**Interviewer:** *Yeah of course. Should we start with your personal item then?*

Yes, just one second...[grabs item] ok you might think is a bit odd [laughs] It's a bull. It's made out of some sort of metal. And I purchased it, I don't know, maybe five, seven years ago when I was in Spain. But the reason I chose it is my experience has been working with individuals who are in a constant pattern of relapse. Or another way we look at it certainly is of re-presentation. Client keeps re-representing...ehm because I've also worked in community services as well, doing outreach work and so forth some years ago. So the difficulties I have come up against and the experience has been this is really tough and people surviving addiction. They get this tough exterior. They're looking at individuals from an inanimate position because they are dehumanised, because that allows them to behave in certain ways and they disassociate. But so it is quite hard, hard to penetrate. And I found that you think you're getting somewhere then actually you realise, you not, or actually the client is closed. Um, the other thing is this is it being a bull is there are wear...ehm they are stand-offish, they isolate or they're even isolated because the nature of bulls, they do isolate among farms and on land and so forth. Um, and they have a tendency to be aggressive. Um, and, um, and the horns represent the prickliness and maybe the actual attitudes represent the actions of the standoffishness position that clients take and but we've been all there...when you see a bull, particularly when it's in the bull ring, I mean, it is a pretty vulnerable individual. And very much alone.

And I know that might sound very melodramatic, but it is my experience, through and through...I'm a strong believer, and the evidence is there to support it, that actually, that if not all but a high proportion of clients who come into treatment with substance misuse, heroin, opiates, crack, are very sensitive, highly sensitive, sometimes ultrasensitive individuals. But over the years, they've developed this armour to keep themselves safe, and they use their substances to self-medicate in terms of, you know, keep the struggles at bay. And I just, you know, a lone bull standing in his field or in his corral or barn can be quite unapproachable at times. But equally, I think that they're also misunderstood. So but the resilience is there. And the ability to survive is there. The sad thing is, is with clients who habitually relapse, sometimes you have to question whether they want to survive. And as much as I have resilience and strength, are they able and willing to use it to make changes that need to happen? Sadly, like bulls and all animals like it...subject to what we say and do is because we manage these creatures, you know. Unless you're lucky to be down in the comarsh where they can roam free in their natural habitat, but equally...addiction, people in addiction, their struggles in society, they're marginalised, they're controlled, lot of people find themselves in prisons sometimes also, sometimes very rightly so. And I think this it changed a lot, the treatment world, particularly in the last five to eight years, it's moved away from a draconian approach of addicts are bad people. They're not. I think they've just been misunderstood for many, many years. And I know for a fact that the processes are changing because it wasn't a large part of the attitude towards individuals who were misunderstood, underrepresented and are in need of a bit of support, care and attention.

**Interviewer:** *Yeah, it's really interesting to me.*

It's very predictable, isn't it? I forget what they call them. The guy, the matador. They know how to play the bull. And the bull is predictable. The behaviours, the conditioning of the individual, the condition of the bull is actually it will charge at any threat. Addicts and crack users and heroin users their self-obsession, the pre-occupation of getting finding and taking their drugs... they choose not to learn and they just on autopilot and do exactly the same thing much the same, as you've pointed out, the bull will keep doing the same thing.

I did I looked around my house, I got many different objects in my house and I thought oh well...I've got a skull sitting over there and it's like, well, that's not strictly true. You know, that's not a real representation because and so forth. But for me, it fits and my struggle within that is the frustrations, the feeling quite impotent at times, you know, unless you're a breeding boy, you castrated. Ehm as a therapist, if you're coming up against that wall all the time or you feel you get a, you know, you're making some headway in supporting the individual, and then it starts to unravel. As a therapist, I've been there feeling quite. Yeah. As impotent. Is it word. It's like, oh what do I do next? Ehm experience has taught me that it's just that's where the client is. That's where they are. And there's absolutely nothing I can do at that time. And being able to accept that, ehm then prevents me from going down the road of 'oh what if I did this or should I have done that or maybe I shouldn't have done that.' I think with experience I don't go down that road anymore because ultimately it's not about me. But I do have my frustrations and things permeate they get under the skin a bit but it's being able to say, 'no actually what we did and the contribution I made was honest, genuine, appropriate for the moment'. As long as I'm not being reckless and inappropriate or neglectful, then I could accept that 'okay, we did what we could do - what I could do, they client and myself.' And they're still on their journey. And sadly, some people don't come back eventually. Because they they fall by the wayside...seen a bit of that this year.

**Interviewer:** *Yeah, I think it's really interesting. How would you position yourself in that kind of scenario?*

Well, I wouldn't like to put myself as the matador or the adversary to the bull. But the fact is, I mean, if we were able to I believe that bullfighting goes on still, but there's no they don't kill them anymore...or maybe they do, but that's probably done behind closed doors. But, yeah, I think actually the matador with the cape minus the spears and the knives and everything you could look at the interaction between the bull and the matador is a bit of a dance. And then in that sense, I would put myself as the matador, but I'd be trying to dance a very different dance to what the traditional matador does. Fighting that I'd be the owner of the bull. But, you know, somebody breeds these animals. They've got to look after them and care for them. And I don't mean to sound melodramatic, because that's not really me, but it's to...see the problem with the spectator is, that is society. 'Oh, well, yeah. That's the guy from the shop lalala' you know, I don't want to be a spectator. By doing nothing, it makes you complicit. So I would have to have an active role in that ring. So if I wasn't the Matador, I certainly would be bull owner or the keeper of the bull or even one of the wranglers. You know, they have the wranglers on the side to distract the bulls to protect the matador. You could look at that even when you're doing group work and you having to two counsellors in a group room...and counseloors need a breather between interactions and everything and then the other one picks up, so you could look at it in that way. In a group, what you have is you also have an arena of experts i.e. their peers. But clients can say and do things that therapists can't. Because we're bound by different ethics, though, and there's nothing more powerful than actually your peer feedback so you could look at the stadium if you like, as the peer group. So it's very colourful isn't it, you can pull it apart.

**Interviewer:** *Amazing, so what would you say what would you say is your understanding of relapse? So from your experience, how would you define or describe what a relapse is?*

My position I work from is actually the relapse starts from a point of planning. So once an individual goes into planning and when I work with relapse, I work with it in forms of storyboarding because I firmly believe that every client I've worked with whether group or in one to one who has habitual patterns of relapse. They all know exactly what they can do. They know where they're going to go. They know what street they're going to walk down, what what phone box they're going to use. When there was phone boxes; where they meet their dealer, then where they're going to go and smoke. And it's all set out in a storyboard. And each bit, as they work through this storyboard, is all part of the whole process of their relapse. Once they're in that pattern, in the first part is they're holding a secret. So and that is a bit like Gollum, you know, my precious. And when you ask them, how are you when you go through this process, they say, well, I'm getting excited, I know when I'm going to use again. And that is all part of the process and then once they've used relapse is over, it is no more relapse because then now they are using now. So the relapse is gone and it's the preoccupation they get caught up with. But before that, my experience has been such that. If they're struggling with a dynamic within the centre, they're struggling with the ownership of their own feelings and not knowing how to express them or actually they're just absolutely overwhelmed with the nature of what they're trying to achieve. A whole gambit of many different things and they can't cope. They do know they can take that away if they use or be it momentarily.

And the other bit that I like to work with clients is actually 'what is familiar?' So when they come up against uncertainty and they're really unsure what was going to happen next or what direction they should take, I mean, I'm supporting individuals to explore change, explore their lives and what all needs to change and so on and so forth. And that can be quite frightening for individuals. And then they recall back to what is familiar and then their pattern of relapse will engage. I've worked with individuals who have such a block to the process of change, whether that block is anger or shame or just inertia. You know, they just will not move or cannot move. So it's very complex. And there's also the part that some people need to relapse, and they may relapse multiple times, but each time they get a little bit of information and it's all part of the same journey. But the sad part is, is that we may not get them back because they lose the fight or, you know, they overdose and so forth. The other thing is, which is very much common knowledge nowadays, is a huge proportion of individuals who have substance abuse problems, heroin and crack use is there is historic trauma. And then you take the substances away and there's nothing to block. And it's resurfacing in these traumas become overwhelming. And they can't manage the trauma. They know that they can deal with it when they use their substances. What we found in in our centre over the years is that we actually tend to see clients coming into our centre who are in their late 30s, 40s upwards, and they're more ready if they survived that long, they're more ready, they're at that place where they're mature and their values are shifting. And there is a level of maturity that goes with successful interventions. And people making changes in life is not synonymous to the age group, but we see a greater proportion in that. So you say 30, 30 to upwards younger people, they're still in their career. They're still, you know. Developing their career. They're ready for their attitudes and work heavily with attitudes, you know, attitude to responsibility, to self-care, to your care of your family, your community and so on, so forth. Very much a social issue. And if your social standing is one that leads you to have questionable opinions, poor experiences and everything. The challenges in engaging that complexity are higher and the habitual relapse is higher...till they're either ready or them values shift.

**Interviewer:** *I thought it's interesting that you said!*

If I used for the first time ever...I'm not in a relapse am I, 'm just using. Then I stop and I'll start again, then you can say they have relapsed back on their drugs. Well, absolutely they have. But it is my is my opinion, that the relapse is the process that leads up to you starting to use your substance again. Because I also think within that, and I'm very I was trained in kind of a draconian period of rehabilitation and the mindset was very bad in terms of and I fought against it all my career in terms of addicts and alcoholics. If I just mentioned alcoholics one minute demonised as bad people that, oh, don't go near them and everything thoroughly was misunderstood. So having to change that attitude to a more person-centred, and say look let's understand the individual, let's understand their levels of functioning, what's going on, where do the problems arise? So, um, to whether you're in relapse...Well, I think that's just actually putting a plaster on it without actually being able to say, no, actually you're using you are in your act of addiction. This is not relapse, it is active addiction. Um, for me personally as a therapist, that clarity is needed for the client. The client needs to understand because there is such an educational element to working with people in addiction with substance misuse. You're working with cognitive emotional and there was a function within it so you have a responsibility as an educator, as a social educator, in terms of what the where responsibility lies, where appropriateness lies, where their social etiquette lies. And educating people or actually being with people and allowing them to establish the coping strategies. That what life is throwing at them or what they struggle with, we have a responsibility to be with them and that's where the emotional growth comes. And a lot of people don't get that in their adolescence for many different reasons because of the social issues they grew up in and the role models and the conditioning they experienced. So I think it's so important to be so clear about what it is you're saying. So the individual in front of you is under no illusion or they're trying to interpret what you're saying. So it keeps saying that people are relapsing, no I personally believe that's misinformation. Sorry I sound a bit rigid on that [laughs].

**Interviewer:** *No it's all good. It's about your understanding, not what mainstream media is saying, but what do you say? What is your experience? Do you remember what did it feel like to you when you first heard of them relapsing again?*

When I was young in my practise and I can think of one particular individual who I was working with, and I call him Barry for the minute, he was a difficult individual to work with. And I think my lack of experience at that time...I wouldn't say I was naive, but basically working with him and him going into relapse and knowing he had this history of relapse and then re-representing and saying 'I know this is all going to sort it out and it's not going to happen again'. And then it happened again in that instance, because I was young and unexperienced as a practitioner, I started to question my practise and saying 'what am I doing that is causing this? Why can't I help this individual to stay on track?' But that was inexperience, because if I if it was filmed and I was able to look at it now, I would probably see that actually it had very little to do with me. But that was my own inexperience. And that's how it presented. As I developed as a practitioner, my experience has grown...I personally cannot foretell which way any client is going to go, which way they're going to fall. But I do like to work with a client in understanding what does your history dictate. And I worked with a young lady and she came from a horrendous background, very abusive father who abused his daughter and actually just put her out to whoever and what she became. She became from a very young age, highly sexualised. She had a position where she thought she was there for the pleasure of men, very young, very pretty. And first of all, she wasn't working with me. She was working with a female counsellor and she relapsed, then she came to me and we started working and she relapsed again. And it didn't seem that there was any sort of rhyme or reason. But so she had a lot of grief in there as well, because she's lost her mother to cancer. And then a few years prior to coming into treatment, she lost a brother in a very nasty accident. Um, and it was just 'oh, well, she's just very young. She's too young.' There were all these things, no excuses, but rationales, you know, she's not ready this, that and the other because she would leave and then 'can we bring her back to you? Yeah, bring her back to me' then she'd come back. Then we sent her to another center then she relapsed. And then eventually the information started to drip. Um and all the background history started to come out, the abuse and so forth, but it was such that it sort of mirrored the big scandal up in the north with the girls in the community that were being moved around by men it sort of echoed that. So what we had to do, we actually got her into a women's rescue centre. So she was safe. So we actually took her from different part of the country and put her in a place down here. And then I got dispensation with the women's refuge that she could leave there to meet me and we would meet at a place where we could actually continue with the work that we were doing, but we kept her working for about six, six to nine months. Then we managed alongside the social services and the impact team and all that got her into a flat and so on and so forth. Yeah, she was doing really well. Then eventually she just drifted back. I don't know why she drifted back. And then she turned up at our centre one day, and she was really well really, really well. She's working now and told me she was doing well and I was so glad and happy to see her because we used to keep a channel of contact open so she knew she could call me if she needed to. And then I think it was five or six months after that, she died of an overdose.

So it's the young lady's demons, of which were many, may have just proved insurmountable for her. But the other side of it is that this, as I said, was from a very young age, this lady was sexualised but I don't think she ever lost that degree of conditioned behaviour. And the sad thing is there's predators out there, people out there that are just honing in on young ladies like that. I'm not saying it's totally a predator's fault but she found her way back and sadly she died. What I've seen is some of the significant things I've seen in working with individuals who are serial relapsers or habitual relapsers is actually they've got such a complex and sometimes disturbed background that they find it so difficult to manage their lives whilst managing the internal stuff that goes on for them. What I've learnt is actually then you're creeping into mental health issues you know like there's the trauma and so forth, mental health problems, whether it's depression, PTSD or self-harming. I think the awareness is growing faster than it ever has, but I think it really is an issue, as I said, social. But this trauma and then the subsequent mental health oh actually there's something more organic in the mental health and they are self-medicating.

**Interviewer:** *It's really interesting for me that I asked you about how did that impact how did that feel to you? When you heard about your client relapsing again, I'd say this lady, for example, you can take this client. What was that like to you? How did that feel like for you?*

Well, I was numbed. And the reason being is the night that she relapsed, she rang me and I didn't take the call. So I was left in quite a quite a numb position. I just felt awful in that instance. I was angry because it was like 'fucking hell you know, you could have...you know, and she could have...'. It's frustrating. And I don't even think frustrated sort of fits in. It's usually sad, it was for me, it affected a lot of people, actually, because she was really well liked. And some of my colleagues as well were devastated by it. And then there was some people wanted to make it better by saying, 'oh, yeah, but she probably rung you by mistake'. [laughs] I knew this young lady very well. You know, she used to ring me if she was in a struggle we had that kind of a relationship, you know. So then I could point her in the right direction. Or actually we could make arrangements to get some support so it wouldn't necessarily be me. So I was devastated. Not once did I think I'm not doing this anymore. I've seen that happen.

I was recently with a male client though he was more party drugs and alcohol but yeah, just ten days before Christmas he died and he was so angry, so, so, so angry. And he could not get over his anger and equally had just as an abusive background as the young lady. So the thing is, you can see when they are starting to go down that road, I say to my colleagues, we can see we where they're going. And, yeah, it's frustrating. And there's nothing you can do. There's absolutely nothing...you could lock them up, if you like, if you had the power to...well I was working with one lady...and she was an addict on party drugs.

Very articulate. She was a dancer, a stunning lady, but was heavy on party drugs, then she was involved in a car accident. She was left with a frontal lobe brain injury. I just happened to be at another treatment centre doing an assessment and they said, would you look at this young lady for us because she's looking to go to another treatment centre from this one. So I assessed her, accepted her for treatment. She worked with my colleague when she came to our treatment centre. But because of the frontal lobe injury, she was prone to verbally aggressive outbursts. And my understanding is with frontal lobe injuries, that's a classic sort of symptom. So she worked with my colleague. She was a private client but her behaviour, she she she kept coming into conflict with the behaviour we worked and worked and worked with her. But we had to part company. She relapsed. Got contacted again. Would you consider taking her back? And then we said, OK, we take her back. And then I started working with her. I questioned, through the time that I was working with her, her capacity. You know, she'd already had capacity assessments. But I believed that she had difficulty in experiential learning so therefore she couldn't learn from relapse through relapse and so forth. I said I'm really questioning her, her capacity to make informed decisions because she's on a loop all the time and we try and work for her. It didn't happen. She left. Then I was called by her parents. We had a meeting in their home and it was about working with her and she relapsed then and there was nothing more we could do. There was nothing new that we could do with her as such. So I believe she went to another treatment centre, then onto a supported housing project. Within that period, there was a small relapsing. However, last September she turned up for a reunion, really well, really healthy. And most recently, I had information she's still in recovery. So something shifted.

**Interviewer:** *Yeah. So that feeling, those thoughts and that kind of sensation you had was that did that change with the number of clients you saw who relapsed or with the number of relapses that particular client had? Or was it kind of is it now do you always feel this sense of frustration initially when you when you hear of your client relapsing again?*

No, I don't feel well, sadness. But the problem is, is which I noticed was actually I started to get cynical. Now, that's really dangerous because if cynicism creeps into my practise, I might as well hang my coat up. How am I going to help anybody from coming from a cynical position? Equally, I have to manage that within a treatment centre and actually it's not how I work it but it's like I can't allow that to grow. So personally, I had to deal with that cynicism in as much as I can't allow this in. This is not a place where I've got the privilege to go because I'm passionate about what I do. So in the first instance, I have to be mindful of if cynicism starts creeping. And thereafter I have to just accept that's where the client is at this time. This is where they are in their life. In their world. I have to accept that. And if that means I have to accept at this time, there's very little I can do for this individual other than do some harm minimisation stuff. If I lose the impetus and the energy and the willingness and if I'm not inspired to keep doing that, then I shouldn't be working in this practise, and that's the sort of ethics that I promote in my own practise. Compassion fatigue I know it's largely applied to long term carers, particularly people been caring for a loved one for many, many years, and then they start to get resentful. I've heard that mentioned before, but when we've looked at it as a team, is that that's not the case with us. If you work in an uphill all the time, it can weigh you down because sadly, the successes are not as great as the people that drop out or fall by the wayside. That's been the nature of addiction. But it can be frustrating. It can be deflating...and I've experienced that. I've never become despondent. But the important bit is just to pick yourself up and actually, stay true to what I'm trying to achieve here.

**Interviewer:** *How does that impact you personally? Like what would you say? Does your clients relapse mean to you?*

It's a reminder of how difficult it is to work with addiction. How challenging it is. But it is also a reminder of how difficult it is for people, for people in their positions. Me personally, I'm in recovery. Yeah, I've been in recovery for 20 years. It took me ehm, from the point that I first asked for help, I went to community projects, you know, community services. It took me eight years of habitual relapsing and using before I started to take a bit of responsibility and started to grow up essentially. So my personal experience, when I look at other people and they're relapsing, I know how difficult it is from a personal position. I don't believe that you have to be in recovery to work with addicts. I do not believe that at all. I see it quite differently. But when I've got another colleague who says, 'ah, well, you know, they really don't want it.' And I say, 'well, how can you say that? How do you know the difference between don't want to do it and can't?' You know, I mean, you can use the two terms. You say, well, one gives you your choice back, but some people just may not have the ability to find that initial step to make a significant change. So I think it's relative to the individual, when people stop relapsing and actually start to take a different approach. So for me, I look at it from a point of view of it's relative to the individual, their circumstances, their history, their functioning, their personality, their life, all of that. But it's sad. It is frustrating for me personally.

**Interviewer:** *Yeah. How do you manage those news?*

I have regular supervision externally. I have regular debriefs with my colleagues at work. We have debrief periods...uhm dark humour, believe it or not is such a tonic as long as it's done privately. And it's not about the individual it's about circumstance. I see a lot of it in many genres of working even like prison officers. It's a sad human fact, but it is a tonic as well.

**Interviewer:** *OK, so how would you say, um, has when you've worked with clients of relapsed multiple times, has that changed the way that you view yourself as a therapist?*

It used to have an influence on how I saw myself as a therapist. Nowadays I'm very much that this is what happens with addiction. I have to accept that some people have a relapse and actually some people may relapse to the degree that it costs them their life. And if I'm not able and willing to work with the realities, then I'm in the wrong job. And being a therapist and you want to be accessible, you want to be empathic, but there's also a reality there of actually not everybody is going to make it.

**Interviewer:** *I completely get that. What does it make you feel, when you work with that same client again?*

I suppose it's a bit tentative not in terms of how I work with them, because I will always be me. But I can only hold a bit of hope that actually a couple of pennies might drop, you know, anything more than that then I might be setting myself up, but more importantly, I'll be setting them up so I try to have no expectation like that they are going to have this epiphany when they're sitting down with me. I can't expect that from clients because, you know, I put myself in a position of.

**Interviewer:** *Yeah, how do you walk a client through a relapse like let's say your client has relapsed and contacted you back and is back with you?*

Initially of course we do assessments and so forth, but it's usually a good place to start with a timeline actually from point of relapse when they start thinking and planning. And what they identify as the catalyst for relapse. So we were we were I worked with the timeline debrief. And then actually what do you look to achieve? what you want to do with this time now, this time in this session? Risk assessments are huge inasmuch as they're important to keep the client safe, keep the client focussed, because, you know, we're also working with clients with real, actual self-harm, you know, who really sort of self-neglect. And then that could be a reflection of their own internal struggle, of how they're seeing themselves or actually how they don't see themselves, actually, that they see themselves results from such a miserable position. So it's really understanding what their expectations are, what they are trying to achieve. While at the same time and again, I don't mean to sound melodramatic, but giving them the care, the respect, the support that they need and sometimes the greatest intervention with somebody who's in that kind of constant relationship, if you just give them some time and space and not even say anything. What they're hoping to achieve and also what they want from me or service to hear what I mean. We need to understand their expectations.

**Interviewer:** *Yeah. So, is there anything else you would say that would be important for people to know in terms of how a client relapse impacts a therapist and how it is for it for you guys as therapists?*

Not to allow cynicism to creep in. Every treatment is relative to them and their experiences and from where they've come from, so it doesn't matter if they relapse two times, four times. OK, the difference between heroin and crack so crack is a stimulant and heroin's a depressant. You could argue the often the crack is the lead. Once they start using the crack first, then the heroin will come in after as they use that to sort of level off. But they do go hand in hand when people are using. The therapeutic side is the real challenge, you know, just treat everybody as an individual. You'll get a better response and understanding.