Helpful and Unhelpful Processes in Psychological Therapy for Female Substance Users: An Interpretative Phenomenological Analysis

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Abstract

This study explored helpful and unhelpful processes in psychological therapy for women with a diagnosis of substance use disorder (SUD). Semi-structured interviews were conducted with eight women, seven of whom were white; and analysed using interpretative phenomenological analysis. Three superordinate themes emerged: *What words can't express—finding another language*, *Identification with my therapist*, and *Getting towards acceptance.* The women identified barriers to finding their voice at the start of therapy but this shifted as the alliance strengthened. They reported that it was important to have a therapist who was also in recovery. Practitioners should consider strategies for helping clients with SUD 'de-shame'; and be willing to challenge their resistance and avoidance from an empathic, accepting, and professional standpoint. Creative methods may help clients to identify and express their feelings, while the availability of therapists with their own histories of recovery may support hope and change.

Key words: Addiction; Substance Use Disorder; Helpful and Unhelpful factors; Gender; Qualitative Methods.

Helpful and Unhelpful Processes in Psychological Therapy for Female Substance Users: An Interpretative Phenomenological Analysis

Substance use disorder (SUD) is a major global concern, with an estimated 29.5 million people drug dependent (United Nations World Drug Report, 2017). The Adult Substance Misuse Treatment Statistics in the UK (NDTMS, 2016/17) reported that, between April 2016 and March 2017, 288,843 individuals made contact with addiction services for substance use disorder and males represented 69% of the entire treatment population. The statistics showed 38% commenced treatment (psychological therapy), and 92% of that 38% completed treatment. Of those that completed treatment, 51% were classified as free of dependence. Opiate users had the lowest success rate, 26%, as they had the most entrenched long term drug use. Rates of return to substance use continue to be high post treatment, with clients often relapsing a short time after treatment ends (Gossop et al., 2002, Sack, 2012). In 2018/19 the number of women attending addiction services remained at 31%, the same as in 2017, but the statistics did not show the proportion of men and women out of the total number that failed to complete (NDTMS, 2019) These outcome suggest that the current system for treating substance use disorder is limited and male focused. The continued development of treatments is required.

Globally, the prevalence of SUD among women has dramatically increased in the past two decades (National Institute of Drug Abuse, 2016). Women attend fewer treatment sessions than men (McCaul et al., 2001) and are more likely than men to abandon treatment (Arfken, 2001). There is some evidence that drug services have attempted to address barriers facing women, such as gender-specific services, so that vulnerable women with a history of sexual and physical abuse, childcare issues, or prostitution can feel safer (National Treatment Agency, 2010). Despite such positive steps, women may be less likely to seek treatment as the stigma and shame is high, and women may fear their children will be taken into care (Grella, 2015). Compared to men who use drugs, women are also more likely to have experienced a traumatic event, and have anxiety, depression, or another comorbidity (Arpa, 2017). These findings highlight the importance of establishing engaging and effective treatments to tackle the multiple needs of women with substance use disorder.

Even though a vast body of literature on addiction exists, research from the perspectives of substance users remains scant (Nordjfaern et al., 2010; Watson & Parke, 2009). In the past, women were not included in most clinical research for the reasons that women were seen as more biologically complicated than men and that, as primary caregivers of young children, they had too many competing time demands to participate in research studies (National Bioethics Advisory Commission, 2001). To reverse this dynamic, there is a need for research that has been informed by female service users' own accounts in the context of their therapeutic recovery.

A review of the literature on a number of electronic databases in the UK—including PyscInfo, APA PsychNet, and PubMed—found only one published study specifically focused on the accounts of substance users who found psychotherapy helpful in assisting their recovery (Waters et al., 2014). The Waters et al paper explored the recovery narratives of women and men who were about to complete their 12-month psychological therapy under a clinical psychologist. The findings indicate that the psychologists served as secure attachment figures, providing closeness, proximity, a safe haven, and a secure base. However, Waters et al did not explore what the participants found unhelpful.

Method

Design

The basic framework for this study was interpretative phenomenological analysis (IPA) (Smith et al., 2009). IPA is a qualitative method with philosophical underpinnings in phenomenology and hermeneutics (Eatough & Smith, 2008). The focus of IPA is to explore,

in detail, how people make sense of their life experiences in the context of their personal and social worlds (Smith et al., 2009). IPA is consistent with the social constructionist claim that sociocultural and historical processes are central to how we experience and understand our lives, including the stories we tell about ourselves (Willig & Stainton-Rogers, 2013). Our research approach also drew on Cooper and McLeod's (2015) *client helpfulness interview studies*: focusing on the particular elements of treatment that clients, themselves, experienced as valuable.

Participants

Eligibility criteria for participants were (a) female; (b) diagnosed with substance use disorder according to the DSM-V criteria; (c) completed at least three months of one-to-one, weekly psychological therapy for SUD; (d) abstinent from drugs or alcohol at the end of therapy or reduced intake; (e) at least 18 years old; (f) English speaking; and (g) not diagnosed with psychosis.

Eight women were recruited for the study, which is within the range of participants typically recruited for an IPA study (Smith et al., 2009) (Table 1). The mean age was 34 years old. Seven participants identified as White British and one identified as Black British. Each woman had been given a diagnosis of substance use disorder under the DSM-V criteria by a mental health professional and had completed successful one-to-one psychological treatment within the past year (defined as total abstinence post treatment). The women had a variety of integrative, psychodynamic, Gestalt, and cognitive behavioural therapies. All completed at least three months of psychological treatment and, at the time of the data collection, had been in recovery between 12 months and 15 months. The therapists were graduates trained in different modalities and half were in recovery themselves. This information was disclosed by the charities that participated.

Procedure

Ethical approval was obtained from the relevant university research ethics committee.

To recruit participants, we contacted charities that offered psychological interventions for individuals with drug and alcohol abuse and provided them with information about the study. This information was then passed on, by the managers, to prospective participants, who were told that they could contact the first author if they were interested in taking part. We also used a snowballing recruitment technique whereby women who took part were invited to inform other women—who they thought might be eligible—to contact the first author should they want to take part in the study.

Interviews were undertaken at the recruiting agencies from which the participants were drawn, to ensure that participants had support if any anxieties arose. A consent form outlined the aims and purpose of the study and had to be signed before the interview commenced. The participants were given the right to withdraw up to the point of analysis.

Semi-structured interviews were used to collect the data. An interview schedule was developed to guide the inquiry. This included prompts to ensure an open, flowing, and informal conversation. Key questions were: What aspects of the therapy did you identify as helpful (if anything)? Why was it you felt this was helpful? Which aspects of the therapy did you identity as unhelpful (if anything)? Why was it you felt this was unhelpful?

Analysis

Analysis was conducted by the first author, with the second author reviewing—and feeding back on—the emerging themes and narrative. Consistent with IPA, each interview was transcribed from an audio recording, and anonymised by removing any personal, identifiable information. Pseudonyms were used to preserve confidentiality. Data analysis began with reading and re-reading each transcript from start to finish. Initial annotations were made in the right hand margins of printed pages with exploratory comments describing initial thoughts about the content and language use. Conceptual, interrogative comments were then added

(Smith et al., 2009). Each segment of the text that had been identified in the initial coding was analysed further to capture the essence of what each participant was trying to convey. Phenomenological reduction was used to bracket off, and reflect on, what therapy was like for the women from their experiential reality. As a *double hermeneutic* (Smith et al., 2009), we aimed to make sense of the women's responses as they made sense of it themselves. That is, to try to imagine what it might be like to be the participant, and to identify the main phenomenological experiences in the participant's words; remaining close to the participant's explicit meaning (Smith et al., 2009).

Following the coding stage, the focus became the development of emerging themes. This involved organising and summarising the analysis, reducing the volumes of comments, while retaining the complexity in the transcript and notes (Smith et al., 2009). Themes were listed and then reorganised to form clusters of *superordinate themes*; and a full narrative of the analysis was then drafted, re-drafted, and finalised.

Reflexive statement

The first author is a counselling psychologist who grew up in a town where drinking alcohol was part of the culture. She has worked with people experiencing addiction throughout her career and feels passionate about work with this client group—having been impacted by it on at both a personal and professional level. The second author is a professor of counselling psychology who has worked with several clients with addictions, but has had limited personal experience in this area. Both authors have been trained primarily in person-centred and relational therapies, but hold a relatively 'pluralistic' outlook (Cooper & McLeod, 2011): open to identifying a range of processes as helpful and unhelpful without strong preconceptions or biases as to what they will find.

Results

Three superordinate themes were established, each of which consisted of two themes (Table 2). The superordinate themes were: (a) *What words can't express—finding another language,* (b) *Identification with my therapist*, and (c) *Getting towards acceptance*.

What Words can't Express—Finding another Language

This first theme encapsulates the difficulties the women had in finding their voice in psychological therapy and finding an alternative form of expression.

Overcoming the painful silence.

Participants reported wanting to talk and open up around their feelings, but expressed how difficult they perceived this might be with their therapist when starting psychological therapy. When asked to pinpoint their feelings, they described wanting the words to come out but feeling that a barrier existed: it felt that their defences were either consciously or unconsciously preventing them from expressing themselves. However, the expectation each woman felt at the beginning was that they should have been able to talk, and they expressed surprise they were unable to.

Several of the women indicated that their addiction had taken away their sense of knowing who they were and the ability to express their needs. For instance, Noreen said, 'The kind of main factor why I kept using was because I was so frightened of actually who I was, so I never expressed what was inside, how would anyone understand?' (l. 28). This illustrates the anxiety many of the women experienced in disclosing: both the vulnerability in accessing suppressed feelings, and a belief that a therapist would not understand or be able to support them.

Helping to identify feelings.

Given the participants' fears of 'opening up', 'alternative', non-verbal interventions were experienced as therapeutically helpful. This included art and music techniques, and the use of metaphors. Sam said, 'Being able to identify how I feel, like the colours and stuff like that,

makes such a big difference because when I am overwhelmed with an emotion, if I can't put my finger on it, that's the void that I can fill and want to fill with drugs' (1. 397-400).

The development of an external symbol such as a song or piece of art was something nearly all the women described as helpful in their sessions, and was perceived as far more meaningful than just a creative outlet. The association with their feelings allowed the women to deal with some of their suppressed pain and trauma that they previously would have used drugs or alcohol to avoid.

Identification with my Counsellor

This superordinate theme captured how the women perceived their relationship with their therapist and the impact that that had on their motivation for therapy.

'Been there, done that'.

Having a counsellor who identified, or appeared to be, in recovery was perceived as important and impacted on whether they found psychological therapy as being helpful or not. It was clear, from all the accounts, that this connection led to a shift in the therapeutic relationship: it was not just a therapist and client who sat together, but two female addicts, embodying hope that they, too, might recover. Further exploration revealed how 'massive' (Jules, l. 292) it was for them to know if their counsellor was in recovery or had some experience of addiction in some way. There was a sense of knowing that their therapist had 'been there, done that' (Louise, l. 551): meaning that they felt understood and in safer hands. 'Because they had "been there and done that", you know… they'd experienced what you'd experienced, be it with drink or drugs, they'd been in those proper depths of despair that you don't want to go back to' (Louise, 551-553).

Emma said, 'It did help the fact that I knew she was in recovery; that really made a difference. I actually found out halfway through treatment and when I did I thought... "You know, she knows"' (l. 214-222).

Emma described this 'she knows' as something that 'really made a difference' (1. 214-222). This recognition that they shared the same disorder was something she described as bringing her 'closer' to her counsellor as she 'knew' she understood. 'She's just a beautiful, graceful, intelligent woman, whose stuck needles in places where I have, and been to the depths I have' (l. 1312).

The participants perceived their addiction as destructive and shameful; and having someone who could really understand—and had shared the depths that addiction had taken them to—made that process easier. This knowledge allowed them to connect without having to explain or describe in detail parts that a non-addict counsellor may not have understood.

Anita said, 'It's like they understand. It's not so shameful. It's like they are telling me, "It is ok; it's alright"' (l. 907). For Anita, knowing someone she has a positive relationship with has had an addiction made her feel that she, herself, must be worth more. Such knowledge was a powerful factor in helping the women to be able to disclose their pasts—motivating them to engage more in the therapy. It created a bond and acceptance: being in a therapeutic relationship with someone who appeared to share the same implicit beliefs and goals.

The importance of a relationship with a therapist that had 'been there, done that' was illustrated when two women disclosed that they told their first counsellors 'bullshit' when they began therapy (Sam, l. 88; Noreen, l. 96). This was either done by not disclosing the truth, or being selective around what content they shared. Interestingly, when Sam and Noreen both changed counsellors and began working with women they knew were in recovery, it was only then they admitted they, 'couldn't get away with their behaviour any more' (Sam, 1.89: Noreen, 1. 97). This relates to the theme, 'She had me all along' (see below).

Symbolising hope and professionalism.

Identification with the therapist was also helpful to the women in terms of symbolising hope and professionalism. Louise said, 'This woman was, you know, together and lovely, and

everything I didn't know an addict could have' (l. 290). Here, Louise alludes to the way in which the perception of an 'addict' is regarded as the opposite of lovely and together, and her surprise that her therapist could identify as both a professional, an addict, and represent something positive. Laura was not alone in her belief that an addict signified someone 'crazy' (Kat, l. 543), 'different' (Rachel, l. 193), or 'shameful' (Anita, l. 277). Therefore, to have a therapist that challenged that assumption was hugely helpful, as it instilled hope that in their future they also could be that person.

For Kat, her therapist represented another face of addiction: 'she made me see there is another side, there is hope' (l. 341). Even though the women recognised hope as an implicit part of the therapeutic process, many accounts gave a sense of isolation linked to the despair that their drug use made them feel. Kat's therapist represented something that she had previously felt out of her reach: a world of hope, recovery, and professionalism.

Also evident in the narratives was the need for the women to perceive their therapists as 'professional' (Sam, l. 939; Kat, l. 565), and not as a peer. Anita said, 'They are trained, which means that, you know, there's confidentiality' (l. 304). As well as feeling safer and more understood by working with someone qualified, Anita's statement highlighted her underlying vulnerability. Her account revealed her struggle to trust, and her desire for confidentiality. Throughout the interviews this was important, as the women expressed their need to know that they could share their trauma and feel safe. Many of the women described feeling disconnected with themselves as they described their addiction as all-consuming and dysfunctional. In this respect, to have someone who understood the addiction, and the 'language'—but who was also professionally trained—was helpful in how they could relate and view themselves.

Sam said, 'If I felt I was talking to someone on a personal level, my fears around being judged would really come into play and would potentially stop me from talking about what I needed to talk about' (l. 1003-1005). This reveals the importance of trust and the distinction between having someone professional and someone as a friend. It would have evoked fears of being judged if someone was relating on a personal level. Sam, like other participants, also talked about how she would use different content if talking to her friends. She described how she would be more casual with friends and would not have allowed herself to get vulnerable. In contrast, by feeling safe with a counsellor, she allowed her vulnerability to emerge. Sam's account highlighted the link between her fears of being judged and feeling shut down. Thus, for the women, having 'boundaries' in the relationship and an expectation of roles was seen as helpful in opening up their 'wounds'.

Linked to this, several women described what they found in the therapeutic session as unhelpful when identifying with their counsellor. Despite the hope they symbolised for most of the women, some of the therapists were criticised for being too sympathetic (Sam, l. 527; Katrina, l. 798) or acting as a mother figure (Jules, l. 116)—both factors experienced as inhibiting the clients' authenticity in therapy. For Jules, it tapped into her relationship with her own mother and wanting to please her. This left her struggling to confront or share information that she felt ashamed of. Jules also talked about her fear of attachment and her ending in therapy, as it mirrored letting go of her own mother. Sam and Katrina defined sympathy as evoking feelings of being seen as a victim and this was unhelpful therapeutically. There was a sense that this left the women feeling disempowered as it meant their counsellors represented positions of power. Instead of feeling equal in the room, the women described how unhelpful it was for their counsellors to make a judgement that they were victims and treat them with pity. Instead of enabling them to have the resources for their own self-empowerment, they were left feeling their addictions were being seen as moral failings. In both accounts, both women alluded to taking time to process their negative emotion: only allowing their irritation to diminish as their psychological relationships strengthened.

Getting Towards Acceptance

Getting towards acceptance describes the women's transition from resistance to acceptance during the therapeutic process.

Resistance.

Resistance indicated an unwillingness to engage. The women's narratives conveyed their shift in acknowledging their 'addict' identity—a label they believed held negative connotations of a medical diagnosis and stigma in society—to a position of growth, change, and acceptance.

The women's resistance seemed to be linked to deeper concerns about confronting their fears. A number of the women had needed to 'test' or 'push' their counsellors to see if they could be 'held' emotionally before they would open up. It seemed that the women were scared of 'letting down their defences' as these were what they had used for survival.

From the outset, most of the women expressed how they were overcome by negative thoughts, recounting how it was a struggle to engage in therapy because they either saw it as 'just another attempt at recovery' (Jules, l. 67; Rachel, l. 69) or a way to 'give my body a break' (Jules, l. 103) from using substances. This lack of hope in their own ability to succeed manifested itself in a resistance to participate. For others, it took reaching their 'rock bottom' (Louise, l. 267; Anita, l. 543): a term that symbolised their lowest point. Even though these women needed help, their resistance was deep rooted psychologically, as it meant overcoming the defences they had in place that had, quite possibly, kept them alive.

Some women described how they had shown resistance to engagement, but had not explicitly realised this until they reflected, retrospectively, upon their psychological therapy. Emma said, 'I didn't fully appreciate I was an addict of any sort' (l. 17). The denial of accepting her addict persona had left Emma questioning whether she could identify as someone different, and this impacted her initial engagement in her therapeutic sessions. As someone that had been using drugs for 28 years, it felt from her words that she was unable to visualise any other reality. This only shifted as the relationship with her counsellor strengthened.

Rachel's resistance manifested itself in her desire not to talk. She said, 'I couldn't understand why I had to talk about it. I thought I just needed to block it out and they'd [the feelings would] go off. I didn't realise how important it was to free yourself from that pain' (l. 428). In common with many of the women, Rachel's resistance to opening up felt like a defence mechanism that had enabled her to survive through her years of addiction. Recounting her difficulty, Rachel talked about not being able to understand why she had to talk about her issues, which indicates how challenging she found the process.

'She had me all along'.

The women recognised that their therapists had understood their needs even when they, themselves, had not realised or wanted to recognise what was helpful to their recovery within psychological therapy. The transition towards acceptance of their identity as an addict meant the women often challenged the process by 'bullshitting' their counsellor (see above) or 'manipulating' (Louise, l. 288) their way through sessions. In many cases, the women only recognised that their counsellor knew what they were talking about at a much later stage.

Noreen stated, 'I think I knew she was right and I didn't want her to be. I just really didn't, you know. I wanted to… to go off into this "la la land" and everything be ok' (l. 423-427). Here, Noreen was conveying her difficulty in being able to engage in psychological therapy and her desire to escape and become abstinent without committing to the process. Despite wanting everything to be OK, Noreen describes not wanting her therapist to be right. It felt that she was projecting her concerns around her own fear of failure onto the therapist as a security blanket. If her therapist failed her, then it would alleviate any blame if she relapsed. This seemed to be a common theme from the women, as it meant that they could avoid taking responsibility for the therapy if anything went wrong. Noreen talked about grudgingly accepting that her counsellor did understand and discussed how this seemed to amplify feelings of letting go and succumbing to the process.

Louise recounts how helpful she found it having a therapist who could identify her avoidance in therapy. She stated, ‘She had this great knack of noticing when I was trying to brush over a subject, if I tried to use humour when painful, which I did’ (l. 440-445). Here, she emphasised that she needed a therapist who could ‘read between the lines’ and understand what she was avoiding. Similarly, Sam describes how, in retrospect, she came to understand her need for ‘boundaries and stuff like that’ as she would ‘bullshit’ in a session to avoid her pain. To Sam, boundaries implied regulation and perimeters within the relationship. She said, ‘Once I was with someone who was a bit stricter, who had, kind of, more boundaries and stuff like that… I couldn’t get away with that. It’s like when I was doing that, I really felt she could see I was doing that’ (l. 93).

The tension between wanting someone to guide them in therapy and accessing their vulnerability is a theme throughout the participants’ accounts. Despite this, a shift began when they found the balance between dependency on their therapist and taking some form of self control. This is when their resistance eased and acceptance of what they needed to process emerged.

Emma talked about being ‘lost, controlled, and unheard’ (1.335-347) in therapy: all words that could describe her life of addiction. The hold that drugs had placed upon her mirrored her role within her relationships and her lost self within the therapy room. She indicated that she only understood and accepted how ‘right’ her counsellor had been once she was abstinent. ‘My triggers are guys, you know. I get lost very quickly, controlled, and I’m unheard. My counsellor asked me to think about my relationship with men but I just wanted to ignore her. Only now I’m clean do I understand how right she was’ (Emma,1. 312). An acceptance that their counsellors knew their needs seemed to elude, not just Emma, but a number of the women. Only through time and the therapy process did they embrace their recovery, and become able to identify these aspects for themselves. The ambivalence was replaced by acceptance of their addiction only when they recognised that the counsellor had identified their needs a long time before they themselves had identified them. The shift in Emma’s description from ignoring her counsellor to understanding how right she was indicated that Emma needed time to really understand her recovery. Having a counsellor who had been ‘right all along’ felt like it gave the women hope that this therapy would have a different outcome, along with the tools to maintain their recovery and the self-acceptance that their therapist had understood their needs and guided them on the right path.

Discussion

The analysis shows the subtle interplay between similarity and difference within the relationship that could be actively drawn upon by therapists working with this client group. These participants needed to feel understood, listened to, and that their therapists had ‘been there’ and experienced similar behaviours. However, they also needed to feel that the therapist was a professional who was willing to challenge them. Clients preferred therapists who had their own experience of drug use. If therapists have not experienced such problems, then developing a greater knowledge of addiction, either by attending AA/NA meetings, reading on the subject, or shadowing in addiction treatment settings may help clients to feel more understood. At the same time, the participants needed to know that their therapist was bound by professional ethics and, whatever similarities emerged between both the client and the counsellor, that they were different enough to feel supported and understood.

The analysis revealed how participants’ interpersonal relationships with their therapists, and their emotional state, impacted their levels of engagement. The meaning they attached to psychological therapy was often entwined with negative affect (shame, sadness) and emotional dysregulation (self-destructive behaviours): two core features of addiction (Garland et al., 2018). Thus having a therapist who could help break down their defences,

normalise the shame, and overcome the women's resistance to engage, enabled the participants to understand their behaviours and what aspects they needed to change.

Shame was not explicitly addressed as a separate theme in the analysis, but it emerged throughout the extracts and impacted all the themes. Shame has been reported as playing a central role in SUD as it disrupts the natural functioning of the self, leading to low self-esteem, insecurity, and inferiority (Kaufman, 1996). Shame is also part of the normal phenomenology of addiction and, conversely, can be a motivation towards change (Flanagan, 2013). Thus, the findings indicated that working with clients to 'process' this feeling may be crucial to the recovery process, as well as a way of establishing intimacy in the relationship.

Past research has illustrated that one of the most important factors in retention of SUD clients is the strength of the working alliance, as it establishes trust and security for the clients to open up (De Weert-Van Oene et al., 2001, NIDA, 2012, NICE, 2017). Many of the participants expressed how difficult they found the initial engagement in the therapy and this could have become a trigger to leave. The importance of retaining a client in the first two sessions is evidenced by statistics that show 20–57% of psychological therapy clients leave after the first session and another 37–45% attend only two in total (Schwartz & Flowers, 2010). For SUD clients, 50% fail to return after the second session (Miller & Rollnick, 2002; White, 2005). For the participants in this study, their resistance to their therapeutic process compounded by their inability to express themselves verbally meant creative outlets, such as art and music, could be critical to success. This is consistent with the finding that the creation of imagery has been found to enhance internal motivation to change for clients with SUD (Holt & Kaiser, 2009). Hence, future treatment models for SUD clients should consider the incorporation of creative methods.

Limitations.

Participants in this study used reflections and descriptions to recall their psychological experience. Therefore, their recall of information may be dependent on their emotional state at the time of interview, as well as self-presentational concerns. Recruitment was targeted to participants who would be able to communicate their psychological experience in a language that the research team would be able to understand (Smith et al., 2009). It could be argued, therefore, that the participants who chose to participate in this study were representative of a group that already had relative ease talking about their experience of addiction and their behaviours. The snowballing recruitment technique used in this study meant that the women may have discussed their interviews with other recruits, biasing the results, and the sample was very selective with limited ethnic diversity.

Clinical implications.

In terms of clinical practice, a question emerging from this study is one of how to actively 'de-shame' clients in the sessions. There has been extensive theorising about shame and how empathic failure with this emotion in therapy can cause premature termination (Tangney & Searing, 2011). Normalising a client's experience, externalising the voice of shame, and validating this feeling through fostering a relationship with the therapist could all be ways of improving engagement of SUD clients. Concomitantly, our study suggests that, when working with female clients with SUDs, it may be important to be willing to challenge resistance and avoidance. The availability of therapists with their own histories of substance abuse and recovery may be important to support hope and positive change in this client group. Finally, as indicated above, the use of creative methods should be considered when working with this client group, as a means of helping them through 'the painful silence'.

Future research.

It would be helpful to explore the experiences of clients with SUD who terminate psychological therapy early, to find out what was unhelpful and the reason they left. Another would be to explore if there is an association between therapist self-disclosure and therapeutic

outcomes for clients with SUD. This could be done by interviewing women directly about therapist self-disclosure; or by undertaking a quantitative study on how they perceived the similarity and difference between themselves and their therapist, while tracking outcomes. Further research could also evaluate the use of art and music in therapy for SUD clients; and exploring—quantitatively and qualitatively—the importance, for clients, of knowing if their therapist is also in 'recovery'.

Conclusion

Previous research indicates that few SUD clients are successful at completing psychological treatment. This research provides insights into what aspects of the therapeutic process contributed to the success of treatment and how the women subjectively experienced therapy. In learning about this, practitioners can develop their knowledge and therapeutic practices when working with this client group.

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Tables

Table 1: Participant Characteristics.

'Name'	Drug of Choice	Treatment Provider	Therapy Modality	Ethnicity	Time in Recovery
Sam	Heroin Crack Cannabis Alcohol	SERVICE A	Integrative	WB	12 months
Anita	Alcohol	A	Psychodynamic	WB	12 months
Emma	Heroin Prescription Alcohol	B	Integrative	BB	15 months
Kat	Heroin Cocaine Alcohol	B	Integrative	WB	13 months
Jules	Heroin Alcohol	B	Psychodynamic	WB	14 months
Louise	Heroin Crack Cannabis	A	CBT / psychodynamic	WB	13 months
Rachel	Heroin Crack Alcohol	A	Gestalt	WB	14 months
Noreen	Heroin Alcohol	A	Psychodynamic	WB	12 months

Note. All names pseudonyms. WB = White British, BB = Black British.

Table 2. Superordinate themes, themes, and illustrative quotes

Superordinate Theme 1: What words can't express—finding another language

Theme 1a: Overcoming the painful silence

Illustrative quote: 'The kind of main factor why I kept using was because I was so frightened of actually who I was, so I never expressed what was inside, how would anyone understand?' (Noreen l. 28)

Theme 1b: Helping to identify feelings

Illustrative quote: 'Being able to identify how I feel, like the colours and stuff like that, makes such a big difference because when I am overwhelmed with an emotion, if I can't put my finger on it, that's the void that I can fill and want to fill with drugs' (Sam, 1. 397-400).

Superordinate Theme 2: Identification with my therapist

Theme 2a: 'Been there, done that'

Illustrative quote: 'Because they had been there and done that, you know….they'd experienced what you'd experienced, be it with drink or drugs, they'd been in those proper depths of despair that you don't want to go back to' (Louise, 551-553).

Theme 2b: Symbolising hope and professionalism

Illustrative quote: 'This woman was, you know, together and lovely, and everything I didn't know an addict could have' (Louise, 290).

Superordinate Theme 3: Getting towards acceptance

Theme 3a: Resistance

Illustrative quote: 'I wasn't completely honest with my counsellor. She went by the notes I'd selectively chosen to share. They were horrific enough. Um…but what I didn't tell her was that actually I wanted to give my body a break and use successfully' (Jules, 103).

Theme 3b: 'She had me all along'

Illustrative quote: 'My triggers are guys, you know. I get lost very quickly, controlled and I'm unheard. My counsellor asked me to think about my relationship with men but I just wanted to ignore her. Only now I'm clean do I understand how right she was' (Emma, 312)