector weighting model, is least parsimonious and hence the most idiographic of the models. A potential 5th model, vector-D model, which integrates dimension and vector weighting would simply imply a standard idiographic design, and thus is very rarely used. The strategy employed here was to identify the models in order from most to least parsimonious. An index of fit was calculated for each solution against the centroid solution. These indices may be interpreted as reliability coefficients and therefore a criterion of 0.70 was set for a reliable fit.

The most parsimonious model is the basic GPA model and this was found to produce an overall reliability of 0.73. As a result this is the strategy which was accepted. This model involves only translation, dilation and rotation of the configurations co-ordinates which means that almost no "force" was needed for each configuration to fit the centroid plot. This model being the one that fits with the fewest parameters provides evidence of a clearer common structure. The first centroid solution for this model is presented in Figure 4.

--- Figure 4 about here ---

It would therefore appear, from the plot of the centroid configuration, that the participant's nominated significant others are primarily ordered by the nature of the social relationship he has with them. There is a distinctly clear demarcation of
regions among his addict friends, his blood relatives, his fellow group members and
the members of staff. It seems that at large the participant perceives these
relationships as essential in shaping his ties with these individuals. Thus, he
appears to situate himself closer to his familiar social network, that of the drug
culture, with which it appears that he finds strong underpinning elements of
identification.

These elements of identification can be identified as belonging to constructs of
personality similarities with people he thinks he knows well and of substance use.
This implication becomes apparent as it is demonstrated by a co-occurring ordering
of significant others in terms of their substance use ranging from addiction to no
use and of personality characteristics ranging from very similar to least similar as
distinct regions of the centroid plot that appear to map almost identically on the
initial demarcations.

This seems to in itself suggest a strong link between the perception and
interpretation of social support in terms of the familiarity and habituation with those
of its sources that he perceives share a basically common self-image. It is worth
noting that such perception and interpretation does not seem, from the plot of the
centroid configuration, to bear much relevance to objective healthy functions of
social support. Thus, there is total consensus between this finding and the findings
reported by Kirke (1995) and Goehl et al (1993) regarding the potentially harmful
interfering effects of social support that is perceived as dependent on a peer
network of other addicts and substance users. The therapeutic and treatment
considerations and implications that this raises will be attended to in the discussion
section.

Coming to the issue of validating the change in perception of social support over
time by the participant as a result of the intervention of treatment, the plot of the
change configuration (where points in space represent each of the three MSA
configurations) is examined. This plot is presented in Figure 5.

----- Figure 5 about here -----
This plot is self-explanatory with no need for overstated interpretations. It is demonstrated that there is a visible change in the participant's perception of social support as facilitated by treatment provisions over time. It is apparent that the major change took place between the first and third week (representing the 2nd MSA) of the participant's treatment, and this change remained relatively consistent. This finding confirms the evidence provided by the independent examination of the three separate MSA configuration plots, cited earlier in the text.
The results of the questionnaire analysis indicate that the most salient aspects of social support are reliable alliance, attachment and reassurance of worth. That is, the most important functions of social support are perceived to be the ones that convey to individuals in treatment that they can depend and count on someone for tangible, practical support in times of need, share a strong emotional bond characterised by feelings of intimacy, peace and security with at least another person, and they are esteemed and valued by others in their life. The specific implications of these functions of social support for the psychological and physical well-being of people in treatment involve a reduced sense of vulnerability and helplessness, a safeguard against states of emotional isolation and loneliness and therefore depression, and an enhanced sense of positive self-regard along with an improved self-esteem.

Considering evidence indicating that addicted persons have a failure identity, a negative self-concept, an inability to maintain stable relationships and a fear of intimacy (Kooymans et al. 1993; Hadley, Holloway & Mallinckrodt 1993; Collins 1993; De Jong et al. 1991), the specific difficulties, deficits, and maladaptive lifestyle patterns that are addressed by the provision of the particular aforementioned elements of support indicate how social support can be at the least facilitative of a better likelihood of successful treatment.

The results of this study, without inferring any causality whatsoever, point to those specific aspects and functions of social resources that appear to be most likely to contribute to successful completion of treatment that in itself contributes to improving the likelihood of longer-term recovery. In this regard the enhanced effects of reliable alliance, attachment and reassurance of worth as advanced by comprehensive treatment provisions appear to be forwarding a consistent and stronger engagement in treatment, and thus a good treatment outcome.

The findings of this study seem to bear important implications for treatment programmes. To start with, the identification of important sources (i.e. friends, family, staff, fellow group members) and forms (i.e. reliable alliance, attachment, reassurance of worth) of social support point to factors that are amenable to
treatment intervention, both during treatment and as part of aftercare. Such interventions may entail educating the client how to develop a supportive social network and to identify supportive others who are not substance users since it was demonstrated how addicted persons tend to initially perceive addict friends as a secure base allowing conflict-free proximity-seeking. Furthermore, training programmes for educating network members on how to provide specific types of support could be promoted, given that they are still in their infancy (Booth et al 1992a) and that social networks in themselves can equally be a source of stress and personal demand.

Most importantly though it is thought that the present study has adequately enough addressed the challenges that the design and implementation of such interventions poses to treatment professionals. Namely, the need to enhance the efficacy of treatment through the identification of beneficial component parts of social support and perhaps through improved matching of these components with individual client psychological variables, mental representations and social predicaments. In this sense the results of this study capitalise on the ever-present realisation that the role of social support systems in the treatment of substance abuse is far from simple and easily grasped and implemented.

It is argued that this study has raised important considerations as far as the role of social support in addiction treatment is concerned. First, the urgent importance for treatment professionals to take a differentiated process view of social support rather than a static, global one has been demonstrably underlined. Second, whilst accepting and recognising the supportive functions of treatment itself, it has emphasised the importance of giving clients new tools in self-understanding and behaviour change and helping them develop new skills in accessing healthy support. In this context, the need for boundaries between professionals and clients that can be permeable enough for support, yet clear enough for individuation to be promoted, and for the locus of control to be shifted from the therapeutic team to the natural support network itself cannot be stressed enough.

Third, such emphasis in itself begs the question (relating closely to both theoretical and treatment issues) of the promotion of a more systematic effort in ensuring the use of good techniques of assessing and formulating client difficulties in mobilising
and using social support. These techniques ought to also serve a therapeutic purpose in giving an unusual opportunity to the client of seeing clearly the size and structure of their perceived social support network and the availability within it of different forms of support, as well as establishing a collaborative process of involving the client in standing back from and examining his or her social world in a way which builds a shared formulation of why there are repeated problems in getting support. In addition, it is considered of utmost therapeutic value that the use of such techniques be perceived by the client as both rewarding and relevant to their perceived problems. Finally, careful and well-documented selection, incorporation and development of such techniques can also constitute an excellent basis for their use for sound and systematic evaluation of treatment progress.

This study has not only raised these important considerations but has also proposed a viable, valid and cost-effective alternative solution to serve these ends through demonstrating how the use of MCSP can effectively and efficiently aid implementation of treatment programmes' provisions and interventions both at a case-level and community level.

It is not argued anywhere that this study is either flawless or exemplary. Rather it needs to be noted that the sample was not only small but also vulnerable to bias. This is because participants were not only self-selected by virtue of coming forth if willing and interested to take part, but were also uniformly characterised by being involved in a very specific Minnesota model based treatment programme. These predicaments limit both the generalisability potential of the study as well as the potential for any comparability claims with studies that have employed populations from treatment programmes based on different models. The exploratory and descriptive nature of the study should also be born in mind.

However, it is equally important to note that, despite the limitations of the study itself, it has been clearly demonstrated that the MCSP method is generalisable, valid and sound as a tool for identifying, understanding and reliably evaluating processes of change and related issues in a therapeutic context. Thus the limitations of the study hardly pose any questions about the intrinsic values and properties of the method itself. Having commented on this, one might possibly reserve a question about the employment of two different instruments (questionnaire and MCSP) that
seem hardly integrated in the context of this study. In light of this, there was never an intention to attempt a demonstration of such integration, simply because of the impossibility of such a task. The questionnaire was employed to address the issue of operationalisational specificity and parsimony emerging in the social support literature, since its properties as a standardised measure could provide a means for extracting specific salient forms and functions within the multifaceted and multidimensional notion of social support. Nonetheless, the primary aim resonated in showing the inadequacies and limitations of such methods as juxtaposed to a more qualitative, idiographic but equally parsimonious method. This aimed at raising concern about the extent to which the research community is willing and/or conditioned to sacrifice individuality, idiosyncrasy and process issues for specificity, precision, statistical power and outcome concerns, when coherent and effective understanding of therapeutic issues lies in the richness of in-depth information about the diverse processes whereby relational and conceptual changes take place.

There is clearly a need to intensify efforts to further research the role and implications of social support in addiction treatment in a similar multifaceted, multiplex and multidimensional manner so as to consolidate confidence in the findings, proposals and suggestions. It would be much more enlightening if such variables as addiction severity, treatment characteristics and follow-up, and psychiatric comorbidities were given due inclusion and consideration. It is deemed that ample intriguing incentive has been documented to warranty such further pursuits not only worthwhile but most importantly urgently needed.
REFERENCES


Dear participant,

My name is Effie Kavatha. I am a PhD (doctorate) student at the University of Surrey. I am in the process of carrying out a research as partial fulfilment of the requirements for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. This piece of work, a required supervised project, is under the supervision of the Psychology department of the University of Surrey.

My doctorate project aims at exploring the relationship between social support and change in the treatment of substance dependence syndrome. Your co-operation in this project would be greatly appreciated and valued. It will involve filling in a short questionnaire now and a day before your discharge, and spending approximately 30 min. with me three times during your stay at SJC; one in the first week, one two weeks later, and one in the last week. During this time you will be asked to sort out a number of cards the content of which you will generate according to your experiences.

Please sign the consent form below if you agree to participate in this study. This is standard procedure. Your name is not required anywhere. I would like to emphasise that anonymity and confidentiality will be strictly maintained and preserved. I would also like to inform you that you have the right to withdraw yourself from this process if at any point you feel like doing so for any reason.

I may also need your help six months after your discharge in which case I will mail a short questionnaire to you. If you would agree to assist my effort could you please indicate whether I have your permission to contact SJC for your address at the time? YES □ NO □

The strictest anonymity and confidentiality will be kept.

If you are interested in the results of this study, please indicate a correspondence address where I will send you the relevant information upon completion of the project.

Thank you very much for your willingness to participate.

SIGNATURE DATE

N.B. The six-month follow-up was not carried out due to time constraints.
SOCIAL PROVISIONS SCALE (APPENDIX B)

In answering the next set of questions think about your current relationships with friends, family members, co-workers, community members, and so on. To what extent do you agree that each statement describes your current relationships with other people? Use the following scale to give your opinion.

1  2  3  4
strongly disagree disagree agree strongly agree

__1. There are people I can depend on to help me if I really need it.
__2. I feel that I do not have close personal relationships with other people.
__3. There is no one I can turn to for guidance in times of stress.

__4. There are people who depend on me for help.
__5. There are people who enjoy the same social activities I do.
__6. Other people do not view me as competent.

__7. I feel personally responsible for the well-being of another person.
__8. I feel part of a group of people who share my attitudes and beliefs.
__9. I do not think other people respect my skills and abilities.

__10. If something went wrong, no one would come to my assistance.
__11. I have close relationships that provide me with a sense of emotional security and well-being.
__12. There is someone I could talk to about important decisions in my life.

__13. I have relationships where my competence and skills are recognised.
__14. There is no one who shares my interests and concerns.
__15. There is no one who really relies on me for their well-being.

__16. There is a trustworthy person I could turn to for advice if I were having problems.
__17. I feel a strong emotional bond with at least one other person.
__18. There is no one I can depend on for aid if I really need it.

__19. There is no one I feel comfortable talking about problems with.
__20. There are people who admire my talents and abilities.
__21. I lack a feeling of intimacy with another person.

__22. There is no one who likes to do the things I do.
__23. There are people I can count on in an emergency.
__24. No one needs me to care for them.
APPENDIX C

DEMOGRAPHIC DATA

Please tick the appropriate box where necessary. Otherwise write on the space provided.

Age: ........................................................................................................................................................

Nationality: ...........................................................................................................................................

Gender: Male □
Female □

Occupation: .............................................................................................................................................

Do you have a problem with: Alcohol □
Drugs □
Alcohol & Drugs □

Marital Status: Married □
Divorced □
Separated □
Widowed □
Cohabiting □
Single □

Are you: Employed Full-Time □
Employed Part-Time □
Laid Off □
Retired □
Unemployed □
Disabled □
Seasonally Employed □
Who referred you to SJC?  
- Self □  
- Family/Friends □  
- Court □  
- Other medical facilities □  
- Employer/Work □  

Which level of school did you reach:  
- CSE O Level □  
- A Level/HNC □  
- College □  

Has any other member of your family been or is addicted to alcohol or drugs?  
Yes □  No □  
If yes, please specify your relationship to them:  

How many times - if so - have you been hospitalised due to alcohol or drug related problems in the 2 years prior to admission at SJC? 

Is this your first attempt to deal with your addiction problems?  
Yes □  No □  
If no, how many attempts have you made within the last 5 years? 

How long do you think that you have had a problem with alcohol or drugs or both? 

Did you attend any AA or NA meetings before coming to SJC?  
Yes □  No □  
If yes, how many meetings per week? 

Is anyone going to be involved in the centre's Family Programme?  
Yes □  No □  
If yes, can you please specify your relationship to the person(s) involved? 

At what age did you approximately start having problems with alcohol or drugs or both?
<table>
<thead>
<tr>
<th>Demographics</th>
<th>Mean</th>
<th>Median</th>
<th>Std Dev</th>
<th>Minimum</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>37.1</td>
<td>36.00</td>
<td>10.90</td>
<td>19.00</td>
<td>58.00</td>
</tr>
<tr>
<td>Starting Age</td>
<td>17.00</td>
<td>15.00</td>
<td>6.43</td>
<td>6.00</td>
<td>33.00</td>
</tr>
<tr>
<td>Addiction Duration</td>
<td>11.4</td>
<td>9.00</td>
<td>7.96</td>
<td>2.00</td>
<td>26.00</td>
</tr>
</tbody>
</table>
Table 2: Results of Reliability Analysis on subscale and total scale scores

<table>
<thead>
<tr>
<th>Scale analysed</th>
<th>Alpha (a)</th>
<th>Mean (x)</th>
<th>Std Dev</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable Alliance (RA)</td>
<td>.79 *</td>
<td>13.73</td>
<td>2.05</td>
</tr>
<tr>
<td>Attachment (ATT)</td>
<td>.83 *</td>
<td>11.10</td>
<td>3.21</td>
</tr>
<tr>
<td>Guidance (GUI)</td>
<td>.65 *</td>
<td>13.26</td>
<td>2.02</td>
</tr>
<tr>
<td>Opp. For Nurt. (OFN)</td>
<td>.52</td>
<td>11.68</td>
<td>2.13</td>
</tr>
<tr>
<td>Social Integration (SI)</td>
<td>.51</td>
<td>12.57</td>
<td>1.89</td>
</tr>
<tr>
<td>Reass. Of Worth (RW)</td>
<td>.76 *</td>
<td>11.05</td>
<td>2.69</td>
</tr>
<tr>
<td>TOTAL</td>
<td>.83 *</td>
<td>73.42</td>
<td>8.90</td>
</tr>
</tbody>
</table>

* denotes values of alpha coefficient that warranty a soundly reliable subscale or scale.
Table 3: Results of the Wilcoxon Matched-Pairs Signed-Ranks Test on subscale and total scale scores

<table>
<thead>
<tr>
<th>Scale analysed</th>
<th>Time 1 (x rank)</th>
<th>Time 2 (x rank)</th>
<th>Z score</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliable Alliance (RA)</td>
<td>2.00</td>
<td>5.38</td>
<td>2.43</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>Attachment (ATT)</td>
<td>0.00</td>
<td>4.50</td>
<td>2.52</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>Guidance (GUI)</td>
<td>4.50</td>
<td>4.50</td>
<td>1.26</td>
<td>ns</td>
</tr>
<tr>
<td>Opp. For Nur. (OFN)</td>
<td>4.67</td>
<td>3.50</td>
<td>0.00</td>
<td>ns</td>
</tr>
<tr>
<td>Social Integration (SI)</td>
<td>3.50</td>
<td>6.94</td>
<td>2.00</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>Reass. Of Worth (RW)</td>
<td>2.00</td>
<td>6.38</td>
<td>2.39</td>
<td>p &lt; .05</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2.00</td>
<td>7.40</td>
<td>2.74</td>
<td>p &lt; .01</td>
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</table>
Table 4: Sorts for Idiographic Analysis I

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Support</th>
<th>Unwarranted Pressure</th>
<th>Understanding of him and his problem with drugs</th>
<th>Personality Elements</th>
<th>Nice Person</th>
<th>Feels at ease to talk to</th>
<th>Reliable to be there</th>
<th>Type of relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-users</td>
<td>Most</td>
<td>Most</td>
<td>Most</td>
<td>Quiet &amp; Sly</td>
<td>Most</td>
<td>Most</td>
<td>Most</td>
<td>Blood</td>
</tr>
<tr>
<td>Users</td>
<td>Least</td>
<td>Least</td>
<td>Least</td>
<td>Aggressive &amp; Upfront</td>
<td>Middle</td>
<td>Least</td>
<td>Least</td>
<td>Friend</td>
</tr>
<tr>
<td>Addicts</td>
<td></td>
<td></td>
<td></td>
<td>Moody</td>
<td>Least</td>
<td></td>
<td></td>
<td>People at SJC</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Honest</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Willing to get off drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Easily intimidated &amp; verbally aggressive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 1a
MSA Solution at Time 1 on all Social Support Figures

Friend

Friend

Friend

Self

Friend

Friend

Sister

Friend

Cousin

Group

Sister

Friend

Group

Group

Group

Group

Staff

Staff

Staff

Nan

Mother

Father

Keyworker
Figure 1b
Partitioning of the Discriminating Sorts

Support

Least

Most

Pressure

Least

Most

Understanding

Most

Least

Personality

Other

Honest

Reliability

Least

Most
Table 5: Sorts for Idiographic Analysis II

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Support</th>
<th>Amount of Contact</th>
<th>Trust</th>
<th>Personality Elements</th>
<th>Personality Elements</th>
<th>Degree of personal isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-user</td>
<td>Most</td>
<td>Regular</td>
<td>Does not trust</td>
<td>Controls anger with drugs</td>
<td>Loud</td>
<td>Isolated</td>
</tr>
<tr>
<td>User</td>
<td>Least</td>
<td>Medium</td>
<td>Does trust</td>
<td>Loud</td>
<td>Quiet</td>
<td>Not isolated</td>
</tr>
<tr>
<td>Addict</td>
<td>None</td>
<td>None</td>
<td>Responsible</td>
<td>Practical</td>
<td>Do not know</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Immature</td>
<td>Keeps family together</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Do not know</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 2

MSA Solution at Time 2 on all Social Support Figures

Self

Staff

Keyworker

Sister

Group

Friend

Nan

Father

Cousin

Friend

Friend

Group

Partitioning of the Discriminant Sorts

Substance Use

Non Users

Users

Addicts

Support

Most

Least

Trust

Does Trust

Does Not Trust
<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Support</th>
<th>Willingness to listen to him</th>
<th>Type of Support</th>
<th>Personality Elements</th>
<th>Personality Elements</th>
<th>Personality Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recovering</td>
<td>Very</td>
<td>Most</td>
<td>Do not know</td>
<td>Pleasant</td>
<td>Honest</td>
<td>Unpredictable</td>
</tr>
<tr>
<td>Users</td>
<td>Moderately</td>
<td>Least</td>
<td>Practical</td>
<td>Moody</td>
<td>Loud</td>
<td>Self-centred</td>
</tr>
<tr>
<td>Addicts</td>
<td>Least</td>
<td>Do not know</td>
<td>Emotional</td>
<td>Sly</td>
<td>Easily irritated</td>
<td>Quiet</td>
</tr>
<tr>
<td>Do not know</td>
<td></td>
<td></td>
<td>No support whatsoever</td>
<td>Loud</td>
<td>Do not know</td>
<td>Good natured</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intimidated by people</td>
<td>Do not know</td>
<td></td>
</tr>
</tbody>
</table>
Figure 3a
MSA Solution at Time 3 on all Social Support Figures

Staff
Keyworker

Group
Group

Group
Nan

Group
Sister
Mother

Group
Father
Sister
Cousin

Friend

Self

Friend

Friend

Friend

Friend

Friend
Figure 3b
Partitioning of the Discriminating Sorts

Support

Some

Least

Substance Use

Non-Addicts

Addicts

Willingness to Listen

Most

Least

Type of Support

Practical

Some

None

Personality

Pleasant

Loud

Other

Personality

Honest

Irritable
Figure 4

PINDIS Analysis

The Centroid Configuration (Z)
Figure 5

PINDIS Analysis: Time Plot indicating relative change in idiographic structure