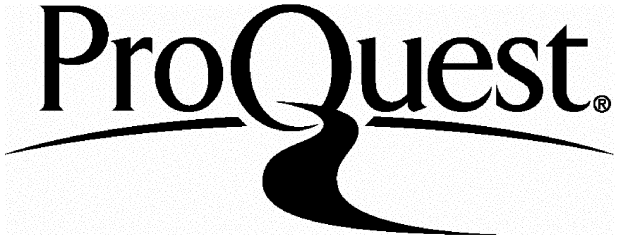
Attachment Patterns and the Early Working Alliance:

A Study of Patient and Therapist Reports of Alliance Quality and Ruptures.

Victoria Eames

Doctoral Thesis in Clinical Psychology, 1998. Volume I



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

ACKNOWLEDGEMENTS

Particular thanks to Tony Roth for his excellent and enthusiastic supervision.

Jeremy Safran for his interest, advice and prompt e-mails.

Matthew Jones-Chesters for his useful suggestions

Robin Johnson for his support throughout.

CONTENTS

ABSTRACT

The current study was an exploratory investigation of the relationships between self-reported attachment patterns in adults and the early therapeutic alliance. Attachment style was measured by self-report following the first session of therapy. The alliance was studied in terms ratings of its quality and tensions or 'ruptures' reported following sessions 2, 3, 4 and 5, among a sample of 30 patients and 12 therapists. The results were analysed using correlation and multiple regression statistics and the findings suggest that different attachment styles are associated with different patterns of alliance difficulties. In line with predictions, fearfulness in attachment style was a significant predictor of lower patient rated alliance at session 5, especially on the subscales measuring goal an task agreement. Against expectations, a dismissing style was associated with higher alliance ratings at session 5. In addition, the rate at which ruptures were reported varied with attachment style. High preoccupied scores were associated with increased rupture reporting and high dismissing scores were associated with decreased rupture reporting. Implications for clinical understanding and future research are discussed.

INTRODUCTION

Most researchers agree that psychotherapy has been proven to be helpful to many people. Talking therapies are now well established as effective, over and above wait list controls, drug treatments and psychiatric case management (e.g., Andrews & Harvey, 1981; Landman & Dawes, 1982; Roth & Fonagy, 1996; Shapiro & Shapiro, 1982; Smith, Glass & Miller, 1980; Stiles, Shapiro & Elliot, 1986). The current challenge for psychotherapy research is to understand the nature of successful therapy so that as clinicians we can ensure we do more of what works and less of what doesn't.

Efficacy studies have demonstrated little reliable difference between the major treatment approaches (e.g., Greenberg & Pinsoff, 1987; Shapiro & Shapiro, 1983). In contrast, research on the 'common variables' present in all therapies has proved a popular and lucrative line of inquiry over the last couple of decades. However, the much quoted Luborsky comment *'everyone has won and all shall have prizes'* disguises the complexity of the issue. Indeed, the common variables account for much of the outcome variance but there is also evidence that different types of therapy suit different types of people (see Roth & Fonagy, 1996 for a review). In addition, clinicians are also required to continually adjust *within* approach to meet the therapeutic needs of individual patients as there is increasing evidence that a rigid adherence to technique can be unhelpful or even harmful (Castonguay *et al.,* 1996). This is where the significance of the therapeutic relationship becomes apparent. Rigidity in approach may be unhelpful as it ignores what is fast being established as the backbone of effective psychotherapy; the working alliance between patient and therapist.

Some of the major models underlying the empirical investigation of the common variables, and the therapeutic relationship in particular, have included; Roger's (1951) client-centred theory, Greenson's (1967) psychodynamic perspective on the working alliance and Bordin's (1975) transtheoretical re-formulation of the working alliance. A considerable amount of research to date has provided support for the importance of the therapeutic alliance in particular; a good alliance[1] has been frequently linked with good outcome and research is now beginning to capture the role of the alliance in the moment to moment transactions of therapy process. Defined broadly as the collaborative bond between therapist and patient (Krupnick *et al.,* 1996) the alliance is now widely viewed as a vital component of successful psychotherapy, *'the quintessential integrative variable'* (Wolfe & Goldfried, 1988).

While the research evidence confirms that the quality of the alliance is critical across therapeutic approach, the specific variables mediating its quality and role will vary as a function of complex, interdependent and fluctuating factors related to therapist, patient and therapeutic approach (Safran & Segal, 1990). The alliance as a construct is therefore conceptually rich and also more complex than it initially appears.

The Therapeutic Relationship and the *Alliance*

The Psychoanalytic Origins

Thinking about the therapeutic relationship originated in psychoanalytic theory. Psychoanalytic writing has mainly concentrated upon the transferential relationship,

[1] The terms *working alliance, therapeutic alliance,* and *helping alliance* have been used by writers to refer to either the alliance as a whole or specific aspects of it. For simplicities sake I shall use the term *alliance* to refer to the construct in the generic sense.

classically defined as the re-emergence of the individual's earlier relationship with parental figures, experienced with a strong sense of immediacy within the therapeutic relationship (Laplanche & Pontalis, 1988). In analysis, the interpretation and resolution of the transference are thought to increase insight and in turn reduce distress/symptomatology. As Alexander & French put it (1946, pp.66-67);

'The old pattern was an attempt at adaptation on the part of the child to parental behaviour . . . the analyst's objective and understanding attitude allows the patient to make a new settlement of the old problem . . . while the patient continues to act according to outdated patterns, the analyst's reaction conforms strictly to the actual therapeutic situation.'

However, the transaction described above cannot be fully understood only in terms of transference; there must be another aspect to the therapeutic relationship which enables the patient to bear to look at their own behaviour patterns and confront difficult feelings. When patterns are re-enacted in the transference, some part of the patient must understand that this is an aspect of their difficulties if they are to remain in therapy. They also need to believe, on some level, that the therapist's aim is to help them recognise and understand their behaviour patterns so they can move towards a new resolution. This aspect of the therapeutic relationship has come to be understood in terms of the *working* or *therapeutic alliance.*

Early views on the alliance also originate within psychoanalytic theory. Freud (1912) spoke of the critical importance of the presence of a bond between patient and analyst. Freud explained this aspect of the relationship within the bounds of the transference construct, arguing that the analyst's efforts to establish rapport revived transference relating to positive early experiences with caregivers. However, in later papers he appeared to acknowledge the presence of a helpful patient-therapist attachment grounded in reality, rather than just the projections of the patient. Later

psychoanalytic writers continued to explore the patient's realistic attachment to the analyst and the factors important in creating a strong therapeutic partnership (e.g., Zetzel, 1956). Particularly, Greenson (1965) differentiated certain aspects of the alliance from the transference by describing it as the rational rapport between patient and analyst and contrasting it with the less conscious and irrational transference;

'. . . the relatively non-neurotic, rational and realistic attitudes of the patient toward the analyst . . . it is this part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with the analyst despite the neurotic transference reactions' (Greenson, 1967, p29).

However, there are some psychoanalytic writers who maintain that all aspects of the therapeutic relationship are transference based (e.g., Brenner, 1979; Curtis, 1979; cited in Horvath & Luborsky, 1993), and that behind the 'alliance' may be the patient's attempts to gain the therapist's approval or covert rivalry. From this perspective the therapeutic relationship is not a 'real' relationship but consists of the patient's misperceptions based upon unresolved aspects of past relationships. Others argue that all human interactions are prejudiced by previous interpersonal experiences and that the alliance is a reflection of both this and the current interpersonal synergy between patient and therapist (Piper, Azim, Joyce & McCallum, 1991a). These ideas raise a key issue which is the extent to which the patient's previous relationship experiences influence the development of the alliance.

The Client-Centred View

Rogers (1951, 1957) was also very interested in the therapeutic relationship. In his very influential work he defined the active components of the therapeutic relationship as empathy, unconditional positive regard and congruence. Rogers'

work played a vital role in generating research and made a particularly important contribution in focusing attention on the patient as an active force in the change process. While research shows that Rogers' Therapist Offered Conditions (TOC's) are closely related to alliance strength, it seems that the role of these variables is not as direct or generalisable as researchers had originally hoped. Research suggests that it is the patient's perception of the therapist as empathic that is most robustly correlated with outcome, rather than the actual behaviour of the therapist (e.g., Gelso & Carter, 1985; Mitchell, Bozarth & Krauft, 1977; cited in Horvath & Luborsky, 1993; Parloff, Waskow & Wolfe, 1978). This finding again relates to the question of the extent to which patients' previous relationships might influence their experience of the therapist. It seems likely that patients who had empathetic and understanding parents are more likely to experience others, including their therapist as empathetic. Roger's emphasis on the behaviour of the therapist meant he did not address the issue of variations in the patient's motivation and ability to make use of the TOC's. Such patient pre-therapy characteristics are now known to be strongly related to outcome (Orlinsky, Grawes & Parks; in Bergin & Garfield, 1994). How such factors relate to alliance development needs further exploration.

The Cognitive-Behavioural View

In the 1970's even behavioural psychologists, who tended to emphasise the technical aspects of therapy, began to acknowledge the importance of collaboration between patient and therapist in successful treatment; for example, Beck (1976) spoke of a 'collaborative empiricism' between patient and therapist. Current Cognitive-Behavioural theorists and clinicians are recognising the importance of the therapeutic relationship and particularly the alliance in the facilitation of therapeutic process (e.g., Goldfried & Davison, 1976, 1994; cited in Raue *et al.,* 1997; Raue & Goldfried, 1994). Researchers are now beginning to investigate how the different

technical aspects of cognitive-behavioural therapy (CBT) may relate to common variables like the alliance (e.g., Castonguay *et al.,* 1996).

Bordin's Transtheoretical Model of the Alliance

In response to the general consensus about the importance of the alliance, Bordin (1979) drew upon these various influences and reformulated the construct to provide a transtheoretical model. Bordin argues that all psychotherapies have an embedded alliance of some sort. Like Greenberg, Bordin clearly distinguished between the unconscious projections of the patient (i.e., the transference) and the working alliance. In contrast to the client-centred conception of the relationship, Bordin emphasised both patient **and** therapist contributions to the therapy - the alliance is described as the collaborative relationship between the patient seeking change and the therapist acting as a change agent. Patient and therapist are conceptualised as joining together in the struggle against the common enemy of the patient's difficulties. Bordin (1994) argues that there are three key elements in alliance theory that have a bearing on therapeutic change; a) the strength of the alliance, b) the power of therapeutic tasks, and c) the dynamics of strains in the alliance. The strength of the working alliance will depend on the closeness of the fit between the particular demands of the therapy and the personal characteristics of patient and therapist. The necessary requirements of a good working alliance are described more specifically by Bordin in terms of three factors; bond, goals and tasks. A mutual understanding and agreement about the change goals of therapy and the tasks required to meet these goals is mediated by the presence of a bond between patient and therapist to maintain the work.

Goals and tasks

Bordin differentiates between therapeutic approaches according to the nature of the goals of change and the therapeutic tasks set to accomplish these goals. The nature and scope of the goals ranges from those directed toward *all* the individual's ways of thinking, feeling and acting, as in the psychoanalytic perspective, to those aimed at specific, explicitly stated problem areas, as in the behavioural approach. Tasks are distinguished from goals as the specific activities designed to move the patient toward their change goals. Again, the nature of the therapeutic tasks differ according to approach. In behaviour therapy the tasks are more prescribed, for example a diary recording the problem behaviour. In psychoanalytic work self-observation of inner experience is required. Bordin suggests that the effectiveness of such tasks will depend upon the extent to which the therapist can demonstrate the link between the task and the patient's sense of their difficulties.

Bonds

Some basic level of trust between patient and therapist is required for all forms of psychotherapy. However, Bordin (1979) suggests that the nature of the bond will differ according to the nature of the tasks shared; a deeper level of trust will be needed and developed when the patient is relating their innermost experience or memories of painful events. The debate about how the concepts of transference and the real relationship may differ from one another continues in the literature on bonding (e.g., Horvath & Greenberg, 1994). Bordin (1994) argues that these different aspects of the therapeutic relationship are sometimes relatively independent, at others intertwined and mutually augmented but are likely to be subject to different change dynamics. When the bond between patient and therapist is strong enough they will be able to cope with the pathological aspects of the transference which work against change.

Strains

Bordin uses the term strain to describe the appearance of a significant deviation in the patient's commitment to the work. Such problems could emerge in relation to goals, tasks or bonds. Bordin relates the idea of the dynamics of strains to the psychoanalytic emphasis on the interpretation of resistance; working through defence or transference based interference within the therapeutic work is fundamental to achieving change. Such difficulties can also be described in non-psychodynamic terms; the problems for which the patient seeks help are manifested in the process of a) entering into the therapeutic task (for example, avoidance of facing difficult experiences or feelings), and b) entering into a relationship with the therapist (for example problems with commitment). The aim is to develop a more helpful mode of response in the therapeutic setting which can be generalised to other situations and relationships.

Research on the Alliance

Over the last two decades the alliance has been studied in relation to patient, therapist, process and outcome variables. There is now a large amount of evidence suggesting that the quality of the alliance in the initial stages of therapy is predictive of a sizeable proportion of the final outcome variance (e.g., Alexander & Luborsky, 1986; Greenberg & Pinsoff, 1986; Horvath & Symonds, 1991; Orlinsky & Howard, 1986). The alliance has been measured from different perspectives (patient, therapist and observer), across different treatment populations and therapeutic modalities. The findings are consistently similar; the alliance as a variable seems to have a more robust relation to outcome than other relationship factor (Horvath & Greenberg, 1994). A good alliance is more than a by-product of therapeutic progress (Horvath & Luborsky, 1993). In fact, it is most associated with outcome at

the beginning of therapy when one would expect therapeutic gains to be limited (Horvath & Symonds, 1991). When therapy gains are controlled for statistically the alliance predicts 36% to 57% of the outcome variance (e.g., Gaston *et al.,* 1991; Barber, Crits-Cristoph & Luborsky, 1992).

Factors in Alliance-Outcome Relations

Some of the factors which have been found to influence the relation between alliance ratings and therapeutic outcome have included:

Perspective

Consistently, across all instruments, the therapist ratings of the alliance have been significantly less predictive of outcome when compared to the patient and observer reports (Horvath & Symonds, 1991). This could suggest that therapists are a poorer judge of the relationship. Henry & Strupp (1994) argue that the therapists own early object relations may bias their judgement. The finding may also, to some extent, reflect a measurement fault; the therapist scales are re-wordings of the patient versions so the specific experience of the therapist may not be being fairly represented. Both therapist and patient ratings are likely to reflect their cumulative experience, influenced by their response to previous sessions. In contrast, observer ratings are more of a 'snapshot' (Horvath, 1994). Therapist's cumulative experience may be influenced by different factors when compared to patients.

Evidence regarding how the patient and therapist view might relate is limited. There is evidence that patients and therapists value different aspects of therapy process. Llewelyn (1988) found that therapists were more likely to report insight events (defined as patient sees something new about self, sees links; a sense of newness is experienced) and misdirection events (defined as patient feels confused or

sidetracked from important thing; therapist interfered) whereas patients were more likely to report reassurance (patient feels supported, relieved, more hopeful or more confident), disappointment (patient feels disappointed), understanding (patient feels understood) and at termination, problem solution (possible ways of coping are worked out, or rehearsed in the session) events. Llewelyn provides an interesting example of the difference in perspective; when describing the same session the client described the most helpful event as, *"working out how to cope with my mother's nagging when she visits next week"* (coded as problem solution), whereas the therapist's most helpful event was, *"realising how she is repeating with me the hostile feelings she has towards her mother"* (coded as insight). In retrospect, both therapists and patients agreed that personal contact (patient experiences contact with the therapist as a person) was important. In terms of outcome, where outcome was better, more problem solution events were reported and when outcome was poorer, more disagreement between patient and therapist was found. However, even when outcome was good there were notable differences between perceptions. Llewelyn suggests that some discrepancy between patient and therapist may be important to stimulate therapeutic movement. Overall, different aspects of therapeutic process seem to have salience for patients when compared to therapists. However, the nature and meaning of the discrepancy between therapist and patient ratings of the alliance is not yet understood. Such knowledge will be important if the understanding of the alliance as a construct is to prove a useful tool for improving therapy (Horvath & Luborsky, 1993).

Therapeutic Approach

Horvath & Symonds (1990) conducted a meta-analysis of relevant studies and concluded that the alliance is significantly associated with outcome across therapeutic modality. However, there is evidence that there may be some variation in the role of the alliance in different therapeutic approaches. Recent studies comparing the strength of the alliance across approach have found mixed results. Some find no significant differences (e.g., Salvio *et al.,* 1992; Krupnick *et al.,* 1996), while others have found higher alliance levels in CBT sessions when compared to psychodynamic interpersonal sessions (e.g., Rau, Castonguay & Goldfried, 1993; Raue, Goldfried & Barkham, 1997). The mixed results may reflect methodological distinctions; the use of different measures, patient versus observer ratings, brief manualised versus ongoing naturalistic therapy. Raue, Goldfried & Barkham (1997) also argue that the differences may reflect the tendency in CBT to concentrate on positive experience and coping strategies, as opposed to the psychodynamic tendency to focus on the more negative aspects of experience and specifically on strains in the therapeutic relationship.

A very interesting recent finding sheds further light on the interplay between the role of the alliance and approach-specific techniques. Castonguay *et al.,* (1996) found that good outcome was indeed predicted by the therapeutic alliance in a study of cognitive therapy for depression. They also found that an aspect of cognitive therapy; focusing on the impact of distorted cognitions on depressive symptoms, was negatively related to outcome. In other words, a major technique associated with cognitive therapy appears to worsen the symptoms of depression. However, the crucial finding was that this result lost significance when the quality of alliance was statistically controlled for. A descriptive analysis suggested that in the low outcome cases the therapists were responding to alliance difficulties with a rigid

adherence to cognitive techniques, which in turn seemed to worsen alliance strains and disrupt therapeutic progress. In other words, it appears that certain therapeutic techniques may only be beneficial if utilised in the context of a good alliance.

Alliance Phase

The early alliance appears to be slightly more predictive of outcome compared to the mid or late phases (Horvath & Symonds, 1991; Piper *et al.,* 1991a; Piper *et al.,* 1991b). This makes some clinical sense in that if a patient and their therapist fail to develop trust or are unable to come to a mutual understanding of the aims of therapy in the first few sessions, the patient is likely to disengage themselves from therapy (whether literally or on a purely emotional level). Indeed, first-session alliance measures are predictive of drop-out (Kokotovic & Tracey, 1990; Plotnicov, 1990). Detailed analysis of the alliance over time suggests that the effectiveness of therapy in the later phases may be related to the extent to which strains in the alliance are confronted and resolved (e.g., Safran, Muran & Wallner Samstag, 1992; Safran & Muran, 1996).

Relatively little is actually known about the factors contributing to the establishment of a good alliance. There is now agreement among the major workers in this area that there is a need to move on from measuring the predictive validity of the alliance towards studies which enhance our understanding of mediating factors in alliance development (e.g., Horvath & Greenberg, 1994; Safran & Muran, 1994).

Process of alliance development

In the last few years some researchers have begun studying the process of alliance development. Therapy is often described in the literature as a phasic process (e.g., Sexton, Hembre & Kvarme, 1996; Tracey, 1987, 1993), consisting of a beginning

phase concentrating on the development of an alliance, a middle or 'work' phase and an end phase characterised by work on the reinforcement of therapeutic gains. A consistent finding is that the alliance is established in the beginning phase of therapy, remains relatively constant and is resistant to change (Eaton, Abeles & Gutfreund, 1988; Horvath, 1981; Luborsky, 1988; Saltzman *et al.,* 1976; Sexton, Hembre & Kvarme, 1996). The beginning phase is therefore of critical importance and deserves close investigation. However, to date research has tended to concentrate on the midphase. Less is understood about the transactions in the early build up of the alliance.

Adequate levels of trust and collaboration must be achieved during the early phase. It seems likely that therapist and patient will have established some agreement on the long-term goals of therapy early on in discussions about the patient's reasons for wanting therapy. However, the short- and medium-term expectations of therapist and patient may differ significantly; '*Clients seek speedy relief from the pain that brought them to therapy, whereas the therapist perceives treatment as a process which will lead to the eventual but not necessarily immediate relief of the client's suffering'* (Horvath & Symonds, 1991). Horvath & Greenberg (1994) speak of a 'good enough' early alliance, describing alliance development in the first phase of therapy as a series of windows of opportunity, decreasing in size with each session. The patient's anxiety and hopes of unrealistically quick relief may in itself create strains in the alliance which are increasingly difficult to confront as time passes. Such conceptualisations of the early alliance need further exploration.

The work phase is characterised in the alliance literature as beginning when the therapist starts to challenge the patient's 'maladaptive' behaviours (e.g., Horvath & Symonds, 1991). The patient is likely to experience such interventions negatively;

they may be felt as a reduction in sympathy or support , a criticism or rejection. This may in turn lead to strains in the alliance. It seems likely the way the patient experiences such therapist activity will depend upon expectations and beliefs developed in response to previous relationships. As already mentioned, there is evidence to suggest that the success of therapy may depend upon the ability of patient and therapist to resolve such difficulties (Crits-Cristoph, Barber & Kurcias, 1991; Safran, Muran & Wallner Samstag, 1992; Safran & Muran, 1996). Presumably when this aspect of the process begins will depend upon factors like the therapist's style, therapeutic approach, and their judgement of the readiness of the patient.

Strains in the alliance

Zetzel (1956) and Bordin (1989) suggested that successful therapy would be characterised by cycles of rupture and repair of the alliance. While the strength of the alliance is relatively stable over time when scores are averaged *across* cases (Gaston *et al.,* 1992), there is evidence that there is notable fluctuation in alliance strength *within* individual cases (Horvath & Marx, 1991).

In a major research programme, Safran and his colleagues have been attempting to develop a model of the processes involved in resolving strains or *ruptures* in the alliance (Safran, Crocker, McMain & Murray, 1990; Safran, Muran & Samstag, 1994; Safran & Muran, 1996). A rupture is broadly conceived as a negative shift in the quality of the alliance or an ongoing problem in establishing one. The term 'rupture' is a little misleading as it seems to suggest an intense event. Conceptually, ruptures may vary in intensity and duration from subtle miscommunications between therapist and patient to major barriers in the establishment of the alliance. More specifically, ruptures can be defined as patient communications which are *interpersonal markers* indicating critical points for exploration. Safran (1993) suggests that ruptures may

emerge when the therapist is drawn into *maladaptive interpersonal cycles* characteristic of the patient's dysfunctional interactions in other areas of their life and hypothesises that these behaviours are representative of the patient's *dysfunctional interpersonal schemas.*

The concept of ruptures in the alliance overlaps with other concepts such as empathic failure or resistance (Safran & Muran, 1996). However, an advantage of the rupture concept is that it emphasises the interactional nature of the phenomenon rather than placing the responsibility purely on patient or therapist. It is also a useful perspective from which to explore the more subtle interpersonal processes assumed to be involved in the therapeutic interaction (Safran, 1993).

In their investigations Safran and colleagues (e.g., Safran 1993) have observed three patterns commonly found to underlie the development of alliance ruptures:

1. *The patient misperceives the meaning or intent of the therapist's actions in a schema-consistent fashion* - the patient experiences a therapist intervention, which would be received by most as facilitative, in line with their dysfunctional interpersonal schema. For example, a therapist expresses concern about a missed session but the patient experiences this as controlling or intrusive.
2. *The therapist participates in a maladaptive interpersonal cycle that is characteristic for the patient* - the therapist is drawn into re-enacting a maladaptive interpersonal cycle. For example, the therapist reacts to the patient's hostility with counter-hostility, perhaps unwittingly responding with subtle sarcasm.
3. *The therapist refrains from participating in a maladaptive interpersonal cycle that is characteristic for the patient* - the therapist (intentionally or unwittingly) disengages from a maladaptive interpersonal cycle and thereby places a strain

on the alliance. For example, the therapist stops responding to the patient's needs for reassurance, leaving a fragile patient feeling rejected or unsupported.

The presence of ruptures in the therapeutic alliance are not viewed negatively by proponents of this model. According to Horvath & Luborsky (1993), the absence of ruptures in the alliance could actually be a sign of a poor alliance. The patient may be viewing the therapist in an idealised way and so avoiding challenging difficult issues and feelings. Ruptures are conceived as important opportunities for observation and exploration of the patient's difficulties and hence an important part of the change process. Safran (1993) argues that the resolution of strains in the alliance could be critical in helping patients at risk of poor outcome and could also provide a 'corrective emotional experience', demonstrating to the patient that the inevitable difficulties people face in relating to others can be worked through.

There is evidence for the importance of working through alliance strains in therapeutic change. A number of studies have demonstrated that poor alliance and poor outcome cases are characterised by a tendency for therapist and patient to have become stuck in negative interactional cycles (e.g., Strupp, 1980; Henry, Schacht & Strupp, 1986, 1990; Kiesler & Watkins, 1989). Foreman & Marmar (1985) reported that therapists were able to improve the alliance by addressing the conflicts in the therapy relationship. Reandeau & Wampold (1991) found that high alliance patients responded to challenging interventions with non-reactive, high-involvement statements, whereas low alliance patients responded with low-involvement statements (i.e., avoidance). Finally, Gaston *et al.,* (1991) found therapists who focused on the problematic relationship as opposed to problem content were more able to improve the alliance. Much of the research is preliminary and based on small samples, however the results consistently suggest that focus on the strains between

therapist and patient, rather than avoidance of such difficulties, contributes to better alliances.

The extent to which tension or strains in the therapeutic alliance are present in the early phase of therapy is not clear. Bordin (1994) argues that later ruptures are more likely to be related to core themes than those taking place earlier. However it may be that for patients who have difficulty establishing an alliance, fundamental issues, such as mistrust, are present from the outset (Safran, 1993). Alternatively, because some patients may idealise the therapy and therapist in the initial stages of therapy, ruptures may not be apparent. The degree to which ruptures are present in the beginning phase is also likely to be related to the interaction between patient and therapist (Horvath & Greenberg 1994). An aspect of the therapist's personality may strongly remind the patient of a difficult relationship pattern, causing a rupture very early on.

Debate continues as to the extent to which such therapeutic events are related to the patient's past relationship difficulties (i.e., transference related) or to the here and now of the therapeutic relationship. Bordin (1994) views patient's core relationship difficulties as valid goals of therapy, rather than determinants of the alliance. More research is clearly needed to further our understanding of the relation between alliance ruptures and interpersonal behaviour patterns (Horvath & Greenberg, 1994).

Patient Pre-therapy Factors

The ability of the patient to make use of therapy is probably the most important determining factor in outcome (Orlinksy, Grawes & Parks; in Bergin & Garfield, 1994). Not surprisingly, psychologically 'healthier' patients achieve better outcomes (e.g., Jones, Cumming & Horowitz, 1988). However, on their own, patient pre-therapy factors are modest predictors of outcome so some researchers are now focusing more on variables interacting with patient factors early in therapy (e.g., Henry *et al.,* 1986). Most investigators now agree that we need to look at the interplay of both patient and therapist variables with process factors (e.g., Horowitz *et al.,* 1984).

The impact of patient variables on the development of the alliance in particular has been assessed in a number of studies. Horvath (1991) summarised some of these studies and sorted the variables assessed into three categories; interpersonal capacities, intrapersonal dynamics and diagnostic features.

Interpersonal capacities

There is evidence to suggest that patients who have problems maintaining social relationships (e.g., Moras & Strupp, 1982) or have poor family relationships (e.g., Kokotovic & Tracey, 1990) are less likely to develop strong alliances. On the other hand, Piper *et al.,* (1991a) found no significant relations between alliance and the quality of the patient's *current* relationships. More research is needed to unravel such findings. A recent study has looked at the relation between patient's interpersonal problems and the alliance in more detail (Muran, Wallner Samstag & Crawford, 1994). The alliance was measured using the Working Alliance Inventory (WAI) which is based upon Bordin's model. As predicted they found that hostile-

dominant interpersonal problems were negatively related to ratings of the task and goal subscales. In addition, more surprisingly, they found that friendly-submissive interpersonal problems were *positively* related to patient ratings of agreement on tasks and goals. The bond subscale was not significantly related to any interpersonal problem. Such findings have implications for the issue of patient suitability for brief psychotherapy (see also Horowitz, Rosenberg & Bartholomew, 1993). Therapists may need to take extra care and time at the beginning with hostile-dominant patients, particularly ensuring tasks and goals are fully worked through and understood.

Intrapersonal Dynamics

Poor alliance has also been associated with pessimism regarding the therapy (e.g., Ryan & Cicchetti, 1985; in Horvath, 1991), defensiveness (Gaston *et al.,* 1988), lack of psychological mindedness (Ryan & Cicchett, 1985), level of motivation (Marmar *et .,* 1989) and poor object relations (e.g., Piper *et al.,* 1991a; 1991b). Orlinksy & Howard (1986) found patient 'self-relatedness', particularly their level of openness as opposed to defensiveness, to be correlated significantly with outcome.

Diagnostic Features

Most studies have found severity of symptoms (e.g., intensity of subjective distress, adequacy of functioning in social and work roles) at the start of therapy to have a limited impact on the development of the alliance (e.g., Moras & Strupp, 1982; Luborsky *et al.,* 1983). However, another study used patient-rated measures of symptoms rather than therapist ratings and found that pre-treatment symptomatology was related to alliance development (Eaton, Abeles & Gutfreund, 1988). It may be that the patients who reported higher levels of symptomatology were more vocal and preoccupied with their symptoms and so found it particularly

difficult to concentrate on establishing a realistic alliance based upon medium and long term goals.

Overall, the research on patient pre-therapy variables suggests that therapists and services in general should pay particular attention to the perceptions and reactions of the patient during the early process of therapy, as these appear to be vital considerations in continuation and final outcome (Orlinsky, Grawes & Parks; in Bergin & Garfield, 1994).

Attachment Theory & Psychotherapy Process

Recently, there has been renewed interest in attachment theory, particularly in terms of its application to psychotherapy (e.g., see Mace & Margison, 1997). A few writers and researchers have conceptualised the therapeutic relationship from an attachment perspective (e.g., Holmes, 1997; Mallinckrodt, Gantt & Coble, 1995) and there are a small number of preliminary studies which suggest an association between attachment experience and the development of the alliance in therapy (Mallinckrodt, 1991; Mallinckrodt, Coble & Gantt, 1995). The attachment theory perspective provides a useful link between the findings described above which associate both interpersonal and intrapersonal capacities with the alliance.

Infant Attachment & Internal Models

Attachment theory was originally developed by Bowlby (1969) to highlight the adaptive behavioural system responsible for regulating infant safety and survival. Bowlby drew on evolutionary theory and observation work with primates to explain the behavioural and emotional responses which guide infants and their, caregivers

to maintain close proximity to one another. The theory as a whole provides a framework for understanding the development of emotional attachments beyond infancy and through adulthood (Bowlby, 1969, 1973, 1980; Ainsworth, 1989). Ideally the attachment bond provides the infant with the comforting presence of another which acts as a secure base from which to explore the environment. However, infants also become attached to maltreating, unreliable or insensitive parents.

Ainsworth, Blehar, Waters & Wall's (1978) studies of infant attachment behaviour observed infants with their caretakers and identified three distinct styles of attachment; (1) *Secure* - freely explore in their mother's presence, show some anxiety upon separation, easily comforted upon reunion. Around two thirds of children behave in this way among normal populations. (2) *Insecure ambivalent* - display anxiety, anger and clingy behaviour, distressed during separation and difficult to comfort upon reunion (one sixth can be classified in this way in normal populations). (3) *Insecure avoidant* - show little interest in their mother and little strong affect throughout observation (representing one fifth of children in normal populations). An additional insecure pattern, has been observed on re-examination of the videotapes of children who could not be clearly classified; (4) *Insecure disorganised.* These children show no coherent pattern of response, perhaps freezing, appearing vacant upon reunion or collapsing on the ground (around one in twenty). These observations have been widely replicated and the different behaviour styles have been associated with the responsiveness of the caretaker.

Bowlby (1973) described how, through interactions with their caregivers the child develops 'internal working models' containing beliefs and expectations about the attachment figure and the self, particularly (a) whether or not the attachment figure is judged to be the sort of person who in general responds to calls for support and

protection, and (b) whether or not the self is judged to be the sort of person towards whom attachment figures are likely to respond in a helpful way. The working models are then carried into new relationships where they guide expectations, perceptions and behaviour.

Four specific components define the attachment process in childhood; proximity seeking, separation protest, secure base and safe haven (Bowlby, 1988; Ainsworth *et al.,* 1978). Environments may be *consistently responsive, consistently unresponsive,* or *inconsistently responsive* (Ainsworth *et al.,* 1978). Insecure attachment behaviours can be viewed as defensive strategies designed to maintain contact with unresponsive, or unreliable parents (Hamilton, 1985). Normally the infant will protest on separation, attempt to seek proximity to the attachment figure and the parent will respond with a comforting presence, thus providing a safe haven and secure base. This experience will gradually be internalised into a sense of security within the self and a belief in the general responsiveness of others - the capacity to rely more on internalised 'objects' increases in the transition to adulthood. However, if the parent is unresponsive or inconsistent the child will develop defensive behaviours designed to cope with and compensate for the insecurity.

Adult Attachment

The relative prevalence of the different attachment patterns have been found to be roughly the same in adulthood as in infancy (Hazan & Shaver, 1987) and there is evidence that attachment behaviours are relatively stable and continuous over time (Bakermans-Krneberg & Van Ijzendoorn, 1993). Bowlby (1973) observed responses such as proximity seeking and separation protest across the life span, particularly in the behaviour of those who had lost a spouse through separation or death.

Empirical research has also demonstrated the important influence of early attachment experience on adult relationships (e.g., Hazan & Shaver, 1987; Main, Kaplan & Cassidy, 1985).

The attachment behaviour system can be activated in adulthood by any close relationship which involves the potential for comfort, love and security. Numerous studies have established the importance of the attachment system in romantic, kinship and friendship partnerships (for a review see Hazan & Shaver, 1994). For adults reporting a secure style, proximity and responsiveness is easily achieved and felt to be available when needed. Those with an ambivalent style may tend to be excessively possessive and jealous and view their partners as fickle. Avoidant people may find closeness difficult and tend to maintain their distance, avoiding sexual and emotional commitment. Another line of work has demonstrated the predictive value of parent attachment status for the security of their child's attachment (Main, Kaplan & Cassidy, 1985; Fonagy *et al.,* 1991).

Attachment and the Therapy Relationship

Bowlby (1988) viewed the therapeutic relationship as a specialised type of adult attachment strongly influenced by early attachment experience. The re-enactment of attachment behaviours in the therapeutic relationship allows the therapist insight into the patient's working models first hand. Through the exploration of the therapy relationship and other outside relationships the patient's working models can become subject to change (Sperling & Lyons, 1994). From this perspective transference can be viewed as the patient's misperception of the therapist based on working models developed from early attachment experience.

Surprisingly there have been few empirical studies investigating the potential role of previous attachment experience in the therapeutic situation. There is evidence that patients with different attachment styles display different types of interpersonal problems and in turn differ markedly in psychotherapy outcome (Bartholomew & Horowitz, 1991; Horowitz, Rosenberg & Bartholomew, 1993). Interpersonal problems are likely to reflect conflicts developed over the course of an individual's interpersonal history - a major part of which is their attachment experience. For example, an early attachment experience with an unreliable caregiver may present itself in adulthood as difficulty trusting others and a corresponding fear of relinquishing control to others. Horowitz, Rosenberg & Bartholomew (1993) found that patients with interpersonal problems of hostile-dominance were particularly difficult to treat. It seems reasonable to suggest that such patients may have difficulty establishing a strong therapeutic alliance, which may partly account for their poor outcome in therapy.

Another line of research has demonstrated that both memories of early emotional bonds with parents and adult social competencies are significant predictors of alliance ratings (Mallinckrodt, 1991; Mallinckrodt, Coble & Gantt, 1995). Together, memories of parental bonds and adult social competencies accounted for 50% of the variance in patient alliance ratings. Patients who characterised their fathers as intrusive and overprotective and their mothers as permissive and low in protection seemed to develop the poorest alliances. Parental bonds were associated with adult social competencies which were in turn also predictive of alliance ratings. Specifically, comfort with intimacy and emotional closeness was predictive of positive alliance ratings and high levels of anxiety in relationships was predictive of more negative alliance ratings.

Mallinckrodt and his colleagues have gone on to develop a scale to assess patients' feelings and attitudes to their therapist from an attachment perspective - the Client Attachment to Therapist Scale (CATS)[2] - with the aim of identifying patterns of attachment in psychotherapy (Mallinckrodt, Gantt & Coble 1995). Preliminary findings in relation to the scale suggest distinct patterns of attachment to therapists. Patients who score high on the CATS *Secure* subscale perceive their therapists as emotionally responsive, accepting and as promoting a 'secure base' from which to explore painful experience. These patients also report positive working alliances, good object relations and a relatively strong sense of self-efficacy. Patients scoring high on the *Preoccupied-Merger* subscale of CATS desire a dissolution of the normal therapy boundaries, wanting to be 'at one' with their therapists. These patients are quick to form an alliance bond with their therapists but find agreement on the tasks and goals of therapy more difficult. Patients scoring high on the *Avoidant-Fearful* subscale are uncooperative in the self-disclosure tasks of therapy and describe feeling humiliated during sessions. These patients report the poorest working alliances and tend to distrust their therapist and fear rejection. A few patient's scores on the CATS clustered in a slightly different way from those fitting into the main three subscales, and this group were described by the authors as *Reluctant.* These patients reported relatively positive working alliances, few object relations deficits and scored high on the secure subscale. However, while they reported feeling engaged with their therapist, they were generally unwilling to participate in the self-disclosing tasks of therapy. The authors speculate that these patient's ratings were influenced by a denial of their difficulties.

[2] The development and validation of CATS is described in more detail in the Methods Section.

Measurement Issues

1. *In the Study of the Alliance*

A clear interpretation of the role of the alliance construct has been hindered by the use of so many different measures across studies. This raises the question of whether the same construct is being considered (Greenberg & Pinsoff, 1986; Tichenor & Hill, 1989). Most of the measures were developed independently and are to some extent based upon different theoretical assumptions. Horvath & Luborsky (1993) review the relations between the different measures and suggest that the core alliance elements shared among the instruments are *personal attachment* and *collaboration.* Beyond these, other constructs measured include; therapist and patient positive or negative contributions (e.g., CALPAS, TAS), shared or agreed goals for therapy (e.g., CALTRAS, WAI, Penn), capacity to form a relationship (e.g., Penn, VTAS, CALTRAS), acceptance or endorsement of therapy tasks (e.g., CALTRAS, WAI), and active participation in therapy (e.g., Penn, CALTRAS, VTAS).[3] Though at a global level there is generous overlap between the measures, correlations across subscales are low, which makes agreement as to the underlying structure of the alliance difficult (Horvath & Luborsky, 1993). Some mixed results and confusions in the alliance literature have been due to measurement issues, e.g., using measures based on a psychodynamic definition of the construct to measure the alliance in cognitive therapy (Castonguay *et al.,* 1996). The Working Alliance inventory (WAI) was developed and validated in relation to Bordin's model of the alliance. The transtheoretical nature of the model means the measure is

[3] 'CALPAS/CALTRAS' refers to the California Psychotherapy Alliance Scales (Gaston & Ring, 1992; Marmar, Weiss & Gaston, 1989; cited in Horvath & Luborsky, 1993); 'Penn' to the Penn Helping Alliance scales (Alexander & Luborsky, 1987; Luborsky, 1976; cited in Horvath & Luborsky, 1993); 'WAI' to the Working Alliance Inventory (Horvath, 1981, 1982); 'TAS' to the Therapeutic Alliance Scale (Marziali, 1984a); 'VTAS' to the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983).

specifically designed to rate the alliance across therapeutic orientation, giving it good research and clinical utility (Horvath & Greenberg, 1989).

2. *In Attachment Research*

Infant attachment can be easily observed, as attachment behaviour is readily provoked and expressed clearly through action (Ainsworth *et al.,* 1978). However, the attachment behaviour system is more difficult to measure in adulthood. For example, how does secure base behaviour present itself in adulthood? Adult relationships are usually more reciprocal, making it difficult to assess specific attachment behaviours (Crowell & Treboux, 1995). Perhaps as a consequence of such difficulties, researchers have focused mainly on individual self-report and interview measurement as opposed to behavioural observation (Hazan & Shaver, 1994). Systems for observing adult attachment behaviour are currently being developed and may provide a useful new perspective on adult attachment in the future (see Crowell & Waters, 1993).

The most widely utilised measures of attachment are the Adult Attachment Interview (AAI) and the Adult Attachment Styles (AAS). The AAI (George, Kaplan & Main, 1987; Main & Goldwyn, 1988) is a semi-structured interview exploring adult representations of childhood attachment experience. Trained coders analyse the interview with particular attention to the *form* and *structure* of the individual's narrative style, rather than the specific content. Adults are then classified into attachment groupings which parallel Ainsworth's original patterns. The AAS (Hazan & Shaver, 1987) is a self-report measure which classifies adults into three categories corresponding to those described by Ainsworth. Research has shown that the AAI and the AAS are poorly correlated (Borman-Spurrell *et al.,* 1994;

Crowell *et al.,* 1993; cited in Crowell & Treboux, 1995). The interview method is related more to other's reports, whereas the self-report method is not.

Bartholomew & Horowitz (1991) argue that the AAI and AAS models obscure conceptually separable patterns of avoidance in adult attachment. In the AAI adults identified as avoidant are conceptualised as people who deny the experience of subjective distress and the importance of attachment needs; they describe themselves in positive terms and others in negative terms. In the AAS those identified as avoidant report subjective distress and discomfort when they get too intimate with others; they describe both themselves and others in negative terms. In response to this discrepancy, Bartholomew & Horowitz developed a four-category model of attachment based on Bowlby's postulates about positive and negative models of self and other. Specifically the model aims to distinguish between the two forms of adult avoidance described above. From this model they developed interview and self-report measures which score individuals in relation to four attachment prototypes; the Peer Attachment Interview, Family Attachment Interview, Relationship Questionnaire (RQ) and Relationship Scales Questionnaire (RSQ).

The four attachment prototypes of the four-category model are; (1) the prototypically *secure* individual, characterised by a positive image of the self and others, has a belief in themselves as lovable and expects others to be generally available and supportive, (2) *preoccupied* individuals are characterised by a negative self model and a positive model of others. They are very preoccupied with having their attachment needs met and so tend to be overly dependent. The other two groups both tend to avoid intimacy but have differing conceptions of their own self-worth; (3) *Fearful* individuals have a negative model of others and a negative model of themselves. They want acceptance from others and are aware of their attachment

needs but fear rejection and so avoid intimacy. (4) *dismissing* individuals also have a negative model of others but in contrast have a positive model of themselves. They appear to have maintained a positive self-image by distancing themselves from their attachment figures and conceptualising themselves as self-reliant.

In contrast to the AAI model of attachment which conceptualises working models as operating on an unconscious level, the four category model assumes they are accessible to consciousness, although operating automatically. However, this does not mean that the models are incompatible, they may be measuring different levels of representation of working models. Bartholomew (1997) suggests that the detached stance of dismissing individuals is probably defending a more unconscious fragile sense of self and similarly the positive other model of preoccupied individuals may represent an idealisation masking a less conscious negative model. This distinction clearly has important ramifications for the validity of self-report as opposed to interview methods of assessment in attachment research. It is also likely to result in the two methods finding quite different proportions of individuals classified within the different attachment groupings.

The shared terminology utilised by workers within the field of attachment implies considerable overlap of meaning but in reality the major attachment measures have different correlates and approach the subject from very different perspectives. Interpretation of the attachment literature is therefore complex and should be approached with particular care (Crowell & Treboux, 1995).

The Current Study

The aim of the current study is to explore any association between patient attachment style, the quality of the alliance and the occurrence of ruptures in the alliance.

Mallinckrodt and his colleagues suggest that patterns of attachment to therapists observed in their study may correspond to the four styles of adult attachment described in the Bartholomew & Horowitz (1991) model. Specifically, people scoring high on the CATS Secure subscale may tend to have a relatively secure attachment style, and that the CATS Avoidant-Fearful, Preoccupied and Reluctant patterns may correspond to the Fearful, Preoccupied and Dismissing attachment styles respectively (Mallinkrodt, Gantt & Coble, 1995). However, I have located no study which tests this hypothesis nor which specifically examined the relationships between adult attachment styles and alliance development. In addition, there is no research examining how patients with different attachment styles may differ in their experience of the development of a therapeutic relationship. As a promising new area of alliance process research, rupture theory may be a useful perspective from which to explore this question.

Patient and therapist reports of the alliance, as it develops over sessions 2-5 of therapy, will be analysed. Attachment will be measured by patient self report using the Relationship Questionnaire (RQ) and Relationship Scales Questionnaire (RSQ) (Bartholomew & Horowitz, 1991). The alliance will be measured utilising both patient and therapist ratings of a shortened version of the Working Alliance Inventory (WAI) (Tracey & Kokotovic, 1989). Ruptures will be detected using a self-report measure

administered to patients and therapists at the end of each session (Safran, personal communication).

Research Questions

The main research questions are:

1. Is attachment style associated with ratings of alliance quality?

2. Is attachment style associated with reported rupture rate?

In addition, the study aims to contribute to the continuing validation of the Client Attachment to Therapist Scale (CATS, Mallinkrodt *et al.,* 1993) in terms of its convergence with the RQ and RSQ.

Predictions

Research in this area is still in the very early stages. However, there is evidence that high levels of anxiety in relationships is predictive of poorer alliance ratings and comfort with emotional closeness and intimacy is predictive of more positive alliance ratings (Mallinkrodt, Coble & Gantt, 1995). A fearful attachment style is characterised by high levels of anxiety **and** discomfort with intimacy so it can be predicted that:

- Those who report high levels of fearfulness in their attachments should experience the most difficulty establishing an alliance ~ fearfulness should be negatively associated with alliance.

Because there has been no research to date linking attachment and rupture reporting it is difficult to make specific predictions. However, hypothetically, patients with different attachment styles should differ in terms of (a) how they experience the process of establishing an alliance, and (b) how they are experienced by therapists. Differences in rupture reporting by both patients and therapists should provide some sort of measure of this.

METHODOLOGY

Design

The present study was based upon a naturalistic design in which data was collected while assessment and treatment continued as usual. Psychologists from several psychology departments across 3 different London NHS trusts took part[4].

Participants

Therapists

Twelve therapists agreed to participate in the study, eight male, four female. Ten were qualified clinical psychologists ranging from 23 to 1 year post qualification, the remaining two were final year clinical psychology trainees. Table 1. details the number of patients obtained per therapist. Therapists were asked to label the therapeutic approach they used with each patient. Most therapists described the therapy their patients received as Cognitive Behavioural Therapy (CBT) (twenty one cases), three patients received Psychodynamic therapy, two received something described as "a mixture between CBT and Psychodynamic" and one case was approached from a Cognitive Analytic (CAT) perspective.

Patients

43 patients agreed to participate in the study. 13 failed to return questionnaires so the final sample included 30 patients. They comprised 17 women and 12 men. The mean age was 34.7 (Std dev; 8.7). In terms of ethnicity, 25 classified themselves as 'White British', 3 as 'White Irish' and 2 as 'White Other'.

[4] Ethical approval for the study was obtained from each trust, a copy of one of the approval letters can be found in the appendix

Table 1. Number of Patients per Therapist

Therapist	Number of Patients
1	3
2	2
3	2
4	2
5	1
6	3
7	2
8	5
9	5
10	3
11	1
12	1

Instruments

Attachment

Patient attachment was measured using the two self-report questionnaires based upon Bartholomew & Horowitz' (1991) four category model of adult attachment styles; the *Relationship Questionnaire (RQ)* and the *Relationship Scales Questionnaire (RSQ).* The RQ/RSQ were preferred as a 'prototype' measure, over the more commonly used Hazan & Shaver categorical measure (Adult Attachment Styles, 1987).[5] Given the difficulties inherent in the measurement of attachment the properties of the measures used need to be discussed in some detail so the meaning of the results can be realistically interpreted.

The RQ and RSQ are designed to measure the match between the respondent and each of four prototypes; *secure*, *fearful*, *preoccupied*, and *dismissing.*[6] The RQ was adapted from Hazan & Shaver's categorical self-report measure and consists of four short paragraphs describing the four attachment prototypes. Each respondent is asked to rate the degree to which they feel they resemble each prototype on a 7

[5] See discussion in the measurement issues section of the introduction.
6 Previously described in the Measurement Issues section in the Introduction.

point anchored response scale (1 = not at all like me, 7 = very like me). The RSQ is a more indirect measure of the prototypes. It consists of 30 statements drawn from the paragraph descriptions in Hazan & Shaver's categorical measure, the RQ and Collins & Read's dimensional measure (Adult Attachment Scales, 1990). Respondents rate how well they feel each statement fits their behaviour in close relationships on a 5 point scale (1 = not at all like me, 5 = very like me).

Scoring

Both assessment measures yield four different ratings for analysis:

1. *Prototype ratings* - a continuous rating of each of the four attachment prototypes provides an attachment profile for each individual.
2. *Insecurity Score* - the three insecure prototypes (fearful, preoccupied and dismissing) are added together to give an overall insecurity score.
3. *Best fitting category membership* - the highest of the four prototype ratings can be used to derive a best fitting category membership.
4. *Model of Self and Other scores* - linear combinations of the four prototype ratings derive ratings of the two underlying dimensions, positivity of the self model and positivity of the other model. The equation used to generate these scores was as follows:

   Model of Self Score: (secure score + dismissing score) - (preoccupied + fearful score)

   Model of Other Score: (secure score + preoccupied score) - (dismissing + fearful score)

The measures are quite new but they have been utilised in a number of studies, the results of which give some insight into how they behave. In non-clinical samples it is generally the case that around 50% rate themselves as secure with the remaining 50% distributed across the insecure patterns (Bartholomew, 1996). In a large study analysing the use of the RQ by college students, men were more likely to classify

themselves as dismissing and preoccupied than women, women tending to be more likely to classify themselves as secure or fearful (Brennen *et al.,* 1991). In the same study those who rated themselves as fearful were more likely to report a parent with a drinking problem.

Generalisability

- Across perspective. Ratings of the self and other dimensions showed high convergence across perspective; that is, self-report, peer-report, partner reports and expert raters' judgement (Griffin & Bartholomew, 1993).
- With ratings on the AAS (Hazan & Shaver, 1987). The RQ/RSQ are highly correlated with the Adult Attachment Styles (Brennan *et al.*, 1991). However, as one is a four category and the other a three category model there are differences. Bartholomew's *fearful* group rated themselves as *ambivalent* on the AAS and *avoidant* (AAS) respondents tended to rate themselves as *fearful* rather than *dismissing* on the RQ/RSQ. This finding supports Bartholomew's argument that the three category model obscures conceptually different patterns of avoidance.
- Between self-report and interview measures. The RQ and RSQ show quite modest convergent validity with Griffin & Bartholomew's own interview methods (Griffin & Bartholomew, 1994b). Some have suggested that the dismissing pattern, the more defensive style might be most difficult to assess using self-report methods (Hazan & Shaver, 1987). However, Griffin & Bartholomew showed respectable convergent validity between the interview and self-report measurement of the dismissing style (r= .40 for the RQ and r= .47 for the RSQ). In fact it was the secure pattern that demonstrated the poorest convergence (r= .22 for the RQ and r= .25 for the RSQ), suggesting that security of attachment may be particularly susceptible to self-report bias. The convergent correlations

at the dimensional level are moderate; the interview measure correlates .41 with the RQ self-model, .37 with the RSQ self-model, .46 with the RQ other-model and .48 with the RSQ other-model.

- Internal Consistency. The internal consistency of the RSQ is variable across prototype and at times quite low (ranging from alpha = .41 for the secure prototype to alpha = .70 for the dismissing prototype).
- Test-retest reliability . The test-retest reliability of the RQ and RSQ is .56 and.63 respectively, after 8 months (Scarfe & Bartholomew, 1994).

Construct Validity

Bartholomew and her colleagues have gone some way towards establishing construct validity for the model underlying the RQ and RSQ by demonstrating convergent and discriminant validity in relation to theoretically relevant outcome variables (Griffin & Bartholomew, 1993). Based upon Bowlby's conception of the two attachment dimensions, they compared the self-model dimension with measures of self-concept and the other-model dimension with measures of interpersonal orientation and found they were highly related. However, they argue that the self and other model dimensions cannot be reduced to fundamental personality dimensions. Further analysis indicated that the traits identified by the 'Big Five' model of personality; Neuroticism, Extroversion, Openness, Agreeableness and Conscientiousness (e.g., Digman, 1990; McCrae & Costa, 1987; Wiggins & Pincus, 1992) can account for 48% of the variance in the self-model variable and 27% of the variance in the other-model variable - part but not nearly all of the reliable variance in the attachment dimensions. Specifically, none of the Big Five Scales can fully capture the element relating to comfort with intimacy versus avoidance of intimacy.

In order to investigate the usefulness of the attachment measures over and above the five fundamental personality factors, Griffin & Bartholomew compared the ability of the attachment dimensions and the Big Five factors to predict reported experience in intimate relationships. They found that the attachment dimensions added significantly to the ability of the Big Five factors to predict two of the three subscales on the Interpersonal Dependency Inventory (IDI, Hirschfield *et al.,* 1977) - Assertion of Autonomy and Emotional Reliance (but not the Social Self-Confidence subscale).[7] Griffin & Bartholomew have also argued, convincingly, that the four attachment prototypes are not reducible to the two attachment dimensions; the particular combination of dimensions underlying each attachment prototype predict distinct patterns of interpersonal problems more effectively than the dimensions alone (see Bartholomew & Horowitz, 1991; Horowitz, Rosenberg & Bartholomew 1993). The validity of the RSQ and RQ could be further assessed by examining their ability to predict reports of relationship satisfaction and quality. It will be interesting following the results of the current study to see if the predictive value of the RQ and RSQ extends to ratings of the quality of the therapeutic alliance.

Alliance

The quality of the alliance was measured using the shortened version of the *Working Alliance Inventory* (WAI, Horvath, 1981; Horvath & Green berg, 1989; WAIs Tracey & Kokotovic, 1989). The WAI was preferred as the alliance measure of choice because (a) it was designed as a transtheoretical measure, (b) it was developed for use in the early phase of therapy. As discussed earlier (see *Measurement Issues* in the Introduction) the interpretation of the alliance research is made difficult by the heterogeneity of measures. This measure provides a more focused conceptual point of reference because it was specifically developed and

[7] Shaver & Brennan (1992) recently drew similar conclusions when relating the Big Five scales to their three-category model of attachment.

validated using Bordin's definition of the alliance construct. Its use also provides an opportunity to evaluate Bordin's model (Horvath, 1994).

The WAI is a 36 item self-report measure which uses a 7 point likert rating scale (1 = never, 7 = always). The measure is re-worded to be used as a therapist's scale (WAIt).[8] The WAI yields an overall score for quality and three summed sub-scale scores (a) Bonds - the emotional bond of trust and attachment between patient and therapist, (b) Goals - the degree of agreement concerning the overall goals of treatment, and (c) Tasks - the degree of agreement concerning the tasks relevant for achieving these goals. The shortened, 12-item version used in this study yields the same ratings as the original.

Validity

- Content Validity. Most alliance instruments have been developed using either factor analytic procedures or alliance-outcome relations (i.e., selecting items found to be most related to outcome). Horvath & Greenberg (1989) argue that these procedures confound theoretical and empirical factors so they took a different approach to the development of the WAI. Items were generated initially by a content analysis of Bordin's model. They were then rated for closeness to the construct by 'experts' who were identified from a review of the alliance literature. The remaining items were then rated by 'professionals' (randomly selected registered psychologists) and the highest rated items were selected for inclusion. By deciding the content of the scale in this way the theoretical model is more accurately reflected (Horvath, 1994).
- Convergent & Discriminant Validity. There have been a number of investigations exploring the relationship of the WAI to other measures of the alliance.

[8] (footnote, an observers version is also available based on the work of Tichenor & Hill, 1989).

Correlations with the global CALPAS scores were typically .72, .84, and .79 for the Bond, Goal and Task sub-scales respectively (e.g., Safran & Wallner, 1991). Correlations with the Helping Alliance and the Vanderbilt scales were significant but slightly lower (Greenberg & Alder, 1989; Tichenor & Hill, 1989; cited in Horvath, 1994). There was lower convergence with a measure of the Rogerian dimensions; empathy, positive regard, unconditionality and congruence (Relationship Inventory, Barrett-Lennard, 1978). This is expected given the greater theoretical divergence underlying the measures. Typically Bond was most correlated (between .6 to .74), followed by Goal (.43 to .59) and then Task (.3 to .49) (Jones, 1988; cited in Horvath, 1994). Again, as predicted, significantly lower correlations were found between the WAI and the Counselor Rating Form (Horvath & Greenberg, 1989). The Counselor Rating Form (CRF, LaCross, 1980) is based upon Strong's interpersonal influence model which is quite theoretically distinct from Bordin's model.

- Predictive Validity. There is a robust relationship between the client reports of the WAI and outcome. Horvath (1994) conducted a meta-analysis of 8 studies and found an average effect size of .33.

Reliability

Adequate reliability has been established for the WAI;

- Internal consistency estimates of alpha were .93 for the overall client score (sub-scale alphas of .85 to .88) and .87 for the overall therapist score (sub-scale alphas of .68 to .87) The sub-scales are strongly correlated (ranging from the low .60's to the high .80's) (Horvath & Greenberg, 1989), though Tracey *et al.,* (1989) provide evidence that the three components may be distinct. Using bilevel confirmatory factor analysis they found that the WAI assesses three specific aspects of the alliance (Bond, Goal and Task) as well as a general

Alliance dimension. The shortened version was developed using factor analysis. It also demonstrated acceptable internal consistency and appeared to be structurally equivalent to the long version (Tracey & Kokotovic, 1989).

- Test-retest reliability across a three week interval was .8 (sub-scales ranging between .74 and .66) (Plotnicov, 1990; cited in Horvath, 1994). The shortened version had a test-retest index of .83 across a two week period (Horvath, in press).

Ruptures

Ruptures will be detected using a self-report measure administered to patients and therapists at the end of sessions 2, 3, 4 and 5. There is no agreed methodology or terminology for use in the detection of ruptures. The questionnaire used in the current study was devised as part of a major programme of research by Safran and colleagues (personal communication). It has therefore been widely piloted but no reliability data is available.

Client Attachment to Therapist Scale (CATS)

The CATS was designed to measure the therapeutic relationship from an attachment theory perspective (Mallinckrodt, Gantt & Coble, 1995). It is based upon ideas about adult attachment processes[9], particularly that adults possess working models which govern expectations of how responsive an attachment figure is likely to be. These expectations then guide strategies for re-establishing psychological availability and in turn, felt security. The authors believe the CATS measures clients' perceptions and behaviour systems for maintaining their ideal level of psychological

[9] See attachment section in introduction for discussion

proximity to the therapist. The measure is in quite early stages of development and its use in this study is a contribution to its continuing validation.

The CATS is administered to clients receiving therapy. It is a 36 item questionnaire using a 6 point fully anchored response scale (1 = strongly disagree, 6 = strongly agree). Respondents are scored on three continuous sub-scales which are hypothesised to represent three related sets of attachment strategies based on different working models of self and others; (a) *Secure* - experiencing the therapist as responsive, sensitive, understanding, and emotionally available, feeling hopeful and comforted by the therapist and feeling encouraged to explore frightening or troublesome events, (b) *Avoidant/Fearful* - suspicion that the therapist is disapproving, dishonest, and likely to be rejecting if displeased, reluctance to make personal disclosures in therapy, feeling threatened, shameful and humiliated in sessions, and (c) *Preoccupied/Merger* - longing for more contact and to be 'at one' with the therapist, wishing to expand the relationship beyond the bounds of therapy, and pre-occupation with the therapist and the therapist's other clients.

The CATS was constructed utilising a rational-empirical approach. Items were initially generated by the authors and other experienced therapists to reflect Ainsworth's secure, anxious-ambivalent and anxious-avoidant patterns. After piloting on a client population (n=138) the final items and sub-scales were selected using factor analytic procedures.

Psychometric Properties

- The internal reliability was good for the Preoccupied-Merger subscale (.81) but somewhat lower for the Secure and Avoidant-Fearful subscales (.64 and .63 respectively).

- The test-retest reliability coefficients were .84, .72 and .86 for the Secure, Avoidant-Fearful and Preoccupied-Merger subscales respectively.
- The Avoidant-Fearful and Secure subscales were significantly negatively correlated, whereas the Secure and Preoccupied-Merger subscales were positively correlated.
- CATS scores were compared according to the length of therapy at the time of completion. Scores on the Secure subscale were significantly higher for groups who had been seeing their therapist for longer, while the other subscales were more stable over time. Though this could suggest that security in attachment to the therapist increases over time, it is also possible that differential attrition may provide an alternative explanation; clients with a less secure attachment to their therapist may not remain in therapy.
- Other relevant measures were included in the pilot to provide data on convergent and discriminant validity, including;

1. Working Alliance Inventory (described above). Clients who scored highly on the Secure subscale of the CATS tended to report positive alliances, whereas those with high scores on the Avoidant-Fearful subscale tended to report less positive alliances. Interestingly, those with high scores on the Preoccupied-Merger subscale tended to rate the bond aspect of the WAI positively in contrast to lower ratings of the goal and task scales. However, the shared variance with the WAI was relatively low for the Avoidant-Fearful and Preoccupied-Merger subscales suggesting appropriate discriminant validity. The authors suggest that the goal and task elements of the alliance may at times be incompatible with the maintenance of the client's ideal psychological proximity to the therapist. For example, the therapist may feel that a client's dependence upon them needs to be discouraged.

2. Bell Object Relations and Reality Testing Inventory (BORRTI, Bell (1991); a measure of ego functioning and object relations). Clients scoring high on the Secure subscale of the CATS demonstrated relatively good object relations on the BORRTI. Those with high scores on the Avoidant-Fearful subscale demonstrated broad deficits in object relations, whereas those scoring high on the Preoccupied-Merger subscale tended to exhibit specific object relations deficits in insecure attachment.
3. Adult Adjustment Scale (AAS, a dimensional measure of attachment by Collins & Read, 1990). Correlations between the AAS and the CATS were inconsistent and not significant. Theoretically, the scores on the CATS should relate to more general attachment behaviours in other relationships so this finding is less supportive of its construct validity. The CATS needs to be compared with other attachment measures to further understanding of this discrepancy.
4. Self-Efficacy Scale (Sherer *et al.,* 1982, yields a separate measure of 'social' self-efficacy which Coble, Gantt & Mallinckrodt (1996) suggest is an important component of the ability to establish healthy attachments in adulthood). In contrast to predictions, the Secure subscale was not significantly associated with self-efficacy, though scores were in the expected direction. The Avoidant-Fearful subscale was negatively correlated with General Self-Efficacy and Social Self-Efficacy as predicted. The Preoccupied-Merger subscale was also negatively correlated with General Self-Efficacy, but not with Social Self-Efficacy.

Procedure

Psychologists were recruited by contacting Psychology Department Heads, sending copies of the research proposal to be circulated and then attending meetings to present the study to the department. Those who agreed to participate were given 'research packs' containing patient and therapist questionnaires and were advised carefully on the administration procedure (they were also given a checklist which is reproduced in the appendices).

At the end of the first assessment session therapists informed patients of the research project, while emphasising that their decision whether or not to participate would not affect their treatment in any way. Therapists then gave patients Envelope 1, containing the information sheet, consent form, background information sheet and attachment measures (which were labeled the *Relationship Questionnaire* on the copy given to participants). The information sheet explained the purpose of the study and the nature of their involvement. A telephone number was provided in case anyone wanted further information. The information sheet also reassured them of the confidentiality of the information they provided. If they were willing to participate patients were asked to return the consent form, background information sheet and relationship questionnaire the following week, sealing it in the envelope provided and posting it in a box made available in the reception area. In departments where access to a reception area was not practical, patients were provided with stamped addressed envelopes to post questionnaires back to the researcher.

At the end of the next four sessions therapists gave patients an envelope containing the alliance measure (WAIs) and Safran's Rupture Questionnaire. They were asked to complete them immediately (if possible) and again to seal and post them. The fourth of these envelopes also contained the CATS. Therapists were also asked to

complete versions of the WAI and the Rupture Questionnaire at the end of these four sessions. These were retained by the therapist in the patient's file until collection by the researcher. The end of the data collection period was following completion of the fourth WAI/Rupture Questionnaire and the CATS.

The results section will focus on the following areas: the reliability of the measures of attachment employed in the study; the pattern of attachment styles and the pattern of alliance ratings over time; and finally the relationship between attachment style and the alliance in relation to the major research hypotheses.

RESULTS

The current study aimed to explore two main research questions from both a patient and therapist perspective:

1. *Is attachment style associated with ratings of alliance quality?*

2. *Is attachment style associated with reported rupture rate?*

In addition, the study aimed to contribute to the continuing validation of the Client Attachment to Therapist Scale (CATS, Mallinkrodt *et al.,* 1993) in terms of its convergence with the RQ and RSQ.

Reliability of the Measures of Attachment

Table 1. shows the intercorrelations between the RQ and RSQ. The two measures were adequately correlated, though perhaps not so well as would be expected for two measures designed by the same authors to measure the same variables. This has implications for their reliability and validity.

Table 2 & 3. show the convergence between the CATS, the RSQ and the RQ. Surprisingly, the Secure and Avoidant-Fearful subscales of the CATS were not significantly correlated with any of the RSQ or RQ scales. Theoretically, it would be expected for the RSQ/RQ Secure subscales to be associated with the CATS Secure scale and for the RSQ/RQ Fearful subscale to be associated with the CATS Avoidant-Fearful scale. The discrepancy could suggest a validity issue or alternatively, there could be a clinical explanation. The CATS Preoccupied-Merger subscale did correlate with the RSQ and RQ and in ways which could be predicted theoretically; positively with the preoccupied and fearful scales and negatively with the secure and dismissing scales.

Table 4. shows the intercorrelations between the CATS (measured at session 5) and the patient WAI (measured at session 5). The direction of the associations between the CATS and WAI were the same as those found by Mallinkrodt *et al., 1995); the* Secure subscale was positively associated with the WAI and the Avoidant-Fearful subscale was negatively associated with the WAI (though in the present study the correlations did not quite reach significance).

Table 5. compares the norms obtained by Mallinkrodt *et al.,* (1995) for the subscales of the CATS with the norms for the current sample. The distribution in terms of CATS scores is very similar between the two studies.

Table 1. Correlations of RQ with RSQ

N=30	RSQ						
RQ	Secure	Fearful	Preocc-upied	Dismiss-ing	Insecurity	Model of Self	Model of Other
Secure	**.59****						
Fearful		**.43***					
Preoccupied			**.62****				
Dismissing				**.60****			
Insecurity					**.37***		
Model of Self						**.63****	
Model of Other							**.77****

*p<.05. **p<.01

Table 2. Correlations of CATS with RSQ

N=17 r	RSQ			
CATS	Secure	Fearful	Preoccupied	Dismissing
Secure	-.17	.12	-.15	.41
Avoidant-Fearful	-.24	.003	.17	-.36
Preoccupied-Merger	**-.50***	**.51***	**.72****	**-.56***

*p<.05. **p<.01

Table 3. Correlations of CATS with RQ

N=17	RSQ			
CATS	Secure	Fearful	Preoccupied	Dismissing
Secure	-.02	.42	-.09	.02
Avoidant-Fearful	-.32	-.02	.23	-.16
Preoccupied-Merger	-.20	-.22	.73**	-.51*

*p<.05. **p<.01

Table 4. Correlations - WAI with CATS

N=16		CATS	
Session 5	**WAI**	**Secure**	**Avoidant-Fearful**	**Preoccupied-Merger**
	Total			
	Bond	.49	-.48	-.40
	Goal	.45	-.80**	-.20
	Task	.35	-.27	-.39
		.43	-.11	-.43

*p<.05. **p<.01

Table 5. CATS Norms

	CATS		
	Secure	**Avoidant- Fearful**	**Preoccupied**
	Mean (SD)		
Mallinkrodt *et al.*, (1995) Sessions 5-8 (N=45)	69.1 (11.7)	23.3 (11.3)	25.1 (6.9)
Current Study Sessions 5 (N=17)	65.1 (9.6)	24.8 (9.2)	26.5 (9.0)

*p<.05. **p<.01

Descriptive Statistics

Sample Size at Each Session

The sample size is relatively small at the first measuring point and, with both therapy and research attrition, it is further reduced over time (see table 6).

Distribution of Attachment Styles

Table 7. shows the distribution of the best fitting attachment prototypes among the sample. As the table shows, very few patients rated themselves as predominantly secure (none on the RQ and only two on the RSQ). It was interesting to note that one of the individuals who rated himself as secure on the RSQ scored himself as a '4' (on a scale of 1 to 7) on all four prototypes on the RQ. The other man who's best fitting category was secure on the RSQ rated himself as predominantly dismissing on the RQ (scoring '7' on the dismissing item, '6' on the secure item, '1' on the fearful item and '2' on the preoccupied item).

Most of the statistical analysis was conducted using the RSQ as the RQ seemed a weaker measure. Respondents seemed to find the RQ more difficult to score. The majority did not seem to prefer one particular prototype description, tending to score themselves highly on at least two of the scales. A large number of respondents could not be allocated a best fitting category on the RQ because they scored themselves as equivalent on two or more of the prototypes. In addition, some respondents seemed only to identify themselves with certain aspects of the RQ prototype descriptions and split the paragraphs into separate sentences, scoring themselves on each.

Table 6. Sample Size At Each Session

	Patient/Therapist dyads
Session 1	30
Session 2	27
Session 3	23
Session 4	22
Session 5	17

Table 7. Distribution of Attachment Prototypes

	RQ Best fitting category			RSQ best fitting category		
	Male	female	**total**	Male	Female	**total**
Secure	0	0	**0**	2	0	**2**
Fearful	5	5	**10**	4	7	**11**
Preoccupied	0	4	**4**	5	4	**9**
Dismissing	3	2	**5**	2	5	**7**
Uncategorised*	5	6	**11**	0	1	**1**

*these patients could not be given a best fitting category as they scored themselves equivalently on two or more categories.

Changes in the Alliance Over Time

Tables 8 & 9. show patient and therapist ratings of the alliance for sessions 2, 3, 4 and 5. Patient and therapist mean ratings of the alliance show a gradual increase over time, which is in line with findings reported in the literature. Paired sampled t-tests were conducted to see if the differences between sessions two and five were significant.

The change between both patient and therapist overall WAI scores was significant. The change was significant for the bond subscale but not the goal and task subscales which suggests the bond variable is subject to most development over this period.

Table 8. Patient Ratings of the Alliance Over Time

	WAI Total	Bond	Goal	Task
		Mean (SD)		
Session 2	**64.3** (10.0)	20.7 (4.3)	21.9 (3.6)	21.7 (4.3)
Session 3	**66.7** (10.0)	22.2 (4.0)	22.3 (4.0)	22.8 (3.5)
Session 4	**66.6** (11.9)	21.7 (4.4)	22.2 (4.1)	22.7 (5.1)
Session 5	**70.1** (8.8)	22.8 (3.6)	23.4 (4.0)	23.9 (3.0)
		t		
T-test comparing Sessions 2 & 5	**-2.1***	**-2.3***	-1.6	-1.2

*p<.05. **p<.01

Table 9. Therapist Ratings of the Alliance Over Time

	WAI Total	Bond	Goal	Task
		Mean (SD)		
Session 2	**57.8** (11.3)	18.7 (4.0)	20.2 (3.9)	18.8 (4.6)
Session 3	**60.3** (9.7)	20.2 (3.6)	20.3 (3.6)	19.8 (4.2)
Session 4	**62.4** (11.5)	20.2 (4.1)	21.3 (4.0)	20.8 (4.2)
Session 5	**64.9** (10.6)	21.3 (3.8)	22.7 (3.5)	20.8 (4.1)
		t		
T-test comparing Sessions 2 & 5	**-2.6***	**-3.1****	-1.9	-1.4

*p<.05. **p<.01

Comparisons Between Patient and Therapist Alliance Ratings

Patient and therapist ratings of the alliance were compared using paired sample t-tests and correlations.

Table 10. compares patient and therapist mean alliance scores for session 2 and session 5. At session 2 patients rate the overall alliance significantly higher than therapists, though by session 5 the difference is no longer significant.

Table 11. illustrates the correlations between patient and therapist ratings of the WAI for session 2. Patient and therapist overall WAI ratings were significantly correlated. However, while the correlations for the bond and task subscales were significant the ratings of the goal subscale were not. The correlations at session 5 showed similar patterns (table 12).

Table 10. Comparison of Patient and Therapist Alliance Ratings - Paired Sample T-test

		WAI Total	Bond	Goal	Task
			Means (SD)		
	Patients	**64.7**	20.9	22.04	21.8
n=27 pairs	Session 2	(9.9)	(4.2)	(3.6)	(4.4)
	Therapists	**57.8**	18.7	20.2	18.8
n=27 pairs	Session 2	(11.3)	(4.0)	(3.9)	(4.5)
	Sig. t	**-3.61****	-2.58*	-2.11*	-3.32**
	Patients	**69.7**	22.7	23.3	23.8
n=17 pairs	Session 5	(8.7)	(3.6)	(4.0)	(3.1)
	Therapists	**67.9**	22.1	23.8	21.9
n=17 pairs	Session 5	(9.0)	(3.8)	(2.6)	(3.3)
Sig t		**-.87**	-.58	.46	-2.47*

*p<.05 **p<.01

Table 11. Session 2 - Correlations Between Patients and Therapists -

n=27	Therapists			
Patients	**WAI total**	Bond	Goal	Task
WAI total	**.58****	.65**	.45*	.46*
Bond	.37	.44*	.31	.25
Goal	.46*	.54*	.33	.37
Task	.58**	.61**	.46*	.50**

*p<.05. **p<.01

Table 12. Session 5 - Correlations Between Patients and Therapists

n=17	Therapists			
Patients	**WAI total**	Bond	Goal	Task
WAI total	**.56***	.47	.27	.71**
Bond	.51	.54*	.23	.52*
Goal	.44	.35	.16	.63*
Task	.44	.32	.30	.59*

*p<.05. **p<.01

Rupture Rate

Table 13. shows the total number of ruptures reported by patients and therapists for each session. Overall, therapists reported more than twice as many ruptures when compared to patients; tensions were reported by therapists in 43% of sessions compared with 20% of sessions by patients.

Table 14. illustrates the frequency of agreement between therapist and patient on the occurrence of ruptures. There were relatively few occasions when patient and therapist agreed on the presence of a rupture (n=13), mostly due to non-reporting by patients. There were few occasions when patients reported a rupture and therapists failed to.

Table 13. Reported Ruptures - Totals

	Session 2	Session 3	Session 4	Session 5	Total (% of sessions)
	n=27	n=23	n=22	n=17	
Patients (total 90 sessions)	6	5	5	2	**18** (20%)
	n=27	n=25	n=25	n=21	
Therapists (total 97 sessions)	14	13	9	8	**42** (43%)

Table 14. Reported Ruptures - Frequency of Agreement

	Agree Rupture Present	Disagree Patient Reports	Disagree Therapist Reports	Agree No Rupture Present
Totals	13	3	24	47

A Note on the Analysis

The distribution of the attachment scores and the small sample size meant that it would not be practical or meaningful to compare the attachment patterns categorically; this directed the process of the statistical analysis. The risk of type I errors due to multiple analyses is recognised. However, with small sample sizes, such as those in this study, there also is a risk of type II errors because (a) there may not be enough statistical power to detect real differences, and (b) effect sizes tend to be small in process research due to the complexity of the subject matter. Overall, it seems appropriate to report significant results at the .05 alpha level so they can be submitted to interpretation and replication.

Question 1 - *Relationship between Attachment Style &* Alliance

To examine the relationship between attachment and alliance, the scores on the four attachment scales were correlated with patient and therapist WAI scores at sessions 2 and 5. The first and last alliance measuring points were chosen for analysis so any change in the impact of attachment as the alliance develops over time could be assessed. These correlations are shown in tables 15 and 16.

The correlations between attachment scores and **patient** ratings of the alliance were not significant. The associations tended to be stronger by session 5 but were still not significant.

There was a significant negative correlation between the fearfulness score and **therapist** ratings of the goal subscale of alliance at session 2. The correlation was no longer significant at session 5. There could be a clinical explanation for the reduction in the effect over time (for example, therapists may feel difficulties with goal agreement have improved by session 5). Alternatively, the loss of data from the analysis due to research/therapy attrition could account for it.

Table 15. Correlations - Attachment & Patient Alliance Ratings

		Secure	Fearful	Preoccupied	Dismissing
Patients			**r** (N=27)		
Session 2	**WAI**	.17	-.07	-.20	.11
total		.23	-.16	-.03	.01
	bond	.20	.14	-.25	.28
	goal	.25	-.11	-.23	.01
	task				
			r (N=16)		
Session 5	**WAI**	.13	-.41	-.30	.43
total		.24	-.21	-.08	.33
	bond	.01	-.38	-.16	.33
	goal	.16	-.44	-.38	.41
	task				

*p<.05. **p<.01

Table 16. Correlations – Attachment & Therapist Alliance Ratings

		Secure	Fearful	Preoccupied	Dismissing
			r (N=26)		
Session 2	**WAI**	.25	-.24	-.18	.04
total		.15	-.15	-12	.10
	bond	.37	**-.41***	-.28	.09
	goal	.17	-.12	-.10	-.07
	task				
			r (N=21)		
Session 5	**WAI**	.29	-.23	-.21	.13
total		.36	-.24	-.11	.01
	bond	.20	-.21	-.21	.17
	goal	.25	-.19	-.26	.18
	task				

*p<.05. **p<.01

Since the attachment scales are inter-related, multiple regressions were conducted to provide a more reliable estimate of the predictive power of the attachment variables independently of one another. The results are shown in table 17 and suggest that, at session 2, the attachment variables did not predict patient or therapist alliance scores.

In order to control for the effect of the initial (session 2) alliance level in the analysis of the relationship between attachment style and session 5 alliance, the session 2 alliance ratings were entered into the equation (along with the four continuous attachment scores).

None of the attachment variables were significant predictors of **therapist** alliance ratings at session 5.

There were some significant relationships between the attachment variables and **patient** alliance ratings at session 5:

- High levels of fearfulness predicted a lower overall alliance rating and poorer ratings of goal and task agreement.
- Higher dismissing scores predicted a higher overall alliance rating.

Table 17. Multiple Regressions - Do the Attachment Variables Predict Alliance Ratings?

		Attachment Prototype Scores (RSQ)			
		Secure	Fearful	Preoccupied	Dismissing
		beta			
Patients Session 2	**WAI total** n=27	.20	.13	-.19	-.03
Patients Session 5	**WAI total**	-.48	**-.61****	.55	**.61***
	bond	-.31	-.19	.46	.56
	goal	-.37	**-.78****	.35	.21
n=16	task	-.50	**-.61***	.22	.56
Therapists Session 2	**WAI total** n=27	.33	-.42	-.53	-.10
Therapists Session 5	**WAI total** n=21	.27	#	.01	.05

*p<.05. **p<.01. # = number too small to print

Question 2 - *R*elationship between *Attachment and Rupture Rate*

To examine the relationship between attachment and rupture rate, the attachment scores were correlated with the patient and therapist reported rupture rate. These correlations are shown in table 18.

There was a highly significant positive correlation between the preoccupied score and **therapist** rupture rate (p=.008). There was also a significant negative correlation between the dismissing score and the therapist rupture rate.

The correlations between the attachment scores and **patient** rupture rate did not quite reach significance. However, the associations showed the same pattern as for therapists, which suggests this was probably because patients reported fewer ruptures, hence reducing the statistical power.

Analysis of the distribution of the sample in terms of the attachment prototypes underscores the difficulties inherent in attempts to categorise adult attachment experience. Respondents did not fit neatly into the attachment prototypes provided and some of the scales are highly related. Therefore it seemed more meaningful to develop categories based on the current sample distribution of scores on the scales and use these groups for more qualitative analysis of the relationship between attachment and rupture rate.

The RSQ attachment scores were split into 3 equal groups representing High, Medium and Low scores for each prototype. Each respondent was given a high, medium and low score for each of the prototypes. This process resulted in 8 categories defined below:

1. **Fearful/Dismissing**

   Three respondents were defined as predominantly fearful and dismissing, scoring high on the fearful and dismissing scales, low on the secure scale and low or medium on the preoccupied scale.

2. **Secure/Dismissing**

   One respondent was defined as predominantly secure and dismissing, scoring high on the secure and dismissing scales and low on the fearful and preoccupied scales.

3. **Dismissing**

   Three respondents were defined as predominantly dismissing, scoring high on the dismissing scale, medium on the secure scale and low or medium on the fearful and preoccupied scales.

4. **Fearful**

   Five respondents were defined as predominantly fearful, scoring high on the fearful scale, low or medium on the secure scale and medium on the preoccupied and dismissing scales.

5. **Fearful/Preoccupied**

   Three respondents were defined as predominantly fearful and preoccupied, scoring high on the fearful and preoccupied scales, low on the security scale and medium on the dismissing scale.

6. **Preoccupied**

   Four respondents were defined as predominantly preoccupied, scoring high on the preoccupied scale, medium on the secure and fearful scales and low or medium on the dismissing scales.

7. **Medium Insecurity**

   Five respondents were defined as medium insecurity, scoring in the middle group on all four scales.

8. **Low Secure/Medium Insecure**

Three respondents fell into this category, scoring low on the secure scale and medium on the three insecure scales.

The attachment groups were then compared in terms of frequency of patient and therapist rupture reporting (Table 19). For patients, ruptures were most likely to be reported by those falling into the fearful and preoccupied groups, and were not reported at all by those with a high dismissing score. For the therapists there is more variability, but again, rupture reporting is concentrated in the fearful and preoccupied groups and also in the less defined low security groups.

Therapist and patient responses to the open-ended rupture question (i.e., *Please describe the problem in the space below*) are reproduced in the appendices with reference to the attachment groups described above.

Table 18. Correlations – Attachment and Rupture Reports

	Secure	Fearful	Preoccupied R	Dismissing
Patients	-.04	.19	.36	-.36
Therapists	-.21	.10	**.50****	**-.39***

*p<.05. **p<.01

Table 19. Attachment Groups and Rupture Reporting

Attachment group	Frequency Patients (sessions)	Frequency Patient ruptures	Frequency Therapist ruptures	Patient Rupture rate % of sessions	Therapist Rupture rate % of sessions
1. Fearful/Dismissing	3 (10)	0	5	0	50%
2. Secure/Dismissing	1 (4)	0	0	0	0
3. Insecure/Dismissing	3 (12)	0	2	0	17%
4. Fearful	5 (14)	6	7	43%	47%
5. Fearful/Preoccupied	3 (7)	2	4	29%	44%
6. Preoccupied	4 (15)	7	15	47%	87%
7. Low secure/medium insecure	3 (11)	1	13	9%	83%
8. Medium insecurity	5 (16)	0	0	0	0

Summary of Key Findings

Question 1 – Is attachment style associated with alliance?

There were some significant relationships between the attachment variables and **patient** alliance ratings at **session 5**:

- High levels of fearfulness predicted a lower overall alliance rating and poorer ratings of goal and task agreement.
- Higher dismissing scores predicted a higher overall alliance rating.

There was a significant negative association between fearfulness in attachment and **therapist** ratings of the goal subscale of alliance at **session 2**.

Question 2 – Is attachment style associated with reported rupture rate?

There were some significant relationships between **therapist** rupture rate and scores on some of the attachment subscales:

- Higher preoccupied scores were related to higher reported rupture rates.
- Higher dismissing scores were related to lower reported rupture rates.

The associations between the attachment variables and the **patient** rupture rate did not quite reach significance, but showed the same pattern as for therapists.

DISCUSSION

This study aims to investigate relationships between self-reported attachment patterns in adults and the development of the therapeutic alliance. The alliance was studied in terms of ratings of its quality and tensions or 'ruptures' reported by patients and therapists. It is an exploratory study in a relatively new area that is not yet well understood. There is little previous research which enables prediction of the extent to which ruptures might be experienced and reported in the early alliance and no prior studies of how ruptures could relate to attachment style. The sample size is small so interpretation must be tempered, but there were a number of interesting associations between self-reported attachment, alliance and rupture reporting. Overall, the results are promising and suggest this could be a fruitful area for continued research.

Problems and Cautions in Interpreting the Results

A common difficulty in the interpretation of process research is the often non-linear relationships that occur between the variables (Stiles & Shapiro, 1994). Therapy is dyadic and operates as a system, so therapists and patients will tend to adjust following moment to moment feedback from one another. Interpretation of such complex, non-linear interactions, can be problematic with a correlational design utilising linear statistics. To use a hypothetical example, if the relationship between warmth and outcome was being studied the association would be confounded if for some patients lower levels of warmth improved outcome and for others higher levels of warmth improved outcome. If therapists responded to the differences between

the two groups by adjusting the level of warmth, the association between warmth and outcome might, erroneously, appear to be very weak. These kinds of difficulties are very relevant to the current study.

Relationship Between Attachment Style and Alliance

One of the main questions of the research was whether attachment style could be related to reports of alliance quality. The results provided some support for an association. Firstly, fearfulness in attachment was a significant predictor of lower patient rated alliance at session 5. Secondly, fearfulness was significantly associated with lower therapist rated goal agreement at session 2. Thirdly, a dismissing attachment style predicted higher patient rated alliance at session 5.

The link between fearful attachment and poorer alliance ratings corresponds with previous research by Mallinkrodt, Coble & Gantt (1995) which demonstrated a relationship between adult social competencies and alliance. Specifically, in the Mallinkrodt study, comfort with intimacy and emotional closeness was predictive of more positive alliance ratings and high levels of anxiety in relationships was predictive of more negative alliance ratings. The current finding suggesting a dismissing attachment style is predictive of higher alliance ratings is more surprising.

The attachment behaviour system is considered to continue to have a major influence on any adult social relationship that has the potential to offer love, security, and comfort (Ainsworth, 1989). Bowlby (1988) viewed the therapeutic relationship as performing a similar role to the parent caregiver, offering emotional

availability, affect regulation, a comforting presence and a secure base from which to explore one's experience. Therefore, it seems likely that an adult patient's working models of self and others will be evoked in the therapeutic situation, influencing their behaviour and expectations of the therapist.

A Fearful attachment style, according to the Bartholomew & Horowitz (1991) four category model, is characterised by a sense of the self as unlovable combined with an expectation that others will be untrustworthy and rejecting. Such negative self and other models are likely to influence the patient's view of the therapist, perhaps explaining the more negative ratings of the alliance found in the current study. Issues around trust relate particularly to the bond aspect of the alliance so fearfulness might have been expected to predict a poorer bond rating. However, analysis of the alliance subscale ratings showed that fearfulness was significantly related to lower task agreement ratings and highly significantly related to lower goal agreement ratings but **not** to lower bond ratings. This finding corresponds with Muran *et al.,* (1996) who found that while goal and task ratings were significantly related to types of interpersonal problem, bond ratings were not. While theoretically the three aspects of the alliance are interrelated, it is possible that bonding is more influenced by factors such as the match between the interpersonal or attachment styles of the therapist and patient.

Another possible explanation for the differential associations between fearfulness and he alliance subscales relates to Stiles & Shapiro's (1994) argument about non-linear relationships in psychotherapy process. Therapists may be particularly skilled at adjusting to meet bonding needs, reducing any association. In the present study, the correlations between the total sample of patients and therapists on goal

agreement were weak relative to bond and task ratings. This could suggest that therapists adjust to meet patients needs more in the areas of bonding and task agreement relative to goal agreement. Indeed, there is evidence that therapists and patients can attach different valences to therapy goals. Llewelyn *et al.,* (1988) found that therapists tend to value understanding and insight, whereas patients are more concerned with finding solutions and feeling better. Mallinkrodt, Coble and Gantt (1995) provide an attachment perspective to this issue, hypothesising that the alliance may be strained around therapeutic goals and tasks that are incompatible with the client's needs to maintain an ideal psychological proximity to the therapist. For example, the therapist may feel the therapy should tackle the patient's over-dependence but the patient might be resistant to such a goal.

A closer look at attachment theory might help explain how the attachment behaviour system could disrupt alliance development. Main (1990) describes *primary* and *secondary* attachment strategies. Primary strategies allow the child to meet attachment needs, for example, separation protest is a primary strategy aimed at reestablishing contact with the attachment figure. Once any attachment discrepancies are resolved the child can then turn attention to other matters such as exploration of the environment. However, those with experience of a less responsive attachment figure may turn to secondary strategies that might be adaptive in childhood but can hinder environmental exploration and over time develop into ingrained, maladaptive patterns of relating. Main described two common types of secondary strategy, *deactivation* and *hyperactivation.* The child tends to deactivates the attachment system when their model forcasts rejection or insensitivity, thus minimising conflict with the attachment figure by avoidant behaviour. The child tends to *hyperactivate the attachment system when their*

model forcasts an inconsistent response, becoming hypervigilant for signs of abandonment by the attachment figure. Adults with a fearful attachment style may be employing such strategies in the therapeutic relationship and this may interfere with alliance development.

Fearfulness was also negatively associated with therapist ratings of goal agreement at session 2. This relationship was not found in the regression analysis so the correlation may be spurious. However, the fact that highly fearful patients and their therapists both report lower goal agreement suggests there may be a real difficulty in this area for these patients. Perhaps therapists find it more difficult to focus on the work of therapy and establishing goals if the patient's attachment anxieties are overwhelming. It is interesting that therapists report the lower goal agreement in session 2, whereas patients report it in session 5. A possible explanation for this is that therapists are more aware of what is expected in the therapy situation and so more tuned in to potential difficulties earlier on. Patients may be too busy struggling to understand the nature of therapy and how it might differ from their expectations in the first few sessions to be able to discriminate particular problems. Compliance may be another possible factor. Highly fearful people are characterised as holding an internal model of attachment figures as rejecting if displeased. They may give the impression of greater compliance with goals and tasks as therapy progresses to avoid rejection and abandonment. The therapist may be convinced that agreement on goals and tasks has improved, while the patients are expressing their more private feelings of disagreement in their alliance ratings.

A dismissing attachment style is characterised by a positive self-model and negative other-model (Bartholomew & Horowitz, 1991). Such individuals are considered to

protect themselves from hurt or rejection by avoiding close relationships and maintaining a sense of invulnerability. In the present study, a high score on the dismissing scale was a significant predictor of higher patient overall alliance ratings at session 5. On first reflection this is a surprising result, given the negative view of others and discomfort with intimacy characteristic of a dismissing style. However, it does correspond with Mallinkrodt, Gantt & Coble's (1995) description of a cluster of patients called *reluctant* who reported good alliances but differed from the secure cluster in their unwillingness to participate in the self-revealing tasks of psychotherapy. They suggested that the reluctant cluster might correspond with the dismissing category on the Bartholomew and Horowitz model.

Mallinkrodt and his colleagues speculated that their reluctant patient's high alliance ratings might have been influenced by a degree of denial of their difficulties. Theoretically this seems possible since dismissing patients are characterised by a tendency to deactivate their attachment system and so deny their attachment needs. However, in the current study, the associations between the dismissing score and the therapist alliance score were weak. If there was a problem in the alliance which the patients were denying, the therapists were either not aware of it or, not reporting it. Most of the patients in the current study were receiving cognitive behaviour therapy; perhaps the structure and practical nature of the CBT approach is particularly appreciated by more dismissing patients. It would be interesting to see if a different result would be obtained with a different therapeutic approach, particularly with more psychodynamic and exploratory therapies which require greater self-disclosure.

It is possible that another factor associated with attachment accounted for the significant relationships found in the present study, for example, interpersonal style. Indeed, previous research has shown that different attachment styles correspond to particular types of interpersonal problem (Horowitz, L. *et al.,* 1993). Horowitz and his colleagues found that highly fearful respondents tended to be to be unassertive and socially inhibited relative to the other attachment styles. Such interpersonal attributes could have a more direct influence on alliance development than attachment related behaviours.

Levels of security and preoccupation in patient attachment styles were not found to be significant predictors of alliance ratings. Returning to the Stiles & Shapiro (1994) point, therapy is dyadic so the apparent lack of a significant relationship in a correlational study does not necessarily mean attachment security or preoccupation do not have an impact on alliance development. It is possible that therapists adjust their approach more readily in response to such behaviour types. However, people with a secure attachment style are characterised as feeling comfortable with intimacy and experiencing relatively low levels of anxiety in their relationships. An association between security and higher alliance ratings might therefore have been expected. In fact, there was a trend (which approached significance) in the opposite direction - towards higher security scores predicting lower alliance scores at session 5. Previous research by Horowitz, M.J. (1984) could help explain both this trend and the surprising association between a dismissing attachment style and higher alliance ratings. Horowitz found that high motivation for therapy and high levels of psychological adjustment were associated with a more critical stance towards the therapist and better outcome. For less adjusted individuals a more critical stance was associated with poorer outcome. Related to this, Safran (1993) talks of

alliances and 'meta-alliances', suggesting that if a patient feels sufficiently safe and trusting in the meta-alliance, they may feel more able to express and explore negative sentiments towards their therapist. In attachment theory terms, it might be argued that more secure patients possess more flexible internal working models which do not view disagreement as catastrophic and likely to result in rejection or abandonment by the attachment figure. They might therefore feel more able to disagree with their therapist, explaining the trend towards lower alliance ratings.

Development of the Alliance Over Time

In the present study, the average patient and therapist ratings of the alliance showed a gradual increase over time, which is in line with larger studies in the literature (e.g., Horvath & Symonds, 1991). The effect was particularly present in the bond subscale which perhaps suggests that this aspect of the alliance is more influenced by time than the task and goal elements. This makes sense, as in any relationship it can take time for mutual trust and understanding to develop. It was interesting to note that a number of respondents felt unable to answer some of the bond questions in sessions 2 and 3, particularly the question based on liking (*I believed that my therapist likes me*) - some patients underlined the word liking and put a question mark in the margin, while others wrote *'I don't know'* or *'it's not his job to like me'*. Perhaps this is indicative of the difficulty some patients may have with adjusting to and understanding a relationship which is on the one hand professional and boundaried but on the other requires them to share some of their most intimate thoughts and feelings.

The significant relationships between the attachment variables and alliance were mostly found at session 5, rather than session 2. This makes clinical and theoretical

sense. Problematic working models are thought to be self-perpetuating, so the problems the patient usually has in meeting their attachment needs are likely to be repeated in the therapy relationship (Mallinkrodt, 1996). However, it seems likely that attachment issues might be more likely to have an impact on the alliance as the patient's attachment to the therapist is developed.

Relationship Between Attachment Style and Ruptures

The phenomena of alliance ruptures in the early alliance has been under-researched. The current study aimed to explore whether there might be any utility in approaching their investigation from an attachment perspective and to provide direction for future more formal qualitative research. The results are very promising. There was (a) a significant positive association between preoccupied attachment reports and the frequency of therapist rupture reporting and, (b) a significant negative association between the dismissing attachment variable and frequency of therapist rupture reporting. The number of ruptures reported by patients was small, though, the associations are in the same directions as the therapist reported rates which adds some weight to their reliability.

The extent to which ruptures occur in the early alliance cannot be reliably judged by asking for patient and therapist reports because of the large potential for reporting bias. However, the results do suggest that they may occur fairly frequently. Therapists reported tensions or ruptures in almost half of sessions. The reliability of this finding in terms of the actual rupture rate is unclear; it is quite likely that therapists would have attended more carefully to tensions between themselves and

their patients because they were participating in the study, particularly those who had an interest in the phenomena. At the same time, ruptures might have been under-reported by therapists, perhaps due to the time commitment involved in questionnaire completion. Patients reported ruptures less frequently than therapists which might suggest they were less aware of tension. Alternatively patients might be more likely to attribute tension to factors outside of the relationship, particularly early in therapy.

The significant relationship between preoccupied attachment reports and higher therapist reported rupture rate was quite striking. It also makes theoretical and clinical sense; highly preoccupied clients are, by definition, preoccupied with their attachment needs and so might be predicted to be preoccupied with their therapist as an attachment figure (Bartholomew and Horowitz, 1991; Mallinkrodt *et al.,* 1995). In terms of attachment theory, a preoccupied attachment style is associated with a tendency to hyperactivate the attachment system. This secondary strategy is associated on the Adult Attachment Interview (Main & Goldwyn, 1985) with discourse incoherence characterised by excessive irrelevant information, difficulty maintaining a clear sense of discourse context, and anger that interferes with a balanced perspective on the self and one's parents (Kobak *et al.,* 1993). The findings of the current research could suggest that such attachment strategies and behaviours among preoccupied clients are experienced by therapists in terms of high levels of tension in the relationship. A number of studies have demonstrated that poor therapeutic outcome is linked to a tendency for therapist and patient to have become stuck in negative interactional cycles (e.g., Strupp, 1980; Henry, Schacht & Strupp, 1986, 1990; Keisler & Watkins, 1989). It may be that this sort of

situation is more likely to occur with highly preoccupied patients and this is reflected in the higher therapist reported rupture rate.

In contrast with preoccupied clients, dismissing clients are likely to deactivate the attachment system and so deny their attachment needs (Bartholomew and Horowitz, 1991; Mallinkrodt *et al.,* 1995). The relationship between higher dismissing attachment ratings and lower rupture reporting is therefore not surprising. Theoretically, dismissing clients would be expected to deny the importance of the therapist as an attachment figure and so be much less attuned to their behaviour. It may be that, as a consequence of this, ruptures rarely occur with highly dismissing patients and the low therapist rupture rate reflects this. Alternatively, it is possible that ruptures which do occur with highly dismissing patients tend to be less dramatic, so both therapists and patients may fail to recognise them. Safran & Muran (1996) describe two main sub-types of rupture marker; confrontation and withdrawal. Confrontation rupture markers are when the patient directly indicates anger, resentment or dissatisfaction with the therapist or therapeutic process. Withdrawal rupture markers are when the patient withdraws or partially disengages from the therapist, his or her own emotions or some aspect of the therapeutic process. It may be that ruptures occurring with dismissing patients tend to more often be of the withdrawal type than the confrontation type, accounting for the lower reported rate. Horvath & Luborsky (1993) argue that an absence of ruptures can be a sign of poor alliance, perhaps suggesting the patient is idealising the therapist or avoiding challenging difficult feelings. The lower rupture rate and higher alliance ratings among dismissing clients in the present study could suggest these patients have genuinely been able to develop a good alliance. Alternatively, this finding

could suggest they are avoiding difficulties in the way that is characterisic of their attachment style.

Security was not associated with the patient rupture rate. Secure individuals have an internalised sense of security in the attachment figure which would mean theoretically that they would be less sensitised to the behaviour of their therapist in terms of looking for signs of rejection or abandonment. The model of the attachment figure as generally responsive would also mean they would feel more able to freely explore feelings of conflict and disagreement (Main & Goldwyn, 1985; Kobak *et al.,* 1993). Therefore, while more secure patients would be expected to experience relatively less tension in the therapy relationship, they might feel more able to report ruptures that did occur, thus canceling out any significant association.

Fearfulness was only weakly associated with patient rupture rate. Again, this can be made sense of in terms of the distinction between actual rupture rate and rupture reporting. On the one hand tensions would be expected to be reasonably high as fearful individuals desire intimacy but expect rejection, making any bonding process anxiety provoking. However, at the same time, they may feel too anxious about the response of the therapist to feel able to explore tensions in sessions or report them in the questionnaire. The weak association between fearfulness and therapist rupture reporting was more surprising. Even if highly fearful patients tend to avoid confrontation, the therapists might have been expected to be more aware of underlying tensions and report them. It is possible that some therapists may have believed they were only to report highly confrontational ruptures, rather than more subtle withdrawals. Alternatively, they may have been genuinely unaware of tensions.

An alternative perspective on differential rupture reporting could be in terms of the particular interpersonal problems associated with the particular attachment styles. On the Inventory of Interpersonal Problems (IIP) Horowitz, Rosenberg & Bartholomew (1993) found that respondents with a secure attachment style tended to be high on warmth and low on problems associated with dominance. The relatively low rupture rate in the current study could be due to a warmer friendlier style, rather than directly related to attachment issues. The fearful group reported interpersonal problems reflecting unassertiveness and social inhibition, which could suggest a tendency to avoid conflict and in turn result in a lower rupture rate. Those with a preoccupied attachment style tended to be overly expressive and high on dominance, which might account for increased rupture reporting. In contrast, respondents with a dismissing style were described as low on the expressiveness and high on introversion, perhaps accounting for fewer rupture reports.

It is not possible to say from this study the extent to which ruptures were occurring which were not reported. To really understand the role of ruptures in the early alliance and their relationship with attachment seeking behaviours, qualitative task analytic procedures, such as those employed by Safran and Muran (1996) would need to be used.[1] It is probable that there are many factors which will influence the likelihood of experiencing and reporting a rupture. Personality factors such as sensitivity and hostility would undoubtedly have a role in whether such events are experienced, as might mood or tiredness. The findings of the current study suggest that attachment related behaviours may have a role, at least in the reporting of such events and probably in the likelihood of ruptures being experienced. Future studies

[1] Task analytic procedures attempt to understand psychotherapy by developing a model of psychotherapy process which is then tested against further examples.

could assess the relative utility of attachment patterns for understanding ruptures, in comparison with associated variables such as interpersonal stance.

Qualitative Exploration of Ruptures

Given the diversity of scores among individuals allocated the same best-fitting attachment category, it was decided that examination of the open-ended data in terms of these categories would be less valid. Attachment groups were therefore developed based upon the analysis of scores on the RSQ. The disadvantage of this approach is that there are more attachment groups and less respondents in each group making generalisations more difficult. However, it does mean the comparisons are more transparent and the variability between respondents is acknowledged.

Examination of rupture reporting by these attachment groups revealed quite a striking picture in which no ruptures were reported by patients scoring high on the dismissing scale. The number of patient reported ruptures is small and based on very few people, but it is interesting that they are concentrated among those scoring high on the preoccupied and fearful scales. The therapist reported ruptures are more evenly spread between the attachment groups, though particularly concentrated among the preoccupied, fearful and low secure groups.

The understanding which can be drawn from the answers to the open-ended rupture question is limited for a number of reasons. Firstly, there are few patient descriptions available; secondly, the descriptions are out of context and so difficult to interpret without making inferences and thirdly, some of the attachment patterns

are not represented (though of course this is interesting in itself). However, close inspection of the reports can add meaning to the findings and could provide direction for future research questions. The rupture reports for patients belonging to the different attachment groups do have a different quality to them. Case examples can illustrate this:

Example 1. A High Fearful/High Dismissing Case

None of the patients scoring high on the dismissing scale reported ruptures, though there were therapist reports which suggest something of the nature of the interaction:

Patient said she was uncomfortable with my looking at her and 'analysing' her although this was what she expected I should do. This was explored in CBT terms. Then she talked about feeling that she mucks up relationships by going cold. Then later she said there was something else she was worried about which may have caused her depression, but felt she couldn't tell me what it is. Asked how long still had in the session, I said 10 mins, she said wanted to wait till next time (Session 2).

The above rupture can be understood from an attachment perspective; she seems to have a model of others as critical and rejecting, which makes the disclosure about her depression difficult. The behaviour she describes as 'going cold' can be understood as a deactivating strategy, designed to minimise conflict with the attachment figure based upon a hopelessness about the likelihood of achieving desired proximity and felt security. She seems to be aware of this behaviour in herself and fear that the pattern will be repeated in the therapy relationship, i.e., that as with other relationships she will not be able to have her attachment needs met.

It would also be possible to make sense of the rupture in interpersonal terms; she has a dysfunctional interpersonal schema of others as critical and rejecting, and so avoids close contact with others. Others experience this as her going 'cold' and perhaps respond in a similar manner resulting in a maladaptive interpersonal cycle which serves to confirm her pre-existing schema. The two views are clearly similar, however I would argue that the attachment formulation has an element lacking in the interpersonal understanding; the idea of a 'primary' strategy (Main, 1990) which is to reestablish contact with the attachment figure. This aspect of the formulation would have important clinical implications in terms of response and interpretation.

Example 2. A High Preoccupied Case

This particular patient reported two ruptures, in sessions 2 and 4. The therapist reported a rupture in sessions 5.

Patient: *I don't think this therapy is going to work for me. My therapist lets me do all the talking - how can I improve by talking? I need advice - feedback - not just the odd prompting question. I can imagine having to do a further 9 sessions with me just talking. Maybe it's too early to tell.* (session 2)

Patient: *I feel that my therapist doesn't understand my problems - that she is perhaps lacking in experience. Maybe I'm just being impatient and expecting results too soon. I keep wondering whether I should see a different therapist. I'll give it more time. Why do I have to answer these questions every session?* (session 4)

Therapist: *She arrived late saying she was going to have to leave early because she had not been able to put enough money in the parking meter to last long enough. She then questioned the value of continuing the therapy altogether because she felt she did most of the talking, and although I had said one or two 'perceptive' things, she was disappointed that I was not giving advice about how to 'get rid' of her mood swings/inability to succeed in life. She did not accept a goal of learning how to manage herself/her moods; she wanted to get rid of the problem altogether. I said I could not guarantee that.* (session 5).

From an attachment perspective, one might understand the rupture in terms of another type of secondary strategy, hyperactivation of the attachment system (Main, 1990). The employment of this strategy is based on a working model which expects an inconsistent response from the attachment figure. In the infant Strange Situation (Ainsworth *et al.,* 1978) this strategy was associated with decreased exploration and contact seeking, together with expressed anger toward the attachment figure (Kobak *et al.,* 1993). Her angry and rejecting tone towards the therapist, her late arrival and threats of ending contact could be formulated in this way. Interestingly, the patient returned her session 5 questionnaire blank. However, she did return the CATS at session 5 writing on it *'very good questions!'*, suggesting that attachment issues were very present for her. Indeed, she had the highest score in the sample on the Preoccupied-Merger scale of the CATS.

Again, the rupture could be formulated from numerous perspectives that are not incompatible with an attachment understanding, such as interpersonal theory, object relations and transference theory. It is important to remember that an attachment view is limited in its scope; the primary goal of attachment behaviour is to maintain

proximity to the caregiver, which cannot explain all goal-directed behaviour. In a recent paper, Mallinkrodt (1996) has attempted to link different theoretical conceptualisations of transference phenomena, including attachment theory, cognitive interpersonal schemas and inflexible patterns of interpersonal behaviour. He suggests that transference could be viewed as in-session samples of inflexible interpersonal schemas (see Safran & Segal, 1990), information processing patterns (Singer, Sincoff & Kolligian, 1989) and social competency deficits (Mallinkrodt, in press). Attachment working models are conceptualised as a particular type of core schema which may have particular relevance for the therapeutic relationship. It seems likely that ruptures might in part arise as an expression of such difficulties.

Rupture Agreement

Sessions where patients and therapists agreed on the presence of a rupture were relatively rare. This was due to patient, rather than therapist, non-reporting. There were very few occasions when therapists failed to report a tension in a session where the patient reported a tension. This could suggest that therapists were generally in touch with their patients, and this was at times clearly the case, for example:

Example 3:

Patient: *It was difficult to make a final commitment to the therapist, until about half way through the session. Then honesty seemed to mind and I was able to speak plainly and describe the deeper rooted problems I was experiencing* (session 3).

Therapist: *Patient talked about feeling angry with me in the previous session but this didn't create tension, it was helpful to talk about this and improved things between us (session 3).*

However, there were other mutual rupture reports where the therapist seemed to be struggling to grasp the nature of a problem in the alliance:

Example 4:

Patient: *He doesn't know (yet?) everything about my situation. Although the therapy approach seems ok I'm not sure I can apply it yet. It feels like it's going a bit fast* (session 3).

Therapist: *Not completing homework tasks. She felt embarrassed sharing written thoughts* (session 3).

Individual patients and therapists varied in their tendency to report ruptures (from none of the sessions measured to all of them). Neither patients nor therapists were given a definition of a rupture so it is highly likely that the tensions reported differed markedly in their strength, nature and importance. It is not clear from this study whether the reported 'ruptures' were ruptures in the sense that Safran & Muran (1996) operationalised them. Some of the ruptures seemed to be strains in an otherwise positive alliance, for example:

Example 5:

Patient: *I had recounted an incident to my therapist. She listened intently and sympathetically as she always does, but at the end she explained that because of*

the limited time that we have together we needed to move on to discussing what was best for me to do next. I fully appreciated this, but then felt awkward that perhaps I was going on about my problems . . . before this I could tell her things I hadn't been able to tell anyone else but now I was anxious not to be going on. I felt betrayed and angry as she is the only person I can really talk to (Session 2).

Therapist: *Conflict between the 'agreed' goals (i.e., graded exposure and anxiety management techniques) versus emotional need of the patient to talk about relationships (past and present) and gain some emotional relief from so doing. The problem arose over trying to keep focused on designing a hierarchy of anxiety provoking situations (to be used as goals in between sessions). I felt that I had (unintentionally) failed to acknowledge and contain the depth of feeling by bringing the focus back to the 'focused' task. I wonder whether she feels less able to 'trust' me as a result?* (Session 2).

Other rupture reports suggested that major difficulties in alliance establishment had occurred, such as in the preoccupied case example 2. above. From an alliance theory perspective, it was clear that in case 2. the therapist and patient described had experienced major difficulties in the establishment of an alliance. There was no agreement on goals; the client wanting to *'get rid'* of her difficulties, the therapist suggesting better management of them being a more realistic goal. In terms of tasks the therapist was using a brief psychodynamic approach which the patient seemed to experience as doing very little to help with her difficulties. They clearly had very different perspectives on what would be most helpful. Llewelyn's (1988) research comparing patient and therapist perceptions, suggested that some discrepancy

between the two participants may be important to stimulate therapeutic movement, but too much disagreement was associated with poorer outcome.

An example below of therapist rupture reports in relation to a patient who dropped out of therapy after session 3 provides an illustration of a therapist's perception of a failure in alliance establishment:

Example 6:

Therapist: *Different understanding of the purpose of the session. I felt helpless in the face of his problems* (Session 2).

Therapist: *I felt bored, disengaged* (Session 3).

Measures

The difficulties surrounding attachment measurement were highlighted by the study. Individuals fitting into the same best fitting attachment category often had a very different profile of scores which are probably indicative of clinically meaningful differences between them. The examination of the sample distribution in terms of attachment provided some support for the validity of a prototype measure which allows degree of fit to a category to be assessed, but also allows individuals to be scored on each attachment scale. The results of this study suggest that self-reports of attachment may be best understood as clusters of overlapping and related perceptions and behaviours, rather than discrete categories.

The convergence between the RSQ and RQ was generally acceptable, though considering that they are designed by the same author to measure the same constructs one might have expected the correlations to have been higher. The utility of the RQ was questioned by the study since the combination of perceptions and behaviours described by each category did not seem to feel meaningful for all respondents. The RSQ's more indirect method of tapping the attachment patterns seemed to have more face validity. The RSQ did demonstrate some ability to predict response to the therapeutic relationship in terms of the patient alliance at session 5, which is supportive of its predictive validity. The contrast between the fearful and dismissing scales in terms of alliance correlations suggests that the Bartholomew and Horowitz' (1991) model of viewing them as potentially distinct clusters of behaviour has clinical meaning and utility.

As an attachment to therapist measure, the CATS would be expected to correlate with adult attachment measures. Mallinkrodt *et al.,* (1995) failed to demonstrate consistent convergence between the CATS and the Adult Attachment Scale (Collins & Read, 1990), which questions its construct validity. In the current study the Preoccupied-Merger subscale correlated well with the Preoccupied scale of the RQ and RSQ, and as predicted in terms of model of self and other (i.e., negative model of self and positive model of other). However, contrary to predictions, the CATS Secure and Avoidant-Fearful scales did not correlate with the RQ or RSQ in the ways that were expected. This perhaps highlights the difficulties in the measurement of attachment related constructs as much as any difficulty with the CATS measure itself. The overlapping of meaning between the different measurement constructs implied in the literature is often highly deceptive. Alternatively, there could also be a clinical explanation for the weak associations. It may be that patterns of attachment in the therapy relationship do not always correspond with patterns in other adult relationships. The nature of the therapy situation may create a special case scenario. The high correlations between the CATS and RSQ/RQ Preoccupied scales could suggest that such individuals' preoccupation with attachment concerns makes re-enactment in the therapy situation more likely. The boundaries of the therapy situation may reduce the expression of transference feelings among the less preoccupied, at least early in therapy. In contrast, preoccupied attachments are characterised by a desire for the dissolution of boundaries, so individuals who tend to make such attachment relationships may find the therapeutic boundaries less effective in their containing function. If this were the case, it would have strong clinical implications, particularly that more preoccupied individuals might require more firm therapeutic boundaries,

whereas the more fearful and dismissing may benefit from being encouraged to express their attachment needs.

Clinical Implications & Future Directions

Current alliance research is moving beyond linking alliance and outcome to an understanding of how the alliance is constructed. The present study aimed to explore the possible role of attachment patterns in alliance development. The findings suggest that certain attachment perceptions and behaviours might predispose the alliance to particular problems. Further research would be needed to see if the findings could be replicated among a larger sample and to study attachment seeking behaviours in the therapy situation in more detail. If the current findings could be replicated and extended there could be significant implications for future research and clinical practice. Future research needs to examine the extent to which the attachment behaviour system is operating in the therapeutic relationship and it's impact. If therapists were expecting particular patients to behave in particular ways, they could better recognise and respond to potential problems and adjust accordingly. An understanding of how attachment patterns are enacted in the therapy relationship might also help clinicians identify the most appropriate and effective balance between wider therapeutic goals and attachment goals for particular patients.

There could also be implications for suitability for brief therapy. Quality of interpersonal functioning has been suggested as an important selection criteria for brief therapy (Horowitz *et al.,* 1993). The current study suggests attachment

patterns may also have particular implications. Future research could assess the relative importance of interpersonal and attachment behaviours. The current results suggest that highly fearful patients may be particularly unsuitable for short-term therapy, since they seem to have more difficulties establishing an alliance. The implications for highly dismissing clients are less clear cut. They rated the alliance positively at session 5, which is interesting since early alliance scores are strongly associated with good outcome (Horvath & Symonds, 1991). The current finding is not consistent with Horowitz' *et al*'s (1991) suggestion that people who express problems primarily of hostile dominance (associated with a dismissing attachment style) would benefit least from short-term psychotherapy. However, Horowitz *et al.,* were referring more to brief dynamic therapy. Perhaps such patients respond well to practical therapies focusing on specific problems, rather than those which tackle core themes. Future research could address this question

Limitations

The naturalistic nature of the design means it is difficult to say to what extent the sample is representative of typical populations within NHS psychology departments. The degree of insecurity reported on the attachment measures was surprising, despite the sample being a clinical population. There was certainly a considerable bias present, particularly in the therapist's choice of participating patients; some admitted avoiding asking patients they felt were going to be particularly problematic to participate. There was a high proportion of therapists in the sample practicing CBT so it is particularly difficult to know if the findings would be generalisable to other forms of therapy. Bias is also present from patients; it seems likely that the

more motivated patients agreed to participate and particularly to continue returning questionnaires. A notable number were lost through research and therapy attrition which may make the sample remaining at session 5, when most of the significant effects were found, less representative.

A reliance on self-report forms of measurement introduces the possibility that correlations are inflated and results biased because of the common response set and methodology. Reliance on self-report is particularly problematic in attachment research because of the poor correlations between these measures and interview forms of measurement. The extent to which attachment organisation is being measured is unclear. It seems more likely that such measures are tapping some of the behaviours and perceptions associated with particular attachment patterns. This makes it difficult to assess whether the associations between alliance and attachment scores relate to attachment per se, or perhaps more to behaviours in current close relationships which are related but influenced by other non-attachment factors. Ideally, future research would utilise a more reliable method such as the Adult Attachment Interview. Such a design might allow more meaningful links to be made between attachment organisation and attachment seeking behaviour in-session.

Another limitation of the study was its sole focus on patient characteristics. Recent research has demonstrated a relationship between therapist attachment organisation and the nature of their interventions with patients (Dozier *et al.,* 1991; Dozier, 1993). Dozier noted that while there are similarities between the therapeutic relationship and the infant-caregiver relationship, there is an important difference; the therapist also has the task of helping the client change working models of

relationships. This is a difficult task given the strong pull to respond in model confirming ways. Dozier's research suggests that therapist attachment organisation might be fundamental in determining whether they respond in model confirming or model challenging ways. She found that secure case managers were more able to respond to the underlying need of clients, such as the attachment needs of dismissing clients. In contrast, insecure case managers responded to the most obvious presentation of needs; intervening more intensively with preoccupied clients and less intensively with dismissing clients, possibly serving to confirm existing working models. Dozier (1993) argues that a preoccupied or dismissing match between therapist and patient may be experienced as less disruptive but may serve to confirm existing models. Linking Dozier's findings with those of the current study raises the question of whether the lower therapist rupture rate for dismissing patients and higher rupture reports for preoccupied patients suggests therapists were intervening in model confirming ways.

Conclusions

The current study has highlighted the conceptual richness of attachment theory for thinking about the way that interpersonal problems are manifested in the therapeutic relationship. The results suggest that there may be different patterns of alliance difficulties associated with different attachment styles. Most notable was the finding that highly fearful patients may have particular difficulties establishing an alliance, particularly in terms of goal and task agreement. It may be that highly fearful patients find it difficult to establish a secure alliance that enables them to freely explore their problems and to fully participate in the work of therapy. Further research is needed to understand whether dismissing patients really establish very positive alliances, or if the lack of rupture reporting indicates a superficial alliance which is tackling only surface problems, rather than attending to core issues. Therapists differential reporting of ruptures between dismissing and preoccupied patients could suggest that therapists are mostly responding in ways that confirm existing models. They may be attending more to the dependency needs of preoccupied patients, therefore failing to challenge their dependence, and less to the dependency needs of dismissing clients, therefore colluding with the invulnerability they present. Subsequent research needs to move in the direction of differentiating between types of alliance. In some cases, a positive alliance may mean the therapy is unchallenging, whereas negative reports may reflect a positive meta-alliance which is strong enough for the more moment to moment alliance to be criticised and questioned.

REFERENCES

Ainsworth, M.D.S. (1989). Attachments beyond infancy. *American Psychologist,* 44, 709-716.

Ainsworth, M.D.S., Blehar, M.C., Walters, E., & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation.* Hillsdale, NJ: Erlbaum.

Al-Darmaki, F. & Kivlighan, D.M. (1993). Congruence in client-counselor expectations for relationship and working alliance. *Journal of Counseling Psychology,* 40, 379-384.

Alexander, F. & French, T. (1946) *Psychoanalytic Therapy.* New York: Ronald Press.

Alexander. L.B., & Luborsky, L. (1987). The Penn Helping Alliance Scales. In L.S. Greenberg & W.M. Pinsoff (Eds.).

Bakermans-Kraneberg, M.J. & Van Ijzendoorn, M.H. (1993). A psychometric study of the adult attachment interview: Stability and discriminant validity. *Developmental Psychology,* 29, 870-879.

Barber, Crits-Cristoph & Luborsky, 1992).

Barrett-Lennard, G. T. (1978). *The Relationship Inventory: Later development and adaptations.* In Horvath (1994).

Bartholomew, K. (1997). Adult attachment processes: Individual and couple perspectives. *British Journal of Medical Psychology*, 70, 249-263.

Bartholomew, K., & Horowitz, L.M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61, 226-244.

Bell, M., *An introduction to the Bell Object Relations Reality Testing Inventory.* (1991). In Mallinckrodt, B., Gantt, D. & Coble, H (1995).

Bordin, E.S. (1975). *The working alliance: Basis for a general theory of psychotherapy.* In Horvath (1994).

Bordin, E.S. (1989) *Building therapeutic alliances: The base for integration.* In Horvath, A. O. & Luborsky, L. (1993).

Bordin, E.S. (1994). Theory and research on the therapeutic working alliance: New Directions. In Horvath, A.O. Horvath & L. S. Greenberg (Eds.), *The working alliance. Theory, research and practice.* New York: Wiley.

Bordin, E.S., (1979) The generalisability of the psychoanalytic concept of the working alliance. In *Psychotherapy: Theory, Research and Practice, 16 (3),* pp 252-260.

Borman-Spurrell. E., Allen. J., Hauser, S., Carter, A. & Cole-Detke, H. (1994). *Attachment in young adulthood: How different measures of adult attachment relate to adjustment.* In Crowell, J.A. & Treboux, D. (1995).

Bowlby, J. (1969). *Attachment and Loss,* vol. I: *Attachment.* New York: Basic Books.

Bowlby, J. (1973) *Attachment and Loss: Vol 2. Separation-Anxiety and anger.* London: Hogarth Press.

Bowlby, J. (1980). *Loss, Sadness & Depression,* vol. III, *Attachment and Loss.* London: Hogarth Press.

Bowlby, J. (1988). Attachment, communication, and the therapeutic process. In *A secure base: Parent-child attachment and health human development* (pp. 137-157). New York: Basic Books.

Brennen, K. A., Shaver, P. &Tobey, A.E. (1991). Attachment styles, gender and parental problem drinking. *Journal of social and personal relationships,* 8, 45-466

Brenner, C. (1979). Working alliance, therapeutic alliance, and transference. *Journal of the American Psychoanalytic Association,* 27, 136-158.

Castonguay, L.G., Goldfried, M.R., Wiser, S., Raue, P.J., & Hayes, A.M.. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology,* Vol 64, 3, 497-504.

Coble, H.M., Gantt, D.L. & Mallinckrodt, B. (1996). Attachment, social competency and the capacity to use social support. In Mallinckrodt, B., Gantt, D. & Coble, H (1995).

Collins & Read, N. L; & Read, S.J. (1990). Adult attachment, working models and relationship quality in dating couples. *Journal of Personality and Social Psychology*, 58, 644-663.

Crits-Cristoph P., Barber, J., & Kurcias, J.S. (1991). *The accuracy of therapists' interpretations and the development of the therapeutic alliance.* In Horvath, A.O. & Luborsky, L. (1993).

Crowell, J.A. & Treboux, D. & Waters, E. (1993). *Alternatives to the Adult Attachment Interview? Self-reports of attachment style and relationships with mothers and partners.* Crowell, J.A. & Treboux, D. (1995).

Crowell, J.A. & Treboux, D. (1995). A review of adult attachment measures: Implications for theory and practice. *Social Development,* 4, 3, 295-327.

Crowell. J. & Waters, E. (1993). *Attachment scoring of marital interactions.* In Crowell, J.A. & Treboux, D. (1995).

Curtis, H.C. (1979). The concept of the therapeutic alliance: Implications for the 'widening of scope'. *Journal of the American Psychoanalytic Association.* In Horvath, A.O. & Luborsky, L. (1993).

Dar, R.. Serlin, R.C. & Omer, H. (1994). Misuse of statistical tests in three decades of psychotherapy research. *Journal of Consulting and Clinical Psychology,* 62, 75-82.

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology*, 2, 47-60.

Dozier, M., Stevenson, A.L., Lee, S.W., & Velligan, D.I. (1991). Attachment organisation and familial over involvement for adults with serious pschopathological disorders. *Development and Psychopathology*, 3, 475-489.

Eaton, T. T., Abeles, N. & Gutfreund, M.J. (1988). Therapeutic alliance and outcome: Impact of treatment length and pretreatment symptomatology. *Psychotherapy, Research and Practice,* 25, 536-542.

Fonagy, P., Steele, H. & Steele, M. (1991). Maternal representations of attachment during pregnancy predict the organisation of infant-mother attachment at one year of age. *Child Development*, 62, 891-905.

Foreman, S. & Marmar, R.C. (1985). Therapist actions that address initially poor therapeutic alliances in psychotherapy. *American Journal of Psychiatry,* 922-926.

Freud, S. (1958). The dynamics of transference. In J Starchey (Ed.), *The standard edition of the complete works of Sigmund Freud* (pp, 99-108). London: Hogarth Press. (Original work published 1912).

Gaston, L., Marmar, C.R., Thompson, L.W., & Gallager, D. (1991). Alliance prediction of outcome beyond in-treatment symptomatic change as psychotherapy progresses. *Psychotherapy Research,* I, 104-112.

Gaston, L., Marmar, C.R., Thompson, L.W., & Gallagher, D. (1988). Relation of patient pretreatment characteristics to the therapeutic alliance in diverse psychotherapies. *Journal of Consulting and Clinical Psychology,* 56, 483-389.

Gelso, C.J., & Carter, J.A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counseling Psychologist,* 2, 155-243.

Gelso, C.J., & Carter, J.A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology,* 41, 296-306.

Goldfried, M.R. & Davison, G.C.(1976;1994); *Clinical Behaviour Therapy.* In Raue *et al.,* (1997).

Greenberg, L.S., & Alder, J. (1989); *The working alliance and outcome: A client report study.* In Horvath (1994)

Greenberg, L.S., & Pinsoff, W.M. (1986). *The psychotherapeutic process: A research handbook.* New York: Guildford.

Greenson, R. R. (1965) The working alliance and the transference neurosis. In *Psychoanalysis Quarterly, 34,* pp. 114-116.

Greenson, R. R. (1967) *The Technique and Practice of Psychoanalysis, Vol 1.* New York: International Universities Press.

Griffin, D. & Bartholomew, K. (1993). *Testing a Two-dimensional Model of Adult Attachment: A Latent Variable Approach.* In Griffin, D. & Bartholomew, K. (1994b).

Griffin, D. & Bartholomew, K. (1994b). The metaphysics of measurement: The case of adult attachment. In K. Bartholomew & D. Perlman (Eds), *Advances in Personal Relationships*, vol. 5, *Attachment Processes in Adulthood,* pp 17-52.

Hazan, C. & Shaver, P., (1994). Attachment as an organisational framework for research in close relationships. *Psychological Inquiry, 5, 1-22.*

Hazan, C., & Shaver, P.R. (1987). Romantic love conceptualised as an attachment process. *Journal of Personality and Social Psychology,* 67, 430-445.

Henry, W. P., & Strupp, H.H. (1994). The therapeutic alliance as interpersonal process. In Horvath, A.O., & Greenberg, L.S. (Eds.), *The working alliance: Theory, research and practice.* New York: Wiley.

Henry, W.P., Schacht, T.E. & Strupp, H.H (1986). Structural analysis of social behaviour: Application to a study of interpersonal process in differential psychotherapeutic outcome. *Journal of Consulting and Clinical Psychology*, 58, 758-774.

Henry, W.P., Schacht, T.E., & Strupp, H.H. (1986). Structural analysis of social behaviour: Application to a study of interpersonal process in differential psychotherapustic outcome. *Journal of Consulting and Clinical Psychology,* 54, 27-31.

Holmes, J. (1997) Attachment, autonomy, intimacy: Some clinical implications of attachment theory. *British Journal of Medical Psychology* (1997), 70, 231-248.

Horowitz, L.M., Rosenberg, S.E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles, and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology*, 61, 549-560.

Horowitz, M.J., Marmar, C, Weiss, D.S., DeWitt, K.N. & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry,* 41, 438-448.

Horowitz, M.J., Marmar, C.R., Weiss, D.S., DeWitt, K.N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome, *Archives of General Psychiatry,* 41, 438-448.

Horvath, A.O. & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology,* Vol 61, No. 4, 561-573.

Horvath, A.O. & Marx, R.W. (1991). The development and decay of the working alliance during time-limited counseling. *Canadian Journal of Counseling,* 24, 240-259.

Horvath, A.O. & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology,* 38, 139-149.

Horvath, A.O. (1981).*An exploratory study of the working alliance: Its measurement and relationship to outcome.* In Horvath & Luborsky (1993).

Horvath, A.O. (1994). Research on the alliance. In A.O. Horvath & L.S. Greenberg (Eds.), *The working alliance: Theory, research, and practice* (259-286). New York: Wiley.

Horvath, A.O., & Greenberg, L.S. (1994); *The working alliance: Theory, research and practice.* New York: Wiley.

Horvath, A.O., & Symonds, B.D. (1990). *The relationship between working alliance and outcome in psychotherapy: A synthesis.* In Krupnick *et. al.,* (1996)

Jones S.S. (1988); *An exploration of the relationship between client expectations and the working alliance.* In Horvath (1994).

Kiesler, D.J., & Watkins, L.M. (1989). Interpersonal complementarity and the therapeutic alliance: A study in relationship in psychotherapy. *Psychotherapy: Research and Practice,* 26, 183-194.

Kirkpatrick, L., & Hazan, C. (1994). Attachment styles and close relationships: A four year prospective study. *Personal Relationships*, 1, 123-142.

Kobak, R.R., Cole, H.E., Ferenz-Gillies, R. Fleming, W.S. & Gamble, W. (1993). Attachment and emotion regulation during mother-teen problem solving: A control theory analysis. *Child Development,* 64, 231-245.

Kokotovic, A.M., & Tracey, T.J. (1990). Working alliance in the early phase of counseling. *Journal of Counseling Psychology,* 39, 32-38.

Krupnick, J.L., Sotsky, S.M., Simmens, S., Moyer, J., Elkin, I., Watkins. J. & Pilkonis, P.A. (1996). The role of the therapeutic alliance in psychotherapy and

pharmacotherapy outcome: Findings in the national institute of mental health treatment of depression collaborative research program. *Journal of Consulting and Clinical Psychology,* Vol 64, 3, 532-539.

LaCrosse, M.B. (1980). Perceived counselor social influence and counseling outcomes: Validity of the Counselor Rating Form. *Journal of Counseling Psychology,* 27, 320-327.

Landman, J. & Dawes, R. (1982). Psychotherapy outcome: Smith and Glass conclusions stand up under scrutiny. *American Psychologist,* 37, 504-516.

Laplanche, J. & Pontalis, J.B. (1988) *The Language of Psycho-Analysis.* London: Karnac Books.

Llewelyn, S.P. (1988). Psychological therapy as viewed by clients and therapists. *British Journal of Clinical Psychology*, 27, 223-237.

Luborsky, L., Crits-Cristoph, P., Alexander, L., Margolis, M., & Cohen, M. (1983). Two helping alliance methods for predicting outcomes of psychotherapy: A counting signs vs a global rating method. *Journal of Nervous and Mental Disease,* 171, 480-491.

Luborsky, L., Crits-Cristoph, P., Minz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy?* New York: Basic Books.

Mace, C. & Margison, F. (1997). Attachment and psychotherapy: An overview. *British Journal of Medical Psychology,* 70, 209-215.

Main, M. (1990). Cross-cultural studies of attachment organization: Recent studies, changing methodologies, and the concept of conditional strategies. *Human Development,* 33, 48-61.

Main, M., Kaplan, N. & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development.* 50, (1-2), 66-104.

Mallinckrodt, B., Gantt, D. & Coble, H (1995). Attachment patterns in the psychotherapy relationship: Development of a client attachment to therapist scale. *Journal of Counseling Psychology, 42,* 307-317.

Mallinkrodt, B. (1993). Session impact, working alliance, and treatment outcome in brief counseling. *Journal of Counseling Psychology,* 40, 25-32.

Mallinkrodt, B. (1996). Capturing the subjective and other challenges in measuring transference: Comment on Multon, Patton and Kivlighan. *Journal of Counseling Psychology,* Vol 43, No. 3, 253-256.

Marmar, C.R., Gaston, L., Gallager, D., & Thompson, L.W. (1989). Therapeutic alliance and outcome in behavioural, cognitive, and brief dynamic psychotherapy in late life depression. *Journal of Nervous and Mental Disease,* 177, 464-472.

Mitchell, K.M., Bozarth, J.D., & Krauft, C.C. (1977). Reappraisal of the therapeutic effectiveness of accurate empathy, non-possessive warmth, and genuineness. In Horvath & Luborsky (1993).

Moras, K., & Strupp, H.H. (1982). Pre-therapy interpersonal relations, patients' alliance and outcome in brief therapy. *Archives of General Psychiatry,* 405-409.

Muran, Wallner Samstag & Crawford, 1994

Orlinsky, D.E. & Howard, K.I. (1986). Process and outcome in psychotherapy. In S.L. Garfield & A.E. Bergin (Eds.), *Handbook of Psychotherapy and Behaviour Change* (3rd ed., pp. 311-381). New York: Wiley.

Orlinsky, D.E., Grawe, K. & Parks, B.K. (1994). In Bergin, A.E. & Garfield, S.L. (Eds.), *Handbook of Psychotherapy and Behaviour Change* (4th ed., pp. 270-376). New York: Wiley.

Orlinsky, D.E., Grawe, K. & Parks, B.K. (1994). *Process and outcome in psychotherapy: Noch einmal.* In A.E. Bergin & S.L. Garfield (Eds). Handbook of psychotherapy and behaviour change (4th ed.). New York, John Wiley and sons.

Parry, G., Shapiro, D.A. & Firth, J. (1986) The case of the anxious executive: A study from the research clinic. *British Journal of Medical Psychology*, 59, 221-233.

Piper, W.E., Azim, H.F.A., Joyce, A.S., & McCallum, M. (1991a). Transference interpretations, therapeutic alliance and outcome in short-term individual psychotherapy. *Archives of General Psychiatry,* 48, 946-953.

Piper, W.E., Azim, H.F.A., Joyce, A.S., & McCallum, M., Nixon, G.W.H., & Segal, P.S. (1991b). Quality of object relations v. interpersonal functioning as predictor of therapeutic alliance and psychotherapy outcome. *Journal of Nervous and Mental Disease,* 173, 726-733.

Piper, W.E., Joyce, A.S., McCallum, M. & Azim, H.F.A. (1993). Concentration and correspondence of transference interpretations in short-term psychotherapy. *Journal of Consulting and Clinical Psychology*, 61, 586-595.

Plotnicov, K.H. (1990). *Early termination from counseling: The client's perspective.* In Horvath & Luborsky (1993).

Rau, P.J., Castonguay, L.G., & Goldfried, M.R. (1993). The working alliance: A comparison of two therapies. *Psychotherapy Research,* 3, 197-207.

Raue, P.J. & Goldfried, M.R. (1994). The therapeutic alliance in cognitive behavioural therapy. In A.O. Horvath & L.S. Greenberg (Eds.). *The working alliance: Theory, research and practice.* New York: Wiley.

Raue, P.J. Goldfried, M.R. & Barkham, M. (1997). The therapeutic alliance in psychodynamic-interpersonal and cognitive-behavioural therapy. *Journal of Consulting and Clinical Psychology,* Vol 65, 4, 582-587.

Reandeau, S.G., & Wampold, B.E. (1991). Relationship of power and involvement to working alliance: A multiple-case sequential analysis of brief therapy. *Journal of Counseling Psychology,* 38, 107-114.

Rogers, C.R. (1951). *Client-centred therapy.* Cambridge, MA: Riverside Press.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting and Counseling Psychology,* 22, 95-103.

Roth, A. & Fonagy, P. (1996). *What works for whom: A critical review of psychotherapy research.* New York: Guildford Press.

Ryan, E.R., & Cicchetti, D.V. (1985). Predicting quality of alliance in the initial psychotherapy interview. *Journal of Nervous and Mental Disease,* 717-725.

Safran, J. D. & Muran, J.C. (1995). Resolving therapeutic alliance ruptures: Diversity and integration. *In-session: Psychotherapy in Practice*, 81-92.

Safran, J. D. & Muran, J.C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology*, 64, 447-458.

Safran, J.D. & Muran, J.C. (1994). Towards a working alliance between research and practice. In P.F. Talley, H.H. Strupp, & S.F. Butler (Eds.). *Psychotherapy research and practice: Bridging the gap* (pp. 206-226). New York: Basic Books.

Safran, J.D. & Segal, Z.V. (1990). *Interpersonal Process in Cognitive Therapy.* In Mallinkrodt (1996).

Safran, J.D. & Wallner, L.K. (1991). The relative predictive validity of two therapeutic alliance measures in cognitive therapy. *Psychological Assessment,* 31, 188-195.

Safran, J.D. (1993). The therapeutic alliance rupture as a transtheoretical phenomenon: Definitional and conceptual Issues. *Journal of Psychotherapy Integration,* Vol. 3, No. 1.

Safran, J.D. Muran, J.C. & Wallner Samstag, L. (1992). *A comparison of therapeutic alliance rupture resolution and nonresolution events.* In Horvath & Luborsky (1993).

Safran, J.D., Crocker, P., Mc Main, S., & Murray, P. (1990). The therapeutic alliance rupture as a therapy event for empirical investigation. *Psychotherapy,* 27, 154-165.

Safran, J.D., Muran, J.C., & Samstag, L.W. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A.O. Horvath & L.S. Greenberg (Eds.). *The working alliance: Theory, research and practice.* New York: Wiley.

Safran. J.D. & Segal, Z, V. (1990). *Interpersonal process in cognitive therapy.* New York: Basic Books.

Saltzman, C., Leutgert, M.J., Roth, C.H., Creaser, J., & Howard, L. (1976). Formation of a therapeutic relationship: Experiences during the initial phase of psychotherapy as predictors of treatment duration and outcome. *Journal of Consulting and Clinical Psychology,* 44, 546-555.

Salvio, M.A., Beutler, L.E., Wood, J.M, & Engle, D. (1992). The strength of the therapeutic alliance in three treatments for depression. *Psychotherapy Research,* 2, 31-36.

Scharfe, E. & Bartholomew, K. (1994a) Reliability and stability of adult attachment patterns. *Personal relationships*, 9, 51-64.

Sexton, H.C., Hembre, K. & Kvarme, G. (1996). The interaction of the alliance and therapy microprocess: A sequential analysis. *Journal of Consulting and Clinical Psychology*, 64, 471-480.

Shapiro, D. & Shapiro, D. (1982). Meta-analysis of comparative outcome studies: A replication and refinement. *Psychological Bulletin,* 92, 581-605.

Shapiro, D. & Shapiro, D. (1983). Comparative therapy outcome research.: Methodological implications of meta-analysis. *Journal of Consulting and Clinical Psychology,* 51, 42-53.

Sherer, M., Maddux, J.E., Mercadante, B., Prentice-Dunn, S., Jacobs, B., & Rogers, R.W. (1982). The Self-Efficacy Scale: Construction and validation. In Mallinckrodt, B., Gantt, D. & Coble, H (1995).

Smith, M., Glass, G. & Miller, T. (1980). *The Benefits of Psychotherapy.* In Llewelyn *et al.,* (1988).

Sperling, M.B. & Lyons, L.S. (1994). Representations of attachment and psychotherapeutic change. In Mallinckrodt, B., Gantt, D. & Coble, H (1995).

Stiles, W.B. & Shapiro, D.A. (1994). Disabuse of the drug metaphor. Psychotherapy process-outcome correlations. *Journal of Consulting and Clinical Psychology,* 62, 942-948.

Stiles, W.B., Shapiro, D., & Elliot, R. (1986). Are all psychotherapies equivalent? *American Psychologist,* 41, 165-180.

Tichenor, V., & Hill, C.E. (1989). A comparison of six measures of the working alliance. *Psychotherapy,* 26, 195-199.

Tracey, T. (1987). Stage differences in the dependence of topic initiation and topic following behaviours. *Journal of Counseling Psychology,* 34, 123-131.

Tracey, T. (1993). An interpersonal stage model of the therapeutic process. *Journal of Counseling Psychology,* 40, 396-409.

Tracey, T.J. & Kokotovic, A.M. (1989). Factor structure of the Working Alliance Inventory. *Journal of Consulting and Clinical Psychology,* Vol 1, No. 3, 207-210.

Weston, D. (1991). Social cognition and object relations. *Psychological Bulletin,* 109, 429-455.

Wolfe, B.E. & Goldfried, M.R. (1988). Research on psychotherapy integration: Recommendations and conclusions from an NIMH workshop. *Journal of Consulting and Clinical Psychology,* 56, 448-451.

Zetzel, E.R. (1956). Current concepts of transference. *International Journal of Psychoanalysis,* 37, 369-376.

APPENDICES

Appendix I.

Responses to Open-Ended Rupture Question

Attachment type	Patients (individual patients are separated by a dotted line)
High fearful/dismissing (n=3, 8 sessions)	**No ruptures reported**
High secure/dismissing (n=1, 4 sessions)	**No ruptures reported**
Low secure/dismissing (n=3, 12 sessions)	**No ruptures reported**
High fearful (n=5, 15 sessions)	**Six ruptures reported by two patients** *I told my therapist at one point but then on my return home, I now believe that something I said in which I've always believed is not possibly true* (session 2) *I talked a lot, trying to break through to my therapist and at the end feel extremely tired* (session 3) *Trying to break down how to feel relaxed regarding my tension in the sessions* (session 4) *Last session I was feeling very alone and did not become with the session until midway* (session 5) *The problem was personal, something that I was scared to face* (session 2) *It has nothing to do with the therapist, I have not even discussed it with her. I would rather she didn't know about it because she has helped me so much* (session 5)
High fearful/ high preoccupied (n=3, 7 sessions) 1 Patient (2 ruptures reported)	**Two ruptures reported by one patient** *Felt anxious relating difficulties experienced in life. Don't know my therapist well enough yet* (session 2) *It was difficult to make a final commitment to the therapist, until about half way through the session. Then honesty seemed to mind and I was able to speak plainly and describe deeper rooted problems I was experiencing.* (session 3)
Medium secure/insecure (n=3, 12 sessions)	**No ruptures reported**
Low secure/ medium insecure (n=5, 18 sessions)	**One rupture reported by one patient** *I had recounted an incident to my therapist. She listened intently and sympathetically as she always does, but at the end she explained that because of the limited time that we have together we needed to move on to discussing what was best for me to do next. I fully appreciated this, but then felt awkward that perhaps I was going on about my problems, where as in fact I had told of the incident to perhaps explain the pattern of my diary more to myself than to her. She asked me how I felt about this and I couldn't answer because I felt that before this I could tell her things I hadn't been able to tell anyone else but now I was anxious not to be going on. I felt betrayed and angry as she is the only person I can really talk to* (session 2)
High preoccupied (n=4, 13 sessions)	**Seven ruptures reported by four patients** *I was 25 minutes late and was embarrassed. This didn't seem to affect the session in any way, except to make it half as long* (session 2) *I agreed with his approach but felt a need to discuss/sort out problems that panic me immediately. I wanted to resolve and get rid of the panic first, even though I know 'his plan' /approach is good for long term.* (session 2)

	He doesn't know (yet?) everything about my situation. Although the therapy's approach seems ok I'm not sure I can apply it yet. it feels like it's going a bit fast (session 3) *I felt like he would think I was wasting his time* (session 3) *I felt I was letting down my therapist by not doing my homework and that he might feel I was wasting his time because I am not sick enough* (session 4) *I don't think this therapy is going to work for me. My therapist lets me do all the talking - how can I improve by talking? I need advice - feedback - not just the odd prompting question. I can imagine having to do a further 9 sessions with me just talking. Maybe it's too early to tell.* (session 2) *I feel that my therapist doesn't understand my problems - that she is perhaps lacking in experience. Maybe I'm just being impatient and expecting results too soon. I keep wondering whether I should see a different therapist. I'll give it more time. Why do I have to answer these questions every session?* (session 4)

Attachment type	Therapists
High fearful/ high dismissing (n=3, 8 sessions)	**Six ruptures reported in relation to three patients** *Very difficult to formulate client's difficulties in the form of suitable goals to focus on. Client wanted to focus on gaining 'control' over anxiety but I felt this could be counter-productive.* (session 2) *It was a 9am appointment and I arrived late (she was on time!)* (session 3) *Issue of asking about personal/family background when I knew this would probably be very difficult thing for the client to talk about.* (session 2) *Patient said she was uncomfortable with my looking at her and 'analysing' her although this was what she expected I should do. This was explored in CBT terms. Then she talked about feeling that she mucks up relationships by going cold. Then later she said there was something else she was worried about which may have cause her depression, but felt she couldn't tell me what it is. Asked how long still had in session, I said 10 mins, she said wanted to wait till next time.*(session 2) *At end of previous session patient had said there was something important she had not spoken about, but felt couldn't go into it then. At start of this session (to which she had arrived late) there was some discomfort as she hesitated to, but then spoke about what was concerning her.* (session 3).
High secure/ high dismissing (n=1, 4 sessions)	**No ruptures reported**
Low secure/ high dismissing (n=3, 12 sessions)	**Two ruptures reported in relation to one patient** *She believed I would be critical of her using medication.* (session 2) *My patient was unsure about whether understanding early experience would help resolve her symptoms and was frightened of CAT techniques of mapping out her problems in diagrammatic form. In particular, disliked the notion of having 'needs' which were beyond the control of her 'will'* (session 5)
High fearful (n=5, 15 sessions)	**Seven ruptures reported relating to four patients** *I felt I was being 'tortured' by a slow and detailed exposition of behaviour to others while he is drinking - felt like unexpressed aggression. Addressed that issue and felt we 'connected' and some rapport was developed. I did not tackle the transference, focusing instead on the aggression he reported others told him about, and giving him some framework to relate it to childhood experience of neglect.* (session 2) *Tension around his desire that I help him vs my desire that he use the therapy as a place to help himself understand his problems, think about it and what to do about it.* (session 3) *There was a feeling of suffocating anger after the beginning of the session: quite hard to hold - I felt as if I was being choked. Reflected on this, and the likelihood of there having been some anxiety re expressing feelings towards me. Patient said he wasn't feeling anything at all. I felt I lost connection with where he was at.* (session 4) *A terrible sleepiness creeping over me, almost closed my eyes. Patient seemed to be talking in a very distant manner. He had made comments at the beginning which indicated dissatisfaction and tension, not feeling heard. On inquiring said no. Said 'I don't know' when talking about being 2 years old and having this terrible fear of death. When I commented that there was a lot of 'not knowing' in his family e.g., not leaving a 2 year old alone with a tricycle near a river, the sleepiness went away and he became animated, saying that he perhaps was angry and session continued.* (session 5)

	Transference message in patient account from start was of not being responded to quickly enough, and I took this to be unconscious communication of gap of two weeks from first appointment as being too long. Material of session that continued was around anger at poor management at work. By middle and end of session, material was of better contact with his father, so I assumed patient began to feel better in session. None of this did I interpret/take up directly (session 2, patient dropped out after this session). *After 2 dna's I hoped patient would dna again and I could discharge her, especially as today I am very busy and could do with the space. She seemed doubtful about coming and then rejecting of my suggestions of what might be useful to work on. Later in session she said she had gone back to using cocaine in the past few weeks. There was a lot of feeling associated with this, I managed to connect with how stuck she feels and create some basis to continue to meet* (session 4) *Patient apologised frequently, said I must be bored and fed up with her. Non-compliant with tasks set previous week.* (session 5).
High fearful/ high preoccupied (n=3, 7 sessions)	**Four ruptures reported relating to two patients** *My patient started to express her doubts/fears about whether anything will ever change for her or whether she'll always be unhappy. It wasn't really a tension in the relationship - perhaps I felt that she was saying she had no faith in me or the therapy. This didn't follow from what she'd been saying up to that point, or what she said at the end.* (session 2) *Patient talked about feeling angry with me in the previous session but this didn't create tension, it was helpful to talk about this and improved things between us* (session 3) *Different understanding of the purpose of the session. I felt helpless in the face of his problems* (session 2) *I felt bored, disengaged* (session 3 - dropped out of therapy following this session).
Medium secure/ medium insecure (n=3, 12 sessions)	**Four ruptures reported in relation to one patient** *Client arrived twenty five minutes late for the session. This was addressed at the start of the session. He remembered the appointment as being 30 mins later than the agreed time. We agreed to finish at the same time as we would anyway. Client apologised for the mistake. Possible reasons for 'mis-remembering' were not explored (because only 2nd meeting)* (session 2) *I felt some reservations about the client's view of the nature of things that he needs to achieve in a particular relationship* (session 3). *It has been 5 months since the previous session due to the disruption caused by the patient spending long periods out of the country. We discussed the effects of this disruption on the work done in the sessions and discussed what we shall do next (continue or not)* (session 4) *Patient spoke re situation re living with a partner who has 'manic depression' and who is currently very depressed. Spoke of sense of not much can be done until she is more effectively treated.* (session 5)
Low secure/ medium insecure (n=5, 18 sessions)	**Ten ruptures reported in relation to four patients** *The problem is not an acute one in that it does not manifest as a failure of trust but in terms of an increased tension in the patient when talking about the problem or when doing an exposure task; the latter left the patient drained and having a little difficulty concentrating on what I was saying, I felt.* (session 2)

	Patient entered very depressed about some panic she had during the week - uncertain about whether to come to the session or not. Would I be able to cope with her feelings? (session 3) *Conflict between the 'agreed' goals (i.e., graded exposure and anxiety management techniques) versus emotional need of the patient to talk about relationships (past and present) and gain some emotional relief from so going. The problem arose over trying to keep focused on designing a hierarchy of anxiety provoking situations (to be used as goals in between sessions). I felt that I had (unintentionally) failed to acknowledge and contain the depth of feeling by bringing the focus back to the 'focused' task. I wonder whether she feels less able to 'trust' me as a result?* (session 2) *Discussion re developing her own interests/activities to help her get out of the home and meet people. She viewed addressing her own needs as 'selfish'. Felt uncomfortable to do this, more familiar thinking about attending to the needs of others. This discussion felt very 'against the grain' to the client.* (session 3) *Discussing 'goals' (i.e., things she would like to change in her life). Any ideas immediately dismissed by her, or hurdles raised to the extent that goals are not seen to be worth trying in the first place. Frustrating to see this undermining of potential routes to change occurring - difficult to achieve the balance between exploring the resistance to change and 'bullying' the patient into changing her mind.* (session 4) *Clients feels that some issues we were discussing need to 'fall into place' (i.e., her relationship with her daughter) and then other things (e.g., thinking about developing her own life) would 'follow'. I agreed with her, but felt that she thought I was over emphasising the latter and feeling bad form not having 'done' things (cf the tasks). We discussed this - and in some ways re-clarified/re-negotiated our shared rationale as a result.* (session 5) *Tension. She (I think) has been wondering if she is 'going about all this in the right way'; read by me as an I (her therapist) going about this in the right way. Plus tension re talking/feeling vulnerable/shameful.* (session 2) *Tension was felt at first as a creeping tiredness/boredom in myself. Found it hard to concentrate or make links. Did not work out what was causing this and therefore did not find a way to bring it into the session.* (session 3) *Tension I experienced was a creeping 'switched-offness' in myself, a difficulty in hearing her pain and anxiety, or more accurately of connecting it to anything else she was talking about/a talked about before. A fogginess. I tried to address it, asking more questions, trying to stay with the feelings but don't feel I really connected with her. Tried at one point to pick up a message re her feeling unheard, not listened to but she said she didn't feel that. ? unsure what this means.* (session 4). *Tension in myself: started feeling disconnected, mind drifting again. Paid close attention to the transference communication of what she was saying e.g., - needs a good manager - needs focus and direction and reflected this to her. Rapport increased and working alliance. Still not much closer to understanding the roots of her feeling of shame and exposure.* (session 5).
High preoccupied (n=4, 13 sessions)	**Nine ruptures reported in relation to three patients** *Patient feeling extremely negative about the situation, sees no solution to the problem* (session 3). *Not completing homework tasks. She felt embarrassed sharing written thoughts* (session 3). *Client expressing doubts about why others bother to help her – attributed it to others need to feel good. Noted others normally abandon her. Discussed motivation of helping professional* (session 5)

	Therapist made a humorous comment - not understood by client. (session 2). *Patient seemed nervous completing the homework diary. Asked her to identify thoughts about the immediate situation – hesitated to discuss her embarrassment.* (session 3). *Diary (homework) was not completed. Thoughts that therapist would consider her lazy. Client asked to address these thoughts herself using techniques taught* (session 4).
	The patient has a complicated relationship with her mother and told me during the assessment that she thought I disliked her. She had specified a preference for a male therapist (I am female) (session 2). *The patient disclosed that she was pregnant and was afraid that I would disapprove if she decided to go for a termination. She also disclosed she had worked as an escort and was afraid I would disapprove of this too.* (session 4). *She arrived late saying she was going to have to leave early because she had not been able to put enough money in the parking meter to last long enough. She then questioned the value of continuing the therapy altogether because she felt she did most of the talking, and although I had said one or two 'perceptive' things, she was disappointed that I was not giving advice about how to 'get rid' of her mood swings/inability to succeed in life. She did not accept a goal of learning how to manage herself/her moods; she wanted to get rid of the problem altogether. I said I could not guarantee that.* (session 5).

Appendix II.

Relationship Questionnaire/Relationship Scales

Questionnaire

PQ1

Relationship Questionnaire

Please complete before your second session.

Post completed questionnaires (and the consent form) in the Orange Box in Reception

Date of first session _____ Your therapist's initials _____

Below are some descriptions [1-4] which people have made about themselves.

Please rate how well you feel each description describes you by circling on the scale below.

1.

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 and having others not accept me.

1	2	3	4	5	6	7
Not at all like me						Very much like me

2.

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.

1	2	3	4	5	6	7
Not at all like me						Very much like me

3.

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.

1	2	3	4	5	6	7
Not at all like me						Very much like me

4.

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

1	2	3	4	5	6	7
Not at all like me						Very much like me

Below are some statements [1-30] which people have made about themselves.

Please rate how well you feel each statement fits you by circling on the scale below.

1. I find it difficult to depend on other people.

1	2	3	4	5
not at all like me				very like me

2. It is very important to me to feel independent.

1	2	3	4	5
not at all like me				very like me

3. I find it easy to get emotionally close to others.

1	2	3	4	5
not at all like me				very like me

4. I want to merge completely with another person.

1	2	3	4	5
not at all like me				very like me

5. I worry that I will be hurt if I allow myself to become too close to others.

1	2	3	4	5
not at all like me				very like me

6. I am comfortable without close emotional relationships.

1	2	3	4	5
not at all like me				very like me

7. I am not sure that I can always depend on others to be there when I need them.

1	2	3	4	5
not at all like me				very like me

8. I want to be completely emotionally intimate with others.

1	2	3	4	5
not at all like me				very like me

9. I worry about being alone.

1	2	3	4	5
not at all like me				very like me

10. I am comfortable depending on other people.

1	2	3	4	5
not at all like me				very like me

11. I often worry that romantic partners don't really love me.

1	2	3	4	5
not at all like me				very like me

12. I find it difficult to trust others completely.

1	2	3	4	5
not at all like me				very like me

13. I worry about others getting too close to me.

1	2	3	4	5
not at all like me				very like me

14. I want emotionally close relationships.

1	2	3	4	5
not at all like me				very like me

15. I am comfortable having other people depend on me.

1	2	3	4	5
not at all like me				very like me

16. I worry that others don't value me as much as I value them.

1	2	3	4	5
not at all like me				very like me

17. People are never there when you need them.

1	2	3	4	5
not at all like me				very like me

18. My desire to merge completely sometimes scares people away.

1	2	3	4	5
not at all like me				very like me

19. It is very important to me to feel self-sufficient.

1	2	3	4	5
not at all like me				very like me

20. I am nervous when anyone gets too close to me.

1	2	3	4	5
not at all like me				very like me

21. I often worry that romantic partners won't want to stay with me.

1	2	3	4	5
not at all like me				very like me

22. I prefer not to have other people depend on me.

1	2	3	4	5
not at all like me				very like me

23. I worry about being abandoned.

1	2	3	4	5
not at all like me				very like me

24. I am uncomfortable being close to others.

1	2	3	4	5
not at all like me				very like me

25. I find that others are reluctant to get as close as I would like.

1	2	3	4	5
not at all like me				very like me

26. I prefer not to depend on others.

1	2	3	4	5
not at all like me				very like me

27. I know that others will be there when I need them.

1	2	3	4	5
not at all like me				very like me

28. I worry about having others not accept me.

1	2	3	4	5
not at all like me				very like me

29. Romantic partners often want me to be closer than I feel comfortable being.

1	2	3	4	5
not at all				very

30. I find it relatively easy to get close to others.

1	2	3	4	5
not at all like me				very like me

Appendix III.

Working Alliance Inventory/Rupture Questionnaire

(Patient Version)

PQ2

Post-session Questionnaire 1

Please complete immediately after the session.
(If possible, complete in the waiting room before you leave the building)

Post completed questionnaires in the Orange Box in Reception

Session number _____ Date of this session _____

Your therapist's initials _____

PART A

The following items reflect your **working relationship** with your therapist **based on your most recent session.**

Please rate each item by circling the appropriate number in terms of how you felt in the session. Please answer all questions.

1. My therapist and I agreed about the things I need to do in therapy to help improve my situation.

1 2 3 4 5 6 7
Never Sometimes Always

2. What we are doing in the therapy gave me new ways of looking at my problem.

1 2 3 4 5 6 7
Never Sometimes Always

3. I believed that my therapist likes me.

1 2 3 4 5 6 7
Never Sometimes Always

4. My therapist did not understand what I am trying to accomplish in therapy.

1 2 3 4 5 6 7
Never Sometimes Always

5. I was confident in my therapists ability to help me.

1 2 3 4 5 6 7
Never Sometimes Always

6. My therapist and I worked on mutually agreed goals.

1 2 3 4 5 6 7
Never Sometimes Always

7. I felt that my therapist appreciates me.

1 2 3 4 5 6 7
Never Sometimes Always

8. We agreed on what is important for me to work on.

1 2 3 4 5 6 7
Never Sometimes Always

9. My therapist and I seemed to trust one another.

1 2 3 4 5 6 7
Never Sometimes Always

10. My therapist and I seemed to have different ideas on what my problems are.

1	2	3	4	5	6	7
Never			Sometimes			Always

11. We had a good understanding of the kind of changes that would be good for me.

1	2	3	4	5	6	7
Never			Sometimes			Always

12. I believed the way we were working with my problems was correct.

1	2	3	4	5	6	7
Never			Sometimes			Always

PART B

1. Please rate how helpful or hindering to you this session was overall by circling the appropriate number below.

1	2	3	4	5	6	7	8	9
Extremely hindering				Neutral				Extremely helpful

2. Please rate to what extent you feel that the problems you had at the beginning of therapy are resolved.

1	2	3	4	5	6	7	8	9
Not at all				Moderately				Completely

PART C

1. Did you experience any problem or tension in your relationship with your therapist during the session?

Yes ☐ No ☐

2. If so, about where in the session did this problem begin?

Beginning ☐ Middle ☐ End ☐

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

1	2	3	4	5
Low		Medium		High

4. Please describe the problem in the space below (continue overleaf if you wish):

5. To what extent was this problem addressed in the session?

1	2	3	4	5
Not at all		Somewhat		Very much

6. To what degree do you feel this problem was resolved by the end of the session?

1	2	3	4	5
Not at all		Moderately		Completely

7. **If there was a problem or tension in your relationship with your therapist during the session, please rate the extent to which each of the following statements reflects your experience by the end of the session.**

a. I felt a closer connection with my therapist.

1	2	3	4	5
Not at all		Moderately		Completely

b. I felt more trusting of my therapist.

1	2	3	4	5
Not at all		Moderately		Completely

c. I felt able to disagree with my therapist.

1	2	3	4	5
Not at all		Moderately		Completely

d. I began to feel that my therapist can help me even if he/she is not perfect.

1	2	3	4	5
Not at all		Moderately		Completely

e. I began to see how I was contributing to the difficulties my therapist and I were having.

1	2	3	4	5
Not at all		Moderately		Completely

f. I discovered feelings towards my therapist that I had not been fully aware of.

1	2	3	4	5
Not at all		Moderately		Completely

g. I felt more comfortable with expressing anger or vulnerability to my therapist.

1	2	3	4	5
Not at all		Moderately		Completely

h. I began to accept a part of myself which I had not fully acknowledged before.

1	2	3	4	5
Not at all		Moderately		Completely

i. I acted in a way which felt more authentic or genuine for me.

1	2	3	4	5
Not at all		Moderately		Completely

j. I told my therapist something I had been hesitant to say.

1	2	3	4	5
Not at all		Moderately		Completely

k. I saw that I can expose risky feelings and not be abandoned by my therapist.

1	2	3	4	5
Not at all		Moderately		Completely

l. I learned that I have the ability to work things out with my therapist after a misunderstanding or conflict.

1	2	3	4	5
Not at all		Moderately		Completely

PART D

Please circle the appropriate number to show how you feel about this session.

This session was:

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

Appendix IV.

Working Alliance Inventory/Rupture Questionnaire

(Therapist Version)

TQ1

Post-session Questionnaire 1

Please complete immediately after the session.

Please replace questionnaire in patient's folder after completion.

Session number _____ Date of this session _____

Your initials _____

PART A

The following items reflect your **working relationship** with your patient **based on your most recent session.**

Please rate each item by circling the appropriate number in terms of how you felt in the session. Please answer all questions.

1. My patient and I agreed about the things he/she will need to do in therapy to help improve his/her situation.

1 2 3 4 5 6 7
Never Sometimes Always

2. My patient believed that what we are doing in the therapy gave him/her new ways of looking at his/her my problem.

1 2 3 4 5 6 7
Never Sometimes Always

3. My patient believed that I like him/her.

1 2 3 4 5 6 7
Never Sometimes Always

4. My patient believed that I did not understand what he/she is trying to accomplish in therapy.

1 2 3 4 5 6 7
Never Sometimes Always

5. My patient was confident in my ability to help him/her.

1 2 3 4 5 6 7
Never Sometimes Always

6. My patient and I worked on mutually agreed goals.

1 2 3 4 5 6 7
Never Sometimes Always

7. My patient felt appreciated by me.

1 2 3 4 5 6 7
Never Sometimes Always

8. We agreed on what is important for him/her to work on.

1 2 3 4 5 6 7
Never Sometimes Always

9. My patient and I seemed to trust one another.

1 2 3 4 5 6 7
Never Sometimes Always

10. My patient and I seemed to have different ideas on what his/her problems are.

1	2	3	4	5	6	7
Never			Sometimes			Always

11. We have established a good understanding of the kind of changes that would be good for him/her.

1	2	3	4	5	6	7
Never			Sometimes			Always

12. My patient believed the way we were working with his/her problem was correct.

1	2	3	4	5	6	7
Never			Sometimes			Always

PART B

1. Please rate how helpful or hindering to your patient this session was overall by circling the appropriate number below.

1	2	3	4	5	6	7	8	9
Extremely hindering				Neutral				Extremely helpful

2. Please rate to what extent your patient's presenting problems are resolved.

1	2	3	4	5	6	7	8	9
Not at all				Moderately				Completely

PART C

1. Did you experience any problem or tension in your relationship with your patient during the session?

Yes ☐ No ☐

2. If so, about where in the session did this problem begin?

Beginning ☐ Middle ☐ End ☐

3. Please rate the highest degree of tension you felt during the session as a result of this problem.

1	2	3	4	5
Low		Medium		High

4. To what extent was this problem addressed in the session?

1	2	3	4	5
Not at all		Somewhat		Very much

5. To what degree do you feel this problem was resolved by the end of the session?

1	2	3	4	5
Not at all		Moderately		Completely

6. Please describe the problem in the space below

7. If there was a problem or tension in your relationship with your patient during the session, please rate the extent to which you feel each of the following statements reflect your **patient's** experience by the end of the session.

a. My patient felt a closer connection with me.

1 2 3 4 5
Not at all Moderately Completely

b. My patient felt more trusting of me.

1 2 3 4 5
Not at all Moderately Completely

c. My patient felt able to disagree with me.

1 2 3 4 5
Not at all Moderately Completely

d. My patient began to feel that I could help him/her even if I am not perfect.

1 2 3 4 5
Not at all Moderately Completely

e. My patient began to see how he/she was contributing to the difficulties we are having in our relationship.

1 2 3 4 5
Not at all Moderately Completely

f. My patient discovered feelings towards me that he/she had not been fully aware of.

1 2 3 4 5
Not at all Moderately Completely

g. My patient felt more comfortable with expressing anger or vulnerability towards me.

1	2	3	4	5
Not at all		Moderately		Completely

h. My patient began to accept a part of his/herself which he/she had not fully acknowledged before.

1	2	3	4	5
Not at all		Moderately		Completely

i. My patient acted in a way which felt more authentic or genuine for him/her.

1	2	3	4	5
Not at all		Moderately		Completely

j. My patient told me something he/she had been hesitant to say.

1	2	3	4	5
Not at all		Moderately		Completely

k. My patient saw that he/she can expose risky feelings and not be abandoned by me.

1	2	3	4	5
Not at all		Moderately		Completely

l. My patient learned that he/she has the ability to work things out with me after a misunderstanding or conflict.

1	2	3	4	5
Not at all		Moderately		Completely

PART D

Please circle the appropriate number to show how you feel about this session.

This session was:

Bad	1	2	3	4	5	6	7	Good
Safe	1	2	3	4	5	6	7	Dangerous
Difficult	1	2	3	4	5	6	7	Easy
Valuable	1	2	3	4	5	6	7	Worthless
Shallow	1	2	3	4	5	6	7	Deep
Relaxed	1	2	3	4	5	6	7	Tense
Unpleasant	1	2	3	4	5	6	7	Pleasant
Full	1	2	3	4	5	6	7	Empty
Weak	1	2	3	4	5	6	7	Powerful
Special	1	2	3	4	5	6	7	Ordinary
Rough	1	2	3	4	5	6	7	Smooth
Comfortable	1	2	3	4	5	6	7	Uncomfortable

PROCESS NOTE

(Please add here any comments about the session, therapeutic relationship or progress of therapy that you feel may be pertinent).

Appendix V.

Client Attachment to Therapist Scale

PQ3

Post-session Questionnaire 2

Please complete immediately after the session.
(If possible, complete in the waiting room before you leave the building)

Post completed questionnaires in the Orange Box in Reception

Session number _____ Date of this session _____

Your therapist's initials _____

These statements refer to how you currently feel about your therapist. Please try to respond to every item [1-36], using the scale below to indicate how much you agree or disagree with each statement.

1. I don't get enough emotional support from my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

2. My therapist is sensitive to my needs.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

3. I think my therapist disapproves of me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

4. I yearn to be 'at one' with my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

5. My therapist is dependable.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

6. Talking over my problems with my therapist makes me feel ashamed or foolish.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

7. I wish my therapist could be with me on a daily basis.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

8. I feel that somehow things will work out for me when I am with my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

9. I know I could tell my therapist anything and s/he would not reject me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

10. I would like my therapist to feel closer to me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

11. My therapist isn't giving me enough attention.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

12. I don't like to share my feelings with my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

13. I'd like to know more about my therapist as a person.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

14. When I show my feelings my therapist responds in a helpful way.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

15. I feel humiliated in my therapy sessions.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

16. I think about calling my therapist at home.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

17. I don't know how to expect my therapist to react from session to session.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

18. Sometimes I am afraid that if I don't please my therapist s/he will reject me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

19. I think about being my therapists favourite client.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

20. I can tell that my therapist enjoys working with me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

21. I suspect my therapist probably isn't honest with me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

22. I wish there were a way I could spend more time with my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

23. I resent having to handle problems on my own when my therapist could be more helpful.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

24. My therapist wants to know more about me than I am comfortable talking about.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

25. I wish I could do something for my therapist too.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

26. My therapist helps me to look closely at the frightening or troubling things that have been happening to me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

27. I feel safe with my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

28. I wish my therapist were not my therapist so that we could be friends.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

29. My therapist is a comforting presence to me when I am upset.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

30. My therapist treats me more like a child than an adult.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

31. I often wonder about my therapist's other clients.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

32. I know my therapist will understand the things that bother me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

33. It's hard for me to trust my therapist.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

34. I feel sure that my therapist will be there if I really need her/him.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

35. I am not certain that my therapist is all that concerned about me.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

36. When I am with my therapist I feel I am his/her highest priority.

1	2	3	4	5	6
strongly disagree	somewhat disagree	slightly disagree	slightly agree	somewhat agree	strongly agree

Appendix VI.

Volunteer Information Sheet

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

Volunteer Information Sheet

Attachment behaviour and the client/therapist relationship

Will you consider helping us with a study looking at how therapists and their clients relate to each other in the first few sessions of therapy?

What's it about?

I am interested in your thoughts about your working relationship with your therapist as it develops. We know that the way people see their therapist is important - therapy is more likely to work when people feel they are understood by their therapist.

We are trying to find out two things. Firstly, we are trying to see how your thoughts about your therapist develop over the first few sessions. Secondly, we are interested to see if there is any link between other relationships in your everyday life, and the way you see your therapist.

How will this study be useful?

The information you provide will be invaluable to psychology services in helping them understand individual client's needs. Your involvement may also be useful in helping you and your therapist think about your difficulties.

What do I have to do?

You will be asked to fill out a short questionnaire (enclosed), before your next session. This questionnaire, which takes around 5 minutes to complete, asks general questions about how you relate to other people.

You will also be asked to fill in a brief questionnaire immediately after your next **4** appointments. This questionnaire, which will take 5-10 minutes to complete, will ask how you felt you and your therapist related to one another during the session.

What about confidentiality?

The confidentiality of the information you provide is guaranteed - **your name will not be stored with the information you provide** - it will be entirely anonymous.

Your therapist will only be given feedback about your responses after therapy has been completed, and then only with your agreement.

You do not have to take part in this study if you do not want to. If you do decide to take part, you may withdraw at any time without giving a reason. Your decision whether to take part will not affect the therapy you receive in any way.

What if I want to know more?

If at any stage in the study you need further information or assistance, contact me, **Vicky Eames** (Clinical Psychologist in training) on: **0171 387 9300 x 8853.**

What do I do next?

If you are willing to participate in the study and do not feel you require any further information, please do the following:

1. Sign the **Consent Form** enclosed
2. Fill in the **Questionnaire** and **Background Information Form** enclosed
3. Place both in the envelope and seal it. Post these in the **Orange Box** in Reception

Your therapist will give you the next questionnaire to be completed at the end of your next session.

If you do not wish to take part in the study I would be grateful if you could return this envelope to your therapist in your next session. Thank you for your time taken to read this.

All proposals for research involving human participants are reviewed by an ethics committee before they can proceed. This proposal was reviewed by Camden & Islington Community Health Services NHS Trust Ethics Committee.

Appendix VII.

Background Information Sheet (Patient Version)

Background Information Sheet

Please fill in this form and place in the **Orange Box** with the Consent Form and Questionnaires

Your name: _____

Your Date of Birth: _____

Your Occupation: _____

Your Ethnic Origin (please tick):

Bangladeshi	☐	Indian	☐
Black African	☐	Pakistani	☐
Black Caribbean	☐	White Irish	☐
Black UK	☐	White UK	☐
Black Other	☐	White Other	☐
Chinese	☐	Any Other	☐

Appendix VIII.

Background Information Sheet (Therapist Version)

Background Information Sheet

Please fill this form in for each patient participating in the research.

When Completed, please replace in the plastic file relating to this patient.

Patient's name: _____

What term best describes the therapeutic approach you are taking with this patient?

CBT/Psychodynamic/Exploratory/Interpersonal/CAT/Humanistic

Other (please state) _____

Please describe the diagnosis/presentation of the patient (any relevant personality disorder?)

_____

Has the patient received any therapy before? **Yes/No/don't know**
Any comments?

_____

_____

In which setting did you see this patient?

Outpatients/Primary care/CMHT

Attendance Information
Please state the number of dna's and cancellations **in between** each session attended:

Before Session 1:	dna's _____	cancellations ____
Between sessions 1 & 2:	dna's _____	cancellations ____
Sessions 2 & 3:	dna's _____	cancellations ____
Sessions 3 & 4:	dna's _____	cancellations ____
Sessions 4 & 5::	dna's _____	cancellations ____

Do you have any general comments to make about this case?

Appendix IX.

Patient/Volunteer Consent Form

PATIENT/VOLUNTEER CONSENT FORM
Confidential

Have you read the Information sheet for patients/volunteers? YES / NO

Have you had an opportunity to ask questions and discuss this study? YES / NO

Have you received satisfactory answers to all of your questions? YES / NO

Have you received enough information about the study? YES / NO

Who have you spoken to?

Dr / Mrs / Ms / Mr .....

Do you understand that your decision to consent is entirely voluntary and that you are free to withdraw from the study at any time, without having to give a reason for withdrawing and without affecting your future medical care?

YES / NO

Do you agree to take part in this study? YES / NO

Do you agree to your therapist being given feedback about your responses once therapy has been completed?

YES/NO

Signed: ..... Date: .....

NAME IN BLOCK LETTERS: .....

Appendix X.

Ethics Approval Letter

KENSINGTON & CHELSEA
AND WESTMINSTER

HEALTH AUTHORITY

Commissioning
Health for You

50 Eastbourne Terrace
London W2 6LX
Telephone 0171-725 3333
Fax 0171-725 3334

ST MARYS LOCAL RESEARCH ETHICS COMMITTEE
(Mail Box 121) 2 FLOOR, Mint Wing, St Marys Hospital
South Wharf Road, London W2 1NY
Tel: 0171 725 6514 Fax: 0171 725 1529

August 6, 1997

Victoria Eames
49 Seymour Road
London N8 0BJ

Dear Ms Eames

EC3592 **Patient attachment styles and the development of the therapeutics alliance**
EC and R&D NUMBERS MUST BE USED IN ALL COMMUNICATIONS

On behalf of the members I am pleased to say that the above project has now been approved by the St Marys Local Research Ethics Committee. This approval is given on the understanding that the research team will observe strict confidentiality over the medical and personal records of the participants. It is suggested that this be achieved by avoidance of the subject's name or initials in the communication data. In the case of hospital patients, which can be done by using the hospital record number and in general practice, the National Insurance number or a code agreed with the relevant GP.

It should be noted:

1. The Ethics Committee's decision does not cover any resource implications which may be involved in your project.

2. The Ethics Committee should be informed of any untoward development, amendments or changes in protocol that may occur during the course of your investigations. Please quote the above EC number in any correspondence.

Chairman's initials

KENSINGTON & CHELSEA
AND WESTMINSTER

HEALTH AUTHORITY

Commissioning
Health for You
50 Eastbourne Terrace
London W2 6LX
Telephone 0171-725 3333
Fax 0171-725 3398

3. Where research involves computer data, this may be subject to the Data Protection Act.

4. The GPs of any volunteers taking part in research projects should be aware of their patients' participation.

5. Every care should be taken to obtain the volunteers' informed consent to participate in the research project with the necessary help being provided for volunteers with language difficulties.

May I take this opportunity of information you that, in accordance with guidelines set down by the Department of Health and the Royal College of Physicians, we will require details of the progress of your project in 12 months' time and every year thereafter for the life of the project, and you will receive the appropriate form for completion.

If you have need to contact us further regarding your project, please quote the EC number as specified in the heading.

Yours sincerely

Dr Rodney Rivers
Chairman