

**How do Clinicians adapt Cognitive Analytic Therapy to Work with Adults with Avoidant and Anxious Attachment Styles? A Qualitative Study**

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### **Abstract**

This is a qualitative investigation of how experienced clinicians adapt Cognitive Analytic Therapy (CAT) to work more effectively with clients who demonstrate avoidant or anxious attachment styles. Clinical vignettes were devised and validated to conceptualise the attachment styles and these were used as prompts in interviews exploring what therapy adaptations were made.

An inductive Thematic Analysis was used as the method of qualitative analysis to examine the themes that emerged. The following themes came from the data: *Creating achievable interpersonal and intrapersonal therapeutic goals*, *Achieving optimum affect for therapeutic work*, *Achieving optimum relational distance for therapeutic work* and *Focusing on anticipating and resolving ruptures*. These themes are discussed with theoretical and clinical implications in mind as well as an evaluation of study methodology.

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## **1.1. Rationale and outline of chapter**

This study is a qualitative study of the adaptations to therapy that Cognitive Analytical Therapists (CAT) make when working with clients with anxious and avoidant attachment styles. The chapter begins by reviewing the literature on attachment theory, its utility and its application in clinical practice. The CAT model is described and its relationship with attachment theory is explored. The dimensional model of attachment will be presented alongside an understanding of how this maps onto clinical presentations. Finally, the rationale for this research project is presented.

## **1.2. Attachment Theory Overview**

Attachment theory (Bowlby, 1969, 1988) proposes that the way in which an infant uses the availability of their primary caregiver for support, protection, and comfort in times of distress, and uses their caregiver as a secure base to explore the world when not in distress. The theory postulates that early patterns of interactions with caregivers become internalised as working models, which guide future interactions and close relationships (Bowlby, 1969, 1982a; George, Kaplan, & Main, 1984; Hazan & Shaver, 1987, 1990; Mikulincer & Shaver, 2010). In addition, these early patterns of relating influence adult emotional regulation, distress tolerance and vigilance to threat (Holmes, 1993).

### **1.2.1. Infant attachment**

Bowlby's theory of attachment describes a biologically-based system which maintains infant/carer proximity in order to promote survival (Bowlby, 1969). When caregivers are sensitive and responsive, infants experience this as a secure base where physical security, nourishment and comfort are available. In these circumstances, the infant is soothed and comforted, a representation of the secure base is internalised, and the infant can safely explore the world (Bowlby, 1969). However, if the caregiver is not perceived to be available and responsive, children may feel anxious about their physical and emotional security. In such cases, infants can respond by either anxiously remaining close to the caregiver and avoiding exploration or becoming detached and avoiding seeking protection from the caregiver (Bowlby, 1969).

Originally, Bowlby drew upon observational studies (e.g. Robertson & Bowlby, 1952; Robertson, 1953b; Heinicke, 1956) to demonstrate the short-term and longer-term effects of early

separation from caregivers. Bowlby (1969) categorised the sequence of behaviours observed in infants who are separated from their caregiver into “protest, despair and detachment”.

Ainsworth and Bell (1970), Ainsworth, Bell and Stayton, (1971) and later, Ainsworth, Blehar, Waters and Wall (1978) operationalized Bowlby’s theory by measuring and categorising the attachment behaviour of infants when separated from and reunited with their caregivers. This was performed using an experimental procedure known as the ‘Strange Situation’ (Ainsworth & Bell, 1970), which produced a systematic categorisation of the observed behaviour of 12-18 month old infants who were separated from their caregivers. Records were made of the infants’ response to separation from the caregiver, exploration of the environment, reunion behaviour, and reaction to the presence of a stranger. Infants were categorised as secure, insecure avoidant and insecure ambivalent. A fourth category was later identified by Main and Solomon (1986; 1990) and labelled as disorganised.

Observations by Ainsworth and Bell (Ainsworth, Bell & Stayton, 1971; Ainsworth, Blehar, Waters & Wall, 1978) corroborated Bowlby’s (1969) theory that responsive care giving would be associated with secure attachment behaviours in infants. Conversely, insecure avoidant behaviours and insecure ambivalent behaviours were observed in infants who had received care that was insensitive or dismissive of their needs, and insecure disorganised behaviours were observed in infants who received inconsistent care.

### **1.2.2 Adult attachment**

Bowlby used the concept of the internal working model to refer to the expectations of self and other which are derived from these early relationships and which inform future attachment behaviour in adult relationships (Bowlby, 1969). He believed that early attachment experiences would affect the security of relationships and form the basis of the internal working model, including patterns of cognition, attention, behaviour and emotion that remain constant across the life course (Holmes, 1993). Loss and trauma particularly within early attachment relationships can pose a serious threat to the infant’s sense of self and impact on their internal working model of relationships (Bowlby, 1969, 1973, 1988). Consequently, behaviours learnt in childhood that hyper-activate or deactivate care in others are present in adulthood (discussed further in section 1.3) but can be revised depending on life stresses and the quality of key relationships (Waters,

Merick, Treboux, Crowell & Albersheim 2000; Weinfield, Sroufe & Egeland 2000). Researchers have developed interviews and self-report models that aim to classify and identify these adult attachment styles. The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984) is an hour-long semi-structured interview. The questions are devised to assess states of mind regarding the self and caregivers. Consequently, the coding system relies on the way a person speaks about their childhood rather than what is said (Hesse, 1999b). Interpreting the interviews entails looking for evidence of coherence, idealisation and denigration to categorise attachment as 'secure', 'preoccupied', 'dismissive', 'unresolved' and 'can't classify' (Main and Soloman 1986). It has inter-rater reliability of 75-100% and after extensive training (> 12 months) has good test-retest stability of 77% (Bifulco & Thomas, 2013).

There are also self-report measures of adult attachment which work on measurements of attachment anxiety and avoidance and can be characterised using categorical vignettes or dimensional scales. Adult self-report measures of attachment are based on one's behaviour in romantic partnerships; these will be explored in section 1.4.

### **1.3. Attachment Issues and Mental Health Problems**

As described by the internal working models theory, early patterns of relating impact on adult emotional regulation, distress tolerance and vigilance to threat (Holmes, 1993) and therefore influence the development of psychopathology (Shorey & Snyder, 2006; Surcinelli, Rossi, Montebanocci, & Baldaro, 2010). Adults with a secure attachment have a more positive self-image, believe that they are worthy of love, experience others as available and trustworthy (Bartholomew, 1990; Cassidy, 1994; Gumley, Taylor, Schwannauer, & MacBeth, 2013) and are less likely to have contact with mental health services (Dieperink, Leskela, Thuras, & Engdahl, 2001; Mikulincer & Shaver, 2007).

MacBeth, Gumley, Schwannauer, and Fisher (2010) found that patients in the early phase of a first episode of a psychiatric disorder and those who experience a chronic psychiatric disorder display high rates of insecure attachment styles compared to the general population (ambivalent and avoidant; 73.6% and 90.5% respectively). Insecurely attached adults are less likely to develop successful, satisfying, and positive relationships with others than those who had secure attachment and are more vulnerable to poor mental health due to cognitions that make them more vulnerable to

the effects of stress (Goodwin, 2003, Shaver & Mikulincer, 2011) and less able to regulate their emotions (Mikulincer, Florian, & Tolmacz, 1990). Mikulincer (1998) describes how emotional regulation is difficult for people with anxious and avoidant attachment styles.

People with avoidant attachment styles try to diminish the impact that stressful events have on them by defensively downplaying the effects (Bowlby, 1988; Kobak, Cole, Ferenz-Gillies and Fleming, 1993). This includes compulsively trying to be emotionally self-sufficient and minimising the importance of stressful events and relationships. They do this by inhibiting expressions of distress by relying on defence mechanisms of repression and dissociation (Collins & Read, 1990; Shaver, Collins, & Clark, 1996). Collectively these are referred to as de-activating strategies.

People with anxious attachment styles attempt to demonstrate the maximal impact of stressful events by expressing emotions in an extreme way in order to keep others close. This can be done by means of clinging, hyper vigilance to distress/rejection or controlling behaviours. These strategies are collectively known as hyper-activating and they prevent the person from distancing themselves from stress, both cognitively and emotionally (Mikulincer & Florian, 1997).

In addition to this, people with insecure attachments are more likely to develop unhelpful coping strategies in the form of substance abuse, dissociation or self-harm (Felittiet al., 1998; Chapman, Gratz, & Brown, 2006; Liotti, 2004). Evidence supports that people with disorganised attachment are over-represented among populations of personality disorders (Lyons-Ruth 2003; Lyons-Ruth, Ditra, Schuder & Bianchi. 2009; Liotti, Cortina & Farina, 2008) which require highly specialised treatments (Morken, Karterud & Arefjord, 2014, Bateman & Fonagy 2004).

### **1.3.1. Therapist as Attachment Figure; Specific Attachment to Therapist**

Bowlby believed that the therapeutic relationship could repair early attachment inadequacies. He saw the therapists' role as equivalent to that 'of a mother who provides her child with a secure base from which to explore the world' (Bowlby, 1988:140). Part of the world to be explored is, of course, the emotional one where the client can review past and present relationships. Therapists can act as attachment figures if they fulfil the specific and defining functions of an attachment figure (Ainsworth, 1991; Hazan & Shaver, 1994). Characteristics of an attachment relationship include, firstly, the urge to seek and maintain close proximity, secondly using the attachment figure as a safe haven of emotional and physical comfort when one is in distress, and

thirdly using the attachment figure as a secure base from which one can explore and develop, secure in the knowledge that one can return. The fourth characteristic is the experience of separation anxiety when it appears that the attachment figure is unavailable and finally that the attachment figure is regarded as stronger and wiser (though this is not always essential for adult attachment). These five elements are paralleled in the psychotherapy relationship (Daniel, 2006; Obegi & Berant, 2009).

### **1.3.2. Attachment and Therapy**

The number of studies examining the effect of attachment on therapy has afforded enough data for substantial systematic reviews and meta-analyses of the topic. This important work has examined the relationship of attachment orientation at the beginning of treatment with attachment style at the end of treatment (Taylor, Rietzschel, Danquah & Berry 2014), with the therapeutic alliance (Bernecker, Levy & Ellison, 2013) and with therapeutic outcome (Levy, Ellison, Scott and Bernecker, 2011).

Taylor et al. (2014) completed a systematic review of studies that examined if client attachment styles changed over the course of therapy and specifically investigated whether psychotherapy can provide experiences that cause a shift toward a more secure attachment style. The review demonstrated that in 10 out of 14 studies, attachment security increased and attachment anxiety decreased following therapy. However, no conclusions could be drawn about avoidance. This pattern was consistent across different methodologies, patient groups, therapeutic approaches, therapy settings and varying levels of study quality.

Bernecker et al., (2013) completed a meta-analysis which synthesized studies that examined the relationship between patient attachment style (in adulthood) and patient-rated working alliance. Twenty-four studies were used (twelve published in peer-reviewed journals and twelve unpublished doctoral dissertations) all of which included a measure of attachment and of alliance with the therapist, which produced 1321 participants. Results found that the mean weighted  $r$  for the correlation between attachment avoidance and alliance was  $-.137(p<.001)$ , and the mean weighted  $r$  for the correlation between attachment anxiety and alliance was  $-.121 (p<.001)$  demonstrating that higher avoidance or higher anxiety in attachment style led to weaker rated alliance. Bernecker et al., acknowledged that there could be many unknown variables influencing

the alliance including symptom severity, social cognitive factors, interpersonal skills and mentalisation abilities (Fonagy, Gergely, Jurist, & Target, 2002). These factors may impact on the client's ability to communicate and set goals which may influence rated alliance, although this requires further investigation.

Levy et al., (2011) completed a review of three meta-analyses examining the relationship between attachment style and therapy outcome. The data of a total of 1,467 participants were included in the analysis and this involved a combination of 19 cohorts from 14 studies. The correlation between attachment anxiety and post-therapy outcome had an effect size (Cohen's *d*) of -.46 and the correlation with attachment security showed a mean weighted *d* of .37 associations with outcome. In this meta-analysis, anxious attachment styles had a negative effect on therapy outcome, attachment security had a demonstrably positive effect on outcome, and attachment avoidance did not have a significant negative effect on therapy outcome (although some individual studies within the analysis demonstrated this). Although avoidance did not show as correlating with outcome in this meta-analysis, it is important to acknowledge that there is evidence to support that participants with avoidant attachments were more likely to drop out of therapy in populations of patients with eating disorders (Tasca, Taylor, Bissada, Ritchie & Balfour, 2004) and substance misuse programs (Fowler, Groat, & Ulanday, 2013). Fonagy, et al., (1995) found that clients classified as fearfully preoccupied were also more likely to drop out of therapy.

Clients with insecure attachment styles can be challenging to manage in a therapy setting as this can bring up relational difficulties. There has been interest in whether having more experience as a therapist is related to better outcomes. Stein and Lambert (1995) conducted a meta-analysis of 36 studies which supported that more experienced therapists have fewer dropouts and better outcomes in therapy (modest effect sizes: mean weighted effect size was .00, *SD*= .40; unweighted effect size= -.01, *SD*= .38). There are also contradictory findings with some studies demonstrating that more experience does not lead to better outcomes compared to novice therapists (Budge, Owen, Kopta, Minami, Hanson, & Hirsch, 2013; Minami, Wampold, Serlin, Kircher & Brown, 2009; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Brown, 2005).

Beutler (1997) describes that the relationship between experience and outcome is difficult to explore due to the vast number of confounding variables such as severity of symptoms, type of therapy, adherence to manual versus absence of manual, time in therapy and number of sessions. Additionally there are differences between studies in measurement of outcome and therapist experience as some studies focus on qualification, therefore a doctoral qualification would be rated higher than a counselling degree regardless of years of experience. Another confounding variable is that in practice, more experienced therapists will take on more complex cases which may lead to them having higher chances of dropout or acute hospital admissions that will disrupt therapy.

#### **1.4. Adult attachment: Categorical versus Dimensional models**

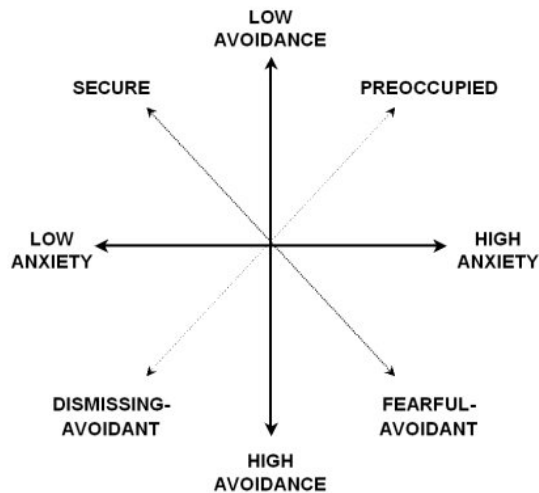
Researchers have developed interviews and self-report models and measures that aim to identify adult attachment styles and there have been debates as to whether attachment difficulties are best represented as distinct categories or as a continuum of traits (see Bifulco and Thomas (2013) for a review). This section will describe both the categorical and dimensional models as well as the methods used to measure them.

##### **1.4.1 The Categorical Model**

Self-report categorical measures are represented by vignettes, where the individual reads the vignette and chooses which is most representative of themselves. The first was the Adult Attachment Questionnaire (AAQ) by Hazan and Shaver (1987). This used the categories defined by Ainsworth which are secure, anxious and avoidant attachment. This has been built on with the addition of a fearful vignette in the Relationship Questionnaire (RQ) by Bartholomew and Horowitz (1991) and in the RQ- Clinical Version (RQ-CV) by Holmes and Lyons-Ruth (2006) who contributed a severely mistrustful vignette. The data on which the RQ and RSQ was based on was drawn out as a dimensional model (Bartholomew, 1990) which is represented in Figure 1 (below).



**Figure 1: Adult attachment types by anxiety and avoidance, adapted from Bartholomew (1990), Mikulincer and Shaver (2007)**



#### 1.4.2. Critique of the Categorical Model

As the field of attachment theory has developed, there has been a general move away from a categorical model of attachment style to a dimensional one (Griffin & Bartholomew, 1994, Fraley & Waller, 1998.). This is because it can be argued that categorical classification is too restrictive, prohibiting an exploration of gradation in attachment style (e.g., Simpson & Rholes, 1994; Simpson, Rholes, & Nelligan, 1992). Categorical measures discard valuable information about individuals as one has to select an attachment vignette to account for how they behave in all of their relationships, when attachment may be more or less active depending on the strength of relationships making the category approach less valid.

Within the categorical approach, more categories have been added over time, with the Dynamic Maturational Model (Crittenden, 2005) having twelve categories, supporting that attachment is too complex to be captured in specific categories and so more have been added to account for this, but this loses meaning for researchers, clinicians and clients. It could be argued that attachment itself is dimensional, therefore should be measured in a continuous way (Mikulincer and Shaver, 2007), otherwise the categories we use are not valid or reliable (Cohen & Cohen, 1983).

More recently researchers have used complex statistical taxometric methods (Meehl and Yonce, 1994, 1996) to determine if attachment is continuous or better described in distinct categories (Beauchaine, 2007). Evidence was found to support a continuous model rather than a

categorical one (Fraley & Waller, 1998; Fraley & Speiker, 2003; Roisman, Fraley, & Belsky, 2007; Fraley & Roisman, 2014; Fraley, Hudson, Heffernan, and Segal, 2015) which accounted for individual differences in both parent and peer relationships (Fraley, Hudson, Heffernan, and Segal, 2015). Ruscio (2014) acknowledges that even in tentative circumstances attributing a continuous model rather than a categorical one will do less harm to psychological research as dimensions can be mapped on to categories at a later date but categories cannot be mapped on to dimensions.

#### **1.4.3. The Dimensional Model**

The Adult Attachment Scale by Simpson (1990) was the first measure to use a Likert scale (seven points). The Relationship Style Questionnaire (RSQ; Bartholomew and Horowitz, 1991) came shortly after and is a 30-item self-report questionnaire using five point Likert scales with a test-retest reliability range of 0.49-0.71 (Bifulco and Thomas, 2013). Later came the Experience in Close Relationships Scale (ECR; Brennan, Clarke & Shaver, 1998) which is a 36-item, self-report, using five point Likert scales. Brennan et al., (1998) conducted a meta-analysis which included items from all of the available self-report measures of adult attachment including items from conference presentations. This totalled 14 measures with a total of 60 subscales and 323 items. The subsequent factor analysis identified two relatively orthogonal dimensions that were labelled Anxiety and Avoidance by Brennan et al., (1998). The 18 items among the 323 that loaded highest on each of these two factors were retained to form the Experience in Close Relationships-Revised (ECR-R, Fraley, Waller and Brennan, 2000). The ECR-R used items from the ECR, the Adult Attachment Scales (Collins and Read, 1990), Relationship Styles Questionnaire (Bartholomew and Horowitz, 1991) and Attachment Scales (Simpson 1990) and found that the ECR-R, with its two factors of Anxiety and Avoidance, had the best psychometric properties. Its internal consistency is alpha 0.90 demonstrating its reliability (Bifulco and Thomas, 2013).

#### **1.4.4. Advantages of using a Dimensional Model**

The dimensional model has greater research and clinical utility, and it is also more pragmatic in research and clinical settings, and avoids the difficulties of using a categorical model (see above).

Dimensional measures can be used to track therapeutic change as they can measure the degree of change in attachment style across a therapy, whereas a categorical measure will only

measure transition from one category to another, for example from insecure avoidant to secure, which makes it less sensitive and which is possibly also an unrealistic therapeutic goal. A dimensional model is more ecologically valid for clinicians as although most therapists will be aware of attachment ideas, many may struggle with keeping distinct categories in mind.

The dimensional model may also have greater clinical utility in terms of conceptualising and formulating clients, particularly as clinicians are not routinely trained in the AAI and other categorical systems which all require a high level of training to achieve reliability.

Perhaps the greatest advantage of the dimensional model is from a research perspective. A fully dimensional measure allows for greater flexibility of research design, for example, correlational studies, the use of simple parametric statistics rather than complex multivariate ones, and smaller N designs to achieve the necessary power.

#### 1.4.5. Mapping the Categorical Model onto the Dimensional

Bifulco and Thomas (2013) describe that terms are changed depending on whether the measure uses categorical or dimensional measures of insecurity which can make comparing attachment measures difficult, but nonetheless the correlations between different attachment self-report measures and between self-report and interviews are modest but significant (Bartholomew and Shaver, 1998; Stein, Jacobs, Ferguson, Allen, & Fonagy, 1999; Bifulco, Mahon, Kwon, Moran & Jacobs, 2003). Table 1 shows the different terms used by different measures.

**Table 1: Measures and Terms used to describe Insecure Attachment**

Measure		‘Anxious’ term used	‘Avoidant’ term used
<b>Dimensional</b>	Experience in Close Relationships scale	Anxious	Avoidant
	Relationship style questionnaire	Preoccupied	Dismissive avoidance & fearful avoidance
	Adult Attachment Scale	Anxious	Avoidant
	Vulnerable Attachment Style questionnaire	Fearful	Dismissive
<b>Categorical</b>	Adult attachment Questionnaire	Preoccupied	Dismissive
	Relationship Questionnaire	Preoccupied	Dismissive
	Relationship Q- Clinical version	Preoccupied	Dismissive

Bartholomew (1990) conceptualised a way of mapping dimensional models onto categorical models using a scale of avoidance and anxiety in attachment style to represent secure, preoccupied anxious (similar to ambivalent, Ainsworth and Bell, 1970), avoidant and fearful avoidant (see Figure 1 above) when developing the Relationship Scale Questionnaire (RSQ, Bartholomew and Horowitz, 1991).

Based on descriptions from the above measures of adult attachment, the classes are described by Howe (2011, p 63-64) as follows:

Individuals classified as secure in their attachments are generally comfortable with intimacy and autonomy. Self-esteem, confidence, motivation to achieve goals, trust in others and cooperate, are high. This group would agree with the statement; “It is relatively easy for me to become emotionally close to others. I am comfortable depending on others and having others depend on me. I don't worry about being alone or having others not accept me”.

Individuals classified as dismissive/ avoidant in their attachments tend to value autonomy but are uncomfortable with intimacy and may dismiss it as unimportant. Achievements may well be valued more than relationships. This group would agree with the statement; “I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me”.

Individuals classified as preoccupied/ anxious in their attachment styles will tend to seek intimacy but autonomy makes them feel anxious. This group are preoccupied with relationships to the point of clinginess and self-esteem is low. This group would agree with the statement; “I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them”.

In some cases, individuals will be classified as fearful (anxious) avoidant, this represents someone who will switch between the styles of preoccupied and dismissing. This group would agree with the statement; “I am somewhat uncomfortable getting close to

others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I sometimes worry that I will be hurt if I allow myself to become too close to others”.

#### **1.4.6 Critique of Attachment Theory**

Attachment theory has been criticised for neglecting the impact of other relationships in the child’s life other than that with a primary caregiver such as relationships with siblings or grandparents but that influence the child’s way of relating to others. Field (1996) adds that it is reductionist to focus on the moments of separation to categorise attachment rather than on consistent, daily interactions. But it must be remembered that attachment behaviours are activated during in times of distress which is why they are so prevalent when one engages in therapy. The belief that attachment can be measured at all has also been questioned as there may more implicit signs of arousal that may be missed (Field, 1996).

Harris (1998) discusses that attachment theory is flawed because it assumes cause and effect. Yet we know that very loving parents can have children that grow up to be cruel or violent and vice versa. She believes that the confusion here stems from misinterpretations of the terms nature, nurture and environment. Nature refers to the child’s genetics which includes elements of stimuli response based on sensitivity of the central nervous system. Nurture refers to the way you are parented and would include the behaviours and responses that we class as attachment. Environment includes your wider environment and peer group. Harris refers to the misunderstanding between nurture and environment as the nurture assumption, giving the example that during teenage years children value fitting in with their peers more highly than fitting in with their parents and so may commit crimes, bully, and show aggression despite not being parented in this way. This perspective gives an account of how personality is formed whereas attachment is a model for relationships rather than of personality.

Burman (1994) adds a socio-political context as to why theories of attachment and primary care giving came into focus at the time they did; following the Second World War when many women had joined the labour force for the first time. Burman discusses that attachment theory was used to drive women back to household labour and re-establish pre-war gender divisions of labour by using attachment theory as evidence that separation could be damaging to children. Overtime the term

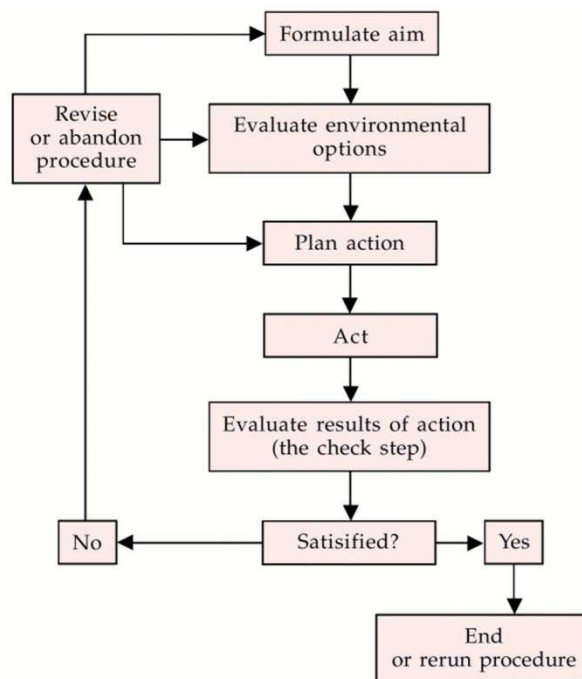
primary caregiver has been used but at first it was the mother that was referred to and indeed the strange situation experiments were all conducted with mothers.

### 1.5 Cognitive Analytic Therapy (CAT)

Developed by Ryle in the 1970's to be a short term intervention drawing on cognitive theory and personal construct theory (Kelly, 1955, 1963), Ryle focused on the concept of using the 'man as a scientist' in that people need to make sense of their experiences and the world they live in. Psychoanalytical ideas, such as transference and object relations theory were also used to form an integrative approach to help clients to understand their difficulties in terms of relating to themselves (intrapersonal relationship) and others (Ryle and Kerr, 2002).

The underlying theory of CAT is based on the Procedural Sequence Model (PSM: Ryle 1990). A procedural sequence will include a description of the individual's active involvement with their environment, their appraisal of their involvement, their context-specific goals and the way they try to achieve them, their expectations of their ability to achieve these goals and the outcome of this. Additionally, factors such as the means available to the person, their evaluation of situations and consequences, and then later whether this brings satisfaction or a need to revise or abandon the procedure (Ryle, 1991). This is represented pictorially by Denman (2001) below:

**Figure 2: Pictorial representation of the Procedural Sequence Model by Denman (2001)**



Denman (2001) discusses that many clients have difficulty in 'revising faulty procedures' and that they have a 'restricted repertoire of procedures'. Ryle (1985, 1990, 1995b) described the difficulty in revising faulty procedures as repeated 'traps' and 'snags' and 'dilemmas'. These are the basis for the psychotherapy file which is a questionnaire given early on in therapy at the reformulation stage to identify the patterns the client replicates in their interactions. The PSM was later adapted to become the Procedural Sequence Object Relations Model (PSORM, Ryle, 19982, 1985, 1990), this introduced the concept of Reciprocal Roles, and these describe the roles we take in relationships with others and with ourselves. These roles are thought of as deriving from early relationships with caregivers and as influencing patterns of relating in later relationships. These can be helpful, such as 'loving to loved' or unhelpful, for example 'criticising to feeling criticised'. The reciprocal roles are used actively to understand, observe and name what is happening within the therapeutic relationship

The repertoire of procedures and roles are identified, they are then shared with the client using the reformulation letter and then represented in a visual form with the Sequential Diagrammatic Reformulation (SDR). When related to the clients' difficulties they are referred to as Target Problem Procedures (TPP). New ways of responding (or 'exits' in CAT terminology) are found during the working stages of therapy.

Typically CAT is offered as 16 or 24 weekly, hour long sessions. The *reformulation phase* of therapy takes place at the beginning. This is a time of assessment and information gathering, focusing on how the clients' earlier life experiences and relationships maintain their current difficulties. The client will complete a psychotherapy file which is a CAT-specific tool (described previously) which will be used with other information to identify TPPs and Reciprocal Roles.

After 3-6 sessions the clinician will then write a 'reformulation letter' which is a comprehensive description of the Reciprocal Roles, the TPPs and anticipated ruptures in therapy or issues with ending. The reformulation letter is generally written in a warm and containing way, summarising the client's early experiences, and linking these to the current presenting problems, as well as thinking about how patterns of relating might get acted out within the therapy and towards the ending.

During the *recognition phase*, the clients' problems are drawn out in a diagram called the Sequential Diagrammatic Reformulation or SDR (often referred to as the map). The SDR names the client's Reciprocal Roles and TPPs and shows how these may be self-limiting and how they may link together. Clients may be asked to complete daily records or rating sheets so that they are aware of the patterns playing out in their real life contexts.

During the *revision phase*, clients develop 'exits' from their TPPs which will focus on adapting, changing or thinking about things differently. Interventions from a variety of different models may be used to support the client in doing this; the exits will be added to the SDR. Finally, at the end of therapy, both the client and therapist write a goodbye letter which they read to one another. The goodbye letter is a realistic summary of the work that has been done in therapy and will review the patterns from the diagram, the client's recognition and any revisions made. It will also discuss the clinicians' experience and discuss the ending. The letter tends to be given in either the final or penultimate session and clients are also invited to write the clinician a goodbye letter.

There has been one randomised control trial of CAT by Clarke, Thomas and James (2013) which found that compared to treatment as usual, 24 sessions of CAT was a more effective treatment for clients with personality disorder. Improvements were seen in reduction of symptoms (DSM-IV) and improved scores on outcome measures for interpersonal difficulties. This study was underpowered and requires repetition but gives encouraging introductory results, particularly because it took place in a naturalistic setting.

### **1.6. CAT and Attachment Theoretical links**

Winnicott said "there is no such thing as a baby" (1952: 99) to conceptualise the essential role of the parent in survival and development. Dialogic refers to the interplay between two parties using language to gain a shared understanding. Reciprocal role procedures develop from internalising experiences with caregivers; these evolve over time as the signs and symbolic communication between infants and caregivers increase in a dialogical way (Leiman, 1992; 1994b; 1995; Ryle, 2001). Reciprocal roles and the concept of dialogical understanding have many similarities to Bowlby's concept of the Internal Working Model, as they both emphasize the importance of internalising the way care is given and received, then repeated in later relationships.

### **1.7. CAT and Attachment Theory Literature**



A literature search was conducted in November 2014 to find papers that explore both attachment theory and CAT (please see Appendix A: PRISMA 2009 Flow Diagram-CAT and Attachment). There were only three published papers in peer-reviewed journals on CAT and attachment all by Jellema (1999, 2000, and 2002).

Jellema (1999) drew comprehensive links between attachment theory and CAT and argues that CAT is a partially integrated theory, listing its influences and evolution over time. Jellema (2000) uses the work of Crittenden (1997b) to demonstrate differences in information processing for ‘cognitive’, seemingly sequential information, encoded as cause and effect (even if it is not in reality) that can be retained to aid survival in ‘dangerous’ situations. This is compared to ‘affective’ information which is delivered when situations elicit feelings of anxiety, comfort and safety (initially processed by the limbic system). These strategies of information processing are applied to attachment theory to plot attachment style development in individuals; avoidance is a ‘cognitive’ (think) rather than ‘affective’ (feel) strategy attachment anxiety is a feel rather than think strategy (Crittenden, 1995a).

Traditional Reciprocal Roles may miss patterns of behaviours for anxious or avoidant clients due to the intensity or near absence of the expressed affect and that the clients themselves may struggle to understand roles in these terms. With this in mind, Jellema describes how CAT can be adapted for therapeutic change. Avoidant clients would require help to access previously neglected affect to acknowledge RR’s and eventually core pain. Anxious clients would need help to develop sequential cognitions to make sense of their core pain and their parts in Reciprocal Roles.

In the 2000 paper, Jellema describes the importance of acknowledging attachment style when working with clients diagnosed with a personality disorder (PD). With avoidant attachment being over represented amongst narcissistic PD (NPD; Rosenstein and Horowitz, 1996) and anxious attachment being over represented amongst borderline PD (BPD; West, Keller, Links and Patrick, 1993). She also acknowledges that CAT is generally not diagnosis specific. Jellema describes Ryle’s Model of BPD (1997a, 1997b) and asserts how it can be adapted to incorporate attachment theory and models of corrective emotional experiences in therapy. These corrective experiences come about through the therapist being conscious not to collude with clients, having an awareness of exclusions, restrictions and distortions in RR’s and addressing them in therapy ,

examining procedures and asking if the aim is more dismissing or preoccupied, and helping the client to develop skills of self-reflection (bringing together affect and cognitions).

Jellema (2002) discusses the practical implications of using CAT when working with clients that have preoccupied (anxious) or dismissing (avoidant) attachment styles from assessment to working through therapy. Using examples of compulsive care giving (Crittenden, 1998), feigned helplessness and unresolved loss, Jellema advises on how to recognise these roles by noticing speech patterns identified from the AAI (George, Kaplan & Main, 1984) to demonstrate how the psychotherapy file can be utilised more effectively with knowledge of how it was developed and the benefit of examining the traps, snags and dilemmas through an 'attachment theory lens'.

Jellema (2002) gives accounts of how those with dismissing and preoccupied attachment styles behave in the therapy room, but her advice on how therapists can respond does not reference empirical studies or describe how these adjustments were developed.

### **1.7.1. Ryle's take on what Attachment Theory can offer CAT**

Ryle states that attachment theory has a narrow focus and is inadequate to explain intense, two-way mother-baby interactions or how humans form socially. Ryle makes the point that the reformulation will identify procedural patterns (that could be described through an attachment lens) but is more powerful as it accounts not just for interpersonal procedures but for self-management procedures. This is supported by his 2007 paper (Ryle & Fawkes) described below.

Ryle discusses the development of CAT in terms of the historical context and is explicit in his use and development of existing theories (Vygotskyan, Bakhtinian; Leiman; 1992, 1994a). An important part of CAT is that it is dialogic (Bakhtin, 1968, 1984, 1986) in its development and in practice. Ryle is clear that the work of Vygotsky (1962, 1978, 1987) rather than attachment theory has influenced the development of CAT (Ryle, 2000, paragraph 8, online article);

- 1) That a child's activity in the presence of (scaffolded by) a more experienced other will come to be repeated independently
- 2) That the activity and the meanings related to it will involve the joint creation and use of signs

3) That internalisation is based on sign mediation rather than on representation and that external conversation is repeated as the internal conversation of the dialogic self (Ryle, 2000, paragraph 8).

In response to Jellema he states that behaviours that could be described as ‘preoccupied’ or ‘dismissive’ are more usefully described in terms of RRP’s and that avoidance of thought/affect could be attributed to the model itself or the personality of the therapist. When discussing the therapist as a secure base he suggests that reformulation can ‘scaffold’ reparative learning, which is similar to models of corrective emotional experiences. Ryle and Fawkes (2007) describe a CAT case of a 70 year-old man with a fearful avoidant (disorganised) attachment but do not state specific adaptations that were made for the attachment style although this was clearly held in mind throughout and was integral to the treatment.

### **1.7.2. Jellema’s response to Ryle**

Jellema (2001) acknowledges that the aims of attachment theory are more restricted than CAT and that a coherent clinical method had not been generated, however since this was written in 2001 a lot more research has been done into how attachment theory can be usefully applied in clinical work (see section 1.2 of this introduction). Jellema makes the important point that insecure attachment will not be all that goes wrong with clients but in cases of dismissive, preoccupied or unresolved attachments these will be important aspects of the RRP’s which could have developed to compensate for a child’s need for secure attachment.

On Ryle’s point about parental scaffolding, Jellema suggests that this can be dangerous. If the scaffolding is damaged, limited or fragile this will inhibit one’s ability to feel secure enough to explore (physically, emotionally and psychologically). Being biologically based, attachment takes account of “real” and powerful bodily sensations such as fear, security and comfort. Amini, Lewis, Lannon, Louie, Baumbacher, McGuinness and Schiff (1996) describe how early trauma in attachment relationships affect one’s neuropsychology, brain and central nervous system. As described in section 1.3 (above) difficulty in emotional regulation and self-soothing is apparent in those with insecure attachments and can be expressed as hyper activating or deactivating strategies. These intense emotions become a part of one’s blueprint for relationships (Clarke and Llewellyn, 1994) and so are repeated as reciprocal roles, or as part of the internal working model.

Ryle and Jellema repeatedly describe very similar practices using differing theoretical frameworks despite disagreeing about the relevance of attachment theory. Theoretical differences like these, between eminent CAT practitioners, may have impeded empirical research being conducted around the relationship between attachment process and CAT therapy. They may also inform the theoretical positions of other CAT practitioners who might find themselves on one side or other of the debate about the relevance of attachment theory. However, knowing that attachment styles are related to therapy outcome in general (Levy, Ellison, Scott and Bernecker, 2011) it seems pertinent that a relational therapy like CAT has ways of approaching and working with attachment behaviour in the therapy relationship, and this is one of the underlying premises of this thesis.

### **1.8. Responding to Attachment Difficulties in Therapy**

Descriptions of how individuals with anxious and avoidant attachment styles respond to therapy are given in psychodynamic literature as case studies or clinical examples. Holmes (1997, 2004, 2010, 2011, 2013) has written extensively about how clients with anxious or avoidant attachment behave in therapy and gives the advice; *“If the task with avoidant patients is to break open the semi-clichéd narratives they bring to therapy, with ambivalent clients it is necessary to introduce punctuation and shape into their stories- a making rather than breaking function”* (Holmes, 2000, p 169). Harris (2004) conceptualises the issues brought by clients with insecure attachments and what the focus for the therapist should be in Table 2:

**Table 2: Using Attachment Classifications to Build the Working Alliance (Harris, 2004)**

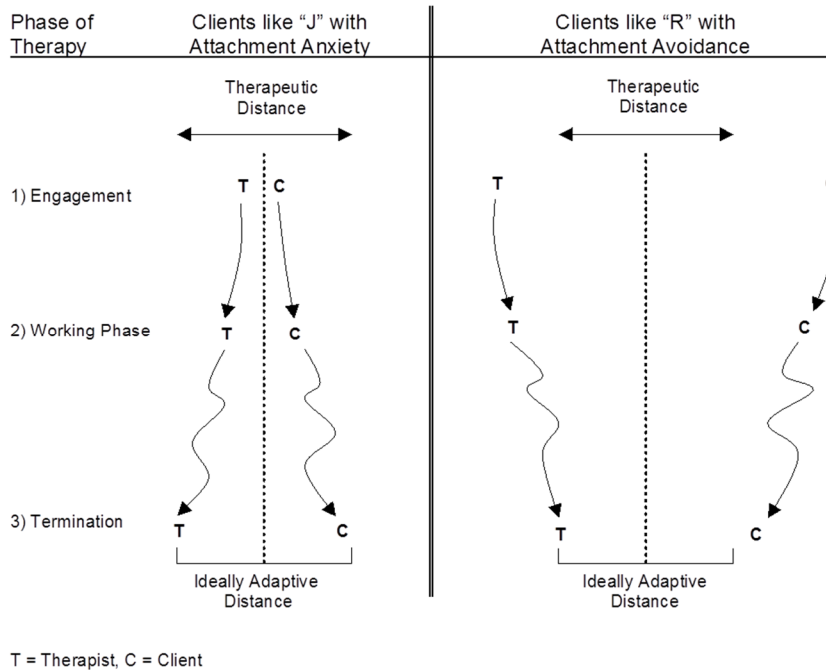
Attachment pattern and type of prior caregiver	Relevant issues for creating a supportive alliance (By disconfirming the internal working models of prior relationships)
<b>FEARFUL (OF REJECTION)</b> Caregiver consistently rejecting/unresponsive to needs	<p><b>Issue:</b> After an initial problem in talking at all, client may develop habit of speaking a lot (to be obedient and thus avoid rejection), but not about the important things of which he/she may be ashamed and which he/she therefore fears will earn him/her rejection.</p> <p><b>Focus:</b> Convey that therapy is non-judgemental: talking truthfully about shameful parts of the self will not call forth rejection or disapproval</p>
<b>FEARFUL (OF ENGULFMENT)</b> Caregiver imposing control/consistently unresponsive to needs	<p><b>Issue:</b> Client may be able to speak freely but may experience therapist’s comments, especially transference interpretations, as controlling or intrusive and so be unwilling to listen/hear. May ward off therapist with a flood of talk.</p> <p><b>Focus:</b> Pace interpretations gradually until client has come to feel there is room for him/her to be himself/herself.</p>
<b>WITHDRAWN</b> Caregiver consistently unresponsive/never taught the value of relating	<p><b>Issue:</b> Client may not have much to say, not having had as much practice in interpersonal communication as others.</p> <p><b>Focus:</b> May need encouragement, even gentle ‘instruction by example’, before can free associate openly</p>
<b>DISMISSIVE</b> Caregiver consistently unresponsive in any, or all, of ways outlined above	<p><b>Issue:</b> Client may ‘dismiss’ what therapy has to offer, denying the truth of valid interpretations.</p> <p><b>Focus:</b> Pace interpretations until client has begun to feel the value of ‘having to’ confide, occasionally interpreting the behaviour of others in his/her network as a way of introducing the genuine value of attachments; remain responsive despite client’s negativity.</p>
<b>PREOCCUPIED/ENMESHED</b> Caregiver inconsistently responsive	<p><b>Issue:</b> Client may get stuck because the boundaries of the therapeutic frame reawaken his/her ambivalence: he/she may try to manipulate some sort of change in boundaries.</p> <p><b>Focus:</b> Initial flexibility may be important as it disconfirms the prior experience of inconsistent responsiveness: only then may it be possible For the client to explore why he/she had such a need for change. Too rigid adherence to the frame may make such exploration impossible as the alliance still feels too unsafe.</p>
<b>STANDARD/SECURE</b> Caregiver consistently responsive enough	<p><b>Issue:</b> Usually none, but sometimes the artificial nature of the therapeutic dyad may discourage a client from using the therapy.</p> <p><b>Focus:</b> Show that the secure internal working model can also be applied in therapy despite constraints.</p>

Despite the fact that many therapists have written about how to respond to attachment difficulties, there is a dearth of empirical research in this area. The first empirical study about what therapists actually do when faced with attachment difficulties was a qualitative study by Daly and Mallinckrodt (2009). In this study, 12 experienced therapists were interviewed about how they would respond to two clients represented by vignettes describing anxious and avoidant attachment styles. The authors conceptualised an integrated theoretical model based on the interviewee responses using grounded theory. They called this model 'change through regulating therapeutic distance' (figure 3). The model describes therapists actively increasing therapeutic distance for anxiously attached clients over the course of therapy by reducing hyper-activating behaviours and allowing them to tolerate uncertainty, once they habituate to this, the working phase can begin. The goal for avoidant clients is to decrease the therapeutic distance through reducing deactivating behaviours. Again the working phase only begins after a period of relational work where the therapeutic distance is reduced.

Within their grounded theory analysis, Daly and Mallinckrodt identified what the therapists did to moderate therapeutic distance in therapy such as managing therapeutic boundaries particularly around the beginning and end, ensuring that they are a consistent attachment figure throughout. This was done by using metaphors, helping clients to 'develop a language' for their difficulties and developing a 'dialogue between parts of the self'. The elements they identified as supporting a corrective emotional experience were centred on 'respectful pacing and timing', increasing relational security and helping to 'repair and change through insight'.

They discussed ways of knowing if progress is being made by client willingness to discuss ruptures, sharing personal information and being affected by the therapists' absence and a greater ability to tolerate emotions.

**Figure 3: Management of therapeutic distance to facilitate a corrective emotional experience for clients with attachment avoidance or anxiety (Daly & Mallinckrodt, 2009)**



Later work from Mallinckrodt, Choi and Daly (2014) examined the development of a specific Therapeutic Distance Scale (TDS) intended to assess clients' experiences of distance versus engagement with their therapist. Four TDS subscales were identified: 'too close', 'too distant', 'growing autonomy', and 'growing engagement'. In a survey study of university based clients, 47 at the "mid-stage" of therapy and 34 at therapy termination, the researchers found that pre-therapy avoidance was significantly correlated with ratings of the therapists as 'too close' (but not 'too distant'). They also found that pre-therapy attachment anxiety was significantly correlated with 'too distant' (but not 'too close'). Some clients developed a secure attachment to their therapist; if their pre-therapy attachment style was avoidant this correlated significantly with 'growing engagement' but pre-therapy anxiety was not significantly associated with 'growing autonomy'. This creates a way to measure how the therapeutic relationship changes over time and can plot the corrective emotional experience.

Much has been written about therapeutic relationships, alliances and reciprocity independent of CAT or attachment. Fluckiger, Horvath, DelRe, Symonds and Holzer (2015) conducted a review of current meta-analyses of working alliance, stating that it is the most

researched feature of therapy worldwide, attributing this to intuitive human elements that are difficult to measure. They found that alliance accounted for an estimated 8% of therapy outcome variance. Despite the fact that there is a huge literature on the relationship between working alliance and therapy outcome (see Martin, Garske & Davies, 2000 for a review), the processes that contribute to alliance are not always measured in routine delivery of therapy. A pre and post measure of symptoms severity would be standard in UK clinical settings. However, measures of alliance and rupture can give lots of relational information which can be valuable for clinicians when working with clients with relational problems, and this information could be used to create corrective emotional experiences within the therapy. Information is lost by neglecting the therapeutic process and relationship and although CAT explicitly attends to these factors, they are not always described in the literature. This study will attempt to fill this gap in the literature.

### **1.8.1. The UK context**

The research described above highlights important process issues and practical implications for working with clients with anxious and avoidant attachment styles. However, this research was conducted using private therapists in the USA and there are important differences between the context for this empirical research on how therapists respond to attachment difficulties (Daly and Mallinckrodt, 2009; Mallinckrodt, 2010; Mallinckrodt, Choi and Daly, 2014) and the British context.

The sample from the Daly and Mallinckrodt (2009) study were therapists of private patients, and in this context therapy takes place over extended periods and is often only terminated by mutual agreement by therapist or client. Additionally, within the US context, the client group as a whole may be relatively affluent, or at least affluent enough to afford good quality health insurance, and this would often not be the case for users of mainstream mental health services in the UK. The therapists in the Daly and Mallinckrodt study were told to assume that the clients in the vignettes had no history of sexual or physical abuse, no organic neurological problems and no history of or current substance abuse issues, and many of these issues would be commonplace in British mental health services. Also, there may be cultural factors in that having therapy is more normative in the USA, whereas in the UK clients often have to fulfil certain criteria and reach a high threshold in order to be referred for therapy.



In the NHS, clients need to present first at their GP surgery with mental health symptoms to receive treatment. Commissioning services use the cost effective stepped-care model. This entails that patients receive the least intensive intervention for their need to limit the burden of disease and costs associated with more intensive treatment (National Institute of Clinical Excellence, 2011). Therefore clients are commonly offered low intensity Cognitive Behavioural Therapy (CBT) interventions for mild to moderate anxiety and depression via the Improving Access to Psychological Therapies (IAPT) programme in the UK. This has made it easier for those with mild-moderate mental health problems to access therapy relatively quickly (after a consultation with their GP). However, it means that therapists who are not working in IAPT settings, but are working in secondary care need to work with clients with greater complexity and severity of symptoms than those in private practice in the US. For example within the Daly and Mallinckrodt (2009) study, most of the clients had “relationship difficulties” rather than psychiatric diagnoses. Another important difference is that short-term interventions are the norm within the UK NHS context, and it is rare, except in specialist tertiary services, that clients receive long-term therapy. In time-limited therapy, the endings are generally negotiated at outset or are fixed by service provisions, and this is another prominent difference to the US context, where clients tended to leave therapy when they felt ready.

### **1.9. Rationale for re-addressing potential contributions of Attachment Theory to CAT**

The aim of this study is to examine how experienced Cognitive Analytical Therapists adapt therapy for clients with anxious and avoidant attachment styles. We know that attachment style has an effect on outcome in therapy and can be an important factor in terms of therapy retention and dropout.

Researchers have examined therapy adaptations; but none have done so in a UK NHS context. Most of the clinical and case examples of how clients with anxious and avoidant attachment styles behave in therapy, and how to respond to these behaviours, are taken from USA private practice or UK private psychotherapy practice. It is important to investigate if models for response are applicable to short-term therapy interventions available through the NHS. We do not know whether therapists working in this context have the timeframe to support the relational changes that Daly and Mallinckrodt describe, or how they adapt a brief therapy to the challenges

posed by attachment difficulties. CAT is an excellent vehicle for this as it is relational, time-limited and in many ways 'ending focused' which is likely to activate attachment behaviour. We know that CAT is a therapy which includes many concepts which have parallels in attachment theory (like the reciprocal role) and whose practitioners are concerned with how early relational patterns become internalised. Due to the relational nature of CAT, it is likely that therapists will already be making adaptations to maximise outcome and reduce the potential of therapy dropout. However, we know little about the pragmatic changes and adjustments in the therapy room and so it is important to give clinicians an opportunity to discuss this.

## **2. Methodology**

### **2.1. Overview of Methodology**

Initially, the qualitative framework for the study is described, and following this other aspects of the design are considered including the use of vignettes and semi-structured interviews. The author's ontological and epistemological position is presented alongside the rationale for choosing thematic analysis as the method of analysis that best reflects the author's position and is best able to engage with the research questions. The study procedure, ethical issues, sample and recruitment are then described. Data collection and analysis are described in detail. The process of coding and analysis are presented with particular reference to issues of data quality, trustworthiness, reflexivity and methodological rigour.

#### **2.1. 1. Rationale for using a Qualitative Framework**

Qualitative research methods aim to examine the experiences of people in specific contexts with unique perspectives and a qualitative design allows investigation into the content of these perspectives (Willig, 2013). Therefore, qualitative research methods are based on eliciting rich, context-dependent data and gaining a grounded understanding (Mason, 1996).

Using a qualitative framework, the question of how therapists adapt their therapy according to client attachment style can be explored flexibly and a more in-depth and full account of participants' experiences can be explored as compared to quantitative methods (Green & Thorogood, 2004).

A qualitative research framework was selected to investigate this topic because this study is exploratory and aims to learn more about individual experiences of, and perspectives on, a phenomenon that has not yet been discussed in the literature (Denzin & Lincoln, 2011). However, once themes have been generated through analysis, follow-up quantitative studies may be indicated.

#### **2.1.2. Rationale for using Semi-Structured Interviews**

Semi-structured interviews were chosen for this research as they offer a loose structure, which allows exploration of spontaneous areas of interest, and have high validity, as respondents are given the opportunity to talk in depth and in detail. Due to this flexibility, meanings behind actions may be revealed through dialogue (Denzin & Lincoln, 2011). Semi-structured interviews

allow the development of novel themes which the researcher could not have anticipated, rather than a structured interview where answers might be over-constrained by pre-ordained questions. This was thought to be of particular value as there are no taught guidelines on how to adapt CAT for specific attachment styles and so it was important for the participants to be able to discuss their experiences in an open, honest way, without fear of being criticised or dismissed. It was the intention of the researcher that the interviews were conducted in a responsive, engaging manner which would build rapport and feel more like a conversation between colleagues (Rubin & Rubin, 2012) in order to gain rich data from participants.

### **2.1.3. Rationale for using Thematic Analysis**

Thematic analysis is a process of analysing and interpreting data that focuses on identifying, categorising and reporting themes (Braun and Clarke, 2006). Thematic analysis is usually conducted using iterative phases or stages of coding and analysis to create established, meaningful patterns. Braun and Clarke (2006) and Guest, MacQueen & Namey (2012) both advocate a six-phase process which comprises familiarization with data, generating initial codes, searching for themes among codes, grouping and reviewing themes, defining and naming themes, and producing the final report.

Thematic analysis was chosen specifically for this project as it is a good fit with the epistemological position of the researcher and with the research questions (as described in section 2.2 below). It allows themes to be generated directly, bottom-up, from the data corpus. Thematic analysis is less concerned with the experience of each individual participant in and of itself, than with themes emerging across the group of participants, which in this case provides information about the participants as a group of professionals. This form of analysis appears to be most appropriate to the research question of this thesis which looks at what adaptations of therapy exist within a group of experienced therapists, in order to inform therapy training for more novice therapists and to generate some research questions for further analysis.

### **2.1.4. A Priori Decisions about the Analysis**

Previously, Thematic Analysis has been criticised for lacking clear, concise guidelines (Antaki, Billig, Edwards, & Potter, 2002). Braun and Clarke (2006) make some attempts to systematise Thematic Analysis, using the six-stage approach described above, and suggest that

prior to starting analysis, a number of decisions should be made about the categorisation of themes, stance and level of interpretation. The following decisions were made before data were collected and these decisions were discussed with the project primary supervisor.

It was decided to attempt an inductive analysis ('bottom-up' themes are grounded in the data, data is collected specifically for the research question) rather than a theoretical analysis ('top-down', driven by the researcher's perspective on theory). Braun and Clarke discuss the pros and cons of an inductive analysis versus a theoretical analysis. An inductive analysis has been chosen because it is a new area of research and therefore important to analyse data that was gathered for the specific research question about adaptations to therapy. However, as CAT and Attachment have such strong theoretical underpinnings it is anticipated that this will influence coding and so the researcher's ability to remain inductive will be evaluated in the discussion.

It was also decided that data would be examined at the semantic level (rather than the latent level), which focuses on what is literally said during interviews rather than trying to interpret subtext or implicit meaning from what has been said. This was chosen because it is a new area for research, and the participants were selected for their clinical expertise and ability to speak to the research question, rather than to document their subjective experiences.

It was decided that **only** themes which spoke to the original research question would be included in the final analysis, and that they would be included on the basis of their pertinence rather than necessarily just their prevalence in the data corpus.

## **2.2. Ontological and Epistemological Position of the Research**

Mason (2002) recommends that the ontological and epistemological framework of the research is defined to clarify the underpinning assumptions of the research. Neglecting to define and state the epistemological and ontological assumptions impacts on the integrity of the analysis as this depends on these assumptions. Therefore unless these assumptions are transparent, it is not possible to judge the worth of the research or to draw wider interpretations from its findings.

### **2.2.1. Ontology**

Ontology is the study of being or the nature of existence (O' Gorman and Macintosh, 2015). Ontology focuses on the extent to which knowledge about the world is a given which is "out there" or is created within our own minds. Quantitative research is focused on the objective and

what is measurable, for example, the quantity of height. Qualitative research is concerned with subjective experience that may not be measurable, for example, the experience of comparing your height to others. Therefore the ontology of this research is more subjective than objective as its focus is on therapists' descriptions of therapeutic adaptations for specific attachment styles. Although attachment styles are measurable, it could be argued that attachment style is a social construction and therefore a relativist or subjectivist perspective may be used. However, what is important in this study is the shared understanding amongst participants and researchers about these concepts rather than the objective reality of attachment styles, therefore a more critical realist ontological perspective is being adopted.

In addition to the participants' perspectives, the researcher too has a subjective experience of conducting subjective research and this influences the project. To explore this, reflective notes were kept throughout the development and execution of the research in the form of a reflective diary.

### **2.2.2. Epistemology**

Epistemology is the branch of philosophy that studies knowledge, how it can be acquired, and how it can be communicated (Scott & Usher, 1999). Epistemology aims to answer the question: how do we know what we think we know and how can we differentiate between truth and falsehood? There are three epistemological positions; positivist, critical realist, and interpretivist (Mikkelsen, 2005).

The epistemological standpoint of this thematic analysis will aim to be critical realist; "the position is 'realist' in believing in an external reality, but 'critical' of our ability to access and measure it" (O' Gorman and Macintosh, 2015, p 62). Critical realists acknowledge that their observations are grounded in reality, but also that their observations are influenced by the subjective lens through which reality is viewed. This research will aim to remain rooted in the critical realist perspective. However from the outset it is clear that there is a lack of exploration around different understandings of attachment, which was not within the scope of this project as the focus is on practical adaptations in CAT.

### **2.2.3. Personal statement: Owning one's Perspective**

This section will be written in the first person: At the time of writing I am a 29 year-old female, in my third year of training to be a Clinical Psychologist, and my job title is Trainee Clinical Psychologist. I am employed by a local Mental Health Trust. I have a BSc in Psychology and Criminology and have published work about memory loss using quantitative methods. My full research credentials can be viewed in Appendix B (Research CV and GCP Certificate). This study is the first time I have used a qualitative approach in my own research but I have received training on these approaches during my undergraduate degree and doctoral training.

As I trainee, I am interested in what “experienced” therapists do in their sessions as I am still learning and hoping to gain knowledge from what they say. I am interested in the patterns and consensus of ways of working that aren’t manualised but learned through experience and think that it’s important that these processes are reported and passed on. I developed an interest in attachment because of my experience as a therapist and from observing the differing ways people respond in therapy and the pulls and pushes that this had on my emotions. I can have a range of emotional responses to people with similar histories because of the way they behave relationally. Awareness of attachment theory has helped me to examine these patterns and my responses. CAT is a relational therapy and since using it I have found that I am more in touch with my emotional responses and can examine them in a more self-compassionate way. Since starting a specialist CAT placement, I have seen that adapting to attachment is an instinctive part of the process even if it isn’t described explicitly. Being a therapist delivering CAT-informed work will have influenced the way I conducted the interviews and had an impact on the way I have analysed the data. I have tried to be aware of this throughout and have been conscious of maintaining a critical-realist perspective by focusing on what is within the data, however from the outset I am aware that my acceptance of these theories may lead me to see stated adaptations through an attachment lens

I recognise my acceptance of the validity of the concept of attachment styles and my acceptance that attachment style influences how people behave in a therapeutic context. This is based on my own experiences and my reading of the research literature. I am aware that my research assumes that participants also accept this and that there is no room to explore alternative perspectives. I have tried to be mindful of this and have coded extracts where participants reported using the same strategies for all clients. I am aware that I have accepted the model put forward by

Daly and Mallinckrodt (2009) and have accepted that clinicians do adapt therapy for clients with anxious or avoidant attachment styles. I am aware that this will influence my position throughout the research and so have been mindful of this through research supervision. Despite these biases, I am invested in producing a robust piece of research with the potential for publication but certainly in producing a thesis that will allow qualification. Therefore methodological rigour and transparency are extremely important to me. With this in mind I kept a reflective diary from the start of this thesis, I have been aware that my epistemological and ontological positions as well as my personal perspectives will have influenced my decisions on all aspects of this research including my choice of topic area decisions around the design, procedure and the way I conducted the interviews and the analysis. These diary entries aim to document my subjective experience to make the process of conducting this thesis as transparent as possible. This will be expanded in the section on methodological rigour.

### **2.3. Rationale for Using a Vignette to Augment the Interview**

Two vignettes were devised for this study to represent extremes of anxious and avoidant attachment styles using the categorical model (Appendix C: Clinical Vignettes) to be used as a springboard for discussion during the interviews and to help participants avoid having to describe any of their own clients in any detail for pragmatic and ethical reasons. The aim was to contextualise the behaviours associated with anxious and avoidant attachments as realistically as possible and to act as a prompt for therapists' thoughts about how they work with clients showing these different patterns of attachment. It was also hoped that the vignettes would help participants hold in mind the differences in these attachment styles throughout the interview. However it must also be acknowledged that the categorical model does not leave room for discussion around different understandings of attachment, which is beyond the scope of this project. This is also discussed in my personal statement (page 39). I am aware that my research assumes that participants also accept this and that there is no room to explore alternative perspectives.. Additionally a validated vignette is a useful research tool that can be used in the future (Peabody, Luck, Glassman, Dresselhaus, Lee, 2000). The construction and validation of the study vignettes will be discussed in the section on procedure.

#### **2.3.1. Rationale for Choice of Validation Method for this Project**



A literature search was completed in October 2014 and no best practice guidelines for validating vignettes could be found. Therefore, following the work by Otsby and Bjorkly (2011) and Atwal, McIntyre and Wiggett, (2012), two methods were chosen; the first was external expert validation to ascertain if the vignettes were true representations of anxious and avoidant presentations in therapy. The vignettes focus on behaviour in a therapy context, therefore the story line reflects the ‘mundane’ rather than the extraordinary (Finch 1987; Hughes 1998) and retains a context which the target audience (therapists) will be familiar with. The vignettes were written from the therapist’s perspective to help evoke empathy and solidarity. The second method was a peer-review sorting task which was used to ensure that the vignettes each represented the attachment style that was intended. Please see Appendix D (Validating Vignettes- Full Information) for a description of previous methods of vignette validation.

Most clinicians working in mental health will be familiar with Bowlby’s theory of attachment and therefore aware of specific terms, but using credible vignettes is a way of refreshing this knowledge. Psychologists and CAT therapists should be used to working with vignettes and case descriptions and may use them themselves throughout their own training or presently for teaching or supervision. This makes the use of vignettes more ecologically valid for this group. The construction and validation of the study vignettes will be discussed in the section about procedure.

## **2.4. Procedure**

### **2.4.1. Process of Review and Ethical Approval**

The project was submitted for formal internal review by UEA doctorate of Clinical Psychology staff and passed (Appendix E: Feedback from UEA from Thesis Proposal) the feedback was taken on board and small elements of the methodology were revised. It was then submitted to the R& D department for review in December 2014 although the feedback was not received until May 2015 (Appendix F: Feedback from Research Governance Committee met on 18th December 2014 was not fed back until May 2015). The project was submitted to the “Inspire panel”, a patient-public involvement (PPI) panel for research whose membership is drawn from service users and carers within a local Mental Health Trust. The project was submitted to the Faculty of Medicine and Health Sciences Research Ethics committee in February 2015, feedback was received (Appendix G: Feedback of Proposal from FMHS), the project was amended and the

approval letter was received 10th March 2015 (Appendix H: Approval letter from FMHS). The project was approved by the university sponsor in April 2015 (Appendix I: Letter to Confirm Approval by University sponsor and Insurance Documents) and the approval letter from R& D was received in May 2015 (Appendix J: R& D Approval Letter). Recruitment began May 2015 and the first participant signed consent in June 2015.

## **2.5. Vignette Construction and Validation**

The vignettes were devised from past experience of the researcher and primary supervisor, by reading the vignettes found in the literature search (Daly & Mallinckrodt, 2009 and Carter, 2011), and by looking at clinical case studies, literature on attachment presentations and using the descriptions/items from measures of attachment including the Relationship Questionnaire (Bartholomew and Horowitz, 1991), Experience in Close Relationships Questionnaire (Brennan, Clark & Shaver, 1998), Experience in Close Relationships-Revised (ECR-R, Fraley, Waller and Brennan, 2000) and Attachment Across the Life Course by David Howe (2011).

The researcher wrote the first draft of the vignettes which described how a person with an anxious attachment style (Appendix C, Vignette R) and how a person with an avoidant attachment style (Appendix C, Vignette S) would behave in a one-to-one therapy setting. These were sent to the primary research supervisor who reviewed and made revisions (please see Appendix K: Vignette Development Timeline). Once amended these were sent to Professor Pasco Fearon and Dr Katherine Berry who were considered to be experts on attachment based on their work in the field;

Professor Pasco Fearon was unable to contribute to the validation process in the timescale available but Dr Katherine Berry was. Dr Katherine Berry, Senior Clinical Research Fellow at the University of Manchester, has carried out extensive research into the concept of 'attachment' in people with psychosis, has developed and validated a self-report measure of attachment style to assess and detect attachment problems specifically for people with a diagnosis of psychosis, and has studied attachment styles and their impact on therapeutic relationships in other types of mental health settings using self-report measures.

The expert validators were asked whether the vignettes captured and described the two dimensions of attachment, whether they had face validity as clinical examples, whether they would be useful prompts for clinicians in the interviews, and whether there would be any additional ways

we could improve their validity (please see Appendix L: E mail Chain for Vignette Validation). Feedback was responded to and the vignettes were amended and submitted for review as part of the submission of the thesis proposal.

Using these vignettes, a sorting task was conducted in order to test the specificity and recognisability of the attachment styles described. This sorting task was conducted at the Confer Transforming Attachments conference (please see Appendix M: Poster for Sorting Task, Transformations in Attachment Conference 20th February 2015 and Appendix N: Instructions for Sorting Task, Transformations in Attachment Conference 20th February 2015).

This was an opportunity sample and participants were asked to give their training or profession before being presented with a copy of each the vignettes to sort as either anxious or avoidant. Of the 25 participants who took part, 24 correctly sorted the vignettes (please see Appendix O: Table 1 Profession of Volunteer Completing the Sorting Task).

## **2.6. Recruitment Procedures**

### **2.6.1. Sample size**

Braun and Clark (2013) recommend the following numbers for data sources for thematic analysis;

**Table 3: Number of Sources for Thematic Analysis, Braun & Clarke (2013)**

<b>Project</b>	<b>Number of Data Sources</b>
Small (e.g., UK undergraduate; NZ Honours)	6-10
Medium (e.g., UK or NZ Masters; UK Professional Doctorate)	10-20
Large (e.g., NZ or UK PhD; NZ Professional Doctorate).	30+

As this thesis is for a UK professional Doctorate, 10-20 interviews would be recommended by Braun and Clarke (2013). However, many factors need to be considered when deciding upon a sample size including time, resources and the research question (Baker and Edwards, 2012). Interviews are the only data sources for this study as this is a new area of research which then reduces the number of sources available. Additionally, interviewing and transcription are time consuming which restricted the number of interviews that could be completed in the timeframe. Whilst conducting the interviews and writing reflective notes it was apparent that the information given by the participants was rich, dense and processed (see 2.7.4). After reading through

transcripts it was agreed with the Primary Supervisor that ten interviews were sufficient to answer the research question.

Other methods of qualitative analysis use more “instinctive methods” (Fugard and Potts , 2015) of knowing when to stop recruitment such as “data saturation” (Glaser, 1965), but this is not possible with thematic analysis as the data is coded and themed as a whole rather than each transcript being coded and themed before moving on to the next.

### **2.6.2. Inclusion and Exclusion Criteria**

Inclusion criteria were that participants should be accredited CAT practitioners working mainly in an adult setting providing individual therapy. This population was chosen as the majority of available evidence examining attachment theory has been conducted on working-age adults. The only exclusion criterion was to have been qualified in their field less than five years.

### **2.6.3. Recruitment strategy**

A purposive, snowball sampling technique was applied throughout the local Mental Health Trust. A Clinical Psychologist who was a CAT specialist was contacted to discuss the research and she provided a list of CAT trained clinicians. The first author emailed the inclusion/ exclusion criteria, the information sheet and consent form to the contact list and clinicians responded if they wished to discuss the research further. The primary supervisor contacted a second CAT specialist who emailed the inclusion/ exclusion criteria, the information sheet and consent to her contact list of CAT therapists. Recruitment started on the 12<sup>th</sup> May 2015 when the approval letter was received from A LOCAL MENTAL HEALTH TRUST & D (Appendix J: R& D Approval Letter) and ended on the 9<sup>th</sup> September 2015. Ten participants were recruited and interviewed and all of their data was used in the analysis.

### **2.6.4. Informed consent**

Informed consent was given by all participants being interviewed for the project. Each participant was given an information sheet (Appendix P: Information Sheet) outlining the study and what would be expected of them. Although they were asked to discuss their experiences, it was stated that participants must remain mindful of clients’ confidentiality and therefore not disclose any identifiable information to ensure anonymity. Each participant had the information sheet for a minimum of 24 hours before being asked to sign an informed consent form (Appendix

Q:Participant Consent Form) and opt into the study. This was to ensure they had time to consider the implications of their participation and to reduce any perceived pressure to consent, therefore minimising the risk of coercion.

Participants were informed that their participation in the study was completely voluntary and that they were free to withdraw their consent, without providing a reason, up until the data was entered for analysis. Contact details and the procedure for withdrawing were included on the information sheet.

### **2.6.5. Anonymity and Data Protection Issues**

Participants' personal information was kept anonymous by giving them a pseudonym by which they are referred to within the results of the study. The participants' details and corresponding pseudonym have been kept on a word document saved on to an encrypted memory stick. The study was conducted using psychologists working for a local Mental Health Trust, where the researcher also worked on placement, but the researcher did not have a relationship with any of the participants prior to recruitment and their understanding of the study aim was as stated in the information sheet. Participants were reminded to protect client confidentiality and preserve anonymity in the interviews. Participants' confidentiality was protected by transferring the digital recording of the interview onto an encrypted memory stick.

There was no deception used in this study and all information relating to aspects of procedure was clearly and explicitly described in the information sheet. It was considered unlikely that this study would cause distress to participants; participants were encouraged to seek support through their professional networks and supervision if any part of the interview was distressing for them.

### **2.7. Interview Procedure**

Potential participants agreed a mutually convenient time for interview, which took place on sites across the local Mental Health Trust. At the start of the interview session, the informed consent form was signed and participants were asked to complete a demographic information sheet (Appendix R: Demographic Information Sheet) before the interview was begun. Participants were each read the same set of instructions about the interview (Appendix S: Instructions for Interview) and were read the two vignettes, starting with Client R (attachment anxiety) and following with

Client S (attachment avoidance). The vignettes were left on the table for the participants to refer back to, and in addition pictorial prompts (Appendix T: Prompt Cards for Interviews) were used for discussion of CAT-specific therapy tools (reformulation letter, psychotherapy file, exits, goodbye letter)

All interviews were conducted by the researcher. Interviews lasted between 41 and 55 minutes; mean interview length was 46 minutes.

Once the interviews were concluded, the recording was transferred to an encrypted memory stick for transportation. The informed consent sheet with identifiable information was transported in a lockable briefcase to the University of East Anglia where it was locked in the primary supervisor's filing cabinet, kept in a locked office.

### **2.7.1. Demographic Information Sheet**

The demographic information sheet was developed to provide information about the participants in order to situate the sample. The following demographic variables were collected: age, gender, ethnicity, estimate of hours of individual therapy they had delivered, years of experience, dominant therapy model and if they had experience of working with clients with anxious/ avoidant attachment styles. Please see Table 5: Participant Demographic Information.

### **2.7.2. Semi-Structured Interview**

A topic guide (Appendix U: Topic Guide) was used to direct the interviewer and interviewee and this was used in a flexible way to allow space for exploration of spontaneous areas of interest relevant to the research focus (Braun & Clarke, 2014). For this study, it was important that the topic guide focused clinicians on how they have acted and how they would act in future rather than how they believe they should act. This means that the focus was on personal preferences and pragmatic, practical adaptations rather than on moral decision-making which can elicit answers designed to please the researcher (Braun & Clarke 2013).

The researcher drafted a topic guide and the primary supervisor reviewed and made revisions. The topic guide for interview included prompts to look at differences between the way therapy is conducted with the two different presentations in terms of how therapists manage the relational/interpersonal aspects of therapy (including engagement and endings), differences in using the tools of CAT (reformulation letter, diagram, ending letter), differences in therapeutic

focus, differences in procedural revision and exits (the change-oriented components of CAT where you may be doing some behavioural change work), and expectations of outcome. This was reviewed after the first interview and it was agreed that this structure allowed exploration to answer the study questions.

### **2.7.3. Transcript Verification Procedures**

The informed consent sheet included a question about whether participants would like to receive a copy of the transcript and they were asked to tick yes or no. One participant answered yes and so they were sent an email containing a password-protected transcript of their interview. They were sent a second email with the password and a transcript accuracy form (Appendix V: Accurate Account of the Interview Form) asking them to sign to confirm that the transcription was a true representation of the interview. They signed this and returned it electronically.

### **2.7.4. Researchers Perspective on Conducting the Interviews**

This section will be written in the first person; I felt that the interviews were relaxed and relatively informal. As a group the participants were all articulate and I felt like they were used to discussing clients in both theoretical and practical terms. As I did the interviews I was surprised at how well-formed participants' answers were, they were clear and well-structured often linking theory and practice in a way that seemed effortless to me. Some people referred to the vignettes a lot more, others spoke about clients they have worked with, but many participants oscillated between talking about the clients in the vignettes and their own clients. The participants came across to me as warm and empathetic when talking about their own clients and about the imagined clients in the vignettes.

There were lots of times when the participants would say things like "there's no difference in how I would respond" or "I would use the same technique for both" or "I've never even thought about it" or "it doesn't matter". Statements like these made me confident that the participants were being honest and I didn't ever get the impression that they were trying to appear expert as they all seemed confident in saying when they didn't know or if they wouldn't make an adaptation.

## **2.8. Stages of Thematic Analysis**

All stages of the Thematic Analysis were carried out by the Researcher.

### **2.8.1. Transcription and Familiarisation**

The recordings of the interviews were listened to repeatedly and notes were made about patterns, thoughts and feelings in a reflective diary. Recordings were transcribed by the author, who then checked the transcript against the recording for accuracy. Any necessary changes were made until the author was satisfied with the accuracy of the transcription. The transcripts were read repeatedly with the aim of immersion into the data. A reflective diary was written alongside the transcription to record impressions and to support any future interpretation. The whole data set was read before coding began, as advised by Braun and Clark (2006), and again after the coding was completed.

### **2.8.2. Generating Initial Codes**

As an inductive thematic analysis stance was employed, data was coded for its relevance to the research question, which may account for the differences in numbers of codes and references between the participants. The data was coded close to the words of the participants throughout (Appendix W: Coded Transcript). Electronic data management software was used to facilitate the coding (QSR NVivo 10). Often multiple codes were generated from single segments of data. For example the code ‘heating up avoidant clients’ had five references from four sources. As the coding progressed this occurred less often and more individual codes were generated. In total 336 codes were generated with 1107 references. Table 4 (below) demonstrates the number of codes and references for each interview (pseudonyms have been given).

**Table 4: Number of Codes and References per Interviewee**

<b>Participant Number and Pseudonym</b>	<b>Codes</b>	<b>Reference</b>
<b>Sam</b>	<b>53</b>	<b>169</b>
<b>Sarah</b>	<b>59</b>	<b>172</b>
<b>Natalie</b>	<b>71</b>	<b>163</b>
<b>Ian</b>	<b>73</b>	<b>115</b>
<b>Luke</b>	<b>97</b>	<b>134</b>
<b>Lucie</b>	<b>50</b>	<b>66</b>
<b>Victoria</b>	<b>90</b>	<b>111</b>
<b>Sophie</b>	<b>25</b>	<b>26</b>
<b>Abigail</b>	<b>69</b>	<b>77</b>
<b>Lewis</b>	<b>67</b>	<b>74</b>



### **2.8.3. Searching for Themes among Codes**

The aim of this phase was to “refocus the analysis” (Braun and Clarke, 2006, p.19). After generating the initial codes the researcher went through to ensure that similar codes, codes where the references were repeated, and repetitions of codes were merged, grouped or deleted as appropriate.

For example at this stage the codes; Anxious seeking reassurance (3 sources, 5 references),, anxious ruptures are more in session (1 source, 1 reference), anxious rupture if you go on holiday (1 source, 1 reference), anxious ‘never enough’ (2 sources, 2 references), anxious DNA rupture(1 source, 1 references), talk about DNA (1 source, 1 references), anxious rupture (6 sources, 13 references) were merged to create the theme ‘Anxious rupture’. This process was done repeatedly.

When identifying themes the pivotal question was always “is this an adaptation?”. The difficulty in searching for themes is that therapy adaptations are concrete statements which are already categorised due to the systematic nature of the topic guide. However, it was important that the themes did not simply follow the topic guide as that does not demonstrate that an analysis has taken place (Braun and Clarke, 2006). A group for “miscellaneous codes” was started to categorise data that was not specific to the analysis for example a narrative about CAT being an intellectualised therapy and this impact on marginalised clients.

### **2.8.4. Reviewing Themes**

The researcher sent the primary supervisor reports twice weekly and these were reviewed with a reflective diary. Reports detailed groupings of codes which were discussed via email and in research supervision. Patton (1990) described internal homogeneity as the data within themes fitting together and external homogeneity as the clear distinction between themes. During this process the internal homogeneity of the codes were checked by reading each one to see if they work together to form a coherent set; moving and reassigning the codes that did not seem to fit, some themes were merged or deleted. The external homogeneity was checked by reading all of the themes and checking that they work together to reflect the dataset, but that they are so distinct from each other. Theme title and content were adapted many times with codes being grouped and regrouped until it was felt that the content reflected the dataset adequately. An example of this is that initially the themes were split into ‘adaptations for clients with anxious attachments’ and

‘adaptations for clients with avoidant attachments’ but it became evident that these should be merged into one theme as the underlying processes were the same, however this lost some of the richness of the data as clinicians referred to both throughout and compared them frequently, thus separating them impaired the external homogeneity (Appendix X: Reflections 11/12/2015).

### **2.8.5. Defining and Naming Themes**

When defining and naming the themes the focus was changed from “is this an adaptation?” to “what links these adaptations?” A thematic map was made to reflect this process. The themes were shaped to reflect the underlying process of why the adaptation needed to be made and concrete adaptations became the subthemes. This meant that each theme told a story and had its own context but by re-reading the transcripts and reviewing the themes it became apparent in supervision with the primary supervisor that this structure was too rigid and the themes did not work together to provide a comprehensive account of the dataset. Therefore the themes were reshaped to better reflect the dataset and are presented in the results section.

### **2.9. Credibility Checks on the Analysis**

Credibility checks were used and applied throughout. The following methods were employed;

1. A structured coding session was attended by the researcher, with the primary and secondary supervisor, and another Trainee Clinical Psychologist using thematic analysis. We each brought a section of transcript and everybody coded it and then discussed the codes they attributed.
2. Monthly meetings and twice weekly e-mail contact with the primary supervisor for research supervision.
3. The first author sent coded transcripts to the primary supervisor to check the coding, these were discussed in supervision.
4. As themes were being developed the first author sent twice weekly reports to the primary supervisor with reflective diary entries to demonstrate the thought process behind the theming.
5. Themes were reviewed and restructured many times throughout the analysis through open discussions and reflections.

6. External validation was sought from the primary supervisor to check assumptions about “what links the adaptations”
7. The final themes were agreed via a final review of the data and thematic process.

### **2.9.1 Methodological Rigour**

In qualitative research methodological rigour is achieved through processes to ensure that the procedure and findings are ‘trustworthy’. The criteria set out by Guba and Lincoln (1989) is shown below with the quantitative equivalents, these are presented with definitions by Shenton (2004) and Morse (2015).

In terms of *credibility* (internal validity), investigators attempt to demonstrate that a true picture of the phenomenon under scrutiny is being presented

In terms of *transferability* (external validity, or generalizability), researchers provide enough contextual information of the work for a reader to be able to decide whether another environment is similar enough to apply the findings.

In terms of *dependability* (reliability): researchers try and present enough information so that the study is replicable and ensure transparency about the research procedure and particularly around the analysis are important aspects here.

In terms of *confirmability* (objectivity) researchers take steps to demonstrate that findings emerge from the data and not their own predispositions. This is done by triangulation, audit trail and reflexive diaries.

These concepts will be evaluated in the discussion.

In addition to the credibility checks included in the analysis above, the guidelines from Elliot, Fischer and Rennie (1999) have been used to ensure clarity around the decision-making process and operationalization of procedure. This is important to allow readers and future researchers to compare and evaluate (Attride-Stirling, 2001). In conjuncture to this the ‘consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups’ by Tong, Sainsbury and Craig (2007) was used to ensure all pertinent information was reported. A completed checklist can be found in Appendix Y: CORE-Q for Present Study.

The Publishability Guidelines Especially Pertinent to Qualitative Research (B) by Elliot et al (1999) state that authors need to demonstrate the following: owning one's perspective (please see personal statement above), situating the sample, grounding in examples (discussed above in relation to themes, and again in the results chapter), providing credibility checks (discussed above), coherence, accomplishing general vs. specific research tasks and resonating with readers. The author acknowledges that 'coherence' and 'resonating with the reader' can only be assessed by an objective reader however these factors will be considered in the discussion chapter.

The remaining guidelines have been considered and applied to this research and discussed below in the following order: Situating the sample, and accomplishing general vs. specific research tasks.

### **2.9.2. Situating the sample**

All of the eventual participants were Cognitive Analytical Therapists working for the NHS in secondary care. They all worked for a local Mental Health Trust which is a mental health trust under significant pressure and which was placed into special measures in February 2015, following a Care Quality Commission inspection in October 2014. Of particular interest for this research is that the inspection report stated that staffing levels were too low and "staff morale was very low across many areas of the trust and concerns were highlighted about the lack of senior leadership support towards staff" (Care Quality Commission, 2015). This gives an idea of the pressures faced by staff working in the Mental Health Trust at the time the research was conducted.

It is important to recognise that this sample is not necessarily representative of all Cognitive Analytic Therapists but it does represent a range of experiences specific to clinical contexts. Therefore it is important to look at each perspective individually, to explore the similarities and differences between participants and to look at all accounts as one data set to develop an understanding.

### **2.9.3. Accomplishing General vs. Specific Research Tasks**

This study aims to achieve a specific research task and has selected a sample and sample size appropriate to this based on the guidelines for qualitative research methods, method of analysis and sample size (please see sample section). The aim of accomplishing a 'specific task' has been explicit throughout. This was described in the section on a priori decisions about the analysis, when the 'number of decisions' put forward by Braun and Clarke (2006) was discussed.

### **3. Results**

This chapter will begin by giving a description of the participants in order to further situate the sample and contextualise the results. The resulting themes and sub-themes derived from the qualitative analysis will then be presented. These will each be described in turn, and data will be presented to illustrate these themes and support the analysis. A summary will then be presented of the main therapeutic adaptations suggested by the participants.

#### **3.1. Participants**

Each participant is presented in a table below, with pseudonyms given to protect confidentiality. This data is presented in order to situate the sample as a group of experienced therapists who were using CAT in their routine clinical work in an NHS setting. There were ten participants in total. These were mainly clinical psychologists (N= 5) and other participants were CAT practitioners from other professions. There were three male participants and seven female participants with an age range from 37- 57 (mean age 46 years). They had between 10 – 31 years' experience in their professional roles, and for those who had attempted to work out their therapy hours, each had in excess of 750 therapy hours. Please see section 2.9.2. Situating the Sample for the context of the interviews.

**Table 5: Participant Demographic Information.**

<b>Participant number and pseudonym</b>	<b>Age</b>	<b>Gender</b>	<b>Ethnicity</b>	<b>Years qualified in chosen field</b>	<b>Hours of individual therapy delivered</b>	<b>Dominant Therapy model</b>	<b>Previous work with anxious/avoidant attachment styles</b>
<b>Sam</b>	42	F	White British	15 years as a Clinical Psychologist	Unable to answer	CAT	Yes
<b>Sarah</b>	56	F	White British	Psychiatrist for 31 years	750 hours of CAT	CAT	Yes
<b>Natalie</b>	35	F	White British	5 years as a Clinical Psychologist, 15 years as nurse	3000 hours	CAT/ Systemic	Yes
<b>Ian</b>	43	M	White British	11 years as a Clinical Psychologist	Currently 6 hours per week	CAT, CBT	Yes
<b>Luke</b>	48	M	White British	19 years as a registered nurse followed by 5 years as an integrative psychological counsellor and 2 years as a CAT practitioner	15 hours per week, about 6840 hours	CAT	Yes
<b>Lucie</b>	57	F	British	21 years as a Clinical Psychologist	Sorry can't work it out	CAT integrate with psychodynamic and systemic	Yes
<b>Victoria</b>	37	F	White British	10 years as a Clinical Psychologist	Average 12 hours per week for 10 years 5760	CAT	Yes
<b>Sophie</b>	49	F	White British	Qualified as a nurse in 1986 (29 years), Psychodynamic Counsellor in 1996 (19 years) and CAT practitioner in 2008 (7	Cannot quantify, I have provided individual therapy since 1990	CAT	Yes

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				years)			
<b>Abigail</b>	44	F	British	10 years as a counselling psychologist	Presently 2 hours per week, previously 15 hours per week for 15 years (10,800)	CAT	Yes
<b>Lewis</b>	51	M	Mixed white/black Caribbean	Occupational Therapist for 28 years CAT therapist for 15 years	7500	CAT	Yes

### 3.2. Thematic Analysis

The original analysis generated four main themes and twelve subthemes;

1. **Creating achievable interpersonal and intrapersonal therapeutic goals;** with subthemes of *Affective Goals* and *Relational Goals*
2. **Achieving optimum affect for therapeutic work;** with subthemes of *Balancing Cognition and Affect*; *Heating up or Cooling down the Emotional Temperature*; *Using External Tools to create distance or prompt affect*
3. **Achieving optimum relational distance for therapeutic work**
4. **Focusing on anticipating and resolving ruptures;** with subthemes of *Managing Process Issues around the CAT Tools*; *Managing Therapist Responses to Reciprocal Roles*; *Managing Ruptures*; *Active Work on Ending Issues*

Please see Appendix C: Clinical Vignettes for how clients with anxious and avoidant attachment styles are likely to behave in a therapy session to add context to the concepts discussed in this chapter.

### 3.3. Creating Achievable Interpersonal and Intrapersonal Therapeutic Goals

All of the therapists stated that that the goals of therapy would be different for the two kinds of attachment presentations from the outset of therapy. Within this theme, there were two subthemes; with participants emphasising that there would be differences in affective goals, and differences in relational goals.

#### 3.3.1. Affective Goals

Seven therapists highlighted that they would have different affective goals for an anxious client than for an avoidant client, with the majority mentioning in some way that the goal for the anxious client would be better emotional self-regulation and the goal for the avoidant client would be to help them recognise and tolerate their emotions. Ian spoke of his emotional goals for an avoidant client in the following way:

Good enough therapy with an avoidant person is for them to just have a bit more of a narrative for their emotional life and a bit more expectance and awareness of emotional reactions and responses and a bit more tolerance of emotional mess, distress, discomfort a bit more tolerance



a bit more kind of capacity to stay with difficult feelings, that's a good outcome (p 2, lines 93-97).

Sarah described the process of helping an anxious client to express and tolerate their emotions and to "hold onto them" a bit more:

So I would be trying to get this person [*the anxious client*] to hold onto some sort of stability around herself in the interview and so the person that comes to mind, who seeks reassurance from me repeatedly I would be very much trying to get her to articulate that in the room, so that it desensitises a little bit to think about strategies and a scaffold for her, how is she going to manage that for herself if I am not there, her boyfriend's not there. I would be doing that I think (p 4, (p 4, lines 102-104, 114-117).

Ian (p 6, lines 266-270) described doing this by helping the anxious client to do things differently, in very practical terms: "my gut feeling is that the exits would be more practical and behavioural and concrete".

Victoria spoke of the emotional goals as "intrapersonal goals" which is a CAT term for how the client relates to their internal world (including emotional experiences) and themselves. Again she had a clear formulation of how she would set different emotional goals for the anxious and avoidant clients. Interestingly, she also felt that the clients were in some ways at opposite poles and that there was a middle ground to be achieved between the avoidant and anxious client:

The intrapersonal goal [for avoidant clients] I think is about emotional regulation, being able to manage either with being less anxious or less disconnected, perfectionist, tightly controlled, so again I might talk about the hyper or hypo arousal model and that sort of thing, so it's really two ends of the spectrum and it's all about trying to bring people to the middle, you are working from different ends but the middle ground is the middle ground for everyone (p11, lines 505-512)

Participants often mentioned aspects of the therapeutic relationship in relation to this affective work which will be discussed within the theme of 'modulating relational distance in the therapeutic relationship'.

### 3.3.2. Relational Goals

With reference to relational aspects of therapy, participants were conscious that avoidant and anxious clients had different therapeutic goals: “The interpersonal goals are to have more, easier connections with people, one is to be less anxious and the other is to be less dismissive”, (Victoria, p 11, lines 505-506)

Participants felt that anxious clients needed to be helped towards increased independence and achieving a healthier distance in their relationships. Sarah discusses doing this in relation to an anxiously attached client, and also explains how the relational goals depend on and link with the emotional goals discussed in the affective goal subtheme above:

So I suppose what I am trying to get this person to do ultimately is to be able to look after herself and be less dependent on the relationship with others, to be able to self-soothe so that she doesn't have to dump stuff so quickly and self-soothe so that she doesn't have to attach herself so anxiously to other people, that she can hold herself in that space for herself a little bit (p 3, lines 92-101).

She later discusses that she would aim to help the client to do this in an active, explicit way as part of the exits in therapy:

This tendency to overdo things and be oversensitive, I suppose I would zone in on those and say how can you be less sensitive?, How can you practice backing off a little bit and creating some space, not having to have the emotional thing present full on all the time, what's that like? So I would be giving her those kinds of tasks I suppose and again most of it in the room. (Sarah, p 12, lines 374-378)

Participants felt that avoidantly attached clients needed to be helped to allow a bit more emotional dependence and closeness in their relationships. Victoria described that one way this can be done by “model[ling] a healthy relationship, where it's not enmeshed and it's not miles apart” and describes how this needs to be achieved in the room: “you want to be clear that your message has been very transparent all along and that you have been predictable and reliable and containing and not hot and cold but just warm all the [way] through if that makes sense” (p 4, 186- 188).

Luke spoke not only of different goals for avoidant and anxious presentations but also about having reduced goals, particularly for an avoidant client:

[In an] avoidant person, the goals might just be that they come for the 16 sessions, it might be quite as simple as that and they might just discuss that and if anything else happens it's a bonus. I would probably set my goals a lot lower with them than with an anxious person, with an anxious person their goals would be coming to the sessions but thinking about our dependency in the room and how that's working (p 7, lines 317-322).

### **3.4. Achieving Optimum Affect for Therapeutic Work**

Through the analysis it became evident that the therapists thought that they would be working consciously and actively to modulate affect in the sessions with both anxious and avoidant clients. Three subthemes emerged from the analysis. The first is that of trying to help clients to introduce either more cognitive structure to an emotional narrative for anxiously attached clients) or more emotional structure to a cognitive or intellectualised narrative for avoidantly attached clients. The second subtheme is of helping the clients to “heat up” or “cool down” emotionally in order to achieve optimal affect for therapeutic work. The third subtheme is of consciously using external tools to help modulate affect in the moment.

#### **3.4.1. Balancing Cognition and Affect**

There was evidence from the interview responses that therapists had experienced anxiously attached clients as giving lots of information in a non-coherent way that was more focused on emotions. This can be overwhelming for the clinician, as described by Abigail below:

The anxious attachment style will be spilling out all over the place and will be wanting to please and make it all alright and that can be quite hard to get a coherent enough story to write your reformulation letter and actually to get to the crux of what the problem is can be quite difficult because sometimes it feels quite overwhelming with these people, it can feel like there is so much and [it is] hard to really pin down what the issues are and also with the [anxious] styles that can mask a whole load of other issues and I think that generally when

people present with anxiety so you can get caught up in the anxiety and not really get to the idea of what's going on (p 2, lines 50-58).

Participants described helping the anxiously attached client to slow down the story and to focus on adding a cognitive structure to the emotional retelling. Natalie describes using a diagram to do this, which she refers to as a map:

I would try and set a context where I had permission to sort of at times almost interrupt. I was thinking about a lady I worked with recently, there would be lots and lots of stories and lots of content and we wouldn't get to process and so we made an agreement that I could just, it would feel quite rude sometimes saying 'I just need you to stop' and then we would get it on to the map, and I think the maps are really useful in a slightly different way of helping someone to slow down and think about where they are (p 2-3, lines 96-103).

The active use of external therapeutic tools to slow things down and create some distance or reflective space for anxious clients and to prompt emotional reflection and recognition in avoidant clients emerged as a theme in its own right and is described in section 3.4.3. Clients with more avoidant attachments were described differently in that they lacked an emotional language and so gave concrete histories without much affective experiencing. An example is given by Lewis:

For these, I, you, can recognise it in the story because there is a lack of feeling if you like and it can be very intellectual, and it can feel like you're not really getting anywhere or you are drifting through therapy I think in the session so lots of talk, but not getting to the heart of things. I think for this group the concept of the core pain is a good tool as well, something to think about so I would think about that as well if faced with a patient like this, what really is the core pain? (p 2, lines 92-97).

Other therapists described feeling as though the avoidant client was often cut off from their emotions to the extent that they had a lesser understanding of their presenting problems due to a lack of emotional language. For example, Abigail felt that clients with avoidant attachment were likely to "struggle to know why they are there and to kind of have a sense of what's bugging them, what's wrong, but something's bugging them" (p 8, line 358-360).

Lewis went on to describe that the work of the therapist was to help the avoidant client to introduce an emotional element to their stories, as described in the affective goals above. The process of balancing cognition with affect is described well by the participants when discussing using timelines. These were used for both anxious and avoidant clients but for different reasons. As described by Victoria (p 8, line 352) it helped with “sticking with one thread” and Sam also made active use of a timeline to put narratives into a linear structure:

With Client R (anxious attachment) I'd be doing that in order to contain her because she is spilling out information left, right and centre and I would be doing that in order to slow down the process so I can get a coherent idea of the order of events and who is important and where they've come in and what's happened when because I think I would be feeling a little overwhelmed by her initial splurge (laughs) let's say of information. (p 1, line 42)

Equally, timelines were seen as useful for the avoidant client where the focus was on structuring their account with more emotion, again described by Sam:

With Client S (avoidance) I would probably also use a timeline but in a way to facilitate trying to get the information out and getting any information out erm as a safe way of just getting some really basic information that she might feel comfortable about sharing, such as I went to school age 5, I went to this school, I moved house so really non emotional things in order to start building up trust in the therapeutic relationship.. (p 2, line 56-60)

As expressed by Sam and Victoria, the therapists appeared to respect the anxious clients' need to tell their story would allow more sessions of history taking than usual (and compared to the avoidant clients) to allow the client to feel that they had told their story, as Sam went on to describe:

I'd be slowing her down probably erm taking as many sessions we need to get the amount of detail so I wouldn't lose detail I'd just be ordering it and starting to get coherence and I guess scaffolding in CAT terms is what I would be doing for her in the sense that there is an overwhelming amount there and I'd be structuring it (p 2, lines 53-56).

The technique for the anxious client mirrors previous techniques of adding a more cognitive element to how anxiously attached people make sense of their relationships.

Victoria (p 8, line 262- 264) described that she might pace the history taking with an avoidant client:

Whereas someone who is very avoidant I might go with the here-and-now a bit earlier and hope that as they trust me a bit more we will come back to the past if that makes sense, it will unfold in its own time.

Other techniques that were used to help avoidant clients discuss their histories were using mentalisation (Sarah, p 3, lines 71-80), focusing on physiological sensations as a pathway to talking about emotions (Ian, p 2, lines 56- 263), and using object sculpts to tell the story (Natalie, p 2, lines 51-63).

Luke, spoke about using summaries to keep the anxiously attached client focused on what they are saying: “An anxious person, there is not a lot of space it’s all filled up and when you’re sort of summarising back with an anxious person they might not even remember that they have told you” (p 3, line 138). Abigail said she had used mindfulness early on in therapy to help the client to focus; “I might do a mindfulness exercise to begin with or something like that, just to slow her down.” (Abigail, p 2, lines 73-74).

Lewis similarly described imposing structure and thinking on a narrative in relation to someone with anxious attachment in order “stop and think” and not get “carried away” and contrasted this with an active role encouraging emotional expression and experiencing with someone with avoidant attachment:

For this person [anxious attachment], [we need] to stop and not go from one thing to another but start to think about what’s she saying and think about the patterns that are coming up in the story in one before we move on to the next one because we get carried away otherwise, and with this one [avoidance] I can imagine needing to stop them and ask them more about how it felt, what’s the affective element in the story that they’re telling, to encourage them, not to stop them but to encourage them to add more detail and feelings of the story. (p 1, lines 17-23).

This process is described again by Lewis who practises bringing the anxious client back to recognition (a cognitive act) rather than allowing them to focus on “drama” ( a more emotional re-telling):

I think with the people that are preoccupied it’s a question of listening to all of the drama and then saying ‘but we are looking for the pattern that you are repeating over and over again’ so we are getting this list of patterns, ‘can you recognise that and see how you have been around the cycle?’, (p3, lines 106-109)

In summary, the participants talked in various ways of “thinking together” with anxiously attached clients and “feeling together” with avoidantly attached clients and much of the data to support this emerged when talking in particular about the early sessions when therapists were actively formulating with clients and helping them to try and make sense of their history.

### **3.4.2. Heating up or Cooling down the Emotional Temperature**

It seemed important to therapists that the level of affect was managed in the therapy, with either too much or too little affect threatening to derail the therapy. Eight therapists spoke of the emotional temperature of sessions, independently commenting on “cooling down” sessions with anxiously attached clients, lest they be overwhelmed, and of “heating up” sessions with avoidantly attached clients so that therapeutic work could be done:

People with avoidant attachments, I have had to think about the right length of letter so that it’s not ‘too hot’, if you like, and I think I would use them differently, so people who have a really explicit anxious attachment, I want the letter to sometimes cool things down so normally by the time people get to therapy they have been on a list and I don’t know, it is interesting before they come there seem to have been lots of crises so the letter might cool things down. People with avoidant attachments, you might want it to cook things about a little bit and bring things to the surface and heat it up, but again not too much so they can’t take it all in” (Natalie, p 7, lines 318-328)

This was also discussed by Luke:

The avoidant person starts to worry about the ending and starts saying ‘well I am going to miss the ending’ so sometimes it does warm up again towards the end where you might get the

opposite with the anxious person, getting really worried about the ending so cooling off a little bit and being a bit more detached but by that time generally you have quite a lot of information and you can word that in to the letter (p 6, lines 269-274).

The same terms were used by Victoria:

Yes, warming it up a little bit and saying 'it's not that you're a cold person it's that this is your coping style because you have had to cope with such difficult things and how does that affect you in your day-to-day life?' ( p 6, lines 250-252)

Therapists felt that they were helping the clients to achieve optimal affect by "cooling down" anxious clients by helping them regulate their emotions and tolerate distress, and "warming up" avoidant clients by helping them recognise and express their feelings a bit more. There was an acute awareness that avoidant clients needed to be warmed up slowly and that the work needed to be paced sensitively so that the emotional intensity was not too strong. Clinicians described the ways in which they did this such as allowing the client to reflect on things outside of the room by completing reflective diaries about what it was like to be in therapy and normalising the client's experience that therapy and its processes were challenging;

I find people often come back and they will read it [the psychotherapy file] out or give it to me to read sometimes and they will say I found it really difficult when I had to talk about that but then you can start to make connections and they might have felt a little bit annoyed with me when I ask that question, 'do you feel like I am pushing too hard?' and then then they will be like 'no no no its fine, I know that's just your job' then trying to say 'I think I would, if somebody was asking me those questions I might feel a bit irritated by them and I wonder if that is ok for you? Is there other times when you have felt irritated by people but you stop yourself feeling that?' or I think it depends on the individual because it is just finding a way to talk about what's in the room. (Natalie, p 4, lines 166-180)

This technique of normalising that it might be okay to have difficult feelings, at a point where an avoidant client might not recognise or be able to express this was also referred to by other participants. Other techniques to moderate the emotional intensity of the therapy that came out of the



interviews were using metaphors (Abigail, p 3, lines 134-149), and using visual aids to help clients identify and express their emotions and difficulties. Luke (p 3, lines 108-109) used the “stones have feelings too” cards (Deal and Masman, 2003) which depict facial expression of emotions pictorially, and Lewis used cartoons with an avoidant client;

There is a set of cartoons that shows a child with a depressed mum developing a reciprocal role of unresponsive to neglected or whatever and a solution of becoming the neglecting, rejecting one, the one who leaves who actually goes off to be an arctic explorer, so there’s a little story, so I might get those out to say ‘is this like your procedure?’ and show them that because people have got a good response to that, in trying to write a strong response so that fits the style.

Interviewer: Why do you think they work well with these clients particularly?

Lewis: I think it helps them, I remember one man in particular who was ‘oh yeah, that’s me, that’s me exactly’ and he had a really kind of emotional response to it whereas he was very much up in his head so it was just like a stimulus of a picture, an image and a little story that helped him express a bit more feeling, he can relate to it (p 1-2, lines 39-52).

The clinicians discussed that achieving optimal affect for anxiously attached clients involved helping them down-regulate emotions in way that did not feel rejecting or abandoning. It was felt that if clients were interrupted too much or too insensitively in the early sessions, this could be perceived as rejecting. This was done by modelling emotional recognition and by helping the client to return to the focus of the session in a gentle way this is warm and reflective. Sarah discussed actively pacing the work to moderate therapeutic distance so that it was manageable for the client “So obviously I am trying to pace the work to what she brings but also tantalise her enough to think that she might be able to spread her wings slightly and look at other things.” (p 2, line 36-38).

### **3.4.3. Using External Tools to Help with Therapeutic Pacing and Affect Management**

Therapists made very active use of a number of different CAT and generic therapy external tools, such as the genogram to take a family history and the CAT reformulation diagram. These tools were used in different ways with anxious and avoidant clients : in anxious clients, the tools were used

to create space for reflection, by slowing things down, pausing, and creating distance; in avoidant clients the tools were again used to create distance and pause but to use this space to prompt for emotional recognition and expression.

Natalie described both of these ways of using tools when she talked about using a genogram with an anxious client to slow down the story and add a coherent structure, and with an avoidant client to add an emotional element to the narrative:

I think I would use the genogram to slow down somebody who had anxious attachment, because it is a cognitive process and I think people with anxious attachment, when they are under stress increase negative affect and find it really hard to connect cognitively so I would use the genogram to slow it down and maybe asking them a bit more questions first so just moving into feelings and then out of them I would start by trying to use the cognitive stuff a little bit more. With someone who had an avoidant attachment I would try and ask more relational questions, so if they are not able to do it for themselves often they might be able to do it for somebody else so if mum was here, so this is a bit more of a systemic question, 'so if mum was here and I could ask her how she felt when you were born or when dad left what do you think she would say?' and often that sees them thinking how do you feel about it and then helping them to make them connections with that." (P 1, line 28-34, 37-40)

Again, this quotation refers back to the previous theme of being aware of balancing cognition and affect, and it was the case with data in general that some quotations were very rich and spoke to more than one theme.

CAT makes active use of a formulation diagram often referred to as a Sequential Diagrammatic Reformulation (SDR). When referring to their diagrams, participants again demonstrated that they were trying to integrate more affect into the narrative for the avoidant client and more cognition for anxious client. Some therapists, such as Sam described using the same techniques in drawing a diagram but for different reasons:

Again possibly using the same strategies but again doing it with slightly different purpose erm drawing out some sequential diagrammatic things not straight to the SDR, I wouldn't do a

complete diagram with reciprocal roles or procedures or anything on it and bring it in but I would start with each of them by picking one from the reformulation letter and drawing it on a piece of paper so if we've got criticising to criticised, say let's think of a time when you felt criticised, how did you feel? Draw an arrow ... what did you do? What might you have done? Just to start putting it on paper, again, to start structuring and containing the overwhelming thing things that might be coming, still, from Client R [anxious attachment] and it will start to show Client S [avoidant attachment] how things do connect that maybe she's unaware of or has been failing to articulate, she might know inside but has never done that. Then for each of them it would be something that could go at their own pace, it might be that Client R gives me thousands of examples of when she was criticised so we will slow it down again, we'll pick one in detail then maybe do a couple of others, Client S it might be harder to get the examples out but I would have been listening very carefully to the timeline and any hint of anything that I can use to expand on if she's not bringing something, Client S I guess would be using more day-to-day examples if she's reluctant to go to the past (p 5 line 91-106).

Other therapists described using different types of diagram specific to the avoidant attachment style. Natalie (p 7, lines 335-34) described that her maps for avoidant clients are "more spaced out because I think that feels a bit more manageable, and possibly in some ways less detailed" and described:

They might be a bit more CBT-ish with a bit more of an avoidant attachment and that's the point where I try to not get to caught into the room because I think someone's already very good at being quite cognitive, I don't want to help them to do more of that but they probably do look a bit more CBT-ish (p 7-8, lines 345-353).

This demonstrates the effort being made to pace the work for the client by moderating the emotional intensity. The participants described that they used the diagrams throughout the therapy as a tool to moderate the cognition/ affect as explained by Ian:

I would probably have, probably use the diagram a lot in helping people, come back to that to try and describe or make sense of what happens within sessions or whatever someone brings

to a session. They may bring a story from the week and I think I would try and just make sense of whatever they brought in relation to a diagram, I think I would be working quite hard in the middle sessions in helping people really deal with the recognition bit so people don't rush away kind of anxiously in a way, but kind of facilitating their own reflection on procedures really and how they're getting played out and try and reformulate stories that people bring to sessions in light of our reformulation and I think I would use the diagram a lot more a bit later on with those clients, whereas with the avoidant people I would use it a lot earlier as a kind of real starting point. (p 2, lines, 263-75)

Nine participants in total made a very clear distinction about how they would use the tools for anxious versus avoidant clients. The main theme which they converged on is that for anxious clients, therapists need to use the tools to create distance, whereas for avoidant clients, the tools were mainly used to prompt affect in a manageable way.

### **3.5. Achieving Optimum Relational Distance for Therapeutic work**

Therapists described being very aware of the distance within and boundaries around the therapeutic relationship. They suggested that they would try to moderate the relationship by using boundaries to set the expectations and perimeters of therapy for the clients in order to provide a safe and consistent environment.

This was felt to be particularly important for the anxiously attached client who might be more likely to become attached to the therapist quickly in a way that would be unhelpful therapeutically.

Lewis describes this well:

So if they were to say 'I spent all week just looking forward to coming back to this session' and 'it's the most important thing in my life at the moment' or whatever, question me, 'how can I get you on the internet when we have finished?' Because we are only meeting for a short time and, if they have got it on the diagram a tendency to romanticise relationships anyway, to say 'do you think this could be happening here?' and keeping mind that's it's a temporary one and it's a temporary relationship, it's a therapy relationship and what's important is that they take away the work (p 4, lines 164-172).

Clinicians anticipated that anxiously attached clients would need the boundaries to be clear around session start times as they might come too early, or expect to be seen earlier than the allotted time or might overrun on session times and call in-between sessions as discussed by Victoria:

With the anxious lady she may feel rejected if you aren't able to stretch the boundaries for example, carrying on longer or taking phone calls between sessions, I don't tend to speak to clients on the phone in between appointments, interesting in the introduction I was thinking if she arrived half an hour early I wouldn't go to speak to her I would just wait until the time and sort of state that quite clearly. She might think against that, might feel very upset, you might have some self-harm if she struggles to manage her distress. (p 5, lines 208-215).

This was also described by Sarah:

There is somebody who brings to mind who actually came in and was very anxious and requiring a lot of reassurance and quickly was quite interesting, even before she arrived in the room I had several texts from her, she was somebody I was seeing privately in fact, so we had agreed an appointment date by phone and so then she had my mobile phone number and I received several texts before she even arrived in the room, looking for reassurance about the appointment time and where it would be, going over all of that stuff again (p 2, lines 40-46).

Therapists tended to respond to this in a boundaried way: "So in terms of engaging her (anxious client), she's not hard to engage so the difficulty will be creating some distance between you, some appropriate distance" (Sarah, p 1, lines 18-19).

The importance of imposing these boundaries skilfully and very sensitively is summarised well in the quote by Sam:

It would be much more about containing [the anxiously attached client] and sort of slowing [the client] down and boundarying, within conversations, within the room and within the therapeutic relationship other than just the session starts at this time and finishes at this time so I would be consciously structuring and framing, scaffolding, kind of putting that framework around everything but not in an explicit, brutal way but just being gentle for someone who is

very emotional and has been through an awful lot so I'd be very mindful of that so it would be just gentle boundaries but I would be naming it and it would be explicit. (P 9, line 237-24)

For avoidantly attached clients, clinicians anticipated that they may need boundaries around "coming on time (lateness), whether that's a cancellation or a DNA" (Sam p 10, line 254). This is expanded on by the following quote from Victoria:

With your avoidant lady, what tends to happen is if you get a bit too close and they open up a little bit they sometimes frighten off and they cancel or don't come back or come back and shut down and are very disconnected, again it's about gently, "I noticed that last week we spoke about this and then you didn't come" (P 5, lines 219-223)

The response and way to maintain boundaries is described by Lewis, who suggested the importance again of gently inviting or "coaxing" the avoidant client back into therapy:

I have always wondered whether something has been repeated and if someone is repeating a rejected procedure, sometimes I have written my letter, invited them to come back for perhaps a review to see if we can get therapy back on track... and have a review session to talk about it' just to kind of coax people back in, if people don't come, or they don't send a message I don't always contact them after, straight always which is great to see if they are going to phone up and say 'sorry I forgot',...but sometimes you can see it's a procedure as well at the same time, or you could see it as a procedure, people are anxious and don't turn up, if they drop out I would worry that they are really disappointed and really disillusioned and unhappy so I would contact them again and maybe the same thing, invite them to come back in, but in both cases it's about that kind of rupture resolution procedure of saying 'I think maybe something's gone wrong between us and perhaps there something you're not very happy with and can we talk about it?' (P 5, lines 206-225)

There are also times when therapists feel that they need to let a boundary violation pass for an avoidantly attached client, as evidenced by the following quote from Natalie, who spoke about not challenging a client's reasons for leaving a session early in the initial stages of therapy in case the client found this too difficult:

There's a chap I have worked with recently with avoidant attachment and he would have made like a doctor's appointment so he would have to leave 10 minutes early and we would talk about that and I would wonder about that and actually it was at the end of the therapy that he was able to say 'actually I never had a doctor's appointment but I just needed a way to get out of the session early because it felt so scary, but I think If I had gone straight for that and that was always my suspicion but if we had tried to talk about it to quickly it would have been too much for him I think. (p 2, lines 74-80)

Participants felt that boundaries needed to be reinforced with both kinds of attachment style, but there was a need to be gentle with anxious clients in order to avoid them feeling rejected or abandoned and a need to be non-intrusive for avoidant clients to avoid them feeling overwhelmed. All of the participants mentioned maintaining session boundaries firmly, flexibly and gently whilst maintaining an awareness of what the client might be able to manage in relation to this. In anxious clients, they perceived there would be a danger in too emphatically or firmly enforcing a boundary and in avoidant clients there might be a danger in interpreting a boundary violation such as non-attendance or lateness too early.

### **3.6. Focusing on Anticipating and Resolving Ruptures**

The issues needing to be considered around potential ruptures are *Managing Process Issues around the CAT Tools, Managing Therapist Responses to Reciprocal Roles, Managing Ruptures and Active Work on Ending Issues*. These will be discussed.

#### **3.6.1. Managing Process Issues around the CAT Tools**

This section examines the way that participants explained the way the CAT tools gave them information about potential ruptures. Eight therapists discussed the differences in the ways they would expect the anxious and avoidant client to fill in the psychotherapy file, which is a document which presents different traps, snags and dilemmas for clients to consider if they apply to them and is usually given to the client in the assessment stage of therapy. The consensus is summed up in this quote by Victoria (p 6, lines 295-297) "The anxious lady would fill it all in and write all over it and add lots of stuff and the avoidant lady I would expect not to bring it back".

Three of the therapists described that the anxiously attached clients could use the psychotherapy file as a tool to please you. Abigail described that the anxiously attached client:

[the anxious client] would probably bring it back it would be very neatly done and perfectly carried out and she would bring it back on time because she might be quite anxious if she doesn't do that, just given that she turned up early for the appointment and she wants to please and that sort of thing, I would imagine the psychotherapy file would be a really good indication of that for her, so it's likely to be filled out beautifully. (p 1 lines 35-39)

Four therapists spoke about how the psychotherapy file can indicate the level of distress felt by the anxiously attached client and their need to communicate this to the therapist, the following quotes are from Lewis:

The preoccupied people will write all over it and you will get loads more detail than and some of them will do the thing where you tick double plus on every box which is really unhelpful but will tell you something about them, (p 7, lines 304-306).

I think people that are more anxiously attached, more preoccupied are a bit more likely to fill in the back differently with the intense and unstable states of mind, at least I think they score higher on it (p 2, lines 286-288). Victoria described the adjustment to therapy would be to break the task down again supporting and helping the client to pick out the specific pattern to focus on:

I suppose that with an anxious lady with so much, I might use the psychotherapy file with her very clearly to think about some target problems because we can't work on everything so there is a lot here 'what do you want to focus on?', lets pick a target problem', because I find very often especially with the very anxious people the target problem shifts as their anxiety shifts and trying to keep the focus can be quite difficult (p 1, lines 39-44).

Regardless of attachment type, all the therapists (N= 8) who mentioned the psychotherapy file felt that they would respond to clients with gentle persistence and by modelling supporting the client through the task which could be done together with encouragement. This quote by Victoria also illustrates how therapists expected that avoidant clients might be dismissive of the psychotherapy file:



I have had several clients where they like 'I didn't have time', 'oh that questionnaire you gave me, oh yes' they can be quite dismissive of it and again that's a very rich area for discussion about what's that's about and how they find that, are they disconnecting with the therapy as soon as they leave the room or is it in their mind during the week, that sort of thing. (P 2, lines 67-73)

Luke (p 4, lines 176-178) described that there is a "risk" in giving the psychotherapy to the client to take home; "Yes, avoidant person, well I may do because there is a risk of giving the psychotherapy file and they don't bring it back or its in their bag or 'I didn't really understand it'." Therapists felt that the way that they would deal with this dismissing response would be to keep hold of the value of it, and to thoughtfully and gently persist with the task, perhaps slowing it down or helping the client with it to make it more manageable. This is described by Ian (p 5, lines 211-213):

I would devote a whole session to it, which I wouldn't by any means with everyone, but with avoidant people I probably would, go through it in quite a lot of detail and I would try and give some attention to the process so what it was like to be asked to do it?

Three therapists described that they would do the psychotherapy file in sections for the avoidant clients:

So the avoidant one, if they were keeping avoiding then perhaps thinking about what might be more relevant to them so perhaps doing sections or doing the last page and doing it in the room and seeing how they are responding to it and using it as a bit of a tool in the room (Luke p 4, lines 180-182)

Sophie described that she would in fact do this for both anxiously and avoidantly attached clients:

There have been occasions where it's been very overwhelming for people so what we have done is, I will always discuss it with someone in the room but it is really important for them to take it away and complete it in their own time because of what its stirs up, and that they're not sitting there just ticking a box or answering things in relation to me being in the room or present, but there have been occasions where we have actually taken the staples out and said

‘ok the whole thing feels too much but this piece or that piece feels manageable to start with’  
and sort of almost breaking it into sections (p 3, lines 71-78).

Alternatively five clinicians spoke about avoidant clients they had worked with who had completed the psychotherapy file but had been critical of it, thereby dismissing it in a different way. This is explained well in the following quote by Victoria:

I would be interested to see the psychotherapy file because sometimes people are very critical of it, and that’s a very interesting discussion because there are some old versions with some spelling mistakes and things because certain clients always notice that. You either get people that say ‘every question in this questionnaire is about me’ then you get other people go ‘well I don’t really know what the point of this was’ and it’s kind of exploring her reaction to it, is she able to name any of those processes?, has she got that observing eye?, can she recognise some of the stuff?, if it’s a very blank psychotherapy file that’s another rich area for exploration really. (P 2, line 54-61)

In the section on collusion and parallel process for therapists (below, page 78) there is a quote by Abigail which discusses the dangers of colluding with the avoidantly attached client by giving the psychotherapy file in a dismissing way or forgetting to ask for it back.

In terms of other CAT tools, participants described how they would expect the clients to receive the reformulation letters depending on the attachment style and how they adapted to this by writing the letters differently for anxiously attached and avoidantly attached clients. Therapists generally gauged how much emotional intensity was appropriate in the letter or as Lucie describes (p 7, lines 340-343) “Reformulation letters aren’t *to get a hit* they are to help somebody”.

The following quote by Sam sums up how most of the therapists believed the anxious and avoidant clients would respond to receiving a reformulation letter:

Yeah, I would expect Client R to cry, because she’s crying before we even start anyway, so unless she’s all cried out at this stage I would imagine that she will get very emotional, she’d tell me I was wonderful, she’d tell me I was perfect, spot on, that’s amazing, how do you do that? That kind of real pleasing, gushing stuff is what I would probably predict at this stage

anyway from Client R. Client S is the kind, and I have had clients like this who fold it up and say “thanks, what now?” and put it down and don’t look at it again (laughs) “yeah... that’s alright” or depending on where she’s at Client S also has the potential to then come back with loads of criticism, to come back with kind of the red pen, and say “well that’s wrong and that’s wrong and I don’t know why you said that, and you missed that out”. I can’t quite tell from this point is Client S is going to be just cold kind of avoidance or try to engage but leading to hypercritical mode in order to feel safe, but I would predict that would come back the following week not immediately. I don’t think R would criticise it unless I got something blatantly wrong I hope that she’d be able to but I am not sure she would at this stage (p 13, lines 351-362)

For the anxious client, there was an anticipation that it would be hard to summarise the information, because there would be so much and because therapists might be unhelpfully drawn into writing very long letters in order to demonstrate to the client that they had been heard and understood. This was described by Natalie:

I have noticed that people who have an anxious attachment, that my letters tend to be much longer and I have to be really mindful of that because I think that I can get because there is often so much stuff that they have told you that I can feel beholden to capture everything almost in the letter and to really pay attention to that and so I have had to be really mindful about not making my letters too long and learn that it will be a good enough letter and I don’t have to capture everything (p 7, lines 314-328).

Lewis spoke about a different adaption to being presented with lots of history and material, in that not only was he aware of the need to be concise and reduce the length of the letter was important but he felt he needed to be very focused on the procedures and reciprocal roles rather than history: Whereas now I think faced with loads and loads of material I really want them to take away something so it’s like ‘these are your procedures, this is some of what we understand has lead into them, this is what we are going to work on’ so a shorter and less inclusive now (p 7, lines 344-346).

As might be expected based on the amount of information given, the length of letter was generally shorter for the avoidant client as described by Luke (p 4-5, lines 198-200) “I think the letter will be different, I think my experience is that the avoidant people, the letter would be shorter, I just think through the parallel process that they are not giving as much information”. The process of writing the letter also appeared to be subject to parallel process:

I know, one of my first clients was extremely avoidant and the first letter I wrote was very tentative and careful and missed out loads of stuff, it was clinical, it wasn't relational, it was very, very clinical, and obviously I had supervision and rewrote it but there's a real temptation to be quite clinical if you are working with someone who is very avoidant so I think the reformation letter gives you huge amounts of information about how you are relating to that person, to kind of not wanting to write it, putting it off and probably with the anxiety style being quite overwhelmed by writing it and it just all feels too much and you might be trying to get it perfect too. (Abigail p 2, lines 90-98).

### **3.6.2. Managing Therapist Responses to Reciprocal Roles**

Clinicians spoke about when doing CAT it is important to recognise your own responses to clients to make sense of the reciprocal roles they have, but this is an active process involving both the therapist and the client, Abigail describes this process well:

If you think about the metaphor we always use in CAT of kind of, the term says ‘not to join the dance’ but I think you do join the dance but you are aware of the steps you are taking and then in the middle bits you are starting to shift the type of dance, and then at the end hopefully its shifted enough to have new ways of doing things. That's where your exits come in so yes, you do join the dance a bit (p 5, lines 227-232).

As discussed, the therapist is not a passive observer in CAT they are involved in the process, this can mean having strong reactions to clients' behaviour that gives clues to the reactions they provoke in others but also this can be evident as being “drawn in” to reciprocal roles, parallel processes or as collusion. All of the participants discussed these therapy processes but there was not a

consensus of how to respond to each attachment style which could demonstrate the importance of individual differences between clients and therapists.

Clinicians described being drawn into dismissing, rejecting, criticising, abandoning reciprocal roles for both types of clients and there was an acknowledgement that the same roles will be activated in different ways for everyone, regardless of attachment style. Lewis (p 5-6, lines 245-258) describes this:

I think the nice thing about CAT is that's its individually made for people isn't it, so you have got this diagram with their reciprocal roles on and that will reflect their attachment style but it's not a step in CAT therapy to identify someone's attachment style, ... not everybody will have the same diagram because it won't be a diagram for attachment style it will be a diagram for them and for their other aspects of them as well so I suppose what I am saying is the process to me feels like it's really similar, the overall process but what you would expect the content to be would be a bit different.

However, clinicians consistently described getting into, or resisting getting into, reciprocal roles of 'controlling to controlled' and 'criticising to criticised' with avoidantly attached clients. Eight clinicians also spoke of dismissive and critical behaviour even if they did not discuss the danger of it being reciprocated in the therapeutic relationship, as Sam does when describing the response to the reformulation letter in the previous section. Here are some examples by Ian and Luke:

Particularly with the avoidant people it is easy to get into quite a controlling, reciprocal role and I think by just talking and filling up the space and asking lots of questions, I don't think that's probably very helpful and it probably reflects the control that perhaps they might have in relation to their emotional life, so I would try and notice being drawn in to that kind of thing and sit with it a bit more than I might do with some other clients. (Ian, p 1, lines 44-19)

I think with the avoidant person they are always waiting for an excuse to blame you for not being good enough and so they can go 'you were crap' so I am going to go, sort of blaming or wanting to blame you or are critical of you as they were in the past so noticing this and

reciprocal roles of criticism and thinking about how you manage that (Luke, p 3-4, lines 146-150)

The way the reciprocal roles were described, even if they were not explicitly stated, was through the parallel processes that therapists found themselves enacting and through the times when they found themselves colluding with clients.

Parallel process can be described as processes where the therapist starts to imitate some of the same patterns and procedures as the client does in the therapy. Some of the therapists described being less challenging with avoidant clients and dismissing the importance of the therapy in subtle ways that are different to their usual practice. This is described by Ian (p 3, lines 131-141):

I think with avoidant clients you can get lazy, and on a Friday afternoon when you are really stressed they are the kind of sessions where you can kind of be lazy and not challenge too much and its quite easy and you both feel comfortable but that's the avoidance and that's, your both having a nice interesting conversation about something but nothing's happening and it's not going to help anyone, so I think you have to be much more challenging with an avoidant group and just mainly what are we advising here? What is happening between us? This feels really nice, really comfortable maybe we need to talk about some of the other things which are less comfortable?

Abigail described colluding with the dismissal of the psychotherapy file:

I think with the avoidant attachment, there is a real temptation to tread carefully and to maybe collude with that a little bit and to, you may forget to give the psychotherapy file or you may give it in a dismissing type of way which isn't helpful but I think that's information that when you are doing that you might start to think about the person who has been avoidant so you have got all this information but actually when you start noticing, when I start noticing myself as treading carefully or not pushing, not asking those questions or forgetting to give the psychotherapy file or not asking for it back then I would be thinking there is something going on here around avoidant patterns, so there is using the tools to help identify what the attachment style is which I think is really, really helpful. (p1, lines 7-16)

Abigail described the invitation to collude with anxiously attached clients who are keen to be pleasing:

So anxious attachment might, there might be a temptation with this lady, client R, if she is trying to please and doing it all very well that can be quite seductive and kind of there might be a temptation to just collude with that entirely and let her do it all perfectly and she could be a really lovely client, a really easy, nice client but actually then you're not getting anywhere.

(p 1, lines 43-47)

Another way parallel process can be present is in the strong reactions clinicians reported having to some clients and not others. Abigail described feeling "irritated" by a client with an anxious attachment:

I am aware of people I have worked with in the past who kind of present like this lady (anxious attachment) and there is a temptation in me, it's part of who I am, to be quite irritated by this and it's an awful thing to admit to and there's kind of a real need to constantly reassure, which I don't think we should be constantly reassuring, but the invitation, I should say to constantly reassure is frustrating, (p 5, lines 204-211).

Luke also spoke about being "irritated" by some clients' lateness but not others. He also described feeling "bored" with some anxiously attached clients:

You are sort of trying to not get to bored of it and thinking about what you are going to be saying because you have heard it and time is ticking away and the sessions are ticking away and trying to make it important to try and bring it back in a sensitive way, (p 4, lines 160-163).

Six clinicians spoke about feeling "overwhelmed" by anxious clients due to the way they communicate, as well as due to their expectations (as described in the section on Ruptures, page 83 number below). This is described by Luke in the following quote:

The anxious lady or people with that presentation would give you lots of information quite quickly and I would feel quite overwhelmed but it might be quite difficult to try and say 'please slow down' if she is a bit sensitive so you have to manage the first sort of half an hour or first hour if you like quite sensitively because she is expecting lots of things to happen in a way so you might just have to listen (p 1, lines 13-18)

This awareness of the way in which clients could present appeared to be helpful in terms of therapists being able to think about, and anticipate how to respond to, these kinds of process issues. The clinicians described how they would manage these strong countertransferential pulls by anticipating them from the outset, and trying to be aware of when they were being drawn into them. Victoria (p 4, lines 172- 181) describes the importance of recognition and self-awareness:

I guess you are looking out for different tugs on yourself, as a CAT therapist obviously you should have done your own therapy and know your own reciprocal roles, some of us are more avoidant ourselves and some of us are more in the rescuer type, so you should know your own style and know whether this client's style so going to touch your stuff, because there are some clients who do and handle that, but with both it's about being warm, not over involved but not under involved but constant yet containing and I think actually although they have got very different attachment styles what you are trying to model is a healthy attachment style of kind of could it get predictable, safe, containing, not over involved, not under involved but boundaried and with very clear expectations of what your role is.

“Working hard” came up with both types of client. Lucie spoke about the pull to give “perfect care” with clients and how having a compassionate understanding of where this comes from for the client can help:

If you're not aware of how powerful that is, it's very easy for people to sort of either overdo and try to give the perfect care and everything or just get really peed off and then pull back too much so being aware of it helps with all of it which then obviously helps with patterns and reciprocal roles and stuff and all of that but I think that, it allows for a bit more 'ok, that's where that comes from' and be a bit kind of more accepting and tolerant of where people are at. (p 12, line 566-572)

Sometimes, being actively aware of their own attachment style was seen to be important as described in the following quote by Abigail:

Being aware of my own responses to both of the people and what they bring out in me and that gives you information for their potential attachment styles and what their needs might be,



but it also is a kind of a warning signal to myself to not activate my own stuff and to be very mindful of transference and counter transference and what reciprocal roles I am getting into and that type of thing, so I think it's about having your own personal awareness particularly when you are talking about attachment (p 5-6, lines 249-254).

Interestingly, four of the ten participants disclosed that they had a more avoidant attachment style and reflected on this, but none of the participants said they felt they were more anxious in their attachment style. It was acknowledged that one way to deal with these countertransferential pulls was to discuss these issues in supervision or in a supervision group. Lucie described it as:

The observing eyes, supervision is that, super-vision, it's the way we have the eyes to help more than one person to do that, we don't have enough space often for those things to happen but that's the way I see it and recognition that I can't capture all of the patterns that will happen so I need super-vision to enable me to do that (p 7, lines 310-314).

Again, Lucie spoke about actively using supervision to help 'forgetting' to name the ending with an avoidant client, and that self-awareness and aware of the attachment style can flag this up:

I think, and again try not to lose myself in it, or try to find myself, not that I am wanting to finish early but falling into avoidance too and 'that's the one that slipped my mind' that sort of thing so being aware, that's where being aware of the attachment style would help in also how to use clinical supervision to keep on track on that.

In summary, therapists highlighted a number of things that were useful in terms of not responding unhelpfully to counter transference. Firstly, participants spoke eloquently about what countertransferential pulls might present themselves with different attachment styles, suggesting that they could anticipate this to a certain extent. Secondly, they felt that understanding these pulls in terms of the clients' early experience was helpful. Thirdly, they felt that recognition and self-awareness was key and that supervision could be used to support and promote this.

### **3.6.3. Active Work on Resolving Ruptures**

All of the participants spoke about predicting the potential ruptures in reformulation letters, using the diagram to draw attention to them and naming them during therapy. They predicted the

ruptures based on the information in the vignettes and described ruptures they had had with clients. Most of them agreed with the sentiments expressed by Victoria, below and ruptures were described as a “gift”:

I always see a rupture as a moment of great therapeutic opportunity, if you can repair a rupture then that’s a therapeutic intervention in itself and it’s often the most useful bit of the therapy that you do so, to not panic and to view it as a really good moment to work through for both.  
(p 6, lines 264-268)

The ruptures and responses will now be discussed for the clients with more anxious attachments and then for clients with more avoidant attachments.

There was a consensus that the potential rupture for the anxious client was that they may feel abandoned or rejected as the relationship will “never feel as close as they want” based on their experiences in previous relationships. This is described Lewis: “I think people who get really preoccupied could get over-attached, could get really disappointed and feel let down. “One patient that did get over attached [to me] really and got really kind of angry because they felt betrayed” (p 4, lines 186-191).

Therapists had developed an understanding of what the potential triggers for this could be. For example, the therapist being “ill or off work or on holiday” or them “seeing you with another client” (Victoria, p 5, line 215) or sometimes saying something insensitive. Victoria gave a good example of this happening in her clinical practice, when a client had a very strong reaction to something she had said. The following quote illustrates the “felt distress” that has been previously described in anxiously attached clients, and how Victoria responded to help the client feel contained and return to therapy:

I did have a very emotionally unstable lady who was quite anxious (in her attachment style), had terrible abuse history and I said something to her and she took offence and she ran out of the room and ran out of the building and threw herself on to the gravel outside and was screaming ‘how could you do that, how could you do that’ and then someone in reception panickingly pressed the alarm and lots of colleagues came down and I was just like ‘ahh’. And I tried to sort of say ‘can we get back in the room?’ and I sat there for a long time, she stayed

there and she didn't say anything and I just sat down next to her and said 'I will stay with you through this moment'. And then we got back in the room and she did complete her therapy, she did 24 sessions so that was good. And I think often people who are emotional unstable or very disconnected have a great fear, they have a huge rage in them or something really ugly that if they really show others, others will reject them. And so when clients behave badly that's the greatest moment to show compassion and acceptance really and if you get that wrong I think you can actually harm people, so it's really important. (p 6, lines 274-288)

Lucie and Sam described that due to the over attachment, the ending could be a catalyst for rupture, due to past issues of abandonment, loss and feeling as though others are reluctant to get as close as they would like:

It's coming to the end and it's going to be difficult and making sure how many there is going to be, being clear about how many sessions, being clear about how many follow ups, things like that because the ruptures might come with "you are not doing enough for me, it's not coming up and then you are going to leave me, you're going to dump me like all the rest" that sort of stuff, potentially I would consider might be there for that person (Lucie, p 4, line 178-184)

Sam spoke about clients needing ongoing input from the wider team, as this would be important to manage ruptures particularly towards the end of therapy:

I think the rupture with Client R would be the escalating distress at the end of therapy if therapy hasn't managed to address to work on that dependency in which case you need a bigger picture of working with the team in order to help them contain that. But I would still want to finish therapy on time unless there was some dramatically different valid reason not to but then I'd want a care coordinator in to help manage that anxiety because that would come up but then I am still maintaining my boundary and I'd still be there for the follow up and I'd still be there kind of like to share the diagram with the care coordinator and I would still build the bridges and still work on the therapeutic relationship but still keep the boundaries (Sam, p 11, lines 283-290).

All ten of the clinicians reported feeling that ruptures needed to be addressed quite actively, and in a collaborative way, by naming them and working through them together. The following quote by Sophie represents the responses from all of the clinicians:

Again it's the same stuff, it's naming it, its bringing it back to the reformulation, it's looking at it in context, its saying it's not about you and me, it's about a bigger pattern and how can we resolve this and work through it together and what will be helpful? Being very mindful of that (p 5, lines 216-219).

The potential ruptures for the avoidant client were identified by the participants as the risk of “dropping out”, “dissociating” or being very “critical of the therapy or the therapist”. Participants felt that this was most likely when the therapy felt too emotionally intense to the client and was out of their Zone of Proximal Development (ZPD) and when they experienced this as challenging. This process is described by Lewis:

With this one, well maybe there would be a rupture with avoidant people because sometimes there's a kind of difference about how you think you're going to make any progress in therapy. And if people come into therapy and think well if we talk about this and we are clever enough we'll understand it and then it will change then it can just repeat that kind of slightly distancing, rationalising procedure, so that can be a rupture in the sense that you haven't got a shared idea of how you're going to make progress really, it can all be done up in their head and I guess they could stop coming or avoid coming. (p 4, lines 191-198)

Ian gave a very good illustration of an avoidantly attached client becoming critical and dismissive from his clinical practice:

The last really avoidant person I did CAT with was really, there was a big rupture towards the end when he started to bring all these CBT diagrams to sessions. I don't know if you know “Living Life to the Full”? It's kind of CBT self-help stuff where they have vicious cycles of your thoughts and behaviours and feelings and physical stuff and he had filled these all in a really detailed way and he had brought these to our CAT sessions and he was saying ‘isn't this brilliant, I just have to stop doing this and it affects how I feel, isn't that amazing?’, and I am

like ‘what are you talking about?’, I didn’t put it like that but I was kind of, you know ‘what’s going on here? Sounds like you found the magic answer there, sounds good’ but it was a bit of a rupture really because he was basically saying, ‘I think’, and we got somewhere towards discussing this, I think he was kind of saying ‘look this makes sense, this is really simple isn’t it, it’s neat and tidy and it doesn’t have to be difficult, you’re making things too complicated, you’re making things too difficult, this CAT isn’t for me, it might be for some people, it’s not for me’ it was kind of a big two fingers really to the therapy (p 4, 159-174).

Like Ian, above, Sam described that his therapeutic response to this kind of dismissal would be naming it in the first instance : “Client S could be quite critical but I don’t mind that (laughs) we would have a conversation about that (laughs) if she’s unhappy with me and she’s telling, that’s a real result (laughs)” (p 11, lines 294-296).

However this is only possible if the client is still attending therapy. Another potential rupture would be if clients started to miss appointments and ultimately drop out of therapy, this is summarised by the following quote by Natalie:

Avoidant ruptures; I think they tend to just not come. I think that you’re, if I get a DNA its often thinking back what happened last session, I think it’s that bit where I can, I have sometimes thought that was a really good session and we really got there and they DNA for a couple of appointments and you think actually it was too much it was too difficult (p 5-6 lines 248-252).

Again Natalie is trying to formulate what may have triggered the rupture in order to help her, and ultimately the client, make sense of it. This close attention to these triggers, with a view to naming the process and working through this together appeared to be the main therapeutic adaptation for both kinds of attachment style.

As mentioned above, dropping out was perceived to be the biggest risk for avoidant clients, and participants felt that avoidant clients needed to be gently invited back in, as described by Sam:

I guess the biggest rupture for Client S [avoidant attachment] would be not coming and for her if she didn’t come one time, whether that’s a cancellation or a DNA [Did Not Attend], either I

would want to respond to that ...thoughtfully, just as a way of maintaining that connection, trying to anyway (p 10, lines 253-255).

Sam felt it was important not to express too much emotional intensity about the rupture (see above). Luke (p 7, lines 332-334) described his way of resolving this therapeutically “if there was a session missed going back and being quite empathic about why they missed and why they come back and understanding that they have come back and saying ‘well done for coming back’”. Modelling positive regard in this way was seen as giving clients a different experience and as something they could then apply to the other relationships in their lives.

To summarise, the potential rupture experience for anxiously attached clients were feeling abandoned or rejected and showing anger about this. Clinicians described that the most helpful response to this was modelling, scaffolding and naming processes of dependency in a compassionate and containing way. The potential rupture experiences for the avoidant client would most likely to be feeling critical of the therapy and dropping out. The clinicians described that the most helpful response would be modelling, scaffolding and naming processes of independence.

#### **3.6.4. Active Work on Ending Issues**

Clinicians described anticipating that both the anxious and avoidant clients would find the ending difficult, regardless whether or not there was a rupture. This section will describe the goodbye letter and the ending. Many of the same behaviours and responses were observed towards the end as in the ruptures and many of the therapists expressed that the ending could represent previous abandonment for the anxious client. Sophie described “for the first client [the anxiously attached one] there could be lots of distress emerging as we are, more so as we approach ending, the fear of being abandoned” (p 5, lines 145-146). Clinicians described that the anxious client may try: “to bring some sort of crisis to the final session which would often try to extend the ending or want more or perhaps be quite angry that the ending was happening” (Victoria, p 3, lines 118-120). Victoria described that CAT allows you to anticipate the difficulties with ending early on based on the client’s previous history of relationships and loss events:

You would have hopefully predicted that in your letter and in your diagram and it would be about naming that and sort of saying well 'you might have expected this and this is part of a bigger pattern and is this how endings have been with other relationships?'... And I suppose you would predict on her map that she might have an idealised rescuer to helpless child or victim on the map. And naming that and saying, well hopefully all the way along you have been identifying that that's not the process of therapy but we might often people progress a bit to that in the last few sessions because of the fear or ending and we might look at rejections in her childhood and how that might echo how she might feel now and hopefully, what you want is somebody to be able to express some dissatisfaction with the ending and perhaps some anger in that might be healthy and to be able to say 'it's ok to feel those ways' (p 2, lines 132-146).

The formulation being used to "predict" how the client might respond to the ending was mentioned by six participants. Predicting how the therapist might feel drawn into responding to the client's ending issues was also mentioned, for example by Lucie who felt there could be a temptation to offer more follow-up sessions to the anxious client to help them through the ending, and needing to be aware of why you might be doing so and being transparent about this:

I would be thinking with where I am at which I feel is that I can be caught between do I give more because more might be better or do I go with that because actually we do need to get to an ending and that's ok too and work with the sort of tensions around that, but keep a clarity to it, to what we are doing. I might be quite clear about follow ups though so I might do who knows, this might be my problem but I might give this person 2 or 3 follow ups but I would want to set out that's what we're doing, so I would want to be clear about how were managing that really (p 4, lines 193-200).

Sam also spoke about the anxious client possibly requiring more follow up but spoke about using the care co-ordinator to do this to maintain the boundary that had been set in therapy;

I am still here so again it shows both clients, well any client that they are still being held in mind. Therapy has an ending but the therapeutic benefits and process can go on and I can

support that in whatever way is appropriate, it might be ongoing follow ups or ongoing meetings with the care coordinator, it might be a chat over the coffee [with the care co] whatever is required (p 17, lines 449-452).

Seven of the clinicians described that avoidant clients may start to withdraw at the end of therapy, Abigail described that it is important to notice it and to discuss it with the client but that this can be uncomfortable for both parties. She discusses holding on to uncertainty in a containing way, which links to Sam's quote above about holding the client in mind:

But to work with that person to notice ways that they be avoiding it, so things like they might turn up late to a session, they might start missing sessions, certainly somebody I was working with just kind of withdrew in the last couple of sessions and it felt like we were skimming really and we were just biding time to end so it takes quite a lot of energy and hard work to not go along with that and to acknowledge the difficulties that are still there, (Abigail, p 4, lines 175-179).

Other therapists described that the avoidant client might become quite critical towards the end of therapy as a way to protect themselves from the pain it causes:

If she has engaged you want to really encourage that, and name that and praise her for that because it's obviously been really difficult and she has taken a real risk to engage with someone and to name that it may feel really hard for that to come to an end and there may be questions like should I have done that? And should I have risked getting close to someone or opening up?, And working on some of that for her and that she may be critical of me and critical of the ending and that's ok and that's normal. It doesn't have to be a perfect therapy, it just has to be a good enough helpful therapy. (Abigail, p 4, lines 154-163)

For both types of attachment, the therapists felt that the adaption would be similar in that managing the ending involved using the formulation to predict the client's response to ending, naming any process issues which might be related to ending, and normalising any responses.

The ability to tolerate an ending was thought to be a good indicator of how well the therapeutic distance had been managed throughout the therapy and many of the participants discussed



that there was a parallel process in that they found themselves “a bit sucked into avoidance at the end” (Sarah, p 4, line 124) and avoiding talking about the ending with both types of clients “without meaning to” (this is also discussed in the section on collusion and parallel process). The adaptations of technique that participants mentioned to cope with this predicted “forgetting” and the parallel process of avoidance, were using supervision, or even external prompts, to increase awareness of the impending ending. This is illustrated by Lucie:

I would be using supervision for my awareness that actually it would be easy to end up avoiding the ending by mistake. So part of clinical supervision would be saying ‘there is a bit of a risk, and I could lose track here’ so need to be reminded to bring in the ending within the last four sessions. (p 2, lines 61-66).

Three clinicians spoke about using calendars and setting alarms to remind them to discuss the ending. Ian spoke about naming the ending from the beginning “giving a list of dates, making sure it’s really explicit, the limitations of the therapy and really trying to not name, but help them to recognise some of the conflicting feelings they have about the ending” (p 3, lines 109-111). When discussing the ending with clients, the focus was on helping them to name some of the feelings they were having around endings in a genuine way while helping the anxious client to acknowledge the changes they have made and helping the avoidant client to acknowledge that therapy had been hard at times. Lewis described helping the clients to do this through modelling and some self-disclosure:

So the technique is the same in the sense of ‘we have two sessions to go, how are you feeling about that?’, ‘what are you going to take away?’, ‘what can you practice?’ with this one [the avoidantly attached client], lots of ‘how do you feel?’ very much and I think it’s important with the avoidant lot to maybe model a little bit, talking in a more personal way about the therapy relationship and what’s its meant, and it’s always a little bit one-sided a therapy relationship, so you haven’t disclosed hardly anything about yourself probably but I think it’s really important to say something personal there so ‘it’s been nice to meet and I have appreciated the trust you have put in me’ and ‘I will think about how you are getting on’ and ‘I feel a bit sad’ or something like that and to invite them and encourage them so maybe a bit

more modelling, whereas with this more preoccupied people it's about keeping in mind that we are ending, we are going to end, giving them a chance to say how they feel about it but not to forget it, because I think the risk is that they talk and talk and talk then you stop almost in mid flow, so a different emphasis, but the actually techniques are the same, counting the sessions down to doing a goodbye letter, talking about the end, thinking about how it links to the reformulation and diagram (p 3-4, lines 144-159)

There was an emphasis on giving clients a well-structured ending as this can be therapeutic in itself, and this is illustrated by Natalie:

Have a good ending. So you can have type of ending that you haven't had in other types of relationships before where you get to say the things that you want to say. So I think that is much easier about talking about it and I think the ending letter is often really helpful for people as a way to tell you how they felt about therapy, but also take a piece of you away with them almost like a sort of transitional object (p 5, lines 237-243).

Participants made fewer distinctions between how they would write the goodbye letter for the avoidant versus the anxious client. Some differences between the letters would still be present;

I think it would have a different flavour a bit like the reformulation letter, it would probably be easier to write the letter to the anxious person than the avoidant one because they have probably been a lot clearer through the sessions, you know this is what we have got to cover ...I think it's a lot easier to write and perhaps a lot more flowing and they might have done a lot more things in the therapy time than perhaps the avoidant person so there may be a bit more to work with, a bit more substance if they have been out or tried different things, then perhaps the avoidant person there may be less actually be done during the therapy and again it would probably shorter I would think, the avoidant letter than the anxious letter, but yes trying to keep a similar sort of warmth and compassion and I think it would be more difficult to write that style with avoidant person, depending on the relationship you have built perhaps over the sessions but sometimes I have been sort of struggling thinking about a letter from session 9,10 onwards and it's not until session 13,14 the avoidant person starts to worry about the ending

and starts saying 'well I am going to miss the ending' so sometimes it does warm up again towards the end where you might get the opposite with the anxious person, getting really worried about the ending so cooling off a little bit and being a bit more detached but by that time generally you have quite a lot of information and you can word that in to the letter, you know 'you're worried about the ending'. With the avoidant person you might not be able to write too much until the last 2 sessions because you might not get too much from them about the ending until that time because of the nature of them being avoidant. (Luke, p 6, lines 255-277)

Abigail (p 5, lines 217-222) described hoping that the goodbye letter would reflect the ways in which the relationship had developed in line with the relational goals that were discussed earlier:

The goodbye letter for the avoidant person could be warmer and more personal and less clinical, you would hope that by that time you have got that relationship in order to do that, and it doesn't feel too intrusive or too much. Probably conversely, for the anxious style I may have a temptation to be a bit more clinical and more structured and containing, to kind of hold that anxiety, which I haven't thought about before but I would be more structured on that one.

It seemed that the participants felt that they couldn't predict if anxious or avoidant clients were more or less likely to give goodbye letters in return to their therapist but that there would be differences in the type of goodbye letters they write which would reflect their relational style. Interestingly participants said that they had noticed that both anxious and avoidant clients can be pleasing in the goodbye letter. A way to moderate this was discussed by Natalie:

I would encourage them to write about something in their therapy that has been most difficult or even if it's like the one thing that I asked you or one session that you felt like you might have felt most annoyed with me or most irritated or most challenged and try and give them lots of permission to do that and actually I am going to the same, I am going to think about the session I found most difficult so that it is almost like yes there is permission to talk about that. (P 8, lines 368-378).

Both Victoria and Sam discussed that receiving a present from an anxious client at the end of therapy can be a sign that the interpersonal goal hasn't been met:

I mean Client R might still be desperate to please and then write a letter to please me so that maybe I'll give her more sessions but actually if it's been a good therapy, a successful therapy then she'll be less preoccupied in pleasing me in which case I think that's good that you don't get a goodbye letter or a gift, I think it's a good thing that you don't get kind of get gifts because it means that you have actually managed the dependency really well, it can be an unhealthy sign. (Sam, p 7, lines 176-181)

To summarise the participants described that the writing of the goodbye letters by clinicians to the client would be the same for both clients which is a different experience from the writing of the reformulation letters. Clinicians described that the goodbye letter they would receive from the anxious client would often be more, structured marking a change from the start of therapy. They advised caution around receiving a present from an anxious client and would encourage clients to write about what was hard in the therapy. Mostly participants expressed that they felt the anxious client would wish to extend the therapy and feel angry about this not happening but that they must be helped with this by both client and therapist remaining aware of the ending. In the case of the avoidant client they anticipated a warmer, less clinical letter and that the client would try to down play the ending and cut off emotionally.

### **3.7. Summary of Results**

Overall, it seemed that participants were quite familiar with the different kinds of attachment style and could use the vignettes as well as examples from their own clinical work to stimulate thought and reflection. The underlying mechanisms appear to be helping avoidant clients to introduce more emotional elements to their narrative and to help them to be more dependent in their relationships. For anxious clients the focus was on adding a more cognitive element to their understanding of their emotions, to work on reducing emotional intensity, and help them to become more independent in their relationships. Participants spoke about the need for "cooling down" or "heating up" the therapy with anxious and avoidant clients respectively. Participants described the ways in which this was done

using the tools and processes of CAT and how this impacted on their own experience of conducting the therapy.

Participants seemed to be working hard to be very self-aware of their own countertransference and to try and understand this in terms of the client's history. They felt there would be specific countertransferential pulls involved in the two different kinds of attachment style, with anxious clients creating a pull to be rescued and not be abandoned and avoidant clients creating a pull to be rejected via their critical and dismissing behaviour. Participants spoke of both types of attachment style needing boundaries but for the boundaries to be reinforced in a gentle way for the anxious client and a non-intrusive way for the avoidant client.

The data that was produced by the interviews was rich, in the sense that some small extracts from an interview might speak to many of the themes that were identified, and leading to overlapping coding.

It is important to recognise that throughout the interviews, many clinicians described using the same techniques in different ways depending on the clients' presentation. Additionally all ten of the clinicians stated that they would not do anything differently at various points throughout the interviews, because of this very little prompting was used; instead we would focus on the areas that the clinicians engaged with. Care has been taken throughout the results section to give numbers for when a theme was discussed to highlight this variation. Due to the inductive nature of the research, and the prior decision to only code information directly linked to the research question, observations around using the same techniques for both attachment styles were not encapsulated by the original coding and a decision was made to go back to the data to recode those statements which talked about not adapting the therapy. This included when participants said that they would use the same strategy or if there was no difference in the way they would respond. For this type of quote there were 78 sources with 120 references (out of a total 336 with 1107 references). One participant in particular described feeling that the premise of the study, adapting therapy depending on attachment style, was at odds with CAT's idiographic approach, this is discussed more in the discussion section.

## **4. Discussion**

The aim of this research was to identify how experienced CAT practitioners adapt therapy for clients with anxious and avoidant attachment styles. The results section has identified firstly that clients with anxious and avoidant attachment styles behave differently during CAT. Secondly, that the attachment style of the client impacted on the therapist. Thirdly, that specific adaptations are made for both clients with anxious and avoidant attachment styles by clinicians and finally that when adaptations are not made the underlying principles and tools of CAT give a way to respond that is containing and therapeutic. These findings will now be discussed in turn.

### **4.1 Clients with Anxious and Avoidant Attachment Styles Behave Differently during CAT**

The behaviours of anxious and avoidant clients in therapy are consistently reported as different throughout the existing literature and these differences were also present in the descriptions the participant clinicians gave, when prompted with clinical vignettes. Even when participants stated that they would not respond differently to the anxiously or avoidantly attached client or make any adaptations, they still described ways in which they perceived clients would behave differently in therapy and ways in which clients have responded differently to the CAT tools and phases. This demonstrates that many clinicians recognise these behaviours and conceptualise clients based on this, even if they don't subscribe to Bowlby's theory of attachment or models of adult attachment (this concept is expanded on later in section 4.3). This was particularly evident throughout the themes of 'Achieving optimum affect for therapeutic work'; with subthemes of 'Balancing Cognition and Affect; Heating up or Cooling down the Emotional Temperature'; 'Using External Tools to create distance or prompt affect' and 'Achieving optimum relational distance for therapeutic work'. Where clinicians described awareness of relational cues and adapted their responses in ways to build trust and rapport with clients. From these descriptions we learn that the clinicians have the relationship at the forefront of their minds and use their knowledge of different defence mechanisms to engage with different clients. This clearly requires a complex set of skills but the clinicians describe it in an intuitive way and this is discussed further in section 4.3 and the practical adaptations are described in Table 6.

The vignettes were used as springboards for discussion but did not contain any reference to CAT-specific tools, phases or descriptions. However, in the interviews vivid pictures of typical behaviour were built up that were consistent across many of the interviews. It seemed that participants could identify with the descriptions, easily relating to the vignettes, which seemed familiar to them from their clinical work and often led to discussions of “clients like this”, that is, similar to the ones in the vignettes. Participants, for example, described the avoidant client completing the psychotherapy file, as being dismissive, minimising it, some of being critical, others of not completing it at all. The descriptions that participants gave concurred with descriptions of these attachment styles in the relevant literature. A good example of this is that clinicians described that due to the over attachment, the ending could be a catalyst for rupture, due to past issues of abandonment, loss and feeling as though “others are reluctant to get as close and intimate as I would like” (David Howe, 2011) as described in the dimensional model.

The descriptions by Harris (2004) of the behaviours of the anxious clients as fearful of rejection and preoccupied, and of the behaviours of the avoidant clients as withdrawn, dismissive and fearful (of engulfment) can be seen in participants’ descriptions in the current study, as can the relevant focus be seen in the adaptations (discussed later).

#### **4.2. The Attachment Style of the Client Impacted on the Therapist**

Clinicians were able to give specific examples of the impact of having clients with insecure attachments had on them. This is described in the subtheme of ‘Process Issues around the Relationship’, but was present throughout the interviews and was a driver for many of the adaptations made. There were many examples of this including noticing that one is avoiding discussing the ending with a client, realising through supervision that there is an underlying fear of how the client will respond and then making the adaptation to set reminders, and naming it explicitly and facilitate discussion around endings with the client. Jellema (2000 describes) how CAT can be adapted to incorporate attachment theory and models of corrective emotional experiences. Jellema described that with attachment difficulties there was a need to be conscious not to collude with clients, and to have

an awareness of exclusions, restrictions and distortions in reciprocal roles and core states in order to address them in therapy. She also suggested examining procedures and asking if the aim is more dismissing or preoccupied and helping the client to develop skills of self-reflection (bringing together affect and cognitions). The themes from this study support Jellema's original ideas about adapting therapy for attachment difficulties and the information in Table 6: Pragmatic Adaptations to Therapy with Anxiously and Avoidantly Attached Clients (below) give practical advice on how to do so.

The above example of avoiding the ending demonstrates that the participants were aware that they were being used as, or had become, an attachment figure throughout therapy (Ainsworth, 1991; Hazan & Shaver, 1994; Daniel, 2006; Obegi & Berant, 2009) as previous patterns of relating are present (even if the clinician does not accept the theory of internal working models, CAT acknowledges that patterns of relating are repeated). From this, the participants appeared to be aware of the need to offer a corrective emotional experience based on the way they choose to respond. Choosing the way to respond is an important element of CAT and is described in the quotes about "joining the dance". Endings and ruptures were seen as particularly important times to give clients a different emotional experience that was seen as therapeutic in itself. This is particularly important when considering the research around therapy and working alliance (Levy et al., 2011) and the association with insecure attachment and higher drop-out rates (Tasca et al., 2004; Fowler et al., 2013; Fonagy, et al., 1995).

#### **4.3. Specific Adaptations are made for both Clients with Anxious and Avoidant Attachment Styles**

As well as identifying the different ways they perceived clients with anxious and avoidant attachment styles behaved in therapy, clinicians gave explicit examples of ways they would respond differently, adapt the therapy, or use the CAT tools in different ways depending on the attachment style. In CAT terms, adaptations were made, so that the therapy remained within the client's Zone of Proximal Development (ZPD, Vygotsky, 1933) consistent with both relational and affective goals. Participants appeared to be very sensitive to what the clients would be able to manage, both in terms of levels of affect in the room and relational closeness.



One of the most prominent themes in the analysis was around being very attuned to the levels of affect in the room and to be working hard to modulate this so that they client stayed within a zone which was manageable for them. This came out in the analysis within the main theme of 'Achieving Optimum Affect for Therapeutic Work' and within the subthemes of 'Balancing Cognition and Affect', 'Heating up or Cooling down the Emotional Temperature' and 'Using External Tools'.

Crittenden (1995a) described that avoidance is a 'cognitive' (think) rather than 'affective' (feel) strategy and that anxiety is a feel rather than think strategy. Balancing cognition and affect is usually described as a long-term goal rather than as something that can be actively done throughout a therapy in a dynamic way. In this study clinicians were aware of balancing cognition and affect and described mediating it through the relationship and through the use of external tools. These pragmatic adaptations have been extracted and put in Table 6 (below).

An imbalance of cognition and affect is a Bowlbian idea that is often discussed in attachment literature. Jellema (2000) explores this concept in line with the Dynamic Maturation Model by Crittenden (1997b) and states that CAT and attachment theory could be integrated by helping avoidant clients' to engage more with affect to aid acknowledgement of reciprocal roles and eventually core pain and by helping anxious clients to think sequentially to make sense of their core pain and their active parts in reciprocal roles.

This process was described previously by Harris (2004) and presented in Table 2 (titled 'Using Attachment Classifications to Build the Working Alliance') in the introduction chapter. Harris (2004) highlights the parenting received, the client's behaviour in therapy and ways to support a working alliance by giving the client a different relationship from their previous experiences. The focus for therapy set out by Harris captures elements of the subtheme 'Achieving Optimal Affect for Therapeutic Work (heating up and cooling down)'. We have also seen this in the modulating therapeutic distance model by Daly and Mallinckrodt (2009). The focus of this model is boundary management through the therapeutic relationship to give a corrective emotional experience. Many of the themes from the Daly and Mallinckrodt study are also present in this research such as managing therapeutic boundaries particularly around the beginning and end (in this study '*Achieving optimum*

*relational distance for therapeutic work*) ensuring clinicians are a consistent attachment figure throughout, helping clients to ‘develop a language’ for their difficulties and developing a ‘dialogue between parts of the self’ (in this study *Balancing Cognition and Affect*), ‘respectful pacing and timing’ (in this study *Achieving Optimal Affect for Therapeutic Work*), increasing relational security (in this study *Relational Goals*), helping to ‘repair and change through insight’ (in this study *Managing Ruptures*), greater ability to tolerate emotions (in this study *Affective Goals*).

The themes in this research mirror the processes that occur during the stages of therapy (beginning, middle and end) demonstrating that a process of achieving optimal affect happens in the therapeutic relationship. This is done by identifying relational and affective goals, pacing the work so that it is within the ZPD of emotional intensity for the client, responding sensitively to ruptures to model emotional regulation and appropriate closeness in relationships. By the end of therapy it is hoped that clients can better recognise their own unhelpful patterns and apply what they have learnt in the therapeutic relationship to other relationships in their lives. This process is similar to that described in Figure 3: Management of therapeutic distance to facilitate a corrective emotional experience for clients with attachment avoidance or anxiety by Daly & Mallinckrodt (2009)

#### **4.4. When Adaptations are not (stated as being) made the Underlying Principles and Tools of CAT give a way to Respond that is Containing and Therapeutic**

As described in the methodology (section 2.7.4.) ‘researchers perspective of conducting the interviews’, all of the clinicians said things like “there’s no difference in how I would respond” or “I would use the same technique for both” or “I’ve never even thought about it” or “it doesn’t matter” at points during the interviews and this has been reflected in the reporting of results where numbers of participants that spoke about themes are given. When these statements were made they were linked to using general therapy skills to respond such as listening, containing, being ‘alongside with the client’, using supervision. The framework of CAT gives ways to pace and respond that will be therapeutic even if clients are not formulated with attachment in mind. A good example of this is that regardless of attachment type, all ten therapists who mentioned the psychotherapy file, felt that they would respond to clients with gentle persistence and by modelling and supporting the client through the task which

could be done together with encouragement. This can be seen through an attachment lens, but equally it fits explicitly with the Vygotskian influences in CAT, which stress the importance of the therapist scaffolding the learning of the client, by doing alongside initially: “what the child is able to do in collaboration today he will be able to do independently tomorrow” (Vygotsky, 1934/1998b, p. 202).

The participant given the pseudonym Sophie described feeling that the premise of the study, adapting therapy depending on attachment style, was at odds with CAT's idiographic approach, and this observation is consistent with the standpoint described by Ryle (2000). Sophie consistently said things like “I don't categorise people in that way”, “I don't want to pigeonhole people” or “I can't quantify exactly in those sort of boxed terms”. However Sophie did describe specific ways that she might respond to clients with relational problems, that demonstrated the thoughtful and responsive way that she used CAT. These were described as procedural revisions rather than as adapting to attachment style. She was not alone in this viewpoint, as CAT is an individualised therapy and the reformulation letter, SDR and goodbye letter will be unique to each client. This is stated in the results section by another participant; “not everybody will have the same diagram because it won't be a diagram for attachment style it will be a diagram for them and for their other aspects of them as well”. Sophie has fewer sources and references (see Table 4: Number of Codes and References per Interviewee) compared to other clients as she used the interview time differently and spoke of things like the differences in the versions of the psychotherapy file, that she was surprised that the diagram was not mentioned earlier in the interview, and the value of an individualised approach. Although these topics are interesting they are not directly linked to the research question and so were not coded.

With reflection, this may be the downside of the researcher viewing the research with an attachment lens as this creates a more theory-driven perspective. Sophie demonstrated a very strong opposing position and this may have led to the researcher taking an equally strong standpoint in a reciprocal manner. This led to rigidly sticking with the prior decision to only code information directly linked to the research question (as described in section 3.7). After some time and emotional distance from feeling challenged it was clear that this method lost valuable information about observations around using the same techniques for both attachment styles. These observations were not

encapsulated by the original coding and a decision was made to go back to the data to recode those statements which talked about not adapting the therapy. This included when participants said that they would use the same strategy or if there was no difference in the way they would respond. All of these incidences could not be reported in the results as the focus remains on pragmatic adaptations but transparency and reflection of them, as done here, remains important. It seems evident now that the analysis was more theoretical than inductive. This is of course one of the pitfalls of theory-driven research, it can be directional, it informs one's thinking in a structured way and may lead to less exploration. However exploring a phenomenon within a theoretical framework allows us to test our theories and adapt them to incorporate new information. As discussed earlier, attachment and CAT have strong theoretical underpinnings which although they are not at odds with other, key figures have taken strong positions that they are separate. This may have played out during the interview with Sophie or informed her perspective. Observations around using the same techniques for both attachment styles were not encapsulated by the original coding and a decision was made to go back to the data to recode those statements which talked about not adapting the therapy. This included when participants said that they would use the same strategy or if there was no difference in the way they would respond. This project is based on two heavily theorised bodies of work, attachment and CAT, and this will ultimately influenced the way that adaptations were thought about and discussed as well as making the analysis more theoretical than inductive.

This research was examined through an attachment lens and from the outset it was clear that this would focus on practical adaptations, which has been achieved. It may have been hard to maintain a critical realist stance within this context. Participants did share their views openly and the researcher was genuinely interested in their perspectives, their perceptions and their experiences, but the interviews, and to some extent the analysis, may have been overly constrained by the theoretical framework. For example, having been presented with vignettes, there was already an implicit assumption about the reality of attachment categories or dimensions and a suggestion of tacit agreement with this theoretical position. Participants were also directly questioned about differences in therapeutic practice and technique with the clients these vignettes, which again presupposed that there

would be differences. This may have created bias as it may not have allowed enough room for assumed knowledge to be contested or for other perspectives to be included. a framework influenced by theory and that they did this whilst being resented vignettes that demonstrated extremes of insecure attachments as springboards.

#### **4.5. Evaluation of Methodological Rigour**

Methodological rigour has become quite a hot topic within qualitative research (Morse, 2015; Kornbluh, 2015) with concepts such as credibility, transferability, dependability, and confirmability and other concepts related to the notion of trustworthiness of the data.

In terms of credibility (or internal validity), efforts were made in this study to ensure that a true picture of the phenomenon has been presented through the clarity of reporting. This was done by being transparent in the reporting of 'A Priori Decisions about the Analysis' (2.1.4), and by setting out clear ontological (2.2.1.) and epistemological (2.2.2.) positions which ensured the transparency of the researcher's position (2.2.3.). This could have been improved by including a member's check at the end to ensure that participants felt the analysis reflects their position.

When considering transferability (external validity, or generalizability) some contextual information has been provided in sections 2.9.2 'Situation the Sample' and in Table 5 which shows Participant Demographic Information. This is considered adequate so that other researchers can decide if the findings are transferable to their specific contexts.

In terms of confirmability (objectivity), this was done by providing a clear audit trail of what was done during the analysis through the 'credibility checks on the analysis' (section 2.9), description of stages of analysis and reflexive diary entries

The Publishability Guidelines Especially Pertinent to Qualitative Research (B) by Elliot et al. (1999) are discussed in the methodology chapter. 'Coherence' and 'resonating with the reader' will now be evaluated.

Coherence refers to the extent to which the analysis forms a coherent story or narrative. Efforts have been made to achieve this by naming the themes and subthemes at the beginning of the results chapter and discussing them in turn with relevant linking text. The themes and subthemes

follow the stages of therapy to give chronological order that is meaningful for the reader as it describes the therapy journey involving both the client and clinician.

Resonating with the reader (this section will be written in the first person); as an active reader of research myself it has been important to try to bring the results sections to life by using vivid quotes and providing sensible descriptions and linking texts. I have used my experience as a therapist on a CAT placement to do this in a way that resonates with me and my primary supervisor. Ordering the themes and subthemes in chronological order was a good way of doing this to make it seem logical and familiar to therapists reading the research.

#### **4.5.1. Study Limitations**

As previously described this research assumes interviewees have some prior knowledge of attachment theory and there is an assumption that they accept this is a consideration during therapy. This may have created a sampling bias in that only people with a strong interest or a strong opposition agreed to participate. This was present with the participant Sophie (described above). Of course attachment is not the only way to understand behaviour. The use of vignettes helped to augment understanding and ensure that there was a baseline shared knowledge but they would have inevitably influenced the discussions. Likewise the topic guide gave some structure and uniformity but care was taken to follow up spontaneous areas of interest particularly around examples of past and current clients. The themes that emerged are based on information that was elicited through the questioning and so shaped study findings. All of the therapists worked in a local Mental Health Trust, therefore it is likely that the pool of CAT trainers and courses is relatively small and that this may influence the way the sample approach clinical cases. If the research were to be repeated it would be useful ask about clinician experience in a more standardised way, this would provide more information and allow easier comparison across studies. Other useful information to collect would be; access to supervision (including group), as the therapists are part of a local network and will influence each other's practice via supervision groups. So it would be good to know if they had arrived at their adaptations independently (as a form of "convergent evolution") or whether it arises from shared cultural ideas from this group of CAT therapists. Also of interest would be the degree to which they are doing 'pure'

CAT rather than something more eclectic, where they did their CAT training, if they feel their primary qualification (occupational therapist, nurse, psychologist) impacts on the type of CAT practitioner they are. It would be interesting to ask if they had received any training on attachment-based therapy or any reading on attachment in CAT and what they remembered from this to ensure that any consistency of themes arises from the analysis and not from received or prior knowledge.

There is a possibility that being interviewed by a junior peer may have influenced participants to appear more expert than they are and appear more certain than they might have been. Efforts were made to reduce this in the informal way the interviews were conducted and as described in the methodology (section 2.7.4.), within the ‘Researchers’ perspective of conducting the interviews’, there was not a sense that this was present. Equally one could argue that giving socially desirable answers could have been reduced as participants were in the “expert role” and there are no standards or guidelines on how to adapt CAT for attachment.

As described above, using members’ checks would have increased the credibility of the work and conducting a secondary stepwise replication of the analysis would improve the dependability of the work. However neither was possible in the timeframe.

#### **4.5.2. Study Strengths**

CAT is an under-researched therapy and this study demonstrates it has a utility with clients with relational difficulties in NHS secondary care settings. This is particularly poignant as CAT is a time-limited therapy and therefore could be argued to be more cost effective (Association of Cognitive Analytic Therapy, 2016.). Additionally it supports the work of Clarke, Thomas and James (2013) who demonstrated CAT’s effectiveness with a groups of clients with differing personality disorders, who are likely to have severe attachment difficulties (Lyons-Ruth 2003; Lyons-Ruth, Ditra, Schuder & Bianchi. 2009; Liotti, Cortina & Farina, 2008).

It was important to explore if the model proposed by Daly and Mallinckrodt (2009) was valid in a UK sample, due to differences in affluence, presenting problem and symptom severity, and most importantly differences in treatment length and the elective ending of therapy by the client within the US model of private therapy. It remains important to consider these factors when applying models

researched in the USA to UK populations. In this way this research is novel. Additionally integrating CAT and attachment has only previously been explored in theoretical papers and so this is the first piece of research done in this area.

#### **4.6. Clinical Implications**

Despite inconclusive evidence that being a more experienced therapist improves therapy outcomes (Stein & Lambert 1995, Budge, Owen, Kopta, Minami, Hanson, & Hirsch, 2013; Minami, Wampold, Serlin, Kircher & Brown, 2009; Okiishi, Lambert, Eggett, Nielsen, Dayton, & Vermeersch, 2006; Okiishi, Lambert, Nielsen, & Ogles, 2003; Wampold & Brown, 2005), it is clear that the collective experience documented here is likely to be of value to more novice therapists. Using clinicians from an NHS trust gave rich and detailed data about issues of counter transference that many novice therapists may not have access to. More importantly, the data from interviews give examples of how to respond in practical terms and what the experience is like, which is not documented in previous literature.

This research forms a comprehensive framework of how to respond and adapt therapy based on what experienced clinicians are already doing in their clinical practice. The pragmatic information has been extracted and put in to Table 6: Pragmatic Adaptations to Therapy with Anxiously and Avoidantly Attached Clients (below).

In the future this framework could be delivered in a training session for clinicians to aid their work with clients with attachment difficulties then used in supervision to support exploration of counter transference issues. This study affords enough data to form vignettes for how anxious and avoidant clients behave in CAT to aid recognition and awareness for clinicians. Furthermore, there is scope to explore if attachment difficulties can be formulated from the outset of treatment to anticipate ruptures and help to prevent drop out. This is particularly helpful when using CAT as a consultation method to help support wider MDT's in their response to client withdrawal and hyper activating behaviours that can be damaging to working relationships with clients and between team members.

The findings of this study demonstrate that this group of CAT therapists are consciously attuned to the level of distress and the relational distance of their clients and have formulated clearly



an idea in relation to this of what is within their ZPD, in the terms of CAT. This may account for why CAT is an effective therapy, for clients with a mixed presentation of Personality Disorder (Clarke, James, Thomas, 2013). It also suggests that therapists are trying to anticipate and address potential and actual therapeutic rupture in a way which is also mindful of the client's ZPD and is neither too cold or clinical (for the anxious client) or too intrusive or interpretive and potentially shaming (for the avoidant one). This supports work by Bennett and Parry (2006) who found that CAT practitioners were conscious of noticing potential ruptures and addressing actual ruptures. It may be that other therapies might benefit from a similar level of formulation about what the client can manage affectively or relationally and that this would improve retention and outcome.

Many of the participants mentioned the use of supervision in helping them realise when they were responding to attachment-related behaviour in a way that could be unhelpful. It might be helpful to have some attachment-based understandings as an explicit part of explicitly in supervision. Also, for individual clinicians, some form of therapy session rating of relational distance and affective levels might be helpful in predicting ruptures and ultimately improving therapists' sensitivity to these factors, which have clearly been identified by this sample as being important factors in treatment retention and outcome. One example would be the Therapeutic Distance Scale (TDS) by Mallinckrodt, Choi and Daly (2014).

**Table 6: Pragmatic Adaptations to Therapy with Anxiously and Avoidantly Attached**

**Clients**

<b>CAT Tool/ Phase</b>	<b>Anxious Behaviours</b>	<b>Adaptation</b>	<b>Avoidant Behaviours</b>	<b>Adaptation</b>
<b>Goals</b>	To be able to regulate emotions better  To foster independence in relationships	Modelling, scaffolding and naming processes of dependency  Help them to take responsibility for self-soothing	To have an emotional narrative  Foster more dependence in relationships	Help the client to attend for the full 16 sessions.  Modelling, scaffolding and naming processes of independence
<b>History Taking</b>	Give lots of information, jump from one thread to another	Slow client down using a timeline or genogram to give a structure.  Summarise often.  Focus on cognitive elements  Consider using a mindfulness technique early on in sessions  Possibly allow more sessions for history taking so that the client feels heard	Give little information. Information is mainly concrete or intellectualised	Help the client to find an emotional language by asking relational questions and questions about emotions and physiological feelings, using timelines or genograms can help with this.  Consider using mentalisation techniques
<b>Psychotherapy File</b>	Fill it in and bring it back, lots of detail, maybe double plus boxes	Help them to pick out a few patterns that are pertinent to work on	Dismissive of it, do not return, return it incomplete, maybe critical of it	Make it less overwhelming  Do it in the session, do it in sections  Check how you gave it and how you asked for it back, are you colluding in being dismissive or critical of it
<b>Writing the Reformulation Letter</b>	Clinician feels overwhelmed, letters likely to be long and unfocused	Focus on target problem procedures or pick out one or two patterns. Focus on doing a “good enough” letter	Write a short letter that feels clinical, not relational, might be perfectionistic	Take letters to supervision to gauge how they are received
<b>Receiving the Reformulation</b>	May cry, praise clinician	Listen and discuss what was useful	May not respond, fold it up, be reluctant to discuss the letter or may	Listen and encourage discussion about the

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<b>Letter</b>			be critical of it	letter
<b>Diagram</b>	Each week talks emotionally about events without structure or recognition	More spaced out	Does not give much information	Can use more examples from the past  Possibly more CBT-ish to contain fear of emotion
<b>Middle/ Exits</b>	Want to focus on history or events from the week more	Help them to recognise the patterns that underpin this by referring back to the diagram  Have permission to say 'stop' when it becomes overwhelming. Find ways to 'cool down' the emotion  Exits are more cognitive and behavioural	Want to rush to exits	Focus on recognition and building an emotional narrative, metaphors and cartoons can be helpful, pace the work so it is in ZPD
<b>Boundaries</b>	Will want more sessions, call between appointments, arriving early for appointments	Talk about it in a containing way. Model boundaries in relationships in a way that scaffolds	Lateness, cancellations, not coming	Talk about it, don't avoid or reject (this could be a repeated pattern), call them and invite them back to therapy, maybe have a review session,
<b>Ruptures</b>	Feeling abandoned or rejected and showing anger about this	Modelling, scaffolding and naming processes of dependency	Being critical of the therapy and dropping out	Modelling, scaffolding and naming processes of independence
<b>Goodbye Letters</b>	Structure of writing is the same for both types of client	More clinical, structured and containing. Be wary of receiving a present. Encourage client to write one about what was hard in the therapy	Structure of writing is the same for both types of client	Warmer and less clinical than reformulation. Encourage client to write one about what was hard in the therapy
<b>Ending</b>	Will want to extend the therapy, express anger	Do not avoid discussing the ending, name the process, and help them to name thoughts and emotions through modelling. Set alarms/ reminders and use calendars to support this. Discuss in supervision if you feel there is a risk you will miss the ending. Consider offering more	Will emotionally withdraw	Do not avoid discussing the ending, name the process, and help them to name thoughts and emotions through modelling. Set alarms/ reminders and use calendars to support this. Discuss in supervision if you feel there is a risk you will miss the ending

		follow ups if appropriate or ask care team to be involved in follow ups		
<b>Clinicians' Experience</b>	<p>Therapist may collude, parallel processes may be played out, strong unexpected reactions</p> <p>Be aware of the client trying to please and then being less challenging, becoming irritated by 'neediness' or feeling overwhelmed. Notice if you are trying to provide 'perfect care'</p>	<p>Use supervision to check own emotional responses and how these impact on the therapy. Name process and reciprocal roles in session</p>	<p>Therapist may collude, parallel processes may be played out, strong unexpected reactions</p> <p>Be aware of controlling/critical reciprocal roles and of being dismissive. Notice if you are trying to provide 'perfect care'</p>	<p>Use supervision to check own emotional responses and how these impact on the therapy. Name process and reciprocal roles in session</p>

#### 4.7. Theoretical Implications and Future Work

The previous exploration of integrating CAT and attachment theory had been purely theoretical, and the current study supports the ideas in the original theoretical papers by Jellema (2000, 2002) and can be used as a starting point for future researchers. Table 6 extends this theoretical understanding by showing how the theory can be applicable in clinical settings, what the adaptations look like in a practical sense and how this may feel for clinicians.

This study has established that experienced CAT therapists have a sophisticated understanding of the presentation of attachment behaviours in therapy and how to respond to them. At present we are unsure of what clients feel to be beneficial in this experience. It is important to understand what the clients feel to be important to them in the therapy journey and whether they think this affective and relational attunement in being "not hot, not cold, just warm all the way through" is a critical factor for them. Future research could focus on the client's experiences of therapy and examine what are the crucial factors which led to staying in therapy, resolution of ruptures, or outcome. If the themes which have emerged in this study are also experienced as helpful by clients, it might be that a more explicit reference to this "middle ground" affectively and relationally can be a starting point for framing therapy goals and monitoring progress, which could later be used clinically.

It would be of interest to see whether measures of extent of emotional dysregulation or relational distance in therapy may also be helpfully used in CAT therapy as self-monitoring tools, again with a view of increasing sensitivity to where the client is at in order to pre-empt or resolve rupture, increase treatment retention and improve outcome in CAT and other therapies. There is research from the large psychotherapy outcome studies that low working alliance ratings predict dropout and rupture (see meta-analysis by Sharf, Primavera & Diener, 2010). It is also sometimes assumed from the literature that high levels of working alliance are always a good thing, but it might be that there is an optimum level of working alliance in these clients with attachment difficulties and this could be investigated in a CAT context. If it can be assumed that experienced therapists have something to offer novice therapists, it might be that a training intervention for novice therapists could be offered and evaluated to see if this improves their retention and outcomes. There may also be merit in looking at whether attachment-informed supervision might ultimately reduce ruptures and produce better retention and outcomes. Although there hasn't been a head –to-head comparison trial of CAT and CBT, it would be worth looking at whether attachment difficulties affect treatment response and treatment retention in CAT and ultimately whether these CAT adaptations improve on this in comparison with other therapies.

This study gives a starting point for quantitative studies wanting to investigate the integration of CAT and attachment theory. This could be done through observing when an adaptation is made or testing the framework through questionnaires. Based on the findings of this research the model for mediating therapeutic distance by Daly and Mallinckrodt (2009) could be extended to incorporate the phases and tools of CAT and then tested in clinical settings

This study supports Bowlbian concepts of balancing cognition and affect and evidences that this actively done during the therapy.

When researching how to validate vignettes for qualitative research there was very little information about how this is done is previous research and how to validate the vignettes. Braun and Clarke (2006) give guidance on the number of sources to be examined when writing vignettes but this study provides a synthesised method for how to validate vignettes for research in new topic areas

when number of sources cited by Braun and Clarke cannot be reached. The full method for vignette validation and exploration of previous methods can be Appendix D: Validating Vignettes- Full Information.

#### **4.8. Conclusion**

The aim of this research was to identify how experienced CAT practitioners adapt therapy for clients with anxious and avoidant attachment styles. Despite the outlined limitations (a possible sampling bias, an assumption of knowledge and acceptance of attachment theory, a lack of standardised reporting of clinician experience and members checks) the themes found through a robust and transparent inductive thematic analysis support the following findings.

People with anxious and avoidant attachment styles were perceived by therapists to behave differently during CAT, this impacted on the therapist. Specific adaptations were described for both clients with anxious and avoidant attachment styles by clinicians. When adaptations are not made the underlying principles and tools of CAT gave a way to respond that was considered containing and therapeutic. These findings have been reviewed in light of study evidence and existing literature. This study is novel and has important theoretical and clinical implications centring on the integration of theories and teaching and training opportunities. Future studies should aim to test these adaptations using a quantitative framework and to compare different models for adaptations.

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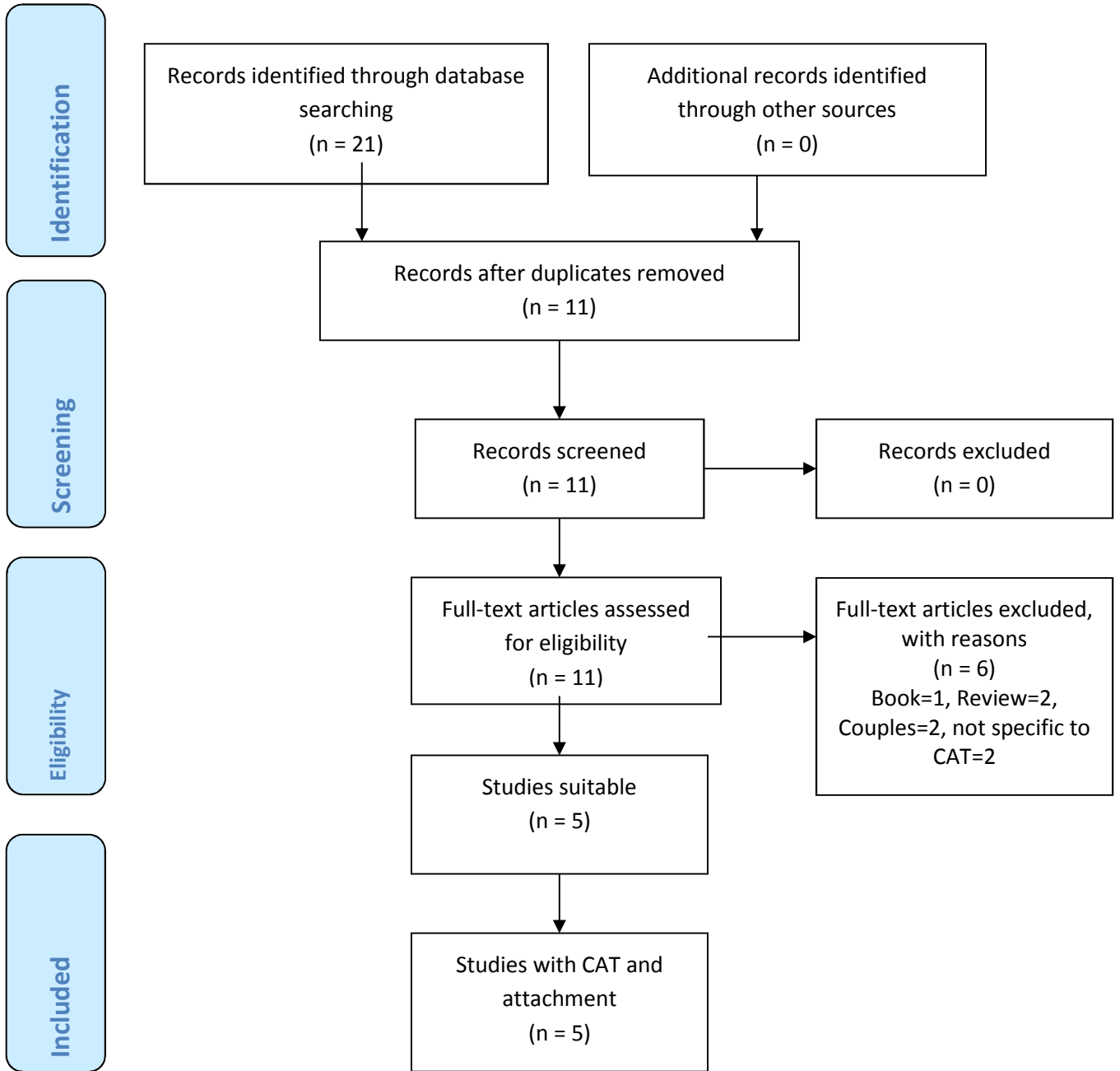
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### Appendix A: PRISMA 2009 Flow Diagram- CAT AND Attachment



**Appendix B: Research CV and GCP Certificate**

<b>Name:</b>	
Rhiannon Quann (nee Ducksbury)	
<b>Present appointment:</b>	
Trainee Clinical Psychologist at the University of East Anglia	
<b>Telephone number:</b>	<b>Email address:</b>
	R.Ducksbury@UEA.ac.UK
<b>Qualifications:</b>	
BSc Psychology with Criminology	
<b>Professional registration:</b> <i>(Name of body, registration number and date of registration.)</i>	
British Psychological Society (200525)	
<b>Previous and other appointments:</b> <i>(Include previous appointments in the last 5 years and other current appointments.)</i>	
September 2013- present; Trainee Clinical Psychologist (CPFT) August 2011- September 2013; Research Assistant (NEPFT) March 2010- August 2011; Assistant Psychologist (SEPFT) January 2008- March 2010; Occupational Therapy Assistant (NEPFT)	
<b>Research experience:</b> <i>(Summary of research experience, including the extent of your involvement. Refer to any specific clinical or research experience relevant to the current application.)</i>	
<p>I co-ordinated the following trials at my study site in Epping (NEPFT)</p> <ul style="list-style-type: none"> <li>• A Principal Open-Label Study to Assess the Prognostic Usefulness of Flutemetamol (18F) Injection for Identifying Subjects with aMCI Who will Convert to Probable Alzheimer's Disease</li> <li>• A Multicentre, Randomised, Open-Label, Comparative Phase 4 Trial to Assess Changes in Dementia Diagnostic Category and Diagnostic Confidence After DaTSCAN Imaging in Subjects with an Uncertain Diagnosis of Dementia with Lewy Bodies (Possible DLB)</li> <li>• Prevalence of Visual Impairment in Dementia (PrOVIDe)</li> <li>• Multicenter, Randomized, Double-Blind, Placebo-Controlled, Parallel-Group Two Year Study to Evaluate the Effect of Subcutaneous RO4909832 on Cognition and Function in Prodromal Alzheimer's Disease</li> <li>• Memantine for the long-term management of neuropsychiatric symptoms in Alzheimer's disease: MAIN-AD</li> <li>• Characteristics and outcomes of subjective cognitive impairment in a memory clinic population</li> </ul>	
<b>Research training:</b> <i>(Details of any relevant training in the design or conduct of research, for example in the Clinical Trials Regulations, Good Clinical Practice, consent or other training appropriate to non-clinical research. Give the date of the training.)</i>	
<ul style="list-style-type: none"> <li>• 2014 Introduction to Good Clinical Practice (GCP) A practical guide to ethical and scientific quality standards in clinical research</li> <li>• 2012 Certified rater of the FCSRT-IR, ADAS- COG, FAQ, NPI-Q, C-SSRS (i3-inventiv healthcare)</li> <li>• 2012 Certified CANTAB rater</li> <li>• 2012 Informed Consent in Clinical Research (PHLEX Global, DeNDRoN)</li> <li>• 2011 Introduction to Good Clinical Practice (GCP) A practical guide to ethical and scientific quality standards in clinical research</li> <li>• 2011 Certified rater of LMT, ADAS- ADL, MMSE and Certified Psychometric rater of cognitive battery by i3</li> <li>• 2011 Pharmacovigilance and safety reporting, trial master file and essential documentation</li> </ul>	



<p>training</p> <ul style="list-style-type: none"> <li>• 2011 Introduction to Mindfulness Based Cognitive Behavioural Therapy (SEPT and University of Essex)</li> <li>• 2008-2009 Introduction to Psychodynamic Thinking (7 Month Course)</li> <li>• 2009 British Sign Language- Level One</li> </ul>	
<p><b>Relevant publications:</b> <i>(Give references to all publications in the last two years plus other publications relevant to the current application.)</i></p>	
<p>Ducksbury, R., Whitfield, T. and Walker, Z. (2014) PET/SPECT findings in Lewy Body Dementia in PET and SPECT in Neurology, Dierckx, R.A.J.O., Otte, A., de Vries, E.F.J., van Waarde, A., Luiten, P.G.M. (Eds.) Springer.</p> <p>Walker, Z., Ducksbury, R., Rodda, J., Nagaraj, C., Whitfield, T., Suresh, K., Stevens, T., Saez-Fonseca, A.(2014) Factors that predict cognitive decline in patients with subjective cognitive impairment, European Journal of Neurology, 21 (Suppl. 1), 104–387</p> <p>Saez-Fonseca, A., Ducksbury, R., Rodda, J., Nagaraj, C., Whitfield, T., Suresh, K., Stevens, T., Walker, Z., (2014) Differences in demographic characteristics and symptoms between patients with subjective cognitive impairment and mild cognitive impairment. Poster presentation at the Royal College of Psychiatrists Old Age Conference 2014, Faculty of Old Age Psychiatry Annual Conference, 12-14 March 2014, Royal York Hotel, York.</p>	
<p><b>Signature:</b></p>	<p><b>Date:</b></p>

# Certificate of Attendance

Rhiannon Ducksbury

attended

Introduction to Good Clinical Practice (GCP): Adults Lacking  
Capacity in Research

A practical guide to ethical and scientific  
quality standards in clinical research

on 21/10/2014

Sessions include:

1. The Value of Clinical Research and the role of the NIHR CRN
2. GCP: the standards and why we have them
3. Study set up: responsibilities, approvals and essential documents
4. The process of informed consent
5. Case report form, source data and data entry completion
6. Safety reporting in clinical trials

*Paul Maher*

\_\_\_\_\_

**Paul Maher**  
NIHR CRN GCP Training Manager



## **Appendix C: Clinical Vignettes**

### **Client S – Avoidant Attachment**

Is a recurrently depressed female in her thirties. In her notes, it says that she has previously had a couple of attempts at therapy but found attendance difficult and dropped out early. Although the notes are substantial, there is a lack of detailed information in them and before you meet her it is impossible to get a sense of any important details about her early history or her presentation beyond the fact that she suffers from recurrent low mood. It says that she is married but again it is impossible to get any sense of what this relationship is like from the notes.

At her first assessment, she is fifteen minutes late. She is vague when talking about her early life and family and there are discrepancies in what she says about her parents. She describes her mother as a “wonderful mother” but it does seem that her mother was often quite emotionally unavailable. Her father drank heavily but she insists that “everyone did back then. It was just the norm.” She seems to lack emotion when discussing past difficult situations which are often neatly summarised as her own fault or unimportant. Many questions are answered with “I don’t know really” or “I’ve never really thought about that”.

When you ask her about why she struggled to engage with therapy in the past, she explains that “it just wasn’t the right time”. She can’t elucidate much further on this when prompted, just saying that at the time she felt it would be better to take some practical steps rather than sitting down and talking about things that were making her miserable.

Although she refers to a few friends and her husband, she seems uncomfortable if you ask about details. Many of her friendships seem to be activity-based, in the sense that she is keen on outdoor pursuits and exercise and knows her friends through these interest groups. When she worked she said she used to take a lot of pride in her work and she says that this sometimes intimidated other people. It sounds as if in the work context she may have been perfectionistic may also have valued performance and achievements over relationships with others. She says she liked to work long hours and “push herself to the limit”. There is a sense that she can be critical of others and seems rigid in her thinking that there are right and wrong ways to behave. You get the feeling that you are not exempt

from that and she is assessing your potential as a therapist. She often seems a bit bemused by your questioning strategy.

When you ask about her relationship with her husband, she explains that the relationship works to the extent that they are both quite independent people and that they both used to have very full programmes of activity from week to week. You ask if he has been supportive through her episodes of depression and she explains that he also is quite a practical person and a great believer in “just getting on with it”. You ask if this can sometimes feel unsympathetic and she says she doesn’t know.

### **Client R – Anxious Attachment**

Is a recurrently depressed female in her thirties. Her notes are substantial and it is clear that she has had quite a lot of input over the years with a potential to become quite dependent on health professionals. She is described in the notes as trying to please others and as needy.

At her first appointment, she is in the waiting room an hour early. You explain that you are sorry but you can’t see her until the allotted time, and she is happy to wait saying it is her own fault but she didn’t want to be late. She is very quick to disclose a lot of personal information early in the session and is weepy and tearful throughout. She discusses her early life in emotionally extreme terms, parents and care givers seem to switch in her narrative from perfectly loving or cold and rejecting. She is very animated and expressive in her retelling of emotional states and there is an uncontained and unresolved feeling about what she is describing. She keeps asking how much time is left before telling you another chapter of her story. At times it is difficult to get a word in edgeways.

The relationships in her life seem equally “up and down” and volatile. She is currently in a relationship but is afraid that this will follow the same pattern as her previous relationships. She says that she tends to “jump in at the deep end”. She says that she needs a lot of reassurance from partners and friends and that this sometimes leads to them being very frustrated with her. In previous sexual relationships, she felt that she could not always trust her partners, and often checked up on where they were and could be “a bit paranoid”. She is extremely distressed about this in relation to her last partner who she says “was a good guy who got fed up of being accused of things he had not done”. In her

friendships she recognises that she can be “over-sensitive” and also that she tends to be “over do” things such as being over-attentive with cards and presents.

She keeps saying things like “you must think I am a bit silly” and asking if you think she is “crazy”. She seems quite girlish and immature.

This pattern is present in all her relationships and also in the work context. She says that when she was working, she could become quite preoccupied about things like the “tone of an email” or whether she was being treated differently to her colleagues. She tended to stay late to get the work done but found that this was “never enough”.

### **Appendix D: Validating Vignettes- Full Information**

Clinical vignettes are short stories that illustrate a real life situation to elicit a response. Braun and Clarke (2006) discuss that previously vignettes were used to measure attitudes, perceptions, beliefs and norms in quantitative studies (Finch, 1987) with the story completion task being more commonly used in qualitative research. In quantitative research vignettes are often used with likert scales and questionnaires to check discrepancies in attitudes and answers (Poulou, 2001). The quantifiable nature of this method means that large numbers of participants can be used, but typically the richness and description of exploration can be lost (West in Finch, 1987). However, there has been a move towards the use of vignettes in qualitative studies, for example; Hughes (1998) devised vignettes to examine drug injectors' perceptions of HIV risk; Barter, Renold, Berridge and Cawson (2004) explored violence between children in residential care homes, and Wilks (2004) looked at social work ethics.

The benefit of using a vignette over story completion tasks is that they are more direct and using them with a topic guide means that there is more uniformity across the data set (Wilks, 2004). Vignettes allow participants to make judgements and to analyse their judgments applied to a situational dilemmas (Barter & Reynolds, 1999). However a potential pitfall of using vignettes is that they are a snapshot where as social life is dependent on the complexity of multiple interactions where the individual or context can change. By comparison, vignettes are unable to provide such complexity, therefore it can be difficult to generalise findings to social life. However, there is value in isolating incidences and examining them in detail and a vignette allows researchers to do this (Corkery, 1992). This is particularly useful for the present study which is using vignettes to represent a 'snapshot' of how dimensionally anxious or avoidant attachment styles behave in a therapy context, not a changeable social context. The complexity will be provided by the participants and their emotional and professional responses to the clients they discuss.

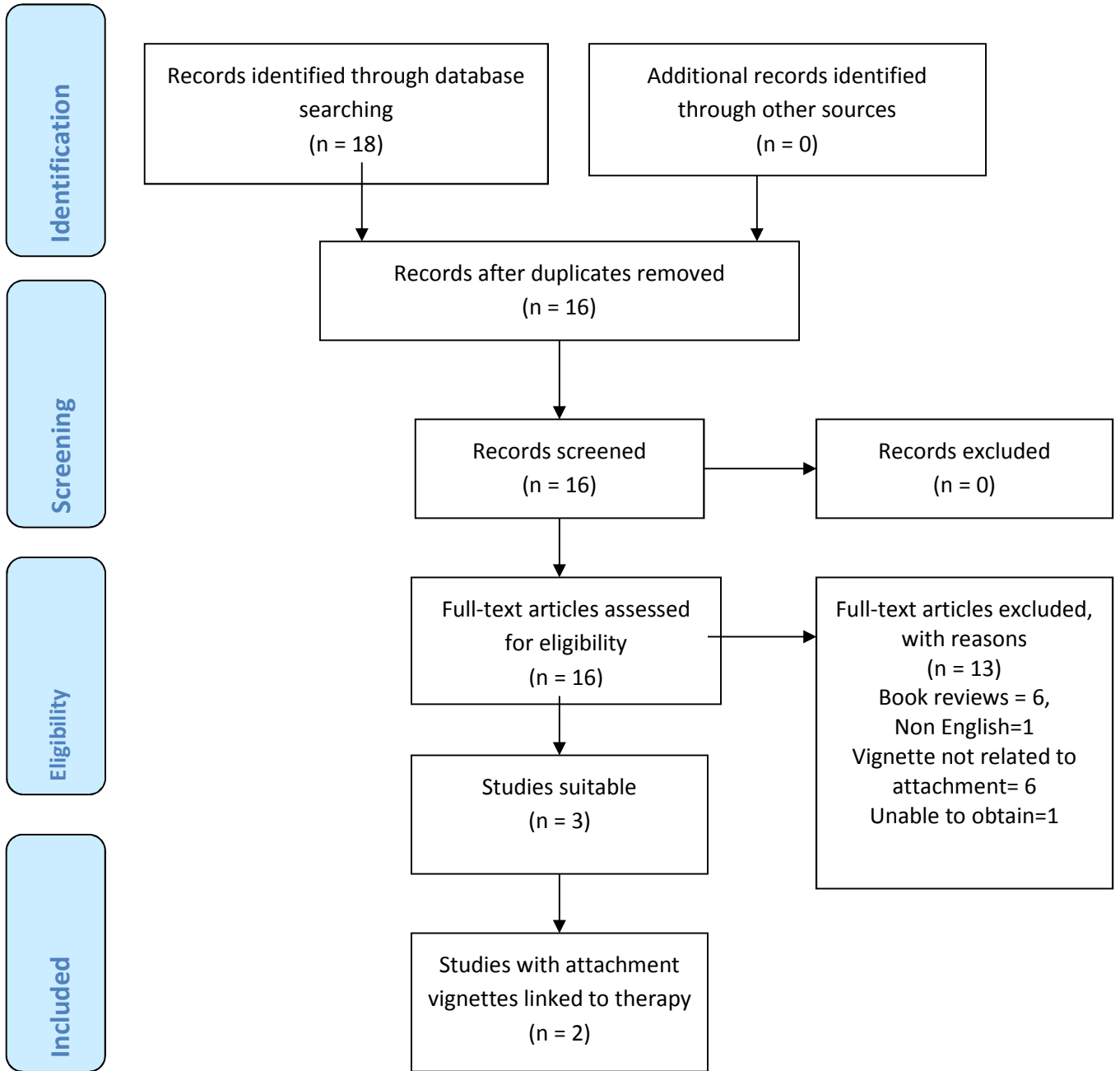
Faia (1979) described that often it is hard to know when a person is answering what they think they 'ought to do' rather than what they 'would do' causing incongruence with social reality. It is acknowledged that some participants may give what they deem to be socially desirable answers (Reynold ,2 002,; Finch 1987). However it is hoped that the vignettes will promote discussions about

descriptions, reflections and vocalised thought processes which are of equal interest as the adaptations made for the client groups.

In order to find existing vignettes relating to how clients with anxious or avoidant attachment styles behave in a therapy context to meet the numbers stated as a guide by Braun and Clarke (above) a literature search was conducted to search for existing vignettes using the electronic databases CINAHL, Medline, PsychINFO, PsycARTICLES. The subject terms 'Attachment' AND 'Vignette' AND 'adult' AND 'Therap\* OR Counsell\* OR Psychtherap\*' NOT "Experience in Close Relationships" OR "Relationship Questionnaire". The Experience in Close Relationships questionnaire (Brennan, Clark & Shaver, 1998) and The Relationship Questionnaire (Bartholomew and Horowitz, 1991) were excluded from the search as these are vignette measures and will be examined separately.

Studies were reviewed up to and including November 2014. Studies were included if they conformed to the following criterion (i) they were published in peer reviewed journals (ii) they were written in English (iii) the participants were over 18 years old (iv) the vignette was related to individual therapy. Please see Appendix D Figure 1 below

Appendix D Figure 1: PRISMA 2009 Flow Diagram- Attachment Vignettes

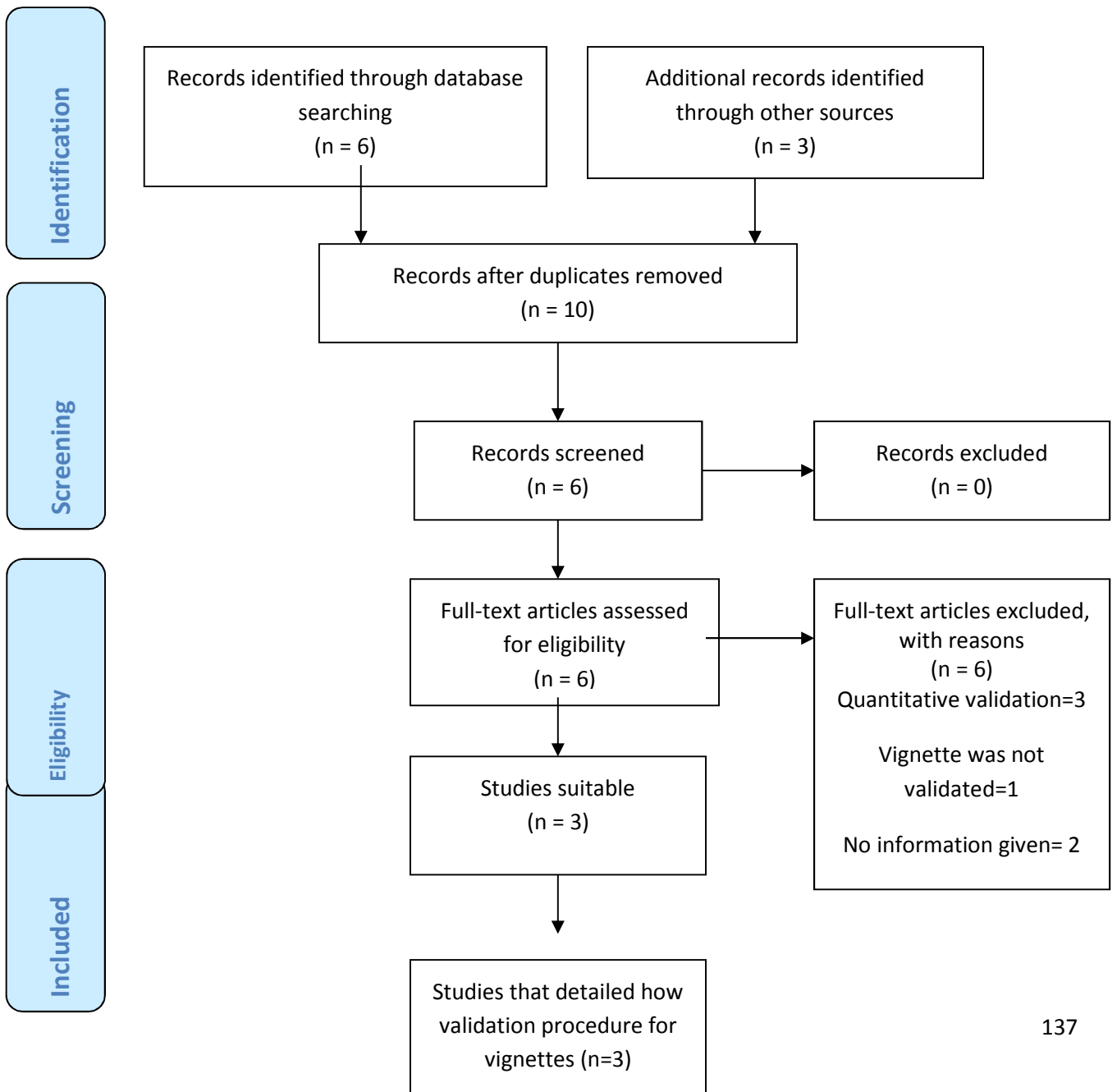




**Methods of validating vignettes in previous research**

A literature search was conducted to search for how previous studies had validated vignettes for qualitative research using the electronic databases CINAHL, Medline, PsychINFO, PsycARTICLES. The subject terms ‘Vignettes’ AND ‘Validat\*’ AND ‘qualitative’ were entered. Studies were reviewed up to and including 2015. Studies were included if they conformed to the following criterion (i) they were published in peer reviewed journals (ii) they were written in English (see below)

**Appendix D Figure 2: PRISMA 2009 Flow Diagram- Validating Vignettes**



A literature search was conducted to search for how previous studies had validated vignettes for qualitative research, two studies were found that described the procedure for validating vignettes for qualitative research using this method (Otsby & Bjorkly, 2011 and Atwal, McIntyre & Wiggett, 2012) and a further one study through other sources (Hughes, 1998). The methods used to validate vignettes are described below:

Otsby and Bjorkly (2011) give the following information about how they devised and validated vignettes to use for testing learning disability nurses on ethics during interview. They completed the following steps:

- 1) A field study produced relevant situations from observations to be included as vignettes.
- 2) A six-step categorizing process to select vignettes with good internal validity.
- 3) The transformation of situations into vignettes by removing elements that may be leading or constricting.
- 4) A test of the familiarity and relevance of the preliminary sample of vignettes (external validation).
- 5) A final selection of four vignettes to be included in the investigation.
- 6) An assessment of the four vignettes' familiarity and relevance undertaken by the final sample of interviewees.

This study is specific to one context, the work setting for which the interviews were being held, therefore the initial generating of vignettes from observations and field study was accessible, in the present study that was not possible but efforts were made to find observational information and previous vignettes in the literature to add to past observations. Steps two and three were study specific. Otsby and Bjorkly's external validation was done via staff survey. They sent 17 vignettes to 20 staff members and asked 'Is this a situation you have experienced in your work?' With options about the frequency of occurrence thus complying with the Miles and Huberman's (1994, p. 83) recommendation that 'the question "is this really typical?" must always be asked'.

Atwal, McIntyre and Wiggett (2012) conducted a study about discharge risks for elderly patients in acute care. They found an existing vignette by Reich, Eastwood, Tilling and Hopper (1998)

and asked four expert occupational therapists four specific questions around perceived risks, risk management, if different professionals could have a different perception about the perceived risks and their thoughts around discharge.

Hughes (1998) wrote a vignette story book with two main characters whose story progresses. This was based on research finding and the accounts of drug users and drug workers. Hughes discussed the vignettes with injectors then tested it with a small group of volunteers who suggest changes.

### Appendix D References

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## Appendix E: Feedback from UEA from Thesis Proposal

### UNIVERSITY OF EAST ANGLIA ClinPsyD FEEDBACK SHEET FOR ACADEMIC WORK - Clinical Psychology

TRAINEE: Rhiannon Ducksbury Date Submitted: 4 November 2014

MARKER: Siân Coker Date Marked:

Thesis Proposal:

**TITLE: How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**

**AGREED MARK 55**

~~PASS/FAIL~~

**DETAILED COMMENTS:**

**GENERAL ORIENTATION** (what is the context for the study and why is it interesting/clinically relevant?)  
Broad aims of the study are described

**BACKGROUND AND INTRODUCTION** (provides a review of relevant and contemporary literature, highlights gaps in existing research, provides a coherent theoretical framework for the study)  
Generally detailed consideration of attachment styles but rather less so for CAT and attachment style. The use of vignettes is rather uncritically accepted

**RESEARCH QUESTIONS/HYPOTHESES** (clear and appropriate questions/hypotheses which follow from the background and which are answerable)  
Broad research question posed, which is relevant for the study methodology

**DESIGN** (clear description of research design which is appropriate for the question)  
Relevant for this novel area

**PARTICIPANTS** (clearly described inclusion/exclusion criteria, rationale for sample size (e.g. power calculation), clear plan for sampling and recruitment)  
A procedure for advertising and promoting the study is outlined but recruitment into the actual study is not- how do participants contact you to take part in your study?

**MEASURES** (clearly described measures/interview topic guide, including rationale for choice and discussion of psychometric properties)  
I am not clear on the process of validation for the vignettes and this seems key to this study. Will the vignettes go through several revisions?  
Likewise the topic guide refer to “differently” from what ? - Usual or differently from either vignette. Will it matter what order the vignettes are presented in. Your demographic information sheet does not establish whether participants have had experience of working with clients with these differing attachment styles before, which would seem to be important

**PROCEDURE** (clearly describes the conduct of the study and what will happen to participants from the point of approach to exit from the study, methodology is appropriate for the research questions and design)  
Rather underspecified in relation to recruitment and conduct of the study

**ETHICAL CONSIDERATIONS** (discusses major issues and deals with any potential problems, discusses plans for seeking ethical approval). I didn't understand the point about client confidentiality given that this study is using vignettes. You need to introduce the idea of the interviews being audio recorded rather than making this

assumption. You need to say how long the data are kept for and where. You need to have your contact details and those of your supervisors on the PIS plus an independent other on the PIS for complaints. Your consent form needs to have a separate box that consents to audio recording

**ANALYSIS** (sets out a clear plan which is compatible with the questions and design)  
Thematic analysis proposed which seems relevant for the study described

**STUDY MATERIALS/APPENDICES** (provide documentation relevant to the study, including Participant Information Sheets and Consent Forms, copies of measures where relevant, thesis budget and timeline for study completion)

See my comments in relation to PIS and CF above. Useful to have a version of the vignettes at this stage however it is key to the study that these (differently) reflect the attachment styles described and the process for this is not clearly specified,

**PRESENTATION** (extent of typographical, spelling and grammatical errors, quality of referencing)  
Generally fine but a few typos and punctuation errors have crept in

**OVERALL STRENGTHS & WEAKNESSES OF THE THESIS PROPOSAL (outline these in detail).**  
This is an interesting project. The clinical relevance is more implicit than explicit and I would like to see this expanded upon (1 sentence in PIS currently). There is a rather uncritical acceptance of the choice of vignettes to investigate the research question (what are some of the problems with using this approach ?) .  
Whether the vignettes actually reflect the differing attachment styles is key to the project and the process for establishing this is rather vague at present. The use of the entire Budget to attend the conference leaves no additional monies for transcription and other study costs. Some of the procedural details are underspecified particularly with regard to recruitment. PIS and CF need changes to be made All of these points merit further discussion with your supervisors prior to considering a submission for ethical review

**Required Changes (if assignment failed).**

**Any required changes have to be made to the satisfaction of the markers before the script can be passed.**

**UNIVERSITY OF EAST ANGLIA ClinPsyD**

**FEEDBACK SHEET FOR ACADEMIC WORK - Clinical Psychology**

**TRAINEE: Rhiannon Ducksbury Date Submitted: 4 November 2014**

**MARKER: Richard Meiser-Stedman Date Marked:**

**Thesis Proposal:**

**TITLE: How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**

**AGREED MARK PASS/FAIL**

**DETAILED COMMENTS:**

**GENERAL ORIENTATION** (what is the context for the study and why is it interesting/clinically relevant?)  
This study is looking at how CAT therapists adjust this intervention to work with adults with particular attachment styles. The study uses a qualitative design and is based around getting therapists' responses to cases presented in vignettes.

**BACKGROUND AND INTRODUCTION** (provides a review of relevant and contemporary literature, highlights gaps in existing research, provides a coherent theoretical framework for the study)  
The background was clear and articulated the rationale for the study well. Some more attention could be given to how the proposed study will be useful, e.g. for informing training and therapist development, for identifying appropriate client groups for this therapy, etc.

**RESEARCH QUESTIONS/HYPOTHESES** (clear and appropriate questions/hypotheses which follow from the background and which are answerable)

## Adapting CAT for Attachment Style

The relatively open research question is appropriate given the study design.

**DESIGN** (clear description of research design which is appropriate for the question)

This seems justifiable.

**PARTICIPANTS** (clearly described inclusion/exclusion criteria, rationale for sample size (e.g. power calculation), clear plan for sampling and recruitment).

This was justified clearly.

**MEASURES** (clearly described measures/interview topic guide, including rationale for choice and discussion of psychometric properties)

**These are appropriate.**

**PROCEDURE** (clearly describes the conduct of the study and what will happen to participants from the point of approach to exit from the study, methodology is appropriate for the research questions and design)

This is appropriate.

**ETHICAL CONSIDERATIONS** (discusses major issues and deals with any potential problems, discusses plans for seeking ethical approval)

These are fine.

**MARK: 55**

**ANALYSIS** (sets out a clear plan which is compatible with the questions and design)

This is appropriate.

**STUDY MATERIALS/APPENDICES** (provide documentation relevant to the study, including Participant Information Sheets and Consent Forms, copies of measures where relevant, thesis budget and timeline for study completion)

The work that has gone into the vignette design is helpful and it is good that a full draft of these are already available.

**PRESENTATION** (extent of typographical, spelling and grammatical errors, quality of referencing)

There are points where the punctuation and typography could be better (e.g. inclusion criteria, p11) and one sentence is repeated (p13) but this is mostly fine.

**OVERALL STRENGTHS & WEAKNESSES OF THE THESIS PROPOSAL (outline these in detail).**

At the moment this project is very clear, has a robust methodology and looks like it will be informative. It lacks any client involvement however, and the trainee will have to demonstrate in their thesis how the data they intend to gather will inform clinical practice.

**Required Changes (if assignment failed).**

**Any required changes have to be made to the satisfaction of the markers before the script can be passed.**



## Appendix F: Feedback from Research Governance Committee met on 18th December 2014 was not feedback until May 2015

SSI A LOCAL MENTAL HEALTH TRUST and RD form

RT

Rhodes Tom (A LOCAL MENTAL HEALTH TRUST) <Tom.Rhodes@a local Mental Health Trust.nhs.uk>

Reply all

To:

Rhiannon Ducksbury (MED);

Tue 12/05/2015 15:46

Inbox

To help protect your privacy, some content in this message has been blocked. To re-enable the blocked features, click here.

To always show content from this sender, click here.

Action Items

Hi Rhiannon,

That is my fault. These comments were originally attached to the approval letter, which was delayed whilst we were waiting for the outcome of the UEA ethics committee. Please find attached the information below.

The Research Governance Committee met on 18<sup>th</sup> December 2014 and made the following suggestions for your consideration. Please note these recommendations do not affect your approval and are not required to be implemented to start your study:

- The committee suggested providing participants 5 minutes reading time for the vignettes.
- The committee suggested the researcher makes the participant aware of a deadline when they are able to withdraw from the study if they wish. E.g. they are able to withdraw up until the point which the information will be analysed or published.
- The committee queried the process if any responses suggested evidence of misconduct or inappropriate practice arises.
- The committee queried having clinical psychologists with less than 5 years qualification as an exclusion criteria. Would it be beneficial to use a demographic form to determine participants experience rather than length of service?
- The committee would like to see a copy of the outcomes/report of the research prior to publication.
- The committee also suggested that the rationale for the study is strengthened for participants, highlighting the potential impact on knowledge and practice.

As mentioned above these are only for consideration and are not required to be implemented. If you do amend any of the study documents please forward these to me.

I am in the process of obtaining a signature for your approval letter.

Kind regards  
Tom

Adapting CAT for Attachment Style

Tom Rhodes - Senior Research Facilitator  
Norfolk and Suffolk NHS Foundation Trust  
Research and Development, The Knowledge Centre,  
Hellesdon Hospital, Drayton High Road  
Norwich, Norfolk NR6 5BE

[tom.rhodes@a.local.Mental.Health.Trust.nhs.uk](mailto:tom.rhodes@a.local.Mental.Health.Trust.nhs.uk)  
01603 421552 (x6552)

[www.twitter.com/A\\_LOCAL\\_MENTAL\\_HEALTH\\_TRUSTresearch](http://www.twitter.com/A_LOCAL_MENTAL_HEALTH_TRUSTresearch)

RD

Rhiannon Ducksbury (MED)

To:

Rhodes Tom (A LOCAL MENTAL HEALTH TRUST) <Tom.Rhodes@a.local.Mental.Health.Trust.nhs.uk>;

Tue 12/05/2015 15:34

No I can't seem to find that either?

**Rhiannon Ducksbury**  
*Trainee Clinical Psychologist*

RT

Rhodes Tom (A LOCAL MENTAL HEALTH TRUST) <Tom.Rhodes@a.local.Mental.Health.Trust.nhs.uk>

To:

Rhiannon Ducksbury (MED);

Tue 12/05/2015 15:18

Hi Rhiannon,

Thanks for this. Tidying up the documents around this study, did I ever send you the recommendations from the Research Governance Committee in December? I can't seem to find an email trail for this.

Kind regards  
Tom

## Appendix G: Feedback of Proposal from FMHS

Faculty of Medicine and Health Sciences Research Ethics Committee



Rhiannon Ducksbury  
MED

Research & Enterprise Services  
R-10 West (SCJ)  
University of East Anglia  
Norwich  
NR4 7TJ

Email: [fmh.ethics@uea.ac.uk](mailto:fmh.ethics@uea.ac.uk)  
Direct Dial: +44 (0) 1603 361120

Web: <http://www.uea.ac.uk>

20<sup>th</sup> February 2015

Dear Rhiannon

**Title: How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**  
**Reference 20142015 - 39**

The submission of your research proposal was discussed at the Faculty Research Ethics Committee meeting on Thursday 19<sup>th</sup> February 2015.

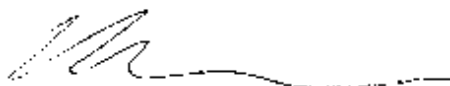
The Committee were happy to approve your application in principle but have the following concerns which they would like you to address and amend accordingly:

1. There is no information on the content of the website.
2. The committee feel that the writing style of the Participant Information Sheet is not representative of the planned study and should be made more appropriate for the participant group. You may wish to speak to faculty members for examples of successful Participant Information Sheets for similar participant groups.
3. Please state in the Participant Information Sheet that quotations will not be identifiable.
4. There is a reference to assessments being destroyed; please clarify what is meant by assessments.
5. Although you have mentioned that participants will have the opportunity to check whether their transcript is an accurate record, you have not explained what happens if a participant feels that the transcript is not an accurate record.
6. Interviews take place in the workplace but there is no mention of participants' information/responses not being passed onto their employer to prevent possible detriment to their working life. Please also specify whether the interview setting is private.
7. On page 28 (page 1 of the Participant Information Sheet), under the heading "Why have I been invited to participate?", please remove the wording "be able to understand and".
8. Please add a section to the Participant Information Sheet to explain what happens to participants' data if they leave the study.
9. Please provide participants with a contact name for complaints.
10. On page 27 (page 2 of the Participant Information Sheet), under the heading "What will happen if I become distressed?", please change the wording "I will stop the interview immediately", to "we will stop the interview and discuss what the next steps should be". Alternatively, you may wish to consider whether this section is required.
11. On page 27 (page 2 of the Participant Information Sheet), under the heading "Are there any expenses to be involved in the study?", the answer currently provided does not relate directly to the question.
12. The committee were grateful to have sight of the INSPIRE comments, a number of which relate to research design but some of which have clear ethical components. The committee request that you provide details of where you have modified your proposal in response to these comments.
13. Please add a date and version number to the consent form.

Please write to me once you have resolved/clarified the above issues. I require documentation confirming that you have complied with the Committee's requirements. The Committee have requested that you detail the changes below the relevant point on the text in this letter and also include your amendments as a tracked change within your application/proposal. The revisions to your application can be considered by Chair's action rather than go to a committee meeting, which means that the above documentation can be resubmitted at any time. Please could you send your revisions to me as an attachment in an email as this will speed up the decision making process.

As your project does not have ethics approval until the above issues have been resolved, I want to remind you that you should not be undertaking your research project until you have ethical approval by the Faculty Research Ethics Committee. Planning on the project or literature based elements can still take place but not the research involving the above ethical issues. This is to ensure that you and your research are insured by the University and that your research is undertaken within the University's 'Guidelines on Good Practice in Research' approved by Senate in February 2012.

Yours sincerely



Mark Wilkinson  
Chair FMH Research Ethics Committee

Cc Dairdra Williams

## Appendix H: Approval letter from FMHS

Faculty of Medicine and Health Sciences Research Ethics Committee



Rhiannon Ducksbury  
MED

Research & Enterprise Services  
West Office (Science Building)  
University of East Anglia  
Norwich Research Park  
Norwich, NR4 7TJ

Telephone: +44 (0) 1603 591720  
Email: [fmh.ethics@uea.ac.uk](mailto:fmh.ethics@uea.ac.uk)

Web: [www.uea.ac.uk/researchandenterprise](http://www.uea.ac.uk/researchandenterprise)

10<sup>th</sup> March 2015

Dear Rhiannon

**Title: How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**  
**Reference 20142015 - 39**

The amendments to your above proposal have been considered by the Chair of the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

Yours sincerely,

A handwritten signature in blue ink, appearing to read 'Mark Wilkinson', is written over a light blue horizontal line.

Mark Wilkinson  
Chair FMH Research Ethics Committee

Cc Deirdre Williams

**Appendix I: Letter to Confirm Approval by University sponsor and Insurance Documents**



**Research & Enterprise Services**  
West Office (Science Building)  
University of East Anglia  
Norwich Research Park  
Norwich, NR4 7TJ

Telephone: +44 (0)1603 591486  
Email: [sue.steel@uea.ac.uk](mailto:sue.steel@uea.ac.uk)

Web: [www.uea.ac.uk/researchandenterprise](http://www.uea.ac.uk/researchandenterprise)

TO WHOM IT MAY CONCERN

27<sup>th</sup> April 2015

**Study: Adapting CAT for anxious or avoidant attachment**

**Chief Investigator: Rhiannon Ducksbury**

This is to confirm that the University of East Anglia and Subsidiary Companies have arranged insurance cover as detailed on the attached Company Public Liability and Professional Negligence Insurance certificates.

The cover is subject to the terms and conditions of the policy. If you require further details, please contact the undersigned.

Yours faithfully

A handwritten signature in blue ink, appearing to read 'Sue Steel', written in a cursive style.

Sue Steel

Contracts Manager



To Whom It May Concern

Our ref: NAP

9 May, 2014

Zurich Municipal Customer: The University of East Anglia and wholly owned subsidiary companies

This is to confirm that The University of East Anglia and wholly owned subsidiary companies has in force with this Company Public Liability Insurance until the policy expiry on 31<sup>st</sup> May 2015

Policy Number: NHE-09CA01-0013

Limit of Indemnity: £ 25,000,000

Zurich Municipal  
Zurich House  
2 Gladiator Way  
Farnborough  
Hampshire  
GU14 6GB

Telephone 0870 2418050  
Direct Phone 01252 387846  
Direct Fax 01252 375893  
E-mail [nicola.pilsbury@uk.zurich.com](mailto:nicola.pilsbury@uk.zurich.com)

Communications will be monitored regularly to improve our service and for security and regulatory purposes

Zurich Municipal is a trading name of Zurich Insurance plc.

A public limited company incorporated in Ireland. Registration No. 13460.  
Registered Office: Zurich House, Ballsbridge Park, Dublin 4, Ireland.  
UK Branch registered in England and Wales. Registration No. BR7985.  
UK Branch Head Office: The Zurich Centre, 3000 Parkway, Whiteley, Fareham, Hampshire PO15 7JZ.

Zurich Insurance plc is authorised by the Central Bank of Ireland and subject to limited regulation by the Financial Conduct Authority. Details about the extent of our regulation by the Financial Conduct Authority are available from us on request.

FCA registration number 203093. These details can be checked on the FCA's register by visiting their website [www.fca.org.uk](http://www.fca.org.uk) or by contacting them on 0845 606 1234.

Yours faithfully

A handwritten signature in blue ink, appearing to read 'Nicola Pilsbury'.

Nicola Pilsbury  
Underwriting Services  
Zurich Municipal  
Farnborough





To Whom It May Concern

Our ref: Our Ref:NAP

9 May, 2014

Zurich Municipal Customer: The University of East Anglia and wholly owned subsidiary companies

This is to confirm that The University of East Anglia and wholly owned subsidiary companies have in force with this Company until the policy expiry on 31st May 2015 Professional Negligence Insurance incorporating the following essential features:

Policy Number: NHE-09CA01-0013

Services covered: Training, research and consultancy services provided by the insured to outside clients in accordance with details lodged with the insurer, and excluding Services more particularly insured under this Policy or elsewhere.

Limit of Indemnity: £7,500,000 any one claim and *in the aggregate for all claims* first made against the Insured and notified to Zurich Municipal during the period of insurance

Excess : £10,000  
any one claim

Retroactive Date: 1st June 2003

**Exclusions**

Standard insurance market exclusions apply, notably exclusion of Pollution other than sudden and accidental; punitive or exemplary damages; express warranties or guarantees; claims the cause of which occurred prior to the Retroactive Date.

*This is a brief summary and the full policy should always be referred to for exact details of cover.*

Yours faithfully

Nicola Pilsbury  
Underwriting Services  
Zurich Municipal  
Farnborough

Zurich Municipal  
Zurich House  
2 Gladiator Way  
Farnborough  
Hampshire  
GU14 6GB

Telephone 0870 2418050  
Direct Phone 01252 383846  
Direct Fax 01252 375893

E-mail  
nicola.pilsbury@uk.zurich.com@zurich.com

Communications will be monitored regularly to improve our service and for security and regulatory purposes

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FCA registration number 203093. These details can be checked on the FCA's register by visiting their website [www.fca.org.uk](http://www.fca.org.uk) or by contacting them on 0845 606 1234.



## Appendix J: R& D Approval Letter

**Norfolk and Suffolk**   
NHS Foundation Trust

Research and Development  
The Knowledge Centre  
Hellesdon Hospital  
Drayton High Road  
Norwich  
NR6 5BE

Telephone 01603 421255  
E mail: [RDoffice@nshf.nhs.uk](mailto:RDoffice@nshf.nhs.uk)

Miss Rhiannon Ducksbury  
Trainee Clinical Psychologist  
Floor 3, Elizabeth Fry Building  
University of East Anglia  
Norwich  
NR4 7TJ

12<sup>th</sup> May 2015

Dear Miss Ducksbury,

**Re: RD #15 169073 Adapting CAT for anxious or avoidant attachment**

Thank you for submitting the above project for local research governance approval. I am pleased to inform you that your project has been given full approval and you may begin your research at the following site:

- Norfolk & Suffolk NHS Foundation Trust

I have enclosed two copies of the Standard Terms and Conditions of Approval. Please sign both copies returning one copy to the Research and Development office, at the above address, and keeping the other in your study file. Failure to return the standard terms and conditions may affect the conditions of approval. Under the agreed Standard Terms and Conditions of Approval you must inform the R&D department of any proposed changes to this study and submit annual progress reports to the R&D department.

Any researcher(s) whose substantive employer is not the Norfolk & Suffolk NHS Foundation Trust must have a Letter of Access or Honorary Research contract and evidence of Good Clinical Practice (GCP) training before coming on site to conduct their research in this project. Please note that you cannot take part in this study until you have this documentation. If a Letter of Access / Honorary Research Contract has not been issued – please contact us immediately.

If you have any queries regarding this or any other project, please contact, Tom Rhodes, Senior Research Facilitator, at the above address.

The reference number for this study is: **RD #15 169073**, and this should be quoted on all correspondence.

Yours sincerely,



**Bonnie Teague**  
Research Manager



Chair: Gary Page  
Chief Executive: Michael Scott  
Trust Headquarters: Hellesdon Hospital,  
Drayton High Road, Norwich, NR6 5BE  
Tel: 01603 421421 Fax: 01603 421440 [www.nshf.nhs.uk](http://www.nshf.nhs.uk)



## **Appendix K: Vignette Development Timeline**

### **2014**

4<sup>th</sup> August 2014 first draft written by Rhiannon Ducksbury (RD)

5<sup>th</sup> August meeting with Deirdre Williams (DW) – discussed changes to vignettes

30<sup>th</sup> August RD send second version of vignettes to DW

7<sup>th</sup> September DW returned vignettes with changes( more relational, less explicit descriptions or emotional regulation- RD accepted

10<sup>th</sup> September RD first draft topic guide

16<sup>th</sup> September DW sent vignettes to Katherine Berry (KB) and Pasco Fearon (PFe)

17<sup>th</sup> September KB replied and suggested changes which were accepted

9<sup>th</sup> December Paul Fisher (PFI) is sent a first draft of methodology

### **2015**

5<sup>th</sup> January PFI returns methodology section, suggests a sorting task to ensure that the vignettes recognisably represent the intended attachment styles , suggests a local psychology meeting would be a good place for this to occur

13<sup>th</sup> January DW e mails local psychology group requesting their co-operation in the sorting task. No response from PFe re validating vignettes, decide to ask other experts to validate the vignettes

16<sup>th</sup> January RD e mail Brent Mallinckrodt (BM) to ask for validation (no response)

3<sup>rd</sup> February RD and DW meet and decide that the Transforming Attachments conference would be a better place to conduct the sorting task. RD e mails conference organisers who agree.

20<sup>th</sup> February RD and DW complete sorting task at the Transforming Attachments conference. There are 24 respondents of which 23 correctly sorted the vignettes

## Appendix L: E mail Chain for Vignette Validation

Study on therapeutic adaptations to different attachment styles

DW

Deirdre Williams (MED)

To:

Rhiannon Ducksbury (MED);

Fri 19/09/2014 10:36

Vignettes DW RD 150914.doc30 KB

Download

Save to OneDrive - University of East Anglia

Hi Rhiannon, glad that you are happy to make the specified changes in response to feedback. Hope you didn't mind me stepping in and "specifying the request".

Over to you now. We can document this methodologically as :

You drafted some vignettes, I reviewed and made revisions, we sent these off for validation and feedback, you responded to the feedback and I checked that these amendments were in line with feedback.

You will need to write all of this down and print out these emails for safekeeping for writing your methods section. Could you check with other published qualitative vignette-based studies(not necessarily attachment) as to their validation methods? It is best to almost write the methods section as you go along.

Deirdre

DW

Deirdre Williams (MED)

To:

Katherine Berry <Katherine.Berry@manchester.ac.uk>;

Fearon, Pasco <p.fearon@ucl.ac.uk>;

Rhiannon Ducksbury (MED);

Thu 18/09/2014 08:14

Thanks so much, Katherine. We will amend in light of the comments - which are spot on!

Deirdre

KB

Katherine Berry <Katherine.Berry@manchester.ac.uk>

To:

Deirdre Williams (MED);

Fearon, Pasco <p.fearon@ucl.ac.uk>;

## Adapting CAT for Attachment Style

Rhiannon Ducksbury (MED);

Wed 17/09/2014 18:37

Vignettes DW RD 150914.doc30 KB

Download

Save to OneDrive - University of East Anglia

Hi Deirdre and Rhiannon

I think these are very characteristic. I have only added a few comments.

Best wishes Katherine

DW

Deirdre Williams (MED)

To:

Fearon, Pasco <p.fearon@ucl.ac.uk>;

Katherine Berry (Katherine.Berry@manchester.ac.uk);

Rhiannon Ducksbury (MED);

Tue 16/09/2014 11:14

Yes, Pasco, exactly that, just to give us some feedback about whether the clinical vignettes that we are developing correspond with your ideas about how attachment anxiety and avoidance might be expressed in the clinical context. Sorry, there is nothing worse than an underspecified task.

So the instructions would be as follows.

“ We are basing these vignettes on a dimensional model of attachment with two principal dimensions of attachment anxiety and attachment avoidance(Brennan, Clark and Shaver, 1998). Whilst recognising that this is a dimensional model, we have tried to create clinical vignettes which describe “pure” presentations of either attachment avoidance or attachment anxiety. These vignettes will be presented to participants to remind them of these attachment styles and as prompts to think about how they would adapt therapy to these kinds of attachment presentations. We would be very grateful for your feedback at this early stage as to :

- (1) whether you think these vignettes capture and describe the two dimensions of attachment we wish to look at
- (2) whether you think they have some degree of face validity as clinical examples
- (3) whether you think that they will be useful prompts for clinicians answer our research questions about how they adapt therapy to these kinds of presentations.
- (4) whether you think there would be any additional ways we could improve their validity (perhaps using raters to do proxy measures for them?)

The topic guide for interview will include prompts to look at differences between the way therapy is conducted with the two different presentations in terms of how therapists manage the relational/interpersonal aspects of therapy (including engagement and endings), differences in using the tools of CAT (reformulation letter, diagram, ending letter), differences in therapeutic focus, differences in procedural revision and Exits (the change-oriented components of CAT where you may be doing some behavioural change work), and in aims and expectations of outcome. “

Thanks again,

Deirdre

FP

Fearon, Pasco <p.fearon@ucl.ac.uk>

To:

Deirdre Williams (MED);  
Katherine Berry (Katherine.Berry@manchester.ac.uk);  
Rhiannon Ducksbury (MED);

Tue 16/09/2014 10:50

Hi Deirdre,

I am no CAT expert either, but also can you give us a clearer brief – what is it you need us to do? Perhaps some instructions could be written to clarify what it is we should be looking for. Or is it just informal feedback you need on whether the vignettes fit well with our ‘templates’ of the different attachment styles?

Best wishes,

Pasco

KB

Katherine Berry <Katherine.Berry@manchester.ac.uk>

To:

Deirdre Williams (MED);  
Fearon, Pasco <p.fearon@ucl.ac.uk>;  
Rhiannon Ducksbury (MED);

Tue 16/09/2014 10:45

Hi Deirdre

I am happy to help, but I am not trained in CAT therapy, so I am wondering if I am the most appropriate person.

Katherine

DW

Deirdre Williams (MED)

[Reply all](#)

To:

Fearon, Pasco <p.fearon@ucl.ac.uk>;  
Katherine Berry (Katherine.Berry@manchester.ac.uk);  
Rhiannon Ducksbury (MED);

Tue 16/09/2014 10:33

Vignettes DW RD 150914.doc36 KB  
Daly Mallinckrodt.pdf315 KB

2 attachments (350 KB) [Download all](#)  
[Save all to OneDrive - University of East Anglia](#)

Hello Pasco and Katherine,

## Adapting CAT for Attachment Style

Thank you so much for agreeing to help us validate the vignettes for Rhiannon's study. To remind you, Rhiannon is doing a qualitative study on how therapists adapt therapy to presentations of attachment avoidance versus attachment anxiety. When Rhiannon was doing her literature search we came across a study which covered the same ground in a North American context of private long-term therapy. I attach the paper we found which really is very interesting from a clinical point of view but hasn't had many citations surprisingly. We therefore reviewed our ideas and are now looking at whether similar themes are generated in briefer therapy within the CAT model in a British context. The reason we chose CAT as the model under investigation is that CAT theory incorporates attachment ideas, there are a number of theoretical papers on CAT and attachment, CAT is widely available in the NHS in the Eastern region, and it is a model of brief therapy that explicitly targets interpersonal and intrapersonal problems (so may get at some of the emotional regulation problems associated with different attachment styles).

We hope that you are still in a position to help us with this project. I attach the vignettes and really look forward to getting some feedback on them.

Would you both like a copy of the thesis proposal (for your information) in due course?

Best wishes,

Deirdre

**From:** Fearon, Pasco [mailto:p.fearon@ucl.ac.uk]  
**Sent:** Monday, March 31, 2014 2:48 PM  
**To:** Deirdre Williams (MED)  
**Subject:** Re: Clin Psy D research at UEA

Hi Deirdre,

Sure, I'd be happy to help. Only thing is that I am hellishly busy now, really until May. Can it wait until then?

Best wishes,

Pasco

**From:** "Deirdre Williams (MED)" <[Deirdre.Williams@uea.ac.uk](mailto:Deirdre.Williams@uea.ac.uk)>  
**Date:** Monday, 31 March 2014 11:46  
**To:** Pasco Fearon <[p.fearon@ucl.ac.uk](mailto:p.fearon@ucl.ac.uk)>  
**Subject:** Clin Psy D research at UEA

Hi Pasco,

I was wondering if you might be happy to be involved with a trainee clinical psychologist's research study here at UEA.

The trainee's name is Rhiannon Dicksbury, and she is going to do a qualitative study which asks experienced therapists how they adjust therapy according to different attachment styles. We need some help (or expert validation) for the case vignettes (of avoidant versus preoccupied/fearful attachment styles) that we are going to use as a prompt for discussion and we were rather hoping that you might be the expert.

I see you have returned to London from Reading, hope all is well with you,

Best wishes,

Deirdre

Appendix M: Poster for Sorting Task, Transformations in Attachment Conference  
20<sup>th</sup> February 2015

## How do Therapists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study

Deirdre Williams, Clinical Tutor & Clinical Psychologist

Rhiannon Ducksbury, Trainee Clinical Psychologist

### Background

Recent interest in the effect of attachment on therapy process has afforded enough data for substantial systematic reviews and meta-analyses e.g.; the impact of attachment orientation on whether attachment style changes in the course of therapy (**Taylor, Rietzschel, Danquah & Berry 2014**), therapeutic alliance (**Bernecker, Levy & Ellison, 2013**) and therapeutic outcome (**Levy, Ellison, Scott and Bernecker, 2011**).

**Daly and Mallickrodt (2009)** interviewed 12 experienced therapists about how they would respond to two clients represented by vignettes describing anxious and avoidant attachment styles. The authors conceptualised an integrated theoretical model based on the interviewee responses called '**change through regulating therapeutic distance**' to bring about a corrective emotional experience.

**Jellema (1999, 2000, 2002)** discusses integrating CAT and Attachment Theory but her suggestions are yet to be tested empirically

**Potential clinical implications of study.** Therapists may suggest specialised ways of working for avoidant versus anxious attachment styles which could later be empirically tested in terms of whether they enhance therapeutic outcome.

### Vignettes

Devised by authors using a dimension model

- There has been a general move from a categorical model of attachment style to a dimensional one (**Griffin & Bartholomew, 1994, Fraley & Waller, 1998.**)
- Categorical measures discard valuable information
- **Mikulincer and Shaver, (2007)** argue that attachment itself is dimensional, therefore should be measured in this way.

The vignettes have received external expert validation and a sorting task will be conducted to ensure validity.

### Methodology

- Qualitative design
- Vignettes to conceptualise attachment dimensions
- Interview 8-12 Clinical Psychologists or healthcare professionals with accredited CAT training
- Hour long interviews using a topic guide
- Analysed using thematic analysis.

### Contact

[Deirdre.Williams@uea.ac.uk](mailto:Deirdre.Williams@uea.ac.uk)

[R.Ducksbury@uea.ac.uk](mailto:R.Ducksbury@uea.ac.uk)

**Appendix N: Instructions for Sorting Task, Transformations in Attachment Conference 20<sup>th</sup>  
February 2015**



**How do experienced therapists adapt  
Cognitive Analytic Therapy (CAT) when  
working with clients with anxious or  
avoidant attachment styles? A qualitative  
study**

Please help us with the above research question by  
taking part in our sorting task.

We have devised two vignettes; Client R and Client S,  
please read the vignettes then place each one into either  
the box marked 'Anxious Attachment' or the box marked  
'Avoidant Attachment'.



**Appendix O: Table 1 Profession of Volunteer Completing the Sorting Task**

<b>Training</b>	<b>Number of respondents</b>
Integrative psychotherapist	2
Clinical Psychologist	5
Professor of psychotherapy	1
Couples counsellor	2
Humanist Counsellor	1
Psychotherapist (adult)	4
Student (attachment/psychology related field)	2
Not relevant, interest in psychology	1
Psychotherapist (child)	3
CAT therapist	1
Retired GP	1
Research Psychologist	1
Counselling Psychologist	1

## Appendix P: Information Sheet



Information sheet V3- March 2015

### **Information sheet for Research -How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**

My name is Rhiannon Ducksbury and I am a Trainee Clinical Psychologist based at the University of East Anglia (UEA). My research supervisors are Dr Deirdre Williams (Clinical Lecturer) and Dr Paul Fisher (Clinical Lecturer) on the Doctoral Programme in Clinical Psychology at the UEA. I am writing to invite you to take part in a research project. This information sheet is to help you decide if you are happy to participate. Please take time to read it carefully and feel free to contact me if you require any further information.

#### **What is the purpose of the project?**

This study will seek to interview experienced clinical psychologists and CAT therapists about how they have adapted Cognitive Analytical Therapy (CAT) when working with clients who demonstrate behaviours synonymous with an avoidant or anxious attachment style. Presently there is research about how people with different attachment styles behave in therapy but attachment hasn't been examined in specific therapy models. The purpose of this study is to conceptualise how CAT is adapted to work with these clients.

#### **Why have I been invited to participate?**

You have been provided with this Participant Information Sheet because you are a clinical psychologist or trained in CAT, working with adults, providing one to one therapy. To participate further you will need to sign the written consent form to provide informed consent.

#### **What will happen if I decide to give consent to take part?**

We will agree a mutually convenient time for a private interview, which will take place at a site across Norfolk and Suffolk Foundation Trust or Cambridge and Peterborough NHS foundation Trust, depending on your locality or at the ACAT conference. Demographic information will be gathered from you including age, gender, ethnicity, estimate of hours of individual therapy they have delivered, years of experience, dominant therapy model and if you have experience in working with people who have an avoidant and/or anxious attachment styles.

I will read you two clinical vignettes representing anxious and avoidant attachment styles and ask you questions about how you have responded to similar clients during your clinical work using CAT, following a topic guide. Each interview will last approximately 45-60 minutes and will be recorded. Once the interview has concluded the recording will be transferred to an encrypted memory stick for transportation. If you would like, I will send you a copy of the interview once it is transcribed for you to read through and decide if it is a true presentation of what was said. If it is you will be asked to sign

a form confirming that it is. If you feel it is not, I will send you the audio recording to check through, via password protected e mail. If you find any discrepancies I will change any errors I have made.

**What do I have to do if I would like to take part?**

If you are interested in taking part in this project, you will need to provide written consent and arrange a time for interview with me.

**Are there any expenses to me to be involved in the study?**

No

**What are the disadvantages and risks of my taking part?**

It is not envisaged that there are any risks to you in taking part. However, we acknowledge that you are giving up time to part take in the study. You will be informed that you can stop the interview at any time, should you wish to or to take a break.

**What are the possible benefits of taking part?**

It is hoped that this research will help therapist to conceptualise different attachment styles when using CAT.

**Will information be kept confidentially?**

All information will be private and safe, apart from if you disclose information which causes concern for your safety or the safety of others. I am obliged to keep you and others safe, and would need to pass on this information to ensure this happens. No information about you or your responses will be passed on to your employer. All interviews will be transferred on to an encrypted memory stick that will be password protected. No identifying information (such as names) will be included in the reporting and quotations will not be identifiable but you will not be anonymous to me as I would be seeing you in person. All interview transcripts will be securely destroyed once analysis has taken place or if you withdraw from the study. You are free to withdraw without needing to give reason up to the point of analysis, in which case your transcript will be destroyed.

**Who has reviewed the study?**

All research in the NHS and at the University of East Anglia is looked at by an independent group of people called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Research Ethics Committee.

Thank you for taking the time to read this information sheet. I hope you will decide to participate.

Should you have any questions I would be very happy to discuss my project further with you and can be contacted by email on [R.Ducksbury@UEA.ac.uk](mailto:R.Ducksbury@UEA.ac.uk)

If you are unhappy with any aspect of this study, have a complaint or wish to speak to one of my supervisors then they are contactable on 01603 593 599 or Email: [Deirdre.williams@uea.ac.uk](mailto:Deirdre.williams@uea.ac.uk)

**Appendix Q:Participant Consent Form**



**Consent form version 1 (December 2014)**

**How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**

**Please initial the boxes**

- 1. I confirm that I have read the information sheet dated..... for the above study.
- 2. I have the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 3. I understand that my participation is voluntary and I am free to withdraw involvement at any time, without giving any reason and without any services I receive being affected.
- 4. I understand that all data collected will remain confidential and that this will be stored securely and destroyed at the end of the study.

Would you like to receive a copy of the transcript following the interview? Please delete as applicable -  YES/NO

Would you like to receive a written summary of the findings on completion of the research? Please delete as applicable -  YES/NO

If yes please print an e mail or post address

_____	_____	_____
Name of Person	Date	Signature
_____	_____	_____
Name of person taking consent	Date	Signature

**Thank you for your help.**

Rhiannon Ducksbury, Trainee Clinical Psychologist. Email:R.Duckabury@UEA.ac.uk

**Appendix R: Demographic Information Sheet**



---

Demographic Information	Details
<b>Age of person</b>	
<b>Gender</b>	
<b>Ethnicity</b>	
<b>Years qualified as a Clinical Psychologist</b>	
<b>Estimate of hours of individual therapy delivered</b>	
<b>Dominant therapy model.</b>	
<b>Have you previously worked with clients who have an anxious/ avoidant attachment style?</b>	

---

### **Appendix S: Instructions for Interview**

During this interview I would like you to think about clients that you have worked with, rather than thinking about what you might do in the future.

I will read to you two vignettes; one demonstrates how a client with anxious attachment might typically behave in therapy and one to show how a client with avoidant attachment might typically behave in therapy.

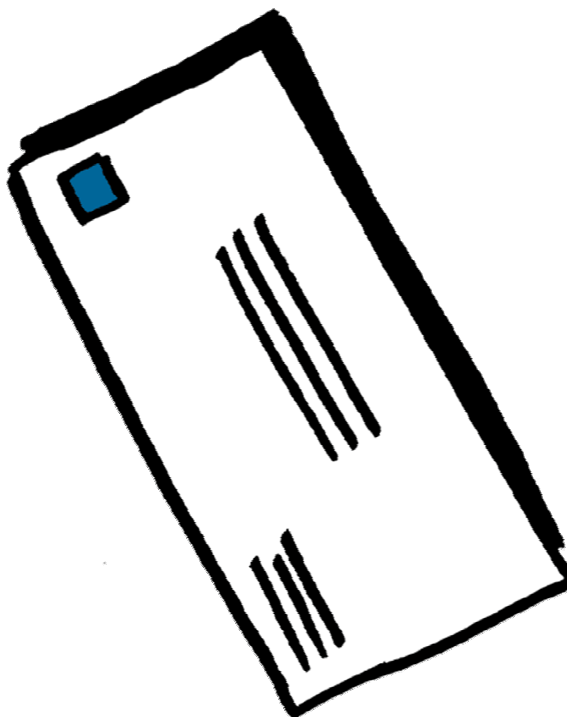
This is just as a springboard for discussion and to jog your memory. I will leave them on the table for you to refer back to.

I sent you the topic guide but don't worry if you haven't looked at it, I will leave out these prompt cards for the CAT tools for reference. We don't have to talk about all of them again they are just for reference.

Appendix T: Prompt Cards for Interviews

**CAT tools**

**Goodbye Letter**



**CAT tools**

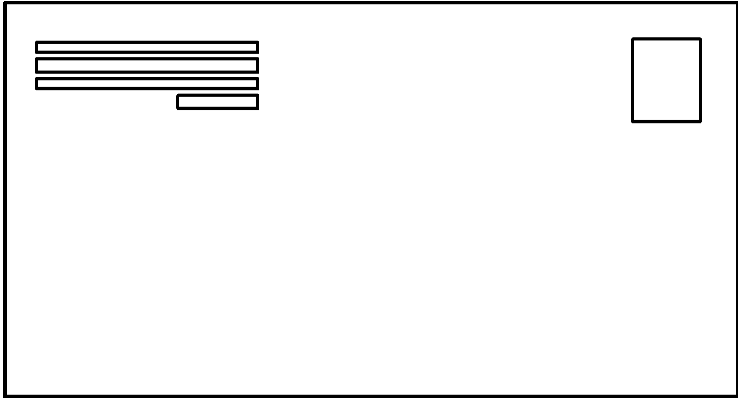
**Procedural revision**

**Exits**



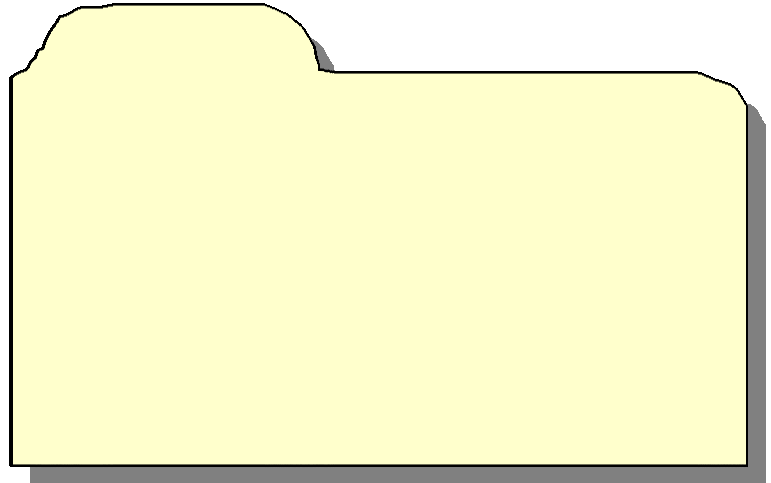
***CAT tools***

***Reformulation Letter***



***CAT tools Psychotherapy***

***File***





## Appendix U: Topic Guide

What would you do differently in terms at these *phases of therapy*:

- Engagement (sessions up to reformulation)
- Middle sessions
- Ending

How would you manage the *relational aspects of therapy*?

- Would you manage the therapeutic relationship differently?
- What kinds of ruptures would you anticipate? Is there anything different about the way you might handle ruptures with these types of clients?

Then talk about specific *CAT-specific tools and activities* (if these haven't come up already)

- Would you use the psychotherapy file differently? Would you expect them to respond differently?
- Would you write the reformulation letter differently? Would you expect them to respond differently to this?
- Would you work on procedural revision or Exits differently? Would you expect them to engage differently with this process?
- Would you write the goodbye letter differently? What expectations would you have for the client's goodbye letter? How might you anticipate that the ending would be different?

Would you have *different goals or expectations of outcome* with these clients?

- Prompt for interpersonal and intrapersonal goals e.g. What would you be expecting to do differently in terms of interpersonal goals for therapy? What might you be expecting to do differently in terms of intrapersonal goals for therapy?

**Appendix V - Accurate Account of the Interview Form**



**How do Clinical Psychologists adjust Cognitive Analytical Therapy (CAT) to work with adults with avoidant and anxious attachment styles; a qualitative study**

**Please initial the box**

1. I confirm that the transcript is an accurate account of the interview

2. The transcript is not an accurate account of the interview

\_\_\_\_\_  
Name of Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of person taking consent

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**Thank you for your help.**

Rhiannon Ducksbury, Trainee Clinical Psychologist. Email:R.Ducksbury@UEA.ac.uk

## Appendix W: Excerpt of Coded Transcript

(code)

Interviewer: If we start by thinking about the phases of therapy, is there anything that you would do differently with clients like these during the engagement, so anything up to the reformulation letter?

Natalie: I think this lady.

Interviewer: Client R?

Natalie: Yes client R, with the anxious attachment. I think I would be trying to slow her down a little bit (slow down anx client) and probably with the client with the avoidant attachment would properly would push them a little bit to see if they could do a CAT (push avoi client), because I think the idea that if someone has got an avoidant attachment, is this women going to be able to manage therapy and stick to there (avoi potential drop out) and so I think there is temptation, sometimes, to make it really easy for somebody and to want to make them able to engage (want avoi clients to engage), but actually when I have done that my experience is they get through to reformulation and it is after reformulation you get drop outs (avoi drop out after reform) so I think that it's trying to help them understand what therapy will be like, to see if they can tolerate it (avoid find therapy hard to tolerate).

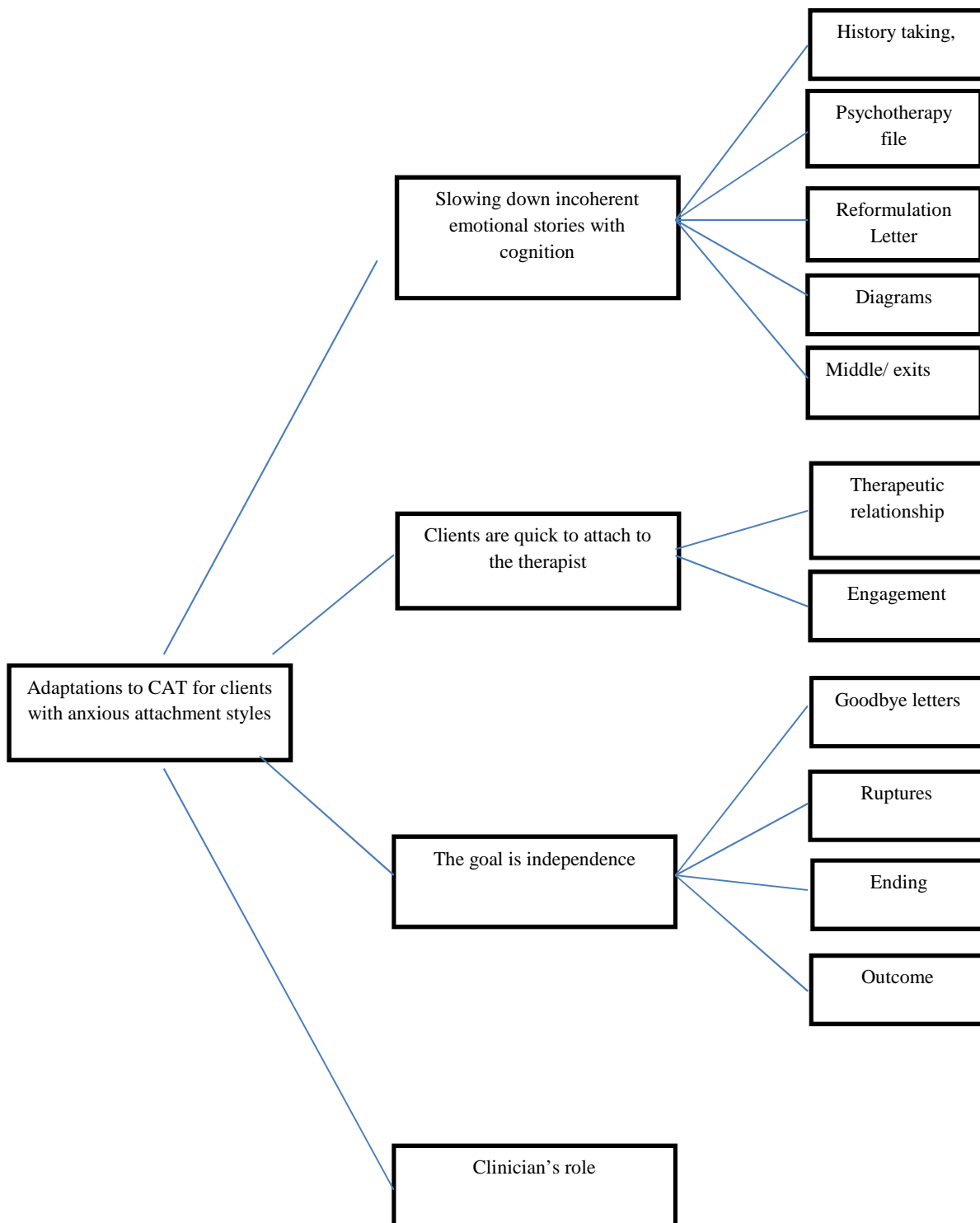
Interviewer: How would you do that in practical terms of slowing somebody down or making them feel comfortable enough to engage?

Natalie : I would focus on the process, (focus on process for insecc attachment) what was happening between us, I would talk about I was finding it hard too, (use own feelings) so I would talk about how maybe I was finding it difficult to follow things and I would use, the joy with CAT is that you have got a mix of tools (Cat many tools, chose) so I think I would use the genogram to slow down somebody who had anxious attachment (slow down anx with genogram), because it is a cognitive process and I think people with anxious attachment, when they are under stress increase negative effect and find it really hard to connect cognitively (anx cognition hard when stressed) so I would use the genogram to slow it down (genogram slow down anx) and maybe asking them a bit more questions first so 'what age this happen?' and so just moving into feelings and then out of them (mix cog and aff with anx) so if we were talking about a relationship with say mother, and that was really difficult and she did this and she did that I then might say or 'just tell me how old was mum when she had you?' or 'what was the age difference with you and your sisters?' (use questions to add cog anx) I would start by trying to use the cognitive stuff a little bit more. With someone who had an avoidant attachment I would try and ask more relational questions, (avoi ask relational Q's) so if they are not able to do it for themselves often they might be able to do it for somebody else so if mum was here, so this is a bit more of a systemic question, 'so if mum was here and I could ask her how she felt when you were born or when dad left what do you think she would say?' (ask

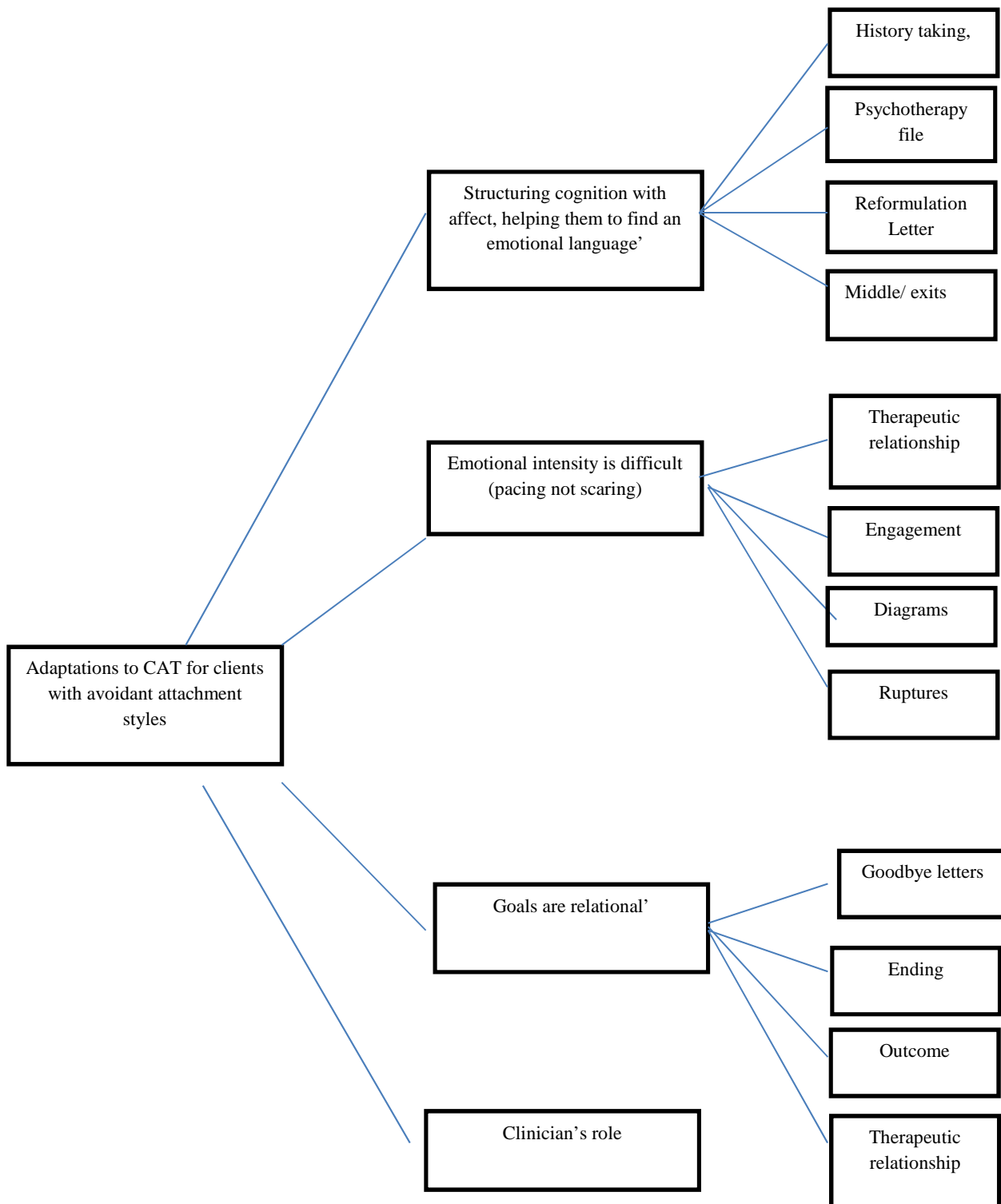
avoid how others feel, more affect) and often that sees them thinking how do you feel about it and then helping them to make them connections with that. (help avoid to engage with emotions).

**Appendix X: Reflections 11/12/2015**

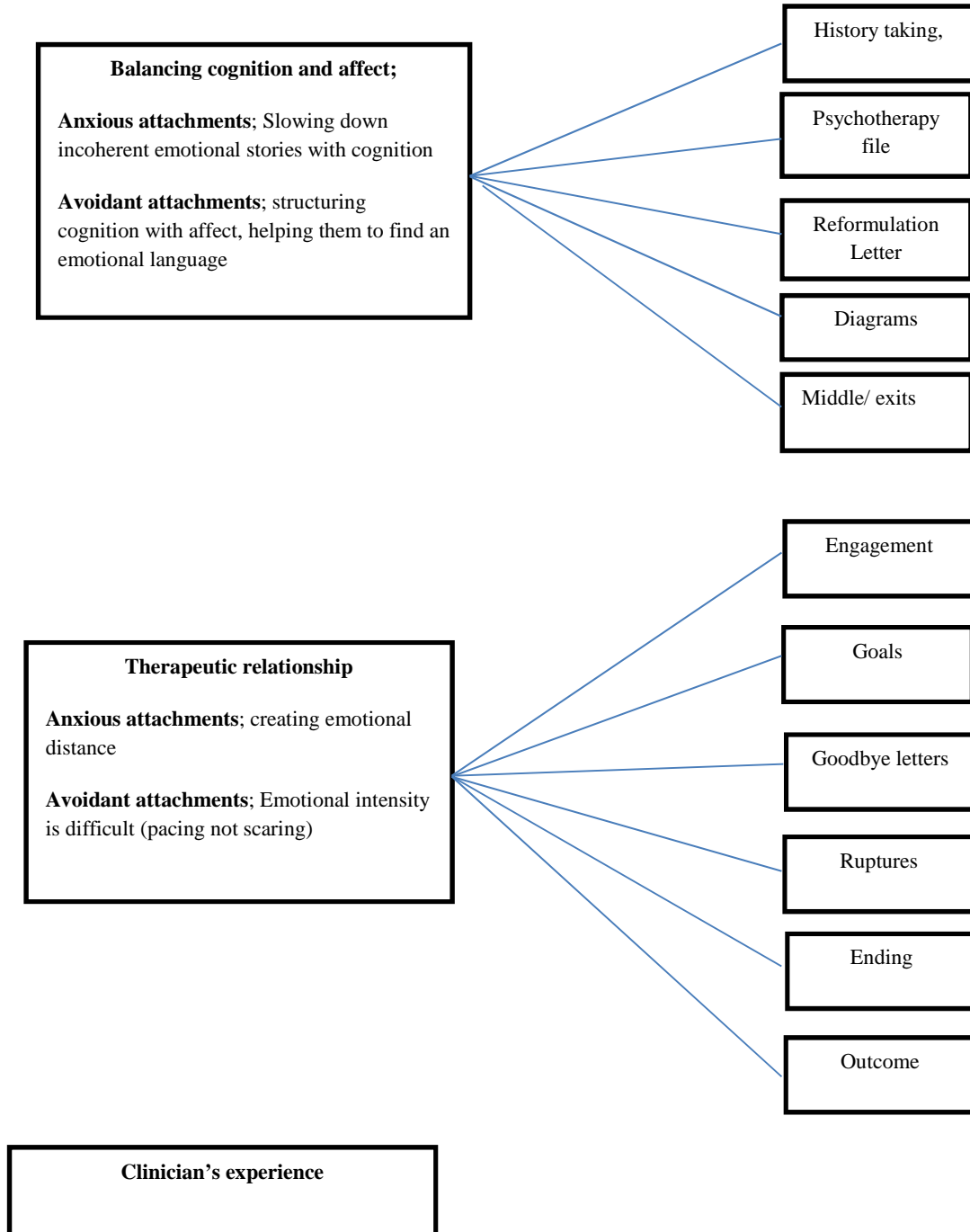
Themes and corresponding subthemes using thematic analysis- ANXIETY



Themes and corresponding subthemes using thematic analysis- AVOIDANCE



Looking at the TA figures its seems very clear to me now that these need to be merged as each subtheme is related and they are different sides of the same coin. It makes more sense for the report to examine this relationally. I have taken out goals as a theme and added it as a sub theme so now have three themes



**Appendix Y: CORE-Q for Present Study**

Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups (Tong, Sainsbury and Craig, 2007)

No Item Guide questions/description

Domain 1: Research team and reflexivity

No Item Guide questions/description	Answer	Section
<b>Domain 1: Research team and reflexivity</b>		
<b>Personal Characteristics</b>		
1. Interviewer/facilitator Which author/s conducted the interview or focus group?	First author Rhiannon Ducksbury	2.7.4.
2. Credentials What were the researcher's credentials? E.g. PhD, MD	BSc Psychology and Criminology	Appendix B
3. Occupation What was their occupation at the time of the study?	Trainee Clinical Psychologist	2.2.3.
4. Gender Was the researcher male or female?	Female	2.2.3.
5. Experience and training What experience or training did the researcher have?	Teaching from BSc and Doctorate	2.2.3
<b>Relationship with participants</b>		
6. Relationship established Was a relationship established prior to study commencement?	No relationship before recruitment	2.6.5.
7. What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	That I was a trainee clinical psychologist completing the research for my doctorate, this was explained in the information sheet	Appendix Q
8. Interviewer characteristics What characteristics were reported about the interviewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	Bias, assumptions, oncological and epistemological positions, personal statement	2.2.2.- 2.3.
<b>Domain 2: study design</b>		
<b>Theoretical framework</b>		
<b>Methodological orientation and Theory</b>		
9. What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	Inductive Thematic Analysis	2.1.3. and 2.1.4
<b>Participant selection</b>		



10. Sampling How were participants selected? e.g. purposive, convenience, consecutive, snowball	A purposive, snowball sampling technique was used	2.6.3.
11. Method of approach How were participants approached? e.g. face-to-face, telephone, mail, email	E mail	2.6.3.
12. Sample size How many participants were in the study?	10	2.6.1.
13. Non-participation How many people refused to participate or dropped out? Reasons?	None	2.6.3.
<b>Setting</b>		
14. Setting of data collection Where was the data collected? e.g. home, clinic, workplace	Could not be included due to confidentiality	2.7.
15. Presence of non-participants Was anyone else present besides the participants and researchers?	No	2.7.
16. Description of sample What are the important characteristics of the sample? e.g. demographic data, date	Descriptions are given	2.9.2. and Table 5
<b>Data collection</b>		
17. Interview guide Were questions, prompts, guides provided by the authors? Was it pilot tested?	No pilot, topic guide provided	Appendix V
18. Repeat interviews Were repeat interviews carried out? If yes, how many?	No	2.7
19. Audio/visual recording Did the research use audio or visual recording to collect the data?	Audio	2.6.5.
20. Field notes Were field notes made during and/or after the interview or focus group?	Reflexive diary	Appendix P and Y
21. Duration What was the duration of the interviews or focus group?	41 and 55 minutes; mean interview length was 46 minutes	2.7.
22. Data saturation Was data saturation discussed?	Yes	2.6.1.
23. Transcripts returned Were transcripts returned to participants for comment and/or correction?	Participants were given the option, one accepted	2.7.3.
<b>Domain 3: analysis and findings</b>		
<b>Data analysis</b>		
24. Number of data coders, how many data coders coded the data?	One coder, the researcher	2.8.
25. Description of the coding tree Did authors provide a description of the coding tree?	No	
26. Derivation of themes Were themes identified in advance or derived from the data?	From the data	2.8.3.- 2.8.5.

