

Exploring the Relationship Between Attachment, Work-
Related Distress, and Emotionally Focused Individual
Therapy (EFIT) as a Potential Treatment: A Realist Review
and Evaluation

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Abbreviations

EFIT: Emotionally Focused Individual Therapy

EFT: Emotionally Focused Therapy

PSRQ: Post-Session Resolution Questionnaire

Abstract

In this thesis, I explore the link between attachment and work-related distress and assess Emotionally Focused Individual Therapy (EFIT) as a potential treatment. This work was inspired by my experiences as a psychotherapist, executive coach, and former Fortune 50 executive, where many leaders expressed distress due to feeling that ‘no one had their back.’ This reminded me of what I learned about attachment theory during my therapist training, sparked my interest, and led to the research questions in this thesis.

I adopted a realist approach for this thesis, combining a narrative review, a realist review, and a realist evaluation. The narrative review provided insight from existing literature into the relationship between attachment and distress at work. Leaders can act as attachment figures, serving as safe havens during stressful times and secure bases for taking risks. When they fail to perform these roles, they may become sources of distress. The realist review then explored the potential of attachment-based therapy, Emotionally Focused Individual Therapy (EFIT), as a treatment for work-related distress. Lastly, I conducted a realist evaluation with ten participants experiencing workplace distress to test the program theory from the realist review. Over the course of twelve sessions with each participant, I gathered and analyzed transcripts, clinical notes, assessments, and participant feedback. Results suggest that EFIT may help participants reduce work-related distress; however, specific micro-interventions may be required to overcome hyper- and hypo- arousal during sessions, which can impede progress.

This thesis aims to improve understanding of the role of attachment at work and attachment-based EFIT as a potential treatment for work-related distress. Its strengths include

being the first study on EFIT for work-related distress and utilizing realist approaches; its limitations include the small, exploratory, and geographically limited sample. My dual role as therapist and researcher was both helpful and challenging: it allowed for practitioner-led insights, reflexivity, and real-time adjustments, but also risked bias and may restrict the generalizability of the findings to other settings. Future research should examine EFIT with larger, more diverse groups and explore how leaders and organizations can apply attachment-based principles to create healthier workplaces.

1 Chapter 1 - Introduction

1.1 About this Chapter

This thesis explores the relationship between attachment and work-related distress and the potential for Emotionally Focused Individual Therapy (EFIT), a new attachment-based experiential psychotherapy, as a treatment. Using realist approaches, this thesis aims to understand what works, for whom, under what conditions, how much, how, and why. This chapter provides a rationale for exploring attachment science in the workplace, how this exploration fits in with modern occupational health theories, EFIT as an attachment-based therapy and high-level background that is expanded in the upcoming chapters.

1.2 My Background

I'm a psychotherapist and executive coach who is also a former Fortune 50 executive. My experience working with clients in executive coaching led me to develop these research questions and this thesis. I noticed patterns in their struggles that reminded me of what I learned during my master's degree in counseling about attachment theory and as I trained to become a certified EFT therapist. I started sharing some principles of attachment with clients and incorporating elements of EFIT, and I saw that it resonated. This motivated me to study the topic formally to help therapists and clients, and to contribute to the body of attachment science and EFT research, which is timely as EFT has only recently expanded to individuals.

1.3 Introduction to the research topic

1.3.1 Research rationale

The well-being of employees is a concern for both employers and workers alike. A recent study of 3400 employees by The Workforce Institute found that 60% view work as the most

significant factor impacting their mental health, while 69% said their manager has the greatest influence, affecting their mental health as much as their spouse. Additionally, 40% of senior management employees said they would leave within the year due to work-related stress (1). The connection between occupational stress and declines in mental and physical health includes issues such as anxiety, depression, migraines, sleep problems, and heart disease (2). These mental health risks are even higher for underrepresented business leaders, including women, people of color, those identifying as LGBTQ+, and individuals living with disabilities, who are still advancing in highly competitive industries like finance and technology (3). Mental health challenges at work also impact employers, leading to \$187 billion in lost productivity in the U.S. alone, a problem worsened by the COVID-19 pandemic (4).

1.3.2 Attachment theory and its relevance to work-related mental health

Several factors influence work-related distress, including, but not limited to, work-life balance, emotionally engaging tasks, communication quality, opportunities for growth, job security, support systems, and participation in decision-making processes (5). Recent years have seen growing academic interest in the role of attachment theory in work-related distress (6). Attachment theory, a well-established framework for understanding human relationships and development, states that the attachment behavioral system, a survival mechanism activated by threat, plays a crucial role in an individual's well-being (7, 8). When there is proximity to an attachment figure who is accessible, supportive, and responsive, the individual feels secure (9). However, if proximity is not possible or if the attachment figure is not supportive or responsive, the person may experience distress and insecurity (9), including mental health issues such as anxiety, eating disorders, suicidal ideation (10, 11), depression and addiction (12, 13), Post-Traumatic Stress Disorder (PTSD) (11, 14) and burnout (15).

Although personal and work relationships are often viewed separately, attachment theory reveals they share core mechanisms. The workplace is inherently relational, with aspects like management style and leader-follower interactions impacting employee well-being (16-18). Leader-follower bonds involve attachment patterns similar to parent-child relationships (19), including unequal power, with leaders seen as stronger and wiser than followers (20), and dual roles as teachers and disciplinarians (21). If an employee experiences stress or inconsistent support from leadership, it can activate the attachment behavioral system, resulting in avoidant strategies like distancing from the leader or anxious strategies such as seeking closeness and attention. Both responses can lead to negative outcomes, such as mistrust of the leader (21), hypersensitivity to feedback, or the need for excessive reassurance (6). Research has shown connections between attachment and various aspects of work-related mental health and performance, which Chapter 2 discusses in detail.

1.3.3 Introduction to Attachment-based Emotionally Focused Individual Therapy (EFIT)

The growing interest and research into the connection between attachment, mental health, and work performance led to my decision to study attachment-based Emotionally Focused Individual Therapy (EFIT) for this thesis. EFIT is part of the Emotionally Focused Therapies (EFT) family, which started as attachment-based, experiential couples therapy (EFCT) and has recently expanded to include individuals (EFIT) and families (EFFT). Various approaches have been used to address work-related mental health issues, with different outcomes for employees and organizations. According to a 2015 meta-analysis from Cambridge, these include medication, cognitive-behavioral therapy (CBT), exposure therapy, physical activity, counseling, well-being education, and increasing employee control over work (22). One study provided early

evidence that attachment-based therapy can help employees with insecure attachment and improve job satisfaction (23, 24).

1.3.4 EFT Theory of Change for Clients

EFT therapists see emotional experience and the attachment bond as the main drivers of change. They aim to intensify emotions in session while keeping a client within a safe window of tolerance, enabling them to take risks and confront difficult experiences. To do this, an EFT therapist first builds an attuned relationship in which they are present and actively respond to the client in the moment. Once established, they follow a five-step cycle called the “tango” to process emotional experiences, allowing the client to clearly identify what they are feeling and share it with someone who matters. This person could be a part of themselves, an imagined other, or the therapist. The goal is to create a new emotional experience during a session that can counteract past experiences leading to insecure attachment (25).

The five specific steps of the tango are Figure 1 (26):

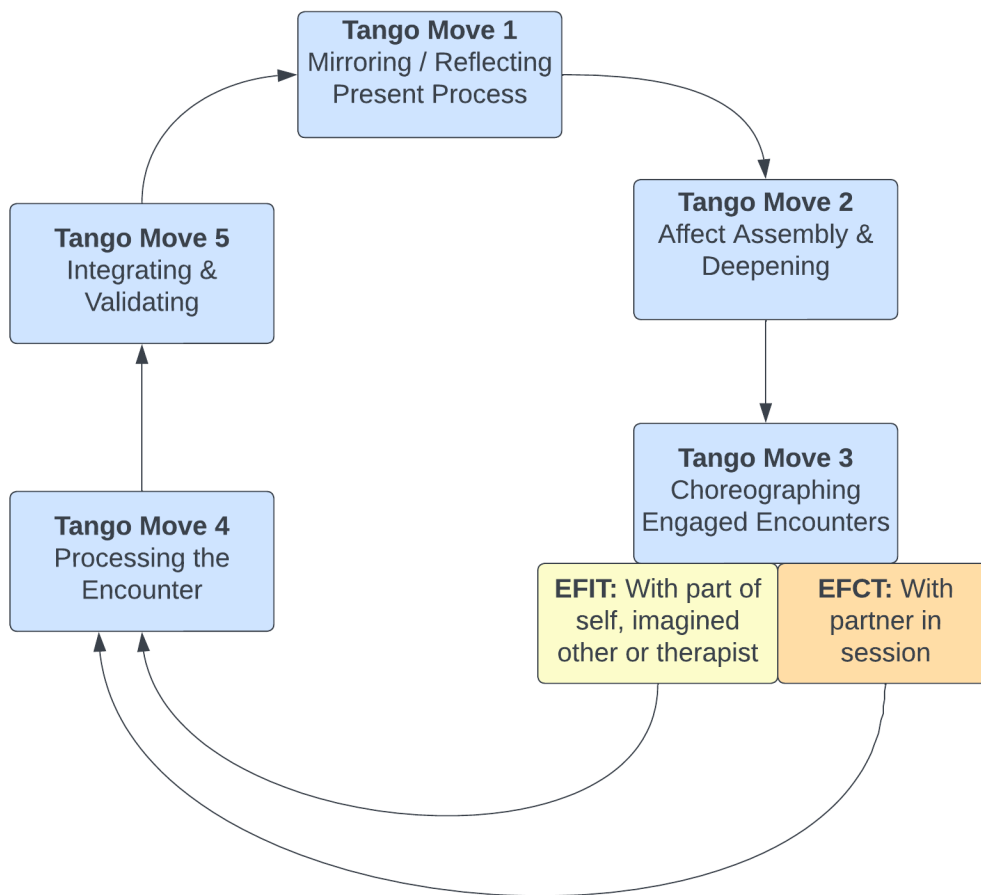


Figure 1: The EFT Tango and variations for EFCT and EFIT (27)

- (1) Mirroring / Reflecting Present Process: Building a therapeutic alliance by echoing and validating what the client says to demonstrate understanding.
- (2) Affect Assembly & Deepening: Deepening emotions by using RISSSSSC words (Repeating, Imagery, Soft, Slow, Somatic, Simple, Specific, Client’s words) and micro interventions (Table 1). The therapist works with the client to understand their emotional experiences and needs through attachment theory.

- (3) **Choreographing Engaged Encounters:** Creating a shared interaction where this newly understood attachment need and emotional experience are expressed. In EFCT, this occurs between partners in the couple. In EFIT, it occurs with a part of self, an imagined other, or the therapist.
- (4) **Processing the Encounter:** The therapist and client talk about the experience of sharing these needs, what went well, and what was challenging.
- (5) **Integrating & Validating:** Acknowledging the client's risk in helping to incorporate the new experience into their internal relationship model.

EFT therapists use micro-interventions (Table 1) across the five steps of the “tango” to help the client progress towards intended outcomes (25, 28):

Table 1: Micro-Interventions used throughout EFT

Reflection	Mirroring back and stating the client’s emotional process as it is occurring in session
Validation	Affirming and normalizing the client’s experience including struggles, protective stances, and attempts to grow to create safety within the session and reduce feelings of shame or being alone
Evocative questions	Asking the client to share their experiences and emotions including sensations and perceptions
Interpretation & Empathic conjectures	Therapists venture an extension of what the client said about their experience, sometimes using a “proxy voice,” framing the statement as if the client is saying it themselves
Deepening engagement & heightening emotions	Using words and tone that are repetitive, imagery, slow, soft, specific, somatic, simple, and the client’s words (RISSSSC)
Reframing	Shifting the perception of the story from a negative view like helplessness to a more positive and productive one like agency

Using the tango and ongoing micro-interventions, EFT and its variants intend to foster change, and this progress is monitored through three stages. By the end of stage one,

stabilization, the client has increased awareness of their struggles with relationships and attachment, as well as of previously disowned emotional parts of self. By the end of stage 2, restructuring, the client has taken greater risks sharing their emotional experiences with parts of self, the therapist, or an imagined other, creating corrective emotional experiences. Attachment needs and fears are normalized with an attachment framework, integrating the new experiences in session from the perspective of self and the world. By the end of the final stage, consolidation, the client applies what they have learned to work through current relationship problems. A new narrative is developed that highlights the client's strengths, resilience, and a new working model of self and relationships (27, 29).

1.3.5 What we know and do not know about EFT's outcomes

Research on EFIT is still in its early stages, and currently, no studies have been published on EFIT for work-related distress. In these aspects, this study is unique. When I began and completed all the studies for this thesis, there were no published studies on EFIT. However, during the final stages of writing my thesis, the first empirical study on EFIT was published, showing reductions in depression and anxiety after fifteen EFIT sessions in a randomized controlled trial with eighty-eight participants (30).

Given the limited research on EFIT when I started my D.Phil., this thesis had to rely on insights from EFIT's predecessor, EFCT, to establish the initial program theory, including:

- 79% of couples experienced significant clinical improvement after EFCT, and 82% showed similar progress three months following therapy. Over 70% of couples reported being symptom-free after EFCT therapy (31).
- Reduced attachment anxiety, receiving support within the relationship, and experiencing greater relationship satisfaction (32).

- Significant increase in trust, a key predictor of healthy relationships, following EFCT (33).
- Improvements in empathy, self-disclosure, intimacy, and stability (31).

EFCT has also been shown to lead to improvements for individual partners within a couple, which is a promising early indicator of its potential as a therapy for individuals.

- In a study by Weissman et al. (2012), one partner in a couple diagnosed with PTSD experienced significant reductions in symptoms after EFCT, along with improvements in mood (34).
- EFCT has been shown to reduce depressive symptoms, with one study finding that women meeting criteria for depression improved after therapy and at six months, with outcomes comparable to those receiving both EFCT and antidepressants (31, 34).

1.4 Conceptualizing Work-Related Distress

This thesis uses the term work-related distress as an umbrella to capture the broad spectrum of experiences and symptoms observed in clinical practice and reported by participants in this study, including, but not limited to, burnout-related symptoms, anxiety, and depressive reactions (Table 2). It captures a range of negative psychological experiences that can be expressed as emotional, cognitive, behavioral, and/or physiological strain with potential impacts on functioning and well-being.

The term is intentionally broader than any single diagnosis because real-world presentations can be mixed (e.g., anxiety, burnout and depressive symptoms may co-occur). Also, distress may fall below formal diagnostic thresholds while still impairing functioning. Further, the literature on mental health at work uses multiple overlapping but non-identical

terms, including psychological distress, burnout, anxiety, depression, and work-related mental ill-health. Using “work-related distress” allows the thesis to acknowledge this conceptual overlap while avoiding the reduction of participants’ experiences to any single clinical or occupational category or diagnosis. It also helps reduce conceptual confusion that can arise when organizational research terms (e.g., stress, burnout) and clinical diagnostic terms (e.g., anxiety disorders, depressive disorders) are used interchangeably. Finally, using the term work-related distress allows the thesis to recognize the continuum between early stress reactions and more severe psychological outcomes, while maintaining a clear focus on the role of workplace context in shaping these experiences.

Table 2: Work-related distress terms and definitions

Term	Definition (aligned)
Work-related distress	A non-diagnostic umbrella term capturing negative psychological, emotional, and physiological responses arising from work (e.g., including but not limited to stress, anxiety, burnout, depressive symptoms).
Stress	A process in which demands are appraised as exceeding coping resources, producing psychological and physiological activation (35)
Anxiety	A state of heightened vigilance, worry, and arousal linked to perceived uncertainty or threat (36)
Depressive symptoms	Low mood, reduced motivation or pleasure, and impaired functioning, considered dimensionally rather than diagnostically (36)
Burnout	A work-specific syndrome involving emotional exhaustion and reduced professional efficacy (37)
Well-being	A state of emotional, psychological, and functional health, including capacity to engage and perform (38)

1.5 Social and Organizational Context of Work-Related Distress

Research on work-related distress spans multiple disciplines, including clinical psychology, occupational health psychology, organizational psychology, and management and leadership, with each offering perspective on the causes, support and treatment of work-related distress. While this thesis takes a more clinical psychology perspective, using attachment theory

as the substantive theory to guide understanding and focusing on treatment-related research questions, there are also traditions within organizational psychology and occupational health psychology that examine employee health within the context of work environments to acknowledge..

Several organizational health frameworks highlight the role of broader workplace systems and culture in shaping employee well-being. For example, the World Health Organization Healthy Workplace Framework conceptualizes worker health as influenced by four domains: the physical work environment, the psychosocial work environment, personal health resources provided by the organization, and the organization's relationship with the surrounding community (39). Similarly, the National Institute for Occupational Safety and Health Total Worker Health framework emphasizes the importance of integrating work hazard protection with policies and practices that promote overall worker well-being (40). These models highlight that workplace mental health is not solely an individual responsibility but is shaped by broader policy and organizational practices. While attachment theory is not explicitly included within these frameworks, it is complementary and offers a potential psychological and physiological explanation for why protective workplace practices are important for individual health and performance.

Further, occupational health researchers Lazarus and Folkman (1984) proposed that stress does not arise solely from external demands or internal vulnerabilities but from the ongoing interaction between individuals and their environment. According to this model, individuals engage in 'primary appraisal,' in which they evaluate whether a situation represents a threat, challenge, or harm to their well-being, and then 'secondary appraisal,' in which they assess their ability to cope with the situation. Stress occurs when environmental demands are appraised as

threatening and coping resources are perceived as insufficient. Importantly, these appraisal processes are influenced by contextual factors, including perceived social support and relational security. In workplace settings, relationships with supervisors and colleagues may therefore shape stress responses by influencing whether employees feel they have sufficient relational resources to manage challenging situations (35).

Organizational stress research has also developed several complementary theories that explain how workplace conditions contribute to employee well-being. The Job Demands-Resources model proposes that employee well-being depends on the balance between job demands and job resources (41). Job demands include aspects of work that require ongoing effort, such as workload, emotional labor, or role conflict. Job resources include aspects of work that support goal attainment, reduce the costs of demands, or promote growth and development, such as autonomy, feedback, and supportive leadership. According to the theory, job resources can buffer the negative effects of demands and promote engagement and well-being.

A related framework is Conservation of Resources theory, which suggests that individuals strive to acquire, maintain, and protect valued resources such as emotional energy, status, time, and social support and even try to create a surplus of them (42). Stress occurs when these resources are threatened, lost, or insufficiently replenished. From this perspective, workplace relationships can function as important psychological resources that help individuals maintain emotional stability during periods of stress. Closely related is social support theory, which proposes that emotional and operational support from others can directly improve well-being and buffer the negative effects of stress (43).

Together, these frameworks provide complementary perspectives on work-related distress. Organizational models such as the Job Demands-Resources model explain how work structures

and conditions generate stressors. Resource-based models such as the Conservation of Resources theory highlight how psychological and relational resources influence resilience or vulnerability. Social support theory emphasizes the buffering role of supportive relationships. This thesis builds on these perspectives by examining how relational processes may shape the experience and regulation of work-related distress. Attachment theory offers a framework for understanding why key work relationships, like those with a boss, can have powerful emotional regulation effects or add to threat and uncertainty.

The perspectives from occupational health and organizational psychology highlight that work-related distress emerges from the interaction between workplace conditions, individual processes, and available resources, including relationships. This thesis extends this literature by examining how attachment processes may shape the experience and regulation of work-related distress and the potential for attachment-based treatment when distress is present.

1.6 Conclusion

This study employs realist approaches to explore the application of EFIT in promoting work-related mental health, with a particular emphasis on the role of attachment theory. By analyzing the outcomes of EFIT and its underlying mechanisms in various contexts, this research aims to advance the field of psychotherapy, providing insights into a potentially innovative treatment for work-related distress and enriching related academic literature. This exploration intends to not only contribute to the expanding body of research on EFT but also represents a pioneering effort in applying EFIT to workplace mental health challenges.

1.7 Research Questions

Aim:

This research aims to explore the relationship between attachment and work-related distress, as well as the potential for attachment-based Emotionally Focused Individual Therapy (EFIT) as a treatment - why it may work, how, in what contexts, for whom, and to what extent.

Research Questions:

1. What is the relationship between attachment and work-related distress?
2. What are the mechanisms by which EFIT might improve work-related distress?
3. What important contexts determine whether EFIT produces intended or unintended outcomes?

Objectives:

- To conduct a narrative review to understand the relationship between attachment and work-related distress
- To conduct a realist review of the literature to understand why, how, in what contexts, for whom, and to what extent EFIT might improve work-related distress
- To conduct a realist evaluation to collect real-world data that can be used to refine the program theory from the realist review.
- To provide initial recommendations on tailoring, implementing, and designing contextually sensitive strategies for using EFIT as a potential treatment option for work-related distress, and to identify areas where further research is needed.
- A potential secondary objective, depending on findings, is to provide insight to leaders and organizations on ways to create more secure attachments in their organization

1.8 Outline of Thesis Chapters

The next chapter (Chapter 2) offers a narrative review of the connection between attachment and work-related distress, the issue examined in this thesis. It then explores a potential attachment-based therapy solution, EFIT, using realist approaches, initially through a review of existing literature to develop a program theory that is then refined using empirical data from a realist evaluation. Chapter 3 explains the realist approaches, followed by Chapter 4, which details the mixed methods used in the studies. Findings from the realist review (Chapter 5) and the realist evaluation (Chapter 6) are presented, along with a discussion and conclusion in Chapter 7.

2 Chapter 2 - Narrative Review: The relationship between attachment and work-related distress

2.1 About this Chapter

Initially, this thesis was designed as a two-phase realist review and evaluation. After feedback during my Transfer of Status indicated the need for more background on the problem that led to the thesis, I conducted a separate narrative review on the relationship between attachment and work-related distress. The narrative review was published in *WORK* in April 2025. For inclusion in this thesis, only the opening paragraph was removed to avoid repetition with the thesis introduction; no other changes were made to the published version. The review was published with my supervisors, Dr. Geoff Wong and Dr. Anne Ferrey (GW and AF) as co-authors, who provided feedback and advice. Accordingly, the article uses the pronoun ‘we’, although their contributions were consistent with their role throughout the thesis: reviewing and providing guidance. The research and writing were undertaken by me.

2.2 Background

Several factors influence work-related mental health, including but not limited to work-life balance, engaging tasks, communication quality, opportunities for growth, job security, and the presence of support and the ability to participate in decision-making processes (5). In recent years, there has been a growing scholarly interest in the role of attachment theory in treating workplace well-being (7). Historically, little space has been given to the topic of attachment in the workplace in organizational psychology and human resource fields (17, 44).

According to attachment theory, when faced with threats, individuals seek support from attachment figures, which is a survival mechanism (7, 8). When there is proximity to an

attachment figure who is accessible, supportive, and responsive, the individual feels secure (9). However, if proximity is not possible, or if the attachment figure is not supportive or responsive, the person will feel significant distress and insecurity (9).

2.3 Attachment theory overview

2.3.1 Origins and theory

Attachment theory, developed by John Bowlby, states that early relationships with primary caregivers shape an individual's expectations and behaviors in their later relationships. Bowlby described the attachment behavioral system as essential for survival, triggering individuals to seek support and safety from attachment figures when faced with threats. (45). Attachment creates a felt sense of security through two mechanisms: a safe haven and a secure base. The safe haven provides comfort in times of stress, and the secure base supports autonomous exploration of one's environment (7, 46). When people believe an attachment figure is available and can provide support in times of stress, there is a sense of felt security. They can explore the world autonomously, a phenomenon known as the dependency paradox; the more support we feel the more autonomous we can become (7).

2.3.2 Building the internal working model of relationships

Early relationships with key caregivers help people form this internal working model of relationships they will carry with them throughout life, also called attachment styles or strategies (7). There are two distinct components of an attachment style, one related to the view of self and one to the view of others. The model a person forms about the self is tied to a person's view of their self-worth. The internal model of others relates to a person's belief, based on their experience, that others will be available and accessible in times of stress and need (7, 8). These

models guide emotions, cognitions, and behaviors in relationships and affect how someone responds to adversity (9).

2.3.3 Attachment styles

The learned internal working model of relationships is expressed through patterns of behaviors that are called attachment styles. While others have been discussed and debated, the three most common attachment styles are anxious, avoidant, and secure attachment. Anxiously attached individuals worry about the availability of support and continually seek reassurance, while avoidantly attached individuals distrust support and strive for extreme self-reliance. (7, 47). Individuals with either of these insecure attachment styles will also often start using attachment strategies such as proximity seeking to be near an attachment figure or withdrawing from the attachment figure (12, 34). In contrast, those with a secure attachment style believe others will be supportive and responsive in moments of need and, therefore show more optimism, emotional stability, and a positive view of self and others (7, 47). Studies have shown that over half of adults classify themselves as securely attached, while the remainder are close to an even split of anxious and avoidantly attached (48, 49).

2.3.4 Secure attachment impact

People with secure attachment believe others will be there in times of need, and they trust their support, leading to greater emotional stability (7, 47). They have more secure coping strategies in times of stress because their internal working model supports their belief that through their actions and behaviors, they can achieve their goals, and they believe that others will respond positively to their actions and behaviors (50). Secure relationships play a critical role in a person's ability to regulate emotional well-being and social behavior (9, 45). Secure attachment has also been linked to resiliency to stress (34), reduced chance of burnout (15),

autonomy, self-efficacy, and effective emotional regulation (11, 12, 51) and as a mediator of the psychological impact of traumatic events (32).

2.3.5 Insecure attachment impact

In contrast, when an attachment figure is not accessible due to inconsistent response, loss, or another reason, it can contribute to mental health distress such as anxiety, eating disorders, suicidal ideation (10, 11), depression and addiction (12, 13), PTSD (11, 14) burnout (15), decreased emotional regulation (52), as well as maladaptive coping strategies, which are associated with high levels of emotional distress (50). Conversely, increasing secure attachment in relationships can improve emotional regulation capabilities, increase resiliency, and decrease mental health distress (52)

2.3.6 Neurological basis for attachment

Attachment science has a neurological basis and a physiological impact on health. Rejection cues are processed in the same area of the brain as physical pain and in the same manner as danger (28). When there is a threat to security, insecure attachment develops, and the nervous system becomes hypo- or hyper-active due to stress (52, 53). This response can negatively impact cardiovascular and immune functioning and the neuroendocrine system that regulates chronic stress (34). Insecure attachment has also been linked to increased activity in the brain's threat response system and decreased engagement in co-regulation, making it challenging to regulate during stress (52).

2.4 Attachment measures

Several methods and tools are frequently used to measure adult attachment and attachment styles (see Table 1) and are included here to move from the theoretical to the

practical and illustrate how attachment theory has been measured in studies included here as well as in real-world contexts.

Table 3: Attachment Measures

Tool	Overview	Main Usage
Adult Attachment Interview (AAI)	Semi-structured interview used to assess adult attachment representations. It builds on Bowlby's attachment theory and focuses on an individual's memories of their early attachment experiences and how these experiences influence their current functioning (54, 55). The reliability and validity of the AAI have been extensively studied and it has been found to be robust (55).	Widely used in both clinical and research settings to assess attachment representations in adults, providing insights into their relational patterns and psychological well-being (55)
Experiences in Close Relationships (ECR) and ECR-Revised (ECR-R)	These self-report questionnaires are used to assess two dimensions of attachment in adult romantic relationships: anxiety and avoidance (56, 57). The ECR-R has demonstrated high reliability and validity across diverse populations (57).	The ECR and ECR-R are commonly used in studies examining romantic attachment and have practical applications in therapy and counselling (57). Recent advancements in attachment measurement include modifications to existing tools to improve their cultural sensitivity and applicability across different populations. For instance, the ECR-R has been adapted to better assess attachment in non-Western cultures (58).
Attachment Style Questionnaire (ASQ):	This self-report questionnaire assesses adult attachment styles and has been widely used in research on attachment in adult relationships (59). It demonstrates good internal consistency and test-retest reliability, although its reliability may be slightly lower compared to the Experiences in Close Relationships (ECR) scales (59).	While the AAI provides a deep, qualitative assessment of attachment, tools like the ECR-R and ASQ offer a more efficient quantitative approach, suitable for large-scale studies.

In summary, attachment has a broad range of impacts on a person's mental health and ability to cope with stress. Due to the central role work plays in most adults' lives, attachment may also affect a person's ability to emotionally regulate through stressful work situations and thus may impact their work performance. Given this, attachment-related issues may have a greater impact on work-related difficulties than previously recognized. If this is the case, it may be possible to use attachment-based treatments for workplace well-being problems. This narrative review will synthesize existing literature on the relationship between attachment theory and workplace mental health, aiming to validate the experiences of employees facing work-related distress and offering employers an alternative approach to supporting employee well-being.

2.5 Methods

In this review, we took a narrative approach to synthesize articles on this topic and identify areas for future work regarding the relationship between attachment and work-related mental health. We followed the SANRA (Scale for the Assessment of Narrative Review Articles) to validate and guide the rigor of the approach and article reporting (60). The initial step involved identifying existing theories and literature related to attachment theory and mental health at work. Relevant literature from these searches and discussions with clinical, human resources and academic experts in the field helped shape interpretations of the findings.

2.5.1 Search strategy

The search strategy focused on gathering data on the relationship between attachment and work-related mental health. We developed the search strategy with support from an expert librarian at the Bodleian Library at the University of Oxford. Sources included academic

databases (PsycINFO, SCOPUS, and Google Scholar) and citation tracking. The initial search was conducted in November 2022, and a second search was conducted in November 2024 to update findings. Our search focused on the following keywords: "attachment AND mental health AND work," "attachment AND work." We used an iterative approach to refine search terms for specificity and inclusion. Additional terms to account for alternate words for mental health (e.g., anxiety) and work (e.g., business) were also included. All search results were exported to EndNote 20 for screening.

2.5.2 Article selection

Articles included in this review were selected based on their ability to provide insights into the relationship between attachment and mental health distress in the workplace (Figure 2).

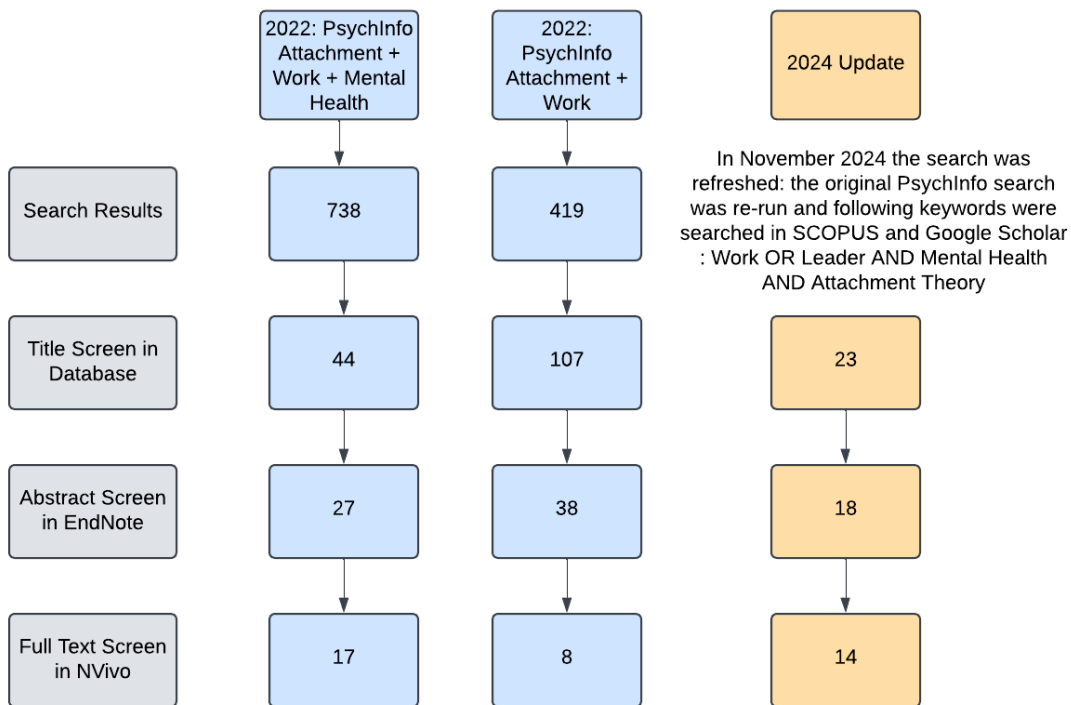


Figure 2: Search and Article Screening Flow Chart

Articles directly focused on attachment theory and work-related mental health were included and articles on attachment at work were sampled for additional context. Exclusion criteria included studies not in English, not in peer-reviewed journals, and those not involving working-age adults (Table 4). GW and AF reviewed a random subsample of ten percent of title and abstracts and full-text articles, respectively, to ensure consistency with inclusion and exclusion criteria. Discrepancies were resolved through discussion. Citation tracking led to the inclusion of other additional articles that informed the narrative review.

Table 4: Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
<ul style="list-style-type: none"> - All articles focused on attachment theory + mental health + work, directly stated in the title or abstract - Sampled articles on attachment theory at work to provide additional background and context 	Articles that were not: <ul style="list-style-type: none"> - In English - Published in peer-reviewed journals - With adults over age 18

2.5.3 Data extraction and synthesis

All selected articles were uploaded to NVivo for coding, which included themes related to work-related distress, leadership traits, and attachment processes. Code development was inductive (from emerging themes) and deductive (based on initial theories). Broader themes were used to organize codes further. Data from the literature were synthesized to develop and refine an understanding of attachment theory's impact on work-related mental health. Judgments were made regarding the article's relevance to the research topic on the relationship between attachment and work-related mental health. These findings were iteratively refined based on ongoing stakeholder input.

2.6 Findings

The initial search in November 2022 produced twenty-five articles that made up the core of the narrative review: seventeen related to attachment, work, and mental health, and eight additional articles more broadly on attachment at work. Articles were researched and authored in the USA (10), Israel (6), Israel & USA (2), Canada and Israel (1), Iran (1), Greece (1), Australia (1), New Zealand and USA (1), and the UK (1) and China and the USA (1). They were a range of quantitative studies (15), qualitative studies (2), commentaries (4), and reviews (4). Snowball sampling led to the inclusion of additional articles, including articles on attachment-based therapies like Emotionally Focused Individual Therapy (EFIT), which provided additional context on attachment and methods of treating insecure attachment. An additional 14 articles, 13 quantitative and one qualitative were added in November 2024, from lead researchers in Egypt (1), China (3), USA (2), Israel (2), Spain (2), Slovakia (2), France (1) and Norway (1). These additional articles further supported the findings of this narrative review that there is a relationship between attachment and mental health distress at work, including during stressful events like COVID-19.

2.6.1 Attachment extends beyond the personal to the professional

Several researchers have shown that attachment models are essential factors in workplace behavior (9, 61). According to attachment theory, emotional bonds based on care seeking and caregiving (attachment needs) are necessary for humans to feel safe enough to explore our environment. These needs continue into adulthood through beliefs and behaviors within love and work relationships (23). Like personal life, work life provides an environment where exploration is required for mastery of new tasks and abilities (61), but this can feel difficult or even threatening. Having a secure base, meaning attachment to an available and responsive protector,

can provide needed support for successful exploration (61). In other words, effective dependence leads to greater autonomy and self-confidence and is a hallmark of health – a counterintuitive concept known as the dependency paradox. (12). This paradox has also been found to exist in not just our personal lives but our professional lives as well.

This narrative review synthesizes the findings on the relationships between attachment and work-related mental health. The impacts are interwoven and complex. Each person brings an internal working model of relationships shaped by their past experiences, and the dynamics at work can further evolve these models.

2.6.2 Impact of attachment at work

While personal and work relationships are often considered distinct, attachment theory suggests underlying mechanisms common to both. The workplace is inherently relational, with factors such as management style and leader-follower dynamics affecting employee well-being (16-18, 62). Humans are social beings, and for many, most waking hours are spent at work. It is therefore unsurprising that relationships and experiences at work significantly affect emotions and mental health.

Research has shown relationships between attachment and many aspects of work-related mental health and work performance, including stress and burnout; job satisfaction, performance and employee retention (Figure 3). Further, during times of significant stress like the recent COVID-19 pandemic, insecure attachment styles can increase negative mental health and physical health impacts, as was shown in a 2024 study of 1047 medical staff by Yang et al. (63).

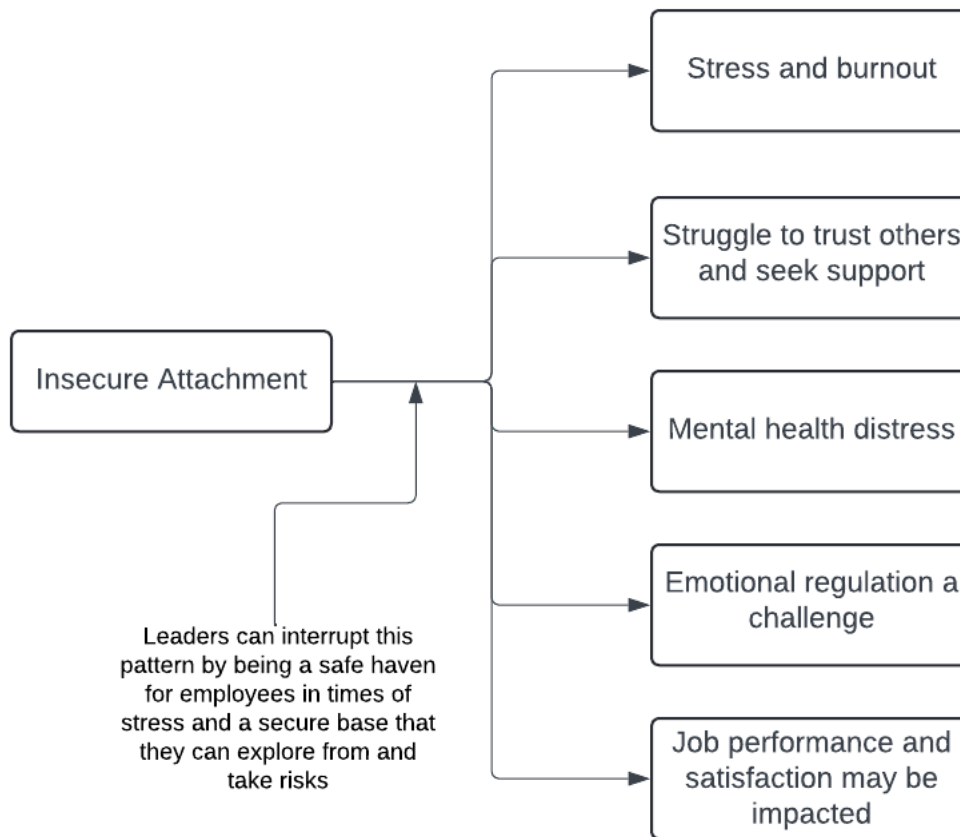


Figure 3: Realist review indicated several potential impacts of insecure attachment

2.6.3 Stress & burnout

Attachment systems and strategies are activated and strengthened by stress in reciprocal ways (2). Increased attachment insecurity has been associated with higher stress and stress symptoms (16, 48, 62, 64, 65). Employees who use anxious attachment strategies have also been shown to have higher stress (21, 64). People with higher levels of attachment anxiety are significantly more likely to interpret situations as threatening and feel less confident in their ability to handle challenges, while those higher in attachment avoidance report less supportive relationships with colleagues and leaders (2). These findings highlight that different attachment

styles influence an employee's view of themselves and others, which contribute to work-related stress. Insecure attachment has also been strongly correlated to burnout in the workplace (17, 66-69). Burnout can be defined as emotional, physical, and cognitive exhaustion (24). Avoidantly attached individuals may be more likely to work long hours, prefer working alone, and take fewer holidays, putting their health and relationships at risk (23). It has been shown that the more securely attached an employee is, the less likely they are to burn out, and the more insecurely attached they are, the more likely they are to burn out (48). In a 2024 meta-analysis by Warnock et al., anxious and avoidant attachment were positively related to burnout (69).

Securely attached employees build more supportive social networks at work and see that support as more positive (2, 8), while insecurely-attached individuals may believe they cannot count on receiving support, are less capable of overcoming challenges at work, and might be more distracted when conflicts arise (24, 70).

Job satisfaction, performance & employee retention

Attachment security can lead to higher satisfaction in most areas of work life, including recognition, relationships with coworkers, job security, and a lower risk of experiencing psychosomatic or physical illness (17, 61). Specifically, avoidantly attached individuals have been shown to have more negative views of organizational fairness, which has been linked to higher rates of job dissatisfaction (66). Insecure attachment also been significantly correlated with lower levels of innovation behaviors at work like 'boundary spanning', which means collaborating and making connections with different groups to share knowledge (71). Further, those with insecure attachment are more likely to share an intention to leave their job (6).

Insecure attachment is also negatively correlated to job performance (61, 69). This can manifest as inability to complete assignments, lower satisfaction with coworker relationships, and lower performance self-ratings (24). When a leader is viewed as a security provider (as measured by the Leader as a Security Provider Scale – LSPS) (72) there is a statistically significant correlation to general work performance (73). As well, leaders contribute to their followers' performance as attachment figures and the best scenario for an improved team performance is a secure-figure leader and followers with low separation distress, a function of secure attachment (74). However, work performance is nuanced and may not have as strong an impact for employees who are already highly engaged (73).

2.6.4 Emotional regulation and surface-acting

Insecure attachment can lead to less effective emotional regulation strategies at work, like surface acting (16) and emotional suppression (18, 20). Surface acting, coined by Arlie Hochschild in 1983, is a form of emotional labor and occurs when workers suppress their genuine emotions, especially negative ones, to display positive affect (16). It has been associated with turnover, decreased well-being, increased blood pressure, and reduced social functioning and relationship formation. Employees who are concerned about social rejection may resort to surface acting as a coping strategy for anxiety, but paradoxically, this can add to their stress (16). Individuals who use more avoidant attachment strategies are more likely to surface act and use emotional suppression (18) those who use more anxious attachment strategies are more likely to emotionally ruminate and use reappraisal (24, 70).

2.6.5 The Impact of leaders on attachment at work

Leaders and supervisors significantly impact employees' lives because they influence the support provided and control over one's work (17). Here, we use the term “leader” to encompass managers and supervisors who have some direct authority over the employee or follower. This aligns with the concept that leader-follower relationships involve attachment dynamics similar to that of a parent-child relationship (19). Leadership is also similar to parenting in its uneven power, the perception that a leader is stronger and wiser than the subordinate (20) and the dual relationship between instructors and disciplinarians (21, 75). Suppose an employee experiences stress or inconsistent leadership support. In that case, it can activate the attachment behavioral system, resulting in avoidant attachment strategies like distancing from the leader or anxious attachment strategies like proximity and attention seeking from the leader, both of which lead to counterproductive outcomes like not trusting the leader (21) or being hypersensitive to feedback or needing excessive affirmation (7).

One of the other hallmarks of an attachment relationship is proximity seeking during distressing times and maintaining emotional and physical availability for these moments (8). Leaders, like parents, can provide a secure base from which employees can feel safe to take risks and explore (20, 53, 76). As we age and view our parents as less infallible, we look to new attachment figures who are stronger and wiser, such as organizational leaders like managers, religious leaders, psychotherapists, teachers, or coaches (19) (70, 77).

2.6.5.1 *Leaders provide a secure base and safe haven*

Leaders are called upon to fulfil the two most important aspects of being an attachment figure: acting as a secure base and being a safe haven during times of distress (19, 76).

Responsive and supportive leaders have been shown to reduce attachment insecurity (17, 70, 78).

When employees perceive more support from their supervisor, they experience less work distress and overall higher job satisfaction (64). Research by Wu and Parker (2017) showed that when a leader can provide this secure base, their employees show more proactive work behaviors, can take roles with more breadth, show more self-efficacy, and have more autonomous motivation (7). Ronen (2012) found that being an attentive, responsive, and supportive leader is a critical factor in employee job satisfaction and the prevention of burnout. Leaders who provide security (as measured by the Leader as a Security Provider Scale LSPS (79)), create a psychologically safe climate at work, which in turn was significantly related to decreasing burnout.

This has been shown to be especially true in times of stress, such as during the recent COVID-19 pandemic. During this time leaders were sought out for comfort and support by employees regardless of attachment style or ability to work autonomously. Hinjosa, et al (2020) recommended several strategies leaders can apply in these moments of collective stress and uncertainty to foster attachment security including being transparent about what is known and unknown, acknowledging employee concerns, and being available for proximity seeking, including virtually (76).

2.6.5.2 Impact of leader attachment styles

A leader's attachment style, meaning the attachment strategies they generally use in times of stress, impacts employees and subordinates in multiple ways. A leader's avoidant attachment style has been associated with subordinates perceiving lower cohesion among the group and having worse mental health (20, 80). Research has also shown that the mental health of otherwise healthy and well-adapted subordinates can deteriorate when led by a leader who exhibits avoidant attachment behaviors (14, 80). Leaders' anxious attachment style has been associated with employees' emotional exhaustion, lower job satisfaction, and reduced job

performance (20, 81). Leaders who showed more secure attachment were better able to support employees and their outcomes (81).

Insecure attachment was also found to be a potential mediator in situations of authoritarian leadership; the negative impact of the authoritarian leader on a follower's sense of their value to the team was statistically less for workers with higher insecure attachment(82). This side of attachment theory is referred to as social deference theory, where reacting with a more urgent fight or flight response may be beneficial in certain circumstances like a fire or when under authoritarian leadership (82).

Attachment insecurity and job performance can be mediated by an employee's level of trust in their boss (15, 21, 44). Some studies have indicated that the more an employee trusts their supervisor, the more they can focus on work tasks instead of "watching their back," improving work performance (15, 24). One attachment-based approach to leadership has been defined and studied, called Secure Base Leadership (SBL), which focuses on leaders exhibiting the supportive traits of providing a safe haven and secure base as discussed throughout the literature (83). In one study by Laguia et al (2024) of 422 employees, SBL correlated to both task ($p < 0.01$) and contextual ($p < 0.01$) employee performance, with disengaged leaders having a detrimental effect on work engagement and performance (83).

2.6.6 Impact of losing a job

When someone loses their job, the impact has been shown to go beyond the financial implications to trigger mental health distress: anxiety, anger, and depression, reduced self-esteem, suicidal intentions, high blood pressure and physical illness (9). Research has also shown that losing one's job creates a sense of loss that is similar to feelings of abandonment after losing

a critical relationship (9). This may be because the attachment behavioral system can be activated by interpersonal situations, such as organizational events like changes in employment (7, 9).

2.6.7 Diversity and cultural considerations

Attachment is often misunderstood as personality traits, without considering the impact of systemic challenges like racism and other biases. However, when we take a systems perspective, we recognize attachment as survival strategies shaped by these and other challenges (14). A group's attachment style may be required for survival, promoting group functioning (14). All groups need people who focus on different aspects of survival: nurturing, hypervigilance against threats, avoiding fights, and similar (14). Individuals who often use a more anxious attachment strategy are highly perceptive and accurate detectors of threats and can navigate those dangers more effectively and quickly than those who are less anxiously attached (14). Fear of vulnerability is understandable for groups that have experienced ongoing biases like racism and sexism (84). For example, an underrepresented and oppressed group may encourage avoidant attachment strategies, like putting up a hard exterior or acting emotionless, to protect their children from abuse and discrimination. In this situation and others, avoidant behaviors are a survival response, rather than maladaptive (14).

2.6.7.1 Cultural influence on attachment expectations of leaders

Many researchers view attachment science as universal due to the universal need for human connection as a basis for emotional, social, and even physical development, shown through similar patterns shown through research across various cultures (32, 45, 58, 81). It also must be noted that attachment as a universal phenomenon has not been empirically proven, and behaviors viewed as insecure attachment in one culture may be viewed as secure in another (58, 84).

The idea of leadership as similar to parenthood in several key ways may not hold in every culture (85). In one study, which surveyed people across eight countries, there was no consistent definition of the most important leadership traits (85). The differences between cultures that value individualism vs. collectivism also lead to cultural differentiation in leadership and parenting. It has been shown that there is more paternalism in collectivist cultures, like Japan, which leads to employees expecting to be treated more like people instead of workers and expectations for greater job security (85).

2.6.8 Attachment styles are malleable

Attachment styles can change throughout one's lifetime through different positive or negative experiences that can create a more secure or insecure attachment style (44, 46, 53). For instance, when someone can examine contradictions within their internal models or they experience a supportive relationship with someone that matters to them, it can enable a corrective encounter (53, 85). This experience has been called a broaden-and-build cycle, and it has been found in many dyadic settings (70).

While attachment literature sometimes describes attachment style as a personality trait, attachment is dyadic, meaning relationship-specific instead of one attachment style for all relationships (7, 17, 21, 86). Attachment theory draws from systems theory to better understand how each person's response leads to the reaction to the other, which can lead to a problematic cycle. In a relationship, each partner may use insecure attachment strategies like proximity seeking or withdrawing to try and bring the relationship back to secure ground (34). When we see attachment as dyadic instead of a personality trait, it can be seen as more changeable.

2.6.8.1 Leaders can have an impact on an employee's pre-existing insecure attachment

Managers can be a secure base and fulfil attachment needs for acceptance and closeness, even for employees who come in with an insecure attached style (77) which improves the employee's well-being and overall functioning (15, 24). According to Mikulciner (2017), repeated interactions with responsive and supportive leaders can fundamentally alter a person's attachment patterns, internal working model of relationships, and psychological well-being (23). Mikulciner and Shaver (2016) have shown that when there is a real or symbolic supportive attachment figure present, it provides hope and optimism, increasing one's sense of self-worth and confidence in the other person's goodwill because the person feels more loved, valued and viewed as unique (70). This is particularly powerful for employees with an insecure attachment style who have come to expect insensitivity and unavailability, providing them with an alternate worldview, which can change their internal working model of relationships (85). This effect has been found in many dyadic relationships, including teacher and student, married couples, and therapist and client (70). It shows that it is possible through new relationships, even at work, to create a more short-term attachment state, independent of a more general and dominant attachment style (7). These findings align with Bowlby's view of the plasticity of one's internal working model of relationships and attachment (70). Therefore, it is possible for a leader who fosters a secure attachment with an employee to make a real difference to the employee's well-being and risk of burnout.

2.7 Discussion

This narrative review highlights the existing literature on attachment in the workplace and the possibilities inherent in using an attachment lens to understand work-related mental health. The literature suggests that when secure attachment is present, it contributes to better

emotional regulation, lower stress levels, and higher job satisfaction. In contrast, insecure attachment styles are associated with an increased risk of burnout, emotional distress, and lower job performance. The workplace environment, particularly the quality of leader-follower relationships, significantly impacts employees' mental health. Leaders who provide a secure base and act as a safe haven can mitigate the adverse effects of insecure attachment, promoting a healthier and more productive work environment.

The review also underscores the importance of considering attachment within the broader context of diversity and systemic challenges. Attachment strategies that may appear maladaptive in one context might be essential survival mechanisms in another, especially for groups facing ongoing bias and discrimination. This perspective shifts the narrative from one of individual pathology to one of resilience and adaptation. It underscores the importance of recognizing how systemic inequalities shape attachment behaviors and the necessity for therapeutic approaches that are sensitive to these broader socio-cultural dynamics. Therapists and researchers alike must consider these factors to avoid pathologizing behaviors that are adaptive responses to a challenging and often hostile environment. As Marmarosh (2022) suggests, acknowledging these interactions is vital for a more nuanced understanding of attachment and its implications for mental health, particularly in diverse populations.

The literature underscores that attachment is a malleable internal model, not a fixed personality trait. This suggests that regardless of whether an employee enters the workplace with a secure or insecure attachment style shaped by their childhood and past relationships, their work relationships, especially with their leader, can significantly influence and reshape these internal models. For instance, an employee with an insecure attachment, rooted in early life experiences,

may encounter a leader who offers a secure base and a safe haven during stressful moments. This new relational experience can transform the employee's beliefs about their environment, leading to shifts in their attachment strategies and behaviors. Conversely, an employee who begins with a secure attachment may, when exposed to a neglectful or abusive leader, begin to exhibit insecure attachment strategies such as avoidance or proximity-seeking. These findings highlight the critical role supportive leadership plays in employee performance and mental health and challenge the notion that attachment styles are fixed and unchangeable, regardless of early life experiences.

2.7.1 Strengths, limitations & future research directions

One of the key strengths of this narrative review lies in its detailed synthesis of existing literature on the relationship between attachment theory and mental health in the workplace. By integrating findings from diverse studies, this review provides a nuanced understanding of how attachment styles influence employee well-being and organizational outcomes. Additionally, the review highlights the critical role of leadership in moderating these effects, offering practical implications for enhancing workplace mental health through supportive leader-follower relationships. However, several limitations must be acknowledged. Firstly, the narrative nature of the review may introduce selection bias, as the included studies were chosen based on the authors' determination of their relevance as well as availability. Secondly, while the review incorporates studies from various cultural contexts, the generalizability of the findings may be limited due to cultural differences in attachment behaviors and workplace dynamics. Also, there are many additional variables beyond attachment that the literature does not disentangle, like job functions and levels, industries, personalities, education and others. Future studies should consider longitudinal designs that track the evolution of attachment styles in employees over

time and across different cultural contexts to provide a more comprehensive understanding of workplace dynamics. Additional research can also focus on potential attachment-based treatment options for work-related mental health distress, the impact of co-workers on attachment at work, as well as a deeper examination of how culture influences attachment in various workplace environments.

2.7.2 Implications for policy

The findings of this narrative review could have significant implications for workplace policies aimed at improving mental health and well-being. Organizations may consider further fostering supportive leader-follower relationships, which have been shown to mitigate the adverse effects of insecure attachment and enhance overall job satisfaction and performance. Training programs and coaching for managers and leaders could be implemented to help them understand the importance of acting as a secure base and a safe haven for employees, providing both support and opportunities for professional growth. Therapists and coaches could also receive training on the link between attachment and work-related mental health as well as attachment-based tools and treatment options. By integrating these attachment-based approaches into organizational policies and practices, employers are more likely to create a healthier, more supportive work environment that enhances employee well-being, reduces turnover, and improves productivity.

2.8 Conclusion

Attachment theory offers a valuable framework for understanding and addressing work-related mental health issues. Secure attachment has numerous positive outcomes, including better emotional regulation, reduced stress, and higher job satisfaction. Conversely, insecure

attachment can lead to significant mental health challenges, affecting both individual well-being and organizational performance.

Leaders play a pivotal role in shaping the attachment dynamics within the workplace. By fostering secure attachments, they can create an environment that supports mental health and enhances overall productivity. Future research should continue to explore the complex interplay between attachment theory, mental health, and workplace dynamics, with particular attention to the diverse experiences of different employee groups and potential attachment-based treatment options.

2.9 Data availability statement:

This narrative review synthesizes information from previously published studies, reports, and publicly accessible databases. As a review article, it does not involve the generation of new datasets. All data supporting the findings of this review are cited within the text and can be accessed through the references provided. No additional data are available beyond what is included in the referenced sources.

2.10 Publication Statement

This article was published in WORK, 81(3), 2833-2843 in April, 2025.

2.11 About the next chapter

The narrative review in this chapter laid the foundation for understanding the link between attachment and work-related distress. This serves as a basis for the next parts of this thesis: a realist review and evaluation of EFIT, an attachment-based therapy, as a potential treatment for work-related distress. The following chapter offers an overview of the realist approaches, and later chapters detail the methods and findings of the realist review and evaluation.

3 Chapter 3 - Methodology: Realist Approach

3.1 Introduction

The realist approaches (realist review and realist evaluation) were developed by Pawson and Tilley (1997) to provide a methodology focused not just on what works, but on how it works, under what conditions, for whom, and why. This chapter provides an overview of the realist approaches, including their aims, ontology, epistemology, and how they refine an initial program theory into a revised one. I then explain why realist approaches were chosen for this study Chapter 3 approaches and describe the guidelines and standards used. I also include details on the ethics approvals for this study.

3.2 Overview of realist approaches

There are two types of realist approaches:

- Realist review (sometimes called realist synthesis): Used to synthesize existing knowledge and literature to test the initial program theory
- Realist evaluation: Used to evaluate or understand an intervention (or phenomenon) through the analysis of primary data

These approaches are based on the principle that the impacts of an intervention depend on the interaction between the underlying mechanisms triggered and the contextual factors in which it is implemented (87). By examining both mechanisms and contexts, realist approaches offer insight into how and why interventions succeed or fail, highlighting the dynamic interplay between structural forces and individual actions across different settings (87). This approach helps researchers better understand the complexity of causal relationships, potentially leading to improved policy and intervention design.

3.2.1 Ontology and epistemology of realism

Together, ontology, epistemology, and methodology form a foundational framework for how researchers understand the world and develop new knowledge. They guide the collection and analysis of data in the pursuit of truth. Ontology examines the nature of reality and being (88). Epistemology concerns the nature and scope of knowledge (89). Methodology is the systematic approach and theoretical analysis of methods used in a field of study (90), which, for my thesis, will be explored in depth in Chapter 4. Each plays a critical role in shaping this study's research questions, design, and outcomes, and reflects philosophical beliefs that will be described here in more detail.

The ontology of realist approaches, or the perspective on the nature of reality, is grounded in scientific realism, which acknowledges an independent reality that is interpreted through human cognition (88). Realism as a philosophy bridges the objective reality of post-positivism and the subjective interpretations of constructivism. It asserts the existence of a mind-independent reality that both influences and is influenced by the people involved and the contexts in which they are situated (88). This perspective recognizes that outcomes are not only products of observable phenomena but also result from underlying mechanisms operating in specific contexts (87).

Bhaskar (2008) describes three ontological domains in realism: the empirical, the actual, and the real. He refers to this concept as a 'stratified reality.' The empirical domain includes our direct experiences and observations of events, providing evidence for verification. The actual domain consists of events that happen regardless of whether they are observed. Finally, the real domain encompasses both the empirical and actual realms, as well as the realm of causality. Underlying causal processes (i.e., mechanisms) exist in the real domain, influencing outcomes

even though they are often invisible (88, 91). These mechanisms are considered context-sensitive, varying across different situations. An example is gravity acting differently on a tennis ball depending on its environment, such as on Earth or in deep space (92). This view of a 'stratified reality' in three layers challenges the idea of a 'flat ontology,' where only observable phenomena are considered real (87, 93).

From an epistemological perspective, realism necessitates specific scientific methods tailored to each layer of this stratified reality. While empirical methods can observe and measure, the underlying causal forces require theoretical investigation through abductive reasoning, which combines intuition, empirical investigation, and experience (93, 94). Guided by this ontology and epistemology, I employed various forms of reasoning to develop the initial program theory and to confirm, refute, or refine it through the realist review and evaluation (Table 5). For clarity and brevity, I will use the word "test" instead of 'confirm, refute or refine' throughout the rest of this thesis.

Table 5: Different analysis approaches used

	Definition	Example from this thesis
Inductive Reasoning	To develop general theories from specific observations. It allows a researcher to form hypotheses based on patterns observed during data collection. This method is particularly useful in the early stages of research when theoretical frameworks may not yet exist (95).	Identifying change moments in session transcripts and coding emerging themes in NVivo.
Deductive Reasoning	Starts with a theory or broad hypothesis that is tested through specific instances to confirm or refute it (89).	Testing the program theory from the realist review with empirical data from the realist evaluation.
Retroductive reasoning	Proposing new theories or revising existing ones when conventional	Inferring mechanisms within the program theory based on

	explanations don't explain observed phenomena. Often helpful in complex fields such as social sciences and psychology, where multiple causative factors may interact in non-linear ways (96).	attachment theory.
Abductive Reasoning	Used when data are incomplete or ambiguous requiring researchers to infer the most plausible explanation based on the available evidence (97).	Developing the program theory by drawing associations between contexts, mechanisms and outcomes from the data and inferences; Important for EFIT, which is new without a body of research, requiring extrapolation from its parent therapy, EFCT.

These different forms of reasoning improved the rigor and depth of my research, allowing a more thorough understanding of a complex and new intervention like EFIT.

3.3 Defining the realist program theory and the context, mechanism and outcome configurations (CMOCs)

In practical terms, realist approaches start with an initial program theory, which is then confirmed, refuted, or refined through stakeholder discussions, literature review, and empirical testing in the field. The methodology is adaptable, combining both qualitative and quantitative data collection and analysis methods. Realist researchers use the Context-Mechanism-Outcome (CMO) configuration (Table 6) to present findings that make claims about causation, aiming to identify the conditions and mechanisms that produce specific outcomes (87). They use an iterative process to develop and refine these CMO configurations to understand the particular contexts and underlying mechanisms that make interventions successful. Researchers need to adapt methods to uncover mechanisms at different system levels and across various time frames,

considering the invisibility of mechanisms and interactions that may reveal them in the system (91).

Table 6: Context, Mechanism, Outcome Definitions

Context	Context is the setting, characteristics, relationships, environments, and the broader societal, economic, and cultural conditions in which an intervention occurs (98). People will have different perceptions of an intervention depending on the context in which they are introduced, which will influence outcomes (99).
Mechanism	Mechanisms are often hidden until triggered by contexts. It is this interaction that produce outcomes (99).
Outcome	Outcomes are the intended or unintended effects when mechanisms are activated by specific contexts (99).

Realist research recognizes the dynamic and complex interactions of these forces when an intervention is introduced to different populations in various contexts. Feedback loops and ripple effects can occur in realist research, meaning outcomes in one context can become contexts in another (100). It also acknowledges that no theory is ever complete; therefore, each step in the realist process focuses on testing the program theory and refining it. However, a well-developed theory shows strong explanatory coherence, which can be evaluated using three main criteria: consilience, simplicity, and analogy (Table 7) (101, 102).

Table 7: Definition of a well-formed realist theory

Consilient	Explains a broader range of data compared to alternative theories
Simple	Requires fewer additional hypotheses to explain exceptions than other competing theories

Analogous	Aligns with and bears similarities to established theories
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Throughout the thesis, I used these criteria as a guide for the initial and revised program theory, from the realist review through the realist evaluation, and validated my assessment with my supervisors. To be consilient, I aimed to account for as much of the data as possible, using tables and quotes to present evidence. I attempted to create simple and analogous CMOCs that could be easily understood and tested, and that aligned with or refined existing knowledge about EFT and attachment theory. This effort resulted in regular iterations, which are discussed further in the chapters on realist review and evaluation findings.

3.4 A case for a realist approach

3.4.1 What makes EFIT a complex intervention

There are several factors that make EFIT a complex intervention:

- **Experiential:** EFT is an experiential group of therapies that rely on the emotional experience of a client in session as they co-regulate with their therapist, for EFIT and their partner for EFT (12, 27)
- **Attachment Theory:** EFT is rooted in attachment theory, which examines the complex needs of relationships and the survival patterns that develop over a person’s life concerning those relationships. (12, 27) Study of EFIT for work-related stress also involves understanding the complexity of a person’s relationship with their workplace and colleagues (7).

- **Therapeutic Alliance:** The success of EFT depends on establishing a secure, trusting therapeutic relationship. Creating such a connection where clients feel safe to explore and express deep emotional pain is difficult and requires consistent, sensitive engagement from the therapist (12, 29).
- **Change Through Emotion:** Emotions are seen as the driving force for change in EFT therapies, and they are complex in nature. Change in therapy occurs by creating new emotional experiences, or encounters, that can alter how the client views themselves and others (25, 26). As a client's emotions shift, the therapist must observe and manage these subtle or obvious changes, which requires training, skill, and experience (25, 103).
- **Dynamic Process:** EFT uses a dynamic process where the therapist must be highly attuned to the client, their emotions and what is happening in the room and then facilitate emotional heightening, consolidation, and restructuring of their experience. The process requires continual assessment of where the client is within the process and adapting to help them progress (27)
- **Individual Differences:** Each client has their own unique history, present problems, and attachment strategies and styles, requiring a tailored approach by the therapist to enable therapeutic change and progress, while adhering to the evidence-based process, adding additional complexity (12, 29).

All these factors contribute to intervention complexity. Given this, EFIT requires therapists to be trained and experienced so that they can navigate emotional terrain in real-time and safely facilitate deep emotional experiences during sessions. All of this complexity, along with considerations on how to best address the research questions, was considered when selecting approaches for this study.

3.4.2 The realist approaches to complexity

Realist approaches are well-suited to understanding complex interventions because they focus not only on whether an intervention works but also on how, for whom, and under what circumstances (104). They go beyond simple cause-and-effect models and aim to reveal the intricate, often non-linear pathways through which change happens. Complex interventions (such as EFIT) typically include multiple elements, each with its own impact on the situation, which can differ greatly across various settings and populations (104). By emphasizing the mechanisms behind these interventions and the contexts where they are effective, the realist approaches enable researchers to develop more nuanced, transferable knowledge that can be adapted to specific situations (99).

The realist approaches also capture the complexity of how clients interact with interventions like EFIT, which is experiential and relies on a client’s engagement. They view individuals not just as recipients but as active agents whose responses and actions help shape the intervention’s outcomes (88). This perspective is especially important for interventions that depend heavily on client engagement and behavior change, such as EFIT, and is significant in fields like health, social sciences, and psychology. It was also crucial for this study, where I served as the therapist during sessions with clients, and was also involved in creating and shaping data, adding further complexity. Additionally, realist approaches have a way of conceptualizing complexity and Table 8 below sets out how from this perspective, EFIT can be considered to be complex.

Table 8: VICTORE - Realist approaches to Complexity (104)

VICTORE	Key question to understand complexity	How it relates to EFIT
Volitions	What choices do clients have?	Clients have a choice on the type of therapy they

		choose and then choices every moment in therapy as to how they react to an intervention. There are also contextual factors that can impact a client's perceived agency: culture, previous experiences in therapy, experiencing bias and marginalization.
Implementation	What are the implementation processes of the program?	From the time a client has a consult to the completion of therapy, implementation times and specific approach may vary depending on the client's experience, presenting problem, therapist experience and training, and reactions to interventions.
Contexts	What are the pre-existing contexts?	Therapy is embedded within the complexity of a client's identity (race, culture, sexual orientation, and other), existing life and previous experiences, which may involve trauma and challenges within their existing life (relational, financial, medical, and other).
Time	What is the history of the family of programs that this intervention is a part of?	EFIT is a part of a family of attachment-based treatments, EFT. The interventions and processes are the same, but the clients participate individually, requiring some adjustments. Clients may have also had previous therapy and they will be in different stages of change and healing when they enter a new therapeutic relationship.
Outcomes	What are the monitoring systems that will be applied to this intervention and how might they be contested?	Every type of therapy with every type of client can lead to intended and unintended outcomes. No outcomes are fixed and even a response that seems like the outcome at the end of one session or treatment can change or revert in time.
Rivalry	What is the pre-existing landscape of interventions in which the intervention is introduced?	For each client, EFIT treatment is only one of the many focuses in their life competing for their attention, energy and engagement.
Emergence	What are the potential long-term adaptations, societal changes, and unintended consequences associated with the intervention?	The client will bring the outcomes of EFIT therapy into their life, families, communities, which will have an impact on their broader relationships and potential a ripple effect from there.

Pawson's work also highlights the iterative nature of realist research, supporting the continuous refinement of theories through cycles of testing and adjustment. This iterative process is especially well-suited for complex interventions that may need ongoing, real-time

modifications to address changing challenges and opportunities within specific contexts, such as EFIT where therapists must react and adapt during sessions based on client responses. The realist approach, therefore, not only improves understanding of the intervention itself but also fosters stronger and more adaptable implementation strategies that can be maintained over time.

This approach to complexity has been supported by the UK Medical Research Council's (MRC) "new framework for developing and evaluating complex interventions." This new guidance emphasizes the important role of context in how interventions are received and their outcomes (Skivington et al, 2021). The MRC guidance notes that research on complex interventions should consider the specific conditions needed for these interventions to create meaningful change in real-world settings. This not only has the potential to improve intervention outcomes but also to make them more applicable across different settings.

Beyond its capacity to handle complexity, I also chose the realist approach for this thesis because it emphasizes the development of context-sensitive explanations for outcomes, resulting in findings that are not only scientifically robust but also practically relevant, actionable, and potentially adaptable to various other situations (87, 99). This is the first study on EFIT for work-related mental health distress, making it a novel contribution that can provide insights to practitioners and foster dialogue among policymakers about the role of attachment science in the workplace.

3.4.3 Reflexivity

A key component of this thesis is reflexivity, the process by which I critically assess my own experiences, biases, and positions within a social or academic context, and their influence on this research. This was especially important because I was the therapist conducting therapy sessions during the realist evaluation, collecting data from clients while also creating and shaping

data through my own clinical and reflective notes. While realist approaches do not specify the practice of reflexivity, they are complementary.

Through reflexivity, I examined my role within the study and the influence I had on the research. This is essential to the iterative nature of realist research, which continually reviews new findings, including researcher perceptions, to test the program theory. Reflexivity involves recognizing how a researcher's beliefs, assumptions, and social position shape the development of research questions, data collection, and interpretation of findings. Taking an intentional and transparent approach to reflexivity helps balance subjective and empirical aspects within a study. In a realist study, this approach is crucial for maintaining the integrity of the causal explanations central to realist research, as it helps ensure that interpretations and findings are not overly influenced by researcher bias while acknowledging the necessary contribution of my positionality as the therapist and researcher (and as outlined in section 4.4) to the findings (105). Reflexivity was applied throughout this thesis and discussed in the positionality statement in Chapter 4.

3.4.4 The selection of realist approaches over other approaches

The realist approaches were chosen because of their ability to capture the complexity of psychological interventions, such as the real-time emotional dynamics like co-regulation between a therapist and a client, as well as the underlying mechanisms, for example, attachment, but other approaches were considered:

- Narrative approach: While this method would provide a deep insight into the client's personal experience, it would place less emphasis on the causal relationships that influence outcomes.

- Post-positivist moderator / mediator: When focusing on statistical connections between predefined variables, the broader context in which an intervention is used and how that context affects the variables and outcomes can be overlooked. For newer therapies like EFIT, predefined variables may be too limiting and hinder exploration.
- Ethnographic: Focusing on cultural insights, certain contexts (such as work) would be well understood, but causal data might be overlooked.
- Interpretative Phenomenological Analysis (IPA): could have captured rich personal experiences, but it doesn't explain causal relationships or the influence of context.
- Grounded theory: While grounded theory is valuable for developing new theories from data, it is less useful for addressing the layered and complex causal mechanisms involved in therapy and work-related distress. Realist approaches allowed me to build on existing theory and examine how EFIT functions differently across various contexts and individuals.

In contrast, realist approaches recognize and address the complexities of human behavior and how it interacts with specific environments, balancing focus on outcomes, contexts, and underlying causal mechanisms. This can be useful when applying EFIT in workplace settings, where it's important to consider various stressors, cultural dynamics, a diverse population, and other factors.

3.5 Two realist phases: Realist review and realist evaluation

This study was conducted in two phases: literature reviews (informal, narrative, and realist) and a realist evaluation.

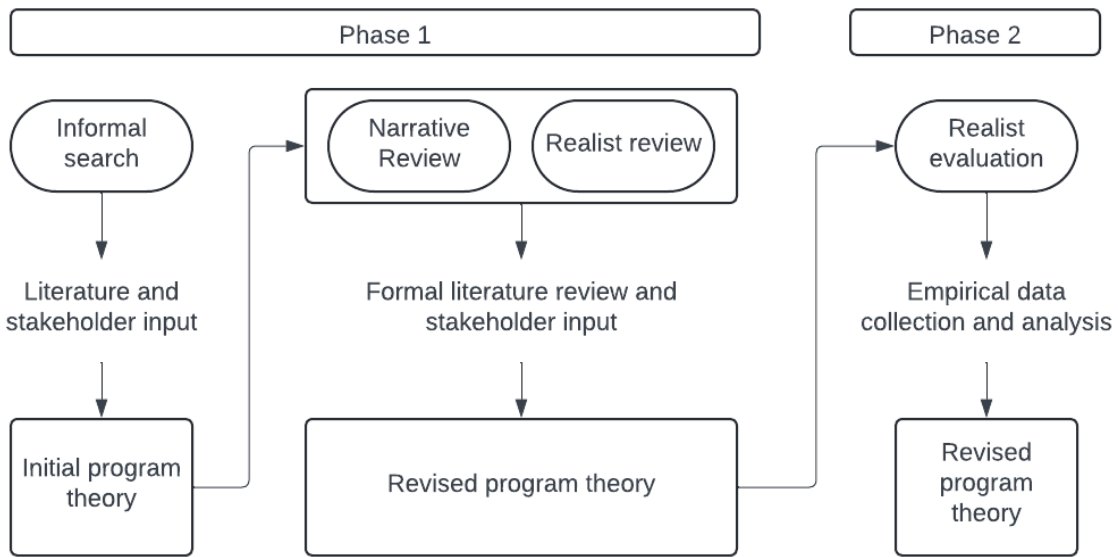


Figure 4: Program theory development

In the first phase, the narrative and realist reviews, I sought to revise the initial program theory by systematically exploring the existing literature on the research questions related to attachment, mental health at work, and the potential of attachment-based EFIT as a treatment. This led to the development of the revised program theory, which outlined the interactions of contexts and mechanisms that may produce desired outcomes. It also helped me identify gaps requiring further research. These gaps guided the second phase of the study, the realist evaluation. This phase involved empirical testing of the revised program theory from the realist review by observing the intervention in practice and examining the outcomes it produces across various contexts. According to Pawson and Tilley (1997), realist evaluation aims to understand “what works for whom in what circumstances and in what respects, and how?” Studying EFIT in a real-world setting provided the opportunity to observe how contexts, mechanisms, and outcomes interact to test and refine the initial program theory from the realist review.

As the realist review progressed and after feedback requesting additional context from my Transfer of Status, I separated out the narrative review to address the research question on the relationship between attachment and mental health at work from the other research questions on EFIT that were covered in the realist review. These three parts across the phases - the narrative review, the realist review, and the realist evaluation - work together to answer the research questions outlined in Chapter 1. The narrative review explains the problem: the relationship between attachment and mental health distress at work. The realist review offers an initial program theory on how a new attachment-based therapy, EFIT, could serve as a treatment for this issue, based on existing literature. The realist evaluation then tests and refines this program theory through empirical research.

3.6 Realist guidelines and standards

While realist approaches offer many benefits for understanding and explaining data, they also present challenges, including the difficulty in identifying and verifying hidden mechanisms and the potential for subjective interpretation of qualitative data. Several guidelines have been developed and used in this study to uphold the aims of the realist review and evaluation.

- Realist Review: Realist and Meta-narrative Evidence Syntheses Evolving Standards (RAMESES I) quality and publication standards (106) serve to guide the consistency and quality of literature searches and reporting of findings.
- Realist Evaluation: RAMESES II guidelines for quality and reporting (<https://www.ramesesproject.org>) (107) to ensure consistency and quality in how the realist evaluation was designed, executed, and reported.

3.7 Practice-Based Research (PBR): Rationale and Integration

Along with adopting a realist approach, I also utilized principles of Practice-Based Research (PBR), a model within psychotherapy and applied psychology (108-112). PBR values practitioner knowledge and real-world complexity, especially in clinical settings, and focuses on creating insights that are immediately useful in practice. While PBR is separate from realist approaches, the intent and guidelines were not in conflict. The Realist approach provides the structure and logic that ensure rigor and transparency. PBR focuses on what happens within that structure - the lived, relational process of therapy where knowledge is created through practice. Using both allows me to stay systematic as a researcher while staying true to the reality of my work as a therapist.

A key reason for including PBR was my decision to act as both therapist and researcher in this study. While this choice introduced ethical and methodological challenges, it also reflected a core principle of PBR: that valuable knowledge can be created through practice, not just about it (110). Instead of seeing this dual role as a threat to objectivity, PBR frameworks recognize that such positioning can enhance understanding, provided appropriate reflexive and validity-enhancing strategies are employed (108, 110). Far from being a methodological problem, this approach is an accepted aspect of practice-based research and is especially relevant when the goal is to develop “clinically representative” knowledge based on routine care (113). PBR advocates argue that small-scale or even single-therapist studies are legitimate methods for exploring context-specific therapeutic processes and outcomes (113, 114).

From the beginning, I understood that being a self-funded doctoral student influenced how I designed and conducted this study. I also recognized that the thesis included several innovative elements, making it a highly exploratory project with the potential to impact future research. Considering this early stage, using my own therapy practice and taking on the role of therapist seemed like a suitable and proportional initial step. There were also benefits to this approach. The therapist-client relationship is crucial to EFIT's effectiveness. My dual role gave me insight into the subtle emotional and relational dynamics that often drive therapeutic change. PBR provided a rationale for this method, supporting my ability to incorporate research directly into clinical practice (108, 109). I upheld the validity of this study's findings through strategies commonly used in practice-based research. These included (111):

- Data Triangulation: Comparing data sources between session transcripts, post-session questionnaires, field notes, and client feedback using realist approaches
- Reflexive memos written after sessions to capture therapist reasoning and decision-making
- Auditing of initial interpretations through discussions with supervisors and peer researchers
- Iterative theory refinement based on both clinical and analytic insight.

These approaches do not aim to eliminate the practitioner's influence but instead focus on how therapeutic change develops in context through the practitioner's work. As Barkham et al. (2007) note, knowledge derived from clinical practice is often the most likely to be adopted by

other clinicians, provided it is generated with care, transparency, and methodological integrity (115).

In short, the decision to incorporate PBR was both practical and philosophical. It reflected the real constraints of my role as a working therapist and self-funded researcher, as well as the exploratory phase of this research. At the same time, it aligned with my view that useful, transferable knowledge in psychotherapy often comes from within the therapeutic relationship itself. By explicitly recognizing and structuring around this dual role, I aimed to produce findings that are not only theoretically sound but also directly applicable to practitioners working in similar real-world settings, while still offering academics guidance for future research.

3.8 About the next chapter

In the next chapter, I describe the methods used in the realist review and realist evaluation to develop the program theory.

4 Chapter 4 - Methods for Realist Review and Realist Evaluation

4.1 About this chapter

This chapter outlines the methods used to answer the research questions through the realist approaches discussed in Chapter 3: realist review and realist evaluation. It provides an overview of stakeholder, patient, and public involvement, then moves into the specific methods of the realist review and evaluation. A positionality statement is included, along with an overview of ethical considerations.

4.2 Methods Introduction

EFIT is a complex intervention with outcomes that vary depending on the context. As discussed in the last chapter, realist approaches, which focus on understanding the contexts and mechanisms that influence outcomes, were chosen to better understand and explain how and why EFIT may produce outcomes in different contexts. While EFT has extensive research supporting it, EFIT is new, and understanding the contexts and mechanisms that might lead to outcomes can aid in its application during this early stage. The aim of the realist review is to develop the program theory based on existing relevant research. This theory will then be refuted, confirmed or refined (i.e. tested) through a mixed-methods realist evaluation. The iterative process and program theory focus of realist approaches allow for an exploratory study of this new therapy, providing valuable insights into its contextual and practical aspects.

4.3 Stakeholders and Patient & Public Involvement

A stakeholder group was formed to offer diverse perspectives on the program theory and to help address participant safety concerns in the research. The composition of the stakeholder

group evolved as the study progressed, with different members joining or leaving over time.

One-on-one discussions with stakeholders included topics such as:

- Guidance and input on the realist program theory
- Feedback on the credibility and completeness of the program theory
- Where to find potential additional data and provide introductions as needed
- Disseminating findings

The Stakeholder group was sourced from my personal network of therapists and business professionals, a request for interested participants through LinkedIn newsfeed, and through snowballing. The group comprised of:

- Practitioners: therapists and researchers with expertise in EFT
- Potential participants: Employees and managers
- Policymakers: human resource (HR) leaders and others leading diversity, equity & inclusion (DE&I) or mental health in the workplace programs

Topics of the discussion with stakeholders focused on their areas of expertise and direct experience. The summaries of input from stakeholders that helped form the initial program theory are included in Table 9.

Table 9: Stakeholder input summary for the initial program theory during the realist review

Stakeholders	Date & Number of Stakeholders	Topics	Examples of stakeholder Contribution
Practitioners: EFT Therapists & Other Professionals	October - November 2022; April- July 2023 (5 Stakeholders)	<ul style="list-style-type: none"> • What makes EFT and EFIT effective in your experience? • Under what circumstances is EFT and EFIT effective and less effective? • Input on initial program theory • Additional contacts that 	<ul style="list-style-type: none"> • The key to EFT and EFIT outcomes is making sense of emotions and sharing them with someone who matters (the encounter) • EFT / EFIT are similar to exposure therapy and require a safe enough therapeutic relationship to take a risk • Therapeutic alliance helps

		could provide insight into the program theory	<p>create the window of tolerance to have an emotionally corrective experience through an encounter</p> <ul style="list-style-type: none"> • Recommendations for assessments to use in the realist evaluation • Feedback on realist review CMOCs
Potential Patients / Clients	October 2022 (4 Stakeholders)	<ul style="list-style-type: none"> • Difficult work experiences, the impact on them, what led to the situation, and what they did about it that helped 	<ul style="list-style-type: none"> • Feeling like boss 'didn't have their back' - lack of trust - led to feelings of intense panic, stress, burnout and anxiety as well as insomnia, increased drinking, and appetite changes. • Made them want to leave role. • Peer support was helpful but not enough to stop thoughts of leaving • Understanding 'I'm not crazy' and 'it's not me' helped
Polymakers: HR and DE&I personnel	October & November 2022 (4 Stakeholders)	<ul style="list-style-type: none"> • Their experience with employees who are experiencing mental health distress in the workplace: the situation, the impact to the employee and organization, and what helped • Groups they found to be more susceptible than others • Help they feel they need to support employees more effectively 	<ul style="list-style-type: none"> • Managers are often uncomfortable having meetings with employees because they "don't know what to say." • Mental health at work remains a highly stigmatized topic – the linkage between mental health and weakness • But mental health is becoming a more important topic due to absenteeism, a younger employee population who is more open about mental health concerns and DE&I and ESG metrics becoming a focus • The problem is systemic – within the organization and the values that capitalism rewards

Throughout the realist review and the realist evaluation, I continued to gain insight into the program theory and overall study process weekly with an EFT certified therapist. I also had email exchanges with EFIT researchers at University of Ottawa (July 2023) and Columbia University (June 2023) for insight and feedback on the realist evaluation protocol.

4.4 Positionality

As a clinician and researcher who actively participated in data collection during the study, reflexivity was essential throughout to acknowledge and address potential bias. To create this positionality statement and reflect on my role and what I contribute to the study, I followed a reflexivity guide commonly used in qualitative research that considers this issue using the four domains outlined below (116).

4.4.1 Personal Reflexivity: How are my unique perspectives influencing the research?

My decision to focus on the connection between attachment and mental health at work was based on my experience as a practicing psychotherapist and executive coach, as well as the trends I observed with clients in my practice. I was familiar with attachment-based EFT through my training as a couples therapist and its recent extension to individuals with EFIT, which led me to choose this modality for the study. While these experiences informed and guided the development of the research questions and objectives, I am not solely an EFT or EFIT therapist in my practice, nor do I have a personal stake in the study's results beyond using them to inform clinicians and improve my own techniques for better outcomes.

Being both the therapist and the researcher in this study provided me with unique and intimate insight into the process. However, it also meant that I was involved in generating the data, which could introduce bias. I recognized this and took detailed clinical and reflective notes after sessions and throughout the study, which became data for the study. Additionally, I met with my clinical supervisor weekly to discuss all cases and help ensure adherence to the EFIT model.

Beyond my therapeutic background, my business experience also provided me with insight into the contexts clients experienced and the potential mechanisms involved. This

knowledge meant I had to ensure that what I was hearing was actually what was said, not just what I inferred based on my background or what I have seen in my executive coaching practice. Coding the transcripts and finding the words to test CMOCs also helped make me aware of these biases.

Being a therapist is also a highly reflexive practice by nature. Continuously observing countertransference (such as feelings of fear, anger, concern) with clients, noticing sensations in the body (like a tight chest from anxiety) as the client shares a story, and recognizing small changes in a client's facial expressions, energy, or resistance can indicate an obstacle to overcome or the need for greater task alliance. All of these guide the therapeutic process and are documented in clinical and, in this study, reflective notes, which are then discussed with other therapists in a consultation, and in this case, with a clinical supervisor.

4.4.2 Interpersonal reflexivity: what relationships exist and how are they influencing the research and the people involved? What power dynamics are at play?

One of the main relationships in the study is between me, the therapist / researcher, and the client. Similar to a researcher and participant, there are power dynamics between any clinician and client, where the client may try to please the therapist by saying what they think the therapist wants to hear. As a therapist, I am continually aware of this transference, questioning it directly during sessions, and I did the same in the study. I also employed triangulation methods to verify what participants shared in sessions: final session interviews, post-session surveys, and assessments. At the start of the study, I also instructed each participant to answer the post-session surveys and assessments honestly, assuring them that all insights are valuable for the study and that they shouldn't worry about how their responses might affect me or the study.

The therapeutic alliance is a vital part of any therapy and is considered a key factor in therapeutic outcomes. Outcomes are inherently connected to the participant's relationship with me as their therapist. This complexity needs to be recognized as an important context in the study. That said, through coding, I focused on the key micro-interventions used in sessions to broadly identify which aspects of the modality were shown to impact outcomes.

4.4.3 Methodological reflexivity: How are we making methodological decisions and what are their implications?

As discussed in Chapter 3, I chose realist approaches after considering and evaluating other options, taking into account the exploratory nature of the research questions. The iterative nature of realist approaches also requires ongoing reflexivity to assess the data collected and test the program theory. This iterative process was used throughout the realist review and evaluation as I continuously assessed the appropriateness and level of data needed to test the program theory.

Realist approaches also employ abductive and retroductive reasoning to develop the program theory. This involves making inferences to identify the contexts and mechanisms that might lead to outcomes when data is incomplete. Conventional explanations about workplace pressure didn't fully account for the disproportionate distress, but attachment theory provided additional insight. I recognized that my background in business, therapy, and conducting this study could bias my interpretation of events and inferences. To manage this, I discussed cases weekly with an EFT-certified clinical supervisor and validated data through clinical notes for my interpretations, therapy transcripts to verify what was said in sessions, assessments to track

participants' experiences before and after therapy, and post-session surveys to monitor therapeutic progress.

Also, since EFIT is a newer therapy and most of the current literature focuses on its use with couples through EFCT, I had to be reflexive about what can and cannot be extrapolated when developing the initial program theory. Since they both share the same basic steps and micro-interventions, there was a solid foundation for the program theory from the review to be tested in the realist evaluation. However, the exploratory nature of the review and the use of extrapolation were limitations that required ongoing reflection and acknowledgment.

Additionally, due to the limited research on EFIT, I incorporated input from stakeholders to help shape the initial program theory and assist with data collection. Balancing insights from stakeholders and practitioner experts required ongoing reflection, questioning where their insights came from and how they related to or differed from the literature and other perspectives. In this study, stakeholder feedback was additive rather than conflicting. This may be because of the strong existing evidence on EFT. An exception was when I was exploring ways to validate the EFIT process used in the realist evaluation, and I discussed options with other researchers and practitioners. There was disagreement over the usefulness of a new scale for EFIT adherence between two researchers, which was significant enough that I chose not to use it. Instead, I focused on clearly documenting the tango steps and reviewing my sessions with participants alongside my clinical supervisor (who is EFT certified) to ensure adherence to the EFIT model.

4.4.4 Contextual Reflexivity: How are aspects of context influencing the research and people involved?

Contextual reflexivity played a key role throughout the study, from deciding to focus on attachment in the workplace to choosing realist approaches, which highlight the importance of context as part of the program theory. Participants attending sessions to discuss work brought a different dynamic to therapy than those who might be there only to talk about personal challenges. I often observed the professional posturing (trying to impress) from participants during sessions, which made it harder to access more vulnerable emotions. I regularly reflected on the study's context in clinical and reflective notes to better understand the biases and challenges influencing the sessions, recognizing how the context could affect outcomes.

The study itself also introduced a new context for participants, a space where they could come every week to critically reflect on and process their work experiences and personal cycles with another trained person. This new therapeutic relationship and environment also created moments throughout their week where they would note things to discuss in session or see a meeting differently based on session discussions.

Participants were also working and attending therapy within the broader context of a moment in U.S. history marked by significant political polarization and acknowledgment of systemic oppressive forces that many in the study directly encounter at work. Several participants described these forces as related to their identities, such as being Jewish, women, Native American, Asian, gay, over 50 years old, or having emigrated to the U.S. All of these identities, along with others, influenced their work experiences and therapy sessions, alongside my identities as a therapist who is white, heterosexual, cisgender woman born in the U.S. in my 40s. As with all therapy sessions, whether part of the study or not, I stayed aware of my identities

and their influence on participants, as well as the broader societal impacts they face. I actively worked to create space for all identities and open discussions about their experiences during sessions.

4.5 Realist Review Methods

A realist review is a specific type of interpretive and theory-driven literature review that focuses on developing an initial program theory and then confirming, refining, or refuting it using existing literature and other types of documents. The purpose of the program theory is to explain how, why, in what contexts, for whom, and to what extent interventions work.’ To provide this explanation, the program theory uses realist causal explanations of outcomes, which take the form of context-mechanism-outcome configurations (CMOCs) (117).

I followed a detailed realist review protocol based on the five iterative steps developed by Pawson (2002): (1) locating existing theories, (2) searching for evidence, (3) selecting articles, (4) extracting and organizing data, and (5) synthesizing evidence and drawing conclusions (Figure 5). The steps in the process are iterative, not linear, moving forward and backward based on what is learned. Findings were documented following the Realist and Meta-narrative Evidence Syntheses Evolving Standards (RAMESES) publication standards (118). The protocol was registered with Prospero on April 4, 2023 (CRD42023408450), and the review lasted from October 2022 to November 2023.

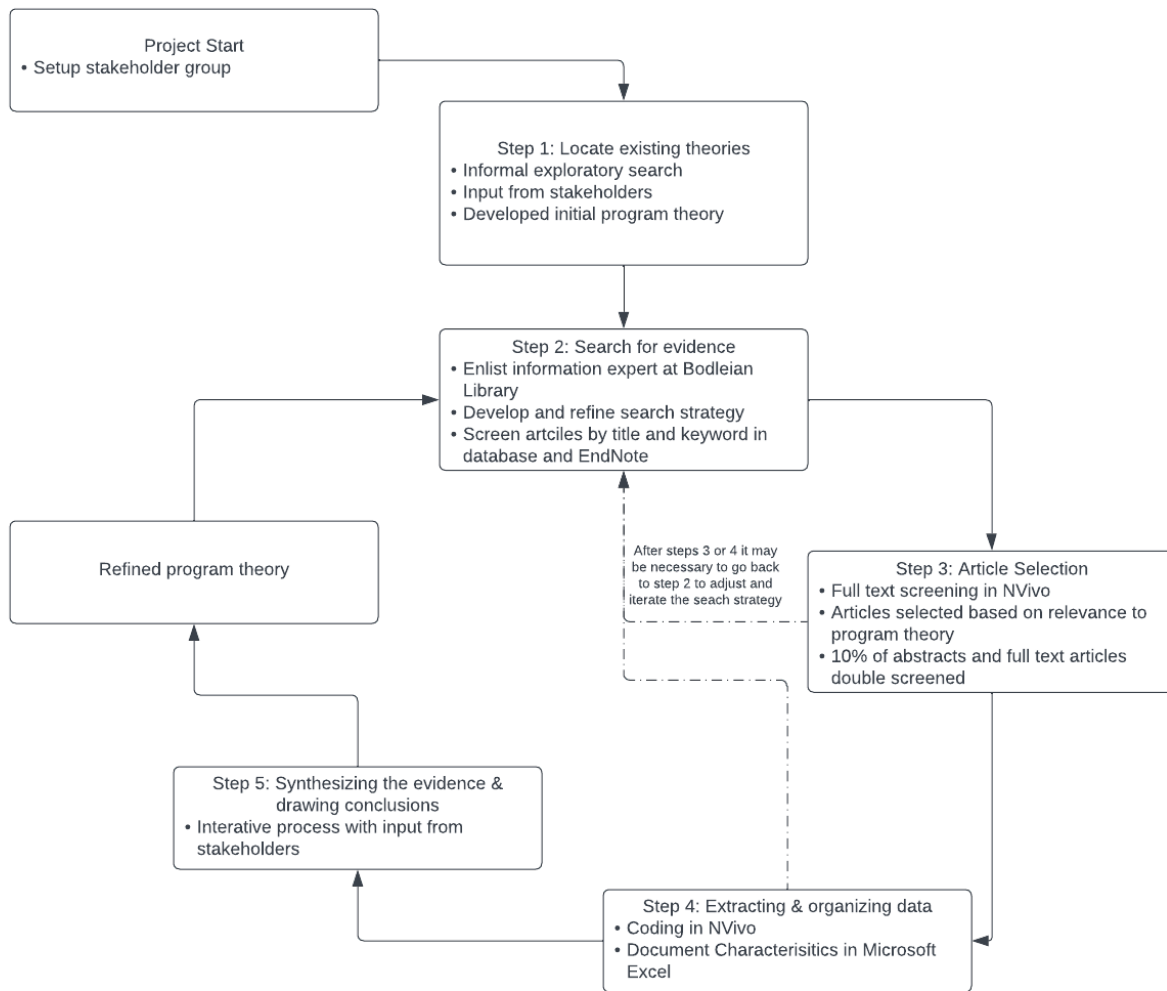


Figure 5: Realist review steps (119)

4.5.1 Step 1: Locate Existing Theories

The goal of this step is to identify any potential theories that could explain how, why, for whom, and under what circumstances an attachment-based therapy like EFIT could treat work-related mental health distress. An exploratory and informal search of relevant literature, including my personal library on EFT and attachment at work, as well as one-on-one discussions with stakeholders, provided the input for the initial program theory.

At the time of the realist review, there were no major studies on Emotionally Focused Individual Therapy, so the initial program theory was based on exploratory literature searches focused on the potential mechanisms that lead to treatment outcomes in attachment-based Emotionally Focused Therapy with couples (EFCT), which has been extensively studied. This extrapolation is possible because EFIT shares the same foundation in attachment science as EFCT, and both utilize similar intervention steps and micro-interventions throughout sessions. The program theory and its mechanisms guided the formal literature search to better understand the broader context of therapeutic application and identify areas for future research. Common factors underlying psychotherapy outcomes were also examined.

Since Emotionally Focused Therapy is based on attachment theory, understanding the attachment dynamics in the workplace and their potential role as a mechanism underlying workplace distress was also examined. An inclusive approach was used without restrictions on the type of study or document. This stage was not intended to be exhaustive, and gaps were expected to be filled gradually throughout the review process. The stakeholder group was consulted on the evolving program theory as new insights emerged from stakeholder conversations and articles.

4.5.2 Step 2: Search Strategy

The goal of the search strategy in a realist review is to locate the secondary data necessary to develop a more detailed program theory and to confirm, refute, or refine the initial program theory from step 1. The formal search strategy was created and implemented with assistance from an information specialist from the University of Oxford's Bodleian Library.

Since there are no published empirical studies and few documents on EFIT, the focus was on EFCT and the relationship between attachment and mental health in the workplace. The final search strategy employed the PICO (Population, Phenomenon of Interest, Context) search question formulation tool (Stern, 2014):

- Population: Business leaders, employees
- Phenomenon of Interest: The potential for attachment-based and experiential therapies like Emotionally Focused Individual Therapy as a treatment
- Context: Relationship between attachment and mental health at work, and its impact, including stress, burnout, and other mental health distress symptoms

An iterative process of adding, refining, and removing search terms was used to achieve the right level of specificity and inclusion. When database results were too broad from certain search terms, results were filtered with more specific search terms, and articles were sampled based on relevance or meta-analyses were sought when available. Sources included PsycInfo Database, SCOPUS, Google Scholar, and citation tracking and snowballing (Appendix A: Database Search Log). I contacted the authors to gather further data as needed. Search results were exported to EndNote 20 for screening. Google Alerts were set up for key terms (“emotionally focused individual therapy,” “emotionally focused therapy,” “mental health and work,” “attachment at work,” “attachment and work”) to stay updated on ongoing research. Although no new articles were added from the alerts, one article was shared by a stakeholder that was relevant and is mentioned in the realist review findings.

4.5.3 Step 3: Article Selection

Articles were chosen based on the inclusion criteria listed below and their relevance to informing the program theory (Table 10). Articles were initially screened by title and keywords in their database, then by their abstract in EndNote to evaluate their potential to inform the program theory. A full-text review was conducted in NVivo 12 (120).

Table 10: Inclusion and exclusion criteria

Inclusion Criteria	<ul style="list-style-type: none"> • All articles on EFIT • All systematic reviews and metanalyses on EFT • Articles containing relevant data on mechanisms and outcomes of EFT with a focus on EFT with different populations (cultural, race, sexuality, partners with depression or trauma), and in different environments (online vs. in person, couple vs. group, and similar), • All articles on the relationships between attachment and mental health distress in the workplace • Articles containing data on common factors and other experiential therapies like Eye-Movement Desensitization and Reprocessing (EMDR) and exposure therapy, which share some similarities with EFT (strengths-based, evidence-based, experiential) • All document and study types included.
Exclusion Criteria	<ul style="list-style-type: none"> • Studies not in English • Studies not with working-age (<18 years of age) adults • Studies that focused solely on EFT supervision and training.

To ensure consistency with my use of inclusion and exclusion criteria, a random ten percent of abstracts was reviewed by GW in Rayyan (a free tool to assist researchers in screening documents), and ten percent of full-text articles were reviewed by AF in EndNote. One discrepancy arose during the abstract review and was resolved through discussion between GW and DM; no questions or inconsistencies emerged during the full-text review. Citation tracking and snowballing continued throughout the remainder of the review. All included articles and their characteristics were extracted into an Excel spreadsheet (Table 19).

4.5.4 Step 4: Extracting and Organizing the Data

Full-text articles were uploaded to NVivo and coded. Initial coding covered symptoms from work-related stress, leadership traits, EFT process steps, and micro-interventions. The development of codes was both inductive (based on themes from the literature) and deductive (based on the initial program theory from step 1). After coding, the codes were organized by theme and whether the content likely functioned as contexts, mechanisms, and/or outcomes (CMOCs).

Based on this categorization, potential contexts, mechanisms, and outcomes, along with their relationships, were outlined in Lucid.app, an online mental mapping tool. The mapping was created by starting with an outcome of interest within the program theory and then working backwards using available data to interpret which mechanism may have produced that outcome and the context that triggered it. Mechanisms were often not explicitly noted in the literature, so where necessary, they were inferred based on stakeholder input and logical reasoning. CMOCs were iteratively refined as understanding of the literature evolved and conversations with stakeholders continued.

4.5.5 Step 5: Data Synthesis and Drawing Conclusions

I refined the initial program theory through an iterative process, based on discussions with stakeholders and data that were extracted and coded in NVivo from the articles. I also used attachment theory as a substantive theory to shape the development of the program theory and CMOCs. It provided the framework for understanding how EFIT’s therapeutic interventions might trigger specific mechanisms depending on the context. For example, the idea of the therapist acting as a secure base and attachment surrogate came directly from attachment theory and informed the development of CMOCs. I applied this mechanism in contexts where a strong therapeutic alliance allowed clients to explore vulnerable emotions safely. Attachment theory also helped me conceptualize how clients’ internal working models could shift through therapy, which I used to develop CMOCs focused on emotional regulation and corrective emotional experiences. The theory’s emphasis on emotional co-regulation was particularly useful for explaining how EFIT’s emotionally focused techniques deepen emotional experiences, helping clients shift maladaptive attachment patterns and reduce mental health distress in different settings. By embedding these theoretical elements into the CMOCs, I was able to ground the program theory in established psychological mechanisms like attachment, providing a clearer understanding of how EFIT works.

Judgments were made about the relevance and rigor of the included articles using the following questions (Table 11) (121):

Table 11: Questions to evaluate relevance and rigor of articles (121)

Relevance	Does the article include data that could be relevant to the program theory?
Judgment of	Are the data sufficiently trustworthy to warrant refining or changing the

trustworthiness and rigor	program theory?
Interpretation of meaning	Could the data inform the contexts, mechanisms or outcomes within the program theory?
Interpretation and judgements about CMOCs	Does the data in this document or other documents further inform that CMOC? How does it relate to other CMOCs?
Interpretations and judgement about the program theory	How does this CMOC relate to the program theory? Does the program theory need to change in light of this CMOC?

CMOCs were created from data in the literature and by comparing them with data in other documents. Several forms of reasoning were used in CMOC creation, as recommended by Pawson (Table 12) (87):

Table 12: Types of reasoning used in the realist review

Type of Reasoning	Definition	Examples from the realist review
Induction	Identifying patterns or regularities from specific observations or cases	Constructing patterns and CMOCs from EFT observations and experiences in the literature
Deduction	Testing a theory by applying general principles to specific cases and seeing if the theory holds	Testing CMOCs through data presented in the literature
Retroduction	Retroduction is the process of reasoning back from an observed outcome to infer the underlying causal mechanisms	Inferring attachment is a mechanism under EFT's outcomes
Abduction	Developing a hypothesis that offers the best explanation for observed phenomena, often by incorporating new or unexpected factors.	Extrapolating CMOCs for EFIT from literature on EFT
Juxtaposition	Placing different pieces of evidence side by side to reveal contrasts or similarities	Comparing EFT case studies with other therapies to highlight unique interventions in EFT, like encounters
Reconciliation	Seeks to align seemingly contradictory findings by understanding how context	Differences in outcomes based on cultural background were reconciled by considering

	shapes outcomes	how varying social contexts influence attachment styles
Consolidation	Drawing together diverse findings or partial explanations into a coherent whole	Drawing together findings from diverse studies to form a coherent explanation of how EFT functions across different contexts
Situating	Placing findings within their specific contexts to understand how they operate in real-world settings	EFT's impact on workplace mental health was situated within the broader context of workplace stressors and attachment needs in professional settings

I shared CMOCs with stakeholders for ongoing input. During the review, I also gathered information on the areas where my realist evaluation needed to focus to develop a more comprehensive program theory. At the end of step 5, I refined the initial program theory in preparation for the realist evaluation.

4.6 Realist Evaluation Methods

I conducted a realist evaluation to test the program theory developed in the realist review using data from a real-life therapeutic setting. The purpose of the realist evaluation is to test the program theory from the realist review to understand how, why, and under what conditions EFIT may address work-related mental health distress in practice. The realist evaluation was especially important for this study given the limited research directly on EFIT, which required extrapolating from EFT with couples to develop the program theory in the realist review. In the realist evaluation, I was able to observe the outcomes and underlying mechanisms in context to test the program theory in practice.

This approach was important for an intervention like EFIT, which is complex and sensitive to context. EFIT works by engaging with deep emotional processes, and the therapeutic outcomes depend on factors like the client's attachment style, the therapeutic alliance, and the workplace environment where distress appears. Traditional evaluation methods might miss these complexities by only looking at outcomes, while realist evaluation helped me uncover the processes behind those outcomes, such as what mechanisms were triggered, for whom, and in which contexts. Additionally, realist evaluation is iterative, allowing me to keep refining the program theory with new insights, which is important for a new, evolving, and relational treatment like EFIT.

To address these complexities and provide a thorough evaluation, I employed a mixed-methods approach to collect data. I gathered both qualitative data (session transcripts and therapist notes) and quantitative data (assessments, end-of-session surveys, and heart rate monitoring). This mixed-methods approach offered insights into how EFIT might work, enabling me to test the initial program theory from the realist review. The realist evaluation took place from March 2023, when I developed the study design, through December 2024, when I finished analyzing the findings (Figure 6).

I also had to balance being the therapist and the researcher in this study and used a Practice-Based Research approach (112). This approach encourages using various types of literature and assessments, extensive data collection, assessments at the point of intake, structured progress monitoring, consultation with another professional to review study plans and progress and investing time in research skill development. All of these have been followed and detailed throughout this section.

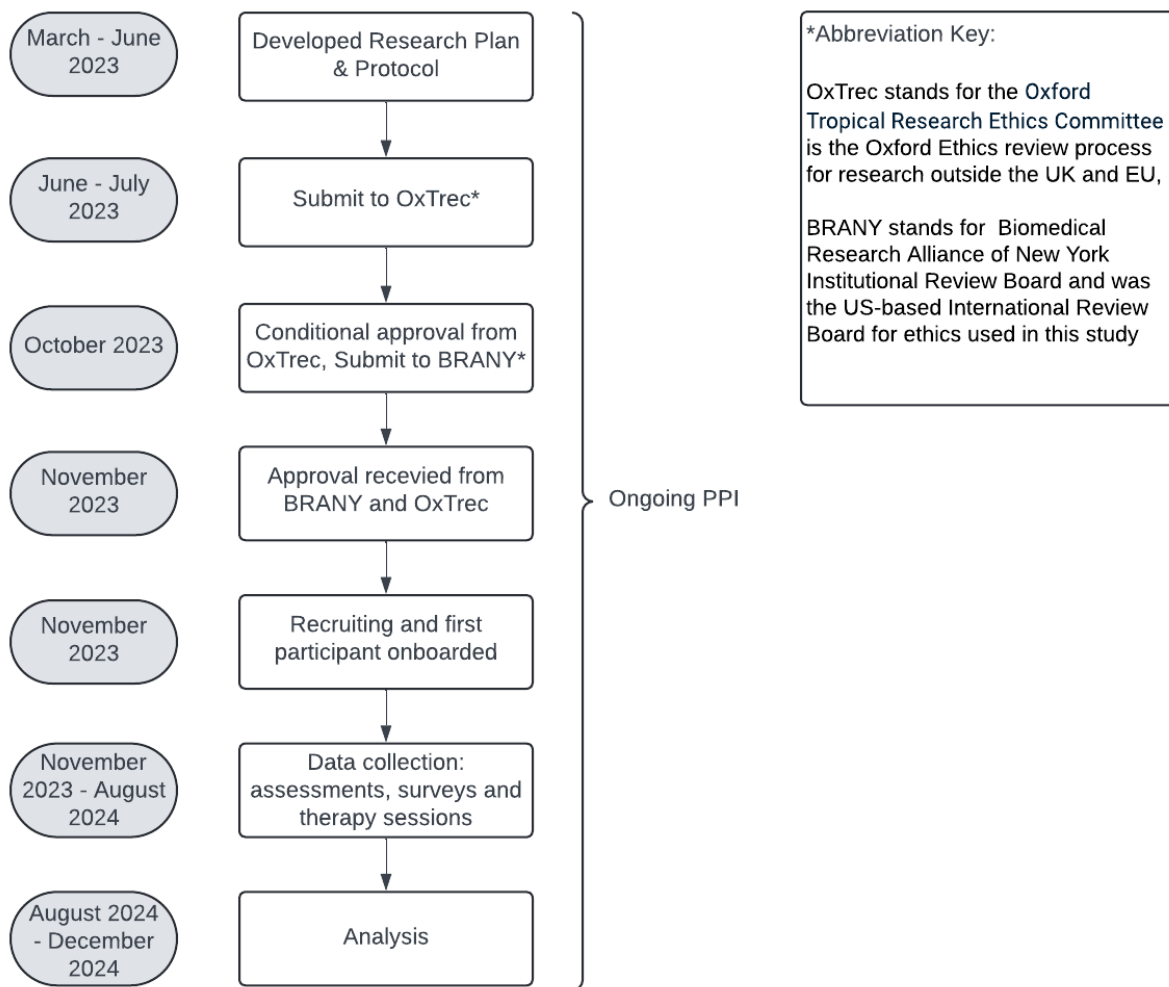


Figure 6: Realist Evaluation Timeline

4.6.1 Ethical Considerations and approvals

I took numerous precautions to protect the safety, privacy, and well-being of participants, who were recruited from a population already experiencing distress. To facilitate informed consent, participants received a detailed information sheet explaining the study and their role, and they had the chance to ask questions during an intake consultation before agreeing to participate. They were informed that participation was voluntary and that they could withdraw at

any time. The consent process adhered to guidelines from the ethics review boards that reviewed and approved the protocol, ensuring participants understood their rights, including confidentiality, and what to expect if they chose to participate.

To maintain confidentiality, participants were given unique identification codes to protect their identities throughout the research. All personally identifiable information was separated from research data to ensure anonymity, and it was stored on a HIPAA-compliant platform commonly used by therapists in the U.S. (Note: HIPAA is the US Health Insurance Portability and Accountability Act of 1996 that sets national standards for handling healthcare data). Research data, labeled by participant code, was stored on the University of Oxford's Microsoft 365 OneDrive, where session recordings were stored, transcribed, and then deleted once transcription quality was confirmed.

During therapy sessions, I monitored participant distress and provided support and additional resources as needed. Participants were informed about the possibility of emotional distress as a natural part of therapy during informed consent. At the end of their participation in the study, I discussed and supplied any additional resources needed.

I also screened for high-risk indicators like suicidality and untreated addiction during the intake process. Participants who exhibited significant risk factors were given additional appropriate referrals. Emergency protocols were also established for participants in crisis, such as referrals to the suicide hotline or emergency services (e.g., 911) if necessary.

The realist evaluation was reviewed and approved by University of Oxford (OxTrec) and by BRANY, a US-based ethics review board, in November 2023.

4.6.2 Evaluation focus

While all CMOCs are discussed in the review, I chose to focus on CMOCs 4-9 from the realist review during the evaluation phase. This allows for a focus on mechanisms that are less understood but critical to EFIT's effectiveness in various workplace settings. CMOCs 1-3, which emphasize the importance of the therapeutic relationship for achieving desired outcomes, are well studied and widely recognized as common factors across most therapies. CMOCs 4-9 investigate more subtle processes such as identifying coherent emotional narratives, facilitating corrective emotional experiences, shaping interactions, and revising internal working models of relationships. These areas are more specific to attachment-based therapy and to EFIT.

These CMOCs offer insight into how change can happen on a deeper emotional level. For example, identifying a coherent emotional narrative (CMOC 4) helps participants better understand their distress and reframe their emotional responses to workplace stressors. Revising internal working models (CMOC 9) influences how participants view others both inside and outside of work, making it easier or harder to seek support. Focusing on these less-explored but essential areas of the initial program theory increases the likelihood that this study will provide new insights into how EFIT helps treat distress.

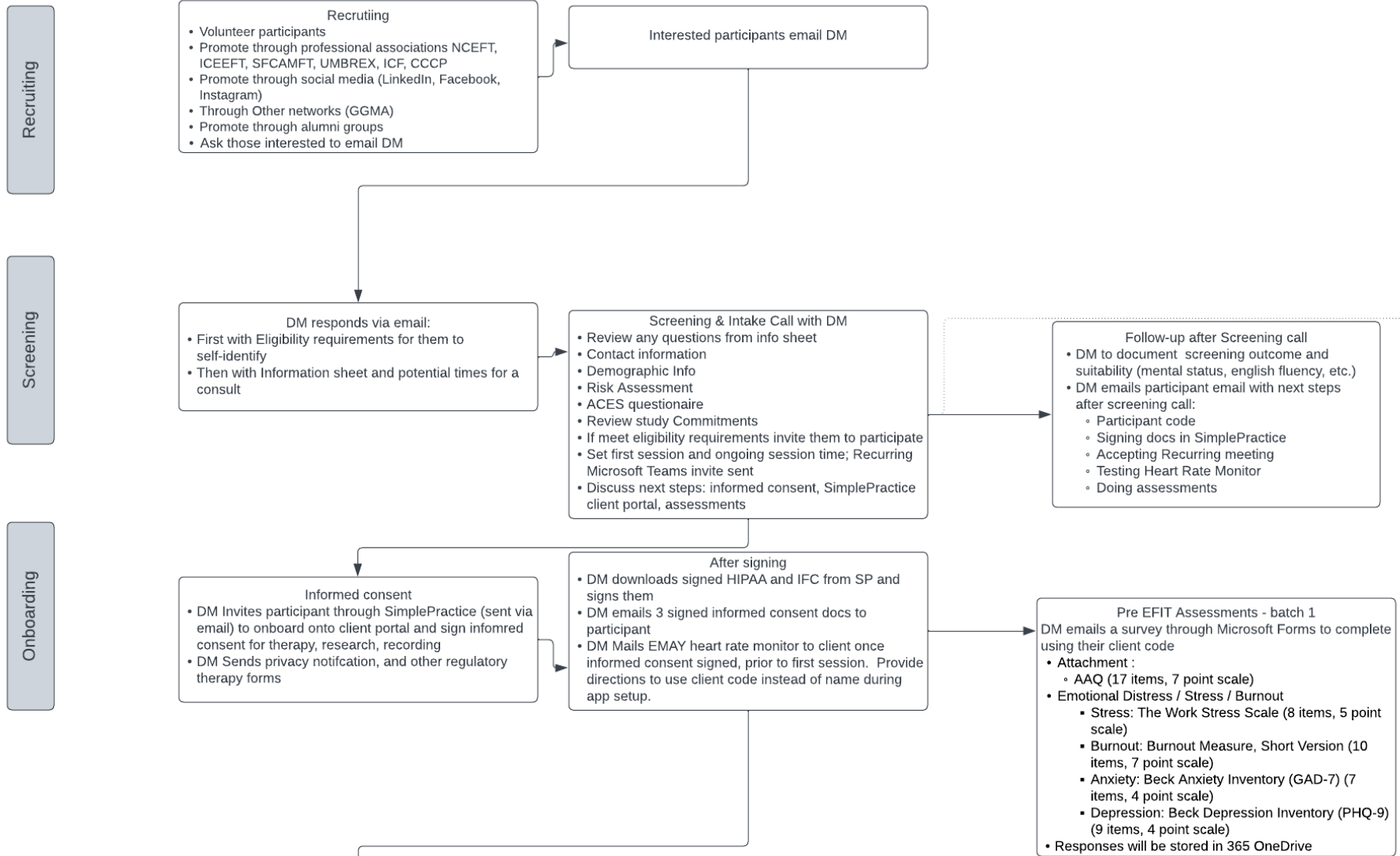
4.6.3 Study Setting

This study was conducted at a private psychotherapy practice in California (USA) that offers online sessions. Participants' personally identifiable information was securely stored on the HIPAA-compliant therapy platform SimplePractice, while all sessions were conducted, recorded, and transcribed using Oxford's Microsoft 365 suite and Teams. I served as the therapist for the study, and I am a Registered Associate Marriage and Family Therapist and Registered Associate Professional Clinical Counselor who is fully trained in Emotionally

Focused Couples Therapy and Emotionally Focused Individual Therapy. I work under the supervision of a licensed marriage and family therapist in California who is also certified in Emotionally Focused Therapy.

4.6.4 Evaluation Design Overview

I used a mixed methods design with a diverse set of both qualitative (therapy session transcripts, clinical notes) and quantitative (pre- and post-treatment assessments, heart rate, brief survey after each session) data. I chose these methods for several reasons. First, to balance the more 'objective' measurable changes pre- and post-therapy with more 'subjective' data that could provide insight into participants' experiences throughout therapy. This approach allows me to not only assess outcomes but also explore the mechanisms and contexts that contributed to them, enabling testing of the initial program theory from the realist review. The following sections will describe the rationale behind each decision that went into the study design ().



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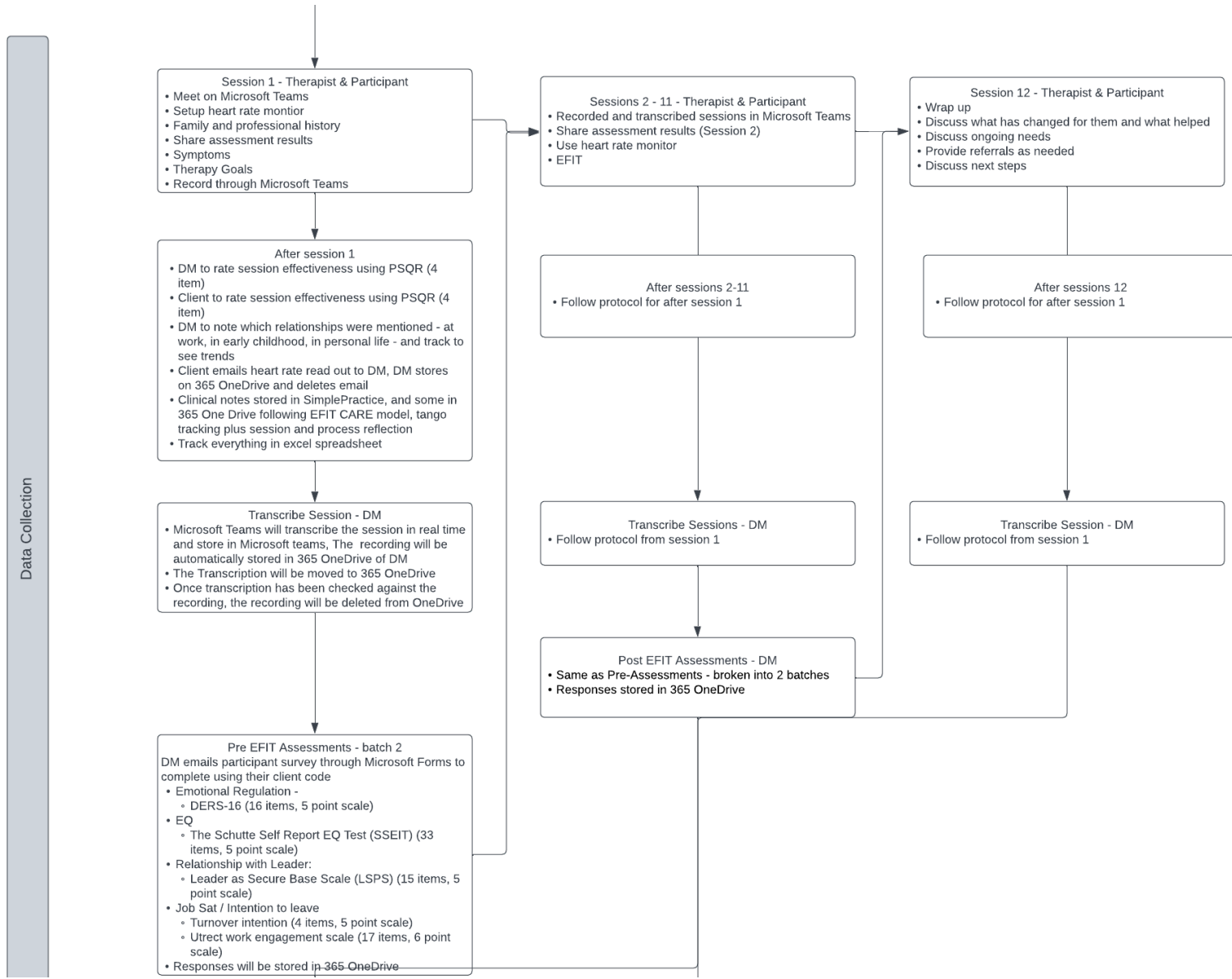


Figure 7: Realist evaluation protocol work flow

4.6.5 Data Collection Methods

I gathered data from pre- and post-therapy assessments and transcripts from twelve 50-minute recorded therapy sessions, during which a participant wore a pulse oximeter and heart rate monitor on their finger, along with my clinical and reflective notes as the therapist, as well as a survey completed after each session (Table 13). The data collected aimed to address the research questions outlined in Chapter 1.

Table 13: Realist evaluation data collected

<p>Outcomes (RQ2, RQ3, RQ4)</p>	<p>....what works?</p> <ul style="list-style-type: none"> - Pre- and Post- treatment assessments to measure initial and changes in mental health and work performance (Table 14) - 4-question survey after each session regarding the sessions relevance to presenting problem, and movement towards resolution: Post-Session Resolution Questionnaire – PSRQ (122) - Final session interview regarding the changes they have experienced during therapy and what they think led to them
<p>Contexts (RQ3, RQ4)</p>	<p>....for whom and under what circumstances?</p> <ul style="list-style-type: none"> - Screening demographics (personal and professional) - Personal and professional history taken in sessions 1-2 - Pre- and Post- treatment assessments (Table 14) <p>...how?</p> <ul style="list-style-type: none"> - Therapist’s Clinical notes about session content and process - Session transcripts that detail interventions used and EFIT tango approach
<p>Mechanisms (RQ1, RQ2)</p>	<p>...and why?</p> <ul style="list-style-type: none"> - Coding portion of the transcripts with the Experiencing Scale (123) to validate level of experiencing in session - Heart rate monitored throughout all sessions as a physiological gauge of deeper experiencing in session

	<ul style="list-style-type: none"> - Quotes from participants throughout sessions in transcripts - Final session interview regarding the changes they have experienced and what they believe led to those changes - Therapist’s Clinical notes about session content and process
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4.6.5.1 Assessments

Assessments were chosen based on their ability to evaluate the initial program theory from the realist review, requiring surveys that covered attachment, mental health, emotional experiences, and work experiences. Participants completed assessments (Table 14) online via Microsoft Forms, split into two batches to reduce fatigue and participant burden. The assessments were conducted before EFIT therapy (batch #1 before session 1 and batch #2 before session 2), with final assessments administered after session 11. Initial assessment results were shared with participants within the first few sessions, and final results were discussed in session 12.

Table 14: Assessments used pre- and post-treatment

Assessment Batch #1 (63 items): Attachment and Distress Experienced	<ul style="list-style-type: none"> • Attachment: Adult Attachment Questionnaire (17 Items, 7 point scale) (124) • Emotional Distress / Stress / Burnout <ul style="list-style-type: none"> ○ Stress: The Work Stress Scale (8 items, 5 point scale) (125) ○ Burnout: Burnout Measure, Short Version (10 items, 7 point scale) (37) ○ Anxiety: GAD7 (8 items, 4 point scale) (126) ○ Depression: Patient Health Questionnaire - PHQ9 (10 items, 4 point scale) (127)
Assessment Batch #2 (85 items): General emotional experience and experience at work	<ul style="list-style-type: none"> • Emotional Regulation: DERS-16 (16 items, 5 point scale) (128) • EQ : The Schutte Self Report EQ Test (SSEIT) (33 items, 5 point scale) (129) • Relationship with Leader: Leader as Secure Base Scale (LSPS) (15 items, 5

	point scale) (72) <ul style="list-style-type: none"> • Job Satisfaction / Intention to leave <ul style="list-style-type: none"> ○ Turnover intention (4 items, 5 point scale): I intend to leave my job in a year, I expect to leave my job in a year, I think about leaving my job, I hope to stay at my job until retirement (130) ○ Utrecht work engagement scale (17 items, 6 point scale) (131)
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I chose a mix of mental health and professional-related assessments to gain a more holistic view of each participant’s baseline and potential changes throughout the study. For each category, I reviewed several possible assessments. Final decisions were based on: 1. Availability of the complete assessment, 2. Trustworthiness of results, evaluated by research on validity and reliability, usage in other studies, or development by a reputable source, and 3. Duration of the assessment to ensure participants would not be overly burdened or reach fatigue.

As discussed in chapter 2, the Adult Attachment Questionnaire is one of the more commonly used attachment surveys for adults. It asks participants to rate statements on a seven-point Likert scale (1: I strongly disagree through 7: I strongly agree). Some statements include: “I find it relatively easy to get close to others,” and “I’m confident others would never hurt me by suddenly ending our relationship.”

I selected four assessments to measure psychological distress, specifically stress, burnout, anxiety, and depression. The Workplace Stress Scale from the American Institute of Stress was chosen for its relevance to the study topic. It uses a five- point scale (1 = Never; 5 = Often) and asks participants to rate eight statements, such as: “Conditions at work are unpleasant or sometimes even unsafe,” and “I receive inadequate recognition or rewards for good performance.” Scores range from 10 to 50; below 15 indicates low stress, 16-20 fairly low, 21-25 moderate stress, 26-30 severe, and 31-40 potentially dangerous (125). The short version of the

Burnout Measure was selected for its relevance and brevity. Its reliability ranges from .85 to .92 depending on the population, with strong face validity based on workshops and clinical experience, and construct validity with a negative correlation range from -.34 to -.39 for measures like life satisfaction, optimism, and work satisfaction (37). The Generalized Anxiety Disorder 7 (GAD- 7) (126) was chosen based on stakeholder feedback, survey length, and research supporting its reliability (internal consistency: Cronbach' s alpha = .93) and validity (convergent validity with depression and anxiety symptoms was $r = .77$), which the literature describes as satisfactory (132). It uses a four- point scale (0 = not at all; 3 = nearly every day) and asks participants to rate seven items, including: “feeling nervous, anxious or on edge” and “being so restless it is hard to sit still.” Results range from 0-21 (0–4: minimal anxiety, 5–9: mild anxiety, 10–14: moderate anxiety, 15–21: severe anxiety). Similar to the GAD- 7, the Patient Health Questionnaire (PHQ- 9) was selected based on stakeholder feedback, survey length, and supporting research on its reliability (Internal reliability: Cronbach' s alpha = .89) and strong construct validity (127). It uses a four- point scale (0 = not at all; 3 = nearly every day) and asks participants to rate nine statements, including: “little interest or pleasure in doing things,” and “feeling bad about yourself...or that you are a failure or have let yourself or your family down” (127).

I selected two assessments that offered insights into the emotional landscape of the participant: the Difficulties in Emotional Regulation Scale (DERS-16) and The Schutte Self Report EQ (Emotional Intelligence) Test (SSEIT). Emotional regulation is a key focus in most psychotherapy, including EFIT, and emotional intelligence is a common term to describe a person’s level of self-awareness, self-regulation, social awareness, and relationship management (133). I chose the DERS-16 based on stakeholder feedback, survey length, strong reliability

(internal consistency: Cronbach's Alpha=.92; test-retest reliability $\rho I = 0.85$; $p < 0.001$), and strong validity when compared to the original DERS-36 (128). The DERS-16 uses a five-point scale (1=almost never; 5=almost always) and asks participants to rate sixteen statements, including: "I have difficulty making sense out of my feelings," and "When I am upset, I have difficulty controlling my behaviors." Total scores range from 16 to 80, with higher scores indicating greater emotion dysregulation (128). To assess emotional intelligence, I selected the SSEIT for its brevity to reduce participant burden; it contains 33 items for rating, compared to 70-153 items in other versions. The SSEIT employs a five-point scale (1=strongly disagree; 5=strongly agree), and the statements include: "When I am faced with obstacles, I remember times I faced similar obstacles and overcame them," and "I am aware of the non-verbal messages other people send."

Three assessments were selected to evaluate different aspects of the work experience: the Leader as a Security Provider scale, a four-question turnover survey, and the Utrecht Work Engagement Scale. The Leader as a Security Provider scale was chosen because it focuses on the relationship between attachment and feeling secure at work due to leadership. The scale demonstrated strong reliability (Cronbach's alpha $\alpha = .96$) and validity, with an $r = .82$ correlation to transformational leadership scales (72). It uses a five-point scale (0=strongly disagree; 4=strongly agree) and asks participants to rate fifteen items, including: "When something bad happens or I feel upset at work I turn to my leader for support," and "When I am under stress at work my leader helps me to remain calm" (72). The four-question turnover survey (Cronbach's alpha = .88) was selected for its brevity and relevance to gauge intention and urgency to leave the current role. Responses were on a four-point scale for the following statements: "In the next few years I plan to leave the company," "In the next few years I expect

to leave the company,” “I think about leaving this company,” and “I’d like to work in this company until I reach retirement age” (130). The final assessment was the Utrecht Work Engagement Scale (UWES-9), an abbreviated version of the seventeen-item UWES, which has shown a median internal consistency of Cronbach’s alpha .77. It uses a seven-point scale (0=never, 6=always/every day) and asks participants to rate nine statements, including: “I am enthusiastic about my job,” and “I am proud of the work that I do” (131).

4.6.5.2 Data Collection through therapy sessions

During the first therapy session on Microsoft Teams, information was collected about the participant’s personal, family, and professional history as part of standard practice of care. EFIT initial assessments focus on attachment, relationship histories, and potential vulnerabilities and strengths (Johnson, 2022, p.109). The EFIT protocol includes capturing the context (identity, environmental factors, experiences with bias), attachment (relationships throughout their life that shaped their view of themselves and others), the relationship with the therapist (therapeutic alliance monitored), and emotion (emotional expression, window of tolerance/emotional capacity, body language, emotional handles) (CARE model) during the initial family history session and throughout the process. In some cases, reviewing a participant’s history required more than one session. After each session, I, the therapist, recorded clinical notes detailing the session’s content and process (Table 15) and checked off what was completed during and after each session (Figure 8) to ensure adherence to protocol.

Table 15: Clinical notes and reflection template used after each session

Session	(1-12)
Date	(Date of session)
EFIT ‘Tango’ Description	(Describes steps 2 – 4 of the tango and what happened during each; 2: creating a coherent narrative and heightening and deepening emotions to prime for

	encounter; 3: The encounter – who it was with, what was said; 4: The outcome of the encounter)
Notes	(General clinical notes on the session; additional techniques used)
Next Session	(Areas of focus and tasks to cover next session)
Reflection on session	(Clinical and research reflection on the session)
Reflection on process	(Clinical and research reflection on the overall EFIT process to date)

During sessions 2 through 11, participants engaged in Emotionally Focused Individual Therapy (EFIT), which consists of the five-step ‘Tango’: (1) Reflect on the present process, (2) Explore more primary, deeper, or new emotions, (3) Set up a coherent encounter (sharing primary emotions with someone who matters – therapist, part of self, or imagined other), (4) Process the encounter, (5) Integrate, validate, and reflect on the process (Johnson, 2019). The EFIT tango steps were documented in clinical notes after each session and reviewed by an EFT-certified clinical supervisor to ensure adherence. Cases were discussed weekly in a one- to two-hour meeting. I also chose to monitor participants' heart rates throughout the sessions to identify any physiological indicators of emotional escalation, which is essential to EFT, to further validate what participants experienced during the sessions (134).

Participant:	P####																	
Action	Content	Complete	Notes															
Screening																		
Send email with	<ul style="list-style-type: none"> • info sheet • eligibility requirements, • MS Bookings link: https://outlook.office365.com/owa/calendar/EFITResearchStudy@UniOxfordNexus.onmicrosoft.com/bookings/ 	X																
Screening call	<ul style="list-style-type: none"> • Contact info • Demographics • Mental Status • Risk Assessment (ACES, Suicide, Alcohol, Drugs) 	X																
Assess Suitability	<ul style="list-style-type: none"> • Document screening outcome 	X																
Invite to participate	<ul style="list-style-type: none"> • Set first session and recurring time • Share next steps: Informed consent, SimplePractice, Assessments 	X																
Onboarding																		
Email link to SP to sign informed consent (10 docs to sign)	<ul style="list-style-type: none"> • Study Informed consent • HIPAA for study • CA Bill of Rights • Privacy Notice • Telehealth - DM • Office Policies - DM • Video Recording - DM • BBS Complaint Notification 	X																
Send calendar invite for sessions via MS Teams and SP		X																
Assign Code and Share with participant	<ul style="list-style-type: none"> • First two letters first name • Last name initial • Last four digits phone number 	X																
Email request for test of heart rate output (baseline 10 mins)		X																
Email Batch 1 assessments via MS Forms - note to use P code	<ul style="list-style-type: none"> • Attachment • Emotional Distress (Stress, Burnout, anxiety, depression) https://forms.office.com/e/5dmnpUKT8z	X																
Mail heart rate monitor	<ul style="list-style-type: none"> • The monitor • Directions * Note to use client code not name for app setup 	X																
Email signed informed consent to participant (via secure SP)	<ul style="list-style-type: none"> • Informed consent • HIPAA for study • Clinical docs * Good faith 	X																
Receive test output from baseline		X																
Verify assessments complete		X																
Analyze assessments batch 1		X																

Sessions																						
Session 1											1											
Start Recording	• State exact time	X																				
Start monitoring heart rate		X																				
Take family history		X																				
Symptoms		X																				
Goals		X																				
	• Emotional Regulation • EQ • Relationship with leader • Job sat / intention to leave	X																				
Send Batch 2 assessments	https://forms.office.com/e/u78V7b82h4																					
Verify all assessments complete		X																				
Analyze assesments batch 2		X																				
Sessions 2-11											2	3	4	5	6	7	8	9	10	11		
Start Recording	• State exact time		X	X	X	X	X	X	X	X	X	X	X	X	X							
Start monitoring heart rate			X	X	X	X	X	X	X	X	X	X	X	X	X							
Share assessment results																						
EFIT			X	X	X	X	X	X	X	X	X	X	X	X	X							
S11: Send Final Assessment Batch 1	https://forms.office.com/e/5dmnpUKT8z														X							
S11: Send Final Assessment Batch 2	https://forms.office.com/e/u78V7b82h4														X							
S11: Verify received assessments															X							
Analyze assesments batches 1 & 2															X							
Session 12																12						
Start Recording	• State exact time											X										
Start monitoring heart rate												X										
Provide referrals as needed												X										
After Each Session											1	2	3	4	5	6	7	8	9	10	11	12
Send PSQR and heart rate readout reminder to P	https://forms.office.com/e/pmnvUKhphw	X	X	X	X	X	X	X	X	X	X	X	X	X	X							
DM PSQR		X	X	X	X	X	X	X	X	X	X	X	X	X	X							
Write up EFIT notes		X	X	X	X	X	X	X	X	X	X	X	X	X	X							
Log clinical notes in SP		X	X	X	X	X	X	X	X	X	X	X	X	X	X							
	• Change name to code • Move to 365 folder and rename • Change to Columns: Insert > Table > Convert Text to Table (1 column, paragraph)	X	X	X	X	X	X	X	X	X	X	X	X	X	X							
Edit and move transcription		X	X	X	X	X	X	X	X	X	X	X	X	X	X							
Receive PSQR from Participant		X	X	X	X	X	X	X	X	X	X	X	X	X	X							
	• Move to 365 folder • Rename • Adjust timing to match transcript	X	X	X	X	X	X	X	X	X	X	X	X	X	X							
P emails heartrate	TIME(HOUR(B2),MINUTE(B2)-8,SECOND(B2)-38)																					

Figure 8: Participant tracking

4.6.6 Recruitment process and sampling strategy

4.6.6.1 Selection of Sample Size

To determine an appropriate sample size for testing the initial program theory, I followed realist guidance and emphasized the depth and quality of data collected, as well as the diversity of sources, rather than adhering to a specific number (105, 135). For the study, I recruited a 100

diverse population using inclusion criteria directly aligned with the study aims and gathered both qualitative (transcribed sessions, interviews, clinical and reflective notes) and quantitative (heart rate, surveys, assessments) data on each participant. The participants' diversity spanned industries, demographics, and presenting problems. This provided a broader range of insights into how EFIT could impact participants in various settings, noting where outcomes were similar and different across contexts.

Another aspect of data quality is the participants' knowledge of events and processes related to the therapy and work outcomes (87, 135). In this case, each participant is an expert on how the therapy affected their work and life, and they reported this in session transcripts, the final session interview, and post-session surveys. Assessments were also used to validate participant experiences. This deep knowledge from participants, collected through various methods to confirm findings, can also make up for the smaller sample size.

This approach is supported by the idea of “information power” (136). This idea states that a smaller sample size can yield valuable insights when the data collected is rich; it is the richness of the data, not the sample size, that provides the “information power.” The five dimensions of information power are as follows:

- A specific study aim: The broader the aim, the larger the sample size needed to study it, and vice versa. The focus of this study is clear and targeted: to test the specific initial program theory identified in the realist review. The subject of the study is also specific: the connection between attachment and mental health at work, along with an evaluation of EFIT’s potential as a treatment.
- Sample specificity: The more specific the sample, the smaller the required sample size, because each participant provides data highly relevant to the study's aims. In the case of

this study, the participants all have experiences and backgrounds that are directly aligned with the study's aim – specifically they are employed professionals who are experiencing work-related mental health distress. As noted above, the participants are diverse in other areas like specific symptoms and demographics, enriching the data with a range of experiencing and outcomes, which will help test the initial program theory.

- **Theoretical Background:** The more a study is grounded in an established theory, the smaller the required sample size. This study is grounded in and guided by the realist evaluation methodology, which is well established and has clear guidelines set by RAMESES II (87, 137). Further, the realist evaluation is focused on testing the initial program theory developed from the literature in the realist review. Also, the substantive theory of attachment was used, which provides a model for human relationships and mental health.
- **Interview (e.g. data) Quality:** The higher the quality of the interviews / data, the smaller the sample size required. In this study, I am coding clinical notes, session transcripts, and an end-of-therapy interview, plus validating observations with quantitative data, including post-session surveys, and assessments. The data has depth and quality and multiple points to validate findings.
- **Analysis strategy:** The more rich and detailed the analysis, the smaller the sample size required for meaningful findings. This study focuses on testing the initial program theory through an iterative analysis process that is part of the realist evaluation approach. The triangulation from multiple data sources throughout this study and its analysis enables detailed insights from each participant.

There were practical considerations when selecting the sample size for the study, based on the number of sessions I could realistically offer as part of the D.Phil. I set the number of sessions per participant at twelve, guided by EFT studies (32) in the realist review, to ensure there was a minimal number of sessions for conducting a family history (1-2 sessions), enough sessions to build a therapeutic relationship and conduct EFIT sessions (10), and a final wrap-up session with an interview (1). Twelve sessions per participant were discussed and agreed upon with my supervisors and also validated with a practitioner stakeholder. With ten participants, this would total 120 sessions for data collection to test the initial program theory.

4.6.6.2 Recruitment

My sampling strategy was purposive, incorporating snowballing and some elements of theoretical sampling. The purposive sampling was intentional, focusing on selecting participants who met specific inclusion and exclusion criteria, and I recruited from settings likely to have individuals meeting these criteria. I also employed snowballing, where people who saw my recruiting advertisement recommended it to others in their network. Additionally, there were some theoretical aspects to my sampling because I aimed for a diverse group of participants across various industries and demographics. However, the actual recruitment process didn't require me to focus heavily on achieving diversity, as it happened naturally through the purposive and snowballing methods. Figure 9 illustrates the entire recruitment process and includes a numerical funnel showing the progression from initial interest to final participant selection.

Participants were volunteers who responded to an advertisement or were referred by someone who heard about the study through an advertisement or network. The study was

promoted through US professional therapy and business associations (e.g., NCEEFT, ICEEFT, ICF), alumni groups (e.g., Columbia Business School alumni, Barnard Alumni), and social media platforms (e.g., LinkedIn, Facebook, Golden Gate Mom’s Group). While the realist review PICO focused on business leaders, I expanded recruitment to include all full-time employees in California to ensure a more diverse group of participants.

Once a candidate expressed interest via email, they were sent the participant information sheet about the study and the eligibility requirements (Table 16). If they believed they met the eligibility requirements and stayed interested after reviewing the information sheet, they were invited to a consultation. A set of standardized emails was created for potential participants, followed by emails to participants once they were onboarded and throughout the study, which can be provided upon request.

Table 16: Realist evaluation inclusion and exclusion criteria

Inclusion Criteria	<ul style="list-style-type: none"> • Employed adults over age 18 • Experiencing work-related mental health distress • In California, due to licensing and registration of therapist
Exclusion Criteria	<ul style="list-style-type: none"> • Suicidal intent, assessed using the 4 items Ask Suicide-Screening Questionnaire (ASQ) from the National Institute of Mental Health (NIMH) • Untreated addiction to substances based on assessment and professional judgement. • Self-employed • Unable to read or converse in English. • Those who lack the capacity to consent to take part • Under 18 years old • A score of 4 or more Adverse Childhood Experiences Scale (ACES), indicating significant childhood trauma. Only 5-10% of the general population has a score of 4 or more, which has been shown to indicate more general long-term health consequences (Hughes, 2017) • Pregnant women, due to their status as a part of a vulnerable population according to BRANY IRB • Currently have a therapist

Consultations are a standard part of therapy designed to learn more about the client, their presenting problems, symptoms, and to conduct risk assessments, ensuring the therapist can ethically treat the client. It is also a time when clients may ask questions about therapy or the study before deciding to participate. For this study, consultations lasted 30-45 minutes. Questions covered the potential participant's current personal and professional situation, symptoms, and the reasons why the study was interesting to them at this particular moment. The session also included more in-depth questions about employment, risk assessments for suicidality, adverse childhood experiences (ACEs) indicating trauma, and substance abuse, which can be provided upon request.

Once a participant was verified to meet all eligibility requirements and that was documented, a regular weekly session was scheduled through Microsoft Teams. Participants received a link to SimplePractice (138), the HIPAA-compliant therapy platform, via email to sign standard clinical forms, the study's informed consent, and other required documents, including HIPAA compliance and California's Experiment Participant Bill of Rights. A participant code was also created to identify each participant in all other research documents stored on the University of Oxford's 365 OneDrive to protect participant confidentiality.

Once informed consent was signed and the participant was onboarded, they were sent a fingertip Bluetooth pulse oximeter with a heart monitor (Brand: EMAY) along with instructions for downloading the associated app. They then completed the first batch of assessments and a ten-minute baseline test on their own to verify that the monitor was working and they knew how to use it before the first session.

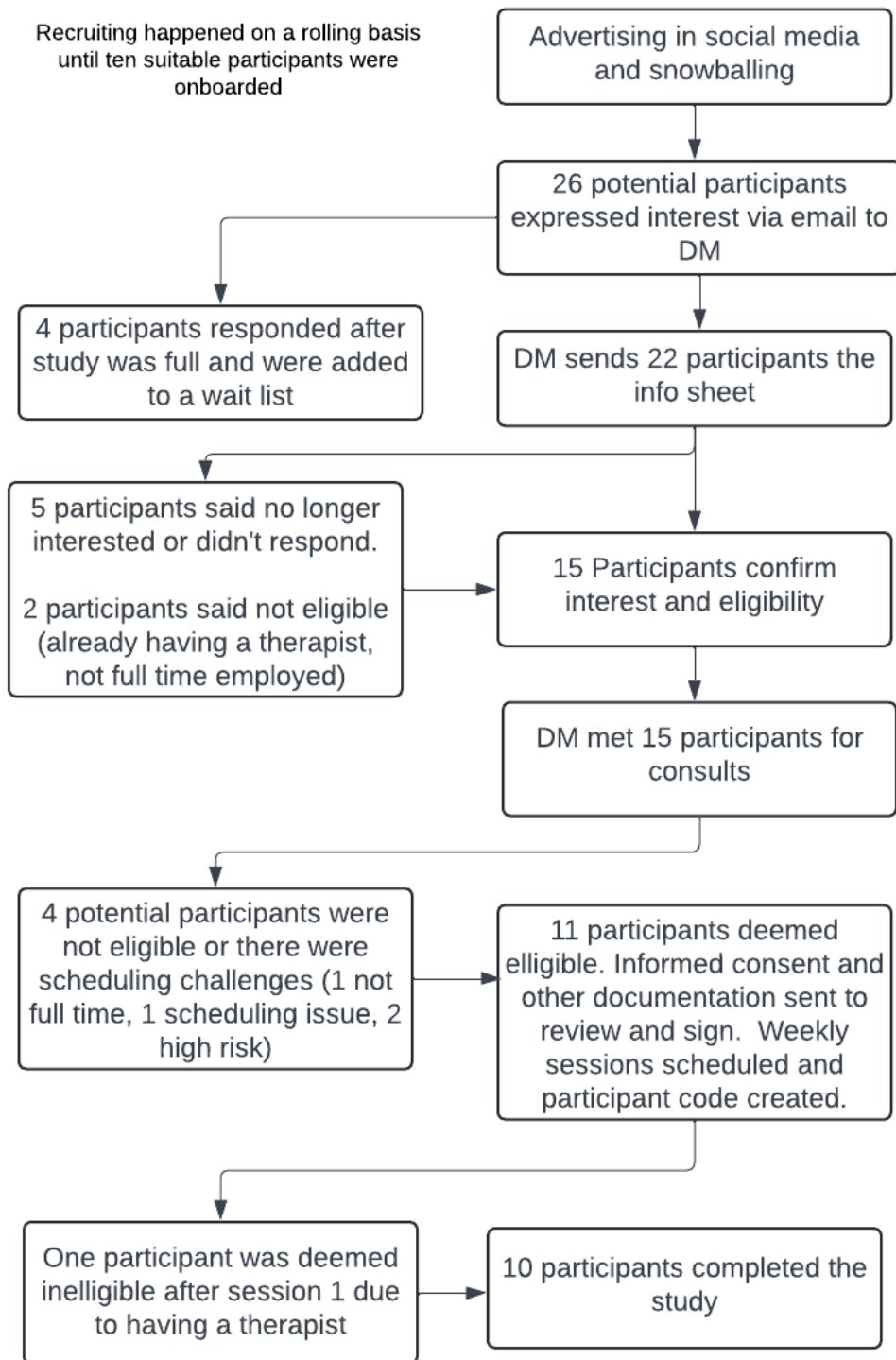


Figure 9: Recruiting process

4.6.7 Data Analysis

Data analysis involved five steps to test the program theory from the realist review (Figure 10), listed here and explained in detail in this section: (1) Consolidating and analyzing the pre- and post-therapy assessments as part of ending therapy with participants; (2) Coding final session interviews and clinical notes to identify qualitative outcomes and possible contexts and mechanisms leading to them; (3) Selecting the sessions that showed the greatest progress toward desired outcomes (e.g., change moment / corrective emotional experience); (4) Coding these sessions in NVivo to identify additional contexts and mechanisms impacting outcomes; (5) Organizing the codes into themes and using them to confirm, refute, or refine the program theory from the realist review. For all qualitative coding, I employed the same process used in the realist review. The analysis was iterative and intertwined with new data collection until the explanations provided by the program theory appeared sufficiently coherent and plausible to DM and supervisors GW and AF, based on the criteria of consilience, simplicity, and analogy—see section 3.3 (Table 7) (101, 102). I also documented my process, experiences, and challenges throughout to ensure proper reflection and reflexivity. This study is a realist evaluation following the RAMESES II guidelines for quality and reporting (<https://www.ramesesproject.org>) (107).

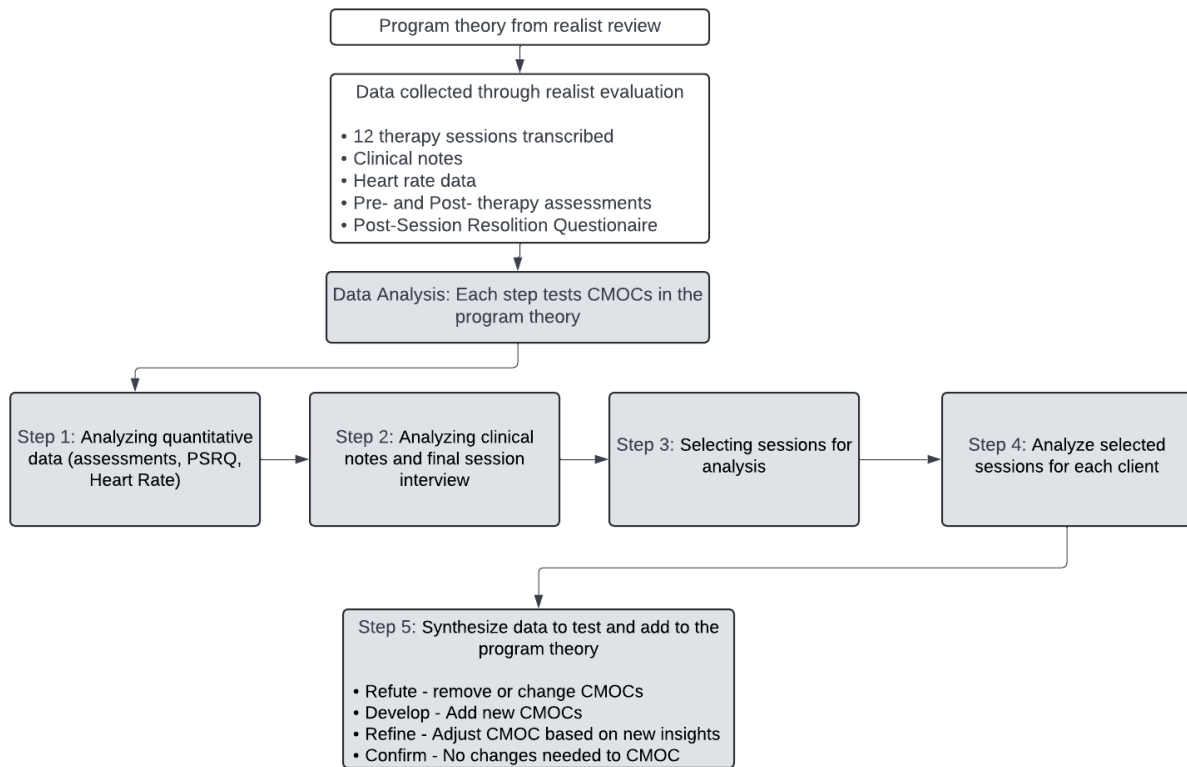


Figure 10: Data Analysis Process

4.6.7.1 Step 1: Analyzing quantitative data

After each participant completed the pre-therapy assessments, I added data to an MS Excel spreadsheet that included sections for each participant and their assessments (Table 17). This helped me understand some of the underlying symptoms participants were experiencing, such as stress and burnout, as well as whether they were at dangerous levels. Once participants completed the post-therapy assessments, I added the results to the same spreadsheet, calculated the percentage change, and noted whether there was improvement or decline in each area. All results were shared with participants and discussed at the beginning and end of therapy. Assessments were analyzed within each participant's case and across cases to identify any

emerging themes using a heat map visual, which can be found in chapter 6 on realist evaluation findings.

Table 17: Example of assessment analysis for one participant

	Pre-Tx Score	Pre-Tx %	-Tx Interpretat	Out of...	Post-Tx Score	Post-Tx %	Post-Tx Inte	Out of...	Percentage change	
Attachment - Avoidance (AAQ)	23	41%	Low-Mid	56	11	20%	Low	56	-52.17%	Better
Attachment - Anxious (AAQ)	26	41%	Low-Mid	63	17	27%	Low	63	-34.62%	Better
Stress (WSS)	33		Potentially Dar	NA	31		Potentially	NA	-6.06%	Better
Burnout (BM)	6		Very Serious Bu	NA	4.2		Burnout	NA	-30.00%	Better
Anxiety (GAD)	15		Severe Anxiety	NA	2		Minimal	NA	-86.67%	Better
Depression	16		Mod Severe De	NA	2		Minimal	NA	-87.50%	Better
Emotional Reg (DERS)	31	39%	Regulated	80	22	28%	Regulated	80	-29.03%	Better
Clarity	2	20%	Regulated	10	3	30%	Regulated	10	50.00%	Worse
Goals	6	40%	Mid	15	3	20%	Regulated	15	-50.00%	Better
Impluses	4	27%	Regulated	15	3	20%	Regulated	15	-25.00%	Better
Strategies	11	44%	Mid	25	8	32%	Regulated	25	-27.27%	Better
Non-acceptance	8	53%	Mid	15	5	33%	Regulated	15	-37.50%	Better
EQ (SSEIT)	135		Very high	NA	145		Very high	NA	7.41%	Better
Leader as Security (LSPS)	8	13%	V low LSPS	60	5	8%	Very low	60	-37.50%	Worse
Work Wellbeing (UWES)	45	44%	Mid	102	67	66%	High	102	48.89%	Better
Vigor	18	50%	Mid	36	23	64%	High	36	27.78%	Better
Dedication	11	37%	Low	30	18	60%	High	30	63.64%	Better
Absorption	16	44%	Low-Mid	36	26	72%	High	36	62.50%	Better
Turnover Intention (TI)	14	100%	Will leave	14	14	100%	High	14	0.00%	No Chang

Post-Session Resolution Questionnaire (PSRQ) data were also analyzed within and across participants in MS Excel. The PSRQ included four questions that participants completed shortly after each session. The first three questions related to the just-concluded session and measured relevance to the presenting problem, the level of progress they felt they made, and how much closer they felt to resolving the problem. These three questions were summed to create the session PSRQ, with a maximum possible score of 15. The last PSRQ question asked how resolved they felt about the problem they brought into therapy, with a total potential score of 7, as referenced earlier in this chapter. Heart rate data were also analyzed by compiling all data in MS Excel and calculating the mean, median, range, and standard deviation for each session.

4.6.7.2 *Step 2: Analyzing clinical notes and final session interview*

I uploaded the clinical notes and final session interview into NVivo. In the interview, I asked what they were experiencing when they started therapy, what had changed since then, and what (if anything) from therapy had helped. This provided deeper insights into the potential outcomes, as well as the contexts and mechanisms that influenced those outcomes.

During analysis, I initially developed a set of themes that each became a code (formerly referred to as a node) in NVivo, based on and to help test the realist review program theory. As the analysis progressed, I refined these codes, creating new themes where necessary and, in some cases, disaggregating broader codes into more specific sub-codes to capture greater nuance within the data. These parent codes included: encounter (problem, target, resolution), encounter difficulties, factors influencing the observed changes in encounters, what aided therapy, participant background, participant symptoms, and tango steps (Table 18). From there, I developed additional child codes and themes based on my understanding of the data. The plan in Table 18 focuses on CMOCs 4-9 because CMOCs 1-3 concentrated on the therapeutic relationship, which is a well-researched and documented common factor of therapy and therefore was less of a unique aspect of EFIT and a focus for data analysis. That said, themes related to the therapeutic relationship were coded and reflected in the findings.

Table 18: Initial Analysis Plan

	Realist Review Program Theory	Qualitative Coding	Related Quantitative Data
4	<p>CMOC 4: Identifying a coherent narrative of the emotional experience to break cycle</p> <p>4. When therapist & client identify and co-regulate disowned emotions and needs (C) they can interrupt a negative attachment cycle (O) because emotions now make sense as a coherent narrative (M)</p>	<p>Parent Nodes</p> <ul style="list-style-type: none"> • Changes noticed • What helped <p>Child codes - emerged from clinical notes, final session interview and selected transcripts (Note: Saturation mostly reached after coding clinical notes and final session so transcripts may be more for examples - and can pull in more examples based on clinical notes for findings write up)</p>	<ul style="list-style-type: none"> • Heart rate
5	<p>CMOC 5: Heightening emotions to enable a corrective emotional experience</p> <p>5. When the therapist heightens a client's emotional experience using RISSSSC and micro-interventions (C) then the client is more primed for a corrective emotional experience (O) because they're accessing deeper emotions (M)</p>	<p>Parent Nodes</p> <ul style="list-style-type: none"> • Changes noticed • What helped • Microinterventions • Encounter difficulties <p>Child codes - emerged from clinical notes, final session interview and selected transcripts</p>	<ul style="list-style-type: none"> • Heart rate • PSQR
6	<p>CMOC 6: Corrective Emotional Experience: Expressing emotions to someone who matters</p>	<p>Parent Nodes</p>	<ul style="list-style-type: none"> • Assessments

	<p>6. When the client can express their deeper emotions to someone who matters (other, imagined other, part of self, or therapist) (C) then they can have an emotionally corrective experience (O) because they took a risk to experience and co-regulate their attachment needs and fears (M)</p>	<ul style="list-style-type: none"> • Client Encounter <ul style="list-style-type: none"> ○ Problem ○ Target ○ Processing outcome • Encounter difficulties • Microinterventions • Changes noticed • What helped <p>Child codes - emerged from clinical notes, final session interview and selected transcripts</p>	<ul style="list-style-type: none"> • Session PSQR
7	<p>CMOCs 7: Revising internal working model of relationships after emotionally corrective experience</p> <p>7. When a client has an emotionally corrective experience in an encounter (C) then they can change their internal working model of relationships (O) because they had a different experience when sharing their attachment needs and fears (M)</p>	<p>Parent Nodes</p> <ul style="list-style-type: none"> • Client Encounter <ul style="list-style-type: none"> ○ Problem ○ Target ○ Processing outcome • Changes noticed • What helped <p>Child codes - emerged from clinical notes, final session interview and selected transcripts</p>	<ul style="list-style-type: none"> • Assessments • Final PSRQ
8	<p>CMOC 8: Better able to regulate emotions after internal working model revised</p> <p>8. When a client revises their internal working model of relationships (C) they are better able to regulate their emotions (O) because they improve their felt sense of attachment security, enabling them to reach out for support (M)</p>	<p>Parent codes</p> <ul style="list-style-type: none"> • Changes noticed • What helped <p>Child codes - emerged from clinical notes, final session interview and selected transcripts</p>	<ul style="list-style-type: none"> • Assessments • Final PSRQ

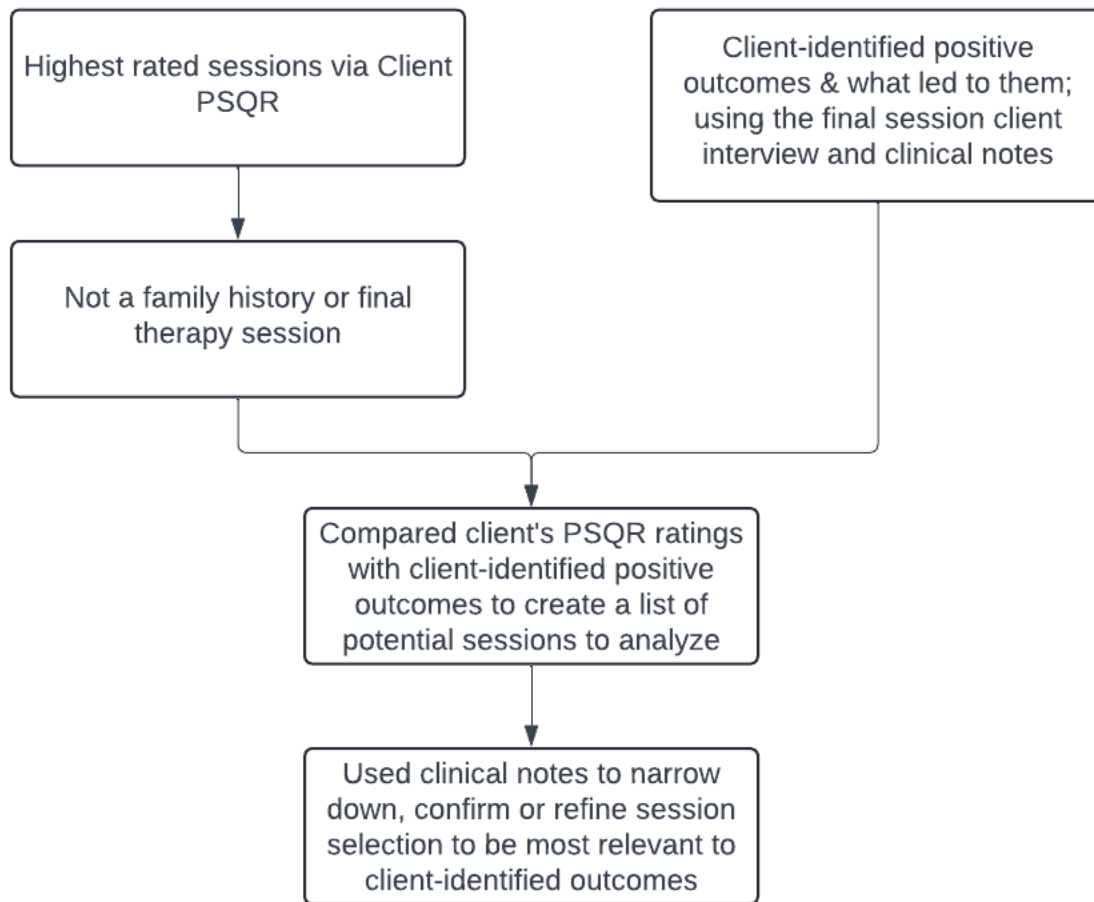
9	<p>CMOC 9: Reduced emotional distress</p> <p>9. When a client can better regulate their emotions (C) then they feel less work-related mental health distress (stress, burnout, and similar) (O) because they have greater confidence they can handle stress and challenges (M)</p>	<p>Parent codes</p> <ul style="list-style-type: none"> • Changes noticed • What helped <p>Child codes - emerged from clinical notes, final session interview and selected transcripts</p>	<ul style="list-style-type: none"> • Assessments • Final PSRQ
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4.6.7.3 Step 3: Selecting the sessions for analysis

A combination of insights from clinical notes, final session interviews, and the PSRQ was used to further confirm which sessions saw the most progress for participants. The PSRQ is a brief 4-item questionnaire that uses a Likert scale and was recommended to me by another EFT researcher and stakeholder to help identify sessions that led to the most progress in a study. It has also been used for this purpose in other EFT studies (Dalglish, 2015). The PSRQ was completed by both the therapist and the participant at the end of each session to identify progress in that session and overall in therapy.

I created a table in MS Excel to document my selection process and reflexive thinking on the sessions chosen for analysis, which is available upon request. I focused on the client session PSRQ data and final session interviews, where clients shared the most impactful moments for them, along with clinical notes to verify this data and consider additional sessions. Whichever data influenced the decision (e.g., quantitative PSRQ), I used the other data (e.g., qualitative clinical notes and final session interviews) to validate the choice. I then selected two initial sessions for each participant to upload into NVivo for analysis and planned to continue coding until no new codes emerged. This approach aligns with realist methodology, which aims not for a ‘complete and final’ theory but for data that can test the program theory, and this sample of transcripts showed participant progress based on various data points.

Figure 11: Process used to select sessions to analyze in NVivo



4.6.7.4 Step 4: Analyze sessions for each participant

Once sessions were uploaded to NVivo, I used the parent codes and process from step 2 and coded sub-themes. The aim for this step was to gain further insight into the contexts and mechanisms that led to outcomes like change moments for a participant. In the end, the top two sessions were coded for all participants, and no new codes were identified because the themes had already been identified through the clinical notes and final session interviews. This indicated that potential inductive thematic saturation had been reached, and no additional sessions were

analyzed (139). The session transcripts did provide additional data to validate the themes I identified from the clinical notes and final session interviews.

4.6.7.5 Step 5: Synthesize data to test and add to the program theory

Similar to the realist review, once coding was finished, I grouped codes by theme and created tables in MS Word identified by participant code, then added relevant quantitative data. I then compared these themes with the program theory from the realist review and visually mapped the themes to the CMOCs using lucid.app (140) to show the connections between the qualitative themes and the program theory. I also used the coded data from NVivo to revisit the transcripts and select specific quotes to illustrate the coded themes.

I used methodological and data triangulation by integrating qualitative data (clinical notes, session transcripts, final-session interviews with participants) and quantitative measures (PSRQ and pre/post assessments) to identify recurring patterns across data types, validate qualitative findings, and detect inconsistencies between data types. This also helped reduce potential bias from clinician observation and my dual role as a clinician/researcher (141).

Through an iterative process and using the same reasoning methods from the realist review (4.5.5), the CMOCs from the realist review were confirmed, refuted, refined, or new CMOCs were developed until the revised program theory met the criteria of consilience, simplicity, and analogy as discussed in section 3.3. (Table 7) (101, 102). I used retroduction and abduction to identify mechanisms, as in the realist review. Transcript quotes were adjusted for clarity (e.g., spelling, removing filler words like 'um,' combining quotes for continuity between talk turns, and similar).

4.7 Use of Artificial Intelligence

I used Grammarly and Chat GPT 4.0 to help grammar and writing clarity and followed University of Oxford's guidance called "Use of Generative AI Tools to Support Learning" (<https://www.ox.ac.uk/students/academic/guidance/skills/ai-study>).

4.8 Conclusion

This chapter explained the methods used for the realist review and realist evaluation to answer the research questions in Chapter 1. I conducted the realist review to develop the program theory based on existing literature, which could then be tested through the evaluation. For the realist review, a limitation of my approach was the lack of research on EFIT. This required extrapolating from EFT research, stakeholder input, and using the realist evaluation to confirm, refute, and refine the program theory from the realist review. I employed a mixed methods approach to collect the data, along with a realist logic of analysis, to analyze a rich data set and gain deeper insights into the outcomes and underlying contexts, and mechanisms for EFIT for work-related distress. This combination of data also helped validate insights and address potential biases, given my roles as both a therapist and a researcher. The iterative nature of realist approaches enabled ongoing learning and refinement, with an intentional focus on reflexivity, allowing me to respond to what I observed with participants and document it in clinical notes as part of data collection.

4.9 About the next chapter

In the next chapter, I present the findings from the realist review and illustrate how the program theory evolved from an initial version based on stakeholder discussions to a revised

version grounded in literature. This updated theory was then used to design and serve as a starting point for the realist evaluation.

5 Chapter 5 - Realist Review Findings

5.1 About this chapter

In this chapter, I review the evolution of the program theory from its initial stage, based on an informal search, to a revised program theory based on the findings from the realist review included in this chapter. As discussed in previous chapters, a realist program theory focuses on the contexts and mechanisms that may lead to outcomes. This chapter begins with the initial program theory, an overview of the articles included in the realist review, and then the revised program theory supported by data from the literature. This revised program theory laid the foundation for the realist evaluation study design, which is discussed in the previous chapter.

5.2 Initial Program Theory

The first step in a realist study is to identify an initial program theory that can be tested (confirmed, refuted, or refined) using additional literature, such as in a realist review, or with empirical primary data via a realist evaluation. To reiterate, realist program theories describe causation using context, mechanism, outcome configurations (CMOC). Developing and refining a program theory in a realist review is an iterative process that draws on data from the literature, stakeholder discussions, and collected empirical primary data.

For this thesis, I developed the initial program theory based on an informal review of literature in my personal clinical library as a therapist who has studied and practiced EFT, along with stakeholder conversations outlined in section 4.3. The goal of this initial program theory was to guide a formal literature search in the realist review and serve as a foundation for testing and refining it.

The initial version of the program theory began as a repository of all potential outcomes, along with their possible contexts and mechanisms, drawn from the literature in my personal clinical library and conversations with stakeholders. It is depicted in Figure 12.

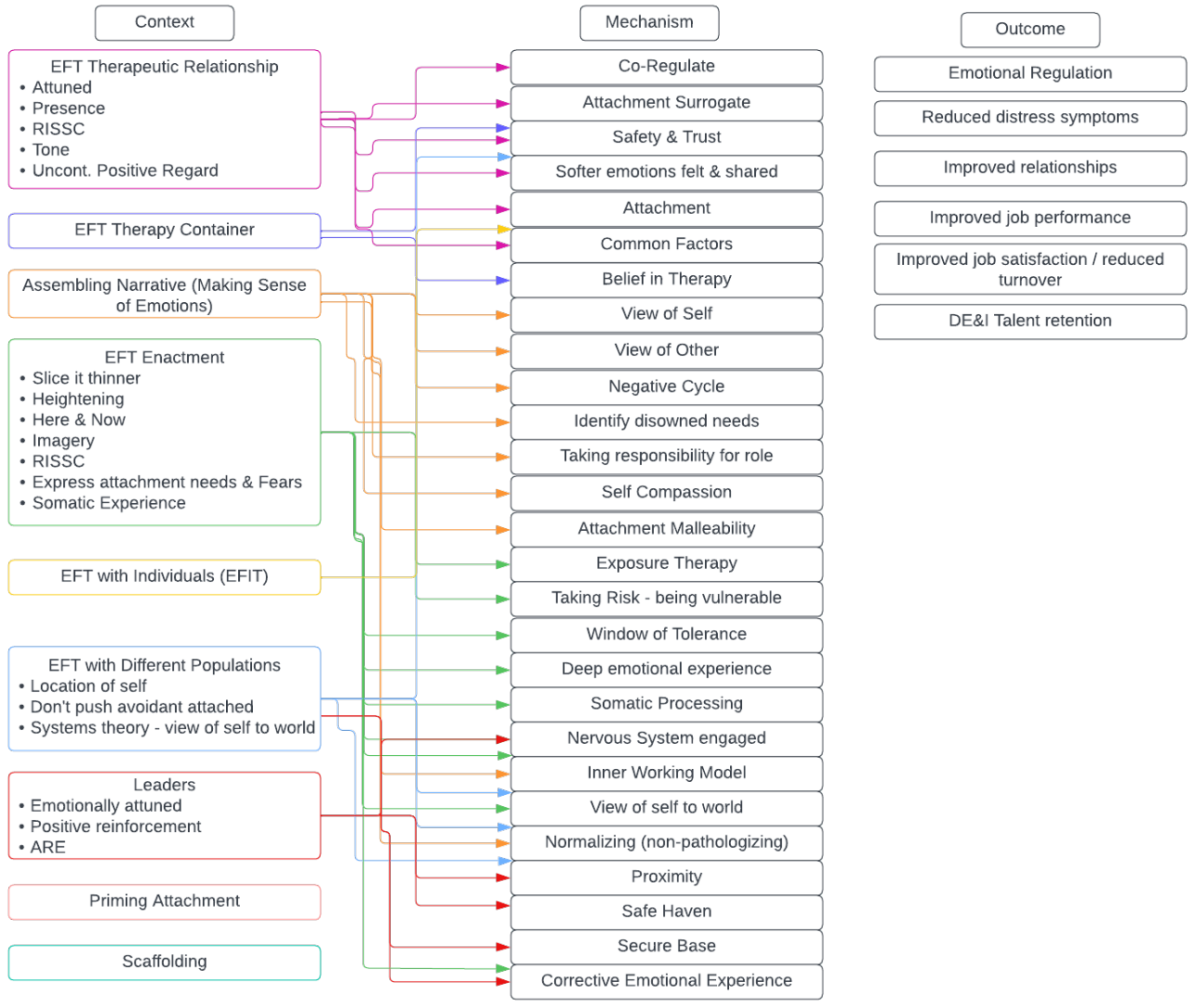


Figure 12: Initial program theory version 1

This program theory was loose and unstructured, offering some guidance for the realist review while intentionally avoiding making strong connections that haven't been tested. As I

gained more insights from analyzing the literature in NVivo, I refined the visual map of

connections between the potential CMOC components. I used version 2 to help visualize the links indicated by the literature (Figure 13).

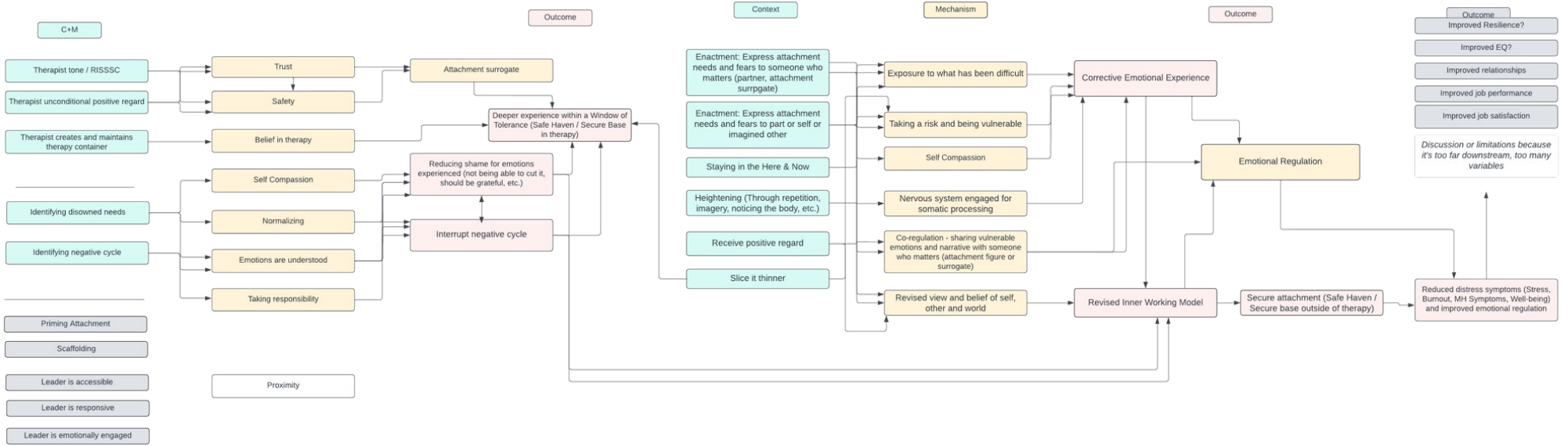
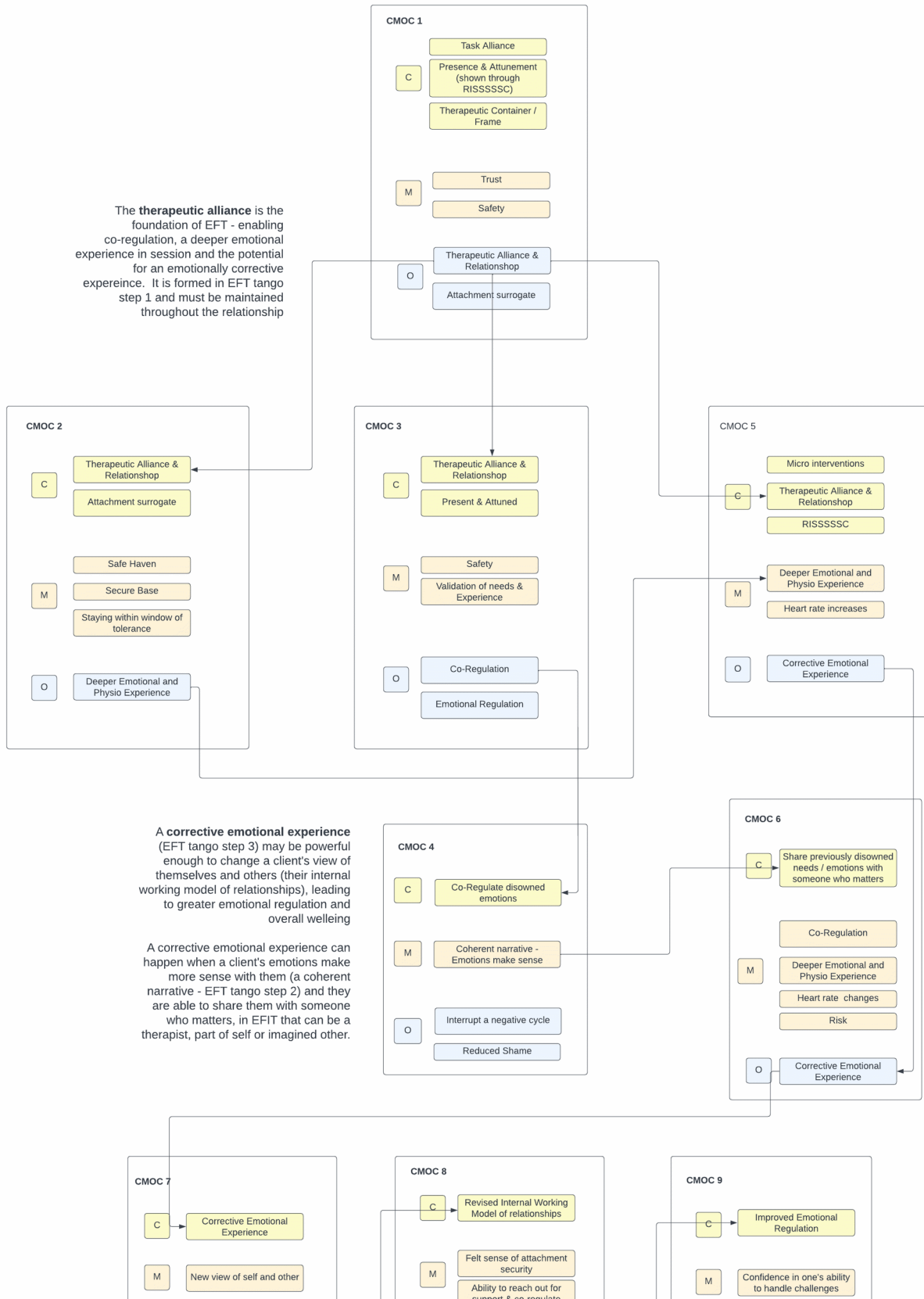


Figure 13: Program theory evolution throughout the realist review version 2

From an early stage in the program theory development, certain components of the theory consistently emerged in discussions with stakeholders and in the literature, but determining the order of the CMOCs was a challenge throughout the review. In some cases, a component of a CMOC, like deeper emotional experiencing, was an outcome, and in other cases, a context or mechanism. To further validate my interpretation of the data and my understanding of the literature, I shared a summary of Version 2 with two of the original stakeholders, who are both certified EFT practitioners, and one of whom is also an EFT researcher and author of several papers included in the realist review. Both agreed with the CMOCs and provided thoughts to consider as the program theory was finalized, for example, the importance of taking a risk during an encounter, and the role of shame, which were both incorporated. This led to the third version below (Figure 14).

The **therapeutic alliance** is the foundation of EFT - enabling co-regulation, a deeper emotional experience in session and the potential for an emotionally corrective experience. It is formed in EFT tango step 1 and must be maintained throughout the relationship

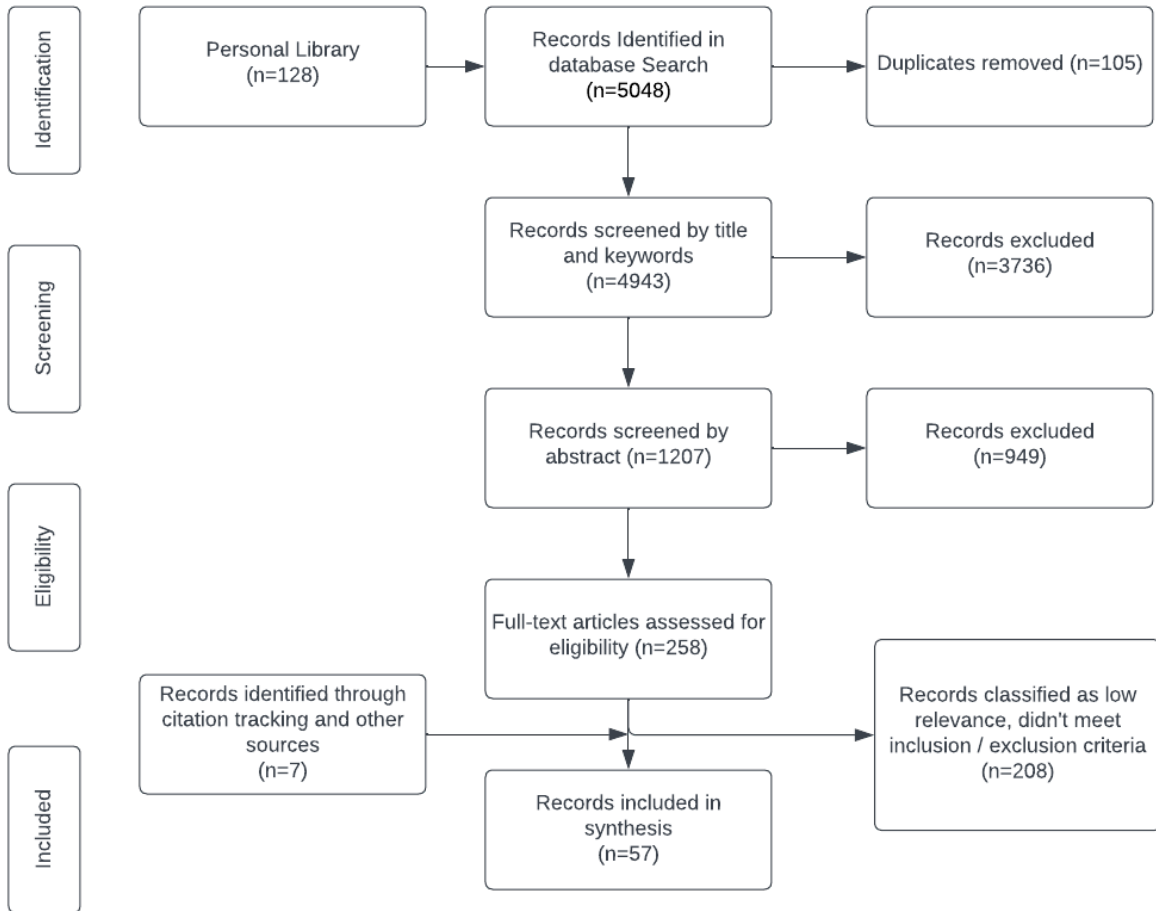


From this version, I developed the refined the program theory discussed in detail later in this chapter (Figure 16). As I wrote the findings, and gathered the data that validated each CMOC, I further iterated on the CMOCs for clarity and to more directly reflect the data from the review. As mentioned previously, while the components consistently appeared in discussions with stakeholders and throughout the literature, the theory of how they work together to form CMOCs required abductive and retroductive reasoning, leaning on the substantive theory of attachment.

5.3 Characteristics of included articles

EFIT, while rooted in the established EFT therapy used with couples, is a developing therapeutic approach. At the time of the review, no published research studies specifically focused on EFIT across any demographic, with only a limited number of commentaries and case studies available. There is however a substantial body of literature on EFT for couples (EFCT), including studies examining its effects on individual partners suffering from mental health issues such as depression or trauma. Also, in July 2025, a randomized controlled study on EFIT for treating depression was published, reporting a significant reduction in depression symptoms among the 88 participants over fifteen weeks of treatment, consistent with the original findings from this realist review (30). The topic of attachment in the workplace has gained considerable attention from scholars in recent years, with numerous articles exploring attachment styles. Only one article found addresses therapeutic interventions for insecure attachment in workplace settings. In conclusion, although there are no direct studies or articles on EFIT for individuals facing work-related mental health challenges, the components central to this realist review, including workplace attachment impact on individual mental health distress and EFT as an

attachment-based treatment, are well-documented in existing literature and formed the basis for this review.



PRISMA flow diagram. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Figure 15: Prisma flow diagram for the realist review article selection

Fifty-seven articles were included in this realist review (Figure 15): three focused on EFIT, 25 on EFT with couples in a range of situations, 17 on the intersection of attachment and mental health distress in the workplace, eight on the broader topic of attachment in the workplace and four on other experiential therapies and common factors that underlie the impacts of all therapy. Please note, some of the articles on attachment at work also formed the basis for the narrative review in Chapter 2. Articles from North America (43) made up 75% of the those included, 12% were from Israel (7), EU (3), UK (2), Australia (1) and Iran (1). The articles showed a link between insecure attachment and mental health distress in the workplace and also the impacts of EFCT in improving couples' satisfaction, with some also showing that EFCT can have a positive impact on an individual partner's depression and other mental health symptoms. The EFT CMOCs were consistent with feedback and input from stakeholders. Table 19 shows the article characteristics of all articles selected to be a part of the realist review.

Table 19: Realist review article characteristics

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
EFIT										
1	Allan, Robert, Wiebe, Stephanie A., Johnson, Susan M., Piaseckyj, Olena, Campbell, T. Leanne	2021	Practicing emotionally focused therapy online: Calling all relationships	US & Canada	Commentary	Review adaptations for practicing EFT with couples online	NA	NA	NA	Provided ideas for what to pay attention to when working online with a couple using EFT
2	Brubacher, Lorrie	2017	Emotionally focused individual therapy: An attachment-based experiential/systemic perspective	US	Commentary with clinical case example	Discuss principles of attachment and how it can set the stage for change within individual therapy	Clinical case example	1 Individual client	Individual	Attachment-based change process in individual therapy has the following components: 1. Identifying patterns of emotional regulation and heightening the underlying emotion, 2. enabling a correcting emotional experience that can shift these patterns into interpersonal and intra-personal secure bonds
3	Schafer, Lukas, Edwards, Caitlin P., Allan, Robert, Johnson, Susan M., Wiebe, Stephanie A., Chyurlia, Livia, Tasca, Giorgio A.	2021	Development of the emotionally focused individual therapy adherence measure: Conceptualisation and preliminary reliability	USA & Canada	Research	Create a measure of adherence to the EFIT treatment tasks	Quantitative	20 Therapists	EFIT Therapists	Twelve treatment task items met the criteria for the adherence scale and the inter-rater reliability and internal consistency point to the scale being a promising measure to evaluate therapist adherence to EFIT treatment tasks
EFT										
4	Allan, Robert, Johnson, Susan M.	2017	Conceptual and application issues: Emotionally focused therapy with gay male couples	US	Commentary	To review some of the issues that are specific to using EFT with gay male couples	NA	NA	Gay male couples	EFT is particularly appropriate for work for gay male couples due to the minority stressors they can experience and the focus on the attachment bond. Building a secure relationship can be a source of resilience and buffer against discrimination, providing a secure base for individual and couple exploration.
5	Beasley, Candice C., Ager, Richard	2019	Emotionally Focused Couples Therapy: A systematic review of its effectiveness over the past 19 years	US	Systematic Review	Evaluate effectiveness of EFT with couples since the last meta-analysis in 1999	Systematic Review	Nine studies that identify as randomized controlled trials (RCTs) for pre-to post-treatment effectiveness. For sustained improvement in follow-ups four RCTs were used.		EFT improved marital satisfaction (Hedge's g coefficient = 2.09) and improvement was sustained.
6	Brubacher, Lorrie L., Wiebe, Stephanie A.	2019	Process-research to practice in emotionally focused couple therapy: A map for reflective practice	US & Canada	Commentary with clinical example	Provide view of what the three EFT active ingredients (task alliance, experiential depth and affiliative interactions) look like in practice	Clinical case example	1 couple	Couple	The effectiveness of TEA (task alliance, emotional experiential depth and affiliative interactions) within EFT can be enhanced by the therapist attuning, monitoring and fostering them in session.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
7	Conradi, Henk Jan, Dingemans, Pieter, Noordhof, Arjen, Finkenauer, Catrin, Kamphuis, Jan H.	2018	Effectiveness of the 'Hold me Tight' Relationship Enhancement Program in a Self-referred and a Clinician-referred Sample: An Emotionally Focused Couples Therapy-Based Approach	Holland	Research	Examine effectiveness of Hold Me Tight (HmT), the group program based on EFT	Quantitative	79 self-referred couples and 50 clinician-referred couples	Couples	1. Self-referred couples significantly improved across all measures including: relationship satisfaction, security of partner-bond, forgiveness. Daily coordination, maintenance behavior and psych effects - moderate to large mean effect (d=.63), maintained during 3.5 mo followup (d=.57) 2. clinician-referred couples saw a moderate improvement (d=.42), which reduced during 3.5 mo followup (d=.22) 3. emotional and behavioral functioning improved during HmT 4. individual psych complaints also reduced during HmT
8	Conroy, Julia, Perryman, Kristi, Robinson, Samantha, Rana, Ryan, Blisard, Paul, Gray, Michelle	2022	The coregulatory effects of emotionally focused therapy	US	Research	Examine the heart rate synchrony among a couple in EFT sessions to measure co-regulatory effects during treatment	Quantitative	1 couple	Couple	Heart rate synchrony was more likely during sessions where attachment injuries, bonds, and longings were shared compared to more cognitive processing. Delays in heart rate synchrony occurred, which may indicate emotional processing and the speed of an empathic response between partners.
9	Crawley, Jim, Grant, Jan	2005	Emotionally Focused Therapy for Couples and Attachment Theory	US	Commentary	Ask how EFT uses attachment theory and whether it could draw on the theory more deeply to inform the therapy process	NA	NA	NA	Recommendations for EFT to further leverage the depth of attachment theory include: 1. assessment of family of origin and attachment within, 2. paying more attention to the internal working model of each partner and transference within the therapeutic relationship, 3. more focus on the process of working through so each partner can see the challenges within the broader context of their life story
10	Denton, Wittenborn, Golden,	2012	Augmenting Antidepressant Medication Treatment of Depressed Women with EFT	US	Research (Randomized pilot)	Evaluate adding EFT to antidepressant treatment for women with major depressive disorder (MDD) and comorbid relationship discord.	Quantitative	24 women and their male partners	Couples with a female partner experiencing depression	Depression symptoms as shown by the Inventory of Depressive Symptomology (IDS-C30) improved over 6 months of treatment for participants who received antidepressants and those who received antidepressants + EFT. Participants who have antidepressants + EFT also experienced improvement in relationship quality, which may reduce the chance of MDD relapse or recurrence.
11	Greenman, Paul S., Johnson, Susan M.	2012	United we stand: Emotionally focused therapy for couples in the treatment of posttraumatic stress disorder	Canada	Commentary with clinical case	Explore EFT as a treatment option for couples where one partner has been diagnosed with PTSD	Case Study	One clinical case	Couples where one person has been diagnosed with PTSD	EFT is suited to treating a number of PTSD symptoms including difficulty with affect regulation, isolation, flashbacks, and dissociation. Based on growing literature, EFT appears to be an effective treatment for PTSD.
12	Greenman, Paul S., Johnson, Susan M.	2013	Process research on Emotionally Focused Therapy (EFT) for couples: Linking theory to practice	Canada	Commentary and literature review	Explore the link between theory, process and outcome in EFT through a literature review	Literature review	NA	Couples	The literature shows evidence that EFT but also how it works, which hinges significantly on the tenets of attachment theory.
13	Greenman, Paul S., Johnson, Susan M.	2022	Emotionally focused therapy: Attachment, connection, and health	Canada	Commentary	Explore EFT as a therapy for couples, families and individuals experiencing loneliness and social disconnection.	NA	NA	NA	Suggestion that strengthening of emotional bonds through EFT can help restore emotional balance, relieving feelings of isolation and resulting health problems.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
14	Hollist, Cody S., Miller, Richard B.	2005	Perceptions of Attachment Style and Marital Quality in Midlife Marriage	US	Research	To examine the effectiveness of EFT on marital quality for couples in midlife	Quantitative questionnaires	429 married people between 40 and 50 years old	Midlife marriages	While insecure attachment styles were associated with marital quality, secure attachment was not. Authors extrapolated this finding to suggest that EFT may be helpful for couples with insecure attachment styles, but may not be effective for couples with secure attachment styles.
15	Johnson, Susan	2019	Attachment in action-Changing the face of 21st century couple therapy	Canada	Commentary	Provide an overview of EFT as an effective couples therapy based in attachment science	NA	NA	Couples	Based on several outcome studies sampled, EFT has shown to alleviate couple distress and individual comorbidities as well, with positive follow-up effects. EFT has been shown to improve relationships but also increase resilience and wellbeing through secure attachment.
16	Johnson, Susan M., Wittenborn, Andrea K.	2012	New research findings on emotionally focused therapy: Introduction to special section	Canada & US	Commentary	Provides an introduction to three studies on EFT	NA	NA	NA	This article provided an overview of EFT and its underpinnings
17	Johnson, Susan M.	2019	Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families	Canada	Book	Provide an overview of EFT for couples, families and individuals	NA	NA	NA	Valuable overview of the practice of EFT
18	Kailanko, S., Wiebe, S. A.,Tasca, G. A.,Laitila, A. A.,Allan, R.	2022	Somatic experience of emotion in emotionally focused couple therapy: Experienced trainer therapists' views and experiences	Finland, Canada, US	Research	Explore the experience of eight experienced EFT therapists regarding their somatic experience when using EFT with couples	Qualitative - Phenomenological analysis of transcribed interviews	Eight experienced EFT therapists	Experience EFT therapists & trainers	Therapists focus on clients' somatic experiences, as well as their own and would benefit from a map to further guide their use of somatic experiences.
19	Karris, Mark, Caldwell, Benjamin E.	2015	Integrating emotionally focused therapy, self-compassion, and compassion-focused therapy to assist shame-prone couples who have experienced trauma	USA	Commentary	Reviews the empirical research on EFT, self-compassion and CFT and looks for integration potential between the three.	NA	NA	NA	Couples, especially ones who are shame-prone in the aftermath of trauma, may benefit from self-compassion practices enhancing their EFT therapy. Self compassion practices may also help dysregulated therapists maintain attunement during sessions.
20	Kennedy, Nikki, Johnson, Susan M.,Wiebe, Stephanie A.,Willett, John B.,Tasca, Giorgio A.	2019	Conversations for connection: An outcome assessment of the Hold-Me-Tight Relationship-Education program, and recommendations for improving future research methodology in relationship education	Canada	Research	Explore the potential of Hold Me Tight program to improve trust and relationship satisfaction in couples.	Exploratory Longitudinal Quantitative research	96 couples	Couples	During program participation, relationship satisfaction & trust increased, but declined after follow-up.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
21	Millikin, John W., Johnson, Susan M.	2000	Telling tales: Disquisitions in emotionally focused therapy	USA & Canada	Commentary	Explore the use of disquisitions (stories) that capture the emotional experiences of couples in EFT	NA	NA	Couples	Disquisitions may be effective when clients have a hard time acknowledging attachment needs and underlying emotions, but they may not be helpful to clients who are highly resistant or who find them too complex.
22	Nightingale, Marjorie, Awosan, Christiana Ibilola,Stavrianopoulos, Katherine	2019	Emotionally focused therapy: A culturally sensitive approach for African American heterosexual couples	USA	Commentary and Case Study	Explore using EFT with African American couples and adjustments that can be made to make EFT more culturally aware and effective with this population	Case Study	1 African American Couple	African American Couples	A racially sensitive EFT intervention is proposed that addresses five key considerations when using EFT with African American couples: the impact of racial stress, client trust in the therapist, expectations of gender-roles, and racial-gender expectations of emotionality and vulnerability.
23	Priest, Jacob B.	2013	Emotionally focused therapy as treatment for couples with generalized anxiety disorder and relationship distress	USA	Commentary with case example	Explore and conceptualize treating Generalized Anxiety Disorder with EFT	Case Example	1 Couple	Couples	More research is needed to understand EFT's potential to treat clients with GAD. Two limitations are known: 1. Client would need to be a part of a couple, 2. EFT may be useful in treating GAD when the source of the worry is the relationship, but if it is another source, focusing on the relationship in EFT may add new worries
24	Spengler, Paul M., Lee, Nicholas A.,Wiebe, Stephanie A.,Wittenborn, Andrea K.	2022	A comprehensive meta-analysis on the efficacy of emotionally focused couple therapy	USA & Canada	Meta-Analysis	Conduct a comprehensive meta-analysis of EFT research including RCTs, quasi-experimental, and dissertations.	Meta-Analysis	20 studies and 323 Couples	Couples	70% of couples symptom free at the end of treatment and a therapists strong adherence to the EFT model correlates to greater gains for the couple.
25	Wiebe, Stephanie A., Johnson, Susan M.	2016	A review of the research in emotionally focused therapy for couples	Canada	Literature Review	Provide an overview of the research on EFT's effectiveness and process.	Literature review	NA	Couples	EFT exceeds the guidelines for classification as an evidence-based therapy and is the only couples therapy to meet these guidelines.
26	Wiebe, Stephanie A., Johnson, Susan M.	2017	Creating relationships that foster resilience in Emotionally Focused Therapy	Canada	Literature Review	Review the literature on attachment, affective neuroscience and EFT to understand how attachment bonds relate to the fostering of resilience.	Literature review	NA	Couples	Attachment literature provided strong evidence that secure attachment can foster resilience through affect co-regulation, a process observed and supported by neuroscience. EFT focuses on bringing affect co-regulation into a couples lives.
27	Wittenborn, Andrea K., Liu, Ting,Ridenour, Ty A.,Lachmar, E. Megan,Mitchell, Erica A.,Seedall, Ryan B.	2019	Randomized controlled trial of emotionally focused couple therapy compared to treatment as usual for depression: Outcomes and mechanisms of change	USA	Research	Examine the effectiveness of EFT for depression and relationship satisfaction and explore mechanisms of change.	Quantitative - Randomized Control Trial	28 couples in the USA, 66.7% married	Couples	EFT showed greater improvements in depressive symptoms for Men compared to usual case and in some cases relationship satisfaction preceded these improvements. Overall encouraging results for the potential for EFT to treat depression.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
28	Wong, Tat-Ying, Greenman, Paul S., Beaudoin, Valerie	2018	Hold Me Tight: The generalizability of an attachment-based group intervention to Chinese Canadian couples	Canada	Research	Test the effect of the Chinese-language version of the Hold Me Tight program	Quantitative	23 Chinese Canadian Couples	Couples	First empirical evidence of potential efficacy and applicability of an attachment-based program like HmT. Supports that attachment orientations may be more malleable and relationship specific than originally thought. Couples made notable improvements couples and family relationship satisfaction after HmT program.
Attachment + Work + MH										
29	Albert, Lumina S., Allen, David G., Biggane, Jonathan E., Ma, Qing	2015	Attachment and responses to employment dissolution	USA	Literature Review	Explore whether attachment theory can provide insight into the psychological and behavioral reactions to losing one's job	Literature Review	NA	Employees who lost their jobs	The feelings of loss and grief after losing ones job are strikingly similar to the loss of a critical personal relationship. Research suggests that a strong psychological tie between the employee and the organization are not always correlated with positive outcomes for the organization.
30	Davidovitz, Rivka, Mikulciner, Mario, et al.	2007	Leaders as Attachment Figures: Leaders' Attachment Orientations Predict Leadership-Related Mental Representations and Followers' Performance and Mental Health	Israel & USA	Research	Examine the contribution of leader's attachment styles to their leadership style and follower's outcomes.	Quantitative	23 women and 177 men with the rank of lieutenant or higher within the Israeli army	Israeli Military soldiers	Leaders attachment anxiety correlated to poorer leadership qualities, more self-serving motives and was predictive of followers' poorer instrumental functioning. Leaders attachment avoidance was correlated with failure to act as a security provider and with followers' poorer socioemotional functioning and long-range mental health.
31	Hardy, Gillian E; Barkham, Michael	1994	The relationship between interpersonal attachment styles and work difficulties	UK	Research	Explore the effects of psychological treatments on attachment difficulties at work.	Quantitative	219 depressed clients receiving psychological treatment for stress at work	Employees experiencing stress	Clients with an anxious attachment style correlated with reported anxiety about work performance and relationships. Clients with an avoidant attachment style correlated with concern over work hours and personal relationships. Relationship problems related to insecure attachment were significantly helped by therapy.
32	Jiang, Lixin, Bohle, Sergio Lopez, Roche, Maree	2019	Contingent reward transactional leaders as "good parents": Examining the mediation role of attachment insecurity and the moderation role of meaningful work	New Zealand & USA	Research	Explore the relationship between contingent reward transactional leaders and "good parents."	Quantitative	320 employees for wave 1 and 264 employees returned for wave 2	Employees	A moderated mediation model where attachment insecurity mediates the relationship between leaders and follower job insecurity, burnout and job performance. Meaningful work can act as a moderator.
33	Johnstone, Melissa, Feeny, Judith A.	2015	Individual differences in responses to workplace stress: The contribution of attachment theory	Australia	Research	Clarify the mechanisms linking insecure attachment to maladaptive coping strategies in relation to work stress.	Quantitative	Community sample of 113 men and 115 women	Adults	Stress appraisal was shown to be a mediator between attachment anxiety and maladaptive coping strategies. Results supported the relevance of attachment theory when studying workplace stress.
			Leaders' and subordinates' attachment			Examine the relationship between a leader's and a subordinate's		Study 1: 45 school directors and 321 teachers Study 2: 25 supervisors and 100		Supervisors anxious attachment style correlated to subordinates lower positive affect and job satisfaction but avoidant attachment style correlated to subordinates lower negative affect and higher job satisfaction. A supervisors emotional regulation capabilities was not a mediator between supervisors' insecure attachment styles and supervisors or subordinates affect and job satisfaction. But subordinates

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
35	Landen, Shoshanna M., Wang, Chia Chih D. C.	2010	Adult attachment, work cohesion, coping, and psychological well-being of firefighters	USA	Research	Explore the factors that contribute to a firefighters psychological well being with a focus on adult attachment	Quantitative	173 professional firefighters in the midwest	Firefighters	Insecure attachment had significant direct correlation with psychological well being.
36	Littman-Ovadia, Hadassah, Oren, Lior, Lavy, Shiri	2013	Attachment and autonomy in the workplace: New insights	Israel	Research	Exploring associations between insecure attachment, job autonomy and work-related attitudes and emotions including distress.	Quantitative	150 Israeli Employees	Employees	Significant correlation between avoidant attachment style and all work related outcomes (work emngagement, career commitment work burnout, and emotional distress), and anxious attachment style and burnout and emotional distress.
37	Lopez, Frederick G., Ramos, Katherine	2016	Predicting well-being in managers: Test of a positive psychology model	USA	Research	Test a positive psychological model linking adult attachment styles and work authenticity with a predicton of well-being for business managers	Quantitative	208 business managers	Business Managers	A manager's level of attachment insecurity and work authenticity had a significant correlation to their reported level of work stress and job satisfaction.
38	Mikulincer, Mario, Shaver, Phillip R.	2017	Augmenting the sense of attachment security in group contexts: The effects of a responsive leader and a cohesive group	Israel	Commentary	Propose a model of attachment priming outside of the lab and in the workplace	NA	NA	Leaders and subordinates	Strong support for the plasticity of the attachment system across the life span and that responsive leaders and cohesive groups can foster attachment.
39	Pines, Ayala Malach	2004	Adult attachment styles and their relationship to burnout: A preliminary, cross-cultural investigation	Israel	Research	Explore the relationship between attachment and burnout	Quantitative	Study 1: 45 MBA students Additional Studies included 2143 students, nurses, and members of the Israeli Jewish and Arab communities	Varied	Insecure attachment correlates to burnout.
40	Rahimnia, Fariborz, Sharifirad, Mohammad Sadegh	2015	Authentic leadership and employee well-being: The mediating role of attachment insecurity	Iran	Research	Study relationship between authentic leadership and employee well-being as measured through job satisfaction, work stress and stress symptoms	Quantitative	212 Health care providers	Hospital workers in Iran	Authentic leadership negatively impacted attachment insecurity. Attachment insecurity impacts job satisfaction and was associated with higher levels of work stress and stress symptoms.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
41	Reizer, Abira	2019	Bringing self-kindness into the workplace: Exploring the mediating role of self-compassion in the associations between attachment and organizational outcomes	Israel	Research	Investigates whether self-compassion can be a mediator that explains individual differences in attachment and organizational outcome.	Quantitative	202 Israeli service-sector employees	Employees	Suggests that self-compassion can provide a mechanism for understanding organizational outcomes and can help explain individual differences in attachment functioning at work.
42	Ronen, Sigalit, Mikulincer, Mario	2009	Attachment orientations and job burnout: The mediating roles of team cohesion and organizational fairness	Canada & Israel	Research	Explore the mediating effect of perceived work team cohesion and organizational fairness on the relationship between attachment and job burnout.	Quantitative	393 Israeli employees	Employees	Attachment insecurity was correlated to higher levels of job burnout and attachment insecurities at work were related to negative perceptions of team cohesion and organizational fairness.
43	Ronen, Sigalit, Mikulincer, Mario	2012	Predicting employees' satisfaction and burnout from managers' attachment and caregiving orientations	USA & Israel	Research	Examine the relationship between a leader's attachment orientation and a subordinates job satisfaction & burnout	Quantitative	483 Employees (subordinates) and their 85 direct managers	Employees	Manager insecure attachment predicted higher job burnout and lower job satisfaction among subordinates. Subordinate attachment insecurity was also associated with burnout and job dissatisfaction.
44	Schirmer, Lisa L., Lopez, Frederick G.	2001	Probing the social support and work strain relationship among adult workers: Contributions of adult attachment orientations	USA	Research	Examine the impact of supervisor support and employee attachment in relation to work-related strain	Quantitative	117 University employees	Employees	Supervisor support and employee attachment insecurity predicted work-related strain
45	Simmons, Bret L., Gooty, Janaki, Nelson, Debra L., Little, Laura M.	2009	Secure attachment: implications for hope, trust, burnout, and performance	USA	Research	Examine whether a model incorporating hope, trust in one's supervisor and burnout can explain the benefits of secure attachment for better supervisor performance	Quantitative	161 Employees & their supervisors at an assisted living center	Employees	Secure attachment has a significant positive relationship with hope, trust in one's supervisor and burnout but only trust has a significant positive relationship with supervisor performance
Attachment + Work										
46	Harms, P. D.	2011	Adult attachment styles in the workplace	USA	Commentary & Literature review	Explain attachment styles, why they may have been overlooked in relation to organization behavior by researchers and potential ways to reconcile attachment theory with other models of personality	NA	NA	NA	Attachment orientation is an important factor in the modern, relational workplace and more research is needed to better understand its role.
47	Harms, P. D., Bai, Yuntao, Han, Guohong Helen	2016	How leader and follower attachment styles are mediated by trust	USA & China	Research	Better understand the influence of attachment within leader-follower relationships has on both emotional and behavioral work outcomes - specifically the impact of insecure attachment on trust in leaders, stress and citizenship behaviors.	Quantitative	152 Employees and 28 supervisors at a restaurant in Ohio USA	Employees and supervisors	When an employee has an avoidantly attached leader, Anxiously attached employees experienced more stress and avoidantly attached employees were less likely to engage in citizenship behaviors. Also attachment orientations and work outcomes were mediated by trust in a leader.
48	Hazan, Cindy, Shaver, Phillip R.	1990	Love and work: An attachment-theoretical perspective	USA	Research	Explore the relationship between attachment theory and work	Quantitative	Study 1: 670 Adults; Study 2: 290 subset of study 1	Adults	Research indicated that attachment at work is similar to attachment/exploration dynamics in infancy, suggesting that the dynamics may be similar throughout one's lifespan.

Column1	Author	Year	Title	Country	Type	Aim	Study Design	Sample	Population	Findings
49	Hazan, Cindy, Shaver, Phillip R.	1994	Deeper into Attachment Theory	USA	Commentary	Respond to comments on their article : Love & Work: An Attachment-theoretical perspective	NA	NA	NA	In th theod aspe not i
50	Marmarosh, Cheri L.	2022	Attachments, trauma, and COVID-19: Implications for leaders, groups, and social justice	USA	Commentary	Emplore how attachment styles impact group leadership through comentary on two published articles, with the aim of informing group therapy leadership	NA	NA	NA	All s style tow men
51	Maysless, Ofra	2010	Attachment and the leader-follower relationship	Israel	Commentary and Literatue Review	To explore the circumstances under which a follower and leader form an attachment relationship and how they attachment styles affect the quality of that relationship	NA	NA	NA	Seve atta soci effe
52	Popper, Micha and Maysless, Ofra	2003	Back to basics: applying a parenting perspective to transformational leadership	Israel	Commentary	Explore the developmental processes that underlie the relationship between transformational leaders and followers	NA	NA	NA	The stud 'scal "exp
53	Yip, Jeffrey, Ehrhardt, Kyle,Black, Hunter,Walker, Dayna O.	2018	Attachment theory at work: A review and directions for future research	USA	Literature Review	Provide an overarching framework for understanding attachment dynamics at work and review findings from attachment research on dyadic relationships, group dynamics and the relationship with employees and their organizations.	NA	NA	NA	Atta orga stab worl belo pers relat orga
Common Factors & Other Experiential Therapies										
54	Bohnein, Joscha, et al.	2029	Factors influencing the success of exposure therapy for specific phobia: A systematic review	Germany	Literature Review	Summarize current state of research on exposure therapy for specific phobias (SP)	NA	111 studies with participants who had specific phobias	NA	Posi anxi high evok relat varia
55	Lambert, Michael J., Barley, Dean E.	2001	Research summary on the therapeutic relationship and psychotherapy outcome	USA	Commentary	Explore the impact of common factors on therapy outcomes	NA	NA	NA	Ther cura relat ther and
56	Wampold, Bruce E.	2015	How important are the common factors in psychotherapy? An update.	USA and Norway	Commentary	Provide a contextual model of psychotherapy to better understand the evidence supporting common factors that underlie therapeutic outcomes	NA	NA	NA	The incu adap for p
57	Whitehouse, James	2018	What do clients say about their experiences of EMDR in the research literature? A systematic review and thematic synthesis of qualitative research papers	UK	Literature Review	Systematic review to assess qualitative experience of EMDR from client's perspective	NA	NA	NA	EMD are e worl and

5.4 Revised Program Theory Based on Realist Review

In this section, I first provide a narrative and visual overview of the revised program theory based on the literature (Figure 16), including a table and overview of each CMOC (Table 20).

5.4.1 Revised program theory narrative overview

For positive therapeutic outcomes to potentially occur in EFT, a therapeutic alliance (including a warm and empathetic therapist, aligned goals, belief in the therapeutic process, and a clear boundary of the therapeutic relationship) needs to be established. Once this is in place, safety and trust can develop in the room, enabling the exploration of deeper emotions (CMOC 1). By building this alliance, the therapist can serve as an attachment surrogate, providing a safe haven for support during stress and a secure base from which clients can explore their deeper emotions, fears, and experiences (CMOC 2). As sessions continue, if the therapist maintains attuned, empathetic, and supportive responses, they can help clients co-regulate the difficult emotions that arise during therapy. Over time, this supportive and validating experience can be internalized by the client, aiding in their ability to regulate challenging emotions (CMOC 3).

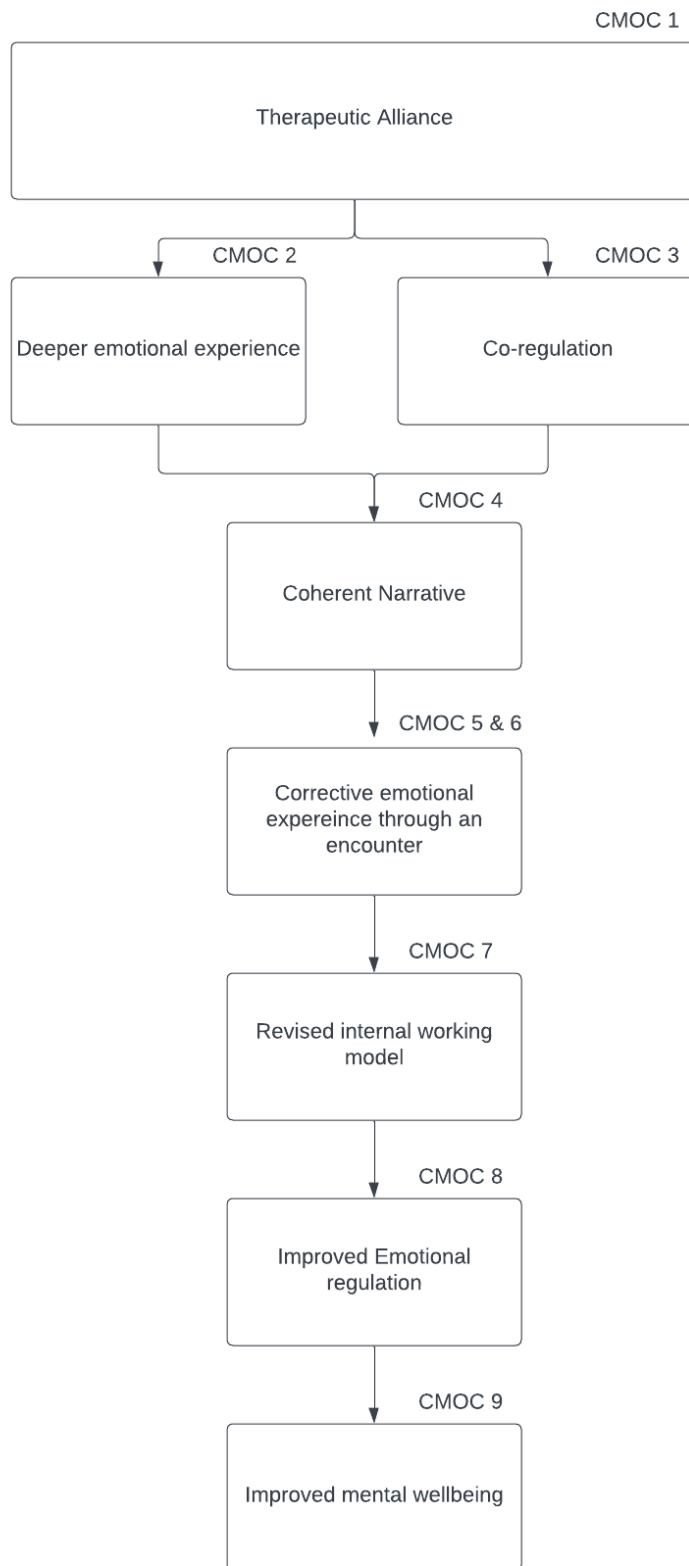


Figure 16: CMOC Map for the Realist Review of Emotionally Focused Therapy

This therapeutic alliance can establish a foundation for identifying and sharing disowned or suppressed emotions like fear, shame, and anger. If left unchecked, these emotions can create a harmful cycle that can negatively impact the client's relationships and health. By naming and constructing a clearer narrative for these emotions, it may become possible to break this negative cycle. This process can help a client replace feelings of shame or confusion about their emotions with greater clarity about their origins, leading to increased self-compassion (CMOC 4).

As part of this process, the EFT therapist uses techniques to help deepen a client's emotional experience through tone, pacing, and micro-interventions like reframing, reflection, and validation, among others. These techniques aim to build emotional depth while ensuring enough safety for clients to explore vulnerable emotions. This can help prepare clients to take risks in the next steps of therapy and set the stage for an experience that can lead to positive therapeutic outcomes (CMOC 5).

When the client is experiencing their vulnerable emotions and acknowledging their attachment needs and fears, the therapist looks to see when they may be ready to share them with someone who matters, called an encounter. In EFCT, that is with a significant other in the room, in EFIT, that is with the therapist, part of self or imagined other. When clients take this risk and are met with empathy, acceptance and support, co-regulating their experience, they may have a what EFT calls a corrective emotional experience that can further disrupt negative attachment patterns and behaviors (CMOC 6).

A corrective emotional experience is one in which a client has a new experience of receiving support at a critical time of need, such as during an EFT encounter (Tango step 3). This experience has the power to show them there are other experiences than the ones they may have

previously known where they didn't receive support. This can change what attachment theory refers to as the internal working model of relationships – a person's view of themselves and others. Specifically, their view of whether they are worthy of receiving support and whether they can trust support will be available when needed. This shift can alter their sense of security in relationships, moving the client from using insecure attachment behaviors like withdrawing to more secure behaviors like seeking support in times of need (CMOC 7).

This new sense of attachment security can help a person feel more confident that support may be available when needed. This new confidence in their ability to find support can help them regulate their emotions more effectively, reducing the occurrence of impulsive reactions, which can help overall resilience in moments of stress. This can remove the need for prior insecure attachment behaviors like isolation and emotional suppression that fed a negative cycle. (CMOC 8).

Finally, improved emotional regulation and a felt sense of attachment security can be tied to improved mental health and well-being. Once a client has improved their emotional regulation skills and internalized this new felt sense of attachment security, they may feel more confidence that they can handle life's challenges because they are better able to self-regulate and seek support from others when needed. This can reduce anxiety, depression, and stress and improve a client's overall resilience (CMOC 9).

This narrative of the refined program theory from the realist review shows the potential of attachment-based EFT to facilitate positive client outcomes. The following sections provide an overview of the revised program theory (Figure 16, Table 19) and more narrative detail on each CMOC.

Table 20: Refined program theory from the realist review

Overview	CMOCs	References
<p>Therapist as attachment surrogate: Creating and maintaining a safe haven & secure base for exploration</p>	<ol style="list-style-type: none"> 1. When the therapist creates and maintains a therapeutic container and task alliance (C) they can build and maintain a strong therapeutic alliance (O) because there is trust and safety in the relationship (M). 2. When the therapist builds a strong therapeutic alliance with the client (C) the client may have a deeper emotional experience in session (O) because the therapist becomes an attachment surrogate providing a safe haven and secure base for exploration (M) 3. When a therapist builds a therapeutic alliance, staying present and attuned with a client (C) then the client may be able to improve emotional regulation (O) because their emotions can be more safely co-regulated (M) 	<p>(12, 25, 27, 29, 32, 34, 52, 84, 142-147)</p>
<p>Identifying a coherent narrative of the emotional experience</p>	<ol style="list-style-type: none"> 4. When therapist & client identify and co-regulate disowned emotions and needs (C) they can interrupt a negative attachment cycle (O) because emotions now make sense as a coherent narrative, reducing shame (M) 	<p>(12, 24, 29, 52, 148-150)</p>
<p>Heightening emotions to prime a corrective emotional experience</p>	<ol style="list-style-type: none"> 5. When the therapist heightens a client's emotional experience using RISSSSSC and micro-interventions (C) then the client is more primed for a corrective emotional experience (O) because they can access deeper emotions (M) 	<p>(12, 25, 32, 52, 123, 143, 151-155)</p>
<p>Corrective Emotional Experience: Expressing emotions to someone who matters</p>	<ol style="list-style-type: none"> 6. When the client can express their deeper emotions to someone who matters (other, imagined other, part of self, or therapist) (C) then they may have an emotionally corrective experience (O) because they took a risk sharing their attachment needs 	<p>(12, 29, 32, 34, 52, 149, 151)</p>

	and fears (M)	
Revising the internal working model of relationships	<p>7. When a client has an emotionally corrective experience in an encounter (C) then they can change their internal working model of relationships (O) because they experienced support when sharing their attachment needs and fears (M)</p> <p>8. When a client revises their internal working model of relationships (C) they are better able to regulate their emotions (O) because they improve their felt sense of attachment security, enabling them to reach out for support (M)</p>	(2, 7, 8, 12, 15, 18, 23, 26, 34, 44, 52, 85)
Reduced emotional distress	9. When a client can better regulate their emotions (C) then they feel less mental health distress (stress, burnout, and similar) (O) because the felt-sense of security provides confidence they can handle stress and challenges(M)	(12, 15, 34, 52, 85)

5.4.2 Revised Program Theory CMOC Breakdown

5.4.2.1 CMOCs 1-3: Therapist as attachment surrogate: Create and maintain a safe haven & secure base for exploration

A foundational element of therapy is the therapeutic relationship and alliance with the client. When the therapist builds a strong alliance with a client, they can act as an attachment surrogate, meaning they can provide a safe haven during times of stress and a secure base in which to explore new possibilities (12). Research has shown this alliance to be an important component for desired therapeutic outcomes (32). In EFT, the therapist starts to build this alliance right at the beginning of therapy, step 1 of the tango, and then works to maintain it throughout the full course of therapy.

CMOC #1: When the therapist creates and maintains a therapeutic container and task alliance (C) they can build and maintain a strong therapeutic alliance (O) because there is trust and safety in the relationship (M).

Relevant extracts from papers included in the review:

1. In a 2011 metaanalysis, Horvath et al. looked at the task alliance (e.g. agreement on the goals and associated tasks of treatment that help build the foundation of a therapeutic bond) between 14,000 clients and their therapists over 200 studies and found that the aggregate correlation to therapeutic outcome was greater than the threshold for a medium-sized effect (144, 156).
2. The therapist creates the therapeutic alliance by first developing task alliance. For therapy to progress, clients need to trust the therapist and believe in the relevance and importance of deepening their experience and having uncomfortable encounters in session. Therefore, task alliance is needed to enable deeper emotional experiences and change for the client (143).
3. EFT asks clients to be vulnerable and engage deeply with their emotions, and this requires a strong container, which generally includes: “confidentiality and privacy, physical safety, scheduling, and availability, clarity about who attends and engages in sessions, and a consistent, reliable therapeutic presence” (153)
4. “In order to create safety and coherence it is important for the therapist to be in control of the sessions,” (26, 143).

Therapeutic alliance, the connection and agreement of work between therapist and client, is a foundational part of enabling intended therapeutic outcomes. For the client to feel safe enough to take risks and identify and explore challenging emotions in therapy, they must first build trust and safety with their therapist (12). There are three parts of the therapeutic alliance: the bond, the agreement of the goals of therapy, and the agreement about the tasks of therapy (144).

Building therapeutic alliance starts with task alliance, meaning agreement on goals between the therapist and the client. There is a strong relationship between this alliance and positive outcomes in therapy, as shown by the Hovarth study in 2011 (144). For therapy to progress, clients need to trust the therapist and believe in the relevance and importance of the work they are doing together in therapy, including deepening their experience and having uncomfortable encounters in session. Therefore, task alliance is needed to enable deeper emotional experiences and change for the client (143).

To build task alliance, therapists show transparency around the process, respond to the client in moment-to-moment interactions and micro-interventions: validating reactive emotions, asking evocative questions, conjecture, and reframing experience through an attachment lens (143). To sense whether clients believe in the shared goals and tasks, EFT therapists need to be highly attuned to whether the client truly believes in the relevance of the tasks (143). These findings are consistent with the EFT process, which emphasizes emotionally attuned responsiveness (12, 32). Therapists' awareness and access to their own emotional experience is also a key part of presence and attunement (25).

Beyond task alliance, EFT therapists create this trust by creating a therapeutic container. This container starts with informed consent and the boundaries set within therapy, like when and where sessions will happen, the length of sessions, and the facilitation of the EFT tango within sessions. Throughout a session, but particularly during moments of deep experiencing or escalation, therapists need to keep control of the session to create and maintain safety (143). Therapists also must act as a process consultant to lead clients through the EFT process with confidence, so clients feel safe enough to have a deeper emotional experience (32).

Once therapists establish a strong therapeutic alliance, this trust and safety needs to be maintained. If during an encounter or at any other time during the session the client doesn't feel safe enough to take the risk the therapist is asking them to take, the therapist can 'slice it thinner' and ask them to take a smaller risk, bringing them back to safety (27). This helps maintain task alliance by continuing to make progress, while maintaining safety of the therapeutic container.

CMOC #2: When the therapist builds a strong therapeutic alliance with the client (C) the client may have a deeper emotional experience in session (O) because the therapist becomes an attachment surrogate providing a safe haven and secure base for exploration (M)

Relevant extracts from papers included in the review:

1. Researchers have shown that therapists can show their presence through tone and non-verbal cues and it can deepen an emotional experience in session. A study by Furrow in 2012 shows that when a therapist softened their voice in an interaction clients' emotional experience heightened 2.2 times. All these findings are consistent with EFT, which emphasizes an emotionally attuned responsiveness (12, 25, 32, 154, 157).
2. "Present process guides the therapist and client into new ways of processing experiences through a surrogate attachment relationship with the therapist. The therapist attunes to the client's experience or interactions with the client as they occur in session and deepens awareness and interactions in the moment to allow new elements of reality to arise" (29).
3. "Rogerian empathic responding is key to creating the 'safe haven and secure base' of which Bowlby (1969/1982) wrote. The responsive and engaged therapeutic relationship provides both the safe haven of comfort, acceptance and understanding as well as a secure base from which a client can safely explore inner and outer worlds...The therapeutic relationship provides a secure base 'platform for the tasks of distilling primary or core emotions and processing these emotions, so that they move the client toward new responses to self and other'" (12)

EFT is an experiential therapy where having a deeper emotional experience in session is believed to be an important precursor to positive therapeutic change (12, 26). Feeling safe in sessions and trusting the therapist can help clients take risks and allow themselves to experience and face difficult emotions (12). This concept is grounded in attachment theory, which suggests that for individuals to engage in deeper emotional exploration and take risks, they must first feel safe and secure.

To enable this, as discussed in CMOC 1, EFT therapists build this trust and safety by creating a therapeutic alliance, including task alliance and a therapeutic container (12, 144, 153). When a therapist builds this safe alliance, attachment theory indicates they can become an attachment surrogate providing a safe haven for support during times of stress and secure base enabling deeper emotional exploration (29, 149). An attachment surrogate can provide support in therapy sessions like a parent in childhood or significant other in adult life (12, 29). The therapist can also play this role when a client does not have access to that support and safety in other relationships in their lives. By being attuned, present and responsive the therapist can create the safe haven and secure base in therapy and sessions and enable the client to delve deeper into their emotions, which is seen as important for positive outcomes in EFT (12). This safety allows the client to be more vulnerable and access and express emotions that may have previously been ‘disowned’ or avoided, and this can facilitate growth and healing (32).

<p><i>CMOC #3: When a therapist builds a therapeutic alliance, staying present and attuned with a client (C) then the client may be able to improve emotional regulation (O) because their emotions can be more</i></p>

safely co-regulated (M)

Relevant extracts from papers included in the review:

1. “Beckes and Coan (2011) asked study clients to estimate the slope of a hill. Standing at the bottom of a hill, wearing a heavy backpack, they judged the slant of the hill they were about to climb to be less steep when they stood next to a friend than when they stood alone. Additionally, the longer the friendship, the less steep the hill appeared. The co-regulation of stress and perception of threat was outside their awareness” (12, 158)
2. One study showed that when given an electric shock, the neurological stress response was lower when holding a partner’s hand after EFT compared to holding a stranger’s hand or being alone. This supports the suggestion that the secure attachment that can result from co-regulation and EFT can bring resilience when faced with stress (12, 34, 159).
3. When therapist and client have an attuned relationship they can co-regulate a client’s emotions and need for connection and the relationship can provide a secure base for processing difficult emotions so the client can develop a new working model for how they relate to themselves and others (12).
4. “Empathically attuned relationship from the first moments of therapy, co-regulating the client’s emotions, validating that longings and needs for connection with the therapist and others in the client’s life are components of healthy functioning” (12, 51).

Sue Johnson, the creator of EFIT, describes emotional regulation as:

"The process by which we manage and make sense of our emotional responses. In the context of attachment, it involves the capacity to experience emotions without being overwhelmed by them, to organize them in ways that support effective functioning, and to reach out for and respond to comfort from others when needed" (27).

When someone is able to regulate their emotions, they are able to detect, assess and change their emotional response to a situation, instead of reacting in a way that may not be in service to their goals (52). The importance of emotional regulation for health and reaching goals makes it one of the key parts of the therapeutic process to develop greater resilience (12, 52).

Building on the previous CMOCs, when a therapist creates a safe environment, becoming an attachment surrogate for the client, they can help the client co-regulate difficult emotions, which can lead to improved self-regulation over time. Co-regulation is a process where the therapist is highly attuned, present and responsive to the client while the client is sharing deeper and often difficult emotional experiences that may feel overwhelming to process on their own. The concept of co-regulation is illustrated by research findings, such as a study where people perceived a challenge to be less intimidating when near a friend, showing how our stress responses can be moderated by the presence of key others (12, 158). Therefore, a bond between the therapist and the client is important for this process and is formed through the therapeutic alliance as described in previous CMOCs (12, 29, 153). Studies have shown that co-regulation is more likely to occur within a securely attached relationship built from emotionally engaged interactions between two people over time (52). EFT aims to create an environment where clients feel safe to explore deeper emotions and having those feelings and needs acknowledged and validated as a part of co-regulation.

5.4.2.2 CMOC 4: Identifying a coherent narrative of the emotional experience

As Sue Johnson, founder of EFT has said, “what we can name, we can tame.” When we don’t understand our emotions, they feel alien to us, potentially bringing shame, and can lead to negative cycles and behaviors that create further distress. EFT therapists use step 2 of the EFT

tango to help clients understand a coherent narrative that makes sense of these previously foreign and disowned emotions. This sets the client up for step 3 of the tango, an encounter where they share these emotions and attachment fears.

CMOC #4: When therapist & client identify and co-regulate disowned emotions and needs (C) they can interrupt a negative attachment cycle (O) because emotions now make sense as a coherent narrative, reducing shame (M)

Relevant extracts from papers included in the review:

EFT's approach to negative cycles and its potential impact:

1. Having a coherent narrative of emotions has been correlated with reduced depression and anxiety as well as creating positive outcomes at work like job performance and reducing desires to leave a job and emotional exhaustion at work (24, 149).
2. EFT therapists use reflections, evocative questions and conjectures at the edge of the client's conscious experience to further follow the cycle and identify the deeper underlying primary emotions like fear of abandonment and unmet needs like being loved or feeling valued and cared for. Since EFIT is dyadic, a therapist can map this cycle between two parts of self (e.g. a younger self and an adult self) or between self and another person (12).
3. Once the cycle is identified, the therapist enables the client to assess the images and beliefs of themselves and their purpose in the past, present and future, if any, to help the client understand what has created those images and beliefs of self and the impact it has had on their actions and experiences (53, 148).
4. "The therapist's fifth task is to enable his patient to recognize that his images (models) of himself and of others, derived either from past painful experiences or from misleading messages emanating from a parent ... may or may not be appropriate to his present or future; or, indeed, may never have been appropriate. Once he has grasped the nature of his governing images (models) and has traced their origins, he may begin to understand what has led him to see the world and himself as he does and so to feel, to think, and to act in the ways he does (53, 148)

Attachment cycles can be created when humans seek comfort in times of stress (12). As primates, we have innate needs for connection especially in moment of distress, and if the needs are met, we feel safe, and if they are not met, panic along with anger, fear, and shame can ensue. This can lead to a hyperactive (pursuing behaviors) or hypoactive (withdrawing behaviors) response to restore security that can continually be triggered forming a repeating pattern. They are recurrent and can exacerbate insecure attachment and lead to maladaptive emotional regulation and relationship strategies (11, 29). This cycle can hold a person back from effectively seeking and accepting support as well as being able to regulate their emotions, further reinforcing the cycle. The patterns themselves often become a reason for therapy because of the inability to self-regulate and relational stress that results from the pursuing and withdrawing behaviors (12).

Addressing these negative cycles can help uncover and process unmet needs and disowned emotions within the context of attachment. Cognitively understanding the negative cycle that is underneath the distress for a client provides a stable and clear structure that is an important foundation for sharing deeper emotions, co-regulating and having an emotionally corrective experience (12, 51, 52). Through co-regulation of these emotions and needs using EFT, a client may be able to reassess their beliefs about themselves and others, helping them better understand how these beliefs were formed and the impact they have had on the person's life and mental health. This clarity can form a more coherent narrative about one's emotions and behaviors, which can be validating and reduce shame that can fuel these negative cycles (52). Shame, feeling unworthy and like there is something wrong with you or you are bad in some way, can be an obstacle and barrier to therapeutic outcomes if not addressed (149, 160). By

understanding, sharing and co-regulating these beliefs, emotions and needs that fuel a negative cycle, clients can reduce shame, interrupt the negative cycle and aim for healthier relational patterns (12).

Using EFT's micro-interventions (reflection, validation, evocative questions, reframing and conjecture) therapists can help clients identify this cycle and co-regulate the attachment fears and unmet needs fueling it, giving a name to emotions that have been previously disowned. EFT therapists use these micro-interventions at the edge of the client's conscious experience to further follow the cycle and identify the deeper underlying primary emotions like fear of abandonment and unmet needs like being loved or feeling valued and cared for (12, 153). Since EFT is dyadic, a therapist can map this cycle between two parts of self (e.g. a younger self and an adult self) or between self and another person (12). Once the cycle is identified, the therapist enables the client to assess the images and beliefs of themselves and their purpose in the past, present and future, if any, to help the client understand what has created those images and beliefs of self and the impact it has had on their actions and experiences (53, 148). This process can create a coherent narrative, meaning developing an understandable and acceptable view of one's emotions, behaviors and why they are the way they are based on a client's previous experiences. It aims to be a normalizing experience, meaning that clients feel validated in their reactions instead of shamed, making it more likely they will be able to identify and interrupt the cycle when it happens outside of session. This type of insight has been correlated with reduced depression and anxiety (149) as well as creating positive outcomes at work like job performance and reducing emotional exhaustion and the desire to leave a job (24).

5.4.2.3 CMOC 5: Heightening emotions to prime a corrective emotional experience

Emotion is seen as the change agent in experiential therapies like EFT. Therapists use micro-interventions, tone, pacing, and other techniques to heighten and deepen the emotional experience while continuing to maintain the therapeutic container and safety so clients can continue to explore and make sense of difficult emotions. The coherent narrative formation discussed in CMOC 4 and the deeper exploration of emotions is what primes clients to move to step 3 of the EFT Tango, the encounter, where they may be able to share their deeper emotions and have a different emotional experience, which can be therapeutic.

CMOC #5: When the therapist heightens a client's emotional experience using RISSSSSC and micro-interventions (C) then the client is more primed for a corrective emotional experience (O) because they can access deeper emotions (M)

Relevant extracts from papers included in the review:

Importance of deeper emotional experiences in session:

1. EFT research has shown that the depth of emotional experience in EFT sessions is a predictor of improved outcomes for a client (25, 32, 143, 152).
2. Further, deeper emotional experiencing in EFT sessions has been said to be related to more self-disclosure and sharing of emotions, also referred to as “affiliative responses,” creating a positive feedback loop between experiencing and sharing deeper emotions and outcomes like improved relationship satisfaction (151).

Micro-interventions and therapist approach that leads to deepening

3. “Zuccarini et al. (2013) sought to better understand the therapeutic interventions involved in fostering healing of attachment injuries in EFT. They found that interventions as formulated in the EFT model including evocative responding, increasing awareness of process patterns and emotions, structuring

encounters, and facilitation of softer, primary emotions were associated with the resolution of an attachment injury in the relationship (151, 152). This is consistent with the emphasis in EFT on interventions that deepen the exploration and sharing of attachment needs and primary affect in the relationship are central to successful outcome” (32, 151).

4. Using the EFT view of therapy presence, specifically repetition, imagery, slow, soft, simple, somatic, specific and client’s words (RISSSSC), creates safety in the session, can lead to a deeper emotional experience, and helps to keep focus in a session (153).
5. “When EFT therapists softened their voice during an intervention, partners were 2.2 times more likely to have a heightened level of emotional experiencing” and clients’ emotional experiencing is a predictor of successful therapy outcomes” (25, 32, 153, 157).
6. “Holding the “container” with heavy doses of RISSSSC soothes partners’ nervous systems and creates an increased sense of safety, maintains the focus of the session, and often leads to further deepening” (153).

EFT sees emotions as the change agent in therapy, and that moment of change is called an emotionally corrective experience. An emotionally corrective experience in EFT is one where a person re-encounters something that was previously distressing but is now being experienced in the context of a co-regulating therapeutic setting where they feel safe (12, 52). This may enable them to respond in a new way, potentially altering future emotional responses and view of self and others (e.g. what attachment theory refers to as the internal working model of relationships).

According to Sue Johnson, founder of EFT, the goal of EFIT is: “to give clients an integrative corrective emotional experience in which they explore new ways to engage with their own experience, with others, and with the existential dilemmas of life” (28). Within EFT, these experiences occur when a client is able to reprocess painful emotional events by deeply engaging

with the emotions they have previously avoided or not understood (12). A client is guided to explore and express vulnerable emotions like sadness, fear, longing and shame, co-regulating with the therapist who is also facilitating a re-examination of these emotions and the behaviors they lead to. This not only allows clients to confront, reprocess and co-regulate emotional pain, but it can also promote the integration of new and positive experiences within the therapy setting. When clients feel safe in therapy, they can explore and find new meaning as well as new emotional responses to these events, aided by co-regulation with the therapist (52). This transformative event and how the depth of emotional experiencing within session correlates to the likelihood of a substantive and corrective emotional shift, with the potential to result in improved emotional regulation, attachment security and relationships (32, 151).

As discussed in previous CMOCs, therapists can build and maintain this trust and alliance using EFT micro-interventions (validation, reflection, reframing, conjecture, and evocative questions) and their tone and pace (RISSSSSC: Repeating, Imagery, Soft, Slow, Somatic, Simple, Specific, Client's words) (12, 153). Researchers have shown that therapists can show their presence through tone and non-verbal cues and it can deepen an emotional experience in session (25, 32, 154, 157).

Physiology, such as heart rate, also plays a role in this change process, providing a tangible indicator of client's engagement and emotional depth according to research. Emotions are a system that process biological information, emotional needs, experiences from past and present, perceptions and beliefs about one's environment, and any expected consequences (84). Heart rate changes have been shown to be an important factor in the success of exposure therapies (161) because they have a strong correlation to depth of experiencing (52, 162).

5.4.2.4 *CMOC 6: Corrective Emotional Experience: Expressing emotions to someone who matters*

An important step that can lead to an emotionally corrective experience happens in the EFT tango stage 3, the encounter, which is when a client shares their unmet attachment needs or emotions that are now a part of a coherent narrative, with someone who matters. In EFCT, that is their partner, and in EFIT, that is the therapist, an imagined other, or a part of self. The previous CMOCs and EFT tango steps are building safety, a coherent narrative and deepening emotions, which all enable and come together in the encounter.

CMOC #6: When the client can express their deeper emotions to someone who matters (other, imagined other, part of self, or therapist) (C) then they may have an emotionally corrective experience (O) because they took a risk sharing their attachment needs and fears (M)

Relevant extracts from papers included in the review:

1. Within EFT it is believed that change comes when clients express attachment fears and needs underlying their pursuing and withdrawing behaviors to someone who matters (29, 34, 163, 164).
2. With individuals, therapists structure an encounter with a part of self, imagined other, or the therapist to create a potential emotionally corrective experience, where the client can take a risk and express their attachment fears and needs, newly realized through EFIT tango step 2, and then co-regulate the experience with the therapist. (12)
3. In couples using EFT, depth of emotional experiencing and the therapist shaping encounters (e.g. expressing these emotions and attachment needs to someone who matters, in the case of couples a person's partner) have been shown to be the two key elements for change in the therapeutic process (32, 151).
4. During an encounter, an emotion is "expanded, expressed and reprocessed" to create a new "broaden &

build” pattern of emotional regulation (47) and changing the way the brain responds to threats and how the client seeks and responds to support (12).

5. During the encounter, receiving comfort from a person who matters, provides a co-regulatory experience that can expand emotional regulation capabilities (52, 165).

When clients express their deeper emotions like attachment fears and needs to someone who matters (in EFIT that would be a part of self, imagined other or therapist) then they may have a corrective emotional experience leading to positive therapeutic outcomes (29, 34, 151). This risk and act of vulnerability is taken by the client and structured and shaped by the therapist into EFT Tango step 3.

Encounters are a highly experiential, immersive and jointly navigated emotional exploration that can enable the co-regulation of deeper emotions, attachment needs and fears. They are highly relevant to client’s challenges because most presenting problems in therapy relate to emotional regulation experienced as a dyadic conflict with another or within oneself (12). Encounters provide a way to confront and reprocess painful relational challenges from the safety of a therapeutic environment. Within these encounters, clients can also call up imagined representations of attachment figures to provide further comfort and a secure base for further exploration (70). Encounters can have the power to alter a client’s internal working model of relationships, which are the blueprint for how a client views themselves and navigates their relationships and world (85). This can fundamentally reshape how a person regulates their emotions and interacts with their environment, including how they seek out and accept support from others (12, 34, 52).

5.4.2.5 CMOCs 7 - 8: Revising the internal working model of relationships

The internal working model of relationships guides our survival strategies for identifying and managing threats as well as seeking support from others. It is formed from the relational experiences throughout our lives. As discussed in CMOc 6, after an emotionally corrective experience, which may occur during an EFT encounter, a client's internal working model of relationships may alter due to the new experience of taking a risk to share something vulnerable, and co-regulating with the therapist. When this happens clients may develop a new view of themselves, others and their world, making it more likely they will reach out to others in moments of distress for support, improving overall emotional regulation and mental health.

CMOC #7: When a client has an emotionally corrective experience in an encounter (C) then they can change their internal working model of relationships (O) because they experienced support when sharing their attachment needs and fears (M)

Relevant extracts from papers included in the review:

Emotionally corrective experiences with couples and individuals:

1. "Insecure models of self and others may be revised or replaced when changes occur in parental caregiving or when the individual is able to utilize his or her ability for reflection to examine contradictions in internal models, as well as to initiate and experience new relationships or when the individual has a corrective experience such as a supportive and sensitive relationship with a significant other, a friend, or a psychotherapist (53, 85)
2. Corrective emotional experiences reshape the internal working model of attachment bringing lasting change (12).
3. EFT research with couples has shown that attachment-based dialogues between partners can shift their individual working models of attachment and their attachment regulation strategies, showing it is

possible to change one's internal working model with a short-term therapy like EFT (26).

Potential for therapy with professional populations:

4. Therapy has been shown to help professionals with insecure attachment at work by altering their internal working model (15, 23, 44). Hardy & Barkham (1994) researched the impact of 18 sessions of therapy on insecure attachment in professionals and found more than a half standard-deviation positive change in anxious & avoidant scale measures (23, 44). This research shows the malleability of internal working models and attachment strategies and the potential for attachment-based therapy to have an impact with a professional population (44).

EFT involves facilitating a process whereby clients can confront, evaluate and co-regulate difficult emotions to move away from emotional suppression and towards breaking negative attachment cycles. As discussed in previous CMOCs, sharing attachment needs and fears with someone who matters (in EFT that is the therapist, part of self or imagined other) while co-regulating with the therapist can create an emotionally corrective experience. EFT research with couples has shown that encounters during the EFT tango have been powerful enough to change a client's internal working model, e.g. their view of themselves and their relationships, changing how they seek out support in times of stress (12, 28, 85). Based on attachment theory, this means a client can shift their negative beliefs about themselves and others to more positive ones such as being worthy of care and support and others having the potential to be trustworthy and reliable providers of support (11).

These internal working models have been shown to be malleable. Bowlby believed that changes to attachment patterns could occur throughout one's life (Bowlby, 1988). An important concept in EFT and attachment science is that people develop internal working models through their interactions in key relationships throughout their lives. These models can have a great

influence on how someone interacts with the world. A negative model can lead to someone feeling unworthy and not trusting others, whereas a positive model can lead to feelings of self-worth and expecting support from others (11, 12). EFT aims to alter these models through positive interactions in the therapy session that can then lead to transformational change outside of the session. Research by Hardy & Barkham (1994) also indicates that therapy can alter the internal working model of people experiencing insecure attachment in a work setting (23, 44).

CMOC #8: When a client revises their internal working model of relationships (C) they are better able to regulate their emotions (O) because they improve their felt sense of attachment security, enabling them to reach out for support (M)

Relevant extracts from papers included in the review:

1. In EFIT, a corrective emotional experience between parts of self (e.g. a judgmental part, a child part, and other) can shift emotional regulation patterns from that of suppression to acknowledging and caring for primary emotions, enabling a shift in a negative cycle where the client will start to reach for safe others and stop pursuing unavailable others (12).
2. “A working model of others is represented by a person's belief regarding the accessibility and availability of other people in times of need (8). Together, these models have been found to predict feelings and behaviors that people adopt towards their work and employment relationships (18), as well as the degree to which individuals may be able to cope with stressors in the work environment (2, 7, 18)
3. Adult attachment researchers have shown that secure attachment is associated with stronger emotional regulation capabilities, self-esteem and satisfying relationships (11, 12).
4. “Since clients’ core problems are viewed as emotional regulation difficulties resulting from the lack of effective connections, the antidote to these problems is to shape loving human connections between the client and others in his or her life, between the client and the therapist and within the individual” (12)

Emotional regulation is an important skill for managing stress and maintaining mental and emotional well-being, further linking secure attachment to mental health outcomes. Building on the previous CMOCs, when a person has an emotionally corrective experience that changes their internal working model – their view of themselves and others – their previous insecure attachment behaviors can shift to more secure ones. Instead of pursuing or withdrawing in relationships, they start to seek support in times of distress believing that they are worth that support and that others may be there to support them (11). When a person believes they can have support when needed, they can have what is called a felt sense of security in the world and with the people around them. This security can make it more possible for them to self-regulate during moments of stress and threat. People who have a felt sense of attachment security tend to exhibit better emotional regulation skills and feel more competent and confident in their ability to reach their goals and have fulfilling relationships (11, 12). The theoretical basis for this approach is attachment theory, which indicates the mechanism under this outcome is a felt sense of attachment security (12).

5.4.2.6 CMOC 9: Reduced emotional and mental health distress

As seen in previous CMOCs, EFT works towards improving a felt sense of attachment through co-regulating deep emotions, attachment needs, and fears in a way that will feel different and healing to the client. When attachment security improves, a person can feel more confident in their ability to handle challenges because they can believe others will be there for them in moments of stress, helping with overall emotional regulation.

CMOC #9: When a client can better regulate their emotions (C) then they feel less mental health distress (stress,

burnout, and similar) (O) because the felt-sense of security provides confidence they can handle stress and challenges (M)

Relevant extracts from papers included in the review:

1. “Emotional regulation is defined as the detection, assessment, and resultant change of emotional responses to accomplish one’s goals (166). When individuals can regulate their emotions, they are better able to respond rather than react. This creates an increased potential for adaptive functioning as reactivity can deter from meeting their goals,” (52, 166)
2. “Decreased emotional regulation is correlated with several mental health disorders, including attention deficit hyperactivity disorder, bipolar disorder, disordered eating, borderline personality disorder, anxiety, and depression,” (29, 52, 167-170).
3. When someone is securely attached it has been found that they have more confidence in their emotional regulation during times of stress and competence to complete goals, which predicted decreased levels of depression and anxiety, which is consistent with attachment theory’s concept of a secure base (34).
4. The importance of emotional regulation for health and reaching goals makes it one of the key parts of the therapeutic process to develop greater resilience (52).
5. People with secure attachment are believed to have more adaptive coping strategies in times of stress due to their view of themselves as capable of achieving goals and view of others as available and supportive (15).
6. There are many studies linking secure attachment to well-being and resiliency in times of stress (34).
7. One study found a significant negative relationship between secure attachment and burnout (15).

The relationship between emotional regulation and mental health was supported by the literature included in the review. Specifically poor emotional regulation skills were associated with burnout, depression, anxiety, bipolar disorder, and other mental health distress (29, 52, 167-170). This link shows the importance of emotional regulation as an aim for therapy and a

foundational element of mental health and well-being. Being able to regulate one's emotions is not only important for managing day-to-day stressors, but also for long term mental health and achieving long term goals (52, 166).

Secure attachment is a key factor in developing emotional regulation (15, 34). People who have a felt sense of secure attachment have greater confidence in their abilities to handle stressful situations and being able to achieve their goals. This is partially because they believe others will be there for them in moments of stress. In attachment theory, this is aligned with the idea of having a safe haven in times of stress and a secure base from which to explore and take risks. This suggests that secure attachment is a component of developing effective emotional regulation abilities including reaching out to others, having a positive self-view and general view of others as supportive (15, 34).

As discussed in previous CMOCs, EFT aims to support and foster secure attachment by creating emotionally corrective experiences through the five-step tango. This approach is supported by the belief, originally from John Bowlby, that attachment is not set but malleable and can evolve throughout adulthood with new positive experiences and relationships. These emotionally corrective experiences, like encounters, co-regulating with a therapist or receiving support from a key person in a stressful time, can help improve secure attachment (11, 12). Secure attachment is important for emotional regulation as well as one's ability to handle stress, contributing to overall mental health (15, 34).

Aligned with these findings, EFT has shown improvements and been considered as a treatment for individual mental health independently of improvements in outcomes for couples. EFT has been considered as a treatment for people with Generalized Anxiety Disorder (GAD) because people experiencing this disorder often report insecure attachment (171). EFT has also

been considered as a treatment for couples where one partner has Post-traumatic Distress Disorder (PTSD). In one study a sample of ten couples where one partner is diagnosed with PTSD received 19 sessions of EFT and 50% of partners showed a clinically significant improvement in PTSD symptom reduction (34).

5.5 Conclusion

The refined program theory captures how, why, and in what contexts EFT may drive outcomes based on the existing literature and provides a framework for empirical research in the realist evaluation. The findings from the realist review confirmed there was no research on EFIT or EFT for work-related distress based on when the formal literature search was conducted. It did provide a refined program theory extrapolated from EFCT research that became the basis for the realist evaluation study design. It also provided insights into how EFIT may work for the population experiencing work-related distress, although this needs to be tempered by acknowledging the limitations due to the lack of specific literature on EFIT or EFT for work-related distress. The refined program theory that is emerging may provide valuable insights for both researchers and clinicians, informing how EFT can be used with different populations like individuals and in different circumstances, like work. The program theory's evolution shows the importance of having a context-sensitive approach to evaluating complex interventions, contributing to the broader evidence base for EFT and attachment-based therapies.

5.6 About the next chapter

The program theory based on the realist review in this chapter provided the foundation for an empirical study to test it; a realist evaluation of EFIT with ten participants experiencing work-

related distress. The next chapter provides the findings from this realist evaluation, further revising the program theory.

6 Chapter 6 - Realist Evaluation Findings

6.1 About this chapter

This chapter provides the realist evaluation study findings, which confirm, refute, or refine the program theory from the realist review (Chapter 5). The realist evaluation approach was chosen to better understand the underlying mechanisms and contexts that may lead to intended outcomes, making insights more targeted for researchers and actionable for clinicians. Mixed methods were used to provide depth and cross-checking of insights within and across clients.

The chapter is structured to answer the research questions set out in Chapter 1: the contexts and mechanisms that could aid intended outcomes for attachment-based Emotionally Focused Individual Therapy (EFIT). The chapter starts with an overview of the study and clients, followed by the outcomes and the contexts and mechanisms that may have led to them. I also provide a deep dive into one of the key aspects of EFIT outcomes, emotionally corrective experiences, and what may have impeded and aided them. The chapter ends with a revised program theory. Due to word count constraints, data and analysis are summarized in this section, but additional data analysis tables for each section are available upon request.

6.2 Realist Evaluation Program Overview

This realist evaluation ran from November 2023 through August 2024 providing ten participants with twelve sessions of EFIT therapy. Figure 17 provides an overview of the twelve-session flow (detailed view in 4.6.4, Figure 7). I was the clinician, and I took structured notes and reflections during and after each session. All sessions were recorded and transcribed, and both the participant and I also took a four-question Post-Session Resolution Questionnaire

(PSRQ) to assess the session and overall progress after each session. Participants also completed assessments before starting therapy and after, as well as using a heart rate monitor during sessions.

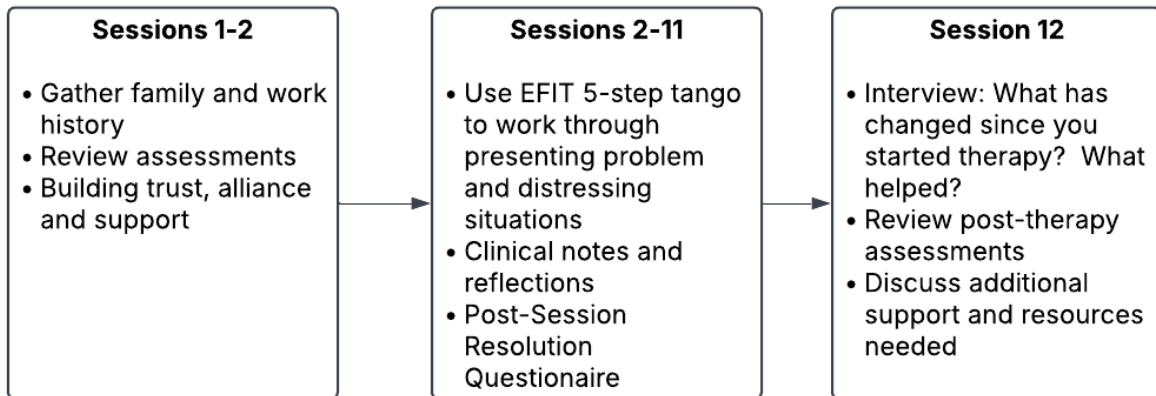


Figure 17: Overview of the twelve sessions

In sessions 2-11, I followed the EFIT tango, but not all sessions completed an encounter (tango step 3). I also used EFIT micro-interventions (Chapter 1, Table 1) and (Repeating, Imagery, Soft, Slow, Somatic, Simple, Specific, Participant’s words). Table 21 provides an overview of the steps. . It must be noted that every session was different, and even though this illustration is laid out in a linear way, not all sessions were this linear.

Table 21: Description of EFIT tango and example potential session flow in sessions 2-11

Example sequence	Overview
Check in	Asking if new thoughts after last session, any updates or challenges over the last week.
Tango Step 1: Mirroring / Reflecting Present Process	Building a therapeutic alliance by repeating back and validating what the participant is saying in a way that shows understanding.
Tango step 2: Affect Assembly and Deepening	Finding a focus for the session that has some emotional activation

	for the client and using attachment theory to help make sense of it - Specifically naming the trigger experienced, the perception of it as safe or dangerous, the somatic response in the body, how they tried to make sense of it cognitively and the action it leads to.
Tango Step 3: Choreographing engaged encounters	Setting up an interaction where this newly understood attachment need and emotional experience is shared with a part of self, imagined other or the therapist.
Tango Step 4: Processing the encounter	Discussing the experience of sharing these needs, what went well, and what was difficult.
Tango Step 5: Integrating and Validating	Celebrating the risk the participant took to help integrate the new experience into their internal working model of relationships.
Closing	May ask what they have coming up in the next week, anything they took away from the session today, or any questions

6.3 Participants

Participants were selected based on the eligibility criteria in Chapter 4 and given a code to protect privacy (example: PU1). Participants came to study screening, reporting a variety of work-related presenting problems, ranging from anxiety, frustration, grieving the loss of a job, and work-life balance challenges, among others. Based on clinical notes, within the first few sessions, attachment issues at work emerged for nine out of ten participants as a potential source of the presenting problem. This is partially supported by six out of ten participants showing low to moderate levels of trust in the leader as a security provider (LSPS scale). For six of the ten participants, their experiences at work were negative enough that they were seriously considering leaving their job (confirmed by transcripts and turnover intent assessment scores of 6-11 out of 13).

Table 22 and Table 23 provides an overview of all participants, their presenting problems and initial assessments.

Table 22: Demographic overview of participants, self-identified

Gender	Male: 5 Female: 5
Race / Ethnicity	White: 6 BIPOC (Black, Indigenous, or Person of Color): 4
Nationality	America: 7 United Kingdom: 1 India: 1 Mexico / America: 1
Sexual Orientation	Heterosexual: 9 LGBTQ+: 1
Industry	Tech & Sub Industries: 5 Education: 1 Government: 1 Healthcare: 1 Consumer Goods: 1 Non-profit: 1

Childhood Trauma and Attachment

Participants were screened for childhood trauma, attachment insecurity and high-risk concerns. Five out of ten participants had 2-3 Adverse Childhood Experiences (ACEs) and all said they had ‘some’ lasting impact on them. Four participants identified one Adverse Childhood Experience. For context, according to the Center of Disease Control (CDC) 64% of US adults report at least one adverse experience by the time they reach 18 and 17.3% report four or more (172). No participants had suicidal intent or active substance abuse based on screening. While eight of ten participants showed some signs of attachment avoidance or anxiety in the initial assessment, only one showed high attachment avoidance (71%, PU1) and one showed high attachment anxiety (63%, PE3). Due to the size of this study, no conclusive findings can be drawn about what level of attachment insecurity or trauma impacts the findings in this study and it has been noted in limitations in the Discussion (Chapter 7).

Other Assessments

Before starting therapy, seven out of ten participants had moderate to potentially dangerous levels of stress and five out of ten scored at burnout level or above. Six out of ten had moderate or higher levels of anxiety and four out of ten had moderate or higher levels of depression. Five out of ten showed low levels of emotional regulation and six out of ten showed low emotional intelligence based on the assessment. Six out of ten had low to moderate trust in their leader as a security provider.

Table 23: Participant demographics, initial presenting problems and assessments

Participant	Participant Overview	Initial Assessments
PA1	Late-40s Male in tech industry reporting panic attacks	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Severe - Burnout: Very serious - Anxiety: Mild - Depression: Moderate - LSPS: Low feelings of security - ACEs: 1 <p>Additional Factors:</p> <ul style="list-style-type: none"> - Panic attacks may have had a medical source - Negative attachment cycles with wife and daughter - Intention to leave: 10/14
PE1	Mid-40s Male in tech industry reporting frustration at work, abusive boss and wanting to leave his job	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Potentially Dangerous - Burnout: Yes - Anxiety: Moderate - Depression: Minimal - LSPS: Low feelings of security - ACEs: 0 <p>Additional Factors:</p> <ul style="list-style-type: none"> - Reports experiencing bias at work - Intention to leave: 10/14
PW1	Mid-50s Male in government reporting frustration about unfair treatment at work	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Fairly low - Burnout: Some signs - Anxiety: Mild - Depression: Mild - LSPS: Mid feelings of security

		<ul style="list-style-type: none"> - ACEs: 1 <p>Additional Factors: Intention to leave: 3/14</p>
PO1	Late 30s female in nonprofit sector reporting work life balance issues	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Potentially Dangerous - Burnout: Some signs - Anxiety: Mild - Depression: Minimal - LSPS: High feelings of security - ACEs: 2 <p>Additional Factors:</p> <ul style="list-style-type: none"> - Reported bias at work - Intention to leave: 6/14
PU1	Mid-40s female in consumer packaged goods reporting anxiety at work	<p>Psychological Assessment:</p> <ul style="list-style-type: none"> - Stress: Moderate - Burnout: Yes - Anxiety: Moderate - Depression: Moderate - LSPS: High feelings of security - ACEs: 2 <p>Additional Factors:</p> <ul style="list-style-type: none"> - Intention to leave: 9/14
PH1	Mid-40s woman in tech industry reporting frustration at work due to unfair treatment from boss and wanting to resign	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Potentially Dangerous - Burnout: Very serious - Anxiety: Severe - Depression: Moderate - LSPS: Low feelings of security - ACEs: 2

		<p>Additional Factors:</p> <ul style="list-style-type: none"> - Reported bias at work - Intention to leave: 10/14
PE2	Mid-50s male in tech reporting grief, anger and betrayal over losing his job	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Severe - Burnout: Some signs - Anxiety: Moderate - Depression: Mild - LSPS: Low feelings of security - ACEs: 1 <p>Additional Factors:</p> <ul style="list-style-type: none"> - Reports bias at work - Intention to leave: 11/14
PE3	Mid-40s female in healthcare reporting social and general anxiety	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Fairly low - Burnout: Yes - Anxiety: Moderate - Depression: Mild - LSPS: High feelings of security - ACEs: 3 <p>Additional Factors:</p> <p>Intention to leave: 10/14</p>
PA2	Mid-40s female in education reporting anger and fixation on previous work betrayal and trauma	<p>Psychological Assessments:</p> <ul style="list-style-type: none"> - Stress: Fairly low - Burnout: Very low - Anxiety: Minimal - Depression: None - LSPS: High feelings of security (for current boss) - ACEs: 1 <p>Additional Factors:</p> <p>Intention to leave: 4/14 (in new job)</p>

PR1	Early-40s male in tech industry reporting anxiety about work	<p>Psychological Assessments:</p> <ul style="list-style-type: none">- Stress: Potentially dangerous- Burnout: Some signs- Anxiety: Moderate- Depression: Moderate- Regulated: No- LSPS: Mid feelings of security- ACEs: 3 <p>Additional Factors: Intention to leave: 4/14</p>
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The next section provides a full narrative of the study and findings in written and visual form, followed by sections that provide details of each theme with correlating data, and finally the revised program theory.

6.4 Narrative Overview of Findings

While participants came to therapy reporting stress, anxiety, anger or similar, relational and attachment challenges at work arose for nine out of ten. This showed that relational issues are not the common work-related presenting problem reported but it may be an underlying factor for many, further validating the narrative review in Chapter 2. Based on qualitative and quantitative analysis in this study, EFIT may have the potential, with some adjustments, to be an effective treatment for work-related mental health distress when at least part of the presenting problem is relational.

EFT with individuals (EFIT) experiencing work-related distress has several differences from EFT with couples (EFCT), which made up the literature base for the program theory from the realist review. First, in contrast to personal life, emotions are less welcome at work. When strong feelings do emerge, they can trigger shame about appearing “weak” or unable to manage pressure, along with real risks if they are perceived as impairing performance. Second, the relationship with the therapist is different in EFIT compared to EFCT. In EFCT, the therapist is mostly a facilitator of the tango and encounters between the couple. In EFIT, the therapist facilitates the process but may also participate in the encounter (EFIT Tango step 3). Encounters are also more fluid and may be less clearly defined since they can happen with the therapist in what can seem like a regular flow of conversation or narrative assembly (EFIT tango step 2). A third difference is it may also have been more difficult to heighten emotions in individual compared to couples therapy since the person directly associated with distress is not in the

therapy room during sessions. Specific techniques to adjust certain EFIT micro-interventions (validation, reframing and evocative questions) were shown to help overcome these differences.

While several different forms of data were collected to validate findings, the most helpful data to answer the research questions were the final session interviews with participants, the clinical notes and the Post-Session Resolution Surveys (PSRQ) by participants. The top two sessions from each participant were also analyzed but did not provide new codes or sub-codes, instead they provided additional context for what was shown in the clinical notes and final interview. The CMOCs within the realist program theory were refined based on the findings (Figure 18). In summary, EFIT can lead to intended outcomes when the presenting problem is at least partly relational, there is a strong therapeutic alliance, and when resistances like shame and fear are overcome using specific attachment-based techniques within the EFIT micro-interventions. This can lead to a new view of self and other (revised internal working model) and in turn improved agency, confidence, emotional regulation and mental health.

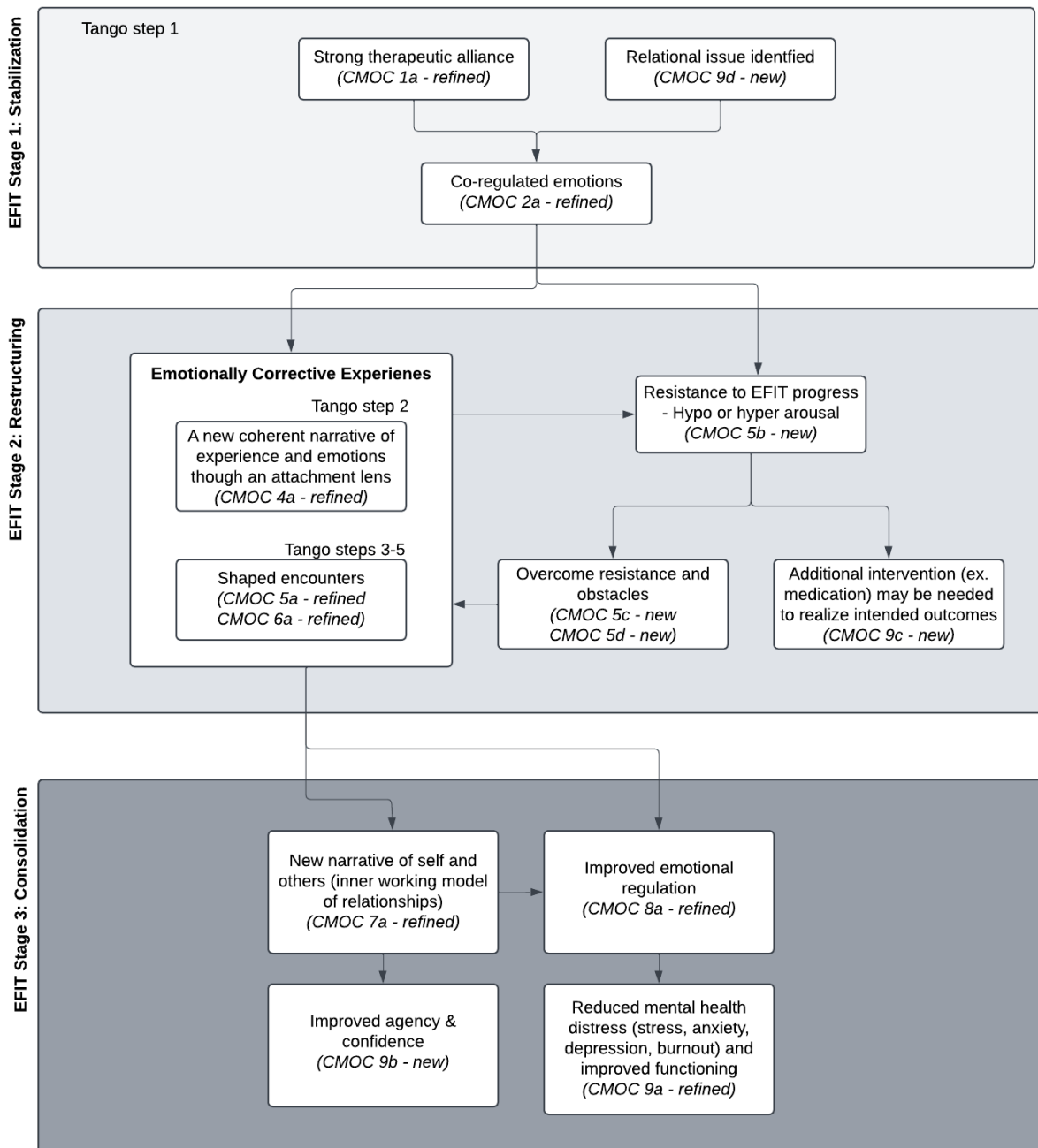


Figure 18: Realist evaluation findings overview and revised program theory

6.4.1 Outcomes

6.4.1.1 EFIT Stages

As discussed in Chapter 1, EFIT has three stages: Stabilization, Reconstruction and Consolidation (Table 24). The stages are iterative and can move forward and backward. Nine out of ten participants progressed through all three stages of EFIT as shown through their final session interviews, Post-Session Resolution Questionnaire (PSRQ) and validated by clinical notes. EFIT as with all therapy is a process and while participants made progress and reached stage 3, if we continued sessions there would be new challenges faced and uncovered moving back to stage 2 or 1. So, stage 3 should not be interpreted as ‘cured’ but instead that the participant made significant progress in their ability to discuss their deeper emotions and reached a new coherent narrative on at least one important aspect of their presenting problem, changing how they then respond to situations in their life.

Table 24: Stages of EFIT (28)

	Stage 1: Stabilization	Stage 2: Restructuring	Stage 3: Consolidation
Goals	Create safety, reduce overwhelming emotional reactivity, increase awareness of inner emotional landscape including cycles and the ways they currently try and cope (e.g. avoidance, etc.)	Deepen emotional processing, experience emotions in new ways to process vulnerabilities, unmet needs, shifting self-perception	Reinforce and integrate new emotional experiences, self-perceptions and relational patterns into day-to-day life
Markers of completion	<ul style="list-style-type: none"> - Strong therapeutic alliance - Participant can name emotions without being overwhelmed & shutting down - Some ability to reflect on emotional cycles 	<ul style="list-style-type: none"> - Participant can engage with primary emotions without excessive avoidance or dysregulation - New emotional responses emerge like self-compassion instead of self-criticism - Corrective emotional experiences interrupt old cycles 	<ul style="list-style-type: none"> - Emotional shifts are consistent across various life situations - Different responses emerge to old triggers (e.g. expressing needs instead of withdrawing) - New coherent narrative about their emotional growth

Throughout the sessions, I attempted to note participant stage in the clinical notes and this proved difficult to track due to the fluidity of the process. EFIT literature does say that participants can move back and forth between the stages and that was my experience facilitating sessions (27). One indicator of moving from stage 2 to 3 is having an emotionally corrective experience. As discussed in chapter 5, an emotionally corrective experience in EFT is one where a person re-encounters something that was previously distressing but is now being experienced in the context of a co-regulating therapeutic setting where they feel safe (12, 52). This experience has the potential to alter their view of themselves and others (internal working model of relationships), and in turn their future emotional responses to similar challenging situations. I used their final session interview, clinical notes and post-session questionnaire (PSRQ) to identify and validate these change moments. Another key aspect of moving through the stages is overcoming understandable resistance to feeling difficult emotions like shame or fear. I discuss how these resistances were overcome to enable deeper emotional experiencing in session in section 6.4.3.

One participant didn't reach stage 3 throughout the twelve sessions. Their presenting problem was ongoing panic attacks, and it became apparent that medical intervention may be necessary. Through encouragement in sessions, they did seek medical help. The one important insight they took away from therapy sessions was the cumulative impact of their home stress on top of their work stress. Their session PSRQs were mostly under 12 out of 15, and their final PSRQ was 5 out of 7, which was low compared to other participants. While the participant stated they appreciated the space to talk weekly, compared to other participants in upcoming sections, they were not able to share the specific ways that the therapy helped their presenting problem, informing CMOCs 9c and 9d in Table 27.

PA1: “I guess that it was like oh great we've done these 12 weeks and it's like I'm cured, right?... But that's obviously not the case...So I think you know, I think it's clear to me that there's more I need to do.” (Final PSRQ: 5/7)

The upcoming sections provide the outcome themes that emerged from the final session interviews and clinical notes, validated with Post Session Questionnaire (PSRQ) scores.

6.4.1.2 Qualitative outcome themes

Two outcome themes arose from the qualitative data: (1) increased agency & confidence; and (2) improved emotional regulation & functioning. For readability and to conserve space I have summarized the findings here with qualitative excerpts. Together, these outcomes informed CMOCs 8a, 9a, and 9b in the revised program theory (Table 26).

6.4.1.3 Increased Agency & Confidence

Eight of ten participants described leaving therapy with a stronger sense of agency, which they linked to acting with clarity, setting limits, and reclaiming a muted voice. One noted being “reminded of the power of my voice” and becoming more intentional about protecting personal needs rather than neglecting them for others (PO1, PSRQ 6/7). Another described feeling “more creative and more like I have more agency” when imagining new possibilities rather than resigning themselves to circumstances (PW1, PSRQ 6/7). For some, agency came from seeing situations more clearly: as one participant put it, “knowing...the situation fully like the Emperor has no clothes, it just makes you have more agency” and a sense of being in control (PH1, PSRQ 6/7).

Four participants specifically reported improved boundary-setting and creating new emotional and practical space by limiting contact with stressors or voicing needs. One realized “how unhealthy that relationship was and my inability to express my needs,” while also working through guilt related to childcare and work hours (PO1, PSRQ 6/7). Another described the choice to “unfollow” on social media after feeling excluded (PA2, PSRQ 6/7). Others made direct changes in close relationships, such as reinforcing priorities with a partner: “this is so very important to me and why” (PE3, PSRQ 6/7). These shifts reduced guilt and fostered better alignment between values and daily decisions

Three participants reported increased feelings of confidence, describing feeling equipped with new tools and less burdened by self-doubt. One explained, “I now feel like I have actual tools... I feel a relative amount of confidence in being able to handle it” (PR1, PSRQ 7/7). Another noted feeling “a little bit better” about the risk of ageism (PE2, PSRQ 7/7). A third reflected that greater confidence had “taken away a layer of self-doubt” and made daily life feel more functional (PU1, PSRQ 6/7).

6.4.1.4 Improved Emotional Regulation & Functioning

Nine of ten participants reported improvements in emotional regulation and daily functioning. Many felt “less stuck” and more accepting of realities that had previously consumed them. For one, even the act of talking about difficulties was a form of “forward movement” that helped create momentum (PH1, PSRQ 6/7). Another echoed this sense of acceptance: “this is the way it is and I have to figure out ways of making it work for me,” noting they no longer wished for things to return to how they were before (PW1, PSRQ 6/7).

Three participants specifically highlighted that their presenting problems no longer dominated mental space. One explained, “I go days without thinking about it,” contrasting this with a time when an old boss was “living rent free” in their head (PE2, PSRQ 7/7). Another described developing “a structure or way to think about it” that made the issue feel less consuming, even if the feelings themselves had not fully changed (PA2, PSRQ 6/7). For others, this shift opened space for daily functioning. As one reflected, “how I spend the hours of my day has changed... I’m more able to brush [worries] off” (PU1, PSRQ 6/7).

Three participants reported physical functioning also improved. Some reported better sleep: “I have slept better for like a month now” (PE2, PSRQ 7/7). While others noted reduced drinking and a renewed sense of vitality: “I feel like a lot more functional than I did 12 weeks ago” (PU1, PSRQ 6/7). Three participants reported emotional reactivity lessened, particularly in response to work stressors. One participant recalled previously reacting to emails before even reading them, but described this pattern shifting through the course of therapy and environmental changes (PE1, PSRQ 5/7). Another simply observed, “I feel calmer,” even without directly targeting reactivity in sessions (PE3, PSRQ 6/7).

Finally, motivation and energy increased for four participants. One explained, “my motivation comes and goes, but it is on the whole higher than it was earlier this year” (PE2, PSRQ 7/7). Others spoke of renewed professional interest and reduced depletion, saying they no longer felt as drained and could even imagine a sabbatical or career shift without urgency (PE3, PSRQ 6/7). Another summarized, “I’ve had a bit more energy... like get up and go” (PU1, PSRQ 6/7).

In summary, the final interviews suggest that participants left therapy with a mix of perceived stronger agency, greater confidence, improved emotional regulation, and enhanced daily functioning. These findings, along with PSRQ scores and quantitative measures, signal potential shifts in how participants approached both inner experiences and external demands.

6.4.1.5 Quantitative outputs

As discussed in Chapter 4, participants took several assessments at the start of therapy and at the end. These assessments provided insights into the participant's current state as well as additional insight into the changes they experienced over the course of therapy. While the sample size was too small to provide statistically significant quantitative findings, the results from the pre- and post-assessments and Post-Session Resolution Questionnaire did provide additional validation for the qualitative findings and are incorporated in the analysis throughout this chapter.

All participants' PSRQ scores increased by the last session. The first three questions were about the session itself, and question four focused on a feeling of overall resolution for their presenting problem. Eight of the ten showed a greater than 3-point change from after the first session to after the last. It should be noted that some participants may have experienced a change in the first session or consultation that impacted the benchmark.

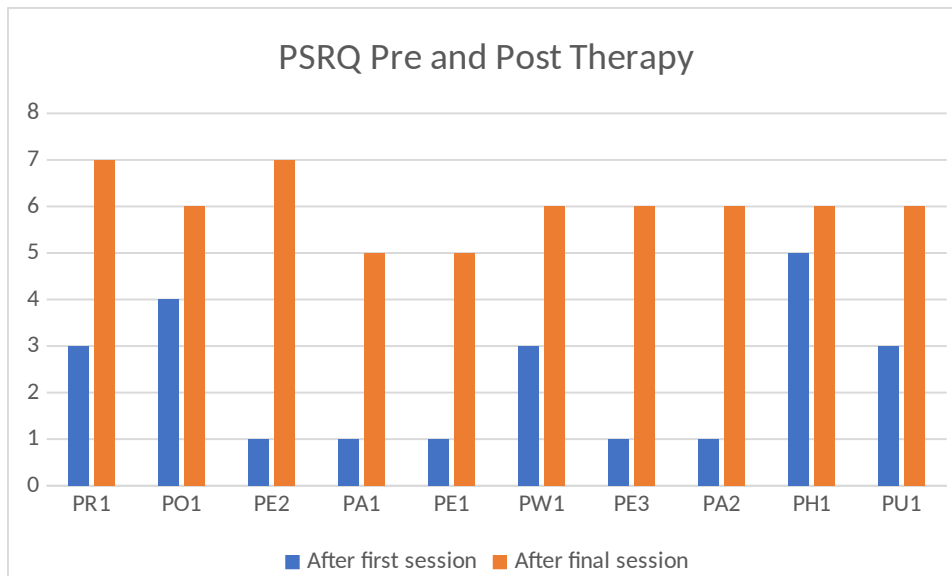


Figure 19: PSRQ Pre and Post Therapy Session - How Resolved is the presenting problem (Q4)

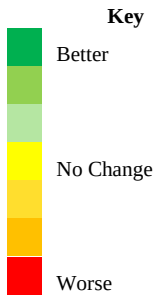
The majority of participants showed at least some improvements of 20% or more between pre- and post-assessments (Stress, Burnout, Anxiety, Depression, and similar), which supports the qualitative feedback, and several showed deteriorations in some areas. Only 1 participant (PH1) showed a 20%+ improvement in attachment avoidance between pre- and post-therapy and they were also the only participant who showed that same level of improvement in attachment anxiety. Two participants showed a 20%+ deterioration in attachment avoidance. The other participants remained similar in their attachment strategies pre and post therapy.

It is difficult to say what led to deteriorations and to say that any improvements were due to therapy, since therapy was only one aspect of their lives over the several months of treatment (Figure 20). This made the assessments more clinically useful for gauging concerning symptoms in clients at the beginning of therapy and for discussing what further support may be needed at the end of therapy. From a research perspective, given the smaller sample size and data

variability, the results directionally indicate broad improvement and provide directions for future research.

P Code	PA1	PW1	PE1	PH1	PU1	PO1	PA2	PE2	PE3	PR1
Assessments										
Attachment - Avoidance (AAQ)	6.5%	16.7%	109.1%	-52.2%	0.0%	-14.3%	-5.9%	3.3%	0.0%	71.0%
Attachment - Anxious (AAQ)	-11.5%	-11.5%	0.0%	-34.6%	3.3%	-16.7%	13.6%	-6.1%	17.5%	-16.0%
Stress (WSS)	-14.3%	6.3%	-15.6%	-6.1%	14.3%	-29.0%	-50.0%	-31.0%	41.2%	-31.0%
Burnout (BM)	4.3%	-30.0%	-20.9%	-30.0%	29.3%	-17.2%	-25.0%	29.6%	-16.2%	-8.0%
Anxiety (GAD-7)	100.0%	0.0%	-46.2%	-86.7%	-63.6%	-40.0%	150.0%	-25.0%	-72.7%	-80.0%
Depression (PHQ-9)	0.0%	-66.7%	100.0%	-87.5%	8.3%	-50.0%	300.0%	-25.0%	-57.1%	-70.0%
Emotional Reg (DERS)	-12.1%	-37.5%	-27.6%	-29.0%	2.0%	-16.7%	15.4%	-28.6%	-38.6%	-24.0%
EQ (SSEIT)	6.7%	8.0%	14.1%	7.4%	-3.9%	4.7%	4.2%	-3.9%	0.8%	3.0%
Leader as Security (LSPS)	-4.3%	-7.4%	650.0%	-37.5%	-4.4%	-39.0%	32.5%	0.0%	-19.4%	33.0%
Work Wellbeing (UWES)	30.8%	20.6%	5.3%	48.9%	-3.7%	6.8%	6.7%	-16.9%	19.6%	11.0%
Turnover Intention (TI)	0.0%	0.0%	-21.4%	0.0%	11.1%	12.5%	-25.0%	-57.1%	-14.3%	0.0%

Figure 20: Pre and Post Assessment Comparison Heat Map



No discernible patterns arose in heart rate mean, median, range, or standard deviation within and across participants. Heart rate also did not confirm or refute qualitative data, meaning heart rate did not prove to be a reliable detector of what was happening in session for the participant based on clinician observation, participant feedback, and other quantitative data like PSRQs

6.4.2 What may have led to outcomes

In this section, I provide an overview of what may have aided outcomes based on final session interviews with participants, clinical notes, and quantitative data. The processes that may have led to outcomes have been organized into four themes: a new narrative, encounters (the crescendo of the EFIT tango), therapeutic relationship, and space to talk. The program theory shown in Figure 18 incorporates these findings. This section informs CMOCs 4a and 7a in the revised program theory, found in Table 27, and provides excerpts from participants for each of these themes.

A new narrative (related to CMOCs 4-9)

Five out of ten participants reported that developing a new narrative to better understand their experiences helped them reach outcomes. In particular, attachment theory education and the identification of recurring relational cycles gave participants a framework that made sense of their distress and often eased the belief that "something is wrong with me". One participant noted that "talking about attachment stuff...that was a healing moment" (PE3, Session 7.9.24, PSRQ 14/15). Another reflected that understanding attachment gave them language for experiences of unsafety and invalidation, explaining, "it just helps right now...I definitely didn't get validation

from the system" (PE3, Session 7.9.24). Others described how this framework clarified previously confusing experiences. As PH1 explained, "maybe I have been a bit gaslit...until I started this, I was like oh, it's actually not me" (PH1).

A new narrative also emerged through the identification of relational cycles. One participant recognized how discomfort in expressing needs led to them being perceived as angry: "the way I express my needs...sometimes it gets wrapped up in a package that is not necessarily as easy to respond to" (PR1). Another described realizing "how unhealthy that relationship was and my...inability to express my needs" (PO1). For PA2, this insight emerged through therapeutic dialogue, in which comparing how they would want their daughter to be treated illuminated how little care they gave themselves: "OK, I get it...that was a really good aha moment" (PA2, Session 3.11.24, PSRQ 14/15). They later reflected that it was "huge" because it changed "how much space" they wanted to give the issue in their minds (PA2, Session 3.18.24, PSRQ 13/15). Taken together, these examples suggest that reframing experiences through attachment theory and relational cycle identification gave participants not just insight but relief, helping them integrate new self-understandings and opening space for change.

Encounters (related to CMOCs 5-9)

Eight out of ten participants reported that some of their outcomes could be traced to encounters with EFIT tango step 3, in which they voiced attachment needs and fears to an imagined other, a part of self, or the therapist. This process appeared to deepen awareness, provide corrective emotional experiences, and build confidence in expressing needs. One explained that being invited to "try saying what you want to say" gave them the experience of

speaking difficult words safely, which translated into confidence that they could also speak the same words outside of therapy (PO1). Another noted that while role-playing with different parts of the self initially felt awkward, it "honestly worked," particularly when confronting an internalized boss figure in what became their "how dare you" conversation. Weeks later, they still described this as cathartic and impactful (PE2). A third participant highlighted the simple but profound experience of feeling heard, noting that "actually putting it all in words" left them more empowered (PW1). Taken together, these examples show how enactments in tango step 3 may have facilitated emotional release and provided a bridge to some of the outcomes in the previous section, namely increased agency and confidence. These findings informed CMOC 6a in the revised program theory (Table 25).

Space to talk and Therapeutic Relationship (CMOCs 1-2, Table 27)

Seven out of ten participants reported that having space to talk in therapy contributed to their outcomes. Participants described that simply being given time and permission to focus on work and its meaning in their lives created clarity, new perspectives, and momentum. For example, one participant reflected that work is central to their identity and that it "felt really good to have this space to like just focus in on that" (PO1). Others emphasized that the act of talking itself was therapeutic: "just to like maybe it is the naming of things or like the digging in a little deeper" (PA1). Another described the need for a regular check-in: "I need to like have that kind of check-in point on a (regular) basis with myself and obviously talking to someone like yourself" (PR1). Based on what the participants shared, the sessions functioned not only as a forum for problem-solving but also as time and space that they don't usually have to focus on their work experience and its impact on them.

Three out of ten participants specifically identified the therapeutic relationship as a factor in their outcomes. They described feeling seen, heard, and understood in ways that felt new or different. One participant said the therapist offered "a lot of accurate reflections" and that they finally "had my own space" (PE3). Another described being unusually comfortable and "heard and understood and directed" in a way that matched how they felt (PO1). A third highlighted the therapist's attunement and preparation: "I felt like you really remembered what I said... You are on it" (PA2). These comments indicate that, aligned with the realist review, relational attunement, consistency, and being heard were factors that helped participants engage with the work.

The following sections take a deeper dive into emotionally corrective experiences due to their importance, EFT literature places on them for outcomes, their complexity, and their process being a key differentiator between EFCT and EFIT.

6.4.3 Deep dive: What impacted emotionally corrective experiences

While each step in the five-step EFIT tango has a role in creating and processing emotionally corrective experiences, step 3, the encounter (sharing attachment fears and needs with someone who matters), is the crescendo. In total, there were 90 encounters noted in clinical notes across the 120 sessions. They ranged in topic, target (who the encounter was with), and outcome, with no pattern across or within participants linking the context of the encounter to the outcome. Topics ranged from anxiety to betrayal and bias, targets ranged from an imagined other, like a boss, to a part of self, like childhood self, as well as just with the therapist.

Outcomes ranged from positive (ex, "I feel calmer"), neutral (ex, "I've said this all before"), or

negative, where they may not have been able to stay within their window of tolerance and felt more stress during or after the encounter.

There were specific obstacles to having emotionally corrective experiences in session with individuals experiencing work-related distress, namely hypo- and hyper- arousal, most likely due to shame and fear. Specific techniques within the micro-interventions (evocative questions, reframing, and validation) were shown to help overcome obstacles and resistance (Figure 21). In the next two sections, I discuss the specific obstacles and resistance that were encountered, as well as the specific micro-interventions used to overcome them, and provide qualitative data on the impact on the participant.

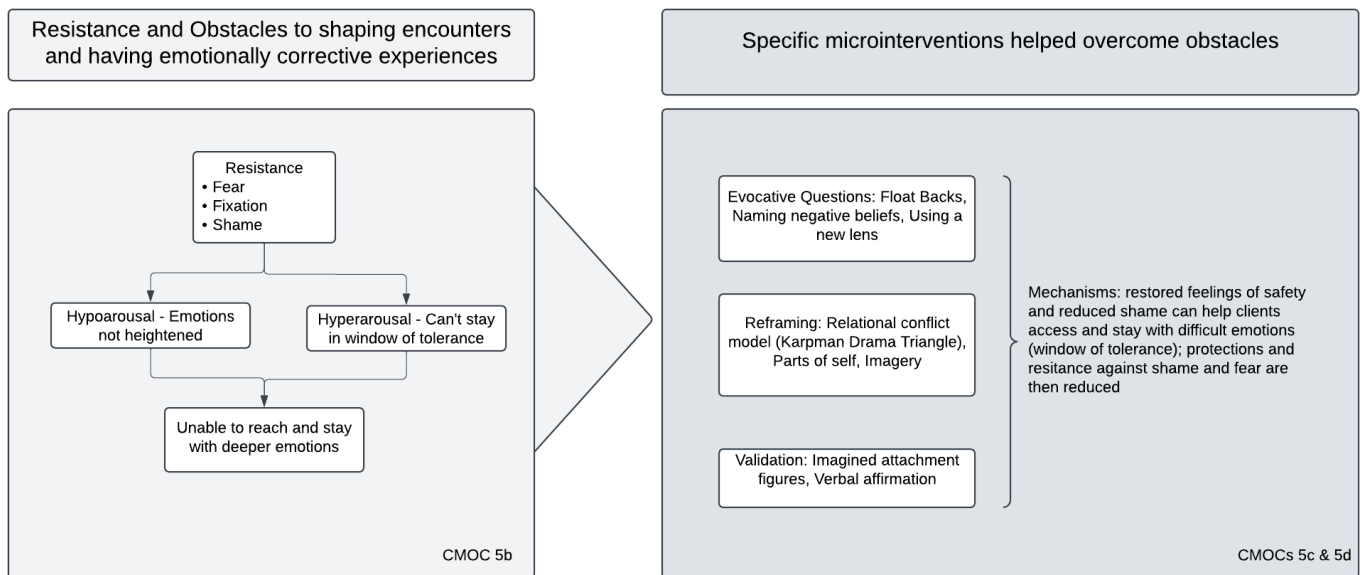


Figure 21: Overcoming obstacles to shaping encounters and having emotionally corrective experiences

6.4.3.1 *Resistance and obstacles (CMOC 5b, Table 27)*

Hypo- and hyper- arousal were the two observed obstacles to shaping encounters and having emotionally corrective experiences. Hypoarousal made it difficult to heighten emotions to the level needed for an emotionally corrective experience; hyperarousal made it difficult for participants to remain in a heightened emotional state long enough to complete an encounter. In total I noted hyper- or hypo- arousal in 26 sessions; 16 of those sessions had lower PSRQ scores (12/15 or lower). I attempted to map these instances to concurrent heart rate data, but the heart rate did not consistently correlate with clinician-observed arousal in any detectable trend.

Concrete examples from the notes illustrate the difference between hyper- and hypo-arousal. Hyperarousal entries include crying and panic that interfere with regulation (“cried throughout the session,” PU1, Session 1, PSRQ 11/15; “physical sensations of the panic attack,” PA1, Session 3, PSRQ 11/15). Hypoarousal entries capture detachment and dissociation that blunt access to affect (“seems somewhat emotionally detached from her story, possibly dissociating,” PH1, Session 1, PSRQ 11/15; “hard to find a target...she doesn’t want to go deep,” PE3, Session 9, PSRQ 10/15). In some cases, I noted an anticipatory avoidance of emotion that appeared to produce shutdown: for example, a participant who “doesn’t want to go deep” (PE3, Session 9, PSRQ 10/15) and other notes that participants “may not want to go there after such an emotional session” (PE3, Session 5, PSRQ 12/15).

These patterns matter especially for an experiential therapy like EFIT, where sustaining a deep level of emotion is a prerequisite for the intended outcomes. When one participant was hyperaroused, it overwhelmed her ability to regulate her emotion and share her experience:

“cried throughout the session...remembers it from growing up anytime she had to see a doctor and talk about herself” (PU1, Session 1, PSRQ 11/15). Another participant described the physicality of panic that arose even while talking: “he could feel the physical sensations of the panic attack even just talking about it” (PA1, Session 3, PSRQ 11/15), which heightened emotion by bringing the trigger into the room but prevented completion of the encounter.

The clinical notes also point to potential mechanisms driving these arousal patterns. Shame frequently presented as a protective posture - for example, “professional positioning to guard against vulnerability” (PR1, Session 5, PSRQ 14/15) - or as raised defenses: “her protections are up...trying to protect herself” (PH1, Session 11, PSRQ 15/15). Fear showed up as fixation on others or demands for external validation, both of which interfered with in-session engagement: one participant continued to want an apology and public acknowledgement to feel relief (“wants others to know what they did wrong,” PA2, Session 8, PSRQ 11/15); another was “resistant – wants to hold on to the anger,” which limited progress through the EFIT stages (PE2, Session 6, PSRQ 10/15). In others, I noted times when it was difficult to find the right triggers to heighten emotions (“hard to find the right words for the encounter,” PE3, Session 5, PSRQ 12/15). These observations suggest a complex interplay between needing to heighten emotions sufficiently to create the environment for an emotionally corrective experience, but not take a client out of their window of tolerance so they become hyper-aroused.

Another aspect of therapy that I had feared would interrupt progress was me not being able to be attuned and present enough in each session. There were fifteen sessions that I noted not feeling like I was able to attune enough, either due to illness, not sleeping well the night before, or too many back-to-back sessions. Of these fifteen sessions, only five of them had a

PSRQ score of 12 /15 or below, indicating that participants may not have been as impacted by my perceived low attunement. This is important to note because the benchmark placed on therapeutic attunement for the session to be effective is high in experiential therapies like EFIT, and it may not be realistic for a therapist to expect they will reach it each and every session.

6.4.3.2 *What helped overcome resistance and obstacles (CMOCs 5a, 5c, 5d, Table 27)*

As mentioned in earlier sections, beyond the EFIT tango, there are several micro-interventions (reframing, validation, reflection, evocative questions, and conjecture) that are used throughout sessions to build the therapeutic alliance, heighten emotions within a window of tolerance, and facilitate and process encounters. While the standard micro-interventions helped participants progress through the EFIT stages, specific techniques had further impact on outcomes based on final session interviews with participants, clinical notes, and often validated by PSRQ scores (Table 26). These techniques may have helped participants overcome obstacles like shame and fear. It must be noted that there are several techniques outlined in EFT literature and training for overcoming resistance in couples sessions Table 25. (27):

Table 25: *EFT Techniques to help couples overcome obstacles in session*

Technique	Overview	Example
Slicing it thinner	When the risk in an encounter feels too large, asking them to take a smaller risk with what they are saying	How about instead you share what is causing the anxiety of taking that risk’
Catching the bullet	When a partner says something hurtful or dismissive to the other and the therapist has to redirect the comment to keep things on track	What just happened to you now when you said that to your partner?
Changing the channel	Used when the therapist needs to redirect the conversation to get back on track. The channel can be changed from past to present, individual to interpersonal, cognitive to	Can we stop for a moment and go back to what about that situation that happened in the past is still most upsetting today?

	emotional, and others.	
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Current EFIT literature and training doesn't offer similar techniques. While the EFT techniques in Table 25 can be adjusted for individuals, other techniques have proven more helpful in keeping progress on track and overcoming obstacles and resistance. Below is a table summarizing these techniques and their impact on the participants. Each of these techniques is designed to help overcome a resistance or protection the participant is experiencing that is hindering deeper emotional experiencing in session and their overall progression through the EFIT stages.

Table 26: Micro-interventions that helped overcome obstacles in the realist evaluation

EFIT Micro-intervention	Specific Technique	Overview	Participant transcript (Final session unless otherwise noted)
Reframing	Relational conflict model (Karpman Drama Triangle)	A model that defines relational conflict among three roles: the victim, the persecutor, and the rescuer. Helps to reach ownership of role and understanding of the others' roles.	<i>PR1: "The Karpman triangle, it actually gives you a really nice goal or an outcome...because at the end of the day, you know, no matter what role you're playing, the way out is to get to that shared reality with the other...And then you know what direction you need to move in." (Final PSRQ: 7/7)</i>
	Parts of Self	Identifying different protective parts with different needs and fears. Helps to access deeper emotions, understand and normalize them.	<i>PU1 Final Session: "I think when we broke it down into the judging part, yes, that helped me to compartmentalize a bit of the my thoughts around my situation and see that some of the thoughts I was having weren't helpful...It helped me to get out to that kind of cycle of feeling bad about the bad thoughts that were making me feel bad." (Final PSRQ: 6/7)</i>
	Imagery	Using images as a metaphor (note: Imagery is also a part of EFT RISSSSSC)	<i>PR1 Final Session: "...basically like [the] mountain – The next one is there and how to think about...aligning the expectation...That's another very useful tool for me." (Final PSRQ: 7/7)</i>
	Using a new lens	Looking at the situation from a different person's perspective	<i>PA2 Final Session: "it was huge because it changed how much... space I want it to occupy in my mind or how much do I want for my daughter." (after using the lens of her daughter in a similar situation and how much space she'd want it to take in her daughter's mind) (Final PSRQ: 6/7)</i>
Evocative Questions	Float Backs	Looking at other times they felt similar to identify cycles and patterns	<i>PH1: "I think the other thing that was really helpful... looking at patterns at work, but also like in my family life... like you would ask me...when did you feel this way?...and it always was sort of obviously clearly from something in childhood or whatever. I think that was really helpful." (Final PSRQ: 6/7)</i>
	Naming	Identifying what the situation made	<i>PE1: Transcript 2.12.24 (truncated) (Session PSRQ: 12/15)</i>

	negative Beliefs	them think of themselves (e.g. I am alone, I am unsafe, I can't trust anybody), or the therapist naming a belief that continues to come up in sessions (also called 'conjecture / proxy voice' in EFIT).	<p>Therapist 6:03 So it almost always goes to this and again give me the right words. But...I can't win.. like there is no winning...</p> <p>PE1 6:15 That's what it feels like going into it. Yes, I don't know... the meeting could ...be completely fine, but...It's just like a dread.</p>
Validation	Attachment Figures	Imaginary figures that provide wisdom, nurturing, or protection	<p>PH1: "The thing that helped like a lot was the exercise around the wise person, the protector and the nurturer and I think thinking through that and what I needed was really good...it was interesting because even going through that ... I've done like mindfulness and there's like this whole thing on self compassion and all that and...it was a very hard thing for me to do. And I think this sort of format is a lot easier." (Final PSRQ: 6/7)</p>
	Verbal Affirmations	Therapist providing sincere affirmations	<p>PU1: Transcript 2.29.24 (Truncated) (Session PSRQ: 14/15)</p> <p>Therapist 14:12 The words that come up into my mind as you're saying all this too is... you are more important than your job. Right. And when you hear me say that what comes up?</p> <p>PU1 14:32 I wanna say flattered. UM, it's uh, obvious...but it feels good to hear actually... I'm battling the tears down.</p> <p>Therapist 14:51 Yeah. But there was something that really struck just hearing that... there's some part of you that really is struggling with that or needing to hear that too.</p> <p>PU1 15:12 I have some just, you know, overall self-esteem issues that I can kind of recognize that are not helping me.</p>

6.5 Refinement of Realist Program Theory

The above sections provide an overview of the contexts and mechanisms that may have led to outcomes. In this section, all these findings are compiled into the revised realist program theory, using the evidence in this chapter to confirm, refute, or refine each CMOC from the realist review as well as add new ones as needed.

The therapeutic relationship has been well researched as a key foundational component and common factor among all therapies (CMOCs 1-2). The realist evaluation provided further validation that the therapeutic relationship is foundational for intended outcomes. All CMOCs from the realist review were based on literature that primarily focused on EFT with couples. The findings from the realist evaluation helped refine all CMOCs for individuals with work-related distress and add new more specific CMOCs.

CMOCs from the realist review were mostly refined and added to for further specificity as shown in Figure 18. As discussed in the previous section, one of the largest changes to the program theory involved the obstacles that arose for participants in this study and the specific techniques that helped overcome them, featured in CMOCs 5a-d. The following table provides the full list of CMOCs from the realist review, and the revisions based on the realist evaluation include new CMOCs added and CMOCs refined, as well as notes of confirmation (Table 27).

Table 27: Revised program theory CMOCs after the realist evaluation

Program Theory after Realist Review	Revised Program Theory after Realist Evaluation	Data Excerpt Examples (Additional excerpts available upon request)
<i>Therapist as attachment surrogate: Creating and maintaining a safe haven & secure base for exploration</i>		
1a. When the therapist creates and maintains a therapeutic container and task alliance (C) they can build and maintain a strong therapeutic alliance (O) because there is trust and safety in the relationship (M).	Refined 1a.: When the therapist creates and maintains a therapeutic container including task alliance (C) they can build and maintain a strong therapeutic alliance (O) because there is trust and safety in the relationship (M)	Nine of ten participants mentioned having a space to talk within the therapeutic alliance as contributing to their outcomes. <i>PE3: “(The therapist) had a lot of accurate reflections of feelings and just kind of what I was trying to talk about... But I connected with (them). So I just felt like I had my own space finally.” (Final PSRQ: 6/7)</i>
2a. When the therapist builds a strong therapeutic alliance with the client (C) the client may have a deeper emotional experience in session (O) because the therapist becomes an attachment surrogate providing a safe haven and secure base for exploration (M)	Refined and consolidated 2a and 3a: When there is a strong therapeutic alliance (C) then clients can co-regulate difficult emotions in session with greater depth (O) because they have a ‘safe haven’ and ‘secure base’ from which to explore (M)	<i>PO1: “I’ve felt just really comfortable, which is unique for me. I think I’ve had challenges in therapy previously...it can be hard to feel like I can speak my truth...I really felt strongly that I was being heard in a way and understood and directed in a way that matched where I felt was right.” (Final PSRQ: 6/7)</i>
3a. When a therapist builds a therapeutic alliance, staying present and attuned with a client (C) then the client may be able to improve emotional regulation (O) because their emotions can be more safely co-regulated (M)		
4a. When therapist & client identify and co-regulate disowned emotions and needs (C) they can interrupt a negative attachment cycle (O) because	Refined 4a.: When therapist & client identify and co-regulate difficult emotions, beliefs and needs using an attachment theory model (C) then they can develop a coherent	Five out of ten participants said developing a new narrative through either attachment education or cycle identification helped them reach outcomes.

<p>emotions now make sense as a coherent narrative, reducing shame (M)</p>	<p>narrative of the client’s experience that may act as or lead to an emotionally corrective experience (O) because their experience is normalized and makes sense, so they may feel less shame (M)</p>	<p><i>PH1: "Just as you were talking about attachment theory and feeling like psychologically safe and all this sort of stuff. I was like, oh maybe I have been a bit gaslighted I hadn't connected any of these dots... I was like, oh, it's actually not me." (Final PSRQ: 6/7)</i></p> <p><i>PE3 Final Session: “And I know when we talked about attachment stuff...that was a healing moment.” (PSRQ: 6/7) (Referring to Session 7.9.24 excerpt (Session PSRQ 14/15 – highest scoring session):</i></p> <p><i>Therapist: That's what I'm hearing. So it's not what's wrong (with me) but it is a response you have when you're feeling like you are not in a safe environment...I can tell it's feeling a bit emotional what's coming up, as we're saying this.</i></p> <p><i>PE3: It just helps right now... I can say it (until) I'm blue in the face, but there's some amount of wanting validation and I definitely didn't get validation from the system.</i></p>
<p><i>Heightening emotions to prime a corrective emotional experience</i></p>		
<p>5a. When the therapist heightens a client’s emotional experience using RISSSSC and micro-interventions (C) then the client is more primed for a corrective emotional experience (O) because they can access deeper emotions (M)</p>	<p>Refined 5a.: When the therapist heightens a client’s emotional experience using micro-interventions (C) then the client is more primed for a corrective emotional experience (O) because they feel safe as the therapeutic alliance is maintained (M)</p>	<p>See Table 26 for deep dive into the micro-intervention techniques and data excerpts</p>
	<p>New 5b: When clients try to access difficult emotions around work (C) they may become hypo- or hyper- aroused and not be able to</p>	<p>Hyper arousal excerpts from clinical notes: <i>PU1: Session 1: 1.11.24 (Session PSRQ: 11/15): She cried throughout the session – struggles to regulate. Says she</i></p>

	<p>heighten emotions or stay in their window of tolerance (O) because they feel shame about these emotions or experiences or fear of reliving them (M)</p>	<p><i>doesn't know why the crying happens but she remembers it from growing up anytime she had to talk about herself.</i></p> <p><i>PA1: Session 3: 1.3.24 (Session PSRQ: 11/15): Went through all five stages of the tango. He wasn't able to complete an encounter - it was too difficult...In processing, he said that he could feel the physical sensations of the panic attack even just talking about it.</i></p> <p>Hypo arousal excerpts from clinical notes: <i>PE3: Session 9: 7.2.24 (Session PSRQ: 10/15): Hard to find a target with her sometimes – she doesn't want to go deep.</i></p> <p><i>PH1: Session 1: 1.22.24 (Session PSRQ: 11/15): Emotions: Seems somewhat emotionally detached from her story – possibly dissociating... Notably unemotional.</i></p>
	<p>New 5c: When a therapist uses specific techniques within the EFIT micro-interventions to restore feelings of safety and reduce shame (C) they may help clients overcome hyper- or hypo- arousal and be better primed for an emotionally corrective experience (O) because clients may be able to access and stay with difficult emotions in their window of tolerance (M)</p> <p>New 5d. When clients have an emotionally corrective experience through specific reframing techniques (e.g. relational conflict model, parts of self, a new lens) (C), then they may be able to take ownership of their role in the new narrative (O) because they are no longer protecting themselves from difficult emotions like shame and fear (M)</p>	<p>See Table 26 for deep dive into the micro-intervention techniques and data excerpts</p>
<p><i>Corrective Emotional Experience: Expressing emotions to someone who matters</i></p>		

<p>6a. When the client can express their deeper emotions to someone who matters (other, imagined other, part of self, or therapist) (C) then they may have an emotionally corrective experience (O) because they took a risk sharing their attachment needs and fears (M)</p>	<p>Refined 6a.: When the client can express their deeper emotions to someone who matters (imagined other, part of self, or therapist) (C) then they may have an emotionally corrective experience (O) because they took a risk and had a new, co-regulated experience sharing their attachment needs and fears (M)</p>	<p>Eight out of ten participants reported that some of their outcomes could be attributable to encounters (tango step 3), where they stated their attachment needs and fears to an imagined other, part of self of therapist (EFIT tango step 3).</p> <p><i>PO1: “the experiences where (you said)...try saying what you wanna say... It (was a) really helpful tool and experience for me to actually just speak and it gave me so much power to trust that I can actually say that even in the safest place, but also my words here also are the same words I'd use outside of this space... So I think that was really helpful for me.” (Final PSRQ: 6/7)</i></p> <p><i>PE2: “Acting out role playing with different parts of my own brain, although I felt really awkward doing it, I think... It honestly worked. I don't know that I'll do it again on my own, but it worked...The one I have the strongest memory of is talking to the little [boss] who was living in my head: how dare you?...I even have a shorthand for it. Now it's the 'how dare you' conversation, which was really, honestly cathartic. It is surprising to me how much impact I feel from that many weeks later.” (Final PSRQ: 7/7)</i></p> <p><i>PW1: “I feel heard... Heard feels good. And I do feel, I guess, actually putting it all in words, I feel like I'm a little bit more empowered...” (Final PSRQ: 6/7)</i></p>
<p>Revising the inner working model of relationships</p>		
<p>7a. When a client has an emotionally corrective experience in an encounter (C) then they can change their internal working model of relationships (O) because they experienced support when sharing their attachment needs and fears (M)</p>	<p>Refined 7a.: When a client has an emotionally corrective experience (C) they can develop a new more secure narrative of themselves and others (internal working model) (O) because challenging previous expectations of relationships (rejection, abandonment, neglect, and such) provides a felt sense of security (M)</p>	<p><i>PA2: Session 3.11.24 (Session PSRQ: 14/15) Transcript – asking the participant to think of the same situation only from a different perspective:</i></p> <p><i>Therapist: How much weight would you want your daughter putting on that other person who wronged her? How much time? How much space would you want that person taking up in her mind and heart?</i></p> <p><i>PA2: Not much.</i></p>

		<p>Therapist: Why wouldn't you care about yourself...in that same way that you would care about your daughter, right?</p> <p>Next session 3.18.24 (PSRQ: 13/15): PA2: "So... that was definitely like a really good a-ha teachable reflecting moment. Like in a good way, you know?...So it was like huge because I think it changed how much...space do I want it to occupy in my mind."</p>
8a. When a client revises their internal working model of relationships (C) they are better able to regulate their emotions (O) because they improve their felt sense of attachment security, enabling them to reach out for support (M)	Refined 8a. When a client revises their view of themselves and their world (internal working model of relationships) (C) they are better able to regulate their emotions (O) because they feel more confident that they can handle stress and challenges (M)	<p>PE1: "Whereas like anytime the email came in...I (would) already be reacting to the email (before reading it)... I think a lot has changed, like environmentally along with...the sessions that we were doing... which has helped." (Final PSRQ: 5/7)</p> <p>PR1: "The biggest difference is I now feel like I have actual tools in addition to sort of my ability to think about things... mental space... I feel a relative amount of confidence in being able to handle it. You know, whatever challenges." (Final PSRQ: 7/7)</p>
Reduced distress		
9a. When a client can better regulate their emotions (C) then they feel less mental health distress (stress, burnout, and similar) (O) because the felt-sense of security provides confidence they can handle stress and challenges(M)	Refined 9a. When a client can better regulate their emotions (C) then they can reduce mental health distress (e.g. stress, burnout, anxiety, depression) and experience improved functioning (O) because they become less overwhelmed (M)	<p>Improved functioning and emotional regulation (9/10 participants):</p> <p>PA2: I have kind of a structure or way to think about it...and I think about it significantly less... I don't know if my feelings about the situation (have) changed. But it's (now) like, yeah, less consuming and like I can just reframe how much I want to think about it." (Final PSRQ: 6/7)</p> <p>PE2: "I have slept better for like a month now." (Final PSRQ: 7/7)</p> <p>PU1: "I think the biggest change I've noticed...I kind of had a breakthrough with reducing drinking... certainly I feel like a lot more functional than I did 12 weeks ago." (Final PSRQ: 6/7)</p>

		<p>PU1: “I’ve been kind of stuck for quite a while there and so I have, uh, felt that I’ve had a bit more energy. You know, like get up and go.” (Final PSRQ: 6/7)</p>
	<p>New 9b. When clients progress through EFIT stages (C) then they may experience an increased sense of agency and confidence (O) because their new narrative about themselves and others reduces shame and fear about themselves (M)</p>	<p>Increased agency and confidence (8/10 participants):</p> <p>PW1: “I guess the biggest change is that I’m feeling more creative and more like I have more agency and just thinking about how I want things to look... This is the way it is, and I have to figure out ways of making it work for me.” (Final PSRQ: 6/7)</p> <p>PU1: “I think having more confidence in myself is making a real difference in how my minutes and hours are directed, yeah... it just kind of has taken away a layer of self-doubt... So I feel like my self esteem has been higher and I’ve been more functional in that way.” (Final PSRQ: 6/7)</p>
	<p>New 9c. When a client’s presenting problem is physiological or neurological in nature (C) more intervention than EFIT may be needed (O) because the issue may stem from biological factors rather than relational (attachment) patterns (M)</p>	<p>One participant didn’t reach stage 3 throughout the twelve sessions. Their presenting problem was ongoing panic attacks, and it became apparent that medical intervention may be necessary. Their session PSRQs were mostly under 12 out of 15, and their final PSRQ was 5 out of 7, which was low compared to other participants.</p> <p>PA1: “I guess that it was like oh great we’ve done these 12 weeks and it’s like I’m cured, right?... But that’s obviously not the case...So I think it’s clear to me that there’s more I need to do.” (Final PSRQ: 5/7)</p>
	<p>New 9d. When a client comes to therapy reporting work-related distress (e.g. stress, burnout, anxiety, depression or similar) (C) then they could be a candidate for EFIT (O) because their challenge may be at least in part relational / attachment-based (M)</p>	<p>Nine out of ten participants, all who reached EFIT stage three and had increased PSRQ scores by the end of therapy, reported relational issues at work significantly contributing to their presenting problem(s).</p> <p>PO1: “It’s like going through this process and realizing...how unhealthy that relationship was and my inability to express</p>

		<p><i>my needs.” (Final PSRQ: 6/7)</i></p> <p><i>PH1: “I think knowing... like the Emperor has no clothes, it just it makes you have more agency...(I’m in) control.” (Final PSRQ: 6/7)</i></p>
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6.6 Conclusion

The realist evaluation findings in this chapter refined and added to the program theory by providing realist causal explanations (in the form of CMOCs) of how, for whom and when EFIT may lead to intended outcomes for individuals with work-related distress (Research questions 2-4). EFIT may be an appropriate treatment for some individuals with work-related distress if that distress is at least partly due to relationships and attachment. Many clients will not seek therapy reporting that attachment or work relationships are their presenting problem, so therapists need to keep this in mind during assessment and treatment. The adjustments to techniques and the program theory focus on overcoming obstacles to progress, specifically hypo- and hyper-arousal that may be due to shame and fear. These findings can inform future areas of research and provide therapists and coaches with ways to enhance potential outcomes for clients experiencing attachment-based, work-related distress.

6.7 About the next chapter

The next chapter provides the discussion and conclusion for this thesis, including a proposed new model based on findings in this chapter, strengths and limitations, directions for future research, and a personal reflection on the DPhil. experience and lessons learned.

7 Chapter 7 – Discussion and Conclusion

7.1 About this chapter

This chapter provides a summary and interpretation of key findings from the narrative, realist reviews and realist evaluation on EFIT as a potential treatment for work-related distress, and an overview of how findings contribute to the field of attachment science, occupational health, , and Emotionally Focused Individual Therapy (EFIT). A model for how to treat / help work-related distress based on the research is proposed for therapists and coaches to consider. Finally, a personal reflection is provided along with a conclusion for the thesis.

7.2 Interpretation of Findings

This thesis explored the relationship between attachment and work-related distress and the potential of attachment-based Emotionally Focused Individual Therapy (EFIT) as a treatment. The narrative review showed a link between attachment and work-related distress. I then used two realist approaches to better understand this link and also explore the potential of attachment-based EFIT as a treatment. The realist review created a program theory that was then tested with empirical data through the realist evaluation of EFIT with participants experiencing work-related distress.

7.2.1 A realist program theory on EFIT as a treatment for work-related distress

During the realist evaluation, nine of ten participants progressed through the three EFIT stages, reporting increased agency, confidence, and improved emotional regulation and

functioning as outcomes. Supporting the program theory from the reviews, attachment, such as

feeling trust and safety during sessions, was an overarching key theme. While many aspects of the program theory from the realist review were upheld, the theory and contexts needed to be revised for these clients to reach desired outcomes. For example, additional techniques within the EFIT micro interventions were shown to help some clients overcome obstacles like hyper- and hypo- arousal in sessions to progress through the stages.

Given the revised program theory and mechanisms that may have led to outcomes, findings suggest that EFIT may be most effective for individuals whose workplace distress is rooted in relational and attachment-based challenges, with some adjustments to techniques. While clients often present with many work-related issues, relational and attachment problems may be an under-recognized source of their concerns. This indicates therapists and others who work with distressed employees may want to assess for relational and attachment distress specifically when starting work together.

7.2.2 Comparison with Literature

The realist evaluation was designed to build on the findings of the narrative review and test the program theory developed from the realist review. As a result, my analysis process was iterative, constantly looping between the data and the literature to evaluate alignment, gaps, and areas for refinement. I found that integrating work-specific content into EFIT sessions is possible. While EFIT literature focuses on emotion, identity, and unmet attachment needs, it doesn't directly address common workplace stressors like performance pressure, betrayal by leadership, or unclear authority. Yet these were some of the triggers that brought my clients into therapy. Treating the workplace as an attachment-relevant environment, one that can threaten or reinforce internal working models, provided a new perspective and potential treatment model.

This finding aligns with the idea that our relationships at work can echo or trigger core attachment responses, particularly under chronic stress (6, 70).

Several core elements of Emotionally Focused Therapy (EFT) that the literature identifies as foundational to therapeutic change, such as the therapeutic alliance, emotionally corrective encounters, and the use of heightening techniques, were also central mechanisms in the realist evaluation (12, 27, 34, 153). For example, EFT literature and the resulting realist review program theory highlighted the importance of attunement and micro-interventions (12, 32), and the realist evaluation supports that by showing how the therapist's presence, pacing, voice tone, and emotional transparency helped shape outcomes. As the therapist, I had to be attuned to the client to see what may be needed to help them deepen and progress and to avoid overwhelming emotions that could become an obstacle to progress. These strategies are supported by the literature and are core to the EFT change process (28, 143).

Similarly, the outcomes in the realist review program theory, such as shifts in internal working models, improved emotional regulation, and reduced work-related mental health distress, were observed or reported by clients and upheld in the realist evaluation (15, 34, 52). Through emotionally corrective experiences, participants were able to begin shifting core narratives related to their sense of agency and confidence in professional settings. These findings are consistent with EFT's core theory of change (12, 28), but they also suggest that it can apply meaningfully beyond personal or family contexts.

Since I completed all studies and while I was editing this thesis, the first randomized controlled trial of EFIT by Wiebe et al. (2025) was published and focused on EFIT's efficacy in

treating depression and anxiety. The study randomized 88 participants (44 EFIT; 44 wait-list control condition) using with clients receiving approximately 15 weekly sessions of EFIT delivered by multiple therapists. Statistically significant reductions were found in overall distress, depression, and anxiety ($p < .001$), with 53% of EFIT clients achieving clinically significant recovery compared to 13% in the control group. Wiebe et al. emphasize that “EFIT helps clients access and organize emotional experiences in the context of the relationship with the therapist and close relationships in the client’s life, thus expanding internal working models of self and other toward greater attachment security”(30). This description supports findings from this thesis’ realist evaluation, where participants reported that sessions fostering trust, emotional coherence, and self-compassion positively altered their internal working models (view of self and other). Both studies highlight corrective emotional experiences within the therapeutic alliance as central mode of change.

The realist evaluation also reinforced key findings from the narrative review, particularly the link between insecure attachment and work-related distress (6, 11), and the potential for attachment-based interventions to support recovery. Attachment emerged as a key overarching theme in the realist evaluation, offering insight into the relational roots of work-related distress. Participants described patterns of anxiety, burnout, and emotional exhaustion that were activated in professional relationships, most often with managers, but sometimes with teams, or organizational systems. These relational dynamics often mirrored deeper attachment patterns, consistent with what I had previously found in the narrative review (6). Being able to bring these patterns into therapy and name them as attachment-related, reframed the narrative and offered clients reported insight and relief. Shifting the narrative from ‘there is something wrong with

me,' to a more nuanced attachment-based narrative, enabled clients to take responsibility for their role in their situation and make active changes, like blocking certain people on social media or setting more clear boundaries in work relationships.

One area where the findings in the realist evaluation diverged from the literature and the realist review program theory concerned how to overcome obstacles such as hypo- and hyperarousal that emerged during sessions with individuals. While EFT literature provides guidance for managing these challenges in couples therapy (28), there is little published detail specific to individuals, especially those experiencing workplace distress. In practice, I introduced several more specific versions of the EFT micro-interventions to normalize, reduce shame, and enable exploration of deeper emotions and experiences. These often involved imagined or symbolic others to help regulate and maintain safety during emotionally intense moments. Although not always explicitly outlined in EFIT protocols, these interventions align with the broader EFT model and are supported by literature using imagined attachment figures in sessions (70). Based on these findings, EFIT may need to offer more explicit guidance for managing hypo- and hyper-arousal in individuals, showing a potential gap in the current literature and training that could make EFIT potentially more effective in certain contexts.

In sum, this evaluation signals the promise of attachment-based therapy models for work-related distress but also highlights where they may need to evolve. Literature of EFT and EFIT provided a strong theoretical foundation, but I had to adapt the model during therapy sessions to meet the specific relational and emotional challenges that arose. The therapist's role as a secure base, someone who offers attunement, containment, and emotionally corrective encounters,

remains central. In environments where workers feel insecure, that kind of relational anchor may help reshape a troubling narrative that isn't serving the client.

7.2.3 Situating the Findings Within Organizational and Occupational Health Psychology

In this thesis I examined EFIT as a therapeutic approach for individuals experiencing work-related distress. While the study focused primarily on therapeutic processes, the findings also connect with research in organizational psychology and occupational health. Organizational models emphasize the importance of job demands, resources, and workplace conditions in shaping employee well-being (41, 42). What stood out to me through this research, however, was how frequently participants described distress in relational terms. The difficulties they experienced were not simply about workload or job design. They often centered on trust, reliability, betrayal, and the perceived safety of key workplace relationships. This ties to the research on worker resources (41, 42) and social support theory (43), described in Chapter 1.

This observation also aligns with Lazarus and Folkman's transactional model of stress, which emphasizes that stress emerges through an appraisal process in which individuals evaluate both the threat posed by a situation and their ability to cope with it (35). Based on attachment theory, relational dynamics may shape both sides of this appraisal. When individuals perceive a leader or colleague as dependable, fair, and responsive, difficult work situations may still feel manageable. When those key relational dynamics are uncertain or fragile, the same situations may feel significantly more threatening. These theories help situate this thesis within occupational health and organizational psychology while highlighting the related relational mechanisms through which work-related distress may be experienced, buffered, and regulated.

Many organizational initiatives emphasize support, openness, or well-being programming, and while well-intentioned, they can overlook or even worsen the more fundamental issue that attachment theory point to, as described in this thesis: relational trust in leaders. Support without trust can feel performative, creating misaligned realities that further erode trust in leaders and organizations and impact feelings of safety and security. Attachment theory helps explain why. For instance, employees may be encouraged to be open about challenges, yet they operate within systems that reward performance, reliability, and competition, making vulnerability feel risky. When messages about openness are not matched by how power and evaluation function in practice, employees can feel caught between competing expectations, further undermining relational trust and activating threat responses.

Overall, this thesis discusses key relationships as an important psychological resource at work. While therapeutic approaches such as EFIT can help individuals rebuild internal resources and relational capacity when relationships and trust are compromised, the broader organizational context remains important, as the conditions that enable or undermine trust are ultimately shaped by leadership practices and organizational systems. Influencing this dynamic may require better alignment with leaders' core goals and fears, as framing the importance of relational trust solely in terms of health may create management theater instead of traction and action.

7.2.4 Unanticipated findings and alternative explanations.

Several findings emerged during the realist evaluation that were not anticipated and warrant further consideration. First, qualitative data proved far more insightful than quantitative measures. While standardized tools provided clinical insight and captured general trends in distress reduction, the nuance, variability, and richness of participants' change processes,

especially around emotion regulation and internal working models, were only visible through qualitative analysis. This imbalance may raise questions about the limitations of using quantitative metrics alone when evaluating experiential therapies like EFIT.

While I hadn't set out to test for attachment-related origins of distress explicitly, nearly every participant's presenting problem, once unpacked, was rooted in attachment dynamics, particularly in relation to work hierarchies, feedback, betrayal, or lack of psychological safety. This was especially apparent once trust in the therapeutic relationship built, and shame and professional posturing had softened, often after several sessions. It took time and co-regulation to reach what participants later identified as the "real" issue, and I was struck by how long that process took, even in a supportive therapeutic context. This has important implications for organizational psychology and occupational health research and consulting: if even therapy clients require multiple sessions to access their core distress narratives, how reliable are quick workplace surveys or interviews that so much of organizational research relies on in capturing the real drivers of workplace suffering or disengagement?

I also expected somatic interventions, such as having a client attune to the physical sensation of an experience, to play a more central role in helping participants regulate and engage with emotional material. While they were helpful in heightening emotions at times, what seemed more critical was the use of flexible, often improvised micro-interventions, such as imagined others, that weren't formally part of the EFIT protocol but were needed to maintain safety and momentum. These techniques helped bridge moments of disconnection, shame, or overwhelm, and often created the conditions necessary for change.

Similarly, I found that encounters, while central to outcomes, were more fluid than expected, making it more difficult to identify the beginning and end. Some key narrative shifts didn't happen in visibly heightened moments but rather through subtle acknowledgements, repeated reflections, or brief but emotionally charged shifts in self-perception. This has implications for how we define and code "change events" in EFIT and similar modalities, as compared to EFT, where the start and end of an encounter between partners is easier to define.

7.3 Implications for Policy and Practice

This study aims to contribute to both theoretical knowledge (attachment theory in workplace settings, research on EFIT) and clinical practice (application of EFIT for work distress). For clinicians and coaches, attachment-based techniques may offer new ways to help clients experiencing burnout, conflict and distress. For policymakers and organizational leaders, the findings may provide additional support for the relevance of attachment in the workplace not just to be kind to others, but as foundational for health and performance.

Provisional Adapted Model

This realist evaluation used qualitative and quantitative data to test the realist review program theory, which was mainly based on literature on EFIT's parent therapy, EFT with couples. It may not be surprising then that adjustments may be needed when using EFT with individuals, and for work-related distress. Based on the findings of this study a proposed model (Figure 22) is presented here to illustrate a more accessible adaptation of findings and EFIT, and a direction for future research. This model is based on existing knowledge about EFIT but provides a simplified three step process and language for the broader business population and

those who serve them, and more specific micro-interventions based on the realist evaluation. It is a high-level overview and would accompany a presentation or paper, and it continues to evolve based on feedback from stakeholders. This model, along with a paper that discusses results of this thesis, adjusted for a coaching audience, was peer-reviewed and accepted to the Columbia University Coaching Conference and was presented in October 2025.

Attachment-Based Intervention for Work-Related Distress

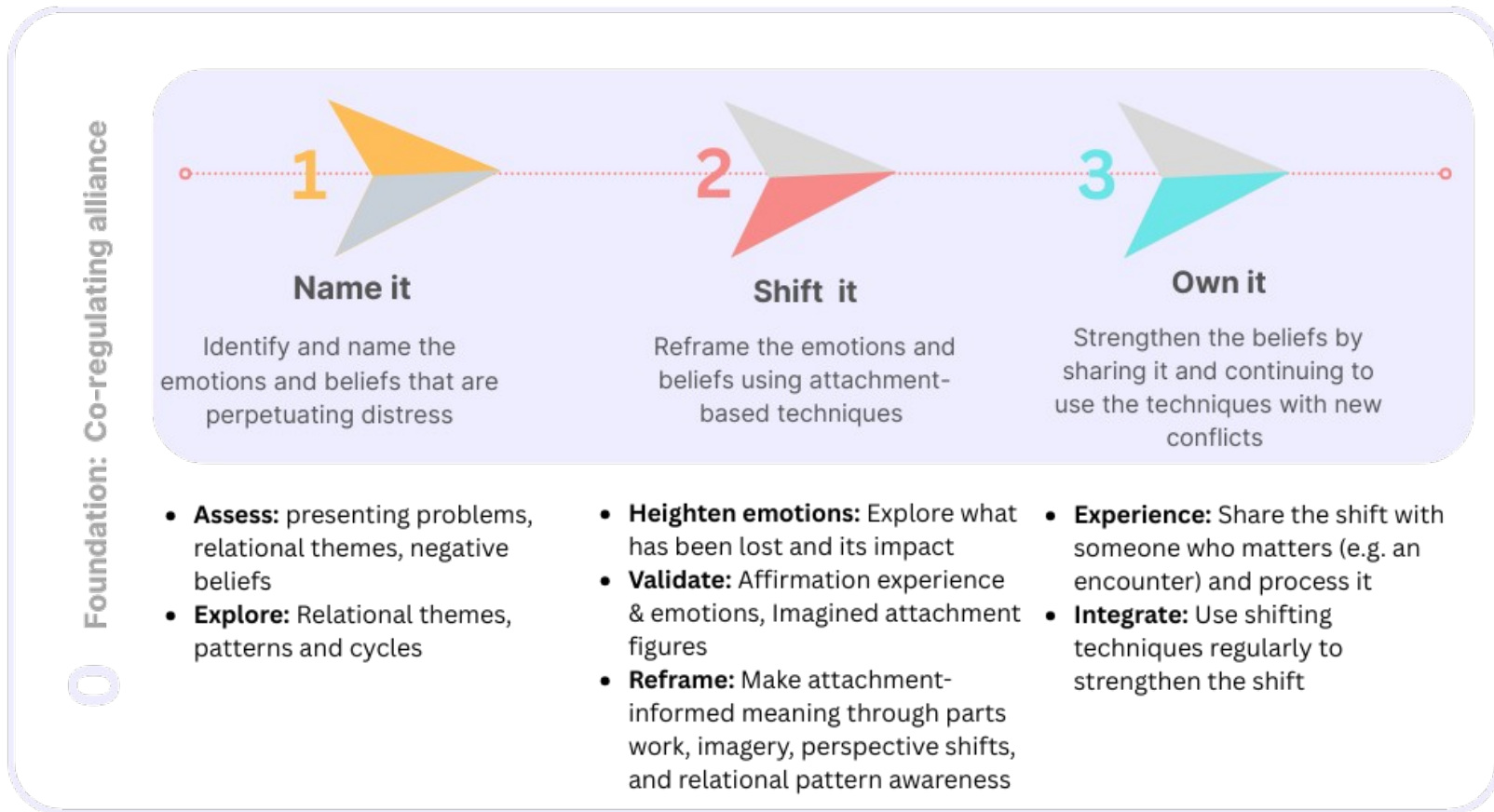


Figure 22: Proposed attachment-based model for treating work-related distress

7.4 Strengths and Limitations

This thesis is both novel and exploratory since it is the first investigation of Emotionally Focused Individual Therapy (EFIT) applied to workplace mental health distress. That novelty is one of its key strengths and it opens a new line of inquiry into attachment-based therapeutic interventions for work-related distress. At the same time, it represents a limitation, as there are no directly comparable studies for benchmarking findings or interpretations.

Another major strength is the use of realist approaches, which enabled me to move beyond simple outcome evaluation and instead explore how, why, for whom, and under what circumstances EFIT may work. These theory-driven approaches allowed for the development and testing of context-mechanism-outcome configurations (CMOCs), which help clarify context-dependent causal pathways rather than assuming uniform effects across clients and settings. I drew on the RAMESES standards to guide design and reporting. The mixed-methods design offered another layer of rigor and cross-method validation.

Still, there are several limitations to acknowledge. The sample size was small and limited to California, and participants self-selected into the study, which likely introduces selection bias and limits transferability. Additionally, because there was no long-term follow-up, I cannot say whether the outcomes endured over time. Participants' lives continued to evolve during the study period, and it's impossible to isolate EFIT as the sole agent of change; in some cases, simply making a decision to participate in therapy or setting an intention may have sparked movement.

A further consideration was my dual role as therapist and researcher. While this gave me rich access to client process and allowed for detailed observation, it also introduced potential

bias in interpretation. I tried to mitigate this through using mixed methods, weekly supervision with a certified EFT therapist, reflective journaling, and stakeholder discussions. I also drew on Practice-Based Research (PBR) principles to enhance trustworthiness, including internal validity strategies such as data triangulation, and external validity conceptualized as the potential transferability of CMOCs to similar workplace contexts. While PBR literature supports these strategies, concerns around the interpretive nature of CMOC configuration and transfer remain (108).

Some methodological constraints also became evident. I had included heart rate variability as a potential somatic indicator of change, but the data were inconsistent and difficult to interpret. In hindsight, one change I would make was to do a pilot of the heart rate data and analyze it before rolling it out to the entire study. Ultimately, I chose not to include these data in the final analysis. Future studies might consider other ways to attempt physiological monitoring if pursuing this line of inquiry.

Finally, while participant feedback on the sessions was positive, supporting desired outcomes and the program theory from the literature, I have to consider that free therapy may have influenced responses on tools like the PSRQ. Clients may have felt grateful or eager to please, which could have led to inflated positive ratings. Still, the convergence of feedback across different forms of data strengthens confidence in the findings. Also, proving EFIT effective was not a goal of the study, but instead to understand the contexts and mechanisms that may aid the outcomes observed.

In sum, while the study has clear limitations, many may be expected in exploratory, practice-based, and realist-informed research. The design choices were intentional and where trade-offs were made, such as extrapolating from EFT to EFIT in the realist review, I deliberately used the realist evaluation to further develop and test those extrapolations using primary data in an effort to mitigate threats to the validity of my findings and strengthen the overall contribution of the study.

7.5 Future Research Directions

This study opens several avenues for future research. First a larger-scale and longer-term investigation could help validate the preliminary outcomes observed here and assess whether these effects are sustained over time. A longitudinal design would offer deeper insight into the lasting impact of EFIT on work-related distress, particularly in relation to internal working model change, emotional regulation, and behavioral shifts.

There would also be value in expanding the research across different populations and industries. All participants in this study were based in California and self-selected into therapy; future research could compare how EFIT functions in different organizations, cultural settings, or among workers in more structurally constrained or lower-autonomy roles. These comparisons might reveal new contextual factors or point to adaptations needed for broader application.

In addition, the exploratory model I proposed (see Figure 22) could be tested in new delivery situations beyond psychotherapy. For example, attachment-informed techniques may have utility in executive coaching, leadership development, or even AI-based support tools. As relational functions begin to shift toward digital systems and AI in the workplace, it becomes

more important to explore how attachment needs are, or are not, being met in emerging configurations. There is also the potential to explore hybrid interventions that combine EFIT with broader organizational mental health initiatives. This might include integrating therapy with workplace accommodations, leadership training, or wellness programs.

Finally, a deeper philosophical and sociological question remains: what forms of attachment are realistically achievable within workplace structures? This study illuminated how often clients struggle with the emotional labor of professional life and the absence of safety at work. Future research could explore whether attachment-informed approaches can meaningfully reshape workplace dynamics, or whether systemic and capitalist cultural constraints limit their potential.

7.6 Personal Reflection

I began this research because of a pattern I saw in my clinical and executive coaching work: clients who were struggling with work-related distress due to the feeling that no one ‘had their back’ at work. I came into the D.Phil. program with a practitioner’s mindset: I had questions grounded in real-life client experience and a desire to find answers that could help. While I was intellectually curious, my academic instincts were under-developed. I didn’t understand the rigor in methodological thinking that academia demands.

Coming from both the business world and clinical settings, I had been conditioned to focus on outcomes. What mattered most was getting to an answer that worked and how you got there was secondary, sometimes irrelevant. The D.Phil. taught me the opposite: that in research, the *how* matters just as much as the *what*. The process, including the methodology, the logic, the

critical analysis of validity, is what gives the findings meaning. Results without rigor are not only weak; they can be misleading. It took time for me to fully absorb this lesson, but it has changed the way I think and work. I now bring a more discerning lens to new interventions and evidence bases, and I feel better equipped to evaluate ideas with depth, whether in therapy, coaching, or business. This is now being tested as I evaluate a potential business idea that came from recent research I completed on AI & leadership (manuscript in peer review), which in turn was inspired by this thesis.

While I knew I would need to defend the decision, being the clinician and the researcher created some unique opportunities for observation and challenges to address to uphold validity. For example, as a clinician I can sense a change moment, or emotionally corrective experience, occurring in real time due to a shift in the participant's tone, energy, and facial expressions. But as a researcher, it was more challenging and required developing a consistent and detailed process with mixed methods and multiple sources of data to compare. The precedent of Practice-Based Research (PBR) provided me with the confidence that the challenges to validity could be defended (108, 111).

Since the thesis and specifically the realist evaluation was designed to be exploratory, I didn't know what I would find. For me, the most interesting findings were the validation of the link between attachment and work-related distress, and the specific techniques within the micro-interventions that helped overcome resistance and obstacles in session. I believe these directional findings can help practitioners (therapists, coaches and leaders) today and provide directions for future research. While participants reported positive outcomes, that was less surprising or interesting to me as a researcher. There is a saying in coaching that if someone takes an hour a

week to talk to a lamppost about the things that concern them most, they will feel some improvements and relief over time. While this saying is not evidence-based, it must be acknowledged that outcomes in the realist evaluation may be attributable to many things, including just space to express oneself.

Throughout this D.Phil., I also grew a thicker skin. Academic work demands that you justify and defend your thinking, again and again. You have to stand on solid ground, knowing you've done the work to make that ground stable. This level of intellectual challenge and confidence in my work felt different than in other environments. It raises the bar not only for rigor, but for self-trust. Facing direct, often difficult questions has helped me build both. I finish this dissertation not just with new knowledge, but with a different way of approaching uncertainty, evidence, and my belief in my own expertise.

7.7 Conclusion

This dissertation set out to explore whether Emotionally Focused Individual Therapy (EFIT), an attachment-based therapeutic model, could be effective in treating work-related distress. What began as a question, drawn from clinical observations, evolved into a multi-stage research project that included narrative and realist reviews, and a realist evaluation. Taken together, these phases helped build and test a program theory explaining how, for whom, and under what conditions EFIT might reduce distress tied to workplace relationships and attachment dynamics.

The narrative review provided insight into the relationship between attachment and work-related distress, and the realist review synthesized existing literature across attachment theory, work-related mental health, and Emotionally Focused Therapy (EFT), surfacing potential

contexts and mechanisms that may lead to improved outcomes in individual EFIT. From this, an initial program theory was developed and formed the basis for the subsequent realist evaluation.

The realist evaluation then tested that theory using primary data: session transcripts, clinical notes, post-session reflections, and psychometric assessments with ten clients experiencing work-related distress. The findings confirmed and refined much of the program theory identified in the review and also revealed the extent to which overwhelming emotions may lead to obstacles to progress in sessions and required adaptations of standard EFIT micro interventions.

The study advances understanding in several ways. It is the first to explicitly investigate EFIT's application to work-related distress, suggesting that attachment-informed therapy may be valuable for individuals whose distress stem from insecure attachment patterns with key individuals like a boss in professional settings. It also makes a methodological contribution by further demonstrating the value of realist methodology in exploring complex therapeutic interventions.

This thesis highlights how difficult it can be to reach the “real” problem the employee is experiencing in their workplace, where people are often guarded and may be unaware of the relational underpinnings of their distress. That process, and the time it takes, has implications not only for therapy but for how we assess and understand employee -being more broadly, whether in research, coaching, or organizational surveys.

Finally, this research reinforced my belief that meaningful mental health support at work must go beyond stress reduction and performance enhancement. It requires an honest exploration

of belonging, trust, shame, fear, and the stories people carry about who they need to be to thrive and succeed. EFIT may offer one way to do that, and this thesis offers one step toward exploring and understanding how.

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9 Appendices

9.1 Appendix A: Database Search Log

Nov 7, 2022:

PsycINFO 1806 to present

1 exp Top Level Managers/ or exp Management Personnel/ or exp Business Management/
39237

2 exp Attachment Disorders/ or exp Attachment Behavior/ or exp Attachment Theory/
34742

3 mental disorders/ or mental health/ 166035

4 diversity in the workplace/ or diversity/ or inclusion/ 15790

5 exp Minority Stress/ or exp Minority Groups/ or exp Sexual Minority Groups/ 20102

6 equity/ or inclusion/ 3095

7 exp Human Females/ 155544

8 exp Social Justice/ or exp Oppression/ or exp Feminism/ 23624

9 self-compassion/ or self-concept/ or self-criticism/ or self-perception/ or self-confidence/
71894

10 exp Emotional Intelligence/ 6600

11 exp Microaggression/ 716

12 exp Well Being/ or exp Coping Behavior/ or exp Distress/ or exp Stress/ 241908

13 exp "Resilience (Psychological)"/ or exp Emotional Trauma/ 35007

14 exp Trauma/ 93125

15 shame/ or emotional states/ or embarrassment/ or fear/ or self-blame/ 63943

16 shame/ or emotional states/ or embarrassment/ or fear/ or self-blame/ 63943

17 shame/ 5146

18 exp Emotions/ or exp Autonomic Nervous System/ 424347

19 exp Self-Regulation/ 11532

20 exp Emotional Disturbances/ or exp Emotional States/ 343945

21 exp Organizational Climate/ or exp Organizations/ or exp Business Organizations/ or exp
Work Teams/ 135419

22 exp Business/ 84529

23 exp Telecommuting/ 653

24 1 or 21 or 22 or 23 223880

25 4 or 5 or 6 or 7 or 8 208293

26 social interaction/ or psychodynamics/ or respect/ or social anxiety/ or social
connectedness/ 49064

27 working conditions/ or employee well being/ or occupational health/ or organizational
climate/ or "quality of work life"/ 41690

28 2 or 10 or 26 89298

29 3 or 9 or 12 or 13 or 14 or 15 or 18 or 19 or 20 or 27 894488

235

30	24 and 28	2697
31	24 and 29	36989
32	24 and 28 and 29	741
33	2 and 24	368
34	2 or 26	82840
35	24 and 34	1853
36	25 and 31	2060
37	25 and 32	30
38	25 and 30	110
39	(Leadership and attachment).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures, mesh word]	421