Key Concepts in the Training of Psychotherapists.

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Introduction.

This chapter reviews the theories emanating from the Maudsley Alcohol Pilot Project (MAPP), an action research project that took place between 1973 and 1977 to investigate the reasons community based therapists had such difficulties in establishing working alliances with alcoholic clients From the MAPP project came a theory linking Basic Role Requirements, Role Insecurity and Therapeutic Commitment to explain why these therapies were often unsuccessful, and a model of training to implement these ideas. This chapter will describe that basic work and then outline the ways, and the contexts, in which the ideas have been developed to inform training programmes. Much of the work was undertaken with therapists working with clients abusing alcohol though many of the training methods described have also been applied in more general psychotherapy training. Underlying this chapter is a belief that the core theories of psychotherapy need to develop toward more pluralistic models which place the therapeutic relationship at their centre.

Current Thinking about the Alliance.

Reviews of psychotherapy research are currently tending toward the view that the most important issue for the future is to understand therapist differences (Roth and Fonagay). Given, within the current state of knowledge, that the therapist's major contribution is in the capacity to build an alliance, theories which help us to understand how this is done may be of importance. The theory linking Therapeutic Commitment and Role Insecurity bears directly on this question.

The alliance, is often conceptualised as having three components. These involve the ability of worker and client to develop a shared understanding of the goals and means of treatment and to form an emotional bond. (Borodin) An effective therapeutic alliance is most likely to occur when the therapist is able to understand, accept and encourage the client. Most of the research into the determinants of the therapeutic alliance have focused on the therapist's capacity to provide such facilitative conditions, particularly their capacity to empathise with the client. A recent development in this area has been the growing interest in alliance ruptures and particularly the capacity of the therapist to heal them. In many ways the MAPP work had a similar emphasis being concerned with the process by which therapies often fail. (Safran and Muran)

Development of the Theory

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The MAPP theories address one aspect of ruptures in the alliance by suggesting that therapist insecurity in their role may play an important part in undermining their capacity to develop and maintain a therapeutically committed relationship. Since the time of that work a number of systematic studies and observations have been made. The following description takes account of these.

MAPP was funded by the British Department of Health and Social Security because it was felt that the then community responses were not effective with people abusing alcohol. It was widely recognised in the research literature that many therapists who did not specialise in work with drinkers felt intense hostility towards the clients who they felt were not motivated to change and unworthy of help. There were two current explanations for the therapists' hostility; the then most recent being that the workers treated alcoholism as a moral failure. The implication was that they needed to be educated to the view that alcoholism was a disease that could be treated. Studies of educational interventions based upon this model had demonstrated that it was possible to change therapists aetiological beliefs about alcoholism but there was little evidence that this would make them more willing to work with this client group.

An alternative explanation was rooted in the theory of counter transference and argued that alcoholics were predominantly of an oral dependent personality type which contrasted with the therapists who were believed to be anal and obsessive. The source of the hostility was to be found in the unconscious envy that therapists felt for the drinkers self-indulgence. In reviewing this literature the team concluded that there was little evidence to support this view though they felt that some psychodynamic factors were involved. (See Shaw, Cartwright, Spratley and Harwin and Cartwright 1979 for a review of this early literature)

MAPP approached the problem by first conducting a number of surveys of clients, therapists and members of the public and supplemented these by observing interviews between clients and therapists. (Cartwright, Spratley, Salter 1975). A theory was then formulated as an explanation for these observations and used to guide an action research project- which aimed to demonstrate that these professional responses could be changed. (Shaw et al, Cartwright 1979)

The reviews of the literature and discussions with clients led to the conclusion that therapy was most likely to be successful if the relationship between client and therapist was co-operative. The model of the therapeutic relationship which was thought likely to be successful was illustrated from the work of Hans Strupp and his colleagues

> "The composite image of the good therapist drawn by our respondents is thus of a keenly attentive, interested benign and concerned listener. A friend who is warm and natural, is not adverse to giving direct advice, who speaks ones own language and rarely arouses intense anger." (Strupp, Fox & Lesser).

This description complemented many of the then current reviews of the research literature which tended to point to the qualities of the effective therapist as including understanding, accepting and encouraging attitudes. The therapists who tended to

behave like this were also noted to want to be involved with their clients and confident in their ability to help. The MAPP team called this configuration of therapist behaviours and attitudes "Therapeutic Commitment".

In the interviews and observations the research team noted a range of behaviours and attitudes which were very different; at a general level these included ignoring the client's drinking or, if it could not be avoided, referring the client to someone else or breaking off the therapeutic relationship by deciding that the client lacked motivation. A not uncommon pattern was for the therapist to become overtly supportive opening themselves to abuse by the client and then reacting by becoming denigrating, hostile and blaming of the client (Shaw et al).

Less documented were a series of observations about the minutiae of the clinical relationship and the ways that therapists actually behaved when they got anxious. They included becoming distant and silent, interrupting and over talking the client, resorting to closed questions, using jargon and on occasions becoming hostile and critical. These were referred to as interviewing errors.

Overall the relationship that was most commonly observed was similar to that described by Mears and Hodgson (1977) in their paper on the "persecutory therapist". They describe the four therapist styles which are experienced by the client has been "persecutory". These styles were marked by the therapist being consistently intrusive, derogating, invalidating or withholding.

The MAPP research called this configuration Low Therapeutic Commitment. The primary goals of the project became to understand the reasons for low therapeutic commitment and devise ways of changing this form of therapeutic response.

The key was that many of the workers felt conflicted in their roles with these clients - they vaguely felt that they should help but felt unable to do so. They were also unclear as to what their roles entailed and uncertain as to the relevance of their knowledge and skills- they suffered from role conflict and role ambiguity. Their responses seemed to fit into the growing body of work on organisational stress and particularly that of (Kahn, Wolf, Quinn & Snoek) who in studies of industrial workers had concluded that

> "The emotional cost of role conflict for the focal person include, low job satisfaction, low confidence in the organisation and a high degree of job related tension a very frequent behavioural response to role conflict is withdrawal or avoidance ….."

> "The individual consequences of ambiguity are, in general, comparable to the individual effects of role conflict. These include, for ambiguity, low self confidence, a high sense of futility and a high score on the tension index."

> "The evidence urges the conclusion that neurotic and non neurotic reactions to role conflict are substantially similar and that sufficient environmental stress may produce neurotic symptoms even in those who show little predisposition to neurotic anxiety."

These features could often seemed to describe the therapists that MAPP was studying. Whilst they were professionally competent in general when it came to work with drinkers they often had little or no training, they consequently lacked knowledge and skills and were generally unsupported in this work. Further more many claimed to be uncertain about their rights to intervene and did not feel that they were "Role Legitimate". It was argued that these characteristics were the "Basic Role Requirements" needed by any person to undertake therapeutically demanding work. Without Basic Role Requirements the therapists' professional self esteem would be threatened and they would feel role insecure. By withdrawing from the therapeutic relationship the therapists could reduce their feelings of insecurity and thus "safeguard" themselves from threats to their professional self esteem. If the therapists felt inadequate in their role it was essential that they felt supported by someone who they felt was role adequate if they were not to feel threatened. It was found that some professionals could have high professional self esteem with some client groups and low with others. What distinguished the specialist workers from the others were that the specialists tended to have high self esteem about their work with drinkers. (Shaw et al, 1977; Cartwright 1979, 1980, 1981, 1985 and 1987).

The MAPP work acknowledged the significance of personal insecurity and the way it might reflect counter transference problems. However, counter transference can be seen as more likely to explain situations where you see either the emergence of an acute problem in relationship to a specific client or repeated examples of the low commitment towards individual clients - though in principle the therapists is committed to the therapy.

One area which the MAPP research did not focus specifically upon was the role of institutional policies in either encouraging or discouraging the therapist's role. This is only tapped indirectly through the concept of role legitimacy but has been taken up by a number of workers since that time.(LightFoot and Orford , Hunot and Rosenbach)

The MAPP action research projects sought to change the community services by intervening with the provision or education and support through a specially devised form of training programme. The intervention was not straight forward as part of the model suggested that the therapist insecurity would lead them to resist attempts to bring about change, thus the intervention would not be successful unless this resistance could be overcome.

According to the MAPP model the workers level of Therapeutic Commitment bears directly on the quality of the therapeutic alliance which the worker is able to establish with the clients. If a good therapeutic alliance is established then the client is more likely to engage in treatment and the treatment is more likely to be effective; this is the case whatever the theoretical orientation of the therapist or the characteristic of the client group (Cartwright 1981, 1985, 1987).

Cycle Figure Here

Figure 1 describes the cycle which links role insecurity and low therapeutic commitment. The cycle could be triggered by an event at any point for instance a

failure of understanding on the part of the therapist. The client would therefore feel uncomfortable and as a result would adopt a defensive attitude which in turn would make the worker feel more insecure. Eventually the client would drop out of treatment and the worker would justify this failure by claiming that the client was not motivated. The training model described later was designed to break this cycle and replace it with a cycle of security (Shaw et al, Cartwright 1979)

Research following MAPP

During the MAPP project an instrument was designed to measure the main concepts. This was called the Alcohol and Alcohol Problems Perception Questionnaire (AAPPQ) and provided reliable scales to measure Therapeutic Commitment, Role Legitimacy, Role Adequacy and the Basic Role Requirements of Support, Training, Knowledge, Experience and Self Esteem. Studies using this instrument have been carried out over the years and have shown that it is valid and reliable instrument which can be adapted to work with other client groups. The predicted relationships between the different parts of the model has also been confirmed, thus workers who had higher Basic Role Requirements tended to be more role secure and have higher levels of Therapeutic Commitment. (Cartwright 1980, Anderson 1985, Clement 1987, Bush and Williams 1988 , Manly 1999).

It was therefore concluded that bringing about changes in Basic Role Requirements would lead to greater clinical effectiveness This lead to the widespread adoption of the AAPPQ as a means of auditing training and other forms of intervention. There were also a number of formal studies As a consequence of this model much of the focus had been on the development of role adequacy based upon the development of clinical "skills" and knowledge. Not only were the psychodynamic issues identified in the early model largely ignored but some workers rejected outright the significance of therapist attitudes.

However many of these studies tended to suffer from limitations. First most were cross sectional in design, drawing causal conclusions on the basis of cross sectional correlations, secondly most used a composite measure which combined the Therapeutic Commitment and Role Security scales of the AAPPQ. Longitudinal studies which kept the scales separate tended to show a different picture. These studies of training programmes suggest that the composite measure of therapeutic attitudes hides the fact that training programmes are most effective in bringing about changes in role adequacy, role legitimacy and knowledge and much less effective in changing Therapeutic Commitment. (Cartwright 1979, Gorman, Werner, Jacobs and Duffy 1990, Gorman & Cartwright 1991, Cartwright and Gorman 1993).

Although there have been reports from some studies (Shaw et al 1977, Cartwright and Gorman) that workers who increased their Therapeutic Commitment were more likely to engage with clients there has only been one study which focussed upon the effect of Therapeutic Commitment on the clients treatment career. This study focused on the effectiveness of workers who were well trained, experienced and role secure in engaging clients in treatment within a specialist Alcohol Treatment facility.

This study was reported in two papers the first of which looked at the impact of client satisfaction on engagement in treatment (Hyams, Cartwright and Spratley 1997). After an initial assessment clients were asked to complete a questionnaire containing 71 items related to their experience of the interview. (e.g. "I felt that the interviewer liked me"). The items had been developed from earlier questionnaires, interviews and pilot work. The items ranged from the clients' emotional experience of the interview to their assessment of the therapists' competence. All the clients included in the study were recommended for treatment by the worker though this might have been in a part of the programme in which the worker was not involved.

The main finding was that clients who reported a positive therapeutic experience with the worker were much more likely to engage in treatment Clients were more likely to engage if they felt "liked" by the worker, if they felt the worker "understood" how they felt and less likely to engage if they felt "criticised" or treated as if they were "stupid" or if the felt the therapist was not genuine and "acting a part". Generally speaking the workers were rated as skilled and competent. However their views of the workers competence had little impact on the clients consequent behaviour.

These findings suggest that the essence of a good assessment interview is for the client to feel relaxed and to be able to talk freely about themselves to a worker who is warm, accepting and understanding and knowledgeable; findings reminiscent of those described in Hans Strupp's earlier work.

A second report examined the relationship between the clients feelings of satisfaction and the Therapeutic Commitment of the worker. The workers were all on senior nursing grades were well trained and experienced and two were also qualified psychotherapists. They agreed with the clients in rating themselves role secure and competent at their job. (See Appendix A for items from this version of the AAPPQ)

Clients were much more likely to engage in treatment if the workers scored highly on measures of Therapeutic Commitment – reporting that they "liked" the client, expected the experience to be "satisfying" and felt they could "understand" the client. Clients were much less likely to engage if the worker felt "uncomfortable", that there was little they could do to "help the client" and that the best would be to "refer the client to somebody else". These feelings being expressed in the context that they believed they had sufficient knowledge and skills to fulfil their role.

Essentially where workers felt a strong sense of Therapeutic Commitment then the clients were likely to report a positive experience and were likely to engage in treatment. Further where workers felt strongly committed they tended to see the client as being more motivated. However it was the workers level of commitment not their perception of the clients motivation which determined the clients behaviour.

The model combining Therapeutic Commitment and clients' attitudes correctly predicted the treatment behaviour of 72% of the clients. There were substantial differences in the effectiveness of different therapists with the least effective engaging 18% in treatment and the most 80% (These remained after taking client characteristics into account) Variations in the Therapeutic Commitment felt by the workers toward their clients explained these differences.

Figure II

To explore the role of positive client experiences further a questionnaire was developed based upon the positively predicting responses of these clients. This is called the Clients Experience of Therapy questionnaire and is given to patients finishing courses of once and twice weekly psychoanalytic psychotherapy with trainees from the Centre for the Study of Psychotherapy. Treatments generally last 12 to 18 months though some clients leave early. (See appendix B for these items)

Positive therapeutic experiences were strongly correlated with clients remaining in treatment, their consequent satisfaction and rating of improvement. In open ended parts of these questionnaires clients stressed the importance of "listening" or being "listened to", rarely both together and seemed to feel that the therapist's "competence" was far less significant than their capacity to form a relationship in which they demonstrated their commitment to the clients well being..

Figure 3

The following sections provide an outline of some of the training procedures which were evolved on the basis of this research. Although the research itself was largely based on the needs of therapists working with drinkers almost all of the later training was developed and used in the training of psychoanalytic psychotherapists.

The Basic MAPP Training Model.
Thus if we are to develop training programmes we need to evolve an understanding of the needs of the trainee if they are to provide a service which clients can use effectively. This was the approach used in the original MAPP project which developed training programmes were designed to intervene in the cycle described in Figure 1.

The aim of training from the MAPP perspective became to reduce the therapists insecurity by which was to be achieved through workshops that focused on the delivery of applied knowledge in the context of a consultancy group and the provision of role support.

Role Insecurity was seen as being like a ratchet, it could only go in one direction, up, unless positive steps were taken to release the catch. Thus the MAPP approach was to place the identification of Role Insecurity and the accompanying safeguarding behaviours at the centre of the strategy. There were four main procedures

- In both workshop and role support situations Role Insecurity was focused upon and safeguarding behaviours were challenged. Part of the purpose of this was to legitimise the feelings of insecurity These were seen as natural responses to problems of delivering the service and not usually approached from a counter transference perspective.

- The second stage of the model involved the focus on appropriate coping skills for handling situations which could not be resolved and this often involved focusing

on reality. Part of the problem for insecure therapists was that they would create a vision of the client which was not modified by observation and like most anxious people would search only for evidence that confirmed their anxiety

- Skills development was the most straightforward aspect. Generally speaking there would be an overall academic input into the workshops but the real focus was on using case material as the basis of discussion. Such teaching would also focus on an assessment of the clients problem the development of a range of possible explanations and the consideration of a detailed plan of action focusing on what had to be achieved as well as how to achieve it.

- Finally at the action stage the therapist had to be encouraged to act "as if" they actually felt role secure and therapeutically committed. The role of the consultant was almost like the auxiliary ego in psychodrama.

Thus both workshops and consultancy groups tended to move between educational and therapeutic modes and between cognition, emotion and behaviour.

These training programmes were designed specifically to deal with the sources of Role Insecurity that stemmed a lack of knowledge skill and experience in working with a\ specific client group. Their evaluation showed that they were felt to be effective by both workers and trainers and objectively increased detection and treatment rates. (Shaw et al,)

Studying Intervention Phrasing.
The experience of providing these programmes and applying similar techniques in general psychotherapy training makes the trainer aware of the significance of self reflection in the training process and a number of formal techniques have evolved which help provide for self reflective learning. The most important of these was the detailed study of audio and video recording of psychotherapy sessions with a view at looking at what Rainer Sachse has called "Intervention Phrasing" which is probably a better term than interviewing errors described above. Apart from Sachse's work there has been little study of the impact of the way the therapist communicates with the client.

In the training situations teaching of intervention phrasing involves trainees in small groups listening to audio recordings of each others sessions. The focus would be on the way the therapist was approaching the client and the implications of the phrasing of their interventions particularly the way that the phrasing was communicating information about the therapist. Though phrasing can be taught as a general skill it is also important to recognise that when the skill fails this often indicates an anxiety on the therapists part. This approach looks at the way the session is conducted in great detail and therapists may write comments about their experiences of the interventions.

One method which was evolved to help in this process was Code-A-Text (Cartwright 98a,b) which was originally developed to enable therapists reflect upon their work with clients. By using computer software like this it is possible to identify subtle patterns of interaction which supervisor and trainee can use in the training situation.

Of great importance in this process is the separation of observation from interpretation which psychoanalytic therapists often find very difficult

Reflective Role Analysis.

I use the term reflective role analysis for a paper and pencil method which can be used to enhance therapists self awareness. The original MAPP research was strongly influenced by the growing body of organisation theory (Kahn et al) which itself drew on role theory. The questionnaire found in Appendix 4 was devised specifically to allow trainees (in this case psychoanalytic psychotherapists) to reflect upon the nature of their relationships with their clients. Although it often appears repetitive the repetition itself ensures an inclusiveness of most areas. Most trainees find the process initially difficult because it exposes areas which they have not considered but invariably they eventually come to learn a great deal from the process.

Research Based Training

Researchers tend to bemoan the lack of interest that many therapists show in research and many clinicians feel that research does not address issues which they consider relevant. Part of the problem obviously lies in the fact that research is often used as a method for determining the value of one method against others, often producing studies which don't relate to the real world of clinical practice. However there is also a need to formulate research findings in ways that are acceptable to clinicians. The notion that one should select clinical trainees on the basis of their potential research skills becomes less and less acceptable as studies such as those described in this paper and projects such as that reported by Anderson(1999) and Valle (1981) indicate the central importance of relating in the therapeutic process. This means that those who focus on research have a need to not only make the findings accessible to clinicians but also to find ways of conveying the significance of research methodologies.

At the heart of the research process are the concepts of validity and reliability. One way of helping clinicians understand the significance of these concepts is to encourage them to undertake informal studies of their own work in which the stress is on the exploration of their sessions in a manner which is valid and reliable. Inter rater reliability is central to such a process because it challenges the certainty which clinical formulations are often made. Such a method can bring the clinician closer to the actual clinical experience. The danger of this process is that researchers who introduce it will loose sight in the need to ground the approach in the clinical values and try and encourage the clinicians to become researchers which will only encourage the dialogue of conflict that already occurs between these tow groups.

A Model for Effective Intervention and its Implications for Training

The belief expressed by Roth and Fonagay that we must begin to study the differences between effective and ineffective therapists represents the culmination of many years research by psychotherapists in which they have sought to find difference in effectiveness between treatments methods. Perhaps it is time to recognise that the academic models of treatment do not reflect clinical reality and that we need to develop models which are influenced by the clinical data and train therapists accordingly.

The predicative items on the Client Experiences of Therapy Questionnaire suggest that the way a therapy is conducted is probably more important than the type of therapy itself in helping the client. The therapy seems to involve a sense of commitment and working together which comes from a mutual understanding of the clients needs. This suggests that what effective therapists provide is a number of functions which the client can use to their advantage. The therapist may not be aware of the need they are fulfilling because they are applying methods which the client then adapts. For instance a behavioural therapist may fulfil the clients need for understanding by conducting a client centred behavioural analysis of a problem while a psychoanalytic therapist might fulfil needs for guidance and direction by formulating and interpreting (Cartwright 1981)

There are certain types of therapy which may not adapt well because they imply a form of relationship which will only be experienced as committed by a small number of clients. For instance some highly confrontational models for the treatment of drug and alcohol abuse would fit into this category. Some years ago a study by Ends and Page on group psychotherapy reported that a behavioural intervention which was tantamount to being told "all the bad things about you" had worse outcomes than a control group. From a totally different perspective recent reports from McCallum & Piper suggest that classical psychoanalytic psychotherapy results in very high drop outs unless it is applied to clients with high "psychological mindedness" and good "object relations". That is to say the model of the opaque therapists cannot be adapted to their own psychological needs by many clients.

Essentially these findings reflect a dilemma which is at the heart of the training problem. Namely that training programmes teach theories and methods which tend to be internally consistent but which may not reflect the needs of the client. Perhaps psychoanalytic training programmes have the greatest difficulty here because the formal clinical model may not necessarily be the most effective variant with the average client. Experienced therapists such as Freud himself are able to adapt the model to the clinical situation (Lynn & Valliant) but trainees are often confused because the essence of the conflict is rarely formally acknowledged in the training situation.

This is most clearly indicated in the attitude toward "supportive psychoanalytic psychotherapy". Supportive psychotherapy is often denigrated though there is substantial evidence for the importance of the supportive elements in effective psychotherapy. The reasons why it is important may be to do with the flexibility that the model offers the therapist. The supportive therapist is not constrained by their theory and can thus adapt to the needs of the client. By starting with the here and now and the real relationship the therapist is able to give advice or make interpretations whenever appropriate. Thus the therapy can be adapted to the needs of the client rather than the client having to adapt to the method of the therapist. However the downside of this is that the therapist needs great skill and knowledge to be able to choose an appropriate intervention.

In this chapter I have tried to advance the argument that the fundamental goals of training must be to create a role secure therapist who is able to provide a therapeutically committed relationship for the client. In terms of the formal theories

of psychotherapy this is an a-theoretical approach though it is not intended as a rejection of theory per se. General clinical theories are important because they provide the therapist with a view of the client and thus makes the therapist more secure. Unfortunately they can also restrict the therapists view of the client making them appear lacking in understanding and ultimately uncommitted. . The advantage of formal theories is that they can provide the trainee with security though that very security may make it more difficult for them to relate appropriately to the client.

It seems that each of the theoretical perspectives is based upon an aspect of client experience. Theories from behaviourism to psychoanalysis are likely to reflect different aspects of that experience which suggests that in time we might develop a general theory which integrates or at least accepts these different perspectives. Unfortunately there is a major impediment to this process, namely therapist don't just tend to "do" a specific form of therapy they "are" that type of therapist.

This dynamic is most clearly illustrated in Britain where psychotherapy has evolved into an independent profession. At the time of the formation of the United Kingdom Council for Psychotherapy the different groups of psychotherapists were so uncomfortable with each other the organisation developed a federal structure with each type of therapy being represented by a section designated by a flag statement which defines that form of therapy. Such a professional structure could be a major impediment to any form of theoretical development which cuts across the identities of the various professional groupings.

Having retired after training therapists for more than 25years this chapter has served as a reflection. What I emphasise more than anything else is the significance of the interpersonal relationship in the clinical process. One should not see this as a simplistic notion of "nice people make good therapists" but rather recognise that the real clinical skill comes from the ability to maintain commitment to that relationship when difficulties arise. With less disturbed clients or in shorter term therapies this is less of an issue but the moment the therapist moves away from this baseline difficulties can emerge and it is then that the inter-personal and intra-personal skills of the therapist come to the fore.

The therapist who is too work well in this situation has to understand their client and this may entail an understanding that goes beyond the bounds of normal empathy to experiences that can sometimes only understood indirectly often from books and theory; concurrently they have understand themselves and how they react when they become insecure and be able to cope with such insecurities in a non defensive way; and finally they have to have the interpersonal skills to deliver that understanding and knowledge and any more formal forms on intervention which are implied.

The challenge for training in the next century is to develop theories and methods that facilitate this process.

REFERENCES

Anderson, P. (1985) Managing Alcohol Problems In General Practice, *British Medical Journal*, 290, pp. 1873-1875.

Anderson T (1999) Specifying "Non Specifics" in Therapists. The effect of Facilitative Interpersonal Skills on Outcome and alliance Formation. Paper presented at the Society for Psychotherapy research Conference Braga Portugal.

Borodin E.S. (1976) The Generalisability Of The Psychoanalytic Concept Of The Working Alliance. *Psychotherapy, Theory Research and Practice* 16, 252-260.

Bush, R.A. & Williams, R.J. (1988) Generalist Health And Welfare Worker's Response To Alcohol-Related Problems: Role Legitimacy And The Need For Role Support, An Example From An Australian Rural Community, *Drug and Alcohol Dependence*, 22, pp. 105-111.

Cartwright, A. (1979) *The Effect of Role Insecurity on the Therapeutic Commitment of Alcoholism Counsellors* . Ph.D. Thesis. Institute of Psychiatry, London.

Cartwright, A. (1981) Are Different Therapeutic Perspectives Important in the Treatment of Alcoholism, *British Journal of Addiction* 76, pp. 347-361.

Cartwright, A. (1985) Is Treatment an Effective Way of Helping Clients Resolve Difficulties, in Heather, N. & Robertson, I. (eds) *The Misuses of Alcoho*l (London, Croome).

Cartwright, A. & Gorman, D. (1993) Processes Involved In Changing The Attitudes Of Clinicians Toward Working With Drinking Clients, *Psychotherapy Research,* 3(2), pp. 95-104.

Cartwright, A. (1980) The Attitudes of Helping Agent's Toward the Alcoholic Client; The Influence of Experience, Support, Training and Self Esteem, *British Journal of Addictions*, 75, pp. 413-431.

Cartwright, A. (1987) A Therapeutic Day Unit for Alcohol Abusers. In Stockwell, T. & Clement, S. (Eds). *Helping the Problem Drinker: New Initiatives in Community Care*, pp. 121-144. London, Croome Helm.

Cartwright A., Hyams G., Spratley T., (1996) Is the Interviewers Theapeutic Commitment an Important Factor in Determing Whether Alcoholic Clients engage in Treatment? *Addiction Research* Vol4 No 3.

Cartwright A (1998a). Personal and professional Factors in the Development of Code-A-Text. *Qualitative Health Research*. Vol 8 No 3.

Cartwright A (1998b) Code-A-Text - A software System for analysing Dialogues. Scolari-Sage London and Los Angles.

Clement, S. (1987) The Salford Experiment: An Account Of The Community Alcohol Team Approach. In Stockwell, T. & Clement, S. (Eds). *Helping the Problem Drinker: New Initiatives in Community Care*. pp. 121-144. London: Croome Helm.

Ends, E,j & Page, C.W (1957) A Study of Three Types of Group Therapy with Hospitalised Male Inebriates *Quarterly Journal of Studies on Alcohol* 18 263-257

Gorman, D. & Cartwright, A. (1991) Implications Of Using The Composite And Short Versions Of The Alcohol And Alcohol Problems Perception Questionnaire(AAPPQ), *British Journal of Addictions 86, pp. 327-334.*

Gorman, D.M., Werner, J.M., Jacobs, L.M. and Duffy, J.W. (1990) Evaluation Of An Alcohol Education Package For Non-Specialist Health Care And Social Workers, *British Journal of Addiction,* 85 pp. 223-233.

Horvath, A.O. & Luborsky, L. (1993) The Role of the Therapeutic Alliance in Psychotherapy, *Journal of Consulting and Clinical Psychology*, 61, 4, pp. 561-573.

Hyams G, Cartwright A, Spratley T. (1996) Engagement in Alcohol Treatment: The Client's Experience Of, And Satisfaction With, The Assessment Interview. *Addiction Research* Vol4 No 2

Hunot V and Rosenbach A (1998) Factors Influencing the Attitudes and Commitment of Volunteer Alcohol Counsellors . *British Journal of Guidance and Counselling* Vol 26 No3.

Kahn R.L., Wolf D.N., Quinn R.P. & Snoek D. (1964) *Organisational Stress* , John Wiley London.

Lightfoot, P.J.C. & Orford, J. (1986) Helping Agents' Attitudes Towards Alcohol-Related Problems: Situations Vacant? A Test And Elaboration Of A Model, *British Journal of Addiction*, 81, pp. 749-75.

Lynn D. J and Vaillant, G.E (1998).Anonymity, Neutrality and Confidentiality in the Actual Methods of Sigmund Freud: A Review of 43 Cases, 1907-1939. *American Journal of Psychiatry* 155:2

Luborsky, L., McLellan, T., Woody, G., O'Brien, C. & Auerbach, A. (1985) Therapist Success and its Determinants, *Archives of General Psychiatry*, 42, pp. 602-611.

Luborsky, L., Crits-Christoph, P., Mintz, J. & Auerbach A. (1988) *Who will Benefit from Psychotherapy: Predicting Therapeutic Outcomes* (New York, Basic Books).

Manley,J., Leiper, R., Therapeutic Commitment and Role Security in work with Men with Violence Related Problems: An Investigation and test of a Model.

McLellan, A., Woody, G., Luborsky, L. & Goehl, L. (1988) Is the Counsellor an Active Ingredient in Substance Abuse Rehabilitation. An Examination of Treatment

Success Among Four Counsellors, *Journal of Nervous and Mental Disease,* 176, pp. 423-430.

McCallum, M & Piper, W Paper during the symposium, on Supportive Psychotherapy . Paper presented at the Society for Psychotherapy research Conference Braga Portugal.

Mears, R. & Hobson, R.H. (1977) The Persecutory Therapist, *British Journal of Medical Psychology*, 50, pp. 349-359.

Roth,A. & Fonagy,P., (1996*) What works for Whom: A Critical Review of Psychotherapy Research* Guildford Press. London

Safran J.D. and Muran J.C. (1995) The Therapeutic Alliance *In Session*. Vol1 No.1

Sachse R. (1993) The Effects of Intervention Phrasing on Therapist Client Communication Psychotherapy Research Vol 3. Number 4. Pgs 260 - 277

Shaw, S., Cartwright, A., Spratley, T. & Harwin, J. (1978) *Responding to Drinking Problems* (London, Croom Helm).

Valle, S.K. (1981) Inter-personal functioning of alcoholism counsellors and treatment outcome, *Journal of Studies on Alcohol*, 42, pp. 783-790.

Figure 1
The Cycle of Role Insecurity and low Therapeutic Commitment.

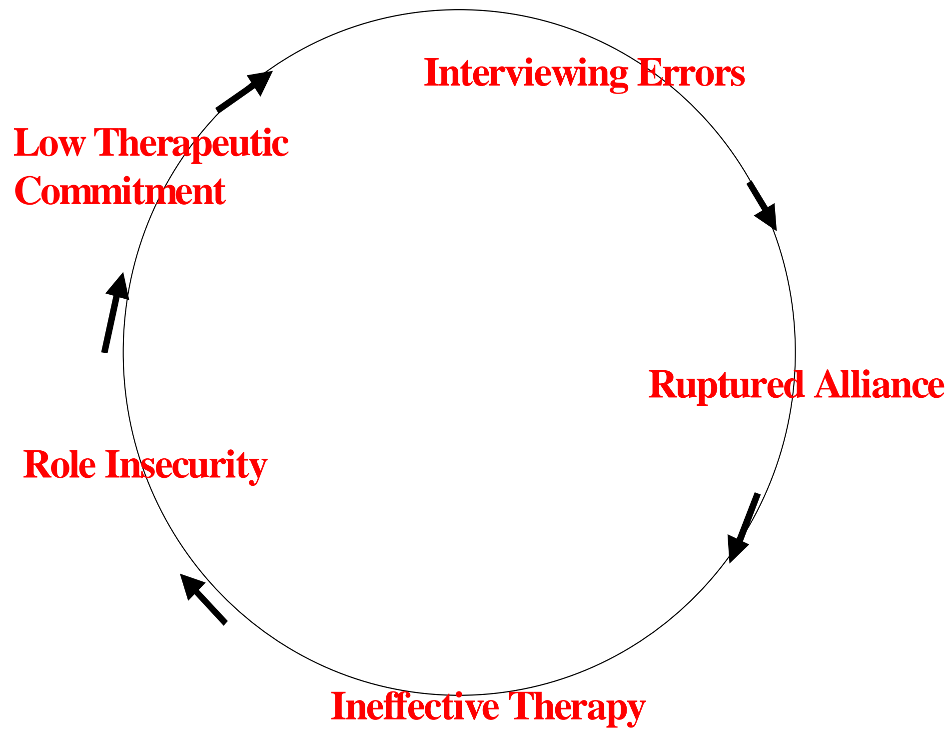


Figure 3
Patients Scores were ranked on the three PETQ Scales and divided into three equal groups. The percentage in each group reporting themselves to be improved or very much improved was then plotted.

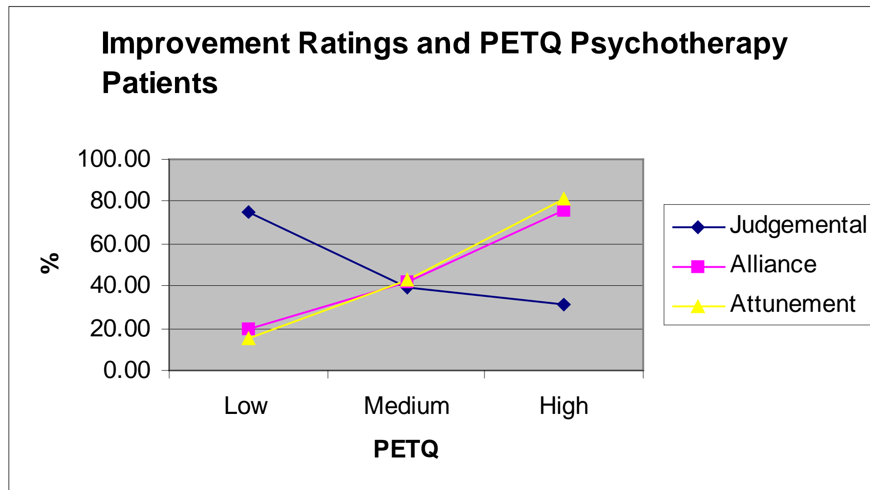
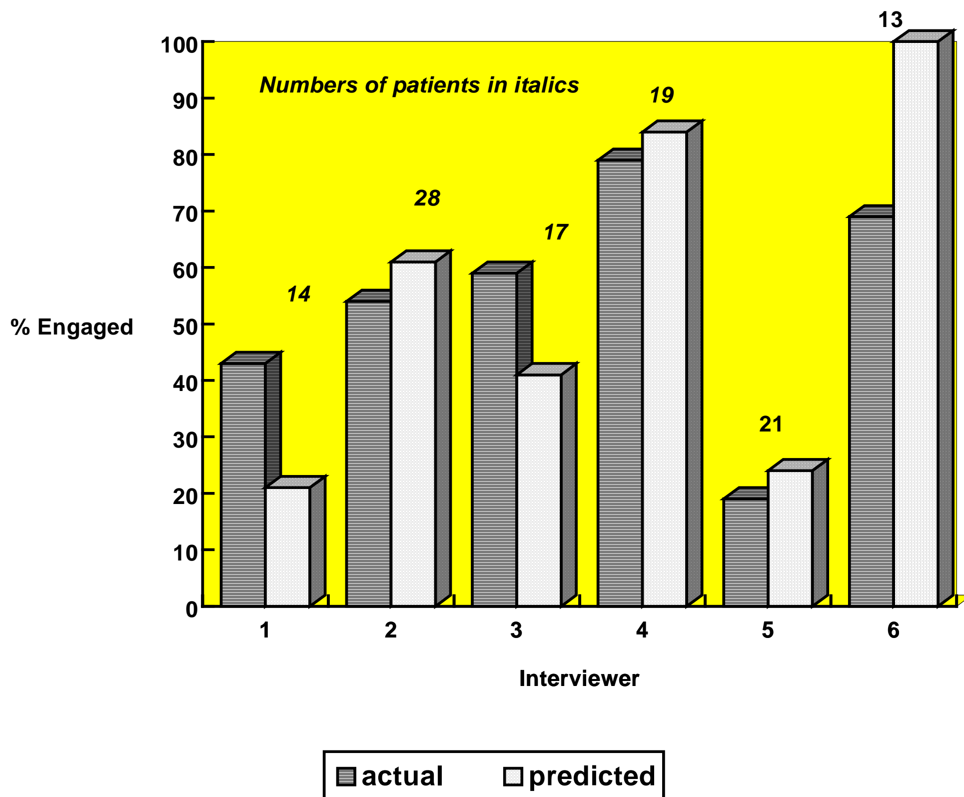


Figure 2



The percentage of each therapists clients who engaged in treatment is represented by the bars. The graphs compares the numbers that actually engaged in treatment compared with that predicted by the combination of therapeutic commitment and client experience.

Appendix 1

ADAPTION OF ROLE SECURITY AND THERAPEUTIC COMMITMENT SCALES OF THE AAPPQ: TO BE USED WHEN ASSESSING AN INDIVIDUAL WORKERS RESPONSE TO A SPECIFIC CLIENT. (AAPPQ(I)

ROLE SECURITY

Role Adequacy

1. I feel I have sufficient knowledge about alcohol and alcohol problems to work with this client.
2. I feel I know enough about the causes of drinking problems to carry out my role with this client.
3. I feel I know enough about the alcohol dependence syndrome to carry out my role when working with this client.
4. I feel I know enough about the psychological effects of alcohol to carry out my role with this client.
5. I feel I know enough about the factors which put people at risk of developing drinking problems to carry out my role with this client.
6. I feel I know how to counsel this client in the long term.
7. I feel I can appropriately advise this client about drinking and its effects.

Role Legitimacy.

8. I feel I have a clear idea of my responsibilities in helping this client.
9. I feel I have the right to ask this client about his/her drinking when necessary.
10. I feel this client believes I have the right to ask about his/her drinking when necessary.
11. I feel I have the right to ask this client for any information which is relevant to his/her drinking problem.

Role Support

12 If I felt the need when working with this client I could easily find someone with who I could discuss any personal difficulties I might encounter.

13 If I felt the need when working with this client I could easily find someone who would help me clarify my professional responsibilities.

14. If I felt the need when working with this client I could easily find someone who would help me formulate the best approach to this client.

THERAPEUTIC COMMITMENT

Motivation.

15. I am interested in the nature of this clients alcohol problems and the responses that can be made to them.
16. I would like to work with this client.
17. The best I can offer to this client is referral to somebody else.
18. I feel there is little I can do to help this client.
19. The thought of working with this client makes me feel uncomfortable.

Expectations of Satisfaction.

20. I feel pessimistic about this client.
21. I think I would find it satisfying to work with this client.
22. I think I would find it rewarding to work with this client.
23. I feel I can understand this client.
24. I like this client.

Appendix 2

PATIENTS EXPERIENCE OF THERAPY QUESTIONAIRRE. (PETQ)

Understanding

My therapist seemed to understand things from my point of view
I felt my therapist's understanding of me was superficial
My therapist seemed to understand my feelings and emotions
My therapist seemed to have very little idea what life is like for me
Sometimes I thought my therapist understood me better than I understood myself

Hostility

I felt my therapist did not take my thoughts and feelings seriously
At times my therapist treated me as if I was stupid
At times I felt as if my therapist disapproved of me
At times the my therapist seemed critical of me.
At times I felt my therapist looked down on me.

Alliance

I felt confident in the ability of my therapist to help me
I trusted my therapist
I felt that I was working together with my therapist in a joint effort
I think my therapist wanted to help me
My therapist often tried to impose their ideas on me
I felt that my therapist liked me
Most of the time I felt at ease with my therapist
I felt that my therapist and I had similar ideas about my problems

On a sample of 50 patients each scale had an alpha value above 0.8. However they are also highly correlated suggesting that the differences are less important than the whole.

Appendix 3

Self reflective Questionnaire for Trainee Therapists

I. THERAPEUTIC ALLIANCE

A. The Goals of Therapy.

{The term "goal" refers to the physical, psychological and social states that might be expected to result from therapy. These can be considered in terms of ultimate and mediating goals.}

1. **To what extent do you feel you have been able to work toward mutually shared goals with this patient ?**
   a. How easy did you find it to come to an agreement with the patient over the goals of therapy?
   b. What goals do you feel that you share with the patient?
   c. What goals does the patient have which you do not share?
   d. What goals do you have that the patient does not share?
   e. How far have the goals of therapy been achieved?
   f. How optimistic are you about achieving the goals?

B. The Patients Role.

{The term "role" is used in this document to refer to the complex of actions (thoughts, feelings and behaviours) associated with the "positions" of therapist and patient.}

1. How far do you feel that this patient has been able to adopt a role which is likely to help him\her achieve the goals of the therapy.

   a. Describe the patients view of his/her role in therapy. (Eg the patient should "say whatever comes into his/her mind" or "explore his/her feelings").
   b. Do you feel that the way the patient views his/her role is likely to help him\her achieve his/her goals?
   c. What changes do you think that the patient will need to make in his/her role behaviour if he\she is to achieve:-
      (1) His/her own goals?
      (2) Your goals, if they are different?
   d. In what ways have you tried to influence the patient's role behaviour?
      (1) How difficult did you find this?
      (2) How successful have you been?

C. The Therapists Role.

1. How far do you feel that you have been able to adopt a role which is likely to help him\her achieve the goals of the therapy.

   a. Ideally, what would your role be with this patient?
   b. How would the patient like you to be?
   c. How does your actual role differ from what you would like to be?
   d. Describe the ways that the patient prevents you from achieving your ideal role?
   e. To what extent, and in what way, do you feel that it is your own lack of skill which prevents you from achieving your ideal role?
   f. To what extent, and in what way, do you feel that role insecurity influences your role behaviour? (see section below on role security)

D. **The Therapeutic Contract.**

{The contract refers to the organisation of therapy and the physical setting. It also involves issues like drug/alcohol taking whether prescribed or not.}

1. Do you feel you have been able to establish an effective contract with this patient?
   a. Did you find it easy to establish a contract with the patient ?
   b. What is the nature of your contract with this patient?

c. How does the actual contract differ from that which you would ideally like to have established?
d. Is the contract kept?
e. If broken by the patient what do you do?
f. If broken by the therapist why?

II. THE CORE ELEMENTS OF THERAPY

{By the "core" elements we mean those qualities of the therapeutic process which are known to be associated with a good alliance and a good outcome. When referring to understanding below we are concerned only with simple elements and not with complex processes.}

1. How far do you feel that you can understand the way this patient feels about important issues and people in his/her life ?

a. How far do you feel able to understand the way the patient feels?
b. How far do you feel the patient understands the way he\she feels?
c. How effectively do you convey your understanding of his/her feelings to the patient?
d. Give some examples of the things you have said to the patient about his/her feelings.

2. How far do you feel that you can understand the way this patient thinks about important issues and people in his/her life ?

a. How far do you feel able to understand the way the patient thinks?
b. How far do you feel the patient understands the way he\she thinks?
c. How effectively do you convey your understanding of his/her thinking to the patient?
d. Give some examples of things you have said to this patient about the way he\she thinks.

3. How far do you feel that you can understand the way this patient relates to important people in his/her life ?

a. How far do you feel able to understand the way the patient relates to others?
b. How far do you feel the patient understands the way he\she relates to others?
c. How effectively do you convey your understanding of his/her relationships to the patient?
d. Give examples of some of the things that you have said to this patient about the ways he\she relates to others.

4. **Are you able to adopt a neutral attitude to this patient?**

a. What do you like and dislike about this patient?
b. Give examples of any things about this patient which make you angry.
c. Give examples of any things about this patient which make you feel anxious.
d. Give examples of any things about this patient which make you feel sad.
e. Give examples of any things about this patient which make you feel happy.
f. Give examples of any things about this patient of which you approve.
g. How do your feelings about this patient influence your behaviour with them?

5. Do you feel authentic with this patient?

a. Do you feel at ease and natural with this patient?
b. If not
 (1) Why do you feel uneasy?
 (2) In what way does this influence your behaviour with the patient?

III. TRANSFERENCE COUNTERTRANSFERENCE AND ROLE SECURITY

A. Transference.

{Specify how you are using the term transference in your response}

1. So far, what are the main transference features of this therapy?

a. Describe any transference interventions that you have made?

b. What effect did these have on the patient.

B. Counter transference.

{Specify how you are using the term counter transference. If you are referring to projective identifications make this clear. Distinguish between Counter transference and role insecurity (see below).}

1. What counter transference issues have arisen for you during this therapy?
   a. How have you dealt with these?
   b. What impact have they had on the therapy?

C. Role Insecurity.

{This refers to anxieties that arise from feelings about yourself as a therapist.)

1. What are the main sources of role insecurity that you experience as a therapist?
   a. How do you deal with these?
   b. What impact have they had on the therapy?

IV. **RESISTANCE.**

1. What forms, if any, does this patients resistance take?
   a. What do you see as the main reasons for this patients resisting?
   b. How and why have you responded to this aspect of the patients behaviour?

V. **FORMULATIONS.**

(For clarity formulations are divided into Dynamic Hypothesis and Developmental Hypothesis. It assumed that the developmental hypotheses will to some extent explain the dynamic hypotheses. You may have several formulations for a given patient, if so, select the one you feel is most apparent at the present)

A. DYNAMIC HYPOTHESES.

(A dynamic hypothesis attempts to link up the conflicting aspects of the patients experience in the here and now. It is usually concerned with the interplay between the patients wishes, anxieties, defences and the consequences of these. It would involve repeated patterns and may involve transference material.

1. **Describe your dynamic hypotheses for this patient?**
   a. Give two samples of the clinical material on which it is based?
   b. How conscious is the patient of this material?
   c. How have you used this formulation with the patient?

B. DEVELOPMENTAL HYPOTHESES

{A developmental hypothesis is one where phenomena which are the focus of either transference or dynamic hypothesis are explained in terms of the patients past experiences. They relate to the classical concept of "reconstruction" but may include conscious and preconscious experiences about which the patient knows.}

1. Do you have any clear developmental hypotheses about this patient? If so describe them.
   a. Have you put any of these too the patient ? If so what have you said?

VI. METAPSYCHOLOGY.

{In this context the term metapsychology refers to an abstract perspective {Eg developmental/structural/economic/dynamic} offered by an analytical theorist. {Eg Klein, Freud or Kohut}. This would refer to the patient in formal terms. {eg paranoid/schizoid features, oedipal features etc}

1. Describe this patient from a metapsychological perspective?
   a. What significant features of this patients behaviour do not fit into this perspective?
   b. Can these features be better described from a different perspective?