Literature Review:

The Relationship Between Therapists' Attachment and their Reflective Function: A Systematic Literature Review

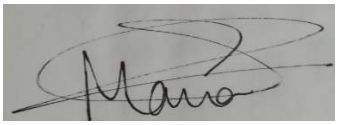
Empirical Paper:

Exploring clinical psychologists' attachment to their own personal therapists: Implications for their clinical practice

Submitted by Maria Gascon-Ramos, to the University of Exeter

as a thesis for the degree of Doctor of Clinical Psychology, May 2020.

I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signature: 

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A mis dos estrellas, Hugo y Tiago.

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SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

LITERATURE REVIEW

The Relationship Between Therapists' Attachment and their Reflective Function: A Systematic Literature Review

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Abstract

Background: Some therapists join their professions motivated by a need to care for others which is rooted on their attachment histories and can jeopardise their clinical effectiveness. Research on mentalizing has shown that these skills in the caregiver can facilitate attachment security. In the therapeutic relationship (TR), therapists' and clients' attachments interact, hence therapists' ability to mentalize about the relational needs in self and others is paramount.

Objective: This systematic literature review investigated the relationship between therapists' attachment and reflective function (RF) - the empirical operationalisation of mentalizing.

Methods: Databases were systematically searched for published research examining therapists, attachment, and RF. Of 971 articles, 11 met the inclusion criteria.

Results: Some studies showed a negative association between insecure attachment and RF. This was more frequently observed in therapists with avoidant attachment, than in anxious counterparts.

Conclusion: In line with the general research on attachment and RF, findings indicate that insecure attachment and lower RF are often associated. Undertaking personal development activities such as supervision and personal therapy, to develop therapists' RF is recommended.

Key words: attachment; reflective function; mentalizing; psychotherapy; systematic review.

Introduction

Factors linked to therapists, clients, treatment orientation and therapeutic relationship (TR) affect the effectiveness of psychotherapy (Cooper, 2008; Norcross & Wampold, 2011). Therapy outcomes are enhanced by therapists' qualities and behaviours, like tailoring and monitoring the TR (Norcross & Lambert, 2010). While therapists' training cultivates their knowledge, competencies, and technique (Norcross, 2011), other aspects like how therapists are in relationships, which influences their professional performance in the TR (Cooper, 2008) also needs to be considered. In a recent systematic literature review, Heinonen and Nissen-Lie (2020) found that therapists' intrapersonal variables (e.g., self-relatedness, attachment) had a direct effect on therapy outcomes. This is of particular importance as some clinical psychologists (CPs) and psychotherapists enter their professions motivated by an early life experience of caring for others to regulate their emotional experience (Barnett, 2007; Cohen, 2009; Cushway, 1995; Davies, 2018; Wallin, 2014). Lack of awareness about these dynamics can be detrimental to psychotherapy (Davies, 2018; Levine, 2015). Attachment and mentalizing theories as relational theories of human development offer a framework to explore the relational dimensions of the TR (Bowlby, 1988; Fonagy, 1989).

Attachment and Mentalizing Theories

Attachment theory was proposed by Bowlby (1988) and is rooted on ethology and psychoanalysis and captures Bowlby's preoccupation with the parent-child bond (Holmes & Slade, 2018). Mentalizing theory was proposed by Fonagy (1989) from his interest in individuals' understanding of their own and others' and is informed by psychoanalytic theory, attachment theory and other developmental and cognitive psychology theory and research. Attachment and mentalizing describe different

developmental processes that are closely interrelated in the individuals' development: mentalizing develops in attachment relationships through the child's experience of being understood by their caregiver (Allen, 2013) and concurrently contributes to the development of secure attachment in the child (Fonagy & Target, 1996). Hence, understanding the relational and emotional development of the individual requires consideration of these processes in interaction.

Attachment theory explains that humans have a hardwired attachment behaviour system (ABS) that when activated by a threat or distress, makes us relate and seek security (primary attachment strategy) from those around us to survive and grow (Bowlby, 1988). Caregivers (or attachment figures [AF]) that are consistently available and emotionally attuned become a secure haven to regulate the individual's emotion when in crisis, and a secure base to seek connection and explore the environment and the inner world of self and others. One of the fundamental aspects of attuned caregiving and emotional attunement is mentalizing.

According to mentalizing theory (Fonagy, 1989), mentalizing involves having an awareness of mental states (intentions, feelings, thoughts, beliefs and wishes) in oneself and in the other people that helps make sense of their actions (Fonagy & Bateman, 2019). By doing this, caregivers model mentalizing skills and language (Fonagy & Allison, 2011); and the child, can see their mind and their emotional states in the mind of the caregiver. This repeated experience helps them to progressively identify their internal experience from the outside and regulate their emotional states.

During infancy and as a result of this caregiving experience, individuals develop (adaptive) internal working models (IWMs) of relating to others and self. IWMs are cognitive schemas that help interpret others' behaviours to facilitate a response to

others' and make predictions about future relationships (e.g., AF's responses when in distress/danger) and own worth; as well as represent our own capacities and worth (Bowlby, 1988). In this interaction, the developing child learns that closeness and reliance on others, are compatible with distance and autonomy (Bowlby, 1988; Mikulincer & Shaver, 2018). Fonagy and Target (1996) explain that in the experience of being mentalized by the AF the individual learns to self-manage their emotional experience and respond to others' emotions in the absence of the AF, driving in this way the development of secure attachment (Bowlby, 1988).

Secure attachment relationships foster good mentalizing skills as individuals are effective in reading the mind and feelings of others and their own in interaction. They equip individuals with emotional regulation skills, empathy, attachment security and interpersonal effectiveness (Fonagy, Steele, Moran, Steele, & Higgitt, 1991; Fonagy, Steele, Steele, Moran, & Higgitt, 1991; Fonagy & Target, 1997).

In contrast, in the absence of attuned caregiving, the initial threat that activated the ABS is compounded by the fear of not attaining security (Mikulincer & Shaver, 2018). Individuals experience the world as unsafe, others as untrustworthy and oneself as worthless (Golding, 2008; Mikulincer & Shaver, 2018). Furthermore, abuse, neglect or early trauma lead the child to defensively inhibit their mentalizing capacities to overlook the hostile intentions and mental states of their caregiver which disrupts the development of mentalizing (Fonagy, Target, Gergely, Allen, & Bateman, 2003).

This sense of vulnerability results in an ABS that is continually activated and keeps the person preoccupied with threats and needs of protection. Adaptive secondary attachment strategies to resolve this situation are adopted: hyperactivation or anxiety- and/or deactivation or avoidance- (Mikulincer & Shaver,

2018). These secondary strategies have been described as organised insecure attachment and/or disorganised insecure attachments (Holmes & Slade, 2018).

As individuals encounter different caregivers, they forge a hierarchy of AF and a repertoire of attachment responses from which to develop a range of IWMs (Allen, 2013). Some IWMs become ‘chronically accessible’ models and manifest as the attachment style or typical way of operating in relationships, while others do not (Mikulincer & Shaver, 2018). However, attachment representations are better understood as dimensional (hyperactivation/anxiety, deactivation/avoidance) where individuals have certain predominant defences that can shift with the relational context, rather than as trait-like characteristics (Allen, 2013; Holmes, 2015). Attachment representations are therefore fluid, contextual, changeable through experience, while tendencies towards hyperactivation/deactivation might remain (Holmes & Slade, 2018). See Mikulincer and Shaver (2018) for a review on stability of attachment representation from childhood into adulthood.

The uses of primary and secondary attachment strategies are key in understanding the dynamic relationship between emotional arousal and mentalizing, because relationships affect individuals’ arousal levels and, consequently, impacts on mentalizing performance (Luyten & Fonagy, 2015). Luyten, Malcorps, Fonagy, and Ensink (2019) advise that the assessment of mentalizing must consider the attachment history of the individual and the relational context in which the individual is immersed. As Fonagy, Steele, and Steele (1991) demonstrated through the study of attachment transmission from mothers and grandmothers’ to their children, RF (the operationalisation of mentalizing) is a better predictor for attachment security than parental attachment even before birth; and prevents the transmission of insecure attachment in the parent-child dyad (Fonagy, Steele, Steele, Higgitt, &

Target, 1994). Hence, why some see in mentalizing the antidote for insecure attachment (Holmes & Slade, 2018).

As seen, IWMs hold information about ourselves and others in relationships that help us mentalize our needs and those of others and respond in interaction in an automatic and rather unconscious way. While mentalizing is often conceptualised as an unitary concept, it is a multifaceted process and requires balance between and within the different dimensions (Fonagy & Bateman, 2019). Lieberman (2007) described mentalization as: involving a self-reflective and an interpersonal component; being based on observing others and reflecting on their mental states; it is implicit and explicit and concerns both feeling and cognitions. Four dimensions with distinct neural circuits underpin mentalizing (Fonagy, Gergely, Jurist, & Target, 2002; Debanne & Nolte, 2019): automatic-controlled; internal – external; self-other; cognitive-affective (Table 1). Mentalizing encompasses related constructs such as empathy, theory of mind, psychological mindedness, and mindfulness. Mentalizing is seen as differing from introspection or self-reflection, which is an intentional form of reflection in conscious awareness and has an impact on the experience of oneself (Fonagy, Target, Steele, & Steele, 1998). To provide an empirical framework for the study of mentalizing, Fonagy et al. (1998) proposed the notion of RF as the operationalisation of this complex process.

Table 1.

Dimensions of Mentalizing (Fonagy & Bateman, 2019)

Dimension	Description
Automatic/implicit vs controlled/explicit	Controlled mentalizing reflects a serial and relatively slow process which is typically verbal and demands reflection, attention, awareness, intention, and efforts.

	Automatic mentalizing involves much faster processing, tends to be reflexive and requires little or no attention, intention, awareness or effort.
Self vs other	Individual's capacity to mentalize his or her own state – the self (including physical experiences) and/or the state of others.
Internal vs external	External indicators of a person's mental state (e.g., facial expression) or figuring out someone's internal experiences from what an individual knows about the person and the situation the person is in. It also includes the individual thinking about himself or herself and his or her own internal and external states.
Cognitive vs affective	Cognitive mentalizing involves the ability to name, recognise and reason about mental states in self or others. Affective mentalizing involves the ability to understand the feeling of such states in self and others.

In the context of unconscious relational processes between clients and therapists, therapists' attachment and mentalizing are pertinent to the development of a secure TR and the psychotherapeutic process.

Therapist Attachment and Psychotherapy

In psychotherapy, providing a safe environment and a secure base is important for the client's development of a secure attachment to the therapist and for the effectiveness of therapy (Bowlby, 1988; Mikulincer, Shaver, & Berant, 2013). In the TR, clients and therapists project their IWMs onto one another (Bowlby, 1988), triggering their emotional arousal and ultimately affecting their ability to mentalize. These relational dynamics influence the therapy process and outcome (Mikulincer et al., 2013).

When investigating the impact of therapists' attachment style on the process and outcomes of therapy, recent systematic reviews suggested that therapists' secure attachment is predictive of positive patient-therapist alliance and better outcomes, despite some mixed results (Degnan, Seymour-Hyde, Harris, & Berry, 2016; Mimura & Norman, 2018; Steel, Macdonald, & Schroder, 2018). In line with research of other caregiving relationships, the ability to provide sensitive, flexible and effective caregiving was influenced by the therapist's own sense of attachment security and ability to mentalize the client's and their own relational-emotional needs in the TR (Borelli & David, 2004; Fonagy & Bateman, 2019; Holmes & Slade, 2018).

Dozier, Cue, and Barnett (1994) found that securely attached therapists showed greater flexibility and responded to underlying, disruptive feelings and needs brought by their clients. In contrast, insecurely attached therapists were often side-tracked by the patients' defences, missing the underlying issues, and responding in non-therapeutic ways, that unwittingly magnified clients' defences. It was suggested this was because clients activated the therapists' own attachment systems. These findings suggest that, as secure caregivers, secure therapists are better able to mentalize the clients' emotional needs and experiences, showing greater attunement and sensitivity to clients relational demands for attachment complementarity in the TR (Kelly, Slade, & Grienenberger, 2005; Stacks et al., 2014).

In fact, Talia, Muzi, Lingiardi, and Taubner (2018) found a high association between therapists' attachment representations and patterns of attunement in therapy which influenced the therapeutic process considerably. In case studies they illustrated that in the therapeutic encounter while a secure therapist was able to keep an open-mind, allow space for the patient to reflect on their own and talk about their feelings in the TR; an avoidant therapist minimised the emotional internal experience

of the client and switched from internal to external experience (detaching strategies); and an anxious therapist used a mixture of joining and withholding strategies.

Daly and Mallinckrodt (2009) researched therapists' behaviours when offering psychotherapy using a qualitative research strategy. They concluded that therapists need to mentalize on clients' relational needs as well as their own to regulate the therapeutic distance (TD) accordingly. Initially, mirroring the attachment style of the clients; and later, intervening by taking a counter-complementary position as the therapeutic alliance develops. Hence, awareness of the attachment interplay between therapist and client is essential to mentalize clients' relational needs as well as their own and to respond therapeutically.

Therapists' IWMs and their ability to reflect on their own and their clients' mental states and relational needs seems to be key to forging an effective TR conducive to positive therapeutic outcomes (Farber & Metzger, 2009). Secure therapists seem to be better able to mentalize their own and their clients' relational needs in the TR, offering more effective attunement and caregiving; meanwhile, their insecure counterparts, might have more difficulty to do so. Mentalizing can improve their performance (Fonagy, Steele, & Steele, 1991). Therefore, it is important to understand how attachment and mentalizing relate in therapists. As mentalization is operationalised in the construct of reflective function (RF), RF will be used hereon to refer to the measurement of mentalization and its different components.

Research Question

This systematic literature review set out to answer the following research question: How does therapists' attachment relate to their reflective function?

Method

The Preferred Reporting Items for Systematic Review and Meta-analysis guidelines (PRISMA-P; Moher et al., 2015) were used to carry out this review to minimise bias and enhance its scientific rigour.

Search Terms

A scoping review was carried out to identify some preliminary literature and was used to adjust the search terms used in the review. Search terms described the range of professionals and trainees within the field of psychotherapy (population); descriptors of attachment (exposure); and descriptors of reflective function (outcome). Table 2 presents the final search terms used to carry out the review with appropriate truncation and wildcards; as well as Boolean operators (OR within sections; AND between sections).

Table 2.

Search Terms

Search	Therapist Section 1 (abstract)	Attachment Section 2 (abstract)	Reflective Function Section 3 (abstract)
Individual search terms	"therapist*" or "psychologist*" or "counsellor*" or "counselor*" or "psychotherapist*" or "clinician*" or "doctor*" or "psychiatrist*" or "nurse*" or "health worker*" or "healthcare worker*" or "health professional*" or "healthcare professional*" or "psychoanalyst*" or "analyst" or "trainee" or "student" or "in-training"	"Attachment" or "high avoidance" or "fearful avoidant" or "high anxiety" or "preoccupied" or "low avoidance" or "secure" or "insecure" or "disorgani?ed" or "low anxiety" or "dismissing avoidant" or "dismissing of attachment" or "enmeshed and preoccupied with attachment" or "free and autonomous with respect to attachment" or "Adult Attachment Interview" or "Adult Attachment Scale" or	"reflective function*" or "mentali?ation*" or "mindedness" or "mind-mindedness" or "reflective function scale" or "AAI-RF" or "Adult Attachment Interview - Reflective Function" or "reflective function questionnaire" or "reflective function rating scale" or "reflective-self" or "self-reflective function" or "reflective functioning scale" or "RFS" or "mental states" or "RFRS" or "Fonagy" or "mentali?e" or

		"AAS" or "Attachment Style Questionnaire" or "ASQ" or "Adult Attachment Style Measure" or "Experience* in Close Relationship* Scale" or "ECR" or "ECR-R" or "Experience* in Close Relationship* Scale – Short Version" or "ECR-12" or "Self-Reliance Inventory" or "adult attachment questionnaire" or "AAQ" or "relationship style questionnaire" or "rsq" or "State Adult Attachment Measure" or "SAAM" or "Experience* in Close Relationship* - relationship structures measure" or "ECR-RS" or "caregiving system scale" or "CSS" or "caregiving questionnaire" or "sexual system functioning scale" or "SSFS"	"mentali?sing" or "reflective-self functioning" or "mentali?ation based therapy"
Combined search	Section 1 AND Section 2 AND Section 3		
Filtered	English language and human		

Search Strategies

To undertake the review five key psychology databases - Embase, PubMed, Medline, Web of Science and PsycINFO- were searched on the 16/10/2019. All terms were searched within the ‘abstract’ field in order to retrieve literature that included all key terms. To access grey literature, searches on two databases were carried out – namely, the British Library Ethos and ProQuest. Moreover, key authors

(e.g., Rosemary Rizq, Tobias Nolte, Diana Diamond and John Cologon) were contacted directly to request access to any unpublished studies. However, this did not yield any studies. Endnote software was used to identify duplicates.

This review focused on publications about therapists or trainee therapists that had drawn a link between therapists' attachment and their reflective function. This included qualitative and quantitative research published in peer-reviewed journals and dissertations only. Relevant studies looked at attachment in humans only and were written in English. There was no time limit in the search. The Population, Exposure, Comparator, Outcome and Study design (PECOS; Methley, Campbell, Chew-Graham, McNally, & Cheraghi-Sohi, 2014) inclusion and exclusion criteria for the study are summarised in Table 3.

Table 3.

PECOS Inclusion and Exclusion Criteria

Research aspect		Inclusion criteria	Exclusion criteria
Participants	P	Therapists, psychotherapists, counsellors, psychologists, healthcare professionals, psycho/analysts	
Exposure	E	Attachment measure or Reflective-function measure	
Comparator	C	Not applicable	
Outcome	O	Attachment measure or Reflective-function measure	
Study design	S	Quantitative, qualitative and mixed	Review papers; case studies.
Other aspects:			
Publication language		English only	
Cultural and linguistic		Studies carried out in any cultural groups. Humans only.	

characteristics of participants		
Time frame	To date.	
Types of publications	Peer-review journals and dissertations	Publication in non-peer review journals; commentaries to articles; books; case studies; theoretical papers; abstracts.

Study Selection

The search retrieved 971 articles, once duplicates were excluded 414 articles were left. All articles were screened by title and abstract using the PECOS criteria. Fourteen articles met PECOS criteria and progressed to the next review stage. These 14 papers were subjected to a full-text appraisal to establish their eligibility. Five articles were excluded. Nine articles fulfilled the inclusion criteria. Reference lists of eligible studies were reviewed at title level only to identify any further articles. This resulted in another article being included. Finally, articles which were excluded from the review due to the type of publication or language, but that otherwise met the PECOS criteria, were also scrutinised to identify any relevant publications which could have been missed. This produced an additional article. A total of 11 articles were seen to fulfil the PECOS criteria and therefore were included in the review.

Following Moher et al. (2015) recommendations, six articles were reviewed (full-text) by an independent second-rater to assess the reliability of the selection. Inter-rater reliability was calculated using Cohen's Kappa. This indicated complete agreement between raters ($\kappa=1$).

Evaluation Criteria

Quality appraisal (QA) of research is fundamental to promote precision, transparency, and evaluation in psychological research. QA tools have been developed but often lead to different conclusions (Protogerou & Hagger, 2019). This suggests that no single QA tool is fully adequate to assess the quality of studies (Alderson et al., 2003) and challenges the validity and reliability of this process.

The quality of the studies included in this review were critically appraised using a standardised tool: the Appraisal Tool for Cross-Sectional Studies (ATCSS; Downes, Brennan, Williams, & Dean, 2016; Appendix B). ATCSS fit the study designs, had guidance, and was developed through a rigorous methodology that maximises its validity and reliability (Protogerou and Hagger, 2019). It is a 20-item questionnaire that assesses: quality of reporting, study design and study bias. Still, a subjective component remains (Protogerou & Hagger, 2019). While the ATCSS does not include a scoring system (Table 4), one was developed to assist in the synthesis of our QA results (1 is achieved; 0.5 partially achieved; and 0 not achieved) and indicated that appraisal was often subjective.

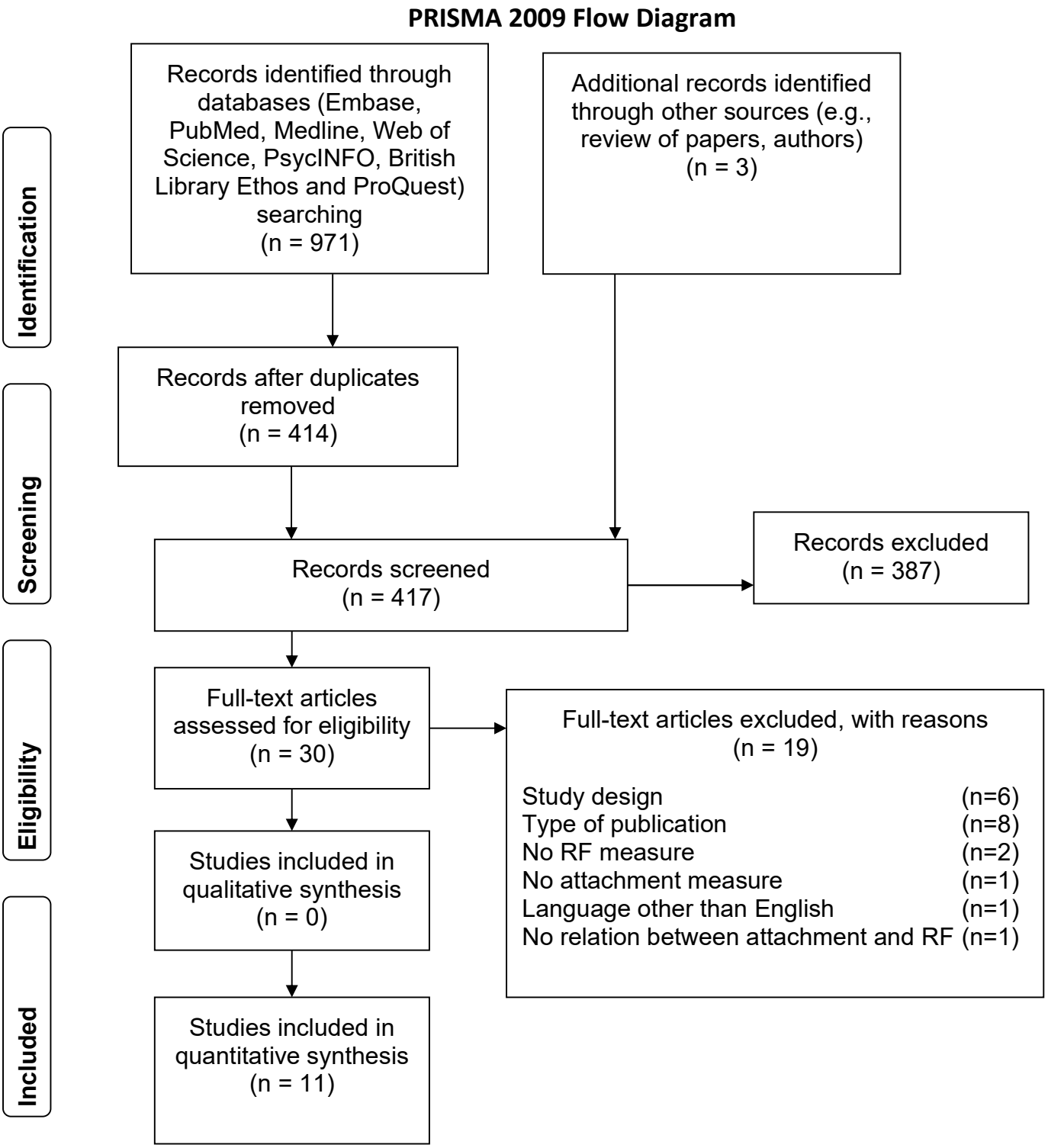
Table 4.

Scoring Developed for Appraisal Tool for Cross-Sectional Studies

Scale	Points	Description
Quality of reporting	1-3	Weak
	4-5	Moderate
	6-7	Good
Study design	1-3	Weak
	4-5	Moderate
	6-7	Good
Biases in the study	1-2	Weak
	3-4	Moderate
	5-6	Good

An independent second-rater, appraised three articles to enhance the reliability of the quality appraisal process (full-text). Inter-rater reliability was 1.0 which indicated a complete agreement (McHugh, 2012).

Figure 1: Flow diagram detailing search procedure.



Results

This review includes 11 papers which investigated the relationship between attachment and RF in therapists or therapists in training[1] (Table 5). Two papers used the same data (Rizq & Target, 2010a, 2010b). Likewise, the work of Cologon et al., (2013) is presented as a thesis and a journal publication. Hence, a total of 9 studies were reported in 11 papers.

[1] Hereon, I will refer to participants as therapists, although different levels of training, professional background, qualification, and experience should be assumed.

Table 5.

Summary of Articles Included in the Present Review

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
Study 1: Berry et al. (2008)	The study investigates how staff attachment style is associated with: (1) patient and staff discrepancies in the understanding of interpersonal problems; (2) staff psychological mindedness and therapeutic relationships in a sample of psychiatric staff and patients with psychosis.	Cross-sectional Pilot study	United Kingdom	**Size**: 20 staff **Gender:** 70% (14) women 30% (6) men **Age:** n/a **Qualifications:** 75% (15) nurses 25% (5) support workers **Experience:** *M* = 11 years (*SD* = 58.1)	**Attachment measure:** Adult Attachment questionnaire **RF measure:** The Five-Minute Speech Sample	Staff psychological mindedness was negatively correlated with staff attachment avoidance, suggesting that staff who were less psychologically minded were more avoidant (*r*= -0.55, *p*=.018). No significant correlation between psychological mindedness and attachment anxiety *(r*=0.19, *p*=.449) was observed.	Cross-sectional study design. Convenience sample. Small sample size. Over representation of nurses and women in the sample.	**A: Mod** **B: Mod** **C: Weak**
Study 2: Brugnera et al. (in press)	The aim of the study was to test the mediating role of reflective functioning on the association between both attachment insecurity and well-being on psychotherapists.	Cross-sectional	Italy	**Size:** 416 Italian psychotherapists **Gender**: 80% (331) women 20% (85) men **Age**: *M* = 43.9 **Qualifications:** 90.8% had a master's degree in Psychology	**Attachment measure:** Experiences in Close Relationships – Revised – Italian version **RF measure**: Reflective Functioning	The correlation between attachment avoidance and RFQ-Certainty was negative and statistically significant (*r* = -0.36, *p*<.001). This had a small effect (-0.15, p<.05); and attachment avoidance with RFQ-Uncertainty was (*r* = 0.27, *p*<.001). The size of	Cross-sectional design. Instrument not designed for non-clinical populations. Use of self-report measures for attachment and RF.	**A: Good** **B: Mod** **C:Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
				8.4% had a Ph.D. in a related field. **Experience**: *M*= 10.1 **Therapeutic Orientation**: 66% integrative 14% psychodynamic 12% CBT 5% systemic 2% humanistic **Supervision:** 84% Yes 16% No	Questionnaire – Italian version	the effect was 0.12 (p<.05, small). Attachment Anxiety with RFQ-Certainty was negative and significant relationship (r = -0.46, p<.001) This had a medium effect (-0.38, p<.001); and with RFQ-Uncertainty was *(r* = 0.35, p<.001). The size of the effect was 0.29 (p<.001, small).		
Study 3: Cologon (2013)	The study aimed to explore two hypotheses: (1) greater levels of therapist reflective functioning will be associated with greater therapist effectiveness. (2) Greater levels of therapist attachment security will be associated with greater therapist effectiveness.	Cross-sectional	Australia	**Size:** 25 therapists **Gende**r: 84% (21) women 6% (4) men **Age:** *M*= 37.86 **Qualifications:** 16 postgraduate students in clinical psychology 9 qualified therapists **Years of experience:** *M*= 7.29 **Therapeutic orientation:** 50% psychodynamic 25% ACT 15% integrative 10% humanistic/CBT	**Attachment measure:** Experiences in Close Relationships Scale **RF measure:** Adult Attachment Interview – Reflective Function Scale	There were no statistically significant relationships between attachment and RF in this sample. A small and positive relationship was observed between attachment avoidance and RF (r=0.057, p >.05); and a similar result was observed between attachment anxiety and RF (r=0.091, p >.05).	Small sample size. Naturalistic design. Sample size. Clients were not randomised to therapists. sample size. Number of clients seen by each therapist (from 4 to 209) affecting the effectiveness measurement.	**A: Good** **B: Mod** **C: Weak**
Study 4: Cologon, Schweitzer,	This study investigated the relationship	Cross-sectional	Australia	**Size:** 25 therapists **Gende**r: 84% (21) women	**Attachment measure:** Experiences in	No statistically significant relationships between	Naturalistic design. Sample size. Clients were	**A: Good** **B: Mod** **C: Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
King & Nolte (2017)	between therapists' reflective functioning and attachment style and client outcome.			6% (4) men **Age:** *M*= 37.86 **Qualification**s:16 postgraduate students in clinical psychology 9 qualified therapists **Years of experience** *M*= 7.29 **Therapeutic orientation:** 50% psychodynamic, 25% ACT, 15% integrative, 10% humanistic/CBT.	Close Relationships Scale **RF measure:** Adult Attachment Interview – Reflective Function Scale.	attachment and RF observed in this sample. A small and positive relationship was observed between attachment avoidance and RF (*r*=0.057, *p* >.05). A similar result was observed between attachment anxiety and RF (*r*=0.091, *p* >.05).	not randomised to therapists. sample size. Number of clients seen by each therapist (from 4 to 209) affecting the effectiveness measurement.	
Study 5: Hartley, Jovanoska, Roberts, Burden & Berry (2016)	The aims of the study were to explore the association of staff experience, psychological mindedness, attachment styles and emotional burnout with case formulation skills.	Cross-sectional	United Kingdom	**Size:** 50 staff members **Gender:** 66% (33) women 44%(17) men **Age:** *M*= 37.5 (SD 10.64) **Qualifications:** 36% (18) nursing 20% (10) support workers/nursing assistants 18% (9) psychology 16% (8) OT 10% (5) psychiatry **Experience:** *M*= 9.21 years working with psychosis (SD 6.50)	**Attachment measure:** Adult Attachment scale **RF measure:** Psychological Mindedness Scale. Psychological Mindedness Speech Sample	A large and statistically significant association was observed between self-reported psychological mindedness and attachment avoidance (*r*=-0.686, *p*=.01). However, when psychological mindedness was rated from speech sample a negative small and non-significant association was found *(*r=-0.121, *p*>.05). Attachment anxiety did not significantly correlate with the PMS (*r*=-0.262, *p*>.05) or the PMSS in this sample (r=.062, p>.05). While correlations were still	Cross-sectional study design. Convenience sample. Small sample. Effects of training or education not considered.	**A: Good** **B: Good** **C: Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
						small, larger correlations were found with the PMS. Finally, the relationships between PMS and attachment anxiety was negative, while with the PMSS was positive.		
Study 6: Hill (2013)	The main aim of the study was to evaluate mentalizing abilities and attachment orientation in therapists and to explore the relationship between the two.	Cross-sectional	United Kingdom	**Size:** 20 therapists and 21 matched non-therapists. <u>Therapists group:</u> **Gender:** 65% (13) women 35% (7) men **Age:** *M* = 38.7 years **Qualifications:** Possessed a counselling, counselling psychology or psychotherapeutic qualification at Masters/Doctorate level or were in last phase of training **Experience:** Participants were all practising.	**Attachment measure:** The Experiences in Close Relationships Scale **RF measures:** *<u>Behavioural measures</u>* Everyday Pictures Eye-tracking measures of social orientation. Recognition of Facial Emotion Task. Perspective Taking Task The Levels of Emotional Awareness Scale The Revised "Reading the Mind in the Eyes" Test	Big negative correlations were seen between attachment avoidance and self-reported empathy (Empathy Quotient, *r*=-0.58, *p*=.004; Cognitive Empathy subscale *r*=-0.48, *p*<.05; Emotional Reactivity subscale *r*=-0.48, *p*<.05). Attachment avoidance was significantly negatively correlated with scores in the Interpersonal Reactivity Index-Perspective Taking subscale (*r*=-0.45, *p*=.023). A marginally significant positive correlation was also seen between avoidance and the Interpersonal Reactivity Index- Empathic Concern subscale (*r*=0.38, *p*=.051). Furthermore, attachment avoidance levels showed a significant negative correlation with Mental	Small sample. Self-report measures for attachment.	**A: Good** **B: Good** **C: Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
					<u>*Self-report measures*</u> Interpersonal Reactivity Index. Empathy Quotient. Autism Quotient.	State Elaboration scores (r=-0.48, p=.016). In the therapist sample anxious attachment, significantly negatively correlated with self-reported empathy (EQ, r=-0.52, p=.01). <u>Control group</u> Neither of these significant relationships were seen in the control group.		
Study 7: Levine (2015)	The purpose was to (a) determine the ability of a childhood relational trauma measure to predict scores on mentalization instruments, and (b) assess for potential factors mediating or moderating the relationship (e.g., relational style) between the mentalization variables and childhood relational trauma scores.	cross-sectional survey methodology	United States of America	**Size:** 121 trainees in CP and counselling programs **Gender**: 83% (101) women 17% (20) men **Age**: *M* = 27.26 (*SD*=5.25) **Qualifications:** 49% (59) Mental health counselling master's programmes 43% (52) were CP PsyD students 8% (10) were clinical psychology PhD students **Experience:** 65% (79) had provided therapy for	**Attachment measure:** The Relationship Structures Questionnaire **RF measures:** <u>*Mindfulness*</u>**.** The Kentucky Inventory of Mindfulness Skills <u>*Affect consciousness.*</u> The Toronto Alexithymia Scale <u>*Psychological mindedness.*</u> The Psychological	Attachment avoidance showed moderate to small significant correlations with alexithymia *(r*=0.29, p<.01), psychological mindedness (r=-0.42, p<.001), and IRI-Empathetic Concern (r=-0.34, p<.001). All other dimension of RF did not show statistically significant correlations with attachment avoidance.: reading the mind in the eyes test (r=-0.03, p>.05), IRI-Perspective taking (r=-0.17, p>.05), mindfulness (r=-0.14, p>.05). Attachment anxiety showed moderate statistically significant correlations with the	Cross-sectional design Self-report measures. Relatively underpowered sample given the number of variables in the study.	**A: Good** **B: Good** **C: Mod**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
				at least 6 to 12 months 35% (42) some had not provided therapy at all	Mindedness Scale *Theory of mind.* The Reading the Mind in the Eyes Test, Revised Version *Perspective taking* The Interpersonal Reactivity Index Perspective Taking subscale *Cognitive empathy.* The Interpersonal Reactivity Index - Emotional Empathy subscale.	following RF dimensions: alexithymia *(r*=0.34, *p*<.001); psychological mindedness (*r*=-0.29, *p*<.01), and perspective taking (*r*=-0.24, *p*<.01). However, no statistically significant associations were observed between relational anxiety and the remaining RF dimensions: mindfulness (*r*=-0.22, *p*>.05), reading the mind on the eyes test (r=-.04, *p*>.05), and empathetic concern (r=-0.09, *p*>.05). It is worth noting that all were negative and small correlations.		
Study 8: Manley (1999)	The study investigated if therapists are more psychologically minded and more securely attached than either clients or members of the	Cross-sectional Case-control	United Kingdom	21 therapists Therapist group **Gender**: 76% (16) women 23% (5) men **Age**: *M*= 42.6 **Qualifications:** 24% (5) CPs 24% (5) nurses 24 (5) social workers	**Attachment measure:** The Adult Attachment Scale . The Hazan and Shaver Questionnaire. Collins procedure.	The Psychological Mindedness Scale was not significantly related to any of the Adult Attachment Scale dimensions. When using Bartholomew's attachment classification, high levels of psychological mindedness	Cross-sectional design. Small sample. Use of self-report measures for attachment and psychological mindedness.	**A: Good** **B: Mod** **C: Mod**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
	general population.			14% (3) counsellors 9% (2) OT 5% (1) psychotherapist. **Therapeutic orientation:** 43% (9) eclectic-humanistic 24% (5) psychodynamic 24% (5) eclectic-CBT 9% (2) pure CBT	**RF measure:** Psychological Mindedness Scale. Toronto Alexithymia Scale.	were observed for secure and insecure attachment classifications in the therapists' sample and no significant differences between these groups (F=0.33, p>.05) for PMS. <u>Group comparisons</u> Higher levels of psychological mindedness were observed in the therapist group when compared to compared to the client and control groups. The therapist group was more securely attached, but only when compared with the client group.	Unclear representativeness of control group.	
Study 9: Rizq & Target (2010a)	The study aimed to examine the role of attachment status and reflective function in counselling psychologists' accounts of personal therapy, focusing specifically on aspects of the therapeutic relationship.	Qualitatively driven, mixed-methods study. Interpretative Phenomenological Analysis	United Kingdom	**Size:** 12 CoP **Gender:** 75% (9) women 25% (3) men **Ages:** ranging from 35 to 65 **Qualifications:** All chartered between 2000 and 2004 as CoP **Experience:** Qualified and practising for between 3 and 7 years.	**Attachment measure:** Adult Attachment Interview. **RF measures:** AAI- Reflective Function Scale.	**Quantitative findings:** RF scores were found to be higher with the secure/earned secure participants. 5 out of 6 secure/earned secure participants having RF scores of 4 or above and 4 out of 6 insecurely attached participants having RF scores between 0 and 3. The two ''earned-secure'' participants had high levels of RF.	Small sample and not representative of population. Low generalisability.	**A: Good** **B: Good** **C: Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
Study 10: Rizq & Target (2010b)	The study aimed to elicit counselling psychologists' subjective accounts both of their early attachment experiences and of their personal therapy, considering their own attachment representation and RF.	Qualitatively driven, mixed-methods study. Interpretative Phenomenological Analysis	United Kingdom	**Size:** 12 CoP. **Gender:** 75% (9) women 25% (3) men **Ages:** ranging from 35 to 65. **Qualification:** All chartered between 2000 and 2004 as CoP **Experience:** Qualified and practising for between 3 and 7 years.	**Attachment measure:** Adult Attachment Interview **RF measures:** AAI- Reflective Function Scale	**Quantitative findings:** RF scores were found to be higher with the secure/earned secure participants. 5 out of 6 secure/earned secure participants having RF scores of 4 or above and 4 out of 6 insecurely attached participants having RF scores between 0 and 3. The two ''earned-secure'' participants had high levels of RF.	Small sample. Low generalisability.	**A: Good** **B: Good** **C: Weak**
Study 11: Seymour-Hyde (2012)	The study aimed to investigate client and clinician attachment styles, psychological mindedness and the working alliance.	Cross-sectional	United Kingdom .	**Size**: 42 therapists **Gender:** 86% (36) women 14% (6) men **Ages:** 5% (2)18-24 56% (23) 25-34 27% (11) 35-44 10% (4) 45-54 2% (1) 55-64 **Qualifications:** 31% (13) CPs 26% (11) PWP 17% (7) high intensity workers, 7% (3) counsellors 2% (1) trainee CPs 17% (7) other **Therapeutic Orientation:**	**Attachment measure:** Relationship Questionnaire **RF measure:** The Psychological Mindedness Scale	No statistically significant relationships were found between psychological mindedness and secure attachment *(r*= 0.13, p = .416). Similarly, no statistically significant relationships were observed between psychological mindedness and therapist insecure attachment styles: Fearful (*r* = 0.09, *p*= .575) Preoccupied (*r* = 0.04, *p* = .82) Dismissing *(r* = -0.01, *p* = .934).	Small sample size. Low response rate. Unrepresentative sample. Attachment and psychological mindedness assessed using self-report measures.	**A: Good** **B: Mod** **C: Weak**

Author(s)	Aim(s)	Study Design	Country	Sample	Relevant Measures (Appendix C/D)	Relevant Findings	Limitations	Quality rating
				41% (17) CBT 21% (9) mixed approach 17% (7) other 5% (2) humanistic/analytic 5% (2) CAT, 2% (1) psychodynamic 2% (1) behavioural				

Note. RF = Reflective Function; A = Quality of Reporting; B = Study Design; C = Bias in Study; Mod = Moderate; RFQ-Certainty = Reflective Function Questionnaire – Certainty; RFQ-Uncertainty = Reflective Function Questionnaire – Uncertainty; CMHT = Community Mental Health Team; PsyD = Psychology Doctorate; PhD = Doctor in Philosophy; CBT = Cognitive Behavioural Therapy; ACT = Acceptance and Commitment Therapy; OT = Occupational Therapist; PMS = Psychological Mindedness Scale; PMSS = Psychological Mindedness Speech Sample; EQ = Empathy Quotient; CP = Clinical Psychologist; CoP = Counselling Psychologist; IRI = Interpersonal Reactivity Index; AAI = Adult Attachment Interview; PWP = Positive Well-being Practitioners; CAT = Cognitive Analytic Therapy.

Study Aims

All papers included in this review offered some evidence on the relationship between attachment and RF in therapists. Two studies (6 and 8) investigated the relationship between attachment classifications and RF in therapists. However, in most studies this relationship was investigated in association with other variables within a wider model. For example, studies explored attachment and RF in relation to therapists' experiences: such as childhood relational trauma (7), wellbeing (2), experience of burnout (5); others, were interested in aspects of their professional performance - their interpersonal relationship with patients (1), therapeutic effectiveness (3), clients' outcomes (4), working alliance (11), use of formulation (5), the therapeutic relationship (9) and how personal therapy informed their work (10).

To answer the research question of this review only findings directly related to the relationship between attachment and RF in therapists or therapists-in-training will be reported.

Study Sample

This literature review considered data on a total of 728 participants. Most studies were carried out in the UK (1, 5, 6, 8, 9/10, & 11), one took place in USA (7), one in Australia (3/4) and one in Italy (2).

Studies included in the review varied in size. The biggest study had 416 participants (2) while the smallest had a sample of 12 participants (9 & 10). Seven papers (1, 3/4, 6, 8, 9/10) had less than 30 participants in their samples; two studies had between 30 and 100 participants (5 and 11); and two studies had a sample with over 100 participants (1, 7). Studies had higher representation of women in their samples (79% women; 21% men). More than three quarters of participants were qualified therapists (86%).

Study Design

Of the nine studies that were included in this review, eight used a quantitative methodology and one study (papers 9/10) followed a mixed-method approach.

Almost all studies (1, 2, 3/ 4, 5, 6, 7, 8, & 11) used a cross-sectional design with a few exceptions, papers 6 and 8 matched therapists to a control group on attachment or RF.

Key Measures

Measures of attachment.

Narrative and self-report measures of attachment were used (Appendix C). The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996; Main & Goldwyn, 1988) is a narrative clinical instrument which elicits the interviewee's early childhood attachment experiences and its impact on their current functioning. The AAI was used in two studies (3/4, & 10/11). However, in Cologon's study (3/4), AAI outcomes could not be used in the analysis, due to low inter-rater reliability.

A range of self-report measures were also used. Seven papers used dimensional measures of attachment anxiety and avoidance. Five papers used either the Experiences in Close Relationships Scale (ECR; Brennan, Clark & Shaver, 1998; 3 /4 & 6), its revised version (ECR-R; Busonera, Martini, Zavattini, & Santona, 2014; Fraley, Waller, & Brennan, 2000; 2) or its subscales (Relational Structure Questionnaire [RSQ]; Fraley, Heffernan, Vicary, & Brumbaugh, 2011; 7). Two papers (1 & 5) used the Attachment Scale (Berry, Wearden, Barrowclough, & Liversidge, 2006).

Two studies used self-reports which categorised individuals into attachment classifications (e.g., secure, avoidant, anxious): the Hazan and Shaver (1987) questionnaire, which requires respondents to describe themselves in terms of

feelings about the self in relationships; the Adult Attachment Scale (AAS; Collins & Read, 1996; Collins & Read, 1990) which classifies individual into three attachment styles (Close, Depend and Anxiety); Relationship Questionnaire (Bartholomew & Horowitz, 1991) which categorises individuals' in Bartholomew's (1990) four attachment categories: secure, fearful, preoccupied and dismissing.

Measures of reflective function.

RF was conceptualised and measured differently in the studies reviewed (Appendix D). Some studies assessed RF (2, 3/4, & 9/10), psychological mindedness (1, 5, 7, 8 & 11), interpersonal reactivity (6 & 7), while others assessed therapists' mentalizing skills as it unfolds in social interaction (6 & 7). Approaches to the measurement of RF included self-reports (2, 3/4, 6, 7, 8 & 11), narrative measures (1, 5, & 9/10) and behavioural measures (6 & 7).

Six papers used self-report questionnaires (2, 5, 6, 7, 8, &11) to measure RF: Four papers (5, 7, 8 & 11) used the Psychological Mindedness Scale (PMS, Conte et al., 1990); Papers 6 and 7 used Interpersonal Reactivity Index (IRI; Davis, 1983), although paper 7 only used the Emotional Empathy and Perspective Taking (cognitive empathy) subscales. Paper 2 used the Italian version of the Reflective Functioning questionnaire (RFQ; Fonagy et al., 2016; Morandotti et al., 2018); Papers 6 and 7 which took a more multi-faceted approach to the operationalisation of mentalization also used self-report measures on empathy (6), autism (6), mindfulness (7), affect consciousness (7), and theory of mind (7).

Some studies used narrative measures of RF. Papers 1 and 5 used the Psychological Mindedness Speech Sample (PMSS; Berry, Barrowclough, & Wearden, 2008; Berry, et al., 2008) which involved recording participants talking for 5-minutes about their thoughts and feelings about the patient and rating them on

psychological mindedness. Other studies (3/4, & 9/10) used the Reflective-Self Function Scale (Fonagy, Steele, Moran, Steele, & Higgitt, 1991) which scores RF showed on the AAI.

In addition, paper 6 used behavioural measures to observe therapists' performance on aspects of mentalization, such as mental state comprehension, production of mentalization and social orientation (Appendix D).

Relevant Findings

The review investigated the relationship between therapists' attachment and RF and presented mixed findings. Some studies were able to report statistically significant relationships between attachment and RF. From those studies, associations between attachment avoidance and RF were the most common (1, 2, 5, 6, & 7). Only three studies found significant relationships between attachment anxiety and RF (2, 6, 7). Four studies did not find statistically significant associations between attachment and RF (3/4, 8, &11). One study offered a descriptive analysis of therapists' attachment and RF (9/10).

Attachment avoidance and RF in therapists.

The relationships between attachment avoidance and RF was always negative and the size of the relationship differed from study to study. Studies 1, 2, 5, 6 and 7 reported negative statistically significant relationships between attachment avoidance and RF; most were negative and size of the associations ranged from small (attachment avoidance and RFQ-Uncertainty, r=0.27) to large (attachment avoidance and psychological mindedness, r=-0.69).

In study 2, which used a measure not indicated for non-clinical population, therapists that scored high on avoidance, scored low on the RFQ – Certainty showing hyper-mentalization and therefore not genuine mentalizing skills. Similarly,

when therapists scored high on avoidance, they also scored high on RFQ-Uncertainty, which denoted hypo-mentalization (i.e., lack of knowledge about mental states). In study 5 and 7, therapists that scored high on attachment avoidance, scored low on psychological mindedness when measured using the self-report PMS (r=-0.69 and r=-0.42) and the narrative Psychological Mindedness Speech Sample (r=-0.55, in Study 1). This means that they struggled to see relationships between thoughts, feelings, and actions; and to generate learning from the meanings and causes of their experience and behaviour. Furthermore, higher scores on attachment avoidance, indicated lower scores on self-reported empathy (6), perspective taking (6), empathetic concern for others (7) and lower mental states elaboration (6). Finally, it showed a positive relationship with alexithymia (7).

Attachment anxiety and RF in therapists.

Only three studies (2, 6, & 7) showed significant relationships between attachment anxiety and RF. Correlations ranged between small (attachment anxiety and perspective taking r= -0.24) to large (attachment anxiety and self-reported empathy r= -0.52).

Therapists that scored high on attachment anxiety also scored low on RFQ-Certainty (r= -0.46), indicating hypermentalization and higher scores on RFQ-Uncertainty (r=0.35) which indicates hypomentalization. In both cases, therapists' attachment anxiety, was related to forms of RF that did not show genuine mentalizing skills. In line with this review, therapists that scored high on attachment anxiety, scored low on self-reported empathy (6), psychological mindedness (7) and perspective taking (7). These therapists also scored high on alexithymia showing difficulties in identifying and describing emotions, minimising emotional experience.

The mixed-method study, which had the smallest sample, reported that higher RF scores were associated with therapists displaying secure attachment and even higher in those with ‘earned-security’.

Four studies (3/4, 8, 9/10 & 11) did not report statistically significant relationships between therapists’ attachment and RF.

Quality Appraisal

Most papers reviewed scored high on quality of reporting and study designs. However, all of them showed bias in the study introduced mainly by the sample design. All papers in the study included samples that were relatively small and non-representative of the population. Even those papers that had bigger samples failed to ensure its representativeness, by using for example stratification (e.g., age, gender, orientation or years of practice). Only study 8 and 9/10 justified the size of the sample. Study 8 did not reach their recruitment target and study 9/10 discussed the lack of generalisability of their mixed-method study. Two studies had bigger sample (2 & 7), however one used an inappropriate instrument introducing a further bias (2). Most studies did not take measures to report on non-responders, limiting our understanding on this bias. Only 8 included some brief description of why people did not respond, but not the characteristic of the population. Authors were not consistent in reporting conflict of interests or funding sources.

Discussion

This literature review set out to explore the relationship between attachment and RF in therapists. The focus of the review was to understand the relationship between these key psychotherapy concepts (Bucci et al., 2016; Degnan et al., 2016; Dozier et al., 1994; Mimura & Norman, 2018; Steel et al., 2018; Talia et al., 2020).

Critical Appraisal

Therapists' attachments mirror levels of security found in the general population: 59% securely attached; 11.3% anxious; 25% avoidant; and 4.7% disorganised (Mickelson, Kessler, & Shaver, 1997). In general, studies described samples of therapists which reported varying levels of attachment security. Samples were small and non-representative; therefore, it is likely that results were biased. So, while generalising to wider groups is problematic, trends observed justify further investigation.

In some studies, therapists scoring high on insecure attachments, whether anxious or avoidant, also showed low RF scores. This is consistent with current understanding about relationships between attachment and RF (Bateman & Fonagy, 2019). This relationship was more frequently found to have statistical significance in therapists scoring high on attachment-avoidance, than anxiety. This could be due to sample bias, with over representation of avoidant therapists, and significantly fewer anxious therapists sampled, or as Hill (2013) suggested, as the result of compensatory processes displayed by therapists with anxious attachments to overcome their own tendencies. Further research is needed to clarify this trend.

The review also found that therapists with avoidant attachments typically score lower in RF measures. There was evidence to suggest that these therapists were less able to integrate and reflect on thoughts, feelings and behaviours to generate meaning and understanding from it (Berry et al., 2008; Hartley, 2016), were less able to identify emotions in others (Levine, 2015; Manley, 1999), were less able to show empathy and empathic concern for others, were less interested in understanding the perspective of the other or in considering their mental states in interpersonal situations, and were less likely use mental state language to create meaning or

causal explanations of other's mental states (Hill, 2013). In addition, they scored high on alexithymia, demonstrating difficulty to identify and name emotions in general (Hill, 2013; Levine, 2015; Manley, 1999). These findings are consistent with research carried out with avoidant caregivers. Avoidant-caregivers find discomfort with expressions of need and dependence which may cause them to back away rather than get involved with someone whose needs are strongly expressed (Mikulincer & Shaver, 2018). Hence, avoidant therapists might struggle to stay in a caregiving position and their difficulty to identify emotions, empathise with others and take the perspective of the other might jeopardise the formation of the TR and the attachment bond.

Empathy is key for successful TR and outcomes. Elliott, Bohart, Watson, and Murphy's (2018) meta-analysis on the relationship between empathy and therapeutic outcome found that therapist's empathy exerted a medium size effect on client success in psychotherapy, which was independent from treatment orientation, format, and client's problem severity. Avoidant therapists' difficulties with emotions, empathy and caregiving might threaten the foundation of the therapeutic process (Cooper, 2004, 2008). Additionally, as seen in the review, reduced use of mental state language and difficulty for psychological mindedness would also prevent clients' accessing to mentalizing role models, essential to improving their mentalizing skills (Borelli & David, 2004; Fonagy & Allison, 2011).

Therapists with anxious attachment styles, who are more preoccupied with the other, were reported to show difficulties in RF, especially on self-reported empathy (Hill, 2013), psychological mindedness, perspective taking and emotion recognition (Levine, 2015), which mirror the patterns of RF in insecure avoidant counterparts. However, this relationship was only found to have statistically significance in three

studies (Brugnera et al., [in press]; Hill, 2013; Levine, 2015) and it is worth noting that Brugnera et al., (in press) used a clinical measure with a non-clinical population. These results suggest greater RF distribution in therapists with anxious attachment. For example, Hill's (2013) study found that therapists with anxious styles were able to supress or overcome their attachment related mentalizing behaviours when required to understand mental states of others, where non-therapists' counterparts could not. Anxious therapists could also produce meanings or interpretations of mental states of others, where non-therapists' counterparts or avoidant therapists could not. This evidence suggests that therapists with anxious attachments are more able to mentalize when arousal levels are low (Hill, 2013). This confirms findings in the wider attachment and caregiving literature which acknowledges anxious therapists' willingness to express emotion, and comfort with psychological intimacy as assets to their caregiving role. However their deficits in emotion regulation makes them vulnerable to experiencing distress, which can jeopardise their RF and interfere with sensitive and responsive care by being side-tracked by self-focus worries, misplaced projections, and blurred interpersonal boundaries, preventing them to focus on others' distress (Mikulincer & Shaver, 2018). For example, anxious therapists who report initial positive therapeutic alliance, struggle to sustain these positive results on the later stages of therapy, which affect therapy adversely (Dinger, Strack, Leichsenring, Wilmers, & Schauenburg, 2008; Sauer, Lopez, & Gormley, 2003), overall report more therapy related problems (Black, Hardy, Turpin, & Parry, 2005) such as therapeutic ruptures, and may struggle or take longer to repair them (Marmarosh et al., 2015). Hence, Hill's (2013) results, while promising, should be further researched by assessing RF in live therapeutic encounters, as

anxious therapists might initially be able to overcome their RF difficulties, but as they develop a more complex TR, defences might return.

Methodological Critique

The major difficulty in this review was the lack of consistency of approach in conceptualising and measuring attachment (Degnan et al., 2016) and RF (Luyten et al., 2019).

The literature highlighted that the measurement of attachment oversimplifies the dynamic aspect of attachment. Some measures conceptualise attachment as categories (Bartholomew, 1990), others as dimensions (Brennan, Clark & Shaver, 1998). Taxonometric studies carried out with both self-report (Fraley, Hudson, Heffernan, & Segal, 2015; Fraley & Waller, 1998) and narrative (Fraley & Roisman, 2014; Roisman, Fraley, & Belsky, 2007) measures have favoured a dimensional conceptualisation of adults' attachment. However, there is still ample instrument choice, making comparability across studies difficult (Degnan et al., 2016).

Similarly, RF's measurement can vary (Luyten et al., 2019). The multifaceted nature of mentalizing means researchers approached its measurement in different ways: some coding and scoring RF from transcripts (RFS, PMSS), others using self-reported questionnaires of different aspects of social cognition (empathy, perspective taking, psychological mindedness, theory of mind), and others using behavioural tests. However, some of these tools would have not provided a relevant relational context to trigger arousal levels like those at play when working psychotherapeutically. Therefore, discrepancies between how therapists perform on dimensions of RF and how they subjectively self-appraised their RF skills often differed (Levine, 2015; Hartley et al., 2016; Hill, 2013).

While in the literature narrative methods like RFS are seen as the gold standard measure of RF, this review found that researchers chose more cost effective and less labour-intensive instruments instead (e.g., PMS), which miss RF dimensions (e.g., automatic mentalizing; Luyten et al., 2019).

Clinical Implications

This literature review suggests that therapists with insecure attachments, whether anxious or avoidant, often score lower in RF despite their training experiences. The association of insecure attachment styles and low RF can limit the success of therapists and clients' outcomes (Mikulincer, Shaver, & Berant, 2013). Therefore, it seems of paramount importance that, as part of their training, therapists undergo developmental experiences that allow them to: identify their own and their clients' attachment; and equip them with enhanced RF that helps them manage the interplay of attachments in the TA (Bucci et al., 2016). Because of the protective function that RF seems to have for the therapeutic process (Fonagy et al., 1991; Cologon, 2013), mentalizing skills are a core competency for therapists when working with clients with complex insecure attachments. Assuming constant security in therapists (or individuals) is an illusion. Instead, a range of responses need to be available to manage threats and attain security (Crittenden, 2012) in the therapeutic setting. Hence, the task for therapists is to develop RF, to enhance their awareness of self and others needs in the TR and in this way use the attachment interplay in the TR.

One way of developing these skills, might be practising mentalizing self and other in emotionally arousing activities such as clinical supervision and personal therapy (Hughes & Youngson, 2009). However, personal therapy is not mandatory

for all clinical psychologists in the UK, and in busy working environments, supervision can be easily reduced to case management.

Strengths, Limitations and Future Research

It is important to acknowledge the strengths and limitations from the review. This review aimed to explore the relationship between attachment and RF in the therapist population, which gave a good focused question to guide the enquiry. However, how the TR related to other variables in the psychotherapy process or the individuals fell outside the scope of the review. Future research could focus on this.

Future research using cross-sectional designs could improve the sampling strategies, enhancing the research quality and enabling the generalisation of findings.

None of the studies reviewed looked at RF when delivering psychotherapy. Future research could investigate RF in-action as therapists are delivering psychotherapy, and compare it with perceived RF to raise their awareness about their RF and suggest ways to improve performance. Another interesting area of future research is the investigation of how training improves RF and offer these opportunities during training.

This review searched publications on psychology databases that could retrieved empirical publications. Databases such as PEP-web were excluded due to search-engine limitations. In future this database could be searched to identify additional publications.

Conclusion

This review provides a synthesis and critical appraisal of research that examines the relationship between therapists' attachment and RF. The diverse

conceptualisation and measurement of attachment and RF, and sample bias makes drawing conclusion difficult. However, findings to date indicate that therapists with insecure attachments score lower in RF. These results would favour secure attachment in therapists. However, as therapists might have struggled with relationships during their early years too (Barnett, 2007; Cohen, 2009; Cushway, 1995; Davies, 2018), the goal of constant security is not always realistic (Allen, 2013). Hence, developing their RF to support their psychotherapeutic practice through personal development activities can compensate attachment insecurity (Cologon, Schweitzer, King, & Nolte, 2017) and support their clinical practice.

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Appendices

Appendix A: Author Guidelines for Psychotherapy Research Article Submission

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

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Appendix B: Appraisal Tool for Cross-Sectional Studies

	Question	Yes	No	Don't know/ Comment
Introduction				
1	Were the aims/objectives of the study clear?			
Methods				
2	Was the study design appropriate for the stated aim(s)?			
3	Was the sample size justified?			
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)			
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?			
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?			
7	Were measures undertaken to address and categorise non-responders?			
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?			
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?			
10	Is it clear what was used to determined statistical significance and/or precision estimates? (e.g. p-values, confidence intervals)			
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?			
Results				
12	Were the basic data adequately described?			
13	Does the response rate raise concerns about non-response bias?			
14	If appropriate, was information about non-responders described?			
15	Were the results internally consistent?			
16	Were the results presented for all the analyses described in the methods?			
Discussion				
17	Were the authors' discussions and conclusions justified by the results?			
18	Were the limitations of the study discussed?			
Other				
19	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?			
20	Was ethical approval or consent of participants attained?			

Appendix C: Measures of Attachment

Table 4.

Measures of Attachment

Measures of attachment		
Type	Name and Authors	Description
Narrative	The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996: Main & Goldwyn, 1990)	It is a clinical instrument designed to elicit the interviewee's early childhood attachment experiences and its impact on their current functioning. Classification and coding system are based on narrative discourse markers that are deemed indicative of an underlying representation of and stance towards early childhood attachment experiences. Congruence in the discourse indicates security; whilst lack of congruence or difficulties to recall past relationships are indicative of attachment insecurity. The AAI is a labour-intensive measure that requires data to be coded by qualified AAI practitioners and sound inter-judge reliability.
Self-report	Experiences in Close Relationships Scale (ECR; Brennan et al. 1998) Experience in Close Relationships Scale-Revised; Busonera, Martini, Zavattini, & Santona, 2014; Fraley, Waller, & Brennan, 2000) Relational Structure Questionnaire subscale in ECR; (Fraley, Waller, & Brennan, 2011)	The ECR and ECR-R include 36-items which are rated on a 7-point Likert scale to assess dimensions of attachment anxiety and avoidance. Internal consistency for the anxiety subscale is reported as α=0.94 and for the avoidance subscale as α=0.91. Test–retest reliability for the anxiety subscales is reported as α=0.90 and for the avoidance subscale as α=0.91 (Fraley et al. 2000). This measure has been extensively translated to different languages and validated in different populations (e.g., Brugnera et al. [in press]).

Self-report	Attachment Scale (Berry, Wearden, Barrowclough, & Liversidge, 2006)	It assesses attachment avoidance and anxiety. It has good psychometric properties (anxiety α=0.72 and avoidance α=0.75) and reasonable concurrent validity with existing attachment questionnaires (Berry, Barrowclough, et al., 2008; Berry, Shah, et al., 2008).
Self-report	Hazan and Shaver (1987) questionnaire	This questionnaire asks respondents to describe themselves in terms of feelings about the self in relationships, which categorises individuals between secure, avoidant, anxious.
Self-report	The Adult Attachment Scale (AAS; Collins, 1996; Collins & Read, 1990)	It is an 18-item self-report measure which assumes that the three attachment styles (Close, Depend and Anxiety) are mutually exclusive. When tested in an undergraduate sample, this measure has been found to have good internal consistency (Close α=0.86, Depend α=0.76, Anxiety α=0.83), and moderate stability test-retest reliability (Close α=0.68, Depend α=0.71, and Anxiety α=0.52).
	Collins Procedure (1996)	This procedure is used to placing people into one of Bartholomew's (1990) four attachment styles categories: secure, fearful, preoccupied and dismissing.
	Relationship Questionnaire (Bartholomew & Horowitz, 1991).	This measure has been seen to have good test-retest reliability of α=0.74 to α=0.88 and is relatively stable overtime (Scharfe & Bartholomew, 1995).

Appendix D: Measures of Reflective Function

Table 5.

Measures of Reflective Function

Measures of Reflective Function.

Type	Name and Authors	Description
Self-report questionnaire	Psychological Mindedness Scale (PMS, Conte et al., 1990)	Psychological Mindedness Scale is a 45-item self-report questionnaire designed to assess levels of psychological mindedness on a 4-point Likert scale ('strongly disagree' to 'strongly agree'). Higher scores are indicative of a higher level of psychological mindedness. The measure has good internal consistency (α = 0.86) and re-test reliability (α = 0.92; Conte, Ratto, & Karasu, 1996). Paper five reported a similar level of reliability in their sample (α = 0.88).
Self-report questionnaire	Interpersonal Reactivity Index (IRI; Davis, 1983)	Interpersonal Reactivity Index (IRI) measures individual differences in cognitive and affective components of empathy: Perspective Taking (cognitive), Empathic Concern, (affective), Fantasy (imaginative) and Personal Distress (affective/introjected). The first two subscales were considered by Davis (1980) to represent the most advanced levels of empathy. The 28 items are rated on a 5-point Likert scale ('does not describe me well' to 'does describe me well'). Higher score suggests greater ability to empathise. The original validation study for the IRI was used to report the IRI internal consistency (α = 0.68 to 0.79; Davis, 1980).
Self-report questionnaire	Italian version of the Reflective Functioning questionnaire (RFQ; Fonagy et al., 2016; Morandotti et al., 2018)	Reflective Functioning Questionnaire - Italian version (RFQ; Fonagy et al., 2016; Morandotti et al., 2018) is an 8-item self-report measure of RF. It measures Certainty and Uncertainty about mental states and in clinical population only were mentalizing difficulties are present or presumed, rather than in the general public. Items are initially scored on a 7-point Likert-type scale (1 = completely disagree; 7 = completely agree) and subsequently converted to capture extreme levels of certainty (low score denoting hyper-mentalizing) and uncertainty (high scores denoting hypo-mentalizing). Items in RFQ-Certainty, are converted to 0, 0, 0, 0, 1, 2, 3. Low scores on this scale reflect and high scores reflect more genuine

		mentalizing. Similarly, RFQ-Uncertainty direct scores are converted to 3, 2, 1, 0, 0, 0, 0. High scores indicate (i.e., a lack of knowledge about mental states), while lower scores reflect more genuine mentalizing. Finally, RFQ has good internal, convergent and divergent validity, and good reliability (Fonagy et al., 2016; Morandotti et al., 2018) which were reported for the study (α =0.64 for RFQ-U; α =0.72 for RFQ-C).
Narrative	Psychological Mindedness Speech Sample (PMSS: Berry, Barrowclough, et al., 2008; Berry, Shah, et al., 2008)	This measure scores staff's narratives about patients to reflect the extent staff interpret patient's problems as deriving from psychological difficulties, which is then averaged up. It involves recording participants talking for 5-minutes about their thoughts and feelings about the patient. Then two independent raters score psychological mindedness by noting. Each explanation is assigned to one of the three levels of psychological mindedness: High level of PM (3): Clear attempt to describe psychological processes (beliefs or emotions) underlying the patient's problem (e.g., "Social situations cause Brian lots of anxiety because he often misinterprets what people mean, he tends to think people have got it in for him."). Some PM (2): Most people would judge there to be a relationship between the inferred cause and the patient's problem, but there is no explicit reference to psychological processes mediating the link (e.g., "Elaine gets anxious a lot of time which is often to do with new staff being around or changes in routine."). Little PM (1): Causal link between a cause and the patient's problem is given or inferred; however, most people would not see the former as a sufficient explanation of the outcome and there is no attempt to suggest any mediating or extenuating factors (e.g., "Mavis finds it hard to feel comfortable around other people. I don't think she's got a lot of insight into how people relate to her."). A mean psychological mindedness score is derived for each transcript by averaging psychological mindedness scores for explanations. Only transcripts that attempted to explain two problems were included in the analysis. Both Studies reported inter-rater reliability

		(*kappa* = 0.84, *p.*=001 paper 1 and *kappa* = 0.84, *SE* = 0.12, *p* < .001 paper 5). Raters were blind to staff's attachment classification/style.
Narrative	Reflective-Self Function Scale (RFS; Fonagy, H. Steele, Moran, M. Steele, & Higgitt, 1991; 1998)	It is a scale that assesses RF by coding examples of participants capacity to understand mental states in self and others on the AAI, using the RF scale: Moderate to High (9 Exceptional; 7 Marked; 5 Ordinary) Low to negative (3 Low; 1 Absent; -1 Negative). This scale goes from negative RF to 9 RF and requires raters to be trained and accredited to use this coding scale. The higher the RF score, the more able to understand mental states in self and others. This scale can be applied to the AAI, the Child Attachment Interview and even psychotherapy sessions transcripts.
Behavioural	Everyday Pictures (Ruffman et al., 2002	This task measures mental state talk. It employs a number of everyday pictures showing emotional or mentalistic situations (e.g., a man trying to kiss a woman, a woman with a child struggling on a high bridge) to study the range of emotional and other mental state language used by participants.
	Eye-tracking measures of social orientation (social stimuli)	This task measures social orientation eye-tracking participants as they describe the photographs of the metal estate exercise.
	Recognition of Facial Emotion Task (Emotion Understanding), (Ekman & Friesen, 1971; 1975)	In this measure of emotion understanding presents photographs of male or female faces showing of six basic facial emotions (sadness, disgust, fear, anger, happiness and surprise).
	Perspective Taking Task (Keysar et al., 2000; Wu & Keysar, 2007)	A computer-based perspective taking task to measure accuracy and speed of responding when taking another person's perspective.

The Levels of Emotional Awareness Scale (LEAS, Lane et al. 1990).	The LEAS is an open response measure that requires participants to describe how they and another person would feel in 20 interpersonal scenarios.
The Revised “Reading the Mind in the Eyes” Test (Baron-Cohen et al., 2001).	This measure assesses the ability to infer the mental state of a person from the information provided in a picture of the person’s eyes (i.e., it measures the social perceptual aspects mental state understanding).

SCHOOL OF PSYCHOLOGY

DOCTORATE IN CLINICAL PSYCHOLOGY

EMPIRICAL PAPER

Exploring clinical psychologists' attachment to their own personal therapists: Implications for their clinical practice

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Target Journal:	Psychotherapy Research (Appendix A)
Word Count:	9955 words (excluding abstract, table of contents, list of figures, references, footnotes, appendices)

Submitted in partial fulfilment of requirements for the Doctorate Degree in Clinical Psychology, University of Exeter

Abstract

Background: Attachment theory has made significant contributions to clinical psychology and there is an interest increasing in attachment-informed approaches to therapy. Attachment research suggests that successful psychotherapy relies on therapists' attachment security and their ability to reflect on the therapist-client attachment interplay. However, therapists with insecure attachment often struggle with lower reflective function (RF). Personal therapy (PT) can develop RF and attachment awareness in clinical psychologists (CPs).

Aim: To study how reflecting about CPs' relationships with their personal therapist contributes to their awareness and understanding of their own attachment and its implications for their practice.

Methods: From a social constructionist approach, 12 CPs were interviewed. Thematic analysis was used to analyse interview transcripts.

Results: Thematic analysis resulted in three main themes: constructing and understanding their own attachment; bringing in an emotional dimension into attachment; and the clinical implications of attachment awareness.

Conclusion: Through PT, CPs' increased their awareness about their own attachment. The idea of attachment security was deconstructed, in support of a range of attachment responses that CPs can reflect about when interacting with others. This forged a sense of robustness in the self from where to work relationally with clients, raising clients' awareness about their relational needs in the TR.

Key words: attachment; personal therapy; psychotherapy; qualitative; thematic analysis.

Introduction

Attachment theory (AT), initially proposed by Bowlby (1988), has been described as a relational theory of human development. AT has made a significant contribution to the development of theory and practice in the field of clinical psychology and psychotherapy (British Psychological Society [BPS], 2007; Marmarosh, 2015; Mikulincer & Shaver, 2018; Obegi & Berant, 2009; Wallin, 2014).

Clinical applications of AT have been increasing in the last few years (Mikulincer & Shaver, 2018) and examples of attachment-informed approaches to therapy are now represented in the clinical work of psychologists and psychotherapists in different specialisms (Bateman & Fonagy, 2004; Guthrie & Blood, 2018; Fletcher, Flood, & Hare, 2016; Holmes, 2001; Hughes, 2011). Consequently, professional organisations like the BPS have developed guidance on working with attachment-informed approaches in clinical practice (BPS, 2007, 2017). However, despite the wealth of research underpinning AT (Connors, 2011; Slade, 2018), there are few National Institute for Health and Care Excellence (NICE) guidelines that recommend attachment-informed interventions (BPS & The Royal College of Psychiatrists, 2015; NICE, 2015).

Attachment-informed Approaches to Therapy

The objective of attachment-informed psychotherapies is to influence clients' closed representations of self in relation to others and the world by reflecting on past and present relational experiences as well as by experiencing a therapeutic relationship (TR) that generates new learning, i.e., comfortable intimacy and flexible autonomy in close relationships (Bowlby, 1988; Holmes & Slade, 2018). In line with AT, the therapist as caregiver needs to be attuned to the client's emotional needs,

provide a safe haven and secure base in the TR from where to explore painful emotions (Bowlby, 1988).

Therapists' willingness and ability to become that secure base affects clients' sense of attachment security (Bowlby, 1988). Offering a secure base is easier for those therapists who have a secure attachment than for others, as their sensitive and attuned caregiving can be disrupted by their own attachment experience (Dozier, Cue, & Barnett, 1994; Dozier & Bates, 2004; Mikulincer, Shaver, & Berant, 2013). Degnan, Seymour-Hyde, Harris, and Berry (2016) in a systematic review of 11 studies on the role of therapists' attachment, working alliance and outcomes found evidence suggesting that therapists' attachment style (and its interaction with clients' attachment style) contributed to positive alliance and outcomes. Of the seven studies that measured attachment security, three demonstrated positive associations between therapist attachment security and positive working alliance; while one found a positive impact on working alliance and outcome (Schauenburg et al., 2010). Subsequent reviews had similar findings (Nimura & Norman, 2018; Steele, Macdonald, & Schroder, 2018).

Concerning clients, research has demonstrated that clients' attachment style has an impact on therapeutic outcomes. In a recent meta-analysis of 14 studies examining clients' attachment orientation and psychotherapy outcome, Levy, Ellison, Scott, and Bernecker (2011) found that attachment security showed a significant positive association with outcome (effect size of .37), while attachment insecurity was negatively related to therapy outcome. Interestingly, clients' attachment does not determine the quality of the client-therapists working alliance to the degree initially expected. A meta-analysis of 17 studies looking at this issue confirmed that clients' attachment security was associated with a stronger therapeutic alliance, but

the size of the effect was small (r=.17). This confirmed previous findings by Diener, Hilsenroth, and Weinberger (2009). Mikulincer et al. (2013) conclude that clients with secure attachment styles consistently benefit from psychotherapy; those with insecure attachments, whether avoidant or anxious, are more dependent in psychotherapy and struggle on termination (Sauer, Anderson, Gormley, Richmond, & Preacco, 2010); while those with disorganised attachments styles are less able to change through this process (Wallin, 2014).

Furthermore, therapists' and clients' attachment interact. This interaction has an impact on the therapeutic alliance and clinical outcomes too. Degnan et al. (2016) identified three studies that suggested that matching therapist and clients with different attachment styles (counter-complementarity) benefited alliance and outcomes. Tyrrell, Dozier, Teague, and Fallot (1999) looked at the interactions between clients' attachment and case-managers. They found that avoidant clients achieved better outcomes and worked better with anxious case-managers, and vice versa. In a qualitative study, Daly and Mallinckrodt (2009) interviewed 12 seasoned therapists considered highly effective in this area of work. Analysis uncovered that to respond therapeutically to clients, these therapists identified clients' attachment needs and, once the TR had been established (Bucci, Seymour-Hyde, Harris, & Berry, 2016), adopted a counter-complementary position that allowed the client to access a corrective relational experience. Most importantly, during therapy they managed the therapeutic distance (TD) in the TR. Findings suggest that those clients that are more avoidant in intimate relationships, once the TR is established, benefit from experiencing a relationship that demands increased emotional dependence and proximity. Therapists need to resist the pull to respond to clients in complementary ways and carefully monitor the therapeutic distance, to remain attuned to the client's

needs and potential space for development (Daly & Mallinckrodt, 2009; Mallinckrodt, 2010).

To do so therapists must identify what relational experience the client requires and what they themselves can offer in that TR – i.e., to hold-in-mind themselves and clients to offer attuned caregiving. However, this is complex. As Dozier et al. (1994) uncovered, clients' attachments are likely to trigger case-managers' own attachment systems. They observed that insecurely attached case-managers were more likely to be side-tracked by patients' defences and responded in non-therapeutic ways. Meanwhile, securely attached case-managers showed greater flexibility, client-focus, and were more likely to respond to underlying and disruptive feelings and needs brought by their clients. They also remained open to new information and maintained compassion and empathy without feeling overwhelmed by their personal experience of distress. These results mirror research in other caregiving dyads (Mikulincer & Shaver, 2018). Dozier et al. (1994) concluded that insecurely attached case-managers unintentionally magnified clients' defences, presumably because of the way the clients activated their own attachment systems; while more securely attached ones were more likely to facilitate clients' attachment security; and the formation of a strong working alliance from where to do constructive therapeutic work.

Despite Dozier et al.'s (1994) findings, complementarity has been seen to be beneficial (Bernier & Dozier, 2002), especially during the initial part of therapy when the TR is developed (Bucci et al., 2016; Mallinckrodt, 2010). However, if unidentified and unaddressed by therapists, complementarity has the potential to undermine the therapeutic process and outcome (Dozier et al., 1994; Talia, Muzi, Lingiardi, &

Taubner, 2020) because it prevents clients from accessing a corrective emotional experience that can enable change.

According to attachment research, therapists' attachment security and their ability to reflect on their clients' and their own attachment needs is key to offering successful psychotherapy. A recent systematic literature review has investigated the relationship between therapists' attachment and reflective function (RF; Gascon-Ramos, 2020). In six studies, therapists with insecure attachments scored lower in measures of RF. This relationship was more frequently reported in those therapists with insecure avoidant than anxious attachments.

Increased RF has been seen to have a positive impact on therapeutic effectiveness, despite the therapist's or client's attachment. Cologon, Schweitzer, King, and Nolte (2017) in a study of 25 therapists and 1001 clients found that while therapists' RF and attachment did not show a statistically significant association, when considering therapy effectiveness, high RF in therapists compensated for attachment insecurity. These results are in line with Fonagy, Steele, and Steele's (1991) findings in other caregivers and underscores the importance of developing therapists' RF during and after training (Holmes & Slade, 2018).

Studies reviewed were carried out with professionals from a range of backgrounds and not necessarily taking and attachment-informed perspective. The wording in the original studies has been used to describe samples. However, they all had attachment dispositions which were activated when working therapeutically with clients. CPs also have attachment styles that get activated when working clinically, regardless of model or orientation. Therefore, these findings are generalisable and of interest to CPs' clinical practice.

Personal Development

Professional development includes a wide range of activities (Bennett-Levy, 2019). Personal therapy (PT) and clinical supervision are often seen as fundamental to the development of CPs (Hughes & Youngson, 2009). Hughes and Youngson (2009) draw a clear distinction between these activities: PT refers to the process of engaging in psychotherapy as a client. Clinical supervision refers to the requirement to fulfil formative, normative and restorative functions with supervisees and personal development is a by-product of the work and not a goal.

Unlike other psychotherapy professions, CPs do not always access PT as part of their training or subsequently. Two reasons have been suggested in the literature (Murphy, Irfan, Barnett, Castledine, & Enescu, 2018; Wilson, Weatherhead, & Davies, 2015): their professional scientist-practitioner model which makes their remit wider and not necessarily linked to their psychotherapy role (Hughes & Youngson, 2009); and the lack of robust and clear evidence-base linking PT with improved clinical outcomes (Norcross, 2005).

However, many benefits have been attributed to PT for psychotherapists and psychologists, and while its impact on clinical effectiveness remains unclear, there is evidence that PT develops therapists' RF (Cushway, 1996; Macran & Shapiro, 1998; Rizq & Target, 2008a, 2008b; Wigg, Cushway, & Neal, 2011). Macran and Shapiro's (1998) literature review of the role of PT on the development of therapists showed that PT had a positive impact on interpersonal qualities such as enhanced empathy, warmth and genuineness traditionally associated with positive client change. Wigg, Cushway and Neal's (2011) subsequent review with a range of professionals including psychoanalytic therapists and counselling psychologists identified various reflective stages (personal, professional, extended and meta; Appendix B).

Self-awareness of therapists' attachments and the development of RF were clear gains from engaging in PT (Murphy et al., 2018; Rizq & Target, 2008a, 2008b; Wigg et al., 2011). In a qualitative study of 12 counselling psychologists, Rizq and Target (2008a, 2008b) observed that a close TR with their therapists, offered psychologists opportunities to explore their attachment relationships and how this affected their trust, closeness and intimacy in the alliance. Increased RF and attachment awareness in therapists have been associated with better outcomes in therapy (Bucci et al., 2016; Cologon et al., 2017; Daly & Mallinckrodt, 2009; Dozier et al., 1994; Talia et al., 2020). These results can be generalised to CPs in their clinical role. However, further research is needed to understand its impact on clinical practice.

The current study investigates CPs' experience of PT, specifically how their relationship with their therapist contributed to the awareness and understanding of their own attachment, and the implications this had for their clinical practice. The term 'personal therapy' throughout this study refers to psychological treatment, mandatory or voluntary, provided from a range of orientations (Geller, Norcross, & Orlinsky, 2005; Hughes & Youngson, 2009). The research questions guiding this qualitative enquiry were:

1. How does reflecting about the relationship with their personal therapist contribute to psychologists' understanding/awareness of their own attachment?
2. How does reflecting about their attachment influence psychologists' clinical practice?

Methodology

Attachment research was initially investigated through observational studies of the behaviours of babies and their mothers, which led to a somewhat objective conceptualisation of attachment categories in childhood (Ainsworth, Blehar, Waters, & Wall, 1978). Then the study of attachment in adulthood suggested that these ties were best understood as a representation of self and others, focusing on individuals' narratives, rather than its content (Main, Kaplan, & Cassidy, 1985). While this approach still classified attachment in categories, it underscored the personal, subjective, and constructed nature of the attachment experience by the individual. Furthermore, this led to different representational models (Crittenden, 1985; Main et al., 1985) showing the socially constructed nature of the (apparently) objective categories. Subsequent operationalisations of attachment measurement adopted a dimensional approach recognising its dynamic and context-dependent nature (Mikulincer & Shaver, 2018). Hence, it deconstructs the idea of objective and static categories of attachment and supports the notion that all attachment behaviours are necessary for survival (Crittenden, 1990; Crittenden, 2012).

The current research is focused on the subjective interpretation of CPs' own experience of attachment, not the empirically measured attachment style. Empiricism and positivism assume that the nature of the world is objective and can be revealed through observation (Bryman, 2001). In other epistemological and ontological approaches, what is real is a constructed reality, i.e., the subjective meaning that experience has for an individual (Fielding, Lee, & Blank, 2008). This investigation of psychologists' experience was approached from a social constructionist framework challenging the idea of a single fixed view of the world and proposed that the social world is constantly defined and transformed (Bryman, 2001). These constructions

provide a version of experience mediated by sociocultural meanings, the participants', and the researchers' interpretative lenses (Finlay, 2002; Holmes, 2019).

This research takes a qualitative approach, where rich and detailed accounts from participants are necessary to contextualise participants' meanings and interpretations. The use of language in participants' construction of their experience is key (Bryman, 2001). The researcher's reflexivity is fundamental to contextualise the findings as a co-construction of meaning between researcher and participants (Baker, Pistrang & Elliott, 2016), including cognitive and emotional processes (Holmes, 2018). Disclosures about the researcher's identity and their positioning to provide the interpretative context for the analysis are necessary (Clarke et al., 2015). Transparency in the co-construction of findings through reflexivity enhances the trustworthiness of the research (Guba & Lincoln, 1994).

Study Design

Using a qualitatively methodology, in-depth semi-structured interviews were conducted using some standardised interview questions to understand CPs' experiences (Bryman, 2001). Demographic information was collected through a questionnaire to contextualise the findings. Data was analysed using thematic analysis (TA) which can be used from a social constructionist approach (Braun & Clarke, 2013). Due to the nature of the research an introspective and intersubjective reflexivity stance informed in Holmes's (2018) reverie research method (RRM) was taken (Finlay, 2002; Appendix C). RRM is based on psychoanalytic intersubjectivity. It considers the interaction between participant and researcher and the emotional impact that this relationship has on the researcher (Holmes, 2018). This requires the researcher to be attuned to their bodily sensations, feelings, behaviours, images and

reverie, defined as a dream-like state of thought or processing throughout the research (Holmes, 2018).

Participants

Purposive recruitment through professional networks at NHS trusts using a brief poster was used. Participants were required to be qualified doctors in clinical psychology, have professional registration with the Health & Care Professional Council, be actively receiving clinical supervision, have experience of receiving PT and use AT to inform clinical work.

Twelve CPs participated in the study from May 2019 to January 2020 (Table 1). They were all women and identified as white-British. All had experienced PT, six had received PT before qualifying and 12 after qualifying, from a range of theoretical orientations. They were all practising CPs registered with Health and Care Professional Council and accessing regular supervision for their clinical practice. All of them used AT to inform their clinical work.

Table 1.

Participants Demographic Characteristics and their Experiences of PT

Demographics		No. (n = 12)
Gender		
	Male	0
	Female	12
Age	Average	36.8
	SD	5.51
	Max	49
	Min	29
Ethnicity		
	White British	12
Years since qualifying		
	Average	7.7
	SD	8.2
	Max	21
	Min	0
Personal therapy		
Hours of PT Pre-qualifying		
	Average	6.6
	SD	8.2

	Max	300
	Min	0
Hours of PT Post-qualifying		
	Average	96.7
	SD	65.7
	Max	240
	Min	12
Frequency of therapy		
	Twice a week	1
	Weekly	8
	Fortnightly	1
	Monthly	1
	Irregular	1
Orientation of PT		
	Psychoanalytic/psychodynamic	5
	CAT	2
	EMDR	2
	Solution Focus Therapy	1
	Core Process Psychotherapy	1
	ISPDT	1
	Energy Psychology and Bodywork	1
	Gestalt	1
Clinical Orientation of CPs	Integrative	6
	Attachment-informed	4
	Compassion Focus Therapy	4
	Systemic Therapy	3
	Relational	2
	Cognitive Behavioural Therapy	2
	Psychodynamic	2
	Acceptance and Commitment Therapy	1
	Social constructionism	1
	Person-centred	1
	Cognitive Analytic Therapy	1
	other	1

Situating the Researcher

I am a Spanish trainee CP and a qualified and registered educational psychologist. I have undertaken my own psychodynamic PT since the beginning of my CP training. I have an interest in psychoanalytic theory and practice. As an educational psychologist and trainee CP, I am interested in the social and emotional development of individuals, AT and its clinical implications. I have often found AT

difficult to apply in practice and have been intrigued about how my attachment is triggered in my clinical practice.

Being with clients' pain and distress has helped me to consider how I am in relation with others and myself, and the impact this has on me. PT has been useful to raise awareness of my relational experiences and has been useful in clinical practice. PT has required me to reflect about my early attachments and how these play-out in my life. Clinically, this has meant working actively with transference/countertransference in therapy and to some extent in research, as that holds information about my experience of the other which is relevant to my thinking. I have taken questions and emotions resulting from my engagement in the research to my PT. This research was driven by my motivation in understanding how personal development through PT improves clinical practice. My personal process of development was also present in my reflections about CPs' interviews.

Instruments

The study used three different instruments:

Demographic questionnaire. A questionnaire was used to collect information about participants to contextualise their interpretations (Appendix D).

The Patient Relationship Interview – Therapists (PRI-T; Katzow, 2011. Appendix E). An adaptation of the PRI-T, a standardised interview, was used to explore feelings, thoughts, and memories of participants' attachment experiences to their therapist. PRI-T is an adaptation of the Patient – Therapist Adult Attachment Interview (Diamond et al., 1999) which mirrors the original AAI (George, Kaplan, & Main, 1985).

The Influence of Attachment Awareness on Clinical Practice Interview (IAACPI; Appendix E). The IAACPI is a semi-structured interview developed for this

study to explore therapists' understanding of their own attachment and the implications for their clinical work, by considering a piece of their clinical work.

Piloting of instruments. Three counsellors in PT and clinical practice were interviewed to pilot the instruments. Difficulties with some of the questions were discussed with supervisors. Changes were incorporated to the interview schedules.

Procedure

Ethical considerations. The project was scrutinised by the University of Exeter Ethics Research Committee and ethical clearance was provided (Reference Number: eCLESPsy000780 v4.1; Appendix F). Participant information sheets and informed consent forms were used (Appendix G,H). The potential emotional impact that the PRI-T interview could have on CPs was a concern. Participants were asked to keep themselves safe during and after the interview by not oversharing deeply emotionally intense material. The researcher had information available about counselling services (online and within participants' local communities) for signposting. All participants were offered an opportunity to discuss their participation prior to consenting into the project and to debrief after the interview. Participants received a £10 'thank you' voucher.

Interview process. The researcher met the participants at a place of their convenience. Three interviews were carried out over the phone. Participants first responded to the PRI-T to elicit their attachment to their own therapists. Next, they answered to the IAACPI. Interviews lasted on average 77 minutes (max = 103 mins ; min = 54mins), were recorded, transcribed verbatim and anonymised.

Data Analysis

TA was used to analyse all transcripts to provide an accessible, systematic and rigorous approach to coding and theme development (Clarke, Braun, & Hayfield,

2015). The analysis was approached mainly inductively, following Braun and Clarke's (2006) 6-step process of TA (Appendix I) by grounding the analysis on the data and staying close to participants' meanings, rather than forcing existing theories and concepts on it. However, it is worth noting that "pure induction is not possible in most forms of qualitative research - analysis is always shaped by a researcher's theoretical assumption, disciplinary knowledge, research training, prior research experience, and personal and political standpoints" (Clarke et al. 2015, p.225)

The researcher stayed close to the meanings in the data, even if theoretical concepts or labels were used by participants to describe their experience, it was not the researcher's intention to impose these as a framework for analysis, as in deductive TA (Clarke et al., 2015). However, the use of these labels (e.g. attachment) in the questions might have influenced how participants described their experience using AT and influencing the CPs' narratives.

Data was coded by listening to interviews and simultaneously coding transcripts using NVIVO-12 (QSR, 2020). This enabled the researcher to connect with the emotional processes during the interviews and notice the researcher's emotional reactions during analysis, in line with RRM (Holmes, 2018). Fieldwork notes on emotional processes, describing feelings and reverie that she experienced during and after interviews were also consulted. This material was brought into the analysis to provide the emotional context which influenced the researcher's interpretations and the emergence of themes during analysis. Hence, this material which is part of the co-construction of meaning was described within the themes. Reflexive notes were not analysed using NVIVO.

Initial codes and preliminary descriptive themes were developed. These were developed into analytic themes, identifying aspects that coherently organised them

(Bazeley, 2009). In this process, some of the descriptive themes, less relevant to the research questions were discarded. Once analytic themes had been identified they were checked for fit against the coded data and full transcripts. Finally, themes were written up and shared with supervisors, peers and three participants for feedback.

Quality of qualitative research. To consider the quality of the research a set of criteria in line with the epistemological and ontological assumptions underpinning the study were used. Guba and Lincoln (1994) recommend considering two criteria: trustworthiness and authenticity. Trustworthiness was built by engaging in ethical scrutiny, being opened to CPs' different experiences of PT, engaging a peer group of CPs in the instrument design and analysis phase and using reflexivity. While the findings of this small qualitative study are not generalisable to the wider CP population, details of the participants' context have been included. Authenticity was built by ensuring that the range of experiences of participants were represented. Participants reported the usefulness of reflecting about their experience of PT, their attachment, and its implications personally and professionally. Some were moved to take their reflections to therapy others to reconsider PT again.

Results

Analysis

Analysis of interviews led to three main themes, each with sub-themes (Table 2). Themes will be described and extracts from interviews will be used to illustrate the themes.

Table 2.

Thematic Analysis Themes and Sub-themes

Theme 1 Constructing an understanding of their own attachment	Theme 2 The emotional dimension of attachment	Theme 3 Clinical implications of CPs attachment awareness
Sub-theme 1.1 'PT was part of the journey' Sub-theme 1.2 Using attachment labels on self and others	Sub-theme 2.1 Feeling differently about themselves Sub-theme 2.2 Feeling differently in their relationship with self and others	Sub-theme 3.1 'The TR is the work': practising relationally Sub-theme 3.2 My stuff, their stuff and what is triggered in the dance Sub-theme 3.3 Noticing: working in the-here-and-now

Theme 1: Constructing an understanding of their own attachment.

Having extensively reflected about their experience of PT and how that might have influenced their personality, CPs were asked how they came to their understanding of their own attachment.

Sub-theme 1.1: 'PT was part of the journey'

CPs constructed their understanding of their attachment as a journey. CPs talked about several influences in helping in this process: training, PT, self-reflection, reflections about their clinical work and supervision.

> "I think also it was a process that started with my clinical training and thinking about attachment. We spent *a lot* of time in reflecting groups [laughter], a lot of fishbowl discussions and so on." (Emma)

> "That (PT) would definitely have been part of the journey, but there is this other therapist, the group, the training." (Zoe)

Despite the extensive discussion about the impact that PT, PT was described

as one of many experiences that had helped them understand their attachments. For some the importance of PT in this process was only considered at the research interview:

> "And it's interesting, I didn't necessarily consider how my interaction and relationship with [therapist] might have influenced my own understanding of my own attachment, but it probably has, in some way. But that wasn't a conscious thing." (Mia)

Most CPs perceived their journey had started when they were introduced to AT during their psychology studies and clinical training.

> "I came to that conclusion before therapy, helped by … [clinical] training that kind of gradually you notice it more and more, like through training, reflecting on things, how I found it difficult" (Helena)

They believed their training had helped them tune in and reflect about how they were in relationships, even when CPs had prior PT experience.

> "My thinking about that only truly started when I did my undergraduate psychology, because I don't remember that ever coming across in a sense within any of the counselling that I'd done prior. […] then going onto clinical training." (Emily)

CPs described wondering how AT applied to them during training or supervision. For them, being introduced to AT triggered an intellectual curiosity and reflection about their attachment.

> "… through supervision and the teaching, that was very much me going away thinking, hmm, I wonder how that applies to me [Laughs]." (Mia)

> "I think I had to do one of those self-assessment thingies when we were on the course. I remember it coming out as secure and thinking I don't think I am. Definitely not. And being quite surprised." (Olivia)

In contrast, when CPs considered the influence of PT, they described an experience that had helped connect with their emotional needs in relationships (Theme 2).

For participants constructing an understanding of their own attachment had been an intellectual and emotional process. PT had been part of the journey, but this group of CPs perceived their journey started during their training. Despite the researcher's experience resonating with that of participants, the researcher was surprised and somewhat disappointed by this finding, given how eloquently they had spoken about the bonds with their therapists and how much they perceived to have learnt in this process about themselves in relation to others. The researcher's own fantasy about the importance of PT and the TR (and perhaps her therapist) was challenged by participants' experience – the image of a collapsing house of cards came to mind and was unsettling.

It made the researcher consider how using attachment terms in the interview questions might have taken participants away from their relational experience in PT to an intellectual dimension.

Sub-theme 1.2: Using attachment labels on self and others. All CPs that took part in the study used AT to inform their work (Appendix J). During the interviews, when the researcher asked CPs to describe their attachment she often experienced a surge of emotion and would become very self-aware, as if she was asking about something too intimate and almost forbidden – the image of a young girl blushing, hands on cheeks. Despite its relevance in a study about attachment, it felt uncomfortable and she would hide away from the question, by minimising its importance and rebuild rapport with participants.

Interestingly, how CPs described their attachments was often far from straightforward, and their descriptions were diverse (Appendix K). Some referred to the attachment categories, but often had difficulties applying them or found the styles confusing; others found the theory simplistic and others complicated; and most used various labels to describe themselves. The researcher sensed how the use of categories and labels generated anxiety, they took time to respond, they wrestled with models, as if it did not fit with their internal experience or feeling. Perhaps, she had picked on their dread to have to use labels to categorise experience or their anxiety about getting it right. In any case, the researcher felt there was an ambivalence to define themselves through single attachment labels which transpired participants' descriptions of their attachment (both in interviews and questionnaire).

> "attachment can be talked about in ways that becomes quite polarising and simplistic. I know that there's the more complicated Crittenden model which I can't remember [laughs]. I've read about it before and got really stuck." (Sarah)

> "my feeling about myself is that I am mostly secure, but in some instances and with some people I will be avoidant, sometimes

> ambivalent, and then at other points if I am put before somebody who was really scary I might even verge on being a bit disorganised. I have come to see it as slightly more fluid than I originally came to see it." (Vicky)

> "Insecure-avoidance with security and some anxiety-ambivalence" (Hazel)

CPs' experiences resonated with the researcher. It seemed that the categorical models could not capture the fluid feeling of being in relation with a range of others.

When describing clients' attachment, using labels felt more straightforward for most. Although some noted a similar dissatisfaction.

> "I think she probably had a disorganised attachment, I would say. She had a tricky complex history, yes, so I think she probably had a disorganised attachment style." (Violet)

> "Again, I don't use attachment terms because they don't make sense to me!" (Zoe)

For these CPs, using AT to describe self and others was perceived as a way of listening and attending to emotional needs in relationships with subtlety, rather than applying categories or labels. AT was perceived as a useful theory to take a meta-perspective on the dynamic relationship between individuals. However, the use of intellectual artefacts (e.g., categories, dimensions) constructed a flat and limiting experience of what attachment in relationships was.

Theme 2: The emotional dimension of attachment. When asked to describe the relation with their therapists using five words, they described these relationships most frequently as warm, open, caring, safe, non-judgmental, and

challenging (Appendix L). Reflecting about the relationship with their therapists, helps CPs construct an emotional dimension to their understanding of their attachment that was felt in the transference with the researcher too.

Nearly all CPs reported a sense of feeling different within themselves as a result of PT. Some referred to this as security, others referred to it as feeling ‘solid’, “stable”, “open” or “confident”. For these CPs, PT had shifted something within them that allowed them to relate to themselves and others in a way that felt different, and to reflect about their emotions and reactions to others. PT and the relationship with their therapist helped them perceive the emotional dimension of relating to others and themselves. Reflecting about their PT they constructed their understanding of attachment from a relational and emotional perspective.

> “I think the work that we've done has affected me so profoundly in terms of… I definitely still have my shadow bits, no doubt, [laughter] but it has really helped me clear some of my stuff around caring relationships. It allowed me to sit more solidly within myself, without rushing into the other.” (Grace)

> “I think it’s evolved over time for me. I would say that I wouldn’t before I started this therapy have classed myself as having such a secure attachment style, it would have fluctuated quite a lot I think, whereas I will now, I'm so much more self-aware about thinking about my responses and why I might be feeling and acting the way that I am.” (Emily)

When reflecting about the relationship with their therapists, the researcher often felt choked-up with emotion as participants described their accounts of gratitude and (for some) loss. The emotional intensity in the transference between participants and

the researcher, often broken up with humour to alleviate the tension and pain, was testament to the emotional bonds to their therapists. Inevitably, reflecting about their therapists helped CPs describe the emotional dimension of attachment, in a way that training or supervision did not.

Sub-theme 2.1: Feeling differently about themselves. Some CPs talked about discovering or raising their awareness about different parts within themselves through PT e.g., new emerging parts, critical parts. Furthermore, what they perceived stood out about this new way of being was a sense of greater confidence, awareness or robustness within themselves.

> "I always find thinking about this really hard because I'd describe it as I *feel* like a different person," (Emily)

> "[laughs] I think I've learned that I'm more harsh on myself than I really realised, and […] I've become really, really aware of that." (Hazel)

> "Well, that sense of self, I suppose, or an idea of an emerging sense of self and self-confidence." (Olivia)

They perceived their relationship with their therapists had uncovered their vulnerabilities and strengths and CPs felt they had enhanced awareness about this too. Some talked about recognising their avoidance to experiencing their own emotions and finding some acceptance and openness towards their own emotional experience which made them feel more secure, even if some "shadow parts" remained.

> "So I think realising how avoidant I was, I thought as myself prior to this therapy as being someone who was quite willing to

> experience and sit with difficult emotions and so on, but I think I realised that I'm more able to sit with and think with somebody else about their emotions than I am willing to think about my own" (Sarah)

CPs also recognised they had been surprised about their inner-strength and resilience. For some this was recognising they already had strong foundations and for others, how they had developed those through therapy. These helped them confront difficult emotional experiences.

> "But I think, actually, the therapy I suppose that I've been through, I've been reflecting, I'm more resilient than I thought I would be." (Olivia)

From this perceived steadier inner place CPs were able to own their emotions, their vulnerabilities, they were able to see more about themselves and reflect about how it was affecting other relationships in their lives. They perceived an emotional dimension in their relationships with themselves which often revealed vulnerable sides to them.

> "I think that's something that I've realised, and it was quite difficult to realise, acknowledging that I can be quite avoidant of my own emotional experience and thinking about that." (Sarah)

> "I think I'm more open generally. I cry more [laughter]. And I try to cover it less, that's the difference" (Hazel)

> "I recognised that's a real shift because I don't do that anymore. I think to a certain degree I probably do when I'm in certain

> environments, experiences and things like that, but certainly not to that extent. And I'm not frightened to be hurt now." (Emily)

Paradoxically, it seemed that opening to their own emotional experience (challenges, vulnerabilities) in the context of a secure relationship with their therapist, made them feel more robust.

> "I think she was one person, part of a good handful of people, who probably have made me feel safe in their relationships. So, I no longer am avoidant of all difficult things. I can address them." (Sophia)

Sub-theme 2.2: Feeling differently in their relationships with self and others. Awareness about their sense of vulnerability in relationships was often constructed in the context of the relationship with the therapist. Thinking how they were in their intimate relationships with parents or partners, had helped them connect with their emotions and the strategies (avoidance, clinginess, difficulty to trust others, rescuing) that they had generated over time to protect themselves emotionally in relationships.

> "I learnt about myself in relationships and I learnt more about my own vulnerabilities and how that was impacting on my life and me functioning in my life, I learnt about my past relationships, I suppose, and where those vulnerabilities had come from and how to move forward with them." (Violet)

> "…Starting this therapy, I think that has been what's really got me thinking and relating back to my attachment patterns and how I respond to others. It has got me reflecting back on old

> relationships and thinking ‘Oh my god, I was very clingy because I was very anxious about losing people, I'm trying to change myself in order to please them’. I recognised that’s a real shift because I don’t do that anymore.” (Emily)

They perceived a trusting, secure and containing relationship with their therapists had allowed them to take a reflective meta-position on how they were in relation to others and developed some insight to take alternative positions, challenge their typical ways of being and flourish in different ways, despite difficulties.

> “I think I've become less avoidant, so there's been little conversations that I've had with my partner that I don’t know if I’d have had if I hadn't thought about certain things in therapy with [therapist]. And even snippets of conversation I've had with my parents and my brother that I don’t think I would have had without therapy.” (Sarah)

> “I think I’ve definitely learned something about trusting other people and being able to talk to other people about difficult experiences.” (Mia)

Through the relationship with their therapists they perceived that they were able to open up to their emotions, their unconscious anxiety, their vulnerabilities, and by reflecting about this bring into awareness the strategies that they had to develop to adapt. In their eyes, they constructed this ‘earned security’ as resulting from the process of noticing what was going on for them in relationships, they tried to do things differently which made them feel more robust, more secure in their relationship with themselves. They perceived themselves as different in their

relationships including the TR with their clients. Their own experience of therapy had helped them construct the notion of attachment as relationships that can be influenced, are adaptive and can be changed through therapy.

> "I think the whole thing has been very helpful in terms of making me feel more securely attached… but I think it's really taught me that people's attachment styles or working models can change and they are adaptive. They're there for a reason." (Olivia)

Theme 3: Clinical Implications of CP's Attachment Awareness

CPs perceived increased awareness of their attachment through their relationship in PT, had implications for their practice. These CPs perceived the relational dimension of the TR as the focus of their work, which they felt led them to work relationally, reflect on the attachment interplay and work in-the-here-and-now. The researcher noticed CPs were drawn enthusiastically to the positives of this experience and minimised or omitted limitations of working in this way, despite attempts to explore this. Listening to the positives was exciting for the researcher, who often had to remind herself to enquire about negative experiences. She wondered if this was a necessary defence against potential feelings of disappointment in their therapists, or perhaps a way of minimising cognitive dissonance given the significant investment participants and researcher had made in PT.

Sub-theme 3.1: "The TR is the work": practicing relationally. The relational lens that they perceived was developed in their therapy translated to their clinical practice in a relational approach to therapy, regardless of their clinical

orientation.

From their perspective being attuned to their clients was paramount for CPs, for them this meant listening and empathising with the client, but also reflecting about their relational response to the client and their own motives, to ensure that they responded to the client's needs and not their own.

> "Yesterday [therapy session] has also made me think even harder about how I am with clients, and think even harder about really, really tuning into what's going on with them and thinking, am I reacting or responding based on myself, or is it really about them?" (Ella)

In order to build a good TR that became a secure base for their clients, they described establishing a robust relational psychotherapeutic frame which included clear boundaries and therapeutic stance to define the limits of the relationship, clear contracting to establish trust through consistency and predictability, and an attitude of warmth, empathy and compassion.

> "I think it allows me to be a bit compassionate about the tendency of all of us to become insecure. I have noticed in myself the tendency to be avoidant, to cling and also to conduct myself quite sensibly. Because I see all of those facets in myself, it makes it sometimes easier to empathise with somebody who is either pushing you away or holding onto you really tightly. It doesn't always mean that is easy in your clinical work, but it helps." (Vicky)

For them, attachment awareness also brought to their fore the potential relational trauma in clients accessing their services. They described how they

worked proactively to protect the TR, preventing ruptures and working with the end in sight, as a way of addressing early relational trauma.

> "I think there was one session quite early on where I did push him a bit too far and we did have a mini rupture. But then we could repair that, so it was okay." (Vicky)

CPs saw endings as triggering for clients and themselves, hence they talked about "paying special attention to them". From their perspective, this meant working hard to make the separation from the therapist a successful experience for clients who they perceived might have often felt vulnerable in relationships. CPs constructed the idea of 'successful ending' as one that included strategies such as discussing breaks and therapy endings frequently, which they portrayed as common good practice in therapy. But, some CPs constructed the ending as a therapeutic tool.

> "[Endings] This was something I used to have to take to supervision a lot, I would avoid it, I would try and avoid the ending. If a client didn't turn up to their last appointment, I'd be relieved [laughter], whereas now I'm disappointed. […] But now it feels like a really nice powerful piece of work, that's changed how I manage it with clients, and hopefully their experience of it as well. Because obviously we give off [laughs]" (Emily)

> "…we'd talked together about her very much wanting to be in control of the ending, and she had quite a complicated attachment history. […] So we were able to work through this. So we acknowledged that the ending was going to be difficult

> and she'd initially said she was going to stop the therapy, I think it was three sessions before the end. And I spoke with her about how I understood that actually might be important for her to feel in control of the ending, by ending with me before I was ending with her, and that maybe in doing that she was keeping me as someone she could have good feelings towards rather than someone she could feel let down by. […] she did decide to complete the sessions." (Sarah)

Sub-theme 3.2: My stuff, their stuff and what is triggered in the dance.

Nearly all CPs reflected on the usefulness of having a level of awareness about their attachment when working clinically with complex cases to be able to think about what was being evoked in them.

> "[working with client perceived as preoccupied] I thought I'm going to have to be careful not to be too dismissive, because that's my response to this, is to just back off." (Olivia)

> "It's really, really hard to not give in to just giving her what she wants. Because I could really easily give it to her and not doing that feels like the kind thing and that's really hard work." (Sophia)

In their eyes, this helped them take a meta-position in relation to the TR and reflect on the interplay of attachments i.e., what was being triggered in their clients and themselves.

> "And I'm aware that it was because it was a bit untangled when there was a bit of a silence and I'd feel uncomfortable, trying to

> disentangle was I feeling uncomfortable because I was picking up that the silence was difficult for her, or was it more, for me, that in the silence I wasn't quite sure what was going on for her, whether she was needing time to think or she was feeling distressed and maybe jumping in to fix it." (Sarah)

In their clinical work they could see that, at times, they probably responded from a complementary attachment position mirroring the client's attachment style or responded to the client's countertransference demands. However by taking that metacognitive and reflective position on the relationship they could see that in the long-term such a dynamic would not provide clients with the necessary experience to change, referred to in the attachment literature as a corrective emotional experience.

> "Yes, so I think in the early stages probably to some extent actually it was quite helpful that we had a matched style because I think if I'd gone too quickly into pushing him he wouldn't have liked that […] But I think I realised towards the middle of therapy there's a real risk here that we're just going to stay stuck" (Hazel)

> "I don't think if I'd have carried on in that avoidant style, that I know is my go-to response, or *was* my go-to response, we would have built a connection. I think we would have had two very avoidant people sat in the room, and it would have been very difficult […] So I think if we weren't thinking about how our attachment styles were and I wasn't thinking about it in my own therapy, I don't think it would have been a very helpful piece of work for either of us." (Emily)

CPs described meeting the relational demands of their clients at the beginning of the relationship, and once the trust and safety of the TR had been established, challenging clients to provide a corrective emotional-relational experience.

> “And actually maybe there is something about doing that dance of maybe some reassurance sometimes is really important to make her feel safe but maybe some of that other part needs to be that I can, when I feel like there’s enough safety there, that I can say difficult things that might just challenge some of the dance-y things that she’s doing.” (Sophia)

So, taking a counter-complementary position that challenged clients, and often CPs, was constructed as an intentional act, which required in their view to reflect on the attachments interplay in the TR, identifying the needs of clients and their own personal struggles in the TR.

> “And I think I'm more trying to hold a dual awareness, thinking about transference and counter-transference, really working to notice my emotional responses rather than more putting myself in the place of the other, or thinking about how the other person wants me to respond. I think that’s something that I've noticed very much that I have to be very aware of from my background of very much being someone who wants to make other people happy and be available.” (Sarah)

Sub-theme 3.3: Noticing: working in-the-here-and-now of the TR. For CPs noticing the client-therapist attachment interplay in the TR, led them to work with here-and-now moments to help clients reflect about their relational and emotional patterns of relating to self and others. However, what they constructed as

distinctive was talking about the emotional impact of the TR in a direct way, forcing therapist and client to reflect on their experience of each other and increasing the emotional intimacy between them.

> "And me naming what I'm seeing in the room. This social awkward thing that says 'oh, we're going to talk about us' that's this exposing thing that... Nobody does that outside the therapy room in the same way and I think that is the really powerful thing." (Sophia)

In their view, CPs brought into clients' awareness the emotional impact that clients had on them and the emotions they felt being with the client in the consulting room.

> "She said something like, 'That doesn't matter anymore,' and I said, 'I don't believe you.' She looked at me for the first time in the session. I said, 'I don't believe it doesn't matter anymore. When you said it I felt sad. I don't know what that is about, but there is more here. You don't need to tell me, but..." (Zoe)

CPs perceived that their attachment awareness helped them identify their feelings in the TR and they believed their increased robustness within themselves allowed them to engage in this personal and intimate way with clients.

> "…because I feel differently attached, I think what I do differently now is that I bring in difficult conversations. I stop working so hard for the other and I'm delivering more 'oh I wonder what's going on here; can you see what's happening in your relationship?' I will talk about what's playing out in between me and the client" (Sophia)

> "I'm not so afraid to talk about and bring that into the room. 'I wonder how me saying that made you feel?" (Emily)

It is worth noting that CPs talked about noticing and raising the client's awareness gently before reflecting on the TR. This progressive build up would culminate with noticing 'here-and-now moments' in the TR, which was what in their view facilitated change, especially when clients as well as CPs were able to notice their own emotions and behaviours in the TR and beyond.

Discussion

Research from attachment-informed psychotherapy has suggested that therapists' attachment awareness and their ability to reflect about attachment interplay in the TR is paramount (Bucci et al., 2016; Daly & Mallinckrodt, 2009). This study explored how reflecting about the relationship with their therapist contributed to CPs' awareness and understanding of their own attachment and its implications for their clinical practice.

Results suggest that while for most CPs security was seen as an aspiration, none of them identified with a fully secure attachment all the time. They suggested that while AT is useful as a conceptual framework, e.g., formulation of psychological hypothesis, it did not fully capture the fluidity of attachment processes observed in their relationships. CPs could also see how they drew on a variety of styles, as suggested in the literature (Allen, 2013; Crittenden, 2012) and fitting the idea that attachment should be considered dimensionally rather than categorically (Mikulincer & Shaver, 2018). Their experience of PT had been a major influence in their understanding of themselves in relationships, including making sense of historical relationships and the impact of these on present relationships with significant others and clients. This is in line with Rizq and Target's research (2008a, 2008b, 2010).

The results suggested that CPs found therapy helpful to develop reflexivity about themselves and their relationships from an emotional perspective. This reflexivity included a greater awareness of triggers for their own and the others' emotional responses, and the underlying emotional communication of their behaviour. Being able to reflect about the emotional experience of being with others was the focus of their interest, not labelling according to AT. By noticing and understanding their way of relating with self and others, in and out of therapy, CPs found some inner "centredness". It was the ability to mentalize themselves (i.e., consider their thoughts, feelings, motivations…) in the presence of the other that seemed to be key to their personal development, their attachment awareness, and their clinical work. This is in line with Fonagy et al.'s (1991) research, where RF was seen to prevent the transmission of insecure attachment from parents to their children, when they were able to mentalize their needs as different from the needs of their children. So, developing RF through PT meant that even those CPs that felt some degree of insecurity in their attachment, were able to mentalize their own needs and those of the client, differentiate them, and respond in ways that facilitated change. These results suggested that mentalizing could override the CPs insecurities played out in the relationship and may explain how insecurely attached therapists with high RF outperform their secure counterparts with lower RF in their clinical effectiveness (Cologon et al., 2017).

In attachment research, secure therapists are seen as more effective developing good working alliance and positive outcomes (Degnan et al., 2016). In line with Cologon et al.'s (2017) research, the current study seems to suggest the need to deconstruct the superiority of secure attachment in therapists, in favour of

strong RF skills, as is the case in other caregiving dyads (Fonagy et al., 1991), although both processes are intertwined (Fonagy, Gergely, Jurist, & Target, 2002).

In clinical practice, being able to reflect about their own attachment, resulted in CPs bringing a relational lens to their work. This mirrored Daly and Mallinckrodt's (2009) concept of TD in the TR. CPs used the TD to reassure and challenge clients. This required CPs to be robust and self-aware, which had been facilitated in PT. Noticing these patterns in the TR, led them to work 'in-the-here-and-now' and transference-countertransference enactments, well described in the attachment-informed literature (Maroda, 2009; Wallin, 2007) and a key feature in relational psychoanalysis (Yalom, 2002).

"Noticing" the interaction in the TR played a key role in developing the self-awareness in the clients and in doing so, developing their RF 'from the outside, in' (Allen, 2013; Fonagy et al., 2002). CPs referred to noticing patterns of relating, including: with others in clients' lives, inviting them to take different perspectives: with themselves, noticing different parts within clients' selves anchored to different experiences; and with themselves as therapists in the room, which for some involved feedback that resonated with early developmental mirroring between mothers and babies e.g., from describing clients' reactions as they talked of an experience, to naming emotions that might have been experienced, to more sophisticated levels of RF. As suggested by Fonagy and Allen (2014) practising in this way offered a developmental context where CPs rekindled the client's openness to interpersonal influence and developed their reflective skills, unblocking obstacles to social learning rooted in early attachment trauma.

Researcher Reflexivity

While carrying out this research, I was aware that I am a CP in training undergoing my own personal PT, with an interest in AT and how AT affects my clinical practice. From a social constructionist epistemological approach (Burr, 2015), my outlook, experience and interests influenced the research process and ultimately the construction of this narrative. Hence, in understanding CPs' experiences of PT, I have drawn inevitably on my own experiences and assumptions to select themes and construct the findings. In my PT, I have reflected about my attachment and I have experienced the benefits in my clinical practice, e.g., working in-the-here-and-now. Hence, I might have been drawn to this subtheme (Appendix N).

Strengths and Limitations

Several strengths and limitations must be noted. Taking a qualitative approach to this study has allowed a closer look at some of the subjective processes that take place when CPs (and possibly therapists) think about their own attachment. It has been possible to show how the measurement of attachment offers a snap-shop of how an individual might feel at a given time, however how we experience an intimate relationship can be at times quite fluid and difficult to capture by research measures. A strength of the qualitative enquiry is that it produces an account of some CPs' clinical experience on how reflecting about attachment they believe is an effective therapeutic tool. It would be interesting to assess the effectiveness of these techniques in practice. Further research could investigate live therapy sessions through narrative research approaches (e.g., Talia, Daniel) to offer a more objective picture of how attachment awareness influences CPs' practice as well as measuring its effectiveness.

In framing the study specifically in AT, we might have ruled out other influences, e.g., from psychodynamic literature, which future research could investigate. Similarly, the AT frame of the research and of the IAAPCI might have influenced how participants described their experiences of relating to others through and AT lens rather than in another way. Future research could try and replicate the study modifying the IAACPI to reduce the AT jargon to explore how CPs describe their ways of relating to their clients in therapy. Another limitation was that in aiming to understand their experiences and gather examples of their practice, barriers that AT might pose to their understanding and practice were not brought up by participants. Future research could investigate this. Finally, it is worth noting that this was a very homogenous sample of CPs and exploring this topic with a more diverse sample might have brought more contrasting experiences.

Future research should investigate the role of clinical training, supervision and self-reflection in raising awareness about CPs attachment and the development of their RF to understand better how each activity contributes to CPs personal development when they are in training as well as once they have qualified. Such research would allow us to build a comprehensive picture of the support that trainee and qualified CPs required in order to work with attachment awareness and high levels of RF on clinical practice.

Assessing the RF of CPs in the current study, would have been of interest to understand if this type of work requires high RF or otherwise. It would be of interest to investigate the effectiveness of different therapy orientations, intensity, modality (face to face vs online) to increase AT and RF.

Theoretical and Clinical Implications

This study offers a clear account of the perceived benefits of PT for a group of CPs. CPs perceived clinical training had triggered their interest in reflecting about their own attachment. This finding suggests training courses can support trainees to develop an understanding of attachment process in self and others and explore their own attachments e.g. by exposing them to AT methods and instruments (Slade, 2018). Furthermore, helping them consider their attachment in the context of the TR with their clients by using the IAACPI during their clinical placements could enhance their clinical practice (Slade, 2018).

The research showed that by engaging in PT most CPs experienced more perceived security in their relationships and felt more able to work with the interplay of attachments and TD in the TR as a result of being able to take a meta-position through AT and enhance their RF. Spending some time in PT can offer trainees the possibility of connecting with a personal emotional dimension of attachment that might not be so easily achieved training or supervision. In addition, PT can offer those with insecure attachment an opportunity to develop their RF further and support their clinical practice (Cologon et al., 2017).

PT as a professional development activity for CPs has been compromised by the lack of evidence-base (Norcross, 2005). Some have argued that in the current climate of therapy needing to be effective and evidence-based a more relevant question is how engaging in PT has an impact on therapists' performance (Macran & Shapiro, 1998). The current study contributes to answering this question. Therefore, this study can be presented to trainees CPs to make an informed-decision.

This study provides evidence for AT informing CPs' clinical practice beyond classification of clients according to attachment styles and formulation. The research

showed how AT offers a way to work with transference in therapy and the benefits that this can have for CPs and clients (Abbas, 2015; Maroda, 2009; Wallin, 2007).

Finally, this research suggests that the interview schedules used were useful tools for CPs to reflect on their own relationship with their therapists and its impact on their practice. These tools support CPs to reflect about their attachment awareness and the impact on their clinical practice. These tools can be used in supervision as well as during clinical training to develop reflexivity in trainees.

Conclusion

The exploration of CPs' attachment relationships with their therapist has provided evidence of the benefits of engaging in PT for their therapeutic practice. Engaging emotionally with their therapists provided CPs with an opportunity to develop a more robust sense of self. PT allowed CPs to approach their work from a relational lens and look at their interactions in the TR. For this group of CPs, PT was an effective strategy to develop security and RF in relationships, positively shaping their clinical practice.

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Appendices

Appendix A: Author Guidelines for Psychotherapy Research Article Submission

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements.

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All authors submitting to medicine, biomedicine, health sciences, allied and public health journals should conform to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals, prepared by the International Committee of Medical Journal Editors (ICMJE).

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Authors will need to include a separate 2-3 sentence summary labelled "Clinical or Methodological Significance of this Article" and should also include a word count with their article.

Word Limits

Manuscripts reporting results of quantitative or qualitative research generally should not exceed 35 double-spaced pages (including cover page, abstract, text, references, tables, and figures), with margins of at least 1 inch on all sides and a 12-point font. Concise manuscripts are favored over lengthier manuscripts, as long as quality is not compromised in abbreviating a paper. For manuscripts that exceed these page guidelines, authors must provide a rationale in their cover letter to justify the length of their paper. Papers that do not conform to these guidelines will be returned to authors without a peer review.

Style Guidelines

Please use APA (American Psychological Association) style guidelines when preparing your paper, rather than any published articles or a sample copy.

Please use American, British-ize spelling style consistently throughout your manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Note that long quotations should be indented without quotation marks.

Formatting and Templates

Papers may be submitted in any standard format, including Word and LaTeX. Figures should be saved separately from the text.

References

All submitted manuscripts should conform to the current APA (American Psychological Association) style. Please use this reference style guide when preparing your paper. An EndNote output style is also available to assist you.

Checklist: What to Include

Author details. Please ensure everyone meeting the International Committee of Medical Journal Editors (ICMJE) requirements for authorship is included as an author of your paper. All authors of a manuscript should include their full name and affiliation on the cover page of the manuscript. Where available, please also include ORCiDs and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the article PDF (depending on the journal) and the online article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after your paper is accepted.

Abstract. Should contain a structured abstract of 200 words.

Graphical abstract (optional). This is an image to give readers a clear idea of the content of your article. It should be a maximum width of 525 pixels. If your image is narrower than 525 pixels, please place it on a white background 525 pixels wide to ensure the dimensions are maintained. Save the graphical abstract as a .jpg, .png, or .gif. Please do not embed it in the manuscript file but save it as a separate file, labelled GraphicalAbstract1.

You can opt to include a video abstract with your article. Find out how these can help your work reach a wider audience, and what to think about when filming.

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Updated 25-05-2018

Appendix B: Development of Reflection in Therapists

Table 3.

Stages of Reflection Development through PT (Wigg et al., 2011)

Stages of reflection	Description
Personal reflections	Reflection that encourages personal growth and development to take place e.g., how personal issues impact on practice, what it is like to be a client, identifying one's boundaries and intense self-experiences in PT. This also included personal reflexivity, insight and acceptance of the self.
Professional reflections	Reflections on the professional self / role, which may occur as a result of making connections between how personal experiences influence professional practice and the learning from the model of the therapist. This includes development of empathy, greater self-awareness within sessions, socialisation to the profession and validation of benefits of therapy. Professional self-honed as the tool of therapy, enabling the practitioner to become more skilful and accurate.
Extended reflection	Reflection that goes on over extended periods of personal therapy, beyond course requirements or presenting issues, as a professional commitment. Less well studied.
Meta-reflections	Reflection that develops authenticity within one's personal and professional self; recognition of imperfectability, self-acceptance, awareness and coherence or integration of thinking and experience. This phase is for Macran et al. (1999) the step of increasing the therapist's ability to work on a deeper, more subconscious level, allowing them to work more effectively and hold more of the client in mind.

Appendix C: Reflexivity Approaches (Finlay, 2002)

Table 4.

Reflexivity Approaches to Qualitative Research (Finlay, 2002)

Types of reflexivity	Description
Reflexivity as introspection	This type of reflexivity underscores the value of self-dialogue and discovery for researchers. For example, beginning research with personal experience embrace their own humanity as the basis for psychological understanding. Researchers' own reflecting, intuiting and thinking are also source of evidence e.g., in defining the research questions there is an intense interest and personal quest for understanding. So, through the process of internal/personal search, meaning is discovered. Insights can emerge from personal introspection which then form the basis of a more generalized understanding and interpretations. Reflections are assumed to provide data regarding the social/emotional world of participants). The challenge is using introspection is to use personal revelation not as an end, but as a springboard for interpretations and more general insight.
Reflexivity as intersubjectively	Researchers explore the mutual meanings emerging within the research relationship between research and participants. It focuses on the situated/negotiated nature of the research encounter. The self-in-relation-to-others becomes the aim and object of focus and some unconscious processes in the relationship is also of interest for those of a psychodynamic orientation.
Reflexivity as mutual collaboration	Researchers use a broad range of methodologies e.g., co-operative inquiry research, sociological, discursive and feminist research approaches. Research becomes a co-constituted enterprise, a participative activity. Participants are co-opted into the research as co-researchers. Participants are involved in a reflexive dialogue during analysis.
Reflexivity as social critique	Researcher use social critique to consider how to manage the power imbalance between researcher and participant. They openly acknowledge tensions in relation to social positions e.g., class, gender and race.
Reflexivity as discursive deconstructions	Researchers use discursive deconstruction to pay attention to the ambiguity of meanings in the language used to express/describe experiences and how this impact on modes of presentation.

Appendix D: Demographic Questionnaire

Participant identification number: (to be completed by the researcher)	
How old are you?	
How do you identify your gender?	
How do you describe your ethnicity?	
Please provide any other identities of diversity you wish to share	
What graduate degree(s) have you obtained?	
What professional registrations do you hold?	
What, if any, professional organisations are you a member of?	
How many years since you started your Clinical or Counselling Psychology training?	
How many years since qualifying?	
How many hours of personal therapy since you started training?	
How often do you access/ed personal therapy?	
What was the orientation of this therapy?	
How many hours of personal therapy prior the start of your training?	
Currently, how many hours of clinical supervision monthly?	
How would you describe your clinical orientation?	
How do you describe your attachment style?	
How do you use Attachment theory in your clinical work?	

Appendix E: Modified Patient Relationship Interview – Therapists (adapted from Katzow, 2011) and The Influence of Attachment Awareness on Clinical Practice Interview

Semi structured interview

Boundaries for interview

- Not an overly emotional conversation however the risk of an emotional reaction is there.
- Please, be mindful of what you are sharing and take care of yourself during the interview to make sure you feel safe and contained.
- Do let me know if you need to stop at any point or have a break.
- You can decline to answer any questions that you don't feel you want to discuss.

Patient Relationship Interview - Therapist (PRI-T; Katzow, 2011)

INTRODUCTION

In this interview, I'll be asking you about your relationship with your individual therapist, and how you think different aspects of the relationship have influenced who you are today. Throughout the interview, I will be asking you a series of questions and I may ask you to change topics periodically so that we can cover all the questions in the interview. This interview should take approximately **one and a half hours**.

1. Briefly, could you start by helping me to get oriented to your work with your therapist?

   Prompts:

   - How do you want me to refer to your therapist, by name, or just your therapist?
   - When did you first start seeing _____ or your therapist?
   - How long have you did you work/been working with your therapist? Or What was the duration of therapy?(added by MGR)
   - How frequently have you seen your therapist?
   - Has the therapy been continuous?
   - Have there been any other therapists involved?

- *What was the reason for accessing PT? ?(added by MGR)*
- *What was the orientation of PT*? *?(added by MGR)*

2. I'd like you to describe your **relationship** with your therapist going back to the beginning.

3. Now I'd like to ask you to choose five adjectives or words that reflect your relationship with your therapist. Then afterwards I'll ask you why you chose them. I'll write each one down as you give them to me.

Adjectives:

1.	2.	3.	4.	5.

3.1 Ok. You say your relationship with your therapist was _____. Are there other any memories or incidents that come to mind with respect to _____?

Probes:
Can you think of a specific memory that would illustrate how your relationship is (...)?

Well that's good general description, but I'm wondering if there was a particular time that happened, that made you think about is as (…)?

4. When you were upset with something going on in your life, how would you handle or address it in therapy? Can you think of a specific time that happened?

Probe:

- How did your therapist respond?

4.1 When you were physically upset with something that went on in therapy, what would you do? Can you think of a specific time that happened?

Probe:

- How did your therapist respond?

4.2 Were you ever ill during the course of your therapy? Do you remember what happened?

Probe:

- How did your therapist respond/next time they saw you?

5 What is the first time you remember being separated from your therapist?
- What was the nature of this separation (e.g., did therapist cancel appointment?)
- How did you respond?
- How did your therapist respond?
- Are there other separations that stand out in your mind?
- What were separations from your therapist like for you?

6 Have you ever felt rejected, pushed away, or criticized by your therapist?
- How did you respond?
- Are there any particular instances that stand out in your mind?
- What do you think the reason was that your therapist did those things?
- Do you think he/she realized he/she was being rejecting or critical?

About the rupture:

Was this addressed or discussed?

Who addressed it?

Why do you think it was addressed?

What was it like to discuss it?

Was it resolved to your satisfaction?

To what extent was it resolved to your therapist's satisfaction?

How did you feel upon the resolution?

Did you discover anything new of different about yourself int his process?

Did you discover anything new about your therapist in this process?

How did the event affect your relationship with your therapist? And therapy?

7 In the course of your therapy, did you ever think about the therapy?
- Could you tell me a bit more about this? (added MGR)

7.2 Did you ever worry that your therapist would end the therapy?
- Could you tell me a bit more about this? (added MGR)

8 Were there many changes in your relationship with your therapist over the course of your therapy?
- Could you tell me a bit more about how the relationship changed? (added MGR)

8.2 Did your feelings for your therapist change over the course of your therapy?
- Could you tell me a bit more about how your feelings changed? (added MGR)

9 Have you experienced any loss through death of a parent or other close loved one during the course of this therapy - for example, a sibling, or a close family member or even a job(moved here from later section MGR)?

9.2 How did your therapist respond? (added MGR)
9.3 Did this experience have an effect on your relationship with your therapist?

10 *In general, why do you think your* therapist behaved the way he/she did with you?

11 In general, how do you think your overall experiences with this therapist [that we have been discussing] have affected your personality/who you are now?
- Can you say a little bit more about that?
- Has informed your clinical practice? (added by MGR)

- How you are with clients? (added by MGR)

12 Is there any particular thing which you feel you learned above all from this therapy relationship? I'm thinking here of something you feel you may have gained from the experience.

12.2 Are there any aspects of this relationship that you feel have been a setback for your development?

13 How do you think your therapist feels/felt about you?

13.2 How do/did you feel about your therapist?

14 If you met your therapist in ordinary life would you want to be his/her friend?

15 Do you think of your therapist outside of therapy?

15.1 How often? and in what ways?

16 Do you imagine having a different kind of relationship with your therapist outside of the therapy situation?

17 What were your feelings about your therapist during the concluding phase of your therapy?

18 Can you describe how you felt about your therapist when your therapy ended?

The Influence of Attachment Awareness on Clinical Practice Interview (IAACP)

1. Thinking about your personal therapy (PT), but also your clinical supervision and your training, how have you come to your current understanding of your attachment styles?

2. How would you describe your attachment styles?

3. Do you think that your own attachment has an impact on your clinical work e.g., therapeutic alliance?
   Follow up:
   - If yes, in what ways it does?
   - If no, in what ways it doesn't?

4. **I would like us to explore how do you think your own awareness about your attachment style and that of your client has impacted your clinical practice.**

   4.1. Could you please think about an example from your - past or current - clinical practice where you think holding awareness about your own attachment (as therapist) and that of your client has made a difference in the therapeutic process and outcome. **I would like you to describe your relationship with your client going back to the beginning**.

   4.2. What were your thoughts about your client's attachment at the **beginning of therapy** / **during therapy** / **at the end** of therapy?

   4.3. What were your thoughts about the interplay of your own attachment and that of your client at the **beginning of therapy** / **during therapy** / **at the end** of therapy?

   4.4. On the basis of that thinking, what kinds of things did you do when working with this client in therapy **at the beginning of therapy** / **once you had a solid therapeutic alliance**/ **at the end of therapy**?
   Probe:
   - Where these actions deliberate?
   - Clearly linked to your thinking about the interplay of attachment?
   - Did you have awareness?

   4.5. What difference do you think it made to:
   - **you as a therapist** to be able to reflect about the interplay of attachments the way you did?
   - **your client** to be able to reflect about the interplay of attachments the way you did?
   - **the therapeutic outcome** to be able to reflect about the interplay of attachments the way you did?

Appendix F: Ethical Approval

Dear Maria Gascon-Ramos,

Application ID:	**eCLESPsy000780 v4.1**
Title:	**Exploring psychologists' attachment representations to their own personal therapists: Implications for professional practice**

Your e-Ethics application has been reviewed by the CLES Psychology Ethics Committee.

The outcome of the decision is: **Favourable**

Potential Outcomes

Favourable:	The application has been granted ethical approval by the Committee. The application will be flagged as Closed in the system. To view it again, please select the tick box: View completed
Favourable, with conditions:	The application has been granted ethical approval by the Committee **conditional** on certain conditions being met, as detailed below. Unless stated otherwise, **please resubmit the requested amendments** via the online system before beginning the research.

Provisional:	You have **not** been granted ethical approval. The application needs to be amended in light of the Committee's comments and re-submitted for Ethical review.
Unfavourable:	You have **not** been granted ethical approval. The application has been **rejected** by the Committee. The application needs to be amended in light of the Committee's comments and resubmitted / or you need to complete a new application.

Please view your application here and respond to comments as required. You can download your outcome letter by clicking on the 'PDF' button on your eEthics Dashboard.

If you have any queries please contact the CLES Psychology Ethics Chair:

Nick Moberly n.j.moberly@exeter.ac.uk

Kind regards,

CLES Psychology Ethics

Appendix G: Participant Information Sheet

Participant Information Sheet

Title of Project: Exploring psychologists' attachment representations to their own personal therapists: Implications for professional practice.

Researcher name: Maria Gascon-Ramos

Invitation and brief summary:

This study aims to investigate the personal experience of psychologists who have undergone personal therapy. The study will focus on psychologists' reflections about their own attachment representation by thinking about their relationship with their own therapists; and to explore what implications this might have had for the clinical practice, alongside other aspects of their training (theory, insight) and professional experience (supervision, clinical practice).

Please take time to consider the information carefully and to discuss it with family or friends if you wish, or to ask the researcher questions.

Purpose of the research:
Attachment theory and attachment psychotherapy are increasingly popular in applied clinical psychology (BPS, 2017). Research has demonstrated that therapists' attachment influences the process and outcome of clinical practice (Talia et al., 2018). Therapists' attachment representations and behaviours interact with clients' attachments and have an impact on the TA, clinical outcomes, influencing their understanding and relationship with their clients. Personal therapy and supervision are recommended to develop therapists' reflectiveness and facilitate insight into their relational experience and its influence on the therapeutic encounter (Bucci et al. 2016). Personal therapy offers psychologists opportunities to develop insight into their own attachments (Murphy et al., 2018). Understanding their personal experience of reflecting about their own attachment representations by exploring their relationship with their own therapists can provide evidence on the role of personal therapy in the development of psychologists' development; and clarify how their attachment representations influence their practice.

Why have I been approached?
You have been approached because you are a clinical or counselling psychologist actively working clinically, who might have undergone personal therapy and who considers attachment theory in your work. This information has been passed onto you through the Head of Psychology in your trust or a colleague that might know of your interest in this type of research. This study will hope to recruit 10-12 psychologists, who have undergone personal therapy.

What would taking part involve?
You will be asked to meet the researcher once only. This meeting will be done face-to-face at a place of your convenience. If this is not possible, we could explore meeting via telephone, if preferred. In this meeting we will review this Patient Information Form and discuss any issues regarding the project. We will then sign the consent forms to start participating in the study. You will be asked to confirm the eligibility criteria for the study and complete a brief demographic questionnaire. Once this is done, you will be interviewed to talk about your relationship with your therapist, and your views about how awareness of your attachment representations might have influenced your clinical practice. This meeting should take around 60 - 90 minutes. The interview will be recorded in an encrypted and password-protected digital recorder.

The interviews will be downloaded to a password-protected computer that will be stored in a lockable cabinet. Then the researcher or a professional transcriber will transcribe the interview. At this point

any identifiable data will be removed and replaced with pseudonyms. A key to identify participants will be also created and saved securely and separate from the interviews. This will allow the researcher to identify participants' interviews in case participants want to withdraw from the study.

What are the possible benefits of taking part?
All participants will reflect on their own therapeutic practice and potentially expand their knowledge on this area of work. The will be rewarded for their time with a £10 amazon voucher.

What are the possible disadvantages and risks of taking part?

Risk to physical harm
Participating in the research will not entail any physical harm.

Risk to psychological harm
Participants will have to meet with the researcher once only.
Although it is unlikely, it is possible participating in the research could cause mild psychological distress to participants. Participants will be reflecting on their relationship with their therapist and their attachment representations as well as their clinical practice. This could potentially bring up some memories about their early history that could be potentially distressing.

The researcher will make herself available after the interview to discuss any issues that the participants might have found distressing. If any further support is needed the researcher will signpost them to organisations that can offer support (e.g., Samaritans on 116 123 or the local Mindline on local number).

Risks to confidentiality and anonymity
Utmost care will be taken to preserve confidentiality and anonymity. No personal details or identifiable data will be revealed when disseminating the findings of the study.

What will happen if I don't want to carry on with the study?
Participants will be able to withdraw until the start of the analysis of the data without having to give any reason by contacting the researcher on mg569@exeter.ac.uk. Once the thesis is passed, all consent forms, questionnaires, audio files and transcription of interviews will be destroyed.

How will my information be kept confidential?
The University of Exeter processes personal data for the purposes of carrying out research in the public interest. The University will endeavour to be transparent about its processing of your personal data and this information sheet should provide a clear explanation of this. If you do have any queries about the University's processing of your personal data that cannot be resolved by the research team, further information may be obtained from the University's Data Protection Officer by emailing dataprotection@exeter.ac.uk or at www.exeter.ac.uk/dataprotection

Interviews will be recorded in an encrypted and password-protected dictaphone. Once the researcher is at her base, the audio-files will be saved onto a password protected computer. The computer will be stored in a lockable cabinet, separate to any identifiable data such as signed consent forms or the study participant key. Consent forms and participant key documents will be stored in a different lockable cabinet.

If data is transcribed by a professional transcriber, audio-files will be sent by secure encrypted emails to the transcribing services and return to the researcher. Transcribers will permanently destroy the audio-files immediately after the transcription is completed. The researcher will destroy all audio-files once the data is analysed and thesis is passed.

Data will be stored in the University of Exeter secure server and kept for a maximum of 5 years. Data will be destroyed by deleting electronic files where it will be stored.

If the researcher and participants discuss any aspects of clinical practice of concern to them, the researcher in keeping with the confidentiality agreement will have to disclose to the participants of the need to seek help to support them in their work and support will be sought from their clinical tutor.

Will I receive any payment for taking part?
All participants will get a £10 Amazon-voucher.

What will happen to the results of this study?
Results of the study will be reported as part of the doctoral thesis of the researcher. In addition, results will be disseminated in conferences, training events, and academic publications.
A summary of the study results will be available for participants.

Who is organising and funding this study?
This research is being carried out as part of an NHS funded doctoral programme at the University of Exeter.

The research team consist of:

- Maria Gascon-Ramos, researcher and doctoral candidate
- Dr Janet Smithson, Research supervisor
- Dr Elizabeth Weightman, Research supervisor

Who has reviewed this study?
This project has been reviewed by the Psychology Research Ethics Committee at the University of Exeter (Reference Number: eCLESPsy000780 v4.1).

Further information and contact details
To discuss participation in the study, please contact Maria Gascon-Ramos at mg569@exeter.ac.uk.

Concerns and complaints regarding this study should be reported to the supervisor Dr Janet Smithson at J.smithson@exeter.ac.uk or Dr Nick Moberly, Chair of Psychology Ethics at n.j.moberly@exeter.ac.uk or Gail Seymour, Research Ethics and Governance Manager g.m.seymour@exeter.ac.uk, 01392 726621

Thank you for your interest in this project.

Participant Information Sheet

Title of Project: Exploring psychologists' attachment representations to their own personal therapists: Implications for professional practice.

Researcher name: Maria Gascon-Ramos

Invitation and brief summary:

This study aims to investigate the personal experience of psychologists who have undergone personal therapy. The study will focus on psychologists' reflections about their own attachment representation by thinking about their relationship with their own therapists; and to explore what implications this might have had for the clinical practice, alongside other aspects of their training (theory, insight) and professional experience (supervision, clinical practice).

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The interviews will be downloaded to a password-protected computer that will be stored in a lockable cabinet. Then the researcher or a professional transcriber will transcribe the interview. At this point any identifiable data will be removed and replaced with pseudonyms. A key to identify participants will be also created and saved securely and separate from the interviews. This will allow the researcher to identify participants' interviews in case participants want to withdraw from the study.

Appendix H: Consent Form

Participant Identification Number:

CONSENT FORM

Title of Project: Exploring psychologists' attachment representations to their own personal therapists: Implications for professional practice.

Name of Researcher: Maria Gascon-Ramos

Please initial box

1. I confirm that I have read the information sheet dated..... (version no.....) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw until data analysis starts without giving any reason and without my legal rights being affected. ☐

3. I understand that relevant sections of the data collected during the study, may be looked at by members of the research team, individuals from the University of Exeter, where it is relevant to my taking part in this research. ☐
   I give permission for these individuals to have access to my records. ☐

4. I understand that taking part involves:

   anonymised questionnaire responses ☐

   audio-recording of interview ☐

   interview transcripts ☐

to be used for the purposes of:

inclusion in an archive for a period of up to ***5*** years ☐

reports published in an academic publication ☐

teaching or training materials to trainee and qualified psychologists, psychotherapists and counsellors. ☐

5. I agree to take part in the above project.

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of researcher taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for researcher/project file

Appendix I: Thematic Analysis

Table 5.

6-Step Model of TA (Clarke et al., 2015)

Step	Description
Familiarisation with the data	Data analysis is facilitated by an in-depth knowledge and engagement with the data set by reading, re-reading, listening to recordings, making notes of initial analytic observations. This process helps move the focus beyond the most obvious meanings.
Coding	A systematic process of identifying and labelling relevant features of the data to answer the research question. Coding is the first step in identifying patterns in the data because it groups together similar data segments. Codes should be succinct labels. It involves coding the entire dataset, and after that, collating all the codes and all relevant data extracts, together for later stages of analysis.
Searching for themes	The researcher clusters together codes to create a plausible mapping of key patterns in the data. Examining the codes, the researcher identifies significant broader patterns of meaning (potential themes). Then the data for each plausible theme reviewed to assess the viability of each candidate theme.
Reviewing themes	The researcher assesses if the themes exhibit a good fit with the coded data and wider data set, determining if each has a clear, unique essence or central organising concept. It is also important to consider if the emerging answers the research question. In this phase, themes are typically refined, which sometimes involves them being split, combined, or discarded.
Defining and naming themes	Writing theme definitions (a brief summary of each theme); selecting a theme name ensures conceptual clarity of each theme and provides a map for the last phase.

Writing up	The researcher weaves together the analytic narrative and data extracts and contextualising the analysis in relation to existing literature. Themes provide the organising framework for analysis, but analytic conclusions are drawn across themes.

Appendix J: CPs' Use of AT in Clinical Practice

Table 6.

Participants Views on Their Use of AT in Their Clinical Practice (Demographic Questionnaire)

Participant	Use of attachment theory in clinical practice
Sarah	I hold attachment theory and the idea of Internal Working Models in mind as an overarching model whether I'm working from a CBT/Compassionate Mind perspective, Trauma-Informed or relationally/psychodynamically as what we understand from attachment research easily blends across models. From all perspectives I might talk with clients about how their past (and sometimes present) relationships have influenced their beliefs about themselves, other people and themselves in relationship to others – as well as their relationship with their emotional experience (and the expression of emotion by others). Where appropriate I might also think about this with the client with reference to the therapeutic relationship. However even when not explicitly discussed I will be thinking about how a client's internal working model/attachment style may influence their engagement in therapy. I also frequently talk with other professionals about the attachment experiences client's may have had and the influence this may have had on how they relate to others so as to re-frame 'personality disorder' as 'attachment trauma' in an attempt to move away from unhelpful 'PD' rhetoric to a more compassionate and attachment/trauma-informed view of clients who present with so-called 'personality disorder'.
Olivia	I formulate using Cognitive Analytic Therapy a lot which draws from attachment theory.
Mia	Formulation with clients. Staff support: reflective practice, risk assessment, complex case formulation.
Sophia	I focus on the way people describe how they relate to others. I think about early attachments/care giving experiences and how this might show in the TR. I talk and ask about early care giving experiences and how these might inform how safe they feel in relationships/how they respond to their own need and the need for the other. I use the theory of attachment styles to explain in MDT settings why people might struggle to engage in services and what can be useful in trying to engage. I see attachment as something that can look differently depending on people/contexts/development. I believe attachment styles are not fixed and can change over time in people's lives.
Emily	To help explain ways in which we start to build relationships. I use with most clients in sessions and it is also used in a compassion focussed group. I include it in my own supervision and with clients in thinking about the therapeutic relationship.

Ella	Using supervision to reflect on my attachment to the client and relationship to colleagues/my position in the team and understanding of our responses toward each other. Make explicit reference to attachment with clients and asking questions to explore this together. Teaching and training on attachment with the team. Providing supervision and training for the team to support them to understand attachment relationships with their clients, particularly in setting boundaries and planning for endings.
Grace	I would not explicitly use the categories with clients, rather, I use the concepts more broadly to help people contextualise their current difficulties with early and previous relational and traumatic challenges. I would look with clients at how their relationship to self and others has been informed by early relationships, with a focus on safety. I would also look at 'threat responses' or strategies that people use which may no longer serve them, and orient these to the past and how these strategies may have developed to help the client, as a child, manage attachment and help them survive.
Hazel	I try to keep attachment relationship in mind with all clients I work with and will often talk about early relational patters and how they affect our later relationships when formulating with people. I tend not to use the term attachment as I think they often simplify things for individuals. it is always useful to have in mind, however. I will often ask other professionals I'm working with as well to help them think about people they are seeing and what the attachment difficulties might be.
Vicky	The idea that early relationships shape templates that shapes a persons' expectations and predictions of other. Relationships is a central assumption I hold. I draw on this when I am thinking about TCT features of the relationships.
Helena	I don't usually categorise clients, but I use attachment theory to help clients to think about their patterns of responding in relationships and linking that to their earlier experiences. I also provide some education around attachment emotions (i.e., pain, anger, guilt, love, grief). I draw on the principles of what it takes to provide a safe base for the client, e.g., reliability. I also use attachment theory when reflecting on a client's relationship with me and how they respond to something like me taking a break or endings e.g., anticipating rejection, trying to please and again may think with them about how this is linked to their early caregiving experiences.
Zoe	Broadly in terms of safety and containment etc Use modern attachment ideas more (e.g., Affect Regulation Theory – Schore)
Violet	I use attachment theory to formulate and help understanding children and young people in my clinical work, particularly those with early developmental trauma.

Appendix K: CP's Understanding of their Own Attachment

Participant	Demographic questionnaire answer
Sarah	I find the categorised attachment organisations slightly reductive as they don't capture the nuances of experience. I would say that I have a secure attachment style but that of that I am probably on the avoidant end of the spectrum in that my family don't really talk about emotions and times when I have been struggling I've tended to play this down to protect my parents from worry even though I know they would want to help.
Olivia	Secure and perhaps slightly avoidant when experiencing a stressful life event.
Mia	Anxious
Sophia	Secure - in the past avoidant
Emily	Secure
Ella	Insecure ambivalent
Grace	Secure
Hazel	Insecure-avoidant with security and some anxiety-ambivalence
Vicky	Predominantly secure
Helena	Anxious
Zoe	Largely secure with some anxious traits
Violet	Generally secure, perhaps some insecure traits (mostly avoidant)

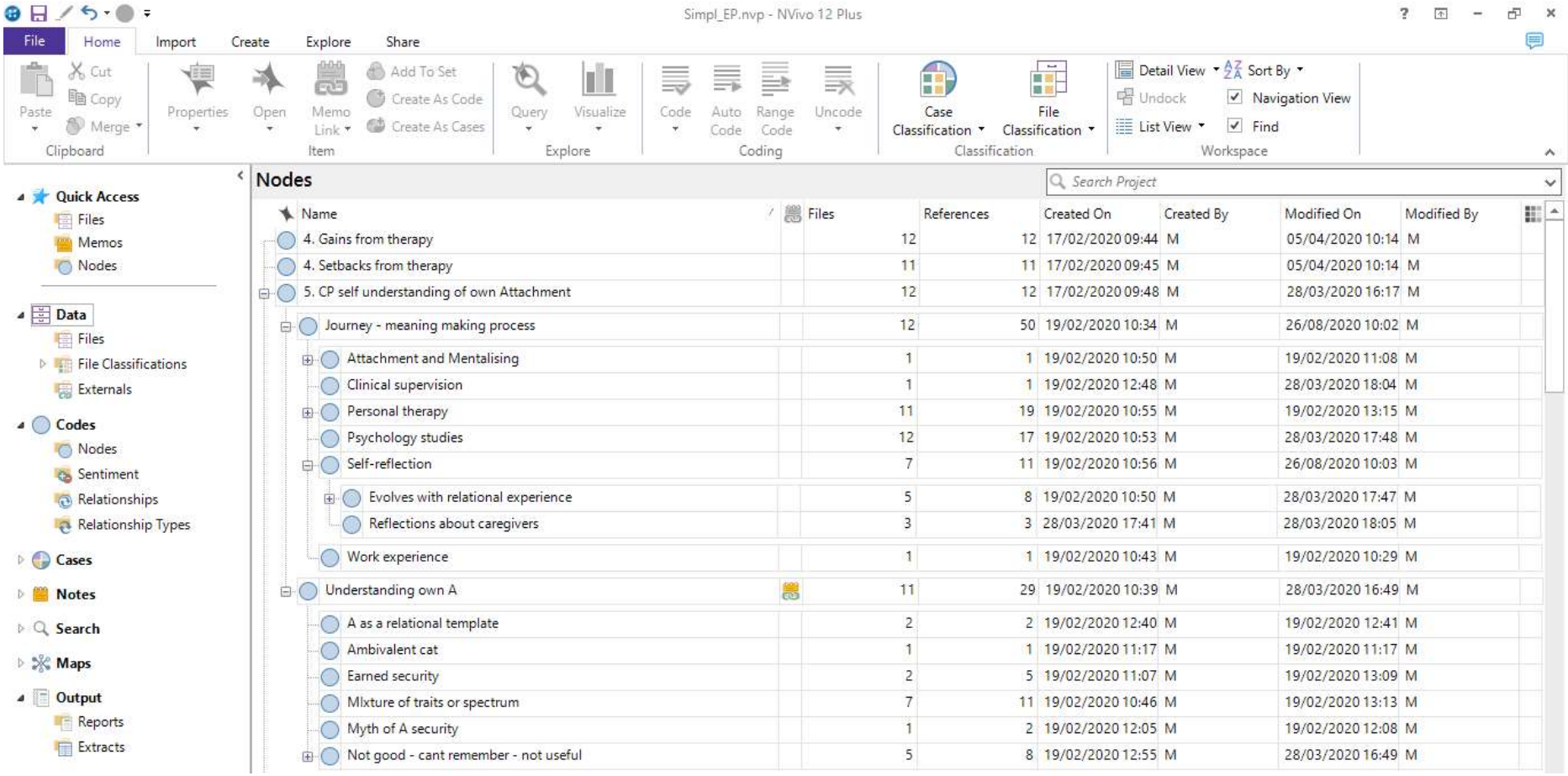
Appendix L: Words Describing the Relationship with Therapists

Table 7.

Adjectives Used to Describe the Relationship with their Therapists

Adjective	Frequency
Warm	6
Open/open-genuine	5
Non-judgemental	3
Safe	3
Challenging/Honest-challenging	3
Holding	2
Caring	2
Comfortable	2
Humorous	2
Distant	2
Reflective	1
Close	1
Mutual fondness	1
Gentle	1
Committed	1
Helpful	1
Nurturing	1
Insightful	1
Supportive	1
Trusting	1
Reflective	1
Intimate	1
Annoying	1
Anxiety-provoking	1
Stretching	1
Growthful	1
Positive	1
Secure	1
Strong	1
Difficult to end	1
Healing	1
Awkward	1
Inconsistent	1
Directive	1
Needy	1
One-sidedness	1
Ambivalent	1
Personal	1
Kindness	1
Empathic-understanding	1

Appendix M: Example of Data Analysis



5. CP self-understanding of own Attachment		12	12	17/02/2020 09:48	M	28/03/2020 16:17	M
Journey - meaning making process		12	39	19/02/2020 10:34	M	20/08/2020 18:19	M
Attachment and Mentalising		1	1	19/02/2020 10:50	M	19/02/2020 11:08	M
Narrative understanding of own A		4	4	19/02/2020 10:33	M	19/02/2020 12:23	M
Psychology studies		12	17	19/02/2020 10:53	M	28/03/2020 17:48	M
Personal therapy		11	19	19/02/2020 10:55	M	19/02/2020 13:15	M
Taking Therapist in as object - ask EW		1	1	19/02/2020 11:17	M	19/02/2020 11:17	M
Self-reflection		7	11	19/02/2020 10:56	M	28/03/2020 17:48	M
Evolves with relational experience		5	8	19/02/2020 10:50	M	28/03/2020 17:47	M
Working with clients		2	2	19/02/2020 12:09	M	28/03/2020 17:35	M
Reflections about caregivers		3	3	28/03/2020 17:41	M	28/03/2020 18:05	M
Clinical supervision		1	1	19/02/2020 12:48	M	28/03/2020 18:04	M
Work experience		1	1	19/02/2020 10:43	M	19/02/2020 10:29	M
Understanding own A		11	29	19/02/2020 10:39	M	28/03/2020 16:49	M
A as a relational template		2	2	19/02/2020 12:40	M	19/02/2020 12:41	M
Ambivalent cat		1	1	19/02/2020 11:17	M	19/02/2020 11:17	M
Earned security		2	5	19/02/2020 11:07	M	19/02/2020 13:09	M
Mixture of traits or spectrum		7	11	19/02/2020 10:46	M	19/02/2020 13:13	M

Myth of A security		1	2	19/02/2020 12:05	M	19/02/2020 12:08	M
Not good - can't remember - not useful		5	8	19/02/2020 12:55	M	28/03/2020 16:49	M
A as oversimplified-overcomplicated		2	2	19/02/2020 12:19	M	28/03/2020 18:05	M

Appendix N: Reflexivity

As an educational psychologist and trainee CP, I have had a keen interested in child social and emotional development and AT and its clinical implications. I have often found AT difficult to grasp and have been unclear and intrigued about my own attachment and how it is triggered in my clinical practice. This research was driven by my motivation in understanding and improving my practice and my commitment to personal development through psychodynamic PT. Alongside my research activity I have taken to my PT questions and emotions resulting from my engagement in the research. Hence, this research is about CPs, but it is also about myself as a developing CP. In doing this, and through my research, I have experienced taking that meta-reflective position and thinking about my interaction with others research participants and clients, observing my triggers and being more mindful and aware of the relationship with my mentalizing abilities.

Talking about attachment involved taking about intimate relationships and representations of self and others. Through the interview participants connected with vulnerable parts of themselves and so did I. I adopted an intersubjective reflexive stance to connect to the-here-and-now of interviews and experience participants emotions as well as my own. The relational interplay between researcher-participant was our object of study, and therefore constituted a source of information. During interviews I often felt I had to be attuned to participants' emotional experience as we progressed through the interview; and felt a constant tension between my researcher-self -wanting to know more, ask further questions- and my clinician-self - wanting to keep participants safe by not tapping further on participants' vulnerability. This inevitably had implications for the data that was elicited. Interviews often left me feeling confused, not knowing where the research was heading, with a sense of

incompetence when talking about attachment; and inspired and motivated when reflecting about the clinical practice.

Participants were all female and of a similar age as me. However, I am a trainee CP and English is my second language. All participants were qualified CPs and English was their first language. These two aspects placed participants in a position of relative power in respect to me. At times, some felt a bit worried to come across as not ‘perfectly knowledgeable’ about AT, in contrast to me the researcher which was seen as well versed in the theory. I did not feel like this most of the time. I worked with this dynamic by anchoring the interviews on their subjective experience rather than the theory in itself and taking a position of curiosity from where we could both learn about their experience of PT and how that might relate to their understanding of their attachment and clinical practice. Despite my efforts to put them at ease, it might have been difficult for participants to show negative parts of themselves.

Appendix O: Dissemination Statement

Dissemination to participants. Participants will be sent an executive summary of the research.

Dissemination to professionals. Findings will be disseminated through ResearchGate and via the British Psychological Society Division of Clinical Psychology Forum.

Journal submission. The researcher will aim to publish in an academic journal the findings of the research: the literature review will be submitted to Psychotherapy Research or the British Journal of Psychotherapy; the empirical paper will be submitted to Journal of Clinical Psychology.