

***What is the role of attachment in contemporary psychotherapy?***  
***A grounded theory exploration of the perspective of experienced psychologists***

**Albert Osthoff**

This thesis is submitted in partial fulfillment of the  
Doctorate in Counselling Psychology programme at  
the University of East London

**34,783 words**  
(including amendments following viva)

**31<sup>st</sup> May 2016**

*What is the role of attachment in contemporary psychotherapy?*

***Be kind, for everyone you meet is fighting a hard battle***

– John Watson –

***Acknowledgements***

After a long road, my thanks are owing to a number of people. First and foremost, is my wife, Jo, who constantly encouraged me and, above all, stuck with me when, as often happened, this undertaking took precedence above all else. Next, I am extremely indebted to my research participants. Not only did they give of their time and provide me with invaluable data, they also provided me with a wealth of knowledge that I was immediately able to bring into my work. I feel extremely privileged to have benefitted from their wisdom and experience. Finally, my heartfelt thanks are owing to Melanie who supervised this work with just the right balance between challenge, support and, not least, excellent cheer.

***Abstract***

Since Bowlby devised his theory of attachment, originally for clinical purposes, refinements and extensions have developed its clinical utility. The research question asked how experienced contemporary clinicians now perceive the role of attachment in the formulation and treatment of distress by reference to their clinical work.

Using grounded theory methodology, underpinned by a relativist, moderate social constructionist epistemology, initial sampling consisted of 16 in-depth interviews with experienced clinicians. The tentative theoretical categories that emerged were then developed in theoretical sampling in further interviews with 5 of the initial interviewees. The final theoretical categories to emerge concerned the prevalence of caregiver-related problems, the provision of safety together with the prioritisation of the relationship with self as attachment-related treatment strategies, and attachment theory's provision of understanding in problem formulation. Whilst this suggests that attachment-related ideas are integrated in contemporary practice, it also suggests that the clinical utility now offered by attachment theory, as established in the literature, has not found broad appeal amongst clinicians despite the commonness of attachment-related presenting problems.

The implications of this are manifold. To begin with, attachment theorists have largely failed to bring the potential now offered by attachment-related therapeutic interventions to the market. This situation makes it incumbent on the next generation of attachment researchers to more clearly articulate techniques with which clinicians, of whatever theoretical orientation, can better leverage attachment-related knowledge in their clinical work. In this enterprise, perhaps the knowledge and experience of expert clinicians could be harvested, as this research has done. Moreover, researchers must expand the evidence base that such interventions actually work. Beyond the implications for clinical utility and efficacy, the findings strengthen counselling psychology's influence on society's perception and treatment of attachment-related problems.

***Contents***

	Page
Acknowledgements	2
Abstract	3
<b>Chapter 1 Introduction</b>	<b>7</b>
<b>Chapter 2 Literature review</b>	<b>10</b>
2.1 Introduction	10
2.2 Review of the literature	10
2.2.1 Bowlby's theory	10
2.2.2 Long-term implications of attachment experience	14
2.2.3 Attachment as a relational and transactional theory	15
2.2.4 Attachment experience and the self	18
2.2.5 Therapist as a secure base	21
2.2.6 Attachment theory in clinical practice	23
2.2.7 Attachment as a function of brain plasticity	30
2.2.8 Relation between attachment, therapeutic relationship and outcome	31
2.2.9 Theoretical model derived from clinical practice	32
2.3 What this research seeks to address	32
<b>Chapter 3 Methodology</b>	<b>34</b>
3.1 Research question	34
3.2 Epistemological stance and methodological framework	34
3.3 Research paradigm and method	36
3.4 Role of the researcher and reflexivity	39
3.5 Generalisability	42

3.6	Sampling framework and participant selection	43
3.7	Data gathering process	45
3.8	Data preparation process before analysis	47
3.9	Process of analysis	48
3.10	Ethical considerations	51
<b>Chapter 4</b>	<b>Findings</b>	52
4.1	Introduction	52
4.2	Theoretical categories	54
4.2.1	Prevalence of caregiver-related problems	54
4.2.2	Use of attachment-related strategies	60
4.2.2.1	Provision of safety	60
4.2.2.2	Prioritisation of relationship with self	64
4.2.3	Provision of understanding	71
4.3	The story of these categories	76
<b>Chapter 5</b>	<b>Discussion</b>	81
5.1	Introduction	81
5.2	How the findings relate to the literature	82
5.3	Possible further research	91
5.4	Critical review of the research and reflexivity	94
5.5	Relevance to counselling psychology practice	100
5.6	Contribution to counselling psychology	101
References		104
Appendices	Appendix A Participant invitation letter	113
	Appendix B Fully informed consent	116
	Appendix C Confidentiality agreement with transcriber	118
	Appendix D Sample interview schedule (initial sampling)	119

Appendix E	Sample interview schedule (theoretical sampling)	121
Appendix F	Sample memo (one-, two-person epistemology)	123
Appendix G	Sample memo (safety in the relationship)	124
Appendix H	Sample memo (procedural sequence)	125
Appendix I	Specimen of transcript showing initial codes	127

## ***Chapter 1 – Introduction***

Early in my training, I noticed that there is not much talk about attachment theory. Yet, in my experience, it offers so much to most of the problems that present for therapy. However, even a modicum of research told me that, although there exists a vast amount of attachment-related literature, attachment theory is somewhat of a niche interest. My intrigue with this paradox would eventually develop into the research question of the present study.

I wondered if my assessment could be right. I wondered what role it plays in the work that other therapists routinely encounter. By then, I had come across Holmes' (1993) remark that Bowlby's influence in the domain of psychotherapy never matched his influence elsewhere. He, more or less, repeated this remark in 2014. Perhaps therapists see attachment theory as a theoretical orientation, not as a paradigm that readily fits in with any of the main theoretical orientations. Or, perhaps there are better theoretical explanations of why things turn out for people as they do. After all, I was, and remain, impressed with constructivist theories, such as Piaget's (1954; 1969) stage theory of development and Vygotsky's (1978) idea of the zone of proximal development. However, I did not hear much talk about these either. For me, they are not broad enough and do not account for either the relational dimension that seems to be inherent, and unique, in each person's effort to exist in the world or the meaning-making dimension that is so instrumental, firstly, in the formation of everyone's destiny and, secondly, in the provision of hope in the therapeutic enterprise. Bowlby's theory, however, detailed in his 1988 account, *A Secure Base*, contains these dimensions. Attachment theory explains our behaviour in relationships as born of survival instincts. The theory places sensitive and understanding caregiving at the core of psychological wellbeing and, on the flipside, suffering in lived experience at the core of the distress that often becomes the subject of our work.

Besides, attachment theory provides a fitting commentary on my own experience of how life has unfolded. I have always noticed how intertwined my way of existing in the world is with my experience of the relationships I have with the most significant, requisite or inevitable figures around me. I can easily relate to the idea



that one's assessment of the viability of proximity-seeking is shaped by one's assessment of the relationships that are on offer from these figures. The thrust of the theory resonates with how my personal relational matrix has signalled the quality, meaning and satisfaction that characterise the central relationships in my life. This resonance contributed to my interest in this subject.

In saying this, I am acknowledging that I am not a neutral observer in this research. However, Charmaz's (2014) constructivist version of grounded theory, my chosen research methodology, demands that my reflexive stance examines, rather than erases, my preconceptions and this remains a consideration throughout. Yet, it is important to make the subtle distinction between having preconceptions about attachment theory and having ideas of how the research question would be answered and what interpretation, or interpretations, the answer might draw. The latter I certainly did not have at the outset. However, I aimed, on completion, to have developed a clear conviction on where attachment theory likely stands in contemporary psychotherapy and what this means for future research, clinical practice and counselling psychology more generally. My work did not disappoint in this respect.

Horvath, Del Re, Flückiger and Symonds (2011) conceptualise the therapeutic alliance as the emergent quality of partnership and mutual collaboration between therapist and client. In this sense, the therapeutic alliance is a component of the therapeutic relationship, the reciprocal relationship between them that, in many cases, is *the* therapy (O'Brien, 2010). Whilst acknowledging the distinction made in the literature between the terms 'therapeutic alliance' and 'therapeutic relationship', the participants in this research do not emphasise a distinction between them and, therefore, for the purpose of this study, they are understood as being used interchangeably.

I shall be using the term 'patient' throughout this work. As this is somewhat unusual in counselling psychology, I would like to explain my preference for this term over the term 'client'. In truth, I do not especially like either as both carry connotations that I would prefer not to build into the substance of my narrative. 'Patient' suggests a medical or pathological dimension to the person's distress whereas 'client' suggests a commercial dimension to his attendance. Yes,

sometimes, there is a medical dimension such as when a person's distress reveals itself in somatisation or when neuroleptics are provided to calm his psychotic break. We also get paid for our work. However, neither association is the main dimension to, or motivation for, my work. That said, there are no other terms to choose from. In the circumstances, I am guided by the Latin origins of each: 'patient' means the one who suffers and 'client' means the one who depends. Of these, I prefer 'patient'. Purely for pragmatic reasons, I will refer to both the patient and the therapist in the masculine except when there is particular reason to do otherwise.

The purpose of this short introductory chapter is merely to set the scene and provide some necessary understandings. The origin and development of attachment theory is revealed in the fabric of the literature review that follows because, as we shall see, much of the same material is relevant to the discussion of the findings.

## ***Chapter 2 – Literature review***

### **2.1 Introduction**

A phenomenal amount of literature concerned with attachment theorising and research has accumulated over the years. There exists a further vast body of literature that, whilst not directly concerned with attachment, nevertheless addresses itself to matters connected to it and relevant here. Of necessity, therefore, this review must be selective. It will start with John Bowlby, the father of attachment, and then present contributions of other thinkers and researchers who are allied or relevant to the story, findings and discussion of this research. Although these contributions are presented in discrete sections, some material has relevance to several of these.

Essentially, the literature speaks of the centrality of attachment to psychological wellbeing and psychopathology. Yet, for all the sophisticated understanding now provided by the literature, there emerges a sense that its clinical application is imprecise and underexploited. This resonates with my own perception of the relative anonymity of attachment theory in the counselling profession. These factors are suggestive of a gap in the research market concerned with gaining a better understanding of the role of attachment in clinical practice. At the end of this chapter, it is intended to identify one such gap in the market and set out why it would be both useful and interesting for the present study to take its place there.

### **2.2 Review of the literature**

#### **2.2.1 Bowlby's theory**

Bowlby's (1969, 1973, 1988) theory of attachment has its roots in psychoanalysis. As a psychoanalyst, Bowlby originally wished to illuminate and strengthen object relations theory (Holmes, 2014), the central tenet of which is that the person is primarily driven by his need to form relationships with other people (Lemma, 2003). Bowlby's attempt to introduce ethological theory as a scientific underpinning to object relations theory was rejected by the psychoanalytical movement, leading him to develop his own attachment theory.

The cornerstone of Bowlby's theory is that psychic structure arises from the child's actual experience of its primary caregivers. He believed that the relationship between parent and child is an instinctive psychological bond that acts to keep the child in close proximity to the mother-figure to ensure its safety. Bowlby's theory departs from object relations theory in that it does not assume that the child's behaviour, and dependency, within this relationship is predicated on the provision of food. Instead, Bowlby contended that the child is innately driven to develop relationships with others who are conceived of as better able to cope with the world and provide protection against potential anxieties. The behavioural patterns, or attachment patterns, which the child develops within this relationship are shaped by the child's experience of pain, fatigue, fear and the mother's accessibility. These factors are accompanied by emotions ranging from joy and security to anxiety, anger and depression, depending on the conduct and quality of the relationship. Consequently, the child forms a three-part internal working model, or set of expectations, comprising of a model of self, a model of the caregiver-figure and a model of the relationship between them. This working model defines the child's sense of whether there is a secure base from which he can explore and experience the world or whether he must learn to live with insecurity and the accompanying affects. This working model comes to define the worthiness that he attributes to himself and the trustworthiness that he attributes to others.

Bowlby contended that this process of internalisation leads to the establishment of attachment patterns that tend to persist over time. Moreover, he held that this process is equally applicable to adolescents and adults as they seek comfort from those around them when they are exposed to potential anxieties. However, he did not believe that the internal working model was necessarily immutable, contending that developmental pathways are continuously subject to revision, or adaptation, as they interact with the prevailing environment (Bowlby, 1973). Bowlby regarded parental behaviour as also being innately rooted, but given individual character by the parents' own environmental and childhood experiences. In summary, Bowlby subscribed to a transactional model of development: both past experiences and current conditions are important and new experiences can transform existing attachment patterns.

These tenets form the basis of Bowlby's five therapeutic tasks where the therapist: provides a secure base from which the patient can explore painful and distressing aspects of his life; encourages the patient to consider the ways in which he engages with significant figures in his life, including his expectations for his own and the other person's feelings and behaviours; encourages the patient to examine the relationship between him and the therapist; encourages the patient to consider how his current perceptions, expectations, feelings and behaviours may have resulted from his childhood and adolescent experiences, especially with his parents, or what he was repeatedly told by them, and; helps the patient to recognise that the models he has constructed of himself may no longer be, or may never have been, justified (Bowlby, 1988). Bowlby was amongst the vanguard of thinkers who believed that the therapeutic relationship must be concerned with the relational needs of the patient, contrasting with the traditional, psychoanalytic therapeutic frame that comprised his background. Psychoanalysis emphasises unobtrusiveness, neutrality and anonymity and is concerned with interpreting the unconscious meanings of the patient's communications that arise from his sexual and aggressive urges (Lemma, 2003). This tends towards a one-person psychology that assumes that the therapist, or analyst, can isolate his impact on the therapeutic relationship and that what emerges is the patient's unsullied account of his mental life and way of being in the world. However, the collaborative approach that characterises Bowlby's five therapeutic tasks, particularly his invitation to examine the relationship between him and the therapist, implicitly acknowledges the therapist's influence on the relationship. In so doing, Bowlby subtly changed the emphasis from a one-person to a two-person psychology.

The internal working models described by Bowlby give rise to certain attachment styles. Whilst accounts of these now vary somewhat, Ainsworth, Blehar, Walters and Wall (1978) originally classified them as secure, anxious and avoidant in their study of how infant behaviour is patterned in response to the 'strange situation', a laboratory manipulation of the environment. Secure attachment is thought to arise from consistently warm and responsive caregiving, leading to a model of the self as worthy and others as dependable. Associated behaviours tend to be assured with a balance between intimacy and independence. Avoidant attachment is thought to arise when caregiving is consistently unresponsive, rejecting and interfering.

Associated behaviours tend to demonstrate self-sufficiency, independence and distrust that others will be available to them. Anxious attachment is thought to arise when caregiving is inconsistently responsive. Associated behaviours tend to reveal hyper-vigilance, concern about being loved and the need to be loved.

Building on Bowlby's idea that attachment patterns tend to persist, Main, Kaplan and Cassidy (1985) developed the Adult Attachment Interview (AAI) designed to determine adult attachment styles. By reference to the structure, detail, consistency and coherence of participants' replies to questions concerning their childhood experiences with their parents, Main et al. identified three attachment patterns that adults demonstrate in current intimate caregiving and receiving relationships with adult attachment figures: autonomous (secure), dismissing (insecure) and enmeshed/preoccupied (insecure). More recently, Bartholomew and Horowitz (1991) proposed a four-category model: secure, preoccupied, fearful-avoidant and dismissive-avoidant. Presently, anxiety (concerned with monitoring the psychological proximity and availability of the attachment figure) and avoidance (concerned with regulating this anxiety by either seeking or avoiding contact with the attachment figure) are considered to be the common empirical dimensions underlying the two most common adult attachment measures (psychometric self-reports and the AAI) (Crowell, Fraley & Shaver, 2008).

Fonagy, Steele, Steele, Moran and Higgitt's (1991) study began to clarify what might be instrumental in transmitting attachment security from parent to child. In their study, they used the AAI to determine parental attachment patterns before the births of their first infants and then related these to the infants' attachment styles in the strange situation test at one year and at 18 months of age. Analysis of the AAI transcripts revealed that the parents' reflective functioning towards their infants, or their capacity to think about their infants' thoughts, feelings and desires, is the decisive mediator of the transmission of attachment security. Fonagy (2001), referring to the capacity for reflective functioning as mentalisation, described it as a product of feeling understood in the context of a secure attachment relationship. He theorised that this capacity confers on the child the ability to find meaning in the actions of others that, in turn, confers on him the ability to label and find meaning in his own experience. Moreover, he theorised that this capacity contributes to the

child's capacity for affect regulation, impulse control, self-monitoring and the experience of self-agency.

### **2.2.2 Long-term implications of attachment experience**

Despite Bowlby's idea that attachment styles tend to persist, a longitudinal study of attachment stability from infancy through to adolescence, conducted by Aikins, Howes and Hamilton (2009), found that only 25% of the participants demonstrated continuity. This study also showed a marked change in secure attachment between infancy and adolescence from 62% to 29%, providing compelling evidence for the potential for change in attachment representations. Aikins et al. put forward two possible reasons for this instability. Firstly, they suggested that it might be due to 22% of the sample having experienced significant negative life events and, secondly, that it might be an outcome of this developmental stage. They suggest that changes in cognition, self-regulation, decision-making, interpersonal relationships and increasing autonomy lead to a reassessment of attachment experiences and representations. Viewed optimistically, the findings suggest that, when reason exists, attachment representations are open to change.

Based on data from the Minnesota longitudinal study, Sroufe, Coffino and Carlson (2010) provide a comprehensive qualitative and quantitative analysis of the role of early experience in developmental outcome. The Minnesota study assessed the progress of 180 people, born into poverty, from three months before birth over a 34-year period by direct observation, formal assessments, such as temperament in infancy and early attachment patterns, and parent interviews. Development was assessed by reference to cognition, language and socio-emotional performance at home, in school, in a laboratory and in peer groups. Various dimensions of parenting were examined, such as the provision of a secure base, structure and limit setting and cognitive stimulation. Also, factors such as parent characteristics, family life stress and the availability of social support were noted.

Sroufe et al. do not link early attachment assessment to temperament, attributing it entirely to the child's interactive experience with its primary caregiver. They found that attachment assessments are strongly related to later dimensions of individual characteristics, such as dependence/independence, self-esteem, self-management

and school achievement. Moreover, attachment assessments consistently predict how later social relationship issues, such as forming close friendships in middle childhood and dealing with the intimacy of adult romantic relationships, are navigated. Sroufe et al. suggest that attachment must be seen in the context of cumulative early risk factors, such as child maltreatment, inter-parental violence, family disruption, low socio-economic status and high parental stress. They found that each of these factors predicted adolescent behaviour problems, although they did not elaborate on what these are. Significantly, they found a linear relationship between the number of risk factors and outcome. Additionally, they found that the risk factors in early childhood for maltreatment and witnessing violence, as well as the cumulative risk index, was more strongly related to adolescent behaviour problems than risk factors in middle childhood.

Nonetheless, Sroufe et al. caution that we must not ascribe unique predictive power to attachment variations. They construct early attachment experience as spawning certain core attitudinal, motivational and emotional constituents that form the basis of the child's way of existing in later peer-relationships. Initially, through responsive caregiving, the infant is likelier to become an enjoyable play partner. However, as life progresses, relational and situational demands become increasingly complex. Sroufe et al. conclude that, although clearly related, the relationship between attachment variation and developmental outcome is probabilistic rather than deterministic.

### **2.2.3 Attachment as a relational and transactional theory**

Wallin (2007) writes that Bowlby's theory can be regarded as a relational theory of development because human development takes place in the context of relationships. The implication for psychotherapy is that if its aim is to nurture the resumption of healthy development, then it, too, must be conceived as a relational process. Indeed, Bowlby's (1988) therapeutic tasks hint at a two-person relational approach. Analogous to attachment theory's idea that healthy development arises when the parent provides a secure base from which the child can make sorties into the world, Bowlby's therapeutic approach was to foster the patient's sense of security whilst inviting him to explore difficult issues within the context of the relationship developing between them.



Wachtel (2008) provides a contemporary account of working relationally. Although Wachtel conceives relational theory as a response to the one-person frame in psychoanalysis, it has relevance to other therapeutic approaches. Firstly, relational theory assumes that each participant in an encounter brings particular psychological structures, some of which are brought into play, depending on the context or events within the encounter. These psychological structures both change and are changed by the context. Secondly, relational theory rests on the assumption that anxiety lies at the core of psychic distress. Instead of facing the patient with the truth underlying his thoughts, feelings and behaviours, relational theory emphasises helping him to overcome his anxiety. Certainly, it remains necessary to expose him to his anxiety by interpreting what he is avoiding or experiencing in an unacknowledged way. Beyond this, however, the patient must be helped to face his anxiety with the emotional participation of the therapist to become experientially persuaded that facing his anxiety will not threaten the foundational relationships in his life. Therefore, the therapist must meaningfully engage with, see and relate to the patient's distress within a psychological framework that acknowledges the reciprocal causality of each participant on the quality of the relationship. The relational approach is a natural extension of attachment theory in that it involves developing the therapeutic relationship as a secure base from which the patient can experience and absorb the emotional challenge entailed in mastering his anxiety. Wallin (2007) refers to the synergy of integrating attachment and relational theories because they identify close relationships as the crucibles in which human relationships are shaped and, potentially, healed.

The mutual and reciprocal causality that is central to relational theory is suggestive of Sameroff's (1987) transactional model of development (based on his earlier work, Sameroff & Chandler, 1975, cited in Sameroff, 1987). This model sees the child as the outcome of continuing dynamic interactions between him and the experience provided by his family and social context, highlighting the complexity of tracing the role of early experience in later life. The model assumes that the child and the environment develop in tandem and that there are successive points of interaction between the two. Although not a new idea, this model emphasises the child's effect on the environment, meaning that the environmental experience is not independent of the child's influence. Besides the fixed familial and social factors,

such as family size and educational level, the social regulatory system directs the child through his development and provides protection against environmental factors with which he cannot yet cope alone. Described in these terms, the social regulatory system is reminiscent of the safe haven provided within the framework of a parent-child attachment relationship. Sameroff's model suggests that intervention strategies designed to address a problematic development trajectory must focus on transactional processes between the child and his environment. This, he says, means transforming either the child or the environment, or transforming the interpretation one makes of the other. In particular, this means remedying a factor, such as the child's diet, redefining an aspect of the situation, such as parental expectations, or re-educating the parents on raising children.

Although not presented as a transactional model of development, Repetti, Taylor and Seeman's (2002) synthetic model of risky families demonstrates the transactional nature of a dysfunctional developmental path. The model shows the influence on developmental outcome of families characterised by conflict, recurring episodes of anger and aggression, and cold, unsupportive and neglectful relationships. This model demonstrates the relationship, and transaction, between environmental and physiological factors. Central to the model is the impact of the stressful circumstances created by risky families on sympathetic-adrenomedullary (SAM) reactivity, hypothalamic-pituitary-adrenocortical (HPA) reactivity and serotonergic functioning. Repetti et al. suggest that, in children, these systems are damaged by repeated activation resulting from the chronic stress of living in risky families, thereby disrupting basic homeostatic processes and compromising their ability to summon up successful neurobiological responses. Ultimately, this leads to a host of physiological and mental health problems, such as chronic hypertension, slower cardiovascular recovery from stress, depression, suicidal behaviour and anxiety disorders. By the same token, Repetti et al. suggest that dysregulated SAM functioning leads to a hostile interpersonal style. In the manner of the transactional model described above, this aggravates conflictual social interactions that, in turn, repeatedly activate the SAM and lead to the possible development of risk factors for coronary heart disease. Unlike attachment theory, however, this developmental model does not make any assumptions about behavioural strategies that the person

might adopt, or that might organically arise, in response to the experience of existing in a risky family.

#### **2.2.4 Attachment experience and the self**

For a long time, self-esteem has been seen as an outcome of our relationships with others. As far back as 1902, Cooley wrote that

“...we find with a chill of terror that the world is cold and strange, and that our self-esteem, self-confidence, and hope, being chiefly founded upon opinions, attributed to others, go down in the crash. Our reason may tell us that we are no less worthy than we were before, but dread and doubt do not permit us to believe it. The sensitive mind will certainly suffer, because of the instability of opinion.” (p. 217)

In contemporary language, this can be taken to mean that our internal working model of self is contingent upon our assessment of how others see us and the relationships we have with them. Therefore, the ultimate arbiter of our self-worth is our fear within these relationships. This is not far off saying that our attachment relationships govern our self-worth. Cooley’s observation could serve as a preamble to Bowlby’s developmental explanation that a person’s treatment at the hands of his attachment figure determines his proneness to fear and sense of security in the world.

Besides being the central subject in Bowlby’s theory, the self is central in other theories also. For example, Kohut’s (1977) theory of the psychology of self conceptualises self-cohesion as the main driver of behaviour, with psychopathology arising when the self is experienced as fragmented. The underlying cause is attributed to a lack of parental empathy that otherwise underpins the child’s development of wholeness and self-esteem. Consequently, treatment aims to help the patient

“...to become sufficiently empathic with himself... [and] view the parental shortcomings with mature tolerance in a more forgiving light... [and] learn to cope with the unavoidable frustrations of his need for the empathic responsiveness of the environment with the aid of an increasingly varied and nuanced set of responses.” (Kohut, 1977, p. 125)

Kohut’s theory is interesting in the context of much of the literature reviewed here because, at once, it speaks to many of the important features of attachment theory and Bowlby’s therapeutic tasks. It speaks to the caregiver’s role in a person’s

development, the cohesiveness of the self, the importance of empathy and, importantly, the significance of reflective functioning and the priority of self-esteem in a person's psychological wellbeing.

Emler (2001), a social psychologist, writes of the wide-ranging and far-reaching consequences of poor self-esteem. Beyond the problems often presenting for therapy, he says that poor self-esteem is implicated in many social problems such as crime and delinquency, racial prejudice, abuse of illegal drugs, alcohol abuse, risky sexual behavior, child maltreatment, educational underachievement and chronic dependency on state support. In his analysis, the largest single source of variation in self-esteem is genetic followed by the experience that parents visit upon their children, such as the degree of love, concern, acceptance and interest shown to them. Interestingly, although Emler implicates concepts that are central to attachment, his analysis makes no reference to attachment theory.

Cast and Burke's (2002) theory of self-esteem does not draw on attachment theory either. Placing it within the framework of identity theory, they conceptualise self-esteem as the outcome of a self-verification process that serves to maintain the person within his social environment and relationships. Key to this process is the person's assessment of how he is matching the meanings and expectations required in his environment. This process, in turn, produces feelings of competency and worth that, in combination, comprise his self-esteem. Cast and Burke's theory conceptualises self-esteem as a finite resource that sustains the person at times when the self-verification process is disrupted.

Harter's (2006) conceptualisation of the self is also interesting because it shows, once again, how concepts that are central to attachment theory are, in fact, very catholic. Harter describes self-representations as cognitive and social constructions that are a function of the person's cognitive development in transaction with the meanings derived from normative social values. This transaction plays out within the realm of social experience, particularly with significant others. Self-esteem is seen as the outcome of this transaction, with the person's perspective-taking abilities playing an increasingly critical role as self-representations become more varied and complex.

Quantitative research has investigated the relationship between attachment and the longer-term impact on self-esteem. For example, Kenny and Sirin's (2006) study explores the relationship between emerging adults' (aged 22-29) assessment of their self-worth and the quality of their attachment relationships with their caregivers. They found that perceptions of parental attachment are positively associated with perceived self-worth that, in turn, have an important role in determining depressive symptoms. Similarly, Flynn, Cicchetti and Rogosch's (2014) study underlines the long-term consequences of poor caregiver experiences for adolescents within a developmental-organisational framework. Their findings revealed that maltreatment simultaneously predicts low self-worth, low relationship quality and internalising and externalising symptoms (such as depression, anxiety, aggression and disruptive behaviour) in early-mid adolescence and that this pattern persists through to mid- to late-adolescence. What makes this study interesting are the longer-term implications of poor caregiver experience on the person's assessment of his self-worth, his relational experience and the affects and behaviours that so often become the subject of therapy.

Foster, Kernis and Goldman (2007) also connect attachment with self-esteem. Their quantitative study of how the attachment system relates to the stability of self-esteem suggests that higher attachment anxiety relates to more unstable self-esteem. They also found that higher levels of self-esteem relate to lower attachment anxiety and avoidance. The researchers suggest that the dynamics of attachment anxiety and stability of self-esteem, therefore, are highly entwined and are likely to mutually impact on each other. Also in this realm is Huis in 't Veld, Vingerhoets and Denollet's (2011) investigation of Type D personality as a possible mediator between attachment style and self-esteem. Type D personality is described as a tendency to experience negative emotion, a hesitancy to self-express and insecure interaction with others. Unsurprisingly, the results confirmed that Type D personality mediates the relationship between attachment style and self-esteem. It is claimed that this evidence provides supplementary clarification of mechanisms responsible for individual differences in self-esteem and factors that need to be considered when making interventions aimed at increasing self-worth. Although the findings of many quantitative studies, such as those mentioned above, are as would have been expected, it is useful to have corroborating statistical evidence.

### **2.2.5 Therapist as a secure base**

Farber, Lippert and Nevas (1995) examined the extent to which the therapist can function as an attachment figure by reference to Bowlby's criteria for becoming an attachment figure. They conclude that, notwithstanding the unique temporal, financial, structural and ethical factors that impinge on the therapeutic relationship, therapists largely satisfy Bowlby's criteria. In Farber et al.'s analysis, patients regard them as secure bases for exploration, insurers of survival, focal points for attachment behaviour, attachment figures of long duration and objects of intense affect. Interestingly, Farber et al. also intimate that, for all the ripeness of the patients' relational nature that emerges in therapy, and our understanding of the potential clinical role of the secure base concept, there is room to more fully articulate an attachment-oriented therapy.

More recently, Farber and Metzger (2009) scrutinised the notion of the therapist acting as a secure base, contending that, at best, the comparison between the therapist's and parents' provision of a secure base is imprecise. Whilst accepting that therapists generally function as a secure-enough base for patients to engage in exploration, there are temporal, financial, logistic and ethical considerations that differentiate the therapist-patient and parent-child relationships. Beyond this, Farber and Metzger wonder if the concept of a secure base is truly distinguishable from the person-centred perspective that prescribes positive regard, empathy and genuineness. They conclude that, yes, despite overlaps, the secure base, as set out in Bowlby's conceptualisation of the therapist's function, has unique features. Firstly, the therapist must have superior ego strength to respectfully challenge the patient's internal working model. Secondly, an attachment perspective permits the therapist to hypothesise presenting problems by reference to the patient's response to the provision of a secure base, such as the extent of his dependency on security-based hyperactivating or deactivating attachment strategies to manage distress. Farber and Metzger argue, therefore, that this conceptualisation of a secure base uniquely provides the potential to explore in depth the self in relationship to others.

There are important clinical implications for Eagle's (2003) idea of an internalised secure base. By this, Eagle means the ability to evoke images of a stable and reliable attachment figure that makes that figure's physical presence, or proximity,

less necessary for security to be experienced. The felt security that arises from the constancy of an emotional connection with an internalised secure base enables the person to engage in exploration whilst also enabling him to regulate accompanying negative affect. Eagle's suggestion is that the therapist becomes available as the patient's internalised secure base when the relationships with his main attachment figures fail to fulfil this need.

Mikulincer and Shaver's (2005) contemporary model of the attachment system hinges on the attachment figure's availability and responsiveness. Ideally, the attachment system aims to create security in the face of potential or actual threats, thereby alleviating distress, fostering supportive intimate relationships and increasing both perceived and actual personal and social adjustment. When there is doubt about the attachment figure's availability and responsiveness, the person must decide about the viability of proximity-seeking as a protective strategy. This results in either hyperactivating or deactivating strategies, involving either intense appeals to attachment figures or a distancing from whatever is activating the system and efforts to manage the distress alone. Within this model, a person's core strategy and behaviour is amenable to change through the activation of mental representations of attachment security. This leads to positive mental representations of others, a stable sense of self-efficacy and self-esteem and constructive coping strategies. In turn, these act as a resource that facilitates emotional strength and stability. Contributing to this process, Mikulincer and Shaver note, is the patient's capacity to reflect on mental states that stems from the quality of his attachment relationships with his early caregivers. Mikulincer and Shaver's social psychological discussion of the creation of security draws parallels between the function served by available, sensitive, responsive caregiving and a safe haven, as described by Bowlby, and the function served by unconditional positive regard, as described by Rogers.

Saunders, Jacobvitz, Zaccagnino, Beverung and Hazen's (2011) quantitative study verifies a support figure's potential to aid the transformation of the attachment representation of a person who recalls an unloving parent-child relationship. Unsurprisingly, it was found that alternative support figures, from inside or outside of the family system, who provide quality emotional support, could facilitate a shift from insecure to earned-secure status. Crucially, such support could come from a

single figure and the age from which this was provided was unimportant. Moreover, they found that, by reference to a control group, attendance at therapy was a significant factor, where the therapist takes up the mantle of an alternative support figure. Whilst Saunders et al.'s study certainly makes a good case for the value of therapy, it hardly tells us anything new. Potentially more useful to clinical practice is their suggestion that future research might investigate how the provision of emotional support and the facilitation of reflective functioning in therapy relate to the transformation of patients' working models and achievement of earned-security.

### **2.2.6 Attachment theory in clinical practice**

Despite offering a broad model of development, attachment theory has struggled to become popular. For our purposes here, suffice it to say that the reason for this appears to be related to Bowlby's relationship with the psychoanalytic movement and the historical development of clinical and counselling psychology more generally. In the early days, its appeal was certainly limited. According to Hamilton (1987), for example, attachment theory only has limited technical applicability. In her experience, the therapist's friendly patience, concern and responsiveness, qualities thought to foster the patient's security and therapeutic change, are subverted by the patient's "wall of distrust" (p. 71). This arises because the patient's existence depends on either avoiding relationships or creating such ambivalence that any development of the relationship, or trusted companionship, ends. Hence, Hamilton states, the clinical application of attachment theory consists of pointing out correlations between attachment patterns, either past or present, and pathological patterns that develop at a later point. However, Hamilton was writing at a time when not a great deal of attachment research existed to suggest how it might find more, or better, application. Moreover, she was writing with psychoanalytic clinical work in mind at a time when the psychoanalytic movement had distanced itself from Bowlby's ideas. Since then, however, more consideration has been given to wider clinical applications.

Holmes (2014) argues that attachment theory should not be seen as a form of psychotherapy, rather as highlighting features relevant to therapy generally. Indeed, for example, central tenets of attachment theory chime with Rogers' (1961) person-centred theory, one of today's major theoretical orientations. Rogers saw the



therapeutic relationship as a helping relationship in which the therapist helps the patient to achieve "...more appreciation of, more expression of, more functional use of the latent inner resources of the individual" (p. 40). In his estimation, the healthy, well-functioning person is characterised by his relationship with himself, founded upon self-acceptance, self-esteem, self-confidence and recognition of his own agency and responsibility. Further, the person's self-actualisation, or realisation of these qualities, is dependent on the development of his self-concept that, in turn, thrives when his environment holds him in unconditional positive regard. When these qualities are lacking and the ensuing distress brings the person to therapy, then a vital dimension of the therapist's work is to create safety. "If I can free him [the patient] as completely as possible from external threat, then he can begin to experience and to deal with the internal feelings and conflicts which he finds threatening within himself", Rogers (p. 54) said. By this analysis, the therapist's role is to enable the patient to gain, or recover, his self-worth through, amongst other things, the provision of unconditional positive regard in the confines of a safe relationship.

Modern cognitive behaviour therapy also recognises attachment relationships as significant in conceptualising what has brought a patient to therapy. Beck (2011) describes how earlier experiences may be implicated in the development of a patient's core beliefs about himself, his world and others. In turn, he may protect himself against such painful core beliefs by developing certain rules for living and patterns of behaviour. Beck's clinical example is of a patient with a major depressive episode whose relevant childhood data included comparison with her older brother and a critical mother. Beck's therapeutic approach emphasises challenging the veracity and continued adaptiveness of her patient's behaviours, such as intensifying her efforts and not seeking help, to stave off her core belief that she is incompetent. However, whilst the approach acknowledges the role of earlier experiences, it does not provide for a deep exploration of how her patient's experience of attachment figures in childhood might have been instrumental in forming her core beliefs or setting up behavioural patterns that enabled her continued existence in her particular relational matrix. Neither does it speak of the role of security in psychological functioning. Importantly, the therapeutic approach

does not speak of interventions designed to alter the effect of insidious attachment manifestations operating at a subconscious level.

Other cognitive therapies, such as described by Sanders and Wills (2005), also recognise the role of early experience, particularly at the hands of caregivers, in the development of a person's core beliefs. However, on account of the possible vulnerability induced in the patient, they caution against uncovering and modifying such core constructs, and their attendant meanings, before he has learned ways of coping with the consequences. Even when working with underlying schematic issues is considered to be safe and appropriate, Sanders and Wills do not go beyond employing a cognitive technique that emphasises stretching out the patient's inflexible categories with a view to him realising that they are inaccurate and counterproductive. However, they do emphasise the significance of a collaborative therapeutic relationship in which the therapist empathises with the patient's childhood experiences with a view to making the presenting problem comprehensible and identifying understandable reasons for its development.

Young (1999) developed schema-focused therapy to treat early maladaptive schema that arise from the interaction between a child's innate temperament and ongoing, dysfunctional and noxious experiences with parents, siblings and peers during childhood. Examples of such schema are the perception that those available for support and connection are unstable and unreliable, the expectation that others will be intentionally abusive and the belief of being deprived of nurturance, empathy and protection. Young's strategies for change go beyond symptom treatment using cognitive techniques. His strategies include experiential techniques, drawn from gestalt therapy, such as creating imaginary dialogues with the patient's parents in which he responds to his parents as he would have liked, thereby helping him to begin to change his belief about himself. Also included are interpersonal techniques that help the patient to test the reality of his beliefs when relational schema are activated within the therapeutic relationship, or by simply providing a therapeutic relationship that counteracts the relational expectations of the patient. Although Young's therapy does not claim to draw on attachment theory, conceptually, it resonates with attachment theory's notion that pathological ways of being are an expression of the person's effort to tolerate traumatic, yet necessary or inevitable,

relationships. Further, his clinical strategies are resonant of Bowlby's five therapeutic tasks described earlier.

Third-wave models of cognitive behavioural therapies, such as compassion-focused therapy, have been developed to treat patients with complex and long-standing problems that, typically, involve abusive backgrounds and disturbed attachment systems (Sanders, 2010). Although presented by Gilbert (2009) as an integrated therapy that draws on social, developmental, evolutionary and Buddhist psychology and neuroscience, compassion-focused therapy fits within the cognitive paradigm in that it seeks to cognitively engage the patient to develop an internal compassionate relationship with himself, replacing the blaming, condemning and self-critical relationship. In turn, this facilitates development of the patient's soothing and social safeness system. Insofar as the therapist's key role in this transition is to help the patient to experience safeness, founded on the view that caring behaviour has a soothing effect on the object's physiology, compassion-focused therapy draws on, and chimes with, central tenets of attachment theory.

Obegi, Shaver and Mikulincer (2009) set out how attachment theory and research are used to inform and supplement clinical practice that is based on another established clinical approach, for example, cognitive-behavioural therapy. The implication for therapy of Bowlby's view that attachment relationships serve as the crucible for personality development, they say, is that the therapist should help the patient to construct, or fortify, a broaden-and-build cycle of attachment security. By this, they mean identifying the circumstances and factors that block the patient's capacity to benefit from the security offered by rewarding interactions with attachment figures. These benefits include, initially, the provision of relief from psychological distress and, ultimately, the promotion of a durable resource whereby the representation of self is internalised as lovable and capable in the face of stress. In practice, Obegi et al. say that this means developing hypotheses about the origins, mental representations and strategies that characterise the patient's attachment system and then adapting treatment, within any chosen therapeutic approach, according to the specific deficits in the patient's attachment strategies. The characteristics of the patient's attachment system are identified not only from his account of relationships and events, but also from the coherence of his narrative.

Then, within a context of an increasingly secure attachment to the therapist, the therapist can, for example, gradually shift towards a more optimal therapeutic distance, or level of intimacy, depending on the patient's anxious or avoidant attachment traits. Further examples include the use of cognitive techniques to challenge distorted ways of thinking that maintain attachment insecurities or the use of guided imagery to invoke mental representations of responsive and encouraging figures that are security-enhancing and known to increase curiosity, flexible learning, positive expectations of partners and altruistic tendencies. Here, Obegi et al. make an important connection with neuroscience, stating that a goal of psychotherapy is to reinforce components of a secure base script that are encoded as declarative and procedural knowledge in the neural networks. Interestingly, although Obegi et al.'s article is titled *A Framework for Attachment-Based Psychotherapy with Adults*, they distinguish between attachment-based therapy that relies extensively on attachment theory to conceptualise problems, assess personality and define clinical interventions, and attachment-informed therapy in which attachment theory and research are used to inform and supplement clinical practice that is based on other established orientations. Yet, the features and interventions described appear to have in mind a therapy that integrates attachment-informed ideas into established orientations.

In her wide-ranging discussion of the implications of attachment theory and research for adult psychotherapy, Slade's (2008) perspective is that this can enrich, rather than dictate, a therapist's understanding of patients, thereby complementing other kinds of clinical understanding. Yet, she notes that, whilst intrigued by attachment research, therapists remain unsure of how to apply it in their work. Slade opines that thinking about patients in terms of attachment organisation has rarely captured their imagination, possibly on account of their unfamiliarity with the methods and measures of attachment research. She notes that knowledge of a patient's attachment style is only useful in clinical work if it is meaningfully linked to technique. Slade then looks at understandings that rest on underlying principles of attachment organisation that hold the potential for techniques. For example, understanding the patient's defences as adaptations to his early relationships illuminate how and when they are activated in his current life. Also, an understanding of a patient's linguistic patterns, such as the coherence of his

narrative, provides a window into how he learned to exist in attachment relationships. This assists the therapist to formulate responses that help the patient to co-construct, with the therapist, a coherent narrative that reflects a singular, organised sense of self. Similarly, it is useful to understand the role played by the fear of failing to maintain relationships with attachment figures in the development of psychopathology, thereby informing how the patient may relinquish maladaptive ways of existing in current relationships. However, in her discussion of the implications of understanding the principles of attachment theory, Slade does not elaborate on specific techniques that might be integrated into clinical practice.

A sophisticated theoretical understanding of the relational patterns that can arise from the vagaries and demands of the primary caregiver relationships during the developmental years are brought to life in Slade's (2004) contrasting clinical examples. Particularly relevant to clinical practice is her insight that, rather than protecting herself from unacceptable unconscious wishes and fantasies, her dismissive patient's breeziness and detachment are driven by her perception that she would drive away those she needed and loved if she was needy, sad, or angry. Slade also draws attention to the role of reflective functioning (discussed elsewhere) in maintaining and alleviating presenting problems and how this reflects in the coherence of a patient's life story. However, her clinical examples are somewhat short of techniques that translate theoretical understanding into clinical practice.

Similarly, Mikulincer, Shaver, Cassidy and Berant's (2009) discussion of (insecure) attachment styles is short on clinical techniques. They describe avoidant and anxious attachment as defence strategies aimed at adaptation and self-regulation in response to distress arising from the unavailability or unresponsiveness of attachment figures. For therapists treating patients with avoidant attachment characteristics, they say that the difficulty is to prevent being drawn into their patients' rejection of emotional expression and their preference for cognitive, task-based interventions. Meanwhile, for therapists treating patients with anxious attachment characteristics, the difficulty is to prevent being drawn into their needs and ambivalent behaviours. Mikulincer et al. advocate that therapists must focus on interventions that challenge these maladaptive defences, although their clinical examples lack suggestions of appropriate clinical techniques.

Holmes (2001) brings attachment theory to life in therapeutic practice. Amongst the attachment-related concepts he discusses is the patient's sense of self and the role of his narrative as an agent of change. Holmes writes that psychotherapy's aim of helping the patient to flourish and foster wellbeing are reflected in his "...development of a strengthened and more versatile set of selves..." (p. 85). These may be a more secure self, a more creative self, a more coping self, a more resilient self or a more autonomous self. Holmes sees the therapist as the patient's assistant autobiographer who helps him to narrate a new context for his distress by seeing himself from a new, external perspective; by forgiving or blaming his parents; by acknowledging his own role in his circumstances, and; by recognising that, sometimes, he unwittingly inherits situations over which he has no control. Ultimately, this helps him to re-tell his story about himself, resulting in a fortified and more adaptable set of selves. Rather exceptionally at the time he was writing, Holmes operationalised his perspective in Brief attachment-based therapy (BABI). This is an integrative, time-limited therapy that provides guidance on how to employ attachment-related principles within various therapeutic orientations.

More recently, evidence-based programmes that apply attachment principles have emerged. For example, Cooper, Hoffman, Powell and Marvin's (2005) *Circle of Security* intervention programme for primary caregivers of infants, toddlers or pre-schoolers is based on Bowlby's therapeutic tasks and research concerning the transmission of attachment security. The programme focuses on the caregivers' internal working models and parenting behaviours and aims to help them to understand how the working models of self and others that they developed in early relationships now affect their interactions with their children. Hoffman, Marvin, Cooper and Powell's (2006) subsequent study of 65 toddler- or pre-schooler-caregiver dyads provides good evidence that, with the right guidance and treatment, attachment status can change. Most of the parents reported that they had been subjected to childhood maltreatment or trauma. The outcome of the study was that, after the programme, attachment insecurity reduced from 80% (percentage of children classified as insecurely attached pre-programme) to 46% (post-programme). It also seems to demonstrate that the major determinant of a child's attachment experience is the origin and development of his parents' internal working models and their capacity to reflect on their child's needs and mental state.

More generally, it underlines that change is possible and that attachment figures, and the quality of the relationships they provide, can make the difference.

According to Allen, Fonagy and Bateman (2008), mentalising plays a key role in healing trauma that arises from attachment relationships, particularly in childhood. However, such patients often cannot avail of the natural healing that is provided by the mentalising process precisely because they are unable to develop secure attachment relationships. The implication of this for clinical practice is that the therapist should offer the patient every opportunity to feel understood, thereby deepening his sense of felt security. In turn, this mobilises and rehearses his reflective functioning and relational skills. To this end, Allen et al. recommend that therapists should continually communicate their mental representations of their patients' current mental states and demonstrate understanding and acceptance of their patient's motivation, both good and bad. Allen et al.'s account provides, at once, a sophisticated, yet accessible, theoretical explanation and clinical guide.

### **2.2.7 Attachment as a function of brain plasticity**

Attachment theory appears to be supported by neuroscience, such as Cozolino's (2014) account of how early attachment experiences become transformed into the substance of a person's nervous system by way of three messenger systems. The first system involves neurotransmitters between individual neurons. The second system involves the biological and metabolic changes within the neuron that are precipitated by the stimulation of the adjacent neuron. The third system involves genetic transcription, triggered by cellular changes, that changes the neuron's shape and, thereby, its connectivity with other neurons. In this way, Cozolino explains, environmental stimulation gives rise to the firing pattern of neurons that, in turn, shapes the circuitry of the brain. Cozolino argues that, just as neural plasticity causes a person to develop a negative narrative out of an adverse attachment relationship, an intimate relationship with a therapist can generate a new narrative that modifies the patient's self-image, aid affect regulation and guide positive behaviour. The clinical implications of neuroplasticity for therapists, regardless of theoretical orientation, are that they should: look beyond their clinical tools to enlist positive influences on the brain; include a neural dimension in case formulation; educate their patients about the brain's role in their distress; leverage the power of

optimism; leverage the malleability of memory to help patients to transform their oppressive memories into healing stories, and; make better use of the role that a resonant, attuned and empathic relationship can play in the change process.

### **2.2.8 Relation between attachment, therapeutic relationship and outcome**

Recent research makes clear the relevance of attachment style in the therapeutic process and its role in the therapeutic relationship and outcome. Bernecker, Levy and Ellison's (2013) meta-analysis of 27 quantitative studies of the relation between patient adult attachment style and patient-rated working alliance showed there to be a negative correlation between attachment anxiety/avoidance and working alliance. This is in keeping with Diener and Monroe's (2011) meta-analysis of 17 quantitative studies which found there to be a convergence between adult attachment style and the quality of the therapeutic alliance. Both of these studies highlight the relevance of attending to the patient's attachment style with a view to fostering the working alliance. This is further highlighted when we consider the relationship between pre-treatment attachment style, the therapeutic alliance and therapeutic outcome. Levy, Ellison, Scott and Bernecker's (2011) meta-analysis of 14 quantitative studies found that attachment security and therapeutic alliance have an almost identical effect on outcome. Specifically, they found that higher attachment anxiety predicted worse outcomes whilst higher attachment security predicted more favourable outcomes, with attachment avoidance having a negligible effect. The relevance of the triangular relationship between attachment style, working alliance and therapeutic outcome is complemented by the finding, most recently in Horvath, Del Re, Flückiger and Symonds's (2011) meta-analysis of over 200 quantitative studies, that the quality of the working/therapeutic alliance still remains the best predictor of treatment success. Such research amounts to therapists being well advised to attend to the therapeutic relationship. Whilst being the best predictor of treatment success, we also know that attachment security has an almost equal effect on outcome. The combined logic of this research would seem to suggest that if therapists could prioritise making the relationships with their patients more secure, they would almost inevitably achieve a better therapeutic outcome.



### **2.2.9 Theoretical model derived from clinical practice**

Daly and Mallinckrodt's (2009) qualitative study generated a theoretical model of a clinical technique. Using grounded theory methodology, the researchers interviewed twelve therapists with various theoretical orientations and who were deemed to be especially effective in working with adults who present with interpersonal problems. The immediate aim was to determine the themes that account for the approaches used by therapists working with patients that were conceptualised as having attachment difficulties. The eventual aim was to develop a theoretical model of how therapists can facilitate a corrective emotional experience. The interviews featured twelve open-ended questions concerning vignettes that told of the behaviour, emotions and attitudes of two fictitious patients, each presenting either with anxious or avoidant attachment attributes, but without explicitly mentioning these labels. Interestingly, the process did not include a theoretical sampling phase, typically a distinguishing feature of grounded theory methodology, although the participants were involved in the data analysis and the verification of the theoretical model developed. The researchers identified eight primary themes that, ultimately, were conceptually linked by the idea that therapists can facilitate a corrective emotional experience by deliberately increasing or decreasing the therapeutic distance with a view to countering hyperactivating or deactivating behaviour. The authors described therapeutic distance as the degree of the here-and-now focus and the patient's willingness to discuss threatening material. The therapist manages these by varying the therapeutic boundaries and his gratification of the patient's needs. Variation of these leads to a corresponding variation in the patient's sense of dependency and vulnerability within the relationship. The purpose is to achieve the ideally adaptive, or appropriate, distance by the end of therapy. This study is a good example of how a theoretical model to guide interventions can be built using grounded theory methodology and data solicited from practicing expert clinicians.

### **2.3 What this research seeks to address**

There exists a vast amount of attachment related literature. Rather than seeking to do justice to what is available, the review above only purports to look at a selection of what is relevant to the current research. In the introduction, I referred to my

experience that almost all of the presenting problems that I have dealt with in my training had their origins in attachment relationships. This experience, together with my reading of the above literature, left me with little doubt about the relevance of attachment in almost all presentations. Yet, I was inclined to agree with Holmes' (1993) remark that the familiarity, acceptance and influence that Bowlby achieved in the domain of psychotherapy never matched his standing in other specialist domains. More recently, he made a similar point, saying that Bowlby's influence within the domain of psychotherapy remains muted (Holmes, 2014). I wondered how other therapists, therapists more qualified and experienced than I, see the role of attachment in their work.

My perusal of attachment-related literature over the years revealed a point that converged with my curiosity and further defined my research question. I noticed that much of the extant research has been conducted using quantitative methods and a great number of attachment measures. Many of the authors and theorists, themselves often experienced clinicians, typically rely on data that they derive from their own clinical work. It seems to me that research based on the experience and work of *other* therapists is the exception rather than the rule. Generally, it strikes me that we are overlooking to ask practitioners what their experience has taught them about certain phenomena. Unless they themselves are also researchers and authors, their wisdom tends to be lost. Perhaps, we are missing out by not tapping into and distilling this into meaningful knowledge that would be useful and interesting to the counselling psychology profession and beyond. Rather exceptionally, Daly and Mallinckrodt's (2009) study reviewed above fulfils such a purpose in the attachment arena.

My curiosity about other therapists' assessment of the role of attachment converged with the general dearth of qualitative research based on the views of everyday, expert practitioners. This led me to identify a gap in the market that the following research question is intended to fill: how do experienced contemporary clinicians perceive the role of attachment in the formulation and treatment of distress by reference to their clinical work?

### **Chapter 3 – Methodology**

#### **3.1 Research question**

How do experienced contemporary clinicians perceive the role of attachment in the formulation and treatment of distress by reference to their clinical work?

#### **3.2 Epistemological stance and methodological framework**

There are three broad epistemological stances chiefly associated with qualitative research (Willig, 2013). Firstly, the realist stance is usually interested in social and psychological processes that recognise one reality that can be understood by uncovering the patterns, regularities and structures of experience and behaviour. The researcher and participant are not assumed to have any role in the existence or construction of this reality. This stance ranges from naïve realism, which emphasises a direct relationship between what the researcher can see and what is really going on, to critical realism that proposes that observations usually require further interpretation of the underlying structures. Secondly, the phenomenological stance is usually interested in understanding the quality and texture of the experience rather than discovering the reality or the causes of it. This stance ranges in emphasis from seeking solely to describe the experience to also providing a critical and conceptual, or interpretive, commentary on the wider social, cultural and theoretical context. This range reflects the difference in the extent to which phenomenological researchers acknowledge what they themselves bring to the analysis. Thirdly, the social constructionist position is more concerned with the role of language in the construction of versions of reality. This position ranges from radical social constructionism, which emphasises people's construction of reality by reference to their particular interactional objectives, to more moderate constructionism that emphasises the influence of the wider social context. Researchers informed by social constructionism are usually assumed to be central figures in the construction of the knowledge, rather than being witnesses to it. The phenomenological and social constructionist stances could both be described as relativist, in that they emphasise the diversity of interpretations that may arise in the search for reality.

Counselling psychologists seek to understand presenting problems by reference to their patients' particular histories, life stories, relationships and meaning-making systems. By definition, this means that context is a significant part of the explanation and that there is never one reality. In this research, I wish to recognise the construction of selected clinicians' perspectives by reference to their patients' experiences that arise in their particular contexts. Further, I cannot overlook the central role that I play in this enterprise: I will have selected the clinicians and, by extension, their gender, training backgrounds, length of experience and clinical settings. I will also have asked the questions and, thereby, I will have impacted on the direction of the interviews and the data that emerge. Finally, I will have exercised choices in the analysis and interpretation of the data and the compilation of the findings. Potentially, this casts me, at once, as both part of the solution to answering the research question and part of the problem. In truth, this is probably the type of dilemma that most counselling psychologists find themselves in daily: being instrumental in the patient's contextual construction of their reality whilst having to take care that the patient becomes the author of his solution.

The research question asked here does not anticipate yielding a realist answer, purporting to have discovered one reality that exists amongst clinicians independently of my standpoint. Nevertheless, some epistemological tension is set up by my wish to act neutrally in the research process, so as to objectively observe and reflect the clinicians' perspectives of reality as they see it. This tends towards a methodology informed by a realist epistemology. However, by reference to Willig's classification of epistemological stances, the question posed here chiefly leans towards adopting a relativist, moderate social constructionist position because it anticipates that a diversity of insights will arise from the data in the search for reality as perceived and understood by different clinicians. Moreover, the researcher mediates the construction and negotiation of meaning. Charmaz's (2014) constructivist stance is highly consistent with social constructionism, perhaps distinguishing itself only in its special emphasis of the researcher's subjectivity in the interpretation and construction of reality.

The moderate constructionist stance taken here is consistent with the qualitative framework selected to address the research question. The objective of the research

question is to explore the role of attachment in contemporary psychotherapy from the perspective of experienced clinicians. This requires a framework that can flexibly capture, explore and analyse data comprising of subjective accounts and respond to emergent meanings as the research progresses. The research is undertaken in a natural setting where the researcher acts to turn the world into representations, empirical materials, with a view to interpreting the meanings people bring to the phenomena under investigation (Denzin & Lincoln, 2011). In Willig's (2013) terms, the qualitative researcher is concerned with how meaning is constructed and negotiated. In the case of this research, the empirical material out of which the meaning is fashioned are in-depth interviews with clinicians.

### **3.3 Research paradigm and method**

Grounded theory and method was selected to conduct this research. The emphasis in grounded theory is on conceptual development and theory construction (Charmaz, 2014). Although this research remained open about the possibility of developing new counselling psychology theory, the systematic and rigorous nature of this method offered the best possibility of exploring this research question.

Grounded theory was originated by Glaser and Strauss (1967) as an alternative social research method to a strict hypothetico-deductive model (Kelle, 2007). Hypothetico-deductivism is a quantitative scientific approach that is rooted in positivism and became the mainstay of social research methodology. It assumes that there is an external reality and is reliant on testing preconceived hypotheses through a process of falsification and deduction (Willig, 2013), aiming to achieve context-free generalisations by way of objective data analysis. Denzin (2011) intimates that the quantitative research paradigm, embedded in randomised control trials, was so dominant on account of its success in medical research and the accompanying political strength of medical science. In contrast to hypothetico-deductivism, grounded theory was originally devised as a method for systematically observing and analysing qualitative data and inductively allowing new ideas to emerge from the bottom up (Willig, 2013).

Willig describes grounded theory method as involving the progressive identification and integration of categories of meaning to produce a theory that provides an

explanatory framework for the phenomenon under investigation. The building blocks of grounded theory's method are data categorisation (grouping of events, processes and occurrences), coding (identification of categories), constant comparison (identification of subcategories within categories), theoretical sensitivity (continuous interaction with the data in light of emergent answers), theoretical sampling (checking and refining emergent categories as data collection proceeds) and theoretical saturation (reaching a stage beyond which no further categories are identified). A further important dimension of grounded theory, and qualitative research generally, is scrutiny of data that contrast with the major pattern, or negative case analysis, because it facilitates challenging and modifying initial assumptions and categories (Henwood & Pidgeon, 1992). This adds depth and density to the research by capturing the full complexity of the data on which it is based (Willig, 2013).

An epistemological challenge is to allow categories to emerge from the data whilst employing previous theoretical knowledge in a manner that is helpful but does not force inappropriate or preconceived categories on it (Kelle, 2007). Kelle suggests that this challenge can be overcome if any previous theoretical knowledge is on a sound methodological and epistemological footing. Thus, the researcher can distinguish between prejudicial theoretical knowledge that forces the data and helpful theoretical concepts that support the emergence of new categories.

Whilst grounded theory was intended to free the researcher from the straitjacket of hypothetico-deductivism, Willig (2013) notes that the principal criticism of grounded theory, as originally conceived, is that it does not adequately take into account that the process of observation and induction is not value-free, but that it is compromised by the standpoint of the researcher. In short, there is no such thing as objectivity. It seems that grounded theorists had not foreseen such criticism, perceiving that the researcher's objective, almost deductive, arrival at accurate depictions of the matter being investigated were protected, indeed guaranteed, by the systematic nature of the method. By this reckoning, grounded theory continued to betray positivist leanings.

Charmaz's (2014) social constructivist version of grounded theory, selected for this research, addresses this drawback. This version asks the researcher to consider and

acknowledge his role in producing a particular reading of the data, where he does not merely act as a witness in pursuit of social reality but, instead, is actively involved in its construction. According to Charmaz's account of it, social reality is constructed by reference to the researcher's position, privileges, perspective and interactions. By definition, therefore, social reality is relative, in that it acknowledges the diversity of interpretations that may arise in search of it and that generalisations are necessarily partial, conditional and situated. Charmaz emphasises the role of language in determining and expressing the diversity of meaning conferred on the phenomenon under observation. Scrutiny by the researcher of the complexities that ensue on account of the researcher's position and role in the conduct and outcome of the inquiry, as opposed to a pretence that he can be a neutral observer and expert, lends credibility to the enterprise. This is suggestive of the situatedness described in Clarke and Friese's (2007) account of situational analysis, a postmodernist development of original grounded theory that emphasises the social dimension of the understanding and analysis of any phenomenon. This assumes that everything in the situation, such as political, sociocultural and human elements, both constitute and affect everything in the situation. In this analysis, research of any kind is invariably a transactional process and transparency is only achieved when the possible dimensions of the transaction are acknowledged and assessed, particularly the researcher's own voice and role.

Coding, according to Charmaz (2014), is the pivotal link between data collection and data explanation. It is also the crucible where the researcher acts on the data by naming segments, or fragments, of it. Thus, the bones of the analysis are generated by reference to the researcher's perspective of what is material and important in the data.

A further key element in the process described by Charmaz is memo-writing. It provides a means of progressively reflecting on, and interacting with, the collected data and forming and expressing ideas. It also provides a method for making and capturing salient connections and comparisons and developing codes and emerging hypotheses and theories. Memo-writing acts as a further theatre where the researcher's perspective of the empirical world, expressed through language resonant with the researcher's meaning-making systems, implicitly frames the

enquiry and its outcome. It is the means by which the direction of the research begins to take shape and charts a path towards the conclusion. Memo-writing acts both as a vehicle for, and a chronicle of, this path.

It is possible that other methodologies and methods could be used to investigate this research question. Any or all others could yield knowledge that broadens our insights into it. However, the starting point of this research is that there is no universal answer. An exploration of the role of attachment in contemporary psychotherapy amongst a particular group of psychologists will, at best, yield only a qualified and situated answer. Simultaneously, the research is concerned with unearthing patterns and structures contained in the data with a view to constructing a conceptual framework, if not a theory, and less concerned with describing the lived and affective experience of the participants. Given the aim of the study and the source of the data, the study also lends itself to the principal characterising feature of grounded theory, theoretical sampling, whereby the researcher engages in further checking, defining and illuminating tentative categories that emerged from the earlier stages of the process (Willig, 2013; Charmaz, 2014). Therefore, grounded theory, adapted from Charmaz's (2014) constructivist version, is, at once, a suitable tool to proceed with this exploration and compatible with the epistemological assumptions underlying it.

### **3.4 Role of the researcher and reflexivity**

In contemporary qualitative research, reflexive thinking is considered to be important because, firstly, it brings scrutiny to the research process and, secondly, it prompts reflection on the ways in which the researcher is implicated in the research process and its findings (Willig, 2013). Moreover, reflexivity is the defining characteristic of Charmaz's (2014) constructivist version of grounded theory. Therefore, it is necessary for me not only to be aware of my preconceptions and how they could influence the direction of the study, but also to take steps to manage them. The objective of managing them is not to eliminate them, but to bring increased rigour and validity to the enterprise by scrutinising them for the context, quality and understanding they bring to the research process and outcome.



Willig (2013) differentiates between personal and epistemological reflexivity. The former is concerned with a variety of personal attributes such as how the researcher's values and social identity may shape the research, and the latter is concerned with a variety of theoretical matters such as how the study design and method of analysis may construct the data and findings. Whilst my personal attributes do not suggest that they will unduly influence the shape of this research, I was mindful that my passion for the subject of attachment, and its place in my professional and personal identity system, could result in an unduly positive presentation of it. As described earlier, the selection of this research originated from observations early in my training that piqued my interest in attachment theory and when I began exploring the different emphases and insights offered by various orientations in counselling psychology. This interest, and my research before I embarked on the current project, led to a growing understanding that suggested to me the importance and relevance of attachment theory to counselling psychology. My clinical experience and early research brought me to the view that attachment is never far from being part of the explanation for a great many presenting problems. Therefore, I presumed that it must also be part of the solution, although I was less certain of how this happens. It has come to play a role in shaping the lens through which I formulate presenting problems and how the aims of treatment might be fulfilled. Today, my clinical framework is assimilative, grounded in a host system comprising of psychodynamic concepts with relational and cognitive-behavioural techniques assimilated into it. Attachment theory, of course, is an important element of this framework, fitting naturally and comfortably into it. This framework has become a significant dimension of my professional identity that, in turn, has become bound up with my personal meaning-making system.

This perspective, or set of assumptions, provides a starting point, alerting me to certain possibilities and processes in the data and, thereafter, the research product will be constructed from the fabric of interactions (Charmaz, 2014). Therefore, however neutral I may wish to present myself in the process, potentially, my perspective will have a bearing on all stages of the enquiry, from my selection of the participants, the questions I choose to ask, my data analysis and compilation of the results through to my discussion of the possible implications. For these reasons, it is important for my reflexive stance to prevent this research from descending into an

indulgence of my passion or becoming a defence of a particular position as being the 'truth' (Rafalin, 2010).

I checked and moderated this possibility, firstly, by recruiting a significant initial sample of 16 participants with a balance of profiles and clinical backgrounds. I judged that this strategy would provide opportunities for a range of divergent, or opposing, data to emerge and challenge any undue influence that I might introduce. Secondly, I asked open and neutral questions that spoke of a person's ways of relating to others rather than attachment *per se*. Whilst I could not avoid alerting my participants to the importance of the subject matter to me, asking neutral questions minimised the risk of introducing 'demand characteristics', or causing the participants to consciously or unconsciously predict what might be helpful to my study and providing assessments accordingly. Next, throughout the interviews, I sought to remain non-judgemental and demonstrate openness and interest in all contributions from the participants. In so doing, I reverted to using the term 'client' during the interviews lest my preference for the term 'patient', discussed in the introductory chapter, inadvertently introduced any controversy into the conversations or distract from my objective of remaining open and neutral. In any event, my continued openness and interest were assured because, besides the research process itself contributing richly to my learning and development, I greatly valued the unique opportunity to meet with and learn from so many master practitioners at this formative time in my chosen profession. Finally, the impact of my perspective on the data gathering process and analysis, and my understanding of the implications, was kept under critical review at supervision throughout the research process. Together, these strategies enhanced the quality and rigour of the investigation, thereby providing a better footing for the outcome to find credibility and transferability outside of the situation in which I mediated it.

My reflexive stance also requires me to consider how other theoretical matters, such as how the sequence of literature review, data gathering and analysis would proceed and shape the data and findings. The use of grounded theory, actually, is somewhat problematic in this regard. The process of proposing and gaining approval from the University for this research required a review of relevant extant literature. Besides, the research proceeded in parallel with other course work that brought me in contact

with relevant attachment-related material. It is difficult to reconcile these practical demands with the theoretical requirement that, for grounded theory to be characterised as generative and emergent, the researcher must be without a preconceived problem statement, interview protocols or extensive literature review (Holton, 2007). In theory, I understand the purpose of this injunction, harking back to the problem of inadvertently employing previous theoretical knowledge in a manner that forces inappropriate or preconceived categories on the data (Kelle, 2007). In the event, I bracketed off my developing knowledge on the subject matter. Beyond this, I set aside any further literature reviews relating to the research until after I completed the data gathering and analysis. My observance of this sequence, or structure, led me to identify a vast body of previously unfamiliar material that is relevant to the findings and significant to the implications that I would eventually identify. In retrospect, I have come to regard this structure as highly interesting and productive, even if proceeding like a naïve experimenter was challenging.

With this in mind, reflexive observations are incorporated throughout this thesis. In the discussion chapter, there will be further scrutiny of my process, decisions and interpretations after the conclusion of my research.

### **3.5 Generalisability**

Glaser (2007) argues that, in spite of the caution against generalising found in qualitative data analysis literature, it is safe to generalise with a grounded category when modifiably applied. By this is meant that the core and sub-core categories of a well-grounded theory are built on contextualised content references. Therefore, Glaser contends, as the theory builds, the abstract power of grounded categories grows and can find multivariate application over a wide range of empirical areas. Put simply, whilst the ideas generated by grounded theory are linked to particular data, they can help us to understand more broadly based phenomena.

Although this research uses grounded theory procedures in the expectation of building categories and abstract concepts, it may be a more modest objective to achieve transferability. Henwood and Pidgeon (1992) describe transferability in qualitative research as the ability to apply the findings in other contexts that are

similar to the context in which they were first derived. This is akin to the discounting process, a rule that permits generalisation to cases similar to the ones the researcher has studied (Hood, 2007).

Closely bound up with transferability is sample size. Because my wish is for the study to have professional credibility and because interviews would be my only source of data, any claims that this research would make require to be grounded in data coming from a significant sample size. This is in keeping with grounded theory that favours collecting data from large initial samples (Charmaz, 2014). In the event, I conducted 16 interviews in initial sampling and five further interviews in theoretical sampling.

It is hoped that the reader will be able to determine the transferability, or the meaningfulness of this research to professional practice outside of the context of this study, from the description of, firstly, the participant selection and profile and, later, the data gathering and analytic processes.

### **3.6 Sampling framework and participant selection**

The framework chosen for sampling was purposive. This means that participants, experienced clinicians, were chosen according to criteria relevant to the research question (Willig, 2013). It was not intended to refine the sample beyond experienced clinicians because the research is intended to have a broad appeal and relevance to psychologists engaged in the counselling profession, rather than appeal only to a subgroup, say, counselling psychologists with a particular orientation.

To ensure that the clinicians could be deemed as experienced, whilst not being excessively restrictive, I decided to seek participants who were either counselling or clinical psychologists, each either registered with the Psychological Society of Ireland or chartered by the British Psychological Society and each with a minimum of 4 years post-qualification experience. To ensure that the outcome of the research would not be based on data originating from clinicians with a particular orientation and, therefore, possibly prejudice the outcome in a particular direction, I sought a broad and balanced profile of orientations. To further ensure breadth and balance, I noted the clinicians' clinical setting and gender, although I deemed a balance of these criteria as desirable rather than essential. I identified participants through a

combination of referrals from a senior member of The Psychological Society of Ireland, the psychiatric hospital where I was on placement at the time and participants in earlier interviews. I did not personally know any of the participants.

I recruited and interviewed an initial sample of 16 clinicians over an 11-week period. The profile of the participants, identified by pseudonyms, is shown in Table 1 below.

**Table 1**

***Profile of participants interviewed for initial sampling***

<b>Experience range</b>	4 – 27 years (average 10.3 years)	
<b>Principal orientation</b>	Humanistic	Catherine, Derry, Anne
	Humanistic and behaviourist	Cathal
	Psychoanalytic and humanistic	Stan
	Psychodynamic and cognitive	Liz
	Jungian and neuropsychological	Moss
	Integrative and psychodynamic	Colm
	Integrative	Tanya, Maggie
	Postmodernist integrative	Conor
	Relational	Niall
	Cognitive behavioural	Fiona, Lisa, Dermot
	Solution focused	Alastair
<b>Current employment setting</b>	Public sector hospital/primary care facility	Catherine, Derry, Conor, Niall
	Public sector hospital and private practice	Tanya, Fiona, Dermot
	Public sector institution and private practice	Maggie, Lisa
	Private practice	Cathal, Liz, Moss, Colm, Alastair
	Community and voluntary sector	Anne, Stan
<b>Gender</b>	Males	Derry, Cathal, Stan, Moss, Colm, Conor, Niall, Dermot, Alastair
	Females	Catherine, Anne, Liz, Tanya, Maggie, Fiona, Lisa

For the purpose of theoretical sampling, I selected a shortlist from the above participants on the basis of my assessment of their ability to provide fresh and interesting perspectives towards the development of my tentative theoretical categories and model. My priority was to obtain further insightful answers and critiques. Their experience, orientation, clinical setting and gender were a secondary consideration. Interviews were conducted over a three-week period. The profile of the participants, identified by pseudonyms, is shown in Table 2 below.

**Table 2**

***Profile of participants interviewed for theoretical sampling***

<b>Experience range</b>	5 – 24 years (average 10.6 years)	
<b>Principal orientation</b>	Humanistic	Derry
	Humanistic and behaviourist	Cathal
	Psychodynamic and cognitive	Liz
	Jungian and neuropsychological	Moss
	Cognitive behavioural	Dermot
<b>Current employment setting</b>	Public sector hospital/primary care facility	Derry
	Public sector hospital and private practice	Dermot
	Private practice	Cathal, Liz, Moss
<b>Gender</b>	Males	Derry, Cathal, Moss, Dermot
	Females	Liz

Overall, I am satisfied that the profile of participants throughout the process would provide me with the quality of data required to make the research appealing and relevant to psychologists engaged in the counselling profession and beyond.

### **3.7 Data gathering process**

I already knew from the referrers that the participants had provisionally agreed to participate and that they satisfied my criteria (they were either counselling or clinical psychologists, either registered with the Psychological Society of Ireland or chartered by the British Psychological Society and each with a minimum of four

years post-qualification experience). I had also been given an indication of their theoretical orientation.

I took up contact with the participants by telephone, giving them an outline of what I was seeking to do and reassuring them that my research process would protect their identity and the data that they provided. This conversation also provided an opportunity for them to clarify any matters pertinent to their decision to participate. Having obtained their agreement to participate, we arranged a time and location for the interview. Interview times and venues were arranged at the convenience of the participants. In most cases, they were held during working hours in their clinical settings although, in three cases, they were held outside of normal working hours in their homes or another venue at the participants' convenience. Some participants were already familiar with my participant invitation letter and consent form (see appendices A and B) when the referrers had forwarded these. In any event, I sent these to the participants by email before the interview. In no cases did I provide, nor was I asked to provide, a copy of the interview schedule. I believe that this ensured that I would gather data most closely aligned with the participants' clinical practice and experience.

Before each interview, I asked the participants to confirm the details of their profile. I also provided them with a further copy of my invitation letter. I then asked them to review the consent form and formally sign two copies (one copy for the participant to retain). I also reminded them that they had the right to withdraw from participation at any time during the interview. (The right to withdraw was limited to the interview because, after that point, transcription and analysis would commence and withdrawal of data would potentially compromise the direction of the work.) I then activated my digital recording device and commenced the interviews. These were semi-structured, taking the form of me reading questions from a pre-prepared schedule and asking supplementary questions to clarify or develop particular answers as the interviews proceeded. I found myself unable to take many contemporaneous written notes because I did not wish to become distracted from the task of engaging with the participants' narratives and formulating appropriate supplementary questions. However, I did write memos immediately after a number of interviews concerning thoughts or feelings that I

considered especially noteworthy. The interviews lasted between 20 and 50 minutes (averaging 36 minutes).

By the end of each interview, the participants often became more interested in the nature of my research, sometimes thanking me for the opportunity to explore this very interesting subject matter! This made debriefing the participants both easy and a pleasure. Debriefing involved apprising the participants of the specific research question and providing an opportunity to discuss these in the context of the overall aims of the research and raise questions or specific concerns. No one expressed any reservation about participating. Participants were then reassured that the interview material would be treated confidentially and as set out in the participant invitation letter. Finally, before thanking them and leaving, I asked if they would be prepared to participate in a further interview, should my data analysis warrant this. All gladly agreed to my request.

The data gathering process for the five follow-up interviews for the purpose of theoretical sampling followed similar lines. These interviews varied in length, ranging between 20 and 72 minutes (averaging 36 minutes).

### **3.8 Data preparation process before analysis**

The electronic sound files of the interview recordings were copied to my laptop as soon as was practicable. My laptop is password protected and the file names created do not contain identifying information other than the participants' pseudonyms. I have maintained a separate password protected file of all participants' names, contact details, pseudonyms and profiles. The sound files were then deleted from the recording device.

In view of the large volume of data, I used a transcriber with whom a confidentiality agreement was put in place (see appendix C). Copies of the sound files, the pseudonym to be used and a template for the transcription were given to the transcriber on a memory stick. Because I was interested only in the content of the interviews, transcriptions do not include non-linguistic features of the participants' speech, but do include incomplete sentences, false starts and repetition of words. Transcriptions were returned to me, together with the sound files, on the same



memory stick. After copying the transcriptions to my laptop, the contents of the memory stick were deleted.

I then reviewed each transcription in detail by simultaneously listening to the sound files and making corrections where appropriate. This activity involved intently listening to each interview on a number of occasions, thereby also ensuring that I became as familiar with each interview as if I had transcribed it myself.

### **3.9 Process of analysis**

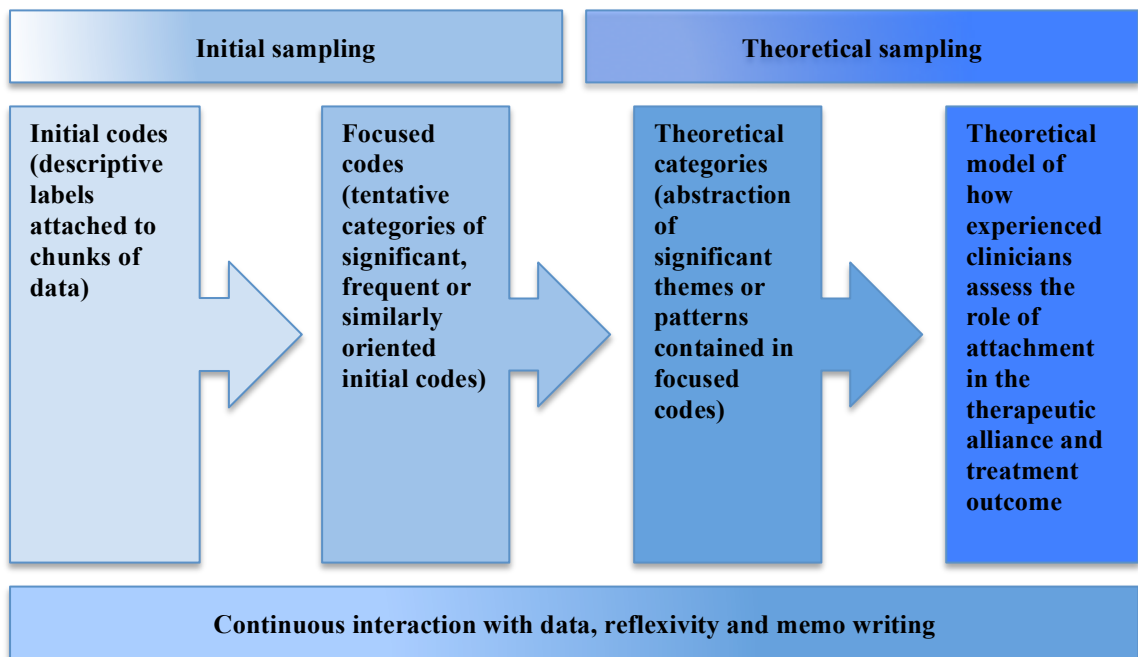
In order to manage the volume of codes that I anticipated would arise, and the subsequent analytic process, I created a spreadsheet. On this, I would record the initial codes, together with their locators in the transcript, against each participant. This would provide several advantages: it would facilitate me to readily scrutinise the data, consider what was contained in it and adjust my questions accordingly; it would facilitate me to manage the comparative analytic process whereby I could readily make comparisons and contrasts amongst and between codes and categories, and; it would facilitate me to conduct credibility checks whereby I could readily provide each participant to whom I was returning to conduct theoretical sampling with an extract of the initial codes pertaining to them for review.

In keeping with Charmaz's (2014) flexible principles of grounded theory, I interacted with the data collected in each interview as transcripts became available to me. This meant that, following preparation of the data, I performed an initial open coding exercise on each transcript. In practice, this involved attaching descriptive labels (where possible, integrating words actually used by the participants) to segments of data on an incident-by-incident basis or each thought that I identified as being material and important. After 16 interviews, using the comparative method, I began to take the view that there was sufficient support in the data to raise the most significant, frequent or similarly oriented initial codes to the level of focused codes, or tentative categories. From these, I developed a number of tentative theoretical categories that, together, would form the basis of a tentative theoretical model to answer the research question. For the purpose of testing, refining and developing these categories, I selected and interviewed five of my earlier participants. Nevertheless, I remained watchful for, and open to, data

that did not necessarily fit with my emerging theoretical categories or model. My analytic treatment of the data is represented in Figure 1 shown on page 50.

Continuous interaction with the data resulted in adjustments to my interview schedules as data collection proceeded to take account of pertinent ideas or concerns that I developed. For example, following the earlier interviews, I formed the view that my questions did not yield adequate data such as the clinicians' assessment of the commonness of distress arising from early caregiver relationships. This process resulted in either the addition or development of particular questions. Later interview schedules designed to test my tentative theoretical categories featured fewer questions than earlier interview schedules (see appendices D and E for samples of earlier and later interview schedules).

Consistent with the principle of maintaining analytic engagement with the data as I was collecting it, I wrote numerous memos concerning ideas that exercised me during the research process. Some of these related to data collected from a particular participant, whilst others related to categories that I was considering or overall impressions that I was forming. (Sample memos dealing with one- and two-person epistemology, safety in the therapeutic relationship and the possible disadvantages of holding over the literature review until after the data gathering and analysis are completed are shown in appendices F, G and H respectively.) Some memos were set aside along the way and others remained relevant until the end of the process. Generally, these memos served to document my changing assessments of the direction my research was taking, to deepen my reflection on emergent themes and to crystallise my awareness and understanding of their implications.



*Figure 1* Analytic treatment of data

### **3.10 Ethical considerations**

My participants are all experienced clinicians, many of whom had previously participated in research. Given the nature of my study, I did not anticipate or face any significant ethical risks and dilemmas. The principal practical concerns have been considered elsewhere in previous sections and appendices. Important amongst these were the participants' fully informed consent, the right to withdraw from participation during the interview, but not beyond, and confidentiality. I considered the latter to be the chief risk and went to considerable lengths throughout the research process, not only to minimise the risk of compromising the confidentiality of the participants' identities and data, but also to satisfy the participants that such was the case.

Beyond this, I sought to maintain a reflexive stance throughout the research process to ensure not only that I interacted ethically and responsibly with my participants but, also, to ensure that my use of their data in the analytic process and this write-up is judicious and respectful. Specifically, this meant continuously holding in mind my responsibility to ensure that my use of their data is faithful to the spirit of what they said and in which it was given, and that they would be satisfied with how it is represented in my findings and discussion of these. This required me, at once, to be mindful that my research aims to make a useful contribution to the profession *and* that my participants are professional colleagues whom I am likely to encounter repeatedly in my career. My handling of these considerations is the ultimate test for my ethical conduct of this research. I hope and believe that my work meets this standard of conduct.

The Research Ethics Committee of the University of East London (UEL) granted ethics approval for this research in February 2014. Whilst UEL's ethics requirements are limited to the BPS Code of Ethics and Conduct, the research is also compliant with The Psychological Society of Ireland's Code of Professional Ethics.

## **Chapter 4 – Findings**

### **4.1 Introduction**

This chapter presents the genesis and development of the three theoretical categories derived from the data. As described in the last chapter, I conducted this research using grounded theory and method. This involved, firstly, identifying tentative theoretical categories from data gathered from 16 clinicians in the initial sampling phase. Five of these clinicians were then selected for further interview in the theoretical sampling phase for the purpose of checking, refining and developing the tentative theoretical categories. The final theoretical categories formed are summarised in Table 3 shown on page 53. The chapter concludes with an outline of the overall story that emerges when the categories are considered together.

Grounded theory and method is a rigorous, yet flexible, research process. Even though the interview schedules were indicative of my area of interest, in keeping with grounded theory, I did not have preconceived ideas about the direction that the research would take. Consequently, I allowed relevant data from throughout each interview to inductively inform my codes and categories. Theoretical sampling, the distinguishing feature of grounded theory, performed precisely the task expected of it, resulting in important and material revisions to my original tentative theoretical categories. Naturally, not all of the data is supportive of the final categories. Therefore, with a view to lending transparency to the genesis and development of each category, as appropriate, the story of each will be traced through the full gamut of relevant data, including negative cases, or data that contrast with the major pattern, from initial to theoretical sampling. It is hoped that this approach will persuade the reader of the provenance and sustainability of each category. It is worth reiterating that whilst the rigour of the analytic process seeks to ensure that the findings are grounded in the data, my epistemological stance leans in a relativist, moderate social constructionist direction. Therefore, ultimately, these findings represent my perspective of what is most important and material in the data.

Where interview extracts are used, these will indicate whether the extract hails from the initial sampling phase (IS) or the theoretical sampling phase (TS) and the page number in the transcription where the extract may be found. The relevant text in the

transcription is highlighted for ease of location. Transcriptions of all interviews are contained on the accompanying USB drive. Appendix I contains a specimen of a transcript showing the initial codes that formed the basis of the comparisons and contrasts amongst and between codes, together with the final categories to which they relate. The transcriptions on the USB drive do not show this information as the initial codes were identified on hard copies of the transcriptions before transfer to the spreadsheet.

**Table 3**

*Theoretical categories derived from the data*

No.	Theoretical categories and sub-categories	Explanatory statement
1	Prevalence of caregiver-related problems	The long-term effects of difficult relationships with caregivers are implicated in most of the distress brought to therapy
2	Use of attachment-related strategies	<p data-bbox="632 1010 943 1039">2.1 Provision of safety</p> <p data-bbox="632 1346 975 1406">2.2 Prioritisation of relationship with self</p> <p data-bbox="1026 1010 1356 1308">The therapeutic relationship facilitates change, development and healing by providing a safe place that is characterised by acceptance and fulfils the function of the patient's original attachment relationship</p> <p data-bbox="1026 1346 1356 1541">The clinical priority is to attend to the patient's relationship with self, with progress towards this being revealed in his sense of worth</p>
3	Provision of understanding	Attachment theory is seen as the key theoretical construct that brings understanding to a patient's relational history and is especially relevant in circumstances where his distress arises from chronic, long-standing difficulties regulating interpersonal and intrapersonal life

## **4.2 Theoretical categories**

### **4.2.1 Category 1 – Prevalence of caregiver-related problems**

One of the principal rationales for this research was to explore if it is the experience of other therapists that much of the distress brought to therapy is connected with difficult relationships with caregivers in the formative years. Therefore, a question with this in mind was included in the initial sampling interviews. The responses ranged from stating that difficult relationships with caregivers in the formative years play only an occasional or minor role in the problems that present for therapy to stating that they are implicated in 80% of all presenting problems. Some of this variation may be attributable to the therapists' theoretical orientation. For example, a therapist with a cognitive orientation may place more emphasis on symptom treatment and, therefore, focus less on early experiences in their formulations. In developing this category, we will begin by looking at data from two participants in the initial sampling phase that does not wholly concur with it.

When asked to quantify if the role of early experiences in the distress that his patients present with is minor or significant, occasional or always, Alastair said that "...it is not an exact science now, but if I try to quantify it... occasional, minor" (IS, p. 3). Lisa, also, did not believe that relational experiences with caregivers are a large factor in the problems that present to her, saying that

...it depends on the nature of the problem. With my clients who I do Obsessive Compulsive Disorder treatment with, a lot of them come from very secure attachment. With OCD, they do believe there is a neurobiological component. Yeah, there will be a psychological component as well, but a number of my clients come from these wonderful families... (IS, p. 3)

Later in the interview, she was even more emphatic, saying

Sometimes, despite how loving a family may be, how good the attachment may be, sometimes life events are just bigger than that, sometimes it is not enough, ...especially if there has been some sort of major trauma... So, sometimes I think there are life events that have a bigger impact than attachment. (IS, p. 11)

Besides these dissenting perspectives, participants in the initial sampling phase spoke of the negative long-term consequences of early caregiver experiences in their patients' distress. Fiona's assessment is representative of, and in keeping with, many of the views expressed. She said that

For people who are more complicated, often with depression, anxiety and all that, the role of early experience is, for an awful lot of them, crucial. ...obviously, for a lot of people, it is the relationship they have with their parents and the relationship the parents have with each other, you know, the environment they are growing up in, but it can also be at school... it is not only the caregivers, but their whole upbringing, their whole experiences in growing up... (IS, pp. 1-2)

Besides her PTSD patients, Fiona implied that, for a great many of the remainder, the relationship and environment provided by their caregivers are all-important factors in the presenting problems. However, she introduced a qualification into her assessment by drawing attention to other significant figures who can impair a person's relational development despite having a secure family base, stating that

...if they have a nice secure base, that makes a lot of difference, but it doesn't protect them entirely from adverse experiences, in school, for example, and, of course, the older the child gets, the more important the peer group is. (IS, p. 2)

In her assessment of the prevalence of negative caregiving experiences, Tanya said of her patients that they have "...often been abused by their early caregivers and, very often, they come into therapy because of distress in their current relationships and there is always a link there..." (IS, p. 2). Of the long-term consequences of this, Tanya emphasised the impact that it has on the person's ability to cope with distress later in life, saying that

...it is hugely important and clients who have had an early negative experience with their main caregiver, like, if they haven't had that parental attunement or if they haven't had positive caregiving experiences as a child, often it will affect their ability to self-regulate, it will affect their ability to form relationships later on, it will affect their ability to trust others. I suppose when they have had severely neglectful experiences ...it will have a massive impact on their distress levels in later life and their ability to self-soothe, their ability to regulate within relationships. (IS, pp. 1-2)

Another participant, Moss, emphasised his personal experience in his assessment of this question, saying that the long-term implications of early experiences of relationships with caregivers are

...significant... not because research says it but what I would see... I would see that even in a man or woman in their forties or fifties could still be acting out something that is learned in the early eighteen months of life. ...I think it plays a significant role, but... it is not totally deterministic of how things are going to work out. So, do I see all people's issues psychological going back to those early years? No, not necessarily, but significantly so, yeah, predominantly so. (IS, pp. 2-3)



Dermot was in broad agreement with the perspective that adverse early relational experiences feature heavily amongst the causes of presenting problems, saying that

...clients that I have encountered over the years who present with significant distress or mood complaints... or psychological diagnoses of some description, more often than not, in my experience, it has a contribution from early life experiences, that's a common source, or a common contributor, early life adversity and dysfunctional family backgrounds, dysfunctional family relationships of some description or some severity, although it is not a given, but it's certainly, I think, more the rule than the exception. (IS, p. 3)

When asked to quantify the cases in which adverse early experiences play a role in the distress he encounters in therapy, Dermot said

Most, yeah... If you are talking about personality disorders or things of that nature... I find those kinds of diagnoses have longstanding dysfunctional parental relationship dynamics. If you are talking about transient or acute isolated mood type episodes... then it doesn't necessarily have to, it can be a situation or a scenario or an experience in life that can trip someone up momentarily in a transient sense. (IS, pp. 3-4)

Although Dermot began his answer by saying that adverse early experiences play a role in most of the distress that presents to him, he then inserted a qualification that would become clearer in theoretical sampling. Meanwhile, Stan's assessment also speaks of the prevalence of caregiver-related presenting problems. He said that

...all of the... presenting problems that would be put in front of you would have something to do with the person's relationship[s]... So, all of it to do with relationships in the here and now and how, I suppose, the backstory and the early primary caregiver relationship might inform that... (IS, p. 11)

Most emphatic in his assessment was Colm who said of the role of early experiences with caregivers in his patients' distress that "...it [therapy] is usually all about that, isn't it? ...I think everyone [all patients] falls into that category [of requiring the therapist to work with issues arising out of early attachments]" (IS, p. 1).

By this time, I was coming to the view that most therapists believe that, notwithstanding some adverse life events that can bring people to therapy, the principal reason is very often, if not usually, significantly bound up with the impact of adverse experiences of relationships with their caregivers from an early age. Therefore, out of the initial sampling phase, the tentative theoretical category that emerged was that the long-term effects of difficult relationships with caregivers are

implicated in most of the distress brought to therapy. There is very good support for this category in the data provided by Fiona, Tanya, Moss, Dermot, Stan and Colm that is presented here. It far outweighs the data that suggests otherwise although, not unreasonably, some therapists qualified their responses. Given the strength of the evidence, I did not, at this point, consider it necessary to further test and refine this category.

Although I did not specifically ask Moss in my first theoretical sampling interview about the long-term implications of early experiences, towards the end, he proffered that

...much therapy and psychology and psychiatry has ignored it [early experience], where people come in and present with symptoms and nobody ever goes back and says "Tell me a bit about what happened in your early years?" Absolutely crazy and I think in years to come, they will hit their heads off the wall and say "How could I be so stupid?" (TS, p. 7)

I perceived Moss's comment as strong support for my earlier conclusion from the data and my decision not to further explore the category that I had formed.

My second interview in the theoretical sampling phase gave me cause to reconsider my decision not to further explore this category. Whilst exploring Cathal's appraisal of the relevance of attachment theory, he wondered

Is it the most important thing in relation to most situations of distress in a therapeutic context? I don't know. Well, first, I don't know and secondly, I don't think so. I think, if that was reframed as distress that comes out of interpersonal processes or plays out even as interpersonal processes, yes. Distress in general? Maybe. Certainly a good portion of it. What portion? I don't know. (TS, p. 6)

As I reviewed the interview recording and transcription, I came to the view that, on the basis of this passage, I should provide future participants the opportunity to specifically comment on this category. Perhaps, an important refinement might result. In this passage, Cathal is uncertain initially, but he then acknowledges that distress emanating from, or manifesting in, relationships is attachment-related and that a good portion of distress in general is also attachment-related. Therefore, I decided to incorporate the substance of my tentative theoretical category into a new question in the interviews that were to follow.

In my next interview, Dermot certainly leaned towards adverse relationships being implicated in most of the distress he encounters, although he expressed some reservation about the possibility that this might be connected with difficult early relationships, saying

...we are social beings... it's a huge part of who we are and when that social fabric breaks down for one reason or another, it's often a primary driver of our distress. So, yeah, do we look to early childhood relationships to identify vulnerabilities that may have existed prior to that social fabric breaking down, I'm not sure. (TS, p. 1)

Here, he said that current relational problems are often a primary driver of psychic distress, but that he is not sure of the extent that this is rooted in early experiences. Given his perspective on this theme in the initial sampling phase, his assessment of the prevalence of the problem is still somewhat unclear. However, Dermot's assessment became clearer as the interview proceeded when he acknowledged the dominance of anxiety amongst the problems he treats and its links with early experiences, saying that

...a lot of people I come across in private practice in particular, where most of the therapy, to be honest, takes place... a huge part of that, there are really three strands, one, is a generalised anxiety, two, would be the bulk of the individuals that show up to me looking for assistance would have a social anxiety difficulty... it's pretty obvious that that is the case [that the influence of early experiences are discussed with these patients], but it is inevitable, really, in a way... (TS, pp. 2-3)

The inference contained in this passage is that early relational experiences are relevant to, and implicated in, most of his clinical work. Later in the interview, in answer to a question about the relevance of attachment theory, Dermot offered an insight that, potentially, was relevant to this category by saying that "...if we were to further split everyone who attends me, at least, into those who have chronic longstanding difficulties regulating their interpersonal and intrapersonal lives, then attachment theory crops up as being relevant most of the time..." (TS, p. 11). In combination with Dermot's previous contribution, I understood this to imply that most of the problems that present to him have their origins in difficult early relationships and now mostly manifest in long-term difficulties with regulating relationships. His comments also resonate with Cathal's remark that distress emanating from, or manifesting in, relationships is attachment-related. Therefore, I wondered if it might be more concise to restate this category as saying that difficult early relationships with caregivers, more often than not, contribute to the distress of

patients whose problems are concerned with chronic longstanding difficulties regulating their interpersonal and intrapersonal lives. However, provisionally, I decided against restating the category in these terms on the grounds that this was being overly cautious and does not contribute much towards answering my research question.

Derry did not contradict me when I alluded to my tentative theoretical category in my opening statement at the beginning of the next interview. However, later in the interview, he said

I think if we ever make statements that sound like one theory or one aspect of human experience is explanatory of all or the majority of human difficulties, that's a dangerous thing to say... people can have neurological problems from birth that are not attachment based... people can experience trauma which overwhelms them and it is not necessarily because they had a difficult attachment history... (TS, pp. 7-8)

Derry's contribution caused me to consider, once again, revising this category. Perhaps, it is the experience of therapists that difficult early relationships with caregivers are mainly associated with relational presenting problems. I sought to test this interpretation of my tentative theoretical category in my next interview with Liz. In addition to agreeing with my interpretation, she proffered that these, actually, are the most profuse therapeutic problems that she encounters, saying that

...when you are working with people who have long-term difficulties in relationships, that, very often, that is a huge contributory factor, that their early relationships with parents were difficult, so they never learned how to be in a relationship or what to expect from a relationship. ...there are, of course, some people who come [to therapy] just because of the situation that they found themselves in... but I would say the vast majority of people who come for therapy have had difficult relationships with one or both of their parents... yes, an awful lot of people who come for therapy, it is because of that... (TS, pp. 1-2)

Notwithstanding the exceptions and qualifications that some participants in the theoretical sampling phase expressed, I concluded that Liz's reference to the profusion of this problem made my proposed revision superfluous. I was again satisfied with my original tentative theoretical category that speaks of the prevalence of caregiver-related problems and describes the long-term effects of difficult relationships with caregivers as being implicated in most of the distress brought to therapy. I believe that this would find agreement from most, if not all, participants overall and four out of five participants in theoretical sampling.

#### **4.2.2 Category 2 – Use of attachment-related strategies**

Two sub-categories, the provision of safety and the prioritisation of relationship with self, formed under this main category.

##### **4.2.2.1 Provision of safety**

I began the initial sampling interviews by asking participants what they regarded as being the most important considerations when thinking about building a therapeutic alliance. The purpose of this question was to gain a sense of how the therapists conceptualised and construed the relationship with their patients. I wondered if they see their role in the relationship as quite active and directive or if they see it as an empathic, respectful and supportive role in an emotionally meaningful relationship. I also wondered how their descriptions would relate to the relational conditions usually associated with attachment literature. The dominant themes emerging from the answers in the initial sampling phase suggested that the most important consideration was to provide a safe place where patients can trust, feel at ease, come to believe that they are cared for and are meaningful in the lives of the therapists. These descriptors are a blend of, and in keeping with, the thoughts expressed by all participants, and are illustrated in the following selection of contributions.

Catherine said that she would “...really deeply care about anybody who is coming to meet me and I try to convey that caring attitude” (IS, p. 1). Lisa said that “...it’s being warm, genuine, being interested as well and showing that I care and that I want to understand” (IS, p. 1). The important considerations for Maggie were

...communicating to the person that you are interested in them, being able to empathise... Creating a space where it’s safe, where they know that you are not going to have a negative sort of reaction to whatever they are telling you... (IS, p. 1)

For Tanya, “...safety issues are very important... checking in all the time around their anxiety in the room, do they feel safe with me? ...you might have to go back to that basic, kind of, mothering...” (IS, p. 1). In Derry’s estimation, the essence of an effective therapeutic relationship centres on “...being real and being human... open and available and interested... genuine... the client needs to experience themselves as having meaning in your role in life...” (IS, p. 1). In his considerations, Stan identified a “...person-centred approach in relation to being empathic, genuine and having a non-judgemental attitude... trying to take the

pressure off them... trying to make them feeling comfortable and safe in the environment...” (IS, p. 1). The important considerations identified by Niall are concerned with “...developing comfortableness for a client... trying to alleviate some of the anxiety around attending a psychologist... trying to develop a mutual purpose...” (IS, p. 1). Dermot also mentioned comfort and safety amongst the most important consideration, identifying “Rapport... trust, pacing, warmth, empathy, having the person feel at ease, establishing a certain amount of comfort and safety within the therapeutic environment...” (IS, p. 1).

The unifying idea contained in this selection of extracts is concerned with helping the patient to feel safe and at ease. I formed the view that the qualities desired by therapists in the therapeutic relationship resembled Bowlby’s (1988) original concept of parenting as the provision of a secure base. The tentative theoretical category that emerged from the participants was that an effective therapeutic alliance provides a safe place where patients can trust, feel at ease, come to believe that they are cared for and are meaningful in the lives of the therapists. As yet, the participants had not spoken of why these qualities are important, so I decided to further explore this way of seeing the therapeutic relationship in theoretical sampling. I was mindful that Bowlby’s original concept spoke only of the parent-child relationship in which the caregiver would serve as a bedrock from which the child or adolescent can explore the world whilst the caregiver remains available to encourage, assist and, when necessary, intervene.

My tentative theoretical category was not challenged by any of the participants in theoretical sampling. Indeed, as I explored the participants’ understanding of the concept of safety, its role and application in an adult therapeutic context became clearer.

Moss described the therapeutic relationship as fulfilling a role that “...the original relationship should have been in the attachment” (TS, p. 1) and that, in these circumstances, healing can take place. He added that the therapeutic relationship

...offers self-respect towards the client where they feel they are being listened to, where they feel they are... meaningful, that they are important, that they are seen, that they are visible. All those things, which I think go back to the early days as well and the attachment where

the kid is made feel that they are important, they're seen... that's what makes it healing... (TS, p. 1)

Essentially, Moss said that the key restorative qualities of a safe therapeutic relationship are the therapist's acknowledgement and acceptance of the patient, akin to that of a parent. This resonates with what Liz said. Alluding to an earlier question relating to patients' previously unmet needs, she fleshed out the quality required of the therapeutic relationship by suggesting that its agency lies in meeting the patient's need for an unconditional relationship by saying that "...you are not punishing them or withholding from them... but where they are at, at that present time is okay, that you will still be there... and it doesn't matter if they don't fully trust you..." (TS, p. 8).

The inference of these contributions is that safety is created by the therapist's acceptance of the patient without sanction. Within this safe and accepting environment, the patient can explore intolerable aspects of himself, beginning the process of healing and transformation. In this environment, Dermot said "...we [the patients] become more accepting of all aspects of who we are. When we feel able to acknowledge things openly... [when] we can accept ourselves, warts and all..." (TS, p. 5). This is similar to Moss's assertion that the therapeutic relationship "...allows the person to go in and open up the sensitive parts of themselves... and possibly begin the process of healing... It can only happen in that authentic human relationship..." (TS, p. 1). Later, Moss emphasised the relevance of the therapist's provision of safety by saying that it facilitates the patient to establish his ultimate place of safety within himself (see separate theoretical sub-category). This "...happens through creating an external safe relationship [that is] meaningful, it's respectful, it's confidential, it's trustworthy [enabling] them to show this other side of themselves, that maybe they were frightened to show, that to be accepted..." (TS, p. 2).

The developing theme was of the provision of safety through the therapist's acceptance, thereby supporting the patient to accept himself. The link between a safe place and the patient's exploration of intolerable aspects of himself was also made by Derry, who said that "...a huge, central part of the work... [is] providing somebody with a place where it is safe to express what it is that they are feeling, to talk about things that, maybe, they have been shameful about..." (TS, p. 2). He

then suggested that change occurs when the therapist "...receive[s] that emotion and help[s] them to tolerate it and, in that, you are helping them to become more regulated, you are helping them to make... meaning of the experience." (TS, p. 3). Although, generally, it was emphasised that the provision of safety is a condition for healing, in the following extract, Dermot's emphasis was somewhat different. He appeared to challenge the value of providing safety all of the time, citing the example of a patient whose parents provided an

...incredibly safe childhood... only for them [the patient] to be smacked firmly in the face by life once they left the home and the safety of the nest. They simply were not adequately resourced and prepared for life as it stood... safety is good in a certain measure, but it is important that we don't... have an idealised view of the world and expectation of the world and that we're still very much cognisant of the reality of life and the world. (TS, pp. 6-7)

As the interview proceeds, Dermot clarifies the importance that he attaches to a safe therapeutic context, safe enough for the patient to test the water and the therapist to "...assist someone [the patient] in growing that comfort zone because it has been damaged from experiences or dysfunctional relationships... but, ultimately, growth only occurs when you stretch slightly beyond the comfort zone..." (TS, pp. 7-8). Although Dermot recognised the need for the provision of safety, his contributions speak of a caregiving role that emphasises preparation for the life ahead. Besides being suggestive of the scaffolding provided by a parent, it also suggests a somewhat more challenging approach. Cathal's perspective, however, was gentler, saying that a

...safe haven environment... is absolutely critical, it's central... so, usually, it [therapy] is starting from an uncomfortable space and, I think, if the space isn't safe enough for them to do it, it just can't get a foothold of being therapeutic... more confrontational type of treatments... [are] not actually therapeutic. (TS, p. 1)

Cathal's gentle approach was evident again when he said that

...often, the therapist can get in the way of that [change] process by their desire for the person to change, to want good things for them, we tend to push a little bit... and we insert ourselves in terms of getting in the way. (TS, p. 2)

Initial sampling illustrated that the qualities contained in Bowlby's original concept of attachment are to the forefront of therapists' minds when conceptualising the therapeutic relationship. The findings suggest that the provision of safety flows from the therapist's acceptance of the patient and that change flows from there. The



resulting category speaks of the therapeutic relationship as facilitating change, development and healing by providing safety. I believe that this commands the support of all participants in theoretical sampling. Beyond this, there is a theme, certainly in the data provided by three of the five participants in theoretical sampling, that the therapeutic relationship fulfils the role of the patient's original attachment relationship. The different emphasis placed by Dermot on the provision of safety may be understood in the context of the somewhat more challenging frame of his cognitive behavioural orientation. However, his emphasis is not sufficiently different to detract from the essence of this category.

#### ***4.2.2.2 Prioritisation of relationship with self***

As we shall see, this sub-category emerged following an extended and winding journey that broached a number of themes. This journey started with my interest in what relevance and importance my participants assign to understanding and working with their patients' ways of relating to others. I sought to discover this with a direct question in the initial sampling phase. Although most participants recognised it as a key element of therapy, their emphasis of this differed.

Stan said that

...all of the... presenting problems that would be put in front of you would have something to do with the person's relationship[s]... So, all of it to do with relationships in the here and now and how, I suppose, the backstory and the early primary caregiver relationship might inform that... So, for a number [ranking of priority in clinical work]... a 2, 3, you know, very, very high. (IS, p. 11)

Stan ranked the development of the therapeutic relationship higher only because he sees that as the basis of therapeutic work. Anne also ranked the person's way of relating to others highly. In our conversation, she concluded that "...it would be in the top three... but, sometimes, because the way that they are relating to other people that is causing them distress, so, sometimes, it is the main factor that you are working on in the session" (IS, p. 11-12). However, she ranked as more important the provision of "...the space where they feel able to look at how they relate to other people..." (IS, p. 12). When I reflected back to her that this implied a close relationship between her priorities of developing the therapeutic relationship and working with the person's way of relating to others, Anne replied "...exactly, so it is... the therapy, almost" (IS, p. 12). I found her suggestion that developing the

therapeutic relationship and working with the patient's way of relating to others as forming the twin pillars of therapy an interesting conceptualisation.

Maggie also attached great importance to understanding and working with patients' ways of relating to others but noted that this priority may be trumped by the requirements of the therapeutic setting, saying that

...this is a primary care practice, so... I get a lot of referrals from doctors... it's very much that symptom management and resolution of symptoms. However, if I was to put the importance that I genuinely feel on it, I think it is probably quite high because I think the way that the person relates... affects everything, even if the therapy is short-term, it is still a significant feature. (IS, p. 9)

Derry was unreserved in his position on the question of where he ranked working with patients' ways of relating to others, saying that he ranked it

At the top, that is what we do, isn't it? ...they [patients] come in here about problems with other people, generally. I mean, obviously, there are other difficulties, but usually they have emerged from within the context of a relationship... usually, it comes down to how they relate to someone... (IS, p. 9)

Liz was even more definite about its importance. However, interestingly, her justification of this stance is that the person's way of relating to others mediates the social support that the person receives which, in turn, informs the therapeutic outcome. Liz said that

...it [working with patients' ways of relating to others] is vital... all the research shows that those clients who do best in therapy are those who have social support and... if, because of the way they are with other people means that they don't get social support, then, in some ways, that's where you have to start. (IS, pp. 14-15)

To emphasise her conviction, she suggested that not doing so is

...ethically... very questionable... you need to know that clients have somewhere to go ...it would be something that I would work with the client to really, to really make sure that they are connecting ...the whole idea of how a client relates to the world is vital, for their recovery and for their safety. (IS, p. 15)

On completion of initial sampling, I came to the view that the data supported a tentative theoretical category that attending to a patient's way of relating to others is the top clinical priority. In light of Liz's contribution, I linked this tentative theoretical category with the notion that, mostly, the therapeutic aim is to help patients to establish a safe place somewhere so that they may achieve greater comfort in relationships. My exploration of this in the theoretical sampling stage

yielded an interesting response, not least because it provided a demonstration of the unique power and application of grounded theory in the process of amending the focus of a tentative category.

In his response, Moss proffered that, ultimately, the primary location where the patient finds safety lies within himself, saying that

...the real place of safety is within themselves and, therefore, for that place to be taken to all other places... finding the place, the safe place, where they can feel safe here, but to allow them to begin to explore outside, so inside becomes a safe place, rather than just safe places in their outside world. ...the real place of safety is within and that's what I would be looking for, but that, again, happens through creating an external safe [therapeutic] relationship... for the safe place to be created within. (TS, p. 2)

Moss linked the patient's inner place of safety with brain and mind development that occurs in the context of early relationships, saying that

...whole brain development and mind development coming from relationship and, particularly, the start of that from early relationship. ...the early relationship is really creating safety within and brain development which creates safety within. ...so, the place of safety, in my opinion, ...is that place within. (TS, p. 3)

In these passages, Moss drew attention to the person's inner world as his primary and real source of safety. He implied that the therapist's priority is to help the patient to find inner safety by recreating a relationship that propagates supportive neural structures. By this reasoning, the therapist helps the patient to look to himself for safety and healing.

Dermot gave me this impression also. In his answer to an earlier question, he said, *inter alia*, that

...the majority of my time in a therapeutic context, whether it's within a hospital or private practice, is often spent engaging with the individual as to how they relate to themselves or aspects of themselves, whether that be thoughts, whether that be emotional experiences, things they do, they don't do, they should be doing... it's an intrapersonal relationship and dynamic between what they may need from that versus what they draw from that within the context of their own life, as opposed to an interpersonal framework. Although that is still relevant, of course, but I would see the intrapersonal world or realm as being a large determinant of the interpersonal realm. (TS, pp. 1-2)

On the basis of Moss's and Dermot's contributions, I was beginning to reconsider my tentative theoretical category. Although Moss spoke of creating the safe place

within and Dermot spoke of the role of the intrapersonal realm, both homed in on the patient's inner world. Together, these contributions seemed to suggest that the clinical priority is to help the patient to establish and harness resources that lie within himself and his intrapersonal relationship. If I was in any doubt about this reappraisal, Liz comprehensively removed any hesitation I had.

In the early part of our conversation concerning the patient's expectations of relationships, Liz had suggested that "...if the client can begin to understand themselves and be in a relationship with themselves and identify their real needs, then go out into the world, they may actually begin to get what they really want" (TS, p. 5). This means that the patient's relationship with himself serves as the starting point from which to have his needs met externally. Later, Liz said that

...for me, the main priority is to help the client to find a safe place in themselves, because it's only when they find a safe place in themselves that they can have any hope of finding a safe place out there... (TS, p. 9)

The development of a person's relationship with himself begins in childhood because, as Liz said, the function of receiving unconditional love and care in childhood is to provide "...an inner sense of worth and esteem..." (TS, p. 9). However, due to the conditionality of relationships in adulthood, Liz's objective, as a therapist, is

...to help the client to find a sense of safety in themselves, that, no matter what happens, that they have somewhere inside that they can come back to and if all they can know is 'I am okay'... there is a small space inside them that, no matter what happens, I [the patient] will stay standing. ...if you can find that value and worth in yourself, then you are much more able to look at what you are bringing to relationships... (TS, p. 10)

For Liz, the person's inner sense of worth and esteem "...is about how the client relates to themselves" (TS, p. 13). This is a strong theme throughout these and other contributions that Liz made.

By this analysis, a patient's internal place of safety arises from his sense of worth and esteem, or his relationship with himself. He cannot presume that his worth and esteem will derive from his relationship with others. The therapist can help the patient to build his relationship with himself by providing a space and environment where he can explore and develop an understanding and acceptance of himself. The emergence of the patient's relationship with himself as the clinical priority

suggested that this should supersede my earlier tentative theoretical category (the patient's way of relating to others is the top clinical priority).

However, before settling on this revision, I reviewed the data from the initial sampling phase for any supportive codes that, at the time, were not deemed sufficient to signal further categorisation. Interestingly, in answer to a question concerning the priorities for intervention strategies, Catherine said that

...their way of dealing with emotions would be something I would look for, their way of how they approach themselves, so how they look at themselves and how they form who they are... and then how they relate to me in the session... (IS, p. 8)

This suggests that she privileges the patient's relationship with himself ahead of his way of relating to others. Conor had a similar priority, saying "...my goal is to help the person to have better relationships with themselves and with others, so better relationships in terms of being more in control of their relationships and themselves in that" (IS, p. 9). He again alludes to the patient's relationship with himself when explaining what lies behind the patient's ways of relating to others, saying that "...your relationship with other people is determined by your narrative position and the stories that you tell about who you are, who yourself is..." (IS, p. 10). This hints at the patient knowing himself. During initial sampling, Liz also identifies this as an important dimension, labelling it as the patient being connected to himself. Liz said

...that [the patient's connection to himself] would be something that I would always be looking at... I always would be looking at how connected is this client to themselves... I think it [connection to yourself] is about knowing yourself and accepting what you experience, even if it is difficult, and it usually is, but when you accept your experience, you are connected. That is the beginning of the work... (IS, p. 14)

These passages from the initial sampling phase further support the patient's relationship with self as the clinical priority.

During initial sampling, the patient's relationship with self did not reveal itself as a significant theme. Had I detected and probed it further, it may have emerged more strongly and opened a specific area of inquiry during theoretical sampling. Nevertheless, I had to consider the implications of its emergence at the beginning of theoretical sampling and again in two further interviews. The other two interviews

did not produce any evidence, either for or against. I also considered that some of the supporting data cited here emerged in answers to questions concerned with other categories. Ultimately, I decided that the process of comparison and contrast amongst and between codes and categories permitted and justified the revision of this category as being concerned with the patient's relationship with self.

In initial sampling, I had included a question designed to explore the implications of relational styles for the therapeutic outcome. Although varied, the responses tended to reveal factors that the participants considered to be important in mediating the therapeutic outcome. Popular amongst these were trust, openness, optimism, guardedness and flexibility. In order to complement my exploration of the therapeutic priority, I included a question in theoretical sampling that explored if levels of trust in relationships and guardedness might be useful barometers for the therapeutic outcome.

Although four of the participants acknowledged levels of trust in relationships and guardedness as useful indicators of therapeutic outcome, none were especially effusive. Liz, having earlier been doubtful that the concepts of trust in relationships and guardedness could easily be measured (TS, p. 18), directed the focus back to the patient's relationship with himself. She concluded the conversation emphatically by saying that "...it's that relationship [that patients have] with themselves that changes everything... everything changes when that changes" (TS, p. 19). Earlier, she had told me that a person's relationship with himself is about his sense of worth and esteem. Therefore, this passage clearly implies that therapeutic progress and outcome are signposted by the patient's assessment of his worth and esteem. Liz's contribution prompted me to review the data, both the participants' answers to my direct question and relevant beliefs expressed elsewhere in the interviews. To my direct question, Moss had replied that levels of trust in relationships and guardedness "...would be a very good indicator... if the person hadn't improved in trust and guardedness, possibly you could say there hasn't been much got out of the therapeutic alliance" (TS, p. 5). However, earlier, Moss had associated healing with the patient's sense of worth, saying that

...it [the therapeutic relationship] offers self-respect towards the client where they feel they are being listened to, where they feel they are... meaningful, that they have importance, that they are seen, that they are

visible. All those things, which I think go back to the early days as well and the attachment where the kid is made feel that they are important, they're seen... that's what makes it healing... (TS, p. 1)

In this passage, Moss clearly intimates that he associates therapeutic progress with the patient's sense of worth. By comparison, Cathal did not make this association. Although he agreed that levels of trust and guardedness could act as barometers of therapeutic progress, Cathal went on to say that it is "...oversimplifying it in relation to the depth that you are looking at it in..." (TS, p. 5). Derry, too, was doubtful, saying that "...simply becoming less guarded, in of itself, it may be helpful, but it may not always resolve a situation, it may not always change everything" (TS, p. 6). Dermot also seemed uncommitted, saying that he was unsure of how high up the pecking order (of indicators) a patient's level of guardedness and trust in relationships would be, but "...my guess would be that they'd be higher rather than lower" (TS, p. 9). However, in an earlier conversation about the healing mechanism in the therapeutic alliance, Dermot had said that healing has taken place

...when we become more accepting of all aspects of who we are. When we feel able to acknowledge things openly... When we feel capable of... redefining things so that they are framed differently for us and we can accept ourselves, warts and all... (TS, p. 5)

This passage suggests that healing has taken place when the patient comes to believe that he is acceptable to himself in all his manifestations, and that, after all, he has worth.

Following reflection on these passages, I was coming to the view that my participants did not endorse levels of trust in relationships and guardedness as barometers of therapeutic progress as strongly as the patient's valuation of himself. Liz provided me with further supporting data. When speaking of a particular patient's unsatisfactory relationship with her mother, Liz said

She [the patient] said to me recently 'Do you know, I'm beginning to think, maybe it wasn't me, maybe my mother wasn't able to love me.' Everything changes, because the possibility is now in her head, 'Well, maybe, I'm not bad.' Opens up a whole new world for us to explore... and if she is now not bad, maybe, she deserves something better and can start to look for that and to not get into situations where what she wants or thinks doesn't matter. She has believed her whole life that she's bad, but is now thinking, 'Oh, you know, maybe, maybe it wasn't me.' (TS, pp. 17-18)

The implication of this passage is that her patient's reassessment of her worth marks her progress towards a tipping point in therapy. Taken together, the contributions of three of the five participants in theoretical sampling strongly suggested that a better indicator of therapeutic progress and outcome is the patient's assessment of his worth.

A significant theme that eventually emerged in this research is attending to the patient's relationship with self. Furthermore, the quality of his relationship with self is bound up with his attainment, or recovery, of his sense of worth. In sum, the data reviewed here supports a category that identifies attendance to the patient's relationship with self as a clinical priority, with progress towards this being revealed in his sense of worth.

#### **4.2.3 Category 3 – Provision of understanding**

The purpose of this research was to gain an impression of the role of attachment in the work of modern-day therapists. Throughout the research, I sought to minimise the risk of causing the participants to predict that I might be seeking answers that are sympathetic to attachment theory. Therefore, in the initial sampling phase, I focused on open and neutral questions that spoke of a person's ways of relating to others rather than attachment *per se*. Having gained an impression, my strategy was for my questioning to be more direct in the theoretical sampling phase so as to allow agreement or otherwise to easily emerge. The impression I gained from the initial sampling phase was that, for a number of reasons, the concept of attachment, although muted, plays a significant role in the formulation and treatment of most forms of distress encountered by the participants.

Firstly, I had come to the view that, notwithstanding some adverse life events that lead people to attend therapy, the participants' dominant reason for their patients' attendance is, more often than not, bound up with their experiences of relationships with their caregivers from an early age. Secondly, the participants' twin priorities are to support the development of the therapeutic alliance and to work with their patients' ways of relating to others. Thirdly, their therapeutic objective is concerned with helping their patients to achieve greater comfort in relationships.



For these reasons, in the theoretical sampling phase, I sought to test if it could be suggested that attachment theory underlies much, or most, clinical work and that it is the most important theoretical construct to both understand and address the distress of most patients.

In his response to this suggestion, Moss said

...I am not going to say it is the most important and I'm not going to say that it is not. I am definitely going to say that it is very important and, therefore, that is something that has to be looked at, or the therapist has to be aware of when working with somebody. (TS, p. 6)

Once I re-emphasised that my suggestion intended to exclude patients whose distress is not concerned with relationships, Moss said "...I think it [attachment] is [probably the single most important theoretical construct] ...it has to be because the medium of the relationship is a lot to do with attachment... I think it is one of the most important tenets..." (TS, p. 7). Although, at the end of the interview, he expressed astonishment at clinicians who never enquire about what happened in their patients' early years, he does not emphasise interventions designed to treat particular attachment presentations. Essentially, Moss's agreement to my suggestion is on condition that the presenting problem is relationally based. However, as Moss made these contributions, I was mindful that, during initial sampling, he had said that, in his experience, patients' presenting problems were predominantly connected to their early experience. The combined logic of his last and his earlier contributions would appear to suggest that, in his work, attachment theory enjoys the highest standing.

Cathal also emphasised his conditional agreement to my suggestion, saying

...I accept that position... if the relationship is the source of the distress... so, taking that position, is attachment one of the most important theories available to us from a therapeutic point of view if there is distress emanating out of a relationship context? Absolutely. (TS, p. 6-7)

When I explored the application of attachment theory further with Cathal, he opined that it is one of the top five theories used by therapists in clinical practice, albeit that "It is something that predominantly features in the background, almost unconsciously, but not necessarily something that we bring into our interventions..." (TS, p. 8). I had earlier wondered if therapists employ attachment theory in the background. I knew immediately that Cathal's elaboration on my

conjecture was a significant contribution, although I would not come to a considered view of how it described the standing of attachment theory in contemporary practice until after the data collection, analysis and literature review were complete. His statement is also in keeping with the data he had provided during initial sampling. When asked if early experiences of relationships with caregivers have a role in the distress that his patients often present with, Cathal said that "...[early experiences of relationships with caregivers] always... contextualises a lot of the problems that the person encounters in their life..." (IS, pp. 5-6).

By this time, my concern was less about what importance my participants considered attachment theory to have in understanding and treating distress and more about how best to frame the condition for when it is a major consideration. I was also becoming increasingly mindful that the condition was related to the development of my first theoretical category (the prevalence of caregiver-related problems).

Initially, when I put my suggestion to Dermot, he judged it to be valid but incomplete, stating that

...it [attachment theory] is always relevant... I always want to know how people experienced childhood, how people experienced their lives. Whether or not they had... appropriate peer relationships throughout their youth and beyond, and whether or not they had supportive, nurturing parents, but attachment is not always the determining factor of why someone is struggling... (TS, p. 11)

Although, he did not set out what other factors account for why people are struggling, he suggested that learning theory is relevant also. Dermot then distinguished between the circumstances in which attachment theory and learning theory find application, saying that

...if we were to further split everyone who attends me, at least, into those who have chronic longstanding difficulties regulating their interpersonal and intrapersonal lives, then attachment theory crops up as being relevant most of the time, but if people's difficulties are more acute in nature and short-lived, well, then it doesn't appear to be... learning theory seems to, kind of, trump it in my view, more often than not, in those circumstances. (TS, p. 11)

This passage cannot be understood in isolation of data that Dermot had provided earlier in the interview. That earlier data, used to support the first theoretical category (the prevalence of caregiver-related problems), suggested that relational

issues, particularly early childhood relationships, are implicated in the problems presented by most of his patients. As with Moss, the combined logic of Dermot's above and earlier contributions would suggest that attachment theory is the theory that finds most application in therapeutic practice. Nevertheless, Dermot's reference to the relevance of attachment theory when chronic longstanding difficulties regulate interpersonal and intrapersonal life offered a sophisticated refinement to this category.

I incorporated Dermot's reference of the circumstances in which attachment theory finds application into my next interview with Derry. He was not minded to make this distinction, saying that people can have problems that are not attachment-related, citing the examples of neurological problems from birth or neurological problems or trauma that arise later in life. Derry summed up his position by saying that

...we need to think of theories as being as relevant as each other. I mean, the salience of particular constructs may be different in different cases, may be different at different points in time... I think that there is an assumption in a lot of attachment approaches that attachment is, kind of, the answer to everything, but it's not... Whereas it's an important thing to consider, it is not the only thing to consider. (TS, p. 8)

Derry also made an interesting point, not touched on by any of the previous participants, that frames attachment as a common denominator in all trauma. He suggested that people's attachment history could mediate problems that they experience insofar as a positive attachment history may act as a protection against the impact of trauma. Interestingly, in my next interview, Liz touched on a similar point, saying that a person with a stable, secure start may use that as a stable reference point to better cope with trauma that befalls him in adulthood. Potentially, this gives a decisive role to attachment in the experience of all trauma. However, I quickly decided not to explore this further because it was unlikely to illuminate or refine the particular theoretical categories that were in formation at that time. At this juncture, my principal concern was how Derry's contrasting assessment of attachment theory would impact on, or could be integrated into, the further development of this category.

Liz's assessment proved to be quite different. She said that

It is certainly important that you understand how people relate and I think that attachment theory brings that understanding... there is one thing knowing how somebody relates, it's a whole other thing understanding why they are doing that... you really do need to understand why that is... attachment theory gives a real understanding of that... it's one of the first jobs... (TS, p. 20)

Here, Liz endorsed the utility of attachment theory. However, she limited its utility to bringing an understanding to how people relate, but not as providing the basis of a clinical intervention. Liz goes on to say "...understanding that [the patient's attachment history], so that you can then work towards building some sort of a relationship... wherein they feel safe with themselves and with you" (TS, pp. 20-21). In these passages, Liz appears to confine the role for attachment theory to the formulation component of psychotherapy. Nevertheless, I formed the impression that the perspective she had conveyed during this interview was strongly aligned with attachment theory. I put it to her that nearly all of what she had talked about somehow falls out of attachment. Liz replied

...yeah... absolutely... because isn't that what attachment is about, isn't that what being a parent is about. It's about providing the child with what they need in order to live their lives on an emotional and psychological level and when they don't get that, or enough of it, then it's going to impact the emotional and psychological part of their lives, no matter what they do. ...for the child, it is as important as the food and drink... (TS, pp. 22-23)

This passage acknowledges the core of what attachment theory has to say about the development and nourishment of a person's psychological and emotional life. It does not, however, speak of an explicit role for attachment theory in clinical treatment.

In the course of the interview, Liz declared that she currently works with people who have experienced abuse in childhood. However, it is important to note that her perspective does not derive solely from her experience of this patient group because, earlier in the interview, Liz had said that the vast majority of people who come to therapy generally have had difficult relationships with one or both parents (TS, p. 2). Therefore, notwithstanding the likely role of her current work experience in fashioning her perspective, it is reasonable to infer that her account is representative of her overall perspective. Indeed, as the interview drew to a close, I felt sufficiently clear about her perspective to deem it unnecessary to invite her to

comment on Dermot's refinement concerning the circumstances in which attachment theory is the most important theoretical construct.

I judged that I now had sufficient data from my participants in the theoretical sampling phase to refine this theoretical category. This category speaks of the provision of understanding. Notwithstanding Derry's counterbalancing perspective, the data of the remaining four participants would seem to suggest that attachment theory is the key theoretical construct that brings understanding to a patient's relational history. The data is somewhat ambiguous about the need to qualify this category further by specifying its relevance in circumstances where the patient's distress arises from chronic, long-standing difficulties regulating interpersonal and intrapersonal life. In the circumstances, I decided to retain this refinement. Cathal's data positions attachment theory as operating in the background, rather than in the forefront of intervention, and would seem to express the standing of attachment theory amongst most, if not all, participants in this research.

### **4.3 The story of these categories**

The research question asked: how do experienced contemporary clinicians perceive the role of attachment in the formulation and treatment of distress by reference to their clinical work? The purpose of this section is to connect the theoretical categories presented in the last section in a coherent story of how this question might be answered.

The first category speaks of the prevalence of caregiver-related problems. Notwithstanding the exceptions and reservations expressed by some participants, the balance of evidence supports the proposition that the long-term effects of difficult relationships with caregivers are implicated in most of the distress brought to therapy. During theoretical sampling, consideration was given to refining this category by associating it with patients who currently experience long-term difficulties with regulating relationships. However, the balance of evidence suggests the predominance of problems that have their origins in difficult relationships with caregivers and, therefore, this revision seemed superfluous.

The next category speaks of the use of attachment-related strategies. These strategies are two-fold, firstly, the provision of safety and, secondly, the

prioritisation of relationship with self. The first of these sub-categories developed out of the exploration of how therapists conceptualised their relationship, or alliance, with patients. At the heart of their conceptualisation lies safety that facilitates change, development and healing. Indeed, in an adult context, an effective therapeutic relationship is characterised by acceptance and offers dimensions of the patient's original attachment relationship with his caregiver.

The second sub-category, the prioritisation of relationship with self, grew out of a tentative theoretical category that stated that the principal clinical priority is to attend to a patient's way of relating to others so as to help them to achieve greater comfort in relationships. Theoretical sampling was to change this from 'other' to 'self' and also bring the concept of safety back to centre stage. Patients' comfort in their relationships with others springs from their sense of safety but, importantly, the data suggested, this emanates from the safety derived from their inner world and their relationships with themselves. Therefore, the resulting category states that the clinical priority is to attend to the patient's relationship with self, with progress towards a good outcome characterised by his achievement of a sense of worth.

The narratives of the participants in relation to these categories do not suggest that they necessarily look to attachment, or attachment theory, when speaking of their experience and beliefs concerning typical presenting problems, the therapeutic relationship and what dimension of therapy is considered to make a difference to the patient's psychic distress. Yet, the findings speak of a preponderance of problems arising out of relationships with original caregivers, the significance of the provision of safety and the prioritisation of the relationship with self. Moss provided a précis of these themes, and captured the essence of contemporary therapy, when he said that

...it [the therapeutic relationship] offers self-respect towards the client where they feel they are being listened to, where they feel they are... meaningful, that they have importance, that they are seen, that they are visible. All those things, which I think go back to the early days as well and the attachment where the kid is made feel that they are important, they're seen... that's what makes it healing... (TS, p. 1)

These themes are to the forefront of what attachment theory has to say about human distress and psychotherapy. On this basis, it could be considered that attachment plays a very significant role in the work of contemporary psychotherapists.

The final category acts to put this conclusion into perspective. This category emanates from directly asking the participants for their assessment of the relevance and importance of attachment theory. Following refinement in theoretical sampling, the category speaks of the provision of understanding, where attachment theory is seen as the key theoretical construct that brings understanding to a patient's relational history and is especially relevant where his distress arises from chronic, long-standing difficulties regulating interpersonal and intrapersonal life. In the course of this refinement, Cathal said that "It [attachment theory] is something that predominantly features in the background, almost unconsciously, but not necessarily something that we bring into our interventions..." (TS, p. 8). Cathal's comment was to become a telling contribution towards my overall assessment of the findings in answer to the research question. Yes, much of the data underlying the categories, although not articulated by the participants as concerned with attachment theory, are replete with ideas relating to it. Therefore, because its fingerprints are all over the work of modern practitioners, I could argue that attachment theory is alive and well. Yet, just like Cathal said, the findings do not speak of interventions designed to address particular attachment characterisations or involving particular principles of attachment theory.

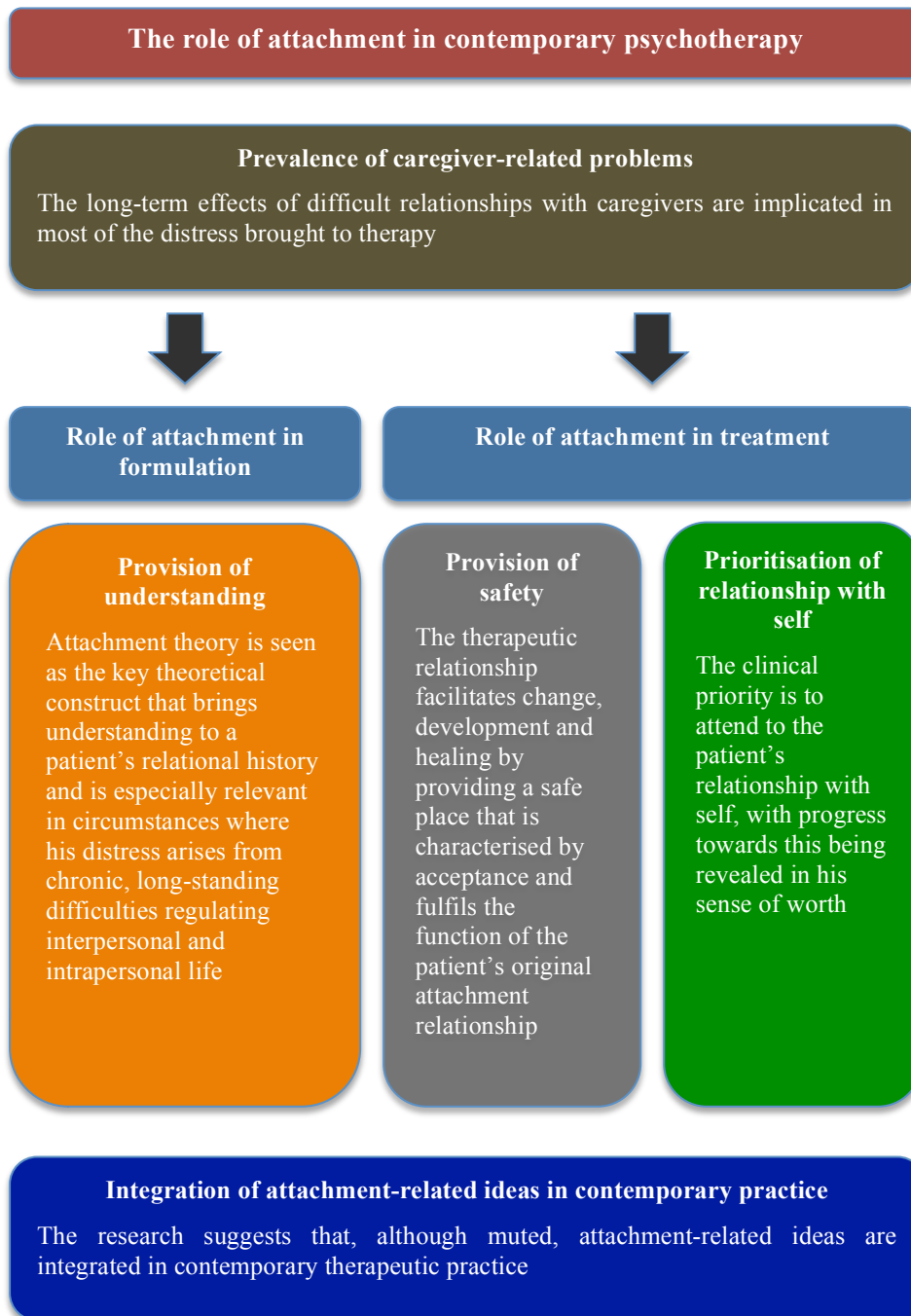
The *prima facie* evidence of the manifestation of the word 'attachment' throughout the interview process would seem to support Cathal's comments. A statistical analysis of the participants' unprompted references to the word 'attachment' revealed the following: in 21 interviews spanning 12 hours and 36 minutes, it was only used on 70 occasions where it had not been introduced by me in my immediately preceding question or contribution to the conversation. If one participant (who, interestingly, is a cognitive behavioural therapist) is excluded from this analysis, then this statistic goes down to 47 references in 12 hours. If this shows anything, it is that attachment, or attachment theory, does not occupy a hallowed and privileged place in their minds and conversations.

Overall, the story of these categories would seem to suggest that attachment plays a more muted role in contemporary psychotherapy than it first appears. The role of attachment theory appears to be mainly reserved for case formulation, bringing understanding to attachment-related presenting problems that appear to dominate the work of therapists. However, its role becomes more subtle in treatment, where

the approach of therapists embodies principles espoused by attachment theorists rather than employ interventions designed to counter particular attachment-related manifestations. In this light, it may be more accurate to speak of the integration of attachment-related ideas in contemporary therapeutic practice.

Attainment of theoretical saturation, or the point at which gathering more data does not serve to further develop a particular category, is a matter of disagreement amongst grounded theorists (Charmaz, 2014). In keeping with my moderate social constructionist epistemological stance, I prefer to think of this as my judgement of when a satisfactory picture of the phenomenon under investigation has been forged within the context of the research. For our purposes here, I judge each category to have fulfilled this standard. However, a critical discussion of this will be included in the next chapter. Beyond this, rather than lay claim to the discovery of new theory, I prefer to describe the findings as a theoretical model of the role of attachment in contemporary psychotherapy, represented in Figure 2 overleaf. This model informs perspective-taking and draws attention to implications that are relevant to counselling psychology practice and the discipline of counselling psychology more generally. These matters will be taken up in the chapter that follows.





**Figure 2** Theoretical model of the elements that comprise the role of attachment in contemporary therapeutic practice

## **Chapter 5 – Discussion**

### **5.1 Introduction**

There is overwhelming evidence that early relationships have a critical role in setting up a person's developmental outcome, or life prospects. Besides what Bowlby (1969, 1973, 1988) and later writers, such as Holmes (1993, 2001, 2014) and Wallin (2007), tell us based upon their own clinical experience, there is an impressive array of large-scale studies that validate this position. Sroufe et al.'s (2010) treatise, based on the Minnesota longitudinal study, stands out amongst these. What this evidence says has probably been beyond debate for a long time, although current researchers, such as Huis in 't Veld et al. (2011) and Saunders et al. (2011), continue to gather evidence. Research, brought together by such meta-analyses as those by Bernecker et al. (2013) and Diener and Monroe (2011), highlights the relevance of attending to the patient's attachment style with a view to fostering the therapeutic relationship. If that evidence is not enough, we should note Levy et al.'s (2011) conclusion, based on a meta-analysis of studies concerning the relationship between attachment style, therapeutic outcome and therapeutic alliance, that attachment security and therapeutic alliance have an almost identical effect on therapeutic outcome. And, as we know from a great many studies, brought together by, for example, Horvath et al.'s (2011) meta-analysis, the quality of the working/therapeutic alliance still remains the best predictor of treatment success.

The foregoing literature would seem to suggest that the case for attachment theory is open-and-shut. However, it may not be as simple as that because the findings suggest that the participants did not blithely fall in with any perception that such might be the case. Indeed, there are a number of ways that the theoretical model that describes the role of attachment in contemporary therapeutic practice, illustrated in Figure 2 on page 80, may be interpreted. These range from the view that attachment is prominent in the work of practitioners to the view that the results reveal a lost opportunity in clinical practice.

The following section will discuss three possible interpretations of these findings by reference to the literature introduced in Chapter 2. I will then consider what further

research the findings, and my interpretation of them, might call for. Then, I will critically, and reflexively, review the strengths and weaknesses of my research before examining its relevance and contribution to therapeutic practice and counselling psychology more generally.

## **5.2 How the findings relate to the literature**

The first interpretation of the findings is that attachment and attachment-related ideas feature prominently in the work of contemporary therapists. Against a background where they believe that the long-term effects of difficult relationships with caregivers are implicated in most of the distress brought to them, their provision of safety and prioritisation of the relationship with self could be regarded as reflecting a strong attachment-related focus. This may be concluded for a number of reasons. Firstly, the provision of safety, and the main qualities of the participants' conceptualisation of the therapeutic relationship, is resonant with the first of Bowlby's (1988) five therapeutic tasks. Bowlby described this as providing the patient with

...a secure base from which he can explore the various unhappy and painful aspects of his life, past and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion, guidance. (Bowlby, 1988, p. 156)

Secondly, the findings suggest that the provision of safety resides alongside the prioritisation of the relationship with self, with sense of worthiness as a measure of progress. Once again, this is suggestive of a close alignment with central tenets of attachment theory. After all, central to Bowlby's theory is the idea that the child's internal working model, inclusive of his model of himself, arises from the conduct and quality of his relationship with his caregivers, thereby setting up his sense of security in the world and his strategies, and attachment styles, for existing in it. The alignment of the findings with attachment theory continues when considered by reference to Ainsworth et al.'s (1978) original account of attachment styles that associates secure attachment with a model of self as worthy. The resonance with attachment theory persists when considered by reference to Mikulincer and Shaver's (2005) contemporary account of the utility of attachment theory that speaks of self-efficacy and self-esteem as dimensions of attachment security. Further resonances

with an attachment-related perspective may be recognised in Holmes (2001). He writes that security and self-esteem are intimately linked and that therapy aims to promote the patient's wellbeing by improving the strength and versatility of his set of selves, such as his secure self, creative self, coping self, resilient self and autonomous self. Recent studies not only draw attention to the relationship between attachment and the model of self, but provide evidence for it. For example, Sroufe et al.'s (2010) extensive study found that early attachment patterns are strongly related to individual characteristics such as self-esteem. All of these practitioners and scholars of attachment appear to place safety, or security, alongside the self, just as the findings appear to do. On this basis, there is good evidence that attachment and attachment-related ideas feature prominently in the work of contemporary therapists.

The second interpretation of the findings is somewhat more complex. This interpretation suggests that the findings are imbued with ideas that masquerade as attachment-related ideas but, in fact, are a sophisticated expression of good counselling psychology practice based on ideas that have gestated independently of attachment theory. By taking account of important dimensions of human functioning, these ideas are bound to share ground with central tenets of attachment theory. As a consequence, a perusal of the findings appears to unwittingly bestow on attachment theory a role beyond its station in the work of contemporary therapists. By reference to the literature, it may be argued that the findings resonate with ideas, theories or models that developed independently of attachment theory. However, because they do not look out of place in an attachment-related account of psychic distress, they could mistakenly be associated with attachment theory, possibly because their origins reached into the same theoretical repositories. This interpretation, perhaps, also accounts for any hesitation the participants had in ascribing unique insight or power to attachment theory.

This raises the question of what is unique about an attachment perspective. Perhaps nothing. Perhaps the bones of certain ideas that run through attachment theory, and these findings, have been around for a long time. After all, for example, as far back as 1902, Cooley alluded to our self-worth, and our internal working model of self, as being forged within the relationships that we have with others. Perhaps the same

bones form the basis of object relations theory of which attachment theory could be regarded as a variant.

Just because the findings suggest that therapists reach for an understanding of their patients' presenting problems by reference to their relational history, and do so frequently on account of the prevalence of caregiver-related issues, does not necessarily confine them to attachment theory for an explanation. The understanding that attachment theory appears to bring to a patient's relational history has a decidedly transactional semblance and, therefore, could equally be brought by Sameroff and Chandler's (1975) transactional model of development (cited in Sameroff, 1987). The person's development, for good or ill, as the outcome of continuous dynamic interactions between him and the experience provided by his family and social context, as Sameroff and Chandler's model suggests, is foundational to attachment theory also. By this reckoning, attachment theory could be regarded as a transactional theory of development that, in this respect, is hardly unique. Indeed, the understanding brought by Sameroff and Chandler's model could also be provided by Repetti et al.'s (2002) synthetic model of risky families that, too, could qualify as a transactional model of development. Arguably, Repetti et al.'s theory is a more complete explanation of dysfunctional development and outcome because it integrates a transactional dimension with a neurobiological dimension that is becoming increasingly important in contemporary understandings of attachment relationships, such as provided by Cozolino (2014) and alluded to by a number of participants. Whilst therapists may appear to be reaching for attachment theory for an understanding of their patients' relational distress, they may, in fact, be reaching for concepts that are generic, rather than Bowlbian, and are shared with other theoretical frameworks.

This idea extends to other categories too. The importance of the self in human functioning is highlighted in various theoretical frameworks that contain, but are not limited to, important attachment dimensions and are in keeping with the findings of this research. For example, Harter's (2006) broad social-cognitive conceptualisation of the self places the self, and self-esteem, and the role of socialising influences, especially of caregivers, in the context of the person's cognitive development. This is consistent with the prioritisation of the relationship

with self that emerged as a theme in the present study. A similar situation pertains with regard to Cast and Burke's (2002) theory of self-esteem that places self-esteem at the centre of a person's efforts to exist in the relationships and environment in which he finds himself. Once again, this conceptualisation contains an attachment dimension and, therefore, sits comfortably with the findings of the research, yet it is not modelled as an attachment-derived, or neo-Bowlbian, theory. Exactly the same could be said about Emler's (2001) exploration of the costs and causes of low self-worth that, besides genetic factors, identifies the degrees of love, concern, acceptance and interest that parents show to their children as the primary causes.

Kohut's (1977) theory of the psychology of self is also relevant in the context of the therapists' prioritisation of the self because, at once, it touches on many of the important dimensions that feature in attachment theory. It touches on the role of caregivers in a person's development, the cohesiveness of the self, the importance of empathy and, importantly, the significance of reflective functioning and the priority of self-esteem in a person's psychological wellbeing. In these respects, Kohut's theory has a similar relationship with the findings as attachment theory, possibly on account of the theories' shared origins in psychoanalysis. By this reckoning, it could be argued that the findings equally demonstrate a Kohutian perspective. A more likely interpretation is that they demonstrate neither but, rather, that the findings simply demonstrate important dimensions of human functioning without being theory-specific.

Similarly, the category concerning the provision of safety easily fits into the contemporary relational paradigm described by Wachtel (2008) and Wallin (2007). Relational theory emphasises that human development takes place within the context of relationships, just as Bowlby's theory suggested, and that, within the therapeutic relationship, the dissolution of anxiety is privileged as the fundamental objective of therapy. The predominantly supportive strategy employed by the participants falls in with this objective. In this respect, the relationships that attachment theory and relational theory have with the findings are indistinguishable, making it possible to imply that working relationally really means working with an attachment perspective. Not for no reason did Wallin describe attachment theory as a relational theory of development and, later, the two theories as a "marriage made

in heaven” (2007, p. 189). Once again, this is supportive of the notion that whilst the therapists’ depiction of the therapeutic relationship appears to draw on attachment theory, the influences are likely to be broader.

As implied by Mikulincer and Shaver (2005), Bowlby’s idea of available, sensitive, responsive caregiving, and the provision of a safe haven, serves a similar function to the idea of unconditional positive regard contained in Rogers’ (1961) person-centred theory. Rogers’ conceptualisation of the therapeutic relationship as a helping relationship in which the therapist “...can free him [the patient] as completely as possible from external threat, then he can begin to experience and to deal with the internal feelings and conflicts which he finds threatening within himself” (1961, p. 54) touches on both security and the self. The idea of freeing the patient from external threat emerges again in relational theory’s idea of prioritising the dissolution of anxiety. By the same token, it could be said that the findings resonate strongly with Gilbert’s (2009) compassion-focused therapy that emphasises making the patient experience safeness and prioritising his internal compassionate relationship with himself. Such fusion and cross-pollination between theories and therapeutic models makes it nigh impossible, perhaps pointless, to trace the original theoretical influences on the categories concerned with the provision of security and the prioritisation of the self.

Although the first interpretation of the findings is that attachment is prominent in the work of practitioners, therapists were hesitant in ascribing uniqueness to attachment theory. Consideration of the findings by reference to the aforementioned literature perhaps tells us why. Important dimensions of psychotherapy that emerged in the findings of this research are, actually, very ecumenical and comprise important elements in a range of developmental models and theories. In sum, they commonly underlie the principles and understandings of therapeutic practice generally. Sometimes, differences seem to be disguised by the use of different theoretical language, such as the distinction between Bowlby’s safe haven and Rogers’ unconditional positive regard. Notwithstanding any such differences, the ideas articulated by the participants in this research find plentiful resonances, making it seem that the lexicon of psychological wellbeing is filled with attachment-inflected ideas. It might be argued, and the participants might agree,

that, therefore, at least, a consensus is emerging about what therapy is about and how it should be achieved. Nevertheless, for all that, it is difficult not to conclude, either, that the influence of attachment theory *per se* in the domain of psychotherapy is, indeed, muted, as suggested by Holmes (2014). This is probably close to the truth. Besides the reasons explored above, attachment theory may be seen as somewhat discredited. Evidence such as that provided by Aikins et al. (2009) suggests that attachment representations can be unstable, meaning that attachment-informed formulations are speculative, although this might equally provide hope that attachment representations are open to change through therapy. It may also be that therapists believe, as Hamilton (1987) does, that the patient's defences make it difficult to bring a knowledge of attachment into clinical work. It is worth noting that the relative muteness of attachment theory in the findings of this research is unlikely to be related to theoretical orientations that might hold different priorities. The findings are based on data provided by clinicians holding a cross-section of orientations, both in the initial sampling and theoretical sampling phases. Although one clinician referred to the short-term priority of symptom management in primary care services, she stated that, in her own assessment, working with her patients' relational ways is, nonetheless, signally important.

By reference to a further body of literature, a third, equally valid, interpretation becomes possible. In recent years, attachment theorising has developed significantly, bringing an enhanced and, indeed, unique, understanding to human functioning. This expansion and raised sophistication might be assumed to provide real potential for clinical application to therapists of any and every theoretical orientation. Against this backdrop, the findings reveal somewhat of a missed opportunity. This begins with the paucity of literature that fully articulates how the theory might find clinical application and ends with therapists favouring its direct use largely in the service of formulation. Use in the service of treatment is more through its association with principles and understandings that commonly underlie therapeutic practice generally. Beyond that, the findings do not speak directly of treating problematic attachment presentations, such as hyperactivating or deactivating behaviours that result from the person's assessment of the viability of proximity-seeking as a protective strategy, as described by Mikulincer and Shaver (2005). Neither are interventions designed to influence reflective functioning



(Fonagy et al., 1991; Fonagy, 2001) or mentalisation (Allen et al., 2008), explicitly identified. Therefore, the potential for the enhancement of reflective functioning may be under-realised.

Obegi et al. (2009) make the distinction between attachment-based therapy that relies extensively on attachment theory to conceptualise problems, assess personality and define clinical interventions, and attachment-informed therapy in which attachment theory and research are used to inform and supplement clinical practice that is based on other established orientations. Slade (2008) makes a similar distinction, suggesting that attachment theory and research potentially enrich, rather than dictate, a therapist's understanding of particular patients. She does not advocate that attachment theory should determine treatment, instead recommending it as a further template for understanding human functioning, and bringing meaning to a patient's experience, without discarding other kinds of clinical understanding. Insofar as the findings of the current research acknowledge the role of attachment theory more in the area of problem formulation than in treatment, the findings chime more with Slade's perspective of practice enrichment. Nevertheless, this does not disguise that therapeutic practice is not capitalising on its potential clinical application.

One might be left to ponder why this is the case. Perhaps it is because, even when the theory is well explicated, there is a paucity of literature that describes how to make it count in the consulting room. As far back as 1995, Farber et al. alluded to this state of affairs. In their exploration of the extent to which therapists can function as attachment figures by reference to Bowlby's criteria, they intimated that, for all the ripeness of the patient's relational nature that emerges in the therapeutic situation, and our understanding of the potential role of the secure base concept, there is room to more fully articulate an attachment-oriented therapy.

The literature contains many comprehensive and convincing accounts of the unique insight and benefits that attachment theory potentially brings whilst its application in clinical treatment is less well outlined. An example is Eagle's (2003) description of the potential for the therapist to act as the patient's internalised secure base when the relationships with his main attachment figures fail to provide him with felt security. A further example is Farber and Metzger's (2009) discussion of qualities

that, within an attachment-based perspective, are unique to the therapist, such as his superior ego strength that permits him to respectfully challenge the patient's internal working model and his ability to hypothesise presenting problems by reference to the patient's response to the provision of a secure base. Also, Mikulincer et al. (2009), in their discussion of different insecure attachment presentations, recommend general intervention strategies that challenge the patient's maladaptive defences, without being explicit about what these strategies might look like in practice.

Obegi et al. (2009) demonstrate the advances that have taken place in attachment theorising in their comprehensive outline of the broaden-and-build cycle of attachment security. This cycle describes how the patient is helped to identify the blockages that prevent him from benefitting from the safety and security offered by rewarding interactions with attachment figures. Yet, by their own admission, their discussion of how an attachment-informed approach organises the practice of psychotherapy does not focus on techniques, leaving it to the therapist to marshal these by himself. Similarly, Slade (2004) is scant on technique. Although her examples of two therapies provide first class theoretical illustrations of the cost of dysfunctional early attachment experiences, they are less adequate illustrations of how, in practice, they are therapeutically addressed. Her advice, with regard to the dismissing patient, is "to open narrative to real and felt experience, which then makes these stories agents of change" (p. 200) and, with regard to the preoccupied patient, "to become the bridge to thinking, providing the memory, the sense of time, and the cohesion that allow stories to slowly emerge" (p. 201). If I were a therapist who wished to be convinced of the merits of attachment-oriented interventions, I would not be sure how I might bring these injunctions to life in my practice.

Writing about the implications of attachment theory and research for adult therapy, Slade (2008), once again, provides an excellent account of how attachment theory can enrich a therapist's work. In her discussion of the application of attachment theory in clinical work, she notes that an understanding of a patient's attachment style is only useful if it is meaningfully linked to a technique that, puzzlingly, her own work fails to elaborate. She comments that, while therapists are intrigued by attachment research, they remain unsure how to apply it in their work. Slade

suggests that thinking about patients in terms of attachment organisation has rarely captured the imagination of clinicians, possibly on account of the limiting effect that classification has on clinical understanding. Whatever the reason, there is a certain correspondence between Slade's remarks and the findings of this research.

Much of the foregoing literature has an accomplished and superior theoretical dimension but is less compelling with regard to its application in clinical practice. This position would seem to bear out Farber et al.'s (1995) observation that an attachment-oriented therapy remains to be fully articulated and may be a contributory factor in why contemporary clinicians choose to engage attachment theory more as an explanatory, rather than therapeutic, agent, as is suggested by the current research. However, it does not comprise the whole explanation because the literature is not devoid of guidance of how attachment theory's unique insights can be meaningfully brought to life in the consulting room. Although, in some cases, it crosses the boundary into what Obegi et al. (2009) define as attachment-based psychotherapy, nonetheless, it contains guidance that would be useful to a broad church of practitioners.

One example is Holmes's (2001) Brief attachment-based therapy (BABI) that provides specific guidance of how important attachment concerns, such as attachment style, internal working models and reflexive functioning may be modified in therapy. Similarly, Cooper et al.'s (2005) *Circle of Security* (COS) intervention program provides detailed guidance on how therapists may help parents to enhance their relationship capacities that, in turn, support the attachment security of their children. Perhaps the most accessible attachment-theoretical guidance available is Allen et al.'s (2008) comprehensive explanation of the principles and practices of mentalising as a treatment to help patients to improve their reflexive functioning with regard to their own and others' mental states. Importantly, it is not put forward as a treatment modality; rather it is seen as a core element of any therapeutic kitbag, revolving around a fundamental human capacity that should be of interest to therapists of all modalities. Also, intervention programmes that engage with patients' attachment histories and patterns are now coming onto the marketplace through other channels, such as the PTSD and family therapy

programmes that I recently attended (respectively based on de Zulueta, 2006 and Diamond, Diamond and Levy, 2014).

Before concluding this argument, it is worth dwelling briefly on the neural dimension of psychotherapy. In the present research, three clinicians alluded to the interdependence between human relationships and neural development, although this did not lead to it being established as a theoretical category. This could be suggestive of not realising the optimum benefit from an understanding of how early experiences become transformed into the substance of the nervous system and how later, adult, relationships can reshape the attachment circuitry, as Cozolino (2014) compellingly outlines. Cozolino's broad point is that an understanding of neuroplastic processes provides both the therapist and the patient with enhanced agency and optimism for the therapeutic enterprise. More could probably be done with this knowledge in clinical practice.

### **5.3 Possible further research**

My conclusions in the previous section spoke of the findings as revealing somewhat of a missed opportunity insofar as the potential that attachment theory offers in the service of treatment is not being fully leveraged. In part, this may be on account of a paucity of literature that shows how attachment-related interventions can be incorporated into other, or integrative, treatment approaches. This nicely presages this discussion of the direction that future research might wish to take.

My review of the literature and my clinical experience have convinced me of the plausibility, relevance and utility of attachment theory. However, it is fitting to make clear that I fully subscribe to the notion that attachment theory is but "...a comprehensive theory of development, motivation, personality, and psychopathology" (Obegi & Berant, 2009). I do not see attachment theory as a separate school of therapy, such as cognitive therapy. I see it as an accessory in any therapist's kitbag that may be used as a lens through which to identify what has happened and to meaningfully supplement engagement with the patient and his experience. If I am taking the position that attachment theory has a significant contribution to make in the therapeutic enterprise that it is not currently making, then the task is to provide it with a better and higher profile in the marketplace.

This means providing the potential customer, the therapist, with material that is compelling and difficult to resist.

During my perusal of extant attachment-related research literature over the years, I noticed how customary it is to employ, and how reliant the research is on, quantitative methods, a great number of attachment measures, including self-report measures, and student participants. I also found myself reading about the same idea over and over again. In other words, what we probably do not urgently need more of is quantitative research that tells us either what we already know or what, intuitively, we already know, such as Kenny and Sirin's (2006) study that bears out the importance of the longer-term role, and consequences, of parental attachment on the person's assessment of his own worth. Further examples are Foster et al.'s (2007) study of how aspects of the attachment system relate to the stability of self-esteem and Flynn et al.'s (2014) study that reveals that caregiver maltreatment simultaneously predicts low self-worth, low relationship quality and internalising and externalising symptoms.

Many of the authors and theoreticians of the non-quantitative attachment literature, such as Bowlby himself, Holmes and Slade, themselves experienced clinicians, typically rely on data that they derive from their own clinical work. It seems to me that research based on the experience and work of *other* therapists is the exception rather than the rule. It strikes me that researchers are overlooking, perhaps failing, to ask practitioners what their experience has taught them about certain phenomena. Unless they themselves are also researchers and authors, their wisdom tends to be lost. Perhaps, we are missing out by not tapping into and distilling this into meaningful knowledge that would be useful and interesting to the counselling psychology profession and beyond.

These factors, in combination with the findings of the present research, would seem to nudge future attachment-related research in the direction of making it more relevant to practicing clinicians. This might be done by filling a gap in the marketplace for qualitative research that focuses on how to recognise dysfunctional attachment presentations, their role in the patient's distress and how they are treated by master clinicians. The data for such research would derive from clinicians who are either master attachment-based therapists or master integrative, attachment-

informed, therapists, so as any difference might be revealed. Specifically, the research might focus on how to reinforce the secure base script, thereby strengthening the broaden-and-build cycle of attachment security, or on how to gradually adjust the therapeutic distance, or on how to rehearse reflexive functioning. In any event, the outcome should be a clear illustration for therapists, whose work is neither attachment-based nor attachment-informed, of how they can bring attachment-oriented interventions into their clinical work without such interventions either supplanting their staple orientation or sidelining their staple interventions. Instead, the emphasis and objective of future research should be on helping attachment-oriented interventions to become more available as accessories in any therapist's kitbag. Such research is also likely to appeal to the meaning-seeking community of counselling psychologists.

Rather exceptionally, Daly and Mallinckrodt's (2009) study is an example of the type of articulation needed to make attachment theory more relevant in clinical practice. Their grounded theory study generated a theoretical model of the approach that experienced therapists take to working with patients who present with anxious or avoidant attachment characterisations. Their eventual theoretical model is based on the core concept of strategically managing the therapeutic distance, although guidance on achieving this might be further developed.

Beyond this, it would be useful and interesting to conduct qualitative research amongst former patients who received attachment-oriented treatment in the past. The purpose of this would be to gain an understanding of their perception of the development and role of their attachment patterns in their lives and, importantly, their perception and experience of the treatment received. This would provide qualitative evidence of the effectiveness of attachment-oriented treatment by reference to the subjects who, after all, are the ultimate arbiters of the quality of their lives. Whilst this would not satisfy those whose principal yardsticks are randomised control trials designed to empirically validate treatments, such research would fall in with the qualitative, meaning-oriented epistemology that more properly lies at the heart of psychotherapy.

Mallinckrodt, Daly and Wang (2009) state that the challenge for the next generation of attachment and psychotherapy researchers is to learn more about session-by-

session interactions between patient and therapist to better understand how Bowlby's secure base concept can facilitate lasting change in adult patients. It is hoped that the research proposed here would go some way towards meeting this challenge. It is also hoped that such research would contribute to addressing the muted influence, spoken of by Holmes (2014), that Bowlby's theory has in the domain of psychotherapy.

#### **5.4 Critical review of the research and reflexivity**

Charmaz's (2014) criteria for evaluating grounded theory studies speak of credibility, originality, resonance and usefulness. The usefulness of the present study will be more properly addressed in the two sections that follow. Here, I will reflect on some matters that concern its credibility, originality and resonance.

To begin with, the strength of the current research is that it is a qualitative analysis of a large sample of a broad church of practitioners. This contrasts with many of the extant studies that are based on quantitative data, often involving self-report measures. At once, this offers credibility, originality and resonance to the community of counselling professionals, the study's main target audience. Furthermore, the data source and the transparency of its analysis and presentation lend to its transferability, or relevance outside of the immediate context in which the study was conducted. That said, I wish to reflect on a number of technical and epistemological challenges that are important to the quality and meaningfulness of this study.

The process of making and registering a research proposal required me to immediately defy the recommendation of grounded theory methodology not to conduct a literature review before embarking on the research. Already, this had given me the impression that attachment issues are ubiquitous and lie at the heart of what practitioners routinely, if not mostly, deal with. Nothing that I have read since, or learned in my clinical experience, has changed my impression of this. For this reason, despite the rigour provided for by grounded theory methodology, it was challenging to ensure that this research did not merely fall in with my perspective of the subject. To complicate matters, I wondered if a more sophisticated understanding of the role of attachment in contemporary psychotherapy might have

emerged if I had allowed myself to be better informed about the subject and had not sought to conduct the study as if I were a naïve experimenter (see memo in Appendix H). In the end, as in psychotherapy, I concluded that the best course was to bracket off my own attitude and adopt an unknowing stance.

I was more concerned by the risk of not successfully bracketing off my own perspective at the outset of the data gathering process. In reality, the steps involved in selecting participants and arranging and conducting interviews necessarily involved revealing the general purpose of my study and raised the possibility of unwittingly introducing concepts. The participants might also be influenced by their wish to be helpful and their unwitting perception of how they might be helpful. My unknowing and neutral stance, particularly my use of open questions that referred to the patient's way of relating to others rather than attachment *per se*, was helpful in countering these possibilities, whilst also providing opportunities for any and all perspectives to emerge. I was rather hoping that I would obtain data that would not fit with my perspective or data that would provide an interesting counterpoint to the commonly available literature. If this were the case, I would gain confidence that my research would freely reveal new or interesting knowledge and that my methodology was doing its job.

As the research wore on, my confidence in this approach grew. During the course of initial sampling, the data was beginning to indicate that my participants used attachment theory as an adjunct, or explanatory framework, in their case formulations. Specifically, they tended not to determine their patients' attachment styles. This made me think that, ultimately, my findings would be less concerned with the particular, such as what intervention strategies might be most effective for particular attachment presentations, and more concerned with how attachment principles fit into their model of therapy. It also gave me confidence that my research was taking me into a direction determined by my participants and the data they provided, and not in a direction determined by any preconceptions I had.

Here, it is also appropriate to reflect on how my choice of the five participants for theoretical sampling might have influenced the findings of the study. In the methodology chapter, I stated that I selected these by reference to my judgement of their ability to provide fresh and interesting perspectives. This judgement was



based on my impression of their ability to engage with my questions and to contribute to this research during initial sampling. My priority was to obtain further insightful answers and critiques, not to prop up my tentative theoretical categories and model. However, efforts at making objective judgements are always vulnerable to subjective assessments that operate subconsciously. Therefore, I cannot discount the possibility that my selection of the shortlist was influenced by my expectations of who might be most interested in participating further in this research or my personal preferences. For example, my general preference for a presentation style that reveals poise and articulacy may have been a factor in my selection. However, the main purpose of theoretical sampling is to develop the properties of the tentative theoretical categories that had already formed. So, theoretically, the consequence of a different combination of participants could have been to vary the quality of this development, not necessarily the thrust, or central meaning, of the categories. In the circumstances of my choice of the five participants having been the product of my explicit and implicit memory systems, it is instructive to consider what difference it might have made to the overall complexion of the research had I selected an alternative combination of participants. While the richness of the data gathered from another combination of participants may have varied, thus varying the quality of my development of the categories, my assessment is that the findings would not have varied materially. This assessment is founded on my view that, save for the sub-category concerned with the prioritisation of the relationship with self, the substance of the eventual theoretical categories is in keeping with the tentative theoretical categories that had formed after initial sampling. However, given the nature of this enquiry and its methodology, it is not possible to demonstrate this hypothesis.

The use of grounded theory from a constructivist perspective cannot quite conceal some inherent epistemological tension. Whilst the systematic and rigorous nature of the method seeks to ensure that the eventual claims are grounded, constructivist grounded theory acknowledges and legitimises the researcher's involvement in framing the analysis. In other words, the outcome would be my perspective of the data gathered. The challenge of maintaining a balance between these forces became especially evident when I began to formally analyse the data and contemplate how to develop the emerging categories in the theoretical sampling stage. This process

required me to make decisions about the 202 initial codes that I had gathered. Of necessity, this would involve privileging certain positions and interpretations whilst setting others aside. For example, in the earlier part of initial sampling, I picked up a theme concerned with the uniqueness of the therapeutic interaction, bringing to mind the transactional and relational idea of a two-person contextual psychology. Therefore, I introduced a question relating to this later in the initial sampling process but abandoned the idea when it did not yield new understandings that contributed to, or stood apart from, themes that were in formation at the time. Whilst, theoretically, I erred by introducing a concept known to me, this is, nevertheless, in keeping with the inductive and bottom-up nature of grounded theory.

Some codes stood out simply for the intrigue that they offered. For example, one participant offered an insight that I restated as meaning that a large part of therapy is concerned with the mismatch between a patient's expectations of relationships and what the world is willing to provide. Although this code did not find its way into any of the categories, I continued to find it noteworthy in the process of constantly comparing codes amongst and between categories. Somehow, it seemed to resonate with the developmental idea that, from an early age, we adapt to relationships on which we are dependent in ways that enable us to survive, if not prosper and thrive. I was slow to let it go and disappointed when there simply was not sufficient and robust support for it to play some role in the findings. Ultimately, whenever there was any doubt, it always came down to the availability of support for a reasonable interpretation. Here, I was, potentially, blurring the divide between making a reasonable interpretation and allowing one code to play an inordinate role in my analysis. I managed this risk by keeping it under critical review in supervision, thereby maintaining focus on the evidence base of developing categories at all times.

After initial sampling, I decided that the category concerned with the prevalence of caregiver-related problems had achieved saturation, or that further data in relation to this category would not yield any new theoretical insights. Nonetheless, I erred in initially exempting this category from further scrutiny in theoretical sampling. Fortuitously, I was prompted to review this decision. Although, eventually, there

was no material change to the category, this forestalled what would have been rightly regarded as a weakness in my analytic process.

The question of theoretical saturation resurfaced after I had conducted five interviews in theoretical sampling. Even though I formed the view that my findings are grounded, it remains a possibility that further interviews might yield further insights. Therefore, it might be considered a weakness of the study that I did not conduct further interviews until I had gained certainty that this was not the case. Neither did I return to my five participants in theoretical sampling to check my final model in order to gain certainty in this way. However, certainty is unattainable. Also, I judged that the participants had been very generous in making themselves available to me and that I could not lean further on their goodwill. I judged that receiving reluctant or no agreement for further interviews risked compromising my methodology. In the end, my reflections repeatedly returned, firstly, to whether my findings were a reasonable and fair representation of my participants and, secondly, to whether I had forged a reasonable and satisfactory picture of the phenomenon under investigation. I am satisfied on both counts.

My constructivist stance must, of course, also be acknowledged in the interview process itself, not just in the analysis and interpretations. The interview schedules that I constructed governed the direction of the research. However, following each interview, I conducted an interim review of the data, resulting in a number of versions of the interview schedule, driven by my detection and assessment of particular trends or points of interest. In addition, as each interview proceeded, I asked supplementary questions. Whilst I had some general supplementary questions in mind before each interview, I conceived others in response to particular conversational passages. As such, I was instrumental in the construction of meaning before, during and after each element of the data collection process. In considering this matrix of construction, I cannot disregard the possible role played by the particular sequence of the interviews either. Whilst my sampling framework was purposive, there was a certain randomness about the sequence in which the individual participants became available for interview. In exploring the interaction between the interview process and my constructivist stance, and its impact on the direction of this thesis, it is interesting to consider what the outcome might have

been had the three participants who made the more explicit references to the neuroscientific dimension of attachment (Moss, Dermot and Liz) become available for interview earlier in the data gathering process. In consequence, it is possible that I might have recognized this as a theme worthy of pursuit in later versions of the interview schedule. In turn, this might have altered the complexion of the eventual theoretical categories, the focus of my literature review and led to a somewhat different emphasis in my interpretations and conclusions. For example, it is possible that, as a result, my recommendations for further research may have emphasised a role for neuroscience in making attachment-theoretical knowledge more relevant in the consulting room. However, given the nature of this enquiry and its methodology, such a construction of this research must remain a supposition.

Finally, there is a matter, located right at the nexus of the study's interpretation, reflexivity, potential weakness and further research, which is significant in any consideration of this study. If I am saying that attachment theory offers benefits that are not being fully capitalised on, my participants might argue that these benefits are being achieved by other means. Other therapeutic approaches *are* achieving results. Perhaps, they *are* taking account of attachment manifestations but are dealing with them in a different, or very subtle, way. Who is to say that one way is better than another way? Counselling psychology is more about being than doing and it is possible that other counselling approaches are dealing with such manifestations in an unsaid and subtle way. Attachment manifestations *per se* may not be to the forefront of my participants' minds. However, on completion of initial sampling, I had come to the view that the data supported a tentative theoretical category that attending to a patient's way of relating to others is the top clinical priority. Although theoretical sampling was to change this, this is suggestive that my participants probably see themselves as providing therapy that goes beyond pure symptom treatment, such as provided by the iterations of cognitive therapy described by Beck (2011) and Sanders and Wills (2005). Undoubtedly, they would contend that, similar to Young's (1999) schema therapy, they employ interpersonal techniques, resonant of Bowlby's therapeutic tasks, to counteract relational schema that are activated within the therapeutic relationship.

This leads back to the question of further research. It may be possible to conduct research, possibly using mixed methods, whereby specific attachment manifestations could be traced through attachment-informed therapy and through non-attachment-informed therapy. For example, with regard to the hyperactivation of an anxiously attached patient, it may be possible to determine if there is a difference in the outcome between the two approaches. If attachment theorists have not excelled in making a case for attachment-informed interventions in clinical practice, perhaps research of this kind is necessary to demonstrate the power of its application. Alternatively, such research might show that the objectives of attachment theory are already being achieved, or addressed, in other, subtle, ways.

In the introduction, I suggested that a contribution to my interest in this subject is attachment theory's fitting commentary on my own experience of how life has unfolded. Now, of course, I recognise this as my relational pattern that is hewn from the quality of the internal working models I have of myself and those around me. The experience of attuning to, and reflecting on, the perspectives articulated by my participants and the authors of the literature has deepened my relationship with, and understanding of, the world and my agency to continually review the conditions for existing in it. As such, this research will act to continually stretch my personal and professional development.

## **5.5 Relevance to counselling psychology practice**

The data provided by practitioners clearly tell us that attachment-related problems are what occupy most of their time. Yet, even though the findings suggest that attachment-related ideas, the provision of safety and the prioritisation of relationship with self, are acknowledged as integral elements of contemporary therapeutic practice, they also reveal somewhat of a missed opportunity. This so because contemporary therapists favour the use of attachment theory largely in the service of problem formulation whilst the potential benefits now brought by the sophistication of a more recent understanding of attachment theory appear to be overlooked. This is evidenced in the fact that the findings do not speak of treating problematic attachment presentations with attachment-oriented interventions or mentalising interventions. This may be due to attachment theorists having done a poor job in articulating attachment theory or demonstrating its clinical utility or not

having given counselling professionals sufficient material that makes its clinical application both judicious and straightforward.

Whatever the case may be, there is a certain incongruence about this state of affairs that this research wishes to address. If we can assume that the findings constitute a true reflection of the role of attachment in contemporary psychotherapy, then this research is relevant to counselling psychology practice because it draws attention to, and challenges researchers to resolve, the disconnect between available knowledge and clinical application.

Professionally, this research has already made a big difference to me. Besides what I learned from my participants, my reflection on the data, the findings and the literature have enhanced my professional identity and enriched my theoretical store. Most importantly, it has manifested in my practice by deepening my understanding of the patient's internalised secure base, narrative coherence and reflexive functioning. Together, these have broadened my window into his psyche, the material of our work and the potential reservoir of his wellbeing.

Of course, I cannot be certain that others would be similarly influenced. In the short-term, this research draws attention to the deficit between clinical practice and the potential that attachment theory offers. In the longer-term, as suggested earlier, it remains for further research to determine how a modern understanding of attachment theory might be made more relevant and readily available. After that, whilst I am convinced it would make a difference, it is up to each practitioner to decide how it fits into his clinical practice.

## **5.6 Contribution to counselling psychology**

This research contributes to counselling psychology because it places attachment theory towards the centre of counselling psychology, it spawns further research, it contributes to the evidence base that is so cherished in the field and it challenges the prevailing preference for quantitative evidence.

The classification of attachment style gives the impression of a narrow and specialised theory. In fact, it is very broad and may be seen as providing a very complete understanding of how we have become who we are. According to Obegi

and Berant (2009), attachment theory is “...a comprehensive theory of development, motivation, personality, and psychopathology.” For all that, as we have seen, its influence has been muted, certainly in clinical practice. At a high level, this could have something to do with its relationship with counselling psychology. Attachment theory is regarded as having developed out of psychoanalysis. Counselling psychology, on the other hand, has a strong association with humanistic values (Strawbridge & Woolfe, 2010). However, in their discussion of what characterises counselling psychology, Strawbridge and Woolfe identify the significance of the helping relationship and its interest in wellbeing as opposed to responding to sickness and pathology. Attachment theory answers to both of these characterisations. It is a relational theory that Bowlby originally put forward as a framework for understanding healthy and unhealthy human development for clinical purposes. Therefore, attachment theory is not at all out of place at the heart of counselling psychology.

Amongst today’s commercially oriented public policy makers, the existence of quantitative evidence is central because it is deemed to be inarguable in cost-benefit considerations. Counselling psychology largely occupies a space in society that is allied to public health services that are under the remit of these policy makers. It is simple enough, therefore, to work out how counselling psychology has had to conform in order to earn a living. In this respect, its existence in mainstream society is akin to attachment theory’s idea that we adapt to the prevailing circumstances in the most expedient and tolerable way. This research contributes to counselling psychology because it spawns further research that will, potentially, add to the evidence base and underpin counselling psychology’s existence under this arrangement. Besides, it gently, but firmly, challenges the preference for quantitative research because the qualitative views of expert practitioners cannot easily be cast aside.

Counselling psychology operates at the coalface of many of today’s social problems such as absence from work through mental ill health, homelessness or drug abuse. The conversations about how these problems arise, and might be addressed, are often dominated by political interests, with little input from experts and practitioners who are most closely acquainted with the psychological development

and treatment of these problems. Research such as this strengthens the credibility and impact of identifying politically shunned or unpalatable links, such as there being a straightforward relationship between the quality of parental caregiving and many of the problems that end up requiring psychological treatment. Society imposes responsibilities on people for all sorts of matters, some relatively trivial, but it tippy-toes around the most important of them all, the quality of the caregiving that is provided for its children. Having a stronger position at the top table in this conversation would, indeed, be a significant contribution to counselling psychology.



## **References**

- Aikins, J.W., Howes, C., & Hamilton, C. (2009). Attachment stability and the emergence of unresolved representations during adolescence. *Attachment & Human Development, 11*(5), 491-512. Retrieved from <http://www.attachmentprojective.com/wp-content/uploads/2011/04/Aikins-et-al.-AHD-2009.pdf>
- Ainsworth, M.D.S., Blehar, M.C., Walters, E., & Wall, S. (1978). *Patterns of attachment: a psychological study of the strange situation*. New Jersey: Erlbaum.
- Allen, J.G., Fonagy, P., & Bateman, A.W. (2008). *Mentalizing in Clinical Practice*. Arlington: American Psychiatric Publishing.
- Bartholomew, K., & Horowitz, L. (1991). Attachment Styles Among Young Adults: A Test of a Four-Category Model. *Journal of Personality and Social Psychology, 61*(2), 226-244. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=a53249e2-512f-4c2f-bba9-9aea03edc1f8%40sessionmgr114&vid=2&hid=107>
- Beck, J.S. (2011). *Cognitive Behavior Therapy, Basics and Beyond* (2<sup>nd</sup> ed.). New York: The Guilford Press.
- Bernecker, S.L., Levy, K.N., & Ellison, W.D. (2013). A meta-analysis of the relation between patient adult attachment style and the working alliance. *Psychotherapy Research (2013)*. doi:10.1080/10503307.2013.809561
- Bowlby, J. (1969). *Attachment and Loss: Attachment (Vol. 1)*. London: Pimbllico 1997.
- Bowlby, J. (1973). *Attachment and Loss: Separation: Anger and anxiety (Vol. 2)*. London: Pimbllico 1998.
- Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. New York: Routledge Classics 2005.

- Cast, A.D., & Burke, P.J. (2002). A Theory of Self-Esteem. *Social Forces*, 80(3), 1041-1068. Retrieved from <http://wat2146.ucr.edu/Papers/02b.pdf>
- Charmaz, K. (2014). *Constructing Grounded Theory* (2<sup>nd</sup> ed.). London: SAGE.
- Clarke, A.E., & Friese, C. (2007). Grounded Theorizing Using Situational Analysis. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 363-397). London: SAGE.
- Cooley, C. H. (1902). *Human nature and the social order*. New York: Charles Scribner's Sons, 1902. Retrieved from <http://hdl.handle.net/2027/uc2.ark:/13960/t2k64cp4n>
- Cooper, G., Hoffman, K., Powell, B., & Marvin, R. (2005). The Circle of Security Intervention: Differential Diagnosis and Differential Treatment. In L.J. Berlin, Y. Ziv, L. Amaya-Jackson & M.T. Greenberg (Eds), *Enhancing Early Attachments: Theory, Research, Intervention, and Policy* (pp. 127-151). New York: The Guilford Press.
- Cozolino, L. (2014). *The Neuroscience of Human Relationships, Attachment and the Developing Social Brain* (2<sup>nd</sup> ed.). New York: W.W. Norton & Company.
- Crowell, J.A., Fraley, R.C., & Shaver, P.R. (2008). Measurement of Individual Differences in Adolescent and Adult Attachment. In J. Cassidy & P.R. Shaver (Eds), *Handbook of Attachment* (2<sup>nd</sup> ed.) (pp. 599-634). New York: The Guilford Press.
- Daly, K.D., & Mallinckrodt, B. (2009). Experienced Therapists' Approach to Psychotherapy for Adults With Attachment Avoidance or Attachment Anxiety. *Journal of Counseling Psychology*, (56)4, 549-563. Retrieved from [http://www.researchgate.net/publication/232445640\\_Experienced\\_therapists\\_approach\\_to\\_pschotherapy\\_for\\_adults\\_with\\_attachment\\_avoidance\\_or\\_atachment\\_anxiety](http://www.researchgate.net/publication/232445640_Experienced_therapists_approach_to_pschotherapy_for_adults_with_attachment_avoidance_or_atachment_anxiety)

- Denzin, N.K. (2011). The Politics of Evidence. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4<sup>th</sup> ed.) (pp. 645-657). Los Angeles: SAGE.
- Denzin, N.K., & Lincoln, Y.S. (2011). Introduction: The Discipline and Practice of Qualitative Research. In N.K. Denzin & Y.S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4<sup>th</sup> ed.) (pp. 1-19). Los Angeles: SAGE.
- de Zulueta, F. (2006). *From Pain to Violence: The Traumatic Roots of Destructiveness* (2<sup>nd</sup> ed.). Chichester: Wiley.
- Diamond, G.S., Diamond, G.M., & Levy, S.A. (2014). *Attachment-Based Family Therapy for Depressed Adolescents*. Washington: American Psychological Association.
- Diener, M.J., & Monroe, J.M. (2011). The Relationship Between Adult Attachment Style and Therapeutic Alliance in Individual Psychotherapy: A Meta-Analytic Review. *Psychotherapy*, 48(3), 237-248. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=a4e8c803-b729-43b0-ab0a-2ab391411601%40sessionmgr4005&vid=2&hid=4209>
- Eagle, M. (2003). Clinical Implications of Attachment Theory. *Psychoanalytic Inquiry*, 23(1), 27-53. Retrieved from <http://web.b.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=0418fe24-2a5a-4453-9c33-3f03131a7314%40sessionmgr110&vid=2&hid=124>
- Emler, N. (2001). *Self-esteem: The costs and causes of low self-worth*. Retrieved from <http://www.jrf.org.uk/sites/files/jrf/1859352510.pdf>
- Farber, B.A., Lippert, R.A., & Nevas, D.B. (1995). The therapist as attachment figure. *Psychotherapy*, 32(2), 204-212. Retrieved from [http://www.researchgate.net/publication/232492633\\_The\\_therapist\\_as\\_attachment\\_figure](http://www.researchgate.net/publication/232492633_The_therapist_as_attachment_figure)
- Farber, B.A., & Metzger, J.A. (2009). The Therapist as Secure Base. In J.H. Obegi and E. Berant (Eds.), *Attachment Theory and Research in Clinical Work with Adults* (pp. 46-70). New York: The Guilford Press.

- Flynn, M., Cicchetti, D., & Rogosch, F. (2014). The Prospective Contribution of Childhood Maltreatment to Low Self-Worth, Low Relationship Quality, and Symptomatology Across Adolescence: A Developmental-Organizational Perspective. *Developmental Psychology, 50*(9), 2165-2175.  
doi.org/10.1037/a0037162
- Fonagy, P. (2001). *Attachment Theory and Psychoanalysis*. London: Karnac Books.
- Fonagy, P., Steele, M., Steele, H., Moran, G.S., & Higgitt, A.C. (1991). The Capacity for Understanding Mental States: The Reflective Self in Parent and Child and its Significance for Security of Attachment. *Infant Mental Health Journal, 12*(3), 201-218. Retrieved from <http://mentalizacion.com.ar/images/notas/The%20capacity%20for%20understandig%20mental%20states.pdf>
- Foster, J.D., Kernis, M.H., & Goldman, B.M. (2007). Linking Adult Attachment to Self-Esteem Stability. *Self and Identity, 6*, 64-73.  
doi:10.1080/15298860600832139
- Gilbert, P. (2009). Introducing compassion-focused therapy. *Advances in psychiatric treatment, 15*, 199–208, doi: 10.1192/apt.bp.107.005264
- Glaser, B.G. (2007). Doing Formal Theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 97-111). London: SAGE.
- Glaser, B.G., & Strauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. New Brunswick: Aldine Transaction.
- Hamilton, V. (1987). Problems in the clinical application of attachment theory. *Psychoanalytic Psychotherapy, 3*, 67-83. Retrieved from <http://www.peweb.org/document.php?id=pptx.003.0067a>
- Harris, J.C. (2009). *The Nurture Assumption, Why Children Turn Out the Way They Do* (2<sup>nd</sup> ed.). Retrieved from <http://emilkirkegaard.dk/en/wp-content/uploads/The-Nurture-Assumption-Why-Children-Turn-Out-the-Way-They-Do-Revised-and-Updated-Judith-Rich-Harris.pdf>

- Harter, S. (2006). The Self. In W. Damon & R.M. Lerner (Eds), *Handbook of Child Psychology, Volume 3: Social, Emotional, and Personality Development* (6<sup>th</sup> ed.) (pp. 505-570). New Jersey: Wiley.
- Henwood, K., & Pidgeon, N.F. (1992). Qualitative research and psychological theorizing. *British Journal of Psychology*, 83(1), 97-111. Retrieved from [http://www.readcube.com/articles/10.1111%2Fj.2044-8295.1992.tb02426.x?r3\\_referer=wol&tracking\\_action=preview\\_click&show\\_checkout=1&purchase\\_site\\_license=PUBLICATION\\_OUTSIDE\\_OF\\_LICENSE\\_PERIOD](http://www.readcube.com/articles/10.1111%2Fj.2044-8295.1992.tb02426.x?r3_referer=wol&tracking_action=preview_click&show_checkout=1&purchase_site_license=PUBLICATION_OUTSIDE_OF_LICENSE_PERIOD)
- Hoffman, K.T., Marvin, R.S., Cooper, G., & Powell, B. (2006). Changing Toddlers' and Preschoolers' Attachment Classifications: The Circle of Security Intervention. *Journal of Consulting and Clinical Psychology*, 74(6), 1017-1026. Retrieved from <http://circleofsecurity.net/wp-content/uploads/2012/02/JCCP-COS-Published-Article.pdf>
- Holmes, J. (1993). *John Bowlby and Attachment Theory*. London: Routledge.
- Holmes, J. (2001). *The Search for the Secure Base*. Hove: Routledge.
- Holmes, J. (2014). *John Bowlby and Attachment Theory* (2<sup>nd</sup> ed.). Hove: Routledge.
- Holton, J.A. (2007). The Coding Process and Its Challenges. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 265-289). London: SAGE.
- Hood, J.C. (2007). Orthodoxy vs. Power: The Defining Traits of Grounded Theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 151-164). London: SAGE.
- Horvath, A.O., Del Re, A.C., Flückiger, C., & Symonds, D. (2011). Alliance in Individual Psychotherapy. *Psychotherapy*, 48(1), 9-16. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=327026e0-b738-48a9-91d9-591d8ae3139b%40sessionmgr198&vid=2&hid=117>

- Huis in 't Veld, E.M.J., Vingerhoets, A.J.J.M., & Denollet, J. (2011). Attachment style and self-esteem: The mediating role of Type D personality. *Personality and Individual Differences* 50 (2011), 1099-1103.  
doi:10.1016/j.paid.2011.01.034
- Kelle, U. (2007). The Development of Categories: Different Approaches in Grounded Theory. In A. Bryant & K. Charmaz (Eds.), *The SAGE Handbook of Grounded Theory* (pp. 191-213). London: SAGE.
- Kenny, M.E. & Sirin, S.R. (2006). Parental Attachment, Self-Worth, and Depressive Symptoms Among Emerging Adults. *Journal of Counseling and Development*, 84(1), 61-71. Retrieved from <http://search.proquest.com/docview/219026201/fulltextPDF/80C54B04B00C4223PQ/1?accountid=17234#>
- Kohut, H. (1977). *The Restoration of the Self*. Chicago: The University of Chicago Press.
- Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy*. Chichester: Wiley.
- Levy, K.N., Ellison, W.D., Scott, L.N., & Bernecker, S.L. (2011). Attachment Style. *Journal of Clinical Psychology*, 67(2), 193-203. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=04537fbd-e36a-400f-866f-891375616cf5%40sessionmgr10&vid=2&hid=21>
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters (Eds.), *Growing points of attachment theory and research. Monographs of the Society for Research in Child Development*, 50, Serial No. 209 (1-2), 66-104. Retrieved from <http://web.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=2&sid=a3b4bb72-41ee-4105-85e4-2eb7600caa52%40sessionmgr110&hid=124>

- Mallinckrodt, B., Daly, K., & Wang, C.D.C. (2009). An attachment approach to adult psychotherapy. In J.H. Obegi & E. Berant (Eds.), *Attachment Theory and Research in Clinical Work with Adults* (pp. 234-268). New York: The Guilford Press.
- Mikulincer, M., & Shaver, P. R. (2005). Mental representations of attachment security: Theoretical foundation for a positive social psychology. In M. W. Baldwin (Ed.), *Interpersonal Cognition* (pp. 233-266). New York: Guilford.
- Mikulincer, M., Shaver, P.R., Cassidy, J., & Berant, E. (2009). Attachment-related defensive processes. In J.H. Obegi & E. Berant (Eds.), *Attachment Theory and Research in Clinical Work with Adults* (pp. 293-327). New York: The Guilford Press.
- Obegi, J.H., & Berant, E. (2009). Introduction. In J.H. Obegi & E. Berant (Eds.), *Attachment Theory and Research in Clinical Work with Adults* (pp. 1-14). New York: The Guilford Press.
- Obegi, J, Shaver, P.R., & Mikulincer, M. (2009). A Framework for Attachment-Based Psychotherapy with Adults. *New Therapist* 61, 10-21. Retrieved from [http://www.joeobegi.com/uploads/1/2/1/8/12183349/obegi\\_shaver\\_mikulincer\\_in\\_new\\_therapist\\_2009.pdf](http://www.joeobegi.com/uploads/1/2/1/8/12183349/obegi_shaver_mikulincer_in_new_therapist_2009.pdf)
- O'Brien, M. (2010). Towards Integration. In R. Woolfe, S. Strawbridge & W. Dryden (Eds), *Handbook of Counselling Psychology* (3<sup>rd</sup> ed.) (pp. 173-192). London: SAGE.
- Piaget, J. (1954). *The Construction of Reality in the Child*. London: Routledge.
- Piaget, J., & Inhelder, B. (1969). *The Psychology of the Child*. New York: Basic Books.
- Rafalin, D. (2010). Counselling Psychology and Research: Revisiting the Relationship in the Light of Our 'Mission'. In M. Milton (Ed.), *Therapy and Beyond* (pp. 41-55). Chichester: Wiley-Blackwell.

- Repetti, R.L., Taylor, S.E., & Seeman, T.E. (2002). Risky Families: Family Social Environments and the Mental and Physical Health of Offspring. *Psychological Bulletin*, 128(2), 330-366. Retrieved from <http://repettilab.psych.ucla.edu/repetti%20taylor%20seeman%202002.pdf>
- Rogers, C. (1961). *On Becoming a Person. A Therapist's View of Psychotherapy*. London: Constable & Robinson.
- Sameroff, A.J. (1987). The social context of development. In N. Eisenberg (Ed.), *Contemporary Topics in Developmental Psychology* (pp. 273-291). New York: Wiley.
- Sanders, D. (2010). Cognitive and Behavioural Approaches. In R. Woolfe, S. Strawbridge & W. Dryden (Eds), *Handbook of Counselling Psychology* (3<sup>rd</sup> ed.) (pp. 105-129). London: SAGE.
- Sanders, D., & Wills, F. (2005). *Cognitive Therapy, An Introduction* (2<sup>nd</sup> ed.). London: SAGE.
- Saunders, R., Jacobvitz, D., Zaccagnino, M., Beverung, L.M., & Hazen, N. (2011). Pathways to earned-security: The role of alternative support figures. *Attachment & Human Development*, 13(4), 403-420.  
doi:10.1080/14616734.2011.584405
- Slade, A. (2004). Two Therapies: Attachment Organization and the Clinical Process. In L. Atkinson & S. Goldberg (Eds.), *Attachment Issues in Psychopathology and Intervention* (pp. 181-206). New Jersey: Erlbaum.
- Slade, A. (2008). Implications of Attachment Theory and Research for Adult Psychotherapy. In J. Cassidy & P.R. Shaver (Eds), *Handbook of Attachment* (2<sup>nd</sup> ed.) (pp. 762-782). New York: The Guilford Press.
- Sroufe, L.A., Coffino, B., & Carlson, E.A. (2010). Conceptualizing the role of early experience: Lessons from the Minnesota longitudinal study. *Developmental Review*, 30(1), 36-51. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0273229709000409#>



- Strawbridge, S., & Woolfe, R. (2010). Counselling Psychology: Origins, Developments and Challenges. In R. Woolfe, S. Strawbridge & W. Dryden (Eds), *Handbook of Counselling Psychology* (3<sup>rd</sup> ed.) (pp. 3-22). London: SAGE.
- Vygotsky, L.S. (1978). *Mind in Society: The Development of Higher Psychological Processes*. Cambridge, MA: Harvard University Press.
- Wachtel, P. L. (2008). *Relational Theory and the Practice of Psychotherapy*. New York: The Guilford Press.
- Wallin, D.J. (2007). *Attachment in Psychotherapy*. New York: The Guilford Press.
- Willig, C. (2013). *Introducing Qualitative Research in Psychology* (3<sup>rd</sup> ed.). Maidenhead: Open University Press.
- Young, J.E. (1999). *Cognitive Therapy for Personality Disorders: A Schema-Focussed Approach* (3<sup>rd</sup> ed.). Sarasota: Professional Resource Press.

## ***Appendix A***

### **Participant invitation letter**

Dear Sir/Madam,

My name is Albert Osthoff and I am currently undertaking a Professional Doctorate in Counselling Psychology through the University of East London. This programme requires me to conduct a research study and I would be very grateful if you would help me by participating in my research. This research will be conducted in accordance with the Code of Ethics and Conduct for the undertaking of research as set out by the British Psychological Society (BPS) and the Code of Professional Ethics as set out by The Psychological Society of Ireland (PSI). In this letter, I will explain what my research is about and how it will be conducted.

#### **What my research is about**

This research intends to explore the concepts of attachment, therapeutic alliance and therapeutic outcome from the perspective of practising psychotherapists with regard to clients whom they are treating or have treated. It is hoped that the knowledge gained will ultimately provide therapists with greater insight into how clients' problems may be addressed.

#### **If you participate, what would be involved for you?**

I wish to collect data by conducting in-depth interviews with counselling or clinical psychologists. In order that the data reflects a significant body of experience, I am seeking participants who have a minimum of 4 years counselling experience. Participants should also be registered by The Psychological Society of Ireland (PSI) or chartered by the British Psychological Society (BPS). If you are willing to participate, I will arrange an interview at a time and location convenient for you. The interview would be approximately one hour in duration and will be recorded electronically.

**What happens to the recording of the interview and do you have the right to withdraw?**

The interview will be recorded on a handheld digital recording device. The electronic file of the recording will then be transferred to a computer device for the purpose of transcription. The transcription will use a pseudonym in place of your name. Therefore, you will not be identifiable in any materials or the thesis submitted to the University or any paper subsequently published. The recording of the interview will not be retained on the handheld device beyond the time necessary to create the transcript. The electronic file of the recording held on the computer device will be retained for academic purposes. A transcription service may be engaged in the transcription process. In this event, the electronic file of the recording, and the transcription generated, held on any third party computer device will be deleted once transcription is completed and delivered to the researcher. At any time during the interview, you have the right to withdraw from the interview, without disadvantage to yourself and without having to give any reason. In this event, the recording will be deleted from the handheld device. The right to withdraw is limited to the interview because, after this point, transcription and analysis will commence and withdrawal of data will alter the direction of the work.

**University of East London**

This study has the formal approval of the University of East London, Stratford Campus, Water Lane, London E15 4LZ. Dr Melanie Spragg, School of Psychology, is acting as Principal Investigator and my Director of Studies. If you have any concerns about this research or issues about the manner in which it is being conducted, you may contact Dr Spragg at: [m.spragg@uel.ac.uk](mailto:m.spragg@uel.ac.uk) (Tel 0044 20 8223 4396) or the Chair of the School of Psychology Research Ethics Subcommittee, Dr Mark Finn, School of Psychology, University of East London at [m.finn@uel.ac.uk](mailto:m.finn@uel.ac.uk) (Tel 0044 20 8223 4493).

I hope that you will participate in this research as it would be of great assistance to me in pursuing my education as a counselling psychologist as well as being a valuable contribution to the production of new knowledge in the field. If you would like further information about any aspect of this research, please contact me at the email address shown below.

*What is the role of attachment in contemporary psychotherapy?*

If you meet the participation requirements (you are a counselling or clinical psychologist, have a minimum of 4 years counselling experience and are registered by the PSI or chartered by the BPS) and are willing to participate, I will be delighted to arrange an interview at a time and location of your choosing.

Yours faithfully,

*Albert Osthoff*

Email [u1129293@uel.ac.uk](mailto:u1129293@uel.ac.uk)

## ***Appendix B***

### **Fully informed consent**

By signing in the space below, you are indicating your free and fully informed consent to participate in this research. Specifically, you are indicating that:

- (a) You have read the information relating to this research study and have been given a copy to keep (the Participant Invitation Letter).
- (b) The nature and purpose of the research have been explained to you and you have had the opportunity to ask further questions.
- (c) The interview process has been explained to you.
- (d) You understand that your participation in this study will remain strictly confidential. Although the researcher will be in possession of your identity, the transcript of your interview, and the data generated, will remain anonymous.
- (e) You understand that the interview will be recorded on a handheld digital recording device. The electronic file of the recording will then be transferred to a computer device for the purpose of transcription. The transcription will use a pseudonym in place of your name. The recording of the interview will not be retained on the handheld device beyond the time necessary to create the transcript. The electronic file of the recording held on the computer device will be retained for academic purposes.
- (f) You understand that a transcription service may be enlisted in this process. In this event, the electronic file of the recording held on any third party computer device will be deleted once transcription is completed.
- (g) You understand that at any time during the interview you have the right to withdraw from the interview, in which case the recording will be deleted from the handheld device. The right to withdraw is limited to the interview because, after this point, transcription and analysis will commence and withdrawal of data will alter the direction of the work.
- (h) You understand that this research will be conducted in accordance with the Code of Ethics and Conduct for the undertaking of research as set out by the

*What is the role of attachment in contemporary psychotherapy?*

British Psychological Society (BPS) and the Code of Professional Ethics as set out by The Psychological Society of Ireland (PSI).

**Signature of participant**

---

**Date**

---

***Appendix C***

**Confidentiality agreement with transcriber**

1. The identities of recorded voices must remain confidential.
2. The electronic files of the recordings will be given to you on a memory stick. You should copy these files to a computer device which is secured by password and protected by a software security system. Once copied there, the files should be deleted from the memory stick.
3. Transcriptions must use pseudonyms in place of the interviewees' real names to ensure the anonymity of the interviewees. I will provide you with pseudonyms.
4. Once transcriptions are made, and the content is reviewed by me, you should delete the electronic files of the recordings and transcripts from your computer device.

Please sign this agreement in the section below to indicate your agreement to these conditions. Your formal agreement to these conditions is necessary because this transcription is a part of research which is subject to a strict code of ethics from the University of East London. Without your agreement, this transcription cannot proceed.

Yours sincerely,

\_\_\_\_\_

***Albert Osthoff***

I agree to the conditions set out above.

Signature of transcriber \_\_\_\_\_

Date \_\_\_\_\_

***Appendix D***

**Sample interview schedule (initial sampling)**

1. From your experience, what are the most important considerations for you when thinking about building a therapeutic alliance?
2. In your analysis, what roles do innate temperament and instinct play in the development of how a person relates to others?
3. When thinking about your clients' ways of relating to others, I am wondering if you regard their way of relating to others as being set, or given direction to, by their early experiences of relationships with their care-givers? I am also wondering if you believe there to be a particularly crucial period in the person's development in this regard?
4. From your experience, do early experiences of relationships with care-givers have a role in the distress that your clients often present with? If so, could you quantify this role? I am wondering if you would consider it to be minor or significant, occasional or always?
5. From your experience, is there a correspondence between what you uncover about the care-giving your clients received early in life and their way of relating to significant others in their lives now? I am wondering, here, about your assessment of the continuity of relational traits from early life into later life?
6. In your opinion, do your clients ever, or often, have a different way of relating to you than to others? If you are of the view that this sometimes, often or always happens, what is your assessment of why this is so?
7. Do you differentiate between different ways that your clients have of relating to others? I am wondering here if you think of your clients' ways of being by reference to particular characteristics or categorise them into main groups?
8. From your experience, what are the consequences of your clients' ways of relating to others for the therapeutic alliance? I am wondering, here, if you make an assessment of the prospects for the therapeutic alliance based on the knowledge you uncover about their ways of relating to others? Would you associate particular ways of relating with particular trends in the alliance?



9. Typically, how would you use the knowledge you uncover about your clients' ways of relating to others? I am wondering if, and how, you tailor your intervention strategies to take account of their ways of relating to others? I am also wondering if, generally, your strategies are aimed at what your clients tell you about how they relate to others outside or at events in the session?
10. From your experience, what are the consequences of your clients' ways of relating to others for the therapeutic outcome? I am wondering, here, if you make an assessment of the prospects for the therapeutic outcome based on the knowledge you uncover about their ways of relating to others? Would you associate particular ways of relating with particular outcomes?
11. In your clinical work generally, what is the relative importance that you assign to understanding and working with your clients' ways of relating to others? I am wondering, here, if there were a table of important things, where in the table would you rank understanding and working with your clients' ways of relating to others? If there are other, more important, things, what would they, typically, be?
12. What is your assessment of the idea of a transaction taking place between you and your client that generates a unique relational outcome?

***Appendix E***

**Sample interview schedule (theoretical sampling)**

- 1 When the therapists were asked about their beliefs about what makes an effective therapeutic alliance, the essence of their reply was that it is to provide a safe place where the client can trust, feel at ease, come to believe that they are cared for and are meaningful in the lives of the therapists. This resembles Bowlby's concept of a safe haven. On the basis of your experience, why is this so important in your clinical work?
- 2 Therapists rated working with a client's way of relating to others as a top priority in clinical work. There was a suggestion that there is an ethical requirement for the therapist to attend to this because it supports the client's ability to establish a safe place outside of therapy. What do you think of the idea that, ultimately, the objective of therapy is mostly about helping clients to establish a safe place somewhere so as to achieve greater comfort in relationships?
- 3 A further priority in clinical work identified by therapists is the development of the therapeutic alliance. There was a suggestion that this, and the priority of working with a client's way of relating to others, together comprise the therapy. What do you make of this suggestion?
- 4 People have a natural disposition to enter into relationships and their early experiences with their caregivers will determine if this instinct will be trusted or, in other words, early experiences of relationships with caregivers will determine their degree of guardedness. It could be said, therefore, that the therapeutic enterprise is very often about helping clients to regulate their levels of trust and guardedness so that they gain greater comfort in relationships. What do you think of levels of trust in relationships and guardedness as barometers for the therapeutic outcome?
- 5 Therapists identified working with a person's way of relating to others and the therapeutic alliance as top clinical priorities. Therefore, it could be said that attachment is the most important theoretical construct to both understand and

*What is the role of attachment in contemporary psychotherapy?*

address the distress of most clients (PTSD sufferers, perhaps, being an example of an exception). In your experience, what do you think of this suggestion?

*Appendix F*

**Sample memo**

**This memo concerns one- and two-person epistemology (written after 3 of the 16 initial sampling interviews had been conducted)**

So far, after three interviews, my impression is that therapists do not seem to regard that the patient will be different with them than with others outside. I had been considering, in later interviews, to discontinue this line of questioning. Now, I am beginning to think that this is very much in the realm of a one- or two-person epistemology. The idea behind the question is to explore how attachment impacts on the therapeutic relationship that, we know from research, is the best predictor of outcome. If it really is the case that therapists think that patients will be no different with them than with others outside, then it seems that they are discounting the dynamic envisaged by a two-person epistemology. Therefore, instead of discontinuing this question, I should explore it more. However, in exploring it, I need to ensure that my questions are not experienced as me being critical of them. Perhaps, it is not the best course to seek answers through direct questions. Perhaps, the answers are contained elsewhere or throughout the participants' narratives. The first three participants have spoken of care, respect, listening and trust as being the important elements of the therapeutic relationship. Besides, I got the impression from them that they really prized the therapeutic relationship and that they try to differentiate its quality from the quality of the relationships their patients experience elsewhere in their lives, very much in the realm of a two-person epistemology. Perhaps, I should gently ask about their assessment of why patients will be different with them (the therapists) than with others outside.

**I find this memo interesting because, at the time, I thought that this matter would play some role in my findings. In retrospect, it shows my development as a researcher because, at the time, I became embroiled in details that, on reflection, were unlikely to yield any insight into such a broad research question. Whilst this might have been a bit naïve, it demonstrates, nonetheless, that any preconceptions that I had did not prevail in the eventual findings.**

## ***Appendix G***

### **Sample memo**

**This memo concerns safety in the therapeutic relationship (written after 11 of the 16 initial sampling interviews had been conducted)**

A theme of safety (as being a very important consideration in the establishment of a therapeutic relationship) is coming through. Whilst this is in keeping with Bowlby's (1988) secure base concept, it is also in keeping with Wachtel's (2008) discussion of Freud's insight that, actually, anxiety makes repression. By this reasoning, undoing anxiety becomes the cornerstone of therapy. This insight opens up the possibility of a different treatment strategy: instead of an adversarial or withholding approach designed to discover what the patient is hiding, it might be more fruitful to make the patient feel safer, enabling him to be less afraid of his feelings, thoughts and wishes. Such an approach, of course, readily fits with a relational approach. When the person becomes less afraid in an environment that is supportive and warm, then the person's thoughts, feelings and desires that, heretofore, had been defended against, can more easily be integrated and no longer require to be defended against. I am finding this interesting because, even though the participants are advocating safety, they are not making a connection with attachment or attachment theory. Also interesting is that Wachtel's discussion does not really touch on attachment theory either. At the moment, I have conflicting views about what role attachment plays in the participants' work.

**In retrospect, I find this memo highly interesting. At the time, I had not conducted an extensive literature review and some of the most insightful interviews had yet to take place. Nevertheless, even then, it had occurred to me that there might not be one answer to the research question, that different interpretations were a possibility. Need I have done five more interviews? Well, some anyway, because, at the time, I did not feel that I had sufficient data to derive tentative categories for further testing in theoretical sampling. This memo also gives me confidence that the eventual findings are well grounded.**

## ***Appendix H***

### **Sample memo**

**This memo concerns the possible disadvantages of a procedural sequence that holds over the literature review until after the data gathering and analysis are completed, as recommended by grounded theory methodology (written after completion of all initial and theoretical sampling interviews, analysis and further literature review)**

Of course, in order to gain approval for this research, I needed to have some knowledge of my subject. When completing my research registration, I became aware of the vast amount of extant literature on attachment and I delved into this to the extent necessary and to the extent opportunity allowed. However, after the registration process was completed, and beyond what I learned about attachment theory and its clinical application in the course of my academic education and working in my placements, I took to heart the recommendation in grounded theory methodology not to pursue further literature review until after data collection and analysis was completed.

Now that I have completed the data collection and analysis process, and have conducted an extensive further review of relevant literature, I am wondering about the benefits of this recommendation. I can understand the point that in-depth knowledge might prejudice the direction of the research and its findings. This touches on the difference that developed between the originators of grounded theory, Glaser and Strauss. Glaser's approach emphasised treating the data without preconceptions so that theory can freely emerge rather than imposing preconceptions. Charmaz (2014) agrees with Glaser's approach, although she acknowledges that researchers will have prior ideas and skills. On this basis, I am happy that I behaved like a naïve experimenter.

On the other hand, it might have been beneficial to have read some of the material that I am now familiar with. Yes, it is likely that it would have influenced my data gathering but it would also have enabled me to better target the major areas of concern in the literature. In other words, the resulting data might have more to say about the issues raised by some of the theorists. For example, if I had read Slade's

(2008) excellent overview of the implications of attachment theory and research for adult psychotherapy, I might have further explored the distinction between a therapeutic approach that is informed by attachment theory and one that is defined by it. At the same time, I feel proud that my research threw up material that plugs directly into the distinction made by Slade. A further consideration is that, had I probed this distinction from a stance of knowing, they may have interpreted me as being critical of their practice and ended the interview!

**On reflection, questions of any kind are always best asked from a stance of not knowing. Like therapy itself, the research enterprise provides many options, some mutually exclusive, and one hopes that the choices made along the way ultimately serve the overall objective of adding to our store of knowledge or making us think about future directions. As it turned out, my participants more than fulfilled this objective, even when I came without apparent preconceptions.**

<i>Appendix I</i>		
<b>Dermot (theoretical sampling) – specimen of transcript showing initial codes (and theoretical categories to which they relate)</b>		
<b>I = Interviewer; P = Participant</b>		
<b>Initial codes (and theoretical categories to which they relate)</b>	<b>I / P</b>	<b>Text</b>
<p><i>The goal of therapy is to make people more satisfied and comfortable with everyday unhappiness</i></p> <p><i>A primary driver of distress is often when the social fabric in which we exist breaks down</i></p> <p><i>Therapist is unsure if we can look to early childhood relationships for vulnerabilities that give rise to distress in the present day (Cat 1)</i></p> <p><i>The relationship we have</i></p>	<p><b>I</b></p> <p><b>P</b></p> <p><b>I</b></p> <p><b>P</b></p>	<p>From the initial sample of participants, it was fairly clear that early experiences of relationships with caregivers, more often than not, contribute to the distress of most people who attend therapy. What do you make of the suggestion that therapists spend most of their time trying to help their clients to address the mismatch between their needs from relationships and what the world is willing to provide?</p> <p>I guess that the word that stands out most there is the word ‘most’, you know, most of their time. I won’t focus in on that too much, but I would agree that therapists spend considerable time helping, I forget that quote from Sigmund Freud himself, but it’s one of a few he uttered in his time that really resonates with me, which is to, you know, <u>the goal of psychoanalysis is to make people more satisfied and comfortable with everyday unhappiness</u>, you know, something to that effect, and we are social beings, really, at the end of the day, it’s a huge part of who we are and <u>when that social fabric breaks down for one reason or another, it’s often a primary driver of our distress</u>. So, yeah, <u>do we look to early childhood relationships to identify vulnerabilities that may have existed prior to that social fabric breaking down, I’m not sure</u>. I am not sure if that is the question you are asking now, I think, well, I suppose a mismatch between, what’s that mismatch?</p> <p>Their needs from relationships and what the world is willing to provide.</p> <p>Yeah. It is a very good question, it’s a really thought provoking one and it has silenced me to some extent. I know life doesn’t pave the way for you, you’ve got to engage with it, you’ve got to grasp the nettle from time to time and wrestle with it and, of course, we have needs within relationships between us and others, but I would be reframing that within my own experience, as saying that it’s really <u>the relationship we have with</u></p>



<p><i>with ourselves is informed by relationships we have with other people (Cat 2.2)</i></p> <p><i>The majority of therapy is often concerned with how people relate to themselves or aspects of themselves (Cat 2.2)</i></p> <p><i>Therapy is often about attending to the intrapersonal dynamic between what patients need from the relationship they have with themselves and what they draw from it (Cat 2.2)</i></p> <p><i>The intrapersonal realm is a large determinant of the interpersonal realm (Cat 2.2)</i></p> <p><i>The intrapersonal realm is probably informed by early relationships and life experiences (Cat 1)</i></p> <p><i>How we were treated informs our early life experiences (Cat 1)</i></p> <p><i>A huge number of presenting problems are concerned with generalised and social anxiety (Cat 1)</i></p>	<p>ourselves which, of course, is informed by the relationships we may or may not have with other people, the successes of those relationships or, perhaps, shortcomings or failures, depending on the terminology one wishes to use, but the majority of my time in a therapeutic context, whether it's within a hospital or private practice, is often spent engaging with the individual as to how they relate to themselves or aspects of themselves, whether that be thoughts, whether that be emotional experiences, things they do, they don't do, they should be doing, they ought to be doing, it's an intrapersonal relationship and dynamic between what they may need from that versus what they draw from that within the context of their own life, as opposed to an interpersonal framework. Although, that is still relevant, of course, but I would see the intrapersonal world or realm as being a large determinant of the interpersonal realm.</p> <p><b>I</b> Not the other way around?</p> <p><b>P</b> Not necessarily the other way around, but the intrapersonal realm, of course, comes from somewhere, doesn't it, and so we are probably drawn back to those early relationships and early life experiences and how we were treated and what values and beliefs we were fortunate or not so fortunate to have been instilled with.</p> <p><b>I</b> You said something there at the very beginning, along the lines of, that you wouldn't think too much about the notion of 'more often than not contribute to the distress of most people who attend therapy'. I got the sense from you that you were not, maybe, you didn't particularly have a view on where most of the distress that you say, in your experience, have dealt with whether it be in your position here or in private practice, where that emanates from.</p> <p><b>P</b> Well, let me put it this way, a lot of the people I come across in private practice, in particular, where most of the therapy, to be honest, takes place. Within the hospital here, of course, there is therapy, but it is more targeted at pain management and acceptance of medical circumstances and what not, which is quite distinct from what people show up to my private practice looking to work on and discuss, and a huge part of that, there are really three strands, one, is a generalised anxiety, two, would be</p>
---	---

<p><i>The therapist is unsure about how much of his time he spends treating patients' interpersonal problems (Cat 1)</i></p> <p><i>It is inevitable that the influence of early experience is discussed with patients who suffer from social or other types of anxieties [in other words, most patients] (Cat 1)</i></p> <p><i>Memories heavily influence the way we conduct ourselves subsequently, whether that be within a relationship context or within a set of circumstances</i></p>	<p>the bulk of the individuals that show up to me looking for assistance would have a <u>social anxiety</u> difficulty, so they find themselves over-thinking heavily about themselves, magnifying and intensifying every little last perceived inadequacy and flaw that they feel they possess and I guess they struggle to cope with that or contend with those perceived issues against a backdrop of everyone else who, of course, is healthier and happier, more competent and capable, etc. So, there is a huge self-focus issue, but again it is within a broader context of interpersonal relationships and so that's really where <u>I am</u>, maybe, <u>struggling to be specific with you about</u>, you know, <u>how much time I spend discussing the interpersonal.</u></p> <p><b>I</b> Well, what about how much time you spend discussing the influence of early experiences on someone who may have a lot of social anxiety or other types of anxiety?</p> <p><b>P</b> Yeah, when you put it like that and I guess as my cogs turn, <u>it's pretty obvious that that is the case, but it is inevitable</u>, really, in a way – am I contradicting myself here? – that, because we experience life and life is, almost by definition, challenging and difficult and we can be fortunate or, as I said, unfortunate to have, you know, a bit more adversity than most people bargain for or plan for or, indeed, deserve, if I can put a value judgement in there. And so, yeah, of course, the people who perhaps end up in the therapy room have a greater challenge than most at having to contend with whatever experiences they've been through, and often those experiences are, I guess, by just being broad, negative, difficult, painful and quite demanding on them and their ability to cope and just simply at a, I stated before that I have an interesting neuropsychology and, you know, I frame things a lot as within a neurodevelopmental model or neurobiological framework, whereby, of course, <u>memories heavily influence the way we conduct ourselves subsequently, whether that be within a relationship context or even within a set of circumstances.</u></p> <p><b>I</b> As somebody said to me last year, you know, even where they don't have a live recollection of those experiences, those early experiences are</p>
---	--

<p><i>Although we usually do not consciously remember our first three years, arguably, they are our most important developmental years</i></p> <p><i>The nervous system is sufficiently developed to absorb information from birth to inform attachment formation and set up how a person relates to others subsequently</i></p>	<p>remembered in the nervous system without being necessarily accessible.</p> <p><b>P</b> Yeah, of course, to the conscious dimensions of our awareness. Since we last met, I've had a baby daughter, who is now twelve weeks old, so I'm in the....</p> <p><b>I</b> Congratulations!</p> <p><b>P</b> Thanks, yeah, I wasn't fishing for that, but I'm in the throes of early development and the impact that, I guess, the potency of relationships at that formative age, you know, and not just the first twelve weeks, but well beyond that as well, before they really develop the capacity to store conscious thoughts and experiences and memories. When I ask most people what their first memory was, not that I am in the habit of doing that, but from whenever I have done it, it's usually four, the odd person might say something that traces back to the age of three. So, <u>for the first three years of our life, we don't really remember facts, details in any conscious way, but the first three years of our lives are argued to be the most important.</u> I think there is even a campaign out there about how important the first thousand days of our life are in terms of <u>attachment formation</u>, in terms of bestowing a certain amount of emotional security on an individual and that really <u>sets us up for how we relate then subsequent</u> to the age of three. Neurodevelopmentally, neurobiologically, I think Freud was bang on and science and neurobiology has proven that, in the respect that the limbic system, the amygdala, are almost fully formed from birth, so, <u>emotionally, we are very spongy from day one.</u> Cognitively, we're all over the shop, we don't know, we just don't have the hardware, let alone the software, to deal with or grapple with that information, but, <u>emotionally, we absolutely do, yeah, we absorb that.</u> So, you said central nervous system and, yeah, I would agree and even go that little bit further by identifying the specific structures, you know. So, yeah, we'd agree on that.</p> <p><b>I</b> When therapists were asked about their beliefs about what makes an <u>effective therapeutic alliance</u>, the essence of their reply was that it is to provide a <u>safe place where the client can trust, feel at ease, come to believe that they are cared for and are</u></p>
--	--

<p><i>Experience has reinforced the therapist's view that an effective therapeutic alliance resembles Bowlby's safe haven (Cat 2.1)</i></p> <p><i>Therapeutic progress is most likely in a therapeutic space that is a safe haven (Cat 2.1)</i></p> <p><i>Innately, we need and seek comfort from birth</i></p> <p><i>The therapeutic alliance works as a mechanism for change when the therapist facilitates the patient to acknowledge and accept all aspects of himself (Cat 2.2)</i></p> <p><i>Acknowledgement and acceptance of ourselves makes for a far more permissive and liberalised existence (Cat 2.2)</i></p>	<p><u>meaningful in the lives of therapists.</u> This resembles Bowlby's concept of a safe haven. On the basis of your experience, why is it so important in your clinical work?</p> <p><b>P</b> Because it's true, really, it at least appears true to me. <u>Experience has reinforced that outlook on my part, belief on my part, which I would share with the question really.</u> I would very much agree with the sentiment within that question about <u>clients and individuals being most likely to progress</u> and develop favourably or succeed in their strides to achieve whatever it is they have come to you about, <u>provided those conditions are in place,</u> you know, <u>and provided that they do feel comfort.</u> There's got to be something innate going on there, <u>innately, we seek comfort from day one,</u> we need it, you know. Apes and chimpanzees do to, they prefer, even in an inert object, they prefer something furry than something hard or metally, but not to digress too much...</p> <p><b>I</b> How does the mechanism work? By you having, by you doing these things, you know, where they can develop trust, feel at ease, feel cared for and feel that they are meaningful in your life, as in, the therapist's life. How does that mechanism, how does that make them better, in your experience?</p> <p><b>P</b> God, I could write a thesis about that or maybe I couldn't write one just yet! It's a big question, how does it make it work? I know I'm saying that I'm pretty sure it does make it work, as to how the <u>mechanism actually operates,</u> I've got multiple things going on in my head and I am trying to consolidate as best I can. I'm not sure how much of the question I am answering, really, here, but, in my view, <u>it's when we become more accepting of all aspects of who we are.</u> When we feel able to <u>acknowledge things openly...</u></p> <p><b>I</b> As in, we the client?</p> <p><b>P</b> We, the client, yeah, with the help of the therapist, if need be. When we feel capable of, I guess, redefining things so that they are framed differently for us and <u>we can accept ourselves,</u> warts and all, it, by definition, becomes a far <u>more permissive and liberalised existence</u> so that we're, I guess, allowed to make mistakes because you don't learn if you</p>
--	--

<p><i>Therapeutic progress is when the patient can reframe matters and learn from them rather than seeing them as failures (Cat 2.2)</i></p> <p><i>A therapeutic environment that permits acceptance and mistakes supports therapeutic progress (Cat 2.2)</i></p> <p><i>The therapist provides the conditions where the therapist helps the patient to accept unhappiness as an element of satisfaction (Cat 2.2)</i></p>	<p>don't make mistakes, even, you know, <u>reframing it as instead of being, appraising something has having failed, now having tried or attempted to learn</u>, even if it didn't go well, I can't help but feel I am deviating from...</p> <p><b>I</b> No, I don't think you are too far away from it. I am just wondering, are you saying that if the therapist provides a certain <u>environment</u>, that, therefore, the client will be able to <u>more easily accept who they are and make those mistakes</u> that you have mentioned. Is that what you are saying? Is that how the <u>mechanism works</u>?</p> <p><b>P</b> <u>Yeah, yeah</u>, I guess the three theorists who come to mind for me in answering this question are Freud, you know, 'making the unconscious conscious' as best as one can. Freud believed that we sought pleasure. I'm sure he went on to develop that further, but, you know, there was the pleasure-seeking principle which he felt we were quite organismic. Subsequent thinkers, I am blanking on the names now, the guy who felt it was all about identity, not Maslow....</p> <p><b>I</b> Erikson.</p> <p><b>P</b> Erickson, sorry, yeah, placed a huge amount of primacy on constructing an identity, you know, and the reassurance and comfort we have with that, you know, even Dr Phil plagiarises Erikson to some extent these days in his positive psychology or psychology self-help books in saying 'create your identity', which I feel he is spot on to recommend us do, you know, rather than stagnate by second guessing ourselves and doing nothing versus doing something, and then there is Viktor Frankl who said 'No, no, no, it's actually about deriving meaning from life', and it's none of those things independently, it's all of those things combined really, but they've each, perhaps, approached the essence of your question through a slightly different angle or they are looking at the same prism or through the same prism, just seeing slightly different colours, and it's, yeah, Rogers as well by, you know, bestowing on someone or context the right conditions, you <u>somehow facilitate the genesis of this movement, this personal shift from inert to, I guess, movement, more, you know, unhappiness to satisfaction inclusive of</u></p>
---	---

<p><i>If the patient expects only happiness as an outcome, therapy is doomed to fail</i></p> <p><i>The therapist questions the usefulness of providing safety all the time (Cat 2.1)</i></p> <p><i>Challenging the patient within a zone of safety is constructive (Cat 2.1)</i></p> <p><i>If the caregiver provides too much safety, then the child may become inadequately resourced and prepared for life (Cat 2.1)</i></p> <p><i>Safety is good in a certain measure but should not obscure the reality that life has lots of thorn bushes (Cat 2.1)</i></p>	<p><u>unhappiness, as opposed to trying to flip the coin around and see only happiness which is doomed to fail.</u></p> <p><b>I</b> Okay. Therapists rated working with their client's way of relating to others as a top priority in clinical work. There was a suggestion that there is an ethical requirement for the therapist to attend to this because it supports the client's ability to establish a safe place outside of therapy. What do you think of the idea that, ultimately, the objective of therapy is mostly about helping clients to establish a safe place somewhere, so as to achieve greater comfort in relationships?</p> <p><b>P</b> Something about that jars with me because I'm not the kind of therapist that sees therapy as being only about a safe place. I do feel that it is important and valuable to challenge people and to, perhaps, <u>question, you know, the entitlement we have to feeling a certain level of safety all of the time.</u> Life isn't as luxurious as that and so, perhaps, it's my own belief or view and I'm not in the business of imposing that on anybody, but rather, at times, my work with an individual might be led by what they're bringing to the table and <u>if an opportunity arises that's appropriate for me to challenge something about that, within a certain zone or parameter of safety,</u> of course, I'm not in the business of making people feel unsafe, far from it, but then we start asking 'Well, how much safety?' Is it all about safety? Because, to me, that's, it might sound strong, but a little bit naïve, there is another word that again is escaping me, <u>sheltered,</u> you know. I think we, if you look at it from the point of view of parents, there are individuals I am currently working with, one in particular who stands out, whereby their parents provided an <u>incredibly safe childhood for them, only for them to be smacked firmly in the face by life once they left the home and the safety of the nest.</u> They simply were not adequately resourced and prepared for life as it stood. Life, as it stood for them, was wonderful and rosy in the garden, but little did they know that <u>lots of bushes have thorns in them.</u> So, <u>safety is good in certain measure, but it is important that we don't allow that ethos or aim of safety to, you know, obscure our views,</u> so that we have an idealised view of the world and expectation of the world and that we're still very much cognisant of</p>
--	---

<p><i>We can learn from getting stuck in the briar (Cat 2.1)</i></p> <p><i>Patients inadvertently harm themselves by bestowing maladaptive behaviours on themselves</i></p> <p><i>The therapeutic space has to be safe enough to allow us to challenge patients to grow their comfort zone (Cat 2.1)</i></p> <p><i>A patient's comfort zone may have been damaged by</i></p>	<p>the <u>reality of life</u> and the world.</p> <p><b>I</b> So get used to the thorns in the bushes?</p> <p><b>P</b> It's okay to get stung from time to time and, hopefully, <u>there is always the potential to learn from getting stuck in the briar</u>, even if it hurts for a while.</p> <p><b>I</b> I am thinking of the guys that you see in your private practice, the anxious people and they are so anxious they have social anxiety and they don't like to leave the house or they don't have a lot of human contact, perhaps.</p> <p><b>P</b> And a huge part of their problem is the amount of safety <u>they bestow on themselves through maladaptive</u>, to use a medical term or a clinical term, <u>behaviours</u> and that's what we call them, <u>safety behaviours</u>. So <u>they, inadvertently, harm themselves</u> further and reinforce their problematic outlooks and notions by acting in a way that affords them some comfort and safety and it's all very understandable, for example, not making eye contact.</p> <p><b>I</b> If they're not safe, they don't feel safe with people, so I am thinking, if we attend, the question is getting at, if we attend to a person's way of relating to others, then we are helping them to help themselves outside of therapy.</p> <p><b>P</b> Yeah, absolutely, yeah, of course. For folks with social anxiety, the problem is that they don't really allow that interrelationship to advance, avoidance of it happening is, yeah, probably the main barrier. Safety is good and <u>I think it is important that the therapeutic context is a safe one, safe enough, in fact, so that you can actually, perhaps, test people or get people to test the water or challenge them.</u> There is a meme I've come across of late, where, it was something we were always told at University, albeit from an athletics coach which was along the same lines of the meme, which is: there's three little balls in a picture, at the centre of a big circle is you, the big circle represents your safety, comfort zone and then <u>your goal should always lie outside of that comfort zone</u> because, otherwise, you are restricting life. So, there may be a period of time where <u>we have to assist someone in growing that</u></p>
--	--

<p><i>experiences or dysfunctional early life relationships (Cat 1, Cat 2.1)</i></p> <p><i>Growth only occurs when you stretch slightly beyond the comfort zone (Cat 2.1)</i></p>	<p><u>comfort zone because it's been damaged from experiences or dysfunctional relationships, in particular. They can be particularly damaging over the long term, especially when those relationships are early life relationships, but, ultimately, growth only occurs when you stretch slightly beyond the comfort zone, so long as it's not too far, then you're playing high-risks poker.</u></p> <p><b>I</b> Okay. A further priority in clinical work identified by therapists is the development of the therapeutic alliance. There was a suggestion that this and the priority of working with a client's way of relating to others together comprise the therapy. What do you make of this suggestion?</p> <p><b>P</b> Well, firstly, the therapeutic alliance is really important. It's really important, it's the vehicle that drives progress. It's hard to work well with someone when that alliance or collaborative mind-set isn't there.</p> <p><b>I</b> As we've said earlier in the first question.</p> <p><b>P</b> Yeah, absolutely. I'm not sure if the question suggested this, but what I thought I might have heard was that it's all about the client's way of relating to people and how the therapist uses that.</p>
<p><i>Working on the therapeutic alliance and working with the patient's way of being are bound up because the alliance leans on the limitations of the patient's way of being</i></p> <p><i>There is a balance to be struck between safety, comfort and challenge (Cat 2.1)</i></p>	<p><b>I</b> I think the question is suggesting that the <u>therapy is mainly about the two things of the alliance and working with the person's way of being.</u></p> <p><b>P</b> Yeah, <u>even if that alliance leans on what it may see as the limitations of that person's way of being or how problematic that person's way of being ends up being for them within the context of their lives, indicating some need for change. I'd agree with that strongly. There is a balance to be struck between safety, comfort and challenge, as I said a little earlier.</u></p> <p><b>I</b> You're introducing the idea of the thorn bush in there, which, I get that, so a little bit of the thorn bush in there or the challenge. <u>What you are suggesting is that that's okay provided the relationship has been established as a good one.</u></p> <p><b>P</b> Yeah. I'm glad you said that last bit because I don't think it is possible really unless that alliance</p>



<p><i>Provided that the relationship has been established as safe, working on the therapeutic alliance and working with the patient's way of being are important for the achievement of therapeutic progress (Cat 2.1)</i></p> <p><i>Therapeutic outcome is related to the patient's willingness or capacity to adapt (Cat 2.2)</i></p> <p><i>An equivalent barometer to the patient's willingness or capacity to adapt is the patient's guardedness and trust in relationships (Cat 2.2)</i></p>	<p>or that relationship is in place.</p> <p><b>I</b> So a 'yes' to...</p> <p><b>P</b> <u>Those two dimensions being pretty damn important within the context of therapeutic progress, yeah.</u></p> <p><b>I</b> People have a natural disposition to enter into relationships and their early experiences with caregivers will determine if this instinct will be trusted or, in other words, early experiences with relationships with caregivers will determine their degree of guardedness. It could be said, therefore, that the therapeutic enterprise is very often about helping people to regulate their levels of trust and guardedness, so that they gain greater comfort in relationships. What do you think of levels of trust in relationships and guardedness as barometers for the therapeutic outcome?</p> <p><b>P</b> As barometers for the therapeutic outcome. I think that there's a lot in that. I've often thought it would be interesting to do a study on how you measure someone's adaptability or <u>willingness to adapt or capacity to adapt</u>, that the words that were in my head at the time, <u>with the success or not or progress in therapy, therapeutic outcome</u>, as it were. I guess you've, maybe, <u>redefined that as saying the barometers around the guardedness of an individual and level of trust in a relationship</u>, I think they are <u>pretty important</u>, you know, if you are to identify potential, determinants of therapeutic outcome, I think they'd show up on the radar. I'm not sure how high up the pecking order or down it they'd be, but my guess would be that they'd be higher rather than lower.</p> <p><b>I</b> I'm thinking of your patients, the socially anxious people.</p> <p><b>P</b> You see, there is no doubt, I am even aware of it, as I said, with my own little one at the moment, there is a certain amount of personality, although twelve weeks is too early to be seeing her personality in all its full bloom, but there is a certain amount of personality that is, it's innate, we scientifically split this dichotomously between 50%, or so, genetic and 50, or so, percent environmental, statistically they are the figures that get thrown back at us and, so, there is a certain amount of it that early life</p>
---	--

<p><i>Even with healthy, nurturative, stable early relationships, we can still possess a vulnerability around being trustworthy (trusting) or guarded</i></p> <p><i>Certain amounts of vulnerability are independent of primary relationships (Cat 1)</i></p> <p><i>Significant adversity or hostility or toxic environments seem to be most damaging when it occurs in the primary school years (Cat 1)</i></p> <p><i>A more chronic outlook arises when the patient's emotional processing is stronger than the patient's capacity to think things through rationally</i></p> <p><i>Potentially, there are many factors that can damage a person</i></p> <p><i>Levels of trust or guardedness are significant in determining or influencing or informing therapeutic outcome (Cat 2.2)</i></p>	<p>relationships doesn't necessarily account for. <u>Even with healthy, nurturative, stable early life relationships, we can still possess a vulnerability around being trustworthy or guarded.</u> There is the intrauterine environment, there is epigenetic factors going back, you know, across, they are trans-generational, aren't they? That's what research is starting to point out more and more, so the misfortune of a grandparent can somehow manifest in the grandchild, which is fascinating and so <u>there are certain amounts of this that are independent of those primary relationships</u> and certainly with the social anxiety folks that I come across, not all, but some have had really good, sound, stable, loving upbringings, but have had the misfortune of encountering <u>significant adversity or hostility or toxic environments at some subsequent stage of their life, and you know, this seems to be most damaging when it occurs in the primary school years</u>, where again, the <u>capacity to think these things through and around them rationally is more limited, yet the emotional processing is quite strong, and so it bestows on the individual a more chronic outlook that they should be vigilant around others</u>, that they are not as important as others, even though, at the time, looking back and cognitively often many of them are well aware of it, that they were being teased by eight year olds. Would they listen to an eight year old or ten year old now? Of course they wouldn't and yet, their entire existence at this point in their lives can be heavily informed by the opinion and perspectives of eight year olds that treated them poorly when they were eight, again, independent of their own family of origin and how healthy or otherwise it might have been. <u>The more factors in the mix, the more, I guess, predisposing factors or contributory factors there are in the potential damage or potential for damage to be done within any of us</u>, but, of course, it's important and, yeah, as things, you know, in terms of how I would rate trustworthiness, not trustworthiness, but the <u>level of trust that someone feels towards the world or others and the extent to which they may or may not be guarded, I think those two things are significant in determining or influencing, informing, therapeutic outcome.</u></p> <p><b>I</b> Okay. The last question is: therapists identified working with a person's way of relating to others and the therapeutic alliance as top clinical</p>
--	---

<p><i>The suggestion that attachment theory underlies much or most of what therapists try to do in their work and that it is the most important theoretical construct to understand and address the distress most patients bring to therapy is valid but incomplete (Cat 3)</i></p> <p><i>The suggestion [above] is always relevant (Cat 3)</i></p> <p><i>The therapist always wants to know how people experienced their childhood (Cat 1, Cat 3)</i></p> <p><i>Attachment theory does not always explain why someone is struggling (Cat 3)</i></p> <p><i>Attachment theory is relevant most of the time for patients who have chronic, longstanding difficulties regulating their interpersonal and intrapersonal lives (Cat 1, Cat 3)</i></p> <p><i>Learning theory is more relevant for patients whose difficulties are more acute in nature and short lived (Cat 3)</i></p>	<p>priorities, as we said. Therefore, it could be said that attachment theory underlies much or most of what therapists try to do in their work and that it is the most important theoretical construct to both understand and address the distress that most clients bring to therapy. In your experience, what do you think of this suggestion?</p> <p><b>P</b> <u>I think it is a valid suggestion. I don't think it's complete.</u> I think it's trying to capture way too much. It assumes to be relevant always, whereas I would feel, or suggest, that <u>it's relevant, particularly relevant, some of the time.</u></p> <p><b>I</b> Not most of the time?</p> <p><b>P</b> Look, let me go back on myself and say <u>it's always relevant, it's always relevant, you know. I always want to know how people experienced childhood, how people experienced their lives. Whether or not they had peer matched or appropriate peer relationships throughout their youth and beyond, and whether or not they had supportive, nurturing parents, but attachment theory is not always the determining factor of why someone is struggling the way they are,</u> if they are. Learning theory is also relevant, it doesn't capture all referral problems either, how could it? It's hard to find a one-size-fits-all theory that accounts for everything we see or encounter, but attachment theory, again, it holds a lot of stock, and is it relevant most of the time, some of the time? I'm not sure, I don't know which one I'm more comfortable committing to. It's definitely some of the time. Do you know, <u>if we were to further split everyone who attends me, at least, into those who have chronic longstanding difficulties regulating their interpersonal and intrapersonal lives, then attachment theory crops up as being relevant most of the time, but if people's difficulties are more acute in nature and short lived, well, then it doesn't appear to be, you know, high up the pecking order in terms of relevance, learning theory seems to, kind of, trump it, in my view, more often than not in those circumstances.</u></p> <p><b>I</b> Okay, so it is, kind of, a similar qualification to the one we gave in the first question?</p> <p><b>P</b> Yeah.</p>
--	--