Towards an Existential Phenomenological Family Therapy Model of Working with Issues of Alcohol Abuse: A Grounded Theory Study.

Submitted to the New School of Psychotherapy and Counselling and Middlesex University in partial fulfilment of the requirements for the Degree of Doctor of Existential Counselling and Psychotherapy.

Andrew Biss

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DECLARATION

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I hereby declare that the work presented in this thesis is written by myself entirely except where other sources are clearly and identifiably cited.

Signed: ………………………………………….

Dated: ……………………………………………

ABSTRACT

This research is a step towards creating an existential phenomenological model of family therapy when working with alcohol abuse. The research method was constructivist grounded theory and involved interviews with twelve experienced family therapists. From an initial one hundred and twenty-five provisional categories the data was analysed to form eight main concepts. Each of the concepts contains a family therapy and an existential phenomenological perspective. The model can be considered in three formats; a review of family therapy when addressing alcohol problems, an existential phenomenological approach to that situation and an integrated version. The model is described and shown in diagram form and can be used by practitioners in part or whole to assist in their work with families.

ACKNOWLEDGEMENTS

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1. Introduction

'We should treat with indulgence every human folly, failing and vice, bearing in mind that what we have before us are simply our own failings, follies and vices. For they are just the failings of mankind to which we also belong and accordingly we have all the same failings buried within ourselves. We should not be indignant with others for these vices simply because they do not appear in us at the moment'.

Arthur Schopenhauer.

1.1 Structure of the Thesis

Chapter 1 provides the introduction to the thesis and an explanation of my personal journey to starting the research. It also covers the aim of my project which was to create a model that is existential phenomenological and assists those with drinking problems to improve their wellbeing through family relationships. I explain my struggle with finding the appropriate terminology to describe someone often referred to as an alcoholic, a name I see as a label that can create shame and guilt.

Chapter 2 is the literature review that I have divided into three sections. The first is a review of the main themes and principles within the field of addiction and alcohol abuse in particular. It covers a neurobiological perspective, DSM-5, Alcoholics Anonymous, Cognitive Behavioural Therapy and Counselling in general. Secondly, the literature in which existential phenomenological psychotherapy is described in relation to addiction. This includes descriptions of definition of self and addiction as a social construct. Thirdly, family therapy literature that appears to have some affinity with an existential phenomenological modality and includes systems theory and structural approaches.

Chapter 3 states how I have explained my research methodology.

Chapter 4 details how I chose my research methodology and explains the main principles of constructivist grounded theory. It is in two main sections, the first covers quantitative and qualitative research, epistemology, phenomenological considerations and grounded theory. The second describes the elements of constructivist grounded theory such as intensive interviewing, data collection and analysis, coding practices, memo writing, developing categories and theoretical sampling and sorting.

Chapter 5 outlines my pilot study and how I applied the constructivist grounded theory principles to the data. It covers sampling and recruitment and ethics. It also includes the details of the data collection and analysis such as initial coding, focused coding, axial coding and memo writing. Further, it describes the transition from the pilot study to the study results.

Chapter 6 starts to present my study findings by firstly showing a table of participants and then the remainder of the principles of constructivist grounded theory that I was unable to employ in the pilot study. In particular these are conceptualization and theory, achieving saturation, theoretical sampling, theoretical sorting and conceptualization. There is an explanation of how I have showed an existential phenomenological perspective in my study findings from my own training and experience as an existential therapist.

Chapter 7 provides my study findings as eight concepts. These are:

- Models

- Training

- Support

- Perspective

- Truth

- Feelings

- Patterns

- Boundaries

There is a section on recommendations for a model collected from participants with a reference back to the appropriate concept.

Chapter 8 details the model which can be considered in three formats; a review of family therapy when there are issues of alcohol problems, an existential phenomenological approach to that situation and an integrated version. The model is described and shown in diagram form and can be used by practitioners in part or whole to assist in their work with families. I am hoping that therapists will select whatever information best suits them. If they are interested primarily in a family therapy approach and want to consider possible interventions when there are alcohol problems present, then figure 5 will be the most appropriate. If someone wishes to gain information on an existential phenomenological approach in such a context, then figure 6 would be helpful. Figure 7 combines the two approaches to show how

someone might work existentially phenomenologically, whilst taking advantage of family therapy principles.

Chapter 9 describes the contribution this research makes to the profession of psychotherapy.

Chapter 10 contains my reflections on my research.

Chapter 11 presents my conclusions on the project and is followed by the Bibliography and the Appendices.

1.2 Towards the Beginning

I had little idea that research could be so personal and reflective. My first degree was in Law requiring no research activities and my initial idea for this thesis was to find something that was known to me that I could expand upon. I had a career of working in human resources and executive coaching and intended for several months to explore the concept of workaholism. I think this would have produced something worthwhile, but would not have created any passion with me. I am grateful to my research supervisors for their guidance and their suggested readings (du Plock 2008, Finlay and Evans 2009) that sparked a desire to answer some forgotten questions from my childhood.

My parents were publicans from the early 1950s to late 1980s and believed in working and playing hard. This meant drinking large amounts of alcohol whilst either behind or in front of a bar. For my brother and I this chosen lifestyle meant we saw

little of our parents and created long periods of loneliness. The situation was intensified by very frequent geographical relocations separating us from any friends we might meet at the different schools we attended. My brother was nine years older than me and turned to alcohol as a teenager to ease his hurt feelings. My father could never understand why he was not able to 'handle his drink' the way he could, holding down a job whilst drinking a bottle of whisky a day and that difference between them often created violence in the home. My brother failed to gain the understanding and compassion he needed, including from me as I avoided any contact with him for over twenty years and he died prematurely from liver failure. My mother was focused on her husband of over fifty years and her attention was only fleetingly directed our way, requiring us to be self-sufficient as early as possible in our lives.

At the time I had no idea this was not the normal way of things in families. My understanding of something different did not arrive until I had children myself and I vowed that they would have a better childhood than me. I had not considered addressing my feelings about my early life until I started therapy, which was when I was approaching retirement, lucky enough to be financially secure and beginning to feel a freedom greater than I ever had before, but yet very bored with my life. I started working with an existential psychotherapist and out of this encounter grew a desire to be a therapist. This would in a relatively short period of time provide me with the purpose and meaning I was lacking.

I have enjoyed my studies greatly, particularly the intellectual challenges of reading Heidegger and Sartre, the thought provoking insights of Laing and Frankl and the warmth and humanity of Yalom. The existential approach was something that

resonated with me almost immediately I encountered it and is now an integral part of who I am.

It seems obvious now that what I wanted to research was a combination of an existential approach, family systemic therapy and alcohol problems. As I move towards the end of my life, I have this fabulous opportunity to offer a positive contribution to families that have similar problems to my own family of origin. I find I am less curious as to why someone has a need to drink, than how we help a person who wishes to stop or reduce their consumption. Although there is a close relationship between cause and desire and I intend to briefly cover in the literature review the thinking on biological and psychological reasons for drinking.

As part of my training to be a psychotherapist I chose a clinical placement where I could work with clients who had problems with alcohol and/or drugs and have more recently started a private practice specializing in the same area. My hope is that I can draw on my academic understanding, professional experience and personal background to do the subject matter justice.

1.3 Aim of the Research

My aim was to create a model of family therapy and existential phenomenological principles that can assist those with drinking problems to improve their wellbeing through family relationships.

For over three years I worked with a mental health charity counselling clients who were struggling with alcohol and/or drug problems. My experience suggested that

when one or more members of a family drank heavily, the response from other family members was usually more negative than positive. Rather than a pulling together to help the person who has the problem, the reaction is likely to be critical and accusatory and can lead to exclusion from the family. Whilst there can be many reasons for such negative reactions, which when viewed from the perspective of the non-drinker could easily be justified, it remains tragic that loving relationships become part of the problem rather than the solution.

There are many benefits that could be achieved by the production of an existential phenomenological model of family therapy and I anticipate some of them to be as follows.

It is probable that most problem drinkers who seek therapy are seen individually. Any discussion about their family circumstances takes place without any direct input from other family members and is therefore a view solely from the perspective of the individual. Even if the client is attempting to give an open and honest account of things, which some will not, they may be unable to do so and it is likely to be a biased and blinkered summary. Any exploration of issues with the client will be limited by the information disclosed and any planned changes may need to be taken back to the family for agreement which could cause disagreements and setbacks.

Family therapy on the other hand provides a more detailed view of what is happening in the family system and why. It creates an opportunity for all the family to comment on issues, to discuss tensions from every perspective, to examine themes such as domestic pressures, adjustments needed as children grow up, unmet needs

and the demands of being with others. Often change by the drinker is resisted by other family members because it is felt as a threat and in family therapy there is an opportunity to discuss those feelings and talk about how to make adjustments. The therapist can consider the family homeostasis and can suggest changes to the system that everyone can accept. The problem drinking could be a direct response to the family pressures experienced by the drinker and without adequate exploration within the family, any intervention outside of the family system is unlikely to be successful.

The main approaches in family therapy are either systems theory or structural and details of these are presented below. The main aim of family therapy is to understand how family members interact and the therapist becomes part of the system and attempts to make changes to it for the benefit of the whole family. This means it is often action orientated with the therapist suggesting changes in behaviours and often asking people to carry out exercises and tasks.

In contrast, existential psychotherapy attempts 'to be with rather than to do to the client and that creates the opportunity for a very different encounter than other orientations' (du Plock and Fisher, 2005). The approach seeks to avoid any expert role which diagnoses the problem and directs actions in order to fix the situation. Instead the therapeutic encounter is seen as an opportunity for reflection rather than a place for the client to have their behaviour, thoughts or feelings analysed and labelled and their causation determined. In being-with the client, the therapist allows the relationship to become a secure and safe context in which the client's ways of being-in-the-world are disclosed. The therapist is concerned with the unpacking of

the worldview and accepts it in its current formation; there is no intention to modify the perspectives, they are accepted as the client's lived reality (Iacovou and Weixel-Dixon, 2015).

There are very few overlaps between these two modalities. I have only been able to find one old research paper which explores an existential family therapy approach and a few references in a small number of therapy books. These are covered in the literature review below. I suspect this is largely because people train to be therapists in their chosen modality and their interests become fixed in that particular training leading to a somewhat blinkered perspective on working with clients.

As a coach previously and now as a therapist, my interest is in helping the client, whatever that means as to how we work together. To be wedded to a particular way of doing things seems to me to restrict how one might work and thereby miss the opportunity to try something that could be of tremendous benefit to the client. The problem though is how do we find something new when we are not even aware of what we are looking for? Where do we start to expand what we offer to clients without spending huge amounts of time and money investigating the many possibilities available?

I am interested in a family therapy approach when working with alcohol problems because I believe some of the reasons for the drinking might emanate from the family system and even if not, the family can be a great source of support for any desired change. Working with the whole family I believe is a highly effective way to tackle what is a difficult and often long process to achieve a permanent change. I am

training to be an existential therapist and I am excited and committed to that modality. I believe there are benefits to working with a family who are suffering because of one or more members drinking lifestyle, in an existential phenomenological way.

I am aiming to produce a model that is simple but not simplistic. It will provide a starting point for other therapists to consider alternative ways of 'being' or 'doing' with clients. By reading about how the research participants have used a family therapy tool or technique or by reading about an existential psychotherapy principle, I hope to encourage therapists to think 'outside of their box' and consider researching alternative ways to help their clients. Once formed, I anticipate developing the model as I communicate it to audiences through presentations and journals and I start to receive feedback from therapists. In this way the end of this particular research will be the start of another.

Initially for many months, I used the word alcoholic throughout the draft thesis. I had recognised that a more acceptable phrase could have been an individual subject to alcoholism, or an alcoholic subject. 'However such phrases are stylistically clumsy, more importantly they are far from the words which are often adopted by those suffering from the condition'. (Kemp 2009, p.358). I did not wish to be diverted from by research into a discussion as to whether a 'recovering alcoholic' needs to be someone who is abstaining from alcohol, or academic endeavours in trying to define phrases such as a heavy drinker. I had thought that by using the word alcoholic, I was referring to an individual who had adopted a particular lifestyle and had been drawn into a way of being that is commonly referred to as alcoholism. Much later in my research I had the good fortune to become friends with Richard Velleman who I

consider to be much more of an expert in this area than I ever will be. Talking with him about the issue of the appropriate name for an individual who has a drinking problem, I realised that even though I was upset by the effects of societal labelling, I had fallen into a similar practice by using the word alcoholic. I therefore changed my references to the word drinker, which I am much more comfortable with. I realise that this name could also refer to someone who drinks but does not have any problems associated with doing so. For the purpose of this thesis, when I use the word drinker I am referring to someone who has drinking problems recognised by them or members of their family. However, I have continued to use alcoholic when referring to or quoting others that have chosen to use that word.

I had similar reservations later in my research about my choice of the term, 'alcohol abuse'. It was suggested to me that I should have used the term of 'alcohol use disorders' (AUD). I had originally shied away from those words as they are the ones used in DSM-5 and had felt to me to be symbolic of the labelling process that I was unhappy about in my clinical work. I reflected for a while on this aspect and decided for practical reasons to leave the original words in place.

My interest was in helping the drinker address the situation using an existential phenomenological and family system approach. In my interviews with psychotherapists, I wanted to find out what family issues were spoken of in therapy, what behaviours occurred and what interventions were tried. I was as interested in talking to therapists about what was not successful, as what was. My perspective was trying to help the drinker through his/her family relationships, although I have in my literature review touched on why someone might drink to excess, as that can be related to how they are helped. I have not explored as a separate issue how non-

drinking family members are affected by alcohol problems, such as the research conducted by Orford et al (2010), although I have briefly referred to such matters when appropriate.

There is no officially recognised existential phenomenological family therapy and my aim in this research was not to strife for something that achieved approval from both modalities. Instead I had a more modest ambition, that of making useful suggestions to practitioners who were working with drinkers and did not want to ignore the benefits of involving family members.

2. Literature Review

2.1 Introduction

On 19 September 2013 I had my first meeting with my primary supervisor. I had not conducted any research before and was therefore dependent on his experience to guide me on my first steps. He recommended seven books and articles on research and suggested I use my curiosity to enjoy some reading and reflection whilst not rushing into any action. This created a sense of excitement and freedom and for me turned the exercise into something greater than a project to be completed. As part of my training I was attending weekly therapy sessions and I was able to merge my thoughts about research with some of the issues I was discussing with my therapist. This led to finding a passion about research and a desire to understand more about addiction.

In addition to reading books about research methods, I started to look at what had been written on addiction. My curiosity was both a strength and a weakness. It motivated me to read over seventy books and even more research articles over the last three years and challenged me to understand many different ideas. However, when I reached the point where I needed to start putting pen to paper, I was almost overwhelmed by the amount of material I had collected. It was not just the large amount of the notes I had, but also the complexity of the issues. An example of what I was experiencing was that I became frustrated at the time of writing the literature review, that I had over many months read and made notes on the same book twice without realising.

I noticed at an early stage that I had a personal reaction against a one size fits all approach. I was not comfortable with trying to create a single analysis and solution as it seemed to me, to be objectifying the person. I saw in my clinical work the problems that came from giving an individual a clinical label that increased the shame they felt. I wanted my research to avoid an either or philosophy and instead to offer many possible ways of working with a drinker. This meant reading as widely as I was able, to stretch my non-scientific mind into the latest research in neuroscience and to read outside of my chosen existential phenomenological approach.

It has been a struggle to capture all that I wanted to within the limits of what is considered to be an acceptable length of a literature review. There are thoughts and suggestions that I have had to put to one side, but I hope I have been able to capture the most relevant and appropriate points.

To provide a structure that I could work with I have created three main sections to allocate the relevant literature. Within the field of addiction, I have reviewed the main themes and principles and focused my attention on alcohol problems. As regards existential phenomenological psychotherapy, I have covered what has been written with regard to addiction. Finally, I have reviewed family therapy literature that has some affinity with an existential phenomenological approach.

In each of these three sections, I have tried to provide a general description and explanation and then sought to compare the views that are relevant for my research.

2.2 Addiction and Alcohol Abuse

Addiction comes from the Latin word 'addictio' meaning enslaved, its original usage referred to 'giving over' or 'highly devoted' and meant engaging in behaviours habitually, whether positive or negative ones. The more modern understanding though is of strong, overpowering urges, sometimes referred to as disease like. An example definition is 'any repeated behaviour, substance related or not in which a person feels compelled to persist regardless of its negative impact on his life and the lives of others' (Matě 2008, p.128). Wilson-Schaef (1987) refers to behaviours that are inconsistent with personal values and lead to becoming compulsive and obsessive.

'The meaning of all addictions could be defined as endeavours at controlling our life experiences with the help of external remedies ... unfortunately; all external means of improving our life experiences are double-edged swords: they are always good and

bad. No external remedy improves our condition without, at the same time, making it worse'. (Hora 2012, p.126).

'Any passion can become an addiction; but then how to distinguish between the two? The central question is who's in charge, the individual or their behaviour?' (Matě 2008, p.129).

My interest is in people drinking alcohol to excess, but when does that practice become an addiction? When does a person become a problem drinker either in their eyes or others? In the UK many people drink large amounts of alcohol and seemingly continue well with their lives, jobs and families and would say it is not a problem to drink for pleasure and/or to ease life's difficulties.

If individuals are regarded as having a disease, they are seen as sick, unable to think rationally and incapable of giving up alcohol by themselves. (Milam and Ketcham, 1983). If not sick, then given adequate time they may summon sufficient self-control to resolve their difficulties. However, I wonder whether too much time has been spent designing labels and attempting to find a one cause, one solution to the alcohol problem. Perhaps time could have been better served by regarding people as individuals, complex and multidimensional within the context of their existence and not attempting to create a simplistic solution based on a single theory of causation.

Should a definition be needed, then after much reading and reflection, I am in agreement with the definition offered by Richard Velleman (1992), if someone's

drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic. I am attracted to Donald Goodwin (1976) words, an alcoholic is a person who drinks, has problems from drinking but goes on drinking anyway. I think further protracted attempts at more sophisticated definitions can often lead to unnecessary labels that are at best unhelpful and at worse, impact on a person's identity limiting their freedom and choice.

In approaching my research, I have been assisted in my view of drinking problems by a pathways model originally developed to help individuals who had difficulties with gambling. (Blaszczynski and Nower, 2001). The model separates addicts into three pathway groups. The first group are those described as prone to bad judgment, impaired control mechanisms and are overly attracted to rewards. This is the largest of the three groups and describes those people who are able to stop their addiction without any outside professional help at all. A similar view exists that the majority of people who have a drinking problem, recognise they have a problem and are able to summon sufficient control to stop without any assistance (Velleman, 2011).

The second pathway group are those with serious mental health problems such as personality issues, antisocial traits and are normally poor at responding to any form of treatment. This is described in the pathways model as normally a neurological or neurochemical dysfunction and requires hospitalization. (Blaszczynski and Nower, 2001).

The final pathway group are those drinkers I am focused on for my research. They are described in the pathways model as having a history of poor coping and problem

solving skills, negative family experiences and life events often alongside anxiety and/or depression issues.

There is information available on what is a recommended level of alcohol intake but the data is only a guide and has been subject to revision and vague guidance recently. The introduction of alcohol units in the UK were arbitrary figures, since there was insufficient evidence to make confident statements about how much alcohol was safe (Royal College of Physicians, 1987). The revised guidelines issued in January 2016 state that men and women should now drink no more than 14 units of alcohol a week in order to keep their health risks low. The Chief Medical Officer for England (Dame Sally Davies) has said that the risks from alcohol start from any level of regular drinking and rise with the amount being consumed (BBC News, 2016). Basically the current statements seem to be saying that there is no such thing as risk free regular drinking.

Unfortunately for many people trying to decide what a reasonable amount to drink is, the international comparisons can create confusion because of large variances between what different countries recommend as being safe. A unit in the UK is equivalent to 8g of pure alcohol and in comparison, Ireland recommend the equivalent of 21.2 units, Denmark 21, New Zealand 19 and Spain 35 (Guardian Alcohol Datablog, 2016). Other countries define a unit differently, for example the alcohol content of a unit of 8g in the UK rises to 14g in Slovakia and USA. (Visser, 2013).

There are different cultural attitudes with regard to drinking behaviour that I have briefly explored, but as I do not believe it is central to my research, I have not pursued the issue in any depth. Briefly, Jellinek (1960) identified a delta pattern where there is no control over whether to drink or not, but usually avoiding total intoxication; in contrast to a gamma pattern where there is control over whether to take the first drink, but after that there is an inability to stop. My interest is focused on behaviours in the UK, which is suggested by Jellinek as being a gamma pattern.

It is very concerning that the latest statistical information shows a 4% annual increase in alcohol related deaths in England and a 13% increase over the last decade. Admissions to hospitals where diseases or injuries were linked to drinking rose by 32% in the year 2004/5 (Statistics on Alcohol: England 2016). This would seem to indicate that there is a rise in alcohol problems despite any advances in medical understanding and changes to social policy. As I have mentioned above, the social consequences of alcohol problems are outside the focus of my research, but I mention it here to show the family context in which the research takes place.

There might be consensus among researchers that there is no single explanation, however complex, of a scientific cause for alcoholism. (Fingarette, 1988). However, I have found it useful to review the literature about what might be considered as the main causes, since understanding more about what creates the problem, assists us in deciding what to do about it.

Richard Velleman and Jim Orford (1999) conducted interviews with 160 young adults who grew up in families where one or two parents had a drinking problem. The aim

of the research was to look at the effects of growing up in such a family and the prospect of the drinking problem being passed on. The typical behaviours in the homes were ones of quarrelling, lack of fun and laughter and children taking on responsibility for the household chores. Some children seemed to be strengthened by these experiences whilst others experienced higher levels of psychological problems than would normally have been expected. The author's conclusions were that boys who had an alcoholic father were 2.2 times as likely to inherit a drinking problem, 1.6 times likely if an alcoholic mother; for girls 3.3 times with an alcoholic father and 2.4 times with an alcoholic mother. The possible causes of transmission were considered to be genetic and/or environmental.

Donald Goodwin (1976) explored the concept that alcoholism was hereditary, either because of some genetic disposition to alcohol, or inappropriate parenting skills such as modelling of drinking habits and expressed family values. He cites the case for nature by referring to case studies in the 70s and 80s in Denmark, that compared adopted and non-adopted children from alcoholic families, against control groups using hospitalization for alcoholism as the determining factor. This research showed that the subjects were four times more likely to demonstrate alcoholic tendencies if they came from biological alcoholic parents. However, similar studies in Sweden and at the Maudsley Hospital using twins as subjects contradicted these findings and showed no significant differences in behaviours. Goodwin's arguments for nurture are largely subjective although perhaps not contentious, that alcoholics make bad parents because they are emotionally depriving and demonstrate inappropriate modelling of drinking habits. This creates frustrated, unhappy and lonely people who drink to feel the pleasure they crave or to escape the pain they experience.

Goodwin's conclusions are that 'severe forms of alcohol abuse may have a genetic predisposition but that heavy drinkers itself, even when responsible for occasional problems, reflects predominantly nongenetic factors'. (Goodwin 1976, p.144).

Similar views are described in the ACOA (Adult Children of Alcoholics) literature, children in such homes learn at an early age that they are worthless, no good, creating a poor self-image and negative thinking and are therefore more vulnerable to alcohol problems.

Richard Bryant-Jefferies states that 'my experience of working with clients who have alcohol problems suggests that a large part difficulty lies with their sensitivity to their emotions' (2001, p.218). This sensitivity could be as a result of biological vulnerability or early life experiences or recognition that in the modern world alcohol is an attractive solution to enjoy life or ease discomfort.

Some people are able to sustain high alcohol consumption for long periods and still function in their jobs and relationships. However even if they are able to do this, it does not mean that sudden cessation of alcohol is not dangerous. The severity and pattern of bodily and mental disturbance varies according to the drinker's constitution, physical health, nutritional status and the duration and quantities of alcohol consumed. When alcohol is removed from the drinker's body, certain systems that have been suppressed overshoot as they spring back into action. This can lead to the drinker being agitated, tremulous, unable to sleep and being confused. In severe cases, hallucinations and accompanying deluded thoughts can occur a few days after the last consumption of alcohol. Care needs to be taken therefore when

counselling a drinker as to the possible consequences of any sudden changes to their drinking pattern and appropriate medical advice sought.

2.2.1 Neurobiological Perspective

Addiction has been described as a neurobiological predisposition 'due to abnormal receptor mechanisms in the brain which have been genetically inherited and certain substances exacerbate this predisposition'. (Nutt and Nestor 2013, p.2). Some substances when taken create pleasure by changing the brain homeostasis, increasing the activity in discrete 'hot spots' within the reward circuitry. They can be a source of hedonistic pleasure or a form of self-medication to reduce suffering, performance or social anxiety. The brain controls motivational and cognitive processes that involve reward and learning (dopamine) and memory (glutamate). Certain substances disrupt these processes altering the conscious experience of pleasure and as the brain's tolerance increases over time, greater amounts are required to achieve the same effect.

The brain changes with addiction 'not in one or two systems, but in dozens. Neuroscientists are still trying to understand the problem and each year they find more changes; changes in dopamine flow, changes in sensitivity to dopamine, changes in neuromodulators, changes in the striatum, the amygdala, the hippocampus and the prefrontal cortex'. (Lewis 2011, p.154). Neurotransmitters are the molecules that actually do the work of crossing the synopses and alcohol transforms the brain's firing patterns. Excitation neurons send packets of glutamate across the synaptic channel creating pleasure and inhibition neurons send packets

of GABA (gamma-aminobutyric acid). Alcohol enhances GABA transmission and squelches glutamate transmission, in other words, the inhibitory chemicals get boosted while the excitatory chemicals get hushed. (Lewis, 2011).

Not only does alcohol temporally alter the chemical structure of the brain by a rapid shift but it also creates long-term consequences by changing the way the genes act in the nuclei of brain cells creating a vulnerability to craving. The concept of choice is different if we understand that the addict's ability to choose, if not absent, is certainly impaired. (Matě, 2008).

It may be that neuroscience can add to the debate on inherited factors leading to a drinker's problem with alcohol. A recent study at the Universitat de Valěncia has identified a genetic component to the consumption and effects of alcohol. Specifically, it points to a lazy variant of the alcohol dehydrogenase gene known to regulate the activity of a key group of enzymes. When drinking, alcohol rushes into the bloodstream, where alcohol dehydrogenase enzymes metabolise the ethanol into acetaldehyde. If this happens quickly, lots of acetaldehyde accumulates in a short amount of time, which can lead to adverse effects such as flushing, nausea and headaches. Conversely if the ethanol is metabolised slowly, the alcohol remains intact in the blood for longer periods, prolonging its more pleasant euphoric effects.

The speed at which this process takes place, the metabolic rate of ethanol, is where the ADH1B gene is important. An efficient gene can make the effects of alcohol more unpleasant, while carriers of a lazy variant can enjoy longer highs. The person's genetic makeup, according to the study, will affect people not only as to their drinking

habits but could also indicate appropriate courses of treatment by determining the detail of their genetic predisposition (Medical Press University of Valencia, 2016).

Addiction can be regarded as a chronic neurobiological disease. However, I think it is still unclear from the current literature whether a drinker has this neurobiological disease from any inherited disposition or has created the disease from excessive alcohol intake.

2.2.2 The Diagnostic and Statistical Manual of Mental Disorders

The DSM is the standard classification of mental disorders used by mental health professionals in the USA. It is intended to be used in all clinical settings, research and collecting public health statistics. The latest edition is DSM-5 that was published in May 2013 and is one of the most common resources for mental health clinicians in the UK. The DSM-5 can be useful in considering whether someone has an alcohol problem, in that it lists the common symptoms associated addictions and gives details of the three primary components, preoccupation, compulsion and relapse. However, the DSM-5 does not mention the word addiction and has removed the alcohol abuse and alcohol dependency disorders described in DSM IV. Under DSM-5 someone meeting any two of eleven criteria can be diagnosed as suffering from alcohol use disorder (AUD). Criteria includes increase in use, attempts to control, increase in time spent, failure in daily life tasks, withdraw from life, continuation despite hazardous situations and physical symptoms. The severity of AUD is based on the number of criteria met.

The main criticism I have of the use of the DSM-5 is its inherent subjectivity, the difference between normal and abnormal behaviour is arbitrary and decisions are often taken without sufficient context of the person's life. An analysis of behaviours without adequate reference to the person's circumstances and lifestyle, can often misconstrue the situation. The danger is that the individual surrenders their agency and in accepting an expert's opinion that he is an alcoholic, adopts a label that has significant consequences. It surely is an obvious matter that when a drinker is seen within a hospital consulting room and asked about his activities, it is a discussion taken out of context. If the person was spoken to in his own home and at times with his family present, a much more accurate picture of what was happening and why, could be established. I suspect this is not a contentious point; the reason why the current system exists is due to resource efficiency and perhaps a professional need by those involved to view themselves as more important and more in control than the people they are seeing.

What I believe is more important than any list of symptoms is how the person views themselves in relation to their alcohol use. Do they believe their current behaviours are abnormal for them, what is the view of their family, friends and colleagues? Overall, is there any opinion from any source that they have a problem with alcohol. There are of course instances where there is sufficient denial and avoidance that a problem is not accepted by the person and in those cases there is a stage of recognition that needs to be undertaken. This seems to me to be best done by working with the person's self-reflection rather than applying a medical opinion.

2.2.3 Alcoholics Anonymous

Alcoholics Anonymous was founded in 1935 from religious views on the social acceptability of heavy drinking. There was a belief that some people have a biological vulnerability that triggers an uncontrollable need for more alcohol and the only cure is abstinence.   (Fingarette, 1988).

The twelve step programme of the AA is regarded by many professionals in the addiction field as the most successful way of helping a drinker. The AA describes the main benefits of their programme as motivation from sponsor support and acceptance by peers. Perhaps the main concern for therapists is the compatibility between AA's methodology and psychotherapy. The potential conflict can be that exploring psychological issues can draw the therapist away from the central goal expressed by the AA, that the client remains sober. (Osten and Switzer, 2014).

The twelve step programme has three main tenets: if a person hopes to end the cycle of addiction they must have a desire to stop drinking, be prepared to remove one's will and place it squarely in the hands of God and recognise the healing power that exists between two alcoholics struggling to stay sober. Some of the benefits of twelve step are that the drinker realises that they are not alone in their problems, they have a safe place to share their experiences, can learn to ask for help and find a way to stay sober just for today. The only requirement to attend a meeting is a desire to stop drinking and most people are given a sponsor who suggests the time frame for completing the steps. (Osten and Switzer, 2014).

The conclusions reached in Osten and Switzer (2014) is that therapy is not ideal for those drinkers who have antisocial adaptations, particularly if they struggle to allow a truly empathic relationship. Where therapy is beneficial is to support the goals of insight and relationship forming, until sobriety is firmly embedded which is recommended as a minimum of a year.

2.2.4 Cognitive Behavioural Therapy

Traditional CBT principles were developed by AT Beck in the 1960's and have been described as understanding the behaviours and emotions driving the thoughts and perceptions of clients, which are explored in therapy to help the client understand those connections, emotional responses and subsequent behaviour. (Hickes and Mirea, 2012). The client's schemas are viewed as the basis for making assumptions about life that are interpreted into behaviours in order to keep the person safe and happy. One of the main strengths of CBT is its ability to develop and offer new methods to meet client's needs. In the 1990's the second wave of CBT was established that integrated elements from attachment theory and in the last twenty-five years, a third wave of CBT has been created. 'The aim of the CBT therapist is to help the client create an alternative sense of self and an alternative way to respond to critical situations'. (Hickes and Mirea 2012, p11). The sense of self being drawn from life experiences creating behaviours that influence thoughts and perceptions.

'Cognitive theory suggests that psychological disorders do not arise from events per se ... but from... the meanings individuals give to events, filtered through the framework of core beliefs and assumptions which they have developed through life

experience'. (Bennett-Levy et al 2004, p.4). The CBT therapist may well therefore start talking with the client about disturbing behaviours in order to reach core beliefs created by past events and then engage with the meanings the client has created.

The CBT approach to substance misuse is to view addiction as a failure of cognitive control motivated by the value given to either addictive processes or substances. Attention is given to the antecedents that lead to the beliefs of taking alcohol and the subsequent consequences either physical or emotional. Treating dysfunctional schemas and negative core beliefs are often successful where there are issues such as depression or anxiety, but require longer term treatment where addiction is present and is more promising when combined with twelve step counselling. (Ryan, 2013).

Acknowledging the limited success of CBT alone for addiction, Frank Ryan (2013) developed a model called CHANGE, an acronym for Change Habits and the Negative Generation of Emotion. This works in four stages of motivation/engagement; managing cravings and impulses; mood regulation; maintaining gains and relapse prevention.

2.2.5 Counselling for Alcohol Problems

If people continue to use alcohol despite developing problems, this must occur for a reason, there are always reasons for people's behaviours. Counselling is about helping people discover the reasons for this behaviour and then empowering them to make changes. (Velleman, 1992).

A single effective approach to help all alcoholics has been looked for but not yet found (Donovan and Mattson 1994). The Centre for Research on Drugs and Health Behaviour suggests that 'no one approach to the treatment of alcoholism has been proved by research, to be superior to any other for all problem drinkers'. (1994, p1.)

Project MATCH conducted in the USA was 'the largest, most statistically powerful and most methodologically rigorous psychotherapy trial ever undertaken' (Velleman 1992, p. 25). The trial involved nine treatment sites and a total of 1726 clients, who were randomly assigned to Cognitive Behavioural Coping Skills Therapy or Twelve Step Facilitation or Motivational Enhancement Therapy (MET). The results showed that substantial improvements in drinking status took place for all three treatments, but there was little difference in outcome between treatments at either the one year or three year follow up points (UKATT, 2005).

The study was later replicated by the United Kingdom Alcohol Treatment Trial (UKATT, 2005) which was the largest trial of treatment for alcohol problems in the UK. It was a multicentred, randomized, controlled trial with blind assessment, representing collaboration between psychiatry, biostatistics and health economics. Approximately 720 clients attended treatment and were randomly allocated to MET or Social Behaviour and Network Therapy (SBNT). This showed very similar results in that the therapy worked in terms of reduced alcohol consumption, dependence and mental health issues, but did not show any significant difference between initiatives.

Project MATCH and UKATT had failed to find any statistical or clinical difference in outcome between a total of four treatment modalities that had firm foundations in theory and research and were widely practiced. In the literature on the effects of psychotherapy in general, this phenomenon has been referred to as the 'dodo bird effect' (Stiles et al, 1986). Whilst there are a number of psychotherapeutic initiatives available to work with alcohol problems there is a 'conclusion that at the present state of our knowledge, there is no best treatment or treatment of choice' (Rist et al 2005, p.4).

In reviewing the literature on counselling drinkers, I have sometimes been confused about what the model or techniques is really addressing. The AA literature is an exception in that it is clear about its aims of sobriety. Other books and articles appear to me to ignore whether it is a requirement to be sober to engage in therapy, or whether its aim is to achieve that, or that it does not matter. If the client is still drinking and wants to stop, then perhaps that as a single objective is sufficient until that goal is reached. If twelve step is something that resonates with the client, then it can be encouraged and supported by therapy. If not, then another methodology can be considered such as the CBT CHANGE model mentioned earlier, or the cycle of change model explained in Richard Velleman's book (1992). Perhaps the main outcome from Project MATCH was that it does not matter what model or method is used in therapy, it is the relationship between client and therapist that creates the desired change. If so, the major challenge which is perhaps not adequately covered in the addiction literature, is establishing a trustworthy therapeutic relationship with someone who may at times, demonstrate behaviours incompatible with therapy.

Whatever the aims with clients, I agree with Richard Bryant-Jefferies (2001) that we should see the person beyond the alcohol problem; they are more than a set of alcohol related behaviours. We may have some specialist knowledge on the topic but we are not the expert on the client, clients are the experts on their own lives and experiences. Bryant-Jefferies also details a cycle of change model that that has stages of recovery. Comparing it with the other two change cycles I have previously mentioned, Ryan (2013) and Velleman (1992), I do not regard one as significantly more substantial than the others. I think the appropriateness for application depends on the modality of training and experience of the therapist and what is most relevant for the client's particular circumstances. I have avoided creating a model that shows a linear progression from alcohol problems to solution as that appears too simplistic to me. My model shows possibilities to aid choices by the client to change as they and/or family members see fit.

Bryant-Jefferies argues that most alcoholics are ambivalent about change. For most of them alcohol is a place where there is no longer any emotional, mental or psychological hurt or discomfort, and they can feel more free. Alcohol helps them to discover this anaesthetized place where they can, in a sense, float away from their problems. (Bryant-Jefferies, 2001). The process becomes one of craving and indulgence that provides short-term relief but causes long-term harm. It is almost always a source of suffering for both the alcoholic and those who care about him or her. (Levine, 2014).

Levine argues that attempts at trying to understand why a person becomes an alcoholic is perhaps pointless, a simpler belief should be considered such as one

based on karma. 'Our bodies naturally crave pleasure, which we think equals happiness, safety and survival. We hate pain that we think equals unhappiness and death. The addict is an extreme manifestation of the normal human condition'. (Levine 2014, p.11). Perhaps our relationship to the craving is the problem, not the substances or behaviours themselves. (Levine, 2014.)

When reviewing the general literature on counselling for drinking problems, I have found books and articles that could be described as parochial in their views and methods because of a tendency to ignore other effective ways of addressing the same problem. I chose to develop an existential phenomenological family therapy approach to alcohol problems but I did not want to produce a one size fits all model. Instead, I searched for many suggestions that are offered in a model useful in part or whole, so that other therapists can encounter their clients with many possibilities and together they can find a way of working that suits them.

2.3 Existential Psychotherapy and Addiction

'When considering existential therapy, it is difficult not to conclude that there are as many unique expressions of existential therapy as there are unique beings who engage and practise it'. (Spinelli 2015, p.12).

In 2014-16 an international group representing a cross section of contemporary existential therapists joined together in a cooperative effort to create a broad definition. This was 'existential therapy is a philosophically informed approach to counseling or psychotherapy. It comprises a richly diverse spectrum of theories and

practices … characterized in practice by an emphasis on relatedness, spontaneity, flexibility and freedom from rigid doctrine or dogma … Existential therapy aims to illuminate the way in which each unique person, within certain inevitable limits and constraining factors, comes to choose, create and perpetuate his or her own way of being in the world. In both its theoretical orientation and practical approach, existential therapy emphasizes and honors the perpetually emerging, unfolding and paradoxical nature of human existence and brings an unquenchable curiosity to what it truly means to be human' (World Confederation of Existential Therapists 2016, p.2).

A reluctance to define and categorize is considered by most existential therapists as part of their approach and in my research, I have not sought to create a model inconsistent with this principle. However, there are values and beliefs that most if not all existential therapists would agree as fundamental to the practice of existential therapy. Avoiding attributing labels to clients is because we believe we do not have a fixed essence, that we are constantly in process and to believe otherwise would mean seeing clients as less meaning making and autonomous than they really are. We believe we are thrown alone into the world with certain givens, for example that we were all born and will die and we can choose our own unique response to those givens before we are thrown out of existence.

Previously I have commented favourably on the work of Alcoholics Anonymous, however from an existential therapy prospective, one could be more critical because of the concept of bad faith. Members of the A.A. are asked to accept the text of the Big Book and meetings follow a format that reinforces the overall philosophy. The first three steps require admitting powerlessness over alcohol, that only by giving

over one's will to a greater power can sanity be restored (A.A. Big Book, 2015). This results in the person falling into bad faith because he denies his freedom to change and pretends to become the essence of an alcoholic. He believes he has a disease over which he is powerless and this view of himself becomes a sedimentation within his self. In accepting the A.A.'s culture the person chooses to see themselves as others see them, to live as though helpless. It is reminiscent of Sartre's (1943) champion of sincerity, who professed his friend's homosexuality. The alcoholic stands before others who choose to see him as a kind of thing, an unfree being with a fixed essence, whose past conduct has decided his future. It is too easy within this methodology for the drinker to avoid any reflection and subsequently restricts his freedom and choice.

In contrast, if the person acknowledged that his past conduct amounted to a pattern of behaviour that could be viewed by others as an alcoholic, but chose to believe that his life should not be defined by such a pattern, it would enable him to retain his transcendence. For an alcoholic this would be a different way of seeing their past, present and future and of obtaining the belief that they are capable of change. It is an opportunity to be more honest with themselves, 'it's the 'role-playing or dwelling in make believe, pretending something is the case when it is not, that creates the bad faith'. (van Deurzen 1997, p.79).

Addiction is an issue that has direct physical, social, psychological and spiritual relevance and as such 'it can be thought of as a project of bad faith that affects all four worlds' (Adams 2013, p.108). People who are addicted often believe that they should be perfect and are unable to live up to their own expectations of themselves.

Yet at the core of the self is a belief that they are failures and nothing can ever be good enough. (Harris, 2000). Wilson Schaef believes that addictions such as alcohol are secondary addictions, 'the primary addiction is the person's sense of powerlessness and nonliving which the addictive process both masks and perpetuates'. (1987, p.16). These feelings of failure mean that most drinkers struggle with strong feelings of shame. 'When a person is looked at by the Other he ceases to be a free transcendence of the world and becomes instead an object in the world of the Other'. (Cox 2008, p.125). The experience of humiliation, being seen by society as an alcoholic object, often leads to a spiral of self-criticism and a mistaken belief that the solution lies in distancing himself from others.

'In the face of almost complete bodily, mental and social breakdown, some chose to walk away from treatment because of the 'place' that will be marked for them by acquiring the signification 'addict' (Kemp 2011, p.440).

2.3.1 The Problem Drinker and Self

Hazel Barnes (1980) analysis of the self details a consciousness reflecting back upon earlier acts and imposing a unity upon those experiences and creating an essence as part of a being, a being-in-itself. David Detmer (2008) suggests that when an alcoholic is asked to give a phenomenological description of his past, he will speak of objects of experience, what he did and when; along with acts of consciousness, what he imagined questioned and doubted. It is only when the client shifts his attention to the reflective mode that he starts to change his self-deception of being an 'alcoholic thing' and allow his consciousness to benefit from the critical resources of reflection.

Existence has anxiety at its centre, 'living is never certain, never fully predictable, never secure' (Spinelli 1997, p.6). In order to deal with this anxiety and feel safe we create a way of being where we attempt to be fixed and substantial. However, a fixed self is not fully possible, despite our very best efforts we are faced with the fact that we are nothing at all and our efforts are in vain, 'man is a useless passion' (Sartre 1943 p.615). We may be 'attracted by the durability of a stone' (Sartre1948 p.19), but the 'self is not a thing but a creation, which is momentary and fleeting, essentially unstable. When I try to capture its image, it flees from me. Trying to catch the self is like trying to catch one's own shadow' (van Deurzen 1997, p.82)

Over time we all build a set of beliefs, values and aspirations, about who we believe ourselves to be and this can be seen as our 'self construct and the product of, or that which emerges from relational experience'. (Spinelli 1994, p.216). There are also judgments as to who we cannot permit ourselves to be. However, when we attempt to make ourselves fixed and substantial we inevitably deny something of our freedom and human nature (Spinelli, 1997). The self is fluid, but what can become fixed are strong beliefs 'that insist on the primacy or correctness of one perspective over all others' and these are seen as sedimented beliefs, as well as being personally derived, they may also be 'socio-culturally influenced' (Spinelli 1994, p.219-220). The drinker has created a self that contains sedimented beliefs that all he is and all he ever can be, is an alcoholic. If he believes that the cause of his situation is an illness over which he is powerless to change, this encourages him to maintain a fixed sense of being and he surrenders some aspects of freedom and choice and his self-construct no longer contains the plasticity to renew.

The self-construct may contain contradictory beliefs and where some are sedimented, the 'others must be disowned or dissociated ... leading to the view that it wasn't me; it was the addict inside me' (du Plock, 2005 p.72). There is a difference between who a client believes he is and what they do. A person may spend the majority of their time drinking, but it is important to observe with them that this is an activity they have chosen to do, it does not define who they are … 'grounded in the understanding that addiction is meaningful and serves a function and only in the course of careful clarification of the individual's self construct can there be a sense of agency which will enable them to decide whether to continue or change their relationship to the phenomenon'. (du Plock 2013, p.214).

2.3.2 Addiction as a Social Construct

I reviewed above the opinions that regard alcoholism as a disease or illness, however existentially 'addiction refers to a social construct rather than a specific condition located within an individual' (du Plock and Fisher 2005, p.68). Social construct can be defined here as meaning a perception of an individual that is constructed through cultural or social practice (Dictionary.com, 2015). Whilst seemingly at odds with each other, I do not think there is a difficulty in reconciling these contrasting views because I think they can both be correct.

For example, it may well be that someone has chosen to drink heavily and that his behaviour is such that he is viewed as an alcoholic by others. That view of him influences how he sees himself, to the extent that he changes his self construct, now believing he is an alcoholic. The more he surrenders to that social construct, the

more he believes his essence is one of an alcoholic and he abandons his transcendence. This does not mean though that there have not been changes to him physically. Drinking high levels of alcohol does change brain chemistry, creating a cycle of cravings and increased tolerance (Lewis, 2011). Therefore, concurrently with changes in his self construct, his physical acts have changed his brain chemistry and he has now become what he originally viewed himself as being. There is no cause and effect between the two developments; they run separately and perhaps at different paces, but towards the same conclusion.

In my research I was curious as to whether a view of addiction as a self construct or a neurobiological illness, could be more helpful. I wanted to explore whether excessive drinking could be accepted as an understandable response to a family system and yet at the same time a sickness. If so, instead of the family avoiding responsibility by labelling the drinking problem as solely a medical one and beyond their influence to change, they might accept the possibility that they can influence the situation by electing a different way of being as a family system. Accordingly, I have reviewed the research of Laing and Esterson in the study of schizophrenia. (1964).

Laing and Esterson conducted research by working with eleven families where there had been a diagnosis of schizophrenia (1964). Their interest was in persons, the relations between persons and the characteristics of the family as a system composed of a multiplicity of persons. They viewed each person as not occupying a single definable position but several family roles depending on the internal relationship of the behaviours. They saw that persons behaved differently in their different alterations and experienced themselves in different ways. When the

'schizophrenic' was studied in the family context, it was possible to view the person as suffering more from the family than from something wrong inside. (Esterson 1970).

Esterson wrote about a person's experience of himself being mediated by the other resulting in an alterated identity. 'For instance, John sees himself as a warm, friendly man. He sees James seeing him as cool and reserved. If John identifies with James's view of him, his identity-for-self is now significantly altered. If he realises through existential self-examination that James's view is more accurate than his, and he sees in what way this is so, his new view of himself is not based on alteration, but on insight facilitated in his relation with the other'. (Esterson 1970, p.39). This example suggests an initial change in the person's self construct as an alteration, but if subject to some reflection would then become sedimentation.

'Addictive clients reveal their stance to be one of deep uncertainty and ambivalence towards what they perceive to be the demands of the world with regard to how and who they are permitted to be, or more specifically, who they must be. Placed in this light, their addictive behaviour, as problematic and dangerous as it may be, nevertheless serves a significant function; it expresses an act of rebellion, a form of aggressive reaction towards the world for not allowing them to be as they are'. (Spinelli 1997, p.112). Addiction activities serve to protect clients' self construct from a variety of debilitating anxieties that arise from his self and other relations. (Spinelli, 1997).

2.3.3 Existential Phenomenological Therapy

It is not possible to experience the experience of the other that we can never fully know, we are thrown into the world alone, we are thrown out of existence alone and we are responsible for our own being in the intervening period (du Plock and Fisher, 2005). What clients present in therapy is not a certain set of symptoms suggesting an underlying illness but their own unique attunement to the human condition and they cannot be cured of the disease any more than they can be cured of life. (Baker, 2000). Reminding clients that they are making choices enables them to review how their choices fit with their values and telling them that they are addicted, may reduce the sense that they might be able to make a difference. (Wurm, 1997). Addicted clients in existential therapy can clarify the underlying purpose and meaning of what so often is explained away as a disease accompanied by psychological and physiological cravings and they can understand better the freedom they have to make alternative choices. (du Plock, 2009).

Other modalities might aim at stopping the behaviour of drinking without acknowledging the benefits as well as the problems. Most drinkers are ambivalent about stopping since drinking makes life more bearable and without drinking the person is left with the conflict in their self construct and they either relapse or spin off into other addictions. An existential approach aims to help the person reflect, to address issues with support, bringing the conflict into the explicit level confronting attitudes and values more adequately and destabilising sedimented beliefs. (Spinelli, 1997)

The therapist attempts to 'be with' rather than 'do to' the client and that creates the opportunity for a very different encounter than other orientations (du Plock and Fisher, 2005). The aim is to encounter the client with the minimum number of preconceptions and biases but with genuine curiosity and naivety about their way of being in the world and encouraging the client to take their being seriously. (du Plock, 2013). Avoiding an expert role and entering into a relationship directly and wholeheartedly will lead the client to question their own way of being and their sedimented beliefs. (du Plock, 2009). The therapist is not seeking to alter the client's way of being via argument, coercion or reward, but to stay with them as they are and explore their experience of being so that sedimentations and dissociations maybe more explicit. (Spinelli, 1997).

Differing from most modalities where the therapist assumes some form of superior or expert role in the room, the existential therapist reaches out with their own failings and sufferings to make a therapeutic connection. 'It is not the absence of life's trauma's that may provide for therapists' ability to connect with their patients, but rather the opposite' (Adams 2014, p.109). 'When both client and psychotherapist turn towards the other and, not in spite of but because they permit themselves to ascertain the other's frailties and are willing to embrace them as their own, then, through this very act of human caring, each experiences that necessary empowerment to be, and to be seen to be, the being they both aspire to become'. (Spinelli 2001, p.168).

Phenomenology is the study of phenomena as people experience them. I have elsewhere described the main principles of phenomenology, but it is relevant here to

mention how the existential phenomenological therapist applies those principles in practice. 'For an existential therapist phenomenology refers to the disciplined philosophical method by which the ultimate concerns or givens are addressed and through which the person's basic experience of being-in-the-world can best be illuminated or revealed and thus more accurately understood' (World Confederation of Existential Therapists 2016, p.3).

What an existential therapist hopes to achieve is an understanding of the complex reality of what the client is experiencing and how the client makes sense of the world. The work is conducted through dialogue; existential therapists are not silent observers like analysts or didactic teachers as perhaps in CBT. Interpretation is always hermeneutic, ensuring meanings correspond to the meaning that was intended by the client. There is no intent to translate clients' experiences into theoretical concepts or symptoms of pathology. It is not the therapist's role to impose or suggest meanings, that is the client's prerogative. The therapist looks for the essence of the experience and often senses when this is correct through their intuition.

The process of phenomenological reduction is used by existential therapists to focus the conscious mind and consists of:

- Epoché

- Description

- Horizontalization

- Equalization

- Verification

The therapist considers each aspect of consciousness by setting aside any prejudice and bias through the process of epoché, often referred to as bracketing off assumptions. Epoché starts by paying attention to the process of observation and experience, considering things for a second time, stopping us from assuming things that might not be correct. 'This does not mean we get rid of our previous assumptions or that we un-think them or are able to un-know anything we already know. It only means that we take awareness of what is going on. We commit to the discipline of thinking about our thinking process and begin to see a lot more than we saw before' (van Deurzen 2014, p.3).

The existential therapist stays with description rather than analysing or explaining. This is observing, noting, watching, describing and avoiding jumping to conclusions. The process is repeated patiently until the therapist begins to see below the surface to the essence of the phenomena.

Horizontalizing is when the therapist places what is becoming known against a horizon, in other words, to add context to the client's worldview. This is important because whilst the clients view is accepted, it is always in context. The therapist should be aware of the limit of what can be seen and aware of their own perspective of the issue being discussed.

Equalization is bringing all the elements into view with equal emphasis. This can be hard to do since what appears closest or loudest can often be viewed as the more important.

Everything the therapist observes is bound to hold some error and will be an interpretation of reality. Verification is the method to check that the observations fit reality and the therapist keeps correcting the picture until it does so.

There is another phenomenological layer to be considered, which is the element of time. This runs through all human lives and needs to be considered in therapy. Heidegger (1927) proposed that human beings are thrown in time and are projected towards the end in a distant future. Clients measure everything in their lives by change and the passing of time, because they are no longer what they were and not yet what they will be. They create different narratives about the past as they seek to forget, remember or re-experience. The objective is 'to own our experience so as to learn from it. Similarly, in the present, we can absent ourselves or truly be in the moment. We can distance ourselves from possible futures or resolutely anticipate their possibility as well as the end of possibility in death (van Deurzen 2014, p.8).

2.4 Family Therapy and Existential Therapy

Early family therapists believed that individual therapy helped to maintain an artificial boundary between man and his social context and gave little opportunity for corrective feedback with the result that the individual came to be viewed as the site of pathology (Minuchin, 1974). The wish to observe and work with the family as the primary unit in the client's social context lead to the development of family therapy, where the focus is on the pattern of connections between one individual family member and another, each component being seen as contributing to the operation as a whole (Rivett and Street, 2009).

Gregory Bateson's work in the mid-1950s with schizophrenic patients was the start of the movement away from seeing the individual as the patient and towards seeing the interactional patterns of behaviour between family members as the unit needing to be cured or repaired. Bateson believed that it is 'patterns which connect' and saw the family as a total system within which there is a 'dance of interacting parts' (1979, p13). Along with colleagues including Jay Haley, Don Jackson, Virginia Satir and Paul Watzlawick, the therapeutic work, from the outset, was with the 'sick family' and not the 'sick individual' (Jackson, 1973). Satir (1967) believed that to understand the meaning of a symptom it is necessary to see how it fits into the family and that every piece of behaviour in a family is logical to that system.

The main approaches in family therapy are either systems theory or structural. Systems thinking regards each part of the family as connected to and interrelating with other parts and what occurs will depend on the nature of the system and the process of information exchange. The structural approach was developed by Minuchin (1974), who used a functional analysis, based on change theory to map out a model of optimal family functioning and ideal family structure. He defined family structure as the invisible set of functional demands that organizes the way in which family members interact and saw it as main source of symptomatic behaviour and therefore the logical target of therapy (1974).

Family therapy tries to understand the nature of family life, it emphasises the contexts and encourages the avoidance of blame and acceptance of responsibility. The family therapist usually becomes part of the system seeking to understand unspoken family rules and bring these out into the open to explore alternatives that

could work better for the family. The therapy explores behaviours and the meanings each family member has created for that action, some shared and others not. This dictates how the past is viewed, the present lived and the future planned. There is a continuous endless looping of information exchange that has no beginning and no end, but is like a spiralling circle moving through time (Rivett and Street, 2009). The therapy concentrates more upon relationships than the process of unburdening emotions and its focus is to enable the family to heal by recognising unhelpful patterns or responses.

There are several schools of family therapy each differing in their particular philosophy, but I have not been able to identify any one school as having any particular interest in addiction. I have though found addiction references in some of the schools as mentioned below.

Gregory Bateson (1971) believed the drinker suffered from a cognitive error that instead of being part of the feedback loop within the family he creates his own loop and objectifies the world and the people in it. Alcohol helps to break down the boundaries between self and the world and makes the situation tolerable. Bateson believed the A.A. was so successful because it helped the alcoholic to have a more complementary existence with others.

Stanton and Todd (1982) developed strategic-structural family therapy and their work showed a regular occurrence of addiction precisely at the moment in the life cycle of the family when the addict was leaving home. This suggested that the family needed the addict in that state because it forced him to remain at home. Their work was

based on a psychodynamic model and operated by indirection, creating an alliance with that part of the family system that wants individualization and recovery.

Edward Kaufman and Pauline Kaufmann (1979) proposed that an addict might remain as such in order to maintain the family homeostasis. Their methods were an integrated modality, but largely based on Minuchin's structural techniques and strategic in that the therapy is carefully planned and controlled. Peter Steinglas (1979) writing within the book edited by Kaufman and Kaufmann summarized the position as; 'the alcoholic member of the family might through his or her drinking be protecting the family from overwhelming depression or intolerable levels of aggression'. (1979 p.152).

Timothy O'Farrell (1993) developed a behavioural martial therapy couple's group programme for alcoholics and their spouses. This was a directional homework based methodology where couples were required to carry out instructions in terms of actions and communication. It enabled issues to surface and was optimistic about sufficient love and commitment being present below the chaos of the alcoholic relationship, to make meaningful changes.

Marc Galanter (1993) developed network therapy where the family was directed to ignore the addiction that was present and to be mobilized into a network that was exclusively about achieving and maintaining sobriety. Building on Galanter's work, Social Behaviour and Network Therapy for Alcohol Problems was developed for the United Kingdom Alcohol Treatment Trial. (Copello et al, 2009). Its aim was to bring together the alcoholic with family, friends and work colleagues to create a supportive team to achieve positive results. It had core topics of communication, alcoholic

problem coping, enhancing social support and relapse management. It addressed problems such as when individuals begin to drink heavily, people around them including family do not always have sufficient knowledge to decide whether or not their drinking is excessive and if they don't know that, or don't know how to respond, the problem is ignored and without adequate discussion, the problems escalate (Copello et al,2009). The therapist used skills such as network management, education about alcohol, coping techniques, communication, planning for lapses and increasing support for the alcoholic.

There is no officially recognised existential family therapy and the closest I have found to that approach is a paper written in the 1980s by Haldane and McCluskey. They suggest that if one were to exist, it would not adopt a structural or strategic method seeking to change patterns of behaviour that hopefully lead to alterations in internal experiences; instead it would promote the reverse, looking for problem resolution through changes in internal experience and the product of a more authentic existence (1982).

I agree with that view and I would suggest it would be an encounter between the therapist and all the members of the family, a shared exploration of the experience of what it is like to be a member of that family and the expectations each person has of all other family members. It would recognise and address the ontological givens I referred to in my earlier section on existential therapy, in particular the existential concept that man can never truly be isolated and is thus always in relation. As Buber proposed there is 'no I without a thou' (1957).

Jim Lantz (1993) wrote about family therapy using the concepts of Viktor Frankl. His aim was to help the family gain awareness and make use of the potential meanings in the family by using for example, Frankl's work on existential vacuum and the tragic triad. Frankl's techniques could be considered as unusually directive within the existential modality and Lantz discusses applying such methods as paradoxical intention, dereflection and Socratic dialogue. The book is a rare example of someone coupling existential principles with family therapy, but does not engage with the field of addiction.

In Canada there have been developments using the disease model, family systems and CBT to create an Addiction Family Therapy (AFT). It contains an existential focus in that clients are encouraged to believe they are more than their deficits and to find greater meaning and purpose in their lives. (Patterson-Sterling 2004). The belief is that sometimes family members unknowingly support individuals' addictive behaviours through enabling actions such as making excuses or ignoring the impact of the addiction. The model brings together the family therapy principles of Bowen (1976) and the logotherapy of Frankl (1948). Families are helped to understand their experiences of coping with addiction are opportunities for greater personal growth.

I remain surprised that more has not been written on linking family therapy and existential therapy in relation to addiction. I hope to be able to make a modest step in rectifying that oversight.

3. Research Methodology

The following chapters contain the following details on research methodology:

- Chapter 4 states how I chose my research methodology and explains the main principles of constructivist grounded theory.

- Chapter 5 outlines my pilot study and how I applied the constructivist grounded theory principles to the data.

- Chapters 6 and 7 detail my research study findings.

4. Choice of Research Methodology

4.1 Introduction

I am a novice researcher and in order to learn the subject as quickly as possible I read a number of introductory books. (McLeod, 2001, 2003; Langridge, 2007; Bryant and Charmaz, 2007; Finlay and Evans, 2009; Breakwell et al, 2012; Charmaz, 2014). I am though a structured and organised person and I have used these skills in my approach to the research project. From the beginning I kept several journals to record my thoughts and feelings, detailed notes of all the books and articles I read, notes from supervisor meetings and research ideas. When I started to write about my research, I used these journals as a resource to provide information and a source of inspiration.

The choice of research methodology has a direct connection to the research findings in almost equal measure to the characteristics of the phenomenon that is the subject of the investigation (Langridge, 2007). My choice of methodology needed to be appropriate to discover the issues that I am interested in and complement how I see myself in the world, particularly in relation to what I understand as reality and truth.

What I explain in the following sections is my rationale for choosing a constructivist grounded theory methodology.

4.2 Quantitative or Qualitative?

Quantitative research focuses on the establishment of objective facts and typically involves inferential statistical analysis by a researcher who is disconnected from the research (Neuman, 2006). I regard quantitative research to be of great value for the type of enquires where there is a necessity to draw generalised results from substantial amounts of participant data. It mostly involves numerical data and there is a belief in an objective reality that can be examined without bias (Silverstein et al, 2006). Quantitative research methods assume a causal relationship in the world grounded within natural science and presume that objective knowledge can be gained through direct experience or observation of the world.

Qualitative research however is concerned with meaning and experience, with the researcher always interacting with what is being observed. A qualitative approach relies on words rather than numerical data and accepts that we are situated in a historical, social and cultural context rather than observers of objective knowledge

(Faulconer, 2005). One of the aims of qualitative research is to record 'the subjective experiences of the participants in a way that reflects the diversity of their lived experience' (Silverstein et al 2006, p.351). It seemed to me that in wishing to create a model that explains the varied and complex interactions that occur in family therapy, a large participant numerical analysis would not do justice to the subject. I did not believe there was a sufficient cause and effect reality that could be measured that way. Only by interviewing experienced family practitioners who shared with me their many and differing experiences, would allow me to gain the understanding I needed to create a model. I therefore believed that qualitative methodology was the correct choice.

Quantitative and qualitative terms are not only associated with particular methods and procedures but also with certain epistemologies or theories of knowledge (Martin and Stenner, 2004). The differences between the approaches and their epistemological underpinnings are significant as they have different philosophical roots and theoretical assumptions that in turn generate different types of questions (Jordan and Shirley, 2000). 'Qualitative researchers have a responsibility to make their epistemological position clear, conduct their research in a manner that is consistent with that position and present their findings in a way that allows them to be evaluated appropriately' (Madill et al 2000, p.17). Thinking about what we can know and how we can come to know it therefore involves the researcher in resonating with a particular paradigm or set of basic beliefs that provide the basic principles for understanding the world (Langdridge, 2007).

4.3 Epistemology

'Epistemology is concerned with the theory of knowledge and the role of science. It asks what can we know and how can we know things. It looks at the way we think about the nature of the social world and our being or ontology'. (Finlay and Evans 2009, p.18). In examining how I relate to the world in order to understand my thoughts on cause and effect, I found it useful to distinguish between a positivist and interpretivist belief.

Positivists are hopeful about finding true knowledge about an existing real world through a relatively simple relationship of perceptions and understandings. They believe it is possible to describe and explain what is going on and that other researchers will find similar relationships between perceptions and events. I struggle with the idea of a one truth, one answer concept. It seems more acceptable to me to view truth and reality as being subjective, dependent on our own personal perspective shaped by our own unique lens through which we see the world. Within research terminology I am content to view myself as an interpretivist.

Continuing to work with a format suggested by Finlay and Evans (2009) it has been helpful for me to consider next, the realist or relativist positions. This is a less clear matter for me. I do regard the world as made up of structure and objects and I believe there is some element of a cause and effect relationship, but this relationship is dependent not just on the world, but on my view of it at that particular time. After some reflection, on the realism – relativism continuum, I believe I am closer to, but not situated in the realist camp.

In seeing the world in this manner, where truth is subjective and cause and effect is dependent upon how I may view it, I wanted to approach my research by sharing my thoughts and ideas with my participants and openly co-constituting the data. Where appropriate, I wanted to disclose thoughts and feelings I had from previous interviews, my experiences from my clinical work and from my family of origin. I regarded this as an authentic approach to interviewing participants and I believe it was more effective for me than attempting to bracket off my thoughts and feelings.

4.4 Phenomenological Consideration

Phenomenology is most frequently associated with a philosophical movement initiated by Husserl although earlier writers such as Kant and Hegel both wrote extensively about phenomenology (Moran, 2000). Husserl's philosophy was a belief in a 'return to the things themselves', by which he meant a return to the primary experience of the subject in the world. He believed that 'until I am able to describe accurately what it is I observe in the world, how the process of my consciousness arrives at awareness of the world and what that consciousness amounts to in the first place, we cannot rely on any scientific data about either the world or the process and experience of consciousness itself' (van Deurzen 1997, p.36).

Heidegger added to Husserl's project and emphasised the material nature of human experience that always takes place within a situated context in the world requiring an interpretative element to be understood. Phenomenology is concerned with attending to the way things appear to us in experience, how as individuals we perceive and talk about objects and events.

'Phenomenology is an umbrella term encompassing both a philosophical movement and a range of research approaches' (Finlay 2008, p.1). In my private practice I adopt a phenomenological approach when working with clients and I anticipated the model emerging from my research to have similar principles. I saw this as a matter of adopting the philosophy in my work. However, the issue to be considered at this stage in my thesis is whether I should have adopted a phenomenological research method.

'The aim of phenomenological research is to achieve an authentic and comprehensive description of the way in which a phenomenon is experienced by a person or group of people' (McLeod 2003, p.79). 'Phenomenological inquiry is not unlike an artistic endeavour, a creative attempt to somehow capture a certain phenomenon of life in a linguistic description that is both holistic and analytical, evocative and precise, unique and universal, powerful and sensitive' (van Manen 1990, p.39). The phenomenological researcher aims to provide a rich textured description of a lived experience, returning to the things themselves meaning the world of experience as lived.

I have stated below in paragraph 4.5, my reasons for deciding on constructivist grounded theory as the most appropriate methodology for this project. However, whilst writing about phenomenological considerations it is worthwhile to comment on the similarities and differences between the two research methods.

Grounded theory and phenomenology both start methodologically with data-collection and generally share a descriptive approach. Both deal initially with

unstructured data that receives extensive refinement and creates central themes. They can both be described as emergent strategies. However, phenomenology investigates the phenomena of lived experiences whereas grounded theory is thematically open. Phenomenology strives to capture the 'essence' of individual experience inclusive of what and how participants have experienced it (Moustakas, 1994). This differs from the goal of logically explaining the phenomena in grounded theory, in other words, phenomenology is interpreting experiences whereby grounded theory extracts themes from the data. The bracketing-out of the researcher's own experience to avoid bias is a major concern in phenomenology; whereas constructivist grounded theory recognizes the inevitability of input from the researcher into the data.

Phenomenology is designed to discover phenomena and unearth previously unnoticed or overlooked issues, as it explores experience and meaning. It reveals meanings that appear 'hidden' or identifies the impact of a phenomenon, rather than making inferences. The approach provides rich descriptions that aid understanding so that researchers may better understand the possibilities embedded in the experience of phenomena. The goal of phenomenology is to develop an understanding of a phenomenon through the specific human experience of the phenomenon, in order to better understand that experience of being in that 'life-world'. It serves to understand a person's experiences rather than to provide causal explanation of those experiences. The process of phenomenological research, therefore, does not 'break down' the experience that is being studied. Instead, it provides descriptions that are rich and full and interpretations that exactly describe what it means to be a person in their particular world. The phenomenological

researcher is committed to understanding the experience of the phenomena as a whole, rather than parts of that experience.

Symbolic interactionism is 'a theoretical perspective derived from pragmatism which assumes that people construct selves, society and reality through interaction' (Charmaz 2014, p.344). It is the major theoretical perspective associated with grounded theory although it is not a mandatory part of the constructivist grounded theory process. It can be used to align an interactionist approach alongside naturalistic inquiry to develop the theory. Where individuals are known to share culturally orientated understandings of their world, where understandings are shaped by similar beliefs, values and attitudes and determine how individuals behave according to how they interpret the world around them. People are seen as being both 'self-aware' and 'aware of others' and, therefore, can adapt their social interactions and situational behaviour to shape meaning and society. In this sense, the focus lies with the symbolic meanings that are uncovered by people's interactions, actions and resulting consequences.

Researchers using symbolic interactionism 'view human actions as constructing self, situation, and society. It assumes that language and symbols play a crucial role in forming and sharing our meanings and actions … it recognizes that we act in response to how we view our situations' (Charmaz 2014, p.262).

If I wanted to research the experience of being a drinker, to try to understand what it is like to be a drinker in the world and in relation to others, I would choose a phenomenological research method. If I wanted to research the experience of being

a therapist working with a family who have alcohol problems, then I would make the same choice. However, I did not want to do either of those things. I was interested in what works in the therapy session rather than understanding what is experienced. I accept that the two views are linked but, 'in phenomenological research the investigator would view a descriptive account as an end in itself, whereas in grounded theory studies the description would serve as a basis for interpretation and analysis' (McLeod 2003, p.95).

In my reflection journal, I kept brief notes on the symbolic interactionism aspects of my interviews. I was interested in how participants described their work, their beliefs, values and attitudes, how their modality had affected their perspective of the work and shaped how they saw themselves in the world. However, this was not an aspect I believed I needed to explore greatly. I was less interested in what the participants felt than in what they did and why. I did not follow a phenomenological process exploring what a participant meant by a particular word or expression, because I believe that would have deflected me away from the task of gathering what I considered to be the relevant data.

Where I did consider a phenomenological input into the developing theory was when a participant had a passion for a particular approach or aspect of their work and showed that in how they spoke to me. So for example, one participant was a strong advocate for brief solution focused work and talked for some time in his interview about the history and theory of that approach. Another participant had a strong spiritual view of the world and because she used that way of being in her therapy sessions with clients, spoke about it at some length. I have made reference to both

of those aspects in the description of the appropriate concept and model. However, I was not sufficiently interested in the lived experience of participants when with clients to consider either a phenomenological research method or greater use of symbolic interactionism. On the whole, the collection of data was driven from a pragmatic perspective of what happened with clients and what was the result. The descriptions of that work by the participants I believe are similar enough with those who will use the model in due course and whilst I could have used symbolic interactionism more and written further in that vein, I do not believe it would have enhanced my research.

Grounded theory research can be conducted according to a variety of perspectives, but with the primary ones being objectivism and constructivism. Objectivism considers that, as in the natural sciences, there are realities/truths/facts (an object) to be revealed. Objectivist grounded theory aims to find and uncover what is believed to be 'there' (to be real) about human action and interaction.

I have stated above I do not see the world as holding absolute truths which can be discovered by different people on different occasions provided they use the same research methods. I see the world as being constructed by individuals through their own unique lens of meaning making. I am therefore drawn towards constructivism which recognizes that there are multiple constructed realities that are determined according to the opinion of the person experiencing the situation and the person conducting the theories. Constructivist grounded theorists view their research product (theory) as representing one of multiple realities about what may be happening regarding human action and interaction.

I wanted to understand from my interviews what approaches, methods, tools and techniques helped the family with the alcohol problem. I was looking for data describing in detail what issues arose, what ways of working were considered and used and how successful they were in the opinion of the therapist. I used that data to create a model that used existential and family therapy principles. I had discussions with participants that built on the training and experience we both had in order to co-constitute the model. I used a research method that extracted from my interviews the data that showed underlying themes, issues and topics.

4.5 Grounded Theory

'Grounded theory is without doubt the current market leader in qualitative research' (McLeod 2001, p.118). It arose from the work of Glaser and Strauss who published their seminal text, The Discovery of Grounded Theory in 1967. It is 'a rigorous method of conducting research in which researchers construct conceptual frameworks or theories through building inductive theoretical analyses from data and subsequently checking their theoretical interpretations. Thus, researchers' analytic categories are directly grounded in the data' (Charmaz 2014, p.343). It has three main principles; the key task of the researcher is to discover new ways of making sense of the social world, the goal of the analysis is to generate a theory for understanding the phenomenon being investigated, the theory should be grounded in the data rather than imposed upon it. It is primarily a method for analysing data, rather than a technique for data collection.

What I want to gather is an interpretative analysis of meanings from 'detailed structures of experience, or taken-for-granted, routine or skilled knowledge and practices' mentioned as the basis of grounded theory (Breakwell et al. 2012, p.464). I see the process of data collection as a means to 'find and develop a theory as it emerges' (Glaser and Strauss 1967, p.45).

Grounded theory shares the following characteristics with other qualitative methods and is compatible with this research study (Marshall and Rossman, 1999).

- Focus on everyday life experiences.

- Valuing participants' perspectives.

- Enquiry as interactive process between researcher and participants.

- Primarily descriptive and relying on people's words.

My first understanding of grounded theory dissuaded me from its use because 'the researcher's role is often viewed as that of a witness who faithfully records what the participant is saying and what is going on remaining neutral avoiding importing bias and assumptions into analysis'. (Finlay and Evans 2009, p.22). However, having read further into different variations of grounded theory, I changed my mind because of descriptions such as, 'I chose the term constructivist to acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data'. (Charmaz 2014, p.14). I was drawn initially to Kathy Charmaz's work when I found a YouTube video of her giving a presentation on the subject (Charmaz, 2013). I was inspired by the video which was a talk to a BPS Conference. In particular, I do not

believe it is possible to conduct any research interview without influencing what the participant says in some way. Charmaz's acknowledgement of that and her description of a grounded theory method of constructing the data in a mutual way was exciting to me.

4.5.1 Constructivist Grounded Theory

Charmaz was dissatisfied with social constructionist approaches to research because 'they treated their analyses as accurate renderings of these worlds rather than constructions of them. Nor did they take into account their processes of construction of the research and the structural and situational encroachments upon it. In keeping with the times, researchers erased the subjectivity they brought to their studies rather than acknowledging it and engaging in reflexivity. I chose the term constructivist to acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data' (Charmaz 2014, p.14).

Constructivist grounded theory can be defined as: 'a contemporary version of grounded theory that adopts methodological strategies such as coding, memo writing and theoretical sampling of the original statement of the method but shifts its epistemological foundations and takes into account methodological developments in qualitative inquiry occurring over the past fifty years. Thus, constructivist grounded theorists attend to the production, quality and use of data, research relationships, the research situation and the subjectivity and social locations of the researcher. Constructivist grounded theorists aim for abstract understanding of studied life and

view their analyses as located in time, place and the situation of inquiry' (Charmaz 2014, p. 342).

This view of research findings fits ideally with my own epistemological position as an interpretivist. I do not see my interviews uncovering some fixed truth that other researchers could also identify in the same way. What will emerge from my participant interviews is my understanding of what is being said between us at that time. Any variation in time or participants will always produce something different.

A constructivist grounded theory approach 'places priority on the studied phenomenon and sees both data and analysis as created from shared experiences and relationships with participants and other sources of data'. (Charmaz 2014, p.239).

The Glaser and Strauss grounded theory approach set out a series of steps to be followed by the researcher. This included the requirement that 'the researcher does not make any attempt to review the literature in advance of collecting the data. The aim is to approach the phenomenon with an open mind so that the themes and categories emerge from it rather than being imposed on it'. (McLeod 2011, p.120)

However, the Charmaz approach is much less prescriptive than traditional grounded theorists on this point. She presents a case for a literature review to be conducted at the beginning of the research in order to 'strengthen an argument and the researcher's credibility and to set the stage for what the researcher wishes to do in subsequent sections or chapters' (Charmaz 2014, p.308). I conducted a literature review at the beginning of the research and found that it gave me insights that

helped my participant interviews. I was aware of the danger that my thoughts and ideas overly influenced the data and produced the results that I wanted them to produce. This was where I was diligent about self-reflection and awareness. I have throughout my research been as open as I can about my influence on my findings.

4.5.2 Constructivist Grounded Theory Methods

In conducting my grounded theory research I have mainly followed the suggested procedures outlined in two books, the Sage Handbook of Grounded Theory by Bryant and Charmaz (2007) and Constructing Grounded Theory by Charmaz (2014).

According to Charmaz (2014) there are some foundational assumptions within constructivist grounded theory and I was comfortable accepting these within my research plans. These are:

- Assumes multiple realities.

- Assumes mutual construction of data through interaction.

- Assumes researcher constructs categories.

- Views representation of data as problematic, relativistic, situational and partial.

- Assumes the observer's values, priorities, positions and actions affect views.

4.5.2.1 Intensive Interviewing

Some other research methods ask the same questions of every participant and seek to remain neutral, but I wanted to openly contribute to the discussions and introduce

my understandings and interpretations to the data. This fitted the philosophy of Kathy Charmaz's methods and in criticism of other approaches where the same questions are asked at every meeting, she writes, 'the logic of that approach assumes that the researcher knows the pertinent questions to ask in advance and that the research participants will interpret the questions in the way the researcher intends. Neither assumption fits intensive interviewing' (Charmaz 2014, p.57).

Charmaz describes the interview process as allowing 'you both to pursue new leads and to pace your queries about key theoretical concerns …. revisiting and reframing conceptual categories … to focus, write, reflect and focus again while interviewing'. (Charmaz 2014, p.108). Intensive interviewing 'focuses the topic while providing the interactive space and time to enable the research participant's views and insights to emerge' (Charmaz 2014, p.85). Different questions are asked in the interviews with the emphasis being that they are an in-depth exploration of the participant's experience and situations; they are open-ended and are designed to obtain detailed responses.

I found it useful to create an interview guide that I sent to the participant a week before our meeting, so that they were less nervous about what might happen and they could give some consideration to what they might say. A copy of that guide is shown in appendix 6, but it is important to stress that at all of the interviews conducted, context relevant questions were asked within the broad content of the guide. My experience was that in asking open-ended questions and by listening with attention and encouragement, the participant was content to talk about what they regarded as relevant. I allowed participants to set the tone and pace and mirrored

that with my presence as much as possible. I disclosed prior to the interview that I had a private practice where I specialized in seeing clients who had alcohol problems and I believed this created a rapport and trust that assisted the interviews. However, I was very careful to maintain the focus on the experience of the participant and not mine.

The question of how many interviews are required to produce a reliable theory is contested amongst grounded theorists. (Charmaz, 2014). The question raises epistemological concerns about what researchers are seeking, what is learnt, how interviews can inform and how grounded theory methods shape the interview study. I was unable to find a view expressed by Charmaz on an optimum number. However, she does refer in her book (2014) to Guest et al (2006) who recommended twelve as being sufficient. On the one hand I wanted to obtain sufficient credibility for my research to be viewed as reliable, but I could not continue interviewing indefinitely. I have therefore chosen the only guide I was able to find, that of twelve, but as I explain below, I chose to conduct the twelfth interview in a different manner to the previous eleven.

4.5.2.2 Data Collection and Analysis

Grounded theory uses a form of purposive sampling, known as theoretical sampling, where participants are selected according to criteria specified by the researcher and based on initial findings. Early analysis of data indicates issues that need exploration; hence the sampling process is guided by the on-going theory development. Data collection and analysis take place in alternating sequences as shown below in Figure 1. This could also be described as an iterative cycle of

induction and deduction, as it consists of collecting data and making constant comparison between results and any new findings, in order to guide further data collections. For these reasons the development and identification of variables does not take place prior to data collection, but instead as part of the data collection process. (Corbin and Strauss, 1990).

Figure 1. Data Collection and Analysis
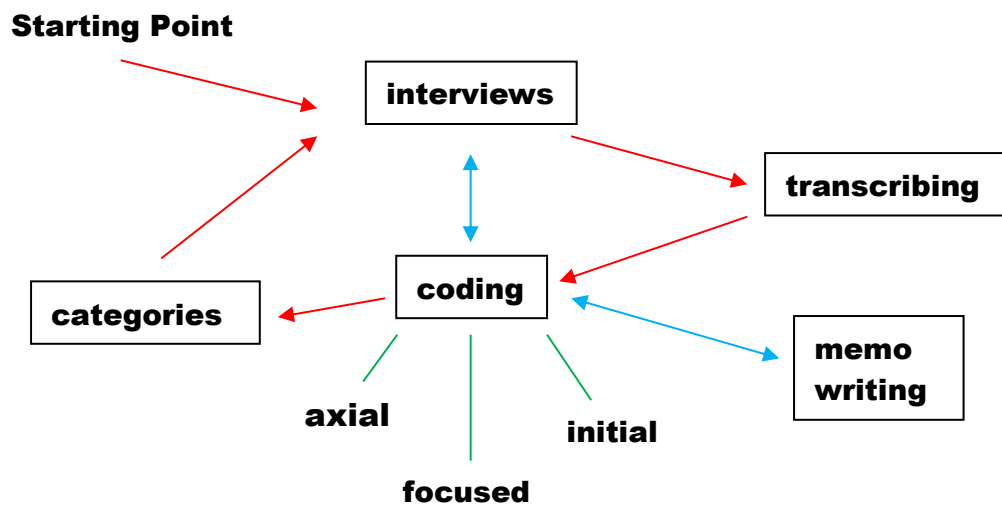
4.5.2.3 Grounded Theory Coding Practices

Coding shapes the analytic frame and provides the skeleton for the analysis (Charmaz, 2014). Charmaz sees coding as an important link between collecting data and developing theory but also as a connection between empirical reality and the researcher's view of it. Coding highlights problems, issues, concerns and matters of importance to those being studied.

There were three phases of coding; initial, focused and axial. Initial coding was line by line coding that started the process of identifying what the data held and led to the process of selection and sorting. The codes stuck closely to the data showing the explanation of events described by the participant. They were consistent with the principles of grounded theory as there was an emphasis on emergence from reading the data and not from any preconceived ideas.

Initial coding defined what happened and began the process of struggling with what it meant. This was what I thought of as significant in the data and believed occurred, but was not an empirical reality, as I see that as impossible. I expected a model to emerge from my research having been drawn from the meanings co-constituted in my interviews with participants. However, I recognised and accepted that it was inevitable that alternative interpretations or further interpretations would always exist. The incompleteness of the interpretation is one of the aspects of the hermeneutic circle. Whilst I was able to draw some conclusions and made some suggestions, every interpretation could have been interpreted differently.

In trying to understand the meaning of participants' experiences, I found in vivo codes to be useful. These were idioms, phrases and expressions often used metaphorically to detail a story and contained a rich source of understanding. I made particular note of in vivo codes during my initial coding and reflected on what they meant within the context of the interview. 'Studying these codes and exploring leads in them allows you to develop a deeper understanding of what is happening and what it means' (Charmaz 2014, p.135).

Initial coding created possible lines of interest and by studying and comparing codes it was possible to devise something that subsumed numerous initial codes and these were referred to as focused codes. They directed the analysis and helped to evaluate the directions to be followed although without committing to any particular course of action. It did not mean the same code had to appear multiple times, but that there was something about the code that was telling in some aspect of the research.

The final phase of coding was axial coding, defined by Strauss and Corbin as "the act of relating categories to subcategories along the lines of their properties and dimensions" (Strauss and Corbin, 1998, p. 123). The aim of axial coding is to add depth and structure to existing categories (see figure below). Charmaz (2014) explained that axial coding re-assembled data that was broken up into separate codes by line-by-line coding. Strauss and Corbin (1998) described axial coding as a way to investigate situations described in the interview. Charmaz (2014) warned that axial coding can be applied in a manner that is too rigid and formal. She recommended a less formalized approach on reflecting on categories and sub-categories in order to establish links and make sense of the interview data. I have largely followed the views expressed by Charmaz and the detail of the approach I took, is described below in the section detailing my study methods.

4.5.2.4 Memo Writing

Memos are informal analytic notes that chart, record and detail the research journey. They start by writing about codes and data and move upwards to theoretical categories. Memos capture thoughts and make comparisons and crystallize

questions and act as an interactive space for conversing with oneself about ideas and hunches. (Charmaz, 2014). I saw memo writing as an exercise that took my codes and data apart, compared bits of the data, created links and was a way of catching meanings. As I built up a memo bank, I compared new data with old and started to put together tentative categories.

4.5.2.5 Developing Categories

The general process of how to code an interview and develop a theory is depicted in simplified form in Figure 2 below and is based upon views expressed by Strauss and Corbin. After coding several interview transcripts, I found it was possible to identify issues that were of particular importance. These issues I regarded as 'phenomena' and assigned them a conceptual label, also known as a concept by Strauss and Corbin (1998). Some concepts will share the same or similar characteristics and can be pulled together into more abstract categories, which can then typically be interlinked and thus build the basis for a theory.

Categories have to earn their way into an emerging theory and counting the frequency with which categories occur in interview transcripts, can be one useful way to confirm their importance. Categories can carry so-called properties and dimensions. A property is a general or specific characteristic of a category, whereas a dimension denotes the location of a property along a continuum or range (Strauss and Corbin, 1998).

Figure 2. Coding an Interview and Developing a Theory
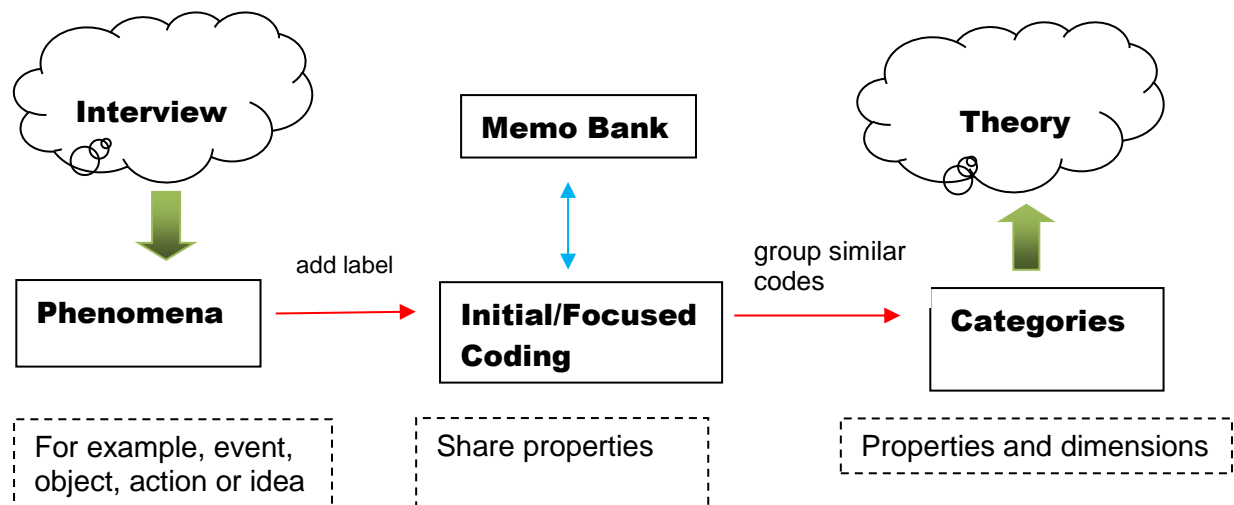
4.5.2.6 Theoretical Sampling

Once tentative categories start to emerge theoretical sampling helps retrace steps or take new paths. The aim is to 'gather more data that focus on the category and its properties, seeking and collecting pertinent data to elaborate and refine categories in your emerging theory... the logic of theoretical sampling distinguishes grounded theory from other types of qualitative inquiry. Theoretical sampling brings explicit systematic checks and refinements into your analysis' (Charmaz 2014, p.192).

Theoretical sampling involves a form of abductive reasoning when it is not possible to account for surprising or puzzling findings. In such a situation the researcher makes an inferential leap to consider all possible explanations, forming and testing hypotheses for each explanation until arriving at the most plausible interpretation (Charmaz 2014). This is not the conclusion but the start of re-examining data and gathering new data to subject the interpretation to further scrutiny.

4.5.2.7 Theoretical Sorting, Diagramming and Integrating

Data is gathered until the properties of the categories is saturated, meaning that new data collected no longer creates additional theoretical insights or new properties of the core categories. Sorting creates the logic for organising the analysis and a way of creating and refining links prompting comparisons between categories. Grounded theory uses various types of diagrams including maps, charts and figures to show the inter-related nature of the categories.

4.5.2.8 Interpretive Definition of Theory

Regarding myself as an interpretivist, I saw my theories as aiming to understand meanings and actions and how people constructed them. I recognised that my ideas brought in my subjectivity and imagination in trying to understand the studied phenomenon. 'This type of theory assumes emergent, multiple results; indeterminacy; facts and values as inextricably linked; truth as provisional and social life as processual' (Charmaz 2014, p.231).

5. Pilot Study

5.1 Introduction

Following on from explaining the research methodology, I now intend to describe the methods I used in my pilot study.

5.2 Sampling and Recruitment

My intention was to interview twelve therapists who had experience of working with families where there were alcohol problems. In an ideal world I would have recruited participants who were existential family therapists experienced in working with alcohol problems. However, from my initial enquiries that seemed an impossible objective. As mentioned above, there is no formally approved existential family therapy and very few practitioners who claim to have an understanding of both modalities. I managed to find two people who described themselves as existential family therapists, but they had no experience and no interest in any form of addiction. I was originally surprised and disappointed by discovering that situation, but I was resolved to continue with my research and believed that the situation showed an even bigger need for something to be presented.

I approached this challenge by considering how I could best bridge the gap between existential and family therapy within the context of alcohol problems. Of those three areas, existential therapy is the one I have received training in both theory and practice. It was the one I was most confident about expressing principles and application. I did consider interviewing some family therapists and some existential therapists but I had to be realistic about my resources and I did not want to dilute my research by reducing the family therapy sample, an approach I was still learning about. Formal training in Family Therapy normally takes four years and I did not want to fail to adequately present its principles by interviewing too small a sample. After consideration and discussion with my supervisors, I decided it was sensible and practical for me to gather data from suitably experienced family therapists and as

they would be unable to contribute information on an existential phenomenological approach, to add those views myself. I believed that was the best way to make the research viable.

This did not mean recruitment of participants became an easy task. On the contrary, family therapy seems not to be widely practised perhaps because of costs in private practice and/or because of resource difficulties within the NHS. The potential pool of participants was further reduced by those who worked with alcohol problems, perhaps still perceived as a field where the work was more demanding and less rewarding.

Although I wanted to develop a model that had some understandings drawn from the data collected in my interviews with participants, I recognised and accepted that it was inevitable that alternative interpretations or further interpretations would always exist. The incompleteness of this interpretation is one of the aspects of the hermeneutic circle, that whilst I am able to draw some personal conclusions and make some suggestions, every interpretation can be interpreted differently by someone else.

I recruited participants through the use of snowballing sampling and advertising. I had met some networking contacts very early on in my research that had expressed an interest in my project and offered to introduce me to possible participants. Snowballing sampling uses such recommendations to find people with the specific range of skills that had been determined as useful. As my research progressed, I hoped that introductions would create useful contacts, much like a snowball that rolls and increases in size as it collects more snow. From working in business for many

years, I intended to fully utilize my networking and relationship skills to find appropriate participants.

However, it was possible that this method alone could have produced a narrow range of participants as people tend to associate with others of similar views and beliefs. I therefore increased my sample by advertising for participants using social media and magazines.

As my research advanced, I considered any lack of missing inputs and sought to address that by networking initiatives and/or advertising exercises. I was hoping to interview participants face to face and prepared to travel to anywhere in the UK to do that. However, if that was impractical for any reason then I offered to conduct the interview using Skype. I was looking for participants who had experience of working with families and alcohol problems and in order to have credibility and provide a professional contribution, I excluded individuals who were not qualified with an appropriate body such as BACP, BPS or UKCP and had less than three years' relevant experience.

My pilot study was an interview with an NHS family therapist working within an addictions unit. She had been introduced to me through a networking contact who had in the past been her manager. Having successfully conducted the interview and analysed the data, I turned my attention to recruiting further participants. As part of my recruitment efforts, I spoke to family therapists who expressed a strong aversion to working with any form of addiction, to experienced addiction therapists who had not received any form of recognised training and a number of practitioners who saw individuals and couples but not families.

I joined twenty-seven social media groups through LinkedIn and Facebook and posted adverts for participants, an example of which is shown in Appendix 1. Unfortunately, I had no response to this advertising despite numerous postings. This may have been because people lead busy lives and scan such postings and seldom have the time to reply to such opportunities. I approached The Institute of Family Therapy and did not receive a reply to my first two emails, was referred on my third and assured of a response but did not receive one and failed again to receive a reply to my fourth email. I had similar disappointing experiences from attempts to contact universities who offered family therapy training. This may have been from a lack of interest in my project or from busy people not having sufficient resources to engage with me.

I decided after these experiences to look at commercial advertising in relevant magazines. Some only offered large advertising spreads with European coverage and charged a large fee. The only magazine that I was able to find that provided a suitable opportunity was the BACP 'Therapy Today'. I placed a small advert which is shown in Appendix 2. Two of my twelve participants were recruited from this initiative and the other participants were all found through the snowball sampling technique described above. I believe I was as diligent as I could be about finding participants who were from different backgrounds whilst remaining faithful to my selection criteria.

As stated earlier, the question of how many interviews are required to produce a reliable theory is contested amongst grounded theorists. (Charmaz, 2014). As I was unable to find a view expressed by Charmaz on an optimum number, I adopted the

recommendation cited in her book (2014) of Guest et al (2006) who suggested twelve as being sufficient.

Although my intention was to interview twelve therapists, after eleven interviews had been conducted and analysed, I had one hundred and twenty-five provisional categories. Some of those overlapped and repeated themselves using slightly different words, but what was noticeable was that my first interview created fifteen categories compared with my eleventh interview which created six. I saw this as a sign that the data was beginning to become saturated and considered an alternative option for my final interview.

During my research I had been networking and talking to interested parties about my intentions. One of the people I was fortunate to meet was Richard Velleman who is an Emeritus Professor of Mental Health Research at the University of Bath. He has written two books on the subject of counselling for alcohol problems and in the past had been a clinical lead for an NHS Addictions Unit. I asked Richard if he would be interested in being my final participant. Whilst not a practising family therapist, he is very qualified to talk about the subject and I believed he was able to critique my research to an extent that it would be far more valuable than conducting another interview similar to the previous eleven.

I sent Richard a draft of my study findings from the eleven interviews that had been conducted and analysed. I then interviewed Richard asking him for his views on what I had produced and pursued lines of enquiry where his experience differed from the data and analysis. I recorded our meeting and had a typed transcript produced as for

all of the other participants and I then subjected the transcript to the same coding practices and sampling techniques.

5.3 Ethics

The research had ethical approval from The New School of Psychotherapy and Counselling and from Middlesex University.

Although I interviewed qualified and experienced psychotherapists and it was very unlikely that participating in my research would result in any adverse reaction, I nonetheless took the necessary ethical precautions.

Once a potential participant had shown any interest and after checking he/she met the selection criteria, I emailed a copy of the participant information letter shown in appendix 3. I checked by email and/or telephone that the person had received the letter and had read and understood its content. I then asked whether the person was willing to proceed reminding them that participating in the research was entirely voluntary. I also pointed out that they could withdraw from the process at any time without giving any reason or there being any consequences.

If the participant was willing to proceed, I then arranged a suitable date and time to meet for the interview. With the exception of the two participants who chose to have the interview using Skype, I travelled to the participant's location and conducted the interview in a suitable venue having regard to confidentiality and my own safety. Before the interview, I emailed a copy of the written consent form shown in Appendix 4. I was aware that research can develop in ways that raise unforeseen ethical

implications, particularly for constructivist grounded theory where I was engaged and contributing to the discussions. I tried to foresee any difficulties and discussed these with each participant, for example, I asked that participants did not disclose any names of their clients and if needed they used pseudonyms. Before commencing the research, I had familiarised myself with the British Psychological Society's literature on the principles, approval procedure and code of conduct for carrying out psychological research (2009) and had also read about ethical perspectives in qualitative research (Willig, 2011).

After the interview I handed or emailed a debriefing letter to the participant which is shown in Appendix 5. To avoid any harm by a breach in confidentiality, I have restricted the scope of any disclosure to that which is consistent with the professional purposes of my research, made constant efforts to anonymize key details and ensured that data collected was stored in a secure, locked area to avoid any inadvertent disclosure. All interview recordings will be erased upon completion of my doctorate.

5.4 Data Collection and Analysis

Grounded theory is not a linear process. Rather, the approach is concurrent, iterative and integrative as data collection, analysis and conceptual theorizing occur simultaneously and from the beginning of the research process. This process continues throughout until the theory is developed.

I recognised from my past that when I have dealt with large and complex data, I could sometimes lack sufficient patience. To avoid that tendency interfering with the analysis, I stayed close to the comprehensive method developed by Kathy Charmaz. I found the initial coding was an effective heuristic device to involve me in the data and focused coding and memo writing was successful in finding patterns. Theoretical sampling was useful to elaborate and refine categories as the theory began to emerge from the data. I also used abduction reasoning as a way of examining some of the more surprising findings.

The method allowed me to 'pursue new leads and to pace queries about the key theoretical concerns … to keep revising and reframing conceptual categories' as I conducted the interviews and the 'iterative process lead to focus, write, reflect and focus again. It fostered studying, revising and developing interview questions and skills'. (Charmaz 2014, p.108).

5.4.1 Procedure

I conducted the pilot study to learn how to apply the methods and to revise any matter before proceeding any further with my research. The procedure I followed is detailed in figure 3 below. Although as referred to above, it was not a linear process but one of looping back from code to data.

I believed it was important to have a means of reflexivity and I kept a journal throughout my pilot study and beyond where I made regular notes. I have written below about the importance of this to my research.

Figure 3. Constructivist Grounded Theory
(as per Kathy Charmaz, 2014)

- Interview

- Typed Transcript

- Initial Coding

- Focused Coding

- Memo Writing

- Theoretical Sampling

- Provisional Categories

- Draft Model

- Model
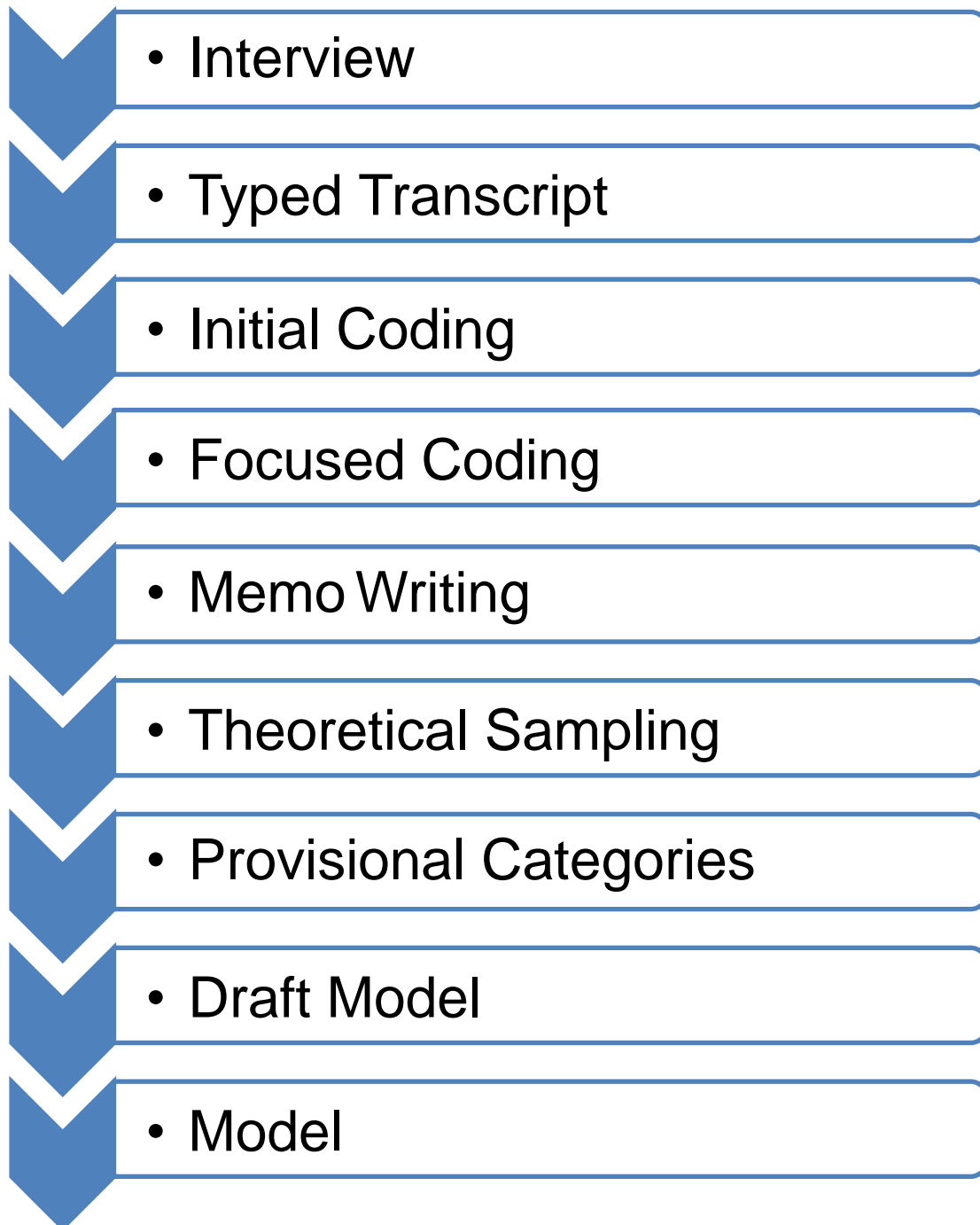
The first participant was an experienced family therapist working within the NHS. I met her at her office and she had booked a meeting room for us that was quiet and confidential. We had exchanged emails and spoke briefly on the telephone, but as this was our first meeting in person, I introduced myself and my research asking if she had any questions or concerns before we started. I checked on matters such as available time for our meeting, temperature of the room and refreshments. I had approximately a week before our meeting sent her an interview guide, a copy of which is shown in appendix 6. I had stressed in the accompanying email that the questions were suggestions as to what I might ask and should be seen as prompts for our discussion and to give her an idea of how the interview might proceed.

As mentioned above, one of the principles of constructivist grounded theory is that questions are tailored to each participant, so the guide was useful to set the scene but not in any way used as a script. I checked that she was comfortable and everything was in order before we started the interview. I attempted to create a good rapport in the room and apart from asking relevant questions, remained silent and attentive. I digitally recorded the interview on two audio devices which were kept close by at all times. The interview lasted for just over an hour and was a very successful start to my research interviewing.

Constructivist grounded theory methods are regarded as very demanding because of the coding and revisiting data procedures. Recognising my own time constraints and energy levels, I had arranged for the audio file to be typed in confidence by a professional secretary. Once I had returned home from the interview, I transferred the audio file from the recording device to my computer and password protected the

information. I then transferred the file to my Dropbox account where only the secretary and I had access.

Once the secretary had typed up the transcript, she emailed a copy to my research email account protecting the data with a password. I checked the transcript and then reformatted the document so that there was a large blank column on the left hand side. It was in this space that I wrote my initial line by line codes in pencil, an example of which is shown below.

5.4.2 Initial Coding

This form of coding required examining each of the transcripts from the participant interviews line- by-line. It prompts close study of the data and the beginning conceptualization of ideas. The initial coding assisted in analysis of the data from the ground up, based on the participant's actions and statements, and reduced the likelihood of superimposing my own preconceived notions on the data (Charmaz 2014). The words on the right hand side of the column are the verbatim typed transcript; the left hand side are my line-by-line codes. I had practiced initial coding on a research module as part of my studies and had found it required patience and commitment and I did not attempt therefore to complete more than three hours work on any one occasion.

Tricky to get support from family Often some initial resistance to change Difficult emotional state to deal with Stress not to look to blame anyone but examine what's happening in the family Explanation about maintaining equilibrium **Solution Focused Therapy** What can we do in order to support positive change? Family blame **'I don't think the blame game is very helpful'**	AL: It can feel tricky to begin with. There is often some resistance of some kind or some difficult emotional state that is not the most conducive for sitting around a table talking or whatever. But what I suppose I refer to is what this is not about is looking for someone to blame but actually that what we're doing here is looking at what happens in the family. I might do a bit of an explanation about maintaining some equilibrium, and I suppose some solution focused thinking comes into this usually. Where it's like what can we do in order to support positive change for the family without going down a line of this is your fate, you are to blame. And I very often just say quite clearly, I don't think the blame game is very helpful. Very often people might expect me to be sitting as judge and jury. That's not my role. I can't do that. I don't want to be that because I think things have been difficult very often blame has been fired around from one

	person to the next already. Let's do something different.
Expectation to be judge and jury Let's not blame Let's try to do something different	AN: What in your experience is the biggest problem to overcome in that sort of situation? AL: I think from the family perspective – when I say that I mean the non-substance user, the non-drinker or the non-problematic drinker – it's probably about maintaining a connection with all, a rapport with all, whilst giving the forum and the space for someone to be able to vent how hard it's been, how difficult it's been without the person whose drinking feeling absolutely awful and like they're the target of everything that's bad within the family. So it's that point and it's usually quite early on that some of that – because people are just driving with a load of feelings about this. Something that quite commonly happens – I say commonly, I've heard it many times – is that the person who is the family member
Difficulty for therapist is maintaining a connection/rapport with all of the family whilst giving the forum and space for a person to vent. How awful for the problem drinker to be seen as the target of everything that is bad within the family.	

	will come and just say "it's alright for them. They've created this mess, if you like, and then they get all the support. Where's my support?" If I'm working with that person. Sometimes I think it can be helpful to just have at least a couple of sessions with that person in order to find a place where it's like "yes, they had all that attention, let me give you some attention of your own first and then we can work together". Sometimes if I get that sense it's like "Yes, you're right, let me give you something extra here" and do that as an explanation, kind of thing. It depends.
The problem drinker gets the attention from the therapist sometimes creating the saying, **'it's alright for them. They've created this mess, if you like, and then they get all the support. Where's my support?'** Separate sessions to give someone attention on their own. **'Something extra'.**	

5.4.3 Focused Coding

Focused coding was the next major step in the coding process and is more directed, selective and conceptual than initial coding. Focused coding was used to synthesize and explain larger segments of data and required using the most significant or frequent earlier codes to sift through this data (Charmaz 2014).

As part of the pilot study, immediately after I completed all the initial coding and was content that I had been thorough and had captured all the relevant information, I started to write the focused codes on a separate paper paying particular attention to in vivo codes. On these pages I recorded the transcript page number against each focused coding section and used a different coloured pen for anything of particular interest. After some reflection, I then carefully re-read the focused codes, going back to initial codes or the raw data where necessary, before proceeding to write my memos. An example of my focused coding for the pilot study is shown below.

Page 1   Broad experience, Arts Degree and interest - voluntary, PCP, Helplines
Solution focused, group, family from learning from Manager, NLP,
Hypnosis, supervision - life experience 24/25 yrs. as therapist and **life
experience of just being in the world.** Working for what fits with her

Page 2   Don't hold herself out as an expert   - after lots of experience don't have to
shout as loud but still learning - values systemic thinking - don't use a
template, no pre session thinking, be curious grappled with theory, use
variety of things, philosophy   language and its importance away **with the
fairies sometimes** - like freedom but have boundaries if client wants/needs

Page 3   No typical client or client meeting - loves her work   - risk assessments in
NHS - private clients often run over time (less boundaries) systemic
means "asking them to consider the impact of their change on somebody
else and how others can impact on the change that they seek" Anyone can
come along they want - most client's substance is their way of coping from
e.g. trauma - trauma and substance misuse go hand in hand

Page 4   Client blames themselves for the trauma and their way of dealing with it -
shame and guilt - important to say as clearly as possible it's not their fault
- "let's just start with understanding this", keep saying in different ways -
process of accepting - attachment to inner child - if have children linked to
that experience, what would you   expect of that child, what power, control do
they have - therefore to blame

Page 5   Predominantly the relationship that important but have to offer more than just that - ask permission to do things so they are part of it - what difference is talking making,   how does it impact on your life exercises - letter writing - safety box - example client abused as child intimacy issues now - compared herself to sunflower - decorated safety box with sunflower pictures - put in box photographs of herself pre and post abuse

Page 6   Be creative about what do and how - letter writing, who to, letter back from that person - have templates from experience but whatever appropriate - good and bad sessions - example of bad session

Page 7   Stretching herself led to problems, use of technology several computer screens. Mum in a different country - not able to interrupt or redirect when things out of hand - need to meet person for first time, perhaps later conference calls - if new person added to group, spend time on that person, create rapport and understanding them - if angry exchanges - stop and into naming what's happening and share impact on you

Page 8   Example of alcohol problem on family - ideally Mum is sober but that might not - so look at safeguarding issues, what was working and a different approach beyond 8 week course offered needed rehab - Mum saw her separately for individual work linked with Social Service involvement

5.4.4 Axial Coding

'A type of coding that treats a category as an axis around which the analyst delineates relationships and specifies the dimensions of this category. A major purpose of axial coding is to bring the data back together again into a coherent whole after the researcher has fractured them through line-by-line coding'. (Charmaz 2014, p.341).

Charmaz distinguishes her approach to axial coding from the Strauss and Corbin procedures, by stressing that 'my analytic strategies are emergent, rather than procedural applications'. (Charmaz 2014, p.148).

My view of axial coding within constructivist grounded theory led me to re-examine the data I had collected during initial coding and consider subcategories of emerging categories. As I wrote my memos I started to underline what I saw as important categories and to go back to the initial coding to consider links with other sections of the transcript, or inconsistencies and generally analyse what had been said more as a whole rather than a narrow focus of the line-by-line and focused coding.

5.4.5 Memo Writing

Memo writing is a pivotal step in grounded theory between data collection and writing drafts and is where researchers stop and analyse their ideas about their codes and emerging categories. Potential categories are established, and the codes they subsume are identified through the activity.

Through memo writing I expressed my thoughts about what I saw in the data, the similarities and differences were captured and explored. I found that the sorting of memos helped in the generation of the theoretical outline or conceptual framework for the work. The process assisted in looking for similarities and connections within the data, where to locate codes and categories and in the resultant theoretical higher order conceptualizations. Ideas and insights were developed and memo writing forced me to stop and engage different categories they formed a place for exploration and discovery around the ideas I had about what I had seen, sensed, heard and coded.

I wrote the memos in a separate journal starting at the back of the book, as the front was used for general reflection and for capturing ad hoc thoughts and feelings. This meant I had one central place for the formation of my theories. I started to introduce my own thoughts and ideas and make references to the literature I had read and to consider different alternatives of approach or understanding, particularly in relation to an existential phenomenological model.

As part of the pilot study, the appropriate section in my memo bank is as follows.

Memo Bank

A. 7 May 2015

Experience and Training is important in that you have some to
offer to the client - not important what it is - any
modality, training can be used - need to have something
after creating relationship. Not expert to dictate methods -
use anything be curious and led by client

Reasons for drinking - Maté's views, attachment theory,
trauma - whatever the reasons - turn to a substance because
it is their way of coping - defence mechanism against
unbearable feelings - numb myself, take away the pain

Separate out through Pathways model - this is not about a
hedonistic habit that's out of control probably stop of own
accord when gets uncomfortable. This is unstoppable upset -
can't think about that so will hide in alcohol

Stress not their fault - if childhood trauma - have
children - would you blame them, how much power/control they
have - don't apply your cognitive abilities now to that
child and judge and criticise

Yalom's work on Content and Process - come out of content
and talk about our relationship - what's happening in the
room, what's our relationship now, how is our work impacting
on your present life (Link Family Therapy to Existential -
difference with individual therapy)

How cope with creating contact with all of them – blame and
resentment in the room – why alcoholic gets all the attention
and support – need to give attention to those feel left out
(individual?) – How balance needs of group and needs of
individual?

Out of content into process - use facts and figures and past
experiences to show what normally happens - research findings
– then move from what is typical to what happening with this

Who are the clients? – the ones in the room at that time but bear in mind those who are involved but not present. If he was here, what would he say/feel – bring into therapy not only the conversations that happen in the therapy but also those that occur back home

What does a model contain? Flexibility, not caught up in only one way of approach, whatever works/fits Family System works even if only working with parts of it at times – does it help you and does it help others not here   Voice – difficult to give everyone a voice

Does and Don'ts

- not work with current domestic violence
- see one but not both parties
- will work with alcohol affected but some won't – talk about what needed   to come recognise the fear of stopping
- not make the client feel judged
- recommend 12 step and use 12 step language if go

Not rigid, not set procedure – learn whatever 'templates' drawn to and seem to fit with you as therapist – then be creative, use curiosity to try things, will have good and bad experiences, don't be afraid to try and fail, learn from that

What forms family therapy? Who in the room and changes – new person into established group, rapport building with them, time for them part of the system including you
Angry exchanges – pull from content to process – interrupt and explain what's happening and share impact on you – what impact on each of them and how helpful that is? Recognise when things not working and look at other options - medication, rehab facilities, is there safeguarding, social services implication?

```
When family not working together break down into different
interventions – individual, 12 step, rehab for alcoholic –
child therapy, individual for others but what about cost
and provision?
Can they pay if not – are resources available?

Manage a family making a change – avoid blame game and
repeating accusations and criticisms - help to make changes
– doing something different - counter the homeostasis
But – how long take, patience, cost – will they stick it
out or give up?
```

5.4.6 Reflexivity

My research into the contribution of reflexivity in grounded theory showed that
considerations about this aspect have only been written about in recent years. (Hall
and Callery, 2001). There also seemed to be confusion over the definition of
reflection and reflexivity with some articles seemingly not discriminating between the
two terms. One writer, Finlay (2002), notes this lack of clarity and attempts to resolve
it, by placing the two concepts at opposite ends of a continuum with reflection at the
one end concerned with 'thinking about' and reflexivity at the other end concerned
with, as she puts it, 'more immediate, continuing, dynamic and subjective self-
awareness'.

Whatever the correct definition, incorporating reflection on researcher–participant
relationships would seem appropriate as a part of the research process. In fact,

Mallory (2001) considers it to be inherent in the grounded theory method. She discusses the reciprocity which she sees as inherent in the grounded theory research method. She states that researchers must be willing to share their personal and professional values with participants. Instead of trying to match characteristics as in some grounded theory methods, Mallory suggests that differences between those of the researcher and the participants should be explored. This, she suggests, increases trust and disclosure, and consequently the credibility of the findings.

I was originally drawn to Charmaz's work because it struck me as an open approach to interviewing participants, fully recognizing an encounter where both parties contributed to the outcome of the data. In seeing the interview in that manner, reflexivity was an important aspect. 'Reflexivity is more than owning and sharing ourselves, we need to examine reflexively how our conscious and unconscious selves may be impacting upon the research process and outcomes. We need to be able to have enough awareness to sift through our personal experience of the relational encounter in order to decide what to respond to and what to put aside and what to take to our supervisor or research mentor' (Finlay and Evans 2009, p.37).

It seemed essential therefore to keep a reflective journal about my research to be more aware of my influence on the participant and the data collected. From the very beginning of my research, I wrote regular notes about my thoughts and feelings within the context of the activities I was engaged in.

An example of my reflexivity journal for the pilot study, I have copied out some entries shown below.

In preparation for my first interview. What clothing to wear? We are meeting at an office during normal working hours. I do not want to appear too formal or casual. The literature says the best data is collected by someone who 'matches' the characteristics of the participant so that there is no obvious power imbalance between researcher and participant. Decide on jeans and casual jacket which seemed to be similar to the participant and others in the vicinity. I think I will stick to that casual nature for further interviews?

How much do I share with the participant about my personal background? The participant today was also the child of publicans and mentioned it in her introduction. I decided not to say anything believing it would turn attention away from her to me. Would it however have brought us closer, created greater rapport?

After my interview today, the participant added something which would have been useful to capture, but I had turned off the recorder. Can I make notes and add it? Need to check that out with my supervisor. What do others do in similar circumstances, who can I ask?

Is there any problem in maintaining contact? Nothing ethically? What happens if I comment later in the year about my thoughts and she makes suggestions, can I include them in my research at all?

Beginning to feel that twelve interviews is too many. The cost of having the transcripts typed is very high, travelling to see participants is time consuming and expensive. Spent the whole day travelling to London. Reduce interviews but need to get approval? Perhaps Skype instead of face to face, but will that reduce quality of interview?

So, so much data worried about making sense of it and doing justice to the subject. Don't need to rush, perhaps more patience and less worry? One step at a time.

5.4.7 Transition from Pilot Study

The pilot project was an opportunity to put into practice what I had been planning and to evaluate the outcome so as to make changes for the future. For the pilot interview, I travelled for three hours and arrived prepared and in plenty of time for my meeting. I was initially disappointed that my participant was twenty minutes late and had not read my email and interview guide sent to her a week previous. However, she was friendly and helpful and I was cognisant that she was giving up her valuable time without any reward. I learnt not to expect participants to be as committed and keen for the meeting as I was. For them, this was just one of several meetings that day and perhaps the least important, whereas for me it was the main focus of the week.

The practicalities of the interview such as the audio recording, prepared and unprepared questions, confidentiality and ethical issues and time keeping all went much to plan and did not need any revision for further occasions. I worked in HR for over eighteen years and during that time conducted many employment interviews. Whilst the subject matter was very different here, the process of establishing rapport, actively listening and asking relevant and appropriate questions, came very easily to me and I did not anticipate making any changes.

After the interview the process of storing the audio file in a confidential manner and forwarding it to be typed, was easier than I had expected and within a week the typed transcript was confidentiality sent to me. Although this was an expensive choice, I was pleased with my decision to have this procedure in place because I

learnt that the initial coding required a lot of patience and concentration. I was unable to maintain focus for any length of time and from the pilot I learnt to limit myself to a three-hour session in any one day. The focus coding stage I found was less demanding and the memo writing enjoyable because it gave me an opportunity to be creative and speculate about my research. With only the information from one participant it was disappointing that I was not able practice theoretical sampling and sorting, but having gained some analytical experience, I found I was able to read the literature with more insight and understanding.

The doctoral programme included a module where I was asked to present my pilot project to a tutor and peers using a PowerPoint presentation and questions. The main benefit from this was preparing for that day. It required me to summarize my research plans, to explain what I was intending to offer to the profession and how I intended to present and communicate my model. Although I had only conducted one interview, I was able to imagine the data from all twelve interviews and start to consider the visual format of the model. Some of the ideas I had at that time changed as I put them into practice, for example for many months I worked with using word clouds as a means to visually display key words or in vivo codes said in the interviews. It was only after the full data collection and analysis that I decided to move away from this visual display as I did not believe it gave any tangible benefits. On the whole though, what I presented at the pilot project stage as my intentions largely occurred and went to plan.

The pilot project presentation and subsequent discussion was helpful in that I received comments from a tutor and peers on my project. I was encouraged that no-

one saw any obvious errors in the research conducted or with my future plans and I emerged with more confidence and enthusiasm.

Through-out the pilot project I was regularly having discussions with both of my research supervisors. I was using the opportunity to talk about potential problems and check my understanding on matters such as possible ethical concerns. However, the pilot ran very smoothly and the advice I had from my supervisors was to continue in the same manner with the rest of the research.

In summary, the main benefit of the pilot was that it confirmed what I had been thinking and expecting and as such, it gave me the confidence to continue. I made no substantial changes to the preparation or delivery of the other eleven interviews. I adapted my style for the coding process taking into account what was needed by way of patience and commitment and I was encouraged and excited about the rest of the research.

6. Study Results – Participants

Set out below is a table containing details of the twelve participants I interviewed. In order to protect their anonymity, I have changed their names apart from Richard whom I mentioned above. He was my last participant and provided an overview of my research and gave his consent to be named. I have included details of role, training and experience in order to show the depth of knowledge being accessed for this research.

Participant	Role	Training	Experience
Angela	Family Therapist within NHS	Personal Construct Psychology, Hypnosis, Groups, Solution Focused, Neuro-Linguistic Programming, Systemic Methods and Supervision	Twenty five years' experience within substance abuse field
Barbara	Family Therapist within NHS and Private Practice	Diploma in Existential Counselling, Masters in Family Systemic Therapy	Ten years working with families and addiction
David	Retired therapist who had managed an addictions unit within NHS and worked with local authority	Trained with the Adler Institute in the USA with Family Systems and in the UK with Solution Focus Therapy	Forty years' experience within the substance misuse field
Mary	Functional Family Therapist within CAMHS.	Masters in Drugs and Addiction and a Masters in Family Therapy	Fifteen years' experience of addiction and over ten years working with families and couples
Isobel	Family Therapist working with a local agency and in Private Practice	Diploma in Counselling and qualified in Family Systemic work	Twelve years' experience and now in a day care rehabilitation service
Mathew	Child and Adolescent Psychiatrist with Tavistock Clinic	Qualified Psychiatrist	Thirty-five years' experience, currently oversees multi-faceted interventions and acts as expert witness with the Family Drug and Alcohol Court
Carol	Family therapist managing an NHS clinic for individuals, couples and families with drug and/or alcohol problems	Masters in Family Therapy	Twenty years with a background in dependency units and community drug and alcohol teams
Linda	Family therapist working with couples and families within an NHS setting	Clinical Psychologist and Masters in Family Systemic Therapy	Ten years' experience within substance misuse

Gail	NHS Team Leader for an Alcohol Assertive Outreach Programme	Diploma in Person Centred Counselling Post graduate Diploma in Addictions, Training in Family Therapy	Eighteen years' experience working with addiction
Colette	Clinical Lead for a Family Therapy Initiative supported by local authority	Diploma in Counselling	Twenty years' experience of drugs and alcohol including residential rehabilitation
Margaret	Private Practice Therapist, Teacher, Supervisor	Diploma in Person Centred counselling	Thirty-four years' experience and a particular interest in a spiritual perspective.
Richard	Emeritus Professor of Mental Health Research, retired Lead of NHS Addictions Unit	Psychologist and Academic Researcher	Written two books on the subject of counselling for alcohol problems and has a wealth of experience over many years

6.1 Study Results – Conceptualization and Theory

I have stated above in chapter 4 the principles of constructivist grounded theory and when describing my pilot study in chapter 5, I explained how I applied the principles of initial coding, focused coding and memo writing. I continued to work in the same manner with all of the other eleven participants and I can now describe how I applied the other parts of the methodology to develop my final model. I followed the constructivist grounded theory methodology shown in figure 4 below:

Figure 4
(as per Charmaz 2014, p.18)

Writing Dissemination

THEORY BUILDING

Categories reaching
SATURATION

MEMO
WRITING

FOCUSED CODING and
CATEGORIZING

Incomplete
understanding
raises questions

CONSTANT
COMPARATIVE
METHOD

INITIAL CODING

Examples present within
the data

Data Collection

**THEORETICAL SAMPLING TO
DEVELOP THEORETICAL
CATEGORIES**

Recruitment and Sampling
of Participants

Research Question

6.2 Achieving Saturation or Theoretical Sufficiency

The principle of saturation in grounded theory is that data collection stops when saturation occurs. This is when new data no longer triggers new theoretical insights, and new properties of core theoretical categories are no longer revealed (Charmaz 2014).

Important to the process of analysis of data is that all data is given equal attention, eliciting all forms or types of occurrences, valuing variation over quantity. Richness of data comes from detailed description and does not depend on the frequency something is stated. It may, in fact, be the infrequently occurring gem that provides perspective and becomes a central key to understanding and development of a theory explaining the phenomenon.

There are few guidelines or tests of adequacy for determining the sample size or the amount of data required to achieve saturation (Morse, 1995). According to Charmaz (2014) the notion of saturation of categories supersedes that of sample size, and sample sizes for some studies may be quite small, yet still achieve the requirements for a project. A grounded theory study needs to be representative, but researchers are advised that it is unnecessary and even defeating to collect huge amounts of data. The risk is that large files go unanalyzed or the researcher becomes overwhelmed by the sheer volume of data and loses sight of the fundamental processes within the area of study.

I have mentioned above that as by interviews continued, I noticed that less and less new categories were starting to emerge and after eleven interviews, I decided it would be more productive to have my final interview as a research study overview with an experienced practitioner and researcher.

6.3 Theoretical Sampling

Theoretical sampling means seeking and collecting data that elaborates and refines categories in an emerging grounded theory, 'it involves starting with data and then examining these ideas through further empirical enquiry' (Charmaz 2014 p, 200). When questions arise from the data and when gaps are identified, the researcher seeks to answer the questions and close the gaps. This can be achieved through returning to individual research participants, or by seeking this information from other research participants. This process of theoretical sampling achieves increased understanding and strengthens the analytic categories.

Theoretical sampling differs from initial sampling and purposeful sampling. In initial sampling, criteria for people, cases or situations are established prior to entering the field - it is where the researcher begins. Purposeful sampling seeks a representative sample based on, for example, quotas or demographics. However, theoretical sampling relates to conceptual and theoretical development – it directs the researcher where to go, based on the theoretical analysis (Charmaz, 2014).

Theoretical sampling is where statements, events or cases are sought to illuminate properties of the categories, as well as to assist in determining how processes develop and change. Figure 5 below shows the process of theoretical sampling.

Figure 5.
(as per Charmaz, 2014)

Theoretical Sampling
Based on concept
For representativeness and consistency

Data Collection
- Observation
- Interviews
- Visual material review

Open Coding
- Conceptual labelling
- Categorizing

Axial Coding
- Finding relationship between categories

Selective Coding
- Selection of a core category
- Checking conceptual density

Memos
Field notes
Acquire conceptual details

Constant comparison
Between incidents, data and theory
For precision and consistency
To avoid bias

Once I had identified the major categories I engaged in theoretical sampling to retrace steps or take new paths. The aim was to gather more data on the category and its properties, seeking and collecting information to elaborate and refine the categories. One of the benefits of the constructivist grounded theory methodology was that as ideas occurred to me from the coding and memo writing processes, I was able to take those thoughts to my next participant interview and ask appropriate questions. I was also able to search for relevant literature and seek views from my clinical and research supervisors and school lecturers. The methodology included abductive reasoning when I came across something surprising and puzzling. I followed the Charmaz principles in these circumstances by making inferential leaps

to consider all possible explanations, forming and testing hypotheses for each explanation until arriving at the most plausible interpretation (Charmaz 2014)

An example of abductive reasoning was the question of location of the therapy that I detailed in concept 8 below. Meeting clients in their own homes was an idea that was new to me and had not been mentioned in my training, although it was the normal routine for three of my participants. I searched through appropriate literature and talked to my clinical supervisor, but the most helpful discussion was with my final participant who helped me formulate the views expressed in the above concept.

6.4 Theoretical Sorting

Sorting, diagramming and integration of memos are inter-related processes that require strategies in the theoretical development of the analysis. The sorting of analytic memos serves the emerging theory and provides the means for creating and refining theoretical links. Sorting assists in the theoretical integration of categories and prompts the comparison of categories at an abstract level (Charmaz, 2014). I based my theoretical sorting on the process described by Charmaz (2014). This was:

- Sort memos by the title of each category

- Compare categories

- Use the categories carefully

- Consider how their order reflects the studied experience

- Think how their order fits the logic of the categories

- Create the best possible balance between the studied experience, the categories and the theoretical statements about them

Theoretical sampling meant seeking and collecting data that elaborated and refined the categories so it could emerge into grounded theory. 'Theoretical sampling involves starting with data and then examining these ideas through further empirical enquiry' (Charmaz 2014 p, 200).

I found that as categories were beginning to emerge I was regularly switching from data collection and analysis to further reading of research articles and books. Additionally, I was particularly fortunate to have met an experienced therapist who was a Clinical Director of an Addictions Unit in the NHS. He became a regular 'sounding board' over coffee and someone who was able to help with my thoughts.

I mentioned above that the amount of data I had collected was challenging to sort and I used a wall covered floor to ceiling with flip chart paper. I proceeded to write all of the provisional categories using a blue flipchart marker on the paper and then with various marker colours wrote descriptions, notes, links to literature and/or other categories and items to be considered further. In order to further sort my study findings, I colour coded all of the information using differently shaped stickers and given this was displayed all on one wall; I was able to see similarities and links and divide the information into the main sections.

6.5 Conceptualization

In order to achieve theorizing, researchers must seek to move beyond the coding stage of analysis to raising main categories to concepts. It is the most significant categories that become concepts of the theory. Determining which categories were

raised to theoretical concepts required identification of categories that rendered the data most effectively and that carried 'substantial analytic weight'. It is these categories that were seen to have theoretical reach, incisiveness, power and related to other categories. (Charmaz, 2014).

'Concepts are abstract ideas that account for the data and have specific properties and boundaries… For constructivists, concepts provide abstract understanding of the studied phenomenon and are situated in the conditions of their production in time, place, people and the circumstances of the research process' (Charmaz 2014, p.342).

Raising categories to concepts includes subjecting them to further analytic refinement and involves showing their relationships to other concepts. For objectivists, these concepts serve as core variables and hold explanatory and predictive power. For constructivists, theoretical concepts serve as interpretive frames and offer abstract understanding of relationships. Theoretical concepts subsume lesser categories... hold more significance, account for more data and often are more evident (Charmaz, 2014).

When staring at my wall of flipchart paper, I found that theoretical concepts were developed through the repeated processes of moving back and forth between the data. I started with the initial 125 categories and by analysing each one for meaning and identifying overlaps between them, I was able to reduce them down to the 56 categories described below. I then grouped these categories together to form the eight concepts. It would have been possible to use an alternative word as a concept

and to group some categories with other concepts, however, what is shown below is what seemed appropriate to me at the time.

6.6 Existential Phenomenological Perspective

As previously mentioned, there is no formally recognised existential version of family therapy and sparse literature available on the subject. A small number of practitioners describe themselves as combining both modalities, but I found it was impossible to find such participants who also had an interest in alcohol problems. Several participants commented to me that family therapists working with addiction were a small number within the profession and this seemed to have been confirmed by the difficulties I had with participant recruitment.

When interviewing participants, it did not seem sensible to engage with them in a discussion about our different modalities, even if they were interested in doing so. There was a danger that we used our time together to discuss the differences between our training and experience, resulting in a diversion away from my research.

What I have shown at the end of each concept section, are my suggestions as to an appropriate existential phenomenological version of addressing those issues within a psychotherapy setting. The ideas are drawn from my literature review and my training and experience as an existential psychotherapist. I offer them as suggestions and not in any way as a definitive explanation of what is a complex topic. To provide adequate signposting, I have placed them at the end of each concept under the heading of Existential Phenomenological Approach. The bold italics below

each concept heading are the categories that I have theoretically sorted with that concept, but as I have mentioned above, other groupings could have been chosen.

My aim was to produce a model that is simple to understand but not simplistic. A way to achieve that is to select one word to represent the concept and a word used regularly by the participants in the interviews.

7. Study Results - Concepts

7.1 Concept One – Models

SBNT – Motivational Interviewing – Drink Diary – Mapping – Genograms

5-Step Method – Cycle of Change – Circular Questioning – Activities

Scaling – Solution Focused – Relational Cycles

All of the participants I interviewed spoke of models they followed when working with clients. Mathew and Margaret were quite eclectic by drawing from different sources on different occasions, whilst Mary, Gail and Linda were institutionally required to use a particular format laid down in manuals and databases. Some of those models are detailed enough for a book to have been written about them and I do not have adequate space to fully describe all that was mentioned to me. Instead, I have below briefly described the main models and referred where appropriate to additional information supplied by the participants.

Angela said that we lived in 'a complex world and the work was aided by simplifying things into a model'. Mathew described his work as normally being in three main phases, 'so phase one is about abstinence, phase two is really trauma and this deeper awareness of what's been driving it. Phase three is about kind of repair and strengthening relationships'.

In my literature review above, I briefly mentioned Social Behaviour and Network Therapy for Alcohol Problems that was developed for the United Kingdom Alcohol Treatment Trial. (Copello et al, 2009). Its aim was to bring together the drinker with family, friends and work colleagues to create a supportive team to achieve positive results. It had core topics of communication, alcoholic problem coping, enhancing social support and relapse management. It addressed problems such as when individuals began to drink heavily, when people around them including their family did not always have sufficient knowledge to decide whether or not the drinking was excessive and if they did not know that, or did not know how to respond, the problem was ignored. Without adequate discussion, the problems escalated (Copello et al, 2009). The therapist used skills such as network management, education about alcohol, coping techniques, communication, planning for lapses and increasing support for the alcoholic.

SBNT differs from family therapy in that it does not try to understand the patterns of interaction in the family and takes a wider focus involving friends and work colleagues. Mathew spoke very favourably about SBNT and about how he regularly used the model, normally towards the end of a client assignment, following a period of family therapy. He used it to look at what each family member wanted from others, what goals they had and what relationships they wanted in the future. He thought it

was important that they saw alcohol as part of a bigger picture which was often about relationships.

Mathew had a great way of using analogies to communicate ideas with clients. He often referred to the Amish principles of a group working together with a common aim, such as building a barn. Linking this with SBNT, the family objectives might at the beginning of therapy seem very large and too difficult to be attempted, but if each person could do one small thing and those things were designed to fit together, then great things could be achieved. Motivating the family and wider group of SBNT had proved for Mathew to be very successful interventions. As he said in his interview, the client 'got the barn for being the guy who saws the wood'.

Richard believed SBNT differed from other initiatives in that it was less about doing something and more about having a good relationship with the client and being focused on their needs. He thought a lot of current addiction thinking used models such as Cognitive Behavioural Therapy (CBT) or Motivational Interviewing (MI) that had elements that did not sufficiently take into account the relational benefits of therapy. He quoted Project Match, described above in the literature review, as showing that it did not matter what model you used, as long as you were good enough in using it. SBNT was described by Richard as assuming the client wished to change their behaviour, needed help to do that and the therapist could be directive on what was needed.

MI is a widely used method of addressing the ambivalence often felt by drinkers. It is a client-centred, directive style designed to enhance readiness for change and an

evolution of Rogers's person-centred counselling approach. Gail and Margaret had trained in person-centred therapy and felt comfortable using MI when appropriate. They both commented that change cannot be forced and MI was a method used to encourage clients to open up about what change meant to them, the difficulty in making changes and the obstacles to success. Margaret spoke of a family where the teenage son had been placed in the role of scapegoat. Using MI over a number of months produced a fresh perspective on family matters with the son being able to better talk about his thoughts and feelings. As Margaret said in her interview, 'you can't get someone else to change, but you can help them to express themselves'.

Richard had different views from Margaret on this aspect of change. He accepted that you cannot get someone to change; however, what you do does have an impact on others. If you use a technique such as MI and it happens in the context of the family situation, then it is very likely the context will change. So one person cannot make change happen if another is resistant to the change, but it will have an impact and if someone is willing to change, even if some ambivalence exists, then there will be a change. Further, Richard thought that most people seeking therapy were wanting to change although struggling to do so and that adopting a view as expressed above by Margaret was somewhat defeatist and contrary to the MI principles.

A drink diary was something Colette and Gail regularly recommended to clients. They described it as a useful way for drinkers to detail daily activities, thoughts and feelings. This could be useful as part of reflection exercises for the drinker and within

the safety of a family therapy session, entries could perhaps be read out enabling the rest of the family to gain useful insights.

Family maps are a graphic representation developed by Minuchin (1974) for understanding the structure, modes of relation and the transactions of the family. They typically involve a family history and an organizational pattern so that the therapist can examine adaptive functioning and uncover any dysfunctional activity. They can also be used to clarify therapeutic objectives with the family. Carol spoke about regularly using mapping alongside the production of a genogram. Linda, Gail and Colette used genograms to understand patterns of behaviour particularly to identify triggers to relapse and sometimes to free people from blame. There is sometimes a tendency for clients to blame themselves for everything that had happened without appreciating the context of their upbringing and the impact of their parent's childhood experiences. Genograms can show the issues that have been passed down through generations and can create a meaningful dialogue with clients about how changes might be affected. Linda said 'it's about people understanding where stuff comes from and that can free them from the blame of what they are doing'.

The 5-Step Method is a counselling intervention developed by the UK Alcohol, Drugs and the Family (ADF) Research Group. The core members of this group are shown below at the end of the bibliography. Colette followed a procedure with clients which included asking them to complete a self-help handbook based upon the 5-Step Method. The steps are:

- ➢ **Step One** – How is the drinking problem affecting the client and the family. What emotions are being felt, what stresses and strains are present. Are there health issues concerning the family.

- ➢ **Step Two** – Increasing knowledge and confidence by getting information. The physical effects of drinking and links to reference materials from organisations.

- ➢ **Step Three** – How are the family responding to the drinking. What are the advantages and disadvantages of the current ways of coping.

- ➢ **Step Four** – What support does the family have and who else could help. Who could provide emotional, practical or material support.

- ➢ **Step Five**– Does the family need any further help. Are there issues such as violence or abuse and if so, where to obtain help

Circular questioning is a technique used in systemic therapy to gather and at the same time, introduce information into the family system. The gathering of information is seen as part of the formulation and validation of the hypotheses of the family structure and the introduction of information aims at changing the family system. It is based on Bateson's (1979) work where he stated that information is the difference which makes a difference. Normally each family member is asked in turn to express his/her view on the relationships and the differences between other family members. This develops an image of the family structure and an understanding of the circulatory nature of the relationships in the family.

Carol commented that 'it's about bringing in different perspectives. Someone might say this about alcohol use, I might say this theory suggests this and so it's about disturbing the system with ideas and then keep going back to the family until they have the last word'.

Two participants spoke about the importance of diverting attention away from the problems associated with alcohol. Gail noticed that when she encouraged a client to do more gardening, 'the more he did the less he drank'. Linda said she encouraged discussions about a range of activities, suggested ideas and at times actively coached people on pursuing things. They could be hobbies or pastimes but were more often different types of sports and particularly for the drinker, recommendations about an energetic activity. The participation in the activity and associated thoughts and feelings were often encouraged to be an integral part of the drink diary referred to above.

Linda used solution focused ideas such as scaling questions, where someone is asked on a scale of e.g. 1-10 to describe their physical or emotional feelings or positioning in relation to a desired change. This dialogue is now so common it often forms part of a normal discussion, but that should not undermine its ability to help change within a family. The origins of scaling questions within therapy can be traced back to the psychologist Hadley Cantril (1965) who wrote The Cantril Self-Anchoring Striving Scale.

David had worked for many years with families and addiction problems and at one time, was a lead consultant managing a team within the NHS. He had considered

many different approaches and models and had come to the conclusion that the most effective method was solution focused brief therapy (SFBT). This is a goal orientated collaborative approach to making changes and is conducted through direct observation of clients' responses to a series of precisely constructed questions. It typically focuses on what clients want to achieve exploring the history of problems although with greater emphasis on the future. The model does not seek to analyse or understand the meaning of why someone is drinking heavily, that is considered to be too complex and unnecessary; instead the focus is on identifying solutions to why someone cannot achieve their desired goals. In common with an existential approach, solution focused therapists believe change is always constant. By helping people identify positive changes and attending to those changes already in process, they assist clients to construct a vision of the future. An acronym used in SFBT that sums up the work quite well is MECSTAT. This stands for miracle questions, exception questions, coping questions, scaling questions, time-out, accolades and tasks.

As David said, 'we were much more interested in how the client saw the problem and what it was they wanted to change. It was about client empowerment, shifting the whole notion of whose responsibility it was for making that change … and a phrase that I absolutely loved, because it just sums it up for me, was sometimes the solution has nothing to do with the problem'.

Carol spoke about recognising the stages in the family life cycle, particularly in relation to power structures. As children grow and seek equality within the family structure there are changes in the family system requiring adjustment and

acceptance. Where people struggle with such changes, alcohol was regarded by Carol as sometimes a refuge sought out by those in difficulty. The therapeutic work was therefore around assisting in understanding and helping family members accept those changes. She said 'so something had changed in the system, they were doing things that they were doing previously, but they weren't helpful anymore'. She said it was very important for family members to understand what the drinker was going through and what treatment looked like. To aid that understanding she used Prochaska and DiClemente's (1983) Stages of Change Model. The brief details of which are:

- **Pre-contemplation Stage** – Helping the client develop a reason for change and validate their experience. Encouraging further self-exploration.

- **Contemplation Stage** – clarifying the client's perceptions about change.

- **Preparation Stage** – Prioritize the behaviour change opportunities, identify and assist in problem solving, encourage initial steps of change.

- **Action Stage** – Practising new behaviour, bolster self-efficacy for dealing with obstacles.

- **Maintenance Stage** – continuing commitment to new behaviour, discuss coping with relapse.

- **Relapse Stage** – evaluating the trigger for relapses and planning stronger coping strategies.

Existential Phenomenological Approach

For over twenty years I worked as an executive coach. In my relationship with clients I regularly asked them to do things; to read a certain book/article, reflection exercise, creative visualization, writing and analytical exercises. When I started to train as an existential psychotherapist it was natural for me to reach for an activity to do with a client. I can therefore easily understand the benefits of using a model which is tried and tested and after repeated use creates a feeling of confidence for the therapist. However, this is not the approach of existential psychotherapy of which I am now a convert and I will try to explain below.

The philosophical aims of existential therapy 'is to work with the client in their search for truth with an open mind and an attitude of wonder, rather than fitting the client overtly or covertly into established frameworks of interpretation' (van Deurzen and Adams 2011, p.11). 'There is no personality theory which divides people into types or seeks to label them. Instead there is a description of the different dimensions of existence which people from all cultures are confronted in various ways. These are the parameters of human existence' (van Deurzen and Adams 2011, p.16).

'Existential therapists see their practice as a mutual, collaborative, encouraging and explorative dialogue between two struggling human beings, one of whom is seeking assistance from the other who is professionally trained to provide it. Existential therapy places special emphasis on cultivating a caring, honest, supportive, empathic yet challenging relationship between therapist and client, recognising the vital role of this relationship in the therapeutic process' (World Confederation of Existential Therapists 2016, p.3).

An existential therapist recognises we all face certain universal conditions and the difference between clients is how they choose to respond to those givens. There is a resistance to categorize people and apply labels particularly from the medical model of mental health which is viewed as largely unnecessary and potentially harmful. 'Existential therapy offers both the therapist and client an opportunity to discover how the client chooses to express their individuality. It's about clarifying their worldview, their values and beliefs and the attitude they take to the world and to the people and events they encounter' (Iacovou and Weixel-Dixon 2015, p.9).

Existential therapists often consider the four dimensions of existence (Binswanger, 1963; Yalom, 1980; van Deurzen, 1997) which is shown in Figure 3 below, but of course these realms in reality intertwine and intersect and are not separate as the diagram suggests.

Figure 3. The Four Dimensions of Existence
(as per van Deurzen and Adams, 2011).
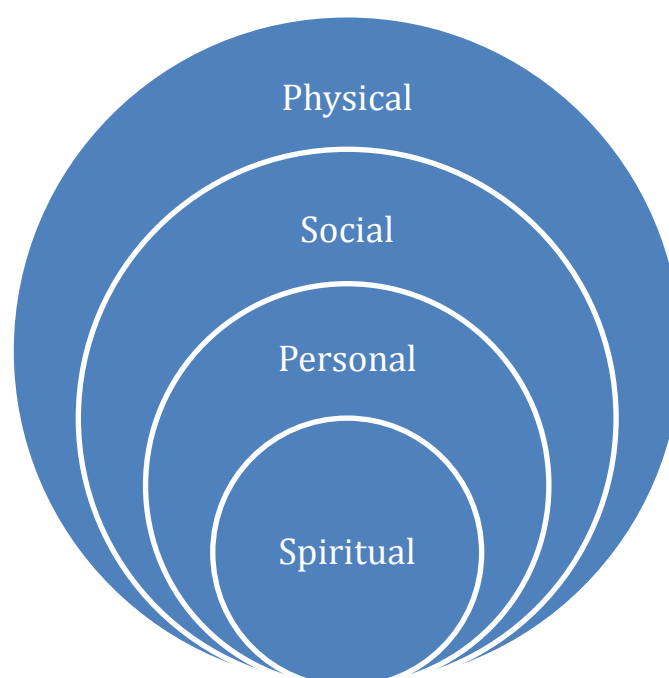
The physical dimension (Umwelt) is where clients relate to the environment and the natural world they live in. It includes the weather, their material possessions, and their physical presence including health and their own relationship with mortality. Clients move and act in relation to a physical world, in which they move forward towards things, or backwards away from things, where they interact with the material world in specific ways, creating a particular kind of intertwinement and interaction (van Deurzen, 2014). For a drinker this dimension can be quite prominent, at one level perhaps being about a shortage of finances to maintain the drinking, but at a deeper level their physical wellbeing and perhaps ultimately, their premature death from their addictive habits.

The social dimension (Mitwelt) is where clients have relationships with others, including their family members. We all rely on others for our physical and emotional needs, although it can be difficult to maintain harmonious relationships at times. Clients move in an inter-personal, inter-subjective way where they engage and disengage with others. They are open to some people and closed off to others. This dimension includes how clients are responding to the culture, class and race they belong to and those who are different from them. In family therapy this is where a lot of the focus is placed upon, what is the family system and what stress does it cause.

The personal dimension (Eigenwelt) is the client's relationship with themselves, their inner world where they view their own character, past experiences and future possibilities. Clients have an experience of an inner world, where they can retreat into a sense of personal privacy and intimacy. For a drinker, this can be where blame and shame are present and the homeostasis mentioned above maintains the status

quo of the family system. Some families believe that there is a way to live according to some undiscovered manual and they have been inadequate in finding it. They come to therapy to be told or directed to that information. An existential approach would seek to show clients the paradox that only when they discover that there is no manual, can they become fully aware of their personal dimension. Through their freedom they can find responsibility, stamina and strength.

The spiritual dimension (Űberwelt) is about relating to the unknown and reflecting to find purpose and meaning. Clients have a worldview which is about their beliefs and ideas and they come together to orientate them in the world. I have often heard drinkers asking, why me, why do I have this problem? As though they must have done something wrong or have some defect that justifies the pain and suffering they have. This can be where the disease model of addiction can be damaging as the person is encouraged to give up responsibility for their situation and blame their bad luck for having such a problem. When clients are able to recognise that they create their own value system, that they are free to create their own meaning in the world, then they can start to exercise that freedom and find a more suitable worldview.

Existential therapists are interested in knowing whether clients are located in the physical dimension, the social dimension, the personal dimension or the spiritual dimension. What are the tensions, desires and fears at each level and how do all these layers affect each other and weave together? It is a useful model to explore client's worldviews and often when they describe their experience in each world they gain insights into how they see the world and their place within it.

In interviewing participants and discussing how they work with clients, I believe one of the main differences between family therapy and existential therapy is the relational aspect of how therapists are with clients.

Sartre (1943) wrote about how beings are in relation to others and described competitive and cooperative relationships. I did not find in my research any overt suggestions of therapists who saw themselves in competition with their clients. However, when a therapist aims to control what is happening in the room, directing the events, giving instructions on what to do, it is difficult not to see that event as one person having power or dominance over the other. The therapist may ask for something, but the client, sitting there looking for help, may be unable to distinguish that request from an instruction to be followed. Arguably this is a dynamic more appropriate within a competitive relationship as defined by Sartre. This would in my opinion be different from what an existential phenomenological therapist is aiming to achieve.

'As therapists we need to learn how to be with others in a cooperative rather than a competitive way, otherwise we cannot be fully available to our clients' (van Deurzen and Adams 2011, p.31). If clients believe they are present at therapy to be told what to do by an expert, they are less likely to speak up in contradiction, less likely to volunteer information where they feel vulnerable and the therapeutic relationship is perhaps not as cooperative as believed. Existential therapists working phenomenologically seek to understand the worldview of their clients. We use empathy, as defined by Jaspers (1912) as a way of feeling into another's experience. While we can never fully know what a client is feeling, we can imagine our nearest experience to that phenomenon and within ourselves engage with our past

experience in order to resonate with it. 'Once we have let ourselves be affected by the other's experience of the world, we can hear and understand them inwardly, from the depth of our own experience' (van Deurzen and Adams 2011, p.31).

Perhaps the best summary of existential therapy and how it differs from family therapy with regard to this category is as follows: 'The existential therapist focuses principally on **how to be**, instead of on **what to do**. The therapeutic encounter is seen as an opportunity for reflection rather than a place for the client to have their behaviour, thoughts or feelings analysed and labelled and their causation determined. In being-with the client, the therapist allows the relationship to become a secure and safe context in which the client's ways of being-in-the-world are disclosed. The therapist is concerned only with the revelation and unpacking of the worldview and accepts it in its current formation; there is no intention to modify the perspectives, they are accepted as the client's lived reality' (Iacovou and Weixel-Dixon 2015, p.98).

Summary

The participants were trained and experienced in using models within their family therapy sessions. Some were required to follow procedures outlined in a manual whilst others were free to use whatever model they believed was most appropriate. The purpose in using models was to change the behaviours of the family through undertaking activities. There was therefore a 'doing' element to the therapy as clients did what was asked by the therapist. Although the participants talked about requesting clients to do things, it was very unlikely clients would refuse and remain in

that therapy and therefore, the therapist would be regarded as the expert, the one who knows what should be done and the one with the main power in the room.

An existential phenomenological approach would not involve instructions to clients to do something; it is about being with the client. The therapist does not regard themselves as an expert directing the therapy, but more as a fellow human being seeking collaboration between themselves and their clients. The therapist strives to understand how clients see the world and may use references such as the four dimensions of existence. The approach is not to categorize or label or prescribe a way of behaving, but for the therapist to try to understand the client's worldview including such matters as how they respond to the givens of existence. Through this work clients have an increased understanding of how they are in the world and are then able to exercise their freedom by choosing how they wish to act.

The main difference between the two approaches is that family therapy seeks to change behaviours through the use of models, whilst existential phenomenological therapists try to help clients understand their choices and way of being in the world so as to create an opportunity to make a change in behaviours. Whilst there are important differences between the two modalities as regards the 'doing' or 'being' with clients, it is worth stressing that there are also many similarities in practice. The essential therapeutic skills that all therapy needs to have such as attention to clients, active listening, understandings, rapport, empathy and care are as present in family therapy as they are in an existential phenomenological approach.

7.2 Concept Two - Training

Experience – Supervision – Education – Spiritual – Reflection

In the research interviews all of the participants commented upon the importance of adequate training and experience. Formal qualification with a recognised professional body was mostly seen as essential, but the varied histories of participants affected the precise recommendation of the required training. For example, Colette and Mary had progressed from social work dealing with addiction issues to counselling and saw the benefits of that type of background and experience. Others such as Barbara and Gail had chosen to follow a more traditional counselling route and advocated more formal training and qualifications.

When asked about the need to attend a course teaching family therapy, there was a mixed response. Everyone thought it was helpful, but opinions varied as to whether it was necessary. Colette who had developed her skills through working with individuals and addiction believed her strength lay in understanding the nature of addiction and having one or a number of people in the room, did not greatly matter. Barbara, Carol and Linda each had a Masters in Family Therapy and believed certain skills were needed and best obtained through formal training. Barbara said 'my therapist friends seem to feel that because they are a therapist, they are automatically also able to see families, but I feel there are specific skills you need. You need to think very differently to be able to see a multiple viewpoint'.

Richard was leading several research projects in India where he used volunteers for counselling work and believed that formal qualifications were not necessary as skills were the important factor. Short practical courses could in his opinion, be better than formal academic courses that addressed theory and enabled practice work, but did not teach the appropriate skills. Richard was a strong advocate for therapists to be skilled in relationship building. What helped clients 'was that therapists had a key and close relationship' what they actually did was not as important provided they did it well and he quoted Project Match to support that view. When recruiting counsellors, he looked for 'people who could establish good eye contact, could smile and soften their facial features and mirror their clients'.

Margaret saw professional training as important in order to raise the student's awareness of their own attitudes or values and beliefs. Addiction is a subject that can raise prejudices and strong negative opinions. Perhaps one would not expect therapists working in this area to consciously hold such opinions, but there might be a need to consider the possibility of deeper unreflected aspects that would benefit from attention. This raised the importance of receiving training that incorporated adequate supervision and personal therapy to uncover anything that might be detrimental to seeing families with drinking problems. Margaret in particular commented upon the need to have an open mind, to recognise and deal with one's own prejudices and assumptions and to arrive at a place where, in her words, 'therapists need to feel strong in themselves'.

Gail had personal experience of alcohol problems having grown up in a family where there were such difficulties and she said this experience helped her understand the

feelings of clients. I have had similar thoughts from my past, although I do not entirely agree with Gail. I think there is a danger that this type of thinking can lead to making assumptions about what clients are thinking and feeling, rather than conducting a phenomenological enquiry to find out. David and Mathew both said that therapists should think carefully about why they wanted to work with families and addiction and through personal reflection and therapy, search for any hidden motives.

Angela believed it was necessary to have adequate 'life experience' in addition to formal psychotherapy training. The particular nature of such experience did not matter greatly, but she thought a therapist who had 'lived a while' could offer more understanding and think more creatively about what would help a family. As she put it, 'you learn a great deal from just being in the world for a while'. Angela also stressed that it was important to remain curious about what was happening in the family and possible causes. Margaret believed strongly in a spiritual aspect to her work and believed this was an approach that greatly helped families.

No matter how well trained, experienced and with the right attitudes, David believed at its essence we would never know exactly what helps and what does not. At workshops he regularly asked participants, 'Have any of you bumped into someone you worked with many years ago and did they say, ''Oh you said that and it made a great deal of difference to me''. Yet we don't remember that phrase or words at all. There is always someone in the audience that has happened to and the point is, you don't know what you are doing at the time'. He was someone who believed in the benefit of brief solution focused therapy where it was not necessary to understand

the meanings of the problem, as long as you could help the family work out what the solution was and support them to implement it.

From my experience of struggling to attract participants, I wondered whether working with families and alcohol problems was more demanding than other therapeutic endeavours. I asked the question of several participants but no-one was of that view, although Margaret commented upon the very demanding nature of the work and the need to have a strategy to look after one's own wellbeing. The precise nature of what, was not discussed in detail, but the principle of having something in place was stressed. It was interesting, although not surprising, that those participants such as Margaret and Isobel who were able to control how many therapy sessions they conducted in a day, had chosen a lesser number of sessions than those operating in a service that required meeting specific targets.

Existential Phenomenological Approach

As Spinelli (1994) suggested training is an essential safeguard for both therapists and clients, but there is an assumption that training itself is directly related to effective therapy.

Research on this point seems to have contradictory results with a study showing that 'para-professionals' (educated people with no clinical training) had more effective interventions than professionals (Hattie et al, 1984). In contrast, Berman and Norton (1985) reviewed the same data and having eliminated some confusing categories, found that both groups (trained and untrained) were equally effective. This is an interesting debate but lies somewhat outside of the core of my research project. I

think it sufficient to say that those family therapists I interviewed did not demonstrate any direct correlation between particular forms of training and successful client outcomes. I viewed this as compatible with the research conducted in Project MATCH and UKATT mentioned above in my literature review. The participant's success I believe depended upon a wider collection of skills and attitudes including the ability to create a good therapeutic relationship.

Training to be an existential therapist is different from other modalities as the therapeutic focus is on 'how to be' rather than 'what to do'. The therapy is an opportunity for reflection rather than a place for the client to have their behaviour, thoughts and feelings analysed. 'The therapist is concerned only with the revelation and unpacking of the worldview, and accepts it in its current formation; there is no intention to modify the perspectives, they are accepted as the client's lived reality' (Iacovou and Weixel- Dixon 2015, p.98).

It is not about learning exercises that can be practised with clients to unveil some hidden issue; it is a framework of interpretation taken from existential philosophy and need not be explainable to others. There are some key aspects of existential philosophy that influence existential therapists and their work, although not necessarily the same ones or in the same way. For example, 'being-in-the-world' was a term created by Heidegger (1978) to describe what it is to be human. Often referred to as 'Dasein', the hyphenated format of the term is designed to encourage people to rethink ideas that they may have taken for granted, in this case, the idea that people are somehow separate and distinct from the world around them. They are always situated in the world involved in a context of people, ideas, places,

objects and events. This leads to the corollary of 'being-in-the-world-with-others', 'that human existence is characteristically and essentially relational and something we cannot escape – any attempt at isolation or total separateness is doomed' (Iacovou and Weixel- Dixon 2015, p.19).

However, the training and influences on therapists need not be explained to clients, in fact it can often be detrimental to the therapeutic process for the therapist to intellectualize about such matters. It is sufficient that it exists and plays a part in how the therapist works with the client. 'Even if the therapist's explanatory system is so complex and abstract and so rooted in unconscious structures that it cannot be explicitly transmitted to the patient, it nonetheless enhances the therapist's effectiveness in numerous ways' (Yalom 1980, p.190).

What impressed me from the research was the variety of interventions, the creative and flexible approach adopted to try to help the client family. An attitude of 'whatever helps is worth considering'. This seemed to be a belief developed from caring for the client irrespective of the therapist's background and experience. All of the participants had frequent supervision and those in employment such as the NHS, had regular performance appraisals. Whilst time was sometimes a difficult resource to find, most spoke of periods of reflection which were helpful in their desire to progress as therapists. I was left with the opinion that what was important about training to work in this area was finding a method that made sense to the individual, coupled with adequate resources and support including accepting responsibility to protect their own wellbeing.

Summary

All of the participants recognised the importance of adequate training but there were differences of opinion over the value of formal qualifications and the need for a family therapy course. One view was expressed that studying theory is less important than undertaking skills training and having effective supervision. It was also said that some of the main benefits of training were those of self-reflection concerning attitudes, values and beliefs.

An existential phenomenological view on training is that it is a safeguard for therapists and clients, but believing that it directly relates to effective therapy, is an assumption. Training to be an existential therapist is not about learning tools and techniques that can be applied in the therapy room, but is about learning how to be with clients, how to see the client's worldview and to how to reference existential philosophy. Learning to understand clients in a phenomenological manner places emphasis on self-reflection and use of self, although this point was also present in the family therapy research data. Both approaches would strongly advocate the need for training although the detail of what that is would be different.

7.3 Concept Three - Support

Resources - Group – Individual – Websites – Interests

All of the research participants commented on not restricting the work with clients to the therapy meetings alone, saying that additional support or resources could be very helpful. Some therapists such as Angela prompted and encouraged additional

work, whilst Colette was more directive and instructed the family to do things between sessions. This was normally a type of homework that was specific to them, emanating either from the last therapy session or from her experience. It often included reflection on issues raised in the session and encouraged communication between family members. Colette approached her sessions in an eclectic manner and described her style as 'a mixture of a load of different things'. She was very pragmatic and would suggest anything additional that seemed to be of benefit. As she said 'if it is working, then let's have more of the same, if it's not let's think of something else'.

The impression I formed from my literature review and interviews was that one of the main challenges of family therapy was creating an opportunity for everyone present to express their thoughts and feelings. Unless the therapist pays particular attention to how often family members speak in sessions and if necessary, influences that communication style, some family members can feel ignored and left out. Sometimes the therapy sessions parallel the family's well established patterns of behaviour, often including elements of blame and/or shame. The family therapist's response to this can be quite directional, seeking to break the system that has been established and encourage a new way of being with each other. One of the most common interview feedback points mentioned for example by Angela and Barbara, was that the non-drinking family member could feel ignored by the therapeutic interventions. Sometimes with anger expressing the view that the drinking had been all about the drinker and now, the therapy was also only about the drinker and their needs.

These types of discussions within family sessions led some participants such as Colette and Isobel, to frequently consider additional resources to help the family. One of the most common was to recommend or refer a family member to individual counselling. This enabled the person to have greater air time to express themselves and work through their own issues before re-joining the family group. Where the participant worked within the NHS, there was normally a treatment plan that included other initiatives. Linda described this as 'when they come to us they're already part of a treatment system, so they will have a key worker who will have developed a care plan with them which would involve having talked through things like 12 step approaches, relapse prevention groups or rehab facilities'.

Mary spoke of additional group sessions that sometimes achieved things not managed within the family therapy session, such as arranging multi couple's groups to get them in the same room as people experiencing similar things. She said 'an hour with someone else in the same situation, it was like a light bulb would click on and in your head you'd be thinking we've been talking about this, why haven't you .... but there is something really powerful about peer support and peer sharing of information'.

Carol organised groups that comprised of drinkers, non-drinkers or a mixed population. She said, 'so interviewing a couple of people who were the drinkers or ex drinkers, while the family members sat around and then we swapped over and that was a very powerful thing, it was hearing that they weren't alone and hearing how other people had coped and managed'.

All of the participants thought there were benefits for the drinkers to talk to others in a similar position. This was encouraged through group meetings as mentioned above or participants such as Colette arranged drop in centres and even a social media forum. It was believed that to share experiences and to feel understood by someone who had been there and 'got the t-shirt' was of significant benefit.

Colette was a keen supporter of a website initiative that had been created by her agency. Family members were given confidential access and encouraged to work through a five stage model (referred to in detail above) and bring their outcomes to the family therapy sessions. The website could be accessed at any time, with exercises capable of being repeated and the site provided links to relevant literature, meetings and other internet resources. Colette spoke about recommending a number of useful websites providing education on related issues to drinking, such as stress and anxiety and these had been a great help for some families.

Colette also spoke about encouraging family members to pursue personal interests outside of the therapy. She expressed the view that experiencing difficult family circumstances often produced an intense focus on the problem and blocked out the rest of life. By spending time experiencing such things as nature, sports and care for animals, there could be a useful distraction away from themselves and their worries, making them more susceptible to gains in the therapy.

I asked all of the participants about their views on attending Alcoholics Anonymous. Some, such as Gail were keen advocates who challenged clients if they did not at least give it a try. Others such as Mary had a more ambivalent attitude and would

perhaps suggest trying some meetings if it came up, but recognised that it was not a culture that suited everyone. Richard said he had heard from many clients that A.A. had been very helpful, but personally he did not like a culture that people had to sign up to believing they had an unchangeable disease. This he believed could lead to a reduction in personal responsibility by avoiding control and change.

When clients attend A.A., I believe it is necessary for therapists to have a good understanding of the philosophy and methods used in meetings in order that the therapy compliments the A.A. approach rather than appear to contradict it. Otherwise it can lead to confusion and demotivation. This can be challenging at times when for example, a client's sponsor suggests a course of action at odds with the therapist's position. I have addressed that problem by having a sensible and open discussion with my client, but remaining sensitive to the possibility that they can feel torn between two opposing views.

Existential Phenomenological Approach

As previously mentioned, the principles of existential psychotherapy are about being with a client, rather than doing anything with or to them. This means that rarely would an existential therapist direct the client to undertake some activity either within or outside of the therapy room. I would suggest though, that one of the main differences between family therapy and an existential approach is not about activities taking place outside of the therapy room, or even the directive nature of the therapist, but the therapeutic purpose of the activity.

'The existential therapist approaches all clients with a humility and compassion that is born of the understanding that we are all alike: we are all struggling to engage with and respond to the anxiety that pervades our existence' (Iacovou and Weixel-Dixon 2015, p.158). Alcohol use is a strategy often used by the client to structure their life and avoid that anxiety as much as possible. The existential approach is not about treatment for symptoms, but an exploration of the client's way of being-in-the-world. As such the existential therapist is not seeking to change the client's behaviour; the aim is to gain an understanding of its meaning, so that the client can use that new insight to choose what actions they wish to take.

Family therapy often involves structural and strategic interventions to change patterns of behaviour, believing that such alterations lead to a change in internal experience. The existential approach is perhaps the reverse of that method. By talking about their way of being and gaining insights and understanding, there is a change in internal feelings and beliefs, which gives the client a choice on whether they wish to change their behaviours.

In practice, a family experiencing an existential approach to their therapy may well decide to utilize additional individual or group activities or the use of journals to capture an intimate record of their therapy, or homework exercises such as reading or watching films, but these activities arise out of the work being done, not a predetermined direction to achieve a behavioural change. It comes from the therapy and may be beneficial, but it is not part of the therapeutic process.

Summary

The participants commented on the benefits of undertaking additional activities to supplement the family therapy. Some encouraged and prompted families with suggestions; others were less directive by referring to what resources were available. The more common activities described were individual therapy sessions or group meetings where family members could talk to like-minded individuals. Some participants were advocates of Alcoholics Anonymous, others were more ambivalent. One participant was very keen on encouraging activities that were a contrast to therapy such as sports or hobbies. I was particularly impressed with one agency that provided website resources available to family clients that included a large number of helpful exercises, educational material and links to other resources.

An existential phenomenological approach does not include directing clients. However, through the questions asked and the flow of the therapeutic discussions, there is an examination of how clients see themselves in the world including what physical activities they undertake. Whilst the aim of the therapy is to gain insights and understandings creating a change in internal feelings and beliefs, there could easily be a narrative about the benefits of additional resources. If the clients feel for example that a group meeting is beneficial, the existential therapist will not seek to direct them to act upon that initiative, but will focus on the possible benefits of attending. Both modalities I believe recognise the benefits of additional resources, the difference is that family therapy can be directive on the matter, whilst an existential approach would regard it as arising out of the work being done, rather than any predetermined direction.

7.4 Concept Four - Perspective

Neutrality - Reflection Team - Reframing – Focus – Labelling

Conducting a therapy session where there is more than one client in the room can create sizeable challenges. One of which is sometimes receiving many differing views on the family situation. Linda stressed that neutrality, in the context of family therapy, did not mean adopting a view that is without opinion, but is accepting the view of each and every one present. She said 'neutrality is a big family therapy concept; it has particular connotations of being on no one side. It is making everybody feel like you are with them on all of their sides'.

Holding multiple views of often the same behaviour is difficult, but it is important that every client feels heard and their perspective held to be as valid as everyone else's. For Linda maintaining the position that every view is valid was seen as important during the exploratory stage, but once she had decided to change the system, then it was necessary to side with one or more family members in order to do that. For her this was particularly important for family members who had felt excluded from any help in the past. Richard was of a different opinion believing that siding with one family member against others could be dangerous. I think after reflection, there is a need to consider what was meant by using the word 'side'. I do not think Linda was suggesting having any sort of argument within the family and expressly supporting one person's views against the others. Richard summed it up well I believe by saying 'once trust has been built and after you have got to know what people think and why,

I would perhaps be tempted to say, you know, I think he may have a point here, what do you think?'

Mathew, Angela and Gail all mentioned that sometimes assistance is only offered to the family member with the drinking problem and others in the family are ignored, despite their obvious pain. Giving them an opportunity to say how things are from their perspective can be extremely valuable for all of the family. I mentioned above the benefits from providing a different forum for others to gain help, but it is also important for there to be therapeutic initiatives to enable different views to be presented within the family session.

The one intervention often in the research interviews was the skill of reframing by the therapist. Feeding back what they had heard but in a modified manner, sometimes using different words and often presenting a more positive perspective on what had been said. A sense of how much change to make to that feedback becomes part of the therapist's skills. Too little change and the intention of reframing is lost, too much and the client feels misunderstood or their opinions ignored. However, the benefits of being heard and understood and feeling the therapeutic intent to help improve the situation, cannot be underestimated. This is perhaps one of the key skills to be recognised and learnt for therapists working in this area. As Linda said 'the view is often so different for different people and understanding that view sufficiently so as to capture its meaning, is a real challenge'.

Angela and Barbara used communication exercises to aid understanding within the room. This was by asking family members to repeat what had been said to them and

then checking out the accuracy of those statements with the appropriate family member. From a family therapy perspective, the focus is on the system and it is important to observe not only what is being said, but the impact the statements are having on all of the family members. If necessary, Angela said she could be very directive on how she wanted people to make comments; this included physical positioning, tone and pitch of voice as well as using specific words. At times she said she 'could be a proper bossy madam' telling people what to do.

Mathew described his practice of recording a video of a family therapy session and the work that followed. I was impressed not only by the idea, but the way he talked about the process which I found very moving and I have therefore included below the relevant section from his transcript:

'And I'll just take 10 minutes of film and I'll probably just use a little like a mobile phone or something this kind of size, very, very simple technology – very unobtrusive. Won't be holding it up to my eye or anything like that. Holding it in my lap like this. And then I'll look at that film and I'll try and find a few moments of real communication, emotional communication that may not even be words but I'm looking for where the ball goes over the net three times, the child sends a message to the parent, the parent really gets the message, the parent responds back and maybe then the child responds back that they've received the return message from the parent. Now that might be 20 seconds at the most. I will pull that out of the film and then I'll have a date for the parent to come in by themselves to see me. We'll sit together, side by side, and look at this – our film on the computer. And I'll say what do you think? And they'll often say, oh that's embarrassing. I can't bear ... It helps that we're actually filming our interaction

and I'm going to take that to my supervisor and say, I hate it as well but I have to take this to my supervisor and talk about my interaction with you. So we're in the same boat. And then we watch it again. And then they get caught up in the situation and then we talk about that a little bit and then we watch it again and I say. "what do you think he was thinking at that time, what was going on in your head" and so on. Slowly we deconstruct it. We might spend 20 minutes talking about 20 seconds which we see 10 times and we talk about what was going on. In his mind what was going on, in your mind what was going on. And parents get to see how important they are to their children. They get to see themselves at their best. They get to see themselves as a role model for positive behaviour. They get to believe that they can be good parents, even if actually a lot of the time it's pretty rubbish and this was the little bit I had to work really hard to get on film. But if I show them this I know, and we talk about this – we really understand the lessons learnt from that – they will be incredibly motivated to go out and repeat that. I don't have to encourage them. I don't have to kind of set them homework. They can't wait'.

In our interview, I showed the above extract to Richard who was impressed with the use of a video in this way. In talking about clients taking something physical away from a therapy session, I was surprised when Richard said he encouraged clients to make notes during a session. For him this was a matter of who was in control in the room, if he was the only one taking notes and using them to think about the next session, then clearly he was the one in control of what was being discussed. This was not ideally the relationship he wanted to establish with clients. Personally, I write notes after a session and would be distracted from being with my client if I wrote

anything in their presence. I have never been asked by a client whether they could make notes whilst with me, but I would respect their wish to do so.

I was impressed by another initiative, which was having a reflection team as part of a family therapy session. It was regularly used by Mary, Gail and Carol where resources could be made available. I think it could be an excellent way for the family to obtain additional perspectives. The following is an extract from Carol's transcript where she describes how this practice works:

'One person might be the primary therapist and there are two or three other people in the room and they openly share, in front of the family, their ideas, their thoughts. The idea is that they obviously introduce themselves when they come into the room and we set the context. We say this is just our way of working. We have found from the feedback from other people, that this has been helpful. Would you give it a go and let us know at the end of the session whether it's helpful and we kind of share the idea that we see the multiple heads brings lots of different ideas and different ways of thinking and that sometimes different ways of thinking is really useful. So if people don't want it they don't have to have it but actually most people really the team.

What we do is, we usually say that the team might, if there's a question they want to ask, they might knock and ask a question. With a screen like here, the team might sit behind the screen and they might call in or they might come into the room about 40 minutes into the session – if we do about an hour or an hour fifteen – they might come into the room and they would talk amongst themselves and the therapist and the family or the couple would sit and listen in. And the idea is that when you're not invited to respond you can listen in in a different way and you maybe hear things in a different way so it

looks a bit like the team's gossiping in a way, because they kind of talk together and they don't directly talk to the family or the couple because if someone talks directly to you it's very much expert, isn't it, and you can't reject it. Whereas if you're talking amongst yourselves then someone can have a bit of distance from it. They don't have to respond to it. They're not invited into responding straight away. And the idea being that team members will build upon positives and strengths. So always thinking about the positive connotation because no-one's going to change, are they, unless there's a positive connotation. So really thinking about strengths, really thinking about the positives, and then maybe thinking about an idea or something that may be related to them personally'.

Nearly all of the participants at some stage of the interview, talked about the harmful effects of a label of alcoholic. I will below refer to the therapeutic endeavours to minimise such labelling, but it is relevant here in that such views can be brought into the therapy room and examined by the family in terms of accuracy and bias. Helping the family to realise that the social stigma is only a view and not a truth, can release a lot of the guilt and shame felt by lots of drinkers. Isobel spoke about a family who believed 'the whole world was against them and it had always been because of this or that'. Rather than accept that as reality and feel the weight of oppression in the room or challenge them as to that view, instead she used narrative to change the perspective. She said to them, 'well that sounds as though you have been incredibly resilient and strong to actually get through that and get to this point of talking about it'. I very much liked her approach which shifted the family from feeling negatively about their position to seeing the much more optimistic perspective of how they were engaged in therapy to improve their lives.

Existential Phenomenological Approach

An existential therapist working phenomenologically will form a view based on what seems similar to them. As individuals seeking to create meaning, we cannot do otherwise. However, in order to fully understand the phenomena in front of us, we need to observe certain stages of phenomenological enquiry. Once we are in attendance and describing to ourselves what we are observing, we need to be aware of our own assumptions that can cloud what is before us. The process of epoché suspends our judgements by metaphorically bracketing them off. This is not to suggest we can ever be fully parted from our assumptions of the world, part of the principle of intentionality says otherwise, but we can become aware of them and aim to put them to one side as much as possible.

Verification is a way we discipline ourselves to keep returning to what we are observing and to check that our observations are correct. Equalization is a way of considering each part of the content, the process and the experience of the family as of equal importance so that we do not allow our own life interpretations to distort what we are seeing.

'The skills of the first stage of epoché are mainly clarificatory and those of verification are interpretative. The bridge between the two is horizontalizing, when we endeavour to place what is becoming known against an horizon, to contextualize the client's worldview' (van Deurzen and Adams 2011, p.50).

In considering the complexity of how therapists view clients and the perception they create of the client's difficulties in front of them, it is worth briefly mentioning Meno's

paradox. Plato was posed a dilemma by Meno. How will you look for something when you don't in the least know what it is? How on earth are you going to set up something you don't know as the object of the search? To put it another way, even if you come right up against it, how will you know that what you have found is the thing you didn't know?

An existential therapist could explain this paradox by reference to Merleau-Ponty's work, Phenomenology of Perception. His writings state that things do not simply impose themselves on consciousness as sense impressions, nor do we construct things in our minds. Rather, things as we experience them are discovered through a subject-object dialogue. His contribution to phenomenology brought us the idea of a lived body, that the body is not a machine run by the mind, but a living organism by which we body-forth our possibilities in the world.

One of the key elements of an existential phenomenological approach to psychotherapy is that we do not limit ourselves to listening to what clients are saying to us, but we use our bodies as well as our minds to try and make sense of the phenomena that is being described. At the end of the day, we still have a perception of the situation, but it is one that is formed from a more searching and unbiased perspective than perhaps some other therapeutic approaches.

For the existential therapist, phenomenology offers a powerful aid to understanding the subjective experiences of clients and the potential to gain insights into their motivations and actions by cutting through the clutter of taken for granted assumptions and conventional wisdom (Lester, 1999). As an approach phenomenology offers the client the potential to make sense of their experience for

themselves and ultimately to transform that experience should they choose to do so (Finlay, 2011).

Summary

Family therapy involves having more than one person in the room and therefore more than one perspective on the matters being discussed. The participants stressed the importance of neutrality and accepting the view of everyone present. They also commented upon the difficulties in being seen as supporting or 'siding' with one member of the family. There were specific pressures often talked about such as non-drinking members of the family feeling ignored and side-lined by the therapeutic process. Participants used a range of skills to achieve and maintain their neutral position, including reframing, communication exercises, video recordings, note taking and a reflection team. One of the key aims of family therapists was to allow perspectives to be heard by other family members whilst remaining neutral in their view.

An existential therapist uses the process of phenomenological enquiry to fully understand what the phenomenon is before them. By having some clarity, the therapist is not only able to see what is really happening for them but through the therapeutic work, pass that understanding onto all of the family. There are skills that need to be learnt such as epoché, verification and horizontalizing and challenges such as trying to find something, when you do not know what it is. The benefits of phenomenology are that it extends beyond listening to clients; therapists use their bodies as well as their minds to make sense of the phenomena. In this way, the

therapist can offer the clients the potential to make sense of the experience for themselves.

The similarities between the two approaches are not to tell the clients what to believe. Family therapy uses exercises and tools to allow all of the different perspectives to emerge and help family members to gain understandings. An existential therapist uses phenomenology to fully understand what is present amongst family members and through the therapeutic work assists the clients to see more and make sense of the phenomena.

7.5 Concept Five – Truth

Trust - Communication - Confidentiality – Blame & Stigma

Some therapists chose to accept what they hear from clients as the truth even where they have doubts. When working with a family the question of truth might be a more complicated matter. If two or more people are describing an incident that appears to differ in fact and well as interpretation, it may not be possible to find out what actually happened and both parties may genuinely believe what they are saying. Whose truth is therefore more accurate and how important is it to establish that.

For example, Barbara said 'because you are dealing with multiple perspectives all the time you can't have a truth that's too fixed, because it wouldn't serve you at all'. Colette talked about a family where truth was at the heart of many of the problems the family experienced. The drinker had been labelled a perpetual liar and nothing

that was said could be trusted. This sometimes led to the drinker being blamed for all of the family's difficulties and a homeostasis established that opposed any change to the system. In such an environment, encouraging anyone to share their vulnerabilities and talk about change was described by Colette as extremely challenging. Carol when describing the benefits of using the reflection team mentioned above, pointed out that 'there's no one truth and attempts to search for it are not necessarily helpful'.

A lot of what I heard from the participants is perhaps summed up well by Margaret when describing the family dynamics at the beginning of working together. She said 'there will automatically be hidden stuff that you are not going to access in a family setting, so when you ask questions, you're not necessarily going to get the truth. You're going to get their pain, their annoyance at the drinker or whatever'.

Some families talked of their struggles with the stigma of having a drinker within the family, often parents blaming themselves for perceived inadequacies of parenting, asking themselves the question, why us. Colette described a typical first session where she handed out many tissues and quoted the families words of 'I feel like it's the first time somebody's listening to us, taking notice, asking how we are and there's still so much guilt and shame around what's happened and what we must have done wrong as a family for this to happen to us'.

Margaret said that everyone lied on occasions and the therapist needed to be self - aware and centred enough to 'sit with it' until the truth emerged. Her belief was that the act of lying eventually became too uncomfortable for the client to bear and a need developed to be truthful. She said 'you hold your awareness in you, your

centred position and then they will feel it and they're oh well I didn't really, I was actually drunk. They will start admitting the truth'. Other participants such as David thought it was the client's choice to be truthful and not their concern. Richard saw the question of truth as a complex matter because of the difficulty for the therapist to know what is truthful. His approach was to listen carefully to what was said, accept and believe what he heard, but think about it and be realistic that people do often lie. However, the question of considering lying or not seemed an odd idea to Richard. As he said, 'even if he is lying, so what? You work with what he brings; it's their time to say what they want and their choice to waste the opportunity if they wish. The lying will either stop or change and as time goes on and the therapist asks questions, things will be added and forgotten'.

Participants such as Angela who addressed lying were asked in the interviews how they did that. The matter of trust between therapist and clients as well as within the family was said by her to be important. She used a gradual process of encouraging people to speak and share whatever they could, whilst others were asked to actively listen and where possible show that views were validated. In some cases, matters were spoken of for the first time and had a big impact on others in the room. Blocks around anxiety or fear were uncovered and with skilful assistance by the therapist, meaningful communication was possible. She spoke of the success of using non-verbal communication where difficult matters were being addressed, particularly where children were asked to show their feelings, using drawings, pictures or toys to communicate.

Whilst talking about truth and trust, Carol mentioned the importance of observing the principles of confidentiality. Most participants formally contracted at the beginning of the therapy sessions and confidentiality was discussed and agreed upon. However, where children were sometimes present, it was important to consider what subjects should be addressed in their presence. Carol mentioned a situation where she was working with the children in a family and 'I was getting calls from the parents wanting to know what was being said, what was happening and I couldn't say anything without breaking the trust I had established with the children'. Colette spoke of a complex set of circumstances, where the parents were attending separate individual/group meetings and although encouraged to share information, one parent chose to do so but the other regarded the matters as private and did not wish to share, leading to resentment between them.

In reviewing the current literature, the word ambivalence appeared regularly to describe the attitude of the drinker. When I spoke to participants about how they addressed that, I was impressed by the pragmatic and direct approach of Colette. She said, 'I believe in being straightforward with people. You have to look at what is going on, not what went on then or what might come tomorrow, but what is going on now. Look at your destructive behaviour. Look at how it's having an effect, not just on you but on everybody in your life ... what I believe you need is acceptance. That is not just like knowing you've got a problem, it's accepting that problem as part of who you are, then you make a choice, not to drink'. Colette used analogies quite a lot with families and spoke of describing alcohol problems in the context of a boxing match. She said 'I always use the boxing ring scenario. If alcohol is in one corner and the alcoholic in the other, they keep jumping in to fight but the alcohol will win

every time. If you're an alcoholic, you cannot win. So my view is get out of the ring, stop fighting, go to A.A. go to wherever you need to go to in order to get the help you need. Why fight when you can't win'?

Existential Phenomenological Approach

Generally speaking, truth is a subjective matter and it is entirely possible that clients are deceiving themselves about issues without being fully aware that is what they are doing. It is also possible that clients are deliberately trying to deceive the therapist or family members for their own purposes. Some existential therapists tend to believe that there is no such thing as truth, only truths as people perceive them. Clients vision of truth is an evaluation of their experience and the notion of an absolute truth that exists independently of a human perspective is not considered credible. Further, as clients are always changing, moving towards a future that is their potential, this movement will affect their perception and how they qualify their experience.

My experience is that where individuals are struggling with alcohol problems, often leading a chaotic existence, lying often exists. The challenge for the therapist is therefore whether to accept everything as the truth or to remain on their guard that it might be a lie.

The phenomenological method can be considered as a means to uncover the reality of living and the meaning construed by individuals. This can produce differences, a bottle of alcohol in the corner may be an innocent object for the child within the family, a threat to the wife of a problem drinker and a mixture of salvation and misery

to the drinker. Depending upon who is being asked, the truth of why it is there in the room and the purpose it serves, will differ. Heidegger suggested that truth is not static and exists in three levels. The first is somewhat forgotten in modern culture and is the level of Being itself, of the realisation that there are things at all. The second is that of concrete lived meaning, everything is revealed in its 'as' function, so the knife is a tool, feeding instrument or weapon and so on. The third is built on the second and allows for scientific truths to emerge including the theory of truth (Heidegger, 1993). However, there are limits. 'Imagine a dark room. You can make out the outline of a few objects, but no detail. You take a torch and shine it into a corner. This corner is now revealed in bright light. Details are available and as such the truth of that corner is revealed. However, as this is happening, the other parts of the room are now even darker than before. So, while 'light' allows for a detailed revealing, it also occludes other phenomena. So, the path to truth is also a path to further concealment, at least temporarily' (Kemp and Lorentzatou 2013, p.6).

A phenomenological approach pursues truth as a process but there will be concealing elements and lies are a natural product of finite revelation, so therapists should not be surprised by lying. For an existential phenomenological therapist, it should be about seeking the existential meaning of the lies (Kemp and Lorentzatou, 2013).

Ryan Kemp (2009) wrote an excellent research paper on the matter of truth in addiction. He argued that relations between addicts and others are dominated by untruth with lying having an origin in the primordial desire for love. 'This form of relating leads to the destruction of self-esteem, the development of shame and

distrust and the breakdown of relationships. Truth is replaced by false narratives that are individualistic and alienating. Instead of dwelling in truth, the addict instrumentally alters their moods to suit their own needs'.

Kemp's paper addresses the existential perspective of always being in relation to others, but the nature of addiction distorts those relationships perhaps rooted, he suggests, in 'lying being used to keep love alive for the child' (2009, p.361). Unable to tell the truth, due to lacking sufficient trust in themselves, the drinker is required to lie leading to shame, but further, 'the effect of the addictive process is to hide the shame and the affects connected to it' (2009, p.364). Kemp poses the question, 'other than opening up to love, is there any other way that the addict might encounter the truth of their being? Obviously engaging in psychotherapy might lead them in that direction, but therapy is not very successful in the area of addiction'.

I am hesitant to challenge Kemp's extensive experience in this area, but I wonder from my research and experience as a therapist, whether it is indeed possible to help a drinker 'open up to love'? In individual therapy sessions it is challenging to create such a strong therapeutic relationship that the drinker is able to let go of past sedimentations to the extent required, although I believe not impossible. If as Kemp suggests, the addiction embodiment begins in childhood, then what better way of offering a change to their way of being than through family therapy. A systemic perspective would suggest that altering the family system, removing any homeostasis that keeps it in place, allows the whole family to relate to each other in a different manner. If a person begins to understand why things occurred through improved communication, to have the opportunity to face up to past mistakes and

receive forgiveness from loved ones, then would it not be possible over time for the drinker to feel love for themselves? Kemp writes 'the addict hides themselves, from the other and themselves. And it is impossible to love that which is hidden' (2009, p.366). I could not agree more and so our quest as therapists is to help the family uncover that which they have hidden, to find the courage to face the unfaceable and change their way of relating.

Summary

An issue that arose in the participant interviews was whether therapists should choose to accept what they heard in the therapy sessions as the truth. In family therapy there will be multiple perspectives as mentioned above, so can there be such a thing as one truth? On the whole, participants believed there was no one truth to be discovered. One participant believed attempts to search for such a thing was not necessarily helpful and another participant believed that when asking questions of the family, what was given came from their pain and annoyance and not an attempt to give an accurate account of matters. There was an overall view that everyone lies at times and the more important issue was around the matter of trust within the family. In attempting to encourage trust, problems occurred in terms of things such as confidentiality, how to manage situations where some family members were not present at certain meetings, or where some issues were to be kept private, for example when children were present.

An existential approach tends to see truth as a subjective matter and is therefore no different from a family therapy perspective. It is recognised that clients can be deceiving themselves without being fully aware of what they are doing and that truth

is a matter of what is perceived. It is a belief within the existential approach that clients are always changing, moving towards a future that is their potential. This movement will alter the perspective of the client and what they regard as the truth. Following a phenomenological method can uncover the realities of living, but it is not static and it depends upon where one looks. It is possible that by shinning a light on one aspect to reveal particular phenomena, one can create a darker picture over other matters. There is the suggestion by one experienced practioner that in addiction there are special circumstances around truth having an origin in the desire for love.

For both modalities, there seems to be the view that there is no one fixed truth, participants saw little benefit in trying to find the truth whilst an existential phenomenological method recognises the continuing changing nature of perspectives and limitations on what can be seen.

7.6 Concept Six – Feelings

Cravings – The Past/Origins of the Problem – Why Me? – Hope & Despair

Hope & Jeopardy - Why Now? -Triggers/Relapse

Participants spoke about client's feelings which could be considered as more common or even unique to addiction. In therapy and at meetings such as Alcoholics Anonymous, there is often a lot of discussion about cravings. This is normally to create an understanding as to what physically and emotionally is happening and what strategy should the drinker have in place to avoid or deal with the cravings. The

opportunity in family therapy is to extent any understanding to the rest of the family. It can be incredibly valuable for the family to be fully aware of the power that cravings have over the drinker and to be able to be part of the coping strategy. Some participants such as Linda and Carol mentioned the importance of talking through cravings with the family.

As I mentioned above in my literature review, there are different views as to whether the origins of the drinking problem should be addressed in therapy. The argument presented by some therapists is that until the drinker understands what led him/her to use that coping mechanism and how it got out of control, then it will always lurk in the background, ready to create problems. The opposing view is that by discussing those issues, the drinker will find it more difficult to achieve objectives such as sobriety and it could create further problems. None of the participants started therapy with families with an intent to address the past and how it created the drinking problems. When I asked participants about addressing the past, the response I received from Barbara was typical. If the families wanted to talk about the past and everyone believed it would be helpful, then they would facilitate those discussions. She warned though that it could 'open a can of worms that could create more problems than it was worth'.

I was surprised that past events were not analysed more by the participants. The views were summed up by Colette who said 'it doesn't matter why; what matters is what is'. None of the participants mentioned searching for answers in the childhood of clients and using approaches such as attachment theory, although somewhat contradictorily some regularly used genograms. Perhaps it was the nature of family

therapy that looked at the present system and how that could be changed, or that models such as brief solution focused therapy were future orientated, but the participants did not see the past or origins of the drinking as that important. I mentioned this in my interview with Richard who was also surprised that other participants were so much in the here and now. He believed that 'if clients were scarred by the past and if they think the matters are important, then of course it should be addressed'.

What was mentioned in the interviews was the family's search for answers, particularly around why these problems were happening to them. Clients were saying in sessions that there was a social stigma for being an alcoholic family which produced shame and guilt for not resolving the problem. Most people outside of the family believed the drinker could stop if only they wanted it sufficiently and the question of 'why us', came up regularly in the family therapy sessions. This is one of the reasons why participants such as Carol, Mary and Gail all regularly used genograms. Mathew believed that when problems were not resolved they were passed down from one generation to the next, a 'handing on of the baton'. He said he had not been able to figure out exactly why that was happening, but from his experience of many years, it seemed to be the case. If one put aside the possibility of genetics or modelling by parents, the clients Mathew saw were from neglected and abused families living in impoverished and dangerous neighbourhoods and in his opinion were going to be at greater risk of substance abuse than others.

Angela saw looking too much at family history as a potential problem to encouraging change in the family. It provided a reason, perhaps alongside the disease model, for

the drinker to deny any responsibility and claim that goals such as sobriety were unrealistic. She would steer families away from their history and try to focus on that part of the system that wanted to change and encourage those ambitions.

Hope and despair were words often used in the family therapy sessions. Isobel said, 'It's an interesting one, hope, because hope is really important. You kind of wonder who does hope best in this family. Well it's always dad that's the positive one or it's always mum or the younger sister and why are they in that role and how can you help them'. When the family felt in despair, participants such as Angela became more directive encouraging them to do things to change their mood. To take part in activities, as mentioned above, or if appropriate, explore and analyse why they were feeling like that at that particular time. Isobel found it helpful to ask the family 'is it possible to have hope and hopelessness at the same time'. She would say 'I think you can have hope and hopelessness at the same time in the family and how that's balanced and how that swings and look at how we can boost up the hope to balance it a bit' Barbara sometimes used a phrase that I was impressed with, which was 'Everyone is capable of changing. This may not be the time for you. If it's not the time, don't give up on hope'.

Mathew worked regularly with the Family Drug and Alcohol Court and his clients were often evaluated by the court on issues such as custody of children. He believed that a lot of the success achieved in his interventions was because clients felt a tension between the hope they may retain custody and the jeopardy of having children taken away. He directed a lot of his attention to maintaining that tension by reminding families of what was at stake and what actions or behaviours would make

a difference. Whilst other participants such as Margaret spoke of matters progressing at a natural rate for the family, he was more directive and 'hands on' when it came to making progress.

The question 'why come to therapy now' was something participants regularly asked the families. The most common reason heard seemed to be that they had experienced a moment of crisis, such as financial or violence. That prompted the sessions, at least in the beginning, to talk about that crisis. As Carol said 'we would get families where there had been some sort of crisis such as domestic violence, sometimes someone had been admitted to hospital, had collapsed on the street or child protection and the care-coordinators were maybe helping the individual think about their own treatment but recognising that something else was happening in the system. They would be referred to us to look at the change in the system'.

Triggers and relapse prevention were mentioned as being a key part of the therapy sessions. It was important to talk about what the triggers were and create a strategy for dealing with the issue. This was often an area where the participants were quite directive, sometimes suggesting ideas or recommending literature to provide education on the subject. Colette was perhaps the most direct and pragmatic of the participants I interviewed. She spoke about a family where the parents were facilitating their daughters drinking by regularly providing money because it was upsetting for them to see her living on the streets. Colette explained her approach in the following extract from her transcript:

'I never say to anybody; you're doing that wrong. What I say to somebody is look, if that's what you need to do, to give that person money, OK that's fine because that's what you feel you need to do. However, be aware of the consequences of that, especially if they're still drinking. Or I might say you need to allow them to take some more responsibility. By not doing that then they're not understanding that there are consequences for the way they behave. I might say that but I don't say that's wrong. I don't say that. Quite often I will say look, you love your son or daughter, or whoever it is, you just don't like their behaviour. So the idea is that you want their behaviour to change. If you want somebody's behaviour to change, and I don't know if I'm right or wrong here, but this is my view, there needs to be an incentive for them to do that, to change their behaviour. If there's no incentive to change their behaviour they're not going to – why should they? Everything's hunky dory as it is. Why should they change their behaviour?'

Existential Phenomenological Approach

I mentioned above that an existential phenomenological approach aims to help the person reflect, to address issues with support, bringing the conflict into the explicit level confronting attitudes and values more adequately and destabilising sedimented beliefs (Spinelli, 1997). To do this, I believe it is helpful to address and try to make sense of the past. Timing is clearly important, too early in the therapeutic relationship and the drinker will either stop attending sessions or relapse. The right time is a matter of judgement by the drinker in discussion with the therapist.

An existential approach to therapy is not about symptom removal or cure, the problem presented is an indicator of the dilemma experienced by the client. A client

who seeks help with his excessive drinking and all the problems that ensue from that, may decide having examined both the positive and negative consequences of his choice, that he no longer wants to stop drinking. He may feel that he wants to embrace it as part of his worldview and recognising the change of attitude towards the issue, contributes positively to his wellbeing.

My personal philosophy creates the existential approach I take in my work and I normally start my thinking by understanding what it means to be a human being. For Sartre it was principally about freedom and nothingness. We are not a fixed object whose purpose was defined before it was made. We were born without essence and in the process of life, create ourselves and become what we are. Sartre's (1943) 'existence precedes essence' explains that at the core of ourselves we will always be a fundamental nothingness attempting to be, only acting as though we are set and substantial.

When a client interprets who they are, their self concept, it is not a static, fixed entity but is something always in the process of becoming, of standing out or emerging, verb-like happenings rather than noun-like things. This view enables therapists working with a drinker's family, to present a philosophy that enables them to be optimistic about forever changing, renewing and becoming (Cooper 2003). We are not trapped by our past in some unchangeable mode of existence; we can encourage them to believe that they have the freedom to change.

I believe attending Alcoholic Anonymous can be beneficial for the drinker because it provides emotional support along with practical advice. However, I am concerned

that in order to fully participate in meetings he must declare that he is an alcoholic and acknowledge that he has an incurable progressive disease which he is powerless to overcome. (Big Book, 1939). From the start therefore, the drinker falls into bad faith by denying the freedom he has to change and pretending to become the essence of an alcoholic, a societal label that has been imposed upon him. In accepting the A.A.'s culture and methods, the person is agreeing to see themselves as others see them, to live as though helpless and without personal freedom. It is reminiscent of Sartre's (1943) champion of sincerity, who professed his friend's homosexuality. The drinker stands before others who choose to see him as a kind of thing, an unfree being with a fixed essence, whose past conduct has decided his future and labelled him an alcoholic.

If the person instead recognised that his past conduct could be viewed by society as a pattern of behaviour labelled as alcoholic, but chose to believe that his life should not be defined by such a pattern, it would enable him to retain his transcendence. For a drinker this could be a different way of seeing their self and encouraging a belief that they are constantly changing. It is an opportunity to be more honest with themselves, 'it's the 'role-playing or dwelling in make believe, pretending something is the case when it is not, that creates the bad faith' (van Deurzen 1997, p.79).

Drinkers can often lead a solitary life and one of the benefits of family therapy is to try to encourage a more relational existence. In doing this an existential therapist may consider Sartre's 'look'. 'When a person is looked at by the other he ceases to be a free transcendence of the world and becomes instead an object in the world of the other'. (Cox 2008, p.125). The humiliation of being seen by his family as an object, as an alcoholic, creates a sense of shame leading to a mistaken belief that

the solution lies in distancing himself from all others. There is a need to discuss with the person his circumstances and relations, to restore a being 'in a situation ... he cannot be distinguished from his situation, for it forms him and decides his possibilities'. (Sartre 1948, p.60).

Hazel Barnes (1980) in her paper on Sartre's concept of self describes the interpretations of self. Her analysis of the self as ego details a consciousness reflecting back upon earlier acts of consciousness and imposing a unity upon those experiences, creating an essence as part of a being, a being-in-itself. In existential therapy a drinker can be encouraged to reflect on his past and hopefully change his self deception of being labelled an alcoholic, to allow his consciousness to be fluid enough to be open to seeing a different future. Adapting David Detmer's (2008) explanation, when a drinker is asked to give a phenomenological description of his past, he will speak of objects of experience, what he did and when; along with acts of consciousness, what he imagined questioned and doubted. It is only when the client shifts his attention to the reflective mode that he starts to change his self deception of being an alcoholic thing and allows his consciousness to benefit from the critical resources of reflection.

Spinelli (1997) wrote about human existence as having anxiety at its centre, living being never certain, never fully predictable, never secure. In order to deal with this anxiety and feel safe we create a way of being where we attempt to be fixed and substantial. However, a fixed self is not possible, despite our very best efforts we are faced with the fact that we are nothing at all and our efforts are in vain, 'man is a useless passion' (Sartre1943, p.615). We may be 'attracted by the durability of a

stone' (Sartre1948, p.19), but the 'self is not a thing but a creation, which is momentary and fleeting, essentially unstable. When I try to capture its image, it flees from me. Trying to catch the self is like trying to catch one's own shadow' (van Deurzen 1997, p.82)

The existential construction of a self 'proposes that the self is the product of, or that which emerges from, relational experience'. (Spinelli 1994, p.216) Whilst the self is fluid, what can become fixed are strong beliefs 'that insist on the primacy or correctness of one perspective over all others' and these are regarded as sedimented beliefs... as well as being personally derived, sedimented beliefs may also be 'socio-culturally influenced' (Spinelli 1994, p.220).

A drinker may have created from their experience, a self that contains sedimented beliefs that all he is and all he ever can be, is an alcoholic. Further, he may be told by others that the cause of this condition is an illness for which he is powerless to find a cure. This may prompt him to maintain a fixed, even secure sense of his being, but in surrendering the aspects of freedom and choice, his self-construct no longer contains the plasticity to renew or change.

'Sedimented beliefs serve to define the self-construct ... the question to be addressed is whether such beliefs 'define us too restrictively or impose unnecessary limitations on our self construct' (Spinelli, 1994 p.220). The self-construct may contain contradictory beliefs and where some are sedimented, the 'others must be disowned or dissociated ... leading to the view that it wasn't me; it was the addict inside me' (du Plock, 2005 p.72).

A consideration to explore with the drinker's family may be the difference between who a family member is and what they do. A person may spend the majority of their time drinking, yet it is important to observe that this is an activity they are able to change. It is how they choose to spend their time; it does not define who they are. There is a stigma attached to being a problem drinker which creates shame and guilt, but my perspective is that one client feeling anxiety within the world might chose to take anti-anxiety medication, a socially accepted activity, another might choose to drink and I wonder if there is really much of a difference.

Working existentially phenomenologically with clients is being with and being for them, reminding them that they are making choices and they are not a fixed unchangeable self. Through our attention and acceptance, the drinker, within the family context, can see the meanings that emerge in encounters and 'when the client can truly see the way they have constructed their way-of-being-in-the-world, they may elect to make changes to it' (du Plock 2005, p.71).

An existential approach is grounded in the understanding that addiction is meaningful and serves a function and only in the course of careful clarification of the individual's self construct can there be a sense of agency which will enable them to decide whether to continue or change their relationship to the phenomenon (du Plock, 2013).

In summary for this concept, an existential phenomenological approach helps the drinker look at his past life, his construction of self, his relations with himself and others, enables him to reflect on what emotions have brought him to this point and to

embrace the freedom to change and become the person he really wants to be. Clients can feel utterly alone in their responsibility and attempt to assign responsibility for their choices to external sources, to their culture, their upbringing or fate. An existential therapist through attendance and acceptance of the person, encountering them with a belief of the above, is able to help a person achieve a more meaningful and fulfilling future.

Summary

Participants spoke about the importance of recognising that intense emotions can be present when attempting to change drinking patterns. Often the non-drinking members of the family were unaware of the power of cravings and the difficulty in dealing with them. Several participants were keen to create better understandings in the family about recognising and dealing with issues such as cravings, triggers and relapse. There was a surprisingly lack of interest in the past and possible origins of the drinking problems, with participants choosing to talk about the present. Hope and despair were feelings often explored and some participants pressed clients to undertake activities or make some changes in their outlook. There were participant views that clients struggled to accept responsibility for their actions and that was why some of them were not in favour of the disease model or Alcoholics Anonymous that encouraged clients to view themselves as powerless over their drinking.

An existential phenomenological approach believes in the construction of self and the formation of sedimented beliefs and would normally see talking about the past and how it is viewed by the client as helpful. Although timing can be a key issue, addressing sensitive issues too early in the therapy could increase stress in the

client and lead to a relapse in the drinking. The existential approach is not about symptom removal or cure, the problems presented are aspects of what is experienced by the client. Using existential philosophy to consider how the client sees themselves in the world and how they respond to its demands, can create understandings as to why a client drinks. Talking about freedom and choice can help the client appreciate their actions and the consequences of them.

Participants were keen to talk about what was possible in the future and to help clients be optimistic. An existential approach helping clients see that their self is not static or fixed but always in the process of becoming has a similar aim. Both modalities wish to explore the client's feelings, to encourage responsibility for future actions and to create a positive outlook as to what is possible. In that sense both approaches are aiming for similar things. Where there is a difference is the directive aspects of family therapy and its view of drinking as a symptom of a problem, rather than an aspect of living.

7.7 Concept Seven – Patterns

Sculpting/Constellations – Roles – Distance - Pace - Divide the Family - Change

In family therapy what is being addressed a lot of the time is what is the system, what is good or bad about it, what changes are needed, when and how. Looking at patterns of behaviour gives the therapist insights into the system. The concept here describes ways of changing those patterns either by direct intervention or by

facilitating discussion and understanding which then leads to changes. Some of the exercises discussed could as easily be placed under the heading of models, such as sculpting, but I have chosen to consider them as addressing patterns of behaviour. They are key to the essence of family therapy work and as Richard said to me in his interview, 'I spend most of my time helping people understand their patterns of behaviour and my work is to recognise those patterns and help people change them'.

Sculpting is a therapeutic exercise examining attitudes and behaviours within the family. Normally one member of the family is asked to physically place everyone else in positions symbolizing the mode of relations between them. This process reflects past events and attitudes that currently exist within the family system and will enable change to occur. Moving people around in the room can evoke strong feelings that can be explored and the therapist can direct and ask questions of the sculptor. In most occasions only the therapist and the person creating the sculpting are allowed to talk. Family sculpting gives rise to new meanings and a new picture of family relations, such as could not be produced by mere verbal expression (Kantor and Duhl, 1973). Sculpting can also be practised by the use of inanimate objects. Gail for example would sometimes ask the drinker to metaphorically place a bottle of alcohol according to how close he felt to it. A family member was then asked to place the bottle in a position they thought would be chosen by the drinker. She commented that in one family session the drinker had placed the bottle on his lap and his wife had placed it outside of arms reach. This enabled her to facilitate a discussion about how important alcohol was for the husband and how his wife had not understood that.

Mary spoke of using sculpting when there 'appeared to be issues of closeness and distance' and Gail commented that 'adolescents often make good sculptors as they are provided with a chance to nonverbally communicate thoughts and feelings about the family'. Gail said she used sculpting when family matters were particularly complicated or there was an issue that was so emotional it was difficult for the family to talk about. I understand from participants that sculpting is sometimes referred to as family constellation work, although I am unaware that it differs in design and principle to any great extent.

Mary gave a good example of how sculpting lead to changes in a family she worked with and below is an extract from her transcript:

'So, they're an Italian family so they're quite matriarchal anyway and the son really struggled to get a voice but the mum and the partner are separated in the house, so both mum and daughter sleep in the lounge together. So she's on about wanting to strengthen the bonds with her son but it's a bit like well "your whole life is in the lounge with your daughter and your son comes in and out and he's feeling really". So I did the sculpting then so she could physically see how close or how distant he feels with the family. Initially she started saying, well actually then maybe Kevin (her partner) should move out. But we just then spoke about how to show closeness and it was about – and practically it was about getting the daughter's bedroom done up so that she could actually go into her bedroom, because they'd been halfway through painting and decorating her room for the last two years. Just making her see small changes to make an improvement'.

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Role play is a common feature of training and can be used effectively within a family therapy session. Gail spoke about using role play when a change occurred within the family system and she gave the following example:

'I do a lot of role play for example a recent family, we talked about the last craving that he had and then talked to his partner about craving and we would kind of coach the partner on how to respond. So it was very practical really. They came away from it feeling that it had been a really good experience and they'd been heard for the first time and they felt more confident in dealing with the relapse, or a lapse should it happen'.

I think one of the disadvantages of individual therapy is that the therapist can only imagine what happens back at home and some of the good work achieved in the therapy room can be undone by family interaction at a later date. In contrast in family therapy and using role play, the therapist can test out assumptions and experiment with changes to the system. If something positive happens within the session, then role play can be used to enhance its effects and embed it into the system before the family leave. What struck me from Gail's extract above was the use of coaching in the role play to embed the change. As she said, it's a practical way of showing someone how they can deal with a difficult situation and give them confidence to tackle it when needed.

Angela spoke about using role play when there was an impasse. What can the family do when they are stuck in repeating patterns of behaviours. She would use role play to show them some ways to resolve issues or create change and coach them on their performance.

Isobel regularly talked about relational distance with her family clients, establishing within a typical family group, who was close to whom and for how long had that been the case. She believed that as families were formed and grew there was pressure because of changing alliances. Did the parents feel as close to each other now children were in the family, what happened as children grew up, was there sibling rivalry and were sides formed? It seemed natural for Isobel that there would be changes over the years and difficulties at times. At a time of pressure did one or more family members resort to their coping mechanism of alcohol and if so, could that pressure be reduced by better understanding of what was happening. These relational issues could be explored through narrative but also exercises such as role play or sculpting. Where young children were part of the system, then interventions could be taken from child therapy such as toys, drawings and modelling.

Isobel also talked about roles needing to change as the work progressed with a family. She spoke about one situation as an example, where the wife's relapse had been brought about by the husband's putting wine in the evening meal. The following is an extract from Isobel's transcript:

She was feeling terrible and I was thinking "well why did you make a meal", because part of me was wondering really why he'd made that decision to include white wine, of all things, in a meal. So we came round and I thought "how do I do this so that it's not a blame and I'm not saying – what a stupid thing to do". Because he's been through a lot. So we looked at the roles and the change of his role – he had to stand back, rather than be that main carer and make sure she's OK and doing it. He was having to stand back and it was very difficult and we had to explore those roles. And I think that, rather than the blaming and the shaming, one way round it, rather than actually you're to blame ….,

and them actually having this going on, one way of looking at it is the change in the roles. So "I've had to do this", so the story comes out. I used to do this and I used to have to come home and I used to have to clear things up. So what takes the place of that now? Because it's a twofold thing, isn't it? Because if somebody's addicted and continue being addicted, there are people that are supporting them in that lifestyle, aren't they? So that they've had those roles and they're unwittingly supporting it sometimes, so it's looking at what those roles were and now how they have to change those roles.

The pace of change is an important aspect of the work with the family. If the family seemed to be struggling and not achieving very much, then it was perhaps a time to suggest something different and/or a change in the way the therapist was interacting with the family. Patience was stressed though by several participants as a skill much needed in the work and it was a matter of judgment on whether to force any changes. Occasionally the pace could be too quick and learning points overlooked and matters not fully resolved before new issues were tackled. Perhaps differing from an existential approach, nearly all participants viewed pace as their responsibility to control and would not hesitate to step in and make changes if they felt they were needed.

David spoke about regularly dividing the family up. He suggested separating certain people out into individual or group activities or using role play in the room or additional rooms. He believed it was beneficial to break up the system and then bring it back together to see whether any useful insights had been gained.

Existential Phenomenological Approach

An alternative to looking at behaviours and the impact they have on others, is to consider what emotions are driving those actions in the first place. An existential therapy session is not just a matter of encouraging clients to express their feelings, 'each emotion indicates something significant about the way in which you are conducting your life. It is meaningful and the meaning can be understood' (van Deurzen 1988, p.146). The aim is to help clients to understand the messages of their emotions so that they can enjoy or control them, whatever is most appropriate. Often clients are overwhelmed by what they are feeling and cannot make any sense of what is happening and in those circumstances; the therapist's job is to provide them with lucid guidelines on how to engage constructively with those emotions. In general, human emotions can be seen as a person's attempt to manipulate reality by magically changing it (Sartre, 1939).

'There are four kinds of emotions: (van Deurzen 1988, p.150).

- Those that relate to us feeling in possession of a value that is threatened

- Those that relate to us feeling we are losing a value

- Those that relate to us aspiring to a value

- Those that relate to us gaining and achieving a value'

Figure 4. Four Kinds of Emotions.
(as per van Deurzen, 1988).
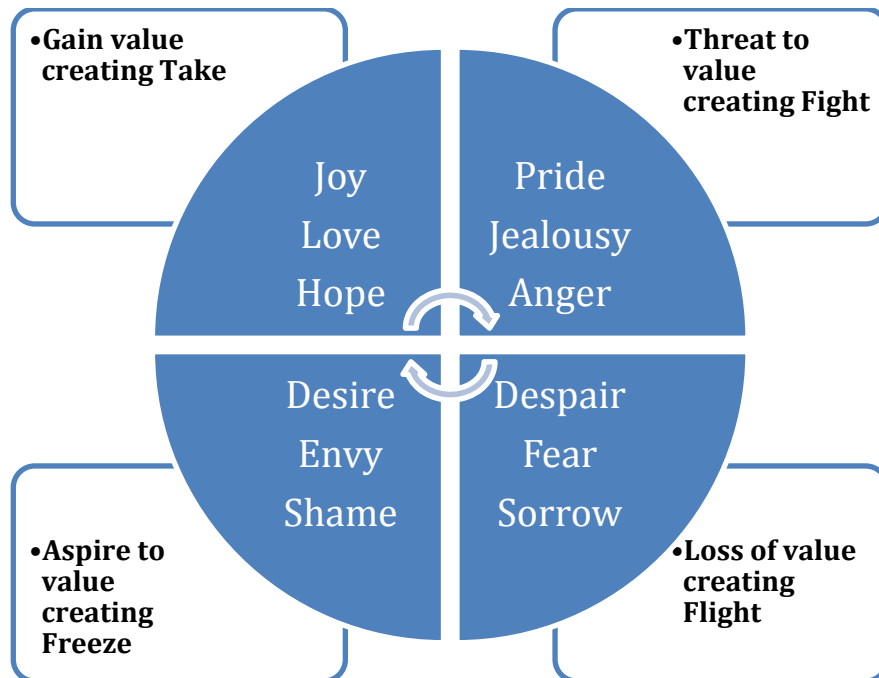
In approaching a family therapy session using the above principles, it is possible to look at the initiating emotions behind what is displayed in the room. Pride is when a client still feels in control of his value but is perhaps too keen to show it off. Jealousy shows the person feels that their value is under threat and anger is an attempt to hold onto it or get it back. Despair is present when the client has given up on their value, fear and sorrow the reaction to getting away from the threat and realizing it has been lost.

When a client has lost their value and starts to want new ones, shame is initially felt as he feels incapable of achieving anything of worth. Then envy occurs as he sees others get what he wants, but eventually desire starts to be felt again. As the client

regains hope he starts to feel love as he commits to this value and joy as he finally feels merged with it.

The language used by most of the participants suggested than when they were making changes to the family system, they were often quite directive and shared their analysis with the family. Existentially the role of the therapist is to help to unravel the emotional experiences but for the clients to learn to interpret the emotions for themselves. Dramatic disclosures of what emotions are really occurring could lead to conflict with clients and at best, will make clients feel more dependent on the therapist. The existential therapist's approach 'is a way of gently prodding the client into active reflection, never allowing her to get away with lazy thinking or lying, but always reminding her of how she herself can unveil the ideas and essential intentions that are hidden behind the apparent confusion of emotion on the surface' (van Deurzen 1988, p.155).

As I mentioned above, the existential therapist is normally against any form of labelling. There is no human nature that defines an individual, understanding someone is not achieved by slotting them into convenient typological boxes in the form of personality types, levels of intellect or groups of medical symptoms. When a client categorizes themselves, say as an alcoholic, an existential therapist will be curious as to how and why they have chosen to identify with that label as part of the essence of who they are and what are the implications for the person in having done that. I would encourage the client to explore the implications of seeing themselves as objects, with fixed, unchangeable ways of being in the world and how different their existence might be if that chose a different way of being.

Summary

Family therapy seeks to identify and change the system that exists within the family. In order to understand that system the behaviours of all family members are examined and patterns of behaviour are identified. The therapist can attempt to make changes through direct interventions using particular exercises or through more subtle means of facilitating discussions. One participant said that he spent most of his time helping people understand their patterns of behaviour and supporting them in making changes. Some of the more common directive activities were the use of sculpting and role play and participants conducted these in their own style adapting them to the particular circumstances of the family. Participants gave examples of where patterns had become outdated and dysfunctional because of changes such as children growing up and the roles of parents needing to be different.

An alternative to changing behaviours is to consider exploring what emotions exist that might be creating such behaviours. The existential view is that each emotion indicates something significant about the way someone conducts their life. The therapist attempts to help clients understand the messages of their emotions and may refer as an aid to the four kinds of emotion model. There is clearly a link between emotions experienced and behaviours enacted and both modalities address both. The difference is that family therapy starts with the system and behaviours whilst an existential approach begins with looking at emotions. The larger difference is concerning analysis and assuming an expert role. A family therapist seeks to analyse the family behaviours and will often express an expert view on what she believes is happening and why. An existential therapist will avoid any form of

labelling and categorization, instead gently prodding the client into self-reflection and supporting them in trying to unravel an emotional experience.

7.8 Concept Eight – Boundaries

Risk Assessments – Adapting to the Room – Procedures – Treatment Systems - Format - Location

All of the participants spoke about the need to establish boundaries for the work they were doing with families. Some issues were common with other therapeutic work with drinking problems, such as high levels of non-attendance or arriving at sessions under the influence of alcohol. How participants dealt with these issues depended on the context of their situation. Some such as Mary, Linda and Gail were required to follow procedures laid down in manuals that were prescriptive as to the appropriate actions. This included counting missed sessions and turning people away if they were drunk, although some individual discretion was possible. Others such as David and Mathew took decisions that were influenced by their past experience and/or training. I could not find any particular differences comparing these practices against those followed in individual therapy. Each person seemed to address these issues as best they could in the circumstances.

Angela spoke about the need in the first session to establish engagement with the family, to make it a positive experience and to start creating mutual trust. She would particularly ask questions around why they were seeking help now and try to find out whether they were 'ready for therapy'.

What perhaps distinguished family therapy from other initiatives, by virtue of the family being seen, was the opportunity to recognise any tensions or strains in the family that could have serious consequences. Where children were part of the family group there could be concerns about safeguarding issues, or there might have been domestic violence. In such instances additional care needed to be considered. Where participants worked in institutions such as the NHS, formal risk assessment procedures were followed.

Whilst it was rare that such facilities were needed, I was struck by the fact that few participants had access to things like panic buttons or available help nearby. Linda, Mary and Gail worked in a functional family therapy team that visited families in their own homes. Whilst I would not want to suggest that drinking problems and violence are necessarily linked, it is not uncommon for the two issues to exist together and I was surprised that greater emphasis was not placed on the risk factors of therapists in certain situations.

Angela spoke about the need to adapt to the people in the room. For example, she spoke and behaved differently when young children were in the family group in order that they did not feel excluded from any of the process. If someone was missing from the normal session, she took particular care to ask others how that person might respond had they been there and how they could feed back their discussions to him/her. Working with a family for Angela meant trying to sense all the different emotions, strains and moods that existed at one time and to put that into the context of the system that was being analysed.

As I mentioned above, Linda, Mary and Gail had manuals that detailed procedures to be followed in their work and they were appraised by their managers as to how well they performed the tasks laid down. Whilst perhaps having a good intention, to guide and support therapists, on the whole there was a negative reaction from those participants. When I asked Mary why she did not follow a more systemic approach with families she cited the manual as the reason and said,

'I think partly they're trying to make the service really cheap, saying they don't need systemically trained therapists because if you are working from a manual sometimes you get adherence to a manual if you're not trained. If you haven't got that much experience ... you don't do an assessment or ask questions and so you kind of lose that curiosity. I am really worried that I am going to lose that curiosity because you are kind of going in and making statements and it's like you're sharing your hypothesis with the family, but the way they trained us, I was quite shocked at some of the statements that came out'.

In talking to these three participants, I was left concerned about the adoption of an American written manual that may not be ideally suited in culture or tone to a UK audience. Whilst it was perhaps not overly surprising that initiatives were being changed to be compatible with current cost constraints within the NHS, I was disappointed that such important work was possibly being compromised by the reduction in the required training and qualifications of family therapists. Later in the interview, Mary gave another example of the effect of working to stages prescribed in the manual and the conflict between her wishes as a therapist and the procedures laid down.

'But while you're in the three phases of the engagement, motivation, behavioural change stage, which is looking at changing things so they fit a bit better at home or at school or in the community. And then you've got the generalisation stage and that's when you're then seeing about individual support. It's quite hard to fit it in. Because they're really wanting you to adhere to the model and there are measures on that as a therapist as well, which are on-line computer systems for everyone to see, which highlights the colours of how well you are adhering. It's very public. It's quite hard to deviate from the model but often I'll be like "I really want to do this or do that", but you can't'.

In contrast, Angela and Barbara who also worked in the NHS, were left largely to their own initiatives when working with clients and did not have such limitations.

Most of the NHS participants could only offer a certain number of sessions and had policies on counting missed appointments, whilst those in private practice were able to offer open ended contracts and be more flexible about terms. David reminisced about his early days in the 1980s in the NHS, when funding was more readily available and they were given more freedom to do the work in the manner they thought best.

I was not surprised that when I asked participants about a typical format of a meeting, all of them said there was no such thing as a typical meeting and that they aimed to be as flexible as possible seeking to help the family in whatever way seemed best. Barbara spoke about finding what worked and then saying to the family, 'let's have more of the same'. Angela spoke about being directive in moving the family away from unhelpful matters such as the 'blame game' and would say things like, 'let's shine another light on the situation' or 'have we done these stories now, can we

move on' or 'this has been around for a while, can we talk about something that hasn't been heard before'.

Working in private practice, one of the differences that struck me when I conducted the interviews was that the NHS participants talked about care packages and key workers and that for them, their work was regarded as part of a greater group of initiatives. Whilst others recognised some of the family might attend e.g. A.A. or individual/group meetings, there was no-one responsible for pulling all of the initiatives together apart from themselves. From a personal perspective, the research on this point left me considering whether I should make greater efforts in my private practice to reach out to clients' A.A. sponsors or agency key workers, subject of course to my client's wishes.

In my meeting with Richard, one of the points we discussed at length was the question of appropriate location for the therapy. His past role in the NHS required him to see people in a hospital consulting room which he acknowledged as being financially and logistically efficient, but he believed incorrect. The work he was currently leading in India was delivered in people's houses and discussions could be held much more within the context of the matters being talked about. We spoke initially about seeing individuals rather than a family and he said to me,

'if you see just the individual and you bring them into the hospital then that immediately isolates the rest of the family. It might support the person and perhaps validate their feelings but there are multiple views of a situation and if family members feel they are not involved then even if it is unconsciously, they may sabotage the work'.

In talking to me about seeing a family in their own homes, Richard said,

'We have known about this for a long time. As far back as the 1980s in the USA there was discussion about the effects of a hospital environment on patients. Or when drinkers go into rehabilitation facilities, they receive a lot of attention and good food and group work and I have always thought it was amazing when they didn't go back out and start drinking again, because it was all done out of context. When you take someone out of the stresses and strains of their normal lives, of course it will get better, but how successful will it be when they go back'.

When I asked Richard about the work of certain participants (Mary, Linda and Gail) as members of a functional family therapy team who saw clients in their own homes, he said,

'It makes so much more sense to see people in the context of how they live. Some therapists are so preoccupied with the individualistic medical approach for so many problems; they can't see the sense of doing it differently. Seeing families in their homes is harder work. There might be risk issues and its resource intensive because you can't see as many people in a day, but so many professionals think they should be at the heart of the issue. I think the problem should be at the heart of the issue. We could compare it for example to a broken leg. The patient comes into the hospital, where the resources are, to have it set but if further treatment is needed such as changing dressings, then the district nurse visits them at home, we don't drag them in every day to do that. We help them where it makes the most sense'.

Richard was of the view that family therapy would be best delivered with the family in their own homes. It is more likely to create the relationship that is fundamental for the

success of the work as it is in their territory and so minimises some of the issues around power and control that families could feel in other locations. The feedback I received from Mary, Linda and Gail as to the success of visiting families in their homes, was largely positive, although there were practical problems at times. My training, supervision and experience at clinical placements, never suggested seeing clients at their homes and I do believe it is something worthy of further consideration.

Existential Phenomenological Approach

In practising existential therapy, 'Any intervention must be consistent with the principles of phenomenology in that they acknowledge the client's fundamental autonomy' (van Deurzen and Adams 2011, p.62). Although there should be some degree of flexibility, there are practical and ethical reasons why boundaries need to be established with clients. In my private practice I aim to be clear with clients about boundaries in a respectful manner and to balance firmness with flexibility. I hope that by being consistent in the boundaries, clients find the relationship freeing rather than restricting and the matter of boundaries is always open for discussion.

The context of the therapy has a huge impact on the work being undertaken, issues such as what motivated the clients to come to the initial session, whether any payment is being made, what issues are being discussed and the duration of the work. Ignoring such factors would be equivalent to ignoring the influence a therapist has over the session. All of the participants spoke about being responsive to the particular needs of the family they were seeing. However, some gave me the clear impression they had a format for conducting their work and unless something very unusual occurred, they would adhere to their modus operandi. I had concerns about requiring therapists to work to a manual given that it cannot cover every eventuality

and yet restricts the discretion of the therapist to adapt the prescribed procedures to the context of the situation.

I have commented above about my interest in an appropriate location for the family therapy. 'Existential philosophy places us firmly in-the-world rather than separate from it, and so existential therapists would readily agree that the therapeutic space is a part of the therapeutic relationship and as such should be considered carefully. However, there are no specific environmental conditions proposed by the philosophical tenets of existential literature ... although therapy most often takes place in a room selected by the therapist, there is nothing in existential thinking that prevents it occurring in different circumstances, e.g. in a room owned and maintained by the client' (Iacovou and Weixel-Dixon 2015, p.83). This is provided the encounter takes place in a space where the client's personal thoughts, narrations and feelings can be described, clarified and understood.

'The spatial and temporal setting for existential psychotherapy remains an open possibility bounded only be the combination of the therapist's and the client's belief-based assumptions and their consequent conditions, as well as any such boundaries as might be expected by professional bodies' (Spinelli 2007, p.94).

As an existential therapist, one of the differences I noticed when talking to the participants about what they prompted clients to talk about, was that it is important to consider examining the paradoxes, polarities and tensions of existence. Paradoxes are those assertions by clients that seem to be self-contradictory but are felt to be true or mostly true. By encouraging clients to consider these areas and make what

was implicit become explicit, there is an uncovering of the real truth. There are benefits on taking a stance on existential polarities such as acceptance and rejection, apathy and concern, balance and extremes, body and mind, conventionality and uniqueness, reason and intuition, solitude and sociability and trust and suspicion (Wahl, 2003).

'Existential tensions reflect challenges we face in tolerating the polarities and paradoxes inherent in existence in areas such as life and death, truth and non-truth, freedom and non-freedom, being and non-being' (Iacovou and Weixel-Dixon 2015, p.145).

Summary

All therapeutic meetings need to have boundaries and it is ethical to make clients clear about what they are at the very beginning of the relationship. The participants spoke about particular issues in relation to either drinking matters or seeing a family. Therapists working with clients who have alcohol problems often experience missed appointments because of the chaotic lifestyle drinkers lead. They can also experience clients attending under the influence of alcohol. In both cases there is a need to be clear on what actions need to happen not only to assist the client in their therapy, but also to maintain the professional relationship and safety of the therapist. Some participants were required to follow procedures laid down in a manual which had the advantage of being thorough, but perhaps lacking in flexibility. One participant spoke about trying to avoid these types of problems by having a good engagement with clients and trying to make meetings a positive experience. Another participant spoke about adapting the work to who was present in the room accounting for people not there and recognising the strong emotions that could be

brought to the surface. There were notable differences between participants depending on the context of their work, those in the NHS spoke of care packages and treatment programmes where other professionals could be involved, whilst those in private practice were largely dealing with matters on their own. I was very interested in the practice of seeing families in their own home which seemed to have benefits, but could also raise concerns over boundaries.

I do not believe there is a fundamental difference between family and existential therapy as regards these principles. Both recognize the client's fundamental autonomy but for practical and ethical reasons some boundaries need to be established. I was concerned about the use of manuals where participants felt they were unable to be as flexible as they wanted to be.

8. Recommendations for a Model

As shown in my interview guide in appendix 6, towards the end of every participant interview, I asked for their recommendations as to the elements of a family therapy model to address alcohol abuse. Some participants referred me back to the hour we had been talking because there are just so many things to consider, some added one/two last minute thoughts. What I have listed below is not a summary of all that was discussed and should not be viewed as such, but they are useful as last minute thoughts and they help to check that I have collected as much as I was able. I have referred in brackets to the relevant section in my study findings above where further details can be found on the recommendation named.

Flexibility – not to get caught up into any particular way of working, try to do whatever works for the family (training in concept 2, adapting to the room and format in concept 8).

Boundaries – create the boundaries for your work including what you will not work with, e.g. domestic violence (experience in concept 2, concept 8).

Communal – work with the whole family even if they are all not present at the time and not focus solely on the drinker (roles in concept 7).

External resources/Additional support – consider other initiatives such as individual/group/peer support and Alcoholics Anonymous (SBNT in concept 1, group/individual sessions and websites in concept 3).

Acceptance of the family – not judging, evaluating, believing what is said (training and experience in concept 2, concept 5).

Neutrality/Recognise all of the emotions in the room – carry all of the different views at the same time (concept 4).

Communication and Motivation – help them to hear each other better, avoid repeating old patterns and motivated to change (MI in concept 1, feelings in concept 6).

Responsibility – guide them to accept responsibility for their actions overcoming if necessary their guilt and shame (concept 5, roles and distance in concept 7).

Change – they are there to change, identify what, how and when that can be done (stages of change model in concept 1, concept 7).

Engagement– try hard to create engagement with them in the first session or else they may not return (concept 5, concept 8).

Appropriate Model – one that fits with the therapist and the family (5-step method in concept 1, SFBT in concept 1).

Reframing – looking all the time for positive perceptions of the situation (circular questioning in concept 1, concept 4).

Sculpting – closeness to alcohol for the drinker and his family (concept 7).

Solution focused approach – the most effective way of helping the family (concept 1).

Cravings – educate the family if needed on the effect of cravings and what to do to help (concept 6).

Reflection – reflection during the session and afterwards (drink diary in concept 1, scaling questions in concept 1, reflection team in concept 4).

Genograms – the use of mapping or genograms (concept 1).

Role Play/Coaching – helping families work through difficulties (concept 7).

Challenge – do not be frightened to engage and if needed challenge them (training and experience in concept 2).

Courage – inspire clients to have the courage they need to make changes (MI in concept 1, spiritual in concept 2).

9. Existential Family Therapy Model for Alcohol Problems

As I have mentioned above, I conducted twelve participant interviews and applied constructive grounded theory methods to analyse the data I gathered. This initially produced one hundred and twenty-five provisional categories and through theoretical sorting I was able to reduce the data down to fifty-seven categories and then eight concepts. I have shown the model below in three diagrams. The first is figure 5 which contains the participant information from the eight concepts. The second is figure 6 which is the existential phenomenological model of the eight concepts and finally figure 7 is a merging of both the previous figures.

The title of my research is 'Towards an Existential Phenomenological Family Therapy Model of Working with Issues of Alcohol Abuse: A Grounded Theory Study'. The word 'towards' is an important part of that title. I was not sure whether I could produce a completed model given the complexity and volume of information of family therapy, existential phenomenological therapy and alcohol problems. I am confident that I have been thorough and accurately presented the information given to me by my participants. I have tried hard to express an existential phenomenological perspective to suggest in addition to participant data. I hope the models below

contain a simple but not simplistic version of my research. I am sure I could have done more if I had further time and resources at my disposal, but a project of this type I do not think can ever be truly completed. I intend to develop some of my ideas further in the years ahead and I would be delighted if someone else considers building upon the concepts I have written about.

By showing the model in three parts, I am hoping that other therapists can select whatever information best suits them. If they are interested primarily in a family therapy approach and want to gain insights into the issues raised and possible interventions when there are alcohol problems present, then figure 5 will be the most appropriate. If someone wishes to gain information on an existential phenomenological approach in such a context, then figure 6 would hopefully be helpful. Figure 7 combines the two approaches to show how someone might work existentially phenomenologically, whilst taking advantage of family therapy principles. I believe I have created something which is 'towards' a model, but is capable of being refined and expanded upon. If it helps a therapist and his/her clients, then it would have been a very worthwhile exercise.

Figure 5. Existential Family Therapy Model – Alcohol Problems
(Participant Data)

SBNT – Motivational Interviewing – Drink Diary – Mapping – Genograms
5-step Method – Cycle of Change – Circular Questioning – Activities Scaling –
Solution Focused – Relational Cycles

Models

Boundaries

Training

Risk Assessments
Adapting to the Room
Procedures - Treatment Systems
Format - Location

Experience – Supervision – Education
– Spiritual - Reflection

Patterns

Existential
Family Therapy
– Alcohol
Problems

Support

Sculpting/Constellations
Roles - Distance – Pace
Divide the Family - Change

Resources – Group –
Individual – Websites -
Interests

Feelings

Perspective

Cravings
The Past/Origins of the Problem
Why Me? – Hope & Despair
Hope & Jeopardy
Why Now? – Triggers/Relapses

Truth

Neutrality – Reflection Team
Reframing - Focus - Labelling

Trust – Communication – Confidentiality
Blame & Stigma

Figure 6. Existential Family Therapy Model – Alcohol Problems
(Existential Phenomenological Perspective)

Existential Phenomenological Principles
Four Dimensions of Existence
Relationships

Models

Context of the Therapy
Location

Boundaries

Training

Being not Doing

Four Kinds of Emotions
Model

Patterns

Existential
Family Therapy
– Alcohol
Problems

Support

Meaning of Behaviours,
Way of Being

Essence, Freedom, Self, Bad
Faith, Meaning, Sedimented
Beliefs

Feelings

Perspective

Phenomenological Enquiry

Truth
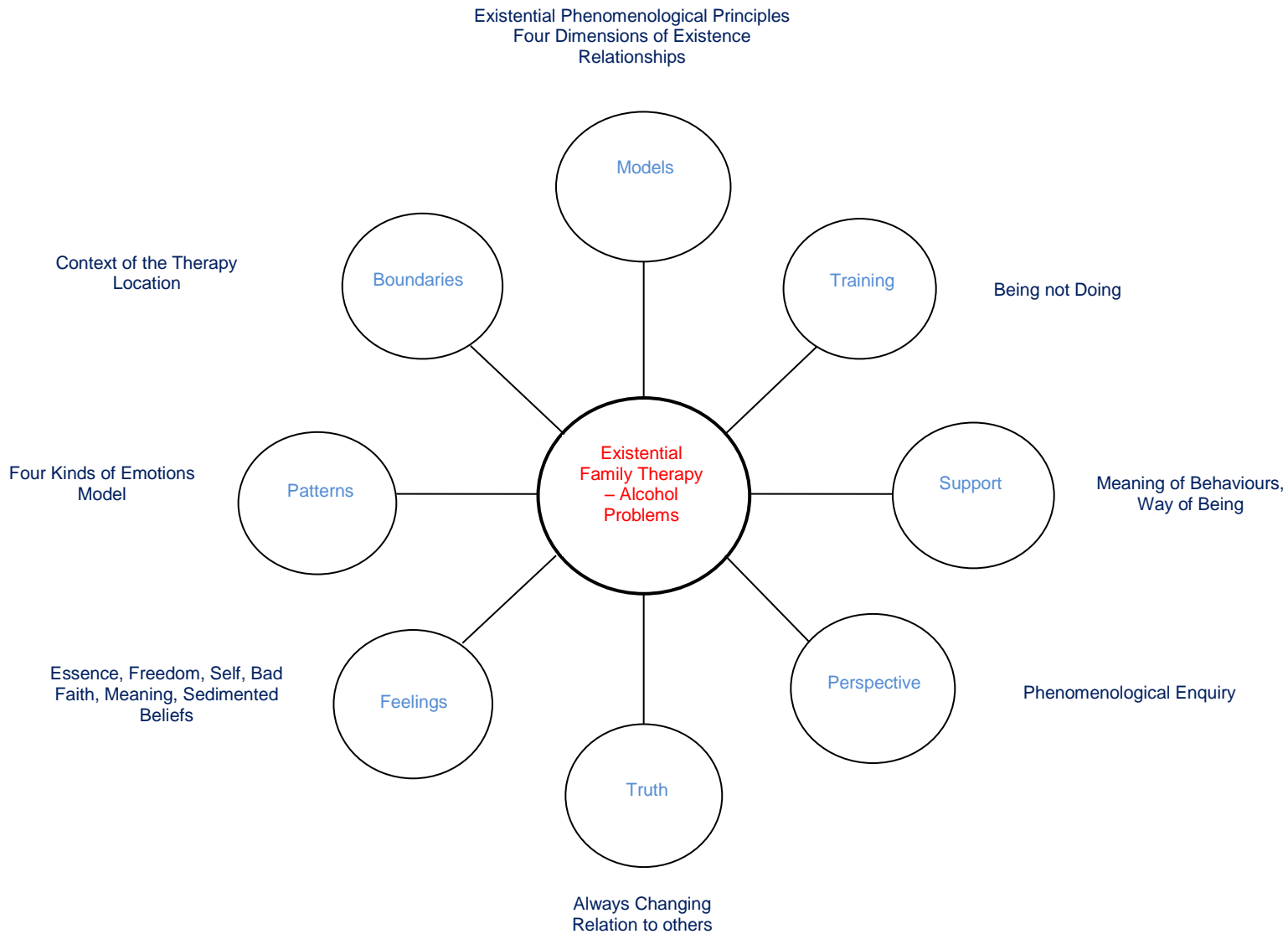
Always Changing
Relation to others

Figure 7. Existential Family Therapy Model – Alcohol Problems
(Integrated Version)

SBNT – Motivational Interviewing – Drink Diary – Mapping – Genograms
5-step Method – Cycle of Change – Circular Questioning – Activities Scaling –
Solution Focused – Relational Cycles
Existential Phenomenological Principles, Four Dimensions of Existence,
Relationships

Models
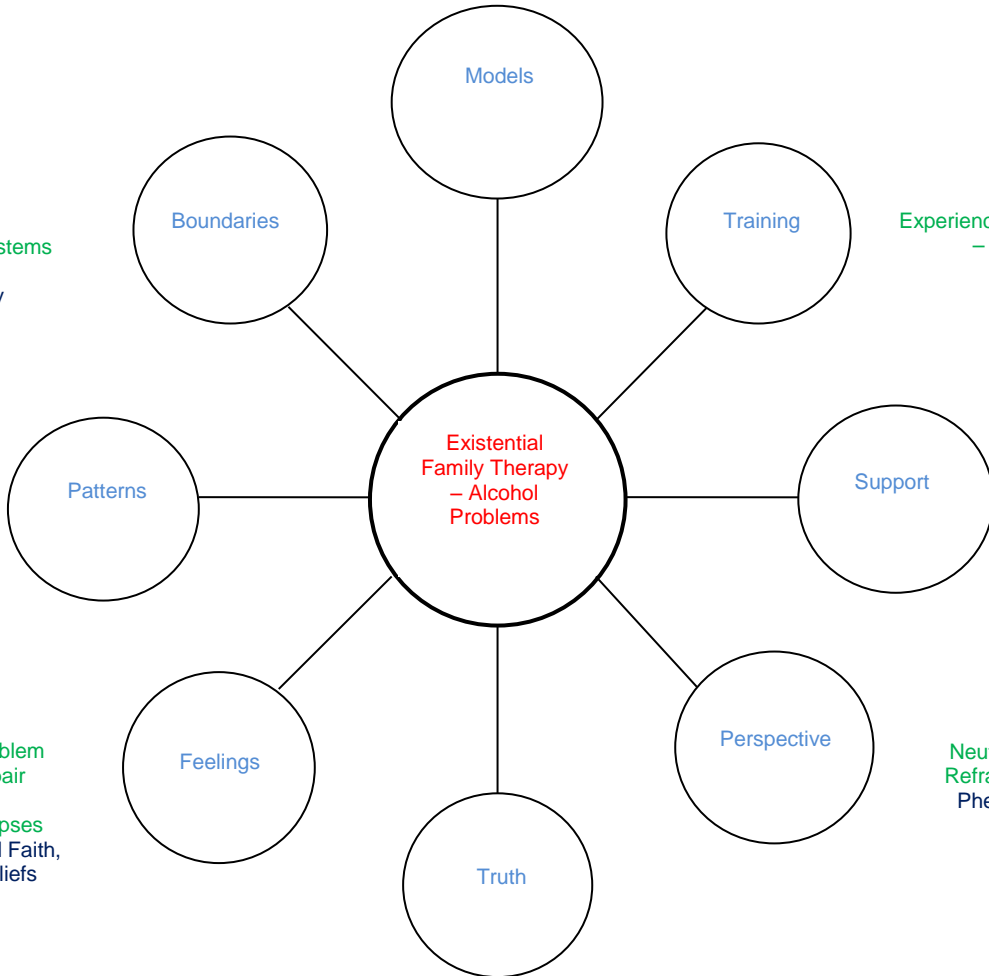
Risk Assessments
Adapting to the Room
Procedures - Treatment Systems
Format – Location
Context of the Therapy
Location

Boundaries

Training

Experience – Supervision – Education
– Spiritual – Reflection
Being not Doing

Sculpting/Constellations
Roles - Distance – Pace
Divide the Family – Change
Four Kinds of Emotions
Model

Patterns

Existential Family Therapy – Alcohol Problems

Support

Resources – Group –
Individual – Websites –
Interests
Meaning of Behaviours
Way of Being

Cravings
The Past/Origins of the Problem
Why Me? – Hope & Despair
Hope & Jeopardy
Why Now? – Triggers/Relapses
Essence, Freedom, Self, Bad Faith,
Meanings, Sedimented Beliefs

Feelings

Perspective

Neutrality – Reflection Team
Reframing - Focus – Labelling
Phenomenological Enquiry

Truth

Trust – Communication – Confidentiality
Blame & Stigma
Always Changing
Relation to Others

10. Psychotherapy Contributions

My aim in this research was to create a family therapy model that was existential phenomenological and assisted those with drinking problems to improve their wellbeing through family relationships. There is no recognised existential phenomenological family therapy and my aim was not to strive for something that achieved approval from both modalities.

I have produced a model that is displayed in three formats; a summary of family therapy when there are issues of alcohol problems, an existential phenomenological approach to that situation and an integrated version. It is a model that is based on sound research from talking to experienced family therapists about what is successful in helping problem drinkers and their families. In the absence of existential family therapists, I have put forward my own views based on research in the literature, my existential phenomenological therapy training and experience as a psychotherapist.

I do not want my model to be viewed as prescriptive or one of simplification with steps to an idealised solution. I have chosen a type of spider diagram so that concepts can be viewed independently or part of a connecting picture, so that therapists can choose whatever best suits them and their clients. I would encourage therapists to explore, try something new and create what they feel is best in the circumstances. I see my model as fluid, changing and developing as I communicate it to therapists. I am hoping it will create discussion and feedback so it can evolve into something that is as helpful as it can be.

I want to encourage therapists to think wider than their chosen approach, to work with families, to consider alternative ways of helping clients and to provoke thought and reflection. I have met therapists who are averse to working with problem drinkers. I would urge them to think again about that choice and consider whether that is a bias they wish to maintain and to encourage them to see drinkers as fellow human beings in pain.

I envisage the model being useful to therapists who are interested but lack the knowledge and/or confidence to address either alcohol problems, family therapy or an existential phenomenological approach. The model can be used to find a suitable starting point, a place to begin reading and reflection leading to trying something new. That journey might involve discussions with supervisors, training courses, discussions with peers, debates in social media forums or whatever seems appropriate to the therapist. I am aiming to encourage these thoughts and actions but not dictate in any way what the therapist should choose. By finding a way forward I am hoping that will create sufficient confidence for the therapist to try new ways which can be further developed. To aid my intentions I have suggested the following three scenarios:

A client hints at some drinking problems but they remain in the background and undiscussed because the client feels shame and embarrassment about his behaviours and the therapist is reluctant to explore something she lacks confidence in dealing with. They fall into a collusion about not bringing the drinking issues into the open and restrict the therapeutic work. The therapist is aware of the problem but thinks she lacks the skills and understanding necessary to deal with drinking

problems. She may try some reading about working with alcohol problems but sees the subject matter as vast and complex and feels overwhelmed by it. I have attempted to write a literature review that is comprehensive within the boundaries of my research and yet straightforward in its presentation. It addresses the main themes of addiction as well as focusing on drinking problems. The therapist in this scenario is able to get an introduction to the key principles by reading the literature review section of the thesis. She can then proceed to look at the models and how the research participants described working with their clients. Although the models describe a family therapy setting, most of the techniques described could also be applied in an individual or couple therapy session. Having achieved some understanding from the literature review and models, there is then the opportunity for further reading by referring to the bibliography.

Another scenario could be; a therapist working with a problem drinker becomes aware of the impact of the family on the client's feelings and behaviour. The client is attempting to remain abstinent but finds he relapses regularly because he turns to drinking as a means to deal with the stress he feels when at home. Being with his family is regularly a time of argument and upset. The client feels to blame for this because the arguments are often around his drinking habits and associated lifestyle. The progress in the therapy room is being undermined by the family relationships, but the therapist is not familiar with family therapy and is reluctant to consider that approach. My model shows concepts identified by the research participants experienced in family therapy. By looking at the model the therapist is able to consider what concept or concepts might be the most appropriate for his client and the family. By then reading through the concepts the therapist is able get a sense of

what actions could be considered and if undertaken, what positives could be achieved. The literature review and bibliography provides sources for further information and the therapist can hopefully consider offering to see the family.

A further scenario could be, a therapist working with a family that has problems because of alcohol use, but the sessions are not making the progress the therapist would normally expect. The concepts could provide additional ideas that might not have been considered and reading through the participant's experiences could provide a source of inspiration. The concepts also provide an existential phenomenological approach that might be new to the therapist. By being with the family accepting each and every worldview, examining the paradoxes, polarities and tensions of life and working with the four dimensions of existence, a different form of relationship could be established. The model shows the existential phenomenological ideas in a simple format and can be understood by reading the relevant sections of the thesis and the books listed in the bibliography.

10.1 Communicating My Research

My aim is to distribute my research as widely as possible and I have considered ways that would best suit my target audience and attempted to balance my enthusiasm for my project, with a realistic appreciation of the amount of information that is offered on a regular basis.

10.2 Presentations

I use the word presentations to include any workshops, seminars, conferences, formal and informal meetings where I can present my research visually as well as giving an oral description. I think it unlikely that interest will be sufficient for me to consider arranging any sort of public organised event, but I can offer to present my findings as part of a regular meeting programme with a society, institute or other similar organisation.

My research includes ways of working with clients that are existential phenomenological, family therapy and counselling for alcohol problems. I intend to initially approach those organisations that have one or more of those interests as part of their remit. I am a member of the Society for Existential Analysis, BACP, UKCP and Society for the Study of Addiction. It might also be possible within organisations such as those to create a special interest group and provide an opportunity to present my findings and create discussions on my research.

10.3 Journals

I intend to offer a written contribution to publications such as the SEA Journal, The Hermeneutic Circular Newsletter, BACP magazine (Therapy Today), UKCP magazine (The Psychotherapist), BPS Psychologist and the Research Digest.

10.4 Social Media

Social media gives me an opportunity to post my research and allows me to add my views to future posts by others. There are multiple platforms and some of these are listed below.

I am a member of thirteen groups on LinkedIn who have daily debates on family therapy, addiction and related topics. I have in the past posted notices in these forums and drawn an interest from therapists in the UK and overseas. I intend to offer a brief summary of my research, enter into discussions on this platform with other professionals and be prepared to email my thesis to any interested parties.

I am active on Twitter and intend to tweet links to my own website or a blog where a summary of my research can be read and if appropriate, further information sought, as well as links to similar research. I also intent to socially share the work of other professionals to allow myself and others to engage, debate and grow the subject area online.

I have a Facebook page for personal use but I intend to create a professional site to enable postings about my research.

Google + is a platform that I do not currently have a presence on, but if interest in my research grows online, the features such as segregated circles of acquaintances, where I am able to allocate followers to certain groups and post specific tailored

content to each depending on population and group hangout, with video chat function, may prove to be a very useful to converse with a wide audience.

I have regularly used Skype and appreciate its merits. In some cases, sensitive material may best be discussed face-to-face using that facility.

I intend to create my own YouTube channel and would be happy to film and upload an initial vlog –a short video discussing my research - in order to gauge reaction. In itself, this vlog would not promote my research but could be used as a point of reference to refer interested parties from Twitter, Facebook or LinkedIn.

11. Strengths and Limitations of the Research

I mentioned above that I regard myself as a novice researcher and as such, feel somewhat reluctant to evaluate my research. I have been diligent in my research methods sticking as closely as I was able to the principles of constructivist grounded theory. I believe I have produced a sound review of family therapy principles when working with alcohol problems. I have worked hard at presenting an existential phenomenological approach, but openly acknowledging that this is my view at the time of writing. Another existential practioner may have a different perspective and I might have different thoughts and feelings in the future.

With the benefit of hindsight and applying a critical eye to what I have produced, I wonder what might have emerged if I had chosen to interview fewer family therapists and instead seen a small number of existential practitioners? I imagine the data on

family therapy would have been less and I would not have been able to produce as many categories and concepts. What might have emerged from a small sample of existential therapists is unclear to me. I am reminded of Ernesto Spinelli's words, 'when considering existential therapy, it is difficult not to conclude that there are as many unique expressions of existential therapy as there are unique beings who engage and practise it'. (2015, p.12). Would I have spent many hours trying to find common ground between existential thoughts and practices and if so, how beneficial would that have been?

Although what I have presented as an existential phenomenological approach are my thoughts, they are the result of a four-year doctorate programme involving eighteen taught modules, nine terms of group supervision, over five hundred hours of clinical work and an extensive literature review. I have had the benefit of reflecting on my own existential practice as well as many hours of discussion with other therapists about our approach to the work.

If I had taken that different approach it may well have reduced the family therapy research findings with little improvement on an existential perspective and as such a less effective model for other practitioners to use. At the end of the day, it would have been a different project and I do not have the ability to go back in time and chose that different route. Others may choose something differently in the future and I would be very interested in seeing their research.

12. Reflections on My Research

I started this thesis by writing about my journey to the beginning of the project. Before stating my conclusions, I would like to comment upon the personal impact the research journey has had upon me. As might be expected with any major project, I have experienced highs and lows but I am delighted to say that the positives significantly outweigh the negatives.

At times I struggled with the amount of work required to adequately analyse the data. Having interviewed twelve participants, I had collected over one hundred and fifty thousand words and I had to summon all of my patience and determination to conduct the coding process. I had not appreciated the detail of grounded theory when I chose my methodology and my personal resources were stretched with the refining of data and formulating ideas. Had I not been engaged with other challenging activities at the same time it might have been less demanding, but during the last three years I have also completed the modular aspects and supervision requirements of the professional doctorate, volunteered over five hundred hours of clinical work and established a private practice. More recently my health has deteriorated as a result of the stresses and strains of trying to do too much and I have had to make adjustments to ensure I had adequate self-care in place. There were some frustrations in the journey, however I suspect all of those negative experiences will fade from my memory in a short while.

What will remain with me for many years is how fortunate I was to meet my research participants. Two people in particular I found inspiring in their work and I was left in

awe of what they were achieving and how dedicated they were to the profession. I have very fond memories of our discussions and I learnt a great deal from their generosity in giving me their time. I enjoyed the literature review, both the reading and writing although it was a challenge to summarize all the books and articles into a reasonable amount of words. During this time, I was volunteering my time to a local mental health charity offering counselling to people struggling with alcohol and/or drug problems. It was very satisfying to incorporate some of my research understandings into that work and to be able to have more in depth discussion with my clinical supervisors. More recently I have established a private practice specializing in seeing clients with alcohol and/or drug problems and my research has provided a strong foundation of knowledge that I can draw on when working in this capacity.

I was interested from the very beginning in an existential phenomenological approach to therapy. The professional doctorate modules have helped me understand the main principles through teaching and recommended reading. However, a result of my research activities and particularly writing the existential responses in the above concepts, has enabled me to embed those understandings into my personal values and beliefs and thereby develop me as an existential therapist. One example of that development is that when I met my final participant who had read through a draft version of this thesis, he asked me whether I was now proposing to see families in my private practice. My initial reaction was that I lacked the confidence to do that without attending a specialized training course. He challenged me on that response and having reflected upon the matter and having

spoken to my clinical supervisor, I am now offering to see families whilst reading further and planning to attend appropriate CPD workshops.

The last three years have been demanding but on the whole very enjoyable and reaching the end of this particular journey will leave a sizeable gap in my life.

13. Conclusions

As I mentioned above, it was not practically possible to recruit family therapists who had experience of an existential approach. On the whole due to lack of time with participants I avoided talking to them about existential principles, but where they arose in discussions, I found a surprisingly lack of understanding and even interest in the subject. Given the participants were working with addiction and issues such as agency, choice, freedom and responsibility, that seemed to me to be at the heart of matters, I was surprised that participants had not read or even considered reading any existential literature. The impression I formed was that participants had created their own style from their training and the context of their work role and whilst this was understandable and I would not wish to criticise their attitude, it did feel to me that it bordered on silo thinking at times. A lack of resources and encouragement meant that continuing professional development did not seem to be a high priority and in particular, the three participants who were asked to conform to a manual was for me a worrying development. I have a strong aversion to people being labelled and treated as a set of symptoms rather than the complicated and multi levelled individuals they clearly are. Applying principles laid down in a manual without adequate recognition of the uniqueness of the family context, just seems

fundamentally wrong to me. Further, to conduct performance appraisals on how well therapists have applied the procedures contained in the manual, adds to that flawed approach.

It seems to me to be unrealistic to expect any therapist to have an in depth understanding of all of the different modalities that exist. The danger though is that we all fall into a blinkered perspective and unquestioning commitment to our own modality and make assumptions based on what might be an incomplete picture. For example, what is otherwise an interesting and informative article, Marc Medina (2010) wrote conclusions that appear to be odds with my research findings. He says 'the assumption that the family is always better together, the predetermination of what is normal and what is deviant for the family as a unit, the belief that positive change for the family will lead to an increase in well-being for all its members and the attempt to move the family from one collective truth to another provides much to question about the efficacy of this form of therapy for individual family members' (Medina 2010, p.269).

This presented a picture to me of family therapy as a rigid perspective only interested in the family as a system or structure, without any understanding or interest in family members as individuals. This is not how I found the participants I interviewed. All of them were aware of the dynamics in the room and any potential difference between individual needs and family needs. All of them considered suggesting additional initiatives such as individual or group therapy, A.A. meetings and activities, alongside the family meetings. Barbara was keen to stress to me the need to listen to all of the voices in the room and be aware of all individual needs,

the main reason she believed it was necessary to receive family therapy training in order to have the skills to do that. The assumption that family therapists always strive to keep the family together, from my research, is false. As Margaret said to me, 'So it is a sentimental vision to think we have to make a family work. That is in a box. That ties us up. Your soul is on a journey and it may be saying get out of that family box'. Or as Mary said, 'Sometimes you just have to acknowledge that what is best for everyone is that the family member has to leave and live apart from the others'.

There is no one existential approach to therapy, I believe we all develop our own style in drawing from the philosophy the insights that seem appropriate to us. For me I start with recognising that there are universals to human existence that apply to every human life. There are certain fundamental givens which are freedom, temporality, facticity, choice, death, uncertainty, isolation and relatedness, meaning and meaninglessness, guilt and anxiety. Whilst we cannot change these givens we can exercise choice in how we respond to them. As an existential therapist I aim to help my clients explore their choices and consider a full range of alternative positions.

I have commented above on family therapy and existential therapy and to try to sum up the differences in a few paragraphs feels to be minimising the importance and significance of both modalities. At its heart both approaches share a common understanding of the human condition and engage in the exploration of client's experiences. However, the existential therapist is more concerned with the 'being' qualities of the relationship as to the application of skills. 'This is more than an inter-relational analysis – it is an inter-subjective phenomenon. As a result, the quality of the situation and the relationship is co-constituted by all of those involved, as well as

by the entire world context. The existential practitioner does not aim for solutions, or treatment, but understanding: both therapist and client, it is hoped will come to a deeper if not final, appreciation of the client's worldview' (Iacovou and Weixel-Dixon 2015, p.240).

For many people life is full of suffering and pain. Using alcohol to reduce what are often unbearable feelings, does not seem to me to be any sign of weakness or mental impairment, but an understandable choice in the circumstances. For some it is a strategy that works reasonably well, for others it becomes a problem so large that it takes over their whole existence. Sadly, there will be individuals who chose not to be helped but there are others who can find a different way of being in the world through, I believe, the benefits of relationships. This includes the therapeutic relationship but more importantly, within their own family.

If there is one belief I have found through conducting this research, it is that relationships are the key. Encouraging and aiding clients in their family relationships will help their situation. In order to do that, the therapist must establish a good therapeutic relationship with clients. Some of the elements of my model I hope will help that happen, but at the end of the day, I believe that it is not what one does, but how one is with clients. I understand the principles of doing things with clients, I spent over twenty years as an executive coach working in that manner. However, as an existential therapist I believe the phenomenological approach of understanding the client's issues as much as possible, of being with them in their pain and suffering creates a stronger relationship and as such, is of greater benefit.

Personally I do not want to be viewed as an expert with a method to resolve the problem, I want to be seen for who I am, a fellow suffer within the world who through my training, experience and reflection has found a resilience that is strong enough to carry myself and my clients through the difficulties that they are experiencing. I passionately hope that this research and model helps others reach out and offer assistance to those so much in need.

14. Bibliography

ADAMS, M. (2014). *The Myth of the Untroubled Therapist.* Hove: Routledge.

ADAMS, M. (2013) *A Concise Introduction to Existential Counselling.* London: Sage Publications Ltd.

ALCOHOLICS ANONYMOUS GREAT BRITAIN (2015) *Citing electronic sources of information.* Available from http://www.alcoholicsanonymous.org.uk/shop.

ALCOHOLICS ANONYMOUS WORLD SERVICES INC. (1939) *Big Book.* USA: The A.A. Grapevine Inc.

AMERICAN PSYCHOLOGICAL ASSOCIATION (2015) *Citing electronic sources of information from Dictionary.com website.* Available from: http://dictionary.reference.com/browse/socialconstruct

BARNES, H.E. (1980) Sartre's Concept of Self. *Studies in Existential Psychology and Psychiatry,* XV11 (1), pp.40-65.

BATESON, G. (1971). The cybernetics of self: a theory of alcoholism. *Psychiatry.* (34) pp.1-18.

BATESON, G. (1979) *Mind and Nature: A Necessary Unity* London: Bantam Books.

BBC NEWS (2016). *New alcohol guidelines: What you need to know.* Weblog [Online] Available from: http://www.bbc.co.uk/news/uk-3522650. [Accessed 04/07/16].

BENNETT-LEVY, J. Et al (2004) *Oxford Guide to Behavioural Experiments in Cognitive Therapy.* New York: Oxford University Press.

BERMAN, J.S. and NORTON, N.C. (1985) Does professional training make a therapist more effective. *Psychological Bulletin* (98) pp. 401-7

BINSWAGER, L. (1963) *Being-in-the-world.* New York: Basic Books.

BLASZCZYNSKI, A. and NOWER, L. (2001). A pathways model of problem and pathological gambling. *Addiction* 97 pp. 487-499.

BRITISH PSYCHOLOGICAL SOCIETY (2009). Ethical principles for conducting research with human participants. [Online]. BPS. Available from: http://www.bps.org.uk/the-society/code-of-conduct/ethical-principles-for-conducting-research-with-human-particpants.cfm [Accessed 3 April 2015].

BPS QUALITATIVE METHODS IN PSYCHOLOGY SECTION CONFERENCE (2013). *A Discussion with Prof Kathy Charmaz on Grounded Theory.* Available from: http://www.youtube.comGrahamR [Accessed 06/03/15]

BREAKWELL, G. M. and SMITH, J.A. and WRIGHT, D.B. (2012) *Research Methods in Psychology.* 4th ed. London: Sage Publications.

BRYANT, A. and CHARMAZ, K. (2007). *The Sage Handbook of Grounded Theory.* London: Sage Publications Ltd.

BRYANT-JEFFERIES, R. (2001) *Counselling the Person Beyond the Alcohol Problem.* London: Jessica Kingsley Publishers.

BUBER, M. (1957) Distance and relation. *Psychiatry* (20) pp.97-104.

CANTRIL, H. (1965). *The pattern of human concerns.* New Jersey: Rutgers University Press.

CENTRE FOR RESEARCH ON DRUGS AND HEALTH BEHAVIOUR (1994) *Alcohol Treatment Since 1983: A Review of the Research Literature, Report to the Alcohol Education and Research Council.* London.

CHARMAZ, K. (2014) *Constructing Grounded Theory.* 2nd ed. London: Sage Publications.

COOPER, M. (2003) *Existential therapies.* London: Sage

COPELLO, A. et al. (2009) *Social Behaviour and Network Therapy for Alcohol Problems.* Hove: Routledge

CORBIN, J. and STRAUSS, A. (1990) Grounded Theory Research: Procedures, Canons and Evaluative Criteria. *Qualitative Sociology* (13) pp. 1-19.

COX, G. (2008). *The Sartre Dictionary.* London: Continuum.

DETMER, D. (2008) *Sartre Explained.* Illinois: Carus.

DONOVAN, D.M. and MATTSON, M.E. (1994) Alcoholism treatment matching research: methodological and clinical issues. *Journal of Studies on Alcohol* (12) p.1

DUHL, F.S. and KANTOR, D. and DUHL, B.S. (1973) Learning space and action in family therapy: A primer of sculpting. *Techniques of family psychotherapy.* New York: Grune & Stratton.

DU PLOCK, S. (2008). Living ME. *Existential Analysis 19.1.*

DU PLOCK, S. (2005). An Existential Perspective on Addiction. In: VAN DEURZEN, E. and ARNOLD-BAKER, C. *existential perspectives on human issues.* London: Palgrave Macmillan.

DU PLOCK, S. (2013) Therapy with Couples Presenting with Issues of Addiction. In: VAN DEURZEN, E. and IACOVOU, S. *Existential Perspectives on Relationship Therapy.* London: Palgrave Macmillan.

DU PLOCK, S. and FISHER, J. (2005). An Existential Perspective on Addiction. In VAN DEURZEN, E. and ARNOLD-BAKER, C. *existential perspectives on human issues.* Basingstoke: Palgrave Macmillan pp. 67-77.

DU PLOCK, S. (2009). The World of Addiction. In VAN DEURZEN, E. and YOUNG, S. *Existential Perspectives on Supervision.* London: Palgrave Macmillan.

ESTERSON, A. (1970). *The Leaves of Spring.* UK: Pelican Books.

FAULCONER, J. (2005) 'Knowledge of the Other'. *European Journal of Psychotherapy, Counselling and Health,* 7(1-2), pp. 49-63.

FINGARETTE, H. (1988) *Heavy Drinking.* London: University of California Press

FINLAY, L. and EVANS, K. (2009) *Relational-centred Research for Psychotherapists.* Chichester: Wiley & Sons.

FINLAY, L. (2008) Introducing Phenomenological Research. Accessed 21 September 2015. http://www.linda.finlay.com/introducingphenomenologicalresearch.doc

FINLAY, L. (2002) Outing' the researcher: the provenance, process, and practice of reflexivity. *Qualitative Health Research* 12 (4) pp. 531–545.

FINLAY, L. (2011) *Phenomenology for therapists.* Chichester: John Wiley & Sons.

FRANKL, V.E. (1948) *Man's Search for Ultimate Meaning.*USA: Perseus Publishing.

GALANTER, M. (1993) *Network Therapy for Alcohol and Drug Abuse: A New Approach in Practice.* New York: Basic Books.

GOODWIN, D.W. (1976) *Is Alcoholism Hereditary.* New York: Ballantine Books.

GLASER, B. and STRAUSS, A. (1967). *The discovery of grounded theory.* New York: Aldine

GUARDIAN ALCOHOL DATABLOG (2016) *How do the UK's new alcohol guidelines compare with the rest of the world's.* Weblog [Online] Available from: http://www.theguardian.com/news/Datablog/2016/jan/08/how-do-the-uks-new-alcohol-guidelines-compare-with-the-rest-of-the-worlds. [Accessed 04/07/16].

HALDANE, D. and McCLUSKEY (1982) Existentialism and family therapy: a neglected perspective. *Journal of Family Therapy,* (4) pp.117-132.

HALL, W.A. and CALLERY, C.P. (2001) Enhancing the rigor of grounded theory: incorporating reflexivity and relationality. *Qualitative Health Research* 11(2) pp.257–272.

HARRIS, M. (2000) Shopping for an Addiction. In: BAKER, A. *Serious Shopping.* London: Free Association Books, pp.199-220.

HATTIE, J.A., SHARPLEY, C.F. and ROGERS, H.J. (1984) Comparative effectiveness of professional and paraprofessional helpers. *Psychological Bulletin* (95) pp.534-541.

HEIDEGGER, M (1927) *Being and time* (trans. J. Macquarrie and E.S. Robinson, 1962) London: Harper and Row.

HEIDEGGER, M. (1978) *Being and time.* Chichester: Wiley Blackwell.

HEIDEGGER, M. (1993) On the essence of truth. In D.F. Krell (Ed). *Basic Writings: Martin Heidegger.* pp. 115-138 London: Routledge.

HORA, T. (2012) *Beyond the Dream Awakening to Reality.* USA: PAGL Press

HICKES, M. and MIREA, D. (2012) CBT and Existential Phenomenological Psychotherapy. *Existential Analysis 23.1.* pp.11-18

IACOVOU, S. and WEIXEL-DIXON, K. (2015) *Existential Therapy.* Hove: Routledge.

JACKSON, D.D. (1973) Family therapy in the family of the schizophrenic. *Therapy, Communication and Change.* Palo Alto: Science and Behaviour Books.

JASPERS, K. (1912). The phenomenological approach in psychotherapy. *Br J Psychiatry* 114 pp. 1313-1323.

JELLINEK, E.M. (1960). *The Disease Concept of Alcoholism.* Oxford: Hillhouse

KAUFMAN, E. and KAUFMANN, P.N. (1979) *Family Therapy of Drugs and Alcohol Abuse.* New York: Gardner Press

KEMP, R. (2009). *Relating to the other: truth and untruth in addiction.*

KEMP, R. (2011). The symbolic constitution of addiction: Language, alienation, ambivalence. *health,* 16(4) pp.434-447.

KEMP, R. and LORENTZATOU, D. (2013) The place of truth in psychoanalysis: A Heideggerian contribution. *European Journal of Psychotherapy & Counselling (10)* pp.1-13.

LAING, R.D. and ESTERSON, A. (1964) *Sanity, Madness and the Family.* UK: Pelican Books.

LANGRIDGE, D. (2007) *Phenomenological Psychology: Theory, Research and Method.* Harlow: Pearson.

LANTZ, J. (1993) *Existential Family Therapy.* New Jersey: Jason Aronson Inc.

LEVINE, N. (2014). *Refuge Recovery A Buddhist Path to Recovering from Addiction.* New York: HarperCollins.

LEWIS, M. (2011). *Memoirs of an Addicted Brain.* New York: Perseus Books Group.

LESTER, S. (1999) *An introduction to phenomenological research.* Taunton, available at www.sld.demon.co.uk/resmethy.pdf [accessed 28 July 2016].

McLEOD, J. (2003) *Doing Counselling Research.* London: Sage Publications.

McLEOD, J. (2011) *Qualitative Research.* 2nd ed. London: Sage Publications.

MADILL, A. JORDAN, A. and SHIRLEY, C. (2000). 'Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies'. *British Journal of Psychology.* 91, (1) p1-20.

MALLORY, C. (2001) Examining the difference between researcher and participant: an intrinsic element of grounded theory. In: Schreiber, R.S., Stern, P.N. (ed) *Using Grounded Theory in Nursing.* New York: Springer Publishing Company, pp. 97–112.

MARSHALL, C and ROSSMAN, G. B. (1999) *Designing Qualitative Research.* London: Sage Publications

MARTIN, A. and STENNER, P. (2004). 'Talking about drug use: what are we (and our participants) doing in qualitative research?' *International Journal of Drug Policy. 15,* pp.395-405.

MATÉ, G. (2008). *In the Realm of Hungry Ghosts.* Toronto: Vintage Canada.

MEDICAL PRESS UNIVERSITY OF VALENCIA (2016). *Alcohol consumption has a genetic component.* Weblog [Online] Available from: http://medicalxpress.com/tags/alcohol+dehydrogenase/ [Accessed 04/07/16].

MERLEAU-PONTY, M. (1945) *Phenomenology of Perception.* London: Routledge

MILAM, J.R. and KETCHAM, K. (1983) *Under the Influence: A Guide to the Myths and Realities of Alcoholics.* New York: Bantam.

MINUCHIN, S. (1974) *Families and Family Therapy.* USA: Harvard University Press

MORAN, D. (2000) *Introduction to Phenomenology*. London: Routledge

MORSE, J. (1995). The significance of saturation. *Qualitative Health Research,* **5**(2), 147-149.

NEUMAN, W.L. (2006) *Social Research Methods: Qualitative and Quantitative Approaches*. Allyn & Bacon, Inc.

NUTT, D. and NESTOR, L. (2013) *Addiction (Oxford Psychiatry Library).* Oxford: OUP

O'FARRELL, T.J. (1993) A behavioural marital therapy couples group program for alcoholics and their spouses. *Treating Alcohol Problems: Marital and Family Interventions.* pp.170-209.

ORFORD, J. VELLEMAN, R. COPELLO, A. TEMPLETON, L. IBANGA, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: Education, Prevention and Policy.*17 pp.44-62.

OSTEN, K.A. and SWITZER, R. (2014) *Integrating 12-Steps and Psychotherapy.* London: Sage Publications.

PATTERSON-STERLING, C. (2004) *Rebuilding Relationships in Recovery.* USA: Xlibris Corporation.

PROCHASKA, J.O. and DiCLEMENTE, C.C. (1983) Stages and Processes of Self-Change of Smoking: Toward an Integrative Model of Change. *Journal of Consulting and Clinical Psychology.* 51 (3) pp. 390-395

RIST, F. RANDALL, C.L. HEATHER, N. and MANN, K. (2005) New Developments in Alcoholism Treatment Research in Europe *Alcoholism: Clinical and Experimental Research* 29(6) pp.1-6

RIVETT, M. and STREET, E. (2009) *Family Therapy* Hove: Routledge

RYAN, F. (2013) *Cognitive Therapy for Addiction.* Chichester: Wiley & Sons Ltd.

SARTRE, J.P. (1943) *Being and Nothingness.* New York: Methuen.

SARTRE, J.P. (1939) *Sketch for a Theory of the Emotions.* London: Methuen.

SARTRE, J.P. (1948) *Anti-Semite and Jew.* New York: Shocken.

SATIR, V. (1967) A Family of Angels: An Interview with Virginia Satir. *Techniques of Family Therapy.* New York: Basic Books.

SILVERSTEIN, L.B. AUERBACH, C.F. LEVANT, R.F (2006) Using qualitative research to strengthen clinical practice. *Professional Psychology: Research and Practice* 37(4): 351–8.

SPINELLI, E. (1994) *Demystifying Therapy.* Ross-on-Wye: Constable and Company Ltd.

SPINELLI, E. (2001) *the mirror and the hammer.* London: Sage Publications Ltd.

SPINELLI, E, (2015) *Practising Existential Therapy*: 2nd ed. London: Sage Publications Ltd.

SPINELLI, E. (1997) *Tales of Un-Knowing: Therapeutic Encounters from an Existential Perspective.* London: Duckworth.

SPINELLI, E. (2007) *Practising existential therapy: the relational world.* London: Sage

STANTON, M.D. and TODD, T.C. (1982). *The Family Therapy of Drug Abuse and Addiction.* New York: Guilford.

STATISTICS ON ALCOHOL: ENGLAND (2016) Weblog [Online] Available from https://www.gov.uk/government/statistics/statistics-on-alcohol-england-2016.

STILES, W.B. SHAPIRO, D.A. ELLIOTT, R. (1986) Are all psychotherapies equivalent? Am Psychol 41 pp.165-180

STRAUSS, A. and CORBIN, J. (1998) *Basics of Qualitative Research Techniques and Procedures for Developing Grounded Theory.* London: Sage Publications

VAN DEURZEN, E. (1997) *Everyday Mysteries.* London: Routledge.

VAN DEURZEN, E. and ADAMS, M. (2011) *Skills in Existential Counselling & Psychotherapy.* London: Sage Publications.

VAN DEURZEN, E. (1988) *Existential Counselling & Psychotherapy in Practice.* London: Sage Publications.

VAN DEURZEN, E. (2014) *Structural Existential Analysis (SEA): A Phenomenological Method for Therapeutic Work*. Published online by Springer Science+Business Media New York.

VAN DEURZEN, E. LAENGLE, A. SCHNEIDER, K. (2016). World Confederation for Existential Therapy. In *World Congress in Existential Therapy. London May 2015.* London: Existential Academy, pp.1-5.

VAN MANEN, M. (1990) *Researching Lived Experience*. London, Ontario: State University of New York

VELLEMAN, R. (1992) *Counselling for Alcohol Problems.* London: Sage Publications

VELLEMAN, R. and ORFORD, J. (1999). *Risk and Resilience.* Abingdon: Routledge

VISSER, R. (2013) Alcohol policy uk www.alcoholpolicy.net/2013/02/

WAHL, B. (2003). Working with 'existence tension' as a basis for existential practice. *Existential Analysis* 14 (2) pp.265-278

WILLIG, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in theory and method.* Buckingham: Open University Press.

WILSON-SCHAEF, A. (1987) *When Society Becomes an Addict.* San Francisco: Harper and Row.

WURM, C. (1997) Deciding about Drinking: An Existential Approach to Alcohol Dependence. In DU PLOCK, S. (ed) *Case Studies in Existential Psychotherapy and Counselling.* Chichester: John Wiley

YALOM, I. (1980) *Existential Psychotherapy.* New York: Basic Books

The UK Alcohol, Drugs and the Family (ADF) Research Group core members are:

- Alex Copello (University of Birmingham, Birmingham & Solihull Mental Health Foundation Trust).
- Akanidomo Ibanga (University of Birmingham).
- Jim Orford (University of Birmingham).

- Lorna Templeton (Independent Research Consultant).

- Richard Velleman (University of Bath, Avon &Wiltshire Mental Health Partnership NHS Trust).

15. Appendices

Appendix 1: Request for Research Participants

Appendix 2: Participant Recruitment Advert

Appendix 3. Participant Information Letter

Appendix 4. Written Informed Consent Form

Appendix 5. Participant Debriefing Letter

## Appendix 6. Participant Interview Guide

Request for Research Participants

I have recently posted the following in several LinkedIn and Facebook groups. If you are interested or know anyone who might be, I would be very grateful for any interest.

If you have experience of working with families in the UK who struggle with alcohol problems, I would be very interested in talking to you about your views. I am conducting doctoral research (NSPC/Middlesex University) to create an existential phenomenological model of family therapy. Participation would involve an hour-long interview either at your location or using Skype. Please contact me if you are interested at: andrewresearch15@gmail.com

Appendix 2. Participant Recruitment Advert

Family therapists working with alcohol abuse. Participants requested for doctoral research (Middlesex University) that seeks to develop an existential phenomenological model of helping families who have alcohol problems. Participation involves an hour-long interview, no travel necessary. For details please contact: andrewresearch15@gmail.com

Appendix 3. Participant Information Letter
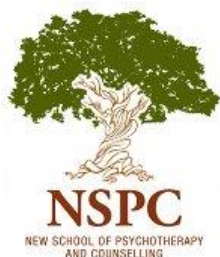
Towards an existential phenomenological family therapy model of working with issues of alcohol abuse: a grounded theory study.
Being carried out by Andrew Biss as a requirement for a DProf in Existential Psychotherapy & Counselling by Professional Studies from NSPC and Middlesex University.

New School of Psychotherapy and Counselling
61-63 Fortune Green Road
London
NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

5 November 2015

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the research?
This study is being carried out as part of my studies at NSPC Ltd and Middlesex University. When one or more members of a family drink heavily, the response from other members could be highly relevant to future outcomes. Does a family pull together to help the person who has the problem or become critical and create exclusion? I want to research what family issues occur, how behaviours manifest and what methods were tried to deal with them. I am as interested in talking to therapists about what wasn't successful, as what was.
My aim is to create a model drawn from the experiences of other therapists, which is existential phenomenological and assists 'alcoholics' to improve their relationships with their family of origin.
You are being asked to participate because you have more than three years' experience of working with families and alcohol problems and are qualified with either BACP, BPS or UKCP and have shown an interest in the research by e.g. responding to an advert.

What will happen to me if I take part?
I would like to interview you for approximately an hour to an hour and a half at a suitable and mutually agreed time and place. Where feasible I am happy to travel to your location but otherwise I will be suggesting we use Skype. I will be using a qualitative grounded theory method where there are no set questions.

What will you do with the information that I provide?
I will be recording the interview on a digital recorder and will transfer the information to an encrypted memory stick for storage, deleting the file from the recorder. All of the information that you provide to me will be identified only with a project code and stored either on the encrypted memory stick, or in a locked filing cabinet. I will keep the key that links your details with the project code in a locked filing cabinet. Another person will transcribe the

interview and so I will not use your full or last name in the interview and the person transcribing the interview will not know who you are.

The information will be kept at least until 6 months after I graduate, and will be treated as confidential. If my research is published, I will make sure that neither your name nor other identifying details are used.

Data will be stored according to the requirements of the Data Protection Act and the Freedom of Information Act.

What are the possible disadvantages of taking part?
It is very unlikely that our discussions will cause you any distress, but should that happen, please let me know and if you wish, I will stop the interview. It is also unlikely that you will tell me something that I am required by law or professional ethics to pass onto a third person, but if that happens I will have to do so. Otherwise whatever you tell me will be treated in confidence. It is possible that our discussions might prompt you to consider your professional practice and should that create any negative impact, please tell me and again if you wish, I will stop the interview.

What are the possible benefits of taking part?
I hope you will find our discussions stimulating and informative and that there may be insights and understandings that you are able to apply in your professional work.

Consent
You will be given a copy of this information sheet for your personal records, and if you agree to take part, you will be asked to sign the attached consent form before the study begins. Participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part, you may withdraw at any time without giving a reason.

Vicarious Consent
In the course of the interview it is likely that you will be discussing interaction with your clients. I believe it is important for your clients' identities to be concealed and I would like you therefore to change any identifying features such as names and locations.

Who is organising and funding the research?
This research study is fully self-funded.

Who has reviewed the study?
All proposals for research using human participants are reviewed by an Ethics Committee before they can proceed. The NSPC research ethics sub-committee have approved this study

Expenses
I would not anticipate you incurring any expenses as a result of this research. If that is not the case, please let me know so we can discuss the matter.

Thank you for reading this information sheet.
If you have any further questions, you can contact me at:
andrewresearch15@gmail.com

If you any concerns about the conduct of the study, you may contact my supervisor:
Professor Simon du Plock
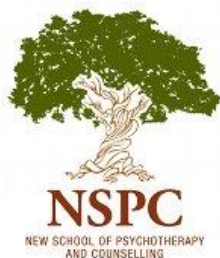Metanoia Institute, 13 North Common Road, Ealing, London W5 2QB.
Simon.duPlock@metanoia.ac.uk
Or
The Principal NSPC Ltd. 61-63 Fortune Green Road, London NW6 1DR.
Admin@nspc.org.uk

Appendix 4. Written Informed Consent Form

New School of Psychotherapy and
Counselling
61-63 Fortune Green Road
London
NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Written Informed Consent

Title of study and academic year: **Towards an existential phenomenological family model of working with issues of alcohol abuse: a grounded theory study. 2015/16.**

Researcher: **Andrew Biss as a requirement for a DProf in Existential Psychotherapy & Counselling by Professional Studies from NSPC and Middlesex University.**

Supervisor*: **Professor Simon du Plock**

☐	I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

☐	I have been given contact details for the researcher in the information sheet.

☐	I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

☐	I further understand that the data I provide may be used for analysis and subsequent publication, and provide my consent that this might occur.

Print name ……………………………..		Sign Name ……………………………..

Date: …………………………………………….

To the participants: Data may be inspected by the Chair of the Psychology Ethics panel and the Chair of the School of Social Sciences Ethics committee of Middlesex University, if required by institutional audits about the correctness of procedures. Although this would happen in strict confidentiality, please tick here if you do not wish your data to be included in audits: ☐
I ensured I had the signed consent form before I started the interview. Of the twelve interviews, nine were conducted in private, confidential surroundings although public environments such as meeting rooms or offices. Two interviews were conducted by Skype because it suited the participant, e.g. a therapist on maternity leave at home with her baby. One interview took place at a therapist's home where she regularly saw private clients.

Appendix 5. Participant Debriefing Letter
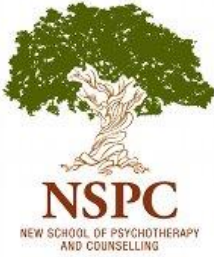
New School of Psychotherapy and
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61-63 Fortune Green Road
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NW6 1DR

Middlesex University
The Burroughs
London NW4 4BT

Debriefing Letter

Title of study and academic year: **Towards an existential phenomenological family model of working with issues of alcohol abuse: a grounded theory study. 2015/16.**

Researcher: **Andrew Biss as a requirement for a DProf in Existential Psychotherapy & Counselling by Professional Studies from NSPC and Middlesex University.**

Supervisor: **Professor Simon du Plock**

Thank you for your valuable time in helping me with this research it is very much appreciated. I hope you have found our meeting enjoyable and interesting. However, if there are any outstanding issues that our discussions have raised, the purpose of this letter is to suggest sources of support and information that may be helpful.

The following are useful websites and helplines:

BACP: **Website:** www.bacp.co.uk   **Email:** bacp@bacp.co.uk **Telephone**: 01455 883300

UKCP: Website: www.psychotherapy.org.uk **Email:** info@ukcp.org.uk   **Telephone: 020 7014 9955**

BPS: Website: www.bps.org.uk **Email**: enquiries@bps.org.uk **Telephone:** 0116 254 9568

There are a number of **LinkedIn groups** that offer information in this area including:

Existential Therapy, Family Therapy Network UK, International Family Therapy Association, Existential & Humanistic Psychology.

If I can be of any help please do not hesitate to contact me at andrewresearch15@gmail.com or my supervisor at Simon.duPlock@metanoia.ac.uk

Appendix 6. Participant Interview Guide

Grounded Theory Interview Guide

Research Question

How might an existential phenomenological model of family therapy address issues of alcohol abuse?

Initial

- Please tell me some brief details about your therapeutic background and experience?

- Please describe for me what happens in a typical client session?

- What interventions do you normally use when working with clients?

Intermediate

- Please describe a client session where you have positive feelings about the outcome?

- Please describe a client session where you have negative feelings about the outcome?

- From your experience which interventions seem to be the most effective in terms of process and outcome?

Ending

- In your opinion what are the main elements of a family therapy model that addresses alcohol abuse?

- Are there any other areas you think we should have addressed?

- Is there anything finally you would like to ask me?