An investigation into the associations between therapist and client attachment styles and the working alliance.

A thesis submitted to the University of Manchester for the degree of Doctor of Clinical Psychology in the Faculty of Medical and Human Sciences

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CONTENTS

LIST OF TABLES

PAPER 1 – The influence of therapist attachment on the working alliance and outcome

PAPER 2 - Client and Clinician Attachment Styles, Psychological Mindedness and the Working Alliance.

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LIST OF FIGURES

PAPER 1 – The influence of therapist attachment on the working alliance and outcome

PAPER 2 - Client and Clinician Attachment Styles, Psychological Mindedness and the Working Alliance.

WORD COUNT

Thesis Section	Text	Abstracts, tables, figures, references	Total
Thesis abstract	432		432
Paper one (Literature Review)	9,885	3,182	13,067
Paper two (Empirical Paper)	9,157	2,759	11,916
Paper Three (Critical review)	4,773	1,676	6,449
Appendices	7,162		7,162
Total	**24,247**	**6,108**	**37,517**

ABSTRACT

This thesis explores the associations between therapist and client attachment styles and the working alliance. It is presented as three papers: a literature review, a report of the empirical research study, and a critical reflection of the research process.

In the first paper, the author provides a systematic review of studies that have investigated the association between therapist attachment and the working alliance and therapist attachment and clinical outcome. A total of nine research studies met the inclusion criteria and were included in the final review. The studies varied considerably in terms of their design and methodology, as well as, the different tools used to measure the therapeutic alliance, attachment style and outcome. The findings were then organized in terms of the relationship between therapist attachment and client-rated therapeutic alliance; the relationship between therapist attachment and therapist-rated alliance; the relationship between therapist attachment and alliance as rated by an observer and finally, the relationship between therapist attachment and outcome. The key findings were that therapist attachment security was associated with client-rated and therapist-rated working alliance. However, the overall association between therapist attachment and alliance was not straight forward. There was evidence to suggest that the attachment style of therapist and the client interact to produce a combined effect on perceptions of the working alliance and outcome.

The empirical research paper examined the extent to which client and therapist self-reported attachment styles were related to the working alliance. The study also investigated any role for client attachment to therapist and psychological mindedness. Both these variables were included as exploratory. It was hypothesised that psychological mindedness may be related to secure attachment and the alliance. Specifically, we investigated the extent to which self-reported attachment styles were related to the working alliance and assessed the relative contribution of psychological mindedness to attachment security and the quality of the working alliance. Thirty clients and 42 therapists from primary care services were recruited. Participants completed measures of anxiety and depression, attachment style, working alliance and psychological mindedness. Therapist attachment security was not related to the alliance. No significant relationships were found between client attachment style and the working alliance. However, therapists and clients with oppositional attachment styles had more favourable alliances. The clinical implications and future research directions is then discussed.

The final paper provides a critical reflection of the research process. It begins by outlining the rationale for the development of the literature review and the empirical research paper, and goes on to discuss some of the methodological considerations of the research paper. The implications for therapeutic practice are then suggested, followed by the wider service-related issues. Attachment theory is then critiqued, and the clinical implications discussed. Finally recommendations are made for future research.

DECLARATION

No portion of this work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

COPYRIGHT STATEMENT

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Firstly I would like to thank my supervisor, Dr Katherine Berry, for always being available and approachable and for her encouragement to consistently aim for a high standard. A big thank you to Alison Harris for her thoroughness and patience. I would like to thank my wonderful parents for their belief in me and support throughout the years. Lastly, thank you to my amazing partner and little girl, for giving me all the love and cuddles that I have needed to complete this thesis.

Paper one: Literature Review.

The influence of therapist attachment on the working alliance and outcome.

Annily Seymour-Hyde

PREFACE

The work for this paper was carried out between October 2011 and May 2012. The literature search was completed at the beginning of January 2011. Dr Katherine Berry provided overall supervision for the thesis which included reading drafts of the manuscript. Alison Harris was involved in reading drafts of the manuscript and providing support and feedback. The author intends to publish the review paper in 'Psychotherapy Research' and the paper has been prepared in accordance with their requirements (see appendix A for author guidelines). Tables and figures have been left in the main text to aid readability. The authors will be: Annily Seymour-Hyde, Dr Katherine Berry and Alison Harris.

ABSTRACT

This review evaluates studies which have investigated the association between therapist attachment and the working alliance and therapist attachment and clinical outcome. There is some evidence that therapist attachment security is associated with client-rated and therapist-rated working alliance. However, the overall association between therapist attachment and alliance is not straight forward; as there was evidence to suggest that the attachment style of the therapist and the client interact to produce a combined effect on perceptions of the working alliance. Consistent with the alliance literature, there was evidence that both therapist attachment style and interactions between therapist and client attachment influences outcome.

INTRODUCTION

The concept of the alliance originated in early psychoanalytic theories (Zetzel, 1956; Freud, 1958; Greenson, 1967). Since then, many different terminologies have been used to describe the alliance, including the therapeutic alliance, the working alliance and the helping alliance, with different conceptualisations of the affective bond between therapist and client (Catty, 2004; Daniel, 2006). These varied conceptualisations of the alliance have yielded different measures of the construct, although none of which have generated more research than Bordin's (1975) conceptualisation. Bordin's (1979, 1994) pan-theoretical conceptualisation of the working alliance is an integrative model. He described the working alliance as "what makes it possible for the patient to accept and follow treatment faithfully" (1980, p2). He defined three components to the working alliance that in combination define both the strength and the quality of all therapeutic relationships.

The three constituents and influencing factors on the alliance are said to be: (a) the therapist's and client's agreement on the goals of therapy; (b) the therapist's and client's agreement on the tasks of therapy needed to attain these goals; and (c) the emotional bond between the dyad. All the components involve a shared purpose and agreement between the client and the therapist and require cooperation and mutuality between both members of the dyad. This conceptualisation has dominated the literature and has generated validated working alliance measurement scales. Horvath and Greenberg's (1989) Working Alliance Inventory is based on Bordin's model and has become the most commonly used measure in alliance research (Martin, Garske & Davis, 2000; Smith, Msetfi & Golding, 2010).

The therapeutic alliance has been rigorously researched, as it is associated with both therapy outcomes and progress. Meta-analyses have found strong support for the influence of alliance on psychotherapy outcome. The alliance-outcome correlation is typically reported in the range of 0.22-0.26, across treatment types and outcome

measures (Horvath & Symonds, 1991; Martin et al., 2000; Baldwin, Wampold & Imal, 2007).

The formation of an effective working alliance involves both members of the dyad. Research has, therefore, focussed on assessing the alliance from the client perspective and the therapist perspective. There are also studies investigating alliance from the observer perspective. In terms of the best predictor of outcome, research suggests that the client perspective is the best predictor of outcome and the therapist's perception of the alliance is the worst (Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Horvath & Bedi, 2002), with only modest overlap between perspectives (Norcross, 2002). Therapist and observer ratings of the alliance are, however, still linked to outcome (Bruck, Winston, Aderholt & Murran, 2006; Schauenburg et al, 2010), so may be important constructs to assess.

Given the importance of the concept of working alliance to outcomes there has been much research to identify the key predictors of alliance, including characteristics of clients and therapists. Research has shown that demographic factors have little influence, but there is evidence that interpersonal characteristics of both client and therapist predict alliance and outcomes (Beutler, Machado & Allstetter, 1994). Characteristics of the therapist that have been associated with more positive therapeutic alliance and outcomes include openness, warmth and trustworthiness (Orlinsky, Grawe & Parks, 1994; Roth & Fonagy, 1996; Akerman & Hilsenroth, 2003).

It has been suggested that attachment theory can provide a framework within which to explore the therapeutic alliance (Bowlby, 1988) and the therapeutic relationship has been conceptualised as an "attachment relationship" (Bowlby, 1988; Mallinckrodt, 2000; Parish & Eagle, 2003). Attachment is defined as a type of affectional bond, which the individual forms with a specific person, who is approached in times of distress (Bowlby, 1973). The attachment relationship is hypothesised to provide the person with a "secure base", which enables the individual to engage in exploration,

and develop and gain independence (Ainsworth, Blehar, Waters & Wall, 1978; Ainsworth, 1989). Attachment bonds are first formed with primary caregivers during childhood, but are thought to be of importance throughout the life cycle (Bowlby, 1973).

Attachment theory asserts that through exposure to attachment relationships, infants construct internal working models (IWMs) (Bowlby, 1969) which contain information and expectations about whether the individual is worthy of love and attention and how they will be treated by others (Bowlby, 1988). In early childhood, the infant's goal is to maintain proximity with the attachment figure. Consequently, children develop attachment styles that are 'in tune' or suited to the type of parenting they have received (Bowlby, 1982). The caregiver's sensitivity to distress appears to be a significant factor in determining the type of attachment that the infant develops (Weinfield, Sroufe, Egelan & Carlson, 1999). If the infant receives sensitive care giving that is responsive to his or her needs, a secure attachment style can be developed. This is associated with a positive image of the self and others, adaptive strategies for coping with distress, behaving autonomously and the ability to develop intimate relationships. However, if the infant receives insensitive care giving and the primary care giver is unresponsive to distress, the individual either escalates levels of distress to get their attachment needs met (insecure anxious or ambivalent attachment), or he or she learns to deactivate his or her attachment system, which is associated with a dismissive approach to affect and an avoidance of close relationships (insecure avoidant or dismissing attachment) (Shaver, Belsky & Brennan, 2000; Shaver & Mikulincer, 2002).

Although Bowlby (1973) proposed that working models persist throughout the lifespan due to their influence on new relationships, there is evidence that changes in attachment patterns can occur in either a positive or negative direction, due to life stressors and changes in key relationships (Waters, Merrick, Treboux, Crowell & Albersheim, 2000; Hamilton, 2000; Hopkins, 2006). Bowlby (1988) argued that the

psychotherapy relationship may provide an important mechanism to help the patient move from insecure to secure attachment and there is some evidence that attachment status can improve as a result of therapy (Diamond et al, 2003; Diamond, Stovall-McClough, Clarkin & Levy, 2003; Daniel, 2006). Bowlby (1988) argued that the role of the therapist is to act as an attachment figure by creating a secure base to enable exploration of attachment-related experiences and provide a corrective emotional experience to disconfirm insecure IWMs.

The hypothesis that the therapist functions as an attachment figure has led theorists and researchers to question whether the therapeutic relationship can truly be construed as an attachment relationship. Mallinckrodt, Daly and Wang (2009) and Mallinckrodt (2010) described five key characteristics of attachment relationships with evidence to evaluate whether the therapeutic relationship can meet these criteria. The criteria outlined are: 1) an attachment figure is a target for proximity seeking; 2) an attachment figure is a safe haven to provide comfort in times of distress; 3) an attachment figure provides a sense of security from which the individual can explore; 4) the individual experiences separation anxiety when the individual is not available; and 5) the attachment figure is stronger and wiser (Mallinckrodt, 2010). Mallinckrodt (2010) presents evidence which provides empirical support for the first four criteria (Vogel & Wei, 1995; Joyce, Piper, Ogrodniczuk & Klein, 2007; Janzen, Fitzpatrick & Drapeau, 2008; Romano, Fitzpatrick & Janzen, 2008) and argues that the fifth element is not essential for adult attachment relationships. The author concludes that although psychotherapy relationships will not always meet these criteria, therapy relationships do have the capacity to be attachment relationships with the potential to modify insecure working models.

As attachment styles shape our expectations and reactions to others, it is not surprising that attachment styles may also influence how people respond to the therapist and the therapeutic process. Secure clients are likely to have more positive expectations about the therapist and have an increased capacity to reflect on their

internal experiences and, therefore, derive more from the therapeutic experience (Wallin, 2007). Accordingly, there is a relatively consistent finding in the literature, that clients with secure attachments have better working alliances with therapists (Smith et al., 2010) and some evidence that client attachment security predicts more favourable outcomes (Meyer, Pilkonis, Proietti, Heape & Egan, 2001; Meyer & Pilkonis, 2002).

There is evidence from the parenting literature, that a caregiver's attachment security predicts their ability to be sensitive and responsive. There is further evidence of transgenerational transmission of attachment styles (Shorey & Snyder, 2006; Eagle, 2006). The therapist's capacity to act as an effective attachment figure and develop good working alliances is, therefore, also likely to be influenced by his or her own attachment style. A number of studies have therefore investigated the influence of the therapist's attachment on alliance and outcome. Although there have been recent reviews on the impact of client attachment style on therapeutic alliance (e.g. Smith et al., 2010), at present there is a lack of synthesis of research on the impact of the therapist attachment style on the formation and perceived strength of the working alliance and client outcome.

AIMS OF THE REVIEW

The aims of the current review are to examine the contribution of therapists' attachment style to perceptions of the working alliance and outcome. In doing so, the review also aims to identify areas for future research. There have been a number of reviews focusing on attachment styles and individual psychotherapy (Daniel, 2006; Diener & Monroe, 2011) and attachment and the therapeutic alliance (Smith et al., 2010). The reviews in this field have predominately focused on client attachment styles with relatively little attention on the role of the therapist's attachment style on alliance and outcome. This review therefore contributes to the literature by specifically synthesising research investigating the impact of the therapist's attachment style on the working alliance and psychotherapy outcome and making recommendations for further work in this area. Understanding associations between therapist attachment and alliance and therapist attachment and outcome may also highlight the importance of therapists considering the influence of their own attachment experiences via training, supervision or personal therapy.

The review will begin by describing the strategy used to identify relevant studies and then present an overview of the study characteristics. The main body of the review will outline and critically appraise the key findings. This will be followed by a discussion of the methodological limitations of existing research and the future research and clinical implications.

METHOD

A literature search was conducted using the online databases; EMBASE, Web of Science, PubMed, Medline and PsychInfo. The search terms therapist attachment AND alliance AND outcome, therapist characteristics AND alliance AND outcome, therapist interpersonal style AND alliance AND outcome, therapist relational style AND alliance AND outcome, therapeutic relationship AND interpersonal style AND outcome were used. All titles and abstracts were examined and full text papers of potentially relevant studies were obtained. All papers were read to determine if they met study criteria. The reference lists of papers meeting criteria were also followed up. To be included in the study the articles had to conform to the following criteria: (a) the article was published in English; (b) included a validated measure of the working alliance; (c) included a validated measure of therapist attachment style; (d) included a validated measure of outcome; and (e) be published from 1980 up to and including the year 2011. Review papers were excluded and studies were excluded if they examined group or couple alliance or sampled participants under the age of 18 years.

Search results

A total of nine studies met the inclusion criteria. The descriptive and methodological characteristics of the studies are presented below.

Descriptive characteristics of studies

Table one provides a summary of the main descriptive characteristics and key findings of the studies.

Table 1: Descriptive characteristics and key findings of the studies

Authors and Date	Country	Participants	Therapeutic Modality and Presenting Problem	Therapist Measures	Client Measures	Outcome Measures	Key Findings
Dunkle and Freidlander (1996)	**American Study**	73 therapists in university counselling centres 1 client per therapist	46% psychodynamic, 11% cognitive/behavioural, 31.5% eclectic, 8.2% interpersonal, 1.4% humanistic and 1.4% did not specify. 22% depression 14% romantic concerns 8% academic concerns 7% marital/family problems	ASS	WAI-S	Not Measured	Degree of comfort in close relationships was significantly predictive of more favourable client rated alliance
Tyrell, Dozier, Teague and Fallot (1999)	**American Study**	21 clinical case managers 54 clients with serious psychiatric disorders	Therapeutic modality not specified. Therapists were case managers 31% schizophrenia 9% schizo affective disorder 8% bipolar 6% major depression 48% comorbid substance abuse		AAI WAI	QOL BDI GAF	Clients who were more deactivating worked better and had better working alliances with case managers who were less deactivating. Clients who were less deactivating worked better and had better working alliances with case managers who were more deactivating.
Ligiero and Gelso (2002)	**American study**	5O therapists in training and 46 of their supervisors	24% psychodynamic 38% humanistic 32% cognitive behavioural 6% other Client problems not identified	RQ WAI-T WAI-O		Not Measured	Therapist's attachment style did not correlate with the overall working alliance or its three component parts. Therapist attachment style was not related to the quality of the therapist-client working alliance as rated by both supervisors and clients.

Authors and Date	Country	Participants	Therapeutic Modality and Presenting Problem	Therapist Measures	Client Measures	Outcome Measures	Key Findings
Black, Hardy, Turpin and Glenys Parry (2005)	**UK study**	491 psychotherapists No clients	34.8% PI, 24.2% cognitive/behavioural, 19.1% CAT/eclectic, 14.9% humanistic, 6.9% did not specify Presenting problem not reported	ASQ	ARM	Not Measured	Therapist attachment styles were significantly associated with their perceived quality of the working alliance. Therapists who reported more secure attachments also reported better therapeutic alliances with their clients. Therapists who reported higher levels of insecure attachment had poorer therapeutic alliance.
Bruck, Winston, Aderholt, Muran (2006)	**American study**	46 therapists 46 clients	Randomly assigned to CBT or STDP Presenting problems included mood and anxiety disorders, cluster C Personality disorder and personality NOS	RSQ WAI-S	RSQ WAI-S	SCL-90R IIP GAS	Therapist who scored higher on fearful, preoccupied and dismissing attachment had less favourable working alliances and outcomes. The greater the difference in attachment style between the client and therapist the better the alliance.
Romano, Fitzpatrick and Janzen (2008)	**Canadian study**	59 trainee counsellors. 59 volunteer clients enrolled on a counselling course	Training informed by psychodynamic, cognitive behavioural, humanistic and process experiential traditions Client problems not identified	ECRS	ECRS CATS WAI-C	Not Measured	No relationship between client and counsellor attachment and the working alliance. Results explained in terms of Type II Error, small sample size.

Authors and Date	Country	Participants	Therapeutic Modality and Presenting Problem	Therapist Measures	Client Measures	Outcome Measures	Key Findings
Dinger, Strack, Sachsse and Schauenburg (2009)	**German study**	12 psychotherapists, half of which were still in post grad training 281 psychotherapy inpatients	Therapists were mostly from a medical background. 9 physicians and 3 clinical psychologists. Orientation mainly psychodynamic 57.6% depression 22.1% anxiety 18.2% eating disorders 16.4% somatoform disorders 8.9% adjustment/stress 5% obsessive-compulsive 20.6% comorbid personality disorder	AAI	IES	Not Measured	Therapist's attachment security was not related to the development of the working alliance. However, high therapist attachment preoccupation was associated with lower ratings of alliance quality.
Schauenburg, Bucheim, Beckh, Nolte,Brenk-Franz, Leichsenring, Strack and Dinger (2010)	**German study**	31 psychodynamically oriented Psychotherapists 1, 381 patients in intensive multimodal inpatient psychotherapy Patients	38% psychodynamic 32% psychoanalytic 19% systemic/family therapy 55.6% affective disorders 35.7% anxiety 32.5% adjustment / stress disorders 19.4% eating disorder 16.9% somatoform disorder 6.6% obsessive-compulsive 38% Psychotic 41% comorbid personality disorder	AAI	HAQ	SCL-90R IIP	36.5% of alliance variation was due to differences between therapists. Expected patients treated by therapist with a secure attachment to report better alliances, and patients treated by highly preoccupied therapists to report less positive alliances. Found no direct influence (no main effect) of therapists' attachment security on alliance. But more securely attached therapists established better alliances with more interpersonally distressed patients.

Notes: AAS = Adult Attachment Scale (Collins & Read, 1990); WAI-S = Working alliance inventory-short version (Tracey & Kokotovic, 1989); AAI = Adult Attachment Interview (George, Kaplan & Main, 1985; Main, Kaplan & Cassidy, 1985) ; WAI = Working alliance inventory (Horvath & Greenberg, 1989); QOL = The Quality of Life Interview (Lehman, 1988); BDI = The Beck Depression Inventory (Beck, Ward, Mandelsen, Mock & Erlbaugh, 1961); GAF = The Global Assessment of Functioning

(American Psychiatric Association, 1994); (AAInv = Adult Attachment Inventory (Simpson, 1990; Simpson, Rholes & Nelligan, 1992); ASQ = Attachment Style Questionnaire (Feeney et al., 1994) ; ARM = The Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkman & Shapiro, 1998); RQ= Relationships Questionnaire (Bartholmew & Horowitz, 1991); WAI-T = Working Alliance Inventory - Therapist (Tracey & Kokotovic, 1989); WAI-O = Working Alliance Inventory - Observer (Tracey & Kokotovic, 1989); CBT= Cognitive Behavioural Therapy; STDP = Short-Term Dynamic Psychotherapy; RSQ= Relationship Styles Questionnaire (Griffin & Bartholomew, 1994) SCL-90R = Symptom Checklist-90 Revised (Derogatis, 1983); IIP = The Inventory of Interpersonal Problems (Horowitz, Alden, Wiggins, & Pincus, 2000); GAS= Global Assessment Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976); ECRS = Experiences in Close Relationships Scale (Brennan, Clark & Shaver, 1998); CATS= Client Attachment to Therapist Scale (Mallinckrodt, Gantt & Coble, 1995); WAI-C = Working Alliance Inventory - Client (Horvath & Greenberg, 1989; IES = Inpatient Experience Scale (Sammet & Schauenburg, 1999) ; HAQ = The Helping Alliance Questionnaire (Bassler, Potratz & Krauthauser, 1995).

The studies were conducted primarily in the United States (Dunkle & Friedlander, 1996; Tyrell et al, 1999; Sauer et al, 2003; Ligiero & Gelso, 2002; Bruck et al., 2006); one study was conducted in the United Kingdom (Black et al., 2005), two in Germany (Dinger et al., 2009; Schauenburg et al., 2010), and one in Canada (Romano et al., 2008). Seven of the studies were questionnaire or survey designs (Dunkle & Friedlander, 1996; Tyrell et al., 1999; Ligiero & Gelso, 2002; Sauer et al., 2003; Black et al., 2005; Bruck et al., 2006; and Romano et al., 2008) recruiting clients already in therapy and, as a consequence, not all participants completed the measures at the same time. Two studies used interview methods in addition to using questionnaire measures (Dinger et al., 2009; Schauenburg et al., 2010).

The number of sessions at which the study participants completed the study measures varied. Three of the studies administered the measures between the third and ninth sessions (Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Romano et al., 2008). Two studies measured attachment and alliance at intake and at termination of therapy (Bruck et al., 2006; Schauenburg et al., 2010); one study (Dinger et al., 2009) assessed the alliance weekly, and did not specify when attachment was assessed. Sauer et al. (2003) administered the attachment and alliance measures at session one and then measured the alliance weekly. Finally, two studies (Tyrell et al., 1999 and Black et al., 2005) did not specify when the measures were completed.

The therapeutic orientation of the therapists in the studies was varied and included psychodynamic, psychoanalytic, humanistic, existential, cognitive, cognitive behavioural, CAT, eclectic, systemic and interpersonal therapies. One study (Tyrell et al., 1999) did not specify a therapeutic orientation as the study looked at the relationship between clients and case managers. Most of the studies involved therapy sessions being delivered on an outpatient basis; with two studies reporting that therapy was conducted in an inpatient setting (Dinger et al., 2009; Schauenburg et al., 2010).

Five studies reported the clients' presenting problem(s) (Dunkle & Friedlander, 1996; Tyrell et al., 1999; Bruck et al., 2006; Dinger et al., 2009; Schauenburg et al., 2010), which included schizophrenia, schizoaffective disorder, anxiety disorders, depressive disorders, personality disorders, stress/adjustment disorders and romantic/academic/family concerns. The majority of the studies (n=8, Dunkle & Friedlander, 1996; Tyrell et al., 1999; Ligiero & Gelso, 2002; Sauer et al., 2003; Black et al., 2005; Bruck et al., 2006; Romano et al., 2008; Dinger et al., 2009 and Schauenburg et al., 2010) reported the gender of the participants in their final sample and used predominately female participants. Five studies reported the participants' ethnicity (Dunkle & Friedlander, 1996; Tyrell et al., 1999; Ligiero & Gelso, 2002; Sauer et al., 2003 and Romano et al., 2008) including White/Caucasian, Black/African Caribbean, Hispanic/Latino, Asian American and European American ethnic groups.

All of the studies (n=9) reported the therapists' levels of experience and training. This ranged from one month to 32 years experience. Five of the studies comprised therapists who were currently undergoing training (Dunkle & Friedlander, 1996; Ligiero & Gelso, 2002; Sauer et al., 2003; Romano et al., 2008 and Dinger et al., 2009).

Measurement of the alliance

The majority of studies (n=6, Dunkle & Friedlander, 1996; Tyrell et al., 1999; Ligiero & Gelso, 2002; Sauer et al., 2003; Bruck et al., 2006 and Romano et al., 2008) used the Working Alliance Inventory (WAI), or some variation of it (Working Alliance Inventory-Short/Client/Therapist/Observer). One study used the Agnew Relationship Measure (Black et al., 2005), one used the Helping Alliance Questionnaire (HAQ) (Schauenburg et al., 2010) and one study used the Inpatient Experience Scale (IES), (Dinger et al., 1999). The majority of the studies (n=8, Dunkle & Friedlander, 1996; Tyrell et al., 1999; Sauer et al., 2003; Black et al, 2005; Bruck et al, 2006; Romano et al, 2008, Dinger et al, 1999 and Schauenburg et al., 2010) used client ratings of the working alliance. Four studies assessed the therapist's perception of the working

alliance (Ligiero & Gelso, 2002; Sauer et al., 2003; Bruck et al., 2006; Romano et al. 2008) and three studies asked both the therapist and the client to complete a measure of the working alliance (Sauer et al., 2003; Bruck et al., 2006; Romano et al., 2008). Only one study used an observer-rated measure of the working alliance (Ligiero & Gelso, 2002).

Two studies measured the working alliance retrospectively; one study asked the therapist to complete the measure bringing to mind their clients in general (Black et al., 2005) and the other study asked the therapists to fill out the measure taking into account the last three sessions combined (Ligiero & Gelso, 2002).

Measurement of attachment

There are two major paradigms in adult attachment research. Both argue that internal working models develop as a result of earlier interpersonal experiences which influence psychosocial functioning in adulthood. However, they differ in their hypotheses about the content and structure of the models and are associated with different methods of assessment (Simpson & Rholes, 1998).

Main and colleagues argue that individual differences in attachment relate to the organisation of representations of earlier attachment figures and developed the Adult Attachment Interview (AAI), which measures 'attachment states of mind' on the basis of the coherence of the individual's narrative in describing parental-child relationships (Main, Kaplan & Cassidy, 1985; Main, 1995). Individuals are classified as secure-autonomous, dismissing (a type of avoidant attachment), or preoccupied (a type of anxious attachment). There is also an unresolved category, which is associated with reports of loss events or abuse, and confusion and disorganisation in discussing the topic (Crowell, Fraley & Shaver, 1999). The AAI can additionally be used to generate a secure versus insecure dimension and a deactivating versus hyperactivating dimension. Individuals high in hyperactivating states of mind are likely to focus on emotional distress and have a high degree of involvement and importance attached to

their relationships. Individuals high in deactivating states of mind are likely to minimise emotional distress and have distant relationships (Dozier, 1990; Dozier, Cue & Barnett, 1994).

The second paradigm developed from Hazan and Shaver's (1987) conceptualisation of romantic love as an attachment process. These authors translated three categories of attachment in infancy (secure, avoidant and anxious-ambivalent) into prototypical adult attachment styles. The first self –report measure was a categorical forced-choice questionnaire asking respondents to choose a description that best suits how they function in close relationships (Hazan & Shaver, 1987). This categorical measure, however, assumed that variation among people within a specific attachment category was unimportant. To address these issues other self-report measures began to use continuous rating scales and have involved rating various attachment-related statements. Research has shown that two dimensions underlie self-report measures of attachment style: attachment anxiety and attachment avoidance (Brennan, Clark & Shaver, 1998). These can also be conceptualised in cognitive terms as model of self and model of others (Bartholomew, 1990). Bartholomew (1990) argued that Main and colleagues' dismissing attachment and Hazan and Shaver's avoidant attachment represented two different types of avoidance, which are respectively motivated by defensive self-sufficiency (dismissing avoidance) and avoidance of rejection (fearful avoidance).

The studies reviewed used a diverse range of measures to assess attachment style, both from interview and self-report traditions. Three studies used the AAI (Tyrell et al., 1999; Dinger et al., 2009; Schauenburg et al., 2010), two of which derived attachment categories (Dinger et al., 2009; Schauenburg et al., 2010) and one used the dimensional approach (Tyrell et al., 1999). Six studies used self-report measures. More specifically, one used the Adult Attachment Scale (AAS) (Dunkle & Friedlander, 1996), one used the Relationships Questionnaire (RQ) (Ligiero & Gelso, 2002), one used the Experience in Close Relationships Scale (ECRS) (Romano et al., 2008), one

used the Relationship Styles Questionnaire (RSQ) (Bruck et al., 2006) and one used the Adult Attachment Inventory (AAInv) (Sauer et al., 2003).

Measurement of outcome

Only three studies included a measure of psychotherapy outcome (Tyrell et al., 1999; Bruck et al., 2006; Schauenburg et al., 2010). Psychotherapy outcome was assessed by two studies using the Symptom Checklist-90 Revised (SCL-90-R) and the Inventory of Interpersonal Problems (IIP) (Bruck et al., 2006; Schauenburg et al., 2010), with one of the studies also using the Global Assessment Scale (GAS, Schauenburg et al., 2010). One study used the Quality of Life Interview, the Beck Depression Inventory (BDI) and the Global Assessment of Functioning (GAF) (Tyrell, et al., 1999).

Study findings

The findings from each study will now be reviewed. The relationship between therapist attachment and client-rated therapeutic alliance will be discussed first, followed by the relationship between therapist attachment and therapist-rated alliance, and then research on therapist attachment and alliance as rated by an observer. Finally, the relationship between therapist attachment and outcome will be discussed.

Therapist attachment style and client-rated alliance

Dunkle and Friedlander (1996) investigated the contribution of therapist attachment style to client-rated working alliance in a sample of 73 counsellors and clients from university counselling centres. They used the AAS and the WAI administered between the third and fifth session of therapy. The AAS consists of three subscales: (a) Depend (the extent to which a person trust and relies on others); (b) Anxiety (the extent to which one feels experiences anxiety or fears of being abandoned in relationships); and (c) Close (the extent to which one is comfortable with intimacy). They found therapists who reported more comfort in developing close relationships had more favourable client-rated alliances. In a multivariate hierarchical regression analysis, therapist comfort with closeness accounted for a significant amount of the variance of the total

score of the client-rated alliance, β= 0.38, p < 0.01. However, no unique effects emerged for the Depend (β = 0.31, p =ns) or Anxiety (β = 0.16, p=ns) subscales of the AAS.

Schauenburg et al. (2010) investigated the association between therapist attachment representations on the AAI, and working alliance as measured by the client-rated HAQ in a large inpatient sample of thirty one therapists and 1, 381 patients. The authors report that 61.3% of the therapists fell within the secure/autonomous category, 6.5% in the insecure/dismissing, 9.7% were in the insecure/preoccupied category and 22.6% fell in the unresolved/disorganised category. Therapist continuous AAI scores were used as predictors of the working alliance. Whilst there was no direct influence of therapist attachment security on alliance (r = 0.07, p = ns), therapist attachment interacted with clients' symptoms to influence alliance. Higher therapist attachment security was associated with better client-rated alliances but only for clients who described high levels of interpersonal problems before therapy (r = 0.16, p <0.05). A similar pattern was found for patients' with high overall symptom distress (r = 0.15, p < 0.05).

The findings suggest that more securely attached therapists are able to establish better alliances with more interpersonally distressed clients. Therapists with a higher level of attachment security may therefore be in a better position to work with clients with greater psychological difficulties. Although the generalisability of this conclusion may be limited by the fact that the research was carried out in an inpatient setting with psychodynamic therapists, it does suggest that client complexity may be an important factor to measure in future studies of therapist attachment and alliance. Therapist scores on the AAI dimension dismissing versus preoccupied did not reveal the expected negative effect on alliance quality. The authors speculate that securer therapists are able to adapt behaviour to fit the needs of their clients, regardless of levels of preoccupied or dismissing attachment.

Sauer et al (2003) examined the relationship between therapist and client attachment and the alliance in 17 dyads, involving graduate level students from counselling centres. They used the self-report Adult Attachment Inventory to measure attachment, which provided two factor analytically derived subscales: avoidance and anxiety. The WAI was used to assess the alliance at the 1st, 4th and 7th sessions. Interestingly they found that therapist attachment anxiety was positively related to client-rated alliance early in therapy, $r = 0.40$, $p<0.05$. They hypothesised that therapists with higher attachment anxiety received initial high ratings of the working alliance as they work extra hard to make the client feel good about the relationship to fulfil their own attachment needs. However, hierarchical linear modelling (HLM) showed that time was also a significant predictor of the alliance, $r=0.60$, $p<0.05$ and although therapist anxiety initially had a positive effect on the alliance, it had a negative effect over time, $r= -0.69$, $p<0.01$.

Dinger et al (2009) replicated the above findings of associations between attachment anxiety (preoccupation) and poorer alliance ($r = 0.12$ $p <0.01$) in a large sample comprising 281 inpatients, who were treated by 12 psychotherapists. They assessed attachment using the AAI and they assessed alliance development over time using weekly measures of the IES over a mean treatment duration of 12 weeks in inpatient psychotherapy. The authors hypothesise that preoccupied therapists display attachment behaviours including clinging, minimizing distance which may lead the client to experience the therapeutic experience more negatively. As previously discussed, individuals with high attachment preoccupation or anxiety often struggle with fear of abandonment and a desire for closeness. This may result in the therapists being unable to relate effectively to the client's needs. However, in line with Schauenburg et al. (2010), Dinger et al. (2009) also report that over half of the therapist sample fell in the secure attachment category (58.3%, n = 7), with only 33.3% (n= 4) classified as preoccupied, and 8.3% (n= 1) categorised as unresolved.

The fact that the studies by Dinger et al. (2009) and Sauer et al. (2003) had similar findings, although they used different methods to assess attachment and had different samples, suggests that associations between attachment anxiety and poorer alliance are relatively robust. However, like the Sauer et al. (2003) study which sampled trainee therapists, half the sample in the study by Dinger et al. (2009) were still in postgraduate training making generalisation to more traditional therapist-client dyads problematic.

Bruck et al. (2006) assessed the attachment styles of clients and therapists using the RSQ, and the match of these styles in client-therapist dyads, to determine their relation to the working alliance. The sample comprised 46 patients from a psychiatric outpatient service who were involved in 30 sessions of psychotherapy and 46 therapists. They calculated the difference between the therapists' and client's score on each attachment variable in the study and then assigned an absolute value called the match coefficient, with greater values indicating greater difference between therapist and client. They found that therapist secure attachment was not related to client-rated working alliance score (although they do not report the figures). They found no relationship between therapist and client match coefficients on secure attachment style and the client-rated WAI. They also did not find any significant associations between the therapist and client match coefficients on insecure attachment styles and the client-rated alliance, but again do not report exact correlations.

Tyrell et al. (1999) also investigated the contribution of both therapist attachment and client attachment representations to the working alliance. The authors do not report the percentage of secure versus insecure classifications within the sample but they examined how the attachment states of mind of both members of the dyad interact to produce a combined effect on the working alliance as measured by the client-rated WAI. This study used the AAI, and the attachment dimensions of deactivating and hyperactivating. Clients who were more deactivating rated the working alliance as better when working with case managers who were less deactivating ($r = 0.53$,

$p<0.01$; $\beta=-0.41$, $p<0.01$). There was also a non-significant trend for more deactivating case managers to from weaker alliances with more deactivating clients than with less deactivating clients ($r= -0.31$, ns). The interaction between client deactivation and case manager deactivation accounted for 16% of the variance of the alliance.

The authors highlight the importance of both clients' and case managers' attachment states of mind for understanding the therapeutic relationship. This study suggests that matching clients and therapists with oppositional attachment dimensions may result in more positive alliances. However, the participants in this study were clients with serious psychiatric disorders and their clinical case managers, who had worked together for a significant period of time. Several authors have suggested that it may facilitate engagement if therapists initially match clients' preferred attachment patterns; for example, initially meet the dependency needs of anxious clients by offering more support and initially giving avoidant clients more distance in the relationship (Wallin, 2007; Mallinckrodt, 2010).

Romano et al. (2008) assessed therapist attachment style, client attachment to therapist and the working alliance in a sample of 59 therapist-client dyads in a university counselling setting. They used the ECRS to assess the global attachment orientations of both clients and therapists. The ECRS derives two dimensional factors; an anxiety dimension and an avoidance dimension. The client-rated WAI was used to assess client self-reported working alliance. They predicted that clients who reported high levels of attachment anxiety or avoidance would report lower working alliances, and that therapist attachment security would moderate this relationship. They found no significant association between therapist attachment and the working alliance and contrary to predictions no interaction effect between client and therapist attachment and the working alliance. The effect size observed for the interaction effect on the working alliance was 0.2 and the authors discuss the possibility of a type II error due to the small sample size.

In summary, there is some evidence that therapist attachment security influences the working alliance as rated by clients, and this may be more influential with clients with more complex presentations. There is also evidence that therapist anxiety is linked to poorer alliance, particularly over time. The finding that therapist attachment anxiety is linked to poorer working alliance has been replicated in inpatients and outpatients, using different measures of attachment. However, the outpatient and inpatient studies discussed all used therapists in training; (or large proportions were still in training). It may be the case that associations between anxiety and alliance are limited to this particular sample of therapists. With increased experience, supervision and training therapists may develop greater insight into their attachment styles and the impact of their own insecurities on the psychotherapy relationship. This insight might help them moderate their interpersonal style and reduce the impact of any maladaptive interactions on alliance.

The reported associations between therapist attachment style and the alliance are not straight forward, as there is some evidence to suggest that therapist attachment may interact with the client's attachment and that a mismatch between clients and therapists level of deactivation may be beneficial in terms of alliance. However, this 'matching' finding may be limited to longer term case manager-client relationships, within severe mental health settings.

Therapist attachment style and therapist-rated alliance

Bruck et al. (2006), as previously discussed, investigated the impact of therapist attachment, as measured by the RSQ, on the working alliance, as measured by the WAI and other outcome variables. They found that therapist secure attachment was significantly associated with therapist-rated working alliances ($r = 0.34$, $p < 0.05$). They also found a significant correlation between therapist and client match coefficients on secure attachment style and the WAI, as rated by therapists ($r = 0.30$, $p < 0.05$), although as discussed above the findings for client-rated alliance were not significant. They did not find any significant associations between the therapist and

client match coefficients on the other attachment insecure styles and the therapist-rated WAI.

Black et al. (2005) used a large sample of 491 psychotherapists to investigate therapist attachment style, using the ASQ and therapist-reported quality of the working alliance, using the ARM. The therapists in this study were asked to think of their clients in general when they completed the alliance measure. This was done for ethical and practical reasons, as individual consent would have been required for every client in the survey if the therapist completed the alliance measure with a specific client in mind. This 'average' client measure of the alliance is problematic because relationships with clients can vary widely within one therapist. Nonetheless, Black et al (2010) found evidence to support the role of therapist attachment style in the working alliance, even after controlling for therapeutic orientation and general personality traits, such as extraversion and neuroticism ($r = 0.4$, $p < 0.01$). They also reported significant negative correlations between the mean working alliance score and subscales of the ASQ representing insecure therapist attachment; ASQ Discomfort with closeness, $r = -0.26$, $p < 0.001$, ASQ Relationships as secondary, $r = -0.18$, $p<0.001$, ASQ Need for approval, $r = -0.28$, $p<0.001$, and ASQ Preoccupation with relationships, $r = -0.33$, $p<0.001$.

In summary, there is some evidence that therapists high in attachment security rate the working alliance more favourably, when measured in relation to a specific client and globally, although it is important to note that associations between therapist-attachment and therapist-rated alliance may be influenced by common method variance. There is also some evidence of an interaction between therapist and client attachment, suggesting that therapists rate alliances more favourably if they are more dissimilar to clients.

There is, however, one study which failed to find an association between therapist attachment and therapist-rated alliance. Ligiero and Gelso (2002) investigated

therapist attachment style, as measured by the RQ and therapist-rated alliance, as measured by the WAI. The sample comprised 50 therapists in training and their supervisors. Consistent with the findings by Schauenburg et al. (2010) and Dinger et al. (2009), reported above in the relation to the AAI, the majority of the sample were classified as secure. In fact, as many of 90% of the therapists rated themselves as above 4 on the RQ secure attachment item, 18% as above 4 on the dismissive attachment item, 27% as above 4 on the fearful attachment item, and 24% as above 4 on the preoccupied attachment item. Therapists were asked if they had any current clients who had attended between three and nine sessions, whom they had discussed in supervision, and whose audiotapes had been listened to by their supervisor. The therapists completed the RQ and the WAI- and the supervisors completed the WAI-O and a countertransference measure about the supervisee's relationship with the same client, taking into account the last three sessions combined. Contrary to predictions, they found that therapist attachment style was not related to therapist-rated working alliance (the authors do not report the r values). It may be that the use of the RQ as a measure of therapist attachment was not sensitive enough to measure attachment patterns that individuals present with; as it is limited to one question per attachment style, highlighting the importance of using multi-item measures.

Therapist attachment style and observer-rated alliance

Only one study, by Ligiero and Gelso (2002), described above, used an observer-rated measure of the working alliance in addition to a therapist-rated measure. Supervisors, whose supervisees had discussed cases with them during supervision, listened to audiotapes of their supervisee's sessions and rated the alliance using the observer-rated WAI. Consistent with their findings in relation to therapist-rated alliance, no significant association between therapist attachment style and alliance was found (again, the authors do not report the r values). However, as highlighted previously, these negative findings may be associated with the use of the RQ which may not be a sensitive enough measure of therapist attachment.

Therapist attachment style and outcome

The study by Schauenburg et al. (2010), previously discussed, also investigated the impact of therapist attachment dimensions, using the AAI, on treatment outcome. Outcome was measured by deriving the mean score (GSI) on the SCL-90R, The Impairment Score (therapist-rating of client psychological, socio-communicative and physical impairment) and the IIP at the beginning and end of therapy. Schauenburg et al. computed multi-level models for the three outcome measures above. The GSI at the end of therapy was not directly predicted by the therapists' attachment dimensions; rather, the influence of GSI scores was moderated by dimensional therapist attachment security. High pre-therapy GSI led to higher post-therapy GSI scores, but this effect was diminished for therapists high in attachment security ($r = -0.07$, $p \leq 0.05$). This corresponds to the finding previously discussed that therapists with high attachment security had better alliances with more severely disturbed clients. The same effect was found for the change in interpersonal problems, with an interaction effect between IIP score and therapists' attachment security dimension. Higher attachment security of therapists diminished the negative impact of high levels of interpersonal problems post-therapy; although this did not reach conventional significance ($r = -0.04$, $p < 0.10$ ns). The authors found no influence of therapists' attachment dimensions on the therapist-rated outcome variable (IS).

In the study by Tyrell et al. (1999), discussed previously, which involved 21 clinical case managers and 54 clients with serious psychiatric disorders; there was a significant effect for case manager attachment states of mind and client outcome. Consistent with the alliance findings, the authors found that more deactivating clients reported higher general life satisfaction when working with less deactivating case managers ($r = 0.60$, $p<0.01$). They also reported a non-significant trend for more deactivating clients to report lower general life satisfaction when working with more deactivating case managers ($r= -0.19$, ns). Furthermore, they report a non-significant trend for less deactivating case mangers to rate more deactivating clients higher on

global functioning than less deactivating clients (r=0.24, ns). Finally, there was a non-significant trend for the reversal of these associations, so that more deactivating case managers tended to rate more deactivating clients lower on global functioning than less deactivating clients; an effect which may have reached significance in larger samples (r=-0.31, ns). However, they found no significant effect of case manager and client attachment interaction on hospitalisation (r = 0.11, p =ns) or depression scores (r value not reported).

Bruck et al. (2006), discussed previously, also investigated the associations between therapist attachment style and client outcome, in 46 therapist-client dyads, in an outpatient setting. They used the SCL-90-R, the IIP and the GAS to assess outcome. Consistent with their findings in relation to alliance, the authors found that therapist secure attachment style predicted improvement on the therapist-rated IIP (r= -0.54, $p<0.05$). Fearful attachment style negatively predicted outcome on the GAS (r = -0.41, $p<0.05$) and the therapist-rated IIP (r = 0.38, $p<0.05$). Therapist preoccupied attachment style predicted outcome on the GAS and SCL-90R, r = -0.35, $p<0.05$ and r = -0.30, $p<0.05$, respectively. In terms of therapist dismissing attachment style, they found that dismissing attachment predicted outcomes on the IIP, as rated by both therapist (r= 0.62, $p <0.05$) and client (r= 0.30, $p<0.05$). As discussed above, Bruck et al. (2006) matched patients and therapists according to how they rated themselves on the RSQ, and created an absolute value called the match coefficient. Consistent with Tyrell and colleagues (1999), the authors found that the greater the difference between the patient and therapist on the RSQ, the better the treatment outcome. The fact that a mismatch between therapist and client attachment on outcome has been replicated, with different measures of attachment and outcome, and in different settings, increases our confidence in the validity of the finding.

Tyrell et al. (1999) suggest that the 'mismatch' in terms of therapist and client attachment allow the disconfirmation of the clients' usual interpersonal and emotional strategies so that they may adopt new and more functional behaviours. However, as

highlighted previously, matching therapists and clients with regards to their attachment style may help to facilitate engagement in the early stages of therapy (Mallinckrodt, 2010).

In summary, consistent with findings in the alliance literature there is evidence that therapist attachment influences psychotherapy outcome. This is a relatively robust finding as it has been found using different measures and samples. The impact of therapist attachment on outcome is not surprising given the associations between therapist attachment and alliance and research linking alliance and outcome (Daniel, 2006). However, also consistent with the alliance findings, it seems that it is important to consider the client's attachment style and how this interacts with the therapist's attachment to influence outcomes.

DISCUSSION

This review provides a critical appraisal of studies that investigate the relationship between therapist attachment and the therapeutic alliance and outcome. The goal of the current review was to examine the contribution of therapist attachment style to perceptions of the working alliance and to clinical outcome. There is evidence that therapist attachment security influences client perceptions of the working alliance, particularly in complex cases. There is also evidence that, in relatively inexperienced therapists, therapist anxiety is linked to a poorer client-rated alliance, particularly over time. Therapists high in attachment security rate the working alliance more favourably, when measured in relation to a specific client and more globally. However, the effect of attachment security on therapist alliance may not be evident if studies use simple four-item measures of attachment, such as the RQ. The review has also highlighted that it is important to consider the client's attachment style and how this interacts with the therapist's attachment style to influence alliance and outcomes. On the basis of the studies reviewed, it seems as though a greater mismatch between client and therapist attachment styles or patterns is associated with better alliance and outcome, at least in more established relationships.

Previous reviews within the alliance and attachment field have focused on the relationship between the attachment style of the client and its impact on the working alliance and outcome (Daniel, 2006; Smith et al., 2010; Diener & Monroe, 2011). This review adds to the literature by focussing on the specific role of the therapist's attachment style. Furthermore, it expands on the previous reviews by synthesising these results in terms of the effect of therapist attachment on therapist, client and independent observer perceptions of the working alliance, and summarising findings about the impact of therapist attachment on outcome, as well as including more recent studies.

LIMITATIONS

The findings of this review need to be interpreted alongside the methodological limitations of the studies. Limitations of the review include the fact that only published studies were included, thus this inclusion criterion may have biased the findings, as stronger and more significant studies tend to be published (Borenstein, Hedges, Higgins & Rothstein, 2009). A number of the studies had relatively small sample sizes, which increases the possibility of type II statistical errors in which significant associations are undetected. The strength of correlations and the sample sizes for each study were reported, when possible, in order to help judge the probability of a type II error.

The studies discussed have used a variety of different tools to measure the therapeutic alliance, attachment style and outcome. The different measures of attachment and alliance used in the studies although well validated and reliable may assess different constructs. In addition the experience level of the therapists varies widely, from less than one month to 32 years; and settings of the research varies from inpatient to outpatients. Although these inconsistencies complicated comparisons between different studies, consistency in research results across studies using different measures and samples suggests more robust findings.

Assessing the effects of therapist attachment style on alliance and outcome is made more difficult by the fact that in the studies discussed, therapist attachment styles were found to be more similar than client attachment styles. The majority of the therapists in the studies were classified as secure. In fact, as many of 90% of the therapists rated themselves as above 4 on the RQ secure attachment item in Ligiero and Gelso's (2002) study.

The participants who took part in the studies may also be unrepresentative of therapists or those who participate in treatment. As is common in clinical settings, there were high numbers of clients who dropped out of the studies and the studies

only assessed perceptions of the alliance in clients who stayed in therapy. Using data from only clients who stayed in therapy may introduce a bias in terms of a better quality alliance. It is also important to note that many of the studies only self-report perceptions of the alliance, not actual behaviours, or observer perspectives which may not reflect the client's or therapist's true experience due to the confounding influence of social desirability and recall bias.

The reliability of reports of alliance may be particularly problematic by clients or therapists with insecure attachment patterns. It may be, for example, that those with dismissing attachment styles report good alliances due to a lack of awareness of their difficultly in engaging in emotional relationships, and those with preoccupied attachment styles report good alliance in response to the importance they assign to attachment relationships and wanting to be closer to others. These difficulties or biases emphasise the importance of measuring alliance from a range of different perspectives.

IMPLICATIONS FOR RESEARCH

The review highlights some keys areas for future investigation examining the effects of therapist attachment style on the working alliance and outcome. Firstly, much of the research on therapist attachment style and client-rated alliance has used relatively small sample sizes and predominately focussed on therapists still in training. More studies are, therefore, needed involving more experienced therapist and client dyads, using larger sample sizes.

It would be helpful to have research studies that compare trainee therapists to more experienced therapists to determine whether therapist attachment anxiety has less of an effect on alliance with increasing experience. Studies focussing on qualified therapists as well as trainees may allow conclusions to be drawn as to whether therapists get more skilled at recognising and preventing their attachment style from influencing the therapeutic relationship over time. Studies should assess alliance at various points in therapy as it has been shown that alliance is not a stable concept and insecure attachment may also influence alliance differently at points throughout the course of therapy.

As not all therapeutic relationships are attachment relationships it is also important to investigate whether therapist attachment security is related to an improved alliance across both short term and long term therapeutic relationships. Furthermore, the complexity of the client's presenting problem needs to be taken into account, as there is some evidence that the therapist's secure attachment may be more important in developing improved alliance and outcome with more complex cases. As therapist and client ratings of alliance and attachment may be influenced by bias, future studies are needed that use both interview and self-reports measures of attachment and assess alliance from different perspectives, including those of an observer.

There is some evidence to suggest that therapist attachment interacts with client attachment to influence alliance and outcome. It is, therefore, important for future

research to include measures of both therapist attachment and client attachment and their impact on the working alliance and outcome in therapeutic relationships. It is possible that a mismatch between client and therapist is important in influencing outcomes and alliance ratings at later stages in therapy, but it may be important for engagement to initially match the client's style (Mallinckrodt, 2010). Studies assessing the influence of attachment interaction on alliance at various points in time are needed to test this hypothesis.

The studies reviewed have only assessed ratings of the working alliance in those clients who have stayed in therapy, it is important for subsequent studies to also include or follow up on participants who disengage from therapy, so that a more representative sample can be obtained. In terms of generalisability, it is also important for research to include clients with a diverse range of clinical presentation and complexity.

Finally, future research should focus on the ways in which a deeper understanding of therapist attachment style could be utilised by therapists in their clinical work to facilitate the formation of the working alliance and ultimately improve the client's outcome. It is also important to address the wider issue of whether the therapeutic relationship is an attachment relationship, and the specific factors which may be influence the development of good attachment relationships between therapists and their clients.

CLINICAL IMPLICATIONS

Attachment theory provides a rationale for why clients seek help, why they pursue treatment and the importance of the quality of the therapeutic relationship in determining successful treatment. Associations between therapist attachment and alliance highlight the importance of therapists being sensitive to their own attachment patterns and behaviours and how these are played out in therapy. A deeper knowledge of their attachment style may help therapists to better understand their own behaviour in therapy, guide intervention, pace sessions, as well as deal with any ruptures in their therapeutic relationships (Dunkle & Friedlander, 1996; Rubino, Barker, Roth & Fearon, 2000).

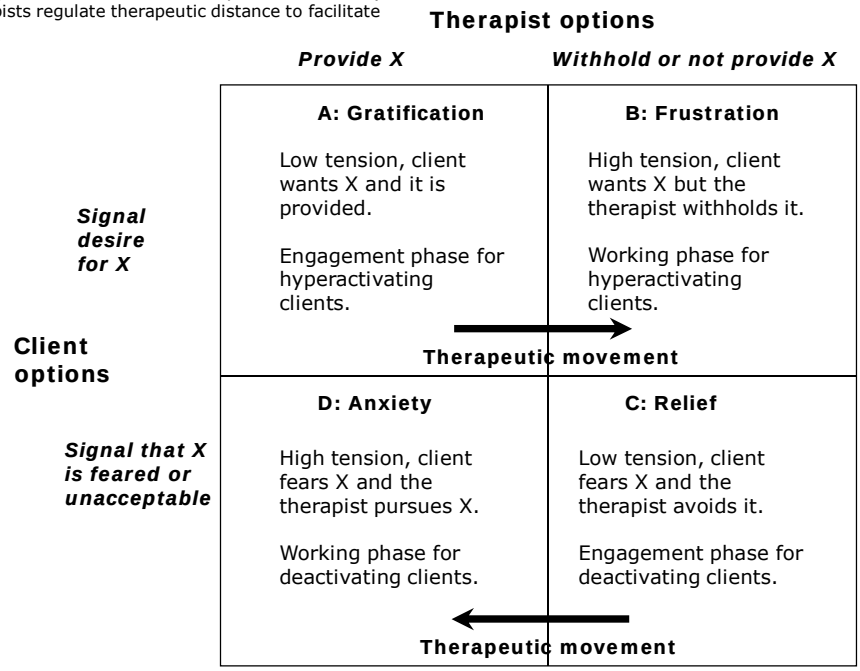
Therapists may increase their awareness of their own attachment styles and attachment-related behaviour via training courses, supervision and personal therapy. Training courses for therapists should include teaching on attachment theory and the effect of therapist attachment on the working alliance and outcome. Attachment-related behaviour and dynamics should also be a regular item in supervision. This review highlighted that particular attention needs be paid to therapist attachment anxiety in training and to therapist attachment security when working with complex cases.

This review not only found that therapist attachment influences alliance and outcomes, but that therapist attachment interacts with client attachment to influence outcome. Although, as discussed previously it may be helpful for therapists to match client attachment in the engagement phase of therapy, better outcomes may be achieved when there is a mismatch between client and therapist attachment styles. Conceptualising the individual differences of clients and therapists in terms of attachment style would assist in identifying those who might work best together and also to identify interventions that may be more appropriately matched and targeted to the client's interpersonal relational style.

Mallinckrodt's (2009; 2010) model emphasises both an engagement stage of therapy, which involves matching the client's attachment strategy and a working phase, which involves encouraging the client towards an optimal level of therapeutic distance. The goal is to move from cell A to B of the figure in the case of anxious clients and cell C to D in the figure in the case of avoidant clients. In successful therapy, this model predicts that as anxious clients move from engagement into the working phase, they will experience frustration and feelings of increased therapeutic distance, but eventually these will be replaced by a stronger sense of self-efficacy and agency, together with an increased capacity for affect regulation. The model predicts that avoidant or deactivating clients who begin the working phase will experience intensified anxiety and a perception of decreased therapeutic distance, but eventually the intensity of these perceptions will fade and will be replaced by more comfort with intimacy and deeper engagement with others, including seeking support from others to regulate negative affect. It is important that therapists monitor clients' frustration and anxiety to ensure that it is not exceeded and clients do not terminate therapy prematurely (see Figure One).

FIGURE ONE:

GRAF model (Gratification, Relief, Anxiety, and Frustration) of how therapists regulate therapeutic distance to facilitate client change



Adapted from Mallinckrodt (2010), p.267.

There is some preliminary evidence to support this model. Daly and Mallinckrodt (2009) showed that experienced therapists are able to facilitate change in clients with attachment anxiety and attachment avoidance by the careful and thoughtful regulation of the emotional distance throughout the course of therapy. However, Daly and Mallinckrodt (2009) used interviews with therapists based on how they would respond to clinical vignettes, rather than actual therapy. Future investigations addressing these process issues in an attachment-formed therapy are needed, including a client measure of therapeutic distance. It would also be beneficial to investigate the role of therapist secure attachment on the management of therapeutic distance, as earlier research by Dozier, Cue and Barnett (1994) which involved interviewing clinicians

about the depth of their interventions with clients, found that clinicians who were more secure in attachment were able to counteract the clients "pull" to reinforce insecure working models and, instead, provide non-complementary feedback thus providing a corrective experience.

CONCLUSION

This review aimed to critically appraise studies investigating the effect of therapist attachment representations on perceptions of the working alliance and outcome. The studies showed that therapist attachment security positively influences client-rated working alliances, particularly in complex cases. There is also evidence for an effect of therapist anxiety on alliance at least in therapists in training in the later stages of therapy. However, the association between therapist attachment and alliance was not straight forward as there is evidence to suggest that the attachment style of therapist and the client interact to produce a combined effect on perceptions of the working alliance and outcomes.

The review summarised some of the methodological limitations of the studies discussed. The keys issues were around small sample size and the use of predominately trainee therapists. The majority of studies also only used self-report measures of attachment and the alliance. The future research implications include using larger sample sizes of therapists and clients, comparing trainee therapists and qualified therapists' attachment styles in relation to alliance development, and measuring alliance at various intervals throughout the course of therapy. Future research should also include an observer-rated measure of alliance, in addition to a client and therapist measure of attachment and alliance. Due to the potential influence of the therapist's attachment style of the working alliance and outcome, therapists may benefit from increasing their awareness and insight into their own attachment styles, and this could be achieved via training, supervision and personal therapy. It may also be beneficial to therapeutic alliance and outcome to match therapists and clients based on their attachment styles.

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Paper Two: Research Paper - Client and Clinician Attachment Styles, Psychological Mindedness and the Working Alliance.

Annily Seymour-Hyde

PREFACE

This work for this paper was completed between January 2011 and May 2012. A number of individuals made significant contributions towards the research study. Firstly, Dr Katherine Berry provided overall support and supervision for the study. Alison Harris was the field supervisor for the study and was involved in recruitment support and reading drafts of the manuscript.

The author intends to publish the research paper in 'Psychotherapy Research' and the paper has been prepared in accordance with their requirements (see appendix A for author guidelines). Table and figures have been left in the main body of the text to aid readability. The authors on this paper will be: Annily Seymour-Hyde, Dr Katherine Berry and Alison Harris.

ABSTRACT

Although attachment theory is well researched, there is relatively limited research on the relationship between therapist and client attachment style and the working alliance. This study examines the extent to which client and therapist self-reported attachment styles are related to the working alliance. Thirty clients and 42 therapists from primary care services were recruited. Participants completed measures of anxiety and depression, attachment style, working alliance and psychological mindedness. The measure of psychological mindedness was included as an exploratory variable and it was hypothesised that it would be correlated with therapist attachment security. Therapist attachment security was not related to the therapist-rated ($r = -0.05$, $p = 0.769$) alliance or client-rated ($r = -0.13$, $p = 0.494$); although there was an association between therapist insecure attachment and alliance, in more symptomatic clients. Specifically fearful attachment ($r = -0.63$, $p = 0.016$), preoccupied ($r = -.80$, $p = 0.001$) and dismissing attachment ($r = 0.75$, $p = 0.002$). There was also some evidence that therapists and clients with oppositional attachment styles (preoccupied and dismissing) also reported more favourable alliances ($r = 0.43$, $p = 0.018$; $r = 0.41$, $p = 0.024$ respectively). There was no association between psychological mindedness and the working alliance ($r = 0.17$, $p = 0.275$) or therapist secure attachment ($r = 0.13$, $p = 0.416$). The clinical implications and future research directions are discussed.

INTRODUCTION

Throughout the past two decades, the working alliance has received considerable research interest (Horvath & Greenberg, 1994; Catty, 2004; Elvins & Green, 2008). There is an empirically established relationship between alliance and clinical outcome, regardless of the modality of therapy (Johansson & Eklund, 2003; Kirsch & Tate, 2006; Catty, Winfield & Clement, 2007). There are many different conceptualisations of the alliance which have yielded different measures of the construct, although none of which have generated more research than Bordin's (1979) conceptualisation. He described the alliance as involving three dimensions (1) the therapist's and client's agreement on the goals of therapy; (2) the therapist's and client's agreement on the tasks of therapy needed to attain these goals; and (3) the emotional bond between the dyad. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) was developed on the basis of Bordin's (1979) theory and it has become the most widely used measure of alliance (Martin, Garske & Davis, 2000).

The formation of an effective working alliance involves both members of the dyad. Research has, therefore, focussed on assessing the alliance from the client perspective and the therapist perspective. There are also studies investigating alliance from the observer perspective (Norcross, 2002). In terms of the best predictor of outcome, research suggests that the client perspective is the best predictor of outcome and the therapist's perception of the alliance is the worst (Horvath & Symonds, 1991; Horvath & Luborsky, 1993; Horvath & Bedi, 2002), with only modest overlap between perspectives (Norcross, 2002). Therapist and observer ratings of the alliance are, however, still linked to outcome (Bruck, Winston, Aderholt & Murran, 2006; Schauenburg et al., 2010), so may be important constructs to assess.

Given the importance of the concept of working alliance to outcomes there has been much research to identify the key predictors of alliance, including characteristics of clients and therapists. Research has shown that demographic factors have little

influence, and there is stronger evidence that interpersonal characteristics of both client and therapists predict alliance and outcomes (Beutler, Machado & Neufeldt, 1994).

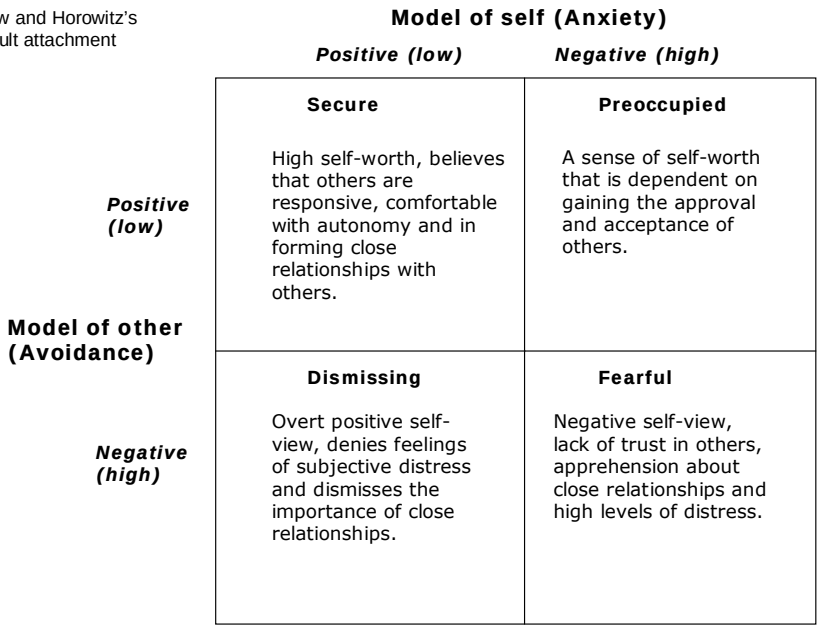
Attachment theory is a key theory of interpersonal relationships. It has been suggested that attachment theory can provide a framework to explore the working alliance. Attachment theory (Bowlby, 1980) is a lifespan developmental theory that proposes that we are biologically predisposed to form close affectional relationships and bonds with a specific person (our primary caregiver), who provides a secure base from which to explore the environment, who is sought out in times of distress, and to whom we seek proximity and experience distress upon separation (Bowlby, 1973; 1980; 1982).

Bowlby (1980) hypothesised that early experiences with caregivers influence later relationships via internal working models. Internal working models are mental representations, about the self and others, based on our experiences of parenting and interactions with our primary caregiver during childhood. The internal working models are hypothesised to include beliefs about whether one is worthy of love and attention and whether others are accessible and trustworthy, as well as emotional experiences of interpersonal interactions (Pietromonaco, Feldman & Barrett, 2000).

Over the past two decades, attachment research has extended beyond infant-parent bonds to examine attachment relationships in adulthood (Berghaus, 2011). Bartholomew and Horowitz (1991) describe a four category model of adult attachment, based on Bowlby's (1968; 1982) concepts of internal working models (see Figure One).

FIGURE ONE:

Bartholomew and Horowitz's model of adult attachment



Their model is conceptualised in terms of two dimensions: model of self and model of other, it can also be conceptualised in terms of affect, namely anxiety and avoidance (Brennan, Clark & Shaver, 1998). High attachment anxiety is conceptualised as a chronically 'hyperactivated' attachment system, so that the individual is preoccupied with the importance of their attachment relationships. The high attachment avoidance is associated with discomfort with intimacy and closeness in relationships and a deactivation of the attachment system so that feelings of need for attachment figures are reduced (Fraley & Shaver, 2000). The two dimensions can be used to derive four prototype categories described by Bartholomew and Horowitz (1991) as: secure, preoccupied, fearful, and dismissing. Secure individuals are characterised by a positive image of the self and others. They are comfortable with intimacy and closeness and maintain their autonomy. Preoccupied individuals have a negative model of the self and a positive model of others; they are preoccupied with their attachment needs and are often overly dependent on others. Fearful individuals have both a negative model of the self and of others; they tend to desire close relationships, but avoid them due

to fear of rejection. Finally, dismissing individuals have a positive model of the self and a negative model of others; they tend to avoid close relationships and minimise the importance of affect.

Bowlby (1988) described how insecure attachment patterns increase vulnerability to psychological problems and empirical research has shown associations between insecure adult attachment and a range of psychological difficulties, including anxiety and depression (Oliver & Whiffen, 2003; Williams & Riskind, 2004; Gamble & Roberts, 2005). Research has also shown a negative impact of client insecure attachment patterns on psychotherapy process, with insecure clients being less likely to seek help (Dozier, 1990) and to form positive working alliances (Mallinckrodt, Coble & Gantt, 1995). Furthermore, client insecure attachment patterns are linked to poorer therapeutic outcome (Schauenburg et al., 2010). In light of these findings, it has been argued that modifying client attachment patterns is an important goal of therapy (Davice and Lary, 2006) and the therapeutic relationship has been described as an attachment relationship (Bowlby, 1988; Daniel, 2006). The role of the therapist is to provide a secure base from which the client can explore difficult psychological territory and to provide a corrective emotional experience which can modify maladaptive internal working models.

An individual's ability to be a caregiver is thought to be related to their own experience of being cared for (Osofsky, 1995; Mikulincer & Shaver, 2007). Therapists who may have received a rejecting or neglectful care giving will have a different set of expectations and internal working models to a therapist that has experience of a loving and available caregiver. These corresponding attachment styles may make it more or less difficult for the therapist to create feelings of security in the therapeutic relationship, and to behave in ways that will help the client to challenge their internal working models.

Accordingly, there is some evidence that therapist attachment security influences therapist and client perceptions of the working alliance (Dunkle & Friedlander, 1996; Black, Hardy, Turpin & Parry, 2005; Bruck et al., 2006), particularly in more complex cases (Schauenburg et al., 2010). There is also evidence that, in relatively inexperienced therapists, therapist attachment anxiety is linked to a poorer client-rated alliance (Dinger, Strack, Sachsse & Schauenburg, 2009), particularly over time (Sauer, Lopez & Gornley, 2003). However, these findings are not straightforward and there is some evidence that oppositional client and therapist attachment styles or patterns are associated with better alliance and outcome (Tyrell, Dozier, Teague & Pallot, 1999; Bruck et al., 2006).

Tyrell et al. (1999) examined the joint contribution of both therapist and client attachment styles to the working alliance, in 54 clients and 21 case managers. They found that case managers worked better with clients who had attachment states of mind that were different (mismatched) from themselves. They found that clients who were more deactivating (avoidant) in their attachment styles and behaviour worked better and achieved better outcomes with case managers who were less deactivating. Furthermore they found that clients who were less deactivating reported better alliances with case managers who were more deactivating.

Bruck et al. (2006) also assessed the attachment styles of clients and therapists, and the match of these styles in client-therapist dyads, to determine how this related to the working alliance and therapy outcome. They report that therapists who scored highly on fearful, preoccupied, and dismissing attachment styles had less favourable alliances and outcomes. They showed that the greater the difference between client and therapist in terms of secure attachment the better the therapist-rated alliance, although not client-rated working alliance. They also found that the greater the difference between client and therapist in terms of attachment, the better the treatment outcome.

The studies by Tyrell et al., (1999) and Bruck et al., (2006) suggest that mismatching clients and therapists with oppositional attachment dimensions could be associated with stronger alliances and improved outcomes. However, the Tyrell et al. study used case-manager and client dyads who had worked together for a long time, with the length of the relationship ranging from 7 months to 69 months (Mean = 31 months), although the clients were not in psychological therapy. The findings of Bruck et al. (2006) were derived from two forms of short-term psychotherapy in a randomised controlled trial. It is not clear whether the same result would be obtained across different psychological treatment approaches and in routine clinical practice.

Therapist attachment may influence the working alliance but it is not yet known what might moderate or mediate this, one possibility is client attachment to therapist (CATS; Mallinckrodt et al., 1995), another possibility is psychological mindedness. Mallinckrodt, Daly and Wang (2009) and Mallinckrodt (2010) described five key characteristics of attachment relationships with evidence to evaluate whether the therapeutic relationship can meet these criteria. The criteria outlined are: 1) an attachment figure is a target for proximity seeking; 2) an attachment figure is a safe haven to provide comfort in times of distress; 3) an attachment figure provides a sense of security from which the individual can explore; 4) the individual experiences separation anxiety when the individual is not available; and 5) the attachment figure is stronger and wiser (Mallinckrodt, 2010). Mallinckrodt, Gantt and Coble (1995) devised the Client Attachment to Therapist Scale (CATS) which reflects each of the five essential components of an attachment relationship and provides evidence that the psychotherapy relationship can meet the criteria of attachment. The non-significant findings concerning the association between the CATS and other measures of adult attachment (Mallinckrodt et al., 1995; Mallinckrodt, Porter & Kivlighan, 2005) demonstrate that clients' therapeutic attachments are distinguishable from their patterns of attachment in other relationships.

It is also plausible that those therapists with secure attachment styles have more Psychological Mindedness (PM) and that it is this concept which enables them to respond more appropriately to the needs of the client. High PM is significantly associated with both autonomous functioning and synthetic-integrative functioning (Conte, Buckley, Picard et al., 1995).

There have been a number of reviews concerning the meaning of PM (Hall, 1992; McCallum & Piper, 1997). PM has been defined as 'a willingness to try to understand self and others, a belief in the benefits of discussing one's problems, openness to new ideas, and access to one's feelings (Conte et al., 1996). The concept of PM originated in the psychoanalytic literature (Taylor & Taylor, 1997), and is considered an important and related outcome of psychotherapy (McCallum & Piper, 1997), and a desirable personality trait (Sifneos, 1968). Research has deemed PM as an essential therapist characteristic (Farber & Golden, 1997). The ability therefore to understand and know how to respond appropriately to client's needs may be related to the therapists level of PM and their attachment style.

The present study aimed to investigate client and clinician attachment styles, psychological mindedness and the working alliance. The aim was to investigate the extent to which client and therapist self-reported attachment styles are related to the working alliance and how these interact to influence alliance in routine clinical practice in NHS settings. We also assessed client attachment to therapist and therapist PM to explore possible mediators or moderaters of any effects.

More specifically, our main hypotheses were:

1. Client symptoms of depression and anxiety will be associated with more insecure attachment styles and poorer working alliances.

2. Clients with more secure attachment will have better working alliance scores

3. Clients with more insecure attachment patterns will have poorer working alliance scores

4. Therapists with more secure attachment will have better working alliance

5. Therapists with more insecure attachment patterns will have a poorer working alliance

6. Clients and therapists with oppositional attachment styles will have better working alliance scores

We measured the therapist's level of psychological mindedness and the client's attachment to the therapist to see if these variables would be associated with therapist attachment and alliance. These additional hypotheses were as follows:

1. Therapist attachment security will be positively associated with more secure client attachment to therapist and therapist attachment insecurity will be associated with more insecure client attachments to therapist.

2. More secure client attachment to therapist will be related to more favourable working alliance scores.

3. High psychological mindedness in therapists will be related to better working alliance scores

4. Therapists' attachment security will be positively associated with psychological mindedness, and therapists' attachment insecurity will be related to poorer psychological mindedness.

METHOD

Participants

Participants were recruited from Primary Care Psychology Services across the North West of England. The sample included 42 therapists and 30 clients, resulting in 30 therapist-client dyads. Twelve clients failed to return their research packs after consenting to take part in the study.

Measures

Demographic information was collected using a question sheet for clinicians (Appendix B) and for clients (Appendix C).

PHQ-9 (Appendix D)

The PHQ-9 (Kroenke, Spitzer and Williams, 2001) was completed by therapists and clients. It is a brief self-report measure of depression, comprised of nine statements related to depressive symptomatology, based upon the DSM-IV criteria of depression (American Psychiatric Association, 1994). Participants are asked to respond on a likert scale ranging from '0' (not at all) to '3' (nearly everyday). The measure produces a maximum score of 27. Scores of 5, 10, 15 and 20 are used as cut-off points for mild, moderate and moderately severe and severe anxiety respectively. Alphas in this study were 0.64 for therapists and 0.92 for clients.

GAD-7(Appendix E)

The GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) is a brief measure of anxiety severity and was completed by therapists and clients. It is a self-report questionnaire comprising seven statements related to anxiety symptomatology. Participants are asked to respond on a Likert scale ranging from '0' (not at all) to '3' (nearly every day). The measure produces a maximum score of 21. Scores of 5, 10 and 15 are used as cut-off points for mild, moderate and severe anxiety respectively. Alphas in this study were 0.66 for therapists and 0.93 for clients.

Relationship Questionnaire (Appendix F)

Therapists and clients completed the Relationship Questionnaire, which is a measure of adult attachment created by Bartholomew and Horowitz (1991) to represent a four group model of adult attachment. The Relationship Questionnaire consists of four short paragraphs describing the four attachment styles. Respondents make ratings on a 7-point Likert scale, (with responses ranging from 1= not at all like me to 7= very much like me) of the degree to which they resemble each of the four attachment styles. Bartholomew and Horowitz (1991) report 2 week test-retest reliabilities of 0.74 to 0.88 and the measure is moderately stable over 8 months (Scharfe & Bartholomew, 1995). The relationships questionnaire also has relatively good convergent and discriminant validity (Griffin & Bartholomew, 1994).

Working Alliance Inventory -Therapist and Client Versions (Appendix G)

The Working Alliance Inventory (Horvath & Greenberg, 1989) is a 36 item self report measure and uses a 7-point rating scale ranging from '1' (never) to '7' (always) to measure the quality of the working alliance. Parallel forms are available for the therapist (WAI-T), and client (WAI-C). The instrument is based on Bordin's (1979) pantheoretical model of the working alliance and has three different subscales (Bonds, Goals and Tasks), which are highly intercorrelated. It also provides an overall working alliance score, with higher scores indicating a more favourable alliance. The WAI has demonstrated stability over time and a good internal consistency (Horvath, 1994). Alphas in this study for total scores for therapists and client were 0.93 and 0.95 respectively.

Client Attachment to Therapist Scale (CATS) (Appendix H)

Clients were asked to complete this measure to assess their attachment relationship with their therapist. The CATS (Mallinckrodt, Gandt & Cable, 1995) is a 36-item measure of client attachment to their therapist; clients are asked to rate each item on a 6-point scale (1=strongly disagree, 6 = strongly agree). The CATS is comprised of three subscales, Secure (14 items), Avoidant-Fearful (12 items) and Preoccupied-

Merger (10 items). The Secure subscale measures the extent to which the client perceives the therapist as emotionally responsive and available, and able to provide a secure base from which the client is comfortable exploring difficult psychological territory. The Preoccupied -Merger subscale measures the degree to which the client is preoccupied with the therapist in terms of contact and closeness. The Avoidant-Fearful subscale reflects the degree to which the client suspects the therapist of being disapproving, dishonest and rejecting. Mallinckrodt et al., (1995) report good test-retest reliability. The alphas in this study for each subscale were 0.88 for secure, 0.85 for avoidant and 0.82 for the preoccupied subscale.

Psychological Mindedness Scale (Appendix I)

The Psychological Mindedness Scale (PMS) (Conte, Plutchik, Jung, Picard et al., 1990) was used to assess the therapist's level of psychological mindedness. The PMS is a 45-item self report measure that is rated on a 4 point Likert scale ranging from 1 (strongly agree) to 4 (strongly disagree). The PMS has been found to have good psychometric properties (Conte at al., 1990). Alpha in the present study was 0.83.

Procedure

Following ethical approval, the research protocol was disseminated to local Primary Care Psychology Services and research packs were delivered to the participating services. The purpose and nature of the study was clearly outlined in the participant information sheets (Appendix J for therapists and appendix K for client information sheets). All participants completed consent forms (Appendix L for therapists and appendix M for client consent sheets). If therapists consented to take part they were given two research packs, one for them to complete and return to the researcher and one to give to a consenting client. Therapists were asked to request participation from their next client who reaches at least the third therapy session. This criterion was chosen because past research indicates that the working alliance is often not well established until about the third session (Ligiero & Gelso, 2002). The participants were

informed that all research questionnaires were anonymous and that the therapist or the client would not have access to their data.

Data Analysis

Data were analysed using SPSS 19.0 for Windows. Descriptive statistics were obtained and skewness and kurtosis values were calculated in order to check if the variables were normally distributed. Twelve of the 24 variables were not normally distributed, and transformations were unsuccessful. For consistency, non-parametric statistical analyses were therefore used. Associations between continuous variables were tested using Spearman's bivariate correlations. Associations between continuous variables and categorical variables were analysed using Mann-Whitney U tests. Missing data were deleted.

RESULTS

Participant Characteristics: Therapists

The characteristics of the therapist sample are summarised in Table I below.

Table I: Demographic characteristics of the therapist sample

Dimensions	Possible responses	Therapists n=42 No.	%
Age	18-24	2	5
	25-34	23	56
	35-44	11	27
	45-54	4	10
	55-64	1	2
Gender	Female	36	86
	Male	6	14
Ethnic group	White British	33	79
	White Irish	4	10
	Pakistani	3	7
	Asian Other	1	2
	Caribbean	1	2
Professional qualifications	Diploma	1	2
	Degree	6	15
	Postgraduate	34	82
Job title	Positive Wellbeing Practitioner	11	26
	High Intensity Worker	7	17
	Counsellor	3	7
	Trainee Clinical Psychologist	1	2
	Clinical Psychologist	13	31
	Other	7	17
Years experience	Under 2	2	5
	2 but under 4	3	7
	4 but under 6	12	29
	6 but under 8	7	17
	8 but under 10	18	43
	10 and over	0	0
Models of therapy used	CBT	17	41
	Psychodynamic	1	2
	Behavioural	1	2
	Humanistic / Analytic	2	5
	CAT	2	5
	Mixed approach	9	21
	Other	7	17
Client presenting problem	Anxiety disorders	10	25
	Depressive disorders	10	25
	Low self-esteem	2	5
	Trauma	1	3
	Mixed	15	38
	Relationships	1	3
	Emotional dysregulation	1	3
Number of sessions offered to client to date	0-5	17	41
	6-10	17	41
	11-15	2	5
	16-20	5	12
	21 and over	1	2

The majority of the therapist sample were aged between 25-34 years old (56%) and were White British (79%). The therapists were predominantly female (86%, n = 36)

and obtained educational achievement up to postgraduate level (83%, n=34). In terms of job title, 31% of the therapists were Clinical Psychologists (n=13), 26% Positive Well-being Practitioners (n=11), 17% High Intensity Workers (n=7), 7% Counsellors (n=3), 2% were Trainee Clinical Psychologists (n=1), and the remaining 17% described themselves as 'Other' (n=7). The most common model of therapy used was CBT (41%, n=17), with 2% using a psychodynamic approach (n=1), 2% behavioural (n=1), 5% humanistic/analytic (n=1), 5% CAT (n=1), and 21% used a mixed approach (n=9) and 17% specified 'other' (n=7). The number of sessions that the therapists had offered varied, with 82% having given under 10 sessions of therapy. Only 2% of the sample had offered over 21 sessions. There were no significant relationships between these demographic or therapy variables and the main study variables.

Table II below displays the therapists' responses to the anxiety, depression and attachment style measures used in the study.

Table II: Therapist-rated anxiety and depression classifications and attachment style preference and rating

Dimensions	Possible responses	Therapists n=42	
		No.	%
Anxiety score	Mild	9	21
	Moderate	0	0
	Severe	0	0
Depression score	Minimal	35	83
	Mild	7	17
	Moderate	0	0
	Moderately severe	0	0
	Severe	0	0
Attachment style preference	Secure	33	79
	Fearful	2	5
	Preoccupied	3	7
	Dismissing	4	10
Secure attachment rating	Somewhat/very like me	38	91
Fearful attachment rating	Somewhat/very like me	6	14
Preoccupied attachment rating	Somewhat/very like me	9	22
Dismissing attachment rating	Somewhat/very like me	16	38

The self-reported depression classifications were 83% in the 'minimal' range for depression, 17% were classified as 'mild'. The median depression score was 2 (range=9). In terms of self-reported anxiety, 21% of the sample scored within the 'mild' range, 0% within the 'moderate' range and 0 % fell within the 'severe 'range. The median anxiety score was 2 (range=8). In rating attachment style preference, 79% of the therapists rated their attachment style preference as secure (n=33), 5% as fearful (n=2), 7% as preoccupied (n=3), and 10% rated themselves as dismissing (n=4). Table III below reports the therapists' median and range responses on the Working Alliance Inventory, the Psychological Mindedness scale and the Relationships Questionnaire.

Table III: Therapist-rated scores on the WAI, PMS, and RQ.

Dimension	Therapists' median	Therapists' Range
Working Alliance Inventory Score	193	111
WAI task scale score	65	50
WAI bond scale score	63	36
WAI goal scale score	62	47
Psychological scale score	81	40
Secure attachment rating	6	6
Fearful attachment rating	2	5
Preoccupied attachment rating	2	6
Dismissing attachment rating	2	5

Participant Characteristics: Clients

The characteristics of the client sample are summarised in Table IV below.

Table IV: Demographic characteristics of the client sample:

Dimensions	Possible responses	No.	%
Age	18-24	2	7
	25-34	14	47
	35-44	4	13
	45-54	5	17
	55-64	4	13
	65 and above	1	3
Gender	Female	22	73
	Male	8	27
Ethnic group	White British	29	97
	White Other	1	3
Educational achievement	GCSE	9	30
	A Level	11	37
	Diploma	1	3
	Degree	7	23
	Postgraduate	2	7
	Other	0	0
Length of time in Mental Health Services	Under one year	20	69
	1 but under 3 years	3	10
	3 but under 5 years	2	7
	6 but under 8	4	14
Number of sessions attended	0-5	13	43.3
	6-10	11	36.7
	11-15	1	3.3
	16-20	4	13.3
	21 and over	1	3.3
Previously seen a therapist	Yes	14	48
	No	15	52
Session frequency	Weekly	20	67
	Fortnightly	9	30
	Monthly	1	3

Most of the client sample were aged between 25-34 years (47%) and were female (73%, n=22). Ninety-seven percent of the sample described themselves as White British (n=29). The majority of the clients (69%, n=20) had been involved in mental health services for less than one year, with 52% (n=15) having not seen a therapist before. The most common session frequency was weekly (67%, n=20), with 30% of the sample seeing their therapist fortnightly (n=9) and 3% monthly (n=1). The therapists were asked to provide information on their clients' presenting problems (see Table I). There was a range of presenting problems including anxiety disorder (25%, n=10), depressive disorders (25%, n=10), low self-esteem (5%, n=2), trauma (3%, n=2), relationship difficulties (3%, n=1), emotional dysregulation (3%, n=1) as well

as mixed presentations (38%, n=15). There were no significant relationships between these demographic or therapy variables and the main study variables.

Table V below displays the clients' responses to the anxiety, depression and attachment style measure (RQ) used in the study.

Table V: Displays client-rated anxiety and depression classifications and attachment style preference and rating

Dimensions	Possible responses	No.	%
Anxiety score	Mild	7	22
	Moderate	8	26
	Severe	6	20
Depression score	Minimal	6	20
	Mild	7	23
	Moderate	9	30
	Moderately severe	3	10
	Severe	3	10
Attachment style preference	Secure	6	14
	Fearful	10	24
	Preoccupied	8	19
	Dismissing	6	14
Secure attachment rating	Somewhat/very like me	15	50
Fearful attachment rating	Somewhat/very like me	25	83
Preoccupied attachment rating	Somewhat/very like me	17	57
Dismissing attachment rating	Somewhat/very like me	11	37

Twenty percent of the clients scored in the 'minimal' range for depression, 23% were classified as 'mild', 30% scored in the 'moderate' range, and 10% were within the 'moderately severe' and 'severe' categories. The median depression score was 10 (range=22). In terms of self-reported anxiety, 22% scored within the 'mild' range, 26% within the 'moderate' range and 20% fell within the 'severe' range. The median anxiety score was 9 (range=21). With regards to attachment, 14% rated their attachment style preference as secure (n=6), 24% as fearful (n=10), 19% as preoccupied (n=8), and 14% rated themselves as dismissing (n=6).

Table VI below reports the clients' median and range responses on the WAI, CATS and RQ.

Table VI: Clients' scores on the WAI, CATS and RQ

Dimension	Clients' median	Clients' Range
Working Alliance Inventory Score	213.5	104
WAI task scale score	73.5	42
WAI bond scale score	70	46
WAI goal scale score	70.5	40
CATS Secure	72	42
CATS Avoidant-Fearful	21	31
CATS Preoccupied - merger	23	36
Secure attachment rating	3.5	6
Fearful attachment rating	4.5	6
Preoccupied attachment rating	4	6
Dismissing attachment rating	3	6

Table VII below displays the differences between clients' and therapists' scores on the RQ and the WAI.

Table VII: Differences between client and therapist median scores on attachment style and working alliance scores.

Measure	Client median	Therapist median	Mann-Whitney U test result			Effect size
RQ Secure	3.5	6	U = 305	z = -3.684	p = 0.000**	0.44
RQ Fearful	4.5	2	U = 182.5	z = -5.134	p =0.000**	0.61
RQ Preoccupied	4	2	U = 350	z = -3.169	p = 0.002**	0.38
RQ Dismissing	3	2	U = 340	z = -0.397	p = 0.691, NS	0.05
WAI	213.5	193	U = 340	z = -3.202	p = 0.001**	0.38
WAI Task	73.5	65	U = 323	z = -3.402	p = 0.001**	0.40
WAI Bond	70	63	U = 402.5	z = -2.476	p = 0.013*	0.29
WAI Goal	70.5	62	U = 377.5	z = -2.766	p =0.006**	0.33

Note: p <0.05, ** p<0.01, NS= Not significant*

There was a statistically significant difference between client and therapist ratings of secure attachment style. The median secure attachment style rating for therapists (Mdn=6, range=6) was significantly higher than the client rating (Mdn=3.5, range=6), U = 305, p = 0.000, r = 0.44. A statistically significant difference was also found for ratings of fearful attachment style, the median fearful attachment style rating was significantly higher for clients (Mdn=4.5, range=6) than therapists, (Mdn=2, range=5), U = 182.5, p = 0.000, r = 0.61. A statistically significant difference was

also found between client and therapist ratings of preoccupied attachment style (U = 350, P = 0.002, R = 0.38). The clients had significantly higher ratings of preoccupied attachment (Mdn=4, range=6) than therapists (Mdn=2, range=6). No significant difference was found between client (Mdn=3, range= 6) and therapist (Mdn=2, range=6) ratings of dismissing attachment style (U = 340, p = 0.691, r = 0.05).

There was a statistically significant difference between client-rated and therapist-rated overall working alliance score (U = 340, p =0.001, r = 0.38) with the clients (Mdn=213.5, range=104) rating the overall alliance more favourably than the therapists (Mdn=193, range=111).

Associations between symptoms, attachment and working alliance measures

We hypothesised negative associations between clients' secure attachment and symptoms and positive associations between clients' insecure attachments and symptoms. We also hypothesised negative associations between clients' symptoms and alliance.

As predicted, client depression was significantly associated with client attachment style (RQ). Specifically, with secure attachment style ratings (r = -0.44, p = 0.014), and fearful attachment style ratings (r = 0.43, p = 0.016). However, there were no significant relationships between preoccupied attachment and depression (r = 0.24, p = 0.206) or dismissing attachment and depression (r= 0.159, p = 0.400) Depression scores were also significantly associated with the working alliance score (r= -0.50, p – 0.004), suggesting that increased levels of depression are related to less favourable client-rated working alliances. In terms of therapist-rated alliance scores, client depression was significantly negatively related to the overall working alliance score (r = -0.46, p = 0.010).

As predicted, client anxiety was significantly associated with client attachment style (RQ). However, as in the case of depression, anxiety was significantly associated, with

secure attachment style ratings (r = -0.39, p = 0.029) and fearful attachment style ratings (r = 0.44, p = 0.013), but not with preoccupied (r = 0.13, p = 0.487) or dismissing (r = 0.04, p = 0.826) attachment style ratings. Client anxiety was significantly associated with the total working alliance score (r = - 0.37, p = 0.044), with higher self-reported levels of anxiety being related to lower client-rated working alliance total scores. In terms of therapist-rated alliance scores, client anxiety was significantly negatively related to the overall working alliance score (r = -0.42, p = 0.023).

Therapist symptoms of anxiety and depression were not significantly related to any of the attachment or alliance ratings, possibly attributable to the relatively low levels of symptoms in the therapist group.

Are client-reported attachment styles associated with therapeutic alliance?

It was hypothesised that clients with more secure attachments would have better client-rated and therapist-rated working alliances and that clients with more insecure attachment patterns would have poorer client-rated and therapist-rated working alliances. Client secure attachment style was not significantly related to overall client-rated working alliance score (r = 0.25, p = 0.176) or therapist-rated overall working alliance score (r = 0.12, p = 0.541). There were no significant relationships between insecure client attachment style and any of the client or therapist-rated working alliance scores. Client fearful attachment was not significantly related to client-rated overall alliance (r = -0.17, p = -0.384) or therapist-rated overall working alliance (r = -0.05, p = 0.790). Client preoccupied attachment was not significantly related to client-rated overall alliance (r = -0.12, p = 0.518) or therapist-rated overall working alliance (r = -0.19, p = 0.315). Finally, client dismissing attachment was not significantly related to client-rated overall alliance (r = -0.08, p = 0.678) or therapist-rated overall working alliance (r = -0.01, p = 0.939).

Are therapist-reported attachment styles associated with the therapeutic alliance?

It was hypothesised that therapists who report more secure attachment styles would report having better alliances with their clients, and that their clients would also report better working alliances. However, contrary to predictions, therapist secure attachment was not related to either therapist-rated overall alliance score ($r = -0.05$, $p = 0.769$), or client-rated overall alliance score ($r = -0.13$, $p = 0.494$). It was also hypothesised that therapists who report more insecure attachment styles would have poorer therapist and client-rated alliances. Correlations between the variables showed that there was no significant relationships between therapist fearful attachment style and client-rated or therapist-rated overall working alliance score ($r = -0.17$, $p = 0.375$, and $r = -0.07$, $p = 0.670$, respectively). Therapist preoccupied attachment style was not associated with client–rated or therapist-rated overall working alliance score ($r = -0.08$, $p = 0.667$ and $r = -0.13$, $p = 0.422$, respectively). Correlations between therapist dismissing attachment style and the overall therapist-rated and client-rated working alliance score were also not significant ($r = 0.11$, $p = 0.252$, and $r= 0.06$, $p = 0.744$, respectively).

We carried out a post hoc analysis to explore the possibility that client complexity influenced the association between therapist security and working alliance. We hypothesised that therapists' attachment security would be more influential in clients with greater psychological difficulties. Depression and anxiety scores were added together and a median split was used to identify high overall and low overall symptom groups. There were no significant associations between therapist secure attachment style and client-rated working alliance in either low or high complex groups ($r = 0.43$, $p = 0.099$, and $r = 0.33$, $p = 0.252$, respectively), and in therapist-rated working alliance in either low or high complex groups ($r = 0.12$, $p = 0.67$ and $r = 0.26$, $p = 0.380$, respectively). However, therapist-rated fearful attachment style was significantly related to client-rated working alliance score in more complex clients ($r = -0.63$, $p = 0.016$), but not in the low complex group ($r = 0.33$, $p = 0.207$). There was

no relationship between therapist-rated fearful attachment style and therapist-rated alliance in either low ($r = -0.04$, $p = 0.896$) or high ($r = -0.29$, $p = 0.299$) symptom groups. Therapist-rated preoccupied attachment style was significantly related to therapist-rated working alliance in more complex clients ($r = -0.80$, $p = 0.001$) but not in the low complex client group ($r = 0.14$, $p = 0.583$)

However, therapist-rated preoccupied attachment style was not related to the client–rated working alliance in either low ($r = 0.204$, $p = 0.448$) or high ($r = -0.32$, $p = 0.258$) complex groups. The same pattern of results was found for dismissing attachment. Therapist dismissing attachment style and therapist-rated alliance were associated in more complex clients ($r = 0.75$, $p = 0.002$), but not in low complex clients ($r = -0.49$, $p = 0.055$). No associations were found between therapist dismissing attachment style and client-rated alliance in either low ($r = -0.04$, $p = 0.88$) or high ($r = 0.28$, $p = 0.339$) complex groups.

In summary, the therapist's fearful attachment was found to negatively influence the alliance from the client's perspective, when the client's symptoms were higher. More fearful therapists had lower client-rated alliance scores. Therapist preoccupied attachment was found to influence therapist ratings of the alliance when client symptoms were higher. More preoccupied therapists reported lower rated alliance. Therapist dismissing attachment was found to influence therapist ratings of the alliance, when client symptoms were higher. More dismissing therapists reported better rated alliances.

Do therapists and clients with oppositional attachment styles have better therapeutic alliance?

It was hypothesised that therapists and clients who had oppositional attachment styles would report more favourable working alliances. On the basis of previous research and in accordance with the study by Bruck et al. (2006), we calculated the difference between therapists' and clients' scores. We focused on the preoccupied and dismissing attachment styles, which corresponds to the hyperactivating and deactivating

dimensions used by Tyrell et al., (1999). The closer the match coefficient came to zero the more alike the therapist and clients were in terms of their levels of preoccupied or dismissing attachment style.

In terms of the preoccupied attachment match coefficient, a significant relationship was found with therapist-rated overall working alliance score ($r = 0.43$, $p = 0.018$), but not with client-rated overall working alliance score ($r = 0.050$, $p = 0.778$). In terms of dismissing attachment, there was a significant relationship between the dismissing attachment match coefficient and the client-rated overall working alliance score, $r = 0.41$, $p = 0.024$, but not with therapist-rated overall working alliance score ($r = -0.10$, $p = 0.597$). Therefore, matching in terms of preoccupied attachment was associated with therapist alliance and matching in terms of dismissing attachment was associated with client perceptions of alliance.

Additional Hypotheses

Therapist attachment style and client attachment to therapists

We hypothesised that therapists with self-reported high levels of attachment security would receive more favourable client attachment to therapist (CATS) ratings. Counter-intuitively, therapist attachment security was significantly negatively related to the Secure subscale of the CATS ($r = -0.37$, $p = 0.047$) and the positively related to the Avoidant subscale ($r = 0.46$, $p = 0.011$) but not the Preoccupied-Merger subscale ($r = 0.122$, $p = 0.521$). The only significant relationship between therapist attachment insecurity and the CATS subscale was between fearful therapist attachment style and the CATS preoccupied-merger subscale ($r = 0.48$, $p = 0.007$).

Therapist attachment style, psychological mindedness and the working alliance

It was hypothesised that therapists with high levels of psychological mindedness would receive better client–rated and therapist-rated working alliances and that therapist attachment security would be positively related to psychological mindedness. We conducted further correlational analyses. No significant relationships were found

between the therapist level of psychological mindedness and either therapist-rated working alliance ($r = 0.17$, $p = 0.275$) or client-rated working alliance ($r = 0.06$, $p = 0.755$). Furthermore, there were no significant relationships between therapist secure attachment style and psychological mindedness ($r = 0.13$, $p = 0.416$) or therapist insecure attachment styles, fearful ($r = 0.09$, $p = 0.575$), preoccupied ($r = 0.04$, $p = 0.82$) and dismissing ($r = -0.01$, $p = 0.934$).

DISCUSSION

The aim of the present study was to investigate associations between therapist and client attachment styles, and the working alliance. We also investigated any mediating role for client attachment to therapist and psychological mindedness. Specifically, to investigate the extent to which self-reported attachment styles are related to the working alliance and to assess the relative contribution of psychological mindedness to attachment security and the quality of the working alliance.

We hypothesised that clients with more self-reported anxiety and depression symptoms would have more insecure attachment styles and poorer working alliances. Higher scores in client self-reports of depression and anxiety were related to decreased client-ratings of secure attachment style, and increased ratings of anxiety were related to increased ratings of insecure attachment. Furthermore, both anxiety and depression scores were related to lower overall working alliance scores. The findings in relation to symptoms suggest that it is secure and fearful attachments that are related to symptoms but not dismissing and preoccupied attachment. Fearful attachment may relate to symptoms as this is a particularly maladaptive attachment style. This is consistent with the literature, which suggests a link between insecure adult attachment and psychological difficulties (Oliver & Whiffen, 2003; Williams & Riskind, 2004; Gamble & Roberts, 2005), as well as evidence that suggest clients with insecure attachment styles are less able to form positive working alliances (Mallinckrodt, Coble & Gantt, 1995).

It was hypothesised that clients with more secure attachments would have better client-rated and therapist-rated working alliances and that clients with more insecure attachment patterns would have poorer client-rated and therapist-rated working alliances. This hypothesis was not supported, as in this relatively small sample no significant relationships were found between client attachment style and the working alliance, as rated client and therapist.

We also did not find any influences of therapists' attachment security on client-rated or therapist-rated overall working alliance, or any of the working alliance inventory subscales. Insecurely attached therapists were as able to form a therapeutic relationship with their client as securely attached therapists. This contradicts previous research (Dunkle & Friedlander, 1996; Black et al., 2005) which demonstrates therapists high in attachment security are better able to form positive working alliances with clients. Those studies however, used therapists in training and from university counselling centres. The current therapist sample included only one therapist in training. It may be that insecure therapists, through their professional training and personal development are able to use their therapeutic skills to compensate for the supposed effect of their problematic attachment histories.

The results of this study support previous research which suggests that therapists with more secure attachment styles may be better positioned to work with more complex clients. Schauenburg et al. (2010) investigated the association between therapist attachment representations on the AAI, and working alliance as measured by the client-rated HAQ in a large inpatient sample of thirty one therapists and 1, 381 patients. They found that therapist attachment interacted with clients' symptoms to influence alliance. Higher therapist attachment security was associated with better client-rated alliances but only for clients who described high levels of interpersonal problems before therapy. A similar pattern was found for patients' with high overall symptom distress. The present study did not find any significant associations between therapist secure attachment style and client or therapist rated working alliance, in either low or high complex client groups. The study did, however, find that therapist-fearful attachment style was related to client-rated (but not therapist-rated) poorer working alliance in more complex clients. Preoccupied and dismissing therapist attachment style were negatively related to therapist-rated (but not client-rated) working alliance in more complex clients. These findings highlight the importance of assessing the complexity of clients' problems in studies of attachment and alliance.

The discrepancies in client and therapist ratings of alliance and in the different types of attachment highlights the importance of assessing both client and therapist perspectives of the working alliance and different types of insecure attachment patterns.

A match between therapist and client attachment styles was derived, with the greater the match coefficient, the greater the difference between the therapist and client in terms of their self-rated attachment style. The greater the difference between the client and therapist in terms of both preoccupied and dismissing attachment style, the more favourable the therapist-rated and client-rated alliance ratings respectively. This study suggests that mismatching clients and therapists with oppositional attachment dimensions may improve the working alliance. This is in line with previous research (Tyrell et al., 1999; Bruck et al. 2006). However, as mentioned above, the differences found between client and therapist ratings of the alliance, suggest that both perspectives need to be measured.

Bernier and Dozier (2002) argue that the ability of the therapist to respond to the client in a non-complementary way is a function of the security of the therapists' own attachment. However, the therapist's own natural variations in preoccupied and dismissing strategies may also help them resist the pull to respond in a confirmatory way. Evidence from interpersonal and attachment research has suggested that the mismatch between therapist and clients attachment facilitates the Corrective Emotional Experience (Teyber, 2000), which allows modification of insecure internal working models.

However, Mallinckrodt (2010) emphasises that there is both an engagement stage of therapy, which involves matching the client's attachment strategy and a working phase, which involves encouraging the client towards an optimal level of therapeutic distance, and mismatching the client's attachment strategy. In the working phase, Mallinckrodt (2000) describes the idea of a 'collision of counter complementary

attachment proximity strategies' by which the therapist reacts to the client's attitudes towards proximity in ways that 'collide' with their expectations and maladaptive patterns. Mallinckrodt (2000) argues that it is this collision that creates the corrective emotional experience. This study provides support for a greater mismatch or collision in preoccupied and dismissing attachment strategies.

It was hypothesised that therapists high in attachment security would receive more favourable client attachment to therapist (CATS secure) ratings. This hypothesis was supported. The more secure the therapist was in their attachment style the greater the client was attached to the therapist.

This exploratory study also investigated therapist-rated psychological mindedness, as previous research has deemed PM an essential therapist characteristic (Farber & Golden, 1997). It was hypothesised that high levels of psychological mindedness would be related to high levels of therapist-attachment security as well as therapist-rated and client-rated working alliance. No significant relationships were found between any of the main study variables and psychological mindedness. These results suggest that therapists with lower self-reported psychological mindedness are as likely to report secure attachment styles and as able as therapists high in psychological mindedness to form positive alliances with their clients.

Finally, it is important to highlight the possibility that self-reported attachment styles may be influenced or confounded by personality variables and symptom severity. Meyer, Pilkonis, Proietti, Heape, and Egan (2001) found that there is indeed some conceptual overlap between attachment and personality, which may complicate the course of symptoms. It is possible that the personality trait of neuroticism (enduring tendency to experience negative emotional states) for example may be related to increased self-reported insecure (anxious) attachment styles. This prompts investigation as to whether insecure attachment captures a key construct in

attachment theory or if it reflects a more general personality trait instead (Crawford, Shaver & Goldsmith, 2007).

LIMITATIONS

Some methodological shortcomings of the present study should be recognised. Mallinckrodt (2010), as discussed, outlined five key characteristics of attachment relationships with evidence to evaluate whether the therapeutic relationship can meet these criteria. Although therapy relationships do have the capacity to be attachment relationships, not all psychotherapy relationships will meet these criteria. It may be that for some of the psychotherapy dyads in the current study the therapists might not be attachment figures,

The number of therapists and clients that were recruited and completed the study was small, thus limiting the statistical power and increasing the possibility of a Type II error. The number of dyads should have ideally been larger to ensure both greater power and greater variability in the study variables. However, the majority of the r values reported throughout the result section are low suggesting that the associations would not be significant even in larger samples. Furthermore, the data were constrained by the low response rate. A large number of research questionnaires were unreturned, thus the sample may be unrepresentative and this limits the generalisability of the results. It was not possible to gain information about the people who chose not to complete the study.

The strength of the research design was its dual perspective, with both the therapists and clients completing measures of attachment style and the working alliance. This method reduced the potential for error resulting from common method variance. However, the data are correlational and all the variables were collected via the therapist's and client's own perceptions. The reliability of reports of alliance may be particularly problematic by clients or therapists with insecure attachment patterns (Norcross, 2002). It may be, for example, that those with dismissing attachment styles report good alliances in denial of their difficultly in engaging in emotional relationships, and those with preoccupied attachment styles report good alliance in

response to the importance they assign to attachment relationships and wanting to be closer to others. These difficulties or biases emphasise the importance of measuring alliance from a range of different perspectives.

There remains controversy and debate within the literature on attachment as to whether self-report measures of attachment style are adequate measures of attachment (Clarkin & Levy, 2003). This study used the RQ, which is limited to one question per attachment style. This classification system may not capture the full range of idiosyncratic attachment patterns that individuals may present with. It is possible therefore, that different results could have been obtained had the study used a different measure of self-reported attachment style, such as the Experiences in Close Relationships Scale (ECRS) (Brennan et al., 1998). Further, it is possible that using an attachment measure from the other paradigm, like the Adult Attachment Interview (AAI), may find different results. This may be due to the fact that the AAI measures 'attachment states of mind' on the basis of the coherence of the individual's narrative in describing parental-child relationships (Main, Kaplan & Cassidy, 1985; Main, 1995) which does not require conscious reflection on ones thoughts, feelings and behaviour (Banai, Weller, Mikulincer, 1998).

There were unequal numbers of secure versus insecure therapists in the study, with 79% demonstrating a preference for secure attachment style, but among the insecure therapists there were more dismissing therapists than fearful or preoccupied. This relative lack of attachment variability may have masked some of the effects of therapist attachment style on the working alliance, as rated by clients and therapists.

This study only collected data on the working alliance at one time point, whereas collecting data across numerous time points in the therapeutic relationship would have allowed analysis on any effects on therapist attachment style on the working alliance throughout the course of therapy.

A further limitation is that the sample participants were predominately white and female, and thus may be unrepresentative. A further limitation concerns the bias in the therapists' reported therapeutic modality, with 41% of the sample using CBT, it could be argued that this may reflect a selective sample, and also there were differing levels of therapist experience.

FUTURE RESEARCH

There is empirical evidence, as previously discussed, that psychotherapy patients view the therapist as an attachment figure (Mallinckrodt et al., 1995; 2005). More research is, however, needed to identify how and why the therapist is experienced as an attachment figure, particularly as it is unlikely that this is achieved simply by virtue of being a 'therapist'.

Future studies should concentrate on obtaining larger samples of therapists using a more representative sample, as this study used mostly white, female CBT therapists. It would be interesting for a larger study to investigate any differential effects of therapist attachment style and their treatment modality as well as any effect on the working alliance. The low response rate in the current study could perhaps been ameliorated in future research by contacting participants via the phone or post. This could also address the discussed limitation concerning no information on non-responders. Future research could post out purpose designed questionnaires to try to gain information as to why participants chose not to complete the study.

This study obtained self-report measures of the working alliance at a single time point but by extending the data collection future researchers could examine the impact of attachment on alliance development over the course of therapy, and examine alliance development using ratings from all therapy sessions.

The primary focus of this study was to explore the effects of therapist and client attachment styles on the working alliance, thus we did not collect data on therapy outcome. In hindsight, collecting this information would have strengthened the study by allowing the investigation of how attachment styles and alliance perceptions are related to therapy outcomes. Future studies could incorporate a standardised outcome measure.

Future studies may consider using multi-item measures of attachment style. The RQ, used in the present study is limited to one question per attachment style. Multi-item measures of self-reported attachment style, such as the Experiences in Close Relationships Scale (ECRS) (Brennan et al., 1998), may more accurately capture the full range of attachment styles.

The question of reliability of reports by clients with different attachment styles emphasises the importance of including ratings by observers and therapists (Eames & Roth, 2000). Future studies may consider using observer measures of attachment and alliance in addition to the therapist's and client's own perceptions.

It would have been interesting for this study to have assessed the clients' level of PM, as high levels of PM in patients has been shown to be positively correlated with the number of therapy sessions attended (Conte et al., 1990), as well as treatment outcome (McCallum & Piper, 1997). Furthermore, given the links between PM and psychological distress (Taylor & Taylor, 1997) this would have been important to consider the mediating effects of this concept on psychological distress.

Future research could also investigate other relationships that may contain similar features to the parent-child attachment relationship, such as the supervisee-supervisor relationship, which may benefit from being explored from an attachment framework. In addition, future studies could explore what impact a mismatch between the attachment style of supervisees and supervisors could have on the supervisory relationship and the supervisees' development.

CLINICAL IMPLICATIONS

Bowlby (1988) anticipated that the principles of attachment theory would have an impact on clinical practice. He proposed a model of therapeutic change that results in revision of insecure internal working models. Dozier and Tyrell (1998) summarise this model in terms of three stages, 1) the therapist becoming a secure base and providing corrective emotional attachment experiences, 2) the client's exploration of current relationships, and relationship to the therapist and 3) the client's reflection and exploration of early relationships with attachment figures. In line with Bowlby, this present study suggests that the attachment styles of both clients and therapists can affect the quality of the client-therapist relationship and it may be an interaction between clients' and therapists' attachment that is most important, particularly in relation to preoccupied and dismissing strategies.

The assessment of therapists' and clients' attachment style could be adopted into routine clinical practice and consideration given to 'matching' clients and therapist on the basis of their attachment statuses, in order to improve clinical outcome and working alliances. This 'matching' could involve establishing optimal complementarity between clients and therapist attachment styles so that preoccupied clients are matched with therapists who (based on their attachment dimensions) are better placed to contain these emotions and help the client to regulate them, whereas dismissing clients are matched with therapists who are more focussed on emotional exploration and acceptance.

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Paper Three: Critical Reflection

Annily Seymour-Hyde

INTRODUCTION

This paper provides a critical reflection on the research process. It begins by outlining the rationale for the development of the literature review and the empirical research paper, and goes on to discuss some of the methodological considerations of the research paper. The implications for therapeutic practice are then suggested, followed by the wider service-related issues. Attachment theory is then critiqued, and the clinical implications discussed. Finally recommendations are made for future research.

Research question

The aim of the current research was to investigate the extent to which client and therapist self-reported attachment styles are related to the working alliance and to assess the relative contribution of client attachment to therapist and psychological mindedness to attachment security and the quality of the working alliance.

RATIONALE FOR LITERATURE REVIEW AND EMPIRICAL PAPER

Attachment theory has been well researched; it is considered an important construct to investigate as it has been empirically shown to influence a number of biopsychosocial factors (Meredith, Stong & Fenney, 2006) as well as therapy outcome (Catty, Winfield & Clement 2007) and therapy process variables (Dozier, 1990). Of particular interest is the impact of attachment style on the formation of a positive working alliance between the client and therapist. Research has consistently demonstrated that clients who have secure attachment styles form better quality working alliances (Mikulincer & Shaver, 2007), and this has important implications for outcome (Baldwin, Wampold & Imal, 2007). Smith, Msefti and Golding (2010) provide a comprehensive review of client-rated attachment patterns and the therapeutic alliance. However, their review does not consider the impact of the therapist's attachment pattern on the working alliance. The therapist's attachment style is important to consider because just as client attachment patterns have been shown to affect the working alliance, the attachment patterns of therapists would be expected to affect their ability to provide a secure working relationship with clients. Daniel (2006) provides a review of adult attachment patterns and individual psychotherapy, and outlines the effect of therapist attachment patterns. However, there is a lack of synthesis of up to date research that has investigated the effect of therapist attachment style on the working alliance, whilst also addressing the impact of therapist attachment on client outcome.

The production of the literature review highlighted a relative lack of research specifically addressing therapist attachment style, the working alliance and outcome, especially when compared to research on client attachment style, the working alliance and outcome. The systematic method with which the literature search was conducted allowed the identification of empirical papers that investigated therapist attachment style, the working alliance and outcome. The inclusion criteria of the literature search did not include book chapters, theses, or unpublished research. The challenges in

conducting the literature review were defining the inclusion criteria, particularly around the measurement of therapist attachment style. Many studies have explored therapist attachment style, but often without including a therapist-rated measure of the working alliance. Further, the measures used to assess the impact of the therapist on the working alliance frequently used measures of interpersonal characteristics, or subscales from other measures, rather than a validated measure of attachment. Nine studies were identified as meeting the inclusion criteria, and initially the author felt concerned that this number may not be sufficient. The author thought about expanding the focus of the review to include studies investigating therapist interpersonal characteristics and the alliance and outcome. After careful consideration, it was decided that the lack of agreement concerning 'therapist interpersonal characteristics' and the inclusion criteria/ measures that would capture this, would in itself sustain a separate review.

The review highlighted that therapist attachment security positively influences client-rated working alliances, particularly in complex cases. There was also evidence for an effect of therapist anxiety on alliance at least in therapists in training in the later stages of therapy. However, the association between therapist attachment and alliance was not straightforward; there was evidence to suggest that the attachment style of the therapist and the client interact to produce a combined effect on perceptions of the working alliance and clinical outcome (Tyrell, Dozier, Teague & Fallot, 1999; Bruck, Winston, Aderholt & Muran, 2006; Schaeunburg et al., 2010).

The present study aimed to make a contribution to this area by investigating client and clinician attachment styles, psychological mindedness and the working alliance. The aim was to investigate the extent to which self-reported attachment styles are related to the working alliance and to assess the relative contribution of client attachment to therapist and psychological mindedness to attachment security and the quality of the working alliance. Therapist attachment may influence the working alliance but we do not know what might mediate this: one possibility was client

attachment to therapist (Mallinckrodt et al., 1995) and another was psychological mindedness (Conte et al., 1996). The research paper extended previous research by measuring the therapists' level of psychological mindedness and the client attachment to therapist to see if these variables would mediate any relationship between therapist attachment and alliance.

The literature review and empirical paper contribute to our understanding of the complex relationship between attachment and the working alliance.

METHODOLOGICAL CONSIDERATIONS

Design

The strength of the research design was its dual perspective, with both the therapists and clients completing measures of attachment style and the working alliance. This method reduced the potential for bias resulting from demand characteristics and from type I error resulting from common method variance. Furthermore, the research design was consistent with relevant recommendations from the literature base indicating the importance of both therapist and client perspectives (Norcross, 2002).

The major limitation of this study was the potential selective nature of the sample of therapists and the sample of clients. Therapists from Primary Care Services across the North West of England, UK were approached to take part in this research study. It is possible that therapists who were more comfortable with their attachment style took part in the study, whereas some therapists may have felt the present study would be exposing for them. Careful consideration was give to this and every effort was made to ensure participant confidentiality. A further limitation was that although therapists were asked to approach the next client who reached the third session of therapy, they may have selected clients to ask to participate in the study with which they felt they had a good relationship, and who they felt may be more likely to complete and return the questionnaire. This may have created an unrepresentative sample.

Recruitment

A large number of services and participants declined to take part in the study, or agreed and consented to the study but did not return their research packs. This may be due to high levels of participant anxiety in relation to exposing their attachment style, therapist anxiety as to their relationships with clients, high rates of distress within the client sample or disengagement with services. It would have been interesting for the study to follow-up non-responders and those who disengaged. It is

difficult therefore to speculate about how representative the sample was as no data was collected on those who declined to take part.

The process of recruitment revealed a number of site differences in the perceived value of taking part in research. Correspondence with one site in particular demonstrated that they were keen to take part and really valued being asked to be involved in the study, and were keen to promote the study to clients because they wanted to promote involvement and discussion of the therapeutic relationship. Correspondence with other sites however revealed services that did not want to engage in the study at all. This was presented to the researcher as due to the time demands of the study and the demands on the therapists who were already feeling overwhelmed and felt that they were at the limit of their working capacity. During the recruitment stages there were a number of research studies recruiting individuals from Primary Care Services across the North West of England, UK. The researcher hypothesised that services were feeling overwhelmed by demands to take part in research and that this was in the context of a difficult working climate.

Sample Size

Due to the difficulties with recruitment outlined above the study did not achieve the anticipated forty therapist-client dyads. A total of thirty dyads were recruited, with a further 12 therapist completed packs. Twelve clients did not return the research pack after consenting to take part. The major limitations of small sample size are that a small sample can lead to loss of power and insignificant findings. When running statistical analyses it can produce false-positive results, or an over-estimation of the magnitude of an association (Field, 2006). However, the sample size used in the current study is similar to previous research (Tyrell et al., 1999; Sauer et al., 2003; Bruck et al., 2006) within the attachment and alliance literature.

Measures

The study used the PHQ-9 (Kroenke, Spitzer & Williams, 2001) and the GAD-7 (Spitzer, Kroenke, Williams & Lowe, 2006) to measure symptoms of depression and anxiety respectively. These self-report measures were used because they are brief tools, and are commonly used within Primary Care Service (Körber et al., in press; Kroenke et al., 2002) The study reported alphas for PHQ-9 of 0.64 for therapists and 0.92 for clients. The alphas for the GAD-7 were 0.66 for therapists and 0.93 for clients. Using George and Mallery's (2003) commonly accepted method for describing internal consistency, the alpha values in the present study for the therapist sample would be considered 'questionable'. This suggests that the measures are measuring different traits within therapists.

There is much controversy within the attachment literature on how best to measure and classify adult attachment. This debate is particularly located around the two traditions of narrative measures of attachment and self-report questionnaire measures, as there seems to be little empirical overlap between the methods (Westen, Nakath, Thomas & Bradley, 2006).

The narrative measures of attachment use the Adult Attachment Interview (Main Kaplan & Cassidy, 1985) which classifies attachment status based on the individual's discourse of their early attachment experiences. Difilippo and Overholster (2002) suggest that this methodology primarily focuses on how the individual's attachment experiences have been organised in the mind, and their experiences of parenting (attachment in childhood). This would then exclude the individual's conscious thoughts, feelings and behaviour and any information relating to their internal working models. In contrast, the self-report questionnaire methods classify attachment patterns on the basis of the individual's *current* attachment related experiences, and on their conscious feelings about their interpersonal relationships. Further the AAI is a time consuming measure of attachment, in which verbatim transcripts of interviews must be coded. The researcher would need to be trained in order to administer it.

Although, if the AAI was used in the present study, it may have produced different findings, it was considered too time consuming. Difilippo and Overholster (2002) argue that it may be more important to capture adult attachment patterns that derive from attachment in adult relationships, as opposed to narrative approaches which capture attachment to parents in childhood, as the former is more related to current interpersonal functioning.

Therapists and clients completed the Relationship Questionnaire (RQ), which is a self report measure of adult attachment created by Bartholomew and Horowitz (1991) to represent a four group model of adult attachment. The RQ is limited to one question per attachment style. This classification system may not capture the full range of idiosyncratic attachment patterns that individuals may present with. It is possible therefore, that different results could have been obtained had the study used a different measure of self-reported attachment style, such as the 36-item Experiences in Close Relationships Scale (ECR) (Brennan et al., 1998) adult attachment measure. The ECR was developed from a thorough literature search of previous attachment measure research, and via a survey of more than 1000 participants, it used factor analysis of 14 self-report measures of attachment. Brennan, Clark and Shaver report that the ECR was consistent with the RQ but showed stronger relationships with other target variables than those found using this measure. Wei, Russell, Mallinckrodt & Vogel (2007) developed a 12-item, short form of the Experiences in Close Relationship Scale. They found that the psychometric properties of the ECR-short form were equivalent to the original 36-tem ECR. Thus, the ECR-short form may be more useful for future research applications.

The clients in the present study completed the Client Attachment to Therapist Scale (CATS) (Mallinckrodt, Gandt & Cable, 1995) which is a 36-item measure of client attachment to their therapist. It was devised following assertions that the therapist could function as an attachment figure (Parish & Eagle, 2003) Research has demonstrated that the CATS may be conceptually similar to the working alliance

inventory (Robbins, 1995), as the two are related (Mallinckrodt, Gandt & Cable, 1995). However Mallinckrodt, Porter and Kivlighan (2005) report that CATS subscales account for a significant proportion of variance in psychotherapy exploration not accounted for by the WAI alone.

Both the RQ and the CATS are self-report measures of attachment style. Self-report measures have been critiqued in the attachment literature, primarily due to their focus on conscious thoughts, feelings and behaviour, which may necessitate some level of insight. This study used the RQ which doesn't require conscious reflection on one's thoughts, feelings and behaviour but rather asks raters to rate their attachment style based on their interactions with a particular individual (Banai, Weller & Mikulincer, 1998). The use of this questionnaire method does however introduce the possibility of self-reporting biases, particularly social desirability biases, where the respondent may have answered in a way that reflects them more favourably.

There are also significant deficiencies in both the conceptualisation and measurement of the working alliance (Elvins & Green, 2008). There are many different conceptualisations of the alliance which have yielded different measures of the construct, although none has generated more research than Bordin's (1979) conceptualisation. The Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) is based on Bordin's conceptualisation and has become the most widely used measure of alliance (Martin, Garske & Davis, 2000) and was therefore used in the present study. In the present study the working alliance subscale findings were consistent with the findings for the overall working alliance.

Procedure

The procedure was designed so that each participating therapist was only asked to recruit one client and complete the research questionnaire once. It was hoped that this would increase the uptake rate. The therapists were asked to request participation from their next client who had reached at least three therapy sessions. This procedure

however, as discussed, may have introduced some selection bias, with therapists asking clients who they thought would complete the research and or with whom they had a good relationship.

DATA ANALYSIS:

Prior to data analysis the normality of each measure was assessed using the Kolmogorov-Smirnov statistic, the skewness and kurtosis values were inspected, and were considered acceptable if they fell within +/- 1.96 standard errors, as recommended by Field (2005). A large number of the measures violated the normality assumptions of parametric statistical analyses, as well as the significance suggested by the Kolmogorov-Smirnov statistic ($p < 0.05$). The appropriate transformations were applied to the data, as directed by Field (2005). Inspection of the transformed data left a number of variables with unimproved skewness and kurtosis values. The researcher sought advice from the university statistician and it was decided that non-parametric statistical analyses were appropriate.

Analysis of the skewed variables showed that the client working alliance total score and the three subscales were negatively skewed. This is of interest as it may reflect inflated ratings of the working alliance, possibly as a result of demand characteristics.

Although the study did not employ Bonferonni adjustment, the author acknowledges the problems of multiple testing (i.e. the increase in the possibility of chance significant results). Because of the small sample size formal adjustment for multiple testing was not applied to the data. However, any (nonadjusted) significant results are considered only as suggestive that there is some limited evidence of a possible relationship, and not taken as definitive evidence of a (clinically) significant relationship. Nakagawa (2004) notes serious problems with the use of the Bonferroni adjustment, in that it may exacerbate any existing problems of low power, indeed, there is no formal consensus for when Bonferroni procedures should be used (Pernerger, 1998).

IMPLICATIONS FOR THERAPEUTIC PRACTICE

Although attachment theory has been widely researched, there has been little investigation of the theory's implications for clinical practice (Weston, 1991). It is important to consider the clinical implications of research on attachment and the questions and possibilities that this area of research raises. There has indeed, been an increase in interest in the relevance of an attachment theory framework and perspective to psychotherapy (Levy, Ellison, Scott & Bernecker, 2011). The use of clinical measures of attachment style in psychotherapy may encourage therapists to take the client attachment styles into consideration when setting both the pace of therapy and selecting the specific methods of intervention. Research has shown the clinically utility in using attachment measures in therapy in a meaningful way (Westen, Makath, Thomas & Bradley, 2006).

Assessing client attachment styles

Assessing client attachment styles may have an important role in therapy practice. There are several reliable and validated self-report measures to assess adult attachment styles that are brief and that can be used effectively in clinical practice (ECR, RQ). The use of these tools in clinical practice can allow the therapist to obtain a quantitative measure of the client attachment style and related behaviour. The Client Attachment to Therapist Scale (CATS) (Mallinckrodt et al., 1995) could also be used as a monitoring tool to assess the client's attachment to the therapist throughout the course of therapy.

The utility in assessing the client's attachment style prior to therapy is important as research suggest that the client's attachment style is related the working alliance (Smith et al., 2010) and clinical outcome (Meyer, Pilkonis, Proietti, Heape & Egan, 2001; Meyer & Pilkonis, 2002). If the therapist has a working knowledge of the client's attachment status this can elucidate the client's internal working models of the self, others and the world that can help the therapist indentify and target specific treatment

goals and interventions (Hardy, Stiles, Barkham & Startup, 1998). The different attachment styles 'pull' for different interventions, awareness of this can help the therapist be responsive to these styles and pace "giving in" to the pull and also countering them in such a way to facilitate a corrective emotional experience. For example preoccupied clients may initially pull for emotion focused and experiential interventions but benefit from interventions that help them to regulate their emotional experience, whereas preoccupied clients may benefit from interventions enabling them to explore emotional development and engagement (Dozier, 1990; Hardy, 1999; Wallin, 2007).

Assessing therapist attachment style

The assessment of the therapists' attachment style could be adopted into routine clinical practice and may be used to 'match' clients and therapist on the basis of their attachment statuses. This 'matching' could involve establishing optimal complementarity between client and therapist attachment styles so that preoccupied clients are matched with therapists who (based on their attachment dimensions) are better placed to contain these emotions and help the client to regulate them, whereas avoidant clients are matched with therapists who are more focused on emotional exploration and acceptance (Dozier, 1990; Dozier, Cue, & Barnett, 1994; Dozier, Stovall, & Albus, 1999).

Mallinckrodt's (2009; 2010) model, as discussed in paper one, emphasises both an engagement stage of therapy, which involves matching the client's attachment strategy and a working phase, which involves encouraging the client towards an optimal level of therapeutic distance. Daly and Mallinckrodt (2009) showed that experienced therapists are able to facilitate change in clients with attachment anxiety and attachment avoidance by the careful and thoughtful regulation of the emotional distance throughout the course of therapy. The research suggests that therapists need to be aware of optimal complementarity (Wallin, 2007) and titrate their interpersonal

styles careful with their client so not to go to far in contrasting the clients attachment style (Levy, Ellsion, Scott & Bernecker, 2011).

Attachment status as an outcome variable

If indeed the major task of psychotherapy is to modify the client's internal working models (Davila & and Levy, 2006), attachment status may be useful to pursue as an identified treatment goal. Thus attachment consideration and assessment may drive the therapeutic goals. The clinical utility of using attachment measures in psychotherapy has however been questioned. Eagle (2006) identified that clinician complaints about the use of attachment measures were related to the categories of attachment being too broad to be clinically useful: the same attachment pattern can mean different things depending on other idiosyncratic factors. Further to this, Eagle cautioned that there may be some risks around pathologising clients according to their attachment status.

WIDER SERVICE-RELATED IMPLICATIONS

Finally, there are also some wider service–related implications of attachment theory and whether mental health service models could or indeed should transition to attachment-oriented service models, to facilitate client outcome. Indeed Goodwin (2003) has suggested that attachment theory may be a useful framework from which to consider aspects of service design and delivery and empirically demonstrated that clients who perceive mental health services as a secure base found therapy more helpful and showed more improvement (Goodwin, Holmes, Cochrane & Mason, 2003).

Attachment theory may also be a useful framework from which to consider aspects of service design and delivery (Goodwin, 2003). It has been empirically demonstrated that clients who perceive mental health services as a secure base found therapy more helpful and showed more improvement (Goodwin, Holmes, Cochrane & Mason, 2003). The national advisory group on mental health, safety and well-being for the Department of Health (Seager, Orbach et al., 2007) report that attachment theory provides the "soundest scientific evidence-base around which to design and measure mental health services" and suggest that the principles of attachment theory need to be "built into the fabric of operational policy and training".

CRITIQUE OF ATTACHMENT THEORY

Attachment is defined as a type of affectional bond, which the individual forms with a specific person, who is approached in times of distress (Bowlby, 1973). The attachment relationship is hypothesised to provide a "secure base", which enables the individual to engage in exploration, and develop and gain independence (Ainsworth, Blehar, Waters & Wall, 1978; Ainsworth, 1989). Attachment bonds are first formed with primary caregivers during childhood, but are of importance throughout the life cycle (Bowlby, 1973). Attachment theory asserts that through exposure to attachment relationships, infants construct internal working models (Bowlby, 1969) which contain information and expectations about whether the individual is worthy of love and attention and how they will be treated by others (Bowlby, 1988). Bowlby (1944, as cited in Mikulincer & Shaver, 2010) essentially viewed attachment as a theory of psychopathology, a way in which he could explain how and why our early relationships with our primary caregiver could contribute to psychopathology.

Bowlby (1980) described the formation of internal working models, mental representations, about the self and others based on our experiences of parenting and interactions with caregivers during childhood. The internal working models are hypothesised to include both emotional and cognitive elements concerning beliefs about whether we are worthy of love and attention, whether others are accessible and trustworthy, as well as our emotional experiences of interpersonal interactions (Pietromonaco, Feldman & Barrett, 2000).

The past two decades has seen the vast expansion of the concepts of attachment theory (Bowlby 1980; 1998) to other adult relationships (Berghaus, 2011). Attachment theory has generated a wealth of research since its conception, and has "become the dominant approach in understanding interpersonal relationships (Simonelli, Ray & Pincus, 2004). It has however; receive criticism from a number of researchers and theorists (Crowell and Treboux, 1995). Berghaus (2011) suggests

that are a number of fundamental flaws in the assumptions of attachment theory, particularly around the concept of internal working models, a concept he considers as largely hypothetical. Attachment theory considers the parent-child relationship and the infant's experiences as determining adult behaviours (Bowlby, 1980;1998); the notion that the parent-infant early relationship shapes the child's development has received significant criticism (Harris, 1998). Indeed, research has shown that attachment styles can be modified due to life stressors and changes in key relationships (Waters, Merrick, Treboux, Crowel & Albersheim, 2000; Hamilton, 2000; Hopkins, 2006) and there is some evidence that attachment status can improve as a result of therapy (Daniel, 2006; Diamond et al., 2003; Diamond, Stovall-McClough, Clarkin & Levy, 2003). Goldberg (2000) notes that although change is possible, it may be constrained by previous attachment-related adaptations.

The categorisation of attachment styles was based on Ainsworth, Blehar, Waters and Wall (1978) 'Strange Situation' in which the infants' behaviour towards the attachment figure (mother) during a separation-reunion situation was recorded and coded. Field (1996) has argued that when defining attachment, this contrived and stressful situation, neglects to include information as to how the infant behaves in non-stressful situations, and further does not take individual differences in infants' reaction upon separation into account. She goes on to argue that attachment theory's focus on one primary caregiver, typically the mother, excludes any other important attachment relationships towards others.

FUTURE RESEARCH

The relevance of an attachment theory framework and perspective to psychotherapy (Levy, Ellison, Scott & Bernecker, 2011) has been well documented. In order to specify the ways in which therapist attachment style may affect the working alliance and ultimately clinical outcome researchers need to measure and define the various ways in which attachment theory can contribute to how therapists 'do' therapy and select intervention techniques.

Research has suggested that the therapeutic relationship can bring about changes in the client's attachment classification (Levy, Kelly, Meehan, Reynoso &Weber, 2006), indeed Makinan and Johnson (2006) identify a change in attachment classification as an outcome of psychotherapy intervention. Further research is however needed to empirically investigate whether indeed attachment style can be modified as a result of psychotherapy (Mallinckrodt, 2000). Although, in a randomised controlled trial of treatment (transference focused therapy) for patients with borderline personality disorder, Levy et al. (2006) found that at one year patients could reorganise their attachment states of mind (as assessed by the AAI). More research is needed to investigate whether this reported change in attachment status, as classified by the AAI, and therefore defined by an increase in the coherence of clients' narratives of their attachment experiences in childhood, actually translates into a shift in the client's interpersonal interaction with their attachment figure.

CLINICAL IMPLICATIONS

This study suggests some implications for the supervisor-supervisee relationship. One could argue that if clients and therapists with opposing attachment styles achieve a more favourable working alliance, this may also apply to the supervisor-supervisee relationship. Just like clients seeking help under stress, therapists may need a safe haven or a secure base in relationships with their supervisors (Kurtz, 2005). A dismissing therapist supervisee may be rejecting of help and support from the supervisor, minimising the emotional component of the relationship and deactivating of their attachment needs: these supervisees may form a better relationship with supervisors who are less dismissing. A preoccupied supervisee may be overly dependent on their supervisor, and hyperactivating of their attachment needs: these supervisees may work better with supervisors with counter-complementary attachment styles. Introducing measures of attachment style with this dyad may result in 'pairings' of supervisors-supervisees, based on their attachment style that will result in improved relationships.

REFLECTIONS ON THE PROCESS OF RESEARCH

During the research process there were difficulties with recruitment which was stressful at times. In an attempt to recruit as many participants as possible the researcher met with a large number of services across the North West of England and gave a number of presentations at service meeting, to try and encourage the participation in the research. Multiple Primary Care Services were recruited from, which meant that the researcher had to complete all the relevant approval processes for multiple sites. Despite ethical and R&D approval previously being granted for some research sites, other sites required more information and the researcher had to respond to concerns that the R&D committees had.

The researcher has always been interested in attachment and enjoyed the process of research. The completion of research project allowed the researcher to reflect upon her own attachment style and attachment-related behaviour, both in her professional and personal life. This piece of research has informed the researcher's clinical practice and her personal development. Through reflection of our own internal working models and insight into our own attachment related behaviour, we can better help our clients to integrate and understand their early experiences and the impact of this on their current functioning. The completion of this piece of research will inform the researcher's clinical practice and guide interventions.

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APPENDIX A: PSYCHOTHERAPY RESEARCH GUIDELINES

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Important note: Ethical and legal considerations require careful attention to the protection of a patient's anonymity in case reports and elsewhere. Identifying information such as names, initials, hospital numbers, and dates must be avoided. In addition, authors should disguise identifying information about the characteristics and personal history of patients. Manuscripts that report the results of experimental investigations with human subjects must include a statement that informed consent was obtained after the procedure(s) had been fully explained. Where children are involved, authors are asked to include information about whether assent was also obtained from the child's legal guardian.

1. General guidelines

- Papers are accepted in English, French, German, Spanish, Italian and Portuguese. American English spelling and punctuation is preferred.
- There is no word limit for articles.
- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; appendixes (as appropriate); references; table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

- Abstracts of 100 words are required for all papers submitted.
- Keywords are not required for this journal.
- Section headings should be concise.
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- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. References

- References should be listed alphabetically at the end of the article and referred to in the text by name and year in parentheses.
- When a work has at least three authors but fewer than six, all authors' names are given at the first citation in the text; thereafter, only the first author's name is given, followed by et al. When a work has six or more authors, cite only the name of the first author, followed by et al., for the first and subsequent citations. The reference list should contain all authors' names as well as titles of papers.
- Description of the Journal's reference style, Quick guide. Visit CiteRefs for assistance in ensuring accurate referencing according to APA style.

3. Figures

- Figures (photographs, drawings, diagrams, and charts) are to be numbered in one consecutive series of Arabic numerals and should follow the tables, or again be uploaded as separate files. The captions for figures should be listed separately, either at the end of the main document or when prompted on file upload if separate files.
- Photographic images should be of high resolution, showing high contrast.
- Drawings/graphs should be prepared electronically, with sharp lines wide enough to reproduce well when copied (1/4 point or larger). Whenever possible, figures should be submitted in the size they will appear in the journal (maximum width of 5-1/2 inches or 12-1/2 cm) or in a size that can be reduced to that width without losing clarity.

4. Tables

Tables should be numbered and referred to by number in the text in order of their appearance. Each table is to be included on a separate page after the references, or uploaded as a separate file; tables should not be integrated into the text.

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Copyright permission letter template

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- Please ensure that all pages are numbered, and that all tables and figures are included.

To permit anonymous review, identifying information about the authors and their affiliations should not appear in the body of the manuscript. These details (full names, affiliations, postal addresses, telephone and fax numbers and email addresses) must be entered when prompted on submission. One author should be identified as the Corresponding Author. Authors should be aware that should any identifying information be included in the main document, peer-review may go ahead unmasked.

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APPENDIX B: CLINICIAN DEMOGRAPHIC QUESTIONNAIRE

STAFF PERSONAL DETAILS

Participant code and NHS Trust	
Age (yrs)	
Gender	
Ethnic group	
Highest level of education achieved (university degree, A levels, secondary school)	
Professional background	
Years experience in mental health	
Experience and training in psychosocial	
Model of therapy used	
Clients presenting problem	
No of sessions offered to client	
No of sessions not attended by client	

Ethnicity: with which ethnic group do you identify?

White

A British

B Irish

C Any other

Mixed groups

D White & black Caribbean

E White & black African.

F White & Asian

G Any other

Asian or Asian British

H Indian

J Pakistani

K Bangladeshi

L Any other

Black or black British

M Caribbean

N African

P Any other

Other ethnic

R Chinese

S Any other ethnic group

APPENDIX C: CLIENT DEMOGRAPHIC QUESTIONNAIRE

CLIENT PERSONAL DETAILS

Participant code and NHS Trust	
Age (yrs)	
Gender	
Ethnic group (see list)	
Highest level of education achieved (university degree, A levels, secondary school)	
Length of involvement in mental health services	
Number of times you have seen the therapist so far	
No of sessions not attended	
How often do you see your therapist	
Have you seen a therapist before, if yes, please provide details…	

Ethnicity: with which ethnic group do you identify?

White

A British

B Irish

C Any other

Mixed groups

D White & black Caribbean

E White & black African.

F White & Asian

G Any other

Asian or Asian British

H Indian

J Pakistani

K Bangladeshi

L Any other

Black or black British

M Caribbean

N African

P Any other

Other ethnic

R Chinese

S Any other ethnic group

APPENDIX D: PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use " " to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself —or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite —being so fidgety or restless that you have been moving .around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

APPENDIX E: GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use " " to indicate your answer"*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

APPENDIX F: RELATIONSHIP QUESTIONNAIRE

RELATIONSHIP QUESTIONNAIRE

PLEASE READ THE DIRECTIONS!

1. Following are descriptions of four general relationship styles that people often report.

Please read each description and **CIRCLE** the letter corresponding to the style that *best* describes you or is *closest* to the way you generally are in your close relationships.

A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

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

C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

Style A.

Style B.

Style C.

Style D.

2. Please rate each of the following relationship styles according to the extent to which you think each description corresponds to your general relationship style.

A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.

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

C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.

D. I am comfortable without close emotional relationships, It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

	Not at all like me			**Somewhat like me**			**Very much like me**
Style A.	1	2	3	4	5	6	7
Style B.	1	2	3	4	5	6	7
Style C.	1	2	3	4	5	6	7
Style D.	1	2	3	4	5	6	7

APPENDIX G: WORKING ALLIANCE INVENTORY (THERAPIST AND CLIENT)

Working Alliance Inventory

Form T

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her client. As you read the sentences mentally insert the name of your client in place of _____in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you *always* feel (or think) circle the number 7; if it *never* applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is CONFIDENTIAL ; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO *EVERY ITEM.*)

Thank you for your cooperation.

1. I feel uncomfortable with _____.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. _____ and I agree about the steps to be taken to improve his/her situation.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I have some concerns about the outcome of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. My client and I both feel confident about the usefullness of our current activity in therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. I feel I really understand _____.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. _____ and I have a common perception of her/his goals..						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. _____ finds what we are doing in therapy confusing.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
8. I believe _____ likes me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. I sense a need to clarify the purpose of our session(s) for _____.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
10. I have some disagreements with _____ about the goals of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
11. I believe the time _____ and I are spending together is not spent efficiently.						
1	2	3	4	5	6	7

	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
12. I have doubts about what we are trying to accomplish in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
13. I am clear and explicit about what _____'s responsibilities are in therapy.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
14. The current goals of these sessions are important for _____.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
15. I find what _____ and I are doing in therapy is unrelated to her/his current concerns.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
16. I feel confident that the things we do in therapy will help _____ to accomplish the changes that he/she desires.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
17. I am genuinely concerned for _____'s welfare.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
18. I am clear as to what I expect _____ to do in these sessions.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
19. _____ and I respect each other.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
20. I feel that I am not totally honest about my feelings toward _____.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
21. I am confident in my ability to help _____.	1 Never	2 Rarely	3 Occasionally	4 Sometimes	5 Often	6 Very Often	7 Always
22. We are working towards mutually agreed upon goals.	1	2	3	4	5	6	7

	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
23. I appreciate _____ as a person.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
24. We agree on what is important for _____ to work on.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
25. As a result of these sessions _____ is clearer as to how she/he might be able to change.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
26. _____ and I have built a mutual trust.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
27. _____ and I have different ideas on what his/her real problems are.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
28. Our relationship is important to _____.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
29. _____ has some fears that if she/he says or does the wrong things, I will stop working with him/her.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
30. _____ and I have collaborated in setting goals for these session(s).	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
31. _____ is frustrated by what I am asking her/him to do in therapy.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
32. We have established a good understanding between us of the kind of changes that would be good for _____.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
33. The things that we are doing in therapy don't make much sense to _____.	1	2	3	4	5	6	7

	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
34. _____ doesn't know what to expect as the result of therapy.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
35. _____ believes the way we are working with her/his problem is correct.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
36. I respect _____ even when he/she does things that I do not approve of.	1	2	3	4	5	6	7
	Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

Working Alliance Inventory

Form C

Instructions

On the following pages there are sentences that describe some of the different ways a person might think or feel about his or her therapist (counsellor). As you read the sentences mentally insert the name of your therapist (counsellor) in place of _____in the text.

Below each statement inside there is a seven point scale:

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

If the statement describes the way you ***always*** feel (or think) circle the number 7; if it ***never*** applies to you circle the number 1. Use the numbers in between to describe the variations between these extremes.

This questionnaire is **CONFIDENTIAL**; neither your therapist nor the agency will see your answers.

Work fast, your first impressions are the ones we would like to see.
(PLEASE DON'T FORGET TO RESPOND TO ***EVERY*** *ITEM.*)

Thank you for your cooperation.

1. I feel uncomfortable with _____.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
2. _____ and I agree about the things I will need to do in therapy to help improve my situation.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
3. I am worried about the outcome of these sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
4. What I am doing in therapy gives me new ways of looking at my problem.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
5. _____ and I understand each other.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
6. _____ perceives accurately what my goals are.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
7. I find what I am doing in therapy confusing.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
8. I believe _____ likes me.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
9. I wish _____ and I could clarify the purpose of our sessions.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
10. I disagree with _____ about what I ought to get out of therapy.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always
11. I believe the time _____ and I are spending together is not spent efficiently.						
1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

12. _____ does not understand what I am trying to accomplish in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

13. I am clear on what my responsibilities are in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

14. The goals of these sessions are important for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

15. I find what _____ and I are doing in therapy is unrelated to my concerns.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

16. I feel that the things I do in therapy will help me to accomplish the changes that I want.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

17. I believe _____ is genuinely concerned for my welfare.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

18. I am clear as to what _____ wants me to do in these sessions.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

19. _____ and I respect each other.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

20. I feel that _____ is not totally honest about his/her feelings toward me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

21. I am confident in _____ 's ability to help me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

22. _____ and I are working towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

23. I feel that _____ appreciates me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

24. We agree on what is important for me to work on.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

25. As a result of these sessions I am clearer as to how I might be able to change.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

26. _____ and I trust one another.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

27. _____ and I have different ideas on what my problems are.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

28. My relationship with _____ is very important to me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

29. I have the feeling that if I say or do the wrong things, _____ will stop working with me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

30. _____ and I collaborate on setting goals for my therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

31. I am frustrated by the things I am doing in therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

32. We have established a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

33. The things that _____ is asking me to do don't make sense.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

34. I don't know what to expect as the result of my therapy.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

35. I believe the way we are working with my problem is correct.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

36. I feel _____ cares about me even when I do things that he/she does not approve of.

1	2	3	4	5	6	7
Never	Rarely	Occasionally	Sometimes	Often	Very Often	Always

APPENDIX H: CLIENT ATTACHMENT TO THERAPIST SCALE

These statements refer to how you currently feel about your therapist. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

	Strongly Agree	**Some-what disagree**	**Slightly disagree**	**Slightly agree**	**Some-what agree**	**Strongly agree**
1. I don't get enough emotional support from my therapist.						
2. My therapist is sensitive to my needs.						
3. I think my therapist disapproves of me.						
4. I yearn to be "at one" with my therapist.						
5. My therapist is dependable.						
6. Talking over my problems with my therapist makes me feel ashamed or foolish.						
7. I wish my therapist could be with me on a daily basis						
8. I feel that somehow things will work out okay for me when I am with my therapist.						
9. I know I could tell my therapist anything and s/he would not reject me.						
10. I would like my therapist to feel closer to me.						
11. My therapist isn't giving me enough attention.						
12. I don't like to share my feelings with my therapist.						
13. I would like to know more about my therapist as a person						
14. When I show my feeling, my therapist responds in a helpful way.						
15. I feel humiliated in my therapy sessions.						
16. I think about calling my therapist at home.						

	Strongly Agree	Some-what disagree	Slightly disagree	Slightly agree	Some-what agree	Strongly agree
17. I don't know how to expect my therapist to react from session to session.						
18. Sometimes I'm afraid that if I don't please my therapist s/he will reject me.						
19. I think about being my therapists favourite client.						
20. I can tell that my therapist enjoys working with me.						
21. I suspect my therapist probably isn't honest with me.						
22. I wish there were a way I could spend more time with my therapist.						
23. I resent having to handle problems on my own when my therapist could be more helpful.						
24. My therapist wants to know more about me than I am comfortable talking about.						
25. I wish I could do something for my therapist to,						
26. My therapist helps me to look closely at the frightening or troubling things that have happened to me.						
27. I feel safe with my therapist.						
28. I wish my therapist were not my therapist so that we could be friends.						
29. My therapist is a comforting presence to me when I am upset.						
30. My therapist treats me more like a child than an adult.						
31. I often wonder about my therapist's other clients						
32. I know my therapist will understand the things that bother me.						

	Strongly Agree	Some-what disagree	Slightly disagree	Slightly agree	Some-what agree	Strongly agree
33. It's hard for me to trust my therapist.						
34. I feel sure that my therapist will be there if I really need her/him.						
35. I'm not certain that my therapist is all that concerned about me.						
36. When I'm with my therapist, I feel I am his/her highest priority.						

APPENDIX I: PSYCHOLOGICAL MINDEDNESS SCALE

45 statements are listed below. Each statement is followed by four options:

Strongly agree; Mostly agree; Mostly disagree; Strongly disagree

Please select the option which best describes how you feel about each statement

	Strongly Agree	**Mostly Agree**	**Mostly Disagree**	**Strongly Disagree**
1. I would be willing to talk about my personal problems if I thought it might help me or a member of my family				
2. I am always curious about the reasons people behave as they do				
3. I think that most people who are mentally ill have something physically wrong with their brain.				
4. When I have a problem, if I talk about it with a friend, I feel a lot better.				
5. Often I don't know what I'm feeling				
6. I am willing to change old habits to try a new way of doing things.				
7. There are certain problems which I could not discuss outside my immediate family.				
8. I often find myself thinking about what made me act in a certain way.				
9. Emotional problems can sometimes make you physically sick.				
10. When you have problems, talking about them with other people just makes them worse.				
11. Usually, if I feel an emotion, I can identify it.				
12. If a friend gave me advice about how to do something better, I'd try it out.				
13. I am annoyed by someone, whether he is a doctor or not, who wants to know about my personal problems.				
14. I find that once I develop a habit, it is hard to change, even if I know there is another way of doing things that might be better.				
15. I think that people who are mentally ill often have problems which began in their childhood.				
16. Letting off steam by talking to someone about your problems often makes you feel a lot better.				
17. People sometimes say that I act as if I'm having a certain emotion (anger, for example) when I am unaware of it.				
18. I get annoyed when people give me				

	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree
advice about changing the way I do things.				
19. It would not be difficult for me to talk about personal problems with people such as doctors and clergymen.				
20. If a good friend of mine suddenly started to insult me, my first reaction might be to try to understand why he was so angry.				
21. I think that when a person has crazy thoughts, it is often because he/she is very anxious and upset.				
22. I've never found that talking to other people about my worries helps much.				
23. Often, even though I know that I'm having an emotion, I don't know what it is.				
24. I like to do things the way I've done them in the past. I don't like to try to change my behaviour much.				
25. There are some things in my life that I would not discuss with anyone.				
26. Understanding the reasons you have deep down for acting in certain ways is important				
27. At work, if someone suggested a different way of doing a job that might be better, I'd give it a try				
28. I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of before				
29. I am sensitive to the changes in my own feelings				
30. When I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before				
31. It is important to be open and honest when you talk about your troubles with someone you trust				
32. I really enjoy trying to figure other people out				
33. I think that most people with mental problems have probably received some kind of injury to their head				
34. Talking about your worries to another person helps you to understand problems better				
35. I'm usually in touch with my feelings				
36. I like to try new things, even if it involves taking risks				
37. It would be very difficult for me to discuss upsetting or embarrassing aspects				

	Strongly Agree	Mostly Agree	Mostly Disagree	Strongly Disagree
of my personal life with people, even if I trust them				
38. If I suddenly lost my temper with someone, without knowing exactly why, my first impulse would be to forget about it				
39. I think that what a person's environment (family, etc.) is like has little to do with whether he develops mental problems				
40. When you have troubles, talking about them to someone else just makes you more confused				
41. I frequently don't want to delve too deeply into what I'm feeling				
42. I don't like doing things if there is a chance that they won't work out				
43. I think that no matter how hard you try, you'll never really understand what makes people tick				
44. I think that what goes on deep down in a person's mind is important in determining whether he will have a mental illness				
45. Fear of embarrassment or failure doesn't stop me from trying something new				

APPENDIX J: THERAPIST INFORMATION SHEET

Client and clinician attachment styles, psychological mindedness and the working alliance

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Ask us if there is anything that is not clear or you would like more information about. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

We are inviting you to take part in a study looking at the attachment styles of staff and patients and its effect on the therapeutic relationship. The study will look at what things are important in the relationship between staff and patients, and how we view relationships more generally. The study will also explore the role of psychological mindedness in attachment style and the working alliance.

Part of this project is being completed as part of a doctorate in clinical psychology and is funded by the National Institute of Health Research.

Why have I been invited to take part?

We are approaching all therapists who work within Primary Care Services and have worked with the client for at least 3 therapy sessions. The unit manager has agreed for us to approach you.

What will I have to do if I take part?

We would like to recruit a total of 50 staff and 50 patients care services. If you decide to take part, you will be asked to complete a questionnaire about your relationship with the next client you have been allocated to work with who reaches their third therapy session. You will be asked to give this client an information sheet, a consent sheet and a questionnaire, which the researcher will give you. If the client agrees to take part they will complete their questionnaire and return it to the researcher in sealed envelope. The researcher will supply a stamped addressed envelope for you to return your questionnaire and consent form.

The questionnaire will ask you about your experience of relationships, the working alliance between you and your client and your level of psychological mindedness as well as any feelings of anxiety and depression. The questionnaire will take no longer than 40 minutes in total.

Will my taking part be kept confidential?

Information which is collected during the course of the study will be strictly confidential, although we do have a responsibility to inform your manager if you tell us information that suggests you or someone else might be harmed. If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. Your name will not appear on any of the forms, we will give you a study number instead. Copies of consent forms may be reviewed by the Trust Clinical Audit Department to confirm that you have given written

informed consent. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What are the possible risks of taking part?

The questions in the questionnaire are simple and unlikely to cause you any distress or harm. Please respond to every question. If you do feel distressed as a result of the interview you can contact the researcher at the University on 0161 306 0400.

Are there any possible benefits?

We cannot promise the study will help you but the information we get from this study will help us to better understand attachment styles and the effect they may have on the relationship between staff and clients.

The findings will be fed back to interested participants at the end of this time period. You will not be identified in any report of the study.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason and this will not affect your position within the Trust. If you take part but later change your mind, you can withdraw at any time from the study without affecting the standard of your care. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.

What do I do now?

A researcher from the study will contact you in a few days. She will go through the information sheet with you and answer any questions you have. We'd suggest this should take about 10 minutes. You can let her know if you are interested in taking part.

What do I do of something goes wrong?

If you wish to make a complaint, you can contact a University Research Practice and Governance Coordinator.

Tel: 0161 2757583 or 0161 2758093

Email: research-governance@manchester.ac.uk

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs.

The normal National Health Service complaints mechanisms will still be available to you.

Thank you very much for considering taking part in our research. Please discuss this information with your family, friends or colleagues if you wish.

APPENDIX K: CLIENT INFORMATION SHEET

Client and clinician attachment styles, psychological mindedness and the working alliance

You are being invited to take part in a research study. Before you decide if you want to take part, it is important for you to understand why the research is being done and what it will involve. Ask us if there is anything that is not clear or you would like more information about. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

We are inviting you to take part in a study looking at the attachment styles of staff and patients and its effect on the therapeutic relationship. The study will look at what things are important in the relationship between staff and patients, and how we view relationships more generally.

Part of this project is being completed as part of a doctorate in clinical psychology and is funded by the National Institute of Health Research.

Why have I been invited to take part?

We are approaching all patients who are in Primary Care Services and have been working with their therapist for at least 3 sessions.

What will I have to do if I take part?

We would like to recruit a total of 50 staff and 50 patients in primary care services. If you decide to take part, you will be asked to complete a questionnaire that will ask you about your relationship with your therapist and your view of relationships generally. You will also be asked questions about your symptoms.

The questionnaire will take no longer than 40 minutes in total and can be completed at the service or you can take it home to complete. You will be asked to return your questionnaire in a sealed envelope to your therapist.

Will my taking part be kept confidential?

Information which is collected during the course of the study will be strictly confidential, although we do have a responsibility to inform your key worker if you tell us information that suggests you or someone else might be harmed. If you agree to take part in the study, any information you give the researcher will be kept strictly confidential and will conform to the Data Protection Act of 1998 with respect to data collection, storage and destruction. Your name will not appear on any of the forms, we will give you a study number instead. As you are under the care of a mental health NHS Trust, a copy of your consent form will be copied into your usual medical notes and this copy may be reviewed by the Trust Clinical Audit Department to confirm that you have given written informed consent. With your permission, we would like to inform your Doctor if you agree to take part in the study. Responsible individuals from the University of Manchester may also look at the research records to audit the conduct of the research.

What are the possible risks of taking part?

The questions in the questionnaire are simple and unlikely to cause you any distress or harm. Please respond to every item on the questionnaire. If you do feel distressed as a result of the questionnaire you can contact the researcher at the University on 0161 306 0400. If you are feeling very distressed out of office hours, we suggest you speak to your key worker or other staff on the unit.

Are there any possible benefits?

We cannot promise the study will help you but the information we get from this study will help us to better understand attachment styles and the effect they may have on the relationship between staff and clients.

The findings will be fed back to interested participants at the end of this time period. You will not be identified in any report of the study.

Do I have to take part?

No, taking part is voluntary. If you would prefer not to take part you do not have to give a reason. Staff involved in your care will not be upset and your treatment will not be affected. If you take part but later change your mind, you can withdraw at any time from the study without affecting the standard of your care. If you do decide to take part you will be given this information sheet to keep and asked to sign a consent form.

What do I do now?

Your therapist will contact you in a few days. S/he will ask you if you would like to take part. If you would like to take part s/he will give you a consent form to sign and the questionnaire to complete.

What do I do of something goes wrong?

If you wish to make a complaint, you can contact a University Research Practice and Governance Coordinator.

Tel: 0161 2757583 or 0161 2758093

Email: research-governance@manchester.ac.uk

In the event that something does go wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against the University of Manchester, but you may have to pay for your legal costs.

The normal National Health Service complaints mechanisms will still be available to you.

Thank you very much for considering taking part in our research. Please discuss this information with your family, friends or mental health team if you wish.

APPENDIX L: THERAPIST CONSENT FORM

Participant identification number :.....

Centre Number :.....

Title: Client and clinician attachment styles, psychological mindedness and the working alliance

Name of Investigator: Annily Seymour-Hyde

Please initial the boxes

1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
3.	I understand that my responses will remain confidential	☐
4.	I agree to take part in the above study.	☐

Name of Participant	Date	Signature
Researcher	Date	Signature

APPENDIX M: CLIENT CONSENT FORM

Patient identification number :.....

Centre Number :.....

Title: Client and clinician attachment styles, psychological mindedness and the working alliance

Name of Investigator: Annily Seymour-Hyde

Please initial the boxes

1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected.	☐
3.	I understand that information from my medical notes, may be looked at by individuals from the University of Manchester, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.	☐
4.	I understand that my responses will remain confidential	☐
5.	I agree to take part in the above study.	☐
6.	I consent to my doctor being informed about my involvement in this study.	☐

Name of Patient	Date	Signature
Researcher	Date	Signature