A multi method approach to understanding and predicting therapeutic alliance in a dual diagnosis population

Elizabeth Knock

BA (Psychology) Hons, University of Newcastle

This thesis is submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical and Health Psychology, School of Psychology, University of Newcastle

December 2011

Statement of Originality

This dissertation contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my dissertation, when deposited in the University Library, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

Signed: _____ Date_____

Acknowledgments

I would like to acknowledge a number of people without whom this thesis

could not have been completed.

Firstly Dr Frances Kay Lambkin for her never ending support, assistance and

encouragement. It is hard to imagine a supervisor more willing to go out of their way

for their students.

Rev. Dr. Martin Johnson, for his encouragement and interest and for being so

available for support and advice.

Prof. Amanda Baker for her support and guidance over the years and for

giving me the opportunity to follow an area of research I am passionate about.

The team at the Center for Brain and Mental Health Research who

kept me going, assisted when they didn't have to, and

generally shared their many skills;

Terry Lewin, Vanessa Williams, Sarah Hiles, Louise Thornton and Joanne Allen.

Thank you to Brendan Carey for putting up with my extreme chaos and for

doing countless loads of washing up, and Gabe Carey for her fabulous editing skills.

I would like to thank those particular friends who have understood my stress

and been an invaluable support at the hardest moments. A special thank you to my

good friend Tash, who has been with me every step of the way. I'm not sure I could

have made it without someone who really knew and understood and was able to

share the ups and the downs.

Lastly I would like to thank my amazing parents who believed in me,

encouraged me and give me the most amazing support and love one could ask for

while putting up with my insanity.

Abstract

Scope

This thesis reviews the significant body of research demonstrating the importance of the therapeutic alliance within psychotherapy, and examines this relationship within the lesser studied area of comorbid substance use and depression treatment. The role of pre-existing client characteristics and within treatment therapist components on alliance development is unclear, both with comorbidity treatment and broader psychotherapy. The role of these factors, as well as their influence on the therapy outcome alongside the alliance, is examined and discussed in light of existing literature.

Purpose

The purpose of the current study is to examine factors influencing the therapeutic alliance in treatment for substance abuse and depression from the client perspective. It aims to examine potential pre-treatment client characteristics associated with alliance, and the relationship between alliance and outcome in the presence of these factors in this population. Furthermore, the study aims to gain a deep understanding of the client experience of the therapeutic relationship, and through this an understanding of the impact of 'in therapy' factors on alliance, within comorbidity treatment.

Methodology

The study employed a mixed methods design within the Depression and Alcohol Integrated and Single focus Intervention (DAISI) study. Quantitative data was collected from participants who completed a 10 week integrated CBT/MI individual treatment addressing their alcohol use and depression (N=75). Baseline predictors of client and therapist rated therapeutic alliance were examined, as well as

the influence of alliance on substance use and depression outcome at six month follow-up. Participants were recontacted post follow-up and seven semi-structured interviews were completed and analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). This approach was utilised to reveal a deep understanding of participant's experiences of the therapeutic relationship within treatment.

Results

Of the hypothesised baseline predictors of alliance , severity of alcohol use and depression at baseline were significantly associated with therapist ratings of alliance, while cluster B personality traits and mother's style of parenting were associated with client ratings of alliance. A significant relationship between alliance and 6-months alcohol use outcome was found, with higher client rated confidence and therapist rated bond associated with significantly lower alcohol use at six months. No such relationship was found for severity of depression at follow-up, with baseline depression the only variable associated with severity of depression at six months. IPA identified four major themes elicited from clients involved in DAISI integrated treatment. 'Nature of the relationship' describes the importance to clients of the relationship experienced during treatment; 'Confidence in therapy' and 'Acknowledgment of experience' address components clients perceived assisted the development of a positive alliance with their therapist, and 'Meeting unmet needs' illustrates the importance of a positive therapeutic relationship for this population.

Conclusions and implications

Together, all components of this study indicate that both client and therapist factors are relevant to the development of alliance in comorbid alcohol use and depression treatment, especially in terms of predicting 6-month alcohol use

outcomes. It is proposed that the therapeutic alliance is particularly important for this comorbid population, stemming in part from client characteristics, which not only have the potential to make the development of alliance more difficult, but also add to the value and significance of the strong alliance relationships for these clients. Quantitative and qualitative results identified these characteristics as being related to interpersonal and social relationship experiences and styles. Of significance is that despite people reporting current, active and hazardous alcohol use problems and current moderate depressive symptomology, engagement in a meaningful therapeutic encounter is possible, as is the formation of a strong and important therapeutic relationship with their treating clinician. Together, this has the potential to meet a number of interpersonal needs for the client with comorbidity and has a positive influence on alcohol use outcomes. This is despite the well documented challenges that working with a comorbid treatment group often presents.

Table of Contents

Definition and history of therapeutic alliance

Therapeutic alliance has been broadly defined as the collaborative and affective bond between therapist and client (Martin, Garske, & Davis, 2000).

Its concept has emerged from over a century of discussion of multiple constructs, beginning with Freud, who described a positive attachment permitting the client to believe in his analyst's "communications and explanations", highlighting the importance of this construct to engagement in and success of therapy (Horvath & Luborsky, 1993).

To the modern therapist, Carl Rogers' client-centred therapy contains many aspects of our understanding of therapeutic alliance, through the use of unconditional positive regard and empathic understanding. However, research continues to indicate that while there is a moderate to strong correlation between client-perceived empathy and alliance, alliance is repeatedly more predictive of outcome than empathy (Horvath & Luborsky, 1993), suggesting additional components of this concept are important in determining the success of treatment.

Luborsky in 1976 described alliance as a dynamic process dependent on different phases of therapy. He was the first to define alliance based on the client's experience of the therapist as supportive and helpful, and the development of alliance on a sense of shared responsibility for working towards treatment goals (Luborsky, 1976). The extension of this by Bordin (1979) provided a broader definition of the therapeutic or 'working' alliance in which three elements were identified as critical to the development of a positive alliance: goals, tasks and bond. "Goals" rely on mutual agreement by the client and therapist about the target of the therapy intervention. "Tasks" refer to the in-counselling behaviours and means of

approaching the treatment and the ability of both client and therapist to perceive the

tasks as efficacious and relevant to the client's presentation and goals. "Bond" refers

to the connection between the client and therapist and the existence of trust,

acceptance and confidence.

Differences in definitions and conceptualisations of therapeutic alliance

continue to exist, however, three common themes are repeatedly found throughout

literature. These are the collaborative nature of the relationship, the client and

therapist's agreement on treatment goals and tasks, and the affective bond between

client and therapist (Bordin, 1979; Gaston, 1990; Horvath & Symonds, 1991; Martin,

et al., 2000).

Therapeutic alliance and outcome in broad psychotherapy research

Extensive research has examined the role of therapeutic alliance within

various fields of psychological treatment modalities and, as such, it has long been

viewed as playing a vital role in the counselling environment (Gaston, 1990). The

sometimes modest but consistent relationship between alliance and outcome has

been documented to the degree that it is often viewed as the distinguishing factor

between therapy styles that are otherwise equal in their effectivness (Castonguay,

Constantino, & Holtforth, 2006; Martin, et al., 2000).

This relationship has been seen in psychotherapy (Constantino, Castonguay,

& Schut, 2002; Horvath & Symonds, 1991; Martin, et al., 2000; Marziali &

Alexander, 1991) and other counselling styles including short term dynamic therapy

(Crits-Christoph & Connolly, 1999), motivational interviewing (Crits-Christoph, et

al., 2009), cognitive behaviour therapy (Waddington, 2002) and general therapist

counselling skills (Ackerman & Hilsenroth, 2003). It has been proposed that

therapeutic alliance forms a common, pantheoretical factor that could account for positive therapy outcome regardless of treatment approach (Horvath & Luborsky, 1993).

The contribution of alliance to treatment outcome has also been found across a variety of clinical presentations including depression (Gaston, Thompson, Gallagher, Cournoyer, & Gagnon, 1998; Krupnick, et al., 1994), addictive disorders (Luborsky & Barber, 1995), psychosis (Frank & Gunderson, 1990; Priebe & Gruyters, 1993), post traumatic stress disorder (Marmar, Horowitz, Weiss, & Marziali, 1986) and in mixed diagnostic groups (Hansson & Berglund, 1992; Neale & Rosenheck, 1995; Solomon, Draine, & Delaney, 1995). This relationship has also held across a variety of settings including in-patient (Clarkin, Hurt, & Crilly, 1987; Frank & Gunderson, 1990; Hansson & Berglund, 1992; Svensson & Hansson, 1999b), out-patient treatment (Gaston, et al., 1998; Gehrs & Goering, 1994; Krupnick, et al., 1996; Neale & Rosenheck, 1995; Solomon, et al., 1995) and homeless populations (Klinkenberg, Calsyn, & Morse, 1998).

In their 1991 meta-analysis, Horvath and Symonds (1991) examined therapeutic alliance and its association with outcome in 24 quantitative studies of individual therapy. They found a moderate but consistent relationship between positive alliance and a positive outcome in therapy, with an average effect size of r = .26. This study failed to find any significant differences in alliance-outcome relationships across different treatment approaches. It also revealed that the association between alliance and outcome was not a function of the type of outcome being measured, whether or not the research was published, the number of participants in the study, nor the length of treatment (Horvath & Luborsky, 1993).

A second meta-analysis conducted by Martin, Gaske & Davis (2000) sought to include over 60 additional studies since 1991. This review examined 79 studies of the impact of alliance on outcome, completed between 1977 and 1997, and found a moderate association of r=.22, which is within the range of many other effect sizes associated with psychotherapy outcome. No moderating relationship was found between the alliance outcome relationship and variables such as outcome type measured, type of treatment provided, method of measuring alliance, and whether or not research was published. The authors suggest that the unified results of two major meta analytic studies provide increased confidence that the relationship between alliance and outcome is not the result of confounds, and support the hypothesis that alliance in itself may be therapeutic.

A very recent meta-analysis compiled over 200 research reports examining the effect of alliance on outcome across many individual treatment programs and settings. Results supported previous studies, showing a moderate but very reliable relationship between alliance and psychotherapy outcome that was maintained with different measures of alliance, different rater perspectives, different time of alliance assessment, different outcome measures and different types of treatment (Horvath, Fluckiger, Del Re, & Symonds, 2011). This finding is particularly important considering the large amount of variability in these factors between individual studies.

Research has considered alternative explanations for the relationship between alliance and outcome, in particular the directionality of this finding. In testing this, it has been suggested that if alliance was a byproduct of positive therapy outcome, its development would track therapeutic increases and decreases, and thus early

measures of alliance would be expected to be a less accurate predictor of outcome than later alliance (in keeping with the gradual increase of therapeutic gain) (Gelso & Carter, 1985; Horvath & Luborsky, 1993). However, Horvath and Symonds reported a strong correlation between early and late alliance and outcome, but little correlation between alliance and outcome mid-therapy. This indicates alliance did not track therapeutic gain, but followed a pattern of "rupture and repair" during middle sessions, referring to the breaking down and rebuilding of the relationship throughout the progression of therapy. Repeated findings have shown that early alliance is a more powerful predictor of outcome than middle or late alliance (Horvath & Luborsky, 1993; Horvath & Symonds, 1991; Martin, et al., 2000), and that early alliance itself predicts later alliance and treatment dropout (Kokotovic & Tracey, 1990). Early symptomatology change has also not been predictive of subsequent alliance, ruling out the potential change occurring prior to the assessment of alliance as being a mediating factor in this relationship (Klein, Schwartz, Santiago, Vivian, & Vocisano, 2003). It is important then to better understand alliance, as an independent therapy component with the capacity to positively impact treatment outcome.

The confirmation of the clear relationship between therapeutic alliance and outcome is an essential starting point, however, it does not begin to explain the complexity of the client-therapist transaction. Both client and therapist bring their own personality, characteristics and history to the therapeutic relationship, and research has since directed its efforts towards an understanding of why alliance is important to outcome (Baldwin, Wampold, & Imel, 2007). Of particular clinical relevance and interest is how alliance influences outcome (Ackerman & Hilsenroth,

2003) and the ways in which alliance can be built and maintained throughout a course of treatment.

With findings overwhelmingly indicating at least shared impact, of the relationship and the treatment mode on outcome, recent publications have seen an important new view emerge. It is suggested that where research has in the past focused on evidence-based treatments as examined in randomised control trials, future directions should instead encourage a rapprochement between examination of the relationship, the treament, and patient and therapist factors, all of which join together to contribute to outcome, with no component existing in isolation. However, the contribution of these components is potentially different for certain disorders and certain therapies, hence research into specific areas of psychotherapy would benefit from examination of how these factors interact for a specific disorder (Norcross & Lambert, 2011).

Therapeutic alliance in substance abuse treatment

To date, few studies have examined the role of alliance in the treatment of substance abuse (Meier, Barrowclough, & Donmall, 2005a). This suggests a very relevant gap in the literature, as factors unique to substance using clients potentially make therapeutic alliance of particular importance for this population. Client characteristics known to be associated with alliance, outcome and related factors are often particularly common within clients presenting with substance abuse or comorbid mental health and drug and alcohol concerns (Meier, et al., 2005a).

Engagement and retention.

A significant problem in the treatment of substance abuse is the excessive difficulty of engaging and retaining clients. It is often accepted rather than

questioned that patient dropout is an inevitable regular occurrence within this population (Onken, Blaine, & Boren, 1997) with clinical trials suggesting that attrition rates can range from 25% to 90% (De Leon, 1991; Sparr, Moffitt, & Ward, 1993; Wickizer, et al., 1994). Furthermore successful engagement of clients in this field positively predicts treatment outcomes over and above other client factors (Fiorentine, 1998; Joe, Simpson, & Broome, 1999; Simpson, Joe, Rowan-Szal, & Greener, 1995; Simpson, Joe, Rowan-Szal, & Greener, 1997c). The studies that do exist in this area show a positive relationship between good therapeutic relationships and treatment engagement and retention in clients with substance abuse problems (Fiorentine, Nakashima, & Douglas Anglin, 1999; Meier, Donmall, McElduff, Barrowclough, & Heller, 2006; Simpson, et al., 1997c).

Within a methodone maintenance treatment population, Simpson, et al. (1997c) found that higher counsellor ratings of their interactions with the client (specifically rapport, motivation and self-confidence) related to longer retention in treatment along with reduced drug use during treatment and motivation for treatment. Similarly, in a study of client characteristics and treatment components, "utitity of treatment" and the client-counsellor relationship, measured by four counsellor-rated retrospective questions, were associated with engagement in treatment. An engagement score was measured by the average number of weekly individual and group sessions attended multiplied by the number or weeks in treatment (Fiorentine, et al., 1999). Meier, et al. (2006) used a more sophisticated measure of alliance; a modified version of the Working Alliance Inventory, and found counsellor rated alliance to be predictive of dropout in a naturalistic residential drug treatment setting. Thus it would seem that the role of therapeutic alliance

serves a particularly important factor in engaging and retaining substance using clients and through this, maximising their outcomes.

Relationships.

Substance using clients frequently report unsatisfactory relationships and current difficulties in their social environments as well as a history of poor social and family relationships. A significant portion of people with substance use problems have histories of family-intimacy dysfunctions, often passed throughout generations, as well as increased risk of sexual abuse, sexual dysfunction and marital problems (Coleman, 1982). Such typical difficulties with attachment often explain the aetiology of the person's substance use problem (Bell, Atkinson, Williams, Nelson, & Spence, 1996).

In their 1991 meta-analysis, Horvath and Symonds (1991) reviewed the impact of interpersonal client variables and found that individuals with poor interpersonal relationships who have difficulty maintaining social relationships or have poor family relationships are less likely to develop strong alliances with their therapists. Strong associations have been made within broad psychotherapy between insecure adult attachment styles and weaker alliance development (Diener & Monroe, 2011). High rates of substance use are seen in people with personality disorders, who also often display issues with attachment and relationships. Such attachment styles and relationship issues may make the development of therapeutic alliance difficult, but increases its importance. For example, it has been suggested that the therapeutic relationship may serve as a model for improved relationships outside of therapy (Henry & Strupp, 1994), which in turn may lead to sustained

improvements after treatment (Broome, Simpson, & Joe, 2002; Simpson, Joe, Greener, & Rowan-Szal, 2000).

History of treatment failures/expectancies.

Many clients in substance abuse treatment have had a significant history of treatment failures (Joe, Simpson, & Broome, 1998). Treatment data suggest that it can take multiple attempts to make successful change in alcohol/other drug use. While this may be considered normal within substance abuse settings, it is not conducive to development of therapeutic alliance, as clients may be hostile and cynical towards treatment (Meier, et al., 2005a). This is a concern, given the documented relationship between alliance and improved treatment response in other populations, and may in part explain the requirement for multiple treatment episodes. Meta-analytic studies have linked clients reporting little hope with poor development of alliance (Horvath & Symonds, 1991) and a recent study of 151 clients experiencing depression found that expectancies of treatment response (which is greatly influenced by past treatment experience) predicted clients' contribution to the alliance and clinical outcome (Meyer, et al., 2002). The same is likely true for substance using populations, however, little research evidence exists to test this directly.

Severity of dependence.

Severity of dependence and level of motivation to change may also contribute to hostility towards treatment, making the development of alliance challenging within the substance using population. Clients may see the therapist as trying to deprive them of a substance, or forcing unwanted change on them (Millman, 1986). Poor object relations and defensiveness, which is very likely

associated with level of motivation to change substance use patterns, have previously been associated with poor alliance in other mental health populations (Horvath & Symonds, 1991), with actual severity of presenting symptoms exerting little influence on the development of a positive therapeutic relationship.

Predictors of therapeutic alliance in substance abuse treatment

Pre-treatment client-related factors that predict therapeutic alliance have been examined within substance abuse populations, but to a lesser degree than in general psychotherapy literature. No relationship has been found between alliance and a number of demographic variables including gender or age (Belding, Iguchi, Morral, & McLellan, 1997; De weert-Van Oene, De Jong, Jorg, & Schrijvers, 1999; Luborsky, et al., 1996), race (Belding, et al., 1997; Connors, et al., 2000; Luborsky, et al., 1996), marital status or employment (Belding, et al., 1997; Luborsky, et al., 1996). Meier, et al. (2006) found a small effect of gender but otherwise supported previous findings that demographic variables do not play a role. While the replication of a number of these findings is promising, data within this area are difficult to compare due to the use of very different treatment settings. The research of Meier, et al. (2006), for example, was conducted within residential drug treatment services, while Belding, Iguchi, et al. (1997) conducted their research within a methadone maintenance program which they acknowledge is not conducive to a fair test of the therapeutic relationship.

Studies are often confused by the difficulty in establishing causality between a number of related variables and outcome measures. Connors, et al. (2000) for example, found that in simple regressions, client ratings of alliance were modestly predicted by age, motivation to change, socialisation, social support, client education

level and severity of depression or alcohol use, however, once this was included in a

multiple regression model, only motivation and readiness to change remained

significant predictors of the alliance. It is thus necessary to interpret evidence of

predictors with some caution in substance using populations. In a study of 295

adolescents in substance use treatment, social support, reasons for quitting and

problem orientation (both related to treatment readiness), cautious personality, and

environmental risk factors significantly predicted client-rated alliance within

univariate analyses, however at the multivariate level, these variables together only

explained 10% of the client-related predictors of alliance (Garner, Godley, & Funk,

2008).

The strongest and most consistent client-related predictors of alliance found

so far in substance abuse are internal or external motivation for treatment, treatment

readiness (Connors, et al., 2000; Joe, et al., 1998), and number of previous treatment

attempts (De weert-Van Oene, et al., 1999). Connors, et al. (2000) included 707

outpatients and 480 after care inpatients, assigned to 12-step treatment, Cognitive

Behavioural coping skills Training (CBT) or Motivational Enhancement Therapy

(MET). Multivariate analysis found strong associations between motivational

readiness to change and client ratings of alliance. Similarly in 2265 participants

across long term residential treatment, outpatient methadone treatment and outpatient

drug free programs, pre-treatment motivation and treatment readiness was

significantly related to therapeutic engagement where other sociodemographic and

background variables were not (Joe, et al., 1998). De Weert-Van Oene et al. (1999)

found the number of previous treatment experiences (possibly a proxy for motivation

and readiness to change) related to helpfulness and cooperation on the client-rated

Helping alliance questionnaire in 340 participants from different inpatient and outpatient clinics. Studies of this nature are useful to examine and establish variables related to alliance that potentially exist across many treatment styles and settings, however, the difficulty mentioned above, of interpreting univariate and multivariate studies, revealing sometimes small variance, suggests that such studies are also necessary within more controlled experimental environments so that the amount of unknown and unexplained variance can be limited.

As previously mentioned, the number of varied settings makes comparison difficult. Meier, et al. (2005) revealed-client rated alliance to be predicted by social support, secure attachment style, motivation, ex user therapists and more experienced therapists in a naturalistic residential rehab setting and identified the need for replication in other environments, while Schiff & Levit (2010) found a small effect of avoidant attachment and pre-treatment opiate use in predicting client-rated alliance in 11 methadone programs in Israel. Other significant differences between these study designs include the measurement of alliance with a validated tool (Meier, Donmall, Barrowclough, McElduff, & Heller, 2005b), or, instead, as retention or engagement (Joe, et al., 1999), and the use of one or two rater perspectives. Only a few studies have used both client and therapist ratings of alliance (Belding, et al., 1997; Connors, et al., 2000; Meier, et al., 2005b) making comparison difficult with those that use only one perspective.
Meier, et al. (2005) and Schiff & Levit (2010) are the only studies within substance abuse research to examine and find a relationship between alliance and attachment. A number of related predictors identified within general psychotherapy research have not yet been studied within substance use treatment. There is evidence that

early relationships with parents, subsequent parental attachment, adult attachment styles, social competencies and interpersonal relationships are associated with alliance (Diener & Monroe, 2011; Hardy, et al., 2001; Hilliard, Henry, & Strupp, 2000; Johansson & Jansson, 2010; Mallinckrodt, 2000; Muran, Segal, Samstag, & Crawford, 1994; Piper, et al., 1991). Early parental relations were found to have a direct effect on client-rated therapeutic alliance (r=.29, p<.05) in a study of 64 clients in psychodynamic treatment. The method of analysis, including examination of the alliance outcome relationship while controlling for interpersonal history, was a strength of the study, allowing authors to conclude that early parental relations had a direct effect on alliance and also an indirect effect on outcome, mediated by alliance (Hilliard, et al., 2000). The precise meaning of 'early parental relations' was not defined within this study.

Within a CBT setting, the interpersonal style, particularly the "uninvolved style" (examples of endorsed statements include "hard for me to socialise with other people" and "hard for me to experience love for another person") of participants suffering from depression, has been found to significantly predict alliance (Hardy, et al., 2001). Higher assertiveness and presence of histrionic, narcissistic, antisocial and paranoid personality subscales were also related to lower alliance (Muran, et al., 1994). Small sample sizes (n=24 and n=32 respectively) were a weakness of these studies in treatment for depression and anxiety although significant effect sizes were found despite this. Mallinckrodt, Gantt and Coble, (1995) examined the relationship between attachment and therapeutic alliance in a number of studies, concluding, particularly, that client-parental bond accounted for 23% of client-rated working alliance with their therapist. This research was extended and suggested that the

ability to form an attachment relationship within psychotherapy (based on constructs of proximity seeking, safe haven, emotional regulation and secure base) positively correlated with working alliance (Mallinckrodt, 2000). Again, this research has only been conducted in broader psychotherapy populations and these concepts have not been tested in substance abusing populations.

Personality traits of "hostility", "cold/distant" (Clarkin & Levy, 2004; Hersoug, Hoglend, Monsen, & Havik, 2001; Johansson & Jansson, 2010; Puschner, Bauer, Horowitz, & Kordy, 2005), 'vindictive/self centred' (Johansson & Jansson, 2010) and "perfectionism" (Zuroff, et al., 2000) have been related repeatedly to alliance. Not surprisingly then, personality disorders more broadly have shown similar patterns (Horvath & Bedi, 2002; Lingiardi, Filippucci, & Baiocco, 2005). Clients rating alliance, with Cluster A disorders (paranoid, schizoid, schizotypal) have revealed a negative relationship with alliance development, while interestingly, therapists reported significantly lower therapeutic alliance with Cluster B clients (antisocial, borderline, histrionic, narcissistic) (Lingiardi, et al., 2005). This study had strong experimental methodology with all clients receiving similar treatment from identically trained therapist's, however this research has not been conducted in substance abusing samples, where the prevalence of personality disorders is high.

Overall, consistently similar findings of specific relationships between interpersonal styles, relationship with parents, attachment style, social competencies, specific personality traits and personality disorders with therapeutic alliance have been replicated across a number of similar and different treatment settings and modalities. This adds strength to the importance of considering these factors in assessing therapeutic alliance. Importantly, none of this research has been applied

specifically to substance abuse settings, where arguably the use of substances may be related to problems in these domains, and difficulties in establishing and maintaining therapeutic alliance are common.

Substance abuse, therapeutic alliance and outcome

Research into therapeutic alliance in the substance abuse field to date has been varied and often inconclusive. A review completed by Meier, Barrowclough & Donmall in 2005 examined the body of research in this area and it is interesting to note that a meta analytic approach was commenced but abandoned due to the small number of existing studies exploring this issue.

It is clear from this review that due to the significant problem with retention in substance abuse treatment, much of the literature in this area has focused on retention as a byproduct of therapeutic alliance, rather than outcome or progression of the presenting issue (Meier, et al., 2005a). Available substance abuse literature has shown that alliance contributes to treatment retention when rated by patients (De weert-Van Oene, Schippers, De Jong, & Schrijvers, 2001), observers (Carroll, Nich, & Rounsaville, 1997; Fenton, Cecero, Nich, Frankforta, & Carroll, 2001) or therapists (Petry & Bickel, 1999). One more recent study examined both client- and therapist-rated alliance and found only therapist-rated alliance, as well as a number of client characteristics and counsellor experience, to be associated with retention (Meier, et al., 2006)

Two studies failed to find a relationship (Belding, et al., 1997; Tunis, Delucchi, Schwartz, Banys, & Sees, 1995), both of which had small sample sizes (n<50), assessed alliance late in treatment and included clients retained beyond this point only, effectively ignoring the impact of early alliance on dropout rates. In

addition, much of the published research in this area is over one decade old. With increasing attention over the past decade on improving the evidence base for substance abuse treatment, and in exploring new methods and modalities of delivering effective treatment to substance abuse populations, much remains to be explored in this important area.

The known impact of retention on outcome has been detailed previously, though it remains unclear how alliance and retention together influence outcome. It is clear that the importance of client retention in substance abuse treatment, and its relationship with alliance (particularly early in treatment), adds strength to the importance of therapeutic alliance within this area of treatment.

The study of therapeutic alliance and its relationship with substance use outcomes, independent of retention, reveals limited and inconsistent results. The small number of studies using different treatment settings, rater perspectives (client, therapist or observer), alliance measurement instruments, different times of measuring alliance (early, mid or late) and outcome, has made drawing conclusions difficult, in contrast to the clear contribution of alliance to outcome in the general psychotherapy literature (Martin, et al., 2000). One study within methadone maintenance treatment (Belding, et al., 1997) reported no relationship between client- or therapist-rated early alliance and outcome, while others showed mixed results. Simpson, Joe, Rowan-Szal, et al. (1997b) found early counsellor-rated alliance predicted outcome, while mid-treatment observer ratings predicted abstinence in Fenton et al.'s (2001) study.

A study of a large cohort of opiate users (n=577) examined only counsellor-rated alliance and found it to be significantly associated with outcome. The

inclusion of retention and treatment satisfaction as covariates adds strength to the finding that clients with low counselling rapport had significantly worse outcomes (Joe, Simpson, Dansereau, & Rowan-Szal, 2001). Alliance was measured using counsellor perspective likert scale ratings of statements, however, the number of statements and number of likert scale points changed midway through the study limiting this measurement tool. Alliance scores were averaged across treatment sessions, so the inability to distinguish periods of alliance was significant considering past evidence that the relationship between alliance and outcome varies significantly at early, mid and late stages of treatment.

Client-rated alliance predicted outcome in two studies. One of the largest studies in the area to date (n=789) found that early client-rated alliance strongly predicted long term drug use outcome, making it the only study to reveal a strong alliance-outcome relationship that was not temporarily related (Hser, Grella, Hsieh, Anglin, & Brown, 1999). Barber, Luborsky et al. (1999) found a weak predictive relationship between client-rated alliance and drug use outcomes in a study of cocaine users.

While research within substance abuse treatment shows, in general, a relationship between alliance and outcome (as well as a relationship with retention, a variable closely related to outcome in this field), the strength and course of this relationship does not seem to be as clear as in broader areas of psychotherapy. One reason for this may be that the number of studies in the field is still too small to draw conclusions, particularly when so many variables (measurement tool, time of alliance, time of outcome and rater perspective) are considered. If so, much further

research is required to expand on current knowledge and allow for replication of results.

The mechanisms of the therapeutic relationship may operate differently in the treatment of substance abuse than in treatment of broader psychotherapy settings (Carroll, 2005). Factors potentially increasing the significance of therapeutic alliance in substance abuse treatment have been mentioned previously. It has also been proposed that the supportive relationship may have difficulty competing with the powerful reinforcer that drugs provide (Carroll, 2005). The therapeutic relationship is potentially complicated by the fact that addiction therapists are sometimes responsible, directly or indirectly, for the restriction of substances to their clients, and it is relevant that there have been many negative findings regarding the relationship between alliance and outcome within methadone maintenance settings or similar where clinicians may often be strict arbitrators of program rules (Carroll, 2005). If it is the case that different mechanisms are at play, extensive further research is required to understand better the complex relationship between the development of alliance and its effect on outcome for clients using a broad range of substances.

Substance use, alliance and psychiatric comorbidity

Meier, Barrowclough & Donmall (2005a) pointed to evidence suggesting that a good therapeutic relationship may be especially important in retaining drug using clients with psychiatric comorbidity. Petry & Bickel (1999) found that in a dual diagnosis population, therapeutic alliance was very strongly associated with retention in clients with severe mental health concerns, however, there was no such relationship in those with no or few dual diagnosis concerns. This influence of

alliance was seen over and above the impact of factors such as severity of addiction or psychiatric concern. Substance abuse clients with psychiatric problems also rated their relationships as worse than substance abuse clients without such problems (Pray & Watson, 2008). Recent research indicates that the prevalence of concurrent diagnoses of substance dependence and psychiatric illness is high (Franken & Henriks, 2001; Marsden, Gossop, Stewart, Rolfe, & Farrell, 2000; Virgo, Bennett, Higgins, Bennett, & Thomas, 2001), however, further research on therapeutic alliance in this area is very scarce.

What contributes to the development of alliance?

The complexity of the transaction between client and therapist, each of whom brings their own characteristics, personality and history to interact together to form a relationship, has been debated, as research begins to consider what actually contributes to the development of alliance. It has been proposed that there are three areas of variability in alliance formation (DeRubeis, Brotman, & Gibbons, 2005). The first is the client, whose pre-treatment characteristics may place them in a stronger position to form a therapeutic relationship with another. The second possible influence is the therapist. Certain behaviours and processes utilised by a therapist may result in more effective therapists who are more able to engage clients in a positive relationship conducive to collaborative, effective work. The third possibility is that there is an interaction between clients and therapists, meaning, perhaps, that some therapists are able to form alliances with all clients while others may only form alliances with clients with positive pre-treatment characteristics (Baldwin, et al., 2007).

As presented earlier, studies of therapeutic alliance have focused upon the first, client-related variability, finding with some consistency that certain client characteristics predict alliance and related factors of engagement and retention, and outcome. Such correlations have been found in the broader psychotherapy context and within substance abuse treatment, where an increase in client predictors of poor alliance and outcome is seen as evidence that this population is difficult to form an effective relationship with. Herein lies a conflict within alliance research. There has been growing suggestion that the degree of importance of client characteristics to alliance and outcome has been exaggerated and that examination of the role of therapist and the client's experience within treatment could be more crucial (Fiorentine, et al., 1999; Klein, et al., 2003; Kothari, Hardy, & Rowse, 2010).

Klein, et al. (2003) studied the impact of alliance on outcome, with the aim of examining the possible confounding effect of prior change and client characteristics on the alliance-outcome relationship. Analysis found that early alliance was a significant predictor of depression outcome even when controlling for prior and concurrent levels of depression, gender, chronicity, comorbid anxiety, substance use, personality disorders, highest level of social functioning in the past five years, and history of abuse and neglect in childhood. A recent study took a new approach and separated client and therapist variability through the use of within and between-therapist correlations, with the aim of exploring the relative importance of client and therapist variability in alliance as they relate to outcome (Baldwin, et al., 2007). They found that therapist variability, as rated by clients, accounted for the alliance-outcome correlation and that client variability within a single therapists caseload, did not predict outcome. Practically, this suggests that therapists who formed stronger

alliances with their clients showed significantly better outcomes, than therapists who did not form strong alliances, but that different client alliance scores within each therapists caseload did not predict outcome (Baldwin, et al., 2007).

This design has been replicated once within substance abuse treatment in a study of MET for alcohol or drug use. It found that between-therapist variability, but not between-client variability, predicted outcome, with an effect size of r=.215 (Crits-Christoph, et al., 2009), which is very comparable to other literature in the area, particularly Martin, et al.'s (2000) meta-analysis (r=.22).

Also within substance abuse treatment, Fiorentine, et al. (1999) examined client characteristics of demographics, pre-treatment drug and alcohol use, treatment history, criminal history, mental health, attitudes and expectancies, treatment experiences including barriers to treatment utilisation, perceived utility of treatment, perceived utility of ancillary services and client-counsellor relationship, and found, with the exception of a few modest statistical relationships, predictors of treatment engagement were confined to current treatment experiences. In particular, the client-counsellor relationship and perceived utility of treatment explained most variance in treatment engagement. Similarly Barrowclough, Meier, Beardmore and Emsley (2010) reported on the importance of clients negative expectation and lack of insight as predictors of poor alliance.

The above mentioned studies share a recommendation that research into the mechanisms by which alliance predicts outcome should give greater consideration to the within-therapy experience a client has, and the therapist-related factors (characteristics and techniques) that guide this experience.

Therapist related factors, the client experience and the impact on alliance

To date, therapist contributions to alliance have been somewhat overlooked, both in general psychotherapy (Ackerman & Hilsenroth, 2003) and within substance abuse treatment in particular (Meier, et al., 2005a). Humanistic and psychodynamic approaches have long discussed of use of client-centred techniques and interpersonal issues in relation to the client-therapist relationship, and terms such as 'unconditional positive regard' are well known (Rogers, 1957), however, as research into alliance has moved into more structured approaches such as cognitive and cognitive behavioural psychotherapies, understanding of therapist-related factors has not kept pace. The available literature within broad psychotherapy has been reviewed by Ackerman & Hilsenroth (2003). They identified therapist attributes and techniques that have been found to correlate with strong alliance across a range of psychotherapy orientations. Attributes included flexibility, experience, being honest, respectful, trustworthy, confident, interested, alert, friendly, warm and open. Techniques include being reflective, supportive, noting past therapy successes, providing accurate interpretations, facilitating emotional expression, being active, affirming and understanding, and attending to the client's experience (Ackerman & Hilsenroth, 2003). Similar features have been described in research detailing factors useful in the identification and repair of ruptures in alliance, including acknowledgement of the therapist's role in the rupture, and affirming, understanding, nurturing and validation of the client through exploration of their experience (Safran & Muran, 2000).

The majority of studies included in the review used correlational analysis which, as well as having the possible influence of many confounds, is possibly

limited by an oversimplification of such complex interpersonal exchanges between client and therapist. Ackerman & Hilsenroth (2003) recommend future quantitative and qualitative analysis of client-therapist interactions in order to present a deeper, more clinically meaningful picture of the data. This gap in alliance literature has been reported elsewhere. Essentially, research into the mechanisms of alliance has focused on determining its relationship to a number of theory-derived variables, with considerable support found for theory-based hypotheses. Information regarding the nature of the clinical reality of alliance, as it is understood and experienced as an actual therapeutic encounter from the perspective of the involved participants, is very scarce, begging the consideration of a qualitative methodology (Ackerman & Hilsenroth, 2003; Bachelor, 1995).

If the aim, as suggested (Ackerman & Hilsenroth, 2003; Baldwin, et al., 2007; Fiorentine, et al., 1999; Klein, et al., 2003), is to gain a deeper understanding of a client's experience of therapy and therapist behaviours contributing to the development of alliance, it follows that the perspective of the client may be of particular interest and clinical relevance to gain an understanding of the aspects of treatment that they themselves have found to help or hinder the development of a positive therapeutic alliance. Essentially, while it is relevant to consider the therapist's perspective of the characteristics and techniques they contribute to the development of alliance, the client's perspective of what the therapist brings to the relationship is potentially of even greater clinical relevance, particularly in substance abuse treatment settings. Also, within psychotherapy research at least, the client's rating and view of alliance has consistently been more accurate in predicting outcome than therapist or observer (Martin, et al., 2000), although this finding is not

so clear within the available studies of substance abuse treatment (Meier, et al., 2005a).

One comprehensive study within broader psychotherapy literature has used a qualitative methodology, to examine therapeutic alliance from the perspective of the client (Bachelor, 1995). Bachelor revealed three types of alliance across therapy, as identified by clients during interview. These were Nurturant alliance, Insight-oriented alliance and Collaborative alliance. Further content analysis revealed lists of alliance-related characteristics, 16 of which related to the therapist, ten to the client, and seven to mutual characteristics. It has been suggested that gaining a client perspective in this manner provides increased potential of revealing new and potentially unpredicted insights. This was evident within Bachelor's study in which he concluded that theoretician-defined alliance variables are not equally relevant for clients and that some crucial features of the perceived working relationship are not accounted for in current alliance theory (Bachelor, 1995) .

Within substance abuse literature, qualitative research to date has only examined the mechanisms of therapeutic alliance from the perspective of the therapist. In a recent study, a qualitative approach was used to examine therapists' understanding of therapeutic alliance and their role within this. When Interpretive Phenomenological Analysis (IPA) was used to analyse semi-structured interviews of clinical psychologists working in outpatient substance abuse treatment, five key themes emerged relating to the therapeutic relationship. These themes were finding hope, core meanings, fear and responsibility, tolerance, and keeping connected (Kothari, et al., 2010). Another study examined alliance from the perspective of nurse counsellors within inpatient substance abuse and dual diagnosis settings.

Themes discussed related to the type of relationship allowed by a good alliance, the benefits of becoming close or remaining distant from a client, and the therapist's role and responsibilities in creating an alliance (Hoxmark & Wynn, 2010).

Within substance use in particular, the importance of client perspectives has been recognised so the lack of qualitative research from the client's perspective appears a significant gap. It is possible that the time consuming nature of qualitative methods and the ease of contacting therapists rather than clients within substance abuse populations is one explanation for the current lack of studies of this nature. The relative recency of this direction of alliance research is another explanation.

More and more, research describes the particular importance of matching between substance abuse treatment programs and specific individual needs of the client (Nordfjaern, Rundmo, & Hole, 2010; Smith & Marsh, 2002). Furthermore, it has been recognised that in order to gain this knowledge, more studies are needed to examine how substance using clients perceive their treatment (Connors & Franklin, 2000; Cooper-Patrick, et al., 2002; Nordfjaern, et al., 2010). It is proposed that quantitative studies of perception of treatment produces data that is positively biased, as clients do not reflect as freely upon positive and negative aspects of treatment when the response options are restricted to a Likert scale (Connors & Franklin, 2000). This suggests the benefits of qualitative research to gain a deeper and potentially more accurate understanding of clients' attitudes, opinions and perceptions around their treatment (Nordfjaern, et al., 2010).

The Current Study

The Depression and Alcohol Integrated and Single-focused Interventions (DAISI) Project.

The DAISI Project is a randomised control trial of treatment of clients experiencing concurrent depressive and alcohol-related disorders. Treatment within the group of interest to the current study consisted of 10 sessions of CBT targeting depression and alcohol misuse concurrently, although participants could also be using a range of other licit and illicit substances. This project evolved from repeated research showing depression and alcohol or other drug use problems to be among the three most commonly occurring psychiatric disorders (Scott, Gilvarry, & Farrell, 1998a), with depression and substance abuse very frequently co-occuring (Teesson, 2000). Of psychotherapy approaches, CBT has the best documented efficacy for both depression (APA, 2000) and treatment of drug and alcohol use problems (Shand, Gates, Fawcett, & Mattick, 2003). Recent evidence leads to the conclusion that an integrated CBT addressing both depression and substance abuse is the most effective method of treatment when compared to single-focused intervention (Baker, et al., 2009).

Comorbid substance abuse and depression and best practice treatment.

CBT within general psychotherapy treatment has shown similar relationships between alliance and outcome to other treatment modalities. Within substance abuse treatment, knowledge of the alliance-outcome relationship within different treatment philosophies is virtually unknown (Meier, et al., 2005a).

The focus of literature in this document has been on substance abuse treatment alone, however, this is primarily a result of the significant lack of research

addressing therapeutic alliance within dual diagnosis treatment, a pattern that is repeated across many domains, with clinical practice, research and policy makers frequently ignoring this population (Clarkin & Kendall, 1992; Teesson, 2000). This is despite evidence that people with comorbid mental illness and substance use problems have poorer treatment outcomes and are considered more complex to treat, and are encountered as the rule rather than the exception, particularly in substance abuse populations. As a result, these disorders tend to be more chronic and disabling than those experienced by people with single disorders, resulting in greater utilisation of services (Brown, et al., 1995; Kessler, et al., 1996; Teesson, 2000). When psychiatric problems have been included in substance abuse research, there has been a consistent finding that this comorbidity contributes to less positive relationships, and that the formation of alliance is of particular importance within this population (Meier, et al., 2005a; Petry & Bickel, 1999; Pray & Watson, 2008). The importance of taking opportunities to develop good models of care for clients suffering comorbid mental health and substance use conditions has been noted in research (Hall, 1996; Scott, Gilvarry, & Farrell, 1998b).

Based on evidence of the commonality of comorbidity, the increased importance of alliance within substance abuse when psychiatric illness is present, and best practice treatment, it is proposed that the use of a comorbid population and treatment setting is a strength of the proposed study of therapeutic alliance and substance abuse treatment.

Broad Aims.

Broadly, the current study aims, firstly, to contribute to research of the mechanisms by which the therapeutic alliance develops, and to shed light on the

current debate within literature surrounding the role of client pre-treatment factors

and the client experience of therapy and the therapist on the development of alliance.

It is hoped that a mixed methods design will begin to address the question posed by

Norcross & Lambert, (2011) of how the therapeutic relationship works for this

disorder. A strong body of research leads to the conclusion that within-session

factors, particularly the actions of the therapist, account for at least the greater

portion of the variability in the development of a positive alliance, rather than client

characteristics, as once believed. In accepting this conclusion, the question arises of

what actually takes place within the therapy interaction, and literature points towards

the role of the client to provide a rich source of information regarding the aspects of

this experience that relate to alliance and their therapeutic relationship. This

conclusion is in contrast, however, to evidence, replicated numerous times, that some

client characteristics, in particular, relationship and interpersonal styles, parental

attachment, personality disorders and traits, and social functioning, as well as

motivation and past treatment experience, have been seen modestly, but consistently

to predict alliance, whether client or therapist rated. A debate has thus ensured, and

while one does not negate the other, and these two opposing processes may well

coexist, further and deeper understanding is hoped to be an outcome of this study.

Secondly, the study aims to contribute to our understanding of the role of

client or therapist-rated alliance in predicting outcome in a dual diagnosis (Alcohol

misuse and Depression) population, in the presence of possible confounds. This

model will help to identify how much of the impact of alliance-outcome relationship

is attributable to alliance itself, and how much of this variability is a factor of

additional aspects related to alliance and outcome. While it is unlikely that we will

be able to account for all of the variability within this relationship, the inclusion of covariates will strengthen any findings relating to this second aim of understanding the relationship between alliance and outcome, while also contributing to aim one by increasing our knowledge of how much certain pre-treatment and within-treatment factors interact with alliance to predict outcome.

Research Questions.

Do pre-treatment client characteristics predict the development of therapeutic alliance?

Interpersonal style, parental attachment, social functioning and personality disorders have been seen to have modest relationships with alliance in general psychotherapy but have not been examined within substance abuse or dual diagnosis treatment settings. Severity of substance use, severity of psychiatric comorbidity (depression) and motivation to change have shown some ability to predict alliance within substance abuse literature. While evidence suggests that the impact of client pre-treatment characteristics is considerably less important than therapist-related factors, it is hypothesised that a relationship will be found between variables entered into the model and alliance. The outcome of this finding will be strengthened by controlling for different therapists.

Does therapeutic alliance rated by client or therapist predict outcome (alcohol use or depression) when controlling for possible covariates within a dual diagnosis population?

Despite clear findings in general psychotherapy, the relationship between client- or therapist-rated alliance and outcome within substance abuse treatment is not clear, with some going so far as to suggest that alliance may infact work

differently within this population. Very few studies within substance abuse and dual

diagnosis fields have examined the alliance-outcome relationship with the inclusion

of possible covariates. This is a significant gap in current literature, particularly as

pre-treatment characteristics related to alliance (referred to in research question 1)

are common within substance abuse treatment presentations. It is hoped that

replication of studies within substance abuse treatment will provide some clarity.

The current study design acknowledges that within examination of the alliance-

outcome relationship, the possible confounding impact of a number of known

predictors of both alliance and outcome must be considered however it is

hypothesised that even in the presence of covariates, alliance will predict alcohol use

and depression outcome.

>   ***What is the client experience of therapists, therapy interactions and
>   procedures, and therapeutic alliance, within an integrated treatment program for
>   clients experiencing alcohol use problems and depression?***

A qualitative methodology will be employed to address this question,

following recommendations within alliance literature that qualitative research is

required for a deeper understanding of in-session and therapist-related factors

(Ackerman & Hilsenroth, 2003). The use of this methodology from the client

viewpoint is also strongly encouraged within substance abuse research (Connors &

Franklin, 2000). Data will be collected via semi-structured interviews and analysed

using Interpretive Phenomenological Analysis (IPA). When considering a topic such

as therapeutic alliance in a qualitative manner, it is important to note from the outset,

that the language used by clients to describe their therapeutic experience may differ

significantly from that used by clinicians and research academics. Even the phrase

"therapeutic alliance" itself, may mean very little to a client but this is not to say that they do not have an understanding of such an experience and its meaning. Therefore in such qualitative research, it is not the language and phrases used that is of interest, but the meaning and essence of an experience as it is told by one, and interpreted by another. IPA is best used to capture information in this way and aims to explore how participants make sense of their experiences, but also recognises that the researcher's own conceptions are required in order to make sense of the personal world being studied (Chapman & Smith, 2002)

Manuscript: A phenomenological understanding of the therapeutic alliance in

dual diagnosis treatment

A phenomenological understanding of the therapeutic

alliance in dual diagnosis treatment

Elizabeth Knock

University of Newcastle, Center for Brain and Mental Health Research

Dr Frances Kay-Lambkin

National Drug and Alcohol Research Center, University of NSW

Rev. Dr Martin P. Johnson

University of Newcastle

Prof. Amanda Baker

University of Newcastle, Center for Brain and Mental Health Research

Louise Thornton

University of Newcastle, Center for Brain and Mental Health Research

Correspondence concerning this article should be addressed to:
Dr Frances Kay Lambkin
Postal address: Level 5, McAuley Centre, Calvary Mater Hospital, Waratah, NSW,
2289, AUSTRALIA
Phone: +61240335690
Fax: +61240335692
Email: f.kaylambkin@unsw.edu.au

Running title: Therapeutic alliance in dual diagnosis treatment

Key words: therapeutic alliance, substance use, depression, alcohol, dual diagnosis,
phenomenological, therapeutic relationship.

Abstract

Objectives: To explore the treatment experience and the therapeutic relationship experienced therein, of participants receiving an integrated psychological treatment for comorbid alcohol use problems and depressive disorders. Design: Semi-structured interviews targeting experience of therapy and the relationship with the therapist were carried out with seven participants who completed treatment. Transcripts were analyzed using Interpretive Phenomenological Analysis (IPA) to reveal major themes. Results: Four major themes were identified. 'Nature of the relationship' describes the importance of the client's perception of the therapeutic relationship experienced, 'Confidence in therapy' and 'Acknowledgment of experience' address components assisting the development of a positive alliance, and 'Meeting unmet needs' illustrates the importance of a positive therapeutic relationship for this population. Conclusions: Clinicians would benefit from a good understanding of the role the alliance relationship plays within comorbidity treatment, of the need this relationship meets for this population, and the importance of engendering confidence in therapy and recognizing client perspectives.

A Phenomenological Understanding of the Therapeutic

Alliance in Dual Diagnosis Treatment

Therapeutic alliance has been broadly defined as the collaborative and affective bond between therapist and client (Martin, Garske, & Davis, 2000). Extensive research over the past two decades has examined the role of therapeutic alliance within various fields of psychological treatment modalities. A modest, but consistent, relationship between alliance and outcome has been documented to the degree that it is often viewed as the distinguishing factor between therapy styles that are otherwise equal in their effectivness (Castonguay, Constantino, & Holtforth, 2006; Horvath, Fluckiger, Del Re, & Symonds, 2011; Martin, et al., 2000). Recently, experts have proposed that the provision of the most efficacious psychological services requires recognition and examination of the ways in which the therapeutic relationship, patient and therapist factors, and treatment modality interact to influence outcome for particular disorders (Norcross & Lambert, 2011).

Within the general psychotherpeutic field, research has shown a relationship between alliance and outcome, across a variety of treatments and presentations (Horvath, et al., 2011; Horvath & Symonds, 1991; Martin, et al., 2000). However, similar research within substance abuse treatment has, to date, been scarce and inconclusive. This comparative lack of research attention represent a significant gap, in light of evidence that clients with substance abuse problems typically report poor engagment and treatment retention (De Leon, 1991; Onken, Blaine, & Boren, 1997; Sparr, Moffitt, & Ward, 1993), poor interpersonal relationships and social concerns (Bell, Atkinson, Williams, Nelson, & Spence, 1996; Coleman, 1982), high rates of personality disorder (Grant, et al., 2004; Verheul, Van den Brink, & Hartgers, 1995),

and history of treatment failures (Joe, Simpson, & Broome, 1998). These particular

client characteristics undoubtedly influence the therapeutic relationship they are able

to establish with a treatment provider (Meier, Barrowclough, & Donmall, 2005).

The nature of substance addiction, and the importance of motivation to change, may

also contribute to hositility towards treatment and therapist in substance abusing

populations (Meier, et al., 2005). A few research trials examining the relationship

between alliance and substance use outcome do exist (Barber, et al., 1999; Hser,

Grella, Hsieh, Anglin, & Brown, 1999a; Joe, Simpson, Dansereau, & Rowan-Szal,

2001; Simpson, Joe, & Rowan-Szal, 1997) but the small number of studies in the

area is a major limitation, particularly given many of these studies are over ten years

old. A good therapeutic relationship may be especially important in improving

treatment retention rates for people with substance abuse problems and psychiatric

comorbidity, as strong associations between alliance and retention have been found

in these populations (Petry & Bickel, 1999). People with substance abuse and

comorbid mental health problems also tend to rate their relationships as worse than

substance abusing clients without such problems (Pray & Watson, 2008). Research

has gone so far as to compare the psychotherapeutic relationship to a strong

attachment based bond, particularly for those lacking such relationships

(Mallinckrodt, 2010). Despite the high prevalence of comorbid psychiatric illness

and substance abuse, (Franken & Henriks, 2001; Marsden, Gossop, Stewart, Rolfe,

& Farrell, 2000; Virgo, Bennett, Higgins, Bennett, & Thomas, 2001), research into

therapeutic alliance in this area is also scarce.

       The complexity of the transaction between client and therapist is an issue for

this area of research, given both bring their own characteristics, personality and

history together to form the therapeutic relationship. With increasing acceptance of the importance of the therapeutic relationship, it is suggested that greater clarity around the client and therapist contribution to this relationship and resulting outcome is needed (Norcross & Wampold, 2011). The impact of the client's pre-treatment characteristics, the therapist's behaviors and characteristics, and the possible interaction between client and therapist, are all sources of variability that need consideration (Baldwin, Wampold, & Imel, 2007; DeRubeis, Brotman, & Gibbons, 2005).

A number of early studies of alliance have found with some consistency that certain client characteristics predict alliance and related factors of engagement, retention, and outcome (DeRubeis, Brotman & Gibbons, 2005). However, a growing body of research has suggested that the role of these client characteristics, while relevant, has been exaggerated, and that the role of both therapist and client experiences within treatment are fundamental in examining alliance (Fiorentine, Nakashima, & Douglas Anglin, 1999; Klein, Schwartz, Santiago, Vivian, & Vocisano, 2003; Kothari, Hardy, & Rowse, 2010). It is likely that an interaction of factors, including the ways in which the therapist adapts therapy and the relationship to individual client needs, is most pertinent (Norcross & Lambert, 2011). Hence these studies share a recommendation that research into the mechanisms by which alliance predicts outcome should give greater consideration to the within therapy experience a client has, and the therapist-related factors that influence this experience. It is suggested that the perspective of the client may be of particular interest and clinical relevance in gaining an understanding of the aspects of treatment that they themselves have found to help or hinder the development of a positive

therapeutic alliance. Hence engaging clients in a discussion of the client-therapist interaction, as understood and experienced as a therapeutic encounter, is required (Ackerman & Hilsenroth, 2003; Bachelor, 1995; Meier, et al., 2005). However to date, such a research study has not occurred for either substance abuse populations or in the general psychotherapeutic literature.

Within substance abuse treatment in particular, the importance of client perspective has been recognized (Connors & Franklin, 2000). In order to encourage clients to reflect freely on the positive and negative aspects of their treatment experience, a qualitative methodology has been recommended in order to gain a deeper and potentially more accurate understanding of patients' attitudes, opinions and perceptions around their treatment (Nordfjaern, et al., 2010, Connors & Franklin, 2000). Gaining a client's perspective in this manner provides increased potential of revealing new and unpredicted insights. This was evident within Bachelor's (1995) study which concluded that theoretically-defined alliance variables, measured quantitatively, are not equally relevant for clients and that some crucial features of the perceived working relationship are not accounted for in current alliance theory.

The current study, utilizing a qualitative methodology, aims to explore the treatment experiences of participants with comorbid substance abuse and depressive disorders. Participants were part of an ongoing clinical research trial, which exposed them to an integrated individual treatment program utilizing cognitive behavior therapy and motivational interviewing to address their substance abuse and depression.

It is important to note from the outset, that the language used by clients to describe their therapeutic experience may differ significantly from that used by

clinicians and research academics. As such, it is not the language and phrases used that are of interest in the current study, but the meaning and essence of an experience as it is told by one, and interpreted by another. Interpretive Phenomenological Analysis (IPA) is best used to capture information in this way and is therefore the method of analysis chosen for the study. IPA aims to explore how participants make sense of their experiences, but also recognizes that the researchers own conceptions are required in order to make sense of the personal world being studied (Chapman & Smith, 2002; Larkin, Watts, & Clifton, 2006; Smith, Flowers, & Osborn, 1997; Smith & Osborn, 2003). Therefore IPA will be employed to encourage clients to reflect on aspects of the treatment process, the therapist and themselves that influenced the therapeutic alliance they experienced with the therapist, and the role of this alliance relationship in their treatment experience.

Method

Participants

Participants were selected from the DAISI (Depression, Alcohol Integrated and Single-focused Interventions) Project (Baker, et al., 2009), which recruited individuals from community settings who were experiencing current moderate depressive symptoms and were using alcohol at or above a hazardous threshold. A detailed description of the DAISI study methods has been reported previously, however, in brief, following a clinical assessment phase and one session of structured feedback, motivational interviewing (MI) and goal setting, participants were randomized to one of four treatment conditions; no further treatment, nine sessions of cognitive behavior therapy (CBT) and MI focusing on either depression alone or alcohol alone, or nine further sessions of integrated CBT/MI addressing both depression and alcohol use problems. Treatment was carried out by registered and clinical psychologists, each of whom received training in the integrated treatment program. It is relevant that all therapists were female and aged between 24 and 38 The study was conducted across several sites in two states (New South Wales and Queensland) of Australia.

The current study.

IPA typically advocates purposive sampling with an aim of examining a relatively small homogenous group in which common and differing experiences can be analyzed (Smith & Osborn, 2003). To minimize variability and assure a degree of homogeneity, the current study used only participants randomized to the integrated depression and alcohol abuse treatment who were recruited from the one study site (Newcastle, New South Wales). Thus the inclusion criteria for the current study, in

addition to that for the DAISI trial were: randomization to the integrated treatment CBT/MI treatment (N=75). Given we were asking participants to reflect on their treatment experience, a further criterion was that the participant had received a sufficient dose of treatment. This was set at five of the ten sessions of DAISI integrated treatment. While participants in the DAISI study may well have had past treatment attempts that are equally relevant to the sense they make of their experience, the use of this group within the DAISI Project ensures an initial level of homogeneity of diagnosis and treatment. Final participants included five males and three females aged between 32 and 68. Both males and females were included as it was not the intention of the study to examine one gender's experience over the other.

A semi-structured interview was utilized, with the broad aim of gaining deeper understanding of the participants' experiences of treatment, including their beliefs, attitudes and the sense they made of their experiences. A very brief schedule of questions was developed with prompts, used as required. This broad interviewing style allowed for flexibility and for topics to be raised by the participant rather than be directed by the researcher. Initial broad questions included:

(a) Can you tell me about your experience in the DAISI therapy?"; and

(b) "Can you tell me a bit about the relationship you had with the therapist you worked with?"

Questions were open-ended and neutral where possible, targeting the participant's experience of the relationship with their therapist and, more broadly, their experience of therapy in general and any other arising areas of conversation. Scheduled and unscheduled questions were worded with the assumption that certain terms would not necessarily be understood by clients as they are used clinically. The

term 'alliance' in particular was replaced with the phrases 'therapeutic relationship' or 'client-therapist relationship'. Towards the end of the interview, if deemed appropriate, a definition of 'therapeutic alliance' designed to be easily understood by the participant population, was read to participants and they were asked if this raised any further thoughts or ideas in relation to topics already discussed, or if there was anything new they wished to add.

Researcher Characteristics

The researcher who conducted the qualitative interviews (EK) has had several years of experience working in a community setting with clients experiencing substance use and mental health treatment, and two years' experience working with this population within a clinical research setting. The interviewer was not a clinician on the DAISI Project. The researcher was familiar with literature addressing therapeutic alliance within substance abuse and general psychotherapy treatment and associated theories. When conducting the study the researcher was a clinical psychologist in training.

Procedure

Potential participants were contacted via letter inviting them to participate in the current study. One week following its mailing, an initial phone call was made to further explain the project, and following this, participants were phoned at an arranged time to complete the interview. It was decided that if a participant declined to participate, or was uncontactable after three attempts on their provided phone number, a replacement participant would be chosen from the participant pool and contacted. Although none of those contacted declined to participate, five were uncontactable.

Verbal consent was gained initially and again at the beginning of the recording of the interview. Interviews took between 40 to 80 minutes, depending on the richness of information discussed, and interviews were generally concluded when it was apparent to the researcher that no new information was being raised. Interviews were not cut short when useful and relevant discussion was taking place.

Analysis

IPA was utilized as described by Smith & Osborn, (2003). Interviews and analysis were conducted until data saturation was reached. Data saturation is the point at which no new information or themes are observed in the data (Smith & Osborn, 2003). This occurs gradually in interviews as it becomes evident that nothing new is being added to what has already been collected. It is suggested that an optimal number at which this may occur when employing IPA would be approximately six-eight participants (Smith, 1995). Smith suggests that this allows researchers to best focus on the depth of a phenomenological experience. For the current study, it was determined that data saturation had been reached after the seventh interview.

Interviews (n=7) were audio recorded and transcribed verbatim and then systematically analyzed searching for the main themes raised by participants and connections between them. Analysis consisted of reading and rereading one transcript at a time. Comments and thoughts from each reading were recorded. Main themes of the transcript were then identified and labeled with key words, documented alongside the transcript ensuring that themes identified remained grounded in the data of the text. For each transcript, themes occurring chronologically were documented first and then re-examined. Possible clusters of

related themes and ideas were identified and brought together into small meaning units, and identifying phrases were given to these themes. At this point, broad or abstract concepts were checked against the transcript to ensure their grounding in meaning in the text.

The analyses of subsequent transcripts were influenced by the themes identified in previously analyzed interviews. After analysis of the fourth transcript, all previous transcripts were reanalyzed to identify any earlier references to newly identified themes. Themes common to all participants were identified. This process was repeated for the following four interviews and at the conclusion of subsequent analysis all seven transcripts were reanalyzed for identification of any themes revealed in subsequent transcripts. From this, final themes, identified by a range of participants, were revealed for all transcripts.

The analysis was audited at various stages. Following analysis of the first four transcripts by the researcher (EK) one transcript was independently analyzed by another independent researcher (LT) and both researchers discussed their interpretations. Where differences in interpretations occurred, conversation was held to establish whether this was a fundamental difference in themes or variation in terminology. No fundamental differences in interpretation of themes occurred. This process was carried out again following the final three interviews. This process was carried out again following the final three interviews. All seven analyzed transcripts were then examined by the independent researcher and the process by which themes were derived by each researcher was discussed. The inclusion of a second analyst enabled the researcher to confirm that the procedure being followed was reasoned and systematic (Smith, 2003)

Results

Overview

IPA of the discourses revealed four major themes. Each theme was related in some way to the participants' experience or interpretation of the therapeutic relationship. The first theme 'Nature of relationship' primarily describes what that relationship experience was like for participants, while the next two themes, 'Confidence in therapy' and 'Acknowledgment of experience' address components that assisted the positive alliance to develop. The fourth theme, 'Meeting unmet needs' illustrates why a positive therapeutic relationship is so important for participants.

Nature of Relationship

This theme addresses the nature of the deep relationship shared by client and therapist when the experience was positive. It encompasses the manner in which participants described and conceptualized the relationship that they shared with the therapist. The distinction between the therapeutic relationship and relationships in day-to-day life was commonly made as participants considered how the relationship formed and developed. There was a deep sense of bond and connection, as well as affection, for the therapist and a sense that the relationship was equal for both parties. For some participants, the bond and 'click' was instant, while for others it developed over a few sessions. For all however, it was an essential component in feeling comfortable to share deep emotions and experiences.

Participants described that it was necessary to be sure that the therapist was genuine, not only in their care for them as participants, but as individual people:

> She gives a little bit of herself, I suppose not enough to feel it's not a
> professional relationship, but enough to feel that she actually cares about me

> as an individual and not as another patient just walking through, that's the feeling that she gives me, that she genuinely cares... that may sound silly but yeah, it's that feeling that she cares, she cares that this happened to me, she cares that I felt this way. (Angela)

Angela describes this need to feel cared for on a personal level, for true interest in the individual, as opposed to just any client in the service. Her comment 'that may sound silly' suggests her awkwardness in feeling this need to be cared for, and her uncertainty of whether or not it is usual to feel this close relationship she describes with the therapist. However the professional nature of the relationship is contrasted to the personal level bond that she was able to experience, as she feels the therapist shared just the right amount of private detail, cleverly walking a fine line between a genuine, safe relationship and crossing a professional boundary.

Similar contrasts were made as participants contemplated the relationship with the therapist in comparison to relationships in day to day life. For some, there was a social nature to the relationship, with a bond developing much as a friendship develops, and sharing many similarities with friendships. For others, there was a clear distinction between therapy and life allowing detachment and anonymity, which provided space for deeper conversations:

> It is very like building up a friendship, well not a friendship, but a relationship over a period of time...Maybe it happens like a friendship but it's not really like that, you know, it's different to that... it was also detached from my normal life if you know what I mean. We were able to talk about things I wouldn't want to talk about in my normal life, you know, but it felt detached. (Phil)

For Phil the nature of the relationship is confusing, as he is conscious that the relationship is different in some way to life, but his experience of the relationship has

been as a 'friendship'. The detachment of this friendship from the rest of 'normal life' is perceived as a strength.

This different type of relationship allowed participants to confide in the therapist in a way that they would not do with someone else, and emphasized this sense of a deep, balanced 'friendship' of sorts.

> To me they're kinda like my confidante, and it feels very easy but that stuff wouldn't be easy with someone else... when I got there she was always looking forward to seeing me, I was looking forward to seeing her. (Kate)

A positive therapeutic relationship was described as equal and balanced, with the therapist and client on the same level. This involved participants feeling respected and treated as equals by the therapist, physically, verbally and emotionally:

> She looked me in the eye and was willing to listen and talk. It's quite hard to explain. I felt I could trust her unequivocally. (Jack)

The experience of being 'looked in the eye' was one of respect, which enabled a relationship of deep trust. The shared process of therapist and client talking and listening in turn was an important part of communicating the genuine equality of the relationship, with participants looking for a relationship in which they could count on constructive interaction from both sides. This and the provision of meaningful responses from the therapist encouraged participants to share more of themselves and increased their sense of the depth of the relationship.

The freedom to share more of oneself as a result of the deep relationship also meant that the interaction often had a large emotional impact on participants:

> In some cases it was very hard, I finished up going through half a box of tissues on a couple of occasions you know, yeah, there was some difficult chats. (Simon)

The hard work that was required to 'open up' is an example of the emotional depth that brought the client and therapist together in a shared, personal interaction.

Confidence in therapy

It was important that therapists were able to present their skills and knowledge in an impressive manner. Participants spoke of the necessary confidence, in both the process and the therapist as an individual that this presentation evoked in them. This 'impressiveness' raised the therapist to a very high position in the participants' estimation, with knowledge, intellect and professionalism increasing participants' willingness to engage and participate wholly in the therapeutic relationship. Confidence was also gained where therapists proved themselves skilled, with an ability to apply their knowledge and intellect flexibly rather than follow the 'textbook'.

Knowledge about problems with alcohol and depression was seen as particularly important; as participants were often surprised and impressed that their therapist understood this specific area of their life and was able to offer relevant and helpful advice relevant to both conditions:

> It was very calming, you could talk to her like she was someone who you know, knows what she's talking about, understands about depression and stuff, and alcoholism, she sorta knew her stuff, yeah... She was very calm, very calm, very genuine, and professional, very impressive, yeah...highly intelligent. (Jack)

The professionalism and intellect of the therapist had a large impact on Jack who was very comforted by the confidence he was able to place in his therapist. While the level of knowledge and impressiveness seemed to standout as an unexpected positive, special skills and abilities to build rapport and make participants feel comfortable were more of an expectation of a trained psychologist.

It did not come as a surprise to most participants that their therapists were able to quickly make them feel comfortable and encourage them to open up in a way that they would not usually. How these skills played out during a treatment session was a frequent topic of discussion, with participant's descriptions akin to a 'magical' quality that they attributed to the therapist's skills at rapport building. With this 'magical' quality, came an inherent sense of confidence:

> Ah I had confidence in her, I just felt as if I could talk to them, I don't really understand, I don't really know why but they gave me the confidence to be able to talk to them and tell them, you know, your deepest fears and all that stuff, you know, it felt easier, yeah... I think, I don't know, I don't know how they did it, um it's a mystery. I don't know. I think they were particularly clever. (Phil)

This sense of special 'mysterious' skills is described by Phil, who was surprised at how comfortable and able he was to open up. There is a sense that he was lost for words as he struggled to explain what it was about the therapist that gave him this unexpected confidence and comfort to expose deep aspects of himself.

Participants also needed confidence in the therapeutic content being offered to them. The impressive and professional nature of the DAISI service engendered trust in a similar way that the impressiveness of the therapist did. For some, this came from the professional presentation of the DAISI service and its structure, for others, confidence in the content stemmed from familiarity with the ideas being discussed, and others found confidence in the process through the therapist's presentation of it:

> It was instilling in me the confidence that what she was teaching me, or putting me through, was correct, it was right. She had confidence in herself and she had confidence in the program, she went through the sheets and she explained why they do it that way. (David)

Participants perceived the confidence of the therapist in themselves and the program as reassuring. The therapist's confident and clear presentation engendered trust in the program she was offering which enabled participants to feel confidence in themselves and the relevance of the program to them.

Participants felt respect for, and through that, had confidence in therapists who demonstrated their skill by being able to disregard the 'textbook' and instead adapt and change the theory to match their individual needs. This allowed an absolute experience of freedom:

> She took time and she let me look out the window, at a little church, and she let me think for a while, she didn't interrupt in those silences, she didn't even say, take as long as you want, she just sat there with me. There were a lot of silent moments, it gave me time to reflect on my situation, therapy, where I was. Yes it gave me time... she didn't put any pressure on me. She was lovely. (Jack)

In recognizing the stage of change that Jack was in, the therapist reduced the pressure on him to change at a certain speed or participate in a particular way. Conversely where therapists were unable to tailor their knowledge to individual needs, participants lacked confidence in them and questioned their validity as someone worthy of their trust and engagement. Participants expressed that the knowledge and skills of the therapist, no matter how impressive, are wasted if they are unable to stay on the same track as the client:

> It's important, if you are both going to reach the same goals, to reach the end game. If you're not in parallel with the other person, who's going straight down the track, right to the big box at the end with all the goodies, if the other person is 45 degrees off, they'll end up in the car park, they'll certainly have all the goodies but you know, you wanted to share them. (David)

The high level of skill required to carry out this interaction described by David, to match to their needs and pace, was recognized by all participants.

However, due to the high importance of this for them, they were unforgiving when it did not occur, and unwilling to place their trust in such therapists.

Acknowledgment of Experience

Participants all touched on the powerfulness of feeling that their experiences were acknowledged and understood by the therapist on a deep level. It was very important for them to feel that there was acknowledgment and recognition of who they were, and where they had come from; as well as acceptance without judgment. There was a sense from participants that therapists had an unusually deep understanding, or alternatively an ability to develop a deep understanding quickly of their story and situation. This understanding on the part of the therapist was a vital component of being able to provide accurate and appropriate recognition and acknowledgment of their experiences.

This acknowledgment and recognition of experience and background was necessary in order to move forward, within themselves, and within therapy as participants wanted reassurance that their experience was real and worthy of the emotions they were feeling. Normalizing was a necessary part of moving forward as participants looked for reassurance that their emotional response to their situation was not unreasonable or out of the ordinary.

Such acknowledgment of experience and validation of feelings gave participants permission to feel and express certain feelings without self-judgment:

> It's nice to feel that the other person is acknowledging the distress, or the sadness. Of what you've been through. To validate your feelings, that you're not being neurotic or there's getting the feeling that oh well, your emotion is of no consequence to them, so therefore maybe you shouldn't be feeling it. You have a, I suppose it's, yeah, giving you that feeling that what you're feeling is valid and that you're not abnormal, or you know, not being silly or whatever. (Angela)

By expressing '…you're not abnormal, or you know, not being silly or whatever' Angela addresses the comfort she gets from having her emotional response normalized, giving her reassurance and validation.

There was a sense that participants had come to expect a shocked or judgmental response to their stories, so that their ability to move forward or make changes had been hampered by downplaying their experiences to themselves and others. The acknowledgment and recognition from the therapist allowed participants to openly acknowledge things to themselves that they may have been avoiding thinking about and addressing:

> It was just like, I don't know, it didn't matter what, you couldn't shock her. It was just what was going on for you and that was OK. (Kate)

The non-judgmental recognition of experiences allowed Kate to be herself and feel comfortable that who she was and the story she had to tell would be accepted by the therapist. This recognition of experience brought relief for participants, that in the face of many challenges, where they were at that point in time was reasonable and worthy of respect, while moving towards change was possible:

> They can make you feel like you could change things but at the same time you're getting it right, or at least that what you're saying isn't crazy and they respect that (Simon).

Simon describes this feeling of encouragement to believe in one's own ability to change having received recognition that he was doing the best he could and that his struggles were genuine.

Often, the ability to acknowledge and accurately validate participants'

experiences seemed for participants, to come from the therapist's deep understanding

of them and their specific issues and stressors:

> It meant that somebody understood. She had a lot of knowledge and she
> went through the various stages of alcoholism. She told me that some people
> drank more than me, and that I wasn't the only one. (Jack)

Jack was grateful to have his experience normalized by someone who had

knowledge and understanding of his concerns.

In positive therapist-client relationships, participants felt that they were

deeply understood and that the therapist could relate fully to them. This

understanding enabled true recognition of experience and for Trevor it was helpful

that he could be sure that what he was saying was really making sense to the

therapist:

> Having someone recognizes what you're going through, and because they
> understand about the links between depression and alcohol, it felt pretty
> helpful. What I was telling her made sense to her and that was good.
> (Trevor)

For some, the recognition and understanding went even deeper, with the

therapist knowing the participant's mind very well:

> Probably being able to relate what I was saying, in some instances she would
> appraise a situation before I could, before I did, but with a same sort of
> appraisal, so in some ways she could understand what wavelength I was
> coming from if you know what I mean. I think there was understanding
> there, of what I was talking about. I think that's a help. (Phil)

Having a therapist who was capable of deep understanding and able to use

this to acknowledge and validate participants' experiences without judgment or

surprise, was an extremely positive experience. For participants, having experiences

understood and recognized seemed to underlie much of the positive change that took

place within therapy.

Meeting unmet needs

This theme encompassed stories and detail of past life experience and client

characteristics that influenced the positive outcome received from the therapeutic

relationship. Participants described life experiences, of social experiences,

relationship styles or interactions with others. In each case these life stories were

negative experiences, described in order to explain why therapy and the relationship

was particularly important for them. Similarly, positives within the relationship

were often a 'new experience' for the participant, contrasted with something lacking

in their own life, and hence meeting a need for the client that has previously gone

unmet.

In one detailed description, meeting the social need is implicit by the

socializing style and the difficulties that are described in social interactions of daily

life:

> Maybe I saw something of me in her... I don't ask questions you know, it's
> like talking, god only gives you so many words in your life and these people
> talk talk talk, they're going to die young... so I don't socialize you know, I
> can't find many people that have the intelligence capacity to talk with me on
> that and I just like to say things to them that just goes straight over their head
> and they don't know..I get a lot of satisfaction from that. (David)

Talking with someone who can communicate and socialize in a way that

David feels comfortable is a rare and pleasurable occurrence. His account tells of

the feeling of isolation in social functioning that was common to many participants

and is told to describe the positive interaction this created for him with his therapist

who met his social needs.

Other participants were explicit about the relationships that are missing in their life and the added importance of the therapeutic relationship for them as a result of their experiences. One account typifies this by clearly comparing his needs as distinct from others who may well already have such needs met in their day to day life:

> I'm not overly wrapped in love and attention, I think I appreciated the psychologist being able to sit and listen and just throw ideas across to each other, if you know what I mean. I appreciated that relationship, not being hostile. I appreciated that relationship probably more than someone that is surrounded by a loving family. (Trevor)

Another participant described how her early learnt experience of interpersonal relationships and sharing of emotions restricted her ability to talk about feelings and receive validation. Like other's her description provides a sense that in meeting this unmet need for her, the therapeutic relationship was of particular importance, while the experience of having this need met is one of relief and positivity.

> We were taught as a family not to show emotions so you're not sort of, you're feeling them, but you're not, you've got this underlying thing of I should be stronger, I shouldn't be like this... and my experience is that you can't talk about it with anyone else... I suppose I learnt fairly early on that people couldn't really handle when I talked about depression and my drinking and how I was feeling... particularly my family, so a therapist was a place I could go and actually talk about what I was really feeling, or what was, had happened that had caused me to feel. (Angela)

Various needs and life experiences were described, including permission to show feelings, affectionate caring relationships, enjoyable social interactions, and as Jack described, a sense of structure and purpose in life that was not familiar to him before therapy:

> She seemed to have a bit of a plan that she stuck too... I thought that was
> very helpful, very... probably because I had no structure in my personal
> affairs at all, I'm very glad I signed up for it really. (Jack)

As with all participants, this story of personal need is told in order to provide

a deeper explanation of the positive experience therapy provided in meeting and

overcoming these needs.

Discussion

The DAISI study is the first to compare the efficacy of integrated CBT/MI for depression and alcohol use problems to single-focused CBT/MI treatments and a brief (one-session) control treatment. Accordingly, the current study is the first to examine the participant's impressions of receiving an integrated CBT/MI treatment, and their perceptions of the therapeutic relationship in this context. Specifically, this study aimed to explore experiences of the therapeutic relationship of participants in an integrated treatment program for alcohol abuse and depression, and reveal information to increase our understanding of factors influencing the therapeutic alliance, and the role of this relationship in their treatment experience.

The four identified themes covered a range of aspects of the therapeutic alliance. The first addressed the Nature of the relationship, describing it as deep and equal when positive, and comparing and contrasting it to relationships outside of therapy. The second and third themes of Confidence in therapy and Acknowledgment of experience detail factors influencing the relationship, while the fourth theme, Meeting unmet needs explains the particular importance of the relationship.

These results provide insights into the factors that contribute to the alliance relationship within substance use treatment, and in particular, the impact of client or therapist/in-session factors on the development of a positive therapeutic relationship. Client-related factors such as sense of self, past life experiences, and the stage of life they were in when entering therapy, were related as part of participants' descriptions of their experience of the therapeutic alliance. Most commonly, these client characteristics were described by participants as examples of factors that had the

potential to make it difficult for them to develop an alliance with the therapist. Overwhelmingly, these client characteristics served not as long-term barriers to alliance, but as evidence that 'who they were' meant that a good relationship with the therapist was particularly important for them. Of significance is that people reporting current, active and hazardous alcohol use problems and current moderate depressive symptomatology at treatment entry will engage in a meaningful therapeutic encounter, forming a strong therapeutic alliance with their treating clinician. This is despite the well-documented challenges that working with a comorbid treatment group often presents (Kay-Lambkin, Baker, & Lewin, 2004).

As all participants were retained in at least five sessions of treatment and reported positive experiences of their relationship with the DAISI therapist (it is noted that some reflected on poor experiences of the therapeutic alliance within past counseling relationships), these client characteristics demonstrated the importance of the in-session therapist components which were necessary to overcome the relationship challenges that clients brought to therapy. Participants therefore saw the 'therapist factors' as invaluable to their ability to form a therapeutic relationship. The interaction between client and therapist characteristics was such that while participants entered therapy with characteristics that made a good alliance particularly important for them, it was the therapist related characteristics that ultimately determined the nature of the relationship, and the therapy experience the client had.

These findings go some way to explaining and understanding past research which has questioned the influence of client and therapist related characteristics on alliance. Prior research has demonstrated that some pre-treatment client

characteristics play a role in predicting the development of alliance (DeRubeis, Brotman & Gibbons, 2005). An emerging, but limited, body of research suggests that even in the presence of influential client characteristics, it is within-therapy considerations and the therapist-related factors that have the greatest impact on the development of the therapeutic alliance within treatment for depression (Klein, et al., 2003) and substance abuse (Crits-Christoph, et al., 2009; Fiorentine, et al., 1999). The current qualitative findings support this notion, and provide a potential explanation of the role of both client and therapist characteristics. Our findings suggest that certain client characteristics, such as poor interpersonal relationships and traumatic life experiences increase the importance of the therapeutic alliance and potentially hinder its development, but that therapist-related factors are essential in order to overcoming these barriers and facilitate this important component of therapy. On a broader scale, consideration of the mechanisms governing the therapeutic relationship and through this, outcome is in keeping with recent suggestion that a number of factors need to be considered together, and that the way these factors operate might be different for different disorders (Norcross & Lambert, 2011). While much prior research has focused on establishing one influencing factor over another, our findings support the American Psychological Association's definition of evidence-based practice in psychology as the integration of the best available research with clinical expertise, in the context of patient characteristics, culture and preferences (APA Taskforce on Evidence-based Practice, 2006). Furthermore, they support the enduring importance of the therapeutic alliance alongside client and therapist factors, within empirically supported treatments (Norcross & Lambert, 2011; Norcross & Wampold, 2011).

The importance of a good therapeutic alliance is evident in all themes. This interaction between the client factors that were brought to therapy and the in-session therapist factors can be best seen taking place within the themes Confidence in therapy, Acknowledgment of experience and Meeting unmet needs.

The theme 'Confidence in therapy' primarily relates to therapist characteristics; aspects of the therapist and the therapy process that enabled the client to feel confident enough to engage in therapy, build a relationship and make changes. Much research within substance abuse treatment and other areas of behavior change considers the role of the clients' confidence in themselves as pertinent to the ability to make positive changes (Miller, 1996). Motivational interviewing techniques often examine client confidence as a marker of stage of change which then guides treatment style (Rollnick, Heather, Gold, & Hall, 1992). There is a clear difference, however, between client confidence in self, and the Confidence in therapy within this study. Here, Confidence in therapy results from therapist impressiveness and professionalism, evidence of the therapist's belief in themselves and the treatment they are offering and the display of skills and competence at the high level expected from professional therapists. Rather than looking within themselves for belief in self, participants described the importance of the above factors, in being able to have confidence that the therapist and the therapy process was worth engaging with.

This conceptualization of Confidence in therapy within this study, is very similar to the concept of confident collaboration, which was revealed as a component of the alliance that has a robust relationship with improvement (Hatcher & Barends, 1996). Hatcher and Barends (1996) performed factor analysis to study aspects of the

therapeutic alliance that contribute most to improvement and change and defined the confident collaboration as the degree to which participants are confidently engaged in a process which they have faith in being helpful, valuable and relevant with a positive outcome to work towards together.

The identification of the confident collaboration as a strong component of alliance, is very interesting given its strong similarities with the Confidence in therapy theme indentified in the current study and its close association with client and therapist ratings of progress (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Hatcher, 1999; Hatcher & Barends, 1996). Clemence et al (2005) proposed that confident collaboration may be similar to concepts of 'patient involvement' or 'investment' which have been found in previous research to be significant components of alliance and positive therapy outcome (Saunders, 2000; Smith, 2003; Smith, Hilsenroth, Baity, & Knowles, 2003).

The interaction between client and therapist factors can be seen within the theme Acknowledgment of experience. It was evident that participants came to therapy with a history of past experiences which had brought them to the point of seeking help with alcohol use and depression. A background of physical or emotional abuse, damaging or dysfunctional relationships, and other traumatic experiences were common for all participants, which is in keeping with known statistics for substance abusers (Medrano, Zule, Hatch, & Desmond, 1999; Triffleman, Marmar, Delucchi, & Ronfeldt, 1995). A positive grounding for therapy and the therapeutic relationship was built when therapists acknowledged and recognized the presence and impact of these experiences. By providing this recognition and understanding of where a client had come from and who they were,

they created an open and non judgmental atmosphere of clients to feel comfortable to examine their own situation and move forward in treatment. Similarities between Acknowledgment of experience and general counseling principles of normalizing and validating experiences can be seen, and this finding seems to provide support for the use of motivational interviewing techniques (especially adopting a non-judgmental rather than confrontational stance) with people experiencing comorbid depression and alcohol use problems.

The role of the therapist in acknowledging a past experience has been well documented within models of care for sufferers of trauma and post traumatic stress disorder. The initial acknowledgment of the role of traumatic experiences is seen as an important component in the early stages of treatment and assists people to make sense of their current situation. In this context, to ignore such a past may inadvertently reinforce clients' beliefs of unexplainable personal inadequacies or failings (Chu, 1991). Such recognition may assist people to move past their ambivalence about the role their trauma and experiences has played in their lives, and into a readiness to address current presenting issues (Chu, 1991). Gunderson and Chu (1993) write of the role of acknowledgment of trauma in clients with personality disorders, in assisting clients to feel confident in expressing their feelings and emotions and lessening the burden of responsibility which otherwise can create a defensive barrier which limits movement within therapy (1993). Their description of the benefits of valuing clients' experiences and their perceptions of their experiences to build comfort and safety is very similar to participants in the present study's descriptions of acknowledgment building a comfortable relationship with the therapist. Within broader psychotherapy contexts there is acceptance that the way in

which people receive acknowledgment for experiences or life events can impact on their wellbeing, and the role of social acknowledgment (acknowledgment of experiences within social systems and relationships outside of therapy) has been found to be particularly important (Shay, 2002, Nietlisbach & Maercker, 2009, Mueller, J, Moergeli, J & Maercker, A, 2008).

The importance of the therapeutic alliance for participants receiving treatment for comorbid alcohol and depression can be seen in the interaction between client and therapist in the theme Meeting unmet needs. The relationship was particularly important for these participants as it provided many components which they felt were missing from their lives. While often this related to the social and interpersonal aspects of the relationship, other new experiences of respect, expressions of emotions, and helpful behavioral routines such as structure and consistency are some examples of areas that participants felt that they did not have in their own lives, but gained from the therapeutic relationship.

Interestingly, much literature addresses the concept of therapy meeting unmet needs, or matching therapy to client needs, however this has been in reference to structuring therapy or services around the hierarchy of practical needs that the client groups present with (Hser, Polinsky, Maglione, & Anglin, 1999b; McLellan & Alterman, 1991). Within substance abuse treatment, provision of services to meet practical needs has been examined however it has been found that successful resolution of such needs does not improve retention or outcome (Fiorentine, 1998) except when client preferences and opinions for specific treatment types or services was considered and successfully matched (Hser, et al., 1999b).

There is a clear difference, however, between service matching to meet practical needs, and the less structured meeting of social and emotional needs through the presence of a positive therapeutic relationship as described by participants within the current study. It is possible that the significance of interpersonal, social and emotional needs, common in those seeking treatment for substance use have been underestimated, as they are often overshadowed by the more practical needs also prevalent within this population. The theme Meeting unmet needs as described in this study suggests that the role the therapeutic alliance plays in meeting these needs increases the importance of this aspect of therapy for sufferers of substance abuse, and provides insight into why this alliance may be particularly important for this population.

Limitations and future research

All participants interviewed had completed a significant proportion of therapy and were available and contactable for follow up interview and so these participants as a group potentially all had a more positive experience of therapy. Availability for research follow-up provides an inevitable bias towards participants who are contactable and willing to participate often due to a desire to 'help' following a positive therapy/research experience. This did not however interfere with the aims of the IPA process, which was to gain a deep understanding of the experiences of a homogenous group. Within interviews, participants compared and contrasted positive and negative aspects of the therapeutic relationship within the DAISI project and in other past treatment experiences, of their own accord, as part of explanation of their story.

Conclusion

This was the first study to examine the client perspectives of an integrated psychological treatment for comorbid depression and alcohol use problems. Given the vast wealth of research detailing the difficulty engaging and retaining clients with dual diagnosis disorders in treatment, as well as the known positive association between longer retention and treatment outcome, any addition to our understanding of the role of therapeutic alliance and influences on this, should not be undervalued. The use of qualitative methodology was particularly useful for investigating therapeutic alliance, as previous quantitative research has inevitably left many questions unanswered. The relative novelty of research within this area, and the ultimate aim of gaining knowledge that has real clinical implications for the clients being studied, meant that the use of IPA was well suited to exploration of clients' experience and thoughts.

In treating people with comorbid depression and alcohol use problems, and potentially any group with a comorbid mental health and alcohol/other drug use issue, strong, meaningful therapeutic relationships are possible to develop, and tend to be characterized by the following therapist-related factors:

(a) Developing a relationship characterized by genuineness, demonstrated consideration of the client as an individual, appropriate therapist disclosure, and equal contribution and communication in the treatment session;

(b) Demonstrated confidence in therapy, including knowledge about both depression and alcohol use, calm manner, and demonstrated intelligence and professionalism. It was expected that therapists possessed the ability to

encourage rapport and comfort. Structure is important to provide in session, along with some flexibility in implementing evidence-based practice;

(c) Appropriate acknowledgement of experience, such as normalizing, validation of feelings, experiences and behaviors, and adoption of a calm/non-judgmental response to disclosure.

(d) Meeting unmet needs, not just for the content of treatment, but in developing a good relationship that is often lacking in life.

Future studies may consider the inclusion of techniques focused on the interpersonal and attachment-based needs, within standard treatment models for this complex population. Clinicians would benefit from a good understanding of the role the alliance relationship plays within treatment for people experiencing comorbid substance use and mental health concerns and the impact they can have on this relationship despite the seemingly difficult nature of this task.

Acknowledgments

Reference

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques postively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33. doi: 10.1016/S0272-7358(02)00146-0

APA Taskforce on Evidence-based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi: 10.1037/0003-066X.61.4.271

Bachelor, A. (1995). Clients Perception of the Therapeutic Alliance: A Qualitative analysis. *Journal of Counselling Psychology, 42*(3), 323-337. doi: 10.1037/0022-0167.42.3.323

Baker, A., Kavanagh, D., Kay-Lambkin, F. J., Hunt, S. A., Lewin, T. J., Carr, V. J., et al. (2009). Randomized controlled trial of cognitive behavioural therapy for coexisting depression and alcohol problems: short-term outcome. *Addiction, 105*, 87-99. doi: 10.1111/j.1360-0443.2009.02757.x

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the Alliance-Outcome Correlation: Exploring the Relative Importance of Therapist and Patient Variability in the Alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852. doi: 10.1037/0022-006X.75.6.842

Barber, J. P., Luborsky, L., Crits-Christoph, P., Thase, M. E., Weiss, R., Frank, A., et al. (1999). Therapeutic alliance as a predictor of outcome in treatment of cocaine dependence. *Psychotherapy Research, 9*, 54-73. doi: 10.1080/10503309912331332591

Bell, D. C., Atkinson, J. S., Williams, M. L., Nelson, R., & Spence, R. T. (1996). The trajectory of client progress. A Longitudinal pilot study. *Journal of Substance abuse Treatment, 13*(3), 211-218. doi: 10.1016/S0740-5472(96)00046-3

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, research, practice, training, 43*(3), 271-279. doi: 10.1037/0033-3204.43.3.271

Chapman, E., & Smith, J. (2002). Interpretative Phenomenological Analysis and the New Genetics *Journal of Health Psychology, 7*(2), 125-130. doi: 10.1177/1359105302007002397

Clemence, A., Hilsenroth, M. J., Ackerman, S. J., Strassle, C. G., & Handler, L. (2005). Facets of the therapeutic alliance and percieved progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology and Psychotherapy, 12*, 443-454. doi: 10.1002/cpp.467

Coleman, E. (1982). Family intimacy and chemical abuse: The connection. *Journal of Psychoactive Drugs, 14*, 153-158.

Connors, N., & Franklin, K. (2000). Using focus groups to evaluate client satisfaction in an alcohol and drug treatment program. *Journal of Substance abuse Treatment, 18*, 313-320. doi: 10.1016/S0740-5472(99)00083-5

Crits-Christoph, P., Gallop, R., Temes, C, M, Woody, G., Ball, S., A, Martino, S., et al. (2009). The Alliance in Motivational Enhancement Therapy and Counseling as Usual for Substance Use Problems. *Journal of Consulting and Clinical Psychology, 77*(6), 1125-1135. doi: 10.1037/a0017045

De Leon, G. (1991). Retention in drug free communities. In R. Pickens, G. Leukefeld & C. Schuster (Eds.), *NIDA Research Monograph* (Vol. 106, pp. 218-245). Rockville: U.S Department of Health and Human Services.

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodlogical analysis of the nonspecifics argument. . *Clinical Psychology: Science and Practice, 12*, 174-183. doi: 10.1093/clipsy.bpi022

Fiorentine, R. (1998). Effective drug treatment. Testing the distal needs hypothesis. *Journal of Substance abuse Treatment, 15*(4), 281-289. doi: 10.1016/S0740-5472(97)00194-3

Fiorentine, R., Nakashima, J., & Douglas Anglin, M. (1999). Client engagment in drug treatment. *Journal of Substance abuse Treatment, 17*(3), 199-206. doi: 10.1016/S0740-5472(98)00076-2

Franken, I. H., & Henriks, V. M. (2001). Screening and diagnosis of anxiety and mood disorders in substance abuse patients. . *The American Journal on Addictions, 10*, 30-39. doi: 10.1080/105504901750160448

Grant, B. F., Stinson, F. S., Dawson, D. A., S.P, C., Ruan, W. J., & Pickering, R. P. (2004). Co-Occurrence of 12-Month Alcohol and Drug Use Disorders and Personality Disorders in the United States: Results From the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General psychiatry, 61*(4), 361–368. doi: 10.1001/archpsyc.61.4.361

Hatcher, R. L. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychological Research 9*, 405-423.

Hatcher, R. L., & Barends, A. (1996). Patients view of the Alliance in Psychotherapy: Exploratory factor analysis of three alliance measures. . *Journal of Consulting and Clinical Psychology, 64*, 1326-1336. doi: 10.1037/0022-006X.64.6.1326

Horvath, A. O., Fluckiger, C., Del Re, A. C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. doi: 10.1037/a0022186

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counselling Psychology, 38*(2), 139-149. doi: 10.1037/0022-0167.38.2.139

Hser, Y., Grella, C. E., Hsieh, S., Anglin, M. D., & Brown, B. S. (1999a). Prior treatment experience related to process and outcomes in DATOS. *Drug and Alcohol Dependence, 57*(2), 137-150. doi: 10.1016/S0376-8716(99)00081-2

Hser, Y., Polinsky, M., Maglione, M., & Anglin, M. (1999b). Matching Clients' Needs With Drug Treatment Services. *Journal of substance abuse treatment 16*(4), 299-305. doi: 10.1016/S0740-5472(98)00037-3

Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93*(8), 1177-1190.

Joe, G. W., Simpson, D. D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatry Services, 52*(9), 1223-1229.

Kay-Lambkin, F. J., Baker, A., & Lewin, T. J. (2004). The 'comorbidity roundabout': A framework to guide assessment and intervention strategies and engineer change among people with comorbid problems. *Drug and Alcohol Review, 23*, 407-423. doi: 10.1080/09595230412331324536

Klein, D., Schwartz, J., Santiago, N., Vivian, D., & Vocisano, C. (2003). Therapeutic Alliance in Depression Treatment: Controlling for Prior Change and Patient Characteristics. *Journal of Consulting and Clinical Psychology, 71*(6), 997-1006. doi: 10.1037/0022-0006X.71.6.997

Kothari, G., Hardy, G. E., & Rowse, G. (2010). The therapeutic relationshiop between therapists and substance-using clients: A qualitative exploration. *Journal of Substance Use, 15*(4), 257-271. doi: 10.3109/14659890903040060

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in Interpretive Phenomenological Analysis. *Qualitative Research in Psychology, 3*(2), 102-120. doi: 10.1191/1478088706qp062oa

Mallinckrodt, B. (2010). The psychothearpy relationship as attachment: Evidence and Implications. *Journal of Social and Personal Relationships, 27, 262-270.* DOI: 10.1177/0265407509360905

Marsden, J., Gossop, M., Stewart, D., Rolfe, A., & Farrell, M. (2000). Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the National Treatment Outcome Research Study. *British Journal of Psychiatry, 176*, 285-289. doi: 10.1192/Bjp.176.3.285

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-440. doi: 10.1037//0022-006X.68.3.438

McLellan, A. T., & Alterman, A. (1991). Patient treatment matching: a conceptual and methodological review with suggestions for future research. In R. Pickens, G. Leukefeld & C. Schuster (Eds.), *Improving drug abuse treatment* (Vol. 106, pp. 114-135). Rockville: US Department of Health and Human Services.

Medrano, M. A., Zule, W. A., Hatch, J., & Desmond, D. P. (1999). Prevalence of Childhood Trauma in a Community Sample of Substance-Abusing Women. *The American Journal of Drug and Alcohol abuse, 25*(3), 449-462. doi: 10.1081/ADA-100101872

Meier, P., Barrowclough, C., & Donmall, M. (2005). The role of the therapeutic aliance in the treatment of substance misuse: a critical review of the literature. *Addiction, 100*(3), 304-316. doi: 10.1111/j.1360-0443.2004.00935.x

Miller, W. R. (1996). Motivational Interviewing: Research, practice and puzzles. *Addctive Behaviours, 21*(6), 835-842. doi: 10.1016/0306-4603(96)00044-5

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*(1), 4-8. doi: 10.1037/a0022180

Norcross, J. C., & Wampold, B. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. doi: 10.1037/a0022161

Onken, L., Blaine, J., & Boren, J. (1997). Treatment for drug addiction: It wont work if they dont recieve it. In L. Onken, J. Blaine & J. Boren (Eds.), *NIDA Research Monograph* (Vol. 137, pp. 1-4). Rockville: U.S Deptartment of Health and Human Services.

Petry, N. M., & Bickel, W. K. (1999). Therapeutic alliance and psychiatric severity as predictors of completion of treatment for opioid dependence *Psychiatric Services, 50*(2), 219-227.

Pray, M. E., & Watson, L. M. (2008). Effectiveness of day treatment for dual diagnosis patients with sever chronic mental illness. *Journal of Addictions Nursing, 19*(141-149). doi: 1080/10884600802306008

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short "Readiness to Change Questionnaire" for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction, 87*, 743-754. doi: 10.1111/j.1360-0443.1992.tb02720.x

Saunders, S. (2000). Examining the relationship between the therapeutic bond and the phases of treatment outcome. *Psychotherapy, 37*, 206-218. doi: 10.1037/h0087827

Simpson, D. D., Joe, G. W., & Rowan-Szal. (1997). Drug abuse treatment retention and process effects on follow up outcomes. *Drug and Alcohol Dependence 47*(3), 227-235. doi: 10.1016/S0376-8716(97)00099-9

Smith, J. (1995). Semi structured interviewing & qualitative analysis. In J. A. Smith, R. Harre & L. Van Langenhove (Eds.), *Rethinking Methods in Psychology*. London: Sage.

Smith, J. (2003). Validity and qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 232-235). London, UK: Sage.

Smith, J., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and health psychology. In L. Yardley (Ed.), *Material Discourses and Health* (pp. 68-91). London: Routledge.

Smith, J., & Osborn, M. (2003). Interpretive Phenomenological Analysis. In J. Smith (Ed.), *Qualitative Psychology: A Practial guide to methods*. London: Sage.

Smith, S., Hilsenroth, M. J., Baity, M., & Knowles, E. (2003). Assessment of patient and therapist perspectives on process: a revision of the Vanderbilt Psychotherapy Process Scale. . *American Journal of Psychotherapy, 57*(2), 195-205.

Sparr, L. F., Moffitt, M. C., & Ward, M. F. (1993). Missed psychiatric appointments: who returns and who stays away. *American Journal of Psychology, 150*(5), 801-805.

Triffleman, E. G., Marmar, C. R., Delucchi, K. L., & Ronfeldt, H. (1995). Childhood trauma and posttraumatic stress disorder in substance abuse inpatients. *Journal of Nervous and Mental Disease, 183*(3), 172-176. doi: 10.1097/00005053-199503000-00008

Verheul, R., Van den Brink, W., & Hartgers, C. (1995). Prevalence of personality disorders among alcoholics and drug addicts: an overview. *European Addiction Research, 1*, 166-177. doi: 10.1159/000259080

Virgo, N., Bennett, G., Higgins, D., Bennett, L., & Thomas, P. (2001). The prevalence and characteristics of co-occuring serious mental illness (SMI) and substance abuse or dependence in the patients of adult mental health and addictions services in Eastern Dorset. *Journal of Mental Health, 10*(2), 175-188. doi: 10.1080/09638230020023732

Discussion

Initial restating of hypothesis and findings

The present study sought to address three main research questions. Firstly, it was hypothesised that a number of pre-treatment client characteristics would be predictive of the development of early therapeutic alliance in a population reporting hazardous alcohol use and depression. This was supported, with our results indicating that therapist rated alliance was predicted by severity of alcohol use and depression at baseline, while cluster B personality disorder traits, and mother abuse, was predictive of client-rated alliance. Secondly it was hypothesised that therapeutic alliance would predict alcohol use and depression outcome, while controlling for a number of potentially influential client and therapy factors. This was supported in the case of alcohol use, with higher client rated confidence and higher therapist rated bond associated with lower alcohol use at 6 months, however depression at 6 months were predicted only by baseline depression scores. Lastly, the study aimed to explore the experiences of the therapeutic relationship for participants in an integrated treatment program for alcohol misuse. This final step aimed to increase our understanding of factors influencing the therapeutic alliance, and the role of this relationship in their treatment experience. Four major themes emerged including 'Nature of the relationship', 'Confidence in therapy', 'Acknowledgment of experience' and 'Meeting un met needs'. These results are discussed in detail below.

Quantitative question one: Do pre-treatment client characteristics predict the development of early alliance?

The first component of this study supported previous research in revealing that a number of client related pre-treatment characteristics were predictive of client and therapist rated alliance. However, some differences emerged in client versus therapist-rated alliance (Refer to Appendix B).

Client rating's of alliance.

Client rated therapeutic alliance was predicted by a number of factors related to interpersonal relationships, attachment and experiences of parenting. Client-rated bond was associated with Cluster B personality traits (antisocial, borderline, histrionic and narcissistic) with those with more cluster B traits reporting significantly lower bond with their therapist. Together Cluster B and Cluster A personality traits with (paranoid, schizoid, & schizotypal), explained 19% of the variance in client ratings of bond. The non significant addition of the therapist variables to the model explained 9% of the total variance.

Partnership was predicted by mother's parenting style, such that those participants, who rated their mothers higher on scales of abuse, over control and indifference, reported lower partnership with their therapist. Together in the model, mother's parenting style, social functioning and cluster A personality disorder explained 28% of the variance in client rated partnership. The non significant addition of the therapist variables to the model explained an additional 8% of the total variance.

When considering the variance explained in each model of client rated Bond and Partnership, it is noted that personality disorder traits commonly relate to

interpersonal styles, while the measure of parenting styles touches on childhood experience of parental attachment. It is interesting then that all client rated predictors of client-rated alliance sit within the domain of interpersonal/social functioning.

This prominent role of interpersonal/social functioning has been seen within previous research to varying degrees. Within the substance use literature, client rated therapeutic alliance has been found to be predicted by social support and socialization (Broome, Joe, & Simpson, 2001; Connors, et al., 2000; Garner, et al., 2008; Meier, et al., 2005b), a secure and avoidant attachment in the expected directions (Meier, et al., 2005b; Schiff & Levit, 2010), and the cautious personality index (measure of psychosocial functioning) (Garner, et al., 2008). Personality disorder and therapeutic alliance has not been examined within the substance abuse field, but within general psychotherapy, Cluster A personality traits have been shown to negatively predict client-rated alliance in terms of the working and commitment component of alliance, while Cluster B predicted therapist-rated alliance development (Lingiardi, et al., 2005). No research has previously examined these issues for comorbid substance use and mental health populations.

The association between the therapeutic alliance and variables relating to interpersonal and social functioning are in line with theoretical explanations of these domains. It follows that clients who have difficulty forming or maintaining social relationships in their day to day lives may struggle to do so in a therapy setting. Attachment and personality disorder styles are in part defined by severe deficits in interpersonal functioning, which have been shown to directly impact on aspects of relationships such as bonding and trust (Lingiardi et al. 2005). The traits associated

with the two personality disorder styles (i.e. Cluster A and Cluster B) are thought to be particularly damaging to relationship styles, perhaps more so than Cluster C (dependent, avoidant, obsessive compulsive). Cluster A traits relate to withdrawal, detachment, and a view of others as hostile and threatening leading to refusal of relationships, while Cluster B traits are particularly associated with trust and interpersonal relating (Lingiardi, et al., 2005).

Therapist rating's of alliance.

Therapist ratings of alliance on the subscales bond and partnership were predicted by baseline client variables. Baseline alcohol use severity was a significant predictor of both bond and partnership, explaining 14% of the variance of the former alongside baseline depression, and 19% alone, of the variance in the latter. The non significant addition of the 'therapist' variables to the model explained an additional 6% of variance for bond and 3% of the variance for partnership. Connors et al. (2000) found a similar impact of severity of alcohol use related variables on the therapist's rating of the alliance at the univariate level, but not at the multivariate level. A number of other studies have found such substance use variables to play a small role in the development of alliance (Barber, et al., 1999; Connors, et al., 2000; Meier, et al., 2005b). For example, more frequent pre-treatment heroin use was found to be associated with lower client-rated alliance, in a setting in which abstinence was encouraged (Schiff & Levit, 2010), and, in this context, the finding was possibly attributed to the resulting trust issues raised by this heavier drug use. It is of note that within the current study and Connors (2000), both of which took place in an outpatient setting, alcohol use has only been associated with therapist ratings of alliance, and not client ratings. It is possible that severity of

pre-treatment alcohol use becomes known by the therapist via information gathering

early on in therapy, and that this knowledge impacts on their own expectations of the

'difficulty' of the client, which in turn may impact on their view of the therapeutic

alliance.

The finding that pre-treatment severity of depression was slightly associated

with the therapist rated bond, supports a previous finding that both therapists and

clients provide lower alliance ratings for client-therapist relationships when the client

has psychological problems (Meier, et al., 2005b). However, this contrasts with

other outpatient studies in which no such association has been found for either client

or therapist ratings of alliance (Barber, et al., 1999; Luborsky, et al., 1996). It is

important, then, that participants in the current study all had comorbid alcohol use

and depression and that therapists had a greater awareness of this coexisting

condition, as well as training in how to specifically manage this comorbidity. It is

the rarity of dual diagnosis-trained therapists and treatment models, and the known

high prevalence of comorbid mental health concerns within substance users, that

makes this an important area of ongoing study, particularly if severity of such

symptoms is found to impact on the therapist forming a positive alliance with clients.

Of the five subcategories of the therapeutic alliance measure, Bond and

Partnership stood out as both client and therapist ratings of each were predicted by

client pre-treatment characteristics. Bond represents the friendliness, acceptance and

understanding felt by the client in the relationship, while Partnership refers to the

extent to which the client feels they are working jointly on the therapeutic tasks with

their therapist. The significance of these, as opposed to confidence, client initiative

and openness, is not known, however, it is possible that they are two components

most related to the original three elements described by Bordin (1979) of goals, task and bond.

Readiness to change.

The study included 'readiness to change' as a measure of motivation, based on the prior knowledge of the importance of this component within substance abuse treatment (Miller, 1996) and previous studies that have linked motivation and readiness to change/treatment readiness to alliance and retention (Connors, et al., 2000; Joe, et al., 1998; Meier, et al., 2005b). The current study did not find an association between readiness to change and alliance rated by either client or therapist. This conflict with prior research is somewhat unexpected but may be the result of the clinical research setting. While naturalistic substance abuse treatment settings would treat many clients who are low in motivation or are even mandated formally or informally to attend treatment, clients who present to treatment within a structured research setting may be more likely to have personal motivation for treatment. Such participants have had to respond personally to service advertisements, rather than being referred by others, therefore the interaction of motivation with alliance may be somewhat different. However, this result may be more a function of the debate that currently surrounds the issue of readiness to change and treatment engagement and outcome. Recent evidence suggests that movement towards the action stage of change is not necessarily associated with actual behaviour change, and that many other factors may be at play as well as a sense of readiness (West, 2005)

Quantitative question two: Does therapeutic alliance rated by client or therapist predict outcome (alcohol use or depression) when controlling for possible confounding variables within dual diagnosis population?

Results provided mixed support for the hypothesis that therapeutic alliance is predictive of outcome within comorbid alcohol and depression treatment, however, clear differences were found between its impact on alcohol use and severity of depression (refer to Appendix B).

Predictors of alcohol use (OTI)

Therapist-rated bond and confidence and client-rated confidence significantly predicted alcohol use at six month follow up, in that higher scores on each alliance subscale predicted lower follow up OTI scores, when other variables known to possibly influence this relationship were controlled for. Therapist-rated partnership also showed a trend towards significance. While these findings generally support a large body of evidence within broader psychotherapy research, and a developing body of evidence within substance abuse literature, the finding that therapist-rated alliance played a stronger role than alliance rated by the client in predicting outcome is interesting. In general psychotherapy research, there is strong evidence for the importance of the client's alliance rating in predicting outcome. In their meta analysis within general psychotherapy, Horvath & Symonds (1991) found client-rated alliance to be the strongest predictor of outcome, and this has been supported by a number of studies examining alliance and retention in substance abuse treatment (Barber, et al., 1999; Barber, et al., 2001; De weert-Van Oene, et al., 1999; De weert-Van Oene, et al., 2001).

The predictive validity of the therapist rating, however, is supported by Meier, et al. (2006) who found therapist-rated alliance predicted dropout in an inpatient substance use treatment setting, while client-rated alliance did not. The design of Meier et al (2006) was quite similar to the current study in its use of client variables as covariates of the alliance outcome relationship and the examination of both client and therapist ratings together.

Confusion around the role of different rater perspectives (client, therapist or observer) is one of the major factors making it difficult to draw conclusions within substance abuse research in this field, and as a result, studies which include more than one perspective in their design have the advantage of being able to make comparisons within the same data set. Using this design, Belding et al (1997) found that while both client and counsellor ratings of alliance in an opiate treatment program were related to four and six month drug use outcomes, counsellor ratings showed the strongest predictive validity. Similarly, Connors, et al. (1997) found both client, and therapist ratings to be predictive of outcome, however, the variance explained was slightly higher for therapist ratings. The similarities of Connors, et al.'s (1997) findings to the present study are encouraging, as both were conducted within a structured clinical trial of outpatient alcohol use treatment. However, Connors et al., did not include psychiatric comorbidity within their design; our study is the first to do so.

One study of outpatient opiate treatment that only examined the therapist rating of alliance provided further support for its importance. This study reported that counsellor-rated rapport was a strong predictor of outcome even while accounting for a number of possible confounders (Joe, et al., 2001). Petry & Bickel

(1999) examined only the therapist rating, and found it only predictive of opiate use outcome only where psychiatric comorbidity also existed. In their study, alliance was rated retrospectively by the therapist, rather than at certain points during treatment, meaning that differences between this and the above mentioned studies may stem from the measurement of alliance at different time points, as well as the possibility of retrospective ratings being influenced by known outcome.

Other studies within substance abuse treatment that have identified the role of client-rated alliance as an important predictor of outcome (Barber, et al., 2001; De weert-Van Oene, et al., 1999; Joe, et al., 1999), but have only assessed the client perspective within their study designs. It would seem then, that while client-rated alliance has been clearly found to be a stronger predictor of alliance than therapist or observer-rated alliance within general psychotherapy, within substance abuse treatment greater attention needs to be paid to the therapist rating as an equal or possibly stronger predictor of outcome. The reasons for this difference within the substance abuse field is unclear, however, it suggests that therapists within this area are particularly sensitive to the therapeutic alliance as its potential to affect clients' capacity to change. One possible explanation is that many clinicians working in substance abuse treatment, including the current study, are trained in motivational interviewing, which specifically asks therapists to be conscious of and recognise where clients are in relation to making change.

Association between alliance and outcome in the presence of covariates.

The validity of the association between alliance and outcome was strengthened by the finding in our study that these alliance variables continued to predict outcome even while controlling for a number of client-related covariates.

Client-rated confidence and therapist-rated bond and confidence continued to

demonstrate a significant relationship with alcohol use outcome while controlling for

client pre-treatment characteristics, baseline alcohol use, and different treating

therapists. Despite the difficulty in establishing causality, this finding is particularly

important in suggesting that the relationship between alliance and outcome is not

spurious. Cluster B personality disorder traits also predicted alcohol use outcome

which is in keeping with a number of studies that have found a similar relationship

for client characteristics related to interpersonal or social functioning or attachment

(Hardy, et al., 2001; Mallinckrodt, 2000; Muran, et al., 1994; Piper, et al., 1991).

The predictive role of pre-treatment alcohol use is particularly important as this

baseline score is often an indicator, to both client and therapist of how the client is

going and how much needs to change. As the variable most directly related to the

outcome score it is not surprising that it played a strong role in this and other studies

(Connors, et al., 2000; Joe, et al., 1999). What is important is that the alliance

remained a strong predictor of alcohol use outcome in the presence of baseline

alcohol use. This result adds significant weight to the importance of the impact of

therapeutic alliance on substance use outcome, suggesting that a positive therapeutic

alliance can contribute to change, irrespective of the severity of dependence or level

of 'difficulty' with which clients first present to therapy.

The inclusion of the variable 'therapist' as a covariate provided a method by

which to examine and then control for any influences on the alliance outcome that

were related to seeing a different therapist. The addition of these variables to the

model added only three percent to the variance explained by the model predicting

alcohol use outcome and four percent to the model predicting depression outcome.

This indicates that allocation to different therapists did not impact one's final outcome and that alliance continued to significantly predict outcome in the presence of any therapist differences. It was not possible, however, to study the differing impacts of therapist variability and client variability in alliance as some studies have done. Baldwin, et al. (2007) in general psychotherapy, and Crits-Christoph, et al. (2009) within substance use treatment, have both reported that therapist variability but not patient variability was associated with outcome. This is an important direction for future research to explore, particularly in the context of substance use and mental health comorbidity, where the therapist-ratings of alliance seem to be influential on outcome.

The particular relevance of the subscales of therapeutic alliance that were associated with outcome is not easily comparable to past literature as much research has used one total score combining a number of components of alliance. Client-rated Confidence, therapist-rated Bond, Confidence and Partnership predicted outcome in our study, while openness and client initiative were not associated. It is interesting that therapist rated Bond and Partnership stand out at this point of analysis, considering client rated bond and partnership emerged in the first research question, for their association with pre-treatment variables. Again it is relevant to consider these components in relation to the early conceptualisations of the factors contributing to therapeutic alliance (Bordin, 1979). While bond and partnership fit clearly within this, the concept of confidence in therapy, which was associated with outcome when rated by both client and therapist, is discussed less frequently. The importance of confidence in therapy is supported by Meier, et al. (2006) who, despite using a general score for measuring alliance, also examined confidence in therapy as

an independent client characteristic. They found client confidence in treatment to be

one of just a few client characteristics other than alliance to be associated with

treatment retention (Meier, et al., 2006). This provides support for findings in the

current study and suggests that the role of confidence in therapy should be

considered further when looking at the therapeutic alliance, despite it not always

being a distinct component making up total alliance scores.

Retention versus outcome.

It is important to note that a number of studies within substance use treatment

use retention, rather than a specific outcome, as their dependant variable. This has

most likely developed out of evidence that retention is associated with positive

outcome (Simpson, Joe, & Brown, 1997a; Simpson, et al., 1997b) and knowledge

that low retention rates are very common within drug and alcohol treatment (Onken,

et al., 1997) and comorbid populations. As a result, examination of the alliance-

outcome relationship tends to include alliance as it impacts on a number of markers

of retention, as well as a number of markers of drug use severity or outcome such as

self-report or urinalysis. It is possible that differences between these dependent

variables make it difficult or inappropriate to compare across results, particularly as

it is clear that there are correlations between these variables and others. It is these

relationships and correlations between variables that has led to their being seemingly

interchangeable. Differences between results across studies using different markers

of retention and outcome must be examined.

Predictors of severity of depression (BDI)

Findings regarding predictors of severity of depression as an outcome, were

markedly different from the predictors of alcohol use discussed above. Therapeutic

alliance was not associated with follow up BDI scores when rated by client or

therapist. Despite a number of client-related variables correlating with BDI at the

univariate level, only baseline BDI predicted six month BDI outcome. As with the

baseline OTI discussed above, it is not surprising that baseline BDI has a strong

predictive association with depressive outcome. It is surprising, however, that no

alliance variables were associated with depression outcome, as within general

psychotherapy research, much of which focuses on treatment of depression, alliance

has consistently been associated with psychiatric outcome (Horvath & Symonds,

1991; Martin, et al., 2000). While the focus of the current study has been substance

abuse treatment with comorbid depression, all participants experienced depression

on entry to the project and all received the same integrated treatment addressing

comorbidity. As such, so the lack of support for past research into the alliance-

outcome relationship is unexpected.

Of the few studies of alliance in substance abuse treatment that have also

included measures of comorbid psychiatric symptoms, results are no clearer. In

contrast to our findings, a study of alliance in counselling for cocaine addiction

found alliance did not predict change in cocaine use, but did significantly predict

change in BDI scores (Barber, et al., 1999). Belding et al (1997) also included a

measure of psychiatric symptomology to examine alongside drug use outcome in a

treatment targeting opiate use. Their results were similar to our findings, with

counsellor ratings of alliance showing a strong association with drug use outcomes,

but neither client nor counsellor ratings of alliance predicted psychological

symptoms and functioning. The authors reported that psychological symptoms were

included as an outcome variable based on prior research regarding the strong

association between these symptoms and alliance (Belding, et al., 1997), and so the reason for the lack of association is unclear.

One possible explanation within the current study, stems from knowledge of the DAISI project population and its features. In studies of the benefits of the integrated treatment of comorbid alcohol use and depression compared to single focused depression or alcohol treatment, researchers found a slight gender difference with males responding better to the alcohol focused treatment (Baker, et al., 2009). Fifty-eight percent of participants within the integrated treatment group used in this study were male and it is therefore possible that they had less interest or preference for the depression focused component of treatment and that this interacted in some way to produce depression outcomes unrelated to the therapeutic alliance process taking place as they addressed their alcohol use.

Qualitative results: What is the client experience of therapists, therapy interactions and procedures, and therapeutic alliance, within an integrated treatment program for clients experiencing alcohol use problems and depression?

IPA was chosen as the method to analyse qualitative data for the final aim of the study with the intention of revealing participant led rather than theory driven descriptions of the role of the therapeutic alliance relationship and factors contributing to its development. Much research inevitably stems from an initial researcher driven model against which further research is designed and tested and, as demonstrated by the above quantitative research, this often focuses on a limited number and type of variables. The final aim of this study was, however, to gain a deeper understanding of participant experience, un-influenced by external influences,

in an area in which the need for the client perspective has been recognised (Connors & Franklin, 2000; Nordfjaern, et al., 2010).

The semi structured interview and subsequent analysis therefore results in themes which do not necessarily match a preconceived design and the manner in which the identified themes addressed the research question reflected this intention. For example, where a theme could be interpreted to be related to common theoretical concepts within the topic area, such as the stages of change model, it is very relevant that no formal reference was made at any time by interviewer or participant to this concept. Alternatively, other themes (for example 'Acknowledgment of experience) seemed to relate to much broader psychotherapy treatment models of care, that would not have been considered or identified by the researcher as relevant to therapeutic alliance within substance use treatment prior to analysis of the data. The four identified themes covered a range of aspects of the therapeutic alliance. The first addressed the 'Nature of the relationship', describing it as deep and equal when positive, and comparing and contrasting it to relationships outside of therapy. The second and third themes of 'Confidence in therapy' and 'Acknowledgment of experience' detail factors influencing the relationship, while the fourth theme, 'Meeting unmet needs' explains the particular importance of the client-therapist relationship.

These results provided insights into the factors that contribute to the alliance relationship within substance use treatment and, in particular, the impact of client or therapist/in-session factors on the development of a positive relationship. Client related factors such as sense of self, past life experiences and the stage of life they were in when entering therapy were told as part of participant's stories of their

experience of the therapeutic alliance. Most commonly, these client characteristics were described by participants as examples of factors that had the potential to make it difficult for them to develop an alliance with the therapist. Overwhelmingly however, these client characteristics served not as long term barriers to alliance, but as evidence that who they were meant that a good relationship with the therapist was particularly important for them. Of significance is that people reporting current, active and hazardous alcohol use problems and current moderate depressive symptomology at treatment entry will engage in a meaningful therapeutic encounter, forming a strong and important therapeutic alliance with their treating clinician. This is despite the well-documented challenges that working with a comorbid treatment group often presents (Kay-Lambkin, Baker, & Lewin, 2004).

As all participants reported positive experiences of their relationship with the DAISI therapist (it is noted that some reflected on poor experiences of the therapeutic alliance within past counselling relationships), these client characteristics demonstrated the importance of the in-session therapist components which were necessary to overcome the relationship challenges that clients brought to therapy. Participants therefore saw the 'therapist factors' as invaluable to their ability to form a therapeutic relationship. The interaction between client and therapist characteristics was such that, while participants entered therapy with characteristics that made a good alliance particularly important for them, it was the therapist related characteristics that ultimately determined the nature of the relationship and the therapy experience the client had.

These findings go some way to explaining and understanding past research which has questioned the influence of client and therapist related characteristics on

alliance. Prior research discussed earlier and the quantitative component of this study have demonstrated that some pre-treatment client characteristics play a role in predicting the development of alliance. An emerging but limited body of research suggests that even in the presence of influential client characteristics, it is within therapy considerations and the therapist related factors that have the greatest impact on the development of the therapeutic alliance in treatment for depression (Klein, et al., 2003) and substance abuse (Crits-Christoph, et al., 2009; Fiorentine, et al., 1999). The current qualitative findings support this notion and provide a potential explanation of the role of both client and therapist characteristics. Our findings suggest that certain client characteristics, such as poor interpersonal relationships and traumatic life experiences increase the importance of the therapeutic alliance and potentially hinder its development, but that therapist-related factors are essential in order to overcome these barriers and facilitate this important component of therapy. On a broader scale, consideration of the mechanisms governing the therapeutic relationship and, through this, outcome, is in keeping with recent suggestion that a number of factors need to be considered together, and that the way these factors interact might be different for different disorders (Norcross & Lambert, 2011).

The importance of a good therapeutic alliance is evident in all themes. The interaction between the client factors that were brought to therapy, and the in session therapist factors can best be seen taking place in the themes 'Confidence in Therapy', 'Acknowledgment of experience' and 'Meeting unmet needs'.

The theme 'Confidence in therapy' primarily relates to therapist characteristics; aspects of the therapist and the therapy process that enabled the client to feel confident enough to engage in therapy, build a relationship and make

changes. Much research within substance abuse treatment and other areas of behaviour change considers the role of the client's confidence in themself as pertinent to the ability to make positive changes (Miller, 1996), and motivational interviewing techniques often identify client confidence as a marker of stage of change which then guides treatment style. There is a clear difference, however, between client confidence in self and the 'Confidence in therapy' within this study. Here confidence in therapy results from therapist impressiveness and professionalism, evidence of the therapists' belief in themselves and the treatment they are offering, and the display of skills and competence at the high level expected of professional therapists. Rather than looking within themselves for belief in self, participants described the importance of the above factors in being able to have confidence that the therapist and the therapy process was worth engaging with.

The conceptualisation of 'Confidence in therapy' within this study, is very similar to the concept of Confident collaboration which was revealed as a component of the alliance that has a robust relationship with improvement (Hatcher & Barends, 1996). Hatcher and Barends (1996) performed factor analysis to study aspects of the therapeutic alliance that contribute most to improvement and change, and defined the Confident Collaboration as the degree to which participants are confidently engaged in a process which they have faith in being helpful, valuable and relevant, with a positive outcome to work towards together. The identification of the confident collaboration as a strong component of alliance, is very interesting given its strong similarities with the 'Confidence in therapy' theme identified in the current study and its close association with client and therapist ratings of progress (Clemence, Hilsenroth, Ackerman, Strassle, & Handler, 2005; Hatcher, 1999; Hatcher &

Barends, 1996). This is in keeping with our concept of the theme "Confidence in therapy" as where such confidence was possible, participants were able to allow themselves to develop a close, flexible and productive relationship with a very positive impact on their therapy experience.

Clemence, et al. (2005) proposed that Confident Collaboration may be similar to concepts of 'patient involvement' or 'investment' which have been found in previous research to be significant components of alliance and positive therapy outcome (Saunders, 2000; Smith, Hilsenroth, Baity, & Knowles, 2003). Another study within general psychotherapy considered confidence in a similar manner, examining client's perceptions of therapists and the therapist's and the client's belief in the efficacy of their therapy. Such confidence was found to have a positive relationship with treatment retention (McGuff, Gitlin, & Enderlin, 1996).

The interaction between client and therapist factors can be seen within the theme 'Acknowledgment of experience'. It was evident that participants came to therapy with a history of past experiences that brought them to the point of seeking help with alcohol use and depression. A background of physical or emotional abuse, damaging or dysfunctional relationships and other traumatic experiences were common for all participants, which is in keeping with known statistics for sufferers of substance abuse (Medrano, Zule, Hatch, & Desmond, 1999; Triffleman, Marmar, Delucchi, & Ronfeldt, 1995). A positive grounding for therapy and the therapeutic relationship was built when therapists recognised and acknowledged the presence and impact of these experiences. By providing this recognition and understanding of where a client had come from and who they were, they created an open and non judgemental atmosphere for clients to feel comfortable to examine their own

situation and move forward in treatment. Similarities between 'Acknowledgment of experience' and general counselling principles of normalising and validating experiences can be seen.

The role of the therapist in acknowledging past experiences has been well documented within models of care for sufferers of trauma and post traumatic stress disorder. The initial acknowledgment of the role of traumatic experiences is seen as an important component in the early stages of treatment and assists sufferers to make sense of their current situation. In this context, to ignore such a past may inadvertently reinforce client's beliefs of unexplainable personal inadequacies or failings (Chu, 1992). Such recognition may assist sufferers to move past their ambivalence about the role their experience and trauma has played in their lives, and into a readiness to address current presenting issues (Chu, 1992). Gunderson and Chu (1993) write of the role of acknowledgment of trauma in clients with personality disorders in assisting clients to feel confident in expressing their feelings and emotions and lessening the burden of responsibility which otherwise can create a defensive barrier that limits movement within therapy (Gunderson & Chu, 1993). Their description of the benefits of valuing the clients' experiences and their perceptions of their experiences to build comfort and safety is very similar to participants in the present study's descriptions of acknowledgment building a comfortable relationship with the therapist. Within broader psychotherapy contexts, there is acceptance that the way in which people receive acknowledgment for experiences or life events can impact on their wellbeing, and the role of social acknowledgment (acknowledgment of experiences within social systems and

relationships outside of therapy) has been found to be particularly important

(Mueller, Moergeli, & Maercker, 2008; Nietlisbach & Maercker, 2011; Shay, 2002).

The importance of the therapeutic alliance for participants receiving

treatment for comorbid alcohol use and depression can be seen in the interaction

between client and therapist in the theme 'Meeting unmet needs'. The therapy

relationship was particularly important for these participants as it provided many

components which they felt were missing from their lives. While often this related

to the social and interpersonal aspects of the relationship, other new experiences of

respect, expressions of emotions, and helpful behavioural routines such as structure

and consistency are some examples of areas that participants felt they did not have in

their own lives, but gained from the therapeutic relationship.

Interestingly, much literature addresses the concept of therapy meeting unmet

needs, or matching therapy to client needs, however, this has been in reference to

structuring therapy or services around the hierarchy of practical needs that the client

groups present with. Within substance abuse treatment, provision of services to meet

practical needs has been examined however it has been found that successful

resolution of such needs does not improve retention or outcome (Fiorentine, 1998).

Hser, et al. (1999) found that when clients' preferences for and opinions of specific

treatment types addressing vocational training, child care, transportation and housing

were considered and successfully matched within treatment, retention and outcome

were significantly improved. There is a clear difference however between service

matching to meet practical needs and the less structured meeting of social and

emotional needs through the presence of a positive therapeutic relationship as

described by participants within the current study. It is possible that the significance

of interpersonal, social and emotional needs, common in those seeking treatment for substance use, has been underestimated, as these needs are often overshadowed by the more practical needs also prevalent within this population. The theme 'Meeting unmet needs' as described in this study suggests that the role the therapeutic alliance plays in meeting these needs increases the importance of this aspect of therapy for sufferers of substance abuse and provides insight into why this alliance may be particularly important for this population.

Broad implications, limitations and future directions

Taken together, quantitative and qualitative components of this study demonstrate the importance of therapeutic alliance within psychological treatment for comorbid alcohol use and depression. Findings suggest that therapeutic alliance is an important part of treatment for clients experiencing dual diagnosis concerns and that this relationship can be quantified through evidence of the role of alliance on substance use outcome. The suggestion arises that therapeutic alliance is perhaps particularly important for this population, stemming in part from pre-treatment characteristics of the client that make it not only harder to develop an alliance, but also add to the value and significance of the alliance for these clients. This was supported both quantitatively and qualitatively, and such characteristics were frequently related to interpersonal and social relationship experiences and styles. This study also demonstrated the role of the therapeutic relationship in meeting unmet needs in the client's life, and that meeting this need was identified as a particularly important role of alliance. For participants who remained engaged in therapy at least, the presence of pre-treatment characteristics, while impacting on the alliance, were not enough to damage the relationship altogether, and a good therapist

was able to overcome any such difficulties and create a positive alliance. Similarly, quantitative findings revealed that when these influential pre-treatment client characteristics were controlled for, alliance still remained a predictor of outcome. The qualitative component was able to identify two themes in particular, 'confidence in therapy' and 'acknowledgment of experience' as in-therapy contributors to this necessary positive alliance and outcome.

Together, all three components of this study indicate that both client and therapist factors are relevant to the development of alliance, and all three of these components influence the resulting outcome, at least for alcohol use. While much prior research has focused on establishing one influencing factor over another, these integrated findings support the American Psychological Association's definition of evidence based practice in psychology as "the integration of the best available research with clinical expertise, in the context of patient characteristics, culture and preferences" (APA Taskforce on Evidence-based Practice, 2006). Furthermore the integrated findings support the enduring importance of the therapeutic alliance alongside client and therapist factors within empirically supported treatments (Norcross & Lambert, 2011; Norcross & Wampold, 2011), and it seems that to ignore any one of these components within dual diagnosis treatment would be a mistake.

With considering behaviour change that is dependent on so many factors, it is to be expected that it will often only be possible to explain a relatively small amounts of variance in key targets for change such as alcohol use and depression. Despite this, research in this field has often attempted to identify either client or therapist as having the greatest influence on the alliance-outcome relationship, or to

quantify the exact influence of each. The results of this study are useful then as an integration of both quantitative and qualitative approaches to this problem. While quantitative research gets closer to a statistical understanding of the relationship between variables, often when so many influences and interactions exist, qualitative research is needed to develop deeper understanding of the way in which these interactions work. The use of a controlled clinical research setting for this study is also advantageous as it allows for a number of factors possibly contributing to unexplained variance to be controlled for in a way that is not possible in a naturalistic setting.

The current study has a number of strengths adding to the utility of its findings. Firstly, it provides an opportunity for replication and further study of the therapeutic alliance in the little studied area of substance abuse with comorbid depression. While the importance of alliance for this population was confirmed, the impact of alliance on depression outcomes where substance use was also being targeted was unclear. While this relationship remains unclear across the few studies of substance use treatment that include depression as an outcome measure, prior research has found that comorbid psychiatric symptoms increase the relevance of alliance to this population (Petry & Bickel, 1999). As past research of depression treatment alone has found strong associations between alliance and outcome, the current findings suggest that perhaps some kind of interaction takes place in which the presence of a substance use issue or preference for treatment focus interacts with the alliance and outcome process. Therefore further research of the interactions within comorbid substance use and depression treatment is needed.

The use of outcome (both severity of alcohol use and depression) as the dependent variable of interest, rather than time in treatment or retention, is a strength of the current design, as it allows this data to be more comparable with research in the broader psychotherapy arena. As retention and follow up is notoriously difficult with substance users, it is not surprising that this has been the focus, however, uncontrollable differences exist between retention and outcome and so further research within the substance use field examining symptom outcome is needed. By examining both client and therapist views of the alliance, the study adds significantly to clarifying which rater perspective is most predictive of outcome in this field. This is a strength, as while the importance of the client perspective has been supported in broader psychotherapy (Horvath & Symonds, 1991), no such determinations have been possible so far within substance abuse treatment. The present study begins to add weight to the role of the therapist perspective and further research should therefore continue to examine both view points for comparison.

A major strength of the study was the inclusion of qualitative methods in an area where many factors provide variability and quantitative research inevitably leaves many questions unanswered. The relative newness of research within this area, and the ultimate aim of gaining knowledge that has real clinical implications for the clients being studied, meant that the use of IPA was very appropriate for exploration of clients' experiences and thoughts. The addition of qualitative methods provided an opportunity to better understand and hypothesise about processes and real world implications behind the variables being examined quantitatively.

The quantitative components of the study are limited by a small sample size, which impacts on the stability of multivariate analysis used. While the use of follow up symptom outcome, rather than retention in the study as a dependent variable, is a strength, it has the effect of limiting final follow up numbers. It was decided to limit analysis to one controlled treatment group receiving the same treatment method and process in order to limit uncontrollable variance. However this also limits study numbers and for this reason many controlled and real world experimental designs combine different treatment types, in an effort to increase participant numbers. It is suggested that further study is required with larger sample sizes in settings in which as many variables as possible can be controlled.

It is quite difficult in studies such as this to account for clients who left treatment prior to in-session alliance being measured, yet, when one is considering concepts such as retention and alliance, these early leavers are potentially very relevant. This study is therefore limited, as many are, by only examining and hence only able to generalise, to clients who completed at least session five of treatment. We are therefore unable to draw conclusions as to the influences on the very early therapeutic processes. This was particularly relevant for the qualitative component of the study, as inevitably all participants interviewed had completed a significant proportion of therapy, and were available and contactable for follow up interview, so these participants as a group potentially had a more positive experience of therapy. Availability for research follow up provides an inevitable bias towards participants who are contactable and willing to participate often due to a desire to 'help' following a positive therapy/research experience. This did not, however, interfere with the aims of the IPA process, which was to gain a deep understanding of the

experiences of a homogenous group. Within interviews, participants compared and contrasted positive and negative aspects of the therapeutic relationship within the DAISI project and in other past treatment experiences, of their own accord, as part of explaining their story.

Lastly, the study limited possible variables for quantitative examination as predictors of alliance to client-related characteristics and did not consider pre-treatment therapist characteristics such as level of experience, past user status and gender as other prior studies have (Meier, et al., 2005b). This may be something of a limitation as such variables may play an important role and are worthy of future study, however within this mixed method design, the role of therapist related factors, both pre-existing and in-therapy, were considered in detail in the qualitative interviews with clients.

Conclusions

These findings replicate and expand on past studies of the role of therapeutic alliance in therapy and extend this body of research into the challenging field of comorbid substance use and mental health. Together, these findings have a number of clinical implications. Firstly, it is necessary that clinicians working within substance use treatment are aware of the importance of the therapeutic relationship for these clients and their treatment outcome. It is particularly important for this population that clinicians feel confident and empowered to work at building the therapeutic alliance despite the complexity of dual diagnosis presentations. While the specific impact of each variable is not known, it is clear that, while such complex clients may present challenges to the development of alliance, it is both client and therapist factors that determine its development. The importance of the therapist's

judgement of the alliance throughout therapy has been discussed and this suggests the value of therapists within this field considering the alliance in a formal or informal manner at points throughout treatment.

Both quantitative and qualitative components of the study raised awareness of the large number of complex comorbidities that clients attending substance abuse treatment services may present with. As well as mental health concerns such as depression, difficulties with social and interpersonal functioning, attachment difficulties and histories of traumatic experiences are particularly relevant to the therapeutic alliance and treatment experience. Qualitative results suggest that where treatment recognises, and to some degree, addresses these life experiences, the therapeutic alliance and outcome is enhanced. Specifically, results suggested the inclusion of acknowledgment of experience, a common component of trauma treatment, in substance abuse treatment, however, it could be useful to consider the inclusion of other techniques focused on the interpersonal and attachment needs of this complex population.

Reference

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques postively impacting the therapeutic alliance. *Clinical Psychology Review, 23*, 1-33. doi: 10.1016/S0272-7358(02)00146-0

APA. (2000). Practice guidlines for the treatment of patients with major depressive disorder. *American Journal of Psychiatry, 157*(4 suppl), 1-45.

APA Taskforce on Evidence-based Practice. (2006). Evidence-based practice in psychology. *American Psychologist, 61*(4), 271-285. doi: 10.1037/0003-066X.61.4.271

Bachelor, A. (1995). Clients Perception of the Therapeutic Alliance: A Qualitative analysis. *Journal of Counselling Psychology, 42*(3), 323-337. doi: 10.1037/0022-0167.42.3.323

Baker, A., Kavanagh, D., Kay-Lambkin, F. J., Hunt, S. A., Lewin, T. J., Carr, V. J., et al. (2009). Randomized controlled trial of cognitive behavioural therapy for coexisting depression and alcohol problems: short-term outcome. *Addiction, 105*, 87-99. doi: 10.1111/j.1360-0443.2009.02757.x

Baldwin, S., Wampold, B., & Imel, Z. (2007). Untangling the Alliance-Outcome Correlation: Exploring the Relative Importance of Therapist and Patient Variability in the Alliance. *Journal of Consulting and Clinical Psychology, 75*(6), 842-852. doi: 10.1037/0022-006X.75.6.842

Barber, J. P., Luborsky, L., Crits-Christoph, P., Thase, M. E., Weiss, R., Frank, A., et al. (1999). Therapeutic alliance as a predictor of outcome in treatment of cocaine dependence. *Psychotherapy Research, 9*, 54-73. doi: 10.1080/10503309912331332591

Barber, J. P., Luborsky, L., Gallop, R., Crits-Christoph, P., Frank, A., Weiss, R., et al. (2001). Therapeutic alliance as a predictor of outcome and retention in the National Institute on Drug Abuse Collaborative Cocaine Treatment Study. *Journal of Consulting and Clinical Psychology, 69*(1), 119-124. doi: 10.1037//0022-006X.69.1.119

Barrowclough, C., Meier, P., Beardmore, R. & Emsley, R. (2010). Predicting therapeutic alliance in clients with psychosis and substance misuse. *Journal of Nervous and Mental Disease, 198, 373-377.*

Belding, M. A., Iguchi, M. Y., Morral, A. R., & McLellan, A. T. (1997). Assessing the helping alliance and its impact in the treatment of opiate dependence. *Drug Alcohol Dependence, 48*, 51-59. doi: 10.1016/S0376-8716(97)00103-8

Bell, D. C., Atkinson, J. S., Williams, M. L., Nelson, R., & Spence, R. T. (1996). The trajectory of client progress. A Longitudinal pilot study. *Journal of Substance abuse Treatment, 13*(3), 211-218. doi: 10.1016/S0740-5472(96)00046-3

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252-260. doi: 10.1037/h0085885

Broome, K. M., Joe, G. W., & Simpson, D. D. (2001). Engagement models for adolescents in DATOS-A. *Journal of Adolescent Research 16*, 608-623. doi: 10.1177/0743558401166005

Broome, K. M., Simpson, D. D., & Joe, G. W. (2002). The role of social support following short-term inpatient treatment. *American Journal of Addiction, 11*(1), 57-65. doi: 10.1080/10550490252801648

Brown, R. A., Inaba, R. K., Christian, G. J., Schuckit, M. A., Stewart, M. A., & Irwin, M. R. (1995). Alcoholism and affective disorder: Clinical course of depressive symptoms. *American Journal of Psychiatry, 152*(1), 45-52.

Carroll, K. (2005). Only connect? *Addiction, 100*, 267-268. doi: 10.1111/j.1360-0443.2005.01005.x

Carroll, K., Nich, C., & Rounsaville, B. J. (1997). Contribution of the therapeutic alliance to outcome in active versus control psychoherapies. *Journal of Consulting and Clinical Psychology, 65*(3), 510-504. doi: 10.1037/0022-006X.65.3.510

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy: Theory, research, practice, training, 43*(3), 271-279. doi: 10.1037/0033-3204.43.3.271

Chapman, E., & Smith, J. (2002). Interpretative Phenomenological Analysis and the New Genetics *Journal of Health Psychology, 7*(2), 125-130. doi: 10.1177/1359105302007002397

Chu, J. A. (1992). The therapeutic roller coaster: Dilemmas in the treatment of childhood abuse survivors. *Journal of Psychotherapy Practice and Research*, 351-370.

Clarkin, J., Hurt, S. W., & Crilly, J. L. (1987). Therapeutic alliance and hospital treatment outcome. *Hospital and community Psychiatry, 38*(8), 871-875.

Clarkin, J., & Kendall, P. (1992). Comorbidity and treatment planning: Summary and future directions. *Journal of Consulting and Clinical Psychology, 60*(6), 904-908. doi: 10.1037/0022-006X.60.6.904

Clarkin, J., & Levy, K. (2004). The influence of client variables on psychotherapy In M. J. Lambert (Ed.), *Bergin and Garfield's Handbook of psychotherapy and behaviour change* (5th ed., pp. 194-226). New York: Wiley.

Clemence, A., Hilsenroth, M. J., Ackerman, S. J., Strassle, C. G., & Handler, L. (2005). Facets of the therapeutic alliance and percieved progress in psychotherapy: Relationship between patient and therapist perspectives. *Clinical Psychology and Psychotherapy, 12*, 443-454. doi: 10.1002/cpp.467

Coleman, E. (1982). Family intimacy and chemical abuse: The connection. *Journal of Psychoactive Drugs, 14*, 153-158.

Connors, G., Carroll, K. M., DiClemente, C. C., Longabaugh, R., & Donovan, D. (1997). The therapeutic alliance and its relationship to alcoholism treatment participation and outcome. *Journal of Consulting and Clinical Psychology, 65*(4), 588-598. doi: 10.1037/0022-006X.65.4.588

Connors, G., DiClemente, C., Dermen, K., Kadden, R., Carroll, K., & Frone, M. (2000). Predicting the therapeutic alliance in alcoholism treatment *Journal of studies on Alcohol and Drugs, 61*(1), 139-149.

Connors, N., & Franklin, K. (2000). Using focus groups to evaluate client satisfaction in an alcohol and drug treatment program. *Journal of Substance abuse Treatment, 18*, 313-320. doi: 10.1016/S0740-5472(99)00083-5

Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002). The Working alliance: A flagship for the "scientist-practitioner" model in psychotherapy. In G.

Tyron (Ed.), *Counselling based on process research* (pp. 81-131). New York: Allyn & Bacon.

Cooper-Patrick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E. (2002). Identification of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine, 12*, 431-438. doi: 10.1046/j.1525-1497.1997.00075.x

Crits-Christoph, P., & Connolly, M. (1999). Alliance and technique in short-term dynamic therapy. *Clinical Psychology Review, 19*(6), 687-704. doi: 10.1016/S0272-7358(98)00079-8

Crits-Christoph, P., Gallop, R., Temes, C, M, Woody, G., Ball, S, A, Martino, S., et al. (2009). The Alliance in Motivational Enhancement Therapy and Counseling as Usual for Substance Use Problems. *Journal of Consulting and Clinical Psychology, 77*(6), 1125-1135. doi: 10.1037/a0017045

De Leon, G. (1991). Retention in drug free communities. In R. Pickens, G. Leukefeld & C. Schuster (Eds.), *NIDA Research Monograph* (Vol. 106, pp. 218-245). Rockville: U.S Department of Health and Human Services.

De weert-Van Oene, G. H., De Jong, C. A., Jorg, F., & Schrijvers, G. J. (1999). The Helping Alliance Questionnaire: Psychometric properties in patients with substance dependence. *Substance Use and Misuse, 34*(11), 1549-1569.

De weert-Van Oene, G. H., Schippers, G. M., De Jong, C. A., & Schrijvers, G. J. (2001). Retention in substance dependence treatment: the relevance of in-treatment factors. *Journal of Substance Abuse Treatment 20*(4), 253-261. doi: 10.1016/S0740-5472(01)00160-X

DeRubeis, R. J., Brotman, M. A., & Gibbons, C. J. (2005). A conceptual and methodlogical analysis of the nonspecifics argument *Clinical Psychology: Science and Practice, 12*, 174-183. doi: 10.1093/clipsy.bpi022

Diener, M. J., & Monroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy, 48*(3), 237-248.

Fenton, L. R., Cecero, J. J., Nich, C., Frankforta, T. L., & Carroll, K. M. (2001). Perspective is everything: the predictive validity of six working alliance instruments. *Journal of Psychotherapy Practice and Research, 10*(4), 262-268.

Fiorentine, R. (1998). Effective drug treatment. Testing the distal needs hypothesis. *Journal of Substance abuse Treatment, 15*(4), 281-289. doi: 10.1016/S0740-5472(97)00194-3

Fiorentine, R., Nakashima, J., & Douglas Anglin, M. (1999). Client engagment in drug treatment. *Journal of Substance abuse Treatment, 17*(3), 199-206. doi: 10.1016/S0740-5472(98)00076-2

Frank, A., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia. *Archives of General psychiatry, 47*(3), 228-236.

Franken, I. H., & Henriks, V. M. (2001). Screening and diagnosis of anxiety and mood disorders in substance abuse patients. *The American Journal on Addictions, 10*, 30-39. doi: 10.1080/105504901750160448

Garner, B., Godley, S., & Funk, R. (2008). Predictors of Early Therapeutic Alliance Among Adolescents *Journal of Psychoactive Drugs 40*(1), 55-65.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*, 143-153. doi: 10.1037/0033-3204.27.2.143

Gaston, L., Thompson, L., Gallagher, D., Cournoyer, L., & Gagnon, R. (1998). Alliance, technique, and their interactions in predicting outcome of behavioural, cognitive, and brief dynamic therapy. *Psychotherapy Research, 8*, 190-209. doi: 10.1080/10503309812331332307

Gehrs, M., & Goering, P. (1994). The relationship between the working alliance and rehabilitation outcomes of schizophrenia. *Psychosocial rehabilitation Journal, 18*(2), 43-54.

Gelso, C., & Carter, J. (1985). The Relationship in Counseling and Psychotherapy: Components, Consequences, and Theoretical Antecedents. *The Counselling Psychologist, 13*(2), 155-243. doi: 10.1177/0011000085132001

Gunderson, J. G., & Chu, J. A. (1993). Treatment Implications of Past Trauma in Borderline Personality Disorder. *Harvard Review of Psychiatry 1*(2), 75-81. doi: 10.3109/10673229309017062

Hall, W. (1996). What have population surveys revealed about substance use disorders and their co-morbidity with other mental disorders? *Drug and Alcohol Review, 15*(2), 157-170. doi: 10.1080/09595239600185811

Hansson, L., & Berglund, M. (1992). Stability of therapeutic alliance and its relationship to ocome in short term inpatient pschiatric care. *Scandinavian journal of Social Medicine, 20*, 45-50.

Hardy, G. E., Cahill, J., Shapiro, D. A., Barkham, M., Rees, A., & Macaskil, N. (2001). Client interpersonal and cognitive styles as predictors of response to time limited cognitive therapy for depression. *Journal of Consulting and Clinical Psychology, 69*, 841-845. doi: 10.1037/0022-006X.69.5.841

Hatcher, R. L. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychological Research 9*, 405-423.

Hatcher, R. L., & Barends, A. (1996). Patients view of the Alliance in Psychotherapy: Exploratory factor analysis of three alliance measures. . *Journal of Consulting and Clinical Psychology, 64*, 1326-1336. doi: 10.1037/0022-006X.64.6.1326

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process. In A. O. Horvath & L. S. Greenberg (Eds.), *The working alliance: theory, research and practice* (pp. 51-84): John Wiley & Sons.

Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of working alliance in psychotherapy: Therapist variables and patient/therapist similarity as predictors. *Journal of Psychotherapy Practice and Research, 10*(4), 205-216.

Hilliard, R. B., Henry, W. P., & Strupp, H. H. (2000). An interpersonal model of psychotherapy: Linking patient and therapist developmental history, therapeutic process and types of outcome. *Journal of Consulting and Clinical Psychology, 68*, 125-133. doi: 10.1037//0022-006X.68.1.125

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). New York: Oxford University Press.

Horvath, A. O., Fluckiger, C., Del Re, A. C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9-16. doi: 10.1037/a0022186

Horvath, A. O., & Luborsky, L. (1993). The Role of the Therapeutic Alliance in Psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 561-573. doi: 10.1037/0022-006X.61.4.561

Horvath, A. O., & Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counselling Psychology, 38*(2), 139-149. doi: 10.1037/0022-0167.38.2.139

Hoxmark, E., M, & Wynn, R. (2010). Health Providers Descriptions of the significance of the therapeutic relationship in treatment of patients with dual diagnosis. *Journal of Addictions Nursing, 21*, 187-193. doi: 10.3109/10884602.2010.520170

Hser, Y., Grella, C. E., Hsieh, S., Anglin, M. D., & Brown, B. S. (1999). Prior treatment experience related to process and outcomes in DATOS. *Drug and Alcohol Dependence, 57*(2), 137-150. doi: 10.1016/S0376-8716(99)00081-2

Hser, Y., Polinsky, M., Maglione, M., & Anglin, M. (1999). Matching Clients' Needs With Drug Treatment Services. *Journal of substance abuse treatment 16*(4), 299-305. doi: 10.1016/S0740-5472(98)00037-3

Joe, G. W., Simpson, D. D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction, 93*(8), 1177-1190.

Joe, G. W., Simpson, D. D., & Broome, T. (1999). Retention and patient engagement models for different treatment modalities in DATOS. *Drug Alcohol Dependence 57*(2), 113-125. doi: 10.1016/S0376-8716(99)00088-5

Joe, G. W., Simpson, D. D., Dansereau, D. F., & Rowan-Szal, G. A. (2001). Relationships between counseling rapport and drug abuse treatment outcomes. *Psychiatry Services, 52*(9), 1223-1229.

Johansson, H., & Jansson, J. (2010). Therapeutic allance and outcome in routine psychiatric out-patient treatment: Patient factors and outcome. *Psychology and Psychotherapy: Theory, Research and Practice, 83*, 193-206. doi: 10.1348/147608309X472081

Kay-Lambkin, F. J., Baker, A., & Lewin, T. J. (2004). The 'comorbidity roundabout': A framework to guide assessment and intervention strategies and engineer change among people with comorbid problems. *Drug and Alcohol Review, 23*, 407-423. doi: 10.1080/09595230412331324536

Kessler, R. C., Nelson, C. B., McGonagle, K. A., Edlund, M. J., Frank, R., & Leaf, P. J. (1996). The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilisation. *American Journal of Orthopsychiatry, 66*(1), 17-31.

Klein, D., Schwartz, J., Santiago, N., Vivian, D., & Vocisano, C. (2003). Therapeutic Alliance in Depression Treatment: Controlling for Prior Change and Patient Characteristics. *Journal of Consulting and Clinical Psychology, 71*(6), 997-1006. doi: 10.1037/0022-0006X.71.6.997

Klinkenberg, W. D., Calsyn, R. J., & Morse, G. A. (1998). The helping alliance in casemanagement for homeless people *Community Mental Health Journal, 34*(6), 560-578. doi: 10.1023/A:1018758917277

Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in the early phase of counselling. *Journal of Counselling Psychology, 37*, 16-21. doi: 10.1037/0022-0167.37.1.16

Kothari, G., Hardy, G. E., & Rowse, G. (2010). The therapeutic relationshiop between therapists and substance-using clients: A qualitative exploration. *Journal of Substance Use, 15*(4), 257-271. doi: 10.3109/14659890903040060

Krupnick, J., Collins, J., Pilkonis, P., Elkin, I., Simmens, S., & Watkins, J. (1994). Therapeutic alliance and clinical outcome in the NIMH treatment of depression collaborative research program: Preliminary findings. *Psychotherapy 31*(1), 28-35. doi: 10.1037/0033-3204.31.1.28

Krupnick, J., Sotsky, S., Simmens, S., Moyer, J., Elkin, I., Watkins, J., et al. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: Findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*, 532-539. doi: 10.1037/0022-006X.64.3.532

Lingiardi, V., Filippucci, L., & Baiocco, R. (2005). Therapeutic allince evaluation in personality disorders psychotherapy. *Psychotherapy Research. Special The therapeutic relationshiop, 15*(1-2), 45-53. doi: 10.1080/10503300512331327047

Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. L. Claghon (Ed.), *Sucessful psychotherapy study of their relationship to its outcome* (pp. 92-116). New York: Bruner/Mazel.

Luborsky, L., & Barber, J. P. (1995). Establishing a therapeutic alliance with substance abusers.

Luborsky, L., Barber, J. P., Siqueland, L., Johnson, S., Najavits, L., Frank, A., et al. (1996). The revised Helping Alliance Questionnaire (HAq-II). *Journal of Psychotherapy Practice and Research, 5*(3), 260-271.

Mallinckrodt, B. (2000). Attachment, social competencies, social support, and interpersonal process in psychotherapy *Psychotherapy Research, 10*(239-266). doi: 10.1093/ptr/10.3.239

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology, 42*(3), 307-317. doi: 10.1037/0022-0167.42.3.307

Marmar, C. R., Horowitz, M. J., Weiss, R., & Marziali, E. (1986). Deveopment of the therapeutic rating system. In L. S. Greenberg & W. M. Pinsoff (Eds.), *The psychotherapeutic process: A research handbook* (pp. 367-390). New York: Guilford Press.

Marsden, J., Gossop, M., Stewart, D., Rolfe, A., & Farrell, M. (2000). Psychiatric symptoms among clients seeking treatment for drug dependence: Intake data from the National Treatment Outcome Research Study. *British Journal of Psychiatry, 176*, 285-289. doi: 10.1192/Bjp.176.3.285

Martin, D., Garske, J., & Davis, M. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*(3), 438-440. doi: 10.1037//0022-006X.68.3.438

Marziali, E., & Alexander, L. (1991). The power of the therapeutic relationship *American Journal of Orthopsychiatry, 61*(3), 383-391. doi: 10.1093/ptr/10.3.239

McGuff, R., Gitlin, D., & Enderlin, M. (1996). Clients' and therapists' confidence and attendance at planned individual therapy sessions. *Psychological Reports, 79*(2), 537-538.

Medrano, M. A., Zule, W. A., Hatch, J., & Desmond, D. P. (1999). Prevalence of Childhood Trauma in a Community Sample of Substance-Abusing Women. *The American Journal of Drug and Alcohol abuse, 25*(3), 449-462. doi: 10.1081/ADA-100101872

Meier, P., Barrowclough, C., & Donmall, M. (2005a). The role of the therapeutic aliance in the treatment of substance misuse: a critical review of the literature. *Addiction, 100*(3), 304-316. doi: 10.1111/j.1360-0443.2004.00935.x

Meier, P., Donmall, M., Barrowclough, C., McElduff, P., & Heller, R. (2005b). Predicting the early therapeutic alliance in the treatment of drug misuse. *Addiction, 100*, 500-511. doi: 10.1111/j.1360-0443.2005.01031.x

Meier, P., Donmall, M., McElduff, P., Barrowclough, C., & Heller, R. (2006). The role of early therapeutic aliance in predicting drug treatment dropout. *Drug and Alcohol Dependence, 83*, 57-64. doi: 10.1016/j.drugalcdep.2005.10.010

Meyer, B., Krupnick, J., Simmens, S., Pilkonis, P., Egan, M., & Sotsky, S. (2002). Treatment Expenctancies, Patient Alliance, and Outcome: Further Analyses From teh National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 70*(4), 1051-1055. doi: 10.1037//0022-006X.70.4.1051

Miller, W. R. (1996). Motivational Interviewing: Research, practice and puzzles. *Addctive Behaviours, 21*(6), 835-842. doi: 10.1016/0306-4603(96)00044-5

Millman, R. B. (1986). Considerations on the psychotherapy of the substance abuser. *Journal of Substance abuse Treatment, 3*(2), 103-109. doi: 10.1016/0740-5472(86)90058-9

Mueller, J., Moergeli, H., & Maercker, A. (2008). Disclosure and social acknowledgment as predictors of recovery from post-traumatic stress: A longitudinal study in crime victims. *Canadian Journal of Psychiatry, 53*(3), 160-168.

Muran, J. C., Segal, Z., V, Samstag, L., W, & Crawford, C., E. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy *Journal of Consulting and Clinical Psychology, 62*, 185-190. doi: 10.1037/0022-006X.62.1.185

Neale, M. S., & Rosenheck, R. A. (1995). Therapeutic alliance and outcome in a VA intensive case management program *Psychiatric Services, 46*(7), 719-723.

Nietlisbach, G., & Maercker, A. (2011). Social cognition and interpersonal impairments in trauma survivors with PTSD. *Journal of Aggression, Maltreatment and Trauma, 18*(4), 382-402. doi: 10.1080/10926770902881489

Norcross, J. C., & Lambert, M. J. (2011). Psychotherapy relationships that work II. *Psychotherapy, 48*(1), 4-8. doi: 10.1037/a0022180

Norcross, J. C., & Wampold, B. (2011). Evidence-based therapy relationships: Research conclusions and clinical practices. *Psychotherapy, 48*(1), 98-102. doi: 10.1037/a0022161

Nordfjaern, T., Rundmo, T., & Hole, R. (2010). Treatment and recovery as percieved by patients wth substance addiction. *Journal of Psychiatric and Mental Health Nursing, 17*, 46-64. doi: 10.1111/j.1365-2850.2009.01477.x

Onken, L., Blaine, J., & Boren, J. (1997). Treatment for drug addiction: It wont work if they dont recieve it. In L. Onken, J. Blaine & J. Boren (Eds.), *NIDA Research Monograph* (Vol. 137, pp. 1-4). Rockville: U.S Deptartment of Health and Human Services.

Petry, N. M., & Bickel, W. K. (1999). Therapeutic alliance and psychiatric severity as predictors of completion of treatment for opioid dependence *Psychiatric Services, 50*(2), 219-227.

Piper, W. E., Azrim, H. F., Joyce, A. S., McCallum, M., Nixon, G. W., & Segal, P. S. (1991). Quality of object relations vs. interpersonal functioning as predictor of therapeutic alliance and psychotherapy outcome *Journal of Nervous and Mental Disease, 179*, 432-438. doi: 10.1097/00005053-199107000-00008

Pray, M. E., & Watson, L. M. (2008). Effectiveness of day treatment for dual diagnosis patients with sever chronic mental illness. *Journal of Addictions Nursing, 19*(141-149). doi: 1080/10884600802306008

Priebe, S., & Gruyters, T. (1993). The role of helping alliance in psychiatric community care: a prospective study. *Journal of Nervous and Mental Disease, 181*(9), 552-557. doi: 10.1097/00005053-199309000-00004

Puschner, B., Bauer, S., Horowitz, L. M., & Kordy, H. (2005). The relationship between interpersonal problems and the helping alliance *Journal of Clinical Psychology, 61*(4), 415-429. doi: 10.1002/jclp.20050

Rogers, K. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*(2), 95-103. doi: 10.1037/h0045357

Safran, J. D., & Muran, J. C. (2000). Resolving therapeutic alliance ruptures: diversity and integration. *In Session: Psychotherapy in Practice, 56*(2), 233-243.

Saunders, S. (2000). Examining the relationship between the therapeutic bond and the phases of treatment outcome. *Psychotherapy, 37*, 206-218. doi: 10.1037/h0087827

Schiff, M., & Levit, S. (2010). Correlates of Therapeutic alliance and treatment outcomes among Israeli female methadone patients. *Research on Social Work Practice 20*(4), 380-390. doi: 10.1177/1049731509347854

Scott, J., Gilvarry, E., & Farrell, M. (1998a). Managing anxiety and depression in alcohol and drug dependence. *Addictive Behaviours, 23*(6), 919-931. doi: 10.1016/S0306-4603(98)00074-4

Scott, J., Gilvarry, E., & Farrell, M. (1998b). Managing anxiety and depression in alcohol and drug dependence. *Addictive Behaviors, 23*(6), 919-931.

Shand, F., Gates, J., Fawcett, J., & Mattick, R. (2003). The treatment of alcohol problems: A review of the evidence. Canberra Commonwealth Department of Health and Ageing.

Shay, J. (2002). *Odysseus in America: Combat trauma and the trials of homecoming.* New York: Scribner.

Simpson, D. D., Joe, G. W., & Brown, B. S. (1997a). Treatment retention and follow-up outcomes in the Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors, 11*(4), 294-307. doi: 10.1037/0893-164X.11.4.294

Simpson, D. D., Joe, G. W., Greener, J. M., & Rowan-Szal, G. A. (2000). Modeling year 1 outcomes with treatment process and post-treatment social influences. *Substance Use and Misuse, 35*(12-14), 1911-1930. doi: 10.3109/10826080009148245

Simpson, D. D., Joe, G. W., & Rowan-Szal. (1997b). Drug abuse treatment retention and process effects on follow up outcomes. *Drug and Alcohol Dependence 47*(3), 227-235. doi: 10.1016/S0376-8716(97)00099-9

Simpson, D. D., Joe, G. W., Rowan-Szal, G., & Greener, J. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse, 7*(1), 117-134. doi: 10.1016/0899-3289(95)90309-7

Simpson, D. D., Joe, G. W., Rowan-Szal, G., & Greener, J. M. (1997c). Drug abuse treatment process components that improve retention *Journal of Substance abuse Treatment, 14*(6), 565-572. doi: 10.1016/S0740-5472(97)00181-5

Smith, B. D., & Marsh, J. C. (2002). Client-service matching in substance abuse treatment for women with children. *Journal of Substance Abuse Treatment, 22*, 161-168. doi: 10.1016/S0740-5472(02)00229-5

Smith, S., Hilsenroth, M. J., Baity, M., & Knowles, E. (2003). Assessment of patient and therapist perspectives on process: a revision of the Vanderbilt Psychotherapy Process Scale. *American Journal of Psychotherapy, 57*(2), 195-205.

Solomon, P., Draine, J., & Delaney, M. A. (1995). The working alliance and consumer case management. *Journal of Mental Health Administration, 22*(2), 126-134. doi: 10.1007/BF02518753

Sparr, L. F., Moffitt, M. C., & Ward, M. F. (1993). Missed psychiatric appointments: who returns and who stays away. *American Journal of Psychology, 150*(5), 801-805.

Svensson, B., & Hansson, L. (1999b). Therapeutic alliance in cognitive therapy for schizophrenic and other long-term mentally ill patients: development and relationship to outcome in an in-patient treatment programme. *Acta Psychiatrica Scandinavica, 99*(4), 281-287. doi: 10.1111/j.1600-0447.1999.tb07226.x

Teesson, M. (2000). Double trouble: Comorbidity between mental disorders and alcohol and other drug use disorders. *Centre Lines, 2*, 3-4.

Triffleman, E. G., Marmar, C. R., Delucchi, K. L., & Ronfeldt, H. (1995). Childhood trauma and posttraumatic stress disorder in substance abuse inpatients. *Journal of Nervous and Mental Disease, 183*(3), 172-176. doi: 10.1097/00005053-199503000-00008

Tunis, S. L., Delucchi, K. L., Schwartz, K., Banys, P., & Sees, K. (1995). The relationship of counselor and peer alliance to drug use and HIV risk behaviors in a six month methadone detoxification program. *Addictive Behaviours, 20*(3), 395-405. doi: 10.1016/0306-4603(94)00080-I

Virgo, N., Bennett, G., Higgins, D., Bennett, L., & Thomas, P. (2001). The prevalence and characteristics of co-occuring serious mental illness (SMI) and substance abuse or dependence in the patients of adult mental health and addictions services in Eastern Dorset. *Journal of Mental Health, 10*(2), 175-188. doi: 10.1080/09638230020023732

Waddington, L. (2002). The therapy relationship in cognitive therapy: A review. *Behavioural and cognitive psychotherapy 30*, 179-192. doi: 10.1017/S1352465802002059

West, R. (2005). Time for a change: putting the transtheoretical (stages of change) model to rest. *Addiction, 100*(8), 1-4. doi: doi:10.1111/j.1360-0443.2005.01139.x

Wickizer, T., Maynard, C., Atherly, A., Frederick, M., Koepsell, T., Krupski, A., et al. (1994). Completion rates of clients discharged from drug and alcohol treatment programs in Washington State. *American Journal of Public Health, 84*(2), 215-221. doi: 10.2105/AJPH.84.2.215

Zuroff, D., C, Blatt, S., J, Sotsky, S., Krupnick, J., Martin, D., Sanislow, C. A., et al. (2000). Relation of therapeutic alliance and perfectionism to outcome in brief outpatient treatment of depression. *Journal of Consulting and Clinical Psychology, 68*, 114-124. doi: 10.1037//0022-006X.68.1.114

Appendix A: Extended methodology -Quantitative component

Participants

Participants were sourced from the Depression and Alcohol Integrated and Single Focused Interventions (DAISI) Project. The DAISI Project examined treatment methods for participants with co-occuring depression and hazardous alcohol use consumption recruited from the community. Treatment conditions included; ten sessions of cognitive behaviour therapy (CBT) targeting depression, ten sessions of CBT targeting alcohol use, ten sessions of CBT targeting alcohol use and depression concurrently, and a control intervention of brief (1 session) treatment targeting alcohol use and depression concurrently. All participants received the same initial session (session 1) prior to randomisation to one of the four treatment conditions.

To minimise variability and confounding factors, the current study took participants only from the ten session integrated treatment for alcohol use and depression.

Measures

Beck Depression Inventory -II

The BDI-II is a 21-item self-report questionnaire used to screen for the presence of depressive symptoms over the previous two-week period, and is commonly used to screen for depressive symptoms among people with drug and alcohol use problems. The BDI-II has good internal consistency among psychiatric outpatients (α=0.93) and with non-clinical samples (α=0.93). In addition, test-retest on the BDI-II is suitably high at 0.93 (Dawe, Loxton, Hides, Kavanagh, & Mattick, 2002). Scores are categorised by severity as follows; 0-13: minimal depression, 14-

19: mild depression; 20-27: moderate depression; 28 and over: severe depression. High scores do not imply a diagnosis of depressive disorder but rather indicate the presence of depressed mood.

International Personality Disorder Questionnaire

The 59-item version of the International Personality Disorder Examination is a self report scale asking respondents to indicate true or false, the extent to which a statement best describes them over the preceding five years. It screens for the presence of Axis II personality disorders, with higher scores indicating an increased likelyhood of one of nine International Classification for Disorders, Version 10 (WHO, 1992), based personality disorders, including cluster A disorders: paranoid, schizoid, cluster B disorders: dissocial, impulsive, borderline, histrionic, and cluster C disorders: anacastic, anxious and dependent. Internal consistency data are not provided by the publishers of the scale, however test-retest reliability is acceptable (range=0.55-0.84 for the individual disorders, and 0.77 for the overall score. Cluster scores tend to have better psychometric properties and stronger associations with relevant selected psychosocial variables than the individual Personality disorders (Lewin, Slade, Andrews, Carr, & Hornabrook, 2005). Cluster scores also provide significant clinical information around personality styles, relevant to the research question, and so were chosen rather than individual disorders, for use as predictor variables.

Agnew Davies Therapeutic alliance measure

This measure of therapeutic alliance contains 28 self-report items regarding client and therapist based domains and impressions of the client-therapist relationship. Each item is rated according to a 7-point likert scale, with higher scores

indicating more positive perceptions of alliance. Five subscales are derived from item ratings. Bond represents the friendliness, acceptance, and understanding felt by the client in the therapeutic relationship (eg. 'I feel accepted in therapy', 'I feel friendly towards my therapist'). Partnership refers to the extent to which the client feels he/she is working jointly on the therapeutic tasks with their therapist (eg. 'my therapist follows his/her own plans', my therapist and I agree about how to work together'). Confidence addresses the extent of optimism and respect for therapy in which the client is engaged (eg. 'I feel critical or disappointed in my therapy', 'I feel optimistic about my progress in therapy'). Client Initiative exams how well the client takes responsibility for the directions of therapy (eg. 'I take the lead when I'm in therapy', 'I am expected to take responsibility rather than be dependent on therapy', 'I look to my therapist for solutions to my problems'). Lastly, Openness concerns the extent to which a client feels free to disclose personal issues and worries in therapy (eg. 'I can discuss personal matters I am ordinarily ashamed or afraid to reveal','I am worried about embarrassing myself in therapy'). The ARM has consistently been used in trials of CBT for depression (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998).

Readiness to change alcohol/other drug use

The Readiness to Change questionnaire is a 12 item self report questionnaire that measures an individual's readiness to start to change or actual changes in current drinking habits. Based on the stage of change model (Prochaska & DiClemente, 1986), it has three subscales: precontemlation - not considering making any changes; contemplation - thinking about changes, may have started a few; and Action -already actively making changes. Analysis of the psychometric properties of this scale, as

applied to people using alcohol, indicate it has good internal consistency (Cronbach's α range: 0.73-0.85 across the three stages of change subscales) and acceptable test-retest reliability (range: 0.78-0.82 across the stages of change subscales) (Rollnick, Heather, Gold, & Hall, 1992).

Measures of Parenting scale

The MOPS is a 15 item self report tool used to measure perceived parenting styles. Three subscales for each parent (mother and father) are derived from item ratings. Individuals are asked to rate how 'true' statements are about parent's behaviour towards them during their first 16 years of life, where 0 = not true at all, 1 = slightly true, 2 = moderately true and 3 = extremely true. Categories include: Indifference (eg. 'My parent was uninterested in me', 'my parent was rejecting of me'), Abuse (eg. 'my parent made me feel in danger' 'my parent was physically violent or abusive of me'), and Over control (eg. 'my parent was critical of me' 'my parent was over controlling of me'). It shows acceptable internal consistency (Cronbach's α range: 0.76-0.93 across maternal and paternal scores for each subscale) and good concurrent validity (Parker, et al., 1997).

Due to a high correlation between all three subscales, found within the present data and supported by Parker's paper (Parker, et al., 1997), and the negative design of all questions on all subscales, it was decided to combine all three subscales for mother and all three subscales for father, to create two variables 'Motherabuse' and 'Fatherabuse'. A high score on either of these variables indicates high levels of negative parenting behaviours of abuse, indifference and overcontrol.

Demographic details

Basic demographic information was collected over the following domains, using the relevant items of the Diagnostic Interview for Psychosis (Jablensky, et al., 2000): age, gender, employment and education status. The DIP section on self-care based on the World Health Organisation Disability Assessment Scale (WHO, 1988) was also included in assessment battery. Aspects of social functioning, disability and impairment in key role domains are assessed by rating performance of household duties, general social contact isolation and withdrawal, access to friends and family, and intimacy. A set of 14 items explores participation in the workforce and perceived capacity for work (including housework and studying). Items related to finances, activities of daily living, self-care and use of leisure time are also examined (Castle, et al., 2006). Using this information from the DIP, two indices of disability were calculated: a personal disability score and a social disability score (Baker, Bucci, Lewin, Richmond, & Carr, 2005). For the current study only the social disability score was used. The scale has good inter-rater reliability for both ICD -10 and DSM -III-V diagnosis. Test-retest reliability showed pairwise agreement of 0.8-1.0 (Castle, et al., 2006).

Opiate Treatment Index

The OTI addresses the quantity and frequency of use across 11 substances. Each drug type is assessed individually, and clients report on their last three occasions of use in the past month prior to assessment, estimating the amount of the substance used on each of these occasions. An average use index for the previous month is calculated for each individual substance. As well as quantity and frequency of use, the OTI also contains subscales on HIV risk taking behaviours, social

behaviours, health status and psychological functioning. The scales of the OTI can

be used as a whole or in isolation from each other, without compromising the

validity or reliability properties of the scale. Within the current study, only data

from the alcohol use subscale was used. Test -retest reliability of substance use

subscales was acceptable (Pearson product moment correlation coefficient was .88)

and this was higher if the same interviewer conducted both assessments (.92). The

scale demonstrated acceptable validity against accepted measures of substance use

(r=.70), and self reports of substance use were in high agreement with collateral

verification of substance use (range = 82%-100%). For the drug use subscales, the

overall agreement between self reported drug use on the OTI and urinalysis results

was 89% (Darke, Ward, Hall, Heather, & Wodak, 1991)

Procedure

Participants completed a baseline assessment and all received one initial

session of therapy. At the conclusion of session 1, participants were informed of

their random allocation to one of four treatment conditions. Both participants and

therapists were blind to treatment allocation until this point. Participants in the

current study then completed 9 further sessions of integrated CBT treatment. At the

conclusion of sessions 1, 5 and 10, participants and therapists completed the Agnew

Davies Therapeutic Alliance measure. Participants completed a follow up

assessment six months after completing treatment, at which point they completed the

Beck Depression Inventory and the Opiate Treatment Index again.

Analysis

Quantitative research question one: Do pre-treatment client characteristics predict the development of early alliance?

Preliminary correlations were performed to examine the relationship between each alliance subscale and within client and therapist ratings, and also between client and therapist ratings.

The dependant variable for this component of the study was therapeutic alliance measured at session 5 rated by both client and therapist in session. Session 5 alliance ratings were selected as they represented the first opportunity for participant and therapist to reflect on the integrated treatment to which people were randomised. Independent variables included readiness to change, severity of depression and severity of alcohol use which have shown some ability to predict alliance in substance abuse treatment and parenting style (motherabuse, fatherabuse), presence of cluster A, B or C personality disorder traits, and social functioning which have been associated with alliance in general psychotherapy but at untested in dual diagnosis settings.

Pearsons correlation analysis and oneway analysis of variance (ANOVA) were used to examine univariate relationships between the primary outcome of interest (e.g. alliance ratings) and possible predictors, and to inform the predictors that were entered into the regression analysis.

Multiple hierarchical linear regression analysis was used to examine the contribution of individual predictors within the context of the chosen hierarchy, not to formulate overall prediction equations. Consequently the statistical tests that are reported indicate whether or not the standardised regression weight (β) for a

particular variable is non zero. For descriptive purposes, increments in variance at each step, and overall are also reported.

Analysis were developed using each therapeutic alliance sub-score as the outcome, with independent variables found to be significant in the one way analysis ($p<0.05$) used as predictors in the model, as well as independent variables showing a relationship of <0.1. This use of the more liberal significance level for entry into the model is a commonly used method and was developed and described by Hosmer and Lemeshow (Hosmer & Lemeshow, 1989). Variables were added to the model in a hierarchical method, with those showing a relationship of $<.1$ at the univariate level entered into the first step. In a second step, categorical variables 'therapist one', 'therapist two' and 'therapist three'(see below) were included, in order to examine and account for the impact of therapist variability on the multiple regression analysis.

The above steps were followed using Session five therapeutic alliance subscales rated by therapist as the outcome variables, and then therapeutic alliance subscales rated by client as outcome variables.

Calculation of categorical 'therapist' variable.

To calculate this variable we examined frequencies of therapists delivering integrated therapy within the DAISI Project (n=12). Three therapists delivered the majority of integrated sessions (68%). Thus, three separate 'therapist' variables were created (therapist 1=1 vs rest, therapist 2=2 vs rest, therapist 3= 3 vs rest). Each participant was given a code (1, 2 or 3) for each therapist variable, according to which therapist had delivered their treatment.

Quantitative Research question two: Does therapeutic alliance rated by client or therapist predict outcome (substance use or depression) when controlling for possible covariates within a dual diagnosis population?

In order to examine predictors of outcome, two primary outcome variables were used: alcohol use at six month follow up (measured by the OTI), and depression at 6 month follow up (measured by the BDI). Independent variables of interest, repeated for both outcome variables, included session five therapeutic alliance rated by client and therapist, all variables examined at baseline (parenting style, social functioning, presence of personality disorder cluster traits, severity of depression, severity of alcohol use, and readiness to change) and the 'therapist' variables.

Variables were entered in the analysis in a hierarchical fashion. Step one contained all baseline client characteristics included in question one, except for baseline OTI and baseline BDI. Baseline OTI and BDI were included alone in the second step of each appropriate model due to the potential importance of the 'pre treatment' score on the dependent outcome at follow up. The 'therapist' variables were added at the third step in order to control for any possible effects of different treating therapists as per question one above.

The therapeutic alliance subscales for both therapist and client ratings were added at the fifth step, however, due to correlations between a number of these subscales, and the small sample size, each variable was added to the model individually to examine its independent contribution to the dependent variable.

Two models were created in this way, one with 6-month BDI scores as the dependent variable and one with 6-month OTI scores (alcohol) as the dependant variable.

Because of possible spurious relationships that exist between a number of pre treatment and in treatment variables, the therapeutic alliance and the dependant variable of outcome, baseline variables, and 'therapist' variables were included in the early steps of the hierarchical regression model to act as covariates to eliminate potential 'third variable' explanations of results. It is acknowledged that, despite these efforts, it is impossible to determine causality between variables when there is such potential for variance. As in the previous question, the primary aim of these regression models was therefore to examine the independent contribution of variables in the presence of other possible influences. Again the contribution of individual predictors was examined within the context of the chosen hierarchy, and overall prediction equations were not formulated. As in question one, the statistical tests that are reported indicate whether or not the standardised regression weight (β) for a particular variable is non zero. For descriptive purposes, increments in variance at each step, and overall are also reported.

References
(Extended methodology -Quantitative component)

Agnew-Davies, R., Stiles, W. B., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Alliance structure assessed by the Agnew Relationship Measure. *British Journal of Medical Psychology, 37*, 155-172.

Baker, A., Bucci, S. R., Lewin, T. J., Richmond, R., & Carr, V. J. (2005). Comparisons between psychosis samples with different patterns of substance use recruited for clinical and epidemiological studies. *Psychiatry Research*(134), 241-250. doi: 10.10.16/j.psychres.2005.02.006

Castle, D., Jablensky, A., McGrath, D., Carr, V., Morgan, V., & Waterreus, A. (2006). The diagnostic interview for psychosis (DIP): Development, reliability and applications. *Psychological Medicine, 36*, 69-80. doi: 10.1017/S0033291705005969

Darke, S., Ward, J., Hall, W., Heather, N., & Wodak, A. (1991). The Opiate Treatment Index (OTI) Researchers Manual. *National Drug and Alcohol Research Center Technical report* (Vol. 11). Sydney: National Drug and Alcohol Research Center.

Dawe, S., Loxton, N., Hides, L., Kavanagh, D., & Mattick, R. P. (2002). Diagnostic and screening instruments for alcohol and other drugs and other psychiatric disorders. *Revised National Drug Strategy Monograph*. Canberra Commonwealth Department of Human services and Health

Hosmer, D. W., & Lemeshow, S. (1989). *Applied Logistic Regression.* (2nd ed.). New York: John Wiley.

Jablensky, A., McGrath, J., Herrman, H., Castle, D., Gureje, O., Evans, M., et al. (2000). Psychotic disorders in urban areas: an overview of the Study on Low Prevalence Disorders. *Australian and New Zealand Journal of Psychiatry, 34*(2), 221-236. doi: 10.1046/j.1440-1614.2000.00728.x

Lewin, T. J., Slade, T., Andrews, G., Carr, V., & Hornabrook, C. W. (2005). Assessing personality disorders in a national mental health survey. *Social Psychiatry and Psychiatric Epidemiology, 40*, 87-98. doi: 10.1007/s00127-005-0878-1

Parker, G., Roussos, J., Hadzi-Pavlovic, D., Mitchell, P., Wilhelm, K., & Austin, M. (1997). The development of a refined measure of dysfunctional parenting and assessment of its relevance in patients with affective disorders. *Psychological Medicine, 27*, 1193-1203. doi: 10.1017/S003329179700545X

Prochaska, J. O., & DiClemente, C. C. (1986). Toward a comprehensive model of change. In W. R. Miller & N. Heather (Eds.), *Treating addictive behaviors: Processes of change. Applied clinical psychology* (pp. 3-27). New York: Plenem Press.

Rollnick, S., Heather, N., Gold, R., & Hall, W. (1992). Development of a short "Readiness to Change Questionnaire" for use in brief, opportunistic interventions among excessive drinkers. *British Journal of Addiction, 87*, 743-754. doi: 10.1111/j.1360-0443.1992.tb02720.x

WHO. (1988). World Health Organisation Psychiatric Disability Assessment Schedule (WHO/DAS). Geneva: World Health Organisation.

WHO. (1992). *ICD-10 Classifications of mental and behavioural disorder: Clinical descriptions and diagnostic guidelines* Geneva: World Health Organisation.

Appendix B: Extended results -Quantitative component

Results

In the sample of 75 participants, ages ranged from 20 to 65 years (M = 46.35, SD = 11.58), with 56% of the sample being male and the majority (75%) having been born in Australia. Additional demographic characteristics are shown in Table 1.

Table 1
Demographic characteristics of the Integrated treatment group at session one

Characteristic		N	%
Gender			
	Male	42	56.0
	Female	33	44.0
Country of Birth			
	Australia	56	74.7
	UK & Ireland	7	9.3
	Europe	7	9.3
	Other	5	6.6
Aboriginal or Torres strait islander decent			
	Yes	74	98.7
	No	1	1.3
Marital Status			
	Single	21	28
	Married	23	30.7
	De facto	3	4.0
	Separated	12	16.0
	Divorced	14	18.7
	Widowed	2	2.7
Has at least one child			
	Yes	53	70.7
	No	22	29.3
Qualification			
	Left school, no qualification	9	12.0
	Finished high school	27	36.0
	Trade	20	26.7
	Professional/diploma	5	6.7
	Bachelors	9	12.0
	Post Graduate	1	1.3
Current Employment			
	No job at present	28	37.3
	Full time job	22	29.3
	Part time job	12	16.0
	Household	1	1.3

Studying	2	2.7	
Retired	8	10.7	
Volunteer	2	2.7	
Main source of income			
Wage	23	30.7	
Own business	7	9.3	
Family/spouse payment	3	4.0	
Govt Pension/Cash benefit	34	45.3	
Superannuation	3	4.0	
Other	3	4.0	
Receiving Welfare			
Yes	42	56.0	
No	32	42.7	

Quantitative research question one: Do pre-treatment client characteristics predict the development of therapeutic alliance?

Pearson's correlations were performed to examine the relationship between subscales with therapist ratings of alliance following the fifth session of treatment (see Table 2) and client ratings of alliance following session five (see Table 3) and also relationship between client and therapist rated therapeutic alliance subscales at this timepoint (see Table 4).

Table 2

Correlation matrix of Therapist rated Therapeutic alliance subscales

		Bond	Partnership	Confidence	Openness	Client Initiative
Bond	r	--	.776**	.564**	.545**	-.185
	n		43	43	43	43
Partnership	r		--	.557**	.438**	-.298
	n			43	43	43
Confidence	r			--	.378*	-.003
	n				43	43
Openness	r				--	.165
	n					43
Client Initiative	r					--
	n					

*p < .05. ** p < .01.

As indicated in Table 2, many of the subscales of the therapist-rated alliance measure, rated after the completion of Session five, were significantly correlated with each other. These include a significant positive correlation between the subscale of bond and partnership, bond and confidence, and bond and openness. Significant positive correlations were also found between partnership and confidence and partnership and openness and confidence and openness. The subscale of client initiative was not significantly correlated with any other alliance subscale (see Table 2).

Table 3

Correlation matrix of Client rated Therapeutic alliance subscales

		Bond	Partnership	Confidence	Openness	Client Initiative
Bond	r	--	.455**	.239	.283	.110
	n		43	40	42	40
Partnership	r		--	.512**	.297	-.158
	n			40	41	39
Confidence	r			--	.331*	-.061
	n				39	36
Openness	r				--	.329*
	n					38
Client Initiative	r					--
	n					

*$p<.05$. ** $p<.01$

As indicated in Table 3, several subscales of the client-rated therapeutic alliance measure, taken following session five of treatment, were significantly correlated with each other. These include a significant positive correlation between bond and partnership, between partnership and confidence, confidence and openness, and openness and client initiative.

Table 4

Correlation matrix of Client rated Therapeutic alliance subscales with therapist rated therapeutic alliance subscales

Therapist rated alliance		Client rated alliance				
		Bond	Partnership	Confidence	Openness	Client Initiative
Bond	r	.101	.125	.336*	-.025	-.125
	n	41	40	37	40	38
Partnership	r	.104	.126	.280	-.154	-.311
	n	41	40	37	40	38
Confidence	r	-.015	-.025	-495**	-.096	-.232
	n	41	40	37	40	38
Openness	r	-.116	-.034	.130	.160	.085
	n	41	40	37	40	38
Client Initiative	r	-.154	-.152	-.015	-.044	.215
	n	41	40	37	40	38

* $p<.05$. ** $p <.01$

In the main, therapist- and client-rated alliance, taken at the same point in therapy (following completion of session 5) were not significantly correlated with each other. The two exceptions to this were a significant positive correlation between therapist-rated bond and client-rated openness, and a significant negative correlation between therapist-rated confidence and client-rated confidence (see Table 4).

Predictors of Therapist rated Therapeutic alliance.

Results of univariate analysis of the relationship between therapist-rated alliance and pre-treatment client characteristics are presented below. Pearson's correlations of continuous client characteristics with therapist-rated alliance are presented in Table 5 (social disability, parental attachment, personality disorder, baseline depression and baseline alcohol consumption).

Table 5
Correlations between therapist rated therapeutic alliance and continuous predictors; social disability, parental attachment, personality disorder, baseline BDI and baseline OTI.

| | | Therapist rated alliance | | | | |
		Bond	Partnership	Confidence	Openness	Client Initiative
BDI baseline	r	.265#	.216	.000	.052	-.118
	n	43	43	43	43	43
OTI baseline	r	-.311*	-.437*	-.298	-.098	.187
	n	43	43	43	43	43
FatherAbuse	r	.016	.088	-.068	.034	.155
	n	35	35	35	35	35
MotherAbuse	r	.146	.206	.102	.124	.039
	n	37	37	37	37	37
Social Disability	r	-.037	-.051	-.104	.014	.217
	n	43	43	43	43	43
Cluster A	r	.044	-.067	.056	-.121	.287#
	n	38	38	38	38	38
Cluster B	r	.018	.107	.139	.108	.201
	n	38	38	38	38	38
Cluster C	r	.073	.118	.086	-.035	.004
	n	38	38	38	38	38

Note. BDI: Beck Depression Inventory; OTI: Opiate Treatment Index
#$p<.10$. *$p<0.5$. ** $p<0.01$

As indicated in Table 5, a significant negative correlation was found between baseline alcohol consumption, as measured by the OTI, and the therapeutic alliance subscales of bond and partnership.

Oneway Analysis of Variance (ANOVA) results for categorical client characteristics with therapist-rated alliance are presented in Table 6 (readiness to change). No significant relationships were detected between these variables.

Table 6

One way ANOVA comparing client rated Therapeutic alliance subscales to Readiness to change

Therapeutic alliance	Readiness to Change	M	SD	ANOVA
Bond				$F(1,38) = 2.78$, ns
	Contemplation	39.90	2.83	
	Action	40.90	1.91	
Partnership				$F(1,37) = .499$, ns
	Contemplation	25.52	3.08	
	Action	26.30	2.71	
Confidence				$F(1,37) = 1.08$, ns
	Contemplation	45.04	4.08	
	Action	46.50	2.72	
Openness				$F(1,37) = .383$, ns
	Contemplation	28.11	4.97	
	Action	29.20	4.08	
Client Initiative				$F(1,36) = 7.27$, ns
	Contemplation	13.78	2.59	
	Action	11.22	1.99	

Hierarchical multiple linear regressions, used to predict therapist rated Bond and Partnership, are displayed in Tables 7 and 8 respectively. The remaining models of therapist-rated subscales of confidence, openness and client initiative were not statistically significant.

Table 7

Multiple Linear Regression predicting Therapist rated Bond

	Increment in R^2	Variable	Simple correlation	β
Step 1	(.14)	OTI (alcohol) baseline	-.311	-.275#
		BDI baseline	.265	.220
Step 2	(.05)	Therapist 1	-.155	-.240
		Therapist 2	-.143	-.123
		Therapist 3	-.028	-.038
Total R^2	.19			

*$p< 0.5$. ** $p<0.01$

As Table 7, indicates, at step one, together baseline OTI and baseline BDI explain 14% of the variance therapist-rated bond. While baseline OTI was a

significant predictor at the univariate level, it did not significantly independently predict therapist-rated bond but moved towards significance (p<.1)

The addition of the 'therapist' variables to the analysis at step three was not significant, and added 6% to the variance explained.

Table 8
Multiple Linear Regression predicting therapist rated Partnership

	Increment in R^2	Variable	Simple correlation	β
Step 1	(.19)	OTI (alcohol) baseline	-.437	-.437*
Step 2	(.03)	Therapist 1	.162	.047
		Therapist 2	-.259	-.179
		Therapist 3	-.102	-.151
Overall R^2	.23			

* *p*<0.5. ** *p*<0.01

Step one of the regression analysis, consisting of baseline OTI alone, explained 19% of the variance in therapist-rated partnership and was statistically significant. As with Bond, the addition of "therapist" to this model was not significant, contributing only 3% to the variance explained and OTI (alcohol) remained the only significant predictor at this step.

Predictors of client rated therapeutic alliance.

Results of univariate analysis of the relationship between client rated alliance at session five and baseline client characteristics are presented below. Pearson's correlations of continuous client characteristics are presented in Table 9 and oneway ANOVA results for categorical client characteristics are presented in Table 10.

Table 9
Correlations between client rated Therapeutic alliance and continuous predictors;
social disability, parental attachment, personality disorder, baseline BDI and
Baseline OTI.

		Client rated alliance				
		Bond	Partnership	Confidence	Openness	Client Initiative
Social	r	-.016	-.338*	-.167	-.152	.143
Disability	n	44	43	40	43	40
MotherAbuse	r	-.309#	-.495*	-.279	-.275#	.175
	n	38	37	35	38	36
FatherAbuse	r	-.083	-.037	-.092	-.088	.214
	n	36	35	33	36	34
BDI Total	r	-.181	.094	.056	-.103	-.065
	n	44	43	40	43	40
OTI Total	r	-.114	-.090	-.165	.126	.167
	n	44	43	40	43	40
Cluster A	r	-.312#	-.328*	-.156	-.031	.116
	n	38	37	34	37	36
Cluster B	r	-.327*	.028	.105	.051	.123
	n	38	37	34	37	36
Cluster C	r	-.058	-.010	-.006	-.158	-.128
	n	38	37	34	37	36

Note. BDI: Beck Depression Inventory; OTI: Opiate Treatment Index
#<.10. *p<.05. **p<.01

As indicated in Table 9, a significant negative correlation was found between

client-rated partnership at session five and the client characteristics of social

disability, mother abuse and Cluster A personality disorder. A significant negative

correlation was also found between Cluster B personality disorders and bond. No

other statistically significant correlations were found.

Table 10

One way ANOVA comparing client rated Therapeutic alliance subscale 'Bond' to readiness to change

	Readiness to change	Mean	Std. Dev.	ANOVA
Bond				$F(1,47)=.104$, ns
	Contemplation	38.63	3.22	
	Action	39.00	4.05	
Partnership				$F(1,49)=1.700$, ns
	Contemplation	24.69	3.18	
	Action	26.08	3.55	
Confidence				$F(1,48)=.639$, ns.
	Contemplation	43.11	5.54	
	Action	44.54	5.33	
Openness				$F(1,50)=2.34$, ns.
	Contemplation	12.54	3.63	
	Action	10.62	4.63	
Client Initiative				$F(1,50)=2.344$, ns.
	Contemplation	12.54	3.63	
	Action	10.62	4.63	

Oneway ANOVAs between the client-rated therapeutic alliance subscales and readiness to change were not statistically significant (see Table 10).

A multiple hierarchical linear regression model for client-rated Bond and Partnership is presented in Table 11 and Table 12 respectively.

Table 11

Multiple Linear Regression predicting client rated Bond

	Increment in R^2	Variable	Simple correlation	β
Step 1	(.19)	PD Cluster B	-.327	-.286*
		PD Cluster A	-.312	-.286#
Step 2	(.09)	Therapist 1	.346	.241
		Therapist 2	-.116	-.051
		Therapist 3	-.173	-.135
Overall R^2	.28			

*$p <.05$. **$p<.01$

Table 11 depicts, the multivariate analysis predicting client-rated Bond. At step one, cluster B and cluster A personality traits were added together. Together they explained 19% of the variance and Cluster B personality traits made a

significant independent contribution to client rated bond while Cluster A personality traits moved towards significance ($p<.1$). The addition of the 'therapist' variables to the model was not significant when controlling for Cluster A and Cluster B personality traits but added 9% to the total variance explained.

Table 12
Multiple Linear regression predicting client rated Partnership at session five

	Increment in R^2	Variable	Simple correlation	β
Step 1	(.28)	MotherAbuse	-.497	-.393*
		PD Cluster A	-.317	-.122
		Social Disability	-.332	-.141
Step 2	(.08)	Therapist 1	.254	.076
		Therapist 2	-.177	-.115
		Therapist 3	-.318	-.252
Overall R^2	(.36)			

* $p<0.5$. **$p<0.01$

The multiple hierarchical linear regression predicting client-rated partnership, is displayed in Table 12. In the first step, Motherabuse, Cluster A personality traits and Social disability, all of which were significantly correlated with Client-rated partnership at the univariate level, were entered into the analysis. At this step motherabuse was the only variable that continued to significantly independently predicted client rated partnership ($p<.05$). The addition of the therapist variable to the model was not significant and added 8% to the total variance explained.

Question two: Is therapeutic alliance, as rated by client or therapist, predictive of outcome?

All variables were included in the hierarchical regression analysis for this question and univariate associations between continuous client characteristics and depression and alcohol use outcome at 6-month follow-up are included in Table 14 and Table 15. Univariate associations between depression and alcohol use outcome

at 6-month follow up and the categorical variable Readiness to change, is presented

in table 13.

Table 13

One way ANOVA comparing dependent variables Depression and alcohol use
outcome with Readiness to Change (RTC)

	Readiness to change	M	SD	ANOVA
BDI Outcome				$F(1,48) = .627$, ns.
	Contemplation	17.92	14.29	
	Action	21.58	12.72	
OTI Outcome				$F(1,48) = .496$, ns.
	Contemplation	7.09	7.34	
	Action	5.29	8.71	

Note. BDI: Beck Depression Inventory; OTI: Opiate Treatment Index

No significant associations were found between 6-month depression and

alcohol use and readiness to change (see Table 13).

Predictors of alcohol use outcome.

Multiple hierarchical linear regression predicting Alcohol use at 6 months is

presented in Table 14.

Step 1 of the model, consisting of 8 baseline client variables, explained 27 %

of the total variance in alcohol use outcome. Within this step, Cluster B personality

disorder traits emerged as a significant predictor ($p < .05$) suggesting that higher

cluster B scores were associated with higher alcohol consumption at 6-months. The

addition of baseline alcohol use, at step two, contributed 23% of variance explained

to the model and remained a significant predictor of alcohol use outcome (p<.001) in

the presence of client characteristic's controlled for in step 1. As expected, and as

seen at the univariate level also, higher baseline OTI (alcohol) scores predicted

higher follow up outcome OTI (alcohol) scores. The addition of the third step, the

'Therapist' variables was not statistically significant and contributed only 3% of the

explained variance.

Table 14
Multiple Linear regression examining the predictive validity of client and therapist
rated alliance on Alcohol use outcome, accounting for possible covariates.

	Increment in R^2	Variable	Simple correlation	β
Step 1	(.27)	FatherAbuse	.245	.133
		MotherAbuse	-.036	-.295
		Social Disability	.115	.168
		Cluster A	.261*	.203
		Cluster B	.401**	.382*
		Cluster C	.158	.056
		Readiness to change	-.036	.123
Step 2	(.23)	OTI (alcohol) baseline	.536**	.524**
Step 3	(.03)	Therapist 1	-.021	.044
		Therapist 2	.211#	.138
		Therapist 3	-.081	-.086
Step 4[a]	(.04)	CBond	-.093	-.283
	(.00)	CPartnership	.052	-.078
	(.12)	CConfidence	-.413*	-.401*
	(.00)	COpenness	.154	.053
	(.01)	CClientInit	.131	-.139
	(.19)	TBond	-.479*	-.476**
	(.09)	TPartnership	-.430*	-.347#
	(.11)	TConfidence	-.435*	-.483*
	(.00)	TOpenness	.006	.056
	(.06)	TClientInit	.362*	.329

Note. All alliance subscales were included individually in separate regression
analysis. [a]This note refers to a particular cell
#$p<.10$. * $p<0.5$. **$p<.001$

At step 4, alliance ratings were individually added to the model. With client

characteristics, baseline alcohol use, and 'therapist' controlled for by the previous

three steps, one client and two therapist rated subscales remained significant

predictors of alcohol use outcome, and one therapist rated subscale moved towards

significance ($p<.1$).

The addition of client rated confidence added 12 % to the variance explained by the analysis. This association was significant ($p < .01$) and negative, indicating that higher client ratings of confidence were associated with lower OTI (alcohol) scores at follow up.

The addition of therapist rated Bond added 19% to the variance explained by the analysis at this step. The relationship was also statistically significant ($p < .01$) and negative, suggesting that the higher the therapist rated bond, the lower the OTI (alcohol) scores at follow up.

The addition of therapist rated confidence added 11% to the variance explained by the model at this step. This change was statistically significant ($p<.05$), with higher rated confidence associated with lower OTI (alcohol) outcome at follow up.

The addition of therapist rated partnership added 8 % to the variance explained by the model at step four, but despite reaching significance at the univariate level, did not remain statistically significant in predicting alcohol use at 6 months in the presence of client characteristics, baseline alcohol use and 'therapist'.

Predictors of severity of depression outcome.

In multivariate hierarchical analysis (see Table 15) the set of client characteristics entered at step 1 explained 23% of the variance in depression outcome (measured by the BDI at follow up) however no predictors made a significant independent contribution.

The addition of Baseline BDI as a second step, added 10% to the variance explained by the model and the change with this addition remained statistically significant ($p<.05$) in the presence of variables in step 1.

The next two steps, including the addition of the 'therapist' variables, and

each therapeutic alliance substance added individually, did not make a significant

contribution to depression outcome, at the univariate level or when controlling for

prior predictors.

Table 15
Multiple Linear regression examining the predictive validity of client and therapist
rated alliance on Depression outcome, accounting for possible covariates.

	Increment in R^2	Variable	Simple correlation	β
Step 1	.23	FatherAbuse	.235	.069
		MotherAbuse	.385*	.181
		Social Disability	.282*	.140
		Cluster A	.337*	.177
		Cluster B	.112	.093
		Cluster C	.256	.038
		Readiness to change	.159	.158
Step 2	.10	BDI baseline	.502**	.378**
Step 3	.04	Therapist 1	-.139	.012
		Therapist 2	.180	.174
		Therapist 3	-.019	-.117
Step 4[a]	.003	CBond	-.003	.075
	.000	CPartnership	-.049	-.008
	.004	CConfidence	.044	.074
	.021	COpen	-.027	.191
	.001	CInit	.025	.043
	.000	TBond	.144	-.012
	.002	TPartnership	.116	.057
	.017	TConfidence	-.147	-.160
	.026	COpen	.196	.177
	.003	CInit	.119	.065

Note. All alliance subscales were included individually in separate regression
analysis
[a]This note refers to a particular cell
# $p<0.1$. *$p<0.5$. **$p<.01$

Appendix C: Ethics approval and information sheets

1 December 2010

HUNTER NEW ENGLAND
NSW HEALTH

Dr A Baker
Centre for Brain & Mental Health Research
University of Newcastle

Dear Dr Baker

Re: The DAISI- Depression & Alcohol Integrated and Single-focussed Interventions (05/05/11/3.13)

Thank you for submitting a request for an amendment to the above project. This amendment was reviewed by the Chair of the Hunter New England Human Research Ethics Committee under the provisions of expedited review. This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Area Health Service website: http://www.hnehealth.nsw.gov.au/Human_Research_Ethics.

I am pleased to advise that the Hunter New England Human Research Ethics Committee has granted ethical approval for the following amendment request:

- For the addition of Ms E Knock as student researcher;
- For the Qualitative Study Script (Version dated August 2010); and
- For the Participant Letter (Version 2 dated 1 December 2010)

For the protocol: **The DAISI- Depression & Alcohol Integrated and Single-focussed Interventions**

Approval from the Hunter New England Human Research Ethics Committee for the above protocol is given for a maximum of **3** years from the date of the approval letter of your initial application, after which a renewal application will be required if the protocol has not been completed. The above protocol is approved until **June 2011.**

The *National Statement on Ethical Conduct in Human Research (2007)* which the Committee is obliged to adhere to, include the requirement that the committee monitors the research protocols it has approved. In order for the Committee to fulfil this function, it requires:

- A report of the progress of the above protocol must be submitted at 12 monthly intervals. Your review date is **June 2011.** A proforma for the annual report will be sent two weeks prior to the due date.

- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled. A proforma for the final report will be sent two weeks prior to the due date.

- All variations or amendments to this protocol, including amendments to the Information Sheet and Consent Form, must be forwarded to and approved by the Hunter New England Human Research Ethics Committee prior to their implementation.

- The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:

  - Any serious or unexpected adverse events
    - Adverse events, however minor, must be recorded as observed by the Investigator or as volunteered by a participant in this protocol. Full details will be documented, whether or not the Investigator or his deputies considers the event to be related to the trial substance or procedure. These do not need to be reported to the Hunter New England Human Research Ethics Committee

    - Serious adverse events that occur during the study or within six months of completion of the trial at your site should be reported to the Manager, Research Ethics & Governance, of the Hunter New England Human Research Ethics Committee as soon as possible and at the latest within 72 hours.

    - All other safety reporting should be in accordance with the NHMRC's Safety Monitoring Position Statement – May 2009 available at http://www.nhmrc.gov.au/health_ethics/hrecs/reference/_files/090609_nhmrc_position_statement.pdf

    - Serious adverse events are defined as:

      - Causing death, life threatening or serious disability.
      - Cause or prolong hospitalisation.
      - Overdoses, cancers, congenital abnormalities - whether judged to be caused by the investigational agent or new procedure or not.

  - Unforeseen events that might affect continued ethical acceptability of the project.

- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand, Manager, Research Ethics & Governance, of the Hunter New England Health as soon as possible.

Please quote **05/05/11/3.13** in all correspondence.

Should you have any queries about your project please contact Dr Nicole Gerrand as per her contact details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For:
     Chair
     Hunter New England Human Research Ethics Committee

Hunter New England Research Ethics & Governance Unit

(Locked Bag No 1)
(New Lambton NSW 2305)
Telephone (02) 49214 950 Facsimile (02) 49214 818
Email: hnehrec@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/Human_Research_Ethics

Qualitative study script

Hello, It's Elizabeth Knock here from the University of Newcastle. Could I please speak to …*Potential Participant…*?

If no:
What would be a more convenient time to call to talk to …*Potential Participant…*? Could I please leave a message with you that I will call back then?

Later if returned call and still not available:
Could I please leave a message for them to give me, Elizabeth Knock a call on 0488530990.

If a person other than the potential participant asks what the call is regarding:
I'm just calling regarding some research that they took part it.

If speaking to participant:
Hi My name is Elizabeth, I'm calling from the Newcastle University, and I am contacting you, as a participant in the ongoing DAISI project.

(Wait for recognition)

You have fairly recently finished your 3rd and final follow up phone assessment for the project. I am a clinical psychology Doctorate student with the University of Newcastle and have been involved with the DAISI interviews for a few years. We are interested in contacting a few participants such as yourself, to do some further qualitative interviews around your experiences of being in the project and what you felt was helpful or unhelpful. We're interested in your opinion so the format of the interviews is a lot less structured than you have been used to in the past and would take 30mins to an hour to complete and you will be reimbursed for your time. Do you think you might be interested in a little more information about this?

If No:
That's fine, Thank you for your participation with the DAISI project in the past *(End phone call)*

If Yes:
That's great, what I need to do then, is explain a bit more about what's involved for you and perhaps book a time that suits you.
It's important that I let you know that Interviews will also be taped so that I can transcribe them, then work out what the main themes and issues brought up in all the interviews are. Audio files of the taped interviews will be stored on a computer and protected by a password that only the people involved with this research have access to, and no identifying personal information will be associated with the interview audio files. You can also decline to participate at any point throughout the interview.

Would you would be willing to take part in one of these interviews?

If No:
That's fine, Thank you for your participation with the DAISI project in the past (*end phone call*)

If Yes:
Thank you. When would be a convenient time for you to do the interview? I'm available …(*Give times available*).. Would any of those suit you?...(*Arrange time to complete interview with participant*).
Well thank you for agreeing to participate. Would you like me to send you any written information with the details of the project on it?
I'll give you a call at …*time*….. on …*date*………. If between now and then you decide that you no longer want to participate in this part of the study you can either give me, Elizabeth Knock, a call on 0488530990 or just let me know that you no longer want to participate when I give you a call on …*date*… Is that ok? Do you have any questions? *(Answer questions and / or end phone call)*

<div align="center">

Return phone call

</div>

Hello, its Elizabeth Knock here from the University of Newcastle. Could I please speak to …*Potential Participant*…?

If no:
What would be a more convenient time to call to talk to …*Potential Participant*…?
Could I please leave a message with you that I will call back then?

Later if returned call and still not available:
Could I please leave a message for them to give me, Elizabeth Knock, a call on 0488530990.

If a person other than the potential participant asks what the call is regarding:
I'm just calling regarding some research that they took part it.

If Yes:
I'm calling as we arranged, to do an interview with you about your experience of being in the DAISI project, are you still happy to do this now?

If No:
Discuss possibility of completing it at another time and arrange this time

If Yes:
That's great.   As I explained last time we talked, the interview will be recorded then word-for word transcripts will be produced from that recording and these will be kept locked with no identifying information on them. You can also ask to discontinue the interview at any point you like. Is this all ok with you?

If No:

It's understandable that you are unsure about this aspect of the project. Not taking part for this reason will have no impact on your role within the DAISI project. Thank you for your participation in the past *(End phone call here).*

If Yes:
We will get underway with the interview then, it may take up to an hour, would you like to get a drink or water or cup of tea before we begin?

When participant is ready, begin semi-structured interview.
I will begin recording from now, at *..time..* on the *..date...* Now we are recording, can I confirm again again with you that you consent to participate in this interview, and that you are aware that the interview will be recorded and transcribed and that you can stop at any time?

If No:
It's understandable that you are unsure about this aspect of the project. Not taking part for this reason will have no impact on your role within the DAISI project. Thank you for your participation in the past *(End phone call here).*

If Yes:

Continue with Semi structured interview

Once Semi structured interview is completed:
Thank you very much for taking the time to complete this interview with me. Now that it is completed, can I confirm again that you consent to the use of this taped interview for transcription and analysis with all identifying information removed?

If No:
Discuss the participants concerns with them.
It's understandable that you are unsure about this aspect of the project. Not taking part for this reason will have no impact on your role within the DAISI project. Thank you for your participation in the past *(End phone call here).*

If Yes:
Thankyou *Participants Name,* Goodbye.

daisi

Depression & Alcohol Integrated
& Single-focused Interventions

Centre For Brain & Mental
Health Research
University of Newcastle
University Drive
Callaghan
NSW, 2308

DATE

Recipient Name
Address 1
Address 2
Address 3

Dear.........

Thank you for recently completing the third and final follow up of the DAISI project, and for your ongoing support of the project over the years.

Researchers on the project are interested in looking further into the experiences of participants such as yourself, of being in the project and what you felt was helpful or unhelpful.

This would involve approximately 30 minutes to an hour of your time, to complete an informal interview over the telephone, to help us understand more about your opinions and experiences.

Data collected in this additional component will be used by Elizabeth Knock (Research Assistant) towards partial completion of a Doctorate of Clinical and Health Psychology, under the supervision of Dr Frances Kay Lambkin.

Your participation is entirely voluntary and you can decline to participate at any stage. Where permission is granted, the interview will be recorded and unidentifiable password protected audio files will be only accessible to researchers directly involved in the study.

A researcher will be contacting you via telephone in the next few weeks, to provide more information. If you decide you are interested in participating, we will then arrange an appropriate time to carry out the interview.

You can decline to participate when contacted, or if you wish to speak to someone sooner about this aspect of the study, you can contact Elizabeth Knock on (02) 40335716 or 0488530990.

Thank you again for you role within the project in the past,

Regards,

Amanda Baker PhD
Chief Investigator
DAISI project
Centre for Brain & Mental Health Research

Complaints about this research

This research has been approved by the Hunter New England Human Research Ethics Committee of Hunter New England Health, Reference 05/05/11/3.13 Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, it may be given to the researcher, or, if an independent person is preferred, to Dr Nicole Gerrand, Manager Research Ethics and Governance Hunter New England Human Research Ethics Committee, Hunter New England Health, Locked Bag 1, New Lambton NSW 2305, telephone
(02) 49214950, email Hnehrec@hnehealth.nsw.gov.au

Appendix D: Measures

Beck Depression Inventory (BDI)

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the **one statement** in each group that best describes the way you have been feeling during the **past two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group.

1. Sadness
   0 I do not feel sad
   1 I feel sad much of the time
   2 I am sad all the time
   3 I am so sad or unhappy that I can't stand it

2. Pessimism
   0 I am not discouraged about my future
   1 I feel more discouraged about my future than I used to be
   2 I do not expect things to work out for me
   3 I feel my future is hopeless and will only get worse

3. Past Failure
   0 I do not feel like a failure
   1 I have failed more than I should have
   2 As I look back, I see a lot of failures
   3 I feel I am a total failure as a person

4. Loss of Pleasure
   0 I get as much pleasure as I ever did from the things I enjoy
   1 I don't enjoy things as much as I used to
   2 I get very little pleasure from the things I used to enjoy
   3 I can't get any pleasure from the things I used to enjoy

5. Guilty Feelings
   0 I don't feel particularly guilty
   1 I feel guilty over many things I have done or should have done
   2 I feel quite guilty most of the time
   3 I feel guilty all of the time

6. Punishment Feelings
   0 I don't feel I am being punished
   1 I feel I may be punished
   2 I expect to be punished
   3 I feel I am being punished

7. Self – Dislike
   0 I feel the same about myself as ever
   1 I have lost confidence in myself

2 I am disappointed in myself
3 I dislike myself

8. *Self Criticalness*
0 I don't criticise or blame myself more than usual
1 I am more critical of myself than I used to be
2 I criticise myself for all of my faults
3 I blame myself for everything bad that happens

9. *Suicidal Thoughts or Wishes*
0 I don't have any thoughts of killing myself
1 I have thoughts of killing myself, but I would not carry them out
2 I would like to kill myself
3 I would like to kill myself if I had the chance

10. *Crying*
0 I don't cry anymore than I used to
1 I cry more than I used to
2 I cry over every little thing
3 I feel like crying, but I can't

11. *Agitation*
0 I am no more restless or wound up than usual
1 I feel more restless or wound up than usual
2 I am so restless or agitated that it's hard to stay still
3 I am so restless or agitated that I have to keep moving or doing something

12. *Loss of Interest*
0 I have not lost interest in other people or activities
1 I am less interested in other people or things than before
2 I have lost most of my interest in other people or things
3 It's hard to get interested in anything

13. *Indecisiveness*
0 I make decisions about as well as ever
1 I find it more difficult to make decisions than usual
2 I have much greater difficulty in making decisions than I used to
3 I have trouble making any decisions

14. *Worthlessness*
0 I do not feel I am worthless
1 I don't consider myself as worthwhile and useful as I used to
2 I feel more worthless as compared to other people
3 I feel utterly worthless

15. *Loss of Energy*
0 I have as much energy as ever
1 I have less energy than I used to have
2 I don't have enough energy to do very much
3 I don't have enough energy to do anything

16. Changes in Sleep Pattern

0   I have not experienced any change in my sleeping pattern

1a I sleep somewhat more than usual
1b I sleep somewhat less than usual

2a I sleep a lot more than usual
2b I sleep a lot less than usual

3a I sleep most of the day
3b I wake up 1-2 hours early and can't get back to sleep

17. Irritability

0   I am no more irritable than usual
1   I am more irritable than usual
2   I am much more irritable than usual
3   I am irritable all the time

18. Changes in Appetite

0   I have not experienced any change in my appetite

1a My appetite is somewhat less than usual
1b my appetite is somewhat greater than usual

2a my appetite is much less than before
2b my appetite is much greater than usual

3a I have no appetite at all
3b I crave food all the time

19. Concentration Difficulty

0   I can concentrate as well as ever
1   I can't concentrate as well as usual
2   It's hard to keep my mind on anything for very long
3   I find I can't concentrate on anything

20. Tiredness or Fatigue

0   I am no more tired or fatigued than usual
1   I get more tired or fatigued more easily than usual
2   I am too tired or fatigued to do a lot of the things I used to do
3   I am too tired or fatigued to do most of the things I used to do

21. Loss of Interest in Sex

0   I have not noticed any recent change in my interest in sex
1   I am less interested in sex than I used to be
2   I am much less interest in sex now
3   I have lost interest in sex completely

BDI Total Score

International Personality Disorder Questionaire (IPDQ)

The purpose of this questionnaire is to learn what type of person you have been during the past 5 years.   If you are unsure of an item, select the one more likely to be correct**.**

1.	I usually get fun and enjoyment out of life	T	F
2.	I don't react well when someone offends me	T	F
3.	I'm not fussy about little details	T	F
4.	I can't decide what kind of person I want to be	T	F
5.	I show my feelings for everyone to see	T	F
6.	I let others make my big decisions for me	T	F
7.	I usually feel tense or nervous	T	F
8.	I almost never get angry about anything	T	F
9.	I go to extremes to try to keep people from leaving me	T	F
10.	I'm a very cautious person	T	F
11.	I've never been arrested	T	F
12.	People think I'm cold and detached	T	F
13.	I get into very intense relationships that don't last	T	F
14.	Most people are fair and honest with me	T	F
15.	I find it hard to disagree with people if I depend on them a lot	T	F
16.	I feel awkward or out of place in social situations	T	F
17.	I'm too easily influenced by what goes on around me	T	F
18.	I usually feel bad when I hurt or mistreat someone	T	F
19.	I argue or fight when people try to stop me from doing what I want	T	F
20.	At times I've refused to hold a job, when I was expected to	T	F
21.	When I'm praised or criticised I don't show others my reaction	T	F
22.	I've held grudges against people for years	T	F
23.	I spend too much time trying to do things perfectly	T	F
24.	People often make fun of me behind my back	T	F
25.	I've never threatened suicide or injured myself on purpose	T	F
26.	My feelings are like the weather; they're always changing	T	F
27.	I fight for my rights even when it annoys people	T	F
28.	I like to dress so I stand out in a crowd	T	F
29.	I will lie or con someone if it serves my purpose	T	F
30.	I don't stick with a plan if I don't get results right away	T	F
31.	I have little or no desire to have sex with anyone	T	F
32.	People think I'm too strict about rules and regulations	T	F
33.	I usually feel uncomfortable or helpless when I'm alone	T	F
34.	I won't get involved with people until I'm certain they like me	T	F
35.	I would rather not be the centre of attention	T	F
36.	I think my spouse (or partner) may be unfaithful to me	T	F
37.	Sometimes I get so angry I break or smash things	T	F
38.	I've had close friendships that lasted a long time	T	F
39.	I worry a lot that people won't like me	T	F
40.	I often feel "empty" inside	T	F
41.	I work so hard I don't have time left for anything else	T	F
42.	I worry about being left alone and having to care for myself	T	F
43.	A lot of things seem dangerous to me that don't bother most people	T	F

44.	I have a reputation for being a flirt	**T**	**F**
45.	I don't ask for favours from people I depend on a lot	**T**	**F**
46.	I prefer activities that I can do by myself	**T**	**F**
47.	I lose my temper and get into physical fights	**T**	**F**
48.	People think I'm too stiff or formal	**T**	**F**
49.	I often seek advice or reassurance about everyday decisions	**T**	**F**
50.	I keep to myself even when there are other people around	**T**	**F**
51.	It's hard for me to stay out of trouble	**T**	**F**
52.	I'm convinced there's a conspiracy behind many things in the world	**T**	**F**
53.	I'm very moody	**T**	**F**
54.	It's hard for me to get used to a new way of doing things	**T**	**F**
55.	Most people think I'm a strange person	**T**	**F**
56.	I take chances and do reckless things	**T**	**F**
57.	Everyone needs a friend or two to be happy	**T**	**F**
58.	I'm more interested in my own thoughts than what goes on around me	**T**	**F**
59.	I usually try to get people to do things my way	**T**	**F**

Readiness to change
ALCOHOL

Administer to all participants

The following questions are designed to identify how you personally feel about your drinking right now. Please think about how your current situation and drinking habits, even if you have given up drinking completely. Read each question below carefully, and then decide whether you agree or disagree with the statements.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Your answers are completely private and confidential					
1. It's a waste of time thinking about my drinking because I do not have a problem	☐	☐	☐	☐	☐
2. I enjoy my drinking but sometimes I drink too much	☐	☐	☐	☐	☐
3. I am trying to stop drinking or drink less than I used to	☐	☐	☐	☐	☐
4. There is nothing seriously wrong with my drinking	☐	☐	☐	☐	☐
5. Sometimes I think I should quit or cut down on my drinking	☐	☐	☐	☐	☐
6. Anyone can talk about wanting to do something about their drinking, but I'm actually doing something about it	☐	☐	☐	☐	☐
7. I am a fairly normal drinker	☐	☐	☐	☐	☐
8. My drinking is a problem sometimes	☐	☐	☐	☐	☐
9. I am actually changing my drinking habits right now (either cutting down or quitting)	☐	☐	☐	☐	☐
10. Giving up or drinking less alcohol would be pointless for me	☐	☐	☐	☐	☐
11. I am weighing up the advantages and disadvantages of my present drinking habits	☐	☐	☐	☐	☐
12. I have started to carry out a plan to cut down or quit drinking	☐	☐	☐	☐	☐
13. There is nothing I really need to change about my drinking	☐	☐	☐	☐	☐
14. Sometimes I wonder if my drinking is out of control	☐	☐	☐	☐	☐
15. I am actively working on my drinking problem	☐	☐	☐	☐	☐

OTI Alcohol

1. When was the last time you drank alcohol?

1.	Never	4.	In the past month
2.	More than 6 months ago	5.	In the past week
3.	In the past 6 months	6.	In the past few days

If subject answers 1, 2 or 3, proceed to *Cannabis*

2. During the past month, how often did you drink alcohol?

Between 6-7 days each week – Score 28		One day each fortnight – Score 2
Between 4-5 days each week – Score 20		One day each month – Score 1
Between 2-3 days each week – Score 12		Not in the last month – Score 0
One day each week – Score 4		

If subject answers 0, proceed to *Cannabis*

3. On what day did you last drink alcohol (in the past month)? _____

4. How much alcohol did you drink on that day?

(Ask about all categories. Figures in square brackets are numbers of standard drinks in one unit)

Wine	Spirits	Full Strength Beer	Light Beer	Fortified Wine
		Middy (10oz/285mL) [1]	Middy (10oz/285mL) [0.5]	
Glass (100mL) [1]	30ml nips [1]	Schooner (15oz/425mL) [1.5]	Schooner (15oz/425mL) [0.75]	Port Glass (60ml) [1]
750ml bottles [7.5]	750ml bottles [25]	Can [1.3]	Can [0.7]	750ml bottles [10]
Flagon (2 Litres) [20]	UDL (cans) [1.3]	Stubby [1.3]	Stubby [0.7]	2 lt. flagons [32]
_____lt. casks [10 per litre]		750ml bottles (longneck) [2.5]	750ml bottles (longneck) [2]	
No. of standard drinks				

TOTAL NUMBER OF STANDARD DRINKS = _____

5. On which day before that did you drink alcohol?_____

6. And how much alcohol did you drink on that day?

(Ask about all categories. Figures in square brackets are numbers of standard drinks in one unit)

Wine	Spirits	Full Strength Beer	Light Beer	Fortified Wine
		Middy (10oz/285mL) [1]	Middy (10oz/285mL) [0.5]	
Glass (100mL) [1]	30ml nips [1]	Schooner (15oz/425mL) [1.5]	Schooner (15oz/425mL) [0.75]	Port Glass (60ml) [1]
750ml bottles [7.5]	750ml bottles [25]	Can [1.3]	Can [0.7]	750ml bottles [10]
Flagon (2 Litres) [20]	UDL (cans) [1.3]	Stubby [1.3]	Stubby [0.7]	2 lt. flagons [32]
_____lt. casks [10 per litre]		750ml bottles (longneck) [2.5]	750ml bottles (longneck) [2]	
No. of standard drinks				

TOTAL NUMBER OF STANDARD DRINKS = _____

7. And when was the day before that? _____

8. **Would this be a typical pattern of drinking?**
1=Yes
2=No, more than usual
3=No, less than usual

9. **If *NO*, What would be a typical pattern of drinking?**

_____

_____

_____

10. **t1 = 3 – 5** ....

11. **t2 = 5 – 7** ....

12. **q1 = 4** ....

13. **q2 = 6** ....

14. **Q =** $\dfrac{\text{q1 + q2}}{\text{t1 + t2}}$

Social Disability Index (taken from the DIP)

Availability of Friends
How many people do you regard as friends?
Ask the name of friend/s. Only count people outside the family. Some form of contact (face to face or phone conversation) over the last 12 months is required for considering a person a friend.
How often have you been seeing them over the past month?
And over the past year?
What do you do together?

0=None	3=Many
1=One	88=NK
2=A few	99=NA

Perceived Need for Friends
Do you feel that you have as many good friends as you need or would you like to have more?
0=Does not need good friends at all
1=Needs and would like more friends
2=Has as many friends as needed
88=NK
99=NA

Overall Socialising during past 12 months
How have you been getting on with other people at work, neighbours, family members during the last 12 months?
Did you go out to any social activities?
Did you meet any friends, or would you say that you are a bit reserved?
Did you make any phone calls to friends or other people you knew?
How much of the time did you spend alone, in your room, or just walking around on your own?
Did you feel lonely?

Rate overall socialising/isolation over past 12 months – rate isolation on its own merits, regardless of self imposed (*eg.* avoidance).
0= No dysfunction; has been socialising during the period as much as could be expected of an average person of same sex/age group and social background
1= Obvious dysfunction; may regard some people as friends but actual socialising with them is minimal, has been significantly reduced, sporadic participation in any organised activity
2= Severe dysfunction; no friends and no organised social activities, extremely restricted social relationships outside the household
88=Uncertain or impossible to assess
99=NA

Social Withdrawal during last 12 months
Would you say that over the past 12 months you enjoyed company a lot or preferred to be on your own?
Did you find it difficult to mix or communicate with people?
Did you prefer to be left alone?
About how much of the time did you spend doing things by yourself?
Would you join in the company of others if encouraged to do so, or would you normally refuse even if asked?
Did the presence of other people annoy you?

Rate social withdrawal (*ie.* isolation which is not imposed by others or by the circumstances, but results mainly from subject's active avoidance of social contacts).
0= No dysfunction; mixes and generally interacts with people as much or more than the average person of the same sex/age group would under similar circumstances
1= Obvious dysfunction; maintains a very restricted range of social contacts, generally avoids being with other people, but would mix with people if encouraged or pressured
2= Severe dysfunction; marked tendency to self-isolation, not responsive to encouragement, inaccessible, may frequently lock him/herself up or wander aimlessly
88=Uncertain or impossible to assess
99=NA

Deterioration in Interpersonal Relationships
If you compare the past 12 months with previous years, do you think that your relations with friends, workmates or other persons may have gotten worse?
Did this happen because of you health or nervous problems?
Or because you lost interest or motivation?
Or because others have lost interest in maintaining a relationship with you?

0= No deterioration perceived in the past year compared to previous years
1= Deterioration perceived mainly attributed to subject's own health/nervous problems or loss of interest
2= Deterioration perceived mainly attributed to other people's loss of interest
3= Improvement perceived in past year compared to previous years
88=NK
98=NA

Intimate Relationships
During the past 12 months have you had a close female/male friend – someone that you would share your thoughts and feelings with or think of as a best friend, or someone you might rely on for support when you need it?
Have you ever had such a special relationship?
How often do you see this special friend?

0= Not dysfunctional; has close and/or intimate affective relationship during the past 12 months
1= Obvious dysfunction; has had close friends or intimate relationship in the past but not during the last 12 months
2= Severe dysfunction; never had close friend or intimate relationship
88=Uncertain or impossible to assess
99=NA

Measure of Parenting Scale (MOPS)

The following questions ask about your upbringing, and how you believe your mother and father related to you

Please indicate how true the following statements are as a description of your **MOTHER's** behaviour towards you in your first 16 years of life:

My Mother was:	Extremely True	Moderately True	Slightly True	Not True
Overprotective of me	3	2	1	0
Verbally abusive of me	3	2	1	0
Over-controlling of me	3	2	1	0
Sought to make me feel guilty	3	2	1	0
Ignored me	3	2	1	0
Critical of me	3	2	1	0
Unpredictable towards me	3	2	1	0
Uncaring of me	3	2	1	0
Physically abusive or violent towards me	3	2	1	0
Rejecting of me	3	2	1	0
Left me on my own a lot	3	2	1	0
Would forget about me	3	2	1	0
Was uninterested in me	3	2	1	0
Made me feel in danger	3	2	1	0
Made me feel unsafe	3	2	1	0

Please indicate how true the following statements are as a description of your **FATHER's** behaviour towards you in your first 16 years of life:

My Father was:	Extremely True	Moderately True	Slightly True	Not True
Overprotective of me	3	2	1	0
Verbally abusive of me	3	2	1	0
Over-controlling of me	3	2	1	0
Sought to make me feel guilty	3	2	1	0
Ignored me	3	2	1	0
Critical of me	3	2	1	0
Unpredictable towards me	3	2	1	0
Uncaring of me	3	2	1	0
Physically abusive or violent towards me	3	2	1	0
Rejecting of me	3	2	1	0
Left me on my own a lot	3	2	1	0
Would forget about me	3	2	1	0
Was uninterested in me	3	2	1	0
Made me feel in danger	3	2	1	0
Made me feel unsafe	3	2	1	0

Agnew Davies Therapeutic Alliance Measure
Client Questionnaire
Please answer each question as honestly as you can. Place a tick (✓) in the circle that best describes your feelings

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1. I feel free to express the things that worry me.	○	○	○	○	○	○	○
2. I feel friendly towards my therapist.	○	○	○	○	○	○	○
3. I am worried about embarrassing myself in therapy.	○	○	○	○	○	○	○
4. I take the lead when I'm in therapy.	○	○	○	○	○	○	○
5. I keep some important things to myself, not sharing them in therapy.	○	○	○	○	○	○	○
6. I have confidence in the therapy and in the techniques being used.	○	○	○	○	○	○	○
7. I feel optimistic about my progress.	○	○	○	○	○	○	○
8. I feel I can openly express my thoughts and feelings in therapy.	○	○	○	○	○	○	○
9. I feel critical or disappointed in my therapy.	○	○	○	○	○	○	○
10. I can discuss personal matters I am ordinarily ashamed or afraid to reveal.	○	○	○	○	○	○	○
11. I look to therapy for solutions to my problems.	○	○	○	○	○	○	○

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
12. The professional skills of the therapist are impressive.	○	○	○	○	○	○	○
13. I feel accepted in therapy no matter what I say or do.	○	○	○	○	○	○	○
14. I feel the therapy influences me in ways that are not beneficial to me.	○	○	○	○	○	○	○
15. My therapist finds it hard to understand me.	○	○	○	○	○	○	○
16. I find therapy warm and friendly.	○	○	○	○	○	○	○
17. I don't get the guidance in therapy that I would like.	○	○	○	○	○	○	○
18. My therapist is persuasive.	○	○	○	○	○	○	○
19. My therapist is supportive.	○	○	○	○	○	○	○
20. My therapist follows their own plans, ignoring my views of how to proceed.	○	○	○	○	○	○	○
21. My therapist is confident in themselves and their techniques.	○	○	○	○	○	○	○
22. My therapist seems bored or impatient with me.	○	○	○	○	○	○	○
23. My therapist expects me to take responsibility rather than be dependent on them.	○	○	○	○	○	○	○
24. My therapist and I are willing to work hard together.	○	○	○	○	○	○	○

25. I take the lead and my therapist expects it of me.	○	○	○	○	○	○	○
26. My therapist and I agree about how to work together.	○	○	○	○	○	○	○
27. My therapist and I have difficulty working jointly in a partnership.	○	○	○	○	○	○	○
28. My therapist and I are clear about our roles and responsibilities when we meet.	○	○	○	○	○	○	○

Agnew Davies Therapeutic Alliance Measure
Therapist Questionnaire
Please answer each question as honestly as you can.   Place a tick (✓) in the circle that best describes your feelings

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
1. My client feels free to express the things that worry him/her.	○	○	○	○	○	○	○
2. My client is friendly towards me.	○	○	○	○	○	○	○
3. My client is worried about embarrassing him/herself in therapy.	○	○	○	○	○	○	○
4. My client takes the lead in therapy.	○	○	○	○	○	○	○
5. My client keeps some important things to him/herself, not sharing them in therapy.	○	○	○	○	○	○	○
6. My client has confidence in the therapy and in the techniques being used.	○	○	○	○	○	○	○
7. My client feels optimistic about his/her progress.	○	○	○	○	○	○	○
8. My client feels he/she can openly express his/her thoughts and feelings in therapy.	○	○	○	○	○	○	○
9. My client is critical or disappointed with me.	○	○	○	○	○	○	○
10. My client can discuss personal matters he/she is ordinarily ashamed or afraid to reveal.	○	○	○	○	○	○	○
11. My client looks to me for solutions to his/her problems.	○	○	○	○	○	○	○

	Strongly Disagree	Moderately Disagree	Slightly Disagree	Neutral	Slightly Agree	Moderately Agree	Strongly Agree
12. The professional skills are impressive to my client.	○	○	○	○	○	○	○
13. I accept my client no matter what he/she does.	○	○	○	○	○	○	○
14. I try to influence my client in ways that are not beneficial to him/her.	○	○	○	○	○	○	○
15. I find it hard to understand my client.	○	○	○	○	○	○	○
16. I feel warm and friendly with my client.	○	○	○	○	○	○	○
17. I do not give the guidance in therapy that my client would like.	○	○	○	○	○	○	○
18. I feel I am a persuasive person.	○	○	○	○	○	○	○
19. I feel supportive.	○	○	○	○	○	○	○
20. I follow my own plans, ignoring my client's views of how to proceed.	○	○	○	○	○	○	○
21. I feel confident in myself and my techniques.	○	○	○	○	○	○	○
22. I feel bored or impatient with my client.	○	○	○	○	○	○	○
23. I expect my client to take responsibility rather than be dependent on me.	○	○	○	○	○	○	○

24. My client and I are willing to work hard together.	○	○	○	○	○	○	○
25. My client takes the lead and I expect it of him/her.	○	○	○	○	○	○	○
26. My client and I agree about how to work together.	○	○	○	○	○	○	○
27. My client and I have difficulty working jointly in a partnership.	○	○	○	○	○	○	○
28. My client and I are clear about our roles and responsibilities when we meet.	○	○	○	○	○	○	○

Appendix E: Qualitative Data Analysis

Table 16

Full Textual examples of theme 'Nature of Relationship'

Participant	Textual examples
P3	Yeh, I would say it would certainly be an ingredient, because I would say even with a patient and psychologist, unless you click, you know you may have a patient who doesn't like the psychologist or vice versa, I spose, but that's the same in any relationship I spose.
P3	I think it would normally take some time, I can't imagine well some people are different but I probably wouldn't, I certainly probably wouldn't have been able to just open up my heart on the first session. I probably would've met the person and then between the first and second session, sort of thought about the person, had time to sort of not analyse but time to evaluate the person, I think the longer you know someone obviously the better you can evaluate them? if the first session was negative that would've been very important.
P3	I suppose if the first session you didn't hit it off with whoever you were with, maybe that would set the tone for the whole course then, I don't know, there's that human element I suppose, different personalities, may never get on.
P4	I: so time helped? P4: I would've thought so, possibly. It's not something I thought about, so just being asked the question now and thinking about it, it was probably, it is very likely that it was, building up a friendship, well not a friendship, but a relationship over a period of time you know. I: is it like a friendship? P4: Well you know, it's different to that outside but when you're there it's like a friend ship but you know, you know that it's got to be different. Maybe it happens like a friendship but it's not really like that you know, it's different to that... the other thing is its anonymous too you know. She's not going to, you're not likely to bump into them on the street or in the shop, after opening your heart up to them. You know even sort of my doctor, I bump into my doctor at the shops and things and it would be difficult if I, if I sort of opened my heart up to the family doctor in the surgery and things I would find it difficult, you know, to, so it was anonymous, as well as umm, as well as umm being nice and friendly it was also detached from my normal life if you know what I mean. We were able to talk about things I wouldn't talk want to talk about in my normal life you know, but it felt detached, it made it easier.
P5	So I would never ring her after hours or you know, it's a really strong relationship but there's still like a bit of a line, and I

know if I had to id ring her but she would kind of be like the last, cos I wouldn't want to bother her, cos its still a professional relationship but there's still that really caring, she actually cares about me as a person not just as a patient... If I had to, I know if I had to I'd call her and she'd be, that's fine, but umm, yeh so it is, is not a social thing, it is a social thing but a professional social thing if that makes sense.

P6   It's all the worries, it's all the fears, it's all the emotion, umm and with that it's not the same with friends or family, or what not, it's a very edited and they only see what I allow them to see, and it's not the warts and all, they see the strong person who can do all these different things but they don't see the person who's at home who's an absolute mess.

P6   I'm aware that my psychologist and psychiatrist are professional people who have their own life and that they're not available to me and I would not expect them to be available to me, 24 hours or 365 days a year and I am respectful of their private life and that they have a private life and what glimpses they allow me to see into their private life is to me a sign of trust but I would, I'm also aware that I respect them enough not to ask private questions.

P7   Umm well it's just, it's always easier to talk to a stranger about stuff that's going wrong in your life than it is talking to a mate. Cos when you get together with a mate you're there for a good time. So the last thing you want to do is dwell on how bad things are going in your life to your mate, where as you're talking to someone as a counsellor or whatever they're doing you know for the daisi thing, and it's just a lot easier to open up I think.

P7   In therapy, I mean the counsellor, you know, they're a little bit smarter than the average bloke that you're drinking with down the pub. Um, and I think it's also because you don't know the person intimately it's a lot, it's a lot easier I think to delve and to talk to someone about your actual self and the side that you don't like. Whereas when you're at the pub with a mate, um, you know you naturally tell them all the good stuff, even if you're having a hard time. You know, you won't own up and say, well look I got up at 5 the other morning and I drank half a bottle of rum.

P7   I think that just, you know, you're sort of treating them as a counsellor. And um, just with the comfortable zone I spose, that's the easiest way to explain it, you've gotta feel comfortable when you talk to somebody but it helps that they're not your best mate or whatever.

P7   With somebody in a counselling role and all that you're actually wanting to hear what they're saying, so it's a friend that you've got that you actually listen to, you know what I mean, instead of half listening to your mate while he's rabbiting on about the football on the weekend... I mean you can have friends and you can discuss it a lot and they do make you feel better, umm, but it's not quite the same.

P7   I found it a lot easier to get to the story than say, as I said just meeting a bloke for the first time down the pub and he says

where do you life? Yeh righto mate, in a house. That's it.

P1   Well it felt like I loved her, she was just so nice, you know, loves a strong word but I guess it felt like there was a connection there with all her understanding... I wrote her a poem, yeh I wrote her just a short poem about my feelings towards what she was doing for me, my depression and that.

P1   She looked me in the eye and was willing to listen and talk. It's quite hard to explain. I felt I could trust her unequivocally.

P2   It was excellent, but I'm just trying to think of a, think of the right words, the relationship I think was ah, she always asked you how am I going, not just how are you going and then righto we move onto the next questions, but I felt a bonding as such, you know, I was quite confident in answering whatever questions she wanted to answer I always considered truthfully.

P2   That lady, she probably is a lady, not a dog, with her, we couldn't seem to agree on anything, you know we started out, this s the time I first physically saw her which is the time she wanted to put me in hospital so it was a 20 minute session, but nothing seemed to be, she would say things "you know I want you to do this" instead of "this would help". Maybe that's just my way of speaking but it was everything, not said in an aggressive manner, accepting I said, I'm not going to hospital. We weren't in parallel in as much as, things she said I challenged, and she never came back to me with the right answer and you know, god almighty you wouldn't never admit you were wrong would you. You know I reckon she's probably a zero -100 girl too, she puts nothing down the middle.

P3   Sometimes depending on counsellors they can be very mamby pamby I think. We had a terrible time with our daughter a few years ago, a really terrible time, we arranged an appointment with a counsellor and we all went and she sort of put her arm around my daughter and was all 'how are you darling' and all this and that, that sort of thing my wife didn't like it either she was very mishy mushy, very mushy, I don't know, ah, namby pamby, maybe that's undeserved.

P3   On the rare occasion that I might have felt uncomfortable, challenged, umm I think because after a couple of weeks I sort of knew the psychologist on, you know, they weren't aggressive, they were sympathetic, that made you relaxed and comfortable.

P4   They delved into, in a half hour session with a psychologist I don't spose you can cover everything, but then, and the daisi project they sorta went back and asked all sorts a questions about your life and what, where you'd been and what had happened to you and all that and that seemed to help a little bit.

P5   It was just kinda like, I suppose I was in there for alcohol and depression, which was totally me, yeh so I basically could tell her everything that was going on, everything and that felt really good, you know when you've got so much on your mind.

P5   I dunno, I just, to me they're kinda like my confident and it feels very easy but that stuff wouldn't be easy with someone else. Yeh, basically I guess you, I am, I'm having trouble explaining it, you get used to seeing them and I had to cancel my last appointment so I haven't seen her for a month so it will be a month tomorrow so I'm just hanging out to go and see her you know.

P5   Some of it does come easier than others it definitely does, it does, but like I said, now I just talk to my psychologist like we're sitting down having coffee or something and that's really good, but she's still professional, but still, still interested in what's going on with my life, you know outside of the problems, the stuff I'm actually going there for.

P5   I don't know, we just got on so well, umm yeh like I said I just looked forward to seeing her, it was good, it was, yeh like I knew she was like the psychologist and stuff but she just made me feel really easy, made it really easy for me to talk about things and I think that's very important.

P6   yeh she gives a little bit of herself, I suppose not enough to feel it's not a professional relationship but enough to feel that she actually cares about me as an individual and not as another patient just walking through that umm, that's the feeling she gives me that feeling that she genuinely cares, she shows emotion I suppose. As well, you know I've had times when maybe we've been talking about something that has happened to me that is particularly sad or distressing to me and I can see that she's got tears in her eyes and I don't know, that may sound silly but yeh its that feeling of she cares, she cares that this happened to me, she cares that I felt this way, um and that I suppose is what makes it easier to talk about is that. yeh I'm not feeling I've got someone sitting opposite me as I did with the psychiatrist whose just got a blank face and is appearing to show no empathy what so ever for what I'm describing for what I went through or how I was feeling or how it makes me feel or whatever. And I suppose that's what I mean by a two way street.

P6   I wouldn't expect them to answer a private question the same as I suppose, I respect that I suppose, they do the same for me, in that what they hear is privileged and that you know maybe if they ask a question and I'm unable to answer it or unwilling to answer it that they respect that.

P7   It just gave me confidence with the therapist because as I said they genuinely seemed to be concerned about what they were doing. I: was that important? P7: oh yeah, yeh, naturally cos if you're speaking to someone and you know they don't seem to be interested or care, you're just going to take a bad thing out of that... so that made you feel like you were worth something because naturally when you hit the depression and alcohol bad you think you're the lowest of low, so to get a, to be smiled at and be spoken to in a nice way instead you know like blokes in the pub speak to you.

P7   and as you're in there and you've got these people who are concerned with ya, it's easier to just say, well, my daughter hasn't

	spoken to me for 2 years, um, I spoke to her the other day and she just hung up on me, was something that you just wouldn't tell a stranger.
P2	she didn't always sit on the other side of the table, sometimes she'd sit ah, alongside and the way she would lean forward when I was talking and again, not sitting back going in one ear and out the other, she always came across to me as being very very interested in what I had to say, apart from what we had to do, you know the questions and that.
P2	I: going back to that word you used, 'Parallel', can you talk a bit more about why working in parallel is important? P2: well it's important, if you are both going to reach the same goals, to reach the end game. If you're not in parallel with the other person, who's going straight down the track, right to the big box at the end with all the goodies, if the other person is 45 degrees off, they'll end up in the car park, they'll certainly have all the goodies but you know, you wanted to share them so for that person, the therapist to have the same, or give me confidence, to think that they've got the same goal as I have or alternatively that I have the same goal as they have, so you know, I hate the word team, I really hate it, but it's really a team effort, in as much as you are both trying to get to a result, and have the same result in mind.
P3	After id finished with this counsellor at lifeline, and then this person attempted suicide and I went back and they arranged meetings with this fellow and I'm afraid I didn't connect with him at all, umm, he's supposed to be one of their best counsellors and I'm afraid I just left with no advantage at all. I: what effected the connection? P3: Well he looked like death warmed up for a start, I mean he just wasn't a picture of happiness and success but at the same time he just sat there and looked at me and waited for me to really, umm, I told him what the situation was and he just kinda sat there and well, what do you want me to do and this type of thing and all that, umm I didn't find it a fruitful encounter. I: so what helped that 'click' in DAISI? P3: Well I think there was for a start, probably more interaction in thoughts and ideas, I think it was more of a umm structured thing, it was a structured situation.
P3	I think it was mostly verbal. I think mutual respect where we could both have our say. She was able to say what she had to say and I did what I did, had to say.
P5	I just remember that she was very kind and you know, when I was, got there she was always kinda like looking forward to seeing me, I was looking forward to seeing her and I don't know, she just had a really good rapport about her and you know she explained things really well and stuff.
P6	Umm it was how she spoke with me, umm my previous experience had been with a psychiatrist that id been under for 3 or so years and his, he was very, he kept things very distant where I talked and he just listened and only made a comment every now and then, you know it wasn't a two way street. And I found that really frustrating and really difficult and the whole

relationship broke down really badly in the end and I just stoped seeing him because it wasn't doing me any good, where as the psychologist that I saw, from the first time I saw her it was a two way street... yeh she talked to me as much as I talked to her and I got feedback on what I was saying.

P7   If you're not asking the right questions you're going to get short abrupt answers and it doesn't help anybody, but if you're getting asked the right questions, and oh could you explain just a little bit more about what that means for you, you also get to think yourself that way, you start to use your brain... you forget about being the patient, and once you forget about being a patient , well you've sort of got no hang-ups. If you keep thinking about you're a patient well that's when you're going to, oh well, I won't mention that. you know what I mean, I won't mention that, I won't tell em that. But if they're making you a part of it with questions and all that, that's when I think, it's a lot easier to open up and go yep, I did that, I did that, I did that.

P1   I wasn't sure what to say, I thought oh well, I'll just be honest, I'll tell her everything and I did. I told her everything. I: was being honest important for you? P1: yeh yeh definitely, that's a major point I think, getting honesty. I was pretty low on confidence, the questions were a bit personal at first, but after that she gave me confidence, confidence and understanding about myself that I didn't have before

P1   I probably wasn't absolutely honest with her in its totality... I think it's a problem, ah, I'll go deep here, it's a problem that humanity should really address. Yeh honesty in our society is pretty much impossible, otherwise you don't get anywhere... I think that spilling the beans is probably our deathnell. Everybody's got their secrets and they'll keep them to the grave. Everybody knows that but only a few people admit it.

P2   if it was five questions, number five would be the best, that would be the DAISI therapist, and id put a zero, id scratch out the one and put a zero for this lady, if it was out of 100 it would be 100 to zero. She wanted to put me in hospital cos I was drinking too much and I did have at that stage, suicidal intentions so it was Friday afternoon and the second time I saw her she said, I think we better put you in hopsital and I said no chance of that, she said I have the power to do that, I said no you haven't you've got to get a doctor to do that. So she was ringing the hospital while I'm sitting there and I said that's not right, I'm not going, she said have you got somewhere you can stay tonight, I said oh yeah, I'll stay at a friend's place had to give her a phone number and she got someone to ring later on, no doubt she was looking after me but we weren't in parallel at all.

P2   She also assisted me in a, at that time it was very stressful for me, I was going through dept veteran affairs to get recognised for the time I had bronchitis, and that has left me with a disease, so I was stressed over that... My therapist, she helped me, she even wrote a letter for me to say that I was under this program, just so that I had some credibility.

P3   And I think maybe that was part of it with the psychologist in this case where I was just able to sit and able to talk freely and

	vice versa you know, just throw ideas you know, it was probably a productive relationship you know what I mean.
P3	In some ways it was a little bit confronting cos it stirs, it stirred things up for me, that were causing me to be depressed and use alcohol, if you know what I mean, I spoke about things that were causing me to behave that way and umm, I found it was a bit, ah, it stirred things up a bit... But of course it was already there but it was just a case of stirring things up I think, umm yeh, in some ways it might have taken me a day or so to settle back down if I had been stirred, if it had brought things to the surface again.
P3	ah, in a psychologist patient relationship I think it's pretty important, umm, oh I just forgot something then, but then I seemed to feel as if I had a thousand things going through my mind when I was there, the sessions, umm, there was so much going through my mind that even doing the tests, my mind was only half on the test and the other half had a thousand things going through my mind, I found it had to concentrate.
P5	It took time, I think because I had time to absorb it all, cos it can, it can be really overwhelming... I think I was just living in a big blur at the time and you know, I just wanted, I was just trying to reach out to someone that, and ah, yeh no I didn't have any expectations I just wanted to be able to get help.
P6	Well I needed a space to talk about it in the open so I could really think about what I needed to do but it's pretty shameful drinking too much, well it feels that way, and so I couldn't talk to anyone about it so I couldn't really acknowledge it in myself either cos I didn't really have a chance
P7	yeh there was a few times there that um, when I was doing the daisi project, cos I hadn't been speaking with my daughter, and I was going through a bit of a hard time, I always felt once Id left them and id spoken about it you know, it was never solved, far from solved, but it made my thinking unbearable as what I'd been thinking of, Cos they'd put some positive spin on it. I: and you mentioned that 'dark side'? P7: yeh I think it's the um, well as I said, I don't know what it is, but it's helpful you know if people are polite, are pleasant, it's very easy for people to talk if they feel relaxed. and if someone smiles at you in an interview you've got a tendency to relax and then you open up. So then yeh, you can open up and talk about those dark things.
P7	In some cases it was very hard, I finished up going through half a box of tissues on a couple of occasions you know, yeh there was some difficult chats but yeh, I think it was useful.

Table 17

Full Textual examples of theme 'Confidence in therapy'

Participant	Textual examples
P1	it was very calming, you could talk to her like she was someone who you know, knows what she's talking about, understands about depression and stuff, and alcoholism she sorta knew her stuff, yeh.
P1	Just the professionalism of the lady who looked after me... She was very calm, very calm, very genuine, and professional, very impressive, yeh. And she was someone who was very professional, highly intelligent.
P1	Well I would've liked to be able to say, will you come to dinner with me? While at the same time knowing that that was completely off the shelf, and a ridiculous idea. She drew the invisible line, and I was like off in the imaginary world, but I knew I was. This young lady, highly intelligent, very precise, yeh that's how I felt
P1	I just like people who are intelligent, I like people who like to talk about that stuff, rather than like, nothing. I like talking to people who are intelligent, I find that most of society are unintelligent, or in intelligent whatever the word is (I just dobbed myself in)... it kind of seems like someone's on your level, without trying to sound like I'm so smart, yeh, somebody who likes to talk about the same subjects. having said that, at the back of my mind I think, ah, I'm being narcissistic.
P2	she was very Knowledgeable, and I ah, I certainly questioned here, I don't believe in taking anything for granted. If someone says something to me, ill challenge it to make sure they know what they're talking about rather than just rattling out of some book written by a mad therapist you know, so again it was the knowledge, ah oh, compassion is not the right word, I don't think, but her interest in my situation and look, the way she conducted herself, all throughout and there was never any difference you know, no change... I mean they were all early morning meetings, it was hard for me, I suppose hard for everybody, I don't go well with early mornings so she must've been going through the same stuff to get to work and then bang! straight into this
P2	I: how did she check your understanding of what was happening? P2: Oh I think it was by her, she had the ability to recognise what was happening and she took action. I think she found out just by listening to me, or in the way of course I don't know what she really thought, but in the way I answered questions, and the way I challenged questions. I think that she got to know me very quickly. Myself, I think I have the ability to sum people up in a very short time, what do they say, 7 seconds is it? well I'm one of those persons, I've very rarely been wrong, so she maybe had that same insight and you know, attribute whatever

you want to call it

P2   well I would hope that in your profession, that that is what you're trained to do, or you have that ability to sum people up and about how you can get across or through to them whatever you need. But I think it was very quickly, and I never, I could see what she was doing from her approach, but that didn't offend me.

P2   It's very important I believe, in that office setting, that he psychologist or psychiatrist would form a bond with you and get to know you and really get to the bottom of things, really quickly, even by not asking the questions, but by doing, you know, all the stuff, the body movements, hesitation to answer questions, eyes not looking straight, clenching hands, you know, I spose that's what it is, I don't know.

P3   I felt confident that she would probably provide a constructive answer, confident in her knowledge and response.

P3   I think I wouldn't have coped as well as I did if I didn't do the course. I don't think they (past experiences) inhibited me at all really though, I think the skill of the psychologist carries you through that I think, I don't think it affected me in any way at all, I think it was only good, it only did good.

P3   P3: it could have been luck that the psychologist was someone that I got on with. I: Luck? P3: Probably, maybe professionalism, maybe umm, had that training how to get on with people, like I say there must have been some pretty strange characters come in, I suppose that's part of the skill of being a psychologist, of being able to umm, just relate to anybody.

P3   There's that human element I suppose, different personalities may never get on. But I think possibly a psychologist has had the training that they're able to go with the flow, with no matter who it is, I don't really know.

P4   Ah I had confidence in her, I just felt as if I could talk to them, I don't really understand, I don't really know why but they gave me the confidence to be able to talk to them and tell them you know your deepest fears and all that stuff, you know, it felt easier, yeh.

P4   I don't know, they were just easy to get along with, I think, I don't know I don't know how they did it, umm it's a mystery. I don't know. I think they were particularly clever

P4   I think as the sessions went on we were both more relaxed and umm, not that they weren't relaxed at the beginning, they were professional, and that's another thing they were very professional, they gave you a feeling of confidence, yeh. I: and how important was that? P4: oh yeh, You wouldn't want somebody stumbling around about in a situation like that, you want somebody who made you feel relaxed and confident in them. I: is there anything about them or what they did that gave that confidence? P4: I couldn't think of it, it was just a feeling I had, a manner of speaking I don't know, I couldn't put my finger on

it. And they knew what they were talking about see.

P5   I: would you talk to other people in your life this way? P5: yeh, but probably not to the same extent. I: I wonder what that is about? P5: I don't know exactly, they just have a way of getting stuff out of you (laughs).

P5   ? I think, I don't know it just depends, I think it depends on the person, it can be hard, it can be really hard, but I think, especially at first I think you're a bit more reserved but once you start, get going, it just starts to flow, and like I said I think the counsellor or the psychologist or whatever, it's how they handle it. And then something happens and before you know it you're in all the way and it's not so bad. I guess it could be!

P5   Yeh yeh.. You know, the majority of psychologists are empathetic because that's what you're trained to do, and I think it wouldn't have mattered who I got and I just needed someone and unless they were a total horrible person..

P6   I think it develops a little bit differently in that umm, by way of the fact that you know they're a professional you skip a few levels with them

P7   And um, I don't know, I just found always them very easy to talk to, they were always umm, they were always asking the right questions to get the person involved in the conversation. That's another key point.

P7   We you know, we sort of tune out whereas when you're talking to um, you know, your counsellors, they're listening, they've got their ears open and because I s'pose they hear very similar stories all the time, they don't hear that same story over and over, where they automatically put the tune up and go, tune out time.

P2   I don't think it was instilling confidence in me, it was instilling in me, the confidence that what she was teaching me, or putting me through was correct, it was right. She had confidence in herself and she had confidence in the program, she went through the sheets and she explained why they do it that way

P2   I personally wouldn't get a positive outcome and I would not be prepared to waste my time (which is nothing) but I'm not prepared to talk to in my mind, well, they're not idiots, but talk to someone who just doesn't understand you know, if they can't assess very very quickly, knock the edge off, break the ice and all that sort of thing, if they can't do that in the first session, well they shouldn't be doing what they're doing.

P4   I didn't find it challenging actually though, yeh, they seemed to ask the right questions, they seemed to be able to ask the right questions at the right time, and sort of make it easy, they made it easy.

P6   Well you know they explained it, and they talked about the confidentiality and the, you know, what was going to happen and what not, so right from the outset it was definitely a professional approach and then I suppose it was part of because I felt that, I

then assumed these people could be trusted.

P7   Um well as I said, id been to rehab so a lot of the advice id heard before, so , so you know naturally, and I suppose realistically, it came down to what they said made sense. You know what I mean? I didn't get a dummy, you know what I mean, I never got someone who was giving me tests, or we were having a chat about life and they were silly things like oh did you go out and have a drink on the weekend? the questions were umm, were all umm, how do you put it, were all generally good feel. You know what I mean, I just felt relaxed and they were good questions, like you don't want to get hit with like a, like I said 'did you go to the pub on the weekend?" you know what I mean?

P7   but once you got that little bit of confidence there, it just made it a lot easier, like, bang, have you got anything that you'd like to talk about today? Yep, bang, get it straight off my chest. Oh ok, well have you thought about doing this? You know, their ideas!

P1   She took time and she let me look out the window, at a little church, and she let me think for a while, she didn't interrupt in those silences, she didn't even say, take as long as you want, she just sat there with me, there were a lot of silent moments, it gave me time to reflect on my situation, therapy, where I was, yes it gave me time... she didn't put any pressure on me, if I had to fill out a questionnaire she would leave the room and come back at the appropriate time. She was lovely.

P1   well it was like she had the time for me... She didn't make me do anything... Not at all, she didn't give me any instructions I didn't want.. Ah, she listened to me.

P2   It wasn't like 'righto, answer these ten questions and ok you're finished now, off you go" you know if half way through something, if I wondered off track, which I often do, if I wandered off the subject you know, there was no immediate attempt to pull me back into line, they would just sort of hear me out, although I was very mindful of not sort of getting too far off the track, I understood time limits but you know, their impact on me was really good, really good.

P2   I: you've mentioned that one of the important things was to listen? P2: yes, listen, that's exactly right, exactly! And they do that well, half way through, I, I won't way staged a conversation, but halfway through or when I think I should ill just tell them my problems and he'll (my psychiatrist) say, oh, I knew you'd get to them eventually.

P2   now how do people get to that position? Is it by bluff? You know, they do the course and they just bluff their way through the world and get a few more little initials after their name, I dunno, I don't know who they answer too. They should answer to the patient.

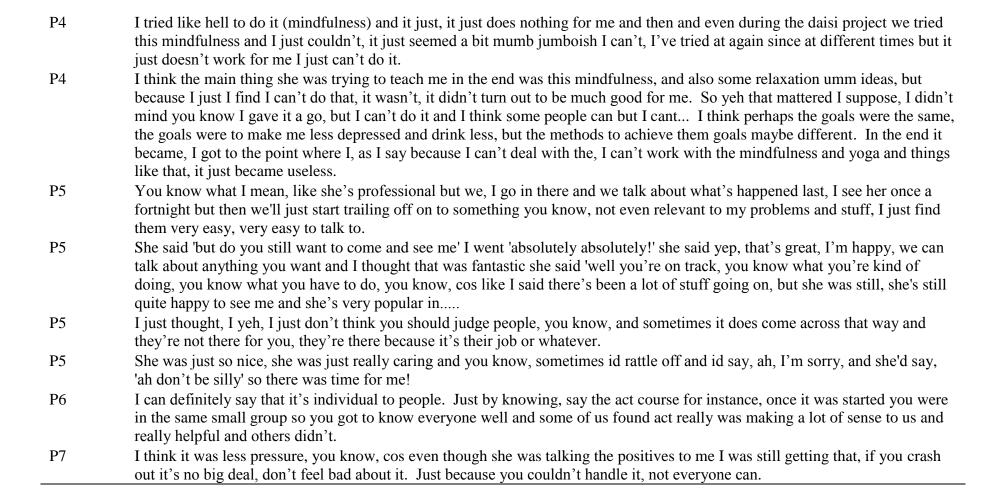P3   Well most of the time the hour session normally ran over so that sort of showed me interest.

P4	I tried like hell to do it (mindfulness) and it just, it just does nothing for me and then and even during the daisi project we tried this mindfulness and I just couldn't, it just seemed a bit mumb jumboish I can't, I've tried at again since at different times but it just doesn't work for me I just can't do it.
P4	I think the main thing she was trying to teach me in the end was this mindfulness, and also some relaxation umm ideas, but because I just I find I can't do that, it wasn't, it didn't turn out to be much good for me. So yeh that mattered I suppose, I didn't mind you know I gave it a go, but I can't do it and I think some people can but I cant... I think perhaps the goals were the same, the goals were to make me less depressed and drink less, but the methods to achieve them goals maybe different. In the end it became, I got to the point where I, as I say because I can't deal with the, I can't work with the mindfulness and yoga and things like that, it just became useless.
P5	You know what I mean, like she's professional but we, I go in there and we talk about what's happened last, I see her once a fortnight but then we'll just start trailing off on to something you know, not even relevant to my problems and stuff, I just find them very easy, very easy to talk to.
P5	She said 'but do you still want to come and see me' I went 'absolutely absolutely!' she said yep, that's great, I'm happy, we can talk about anything you want and I thought that was fantastic she said 'well you're on track, you know what you're kind of doing, you know what you have to do, you know, cos like I said there's been a lot of stuff going on, but she was still, she's still quite happy to see me and she's very popular in.....
P5	I just thought, I yeh, I just don't think you should judge people, you know, and sometimes it does come across that way and they're not there for you, they're there because it's their job or whatever.
P5	She was just so nice, she was just really caring and you know, sometimes id rattle off and id say, ah, I'm sorry, and she'd say, 'ah don't be silly' so there was time for me!
P6	I can definitely say that it's individual to people. Just by knowing, say the act course for instance, once it was started you were in the same small group so you got to know everyone well and some of us found act really was making a lot of sense to us and really helpful and others didn't.
P7	I think it was less pressure, you know, cos even though she was talking the positives to me I was still getting that, if you crash out it's no big deal, don't feel bad about it. Just because you couldn't handle it, not everyone can.

Table 18

Full Textual examples of theme 'Acknowledgment of experience'

Participant	Textual example
P3	"Unless things are resolved or you get some reasons why or acknowledgment, I don't think you ever come to terms with it, one thing about seeing the psychologist with the DAISI project, was I think a big thing is acknowledgment, she did acknowledge where I had concerns or things that had happened, and I think acknowledgment is very important for anybody, if you know what I mean"
P3	I think probably making progress, and acknowledgment, of being able to say something without being rebuffed, you know, like things that were troubling me and even if I was wrong, she didn't say I was wrong but was quite accepting to listen to what I had to say, which in a way is sort of acknowledgment
P5	It was just like, I don't know, it didn't matter what, you couldn't shock her. It was just what was going on for you and that was ok.
P5	Sometimes you feel like you're going mad, and they tell you you're not, that you're quite normal. Do you know what I mean?
P6	I got feedback on what I was saying and umm, reassurance I suppose, reassurance that what I'm feeling was not abnormal, and that you know, like and I still get it, that reassurance that even though I'm feeling depressed again, and this bout of depression has been going for 6 months now, that reassurance that it is going to go away again, and our know, just staying with it.
P6	It's nice to feel that the other person is acknowledging the distress, or the sadness. Of what you've been through. To validate your feelings, that you're not being neurotic or there's getting the feeling that oh well, you're emotion is of no consequence to them, so therefore maybe you should be feeling it. You have a, I suppose it, yeh giving you that feeling that what you're feeling is valid and that you're not abnormal, or you know, not being silly or whatever
P7	Like I went to a shrink, a psychiatrist, and the amount of garbage he give me for the hour was just absolute crap, and he said to me, he said, would you like to come back, and I was like 'you're kidding me mate' I said. Unbelievable, cos all you've told me for an hour is I brought this all on myself. I said mate, I know I've don't everything wrong and its all my fault, I'm not here to get the blame. but yeh, he was terrible.... I mean, I didn't expect to get gold stickers cos id done a lot of wrong things, but I didn't expect to be told that Id brought it on myself because you know once I walked out of the office I felt like shit.
P7	And if you chose not to have a drink that day, I mean it was only one day, but that day, and for the people that you were talking to and to see the smiles on their faces when you say you haven't had a drink, I like I might have like every fortnight the meeting

was, I might not have had a drink in that fourteen days, for three days, and that doesn't seem a lot, but to me three days was a hell or an achievement and to get recognition even if it's just oh congratulations, so you didn't have a beer on the weekend or whatever. It made you think, well I can do it, it's not that hard, and once people are giving you that little pat on the back which we all need, it just peps you up.

P7   They can make you feel like you could change things but at the same time you're getting it right, or at least that what you're saying isn't crazy and they respect that

P1   It meant that somebody understood. She had a lot of knowledge and she went through the various stages of alcoholism, she told me that some people drank more than me, and that I wasn't the only one.

P1   How did she know what I was looking for? She was highly intelligent and knew my problems -at a deeper level, about depression and drinking... She was very calm.

P2   The therapist knew my mind, I didn't really know hers that well, people in different professions come from different angles, so it takes me while to get my head around it sometimes, but we were in parallel because we were both, I suppose the subjects that were in the project were things that I knew were wrong with me.

P3   Having someone recognise what you're going through, and because they understand about the links between depression and alcohol it felt pretty helpful. What I was telling her made sense to her and that was good.

P4   I think the private psychologist seemed to, it was just part of her job, you know, just sort of going through the motions, they've seen it all before, they've seen a grown man cry. And then, umm, but the Daisi people seemed to... More feelings, you know. More understanding perhaps is the word. I suppose they seemed to know what I was going through and they were, they were quite impressive actually.

P4   Probably being able to relate what I was saying, in some instances she would appraise a situation before I could, before I did, but with a same sort of appraisal, so in some ways she could understand what wave length I was coming from if you know what I mean. I think there was understanding there, of what I was talking about. I think that's a help.

        Not to be judging, and I don't know, just, it's really hard to explain, you don't like, how do you say it, you don't have to be over the top and stuff, to me, just be able to understand. I just get on with people that don't sort of look down at me or make me feel that I'm stupid or whatever.

P6   I felt comfortable with them and I suppose, felt that they had some empathy and understanding of what I was saying to them. They certainly didn't show any evidence of being shocked or upset or whatever

| P7 | Which sort of, as soon as they were relating something to me I could sort of, id relate to them and say, yeh well I haven't had a drink this week and blah blah blah, and or if I'd had a drink like I said they were very understanding, um I think because they weren't pushing the subjects it was a lot easier to talk you know what I mean? |
| P7 | When I went to rehab I found a lot of the counsellors there were virtually out of uni, and they were trying to tell me about how drinking, uh like it started and how you should put this into practice and all this, to solve your yearnings and all that, and I just found, I found a lot of the younger people actually coming up and talking to me, rather than the counsellors. Because they could understand, well I could understand what they were talking about and they could understand the answers |

Table 19

Full Textual examples of theme 'Meeting unmet needs'

Participant	Textual examples
P1	P1: She seemed to have a bit of a plan that she stuck too... I thought that was very helpful, very. I: why do you think that was? P1: oh there was a bit of structure to it. I: why was structure helpful for you? P1: Probably because I had no structure in my personal affairs at all, I'm very glad I signed up for it really.
P1	I told her things that I probably wouldn't tell anybody else. It was very important. It's like, ah, I was in a marriage, and we sorta didn't talk about things in that depth, and then I found someone in the therapist, who could talk in that depth. Well even talking to you today, doing a bit of thinking.
P2	P2: Maybe I saw something of me in her, but again, I only saw it, I don't ask questions. It's not that I couldn't be bothered, but I couldn't be bothered you know, it's like talking, god only gives you so many words in your life, and these people talk talk talk, they're going to die young, it's true, I tell them that people talk talk talk. I: So this relationship was different? P2: Different to anything that I've experienced.
P2	Yeh well once I did really attempt suicide, took an overdose of my tablets and it gave me a seizure went off in the ambulance, so when I told my psychiatrist, he said, oh that's alright, once is a mistake, if you do it twice its serious. He said 'you going to do it again?" I said noooo way! things like that, we sit all day, well not all day, for an hour, and I have a lot of hobbies and we talk about those and we talk about ah, excuse me, putting shit on people without them knowing we're doing it, we made up all these ways you know, you could just go to funerals and you could get a free feed and you just ask a few pertinent questions and you'll soon know who was who, 'where did you go to school?" ah right, that's right I went to school at... then next conversation

"oh I used to go to school with him", ahh its silly, but I think they're mind games I like to play, they're not offensive and they're not harmful.

P2   I did ask her at the end, would she write a few words for me to submit in my application. So at the time of the Daisi project she knew what I was going through and she was prepared to assist me. In saying that, I also wrote to the specialist lung bloke that inspected me, and he said "no no, he couldn't do that". I was really over the moon because I was really taking a kicking you know.

P3   Back to Daisi and what went on, and those tests at the end, I was happy that I did pretty well, after I've had a life of being rubbished and being put down by my mother and my brother, and it gave me reassurance that I am what I think I am and that without that rubbishing, I probably would have been a lot more successful in life, with a bit more confidence you know what I mean?

P3   I'm no wrapped in, I'm not overly wrapped in love and attention, I think I appreciated the psychologist being able to sit and listen and just throw ideas across to each other if you know what I mean. I appreciated that relationship, not being hostile, I appreciated that relationship probably more than someone that is surrounded by a loving family. I left home when I was 18 and I struck up mates with a friend where I moved too and I met his mum & dad & they asked me for Sunday dinner and then friends of his mate id met their parents and they were all very kind & I often remember now I'd never felt warmth like that before. And I often wonder if I should've stayed there. that's back in the UK, but I often think geeze, I should've stayed here you know. I hadn't felt that before...

P4   It depends how you define socialising, if you mean having a chat to a bloke at the bar at a pub or opening your heart up to someone. Big difference. I don't have a lot of problems with chatting to the bloke at the bar but that's not going to help my depression is it. I don't know if other people do but I don't think I've known anybody I could talk to about this stuff usually, I mean, ahh, it's very personal isn't it. If I did have someone, I don't think id talk about it.

P5   Well I was getting to the point where I didn't want to leave the house and I sort of cut myself off from friends and everything and umm, yeh, I worked from home, I brought up my kids and I just got into this really bad thing, my sister passed away and everything just sort of fell into a heap and just to have that kinda outlet, just to jump in the car and basically, cos by the time you drive down and have your session and drive home it was nearly the whole day so it was giving me kind of like a bit of a purpose.

P5   I sort of suffered a bit of anxiety so making myself drive from XXX to XXX I think once a week, it was a bit of structure for

me, ummm and it was kind alike a bit of a release. I really needed that... And I really did look forward to it cos umm when you're in xxx it's kinda a bit isolated sometimes.

P6   Well my experience is that you can't talk about it with anyone else... I suppose I learnt fairly early on that people couldn't really handle when I talked about depression and my drinking and how I was feeling... Particularly my family, and umm, and what not, so a therapist was a place I could go and actually talk about what I was really feeling, or what was, what had happened that had cause me to feel

P7   I found that it was, umm by doing it, see you've gotta get up, you've gotta get out of bed, you've gotta get dressed because you're going to go and meet someone and do an interview and that and you've gotta try and look a bit respectable. So that also helps in pushing yourself to a better, to a better way than you'd normally do than if you were drinking. Because if you're drinking, you're letting yourself go, you don't give a flying fuck what anyone says, pardon the French.

P7   I think it's very much like a friendship, but it's a friend that you don't have, um, or it's a friend that you just want to keep to yourself because it's a friend that you feel safe with

P7   If I wasn't going to therapy I would have the whatever the problem was, building up in the back of my head and it wouldn't have come out with mates or anything because I don't want to drag my mates into my shitty life

P1   At the time I felt fairly lonely, and lost. It sort of calmed me down...Loneliness, I dunno, I've got friends but I dunno, I've had depression since I was a young age, since I was about 12 or something, I dunno why...

P2   it did have an impact, when I say I don't have any friends, I have one, a long term friend, but him and I are like, he's not made though, but him and I have got the same interests and we don't see each other in 8 months say, and just say g'day and just carry on, you don't say 'what've you been doing', 'how are the kids' all that stuff, who wants to know?? So I don't socialise you know, I can't find many people that have the intelligence capacity to talk with me on that, and I just like to say things to them, that just goes straight over their head and they don't know, I get a lot of ah, satisfaction out of that... I never asked the lady was she married, did she have a boyfriend, where she lived really. Although that would show some sort of bonding, it's none of my business and I didn't see why I had to know that. She didn't have to go through the nausea of telling me all about her life.

P2   It doesn't take me long to sum somebody up it's almost like giving them a test, but anyway, that's my way of getting through life, just to make sure you only pick people that you know you can trust, to be a part of your medical team, or part of your therapy team.

P3   I sometimes think that because in my opinion my wife and I are kinda kind loving people we tend to be trodden on, used, I

think we're probably too kind and turn the other cheek too much, I think that's the problem really we're just a target for certain types of people. We often said once that we felt we, when we were born we got a rubber stamp on the forehead to be punished.

P4   It's not something that a grown man does on a regular basis, you don't sort of open up your inner thoughts very often.

P5   cos I was having so many problems and it being such a small town, well its heaps bigger now, but umm, people don't really want to know your problems and that's when I started to shut myself off and I only kept one good friend and then I got to the point where I hated it p there and then the marriage was falling apart and stuff and it's just I'm from Sydney originally and my husband wanted to move up there and I didn't want to go, and it was a great place for the kids to grow up in but, it was just too clicky and I just hated it... the best thing was it was out of the bay, I could go in there and be myself and not be judged do you know what I mean.

P6   I suppose, umm I know that in some instances it has caused people discomfort and real discomfort, and it has caused people to withdraw from me, and cease contact, particularly hospitalisations, my family don't visit when I'm in hospital, so umm, I've learned early to be guarded about how much I tell them. They know I'm unwell, they accept that I suffer from depression, but, it's not that they're not caring, but they don't know how to help. They don't know how to respond and as a result I suppose I've learnt to protect them from that. And with other people, it's been to some extent, maybe I had that reaction when I tried to talk to friends or something, or because I got so much initial negative reaction to it I've just expected everyone to be that way so I stopped, I didn't, I don't tell people about it and I suppose it's sort of a number of years down the track now and that's one of the approaches my current therapists are working with me on, to actually to start to re involve people. To be able to talk with people.

P7   Blokes don't talk about feelings... Blokes are umm, I suppose we're selfish when we talk. Like I had a mate who split up with his missus before I did, and I mean I had him every bloody day crying to me and all that. I wasn't taking much attention, I wasn't really seeing how much pain the poor bastard was in and all that.. you know, because you're just sitting there going yeh, righto mate, I've heard all this before for Christs sake, you know, turn the record over.

P3   In some way I was hampered in delving into that with the person concerned because I'm sort of held back from confronting things, because the general atmosphere around me is to don't upset people, rather than be able to confront things, I've had to shut things down rather than get them sorted out. So it was sort of, 'what proof do I have that certain people think this of me or that of me', but I haven't been able to confront that because the people around me would rather just sweep things under the carpet. I would probably like to confront things that were of concern to me but I've been sort of hamstrung to do that.

P3	In some ways it's a little bit opposite from my character because I tend to be a little bit modest, not humble, where as I'm not the type of person who wants to talk about themselves, that's all they're interested in, it's a little bit unnatural for me to sit there and talk about myself so much, I'm more of a modest quiet person.
P4	P4: I found it useful seeing someone on a weekly basis, or monthly... Somebody to talk too, I didn't do that so much otherwise, and ah setting up challenges, and making promises to them as well as myself that I wouldn't have a beer on that particular time, or not until later or whatever we decided on, I found that really useful at that particular time. I: You mention someone to talk too? P4: ah yes, ah well I guess that's nice isn't it. If they listen. Not everyone wants to hear your problems if you know what I mean.
P4	Umm, there's no comparison really, I have nobody to compare that type of a relationship with. It was ah, I was able to talk to her about things I would never talk to anyone else about, ah, yeh, just a totally different relationship altogether to anybody else
P6	We were taught as a family not to show (emotions) so you're sort of, you're feeling them, but you're not, you've got this underlying thing of I should be stronger, I shouldn't be like this... The anger still is a problem, but I'm able to sort of cry now, umm and you know at times it sort of feels like I've turned on the tap and don't know how to turn it off, but yes, I show distress now.

Appendix F: Detailed procedure undertaken for Interpretative

Phenomenological Analysis

1. Verbatim transcription of the interview was recorded; this may have included pauses, laughing, tone, minimal prompts and other expression.

2. Text from verbatim transcription was converted into a table with three columns for initial analysis. Columns were labelled: Transcription , Notes and Psychological Themes.

3. Transcription was then thoroughly read for the first time making any notes/reflections about the text in column two- 'Notes'. The Notes column summarised thoughts and made any initial formulations about the meaning of text.

4. Transcription was then read for a second time, writing down statements in the third column- "Psychological Themes" to reflect the psychological meaning of the text/notes and any themes reflective of the meaning of the text. The label or psychological theme was a sentence or word reflective of textual meaning. During this stage, the analysers focussed ensuring that every line of text was represented somewhere and all themes accurately reflected meaning.

5. In a separate document, a chronological list of the psychological themes was created, identified in the order in which they occurred in the transcript. All themes were included.

6. A new document was created which contained a table with two columns and several rows. Themes were then grouped together into similar concepts and entered into individual cells of the table.

7. Once all psychological themes were in one cell of the Table, each cell was labelled by considering the meaning of themes included in that cell.

   Steps 1-7 were completed for each interview prior to commencing the subsequent interview.

8. Each interview was allocated a colour (e.g. Purple). The Step 5 table was cut up into individual cells (label and related psychological themes) and each cell was pasted onto the colour allocated to that interview.

9. Psychological themes (individual cells) across interviews were then considered, with each colour describing psychological themes expressed by individual participants. Similar Psychological themes were grouped across participants. During this process the analyser repeatedly referred back to the original text to ensure accurate representation of the label/psychological themes and to consider meaning behind the theme. Labels were not always retained in their original form.

10. These groups of themes, which were compiled into a separate envelope for each were retained as major themes. Each person must have contributed to an envelope in order for it to be retained as a major theme. Participants may have expressed different perspectives (e.g. Positive and negative) on the same theme, but in order for a theme to be retained as a major theme, it must contain a contribution/perspective from each participant.

11. Following this a process of 'textual grounding' occurred. An excel spreadsheet containing the following: a column for the participant number, and a column for a text quotation was created. For each theme, the participant number and the actual text (quotation/s from the transcript) related

to that theme was recorded. This was completed for all interviews and all

themes

Appendix G. Journal submission details

Journal Submission Details

The paper "A phenomenological understanding of the therapeutic alliance in dual diagnosis treatment" included within this thesis, has been submitted to the Journal of Clinical Psychology, for consideration.

Journal of Clinical Psychology

Edited By: Timothy R. Elliott (Editor) and John C. Norcross (In Session)

Impact Factor: 1.612

ISI Journal Citation Reports © Ranking: 2010: 46/102 (Psychology Clinical)

Online ISSN: 1097-467.

Aims and Scope

Journal of Clinical Psychology: Founded in 1945, the *Journal of Clinical Psychology* is a peer-reviewed forum devoted to research, assessment, and practice. Published eight times a year, the Journal includes research studies; articles on contemporary professional issues, single case research; brief reports (including dissertations in brief); notes from the field; and news and notes. In addition to papers on psychopathology, psychodiagnostics, and the psychotherapeutic process, the journal welcomes articles focusing on psychotherapy effectiveness research, psychological assessment and treatment matching, clinical outcomes, clinical health psychology, and behavioral medicine. From time to time, the Journal publishes Special Sections, featuring a selection of articles related to a single particularly timely or important theme; individuals interested in Guest Editing a Special Section are encouraged to contact the Editors.

Journal of Clinical Psychology: In Session. The twin challenges for mental health practitioners are to stay abreast of emerging therapeutic innovations and to identify the treatment methods and relationship stances that will prove most effective for each client. *In Session,* a branch of the *Journal of Clinical Psychology,* focuses on the clinical challenges confronting psychotherapists, in the form of either a distinct patient population or a therapeutic dilemma. Published four times a year, each issue of *In Session* features original articles illustrated through case reports by seasoned clinicians and informed by research reviews translated into clinical practice. Each issue examines a variety of theoretical orientations and treatment formats in jargon-free language. Case examples, clinical recommendations, and relevant research findings are combined to facilitate the selection and integration of effective methods.

> *Readership: Clinical psychologists · psychotherapists · counselors · mental health professionals*

Information sourced from journal home page:

http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-4679

Guidelines for Authors

Author Guidelines

Wiley's Journal Styles and EndNote

Manuscript Submission

Manuscripts for submission to *The Journal of Clinical Psychology* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).

2. Go to the URL http://mc.manuscriptcentral.com/jclp

3. Register (if you have not done so already).

4. Go to the Author Center and follow the instructions to submit your paper.

5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure. 6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).

7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

Timothy R. Elliott, Editor-in-Chief The Journal of Clinical Psychology 4225 TAMU Texas A&M University

College Station, TX 77843-4225 Email: timothyrelliott@tamu.edu

All *Journal of Clinical Psychology: In Session* articles are published by invitation only. Individuals interested in nominating, organizing, or guest editing an issue are encouraged to contact the editor-in-chief:

John C. Norcross, Ph.D. Department of Psychology University of Scranton Scranton, PA 18510-4596 E-mail: norcross@scranton.edu

Manuscript Preparation

Format: Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5) References 6) Tables 7) Figures 8) Figure Legends 9)

Permissions. Start each element on a new page. Because the ***Journal of Clinical Psychology*** utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style: Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition,* available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote: EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal:* If you already use EndNote, you can download the reference style for this journal. *How to Order:* To learn more about EndNote, or to purchase your own copy, click here .*Technical Support:* If you need assistance using EndNote, contact endnote@isiresearchsoft.com , or visit www.endnote.com/support .

Title Page: The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the

author responsible for correspondence. Authors should also provide a short title of

not more than 45 characters (including spaces), and five to ten key words, that will

highlight the subject matter of the article. Please submit the title page as a separate

document within the attachment to facilitate the anonymous peer review process.

Abstract: Abstracts are required for research articles, review articles, brief reports,

commentaries, and notes from the field. Abstracts must be 120 words or less, and

should be intelligible without reference to the text.

Permissions: Reproduction of an unaltered figure, table, or block of text from any

non-federal government publication requires permission from the copyright holder.

All direct quotations should have a source and page citation. Acknowledgment of

source material cannot substitute for written permission. It is the author's

responsibility to obtain such written permission from the owner of the rights to this

material.

Final Revised Manuscript: A final version of your accepted manuscript should be

submitted electronically, using the instructions for electronic submission detailed

above.

Artwork Files: Figures should be provided in separate high-resolution EPS or TIFF

files and should not be embedded in a Word document for best quality reproduction

in the printed publication. Journal quality reproduction will require gray scale and

color files at resolutions yielding approximately 300 ppi. Bitmapped line art should

be submitted at resolutions yielding 600-1200 ppi. These resolutions refer to the

output size of the file; if you anticipate that your images will be enlarged or reduced,

resolutions should be adjusted accordingly. All print reproduction requires files for

full-color images to be in a CMYK color space. If possible, ICC or ColorSync

profiles of your output device should accompany all digital image submissions. All illustration files should be in TIFF or EPS (with preview) formats. Do not submit native application formats.

Software and Format: Microsoft Word is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the journal design specifications. Do not use desktop publishing software such as PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

Article Types

Research Articles: Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).

Review Articles: Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.

Brief Reports: Abbreviated reports will be considered, and are especially encouraged if they involve: 1) replications; 2) replication failures; 3) well-designed clinical trials and other studies with negative findings; 4) potentially interesting serendipitous findings or results obtained by post-hoc hypotheses; or 5) Dissertations in Brief (DIB). DIB is intended to encourage students to submit innovative research conducted during the student's graduate studies. It is expected that DIB manuscripts would be submitted by the student, who would be the first author. All Brief Reports should contain an abstract and provide a concise synopsis (12 manuscript pages or less) of the major findings presented in the study. The format of manuscripts submitted for Brief Reports may adhere to the Research Report or Review Article format as appropriate. Authors of Brief Reports should make available a full description of method and statistical analyses with a report of all data and information needed for meta analyses. Brief Reports should include explicit statements of limitation, and power analyses may be necessary.

Commentaries: Occasionally, the editor will invite one or more individuals to write a commentary on a research report.

Editorials: Unsolicited editorials are also considered for publication.

Notes From the Field: Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.

News and Notes: This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

Editorial Policy

Manuscripts for consideration by the *Journal of Clinical Psychology* must be submitted solely to this journal, and may not have been published in another publication of any type, professional or lay. This policy covers both duplicate and fragmented (piecemeal) publication. Although, on occasion it may be appropriate to publish several reports referring to the same data base, authors should inform the editors at the time of submission about all previously published or submitted reports stemming from the data set, so that the editors can judge if the article represents a new contribution. If the article is accepted for publication in the journal, the article must include a citation to all reports using the same data and methods or the same sample. Upon acceptance of a manuscript for publication, the corresponding author will be required to sign an agreement transferring copyright to the Publisher; copies of the Copyright Transfer form are available from the editorial office. All accepted manuscripts become the property of the Publisher. No material published in the journal may be reproduced or published elsewhere without written permission from the Publisher, who reserves copyright.

Any possible conflict of interest, financial or otherwise, related to the submitted work must be clearly indicated in the manuscript and in a cover letter accompanying the submission. Research performed on human participants must be accompanied by

a statement of compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) and the standards established by the author's Institutional Review Board and granting agency. Informed consent statements, if applicable, should be included with the manuscript stating that informed consent was obtained from the research participants after the nature of the experimental procedures was explained.

The ***Journal of Clinical Psychology requires*** that all identifying details regarding the client (s)/patient(s), including, but not limited to name, age, race, occupation, and place of residence be altered to prevent recognition. By signing the *Copyright Transfer Agreement,* you acknowledge that you have altered all identifying details or obtained all necessary written releases.

All statements in, or omissions from, published manuscripts are the responsibility of authors, who will be asked to review proofs prior to publication. No page charges will be levied against authors or their institutions for publication in the journal. Authors should retain copies of their manuscripts; the journal will not be responsible for loss of manuscripts at any time.

Production Questions:

Andy Elder

Tel: 201-748-6694 Fax: 201-748-8852 E-mail: aelder@wiley.com

http://onlinelibrary.wiley.com/journal/10.1002/(ISSN)1097-4679/homepage/ForAutho... 14/10/2011

Appendix H: Evidence of Submission

Journal of Clinical Psychology - Manuscript number JCLP-11-0297

Sent: 14 December 2011 01:18

To: Elizabeth Knock; f.kaylambkin@unsw.edu.au

13-Dec-2011

Dear Miss Knock:

Your manuscript entitled "A phenomenological understanding of the therapeutic alliance in dual diagnosis" has been successfully submitted to Journal of Clinical Psychology. If this is your first submission of this manuscript, we will briefly look it over for suitability and correct formatting before sending it out for review.

Your manuscript number is JCLP-11-0297. Please mention this number in all future correspondence regarding this submission.

You can view the status of your manuscript at any time by checking your Author Center after logging into http://mc.manuscriptcentral.com/jclp . If you have difficulty using this site, please click the 'Get Help Now' link at the top right corner of the site.

Please contact us at jclp@tamu.edu if you have any questions. Thank you for thinking of JCLP as a potential outlet for your paper.

Cordially,

Rich Roberson
Journal Assistant

Timothy R. Elliott, Ph.D.
Editor-in-Chief, Journal of Clinical Psychology
Professor
Department of Educational Psychology
4225 TAMU
Texas A&M University
College Station TX 77843-4225
Phone: 979-862-3095
Fax: 979-862-1256