Psychotherapeutic Interventions for Clients Seeking Long-Term Romantic Relationships, Yet Displaying Intimacy Avoidance Patterns: A Thematic Analysis of Clinicians Experiences

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Abstract

Relational issues are common reasons people seek psychological help, hereunder issues regarding romance, where many people struggle with dating and relationship formation. This is often due to a fear of emotional intimacy expressed as avoidance of emotional and physical closeness, explained in part by attachment theory. The present study is a qualitative investigation into what therapeutic interventions psychological practitioners employ when they encounter clients who experience avoidance attachment patterns in dating and relationship formation. Taking a point of departure in attachment theory the paper considers how secondary attachment avoidance patterns, or emotional deactivation strategies, contribute to these difficulties and argues a need to clarify what therapeutic interventions clinicians' practice to remedy the adverse effects of avoidance patterns in intimacy. While some therapies incorporate attachment theory in their approach to alleviating attachment-related issues, it is less clear what practitioners can do to service people specifically displaying intimacy avoidance in romance. Adopting a critical realist perspective, this paper aims to disseminate a complementary lens to the psychological profession in approaching psychological therapy for this specific demographic. A thematic analysis carried out on ten semi-structured interviews with highly experienced practitioners revealed four themes relating to interventions employed in therapy; *'Create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques', 'Use self and the therapeutic relationship as a conduit to change avoidance patterns'*, '*Apply measured humanity to heal and restore trust in intimacy'* and '*Contextual and conceptual positioning in therapy'.* Sub-themes to each intervention are considered and their implications discussed.

Keywords: psychological therapy, dating, relationships, avoidant attachment, fear of intimacy, thematic analysis

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CHAPTER ONE: Introduction

1.1 Overview

Optimal human relating is at the forefront of current psychological lines of enquiry (Cassidy & Shaver, 1999; Hefferon, Ashfield, Waters & Synard, 2017; Snyder & Lopez, 2005; Sprecher, Wenzel & Harvey, 2008; Vangelisti & Perlman, 2006; Vohs & Finkel 2009) possibly because poor relationships have been shown to increase loneliness, depression, anxiety and other psychological issues (Murphy & Bates, 1997; Ottenbreit & Dobson, 2004; Tasca, Tayler, Ritchie & Balfour, 2004;) whereas healthy relationships enhance longevity, facilitate mentalization, pro-social behaviour and mental well-being (Cozoliono, 2014). Indeed, relational difficulties are among the most common reasons people seek psychological help (Creasy & Hesson-McInnis, 2001; Horowitz, 1979; Kennerley, Kirk & Wesbrook, 2017; Lemma, Target & Fonagy, 2011). Romantic relationships are a prominent area in human life where many struggle to form or maintain meaningful connections. Sserwanja & Marjoribanks (2016) found in their UK nationwide survey, that nearly 3 million people in romantic partnerships were distressed. Divorce rates in the UK alone have risen steadily in recent decades, with over 50% of the adult population classified as ‘single’ (never married, divorced, widowed), Census 2011. Furthermore, there appears to be a link between single marital status, lower ability to relate to others, and an increased risk of mental health issues such as depression (Cole-Detke & Kobak, 1996; Scott et al., 2010).

Several theories and models illuminate the mechanisms of human relating: Internal motivational drive (i.e., McClelland, 1951; Murray, 1938), evolution (Buss, 1994), social

construction (Lange, 2009), social exchange (Berscheid & Walster, 1978), personality (Swami et al., 2007), self-regulatory mechanisms (Campbell et al., 2006), cognitions and schemas (Beck, 1988, Ross, 1989; Dweck et al., 1995) and biopsychological processes through the attachment system (Ainsworth et al. 1978; Bowlby,1977; Hazan & Shaver, 1987). Of the above theories, Bowlby's (1977) attachment theory appears to be the most robust and broadly accepted (Creasy & Jarvis, 2008; Holmes, 2001, Harvey & Wenzel, 2006, see also Cassidy & Shaver, 2016). It incorporates some of the aforementioned theories and is systematically researched and validated (Harvey & Wenzel, 2006; Shaver & Mikulincer, 2006). Moreover, it includes strands of theory and research, specifically focusing on romantic relationships (Creasy & Jarvis, 2008; Hazan & Shaver,1987).

Attachment theory provides a robust explanatory model of why some people struggle to form and maintain romantic relationships. One part of attachment theory includes a 'style' known as 'insecure-avoidant attachment style.' A feature of this is a fear of intimacy (Bartholomew, 1990), employment of distancing behaviours, downplaying a need for emotional support (Drago, Marogna & Søgaard, 2016; Hazan & Shaver, 1987) and emotionally deactivating strategies (Shaver & Mikulincer, 2006) what might collectively be called intimacy avoidant patterns or avoidant attachment patterns. People who fall under this category are less likely to seek help for their mental health, unlike their anxious and secure attachment style counterparts (Cundy, 2019).

Most clients seeking mental health services have some form of insecure (hereunder avoidant) attachment style (Daniel, 2006). It supposes that many clients seeking therapy struggle with forming and maintaining romantic relationships as explained by attachment theory. In turn, they are at risk of deteriorating or developing poor mental health (Daniel, 2006). Research suggests that people with an avoidant attachment style are more likely to feel lonely, develop depression, eating disorders (or other mental health difficulties), and have a

lower quality of life than their non-avoidant counterparts (MacBeth, Gumlet, Swannauer & Fischer, 2010; Shaver & Mikulincer, 2010;). Thankfully it is thought that therapy can help people better facilitate and maintain healthier relationships and, therefore, moderate poor mental health. According to Holmes (2001), 'Attachment theory puts the search for security above all other psychological motivation and posits the attachment bond as the starting point for survival, a precondition for all meaningful human interaction' (p. xii).

Clinicians will inevitably encounter clients with avoidance patterns regardless of therapeutic modality. While there are a couple of attachment-based therapies, (i.e. Emotion Focused Therapy and Attachment-Based Therapy), a growing number of therapies informed by attachment theory (i.e. Dynamic Interpersonal Therapy and Brief Dynamic Therapy) and an increased interest in including attachment theory across other therapeutic modalities (i.e. Cognitive Behavioural Therapy, [Parpottas, 2012]), there are no disseminated instructions on what therapeutic interventions are best suited specifically to people who display avoidant attachment patterns. Research and therapies consider anxious and avoidant attachment styles under the single term of 'insecure attachment', without distinguishing between their therapeutic differences. This lack of distinction can be unhelpful therapeutically as each style requires vastly different interventions (Cundy, 2019). Throughout I will reference research on anxious and secure attachment patterns to highlight this difference and to provide a context to better characterise avoidance.

Momentarily suspending what therapeutic modalities clinicians are trained in, this paper explores treatment interventions current clinicians utilise that benefit people with avoidant attachment patterns. Holmes (2001) notes that therapists with clear theoretical underpinnings in their therapeutic models get better outcomes with their clients. By investigating what clinicians already do, we may begin to evaluate and employ, perhaps more

cleverly, psychological interventions for single people struggling to form and maintain romantic relationships due to avoidance of intimacy as explained by attachment theory.

1.2 Attachment Theory

Attachment theory is a theory of human interpersonal and psychological functioning manifested as a motivational and behavioural system (Shaver & Mikulincer, 2006). The attachment (behavioural) system is thought to be an evolutionary system developed to maintain the species' survival. For example, the survival advantage of infants and children who can maintain close proximity to their mothers, in that they are less likely to be killed by predators (Bowlby, 1988; Cassidy, 2016). The attachment system acts as a behavioural homeostasis, a behavioural 'control system,' organised within the central nervous system (Cassidy, 2016). While never fully shut-down it is activated, in the form of physiological and psychological distress, when internal set-limits for perceived danger or stress (i.e., prolonged absence from an attachment figure), and novelty are surpassed (Crowell, Fraley & Roisman, 2016).

With the advances in neurobiology attachment theory has, since Bowlby's formulation, been expanded to highlight affective bodily-based processes and interactive regulation. Research has found that brain development in areas regarding processing of emotion, modulation of stress and self-regulation is related to attachment communications between infant and parent, which in turn facilitates the development of 'the social brain' an essential component of human functioning (Cozolino, 2014; Schore & Schore, 2008). As a result, Fonagy and Target (2005) note that the attachment relationship serves as a major organizer of the brain, and goes beyond Bowlby's assertation that it provides a sense of safety. As such, Schore and Schore (2008) propose that attachment theory be expanded to be seen as affect regulation theory (p.9).

Originally, Bowlby developed the theory in the 1960s and 70s, based on observations that delinquent boys often had a history of familial dysfunction (Bowlby, 1944; Cassidy, 2016). Along with subsequent clinical observations of the bonds formed between infants and their primary caregivers (observed initially in infants and their mothers [Ainsworth et al. 1978]) and how the bonds manifested themselves in a close relational context (Bowlby, 1977), the attachment theory gained clarity. The various observed relational manifestations became known as ‘styles’ and were collectively labelled ‘attachment styles,’ forming the psychodynamic tradition's attachment theory framework.

The theory posits that early human interaction with primary caregivers establishes mental representations and internal working models (IWM’s) about close relationships influencing the subsequent quality of adult bonding and relationships (Bowlby, 1969, 1973; Bucci et al., 2015; Shaver et al., 1988). The original theory's mechanics proposed four primary functions of the attachment system: proximity maintenance, separation protest, secure base, and safe haven. In times of distress, real or imagined, the innate psychobiological (attachment) system is activated, motivating humans to seek proximity to significant others in order to alleviate the distress (Bowlby 1973; Shaver & Mikulincer, 2006). The availability and responsiveness of the primary attachment figure (for example, a parent) facilitates the attachment system's optimal functioning. That is, when a sense of security, support, or safety is achieved, the system is deactivated, and distress is reduced (Sroufe & Waters, 1977). If an infant experiences consistent availability and support from their primary caregiver, they will develop positive internal working models of relationships (Sroufe & Waters, 1977). In other words, the child forms an expectation that he or she can rely on receiving support and comfort in times of distress and internalise a sense of worthiness of love and support. In this ‘state of mind’, the infant is confident to play, learn

and explore the world around him; what Ainsworth et al. (1978) termed ‘the secure base phenomena’.

Conversely, when attachment figures are not reliably available and supportive, or altogether absent in times of need, negative working models of relationships develop (Shaver & Mikulincer, 2006; Sroufe & Waters, 1977). As a result, the ‘neglected’ child does not develop expectations of reliably receiving support and must employ other strategies for stress reduction, such as attention-seeking (hyperactivation-) or social withdrawal (deactivation-strategies). This subsequently alters the quality of the relationship between the primary attachment figure and the child. In this ‘state of mind,’ the child has reduced confidence to seek out and explore the world and is more likely to develop psychological maladies later in life. Similar strategies have been identified in adult behaviour, known as secondary attachment strategies (Main, 1990; Mikulincer & Shaver, 2003), where people employ ‘hyperactivation strategies’ (often construed as needy behaviour) and ‘hyperdeactivation strategies’ (identified as distancing or avoidance behaviours).

Indeed, Bowlby (1979,1988) hypothesised that the attachment system is a healthy and normal part of adult functioning across the entire lifespan, and Ainsworth (1991) highlighted the secure-base phenomena as the critical element in adult couples’ attachment. The evidence that romantic partners activate the attachment system (Feeney, 2016; Levine & Heller, 2010;), in line with Bowlby’s hypothesis, supposes that human adults also need a primary attachment figure to provide a source of support, comfort, and reassurance (Holmes, 2001; Zeifman & Hazan, 1997). Hazan and Shaver (1987) extended Bowlby and Ainsworth’s attachment theory to create a framework for understanding adult pair-bonding in romantic love, supporting the theory that a romantic partner functions similarly to a child’s primary caregiver. Indeed, a growing body of research indicates that child-caregiver attachments

share unique physiological properties (hereunder hormonal and neurophysiological mechanisms) with adult romantic relationships (Zeifman & Hazan 2016).

1.2.1 Adult Attachment Theory

When attachment was originally formed, three different attachment styles were observed. They were coined ‘secure’, ‘anxious-ambivalent’ and ‘anxious-avoidant’ respectively (Ainsworth & Wittig, 1969). The last two referred to manifestations of different types of negative internal working models and collectively known as ‘insecure attachment styles’; shortened to ‘anxious’ and ‘avoidant,’ respectively. Since then, two main approaches conceptualising adult attachment has emerged in the research field.

The first line of enquiry on adult attachment started with George, Kaplan and Main (1984) when they devised aa assessment on adult attachment styles, the AAI (Adult Attachment Interview; Main, Kaplan & Cassidy, 1985). The focus was on assessing peoples IWM’s. In the test, they added a fourth category, the ‘anxious + avoidant’ style, and introduced new labels for the attachment styles: ‘autonomous’ (instead of secure), ‘preoccupied’ (instead of anxious), ‘dismissing’ (instead of avoidant), and ‘disorganised’ for the fourth attachment style.

Building on Main et al.’s (1985) work on the AAI, Brennan, Clark and Shaver (1998) developed a self-report normative assessment, the Experiences in Close Relationships Scale (ECR). They found two higher-order dimensions emerge from a factor analysis on the AAI; ‘anxiety’ and ‘avoidance’. This supported the notion that attachment styles are best conceptualised as two continuous, but orthogonal dimensions; not too dissimilar to Ainsworth’s (1978) two distinctions in attachments: a security- anxious dimension and closeness/intimacy – avoidant/ resistant dimension. For Brennan et al. (1998), the avoidance dimension referred to the ability to be vulnerable, depend on others for help and be comfortable with closeness. Those who were classified as avoidant were low on these traits.

The avoidance scales in the attachment tests included statements such as ‘I prefer not to show a partner how I feel deep down’ and ‘I am nervous when partners get too close to me’ (AAI, Brennan, et al.1998). People who obtain high scores on this dimension feel discomfort with emotional and physical closeness, distrust their partner's goodwill, and prefer to rely on themselves to solve problems. In contrast, those who score low on the avoidance dimension find it easy to ask others for help and are comfortable expressing emotions and needs.

In comparison, the anxiety dimension scores refer to the degree of an assumed availability and support from an attachment figure. For example, people who score high on this dimension worry about the relationship's stability and are hypervigilant to any signs of rejection, sometimes over-interpreting signs of rejection. Anxiety scales include: ‘I worry about being abandoned’ and ‘I worry that romantic partners won’t care about me as much as I care about them’ (AAI, Brennan, et al.1998). Their findings formed a two-by-two quadrant creating the fourth attachment style. They labelled the attachment styles ‘secure’, ‘preoccupied’, dismissive’, and ‘fearful. Unhelpfully perhaps, given their different manifestations, the latter three are collectively known as ‘insecure attachment styles’. See table 1 for an overview of attachment styles.

The second line of enquiry started with Bartholomew and Horowitz's (1991) research. They also adopted the 2-dimension conceptualisation of attachment. However, they regarded the dimensions in terms of ‘model of self and other’ and ‘negative or positive internal working model’. The attachment style labels they used were ‘secure’ (positive self, positive other), ‘preoccupied’ (negative self, positive other), ‘fearful-avoidant’ (positive self, negative other), and ‘dismissive-avoidant’ (negative self/ negative other). In this theory of attachment, they labelled the dimensions ‘avoidance’ and ‘dependence’. See table 1 for an overview of attachment styles.

Building on the above models, Mikulincer and Shaver (2003) proposed an integrative theoretical model of adult attachment, considering the interplay between the attachment system dynamics. They proposed that activation of the attachment system only occurs when there is a perceived threat. If a person's attachment figure (whether an external, often a spouse, or internal figure, for example, a religious figure) is unresponsive, or in some way unavailable, secondary attachment strategies are employed in an attempt to seek reassurance from the attachment figure. Should these attempts fail, the behaviours either become more 'needy' or more 'dismissive,' depending on what attachment style the adult has.

While it is popular to divide people into attachment style categories, these behaviours are not restricted to any particular attachment style. Someone who displays a secure attachment style may still engage in hyperactivation (increased bids for attention) or deactivation strategies (emotional or physical distancing). It is worth noting that while the styles may denote fixed categories, the attachment system is normative (Crowell, Fraley & Roisman, 2016) as in, one's attachment style sits along a continuum, such that someone, for example, can be more or less avoidant.

Table 1

Overview of Attachment Styles from Various Research Strands and Corresponding Dimensions

Researchers	Labels of attachment styles			
Ainsworth & Wittig (1969)	Secure	Anxious-Ambivalent (Anxious)	Anxious-Avoidant (Avoidant)	n/a
Two dimensions:	*Security vs. anxious*	*and Closeness/intimacy vs avoidance/ resistance.*		
George, Kaplan & Main (1985)	Autonomous	Preoccupied	Dismissing	Disorganised
Dimensions; n/a				
Brennan, Clark, Shaver (1998)	Secure	Preoccupied	Dismissive	Fearful

Two dimensions: Anxiety (assumed caregiver reliability & availability) and Avoidance (ability to be vulnerable and seek comfort) i.e.' secure' assumes availability of others and is able to seek comfort				
Bartholomew & Horowitz (1991)	Secure	Preoccupied	Fearful-Avoidant	Dismissive-Avoidant
Two dimensions: Dependence and Avoidance (i.e. Secure has a positive (IWM of) self and others, assuming 'low dependence' and 'low avoidance')				

Studies have shown that experiencing a sensitive, available and responsive attachment figure (that of a securely attached individual) in times of distress has positive psychological effects (Berant, Mikulincer & Florin, 2001; Roberts, Gotlib & Kassel, 1996). Indeed, there is general agreement that having a secure attachment style is more beneficial than having an insecure one. Shaver and Mikulincer (2010) draw on Fredrickson's (2001) broaden-and-build theory to explain how a secure attachment style serves as a positive function. They maintain that those who have access to a reliably consistent available, physically and emotionally, attachment provider (or have access to a stable mental representation of such attachment figures) develop a sense of security. This allows the individual to devote better time to explore goals, take risks, and demonstrate resilience. Fonagy et al. (2008) indicate that attachment security is related to the ability to mentalise, a higher-order capacity enabling better relational functioning. It is thought that having a developmentally secure attachment style is a precursor to the development of higher order thought processes, the ability to mentalize, that promotes emotional regulation.

In essence, having a secure attachment style functions as an augmenting of a person's emotional and psychological resources. Secure individuals tend to have higher self-esteem (Bartholomew & Horowitz, 1991), feel more efficacious and competent (Cooper et al., 1998), have positive self-appraisals, and can better tolerate their weaknesses (Shaver & Mikulincer, 2010). Furthermore, there is evidence that securely attached individuals score higher on (self-reported) measures of support and responsiveness to partners needs and distress (Fraley &

Shaver, 1998; Kunce & Shaver, 1994). This suggests that securely attached individuals have a positive effect on relationship maintenance, ultimately fostering pro-social behaviour (Shaver & Mikulincer, 2010). As such, it seems desirable for people to attain a secure attachment style.

In summary, people fit, more or less, into one of four attachment categories, with the manifestation of their behaviours best conceptualised along two orthogonal dimensions through 'hyperactivation strategies' or 'deactivation strategies.' While these behavioural strategies can be employed by anyone in any of the four attachment categories, it may make better sense to distinguish people by their use of 'relating' strategies than a particular attachment style. This paper is interested in people who display avoidant or dismissive patterns within the romantic context.

1.2.2 Attachment, Avoidant Patterns and Romantic Relationships

Most of the adult population is said to have a secure attachment style (Levine & Heller, 2010). However, most people who experience significant mental health problems display an insecure attachment style (MacBeth, Gumley, Swannauer & Fischer, 2011). It also appears to be the case in the non-clinical population. Levine and Heller (2010) reported that the majority of single people have an insecure attachment style, with the largest proportion displaying avoidance patterns. It appears that people with avoidant attachment patterns are the ones who struggle the most with initiating, consolidating, and maintaining relationships due to the very nature of their distancing attachment style and deactivating coping strategies.

According to the psychodynamic model of the avoidant personality, the behavioural patterns are identified by staying away from certain perceived dangers and dealing with anxiety by avoiding specific situations (Drago, Marogna, & Søgaard, 2016). In a study on hemispheric lateralisation of avoidant attachment, Cohen and Shaver (2004) concluded that avoidant individuals show "a right hemisphere advantage for processing negative emotion

and attachment related words [where] emotional negativity and withdrawal motivation have been connected" (p. 807).

In line with this, Shaver and Mikulincer (2006) found that in the relationship initiation phase of dating, characteristic avoidant behaviours include emotional shallowness, detachment, low self-disclosure levels, self-inflating presentation, typical of deactivating strategies. In contrast, people with a secure attachment style display positive, warm emotional tones, have a balanced self-presentation, and a responsive self-disclosure style. In comparison, people with a preoccupied (or anxious) attachment style display an anxious emotional tone with self-defeating presentation and effusive self-disclosure (Shaver & Mikulincer, 2006).

In preliminary studies focusing on romantic adult attachment, Hazan and Shaver (1987) mapped their theory of adult attachment onto Ainsworth's three attachment styles. Based on self-reported attachment, they found that securely attached adults considered themselves to be happy, friendly, and trusting, and were able to accept and support their partners, whereas avoidants characterised their main romantic relational experience with fear of intimacy, emotional highs and lows, and jealousy. In contrast to anxious-ambivalent's, who reported being more obsessive about their partner, desiring reciprocation and union. They also reported more emotional highs and low, extreme sexual attraction and being more jealous.

The study highlighted an added component to the avoidant's characteristic, in that not only do they have negative working models of others, they also have a fear of intimacy and closeness. Hazan and Shaver (1987) found that secure adults represented 56% of their sample size (comparable with secure child-carer attachment population found in Ainsworth work) and tended to be in significantly longer relationships than their insecure counterparts.

Furthermore, it appeared those classified as secure sustained longer relationships. Only 6% of the secure adults had been divorced compared with 12% for those who classified themselves as avoidant and 10% of those classified as anxious. Despite the acknowledged limitations of the studies (i.e., using a forced-choice 3-item measure of attachment), these initial findings supported a variety of hypotheses, which included that IWM's differ according to adult attachment style, and that avoidants tended to be fearful of closeness and be mistrustful of others. This has been supported in other studies, where it has been found that around 23% of the adult population display an avoidant/dismissive style, in contrast to roughly 58% of the adult population displaying a secure attachment style[1] (Bakermans-Kranenburg & IJzendoorn 2009; Levine & Heller, 2010).

Levine and Heller (2010) highlight a fruitless relational cycle often observed in dating between couples, where one has a preoccupied/anxious attachment style, and the other has an avoidant attachment style. The person with a preoccupied attachment style tends to overinterpret signs of rejection, activating their attachment system, upon which they employ hyperactivating strategies, such as biding for attention and seeking excessive reassurance. They appear to 'chase' their love interest as a means to reduce their activated attachment system (Johnson, 2012; Shaver & Mikulincer, 2006). This activates the attachment system in the person with the avoidant attachment style, as they are incapable of providing reassurance. Instead, they consistently withdraw, physically or emotionally, to reduce their activated attachment system. The distancing behaviour inevitably maintains the anxious partner's triggered anxiety escalating further bids for closeness, exacerbating the avoidant's attachment system. This circular escalation inevitably leads to the termination of the relationship (or dating-relation), causing distress for both parties.

[1] 19% displayed an anxious/preoccupied attachment style and 4-7% displaying a disorganised style

It is interesting to note that while people who display avoidant behaviours typically pride themselves on independence, high emotional regulation, and outwardly rejecting a need for closeness, they do, in fact, crave emotional intimacy and a need to belong. In a study by Carvallo & Gabriel (2006), people with avoidance patterns were sensitive to acceptance cues reporting higher levels of self-esteem following positive social feedback than a control group. There appears to be a negative consequence for people with avoidance patterns as they are at greater risk of experiencing depression, eating disorders, low resilience, and poor emotional reactions in times of distress (Bowlby, 1980; Ottenbreit & Dobson, 2004).

Combing the adult attachment models, we can infer that someone with a secure attachment style is said to be autonomous and comfortable with their relations to others, have a positive view of themselves and others, believe they are deserving of love and support, and are willing to reciprocate this in their romantic relationships, whereas people with a more dismissing or avoidant attachment style downplay the importance of close relations with anyone, have a fear of intimacy, have a positive view of themselves, but negative one of their partners (in that they do not fully believe their partner can be relied upon for love and support). In contrast, a preoccupied/ anxious attachment style denotes someone who is (hyper)vigilant about their attachment relations, fearful that the relationship will end, and view themselves negatively. They also see themselves as undeserving of love and affection, have a positive view of others, and are prone to fall in love more easily. The fourth category refers to a small subcategory of the insecure attachment styles that appear to display both dismissing/ ‘anxious-avoidant’ and preoccupied/ ‘anxious-ambivalent’ styles.

Weiss (1973, 1991) maintained that without a sense of belonging and security afforded by the attachment system, one is likely to experience loneliness and restlessness. This supposes that those with an avoidant attachment style are at risk of experiencing loneliness. They also make up the largest pool of adults whose marital status is single (Levine

& Heller, 2010). There seems little to be desired by having an avoidant (fearful or dismissive) attachment style from a dating and romantic relationship perspective. Therefore, it presumes that if people could reduce their avoidance tendencies, they may be better able to enjoy more wholesome and lasting relationships, as well as enhanced mental health.

1.2.3 Critique of Attachment theory

Attachment theory appears to undergo semantic and conceptual differences which are confusing. However, there is a general agreement about the number of dimensions or categories, and despite variations between adult attachment measures (Shaver & Mikulincer, 2010), there is a convergence between some of the measures (Feeney, 2016). As a result, Shaver and Mikulincer (2010) recommended that when one applies attachment theory in clinical research, to be mindful of the differences between measurements and theoretical conceptions. (For example, Main's Adult Attachment Inventory does not include Bartholomew's fourth 'fearful' category). Indeed, Berry and Danquah (2016) highlight that two main paradigms have emerged in adult attachment research. One is the development of measurements of 'attachment states of the mind' (Hesse, 1999; Main & Solomon, 1990), and the other is the conceptualisation of romantic love as an attachment process (Creasy & Jarvis, 2008; Hazan & Shaver, 1998) which may cause confusion when conceptualising the attachment system.

Berant and Obegi (2009) note that there is a gap between what we know about attachment in the general adult population and to what degree that manifests in psychotherapy, conceding that there is a tendency in the literature to 'rely on an amalgamation of inferences based on studies of non-clinical samples and clinical experience' p. 462. For example, Farber and Metzger (2009) note that there are not any studies examining whether 'dismissing [avoidant] clients are as hesitant to disclose personal information as their

non-clinical counterparts' (p. 52). A search on the PychInfo databased does not immediately present any recent papers considering this line of enquiry.

There are issues of discourse. Attachment styles are normative phenomena, yet in research and therapeutic parlance, they are categorical. The literature and therapists talk about 'avoidants' as if all people who fall under this category demonstrate equal amounts of dismissing behaviours or have equal sensitivities when the avoidant attachment system gets activated. Instead, it may be more useful to consider 'scales of avoidance', such as those used by the ECR, and recognising that some people may be more sensitive to intimacy than others, rendering the attachment framework perhaps too simplistic. Indeed, Mikulincer and Shaver (2007) note that categorical measurements of attachment styles ignore individual variability within each attachment classification. Nevertheless, it can help people label their experiences and useful to clinicians to have a shorthand for the set of experiences people might have.

1.3 Attachment Theory, Therapy and Avoidance Patterns

Despite the limitations in attachment theory and it's clinical application, there is a growing interest in how psychotherapeutic practice with adults can be informed by attachment theory (Burke, Danquah & Berry, 2016; Mikulincer, Shaver & Berant, 2013), possibly because research has shown it is possible to reverse the negative effects of insecure attachment styles (Levine & Heller, 2010; Mikulincer et al., 2013). If people with insecure attachment patterns, including avoidance, encounter a relationship with someone who provides a secure base, they can learn to adopt a more secure style. Bowlby (1988) proposed five therapeutic tasks in the psychotherapeutic process to address insecure attachment, of which the first is for the psychotherapist to provide the client with a secure base or 'safe-haven.' In general, this principle is adopted across all talking therapies albeit under the guise of 'the therapeutic relationship' or 'therapeutic alliance' (McBride & Atkinson, 2009) and has shown to be a powerful predictor of positive therapeutic outcomes (Wamplod & Imel,

2015; Zuroff & Blatt, 2006). The remaining tasks involve exploring past attachments, exploring the therapeutic relationship, linking past experiences to present ones, and revising internal working models (Bowlby, 1988).

Indeed, it seems that positive changes in attachment can be achieved across a variety of therapeutic modalities. Theorists have examined similarities between the attachment theory model and other modalities, i.e., individual psychology and cognitive-behavioural theories (Dowd, 1997; Jones & Lyddon, 1997; McBride & Atkinson, 2009) and found no difference in efficacy. Studies carried out by Tasca et el. (2007) on efficacy between CBT and Psychodynamic Interpersonal Psychotherapy, and McBride et al. (2006) on efficacy between CBT and Interpersonal Psychotherapy, did not find significant differences between therapy modalities and changes in attachment. All therapy forms provided a positive change in attachment. However, it is not clear whether the changes occurred specifically for those displaying deactivating strategies as a means to regulate their fears around intimacy and closeness and what the exact interventions were.

Berant and Obegi (2009) theorise that avoidant adults are less likely to seek psychotherapy because they place a high value on independent problem solving and are reticent to admit distress. There is also evidence that clients with avoidance patterns tend to drop out of therapy (Tasca et al., 2004), although there is little knowledge around how avoidant attachment predicts premature termination of therapy (Berant & Obegi, 2009). It is suspected that clients fearful of intimacy and relationship closeness may be inclined to drop out of therapy if early in therapy they get their need for independence and self-sufficiency challenged along with being pressured to disclosed affect-laden and private material, or the therapy focus is on personal deficiencies (Berant & Obegi, 2009). It may also be that it is difficult for clinicians to form a working relationship with emotionally avoidant clients. Farber and Metzger (2009) note that avoidant attachment undermines the therapeutic

relationship because the client's avoidance patterns gets activated as the therapeutic relationship forms.

Horowitz et al. (1993) found evidence that interpersonal problems in a clinical population were correlated with attachment style. They concluded that patients with avoidance patterns (dismissive and fearful attachment styles) were less likely to respond to brief psychotherapy, potentially due to their inability to describe relations. Using Bartholomew's attachment terminology, McBride and Atkinson (2009) believe that in order of therapeutic suitability for CBT, securely attached clients are most suitable, followed by dismissive, then preoccupied, and finally fearful. They support Horowitz et al. (1993) in asserting that people who display a fearful-avoidant attachment style are likely to present with the most challenges in any psychotherapeutic intervention.

Both psychodynamic/psychoanalytic (i.e., Clulow, 2001) and CBT (i.e., McBride & Atkinson, 2009) traditions can adopt an attachment theory framework; however, this would depend on the practitioner's knowledge and extracurricular training. While there are therapies that focus on the relational aspect in their interventions, such as Interpersonal Therapy (IPT), Dynamic Interpersonal Therapy (DIT), and Brief Dynamic Psychotherapy (BDT), not many therapies for adults explicitly use attachment theory in their approach. The exceptions seem to be Emotionally Focused Therapy (EFT), devised by Johnson & Greenberg (1985), Attachment-Based Psychoanalytic Psychotherapy (Heard, Lake & McClusky, 2009; see also Linington & Settle, 2017) and Holmes's (2001) Brief Attachment-Based Intervention (BABI). Others mostly focus on children, adolescents and families, for example, Cline's (1995) Attachment Therapy, based on interventions around the nature of play with children and caregivers, or Dallos and Rudi's (2014) Attachment Narrative Therapy (ANT).

Emotionally Focused Therapy (EFT), based on attachment theory, has its root in the humanistic tradition, adopting experiential techniques borrowed from Rogers (1951) and

structural techniques such as reframing. Two major therapeutic principles guide EFT, namely, ‘the provision of a therapeutic relationship’ and ‘the facilitation of therapeutic work’ (Greenberg, 2017, p. 67). Originally, Johnson and Greenberg (1985) designed EFT for couples, identifying nine steps that led to positive changes, derived from video observations between couples in therapy. The nine steps include: Assessment and creating a therapeutic alliance, Identifying problematic interactional cycles, Accessing unacknowledged emotions, Reframing the problem, Promoting identification of needs and interaction of these into relational interactions, Promoting acceptance, Facilitating expression of needs and creating emotional engagement, Facilitating new solutions, and Consolidating new cycles of behaviour (Johnson & Whiffen, 1999).

EFT has been empirically validated to treat relationship distress (Johnson, 2004; Baucom et al., 1998). Taking individual attachment patterns into consideration, Burgess et al. (2015) studied the impact EFT had on relationship-specific attachment bonds as measured by Brennan et al.’s (1998) ECR and The Secure Base Scoring System (SBSS; Crowell et al., 2002). Their study included 32 couples drawn from the general public, of which 27 completed the post-therapy assessment. While it is unclear in their paper how many of each participant had what levels of avoidance or anxiety, they found overall that EFT significantly reduced avoidance patterns. Subsequently, Greenberg and colleagues (1993) refocused EFT from couples towards developing the intervention for individual therapy. They created a treatment manual incorporating principles they refer to as a process-experiential approach to psychological change, which seemed to move away from using attachment theory and incorporated cognitive-behavioural techniques.

Attachment-Based Psychoanalytic Psychotherapy (Heard, Lake & McClusky, 2009) is another therapy that is based on attachment. The central idea is that most emotional and relational problems originate from early insecure relationships with caregivers. The therapy

takes a point of departure in the ‘Circle of Security’ (Powell, Cooper, Hoffman, & Marvin, 2014), where the aim for therapy is to provide the client with a safe base and sense of security from which they access and reflect on their attachment difficulties. The assumption being that the therapist functions as an attachment figure, and change occurs when the clients feel safe (Holmes, 2010).

McCluskey (2005) highlights that therapists must consider two forms of caregiving, depending on whether their clients come to therapy in a state of fear or distress. If clients are in a fearful state, clinicians must employ ‘type 1 caregiving’ characterised by soothing, comfort, and regulation of emotions. Otherwise, ‘type 2 caregiving’ is needed, which is characterised by recognition and validation, along with encouragement to explore the client's external and internal worlds. Attachment-Based Therapy is not prescriptive or protocol-based but draws on a number of integrated skills and strategies that therapists are required to provide, drawn from both attachment theory and psychoanalysis. These include; Empathetic attunement, Attentiveness and responsiveness to fear, Provision of secure caregiving, Use of countertransference, Facilitation of mourning (Livington & Settle, 2017). The aim is to help clients regulate fear and distress and then facilitate reflective and narrational exploration.

Most recently, Berry and Danquah (2016) proposed an integrated model of strategies for attachment informed therapy based on a thematic review of the clinical implications found in the attachment literature. It was explicitly aimed at adults in psychological treatment. Of the 58 papers and chapters that fulfilled their inclusion criteria, six key themes emerged: Changing internal working models, The therapeutic relationship and creating a secure base, Formulating and processing relationship experiences, Countertransference, Separation, termination and boundaries, and Working with different attachment styles or patterns. They did not consider any specific therapeutic modality (i.e., psychodynamic, CBT, or person-centered) nor made suggestions to how the model may be implemented in practice

(for example, in what ways might a therapist change internal working models). This is possibly because attachment theory can be applied across a variety of modalities. They concluded in their study: ‘Attachment theory provides a useful framework to inform psychological therapy with adults, but there is a pressing need for further research to empirically demonstrate the 'added value' of an attachment perspective’ (p.15).

Obegi and Berant (2009) distinguish between attachment-based therapies from attachment-informed ones, the latter being more pervasive (Burke, et al., 2016). Perhaps recognising this, Holmes and Slade (2017) reflected on the guiding principles of attachment-informed psychotherapy, based on assumptions such as the therapists aim is to ‘soften rigid and non-productive states of mind, enhance flexibility and openness and promote genuine, safe closeness and rich exploration and autonomy’ (p.22). This depends on, amongst other things, the therapist’s capacity to be regulating, sensitive, non-threatening, synchronous, accepting, and ability to mentalise (Holmes & Slade, 2017). They propose three key therapeutic competencies for attachment-informed psychotherapy: Establish a relationship, Make meaning, and Promote change.

While attachment theory appears to have clinical application across therapeutic modalities, there is little research on how and whether clinicians utilise attachment theory. In the first qualitative paper on the subject, Burke, Danquah and Berry (2016) explored how 12 therapists used attachment theory in their clinical work. They concluded that attachment theory complemented other therapeutic models, provided a framework for creating developmental formulations, allowed clinicians to consider working with different attachment styles, and helped conceptualise the therapeutic relationship as an attachment relationship. Most of the literature and research considers therapies that are either driven or informed by attachment theory, a top-down theory-driven approach to interventions. There has to date been no investigation into how clinicians work when they encounter people who

struggle with relationship formation due to fear of emotional closeness and bonding. Despite training across modalities, what do practitioners actually do? Despite the prominence of attachment theory across therapeutic modalities, there appears to be an empirical gap in investigating specific interventions for single people with avoidant attachment patterns.

1.4 Research question

In conclusion, while it is promising that insecure attachment styles can be altered to a more secure one, there is a problem for those who display avoidance patterns as they, by definition, struggle to form romantic relationships. Most studies on attachment focus on treatment for ailments such as depression, and there is little research on avoidance patterns in other client difficulties, such as failures at dating and relationship initiation and what practitioners do to help this particular demographic. Given that a large portion of people seeking therapy are doing so fundamentally because of relational issues, it is likely that a sufficient number of these clients will be struggling with romantic relationship initiation due in part to avoidant attachment patterns and fear of intimacy. They are at risk of developing further psychological difficulties as a result of their avoidance patterns. If we can unpick what clinicians already do to help this demographic and relate this to the 'top-down' approaches, we may place ourselves in a stronger position to carry out better therapy. As such, this paper is interested in the following question:

What interventions do psychotherapists and psychologists use when they work with clients who seek long term romantic relationships yet display avoidant attachment patterns?

1.5 Defining terminology

In order to clarify the terms within the research questions the following sets out the definition of the key terms: *interventions, clients, psychotherapists/ psychologists, and avoidant attachment patterns.*

1.5.1 Interventions

According to Slade (2018), ‘an intervention (a question, an observation, an interpretation or even a silence) has helped overcome avoidance or resistance or heightened it’ p.774. The current paper adopts a similar definition of intervention. In essence, it is a broad and inclusive term covering any considered action or ‘positioning’ a therapist may use consciously or not, taking non-verbal tacit knowledge and automation of therapy into account.

1.5.2 Client, Patient or Service Users

Most people who seek therapy are called ‘clients’, ‘service users’ or ‘patients’ depending on the service. For the sake of simplicity, I refer to anyone seeking therapy as ‘clients’.

1.5.3 Clinicians, Practitioners, Therapists, Participants and Interviewees

In this paper, those who are trained to deliver therapy are collectively called clinicians, practitioners, and therapists interchangeably. There is no emphasis on the type of therapy delivered; it is not relevant to answering the research question, nor whether they are trained as psychologists, psychoanalysts, or psychotherapists. This group of people is also the target audience of the research question and will be referred to as 'participants' and 'interviewees' in some parts of the paper.

1.5.4 Avoidant Attachment Patterns

Avoidant attachment patterns in this paper refer to secondary attachment avoidance patterns, or emotional deactivation strategies (indicated by distancing behaviours avoiding relational intimacy and emotional closeness), that get activated in therapy and romantic relationships. This includes actions such as avoidance of emotional content, systematically not allowing to ‘feel’ or ‘access’ uncomfortable or distressful emotions and memories, being emotionally detached, avoiding ‘personal conversation’, having a pessimistic view about

commitment and others' need for closeness, changing the subject when conversations require opinions on emotion, inability to express emotions, being tardy or inconsistent, and leaving therapy abruptly either temporarily or permanently.

CHAPTER TWO: Methods

2.1 Epistemological and Ontological position

In order to decide the methodology best suited to a research question, one needs to consider and acknowledge the researcher's epistemological stance (Crotty 1998; Willig, 2013). Epistemology, the study of knowledge acquisition and the justification for claims to knowledge (Williams & May, 1996), is concerned with methods of knowledge acquisition (how we go about knowing things) and validation of said acquisition (how do we know what the 'truth', or validity, of knowing what we know) (Howitt & Cramer, 2020 p.370).

What we believe about the nature of reality, the nature of what exists is our ontology. Our ontological position informs us on how we can obtain and gain access to that reality (Williams & May, 1996). There are three common beliefs about reality. One is that there is a single reality; the world exists of stable, observable entities of which some are out of our conscious awareness. Knowledge is objective; it can be measured and quantified (positivism), and the therefore, variables within reality are controllable and predictable (Yardley, 2000). This has been the predominant research paradigm from which most of our modern time knowledge, collected via quantitative research methods, stems from.

In contrast, there is a belief that reality is constantly renegotiated and interpreted; we cannot always know reality. Our only way of knowing anything is to interpret our idiosyncratic lived experiences of the world (hermeneutics/ phenomenology/ constructivism), (i.e. Burrell & Morgan, 1979). Here, knowledge and truth are relative, multifaceted and

subjective, accessible only via our senses, and at best through discourse. As Taylor and Ussher (2001) put it, 'There is no search for a singular, objective, empirically valid, universal truth, existing out there in the world [but rather] an emphasis upon the multiplicity of interrelated, subjective and often oppositional understandings, each with their own inherent validity' (p.295).

Somewhere in between these two positions lie critical realism. This position states that there is a single reality or truth, that physical objects exist independently, but they do so outside our full perception of them (Williams & May, 1996). While there is a fundamental disagreement at the heart of social science about whether social phenomena can be subject to the same kinds of explanatory goals as physical phenomena, critical realists maintain we cannot access reality solely through objective means (Williams & May, 1996). Reality is therefore multifaceted and somewhat subjective. To access knowledge or reality, one must adopt multiple lenses and interpretations; 'there is a reality out there, but we best view it through an infinite regress of windows' (Howitt & Cramer, 2020, p. 370). In contrast to the hermeneutic-phenomenological position, Bhasker (1989, p. 4) maintains that social practices are not only concept-dependant but have a material dimension, as such biochemical, economic and social structures are considered to be relatively enduring (Willig, 1999).

My epistemological position is that of a critical realist, in that there is a reality 'out there' accessible through different lenses. This study investigates psychological interventions for a specific client group, suggesting the existence of entities such as 'avoidant attachment patterns' and 'psychotherapeutic interventions' which can be observed and measured. While this implies a positivist epistemology, I am asking clinicians about their practical experiences applying therapy to a particular client group; implying a phenomenological approach. (Clinicians experiences are subjective and malleable; the words used to describe experiences are loose interpretations and approximations of said experiences. For instance, what is meant

by ‘intervention’? Do we have the same understanding of ‘avoidance patterns’?). My way of accessing psychological interventions is through the various lenses, and idiosyncratic experiences clinicians have with therapy. Therefore, this study sits between a positivist/realist and hermeneutic phenomenological epistemology, indicative of a critical realist position.

2.1.1 Brief Overview of Critical Realism

Critical Realism (CR) was born out of the positivist/constructivist ‘paradigm wars' of the 1980s’ as a scientific alternative, utilising components of both approaches (Denzin & Lincoln, 2011, p1). Bhaskar (1998), the founding father of CR, critiqued positivism for promoting ‘the epistemic fallacy’; the conflating of ontology with epistemology (p. 27). He offered a similar critique of constructivist perspectives, in that reality is constructed through and within human knowledge and thus becoming circular and limited to discourse. Within CR, ontology is not reducible to epistemology as human knowledge only captures a small part of a deeper and greater reality (Fletcher, 2017, p.4).

CR treats the world as theory-laden, in contrast to the positivist/constructivist views, which treat the world as theory-determined. A core assumption in CR is that there is a relationship between material and social structures which are not accessible to us because they are not object-like and concrete (Sims-Schouten, Riley, & Willig, 2007). In this line of thinking, Danermark, Ekström, Jakobsen, and Karlsson (2002), proponents of CR, state that our knowledge can only ever be more or less close to reality and the critical realist derive theories about the world, of which some are closer to the truth than others. According to Brown, Fleetwood, and Roberts (2002), this makes CR a comprehensive philosophy of science.

The ontology in CR is stratified into three levels; empirical, actual, and real (Danermark et al., 2002, p. 205). The empirical level is where we experience events. Events and objects can be measured empirically, albeit through the lens of human interpretation.

This is where social ideas, meanings, decisions, and actions occur. The actual level is void of human interpretation. Events at this level occur regardless of human interpretation or experience. At the real level, causal structures or mechanisms exist the inherent properties of an object or structure that produce events, one that may be experienced or observed at the empirical level. The primary goal of CR is to explain social events throughout the three-layered 'iceberg' of reality by referencing the causal mechanisms and their potential effects (Fletcher, 2017).

The relationship between the structures and the phenomena they generate are not direct, linear or causal, but interact in a dynamic and dialectical way with each other, holding more potentialities than can be realised at any one time (Sims-Schouten, Riley, & Willig, 2007). Hence why we can only ever make attempts at understanding 'reality', and thus be critical of what we think we know about reality.

2.1.2 Critique of Critical Realism

Two main criticisms have been directed against the CR approach (Sims-Schouten, Riley & Willig, 2007). The first is the issue of discourse. What can be talked about can be analysed from a constructivist/relativist perspective (Edwards et al., 1995), and all material practices can be reduced to discursive practices. For example, the CR position that reality cannot be denied is, in fact, a reality that can only be accessed by being 'represented and interpreted', thus reducing CR to a constructivist/ relativist position (Edwards et al., 1995, p. 32.).

The second criticism is that there is no systematic method of distinguishing between discursive and non-discursive entities. What constitutes an entity, or unit, of understanding is down to the choice of the individual researcher, jeopardising the measurability of the positivist position within CR.

Sims-Schouten, Riley and Willig (2007) defend against the critics by arguing 'that additional insights can be gained by adopting a critical realist perspective that allows us to address questions about the relationship between our physical and social environments, what we do and say about them and how we live within them' (p.105).

Bearing this in mind, my position is that clinicians do something that changes, or alleviates, client distress and psychological difficulties, and that something can be labelled a psychological intervention, or intervention for short. I make the assumption that there is a large enough pool of clients who display characteristics of distress under certain circumstances (i.e. forming relationships) that it may be considered a psychological phenomenon or structure which we can access and talk about as an entity (avoidance patterns). I make a further assumption that these can be addressed with the help of psychological interventions. The labelling of entities (i.e. using the term intervention) is relatively arbitrary, and what I deem to be an intervention is indeed influenced by my restricted worldview.

2.2 Methodology

2.2.1 Methodological Considerations

Possibility due to the breadth of CR, allowing for a variety of qualitative research methodologies, there is little guidance available on which methods of data collection and analysis are best suited to applied CR research (Fletcher, 2017; Hu, 2018). Methodologies used include Interpretative Phenomenological Analysis (IPA) (i.e. Fade, 2004), Grounded Theory (i.e. Oliver, 2012), Case Study (i.e. Hu, 2018), Discourse Analysis (i.e. Sims-Schouten, Riley, & Willig, 2007; Clarke 2005) and Thematic Analysis (TA) (i.e. Fletcher, 2017).

IPA is typically used for exploring, as opposed to explaining, lived experiences of an individual or a small homogenous group of individuals. Situated within phenomenological

epistemology and theories of hermeneutics, IPA is underpinned by the circular process of meaning making between an individual's, or groups experience, and the researchers understanding and interpretation of said experiences. IPA is committed to generating a deeper understanding of phenomena within a specific context (Smith & Osborn, 2003; McLoed, 2001). Because this study is interested in the description of interventions used by clinicians, and not their experiences of using interventions, IPA was not considered applicable.

Grounded Theory aims to unearth new information and theoretical knowledge by detecting emerging categories from a body of data (i.e. interviews). The researcher is required to continue to gather data until they reach a saturation point on the emerging categories. That is until no further categories are discovered (Glaser & Strauss, 1967). While this paper is attempting to delineate interventions used in therapy, it is not trying to produce new knowledge in the sense Grounded Theory proposes, and so was discarded for this study.

Discourse analysis incorporates discursive psychology (Potter & Wetherell, 1987) and Foucauldian discourse analysis. Discursive psychology is concerned with how culture and meaning are negotiated within a particular linguistic context. Foucauldian discourse analysis considers how language shapes and constructs our social and psychological lives (Parker, 1992). Given there are semantic differences in how clinicians and theorists use words to describe attachment styles differently, makes for an interesting line of enquiry. However, the focus of this study is not on the discursive aspect of meaning-making.

TA is an atheoretical method to organise and make sense of narrative content allowing, on the one hand, the researcher to immerse themselves in large volumes of data, and on the other hand to decide what level of depth and breadth to analyse and describe themes in the data. It allows for examination of a range of discourses. It can be a realist method (reporting experiences, meanings, and participant realities), a constructionist method (examining the effects of events, realities etc on a range of discourses operating in society),

or a contextual method (acknowledging the meaning individuals make of their experiences whilst retaining focus to 'reality') (Braun & Clarke, 2006, p. 4). The fact that TA lends itself to a semblance of positivism (themes as units of measurements), whilst taking idiosyncratic experiences into account, made this the most suitable research method for this study.

2.2.3 Rationale for Thematic Analysis

Braun & Clarke, (2006, p. 4) note that in choosing a qualitative research methodology, one needs to consider whether it is tied to a particular epistemological position. For example, whether to choose IPA, which is situated more broadly within a theoretical framework. Given that CR does not require or lends itself to a particular methodology, and allows freedom to explore material theoretically, I have chosen to address this study with thematic analysis.

Thematic analysis allows for a transition between emerging phenomena and measurable units (Coffey & Atkinson, 1996), and therefore sits comfortably between a positivist and interpretive social scientist (i.e., Joffee, 2010; Boyatzis, 1998), which is a critical realist position.

I am attempting to uncover 'units' of sociopsychological phenomena (interventions) that can only be accessed by lived experiences (clinician interviews). Thematic analysis is a method to source units within discursive material, for example, interviews, in the form of codes and themes. Also, there is a call for further qualitative studies around attachment and therapy (Burke et al., 2016) and to my knowledge, there is no research using thematic analysis within this context.

2.2.4 Rationale for Semi-Structured Interviewing in TA

There are a variety of means in which to elicit qualitative information, such as case study, focus group interviews, open-, structured- or semi-structured interviews, texts, and video observations. If a research question calls for specific experiences while inviting

idiosyncratic experiences, as is the case with this study, semi-structured interviews are considered the best method to employ (Joffe, 2012). The structured interview would curb experiences the researcher is not aware of or have missed in their questions, and an open-ended interview would risk missing techniques and interventions if the participants talk off-topic.

With the aim to gain as many interventions as possible, the semi-structured interview would be applied to one participant at a time, rather than a focus group. This would allow each participant more time to reflect on their practice and not be influenced by other practitioners' methods. It will also generate more hours of transcript and allow for a richer understanding of how clinicians go about their therapy.

In developing the semi-structured interview questions, two underlying principles need to be taken into consideration: avoid leading questions and attempt to create relaxed and natural conversation (Patton, 2002). As recommended by Dickson-Swift, James, Kippen & Liamputtong (2007), an overall research question was delineated, followed by a set of 'narrow' questions that drove the interview. It is recommended that the interview contain 5-7 questions, allowing for probing questions (McIntosh, M. J., & Morse, 2015). These can be scripted or unscheduled (p.5).

In this study, five questions were developed with additional optional probing questions. I sense-checked these with my academic supervisor and trialled them on my first interviewee. The opening question (What is your experience working with people who have avoidant attachment patterns?) was a useful 'ice breaker' to ease into the topic of attachment and clinicians experience; however, the subsequent question (how do you identify their attachment patterns?), seemed redundant and was excluded from the schedule (see appendix 3 for final interview schedule).

2.2.5 Critiques of TA as a Qualitative Research Method

Access to interventions (the 'units' of the sociopsychological phenomena I am attempting to 'measure') is limited by language. Clinicians will have a certain amount of tacit knowledge they are unable to articulate, and perhaps even unaware of. Furthermore, my understanding of what they tell me will be limited by my worldview and the lens through which I understand their discourse. This is the risk of interpretative work. However, within the CR position, I can only ever attempt to get as close to reality as possible.

2.3 Design and Study Procedures

2.3.1 Recruitment

Participant recruitment followed 'purposeful sampling' (as opposed to 'random sampling') a technique widely used in qualitative research (Patton, 2002). This involves identifying and selecting individuals who are especially knowledgeable about or experienced with a phenomenon of interest. Under the assumption that clinicians from all persuasions encounter clients who display avoidance patterns, and not only those confined to attachment therapy training, this study is interested in the broad range of interventions regardless of therapeutic modality. To this end maximum variation was chosen as it aims to curate important shared patterns that cut across features such as gender, race, age and also in this case, psychological training. Essentially the data emerges out of heterogeneity (Patton, 2002).

In order to best capture techniques and interventions used in psychotherapy, participants would require having considerable experience as well as expert knowledge in delivering therapy. Ericsson (2006) argues that expert status is achieved after ten years' experience. Joffe (2012) recommend therapists see a minimum of 32 clients over the course of their clinical work to be deemed sufficiently knowledgeable about a particular client group. I assumed that clinicians with ten or more years of clinical experience will have likely encountered at least 32 clients displaying avoidance patterns.

There was an attempt to achieve a 50% gender split and recruit a mix of ethnicities to reach heterogeneity. To maintain the same cultural language reference, only clinicians who received training and had work experience in the UK were included. To increase the chances of clinician's work experience to include generalised attachment difficulties, clinicians who worked in services that provided specialist treatments such as addictions or eating disorders were excluded.

Inclusion Criteria:

The following criteria for participant recruitment included:

- Chartered psychotherapists, clinical - and/or counselling psychologists with minimum 10-year client-facing post-qualification experience, and knowledge of the attachment theory framework
- Work experience in a generalised clinical setting
- Have worked with enough clients displaying avoidant patterns who desire long-term relationships and can recall specific cases
- Willing and available for up to a 50-minute* interview either in person or over Skype/ video call

  *a clinical hour, accommodating a typical work schedule

Exclusion criteria:

- Therapists whose only experience is in treatment of a narrow set of pathologies (i.e. addictions) as the client demographic are most likely to be seen for a particular outcome focused problem. In this clinical setting, there will be less flexibility in treatment goals, especially where interventions are manualised. Unless the clinical setting is specifically targeted for people with avoidance attachment patterns.
- Trained outside the UK or work predominantly abroad.

Recruitment of participants included a recruitment email sent out to clinical and counselling psychologist members of the British Psychological Society (BPS) and members of the British Association of Counselling and Psychotherapy (BACP), as well as on LinkedIn and Facebook, through direct contacts in the researchers' network and the network beyond.

The potential challenge was that therapists were either too busy, disinterested or unwilling to share their experiences. Another challenge was physical distance and video call not feasible. In the former issue, I would reduce the length of experience to five years, in order to reach a wider audience. In the latter case, I considered travelling to therapists in order to interview them. See appendix 1 for participant information form and appendix 2 for the consent form.

While Joffe (2012) acknowledges that power is not a concern in qualitative research, she recommends a sample size of anywhere between 32 to 80. Conversely, Fugard & Potts (2015) note that samples sizes can vary from 2 - 400. For TA research, in particular, Braun, Clarke and Weate (2016) argue that between six and ten participants are sufficient for a 10-15000 word research piece, providing the researcher can capture rich data. Considering the above, the aim of this study was to recruit a minimum of ten participants.

2.3.2 Participants

A total of ten participant interviews were included for this study. Thirty people were contacted, sourced through a variety of channels, including recommendations from people responding to my advert on social media (Facebook and LinkedIn), through my network and from clinicians appearing in The Psychologist. A total of 11 participants agreed to take part. While willing to be interviewed, one person was not included, as they did not embrace the concept of avoidance difficulties.

Practitioners' clinical experience spanned from eight to 40 years, averaging 20 years' experience. The one participant, whose clinical experience was eight years, was deemed

suitable to include in the study as he was working in a service with avoidant personality disorders, was trained in the UK and had a working knowledge of attachment theory. Of the ten participants, six were HCPC registered clinical or counselling psychologists, with the remaining UK chartered psychotherapists. Four were male, reaching a 40% gender split. The ethnicity of the ten interviewees was mixed. There was one Black British, one Asian British, four White British, and the remaining four identified as White Other. At least seven stated using CBT principles in therapy, six used psychodynamic principles, two were informed by psychoanalysis, three used EMDR in therapy, two used DBT principles, one predominantly used CAT, another predominantly used MBT and another schema therapy. All had knowledge of attachment theory and experienced clients with avoidance patterns. None of the clinicians worked exclusively in a specialised service with a narrow set of pathologies. Collectively the participants formed a heterogeneous group fit for the purposes of this study. See table 2 for an overview of the interviewees.

Table 2

Overview of Interviewees; Their Profession, Years of Experience, Main Therapeutic Modality, Knowledge and Use of Other Modalities

Interview number	Pseudonym	Profession	Years of experience	Main modality	Other modalities
1	Sophie	CBT Therapist	15	CBT	Aware of psychodynamic therapy
2	Teresa	Clinical Psychologist	16	CBT/ Psychodynamic	DBT
3	Sam	Clinical Psychologist	40	MBT	Psychoanalysis, psychodynamic, DIT
4	Robert	Clinical Psychologist	25	CAT	
5	Rachel	Psychotherapist	16	Eclectic	Systemic, psychodynamic, TA, CBT, solution focused, EMDR, self-psychology

					interventions, parts theory
6	Nina	CBT Therapist	10	CBT	EMDR, DBT
7	Lilly	Counselling psychologist	28	Psychoanalysis	
8	Priya	CBT Therapist	15	CBT	EMDR, DBT
9	John	Counselling Psychologist	28	Integrative	CBT, psychodynamic, EMDR, humanistic
10	Bart	Clinical psychologist	8	CBT/ Schema therapy	Psychodynamic

2.3.3 Data Collection & Interview Schedule

Three interviews were conducted in person (Sophie, Samuel and Robert), and the remaining conducted via video due to COVID-19 travel restrictions. All interviews were audio-recorded and uploaded into transcription software 'Otter.ai' for processing. The transcripts were checked for accuracy before being exported into word documents for analysis. The interviews were carried out in private, quiet settings.

It was expected that themes related to the research question would be found predominantly in questions two and three:

"What specific methods did you use to help clients with avoidant attachment patterns looking for a long-term relationship?

"What patterns, if any, have you experienced in your interventions? (see appendix 3)

The researcher allowed for spontaneous prompts in order for participants to fully express their perspectives. This was in line with Berg's (1985) recommendation that key themes can be explored, should the researcher feel the interviewee is not accessing reflections of practice. However, the whole data set was considered as participants knew the overall research question and alluded to therapeutic methodologies throughout the interview.

2.3.4 Analytic Strategy

Data analysis followed Braun and Clarke's (2006) six phase model:

1. Familiarising yourself with your data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

I also followed their '15-point checklist of criteria for good TA' (Braun & Clarke, 2006, p. 36), which included 'data transcribed to an appropriate level of detail', 'each data item given equal attention in the coding process', 'data has been analysed – interpreted, made sense of- rather than just paraphrased or described', and 'the researcher is positioned as active in the process' (see appendix 4).

As there are no strict rules for conducting TA, Braun and Clarke (2006) highlight the importance of being consistent in the analytical approach. They set out guidelines for a series of decisions a researcher must consider before analysis. These include deciding on what counts as a theme (i.e. the prevalence of data across the data set and the 'keyness', or how well a theme captures something in relation to the research question), whether to conduct inductive or theoretical TA (a 'bottom-up' vs 'top-down' approach), and what thematic level to include (semantic and/or latent themes).

This study took an inductive approach. I discussed what counted as a theme and decided on theme ' keyness' with my supervisor and included both latent and sematic themes found throughout the dataset.

2.4 Ethical Considerations

Ethics was approved for this study, in line with BPS ethics and research guidelines (2014), informed consent was gained by participants signing a form in which all the details of the study, including expectations of their involvement, confidentiality and how data will be

stored and analysed (see appendix 2). These were stored in a closed cupboard in the researcher's home. Participants identity were kept confidential, although non-identifiable data points such as years of experience and therapeutic modality were logged (see table 2). The forms were kept separately so the data could retain anonymity.

An additional confidentiality issue was the interview content. Participants were reminded not to reference any identifiable client features when explaining their work. In line with BPS ethical guidelines, they did not disclose any client sensitive information, and the interviewer ensured not to ask probing questions that may have 'forced' the participant to give client-sensitive information away. Given the research question was interested in techniques employed to a specific demographic, the language used in the interviews referred to as 'them'. However, when participants felt that in order to answer the question fully, they needed to reference particular cases, they used anonymised information as per ethical guidelines akin to a supervision session. No identifiable features of clients were mentioned in the data set. The researcher had two primary goals, to ensure participants did not feel obligated to share client sensitive information and, in the event that specific client data was shared, to omit it from the transcript.

The researcher interviewed expert psychologists who, by virtue of their expertise and profession, were familiar with ethical code of conduct and acted in accordance with this, minimising any risk of sensitive information leaks. They were familiar with the nature of the questions. This familiarity minimised any distress involved in the interview process. However, should a participant have felt distressed, the interviewer would follow the distress protocol (see appendix 4). To my knowledge, no participant experienced any distress through the interviews.

The interviews were audio-recorded and stored on a password-protected computer. The audio recordings and transcripts will be deleted once the researcher's paper has been submitted and marked as part of a doctorate programme.

Once the interviews were completed, the participants were be debriefed in accordance to the debrief statement (see appendix 3) and subsequently informed of the outcome of the study once complete. The results will be kept for a minimum of five years to allow for publication.

2.5 Quality Assurance

Quantitative research prides itself on generating valid knowledge through 'power' (i.e. large sample sizes) and yielding of ostensibly replicable, reliable findings. The logic is, that if we can demonstrate that something exists in a large enough sample size and we can replicate this finding, we can be confident that that 'thing' exists. This is not the case in qualitative research. For example, the subjectivity of the researcher heavily influences the outcome of the findings, and one cannot employ the same 'quality assurance' criteria for qualitative research. Yardley (2000) proposes four principles for assessing the validity of qualitative analysis; Sensitivity to context, Commitment and rigour, Transparency and coherence, Impact and importance.

Sensitivity to context refers to several facets, which include adhering to the context of theory and being aware of relevant literature, awareness of socio-cultural settings of the study as well as sensitivity to speech and discourse, and the influence of power within the researcher-participant dynamic (p.221). This study is committed to sensitivity to context in that is has considered theory and relevant literature (see chapters 1 and 2), is sensitive to the socio-cultural settings and reflection of power dynamics (see the reflexivity section below).

Commitment and rigour refer to the typical thoughtfulness and diligence in data collection employed in research, where the researcher is emersed in the process and ensures

comprehensive or completeness (as opposed to depth) in data collection and interpretation (p. 222). This was demonstrated from the outset, by selecting highly experienced clinicians, ensuring to meticulously engage with each individual account whilst adhering to Braun and Clark's (2006) 15-point checklist for good thematic analysis.

Transparency and coherence relate to the clarity, cognancy and quality of the researcher's construction (i.e. descriptions and arguments) of a version of reality (p. 222). Every effort was made to create a clear and coherent account of the data in a meaningful way to the reader, including the provision of a detailed description of the analytic process (see chapter 3). Further transparency is provided in the reflexivity section, where I disclose my reflections on how my epistemological position and choice of data analysis may have impacted the study, and what steps were taken to minimise this.

Impact and importance refer to the utility and relevance of the findings of the study to a broader audience (p.223). The impact and importance principle is fulfilled here, in that this study aims to generate a consolidated lens to approaching therapy for a client group which has not been considered before. The findings can be applied across silos of therapy, affording it the potential to be impactful to both psychological therapists and clients alike.

2.6 Statements of Reflexivity

To accommodate the fact that a researcher's personal experiences and expectations influences their study focus and methodology, Kasket (2012) suggests that a personal reflexivity statement is necessary to inform the research process. It is also important that the researcher engages in epistemological reflexivity, and critically reflects on the assumptions they make about the world and research question. This is to better consider what limitations arise from the study (Nightingale and Cromby, 1999). Finally, Kasket and Gil-Rodriguez (2011), recommend that a statement of methodological reflexivity is needed in order to consider how one's position and decision-making process has affected participant sampling,

data collection and analysis. By addressing these issues, the following statements of reflexivity consider my personal, epistemological and methodological stances, and their influences on this research piece. I also explain how I dealt with identified limitations.

2.6.1 Personal Statement

Prior to commencing my doctorate in Counselling Psychology, I had a private practice as a CBT-based date coach, helping people navigate their dating lives into relationships. It struck me that a number of my clients appeared fearful of engaging in behaviours that required openness around feelings. Sometimes I would describe to them the attachment system, under the hypothesis that they may be avoidant in some way. It would be when clients, with a sigh of relief, exclaimed 'that's me! I'm avoidant! What do I do now?' that I would be slightly stumped. I found myself struggling between having some ideas about what to do but did not feel that there was a straightforward approach in the therapeutic literature to guide me. On reflection, I could also have been picking up on the client's transference, the solution being to embrace the very thing they found difficult, namely being vulnerable and trusting of the other persons' provision of care and support. Nevertheless, I felt that if we could somehow identify clients with avoidant issues and work out the best interventions for them, then a big problem (being frustratedly single) would be solved.

As Lennie and West (2010) point out, the research process is born out of a 'niggle' (p.87), and that was mine; How to best go about helping clients with avoidance problems. Initially, I made the naïve assumption that we could use the attachment theory as a diagnostic tool to find 'avoidants' and work out some sort of therapeutic protocol, a typical component of CBT. However, during the process of the interviews, I came to learn that while therapists 'did stuff' it's too simplistic to assume that avoidant attachments theory explains all emotionally-avoidant behaviours. As a CBT trained dating coach but new to the field of Counselling Psychology, the journey through my research has been an exciting education in

its own right. I found that I needed to abandon the protocol idea and embrace a more nuanced approach. I had to let go of my assumptions and allow the participants and research data to guide me. On reflection, Norcross (2002) makes a strong argument against the use of manualised treatments, as it risks reducing clients to a set of symptoms and ignores that clients respond differently, and sometimes better, with different types of treatment (p.6).

2.6.2 Epistemological Statement

I am a critical realist at heart. I love facts and knowing 'stuff'. Structure, causality and predictability are my friends. My most significant psychological assumption is that everything, from personality traits to social anxiety, is more or less normally distributed. However, I am also aware that my knowledge and the facts I am presented with are limited. There is always a new lens from which to view any given 'thing'. Once the Earth was flat, and now it's not. Once all psychological ailments were a result of suppressed sexual urges, now they are not. And everything is not normally distributed.

I think in psychological practice this bodes well, as I can sit with a client and both acknowledge and understand their ailments, while simultaneously hold other possibilities in mind and not take up any position (ultimately it's the client, and not me, the therapist, that has to make sense of their reality in order to experience change). I am reminded of the elephant and four blind men, each certain that their account of what an elephant is, is correct (it's a trunk, tusk, tail, leg) when in fact their collective account, their different lenses triangulated, is a closer proximation for what an elephant is. The world is both flat and spherical. With the risk of never having any conviction, for me, it is about being in a position where I am both able to accept and suspend what I know about the world.

This is reflected in my interviews when, for example, I was met with challenges around discourse. On one occasion, a participant revealed 'I don't use interventions'. This did not impede me, I was not bothered about labels, instead, I changed lens or position, as in "ok

if you don't want to call it a tusk, then describe to me 'the elephant in the room'", i.e., 'what do you do when you experience a client that behaves in ways that indicate they struggle with forming relationships'. I felt that something shifted in the dynamic of the conversation, in that we both felt heard and understood, we both wanted to engage and understand something together, as opposed to being fixated on semantics.

I assumed that practitioners understood the term 'avoidant attachment patterns' and 'interventions' in the way that I did. I did not take into account that different strands of therapy consider, to my mind, 'general terms' differently. I had forgotten about 'silos in therapy'. Until relatively recently, therapeutic approaches would seem to go to lengths to differentiate from one another (Arkowitz, 1991) and had developed a variety of terms that covered similar concepts (i.e. schemas vs internal work model). I had also not considered that therapists might differ from each other despite similar training. To address this issue, I used a typical CBT intervention, which is to understand a process by taking point of departure in an example. I found myself encouraging my participants to give examples of interventions from either hypothetical cases or actual practice (ensuring client anonymity).

2.6.3 Methodological Statement

On participant sampling, I had initially thought to interview psychodynamic and CBT clinicians, thinking that the former were well versed in attachment theory and the latter versed in delivering therapy in protocol form. My assumption was that both types of therapy would see clients with avoidance patterns and some clinicians will have knowledge and experience in both types of training, and therefore have access to interventions. In reality, many clinicians have additional training throughout their careers and identify with different therapy forms despite being knowledgeable and proficient in other forms of therapy. On reflection, I did not need to limit my focus in this way. As a result of this reflection, I eliminated therapeutic approach from my inclusion/exclusion criteria.

When it came to the interviews (data collection), I tried to position myself as open, curious, and non-judgemental in order to gain as much richness in the data. I found myself feeling 'subordinate' and self-conscious, that I was taking up valuable time from busy professionals, many of which are highly regarded in the field. This impacted my interviewing schedule as I did not ask all of the questions in all of the interviews, due to worrying they might think I was wasting their time. However, I was careful to focus on the central questions around interventions and allowed them to reflect on their work, as this was my main goal.

Despite my worries, many of the participants spontaneously expressed gratitude at the opportunity to reflect on their work. They had found the interview interesting, one expressing an active interest in reading the results once the study was finalised. Perhaps a little more allocated interview time and stricter adherence to the questions would have yielded a richer data set, conversely, this might have been at the expense of the time participants needed to reflect and access more automated or tacit knowledge.

I found the analysis exciting and painful in equal measures. The interviews were rich with information about therapy, processes, thoughts on attachment and of course, interventions. It was exciting to gain first-hand access to experts in psychological therapies. There was a sense of intrigue and wonder at learning new aspects about therapy, but I needed to restrain myself to considering only the relevant ones to the research question, and this was painful. It was painful to cull data and retain a smaller portion of it. There was a moment of feeling inarticulate when looking at the themes and asking myself over and over 'what are the interventions'? They were there, but opaque as it seemed many themes converged. The iterative process suggested by Braun and Clark (2006) and turning to supervision were the key to deciding on the final themes. After relentless reflection and considerations of different constellations, focusing on convergence and divergence on each sub-theme, I made a case for and against where they should position themselves in order to best answer the question. I

then asked a recent counselling psychologist graduate and my supervisor to read through to sense-check. The biases that may have impacted the analysis, was the assumption that I could find therapeutic interventions in the interviews, a belief that they exist, which in turn meant that I found something that I could package into a narrative. In this sense, the thematic analysis and research question, did not stand to be challenged, as in, could it be possible that interventions don't exist at all?

CHAPTER THREE: Analysis

3.1 Thematic Analysis Following Braun & Clarke's (2006) 6 Phase-Model

The following data analysis is based on ten interviews, totaling eight hours of interview time, generating roughly 70 000 words of transcription (including interviewer content). A thematic analysis was carried out based on Braun and Clarke's (2006) six phase approach.

I expected there to be between two and five themes. Braun and Clarke (2013) maintain that 'you generally want more than one, and probably less than six, in a 10 - 15,000 word report' (p. 11). As long as the themes have a central organising concept 'so that all the data and codes cohere around a single key analytic point' (p.12), that are distinct from each other with clear relationships and boundaries, and overall 'tell a coherent and compelling story of the data' whilst addressing the research question (p.12). In the following analysis four overarching themes were identified.

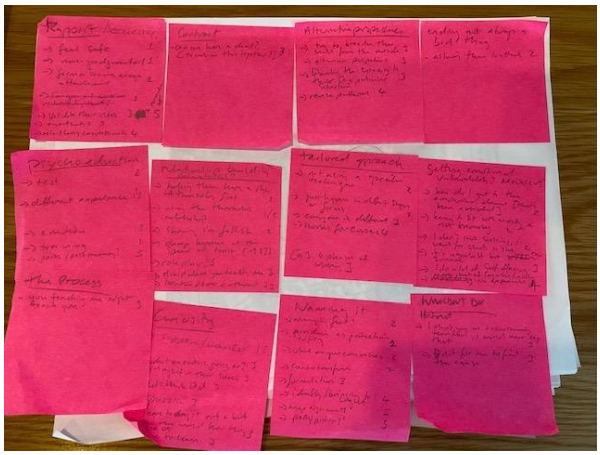
Definition of terms
Data (extract) – a section of the transcript (what was said in the interview)
Code - a notation describing the content of a data extract
Sub-theme - a heading describing a theme seen in a cluster of codes
[Overarching] theme – a heading describing related sub-themes

3.1.1 Familiarize Yourself With The Data

This phase is characterized by reading the transcripts in an 'active way', taking notes on any patterns or relevant meanings in order to create an initial list of ideas of what is in the data. I read the transcripts and created headings of patterns on post-it notes, noting potential codes and which transcript they came from (see image 1). Patterns that seemed to cluster as I read the transcripts were given the following headings: *Tailored approach, Rapport/ security, Psychological contract, Relationship building, Getting emotional/ vulnerability/modeling?, Naming it, Curiosity, Psychoeducation, Alternative perspective, The [therapeutic] process, [Things I] Wouldn't do*.

Image 1

Post-it notes listing initial ideas of what I saw in the data



3.1.2 Generating Initial Codes

This phase involves reading the transcripts more closely, identifying key features of the data and giving them codes. Both semantic (the explicit 'surface' meaning of what is said) and latent themes (identification of underlying ideas or assumptions in the data) were included.

I migrated the transcripts from Word documents to Microsoft Excel, where each transcript was allocated its own tab. Within each tab, the text was split into segments of extracts in one column, allowing for me to add codes in a second column. I read and reread the transcripts noting codes regardless of whether the extracts covered content about interventions. See Table 3 for an example.

Table 3

Sample of Coding from Interview #1; Transcript in the Left Column, with Accompanying Codes in the Right Column

Transcript #1	CODES
#1 5:03	
kind of depends how the avoidant system pops up. Okay? So those who are not seeking relationships are going to be handled differently to those who are finding inappropriate relationships, or perfectly decent relationships and messing them up.	Attachment system is addressed differently depending on whether client is overt about the issue
So let's start with the easy ones, people who kind of go, I really want to have a boyfriend or husband or girlfriend or wife; and yet don't take any active steps to make this more likely, that was relatively easy, *because it's kind of there you can see the behaviour is missing from what they claim to want.*	Address behavioural elements when clients are explicit about their relationship difficulties
The way I work, I will look at achievable goals in therapy with my tripartite goal sheet. And I posed the question, you know, *what do you want to get out of these sessions and often people will say what I want to get out of life.*	Set achieveable behavioural goals (with clients) Ask clients directly what they want to achive in therapy
And it will be get in a relationship. And we might say, well, that might be something we could work towards, we can't guarantee that you'll have therapy and lo behold, you'll become married.	Don't guarentee clients can achive romantic relationships (Re)frame therapy goals to something realistic, such as working towards getting a relationsip
But once it's on the goal sheet, then it's perfectly fair game for me to start kind of doing something with it. Okay. So within a cognitive behavioural therapy mode, that's quite easy, because it's like, behaviour, you know, what behaviour are you doing in order to bring this about?	Obtain permission to collaborate with client Use CBT model to address the connection bewteen behaviours and (negative) experience of not having a romatic relationship
And if the answer is actually very little, then we can take sort of baby steps towards making it more likely that a relationship will come your way. So..	Consider collaboratively what behavorioural changes the client can make
Interviewer 6:40	
is that is that sort of based from an from anxieties and an anxiety there	
#1 6:46	
well I was giong to say, You come *back to the good old Hot Cross Bun [yeah], you know, what are you thinking? What are you feeling? What are you doing?* So when a client coming to mind, who had had some very difficult early sexual experience, unwanted sexual experience.	Use the hot cross bun to help clients gain insights into their experiences Psychoeducation? - using the hot cross bun
So she had quite a lot of anxiety provoking thoughts about what it would be like to get beyond a certain	Using hot cross bun to identify

All transcripts were coded from an analyst-driven methodology. That is, the codes relevant to the research question, were generated across the entire data set. The researcher being careful to include codes from sections that may not be answering the research question directly, but may nevertheless be useful in terms of how to organise themes at a later stage. For example, in Table 3, the first line of the transcript reads *"[it] kind of depends how the avoidant system pops up, okay? So those who are not seeking relationships are going to be handled differently to those who are finding inappropriate relationships or perfectly decent relationships and messing them up",* has been coded as '*Attachment system is addressed*

differently depending on whether the client is overt about the issue'. While the code does not directly answer the question on what interventions clinicians utilise, it does inform us how a clinician might choose their intervention which I thought could be relevant to answering the research question.

At this stage, it is recommended to be more inclusive and 'code for as many potential themes/patterns' (Braun & Clarke, 2006, p.19). Each transcript was given equal amount of attention, generating around 850 codes across the data set.

3.1.3 Searching for Themes

In this phase Braun and Clarke (2006) suggest to 'play around' (p.19) with the codes and organize them into theme variations in order to generate a best fit between codes, subthemes and overarching themes. In order for a theme to be considered, it did not have to have prevalence across the entire data set, because clinicians came from a variety of clinical backgrounds and would not necessarily use similar interventions. Given that the research question is relatively specific, and therefore likely to be coding for psychotherapeutic interventions, I conducted a theoretical TA (as opposed to an inductive TA, which is 'data-driven' and does not process codes to fit with a pre-existing frame, such as 'therapeutic interventions').

Thinking about what interventions clinicians use in therapy with clients displaying avoidance behaviors, I chose 351 of what I thought were the most relevant codes and organised them into rough piles of thematic clusters, with some codes duplicated to fall under other clusters. This generated a list of 17 clusters or potential themes, which included the following headings:

- *No standard approach [to therapy]*
- *[there is an] Order of therapy*

- *Building the therapeutic relationship* (i.e., build rapport & trust, being non-judgmental*)*
- *Looking for patterns in current and past relationships*
- *[clinicians] internal reflections about avoidance* (i.e., that their aim with a client is to strengthen client's capacity to think differently about how they relate to others)
- *Using self as a tool for change* (i.e., noticing transference, allowing to be fallible)
- *Indirect interventions* (i.e., pacing therapy, gaining clients perspective*)*
- *Therapeutic relationship as a vehicle for change (*i.e., using silences and breaks in therapy to address/ work with avoidance in the 'here and now')
- *Therapist as a secure base* (i.e., being empathetic, creating a space for the client to feel connected)
- *[asking] Direct questions*
- *Active listening* (i.e., being curious, wondering, supposing, validating client material)
- *Being compassionate*
- *Naming the avoidance*
- *Direct interventions* (i.e., using hot cross bun/CBT, EMDR, formulation),
- *Psychoeducation* (i.e., talking about attachment theory or the wheel of emotions),
- *Don't do* (what therapists wouldn't do, i.e., telling off or demand emotional content)
- *Miscellaneous* (i.e., consider that a client asking for help or being needy, is shameful, embarrassing & humiliating to them)

Under each potential theme I added the relevant codes, noting the interview number and corresponding transcript line number a second column. See table 4 for an excerpt of the excel sheet.

Table 4

Partial View of the Initial List of Themes with Corresponding Codes Noted Underneath

No standard approach		Building the Theraputic relationship		Looking for patterns in cu re		Internal reflections		Active listening; wondering, supposing,		Direct questions		Psychoeducation	
No standard approach for dealing with avoidant clients	1.07	Forging of trust in the therapeutic relationship is key	1.83	stories that indicate avoidance									1.18
Avoidant clients often present with a different issue	1.08	Be mindful to foster trust in the therapeutic relationship	1.84	Look for patterns (of avoidance) in all relationships, current and past	2.19	Noticing something is missing	1.14	Being curious and questioning	2.51	Asking the question 'Is this working?have you thought about trying this?'	1.63 /65	Give clients an attachment questionaire	2.19
Some clients like data	2.19	Show that you understand the client	2.53	Looking for patterns either by assessment or through conversation	2.24	Use tranference to detect something is missing	1.14	Allow time for explorations, espcially in long term therapy	2.51	Always focus on the (unhelpful) behaviour	1.7	Discussing attachment, is like psychoeducation	2.32
Introduce attachment theory if relevant	2.29	Work on building rapport, so clients feel safe to bring things	2.73			Always question, whose needs are being met?	2.26	Use validating	2.59			Explain how avoidant behavours were once adaptive	2.65

THEME

WHERE IN THE TRANSCIPT CODE/DATA EXTRACT IS LOCATED (INTERVIEW NUMBER.LINE NUMBER)

CODE CORRESPONDING TO THE THEME

Image 2*: 'playing with codes'*

I printed out the excel sheets and cut the codes into separate pieces. I arranged them on a table in the 17 columns corresponding to the potential themes, or clusters, upon which I looked at the data in order to see how they could be arranged into overarching themes, using a blackboard and mind maps to create links (see image 2).

The codes for '*active listening'*, '*therapist as a secure base'*, '*indirect interventions'* and '*direct questions'* were moved to other clusters thus discarding those headings. In the process new cluster headings were formed in addition to the remaining ones; '*retain client in the room'* and '*curiosity*'.

The first iteration of creating themes saw four overarching themes come to light:

1. *Context and positioning*, referring to codes that captured the clinician's frame of mind (i.e., knowing people are different), a general understanding about the order of therapy (i.e., building a relationship with clients first, then understanding the issue), and their approach to working with people with avoidant difficulties, as a prerequisite for the successful execution of interventions.
2. *Using self and the therapeutic space as a conduit for change*, denoted codes that referred to the clinicians use of self, (i.e., using transference, allowing for fallibility, setting the therapeutic pace) and the psychological space created between them and the client (i.e., using the here and now, silences and breaks) as a means to facilitate awareness and change for the client.
3. *Implicit psychological methods*, denoted therapists use of internal reflections and tacit knowledge to drive their therapy. These included looking for patterns in client material, (psychologically) retaining the client in the room and naming client avoidance as they arose, along with being compassionate and curious.
4. *Explicit, validated therapeutic applications relating to emotional, cognitive and behavioral change*, covered codes that one might consider a 'toolbox', a selection of actions that the therapists bring to the therapy from their training, such as EMDR, hot cross bun (CBT), psychoeducation and formulation. See figure 1 for the initial thematic map.

This phase ends with the researcher collating themes, sub-themes, their accompanying codes and data extracts (see table 5 for a partial view of the spreadsheet used for this).

Figure 1

Initial Thematic Map with Emerging Themes in Bold

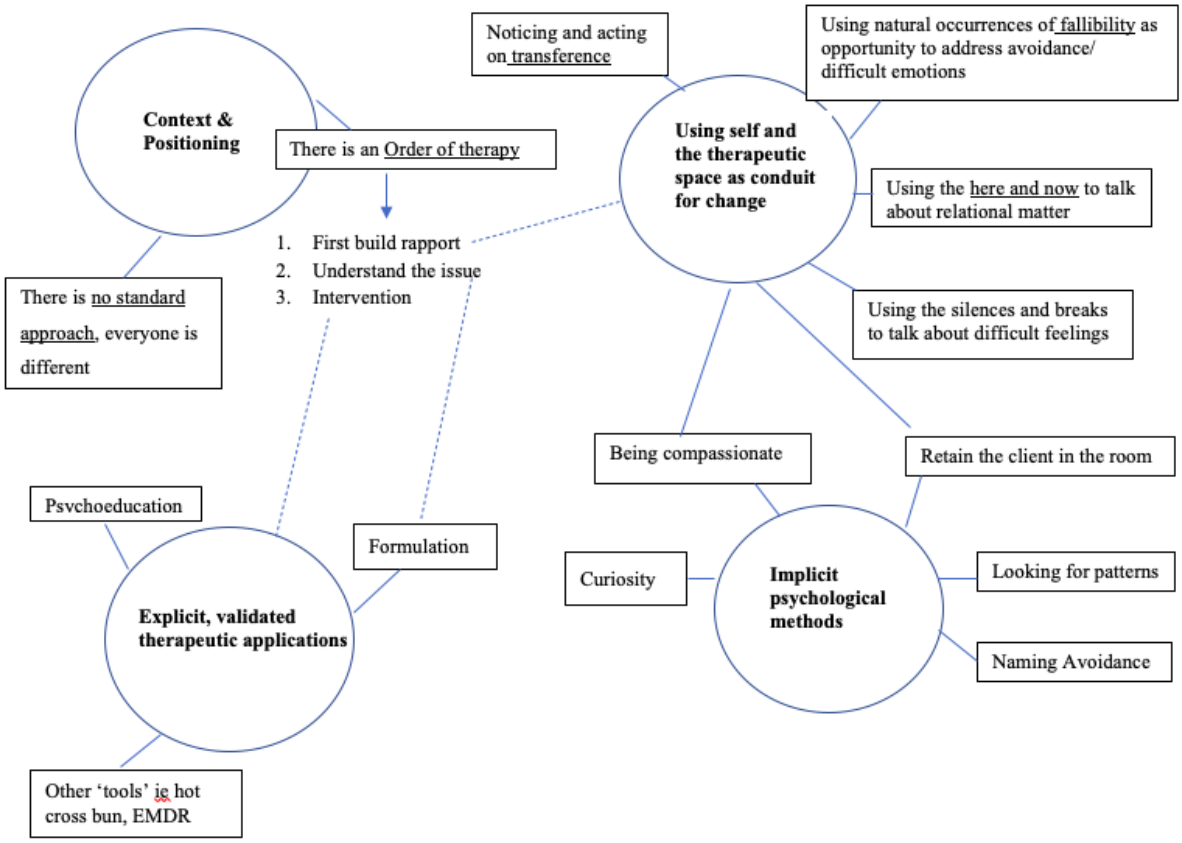
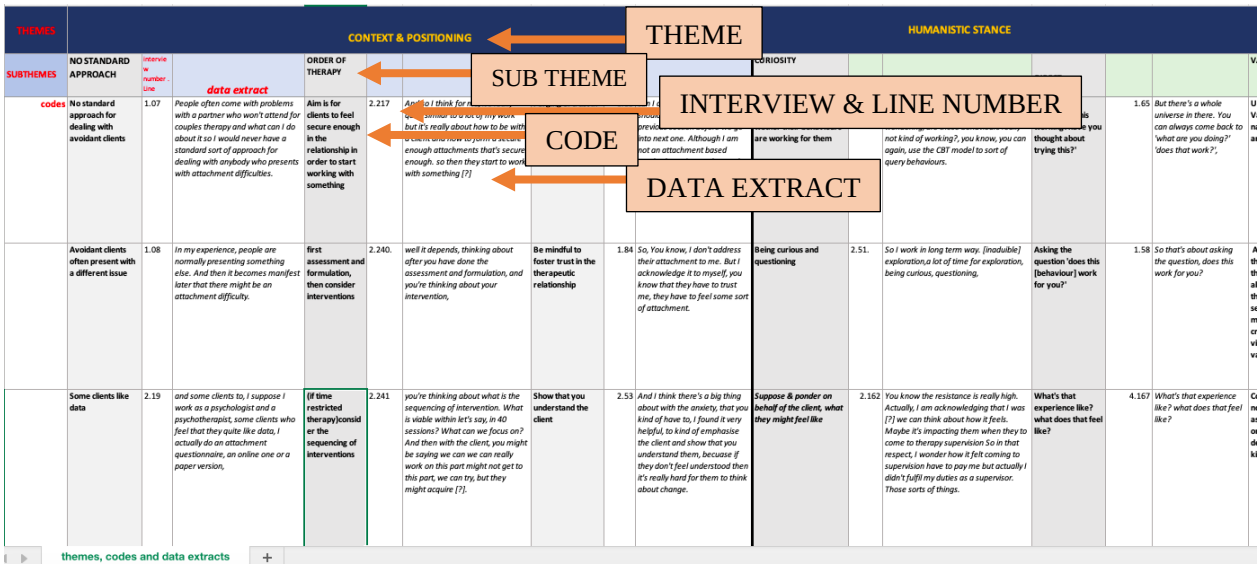


Table 5

Partial View of the Spread Sheet Containing Collated Data, Codes, Sub-themes and Themes



3.1.4 Reviewing Themes

In this phase, Braun and Clarke (2006) recommend that the researcher refine candidate themes, decide whether to discard, keep or combine themes and subthemes. This is done by judging their internal homogeneity and external heterogeneity (p.20); that is revisiting the codes and extracted data and reviewing these critically to determine whether a coherent pattern is being formed under each subtheme and theme. Where any lack of fit is found, the researcher must decide whether to discard, rework or move to a more relevant theme.

I returned to the data set, reread the data extracts under each code and theme. I then reconsidered the clusters and rearranged codes into different thematic clusters, bearing the research question in mind. I arrived at a more meaningful arrangement, which included new sub-themes ('*Understand the issue', 'Create awareness'* and *'Build psychological capacity*'), as well as adding '*Empathy*' and discarding others ('*Implicit psychological methods'* and *'Explicit, validated therapeutic applications').*

It seemed to me that the clusters could remain in four overarching themes: *Context and positioning, Humanistic stance, Using self and the therapeutic relationship as a conduit for change, and Doing therapy.*

1. *Context and positioning,* still referred to a prerequisite for successful therapy. It included sub-themes such as building a therapeutic relationship (and understanding that all clients and their presentations are different), not having a standard approach to interventions, while considering the order by which one goes about helping clients (such as understanding the issue before addressing their difficulties).
2. *Humanistic stance* referred to a 'driving' ingredient a therapist utilizes, this includes being actively curious, validating, non-judgmental and compassionate. What one

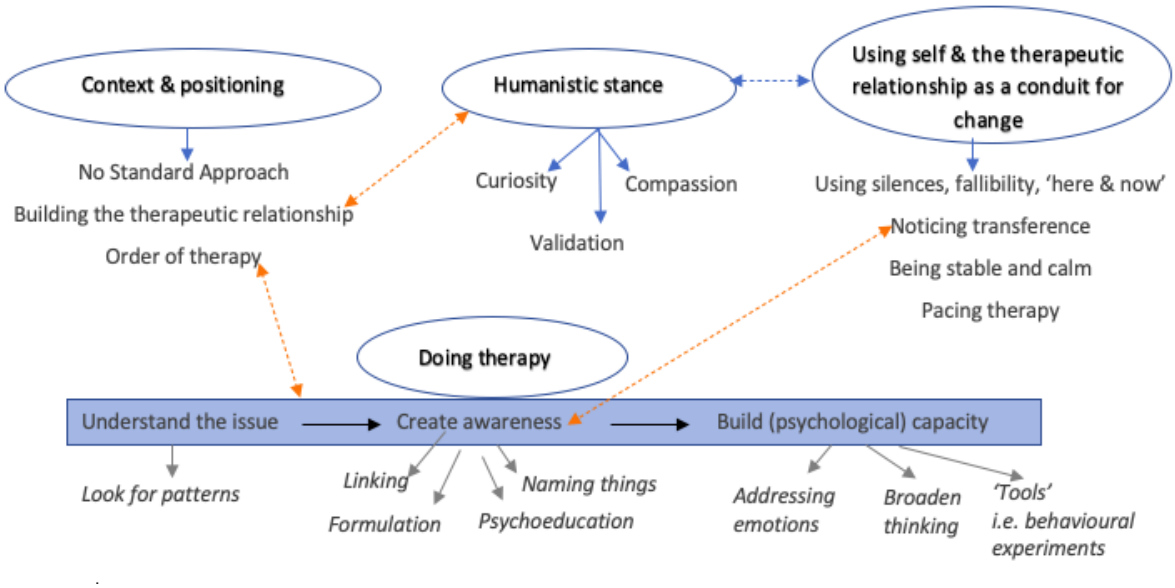
might consider ‘emotion work’ and felt like aspects of Rogerian therapeutic conditions (i.e., unconditional positive regard) (Hadjiosif, 2012).

3. *Using self and the therapeutic relationship as a conduit for change*, referred to how clinicians use themselves (i.e. being consistent, reliable, and using their fallibility), which I thought was separate from the humanistic stance. To me it seemed possible to be compassionate and validating for example, while also being unreliable or unable to use one’s fallibility and vice versa (be reliable but unable to provide compassion). This theme also included the therapeutic space (i.e. use of transference, breaks/ holidays, and relational occurrences in the space) to work on client difficulties in the ‘here and now’.
4. *Doing therapy*, related to themes that collectively demonstrated a therapeutic process. Once practitioners understand the issues, they aim to create awarenesss and understanding for the client of their difficulties, from which they attempt to build psychological capacity to better sit with and ‘deal’ with emotions and relational material. They do this through a variety of means, from consciously looking for patterns of psychological difficulties in client material, linking things together, naming the avoidance difficulties, creating a formulation and making use of interventions such as psychoeducation, addressing emotions, broaden client thinking and specific ‘tools’ such as EMDR, hot cross bun, behavioral experiments and diagrams.

The outcome of this process is presented as a developed thematic map (see figure 2).

Figure 2

Developed Thematic Map



3.1.5 Defining and Naming Themes

It is expected that some recoding will occur as the analysis is an ongoing organic process. Braun and Clark (2006) suggest to 'review and refine your coding until you have devised a thematic map that you are satisfied with' (p.21), much like an iterative process of editing written work. Phase five requires the researcher to 'define and refine' (p.22) the themes further, identifying the 'essence' of each theme ensuring coherence and internally consistent accounts of the data.

Upon taking time out to reflect on the themes, then revisiting the data with the research question in mind, particularly focusing on what interventions were being used, it seemed that I needed to separate 'what' clinicians were doing (i.e., understand the issue, create awareness and build psychological capacity) from 'how' clinicians were working (i.e., using formulation or psychoeducation). The 'what' referring to latent interventions and 'how' referring to overt 'branded' interventions.

Furthermore, some of 'the what' related more to a therapeutic stance than interventions per say (i.e. understand the issue). It made sense to split the 'what clinicians do'

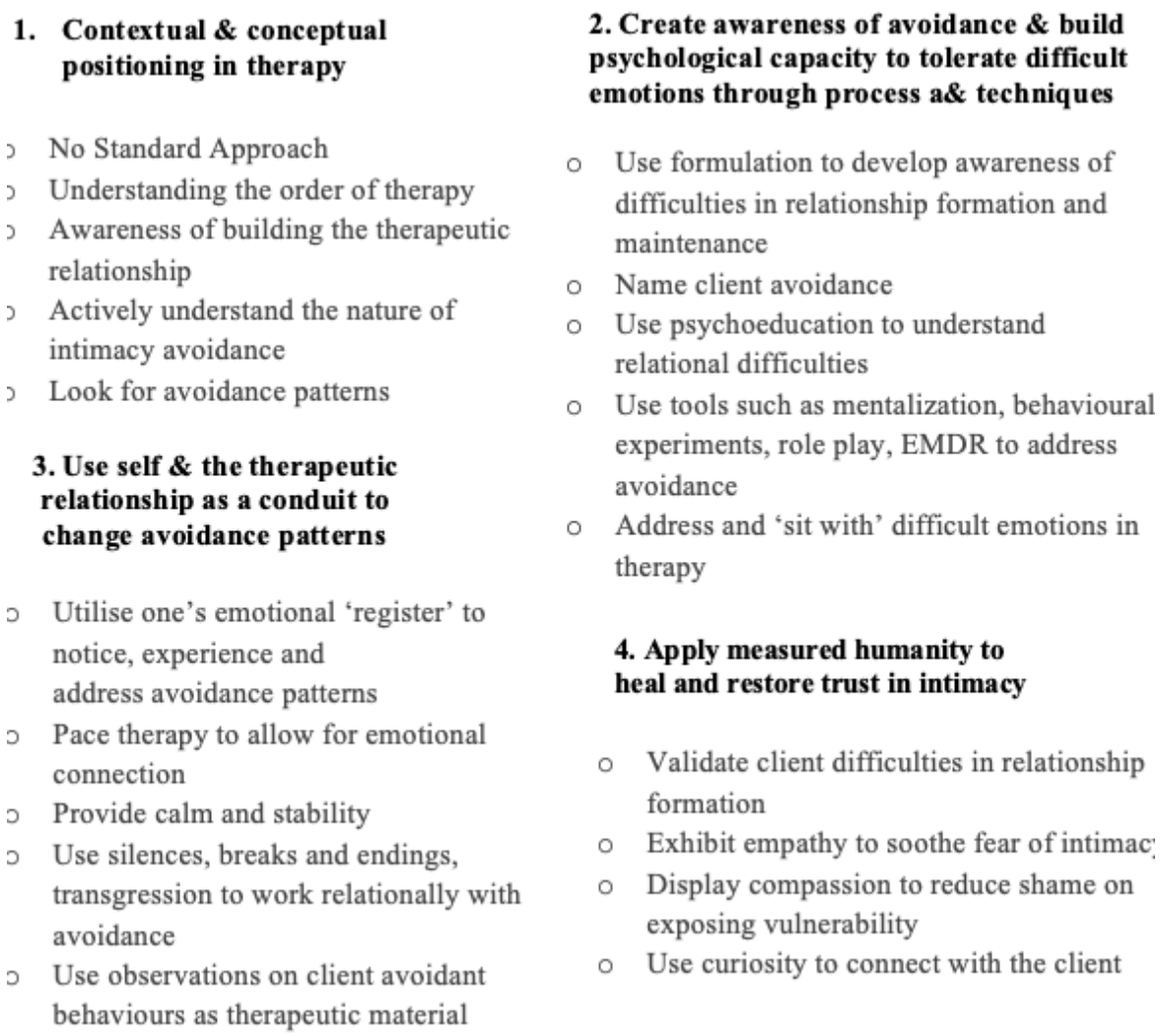
element highlighted in ‘doing therapy’ in figure 2 (‘*understand the issue -> create awareness -> build psychological capacity’*) and move the first element ‘*understand the issue’* (and ‘*looking for patterns*’) to the theme ‘*context and positioning’* (see figure 3). The remaining sub-themes ‘*create awareness -> build psychological capacity’* became the overarching theme with the ‘how’ elements as a reflection of interventions (thus discarding *‘doing therapy’*). The end result produced the overarching theme ‘*Create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques’*.

On reflection with regards to the theme ‘Humanistic Stance’, it seemed that there was something more than considering Rogerian conditions, it was re-named ‘*Apply measured humanity to heal and restore trust in intimacy’*. With regards to the sub-themes, some of the headings were fleshed out to highlight the focus of avoidance difficulties echoed in the transcripts, for example ‘*understand the issue’* became *‘Actively understand the nature of intimacy avoidance’* (See figure 3 for final list of themes and sub-themes).

In conclusion to this part of the analysis, the first theme was renamed ‘*Contextual and conceptual positioning in therapy’.* It denoted the perquisite for the success of the interventions used, despite it in and of itself is not an intervention. The essence of this theme highlighted the importance of the training that lies behind any intervention utilized. It is the knowledge with which one needs in order to practice effectively. The theme consisted of five subthemes; *No standard approach, Understand the order of therapy, Awareness of building a good therapeutic relationship, Actively understand the nature of intimacy avoidance* and *Look for avoidance patterns.*

Figure 3

Final Thematic Map



The second theme was now labeled; '*Create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques'.* This represented the more overt aspects of therapy, using specific therapeutic 'tools and techniques' such as psychoeducation, Socratic questioning, diagrams, models, behavioral experiments etc. As such this theme contained five sub-themes: *Use formulation & spontaneous client material, Naming the avoidance, Psychoeducation, Address and 'sit with' difficult emotions in the therapy room* and *Tools such as mentalization, behavioural experiments, role paly, EMDR to address avoidance.*

The third theme was altered slightly to, '*Use self and the therapeutic relationship as a conduit to change avoidance patterns'.* The essence of this theme captured the way therapists 'use' themselves and the invisible space between client and therapist, such as emotional tensions, silences and session endings as conversation points to enable clients access their own material. Sub-themes included, *Utilise one's emotional 'register' to notice, experience and address avoidance patterns, Pace therapy to allow for emotional connection, Provide calm and stability, Use silences, breaks, endings, and transgressions to work relationally with avoidance behaviours,* and *Use observations on client avoidant behaviours as therapeutic material.*

The fourth theme was renamed '*Apply measured humanity to heal and restore trust in intimacy'.* This theme captured the healing nature of human compassion, validation of experiences and being 'wanted' demonstrated by the therapist's curiosity. It captured four sub-themes comprising of *Validate client difficulties in relationship formation, Exhibit empathy to soothe fear of intimacy, Display compassion to reduce shame on exposing vulnerability,* and *Use curiosity to connect with clients.* See figure 3 for an overview of the final thematic map.

A note on the findings. My impression is that most practitioners agree on the whole with one another, and where a transcription did not contain a certain viewpoint or intervention that another transcript did, was not indicative of whether the initial interviewee agreed or made use of the intervention mentioned in a different transcript. For example, some practitioners may not think to mention that building the therapeutic relationship is an intervention they employ, because it's so universal to therapeutic work. Another example is a clinical psychologist mentioning the use of Freudian slips and dreams, but neither of the psychoanalytically trained clinicians mentioned this, and I would assume they use such interventions (unless the omission is due to them being unfavorable for this particular client

group). Another reason why some interventions came to light in some transcripts over others, is the nature of the interview structure. The interviews were semi-structured, purposefully allowing for exploratory material which inevitably results in diverging content and given the time limit of the interviews, some interventions will not have been mentioned.

3.1.6 Producing The Report

This phase is the final analysis and write-up of the report. I will share this phase in the next chapter: Thematic Findings.

CHAPTER FOUR: Thematic Findings

This section uncovers in detail the four overarching themes and corresponding sub-themes delineated from 10 interviews by way of thematic analysis, answering the question: What interventions do psychotherapists and psychologists use when they work with clients, who display avoidant attachment patterns and seeking long term romantic relationships?

4.1 Contextual and Conceptual Positioning in Therapy

The first theme that was identified was ‘Contextual and conceptual positioning in therapy’. It denotes the prerequisite to applying interventions. This may be considered higher-order therapy that is not necessarily unique to clients with intimacy avoidance. Practitioners come to the therapy room armed with knowledge about therapy and adopt a stance that enables them to help their clients. Regardless of the therapeutic framework clinicians work from, they understand that clients with intimacy difficulties are different and therefore need a tailored and individualized approach. As such, there is no standard approach to their interventions.

Despite this understanding, clinicians have a sequence by which they go about therapy. They start with building a therapeutic relationship, look for avoidance patterns, try to understand the issue before implementing interventions. If they suspect a client struggles with

relationship formation, they take this into account and tailor their approach to the client in a way that reduces activating shame and being mindful not to trigger avoidance patterns or deactivating strategies in the client (the remaining themes cover how they do this). Without this positioning, or approach to therapy, an implicit understanding seems to be that interventions risk being ineffective or unhelpful.

This theme consisted of five subthemes: No standard approach, Order of therapy, Awareness of the need to build the therapeutic relationship, Looking for patterns and Understanding the issue.

4.1.1 No standard Approach

Therapists understand that people are different including clients who struggle with intimacy avoidance. How clients present their avoidance problems are so different that one can't "*have a strict protocol*" (Nina). Both Samuel and Lilly, emphasised that people are different. *"Everyone is different*" Sam stated. "*You know, what I've learned over the 40 years is just how different people are".*

Relational difficulties may not be apparent at first. People who pride themselves on their independence and emotional resilience, typical of an avoidant stance, are not likely to admit in the first instance that they struggle with relationship formation and maintenance. "*people are normally presenting something else, and then it becomes manifest later that there might be an attachment difficulty"* (Sophie). Understanding that people are different, also implies understanding that they present their relational difficulties in therapy in different ways. "*It's either, you know, entrenched and pervasive and much more subtle, or it's kind of in your face" (Robert).* Which means as a therapist, they must acknowledge that each client is unique and in order to help them they must suspend their judgements about what they think makes relationships difficult for their clients. "*You learn about attachment a fresh, every time*

you meet somebody new, […] there's no generalising to be done, you have to learn, brand new every single time with every new person what it means" (Lilly).

This supposes that clinicians cannot have a standard approach as interventions must be tailored to each client and their individual experience. The quote that captures this subtheme the most is probably Priya when she said; *"that's where it becomes quite individual, and it really depends on the person how [the avoidance] affects their quality of life and how they experience others in the world […] So it's a very individual understanding of that person […] it's really important so that you can tailor the intervention."*. As Robert puts it, "*you know, those [different presentations], they do need something slightly different".*

By acknowledging these differences, therapists are able to make judgements about the most appropriate interventions for their clients. For example,*"some clients who feel that they quite like data, I actually do an attachment questionnaire"* (Teresa).

4.1.2 Understanding The Order of Therapy

Despite acknowledging that people demonstrate their relational difficulties in different ways requiring a tailored approach, there is an understanding that there is an order, or sequence, of going about conducting therapy. This includes initially building a rapport, or therapeutic relationship, with clients and spending time understanding their difficulties before applying interventions. This is captured best by Teresa, "*it's really about how to be with a client and how to form a secure enough attachment, that's secure enough, so then they start to work with something […] after you have done the assessment and formulation, and you're thinking about your intervention, […] about what is the sequencing of intervention".*

Various therapeutic models consider an order from which they apply themselves in therapy, for example Robert works predominantly from a CAT model, "*in Cognitive analytic therapy model, or CAT model, you know, there is a protracted assessment period of about*

four or five sessions, where patterns of relating are identified and then begin to be unpacked. And then that's formulated, first in a letter and then then in a diagram".

Samuel, when using mentalized based therapy, also considers an order of therapy, *"there are basically four phases of working. First of all, I start by being empathic and supportive and appreciating their distress and the frustration with their life […] then you can start clarifying and elaborating, and sometimes mildly challenging. [Then] I broaden their mind from the outside, […] and then the final phase, this four-phase step process, is what we call relational mentalizing".*

On closer inspection of these examples the order is similar; understand the issue by way of conversation or formal assessment, before applying interventions, whether they be letters and diagrams or mind-broadening conversations.

4.1.3 Awareness of [The Need to] Building The Therapeutic Relationship <u>Gently</u>

Building the therapeutic relationship is a prerequisite for applying interventions, similar to building a foundation upon which one can build a house. This theme, 'Awareness of building the therapeutic relationship' refers to clinicians having an awareness that this is a task they need to accomplish in therapy in general. As Samuel says; *"[it] is something that we have to discover together, for it to work".* Sophie, a CBT therapist, acknowledges this, "*Although I am not an attachment-based psychotherapist, you know, the forging of the trust relationship between self and client is key".* The reason being that *"working on the relationship between myself and my client, [is] helping to build rapport where they feel safe enough to bring things" (*Teresa).

It seems especially important when considering clients who tend to be avoidant of intimacy, as the very act of engaging in a relationship, even a therapeutic one, will feel difficult for them. As Nina noted, "*what I tend to do when I notice someone who is very avoidant, I will first allow a lot of space to create a good therapeutic relationship".* Thus, in

the context of clients who struggle with emotional closeness, building the therapeutic relationship needs to be done gently. Should the therapist not have this sensitivity, "[the client] *threatens to leave either overtly or implicitly if you approach things that they find too difficult"* (Lilly) or as John puts it, *"they walk away".*

4.1.4 Actively Understanding The Nature of Intimacy Avoidance

In order to know which interventions to use, clinicians need to understand client difficulties first and how the emotionally deactivating strategies come about. As Samuel says, *"really, I need to find out before that, what on earth is happening in this relationship [client relational difficulties]?".* It is not sufficient to assume that clients with avoidant of intimacy will be forthcoming in therapy about their relational struggles. Indeed, in some cases clients may not poses the awareness that they have difficulties with relationships, instead blaming everyone else for being too needy, demanding and emotionally intolerable to be around. Clinicians need to be active in finding out what the nature of the avoidance patterns are *"because it's so woven into the experience that you [need to gain] a particular way of relating, […] with someone who you might call avoidant"* (Lilly).

Bart fleshes this point out; "*it's more of thinking about […] 'how is the relationship working?' […] 'how are they avoiding the conflict, the emotions and asserting themselves?'. So sometimes you see it play out in the [therapeutic] relationship. And then sometimes what happens is that people just find that relationships to be difficult for them, so they end up kind of, you know, withdrawing from it and then still having a wish or a longing to be in a relationship […]so you'd kind of [that]".*

However, it is not adequate to ask a series of questions. It requires the therapist to emotionally immerse themselves into the experience of how their client struggles with relating. *"So, if you're a therapist, you are trying to enter into a relationship with someone who's got some pretty serious doubts about relationships. So […] your first job is to get to*

know what something feels like for this person […] you need to actually try to enter into the very thing that they're finding difficult " (Lilly). In essence, therapists are required to be simultaneously proactive, yet gentle and cautious in their approach.

It may be worth noting here, that it could be argued, that establishing a good relationship with the client is woven into understanding the issue, both aspects serving as a precursor to implementing therapeutic interventions. However, it is possible to build a good rapport with someone, without truly understanding what brings them to therapy.

4.1.5 Look for Avoidance Patterns

One way of achieving an understanding of client difficulties, is to look for and bring out emotional, behavioural and experiential patterns in client material through explorative conversation. Bart continuing from his quote above, "*So I think it's through that kind of process you then start to identify the patterns".* Or as Lilly puts it " *we've got a lot more exploring to do, once you get into exploring and thinking about people's difficulties".*

In the context of intimacy avoidance and relational difficulties, this includes exploring past relationships and relational experiences. Using biodata and past experiences, help clinicians gain insight into the relational difficulties clients are facing, as Teresa highlights*; "I'm really looking for patterns, [either by assessment or through the conversations I have with them] and the patterns even with other relationships or friendships or usually the parents, and kinda go back to them, relook at the family structure family relationships with their parents".* Rachel adds, *"so what you need to do then is look back out what what kind of relationships they've had in the past and how, and how they've been socialised to treat feelings".* As clinicians gain insight in to the avoidance patterns or deactivating strategies clients use, they can begin to understand the client context and position themselves therapeutically so as to achieve a therapeutic relationship without inadvertently breeching it.

This serves as a springboard into the next theme, where clinicians aim to create awareness of avoidance in their clients.

4.2 Create Awareness of Avoidance and Build Psychological Capacity to Tolerate Difficult Emotions Through Process and Techniques

This theme embodies a 'double layered intervention'. The first layer constitutes clinicians implicit aim of therapy, which is to create awareness about the nature of client deactivating strategies and then build the clients psychological capacity to better endure the difficult emotions that usually elicit avoidant behaviours. This is the overarching intervention. Nina sums it up the best; *"I think the best technique for people that are emotionally avoidant, is to have a base, a safe place that they can go to the memories [of coping with difficult emotions learned through behavioural experiments]… and then to store that memory as a resource. […] that can help this person in the future in whichever circumstance they might get themselves into, to remember that they have that capacity and they can feel that capacity*. […] *So I guess my position in that sense is, that it's like a very constructivist, so you basically build, you keep on building".* In a similar vein Samuel adds, *"Basically, the aim of my work is to strengthen, it's like a muscle building exercise to strengthen their capacity to think for themselves".*

How clinicians go about achieving this, constitutes the second layer of the intervention. These are more overt, what one might call tools or techniques that are taught on courses and in books. These include formulation, psychoeducation, theoretical models (i.e., CBT, parts-theory), Socratic questioning, behavioral experiments, social skills training (i.e., role play), letter writing etc. The choice of tools depends on the clinicians training and the models or frameworks they work from that they in their own way aim to create awareness of intimacy avoidance and build psychological capacity to tolerate difficult emotions. The following unpicks the subthemes.

4.2.1 Use Formulation to Develop Awareness of Intimacy Difficulties in Relationship Formation and Maintenance

Clinicians in this study mentioned the use of formulation to develop an understanding of their client patterns of avoiding intimacy, either as a formal process or a more spontaneous organic one, and "*try to understand why they might be having difficulties" (Bart).* For example, *"in cognitive analytic therapy, we would formulate something in writing"* (Robert), create a personal formulation "*focused on the present, in the here now"* (Nina) or *"the schema therapy approach is very relatable once you get the kind of mode formulation written up"* (Bart). It is a useful way to unpick early relational experiences and make sense of them to use in the here and now highlighting "*kind of what's happening now, and how this might have developed over time[…] tracking their different significant relationships, how they started, how they ended, trying to identify patterns [and] draw[ing] out a diagram"* (Priya).

Therapy is non-linear, and clinicians will use interventions such as formulation to drive the therapy. For instance, formulation can be used as a way to identify patterns, and vice versa, the patterns that emerge help inform the formulation. The process of highlighting the patterns allows clinicians to introduce the topic of avoidance into the therapy room from a relational point of view *"you know, are any of those patterns getting repeated here between us?" (Priya).*

Creating awareness needn't be formal. Clinicians also make links in client material through reflective more spontaneous conversation in the therapy room; as Robert notes, "*then links begin to get made, perhaps with early relations and in quite an explicit way with direct questions and so on".* Or as Sophie points out, "*When a client concedes something is not working for them, you can introduce thoughts box or developmental formulation. Always focus on the (unhelpful) behaviour".*

4.2.3 Name Client Avoidance of Relational Connection

Verbalising emotions and relational dynamics either in the here and now, or as part of a commentary to past experiences, is perhaps one of the most straightforward forms of creating awareness for clients. Often at the heart of avoidance behaviors, is the avoidance of emotions and thereby relational connection. If they go unaddressed, the client will not be in a position to change. As Nina puts it, *"You will soon meet a point where you will not be able to move on [in therapy] if you don't address emotion".*

Thus, clinicians will 'name' or put words to behavioural and emotional observations around the avoidance. *"I would name it. [..] so I think naming stuff. I personally think it really helps"* (Sophie). Teresa agrees*; "I think part of it is about identifying [the avoidance], so I think naming it is huge. And the naming the pattern".* For those who use CBT or similarly more structured approaches, 'naming it' emerges as part of a structured conversation, for example, when *"identifying […] beliefs […] some interventions we use were around, identifying what some of those beliefs were"* (Priya).

Six of the participants mentioned this intervention referring to it as 'name it' (Sophie, Teresa & John), 'naming difficulties' (Rachel), 'naming things' (Nina) or 'identifying beliefs' (Priya).

4.2.4 Use Psychoeducation to Understand Emotional Difficulties

Clinicians referred to the use of psychoeducation for the demographic in question, with the aim of creating awareness of emotions and relational dynamics for clients. Introducing the attachment system model is used as a part of psychoeducation. *"You describe those early different forms of attachment- the kind of dismissive, the avoidant, the anxious, the secure, insecure, disorganised and you, you kind of have a psychoed kind of session around that literature […] I think […] people click with it, they get it. Because it actually makes a lot of sense"* (Robert). The clinicians deliver the information in a variety of ways

suitable for the clients. Sophie "*[has] a little [information]pack with attachment,*", and Teresa will use online or paper-based attachment questionnaires for *"clients who feel that they quite like data"*. An attachment model can help clients frame their difficulties and perhaps normalise their experience, which in turn possibly gives a sense of control.

Clinicians will also draw on other psychoeducational interventions where relevant, for example regarding how emotions work or other models such as internal family systems (or 'parts-theory') to give clients a narrative they can use as an internal resource to help them resist the urge to avoid emotional situations. Nina will talk about emotions, "*what [they] are, how they work and why they're important",* she will *"send them to watch 'inside out' the film. And [..] give them the wheel, the UK wheel of emotions".* Teresa might also *"use an emotions list",* because she thinks *"we often believe our clients are emotionally illiterate and they're not".* Samuel will "*do a bit of mentalizing psychoeducation"* and Rachel will talk about *"different part all hijacking [the client], because it's not just the left-brain right brain thing."*

4.2.5 Use Tools Such as Mentalization, Behavioral Experiments, Role Play, EMDR, to create awareness and capacity to tolerate difficult emotions

One of the reasons for creating awareness and building capacity, as Bart puts it *"is it just puts [one] in a little bit stronger position to deal with whatever life throws at you".* Samuel likens the therapy to that of strengthening a muscle; *"mostly, what happens is that you free the individual's capacity to think enough in that context, that next time they stop making that mistake".*

Clinicians do this in several ways, depending on which therapeutic model or psychological framework they are working from. They make use of behavioral experiments and other 'tools and techniques', such as 'part-work', diagrams, EMDR or the hot cross bun CBT model. Clinicians mentioned a range of therapeutic 'tools and techniques' they used to achieve the aim of building psychological capacity. Most notably behavioral experiments

(Sophie, Teresa, Priya, Bart), EMDR (Rachel, Nina, Priya, John), diagrams, maps or models (Sophie, Teresa, Robert, Rachel, Nina, Priya, Bart), psychodynamic principles such as dreams and Freudian slips (Teresa), emotional regulation activities (Nina, John, Bart) and social skills training (Rachel, Nina). It's perhaps important to note, that because a clinician did not mention a specific tool or technique, does not mean they do not make use of the interventions despite being mentioned by others.

A large part of building psychological capacity is to expand client's cognitions and mentalization. That is, to reframe their avoidance and help them see a different type of reality. *"One thing about avoidant people who display avoidant attachment patterns, [is] they often really want something, but they kind of couch it in terms of what they're going to lose, a fear of anxiety. There's that thing about, you know, 'what do you fear losing?', but actually [it's about reframing it to] 'how can you see it as a way of how you are protecting yourself from childhood issues', or past relationship or something they found very difficult"* (Teresa). Or as Samuel puts it, to *"broaden their mind from the outside, not because I think that my ideas are necessarily any better than theirs, but because broadening minds in that way, taking alternative perspectives into consideration, taking my take on them into consideration, actually helps them think about themselves".*

4.2.6 Address and 'Sit With' Difficult Emotions in The Therapy Room

Building psychological capacity is not about only addressing avoidance at the cognitive level, connections between emotions and bodily sensations are also essential; *"I ask them to locate emotion in their body. So, so once they have located the emotion in their body, then they know what it is that they're referring to sensation. And then we can work with that as an emotion as well"* (Nina).

Therapists address relational connectedness directly in the therapy room, inviting clients to feel their emotions. As Teresa demonstrates, "*how does it feel to be understood [by*

me]', 'how does it feel I actually understand what you're saying', or, 'you can actually be angry with me, and here the next week, I haven't gone anywhere'. Addressing avoidant emotions can manifest as exploratory conversation. As Bart demonstrates; *"you'd kind of explore ' what is holding you back?' 'What's your anxiety around being in a relationship?' 'What do you fear?'.*

The aim with allowing space to experience relational emotions is to help clients tolerate those feelings, normalise them and become more confident in sitting with them rather than avoiding them. John summarises the point, *"talking about the emotions, they feel they've been heard. They feel they've got some space, they they've been reassured, or it's been normalised away. Even with [personality disorders] that's useful".*

4.3 Use Self and The Therapeutic Relationship as a Conduit to Change Avoidance Patterns

The essence of this theme, 'using self and the therapeutic relationship as a conduit to change avoidance patterns', captures the way therapists 'use' themselves, as well as the psychological and the therapeutic relationship; the social space between client and therapist. This differs from the first theme, which simply suggests clinicians know they need to build rapport and engage in a relationship with their clients. It is also differentiated from the emotion work, such as demonstrating compassion or empathy, typical of therapy. It does not refer to the demeanor or personal character of the therapist, but rather how the clinicians Being functions as a vessel, a conduit, or conductor, for observing emotions and deactivating strategies. Clinicians use themselves to notice changes in therapy and psychologically positioning themselves in a way that helps client change or gain insights. It is important to note the distinction between creating and fostering a (good) relationship and using the relationship. In the case of this theme, it's the use of relational structures surrounding the interactions, such as boundaries, pauses, breaks that are the 'tools' of the intervention.

4.3.1 Utilize One's Emotional 'Register' to Notice, Experience and Address Avoidance

Clinicians use their own emotional 'register' to pick up on client projections of emotional avoidance and transference. As Sophie notes: "*I sort of use myself. […] you'll come away thinking, 'I think we've missed something'. So, often 'What am I missing?' is quite a good question".*This helps clinicians gain insights into how clients relate to others and "*what relating means for this person and how they go about it, and how you and that person go about forming, whatever kind of relating seems possible"* (Lilly).

Using their emotional register, also allows clinicians to be active 'agents' in the room. By using their emotional register, clinicians can notice when clients are zoning out and avoiding getting in touch with emotional content. Clinicians attempt to 'live' the difficulty. *"You go with that. You're going alongside your client, and you're experiencing the kind of relating that this client, perhaps it's the only kind of relating that they can engage in, that's what you're getting a direct experience of"* (Lilly). Once clinicians are able to tap into client avoidance, " *you got to keep on working at retaining them in the room with you"* (Samuel).

Without this, I would assume clinicians risk colluding with their clients emotional avoidance. By being an active agent, clinicians are not only relationally 'seeing' the client, but also modelling how they might address avoidance (by being present and allowing to 'be' in the discomfort that leads to avoidant behaviour).

4.3.2 Pace Therapy to Allow for Emotional Connection

Another way clinicians use themselves is to steer and manoeuvre the pace of therapy by the way they position themselves, ask questions, allow for pauses etc. As a result, they are able to pace the speed of therapy, which allows clients to feel connected; "*So it's really about going slow enough for them to really feel connected, and actually experience what it feels like to be connected"* (Teresa).

Clients who avoid emotional content are not likely to elaborate on how they feel and it's up to clinicians to gauge whether to sit in the discomfort of awkward silence and then talk about how that feels. The clinicians use their emotional register and mentalization capabilities to gauge where the boundaries lie.

4.3.3 Provide Calm and Stability

Another use of self is that of providing calm stability, by positioning oneself as non-judgmental, benign and safe. For people who struggle with exploring emotions and relational feelings, addressing them can often feel excruciating, shameful and embarrassing. Interviewees here talk about being neutral and consistent, otherwise they risk tiggering negative feelings to a degree that they trigger sustained avoidance in their client and termination of therapy. Robert describes the stance as, *"not taking up a position of good or bad, or judgment of any kind, just taking up a position of 'let's think about that'".* Lilly describes it as *"maintaining a very stable frame and […] maintain as consistent and reliable frame as possible. […] I think that helps us with people who have significant problems in relationships".*

An advantage of taking up a stable position is that "*it's much more [easy] to see how people are relating to you; buy maintaining something very consistent enables you much more, I think, consistently yourself to see how people are relating to you" (Lilly).* Practitioners are in a better position to highlight, explore and enquire about clients behaviours and experiences as they emerge. Presumably, preserving a calm demeanour reduces the risk of unintentionally triggering avoidance patterns.

Furthermore, maintaining a stable, neutral and non-judgemental stance help clients have a different relational experience. There is no retaliation, disappointment, shaming or anger from the clinician's part. Instead the stability that is provided is "*an intervention;[that]*

knowing that they could come back [to you], can be holding [for them], which can be quite useful" (John)

4.3.5 Use Silences, Breaks, Endings and Transgressions to Work Relationally With Avoidance

The therapeutic relationship refers to the 'space' between client and clinician. It brings about emotional content in the sense that when relating to someone, emotions are evoked, whether they be neutral or charged. Therapists use these emotions 'in the here and now', to understand and work on the expectations and assumptions people (clinicians and clients alike) have about themselves, others and the world. The space becomes a 'tool' in which to learn.

This subtheme does not refer to the quality of the relationship or how to build one, as noted in the sub-theme 'Building the therapeutic relationship' (in theme 1), but how clinicians use some of the aspects of relating to help clients with avoidance of emotional intimacy. It is the aspect of the therapeutic relationship, such as silences, breaks, endings, transgressions and mistakes, that can be used as interventions. For example, clients can learn that they can survive the difficult feelings that arise under those circumstances; *"Learning to sit with that anxiety and also sit with the not knowing, you know the things that not knowing brings up, for both people and tolerating that*" (Teresa).

There are parts of the relationship that have spontaneous opportunities for learning which the clinicians can make use of, "*what you can do is when things happen, and they always happen, things go wrong, you make a mistake, you say something clumsy, get it really wrong, you fuck up. […] or you go on holiday. There's a big one. You go on holiday, deary me, rightly, people have, rightly so, very strong feelings about all these kinds of things. And then, it really matters how you respond"* (Lilly).

4.3.6 Use Observations on Client Avoidant Behaviors as Material to Bring Into Therapy

The opportunities to learn also arise from client behaviors in relation to the therapeutic structure, such as consistent tardiness. Clinicians can use these observations as an intervention. "*Things like, I guess we'll call them like boundary violations, where [for example] people don't turn up for appointments or they keep turning up late. I would kinda just talk to [them] about that*" (Priya). It can be illuminating for clients to not only discuss their avoidant behaviour, but also practice talking about difficulties without their feelings of shame or weakness ending in their anxious predictions of negative judgement and rejection.

In addition, the is space used to figure out what is going on between the client and clinician in the room, *"Is there always like a massive crisis? Is there no room for me? Or when they look at me expectantly as if to say give me the answer. And you know, what are they feeling at that moment, so I think for me, it's how do I get to the emotional element because that's what's been avoided"* (Teresa). If people struggle to verbalise how they feel, or indeed are completely unaware of their feelings, clinicians can use their observations of client avoidance to introduce clients to emotional content and behavioural patterns, similar to the idea of graded exposure in therapy.

The observations also arise within the material clients bring. The therapeutic space allows for clients to explore and act out their thoughts and experiences, which manifest as a result of a relation building between client and therapist. The therapist can use this to connect with the client as well as increase client awareness on moments of avoidance. Samuel notes, *"Yeah. That difficulty in setting up an intimate relationship with me. And and I would, you know, [say] 'I noticed […] there's a bit where we kind of see things together and we are […] understanding the same thing, and then it all goes, and you kind of go back into a shell, have you noticed that? can we understand that a little bit better? 'coz it puzzles me'"*. Priya summarises it nicely*, "I think around relationship issues [clients] seem to have the highest*

outcomes. And I think that's because the relationship, not the individual, but the relationship, the space in between is the is the vehicle for change".

There is an overlap between using the self and the therapeutic relationship. If a therapist is to be able to make use of the relational space, it requires them to use themselves, their observational skills, and their emotional register. As John notes, "*so my approach is creating some space to actually look at what comes out in those sessions. […] it's the therapeutic relationship I suppose that I find quite powerful. […] But actually, in the room with regards to attachment, and the therapeutic relationship, absolutely that's that's gold dust, you can work with that".*

In summary, clinicians use their interpersonal skills to psychologically position themselves in the relational space enabling clients to come forward and share, reflect, react, engage etc, all of which have therapeutic effects "*and kind of holding people at the point where there's enough tension to work with and yet not so much tension that they are going to do a runner"* (Robert). Getting the balance between bringing observations into the therapy, allowing for emotional content to be processes, without being too intrusive seems crucial.

4.4 Apply Measured Humanity to Heal and Restore Trust in Intimacy

The final theme is, 'apply measured humanity to heal and restore trust in intimacy, and covers relational skills therapists provide in therapy. Humanity is defined as 'compassionate, sympathetic, or generous behaviour or disposition: the quality or state of being humane' (www.merriam-webster.com, 2020). This theme comprises of subthemes: 'validation', 'compassion', 'empathy' and 'curiosity'. Their very presence function as an intervention in and of themselves because they embody relational-healing qualities which have the ability to restore experiences of intimacy. The difficulty for people who struggle with emotional closeness, is that receiving validation, compassion or empathy activate feelings of, sometimes excruciating, discomfort and shame, along with a sense of weakness

and failure. They tend to employ emotional and behavioral deactivating strategies when they encounter relational emotions such as warmth and care. This means that clinicians must be careful to apply humanity in a measured fashion.*" I think [showing compassion and enpathy in] quite gentle ways because I think if it is too much, it gets pushed into them, and then they just disengaged. [..] because by definition of the avoidant attachment, they leave, that's their way of protecting themselves"* (Teresa). Bearing this in mind, it seems that each sub-theme has merit as individual interventions.

4.4.1 Validate Client Difficulties in Relationship Formation

Validation is the act of recognising, or affirming, that a person's feelings or opinions has meaning; 'to recognize, establish, or illustrate the worthiness or legitimacy of' (Merriam-Webster. (n.d.)). In therapy, the therapist demonstrates an appreciation and acknowledgement of their client's difficulties with forming relationships. As an intervention, it likely helps clients feel connected and understood. Validation covers the act of normalizing people's experiences, in that clients learn that their experiences are not only tolerable to the listener but can be understood and acknowledged*; "I would normalise all of it. I would normalise the behaviour in the first place, their feelings about not wanting to be intimate and that it's completely reasonable"* (Rachel). Validation serves to bond with the listener. It gives clients the mandate to feel and verbalise those feelings, because through gentle validation they are likely to feel safe to express themselves. "*so, for them to feel that I'm aligned with them, and I see, that no matter how crazy their view is, I validate it […]* (Sam).

Once clients feel understood and their shame is tolerated, they can begin to think about change. As Teresa points out, "*I found it very helpful, to kind of emphasise the client and show that you understand them, because if they don't feel understood then it's really hard for them to think about change. [...] I just use validating, emphasising, naming things,*

naming emotions. [for example] 'you say this is bizarre or stupid, but it actually sounds like you know you're protecting yourself'".

Nina gives an example of how it might sound, "*So, so like 'I get you had this horrible situation when you were little'. 'I get that you experienced […] neglect' or 'trauma, and that by some reason, you end up believing that if you get very close to people you will be hurt'".*

4.4.2 Exhibit Empathy to Soothe Fear of Intimacy

Empathy is 'the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner' (Merriam-Webster). Samuel put's in similar terms:*"So I'm going to try and put myself in their shoes[…] usually you do that by sticking very closely to them, […] you know, me as a therapist trying to be as much as I can to be seeing the world the way they see it".* Demonstrating measured empathy may help soothe the initial fear of emotional intimacy.

Furthermore being unempathetic may come across as shaming and judgmental compared to having an empathetic stance. Rachel offers an example, "*You know. 'Oh, wow. Poor you. You must be feeling really awful feeling you let yourself down'. That is so much more useful than 'Well, I told you not to have sex, and you did'".*

Being empathetic towards someone who fears intimacy is not about agreeing with everything they say or letting them go unchallenged. For therapist it's about expressing themselves and framing questions in a way that does not raise the client's defences. As Priya puts it *"being direct in the most simplest empathic way possible."*

4.4.3 Display Compassion to Reduce Shame in Exposing Vulnerability

Compassion defined as 'sympathetic consciousness of others' distress together with a desire to alleviate it' (Merriam-Webster). This attitude can have a healing effect on

people (Gilbert, 2009). Compassion in therapy is conveyed consciously through the verbal and body language therapists use; "*it's sort of delicately highlighting bits of behaviour and raising the question […]"* (Sophie). It's "*showing that I can hear what they're saying, and I'm not repulsed. I'm not angered. I'm not disgusted. You know, I'm not mocking them [..]"* (Teresa). The importance in this is to create trust for the client in the relationship with the therapist. By being non-judgmental and consistently compassionate, the client who fears expressing their feelings will reduce the shame they feel in sharing their innermost thoughts and gradually learn that it is ok to express emotion.

For Robert, compassion "*is the antidote to shame*". He gives an example of a very avoidant client, who despite leaving therapy on a number of occasions, still returns. For Robert, his stance is "*for a number of years of just, this kind of sounds really cliché, […], but just being unrelentingly compassionate about the material [the client] brings."* This presumably helps clients feel more confident in the relationship with the therapist.

Bart demonstrates compassion by the type of language and approach he might use to a client who is not engaging in therapy; *"'I'm, I'm sitting here and finding it quite hard to know what to do, because I can't quite feel where you're at, I not quite sure how you feel about this thing, you know, it seems that there's something coming in between us here' […] then, of course, you talk about how that's not always an intentional thing and that defence serves as a purpose and how it might have come about and how it's understandable".*

It is highlighted in this subtheme that compassion must be applied gently. As Robert puts it; "*I'm not sure I'd […] go charging after somebody who is avoidance that's just gonna frighten them and […] make them run, but you kind of weave [compassion] into the to the hour, the therapeutic hour".* It seems important that clinicians must be measured in their delivery of compassion and other relational skills.

4.4.4 Use Curiosity to Connect With The Client

The clinicians in this study talked about and use curiosity as a means to understand and learn about client material. Another intention is to help clients create awareness about their own material. In addition to this it seems that an unintended positive consequence is that the very act of being curious itself has a therapeutic effect. It serves to connect emotionally as the client engages in answering the clinician. *"Curiosity is THE thing absolute. Curiosity is absolutely it. And if you've got curiosity, they'll pick it up and run with it. Absolutely. So being curious is the main most important thing I would say. Ever. Always"* (Rachel). Samuel calls it "*the inquisitive stance […] basically I'm a little bit be like a terrier, just kind of […] I really am curious, I want to understand".*

Curiosity can manifest as a set of questions to client material, as Nina demonstrates; "*I will ask them about how it is that they are relating in the past to, to the people that they care about, or to the things or objects or situations or jobs and stuff that they care about."* Or it can also be voicing observations in the here and now, as Teresa demonstrates; *"We're having a conversation, I might notice that if they might change their fists, that also gives me some basis to be curious about. "I wonder have been angry right now". "Oh, no, no, no. I'm not angry". Well, I noticed that you clenched your fists when we talked about that….".*

Without curiosity, there is a risk that therapists miss an opportunity to connect well with their clients; *"I mean, there's real, there's a real issue sometimes with people [therapists] just assuming that [clients] all saying the same thing"* (Rachel). By actively understanding what is going on for the client, not only is the clinician demonstrating a willingness to engage with the client which can help them experience warmth, but also the effort to understand helps restore the mistrust in intimacy the client has of relationships. The clinician demonstrates a non-threating presence by their curiosity.

CHAPTER FIVE: Discussion

The main findings that arose from the overarching themes and their practical implications for professional practice are discussed in the following chapter. In addition, a reflection of the strengths and weaknesses of the study, along with suggestions for future research practice, are also considered.

5.1 Discussion of main findings across themes

With a point of departure in attachment theory, as proposed by Bowlby (1988), Hazan and Shaver (1987), Bartholomew & Horowitz (1991), Mikulincer and Shaver (2003), it is argued that some single people struggle to form and maintain relationships because avoidance patterns, or emotional deactivating strategies, sabotage their dating efforts. The attachment system is activated when the emotional gap between them and their romance interest closes, triggering a fear response. This response is thought to be the result of poor early caregiving experiences, but it can also result from previous unfortunate romantic relationships (Bowlby, 1988; Levine & Heller, 2010). However, with therapy, this can be reversed and people can learn to better tolerate difficult emotions and feel safe to express them, ultimately enabling them to forge better relationships. This paper set out to explore what interventions psychotherapists and psychologists use when they encounter clients with emotionally and behaviourally avoidant patterns, who are seeking long term relationships.

Summarising from the thematic analysis of interviews conducted for the present study, the following therapeutic interventions can help address clients with avoidant attachment patterns: ‘Create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques’, ‘Use self and the therapeutic relationship as a conduit to change avoidance patterns’, ‘Apply measured humanity to heal and restore trust in intimacy’. In order for that to have an impact, therapists must consider

their ‘Contextual and conceptual positioning in therapy’. In the following, each theme and their potential implications are discussed in more detail.

5.1.1 Create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques

The first theme, ‘create awareness of avoidance and build psychological capacity to tolerate difficult emotions through process and techniques’, represents a ‘double layered intervention’, an overarching set of interventions and the specific methods to achieve that.

The first layer represents the clinicians therapeutic intention in therapy, which is creating awareness of avoidance patterns and building psychological capacity to tolerate difficult emotions. The second layer embodies the relatively arbitrary means, or tools, in which to achieve that (i.e. the use of formulation, psychoeducation, role play, behavioural experiments, and mentalising).

Creating awareness for clients can in and of itself have remedying effects (Godfrey, Minian, Krauss, Nwakeze, Freudenberg & Kaplan, 2004). It is a common aim across various schools of psychotherapy and seen as an important marker of client growth and can be achieved in a variety of ways (Levitt & Williams, 2010). For example, Luft and Harrington-Ingham (1955) developed the Johari Window model used in self-awareness training, which has since demonstrated its efficacy (Saxena, 2015). In the present study, clinicians revealed several ways by which they generated awareness for clients; namely formulation, psychoeducation and naming the avoidance.

Formulation is the act of generating a (psychological theory-based) hypothesis about a person’s difficulties, typically in collaboration with the client (Johnstone & Dallos, 2014). Sometimes formulation follows a therapeutic model for example, in CBT, Schema Therapy or CAT, in other cases, it is used as a loose framework. Clinicians made use of both formal

and informal formulations to help clients generate awareness of their avoidance patterns. The formulations serve to create a narrative or understanding of how their avoidance came about.

Also mentioned by the clinicians was the use of psychoeducation. Psychoeducation refers to the act of disseminating information about psychological aspects of human nature and illnesses, sometimes involving psychological theories and models. Lukens and McFarlane (2004) highlight psychoeducation as a flexible tool with broad application, operating on the premise that the more knowledgeable clients are, the more positive health-related outcomes (p. 206). Psychoeducation is effective in symptom reduction for depression and psychological distress (Donker et al., 2009). Clinicians in this study used the attachment model to explain avoidance patterns. They also introduced information about emotions and emotion management and how the 'brain works' in terms of mentalization.

In addition to this, clinicians used an 'informal' intervention for creating awareness of clients avoidance patterns. Informal, as in, techniques that are not 'branded' in the same way as formulation or psychoeducation is. One of them was 'naming the avoidance'. Clinicians in this study mentioned 'naming it', as in naming the avoidance when they encountered it. This intervention does not appear as a taught or explicit intervention; it does not feature in the literature. Perhaps it's a latent one. For example, to reframe the problem in EFT (Johnson & Greenberg, 1985), or formulate and process relationships in attachment informed therapy (Berry & Danquah, 2016) clinicians need to have 'named' the difficulty. It is something that happens as a means to achieve a 'branded intervention'. However, the clinicians in this sample didn't necessarily use 'naming it' in conjunction with a formulation or other intervention. In most cases (five out of six), clinicians mentioned this intervention in the context of a spontaneous opportunity to create awareness for their client while the clients were reflecting on their difficulties. On reflection, it is worth noting that putting words to someone difficulties, or 'naming it', is as much an intervention as deciding to remain still

when there is a silence in the therapy, and perhaps particularly useful for clients displaying avoidance patterns.

Further to creating awareness of client avoidance patterns, is another core feature of this theme, namely development a psychological capacity for clients to better manage and navigate the emotional aspect of human relating. For example, when clients engage in deactivation strategies, they are likely shying away from difficult emotions that can arise in emotionally intimate contexts, from accepting a compliment to sharing how they feel. Psychological capacity, in this case, refers to a capability to deal more effectively with difficult or overwhelming emotions and regulation of affect. Fonagy et al. (2002) highlight the importance of creating self-awareness in order to achieve affect regulation, as in, one cannot address one's emotions or emotional states without having an awareness of them. Indeed, through therapy, Fonagy et al. (2002) propose that (some) clients are then able to achieve mentalised affectivity, an aptitude transcending affect regulation. Mentalised affectivity enhances clients capability to accept and cope with negative affect. It seems that the clinicians in this study, whether consciously or not, are attempting to achieve this for their clients.

With regards to building psychological capacity, there were a couple of interventions that clinicians used, one of which is to reframe the avoidance and increase mentalization. Reframing refers to a therapeutic technique whereby a clinician 'change[s] the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changing its entire meaning (Watzlawick et al., 1974, p. 95). In the context of this study, clinicians create an alternative lens to view to their clients' avoidance, and thus expanding the clients' cognitions freeing them to experience their emotions. Perhaps

reframing their emotionally deactivating strategies, as them protecting themselves from hurt, can encourage clients to open up and feel more confident in being vulnerable.

Another intervention clinicians mentioned in building psychological capacity was addressing and sitting with difficult emotions in the therapy room. This is a typical intervention in psychodynamic psychotherapy, in that clinicians are trained to 'recognise and tolerate their own true state of mind in the presence of a client' (Segal, 2017, p. 208). The objective being to invite clients to 'become aware of their experience [… and] increase the client's capacity to use and accept more aspects of themselves' (p. 208). Participants in this study addressed emotions with clients who displayed avoidance of intimacy as part of building capacity to tolerate the emotions better.

There were an array of other therapeutic 'tools' or 'techniques that were mentioned in the study as a means to help clients gain awareness and psychological capacity. This is what was earlier referred to as the second layer of this theme. Clinicians came from a variety of therapeutic backgrounds and training, and considering the fact the clients are different, it is no wonder that clinicians employ a variety of interventions in order to achieve their therapeutic goals of awareness and emotional capacity. The interventions ranged from behavioural experiments, EMDR, diagrams, maps or models, psychodynamic principles such as dreams and Freudian slips, emotional regulation activities and social skills training. The list is probably longer. Cundy (2019) notes 'psychotherapy aims to help clients not only reflect on their mental activity, but also to make their once-repressed emotions available for reflection' (p.99) and 'to tolerate the full range and intensity of emotions' (p. 98). She makes the observations that specific techniques are not required as much because the approach to change is relational. Indeed, meta-analyses of general psychotherapy reveal that specific techniques only account for 5-15% of therapeutic outcome (i.e., Ahn & Wampol 2001). From this point of view, perhaps the specific 'tools' are not as necessary, as it is to tailor them to

the over-arching aim of the therapy, which is to generate awareness of the clients' avoidance and build psychological capacity to tolerate difficult emotions.

5.1.2 Use self and the therapeutic relationship as a conduit to change avoidance patterns

The second theme, 'use of self and the therapeutic relationship as a conduit to change avoidance patterns', encompasses how clinicians use their 'Self' or 'Being' and the therapeutic relationship in a way that serves as an intervention, or perhaps rather interventions. 'Use of self' serves as one form of therapeutic intervention and 'the therapeutic relationship' as another. They are both 'structural' in nature, as opposed to 'relational' (see next theme). For example, it is possible to use one's self and the therapeutic relationship in therapy without employing relational interventions such as empathy or compassion.

The term 'use of self' refers to how therapists draw upon their emotional register, experiences, and character to enhance the therapeutic process (Wosket, 2016). It involves 'the operationalisation of personal characteristics so that they impact the client' (Wosket, 2016, p. 11). The term also covers the therapists behavioural and psychological positioning. Linington and Settle (2017) highlight that change in therapy can be facilitated when the therapist can hold a solid position. This enables the client to 'reintegrate repressed, disowned, projected or dissociated affects or parts of the self' (p.193), referring to clinicians ability to remain reliable and predictable with boundaries, emotionally stable and responsible. When it comes to clients with relational difficulties, this feature may be more pertinent than other client groups, in that clinicians may need to work harder at finding the right balance between engaging in emotional content and not being so forward that the client feels triggered to leave therapy.

It seems here, that therapists use themselves as something instrumental, in line with Rowan and Jacobs (2002) understanding, where clinicians put on a 'mask of the calm therapist' (p.11), 'holding back negative feelings until the client is ready to hear them' (p.12)

and 'working with countertransference' (p.17). The therapists in this study appeared to use themselves in similar ways to achieve therapeutic effects for clients displaying avoidance attachment patterns. This makes intuitive sense, clinicians would probably not be effective if they were effusive, eagerly positive and doling out compliments, (which may benefit other clients, Cundy, 2019). Pacing therapy slowly enough for clients to feel safe in the relationship with their therapist appears to be crucial. On reflection, I wonder if this means being less strict, as a clinician, on appointment times for therapy, allowing for clients to postpone sessions and let them set the pace for interaction.

Another 'use of self' in therapy are meta-cognitive skills such as reflectivity and reflexivity (Wosket, 2016). Clinicians in this sample did not mention these uses specifically; however, they demonstrated them through their narrative in the interviews. (i.e. in Sophies interview when she says *"[asking myself] "What am I missing?" is quite a good question*"). By being reflexive and registering the projected emotions of clients, clinicians are able to strategically feed this back to the client in order for the client to either gain awareness or 'sit with' the therapist in this 'new insight' enabling a new experience, potentially bringing about positive change for the client.

I think it is worth noting that these interventions are generic, as in, they may be applied to several other client groups. For example, there is evidence to suggest that the therapist accounts for a more significant proportion in therapeutic effectiveness than treatment modality (Wampold, 2001; Wampold & Brown, 2005). Hubble, Duncan and Miller (1999) made the observations that one of the core conditions necessary for clinicians to be successful therapy is their ability to use themselves in different ways. They cited examples such as taking on a formal versus informal manner or adopting a faster versus a more laid-back pace with a given client. So it comes as no surprise that seasoned clinicians would highlight their use of self in therapy, however for the avoidant client, there may be less room

for error when approaching therapy with them. It's perhaps being mindful to use oneself as more instrumental, than focusing too quickly on affect-laden and private material as Berant and Obegi (2009) notes.

The second intervention in this theme refers to the therapeutic relationship. It is said that the success of therapy is predicted in part by the relationship a client or patient has with their therapist (Norcross & Goldfried, 1992). According to Henry (1998), the therapeutic relationship comprises of the largest portion therapeutic efficacy, 'regardless of technique or school of therapy' (p.128). Clarkson (2003) notes, '[the] relationship, or the interconnectedness between two people, has been significant in all healing […] it seems to be one of the principal features in any major change in people's lives' (p.3). Indeed, Holmes and Lindley (1989) define psychotherapy as 'systematic use of a relationship between therapist and patient – as opposed to pharmacological or social methods – to produce changes in cognition, feelings and behaviour' (p.4). However, the challenge for therapists in this study, is to engage meaningfully with someone who is defensive about relationship formation and maintenance. Perhaps a slower pace, stability and calm of the therapist are crucial to the success of relationship building.

The therapeutic relationship can function as data gathering for therapy, in that clinicians can observe how clients engage with the process, give clues to the therapist about their avoidance of emotional intimacy. Considering avoidance attachment patterns, which may be described as a 'closed style of relating' (Oskis, 2019, p.28), clients with dismissing/ avoidant attachment styles may give the clinicians clues to their fear of intimacy in how they engage with the therapeutic alliance or relationship. For example, they 'are likely to pay promptly and in full to avoid exposing an urgency for their need and to underscore the relationship is contractual' (Cundy, 2019, p.69). There is a preference to contact through email, rarely make contact between sessions and any tardiness is put down to 'more

important' external factors (Cundy, 2019, p.69). In contrast, clients who are preoccupied or anxious tend to test boundaries by frequent contact between sessions (Cundy, 2019).

Clarkson (2003) distinguishes between 5 different types of therapeutic relationships: the working alliance, the transference/ countertransference- , the reparative-, the person-to-person- and the transpersonal relationship. This sub-themes of this section maps onto Clarkson's (2006) working alliance. The working alliance 'contains the ground agreements between psychotherapist and client, without which therapeutic work cannot take place' (p.36) and forms the structure of the relationship, such as agreeing when and where to meet, session duration, payment amount and methods. It is in this 'space' clinicians can observe and highlight client avoidance patterns. Clinicians in this study mentioned using the therapeutic relational structure, such as silences, breaks, endings, transgressions and mistakes, as interventions in and of themselves. Some of these may be construed as ruptures, defined as any minor to more dramatic tensions or breakdowns in the therapeutic relationship (Safran & Muran, 2006) and others natural occurrences in the space where people meet, such as small talk, silences etc. Clarkson (2009) considers how 'extra-therapy factors', such as client tardiness or clinicians taking leave, contribute to therapy. Similar to Kohuts concept of emphatic failures (Kohut, 1984) and Safran's (1993) therapeutic ruptures, these occurrences serve as opportunities for the client to 'revise or rework fundamental psychotherapeutic issues' (Clarkson, 2009 p. 53).

Observing how clients interact within the therapeutic alliance, clinicians can use the therapeutic relationship as an intervention by bringing the observations into the clients' awareness. When considering that clients who struggle with emotional intimacy may be likely to pride themselves in being independent and conscientious, using the therapeutic relationship may provide important early cues to detect this type of client, before they inadvertently get triggered by therapy and leave.

5.1.3 Apply measured humanity to heal and restore trust in intimacy

The third theme, 'apply measured humanity to heal and restore trust in intimacy', is more relational in nature. Within the health care profession, humanity refers to compassion, empathy and care. Collectively, humanity encompasses healing elements in the person-to-person relationship. Robbins (2015) notes that humanistic psychology espouses attitudes of 'charity, empathy, and openness' (p.9). When a person is sincerely approached through these attitudes, a sense of trust and non-defensiveness ensues, allowing them to 'reveal otherwise hidden truths' (p9). It is a large part of many therapies. In the UK for example, the Humanistic Psychological Therapies Competence Framework, highlights 'the ability to offer a therapeutic relationship that facilitates experiential exploration within a relational context' (Hill & Cooper, 2016, p. 285). This is similar to Clarkson's (2003) notion of the therapist voluntarily entering into a kinship with the client, where empathy and accepting attitude (validation) are considered necessary competencies within the framework (Roth, et al., 2009). Humanity fits with the components of the successful helper (Egan, 2014), which include attitudes of empathy, compassion, warmth and being non-judgemental (Hill, 2014). Unsurprisingly, clinicians in this study mention the use of humanity to restore trust in emotional intimacy. In the following, each of the sub-themes around validation, empathy, compassion, and curiosity are discussed.

With regards to validation, clinicians use this to acknowledge the current difficulties that their clients experience. Clients who struggle with affect-laden content, may find themselves creating self-sabotaging behaviours as they for example avoid seeking help or ignore their distress towards others, creating feeling of frustration. Validating their experiences for may prove useful. In 'validation therapy' (Feil & de Klerk- Rubin, 2014), which highlights the healing effect validation has on people, techniques involved include 'rephrasing' using the same keywords the client uses and 'using polarity' (i.e. thinking about

worst-case scenarios) in order for the client to access otherwise hidden feelings. As such, the very act of being validated is cathartic, and may be a gentler emotional approach to clients with emotional intimacy difficulties, then dealing with their feelings ‘head on’.

Validtaion here is similar to Carl Rogers principle of unconditional positive regard, where acceptance and support of a person, regardless of what they say or do (Rogers, 1951). In addressing clients with avoidance attachment patterns, validating, being acceptant of and acknowledging their relational difficulties, can provide them with emotional relief. I suspect this could be a challenge for clinicians, when the presentations highlight self-sabotaging content; “why don’t you ask why he didn’t return your call?” as opposed to validating their experience; “it sounds like it felt upsetting that he broke up with you”.

Regarding empathy, here defined as 'the therapist’s sensitive ability and willingness to understand the client’s thoughts, feelings, and struggles from the client’s point of view [..] seen completely through the client’s eyes, to adopt his frame of reference' (Rogers, 1980, p.85), is seen to be effective in soothing distress. The therapeutic effect of empathy enables the client to feel safe enough to disclose themselves to the therapist (Robbins, 2015) and has a basic ‘facilitative condition in the healing encounter’ (Clarkson, 2003, p.116). Thus, change can be brought about within a therapeutic setting where ‘conditions of […] empathic understanding are present’ (Tudor, 2017, p. 282). Indeed, Greenberg et al. (1993) found that the effects of therapist empathy correlated positively to therapeutic outcome. As noted in the literature, simply because someone prides themselves in their independence and emotional autonomy, does not mean that they don’t have a real need for relational connection, herunder empathy.

In a similar vein, another feature of humanity, compassion, is also used as an intervention. It may be similar to McClusky’s (2005) notion of ‘type 1 caregiving’, which is characterised as soothing, comforting and regulating of emotions. Compassion has remedying

therapeutic effects when enacted by the therapist. Gilbert (2009) defines compassion as ‘a basic kindness, with a deep awareness of suffering of oneself and of other living things, coupled with the wish to relieve it’ (2009, introduction). According to Gilbert (2009), being at the receiving end of compassion enhances mental wellbeing. He notes how compassion has beneficial effects on people, but also acknowledges that it is not uncommon for some people to feel uncomfortable when receiving care and compassion (Gilbert et al. 2014; Pauley & McPhearson, 2010). For the client group in question in this study, this may be particularly true and must therefore be applied in a measured fashion. Ultimately applying compassion may help mitigate the shame they experience when exposing their vulnerabilites in therapy.

The final subtheme, curiosity, can also be seen as an intervention, in that curiosity can assume an organising and calming effect on people (Ofer & Durban, 1999). This is to be distinguished from Nunberg's (1961) notion of curiosity as a compulsive ‘urge for knowledge’ (p.9). McNamee and Gergen (1992) highlight that in the therapeutic conversation the therapist position themselves as someone as not-knowing with a curiosity to learn, in order to stimulate a more detailed, concrete and individual life story in their client’s narrative. It is the position of purposeful curiosity that contributes to a client’s ‘narrative development of new agency and personal freedom’ (p.38). Given that people with avoidance attachment patterns are likely to be less detailed in their life narrative often citing their childhood as perfect with a reluctance to disclose personal information (Cundy, 2019), curiosity in therapy may serve as an intervention to address this. (In comparison, people with secure attachment styles can address painful life events and relational experiences in a balanced, considered, and undefended way [Cundy, 2019]). The utility of clinician curiosity towards people who struggle with relationship formation, may be that clients initially do less of the emotional work. It may be an emotionally safer option to connect with a therapist as they co-collaborate

on the client's narrative, than feeling they must conjure content to reflect on in the therapy room.

A subtly to these interventions is the risk of the client feeling shame or intrusion (Elliot et al., 2011). Cundy (2019) notes that with dismissive clients, in particular, clinicians need to be mindful of triggering avoidance behaviours such that they abandon therapy altogether (albeit acknowledging that clinicians must accept that sometimes 'this is all that can be achieved [in that time]' (p. 97)). Elliot et al. (2011) note the importance for therapists to know when to respond with empathy. Participants in this study were aware of this. They seemed to have an understanding that they needed to navigate therapy by making judgements of when was most appropriate to use humanity.

5.1.4 Contextual and conceptual positioning in therapy

The final theme, 'contextual and conceptual positioning in therapy', is not a direct intervention, but a prerequisite to implementing the above interventions. Throughout the interviews therapists implicitly referred to positioning themselves through their understanding of therapy and knowledge-base from which they deliver therapy. They conceptualised their approach and observed the context of client material. The word conceptualisation is a term used in clinical practice to convey 'a need to make sense of [client] experience, to place some order on what might otherwise be chaotic and random' (Douglas, 2016, p.151). Psychologists conceptualise their work through models and therapeutic principles and frame their work with clients in order to bring understanding and meaning to their client's experiences (Douglas, 2016). People working in counselling and psychotherapy are trained to think or position themselves in a certain way to facilitate changes for clients (Mozdzierz, Peluso & Lisiecki, 2009; Douglas, 2016). The theme here highlights this fundamental understanding which is linked to the literature. As practitioners, we need to be aware of our therapy and the things we need to take into consideration when

going about therapy with a particular client group. In this case, it is understanding the fact that people are different (i.e. Mozdzierz, Peluso & Lisiecki's, 2014), that one needs to establish a therapeutic relationship with clients (i.e., Clarkson, 2009) and that there is a sequence to going about delivering therapy (i.e., Greenberg et al., 1993; Holmes & Slade, 2017) and one needs to understand avoidance issues by looking for relational patterns.

This theme is noteworthy because it is in and of itself, not an intervention, but more of a stance or approach to therapy. However, without it, therapists would not likely be able to deliver therapeutic interventions as successfully. The subthemes; no standard approach, understanding the order of therapy, awareness of building a therapeutic relationship, actively understanding the nature of client issues, and looking for patterns in client materials, suggest a generic approach to therapy. For example, the notion that everyone is different (and that therapists cannot apply a standard approach to their clients), echoes the argument presented in a recent publication by The British Psychological Society, 'Power Threat Meaning Framework' (Johnstone & Boyle, 2018). It is an alternative approach to functional psychiatric diagnoses accommodating for the fact that, while there may be global 'trends' or 'patterns' in human distress, therapists must acknowledge and take idiosyncratic experiences into account in order to help their clients better.

However, once therapists suspect clients have relational initiation and maintenance difficulties, they begin to tailor their positioning and approach to their client accordingly. For example, a precursor to undertaking therapy is understanding that building a relationship with the client is essential. Relationship referring to 'the interconnectedness between two people' (Clarkson, 2003, p.3). Within psychotherapy, there is the notion of a therapeutic relationship as opposed to a romantic or platonic one. Under this notion, psychological therapy needs to be collaborative and feel safe in order it to work (Holmes 2001; Bowlby, 1988), and the therapist is the driving agent in this manifestation. Research has shown that a good

therapeutic relationship increases the likelihood of improvement (Norcross & Goldfried,1992). Being able to build a therapeutic relationship is a fundamental competency in therapy and drilled into psychotherapeutic training. Even therapeutic approaches such as CBT, which do not necessarily emphasise the therapeutic relationship in the literature, acknowledges 'that therapy needs to be collaborative in order for it to work' (Kennerly et al., 2017, p.26). Indeed, this understanding is fundamental in attachment-based and informed therapies; for example 'establish a relationship' in Holmes and Slade (2007, p. 22), 'creating a therapeutic alliance' in Greenberg's EFT (2017, p.67) and provision of a secure base as noted by Bowlby (1988) and Berry and Danquah (2016). However, when it comes to clients who struggle with emotional intimacy, therapists must be cautious in their interactions so as not to activate avoidance patterns in their clients as considered in the previous themes. It may be crucial to therapy that clinicians are awareness of this and have the ability to position themselves in order to drive therapy to cater for emotional intimacy difficulties.

5.2 Strengths and limitations of the study

This study, possibly the first of its sort, explored interventions used by clinicians to address client avoidance patterns, (as opposed to considering what interventions attachment theory offers from a theoretical point of view). Its strengths lie in the fact that it considers interventions regardless of modality, under the assumption that clients with these difficulties will approach therapists indiscriminately of their therapeutic training. This allows for a broad consideration of interventions and opens up therapeutic possibilities for psychotherapists regardless of training. Another strength is that it focuses on a specific demographic that appear to have real difficulties in the general non-clinical population and for whom may be at risk of developing clinical mental health issues. Becoming more aware of this demographic, and inspired by what clinicians already do, the psychotherapeutic community may be more

focused and effective in helping people who struggle to form and maintain meaningful romantic relationships.

Berant and Obegi (2009) noted that little was known 'about the specific intervention that either avoidant and anxious adult would find welcoming […] or therapeutically helpful' (p.464). The interventions delineated here may serve as a stepping-stone into this line of enquiry.

The limitations of this study lie in the problems of the general definitions and varying understanding of attachment theory. It was not clear in this study how clinicians go about identifying clients with avoidance attachment patterns and at what level they identified these (as primary or secondary attachment difficulties). It could have been made clearer to the participants what was meant by avoidant attachment patterns. Perhaps the use of vignettes to contextualise avoidance of intimacy and deactivating strategies would have been helpful. This study did not take clinicians attachment style into consideration, and whether this would mediate their use of interventions.

One aspect that was not addressed was the outcome of the interventions considered here, mostly because clinicians do not always measure attachment or avoidance of intimacy. Often intimacy difficulties is not the primary goal of therapy when clients with avoidance patterns decide to attend (Cundy, 2019).

Finally, from a research methodology point of view, despite having clinical experience, I am a novice counselling psychologist with limited interviewing experience and knowledge of therapy. This may have limited my questioning ability and hindered procurement of further interventions.

5.3 Implications for professional practice

The findings in this study suggest that there is an array of interventions practitioners are able to employ when helping people with avoidance attachment patterns and that when it

comes to ‘tools and techniques’ clinicals need not worry about utilising a particular protocol. Therapy is interwoven with a number of interventions. It is a non-linear process, where one intervention, for example formulation, can be used as a frame to create awareness, but also support the forging of the therapeutic relationship as the clinicians curiosity ‘populates’ the formulation. While they may be able to stand alone as interventions, it is the symphony of interventions clinicians rely on in order to drive the therapy forward and help clients be more proficient at engaging in relational dynamics required of intimate relationships.

It appears relevant for clinicians to look out for avoidance cues early on in therapy, so they may position and pace themselves to cater for clients deactivating strategies, and keep clients in therapy for long enough that they have a more positive experience with relationship formation.

5.4 Future directions for research

A line of enquiry that may be useful to explore is the efficacy of these interventions. Do people with avoidant attachment patterns find these interventions useful? Considering that many avoidant people are less likely to seek therapeutic help, would clarity on how therapy works for this demographic serve as a way to offer help? It could be interesting to see whether people would take up therapy if they knew it would be helpful to them.

Another direction for future research may be understanding whether there are any interventions used in therapy that one shouldn’t apply to this demographic. Many of the interventions cited in this study may appear as higher order therapy, that is, ‘generic’ interventions applicable to any client group, albeit in some instances modified to cater for the avoidance of affect-laden content.

5.5 Conclusion

This study serves to inspire the psychotherapeutic community when they reflect on their practice in seeing clients with avoidance attachment patterns. It also serves as a

reminder about the complexity in the use of attachment styles and models, and how clinicians needs to be mindful of how the framework used in therapy.

In summary, the findings imply that practitioners acknowledge that clients are different and highlight the need for an individualised approach. Despite this stance, they approach therapy as a three-pronged structure (build rapport, understand the issue, apply interventions). When it comes to specific psychotherapeutic interventions for people with difficulties in relationship formation and maintenance due to fear of emotional intimacy, there are three broad possibilities to draw from; ‘using self, (i.e. registering transferences of avoidance), and the therapeutic relationship (i.e. processing natural ruptures in therapy) to change avoidance patterns’, ‘apply *measured* humanity (compassion, validation, empathy, and curiosity) to heal and restore trust in intimacy’, and ‘employ any psychotherapeutic tools and techniques that help generate awareness of the avoidance and build psychological capacity to tolerate difficult emotions’.

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APPENDIX 1: Participant Information

To whom it may concern,
My name is Madeleine Mason Roantree. I am a trainee counselling psychologist at the London Metropolitan University, researching what psychological professionals do to help people who display avoidant attachment patterns yet are looking for long term relationships. I would like to understand what experiences clinicians have with this client group and what therapeutic interventions have they found useful. Colloquially "how does one treat commitment phobia?"

As you may have experienced, one of the most difficult client demographics include those who display avoidance patterns. There is an observation that the majority of people who display avoidance patterns are also single. Some will seek psychological help when they experience consistent disappointment in relationship formation. This disappointment motivates some clients to seek help, and therapy may be a 'way in' to help change their avoidance patterns, yet there is no known delineated psychological intervention for this demographic.

I am writing to you in the hope that you will be interested in helping me in this endeavour and share your experience of working with clients who display avoidance patterns and struggle to find romantic relationships. The interview would last approximately 1 hour and will be voice recorded. Data from your interview will be used for my Doctoral level counselling psychology project.

Participation is entirely voluntary. If you choose to participate you are free to withdraw at any point without question. Interviews will be voice recorded and strictly confidential. All recordings will be kept securely and destroyed once the project is completed.

Before you decide to participate it is more important that you understand that the interview will be discussing a potentially emotive topic and therefore may evoke some distressing and difficult feelings for you. In line with this it is also important that you have left the relationship that you will be discussing for a minimum of four months and be older than 18 years of age. Therefore, please take your time in deciding whether or not you wish to take part.

You will have the opportunity to discuss any feelings evoked at length post interview with the researcher and be given information on sources of support if you would like this.
Thank you so much for your time, if you have any further queries please do not hesitate to ask either by phone: [redacted] or email: [redacted]
I look forward to hopefully hearing from you soon.
Yours Sincerely,
Madeleine Mason Roantree
If you would like to get in touch with my supervisor, please contact [redacted] AFBPsS on e-mail: [redacted]

APPENDIX 2: Consent Form

Consent Form for interview on

"Clinicians practical experience with clients who display avoidance attachment patterns"

Thank you for taking part in this study. In order to proceed I would like to gain your formal consent, by way of singing this form.

Name: Date:

Profession: Location:

Years of clinical experience:

Your preferred therapeutic modality:

Other therapeutic modalities used in practice:

Researcher (student) name: *Madeleine Mason Roantree*

1.I confirm that I have read and fully understand the information sheet for the above study and have had the opportunity to ask questions. **Please initial here:**

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason. **Please initial here:**

3. I agree to take part in the above study. **Please initial here:**

Name of Participant: Name of Researcher:

Date: Date:

Signature _____ Signature _____

APPENDIX 3: Interview Statement & Debrief Statement

Semi-Structured Interview protocol for "methods and interventions used in therapy for clients with avoidance attainment patterns"

[The interviewer is likely to be the same person as the researcher. Nevertheless, as a a reminder to the researcher, or in the event the interview is someone else, these are the following instructions].

Interviewer instructions:

- Ensure room is quiet and undisturbed for 70 minutes.
- Check audio recording equipment is functioning before the interviewee arrives. Once interview arrives, great them and thank them for their time.
- Go over the informed consent sheet. Ideally, they would have read this beforehand via earlier email correspondence.
- Ensure you have 2 hard copies of the form for both of you to sign. One copy for the interviewee (participant) and one for the researcher.
- Turn the audio reducing equipment on, make one final test that the recording of both people is audible.
- Then follow the script below:

Interview questions

"Thank you for your time today, it is greatly appreciated. I would like to spend the next 60 minutes asking you a couple of questions about how you work with a certain client group. I am interested to know how you work with them and what interventions you have found useful. In order to gain a feel of this group of clients, I would be interested to know:

1. *What is your experience working with people who have avoidant-attachment patterns?*
2. *I am interested to know about clients who display avoidant patterns, yet want a committed long-term relationship.* ***What specific methods did*** *you use to help clients with avoidant attachment patterns looking for a long-term relationship?*

3. *What patterns, if any, have you experienced in your interventions? (what **techniques do you replicate** in your interventions between similar client presentations?)*
4. *What was the **outcome of your interventions**?*
5. *What was the most challenging about this client group and how did you overcome these challenges?*

Debrief statement

"This brings us to the end of the interview, many thanks for sharing your knowledge and giving up your time. The interview will be transcribed in the next few weeks, should you in the meantime feel you have something you would like to add, or more importantly you have regretted something you have said, please let me know and I will ensure it's get omitted from the transcript. I will keep you updated on the outcome of the study. Do you have any questions or comments at this point? Thank you once again for your time."

APPENDIX 4: Braun & Clarke's (2006) 15-point checklist

1. Transcription: The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes for 'accuracy'
2. Coding: Each data item has been given equal attention in the coding process
3. Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive
4. All relevant extracts for all each theme have been collated
5. Themes have been checked against each other and back to the original data set
6. Themes are internally coherent, consistent, and distinctive
7. Analysis: Data have been analysed – interpreted, made sense of - rather than just paraphrased or described
8. Analysis and data match each other – the extracts illustrate the analytic claims
9. Analysis tells a convincing and well- organized story about the data and topic
10. A good balance between analytic narrative and illustrative extracts is provided
11. Overall: Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly
12. Written report: The assumptions about, and specific approach to, thematic analysis are clearly explicated
13. There is a good fit between what you claim you do, and what you show you have done – i.e., described method and reported analysis are consistent
14. The language and concepts used in the report are consistent with the epistemological position of the analysis
15. The researcher is positioned as active in the research process; themes do not just 'emerge'