Volume 1

The influence of therapist's attachment style on the resolution of ruptures in the therapeutic alliance.

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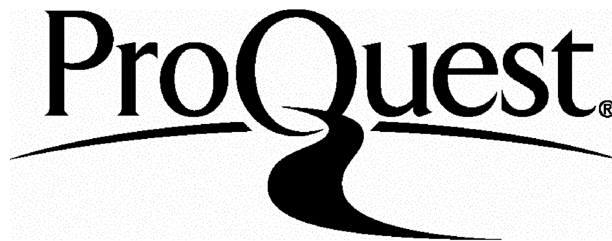

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ACKNOWLEDGEMENTS

I would like to thank Dr Tony Roth for his excellent supervision, continuous support and significant contribution to the development of the research questions and Dr Chris Barker for his excellent supervision, knowledgeable advice on the rating of the responses and constructive feedback about the research progress.

I would also like to thank Prof. Peter Fonagy, Dr Howard Steele and Dr Pasco Fearon for their useful comments on the clinical vignettes. A big thank you to Dr Pasco Fearon for patiently helping me to make sense of my data and for his assistance in the making of the videos.

Thank you to Yvonne and Tania, for their convincing interpretation of the therapist(s) and their valuable input during the numerous pilot studies. I am also very grateful to Sayra and Hanne for their help with the rating of the responses, to Sharon and Roger for reading through a draft of my thesis and to Jon for his support and understanding.

Finally, last but not least, I would like to thank all the Clinical Psychologists in Training who accepted to participate in this study: it simply would not have happened without their kind help!

ABSTRACT

This study was an exploratory investigation of the impact of therapists' self-reported attachment styles and parental bonds on the way in which they resolve ruptures within the therapeutic alliance. The study used an analogue of the therapy situation. Seventy-seven Clinical Psychologists in Training from University College London, taken from three consecutive years, participated in the study. Their attachment style was measured by means of the Relationship Scales Questionnaire and their parental bonds by means of the Parental Bonding Instrument. Participants also watched four video clips of hypothetical patients interacting with their therapist. Patients were meant to display one of four attachment styles (one secure and three insecure). The role-played therapy sessions exemplified a strain or 'rupture' in the therapeutic alliance and ended with the patient making a statement, which participants were asked to respond to. Participants' responses were tape-recorded and followed by a brief exploratory interview adapted from Interpersonal Process Recall. It was predicted that securely attached participants would respond overall more deeply and more empathically than insecure participants. It was also predicted that insecure participants would respond less deeply and less empathically to patients whose attachment style was similar to their own. The responses produced by first year trainees were also compared to those produced by second and third year trainees, with a view to exploring whether training moderated the impact of attachment styles and parental bonds on their responses.

Participants clustered into two groups: 1) the 'secure group', characterised by optimal parenting (i.e. high parental care and low paternal protection), high security, low fearfulness and low preoccupation and 2) the 'insecure group', characterised by less positive parenting (i.e. lower parental care and higher protection), lower security, higher fearfulness and higher preoccupation. The results provided some evidence for the first prediction, in that there was a trend for the secure group to respond more empathically than the insecure group, although the null hypothesis could not be

rejected with confidence. There was also some evidence for the second prediction, in that the insecure group responded less empathically than the secure one to the fearful patient. As the insecure group was high on fearfulness, there seemed to be some patient-therapist match effects in the predicted direction.

As insecure third years responded overall more deeply than insecure second and first years, training seemed to moderate the effects of insecure participants' attachment styles on their responses. These results have implications for the training of Clinical Psychologists and also highlight the importance for therapists to be aware of and reflect on their own conflicts, as these may affect the quality of their clinical work.

CHAPTER 1
INTRODUCTION

The therapeutic alliance, or the collaborative bond between the patient and the therapist, is increasingly being regarded as an essential ingredient of psychotherapy, affecting both therapy progress and outcome (Horvath & Symonds, 1991). Recently, Safran, Muran & Wallner Samstag (1994) and Safran & Muran (1996) have turned their interest to studying the factors involved in repairing strains or 'ruptures' in the therapeutic alliance. These can be viewed as crucial moments in therapy, the resolution of which is central to both therapy progress and therapeutic change.

Attachment theory (Bowlby, 1969; 1979; 1988) can be illuminating about the dynamics involved in the development and maintenance of the therapeutic alliance and in the resolution of ruptures. The theory views the therapeutic relationship as a situation amenable to the reactivation of the patient's long-standing expectations about the responsiveness and availability of others. Recent research has suggested that the patient's attachment style may influence the development of a good working alliance. Specifically, those patients who display insecure attachment styles tend to evaluate negatively their relationship with their therapist (Mallinckrodt, Coble & Gantt, 1995; Satterfield & Lyddon, 1995). Far less research has been carried out on the possible impact of the therapist's attachment style on the development of the alliance. However, there is some evidence that therapists who are comfortable with closeness are more likely to perceive their alliance with their patients as strong (Dunkle & Friedlander, 1996). Moreover, a study by Dozier, Cue & Barnett (1994) suggested that insecurely attached clinicians respond to insecurely attached patients in a complementary way; for example, they might be distant towards distant patients or overly supportive with dependent patients. This behaviour can be problematic because clinicians should challenge patients' expectations of others by providing responses that are not confirmatory of these expectations. There is also some preliminary

evidence that a difference between case managers and their patients, in terms of interpersonal strategies in close relationships, predicts a stronger alliance and better outcome (Tyrrell, Dozier, Teague & Fallot, 1998). Some of the psychoanalytic literature suggests that Tyrrell et al's findings are generalisable to more formal psychotherapy situations (Kantrowitz et al, 1989; Kantrowitz, 1995).

The central aim of this study is to explore whether therapists' attachment styles influence their responses to securely and insecurely attached patients by investigating how Clinical Psychologists in Training respond to ruptures generated by patients displaying different attachment styles. The study also aims to investigate whether the effects of participants' attachment styles on their responses are moderated by training.

As the quality of the therapeutic alliance predicts therapy outcome, it seems important to investigate how therapists' personal characteristics (e.g. their adult attachment style) affect the way in which they respond to ruptures in the alliance. Cushway (1996) suggested that if therapists remain unaware of their own conflicts, they may unwittingly act these out with their patients and their effectiveness as therapists may be diminished. Thus, knowledge about the impact of the therapist's attachment style on rupture resolution might have implications for the training of Clinical Psychologists, who, unlike other groups of therapists (e.g. Psychotherapists, Counselling Psychologists, etc.) are not requested to pursue personal therapy as part of their training.

This chapter is divided into three main sections. The first presents a review of the literature on the therapeutic alliance, with specific focus on the relationship between the alliance and outcome and recent research into the resolution of ruptures in the alliance. The second discusses one of the factors which may be influencing the development of the alliance, namely, the patient's and the therapist's adult attachment style. The last section describes the current study and articulates the research questions.

THE THERAPEUTIC ALLIANCE: THEORETICAL BACKGROUND

Although the usefulness of psychotherapy with psychological problems has been established, comparative therapy outcome studies (e.g. Greenberg & Pinsoff, 1987) and reviews of comparative outcome research (Luborsky, Singer & Luborsky, 1975) have failed to demonstrate a reliable difference in efficacy across the different theoretical models. Sophisticated meta-analyses have provided some evidence for the slight superiority of Cognitive-Behaviour Therapy over other therapeutic approaches, although Stiles, Shapiro & Elliott (1986) suggested that this finding might be a consequence of a dearth of well-designed studies within the Psychodynamic and Humanistic traditions. Researchers have attempted to understand this apparent homogeneity of effectiveness across therapeutic models either by viewing all psychotherapies according to a common theoretical framework (e.g. models of change) or by moving their attention from therapy technique to a common core of therapeutic ingredients, e.g. patients' behaviours and attitudes and the therapeutic alliance (Stiles et al, 1986). Roth & Fonagy (1996), who reviewed the research into the effectiveness of different psychotherapies for different types of psychological difficulties, regarded the therapeutic alliance as an important factor, alongside therapeutic technique.

The interest in the therapeutic alliance[1], or the bond that develops between the patient and the therapist during therapy, has increased dramatically over the last two decades. Early conceptualisations of the alliance originated in psychoanalytic thinking. Freud (1912), who had primarily been interested in the transference and resistance aspects of the psychoanalytic relationship, had also made a distinction between the patient's ‘neurotic’ and ‘friendly’ feelings towards the therapist. In his later writings, Freud became more interested in the bond between the patient and the therapist, which he regarded as more real than the mere unconscious re-emergence of the

[1] Although the terms 'working' and 'therapeutic' alliance have been used in the literature to signify either specific aspects of the alliance or the whole concept, in this thesis they will be used interchangeably.

patient's early relationships with caregivers, and which permitted them to work towards the accomplishment of therapeutic goals. Greenson (1965) later termed this more conscious, rational element of the relationship the 'working alliance'. Other therapeutic approaches besides the Psychoanalytic one (e.g. the Client-Centred and Cognitive-Behavioural ones) also emphasise the importance of a positive relationship between the patient and the therapist (Eaton, Abeles & Gutfreund, 1988).

Bordin (1979) put forward a pantheoretical conceptualisation of the therapeutic alliance that clearly marked the difference between unconscious transference phenomena and the idea of the therapist and the patient uniting, with a view to resolving the patient's difficulties. Bordin identified three integrated components of the alliance, that is goals, tasks and bond. He defined 'goals' as the mutually agreed targets that are to be achieved in order to produce a positive outcome; for example, a common goal in Cognitive-Behaviour therapy is to reduce the patient's symptoms, whereas a common goal in Psychodynamic therapy is to help the patient gain greater self-awareness. Bordin defined 'tasks' as the behaviours and thoughts displayed by the patient and the therapist, which they agree to undertake in order for therapy goals to be achieved; a typical task in Cognitive-Behaviour therapy is the monitoring of negative automatic thoughts, while in Psychodynamic therapy a typical task is the exploration of memories of early relationships with caregivers. Finally, Bordin defined 'bond' as the personal attachment that develops between the patient and the therapist during therapy.

Bordin (1980, quoted in Horvath & Greenberg, 1989) viewed the goal, task and bond components of the alliance as interdependent, in that, the quality of the bond is likely to influence the therapist's and the patient's ability to define and agree on tasks and goals and vice versa. He also proposed that different therapeutic models might assign different degrees of importance to the three components of the working alliance. For example, Psychoanalytic models might place greater emphasis on the bond component of the alliance, while Behavioural models might be more concerned with the goal component.

In short, Bordin's view of the working alliance involves not only the concept of an attachment between the patient and the therapist, but also the notion of mutual co-operation and agreement. His conceptualisation of the alliance views therapy effectiveness as dependent on the quality of the mutuality between the patient and the therapist. The next section will discuss some of the empirical evidence in support of this hypothesis.

The role of the therapeutic alliance in therapy progress and outcome

A growing body of research has explored the existence of a relationship between the strength of the therapeutic alliance and therapy outcome. Horvath & Greenberg (1989) requested counsellor-client dyads engaged in short-term counselling to assess the strength of the working alliance after the third session. The clients also assessed their outcome after the tenth session. The strength of the alliance was measured by means of the Working Alliance Inventory (WAI), a self-report instrument developed by the authors, which elicits both clients' and therapists' perceptions of Bordin's alliance components (i.e. tasks, goals and bonds). Outcome was measured by means of the Client Post-therapy Questionnaire (Strupp, Wallach & Wogan, 1964), which addresses three areas of client outcome (i.e. satisfaction, perceived adjustment and perceived change). The results suggested the presence of a relationship between early working alliance, as rated by client and counsellor, and client-reported satisfaction and perceived change; no relationship was found between early alliance and client-perceived adjustment. The authors explained this finding as relating to the point in time at which outcome was measured, as it might take longer than ten weeks for clients to become aware of their adjustment. One problem with this study is that the authors relied on self-report methods to assess the alliance and solely on clients' reports to evaluate outcome, which may have affected the validity of the obtained information.

However, an early study by Hartley & Strupp (1983) had found similar results with alliance and outcome measures completed independently by the therapist, the patient and an observer. The authors explored the relationship between the strength of the working alliance and outcome in brief psychotherapy by looking at differences in alliance between successful and unsuccessful cases. The strength of the alliance was measured by means of the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983), which is completed by clinician observers on the basis of tape-recorded therapy sessions. In this study, only the first, middle and last 5-minute segments from each session were rated. Two independent judges, blind to the study hypotheses, coded therapy excerpts from the sessions at the quartile points for each complete case; there was good agreement between raters. No significant differences were found between high outcome and low outcome cases in terms of the strength of the alliance. However, while in the high outcome group the alliance ratings increased in the initial phase of therapy, in the low outcome group they decreased in the initial phase and increased again in the middle phase so that, at the end of therapy, no differences between the two groups were observed in this respect.

Hartley & Strupp (1983) viewed this finding as congruent with psychoanalytic theories advocating that a sound alliance in the early phases of therapy establishes the grounds for work in the middle phases and concluded that the initial phases of therapy are crucial for the establishment of the alliance and for therapy outcome.

A review by Horvath & Symonds (1991) corroborated Hartley & Strupp's conclusions on the importance of the initial alliance for therapy outcome. These authors reviewed the literature on the relationship between the working alliance and therapy outcome and then meta-analysed the results from 20 studies that met the inclusion criteria (i.e. robust design, experienced therapists, clinically valid setting). A moderate association between early working alliance and therapy outcome was found. The association between the strength of the working alliance and therapy outcome was not found to be a function of length of treatment and therapeutic model utilised by the therapist (e.g. Cognitive, Psychodynamic and Eclectic), although most

therapists who participated in the studies included in the meta-analysis had described themselves as Eclectic. The issue of whether outcome may be related to the type of model utilised by the therapist, rather than to the strength of the alliance per se, was clarified in a study by Krupnick et al (1996). They studied a large sample of patients with depression, as part of a post-hoc analysis of a National Institute of Mental Health trial (Elkin, 1994). Patients were randomly assigned to one of four treatment conditions, i.e. Interpersonal Psychotherapy, Cognitive-Behaviour Therapy, anti-depressant medication plus clinical management and placebo plus clinical management. The strength of the therapeutic alliance was rated by means of the Vanderbilt Therapeutic Alliance Scale, completed by an independent observer on the basis of videotaped therapy sessions. Outcome was assessed by means of two measures of depression severity, completed by the patient and by the clinician. The results suggested that therapeutic alliance levels were similar across the four treatment conditions and most of the variance in outcome was related to alliance levels rather than to intervention type.

Research into the impact of specific therapeutic skills on the development of the alliance and outcome has also provided evidence for the important role played by empathy and exploration. Bachelor (1991) asked a group of therapists in training and their patients to rate the therapeutic alliance by means of several well-established measures. She also assessed therapy outcome by means of patient-rated or therapist-rated instruments focusing on symptom and problem resolution. The results suggested the presence of a relationship between alliance ratings and outcome. Moreover, when patients were rating the alliance, they identified therapist's warmth, caring, emotional involvement (i.e. empathy) and exploration (i.e. providing a novel perspective on the problem or aspects of their personality) as the most therapeutically significant factors. Warmth, caring and emotional involvement were the main predictors of patient-rated outcome, whereas exploration was mainly associated with supervisor's assessment of patient improvement. A study by Green (1996) produced congruent findings in a sample of children/adolescents and their parents. The parents rated, amongst other

things, therapists' empathy and therapy usefulness. Therapists rated the child/parent's engagement in therapy, which was operationalised in terms of their contribution to the 'bond' and 'task' aspects of the therapeutic relationship. The results showed that therapists' ratings of patients' engagement in therapy were the best predictor of outcome and that parents' ratings of therapists' empathy most closely predicted therapeutic engagement. It is uncertain to what extent these results can be generalised to adult psychotherapy patients, as parent-rated, and not patient-rated therapist's empathy, predicted engagement. However, the study suggests the presence of a relationship between therapist's empathy, the therapeutic alliance and outcome.

Gaston, Thompson, Gallagher, Cournoyer & Gagnon (1998) researched the influence of the therapeutic alliance and exploration on therapy outcome in a sample of depressed elderly patients treated with Behavioural, Cognitive or Brief Dynamic therapy. The alliance was rated by means of the California Psychotherapy Alliance Scale-Rater version (Gaston & Marmar, 1991). 'Exploration' was assessed on the basis of therapists' ability to explore patients' maladaptive reactions in terms of defences, wishes, emotions, cognitions and behaviours. Outcome was assessed by means of the Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erlbaugh, 1961) and the Hamilton Rating Scale for Depression (Hamilton, 1967). The authors found that exploratory interventions and alliance ratings predicted outcome in all the three approaches, although at different phases of therapy, depending on the approach. In Cognitive Therapy exploratory interventions contributed to outcome throughout treatment. The studies by Bachelor (1991), Green (1996) and Gaston et al (1998) are in line with a widely held view of the important therapeutic role of therapist's warmth and exploration (Stiles et al, 1986; Luborsky, McLellan, Woody, O'Brien & Auerbach, 1985).

In short, there seems to be an overall agreement that the relationship between the patient and the therapist develops early, usually within the first three sessions (Salvio, Beutler, Wood and Engle, 1992). Therapists' behaviours such as empathy and exploration have been found to impact on the development of the alliance and

therefore on therapy outcome. Moreover, there is growing evidence for the hypothesis that a sound therapeutic alliance early in therapy is a stronger predictor of outcome. However, Roth & Fonagy (1996) speculated that weaker associations between a good alliance later in therapy and outcome might reflect the greater occurrence of strains in the alliance, which may impact on the statistical associations. The next section will review some of the recent research on strains or 'ruptures' in the therapeutic alliance.

Resolution of ruptures in the therapeutic alliance

Safran et al (1994) commented that, whilst there is abundant evidence for the existence of a relationship between the quality of the therapeutic alliance and therapy outcome, less is known about the factors mediating this relationship. It has been suggested that, after an alliance has been formed, it usually becomes implicit until there is a disruption (Langs, 1974) and that the resolution of disruptions might be an important part of the therapeutic process (Bordin, 1989, quoted in Horvath & Luborsky, 1993). In this light, therapists' ability to resolve strains in the alliance is likely to influence patients' progress and outcome.

Safran, Crocker, McMain & Murray (1990) termed disruptions in the therapeutic alliance 'ruptures' and defined them as 'negative shifts in the quality of the therapeutic alliance or ongoing problems in establishing one'. Safran (1993) viewed the concept of rupture as similar to the Kohutian concept of 'empathic failure' (Kohut, 1984), although the latter undermines the essentially interactional nature of the phenomenon. The concept of rupture also differs from that of resistance because it is concerned with subtle interpersonal exchanges between the therapist and the patient, rather than viewing the difficulties of the latter as the sole cause of therapeutic problems. Both the patient and the therapist contribute to strains in the alliance,

although the contribution made by each party might vary on different occasions. Ruptures can range from temporary minor conflicts, which the therapist can sometimes be unaware of, to major obstacles in the establishment of an alliance, which could result in the patient terminating therapy prematurely (Safran et al, 1990; 1994).

Safran (1993) hypothesised three common patterns leading to the emergence of ruptures, i.e.: 1) when the patient misperceives the meaning or intent of the therapist's actions in a way that is consistent with his/her maladaptive schema; for example, the therapist makes a supportive comment and the patient perceives it as critical and patronising. Exploration of the meaning that the patient attaches to the therapist's comment is likely to generate valuable information about his/her way of relating to others; 2) when the therapist participates in a dysfunctional cognitive-interpersonal cycle that is typical of the patient; for example, the therapist might become aware of the patient's hostility and respond to it with hostility; this may in turn confirm the patient's expectations of others and generate a conflict. Exploration of both the therapist's and the patient's contribution to this conflict can promote exploration of unconscious negative feelings towards the therapist and important others; 3) when the therapist refrains from participating in a dysfunctional cognitive-interpersonal cycle. For example, she/he might not give the patient immediate reassurance, with a view to providing a new interpersonal experience for him/her and to disconfirming his/her internal working models. However, the patient might misinterpret the therapist's behaviour and become anxious. Again, exploration of the rupture can be informative about the patient's understanding of other people's responses.

In short, if detected promptly by the therapist, ruptures can represent a unique opportunity to understand, explore and resolve some of the patient's underlying difficulties. Safran (1993) advocated that, when ruptures occur in the context of an established good relationship or 'meta-alliance', they are indicative of therapy progress, in that their emergence may be a sign of the patient's increasing ability to trust the therapist sufficiently to articulate his/her negative feelings.

Castonguay, Goldfried, Wiser & Hayes (1996) investigated how therapists resolve strains in the alliance by following a group of patients receiving either Cognitive Therapy or a combination of Cognitive Therapy and Pharmacotherapy. The study used data collected during the Cognitive-Pharmacotherapy project (Hollon, DeRubeis, Evans, Wiemer, Garvey, Grove & Tuason, 1992). The authors randomly selected one taped session for each patient from the first half of therapy and asked independent raters to code the tapes by means of the Coding System of Therapist Feedback (Goldfried, Newman & Hayes, 1989), in order to explore the therapist's ability to make connections between different aspects of the patient's functioning. The tapes were also rated by means of the Working Alliance Inventory (WAI). The raters identified fifteen sessions during which therapists made such connections; of these, 9 sessions received below average alliance scores and 6 above average alliance scores. Exploration of the former revealed the presence of frequent alliance ruptures, which therapists attempted to resolve by defending the validity of the cognitive model or by explaining them as a manifestation of patients' cognitive distortions needing challenging, rather than by exploring the meaning of patients' experience. In contrast, in the high alliance sessions, therapists attempted to identify what had contributed to the rupture and explored patients' feelings about it. The authors concluded that the resolution methods adopted by therapists impact on the strength of the alliance. However, it is also possible that a pre-existing stronger meta-alliance encouraged some therapists to move away from a strict adherence to the manual and to focus on the patient's immediate experience. The authors did not specify whether therapists differed in terms of their experience; it is possible that level of experience might have influenced therapists' ability not to adhere strictly to the rules and assumptions of Cognitive-Behavioural therapy and to explore the patient's immediate experience. Also, the sample of sessions examined in the study was quite small, which reduces the generalisability of these results.

To summarise, Safran and his colleagues have researched the factors mediating the development and maintenance of the alliance and specifically the

occurrence of 'ruptures' in the therapeutic relationship. Ruptures can be informative about the patient's expectations in relationships and, if detected promptly, they can result in therapeutic progress and strengthen the alliance. There is some evidence that the therapist's rupture resolution method impacts on the strength of the alliance; this raises questions as to which factors in the therapist may influence the chosen resolution method and ultimately the alliance. The remaining part of the introduction will focus on the impact of patients' and therapists' personal characteristics on the therapeutic alliance.

FACTORS INFLUENCING THE ALLIANCE: THE ROLE OF ADULT ATTACHMENT STYLE

The research on the therapeutic alliance presented in the previous sections essentially recognises that therapy begins as a relationship between two people, one seeking help and one providing such help. Strupp (1974) argued that patients' previous experiences with important others and ability to form relationships are likely to influence their capacity to engage with their therapist and to establish a sound therapeutic alliance. This idea is in line with research suggesting the presence of a correlation between patients' lifelong patterns of relationships, patient-rated and therapist-rated alliance and outcome (Piper, Azim, Joyce, McCallum, Nixon, & Segal, 1991). There is also evidence for an association between patients' negative family and social relationships and difficulties with developing a strong alliance with their therapist (Kokotovic & Tracey, 1990; Moras & Strupp, 1982).

Attachment theory (Bowlby, 1969, 1979, 1988) represents an interesting framework for thinking about relationships, including the therapeutic one. Broadly speaking, the theory views the bond between child and caretaker as impacting on the child's self-concept and understanding of his/her social world. The quality of infants' relationships with their caregivers are also hypothesised to affect their way of relating

to close others later in life. Bowlby (1969) initially developed his theory to account for those behaviours and emotional responses which ensure that infants and their caregivers retain physical proximity. As behaviours like crying usually result in caregivers approaching infants, over time the latter learn to direct these initially random behaviours towards specific attachment figures when in distress. Bowlby viewed these 'attachment behaviours' as the manifestation of a behavioural system present at birth, the goal of which is to ensure survival through the maintenance of proximity to a caregiver. The development of locomotor skills, around six months of age, coincides with a more active and effective engagement in this proximity-seeking behaviour. Around this age, the infant also develops some kind of understanding that the caregiver exists even when s/he cannot be seen, heard or touched; this results in the infant feeling distressed when the caregiver leaves him/her and therefore in an ability to become attached to familiar persons.

The quality of this early attachment between infant and caregiver is largely determined by the caregiver's responsiveness and emotional availability, which evokes feelings of security in the infant, thus creating a secure base from which s/he can explore his/her environment. Caregiver's responsiveness also impacts on the development of the infant's expectations about the availability of close others, which s/he will eventually organise into 'working models' of the environment, his/her caregivers and him/herself (Bowlby, 1982). The child will then use these working models in new relationships and they will influence his/her perceptions of and behaviours towards others.

Attachment style in childhood

Ainsworth, Blehar, Walters & Wall (1978) elaborated Bowlby's original theory by exploring individual differences in attachment relationships through the observation of interactions between infants and parents in the well-known 'strange situation'

procedure. This involves bringing infants to a strange room, separating them from their caregivers for several three-minute periods and observing their reactions to their parents on reunion. The authors viewed infants' responses on reunion as informative about their expectations of their caregivers and their perceptions of separations.

Ainsworth et al's research resulted in the identification of four distinct styles of attachment: secure, insecure/ambivalent, insecure/avoidant and insecure/disorganised. Infants are classified as secure if they show a degree of distress at separation but are quickly comforted by the parent on reunion. Approximately two thirds of children from normal populations tend to behave in this way. Those infants who protest at separation, but cannot be comforted when the caregiver returns, are classified as insecure/ambivalent. Infants are classified as insecure/avoidant if they show little sign of distress at separation and no interest in the parent on reunion. Infants whose responses to separation and reunion were not coherent (i.e. freezing, leaning against a wall) and could not be easily classified as ambivalent or avoidant were classified as insecure/disorganised. Crittenden (1988) found that, in normal populations, one fifth of children are avoidant, one sixth are ambivalent and approximately one in twenty disorganised. Main, Kaplan & Cassidy (1985) suggested that attachment styles could be understood as 'terms referring to particular types of internal working models of relationships, directing feelings, behaviour, attention, memory and cognition'. Insecure attachment patterns have been viewed as serving the function of gaining the proximity of unresponsive or rejecting parents (Hamilton, 1985).

There is also evidence for Bowlby's hypothesis that caregivers' warmth and responsiveness is associated with feelings of security in the infant. Holmes (1997) summarised this evidence as follows: the parents of secure children seem quick at comforting their children when they are distressed, they play with them more and they seem more aware of their needs. The parents of avoidant children tend to be detached and abrupt in their interactions with them. The parents of ambivalent children tend to display less awareness of their needs, for example they might ignore them when they

cry. The mothers of disorganised children tend to be under a lot of stress and to have experienced abuse as children.

Some research has indicated that available and responsive parents appear to have had similar parenting or to have recently reorganised and worked through their attachment experiences (Egeland, Jacobvitz & Sroufe, 1988). A study by Fonagy, Steele, Steele, Moran & Higgitt (1991) further clarified how parental characteristics influence infants' attachment style. The authors interviewed a large sample of first time mothers and fathers at three points in time, i.e. before the child's birth, when the child was one year of age and when s/he was 18 months old. The parents' attachment style was assessed by means of the Adult Attachment Interview (AAI - Main, et al, 1985). The infant's attachment style was also assessed in the 'strange situation'. The results showed that caregivers' ability to reflect on one's own and other people's mental states, thus understanding why people behave as they do (i.e. reflective-self function), was a key determinant of security in the infant. Specifically, the coherence of parents' AAI transcript correlated highly with their reflective-self function ratings; moreover, although parental script incoherence is often observed in parents of insecure children, when parental reflective-self function was controlled for, transcript coherence was no longer related to infant security. The authors concluded that parents' ability to understand the infant is based on their ability to self-reflect, which is in turn dependent on their internal working models. In a later paper, Fonagy, Steele, Steele, Leigh, Kennedy, Mattoon & Target (1995) argued that a child is likely to be securely attached if his/her parents have either a secure attachment style or they have developed sufficient reflective-self function to avoid using their working models, based on their own adverse attachment history, in their relationship with the infant.

Longitudinal research has also explored the existence of a relationship between attachment style in infancy and later behaviour in interactions with others. For example, Bretherton (1991) found that attachment style at one year of age predicted children's ability to interact with peers and teachers at school entry. Insecure children were found to be experiencing difficulties with forming relationships

at school; specifically, the insecure/avoidant children tended to be more introverted and more prone to unprovoked aggression, while the insecure/ambivalent children tended to cling to their teachers and to be the target of aggression. There is also evidence that children's attachment styles can change; for example, a change in caregiver's circumstances and/or him/her receiving successful therapy have been found to be related to the reclassification of insecure children as secure (Murray & Cooper, 1994).

Attachment style in adulthood

During the last decade, there has been a growing interest in the exploration of adult attachment as an elaboration of early attachment experiences. Weiss (1982) identified three main ways in which attachment in adulthood differs from attachment in childhood, in that the former is: 1) also manifested with peers 2) less likely to have a negative impact on other behavioural systems 3) activated within close sexual relationships. Sperling, Berman & Fagen (1992) also suggested that working models may play a greater role in adult than in childhood relationships. This is because children have little history of prior attachments and therefore bring mainly temperamental characteristics to the bond with their caregiver(s). In contrast, by adulthood, working models are established and tend to guide the individual's behaviour and expectations of others. Crowell & Treboux (1995) also noted that unlike child-adult attachments, adult-adult attachments are reciprocal; for example, both partners are likely to play both the 'care receiving' and the 'care giving' roles at different times. Moreover, attachment relationships between adults serve a variety of other purposes besides the care giving one, e.g. sexual bonds, companionship, shared experience etc. (Ainsworth, 1989). Despite these differences, there is considerable conceptual and behavioural overlap between childhood and adult attachment styles (Sperling et al, 1992).

Two main lines of research have looked at adult attachment patterns. Hazan and Shaver (1987, summarised in Collins & Read, 1990) used the childhood attachment paradigm to explore intimate sexual relationships between adults. They measured adult attachment by means of a self-report adult attachment measure, which was designed to tap into the three main attachment categories identified by Ainsworth et al (1978), i.e. secure, ambivalent and avoidant. The main finding of the study was that secure adults described their relationships as characterised by happiness, trust and availability at times of need. In contrast, ambivalent adults described their relationships as tumultuous and characterised by jealousy and over-preoccupation with their partner. Finally, avoidant individuals described their relationships as characterised by difficulties with dependence and intimacy. Adult attachment style was also found to be predictive of participants' perceptions of themselves and their social world, with secure participants generally feeling liked by others and experiencing others positively. There was also a relationship between self-reported adult attachment style and participants' self-reports of early relationships with caregivers; specifically, secure adults described their parents as more respectful and accepting than insecure adults.

One of the problems with this study is that the instrument used to measure adult attachment consisted of three paragraphs describing the three main attachment styles and forcing participants to accept a description they might have only partially agreed with. This measure also assumed the presence of mutually exclusive attachment styles (Collins & Read, 1990).

Collins & Read (1990) developed a 21-item scale inspired by Hazan & Shaver's measure of attachment. The Adult Attachment Scale (AAS) consists of three different sets of items tapping into three distinct styles of relating. These are: 1) items reflecting the extent to which someone feels that others can be trusted and depended upon and tapping into the 'depend' dimension 2) items reflecting the person's anxieties in close relationships (e.g. fear of abandonment) and tapping into the

'anxiety' dimension and 3) items reflecting the extent to which a person is comfortable with closeness and intimacy and tapping into the 'close' dimension.

Collins & Read (1990) used the AAS to assess adult attachment style in a sample of couples. Participants were also interviewed about their perceptions of their attachment histories with their parents, their satisfaction with their relationships and their ability to communicate feelings within their relationships. The results suggested that self-reported adult attachment style predicted choice of partner. Overall, participants tended to choose partners who shared their beliefs and feelings about closeness to and dependability on others. However, perhaps in line with Weiss' claim (1982) that individuals sometimes choose partners to whom their attachment style is already equipped to respond, anxious participants appeared to be in relationships with partners who were uncomfortable with getting close to others, which may in turn, confirm their fears about being unloved and abandoned. This finding is consistent with Bowlby's conceptualisation of individuals as shaping their social world so that it confirms their working models, thus perpetuating the attachment patterns acquired in childhood. Collins & Read's study (1990) also showed that partner attachment style predicted participants' views of the opposite-sex parent's care giving style. The authors concluded that the opposite sex parent might be used as a model for heterosexual relationships and for expectations about future partners.

The second line of research on adult attachment has looked at adults' memories of their childhood experiences with their caregivers. Main et al (1985) devised a semi-structured interview, the Adult Attachment Interview (AAI) aimed at assessing in adult populations the attachment patterns identified by Ainsworth et al (1978) with infants. Analyses of the interviews focus on individuals' narrative styles when discussing their childhood, rather than on the content of the material disclosed. Participants' narratives are then classified into secure/autonomous, insecure/dismissive (or avoidant), insecure/enmeshed (or preoccupied) and insecure/disorganised (or unresolved). The narratives of secure/autonomous participants are characterised by a coherent, logical and concise description of past

events, even if these were problematic. The narratives of insecure/dismissive participants are usually poor in content, and are characterised by an inability to report any childhood memories or by a tendency to describe their childhood as happy, without producing any concrete examples. Insecure/enmeshed narratives tend to be incoherent and overinvolved accounts of past painful events, which are described very vividly, as if the individual is still experiencing pain. Insecure/disorganised narratives typically appear disjointed and interrupted.

There is some evidence for a correspondence between attachment status in childhood and later narrative style. For example, some longitudinal studies have indicated that attachment characteristics in infancy predict attachment style in adolescence as measured by the AAI (Benoit & Parker, 1994; Ward & Carlson, 1995). However, more long-term longitudinal research is needed to establish the continuity of childhood attachment patterns across different developmental stages.

The AAI has some advantages when compared to other measures of adult attachment, in that it overcomes common problems of self-report questionnaires (e.g. social desirability) and it permits the investigator to tap into material of which the individual might not be aware. However, the AAI is a lengthy procedure requiring the transcription and scoring of interviews lasting a minimum of one hour, which may explain why a lot of studies in this area utilise self-report attachment questionnaires.

As noted at the beginning of this section, psychotherapy essentially begins as a relationship between two people. Bowlby (1988) viewed close relationships, including the therapeutic one, as situations amenable to the reactivation of the patient's long standing expectations of others. He also argued that the therapist should undertake the role of an attachment figure, providing a secure base from which patients can explore and challenge their working models of themselves and others. As with other forms of adult attachments (e.g. friendships, sexual relationships), the development of the therapeutic relationship is likely to be strongly influenced by patients' ability to become attached to another person.

Patient's attachment style and the therapeutic alliance

The research on attachment reviewed above suggests that patients displaying insecure attachment styles might develop weaker alliances than secure patients. There is in fact some research giving credence to this hypothesis. In their study of counsellor trainees, Satterfield & Lyddon (1995) assessed patients' attachment styles by means of the Adult Attachment Scale (AAS) and the strength of the working alliance by means of the patient version of the Working Alliance Inventory (WAI). The results indicated the presence of a positive correlation between patients' scores on the 'depend' dimension of the AAS and working alliance scores. The authors concluded that patients who have difficulties with depending on and trusting others are more likely to have difficulties with forming a relationship with their therapist than those who fear abandonment or those who are uncomfortable with closeness and intimacy. However, there seems to be disagreement in the literature about which AAS attachment dimensions are most likely to be associated with poorer alliance ratings. For example, Mallinckrodt et al (1995) explored the impact of adult attachment style and parental bonds on the development of the therapeutic alliance. Participants were a group of women receiving brief therapy and were requested to complete the WAI, the AAS and the Parental Bonding Instrument (PBI - Parker, Tupling and Brown, 1979). The PBI requests individuals to rate the quality of the parenting that they received between the ages of 0 and 16 years and it consists of a protection and a care scale; optimal parenting is characterised by high care and low protection. Multiple regression tests showed that the 'anxiety' dimension of the AAS (i.e. fear of abandonment and rejection in close relationships), rather than the 'depend' dimension, predicted lower working alliance ratings. Moreover, the 'close' dimension of the AAS (i.e. a willingness and an ability to form emotional attachments) predicted a strong, positive alliance. The discrepancy between the results obtained by Mallinckrodt et al and Satterfield & Lyddon may be partially related to the sample in the Mallinckrodt et al's study being completely female, which also reduces the generalisability of these

results. However, the distinction drawn by Horowitz, Rosenberg & Bartholomew (1993) between two types of avoidance (i.e. one type related to a need to maintain distance in order to avoid rejection or abandonment and the other type related to a desire to do this in order to remain independent) can be used to reconcile these apparently conflicting results. In other words, both studies seem to suggest that individuals using avoidant attachment strategies may have greater difficulties with developing an alliance with their therapist than other patients.

The study by Mallinckrodt et al (1995) also showed that parental bonds, and especially bonds with father, predicted the strength of the therapeutic alliance. Specifically, patients who rated their fathers as high on protection (i.e. as intrusive, controlling and unwilling to promote autonomy) rated the working alliance lower than those who did not. Memories of a positive bond with father were also associated with the individual's ability to depend on others for emotional support. These findings are in line with Bowlby's hypothesis that caregivers' responsiveness and availability affect the formation of internal working models of relationships and therefore individuals' ability to form satisfactory relationships later in life.

One of the difficulties with both studies is that only patients were asked to rate the quality of the working alliance. Moreover, patients' attachment styles and the strength of the alliance were measured by means of self-report instruments, which merely elicit information which is readily accessible to the individual. Social desirability is also likely to have impacted on the quality of the material disclosed. Despite these shortcomings, this research suggests that patients' attachment styles impact on either patients' or therapists' perceptions of the quality of the working alliance. However, as the therapeutic relationship is an encounter between two persons, it is likely that both therapists' and patients' characteristics together affect the quality of the working alliance. Therefore, whilst these studies indicate that insecurely attached patients might have difficulties with developing a sound therapeutic relationship, they neglect to explore the possible impact of therapists' attachment patterns on the development of the alliance.

Therapist's attachment style and the therapeutic alliance

The studies reviewed in the previous section suggest that attachment theory can make substantial contributions to the understanding of psychotherapy process. However, although there is increasing recognition that patients' attachment styles impact on the development of the therapeutic alliance, less is known about the impact of therapists' attachment styles. Dunkle & Friedlander (1996) speculated that the greater interest in the influence of patients' rather than therapists' characteristics may reflect a uniformity myth, i.e. a belief that there are no differences across therapists in their work with patients. The dearth of research in this area is probably also related to beliefs about the predominance of patients' contributions to the development and maintenance of the working alliance. For example, Colson et al (1988) discussed studies by Hartley (1985) and Stiles et al (1986) which viewed the little variation in terms of personal characteristics across therapists taking part in psychotherapy research as an indication that patients' contributions to the working alliance are more crucial than therapists' contributions. However, the observed similarity across therapists participating in psychotherapy research could be due to a self-selection bias; in other words, it is possible that similar, and possibly more adjusted therapists, agree to participate in psychotherapy process studies.

Dozier et al (1994) proposed that, as sensitive parenting is strongly influenced by parents' attachment styles, clinicians' attachment styles are likely to influence their ability to be attuned to and to respond sensitively to patients, which might in turn affect the development of the alliance. Dunkle & Friedlander (1996) explored this possibility by requesting a large sample of therapists to complete the Intrex Introject questionnaire (Benjamin, 1982) to assess their level of self-directed hostility, the Social Provisions Scale (Cutrona & Russell, 1987), to assess the quality of their social support network and the AAS, to assess their ability to develop healthy relationships.

Patients completed a short version of the WAI (Tracey & Kokotovic, 1989) to assess the strength of the working alliance. Multiple regressions showed that those patients whose therapists reported less self-directed hostility, more social support and greater comfort with closeness were more likely to rate the bond component of the working alliance favourably. No effects for total alliance scores were found and no unique effects were observed for the 'depend' or 'anxiety' components of the AAS. The study suggested that therapists bring to the therapeutic relationship their own history of relating to others and this affects their interactions with patients. This study suffers from some of the shortcomings of other studies in this area, i.e. only patients were rating the alliance and its quality was assessed by means of self-report measures. Moreover, the study only assessed the contribution of therapists' characteristics, rather than the effects of an interaction between patients' and therapists' characteristics. Dozier et al (1994) attempted to address this issue by investigating whether case managers' attachment organisation affected the way in which they intervened with patients. These authors argued that psychotherapy differs from other relationships in that it should avoid confirmation of patients' working models, thus helping them to reformulate their expectations of others. This might involve resisting the temptation of, for example, responding to patients who present as self-reliant and invulnerable in a dismissing manner and to patients who present as vulnerable and dependent in a protecting manner. In other words, one of the therapist's tasks is to behave in a way that is not complementary with the patient's working models, thus avoiding his/her view of relationships being perpetuated. Dozier et al (1994) administered the Adult Attachment Interview to 27 patients suffering from serious psychopathological disorders and their 18 case managers; the authors also conducted telephone interviews with the latter to explore their most recent face to face contact with their allocated patients. These interviews involved the case managers describing the problems they had dealt with on this occasion and reflecting on how they had intervened. The interviews were scored in terms of intervention depth; interventions like 'enabling the patient to reflect on their anger towards a family member' received

high depth scores, whereas interventions like 'helping patients with their benefits' received low depth scores. A series of hierarchical regressions revealed that insecure case managers tended to respond more deeply than secure ones to patients who presented as vulnerable and dependent (i.e. preoccupied patients). Insecure case managers were also more likely than secure case managers to perceive preoccupied patients as having greater dependency needs than self-reliant and independent patients (i.e. dismissing patients). Moreover, preoccupied clinicians perceived patients as having greater dependency needs than dismissing clinicians and tended to intervene in greater depth with them. Dozier et al (1994) concluded that secure clinicians are more able than insecure ones to respond to patients' underlying needs rather than to their most obvious ones and to resist patients' pull to behave in a way that is confirmatory of their internal working models.

Unfortunately, Dozier et al did not specify how many of the case managers were classified as insecurely attached and how many as preoccupied and dismissing. It is possible that the number of clinicians in each of the groups was rather small, which would reduce the generalisability of these results. Nonetheless, the study suggested that clinicians' attachment organisation may influence the way in which they react to patients with similar or different attachment styles. The study also raised questions about whether these dynamics are likely to affect the therapeutic alliance and whether they are likely to manifest themselves during formal therapy sessions.

In a later study, Tyrrell et al (1998) investigated whether the state of mind of both patients and their case managers with respect to attachment affected the strength of the therapeutic alliance and outcome. They administered the AAI to 54 patients with severe psychiatric disorders and 21 case managers. The patients also completed the Working Alliance Inventory (WAI), the Quality of Life Interview (Lehman, 1988) and the short form of the Beck Depression inventory (Beck et al, 1961). The case managers rated patients' overall functioning by means of the Global Assessment of Functioning Scale (GAF; DSM-IV, 1994), which generates information about patients' overall psychological, social and occupational functioning. The authors

coded the AAI transcripts by means of a method developed by Kobak (1989), which measures two independent attachment dimensions. One assesses the extent to which participants are secure or insecure, while the second assesses the degree to which a person deactivates or hyperactivates in close relationships. 'Deactivation' refers to a tendency to avoid discussing attachment related issues, with the intention of diminishing the importance of early relationships. Individuals with this state of mind tend to maintain interpersonal distance from others. 'Hyperactivation' refers to a preoccupation with attachment relationships and greater overall emotional distress when compared with other individuals. As most patients were rated as insecure and most case managers as secure, the analyses focused on the deactivation/hyperactivation dimension. A series of regression equations showed that less deactivating case managers formed stronger working alliances with more deactivating patients than with less deactivating ones and vice versa. Moreover, more deactivating patients reported higher general life satisfaction when working with less deactivating case managers than when working with more deactivating ones. Similar interactions were found between the patient deactivation, the case manager deactivation and the patient's GAF ratings. The authors concluded that more deactivating patients tend to work better and to have better outcomes when matched to clinicians who are less deactivating and vice versa. Tyrrell et al (1998) proposed that this might be due to the fact that working with a case manager utilising different emotional and interpersonal strategies is likely to result in the patient's strategies being disconfirmed. However, patients and case managers had been working together for seven months when the alliance was measured. It is possible that the picture emerging from these results would have been different had the alliance been measured in the early phases of therapy, at which time patients might have found difficult working with clinicians who utilised emotional and interpersonal strategies different from their own. It is also worth noting that early alliance is a stronger predictor of therapy outcome than later alliance. Unfortunately, Tyrrell et al (1998) did not specify how many clinicians and patients were classified as deactivating/hyperactivating. Also,

the generalisability of these results to the therapy situation is questionable, because the psychotherapy relationship is qualitatively different from the case management one. However, the study is in line with earlier work suggesting that the therapist's style enhances or inhibits treatment, depending on patients' characteristics; specifically, dependent patients tend to show greater improvement when treated by 'autonomy-orientated' therapists, while independent ones do better with 'attachment-orientated' therapists (Berzins, 1977, quoted in Beutler, Machado & Allstetter Neufeldt, 1994).

Some psychoanalytic literature has devoted attention to the impact that an overlap between the therapist's and the patient's conflicts can have on therapeutic outcome. Kantrowitz (1993) discussed the importance for therapists to be aware of the possible similarities between their own conflicts and those experienced by their patients. Her research on the effects of patient-analyst match suggested that such similarities can result in 'blind spots', that may in turn represent an obstacle to treatment. Kantrowitz et al (1989) followed-up 17 patients who had received a course of psychoanalysis at the Boston Psychoanalytic Institute five to ten years after termination. The interviews with patients' analysts were designed to obtain information about their personality, style, values and feelings about their patient. Independent judges subsequently rated these variables from transcripts of the interviews. Patients were interviewed about their perceptions of their therapist and therapy, both in terms of process and outcome. Successfulness of analysis was defined in terms of 'developing, understanding and resolving the transference neurosis' (Kantrowitz, 1995, p. 321). Outcome was also evaluated by means of pre and post analysis psychological tests of reality testing, level and quality of object relations, affect availability and tolerance. The authors found two types of impeding match between the analyst and the patient: 1) a match of similarity, when the analyst and the patient shared similar issues, traits or expression of conflicts and 2) a match of complementarity, when the analyst and the patient used different strategies to express similar conflicts. They also found evidence for a facilitating or compensatory match, i.e. when the therapist's style or personality provided the patient with a novel

dimension with which to identify. Patient-therapist match was found to play a role in therapy outcome for 13 of the 17 patients, with 7 cases being rated as impeding, five as facilitating and one as mixed. In the impeding match cases, therapists' 'blind spots' about unresolved conflicts, personal style or characteristics that 'interdigitated' with patients' ones resulted in the patient's core conflicts not being explored and worked through. However, when the therapist was aware of this overlap of conflicts, exploration during therapy was not impeded.

These results need to be evaluated with caution due to the small numbers of patients involved in the study; also therapists were trainees and only their work with one patient was observed: it is possible that these dynamics would not have occurred with more experienced therapists and also between the same trainee and other patients. However, this research is reminiscent of Tyrrell et al's (1998) finding that a difference between the therapist and the patient in terms of their interpersonal strategies impacted positively on outcome. Although Kantrowitz et al (1989) did not measure the strength of the therapeutic alliance between patients and analysts, their study suggests that the findings of Tyrrell et al (1998) with case managers might be relevant to more formal therapy situations.

In conclusion, although the research in this area is still in its infancy, the studies discussed in this section suggest that clinicians' attachment organisations can affect their ability to form a bond with their patients, their perception of patients' needs, their choice of intervention and patients' outcome. Some of the psychoanalytic literature has explored the impact of the therapist-analyst match on therapy outcome; it seems that a similarity between the patient and the analyst in terms of personality characteristics and conflicts results in a less favourable outcome if these are similar to the patient's central difficulties and the therapist is unaware of these dynamics. This preliminary work represents a starting point for generating hypotheses about how patients' and therapists' attachment styles may affect interactions during psychotherapy.

SUMMARY OF THE REVIEWED LITERATURE

The literature reviewed here suggests that the therapeutic alliance, or the collaborative bond between the patient and the therapist, plays a crucial role in influencing therapy outcome. Recently, researchers in this area have turned their attention to the exploration of the factors involved in the reparation of ruptures in the therapeutic alliance. As psychotherapy is ultimately a close relationship between two individuals, it is also amenable to the reactivation of their expectations of others, which, according to attachment theory, are formed in childhood during interactions with caregivers. Attachment theory can be informative about the dynamics involved in the development and maintenance of the therapeutic alliance and in the successful resolution of ruptures in the alliance. Research has shown that insecurely attached patients are more likely than secure ones to evaluate negatively their relationship with their therapist. Far less research is available on the impact of therapists' attachment styles on the development of the therapeutic alliance and none on whether their attachment style affects their ability to resolve conflicts during therapy. Research on the relationship between therapists' attachment styles and the alliance has suggested that therapists who are comfortable with closeness and low on hostility are more likely to develop a sound therapeutic alliance with their patients. However, most studies in this area have either explored the influence of patients' attachment styles or therapists' attachment styles, rather than the effects of an interaction between the two. Some research with case managers has shown that insecurely attached clinicians tend to focus on patients' most obvious needs and to intervene with them in a way that is complementary to their working models, thus not challenging their expectations of others. Later research with case managers has also indicated that a dissimilarity between patients and clinicians in terms of attachment strategies in close relationships predicts a stronger therapeutic alliance and better outcome. Some of the

psychoanalytic literature suggests that these findings might be relevant to the psychotherapy situation.

THE CURRENT STUDY: AIMS AND RESEARCH QUESTIONS

This study was inspired by the work with case managers carried out by Dozier et al (1994) and Tyrrell et al (1998). It aims to explore the relevance of some of this research to the therapy situation, by looking at whether therapists' attachment styles affect their ability to respond to ruptures generated by patients with similar or dissimilar attachment styles. Specifically, the study aims to explore whether therapists' attachment styles affect their ability to understand patients' mental states (Eagle, 1996) and therefore to be explorative and empathic with securely and insecurely attached patients.

The study will use an analogue of the therapy situation and will involve participants watching video clips of four different patients displaying one of four attachment styles (one secure and three insecure). Each video clip will terminate with the patient making a statement, which will be informative about his/her central difficulties, and to which participants will be asked to respond. The responses will be tape-recorded and subsequently rated in terms of their depth and empathy.

Response depth and empathy

Psychotherapists often make interpretative comments about the patient's emotions and motivations to promote exploration of conflicts and increase his/her self-awareness. Raush, Sperber, Rigler, Williams, Harway, Bordin, Dittman & Hays (1956) viewed interpretations as constituting a continuum, ranging from superficial to deep and proposed that, as patients' awareness of their emotions and motivations vary, the depth of an interpretation varies according to the distance between the therapist's comment and the patient's awareness. An early study by Speisman (1959)

found that, unlike superficial and deep interpretations, moderate interpretations were followed by less resistance and greater exploration. The author speculated that deep and superficial interpretations are less likely to bring about exploration because the former focus on material which is not yet conscious and therefore difficult to explore, while the latter focus on material of which the patient is already conscious and therefore redundant with respect to exploration. There is continuing interest, within more recent psychoanalytic literature, in the categorisation of interpretative comments according to their depth. For example, Horowitz (1989) identified eight levels of interpretation, ranging from superficial ones (i.e. aimed at making connections between life events and emotions) to deep ones (i.e. focusing on unconscious feelings and impulses). The chosen level of an interpretation usually depends on the patient's ability to process the therapist's comment at any given moment in treatment.

Although empathy and interpretation have sometimes been regarded as conceptually different, they often co-occur. Greenberg & Elliott (1997) proposed that both empathic and interpretative responses intend to communicate understanding and to encourage the patient to explore what he/she is experiencing. In addition, interpretations also serve the function of making the patient aware of something new about him/herself.

Client-centred therapists have traditionally regarded empathy as one of the necessary and sufficient conditions for change in therapy (Rogers, 1957), and therefore as playing a crucial role in therapy progress and outcome. Although to a lesser extent, most psychotherapy models recognise the importance of empathy in the psychotherapeutic process. Bohart & Greenberg (1997) commented that most models would view empathy as involving the therapist's effort to 'sense, perceive, share or conceptualise how another person is experiencing the world'. An empathic response is likely to communicate to the patient that the therapist understands, feels for him/her and validates his/her experiences. Some of the studies discussed earlier also suggest the presence of a link between the therapist's empathy and exploration, the alliance and therapy outcome (Green, 1996; Bachelor, 1991; Gaston et al, 1998).

This study will assess the depth and empathy of responses produced by securely and insecurely attached participants to patients displaying similar or dissimilar attachment styles.

The effects of training on therapeutic skills

One question emerging from the discussion on response depth and empathy is whether the development of therapeutic skills during training can moderate the effects of therapists' personal characteristics (e.g. attachment styles) on their responses. The literature on the effects of training on therapists' behaviours has produced mixed results; some studies have found no or modest changes as a result of training in facilitative style, amount of questions asked and interviewing skills (Hill, Charles & Reed, 1981; Spielberg, 1980), while others have found significant gains in empathy and warmth (Perlman, 1973; Abramowitz, Abramowitz & Weitz, 1976). It is difficult to explain these seemingly contradictory findings because these studies measured skill acquisition in different ways, ranging from ratings of counselling sessions to paper and pencil exercises. Other problems with these studies include the absence of control groups, minimal follow-up and a lack of information about the type of training being evaluated (Aronson, Akamatsu, Horace & Page, 1982).

A study by Shiffman (1987), exploring the effects of Clinical Psychology training on trainees' interview skills, overcame some of these problems. The author used the Group Assessment of Interpersonal Traits method (Goodman, 1972) to obtain information about participants' helping behaviour during tape-recorded, role-played psychotherapy sessions; participants role-played both the therapist and the patient, but never directly reversed roles. In year one, the study compared the performance of trainee Clinical Psychologists with 0 to 2 years of training to that of non-clinical psychology students. In year two, trainee Clinical Psychologists with 0 to 3 years of training participated in the study. The interviews were coded by three

groups of raters, each focusing on a different dimension: therapist facilitative conditions (e.g. empathy and acceptance), response modes used by the therapist, and patient openness. The results showed that clinical trainees were more empathic and accepting than other psychology graduates, their style was more reflective and less directive and they tended to ask fewer questions. However, there was no evidence for a training effect, in that clinical trainees with up to three years of training were not better on the rated dimensions than those who had just started training. Shiffman (1987) speculated that, since graduates intending to become clinicians tend to show better interviewing skills than other ones (Carkhuff, Kratochvil & Friel, 1968), these results might be related, not only to the stringent selection criteria for clinical training, but possibly also to self-selection. It is possible that the artificiality of the therapy situation (i.e. therapists interacting in an experimental setting, with peers rather than with real patients) affected these results, although it is difficult to imagine how the setting per se could account for the observed pattern of results. Unfortunately, due to a general lack of research on the effects of Clinical Psychology training on trainees' therapy and interviewing skills, it is difficult to evaluate Shiffman's findings. Therefore, the current study will also attempt to contribute to the discussion on the effects of Clinical Psychology training by exploring whether training moderates the effects of trainees' attachment styles on their responses to securely and insecurely attached patients.

The four-category model of adult attachment

This study will use Bartholomew & Horowitz's (1991) four-category model of adult attachment, which represents an elaboration of the original work of Bowlby. The model comprises four prototypic attachment patterns (i.e. secure, preoccupied, fearful and dismissing), which are defined in terms of the intersection of two underlying dimensions, the person's positivity of self-image versus the person's

positivity of the image of others (Bartholomew, 1997). Siegert, Ward & Hudson (1995) identified its distinction between two types of avoidance (i.e. dismissing and fearful avoidance) as one of the strengths of the model.

The model postulates that secure individuals have a positive view of both self and others, high self-esteem, confidence in the availability of others and are comfortable with both autonomy and intimacy. In contrast, preoccupied individuals, have a negative model of self and a positive model of others; they tend to be preoccupied with relationship issues, to be excessively dependent on others and to enhance their self-esteem by seeking external approval. Both fearful and dismissing individuals tend to avoid close contact with others, the former in order to avoid rejection and abandonment and the latter in order to fulfil their desire to be independent. However, while fearful individuals have a negative view of both self and others, dismissing individuals tend to display a positive self-image and a negative one of others. In addition, fearful individuals have doubts about the availability of others, thus avoiding approaching them for help. In contrast, dismissing individuals distance themselves from others in order to maintain a positive self-image and regard themselves as invulnerable to rejection.

Brennan, Shaver & Tobey (1991) suggested that the four-category model is consistent with research into attachment in infancy, as the fearful avoidant group could be viewed as corresponding to the disorganised-disoriented group. However, the model's assumption that individuals are able to report their attachment style contrasts with Main et al's (1985) view that unconscious working models are by definition impossible to assess by means of self-reports. Bartholomew (1997) attempted to reconcile this difference by proposing that the four-category model is concerned with automatic, but more conscious, assumptions and behaviours in close relationships, while Main et al's model taps into deeper, less conscious working models of relationships. Thus, the way of relating to others adopted by dismissing individuals enables them to defend against an unconscious negative self-image, while the interpersonal strategies of preoccupied individuals represent a way of denying

their negative feelings towards others. Research studies with the four-category model have shown that 50% of individuals from non-clinical samples display a secure attachment style, with the remaining 50% being distributed across the three insecure styles (Bartholomew, 1997).

The impact of early bonds with parents

As noted earlier, parental responsiveness and emotional availability foster a sense of security and influence the way in which children will relate to close others later in life. Thus, the attachment literature places a lot of importance on the quality of the bond between parent and child for the latter's emotional well-being. Parker et al (1979) identified three factors influencing parent-child bonds, namely characteristics of the child, characteristics of the parent and characteristics of the relationship between the parent and the child. These authors also developed a self-report, retrospective measure of parental behaviour and attitudes, the Parental Bonding Instrument, to assess parents' contribution to this bond. Parker & Gladstone (1996) reviewed the research into the implications of the quality of early bonds, as measured by the Parental Bonding Instrument, on the person's social adjustment and behaviour. They concluded that early negative experiences with parents do not necessarily result in adult emotional problems, but that negative parenting is likely to create a vulnerability to psychological dysfunction, which can, however, be modified by later interpersonal experiences.

Some psychotherapy process research has also suggested that patients' quality of early bonds predicts their ability to establish a working alliance with their therapist (Gelso & Carter, 1985; Mallinckrodt et al, 1995). In this study participants' retrospective accounts of their early bonds will be utilised to integrate the information on their attachment style.

To summarise, the central aim of the current study is to explore the relevance of trainee Clinical Psychologists' attachment styles and parental bonds to the way in which they respond to ruptures generated by patients displaying a similar or dissimilar attachment style. Specifically, the study will explore whether therapists' attachment styles impact on the empathy and depth of their responses to securely and insecurely attached patients and whether training moderates these effects.

Research questions

1. **How do Clinical Psychologists in Training respond to ruptures in the therapeutic alliance?**

It is expected that participants' attachment styles and parental bonds will impact on their responses to patients displaying similar and dissimilar attachment styles.

Specifically, it is hypothesised that:

a) The responses produced by participants with a negative model of others (i.e. dismissing and fearful participants) will be less empathic and less deep than those produced by participants with a positive model of others (i.e. preoccupied and secure participants). However, the responses produced by secure participants will be overall more empathic and deeper than those produced by the three other groups.

b) Insecure participants will respond less empathically and less deeply to patients displaying attachment features similar to their own. In other words: 1) dismissing participants will be less empathic and respond less deeply to the dismissing patient 2) preoccupied participants will be less empathic and respond less deeply to the preoccupied patient and 3) fearful participants will

be less empathic and respond less deeply to the fearful patient. Due to the greater effectiveness of secure individuals' working models in guiding their responses to others, no such differences are predicted for secure participants.

2. How does attachment style affect the responses produced by trainee Clinical Psychologists as they progress through training?

This exploratory question aims to investigate whether the responses of insecure third year trainees will be more or less empathic and deep than those produced by insecure participants in their first and second year of training. In other words, the study will explore whether training will or will not moderate the effects of attachment style and parental bonds on participants' responses to patients.

CHAPTER 2

METHOD

OVERVIEW

This study used a video vignette method to simulate alliance ruptures in the therapy situation. A group of Clinical Psychologists in Training, sampled from three consecutive years, responded to statements made by four patients displaying different attachment styles. Their responses were subsequently rated in terms of their empathy and depth of interpretation. Participants' attachment styles were measured by means of the Relationship Scales Questionnaire and their parental bonds by means of the Parental Bonding Instrument.

PARTICIPANTS

The study used a sample of Clinical Psychologists in Training from University College London (UCL). 89 of the 92 trainees from three consecutive years were invited and 77 (87%) agreed to participate. Of these, 27 (35%) were interviewed at the beginning of their first year, 28 (36%) at the end of their second year and 22 (29%) at the end of their third year. Ethical approval was obtained from the joint UCL/UCLH Committees on the Ethics of Human Research (see Appendix 1).

DESIGN

This exploratory study attempted to detect the impact of therapists' and patients' attachment styles on therapy process by using an analogue of the therapy situation. An experimental design was preferred to a more naturalistic one because the latter would have been more time-consuming and expensive.

PROCEDURE

Overview of procedure

Participants completed an informed consent form (see Appendix 3) and then the Relationship Scales Questionnaire (see Appendix 4), the Parental Bonding Instrument (see Appendix 5) and a demographic information sheet (see Appendix 6). They then watched video clips of 'patients' with different attachment styles, interacting with their therapist. Before each video, participants read some background information about the patient. Participants were encouraged to act as if they were therapists while watching the videos, each of which terminated with the patient making a statement; participants were asked to respond to this statement aloud and in the second person, as if they were addressing a real patient. The order of the videos was randomised.

Participants' responses were tape recorded and followed by a short exploratory interview derived from the research on Interpersonal Process Recall (Elliott, 1986; Kagan, 1984). The interview included questions about the intentions underlying the participants' response, their feelings before making the response, their feelings towards the patient and their understanding of his/her difficulties (see Appendix 7). This data was not analysed as part of this thesis. At the end, participants were debriefed and asked for some feedback about the study.

Recruitment

The investigator approached participants as a group before lectures to tell them about the study and show them the information sheet (see Appendix 2). Those who were interested were asked to provide a contact telephone number to discuss the study further or to make an appointment.

Clinical vignettes

Each vignette comprised a short video extract of the patient in therapy, together with a brief written description of the patient's presenting problem and background history (see Appendices 8, 9, 10 and 11). Patients were described as having been in therapy for two months and as experiencing emotional difficulties following a relationship break-up. The vignettes were meant to represent one of four attachment styles (i.e. secure, dismissing, fearful and preoccupied) and were broadly based on clinical material.

Validity

In order to check their validity in relation to attachment, three raters examined independently four sample clinical vignettes. The raters were senior researchers involved in major research projects on attachment. They were asked to judge the extent to which the clinical vignettes approximated the four attachment styles and to suggest how to amend the material. Their suggestions were incorporated in the final clinical vignettes.

Videos

The final videos lasted a maximum of three minutes each. Four professional actors, two males and two females, played the patients. Prior to learning the script, the actors were given some information about the study and about their patient's way of relating in close relationships. Two female Clinical Psychologists in Training, who did not participate in the study, played the therapist. In order to facilitate participants' identification with the therapist, the camera gave a full picture of the patient's face and upper body; the therapist did not appear on the screen.

The four videos were based on fixed scripts written by the investigator (see Appendices 12, 13, 14 and 15) and consisted of role-played therapy sessions, one for each attachment style. Each script contained equal numbers of 'speaking turns' or 'uninterrupted utterances by one speaker surrounded by utterances of another speaker' (Elliott, 1991). The last speaking turn in each of the scripts was uttered by the patient and essentially exemplified a rupture in the therapeutic alliance (e.g. 'I'm not sure whether you care enough about me ...... maybe it's best if we leave it'). The scripts for the secure, preoccupied and fearful patients involved a withdrawal rupture and the script for the dismissing patient involved a confrontation rupture. Safran et al (1994) defined a 'withdrawal rupture' as a behaviour or statement used by the patient to distance him/herself from therapy, the therapist or his/her internal experience (e.g. shifting the topic, intellectualisation etc.). They defined a 'confrontation rupture' as a behaviour or statement used by the patient to express dissatisfaction about the therapist or therapy, (e.g. 'You are not helping me enough').

MEASURES

The measurement of adult attachment

Griffin & Bartholomew (1994) identified various approaches to the measurement of adult attachment (i.e. categorical, dimensional and prototype). The categorical approach is the original and most common way of measuring attachment style and it involves the categorisation of individuals into distinct groups. The Adult Attachment Interview (Main et al, 1985) and the Hazan & Shaver's adult attachment self-report measure (1987) belong to this approach.

The dimensional approach is less common than the categorical one, and it advocates that fundamental dimensions underlie adult attachment styles; for example, dimensions of model of self vs. model of others (Griffin & Bartholomew, 1994), dimensions of comfort with closeness vs. anxiety over relationships (Simpson, Rholes & Nelligan, 1992). Within this approach, individuals are scored along one or more

dimensions by means of continuous measures (e.g. West & Sheldon, 1992; Simpson et al, 1992); these dimensions are often combined to generate information about individuals' patterns of relating to others.

A third approach to the measurement of adult attachment, the prototype approach, was inspired by prototype theory (Rosch, 1978). According to the theory, a 'prototype' is an ideal category member, possessing all the most common characteristics defining the members of a specific group (e.g. vegetables). As no features are hypothesised to be individually necessary or jointly sufficient to define group membership, group members differ in the extent to which they are similar to the ideal category member. Griffin & Bartholomew (1994) advocated that the prototype approach is particularly useful to conceptualise adult attachment because, due to the diversity of their past experiences and present circumstances, individuals are unlikely to fit perfectly into any one attachment category, but are more likely to display complex patterns of attachment organisation. Each of the four attachment patterns described by Bartholomew and Horowitz's (1991) four-category model of adult attachment corresponds to a 'prototype', which individuals fit to varying degrees (Griffin & Bartholomew, 1994). Thus, an individual scoring high on security and high on dismissiveness is expected to behave differently in close relationships from someone scoring high on security and high on preoccupation.

The Relationship Scales Questionnaire (RSQ: Griffin & Bartholomew, 1994)

In this study, adult attachment style was measured by means of the Relationship Scales Questionnaire (RSQ), a self-report questionnaire inspired by the four-category model of adult attachment (Bartholomew & Horowitz, 1991). The RSQ belongs to the prototype approach to the measurement of adult attachment, although information about the two dimensions (i.e. model of self and model of others) underlying the four prototypes can be obtained. The RSQ is an indirect

measure of the four attachment prototypes and it consists of 30 statements derived from widely used attachment measures (e.g. Hazan & Shaver's adult attachment self-report measure, 1987; Bartholomew & Horowitz's Relationships Questionnaire, 1991; Collins & Read's Adult Attachment Scales, 1990). The RSQ comprises four subscales, one for each of the prototypes; the subscales are:

1. the secure subscale (e.g. 'I find it easy to get emotionally close to others')
2. the preoccupied subscale (e.g. 'I want to be completely emotionally intimate with others')
3. the dismissing subscale (e.g. 'It is very important to me to feel independent')
4. the fearful subscale (e.g. 'I find it difficult to depend on other people').

In this study, participants were asked to think of close relationships (e.g. friendships, sexual relationships and relationships with parents) and to rate on a 5-point scale (from 'not at all like me' to 'very much like me') how well each of the statements described their behaviour in these relationships.

Scoring

1. *Prototype ratings* - a continuous rating of each of the four attachment prototypes is obtained by computing the mean of the relevant items. These ratings permit an attachment profile for the individual to be built.

2. *Model of self and other scores* - The prototype ratings can be used to generate information about the dimensions underlying the four attachment categories, i.e. model of self and model of others. The model of self and model of others scores are obtained by following the procedure outlined below.

a) The model of self score = (secure score + dismissing score) - (preoccupied score + fearful score)

b) The model of others score = (secure score + preoccupied score) - (dismissing score + fearful score).

3. *Insecurity score* - this is obtained by adding up the three insecure prototypes (i.e. fearful, preoccupied and dismissing).

Reliability and validity of the RSQ

Although the RSQ was developed relatively recently, it has been regarded as a promising measure of adult attachment. However, one problem with this and other self-report questionnaires is that they are likely to produce less reliable information about a person's attachment style than interview methods such as the Adult Attachment Interview (Crowell, Treboux & Waters, 1999). Unfortunately, the AAI is very lengthy to administer and code, and therefore it was not considered practical to use in this study. Two of the main problems with self-report questionnaires are social desirability and merely tapping into material of which the participant is aware. The investigator attempted to overcome the first problem by reassuring participants about anonymity and confidentiality. Moreover, it was assumed that because of their career choice, participants would be reasonably aware about their ways of relating to close others.

Generalisability across instruments - RSQ ratings show at times rather modest convergent validity with the attachment interview methods developed by Bartholomew & Horowitz (1991). Griffin & Bartholomew (1994) found the correlations between interview prototype ratings and RSQ scores to vary depending on the attachment prototype: correlations were highest for the dismissing style (.47) and lowest for the secure style (.25). Correlations for the preoccupied and fearful

styles were .34 and .32 respectively. As expected, the two different methods of assessing attachment style showed discriminant validity, in that low correlations were found between two different patterns of attachment identified by the two measures. The convergent validity between interview and self-report methods was somewhat higher when the dimensional level of analysis was considered, i.e. the model of self and model of others scores. The correlations were .37 for the model of self and .48 for the model of others.

Griffin & Bartholomew (1994) found high correlations between the model of self RSQ score and direct measures of this dimension, e.g. self-report measures of self-esteem, subjective distress and self-acceptance. The authors also found moderate correlations between the model of others RSQ score and direct measures of this dimension, e.g. self and friends' reports of sociability and warmth. Self-report measures of the self-dimension also predicted self-esteem eight months later. A study by Brennan et al (1991) also indicated that the RSQ correlates highly with a widely used categorical measure of attachment, Hazan & Shaver's adult attachment self-report measure.

Generalisability across occasions - Scharfe & Bartholomew (1994) researched the test-retest reliability of the RSQ over a period of eight months in a sample of young couples. They found that females' self-reported RSQ ratings had an average stability of .53 (range: .45 to .58); males' self-reported RSQ ratings had an average stability of .49 (range: .39 to .58). However, the same study also showed that Bartholomew & Horowitz's (1991) interview method had better test-retest reliability than self-report ratings (Range: .58 to .82).

Internal consistency - The internal consistencies of the RSQ prototype scores have been found to range from alpha = .41 for the secure pattern, to alpha = .70 for the dismissing pattern. Griffin & Bartholomew (1994) explained the relatively low internal consistency of the RSQ as due to the questionnaire items tapping into two orthogonal dimensions (i.e. the model of self and model of others).

Parental Bonding Instrument (PBI: Parker et al, 1979)

The Parental Bonding Instrument was used to assess participants' retrospective accounts of their bonds with their parents, with a view to exploring any relationships between self-reported adult attachment style and perceptions of childhood experiences with parents. The PBI comprises two parallel forms, one for fathers and one for mothers. Each form consists of 25 items, 13 of which make up the 'care' scale and 12 of which make up the 'protection' scale. The care items (e.g. 'Was affectionate to me') tap into a continuum of memories ranging from parental affection, warmth and empathy to coldness, indifference and rejection. The protection items (e.g. 'Tried to control everything I did') tap into a continuum of memories ranging from intrusiveness and infantilisation to a distant encouragement of independence. The items are worded positively and negatively to control for acquiescence. Respondents are asked to rate their parents, as they remember them during their first 16 years, on a 0-3 scale (from 'very like' to 'very unlike').

Care and protection scores are obtained by summing up all the relevant items for each parent. In addition, the person's quality of parenting can be assigned to one of four categories: 1) optimal parenting (i.e. high care and low protection) 2) affectionate constraint (i.e. high care and high protection 3) affectionless control (i.e. high protection and low care) and 4) neglectful parenting (i.e. low care and low protection). Parker et al (1979) also asked patients attending several GP surgeries to complete the PBI. This study suggested normative cut-off scores for maternal care and protection equal to 27 and 13.5 respectively and normative cut-off scores for paternal care, and protection equal to 24 and 12.5 respectively.

Reliability and validity of the PBI

The PBI has been used with a variety of populations, including university students and community and clinical samples. Since the original study with university students and GP patients, the structure of the PBI, consisting of items tapping into two independent dimensions (i.e. care and protection) has been replicated in community samples (MacKinnon, Henderson, Scott & Duncan-Jones, 1989) and in cross-cultural studies (Sato et al, 1998).

Generalisability across occasions - In the original study, Parker et al (1979) requested part of their sample to complete the inventory on two occasions, three weeks apart, to assess test-retest reliability. The obtained correlations were .76 for the care scale and .63 for the protection scale. In a study with depressed students the test-retest reliability agreement at three months interval was .86 for the care scale and .85 for the protection scale (Whisman & Kwon, 1992). Plantes, Prusoff, Brennan & Parker (1988) asked depressed individuals to rate their parents when depressed and then 4-6 weeks later, when their depression had lifted, and found reliability agreements of .94 for maternal care, .93 for maternal protection, .90 for paternal care and .96 for paternal protection. Wilhelm & Parker (1990), who studied the reliability of the PBI over a 10-year period, with a cohort of teachers, found correlation coefficients for maternal care of .63, for maternal protection of .68, for paternal care of .72 and for paternal protection of .56.

Generalisability across instruments - PBI scores correlate with measures of the person's number of and satisfaction with support figures (e.g. the Social Support Questionnaire - SSQ). Sarason, Sarason & Shearin (1986) found that individuals' scores on the SSQ correlated positively with maternal care ($r = .43$ to $.63$) and paternal care scores ($r = .40$ to $.48$) and negatively with maternal protection ($r = -.21$ to $-.32$) and paternal protection scores ($r = -.17$ to $-.26$). These authors also compared PBI scores with scores on the Inventory Schedule for Social Interactions (Henderson, Byrne & Duncan-Jones, 1981), a measure of perceived availability and adequacy of

attachments and social integration. They found a positive correlation between the availability of attachments component and maternal (r = .41) and paternal care ratings (r = .33). The social integration component was found to be negatively correlated with maternal (r = -.35) and paternal (r = -.51) protection.

Generalisability across observers - Two of the authors from the original study (Parker et al, 1979) jointly interviewed a subgroup of the sample and then independently gave them a care and a protection score. The inter-rater reliability coefficient for the care dimension was .85 and for the protection dimension was .68. The average correlation between the scores obtained by participants during the interviews and those determined by the scales was .77 for the care and .49 for the protection dimensions. Parker (1981, 1983) also found a moderate agreement between the PBI ratings produced by individuals from a mixed (i.e. clinical and non clinical) sample and those produced by their siblings based on their observations of their parents' behaviour towards the participant. Finally, Parker & Lipscombe (1981) also found that mothers who perceived themselves as overprotective were rated as such by their children; moreover, children's ratings correlated with scores of overprotection given by an independent rater. These studies have been taken as evidence that the PBI is a good measure of actual as well as perceived parenting.

Internal consistency - Studies exploring the internal consistency of the PBI have found overall moderate homogeneity for ratings on the protection scale and excellent homogeneity for ratings on the care scale (Parker & Gladstone, 1996).

Response rating scales

Participants' responses were transcribed and rated by means of an Empathy Scale (see Appendix 16) and the Depth of Interpretation Scale (see Appendix 17). All the responses were rated independently by three raters, i.e. the investigator and two third year Clinical Psychologists in Training. The latter two were blind to the study

hypotheses and its design, as well as to participants' identity, attachment style and year of study. The former was blind to participants' identity and attachment style. The investigator trained the raters using the two scales for a total of four hours. The responses were rated in a random order, both with respect to vignette presentation and time of participation in the study. Averages of the ratings produced by the three judges were used in the statistical analyses. The Pearson's correlation coefficients between ratings of empathy and depth ranged from .52 (secure patient) to .75 (fearful patient). Appendix 18 gives examples of responses coded at each level of empathy and Appendix 19 examples of responses coded at each level of depth.

Empathy

Following Goodman (1972), empathy was defined as the participant's ability to: 'tune into what the patient was saying, understand his/her feelings and respond sensitively'. Participants' empathy was rated by means of a five-point Empathy Scale where 1 = not at all empathic and 5 = very much empathic (Goodman, 1972). Cape (1996), who employed Goodman's Empathy Scale in a study of interactions between GPs and patients with emotional problems, found a reliability coefficient equal to .85. Pistrang & Barker (1998) used this Empathy Scale in a study of helping behaviour among non-professional helpers and found a reliability coefficient equal to .76.

In the current study, intraclass correlation coefficients across the three raters ranged from .66 (secure patient) to .76 (fearful patient).

Depth

Response depth was rated by means of the Depth of Interpretation Scale (Harway, Dittman, Raush, Bordin & Rigler, 1953). This is a nine-point scale comprising three levels of interpretation, i.e. superficial, moderate and deep

(Speisman, 1959). Items 1-3 (superficial) describe responses which are either restatements or repetitions of the patient's comment. Items 4-6 (moderate) describe responses which aim at providing a re-elaboration of the material disclosed by the patient. Items 7-9 (deep) describe responses commenting on material of which the patient does not appear to be aware. Harway et al (1953) reported inter-rater reliability coefficients ranging between .51 and .74. When the authors pooled the ratings produced by several judges on individual items, inter-rater reliability coefficients ranged between .89 and .94.

In the current study the intraclass correlation coefficients across the three raters ranged from .80 (secure patient) to .94 (preoccupied patient).

CHAPTER 3

RESULTS

OVERVIEW

The study aimed to explore the effects of therapists' attachment styles and parental bonds on their ability to resolve conflicts within the therapeutic alliance. The results are presented in five sections. The first will describe the procedures utilised to prepare the data for the main analyses. The second will present some information about participants' demographic characteristics and some related descriptive statistics. The third and fourth sections will focus on the two main research questions: (1) How do Clinical Psychologists in Training respond to ruptures in the therapeutic alliance? and (2) How do attachment style and parental bonds affect participants' responses as they progress through training? The final section will summarise the main findings.

DATA PREPARATION

As the PBI and RSQ scores were not normally distributed, square root transformations were performed. Visual inspection of the RSQ scores also revealed that a substantial number of participants rated themselves as equivalent on two or more of the prototypes (e.g. high on both dismissiveness and preoccupation). This complicated the interpretation of the attachment data and raised questions on how to utilise it in the statistical analyses. In order to overcome this problem, the PBI and RSQ scores were entered into a cluster analysis and into a factor analysis, one for each of the two main approaches to the measurement of adult attachment, i.e. categorical (cluster analysis) and dimensional (factor analysis).

Cluster analysis

This procedure aims to identify natural groupings based on given characteristics. The four sets of RSQ scores (i.e. dismissiveness, fearfulness, preoccupation and security) and the four sets of PBI scores (i.e. paternal and maternal care, paternal and maternal protection) were entered into a hierarchical cluster analysis, which extracted two distinct clusters. Independent samples t-tests were carried out to identify the characteristics of these two groups. The tests indicated that participants from Cluster 1 scored higher on maternal and paternal care and on security than those from Cluster 2. Cluster 1 also scored lower than Cluster 2 on paternal protection, preoccupation and fearfulness. Maternal protection and dismissiveness did not discriminate between the two groupings. The results of these tests are presented in Table 1. Cluster 1 was labelled 'secure attachment' group and Cluster 2 'insecure attachment' group. There were 39 (52%) participants in the secure attachment group and 36 (48%) in the insecure one (two participants were excluded from the analysis due to missing data).

Factor analysis

The PBI and RSQ scores were also entered into a factor analysis, employing a principal component analysis followed by Varimax rotation, with a view to identifying any independent dimensions in the data. The results of this analysis are presented in Table 2.

Table 1

Differences in PBI and RSQ scores between the two clusters

Scales	**Cluster 1**		**Cluster 1**		
PBI	**M**	**SD**	**M**	**SD**	**t[a]**
Maternal care	31.21	(4.46)	25.28	(7.80)	4.00 ***
Paternal care	30.77	(3.77)	14.53	(5.64)	14.75 ***
Maternal protection	9.03	(6.06)	10.53	(6.41)	- 1.04
Paternal protection	8.03	(4.65)	11.58	(7.33)	-2.49 *
RSQ					
Dismissiveness	1.68	(.18)	1.71	(.21)	-.64
Preoccupation	1.60	(.19)	1.71	(.14)	-2.90 **
Fearfulness	1.40	(.24)	1.58	(.26)	-3.15 **
Security	1.90	(.16)	1.79	(.19)	2.58 **

a: The d.f. for most of the t-tests was 73, except for maternal care and paternal protection, where an unequal variance test was performed with d.f. equal to 54.

*** p <.05 , **p <.01, ***p <.001**

Table 2

Factor analysis of RSQ and PBI scores

Scales	Factor 1	Factor 2	Factor 3
PBI			
Paternal protection	_	_	.89
Maternal protection	_	_	.80
Paternal care	.52	_	_
Maternal care	.78	_	_
RSQ	_	_	_
Dismissiveness	_	.92	_
Fearfulness	- .47	.68	_
Security	.66	-.49	_
Preoccupation	-.84	_	_

Note. All loadings below .40 were removed for clarity.

As shown in Table 2, the analysis extracted three factors. The main factor, factor 1, included paternal and maternal care ratings as well as security, preoccupation and fearfulness scores, although fearfulness loaded more strongly on factor 2. Factor 2 included dismissiveness and fearfulness scores and factor 3 consisted of paternal and maternal protection scores.

Independent samples t-tests were carried out to explore whether these three factors differentiated between the secure and the insecure attachment groups identified by the cluster analysis. The results of these tests are presented in Table 3.

Table 3

Differences between the two attachment groups in terms of the three factors

	Secure		**Insecure**		**t (73)**
	M	**SD**	**M**	**SD**	
Factor 1	.48	(.88)	-.56	(.81)	5.26 ***
Factor 2	-.13	(.92)	.07	(1.05)	-.89
Factor 3	-.21	(.98)	.20	(.99)	-1.77

*** p <.05. , **p <.01, ***p <.001**

As shown in Table 3, the t-tests suggested that the two attachment groups scored differently on the first dimension (i.e. factor 1) but not on the other two. As factor 1 consisted of parental care ratings and security, preoccupation and fearfulness scores, which also differentiated the secure from the insecure attachment group, it was concluded that the two analyses had generated overlapping information. As the cluster analysis was easier to interpret, subsequent analyses utilised the two natural groupings identified by this test, rather than the dimensions identified by the factor analysis.

PARTICIPANTS' DEMOGRAPHICS

Participants classified into 20 (26%) males and 57 (74%) females. 9 (12%) participants fell into the 21-24 age band, 44 (57%) into the 25-29 age band, 18 (23%) into the 30-35 age bracket, and 6 (8%) into the 35 and above age bracket.

As admission to the training programme at UCL is highly selective (approximately 5% of the applicants), most individuals obtaining a place have some pre-training clinical experience. 10 (13%) participants had between 0 and 6 months pre-training clinical experience, 35 (45%) between one and two years, 32 (29%) between three and four years, 7 (9%) between 5 and 6 years and 3 (4%) more than 6 years experience.

The clinical orientation of the training programme is Eclectic and trainees receive some teaching on all the main psychological models and interventions. Table 4 gives the number/percentage of participants who identified a given psychological model as their primary, secondary and tertiary orientation.

Table 4

Distribution of psychological orientation(s) in the sample

	Primary orientation	**Secondary orientation**	**Tertiary orientation**
Cognitive Behavioural	33 (43%)	20 (26%)	3 (4%)
Systemic	7 (9%)	21 (27%)	8 (10%)
Psychodynamic	4 (5%)	9 (12%)	16 (21%)
Humanistic	3 (4%)	2 (3%)	3 (4%)
Eclectic	27 (35%)	7 (9%)	4 (5%)
Other	3 (4%)	1 (1%)	2 (3%)
N/A[a]	_	17 (22%)	41 (53%)
TOTAL	**77 (100%)**	**77 (100%)**	**77 (100%)**

a. This category includes those participants who did not indicate their secondary and/or tertiary orientation.

A chi-square analysis with age and year group revealed the presence of age differences across the three years. Significantly more first year participants than expected fell into the 21-24 and 30-35 age bands; significantly more second year participants than expected fell into the 30-35 and above 35 age bands; finally, more third year participants than expected fell into the 25-29 age band ($X^2(6) = 15.66$, $p < .01$). Moreover, more male participants than expected fell into the two older age-bands and more female participants than expected fell into the two younger age bands ($X^2(3) = 8.85$, $p < .05$). No effects were observed for gender and year group, age and primary orientation, gender and pre-training experience, primary orientation and year group.

A chi-square analysis with attachment group and age group revealed that significantly more insecure participants than expected fell into the 25-29 and 30-35 age bands and more secure participants than expected fell into the 25-29 age band ($X^2(3) = 7.85$, $p < .05$). Moreover, the insecure group seemed to have more pre-training clinical experience than the secure one ($X^2(4) = 10.39$, $p < .05$). No effects were observed with attachment group and gender, year group and primary orientation.

RESEARCH QUESTION 1:

THE IMPACT OF ATTACHMENT STYLE AND PARENTAL BONDS ON RESPONSES

It was expected that participants' attachment styles and parental bonds would affect their responses to patients displaying similar or dissimilar attachment styles. Specifically it was predicted that:

1. The responses produced by dismissing and fearful participants would be less empathic and deep than those produced by preoccupied and secure participants. Secure participants were expected to respond overall more empathically and deeply than the other three groups.

2. Participants would respond less empathically and less deeply to patients with the same attachment style as them. Specifically: a) dismissing participants would respond less empathically and less deeply to the dismissing patient b) fearful participants would respond less empathically and less deeply to the fearful patient and c) preoccupied participants would respond less empathically and less deeply to the preoccupied patient. No such effects were predicted for secure participants.

Due to the previously discussed difficulties with the RSQ (i.e. some participants scoring high on more than one attachment prototype) it was not possible to explore this hypothesis in such detail. Thus, the statistical analyses compared the empathy and depth of the responses produced by the two attachment groups (i.e. secure and insecure). Since a high correlation (average correlation coefficient = .69) was found between empathy and depth, the two dependent variables were entered together into a 2 x 4, doubly multivariate repeated measures Anova. The patient's attachment style was entered as

within-subjects factor and participants' attachment group as between-subjects factor. Two further participants were excluded from these analyses because of missing data; therefore, the final sample consisted of 73 participants.

Multivariate tests revealed that participants' responses to the four patients varied depending on the patient's attachment style (Wilks' Lambda = .40, Exact F (6,66) = 16.69, <.001). Pairwise comparisons with response empathy suggested that participants responded more empathically to the preoccupied patient than to the dismissing ($p < .05$) and to the secure patients ($p < .05$). Participants also responded more empathically to the fearful patient than to the dismissing ($p < .01$) and to the secure patients ($p < .001$). There was no significant difference between the fearful and the preoccupied patients and between the dismissing and the secure patients in terms of the empathy they elicited from participants.

Pairwise comparisons with response depth suggested that participants responded more deeply to the preoccupied patient than to the dismissing ($p < .001$) and to the secure patients ($p < .001$). Participants also responded more deeply to the fearful patient than to the dismissing ($p < .001$) and to the secure patients ($p = < .001$). There was no significant difference between the fearful and the preoccupied patients in terms of the depth of the responses they elicited. However, the secure patient elicited less deep responses than the dismissing patient ($p < .001$). Table 5 shows the mean empathy and depth ratings for each of the four patients.

Table 5

Differences in empathy and depth ratings across the four patients

	Preoccupied		Fearful		Dismissing		Secure	
	M	SD	M	SD	M	SD	M	SD
Empathy[a]	2.65	(.84)	2.76	(.94)	2.36	(.76)	2.43	(.70)
Depth[b]	4.85	(1.65)	4.79	(1.98)	3.74	(1.35)	3.20	(.99)

a. Ratings ranged from 1 = not at all empathic to 5 = very empathic

b. Ratings ranged from 1 = superficial to 9 = deep.

Multivariate tests also revealed a general main effect of participants' security, in that the responses of the secure group were significantly different from those of the insecure group (Wilks' Lambda = .82, Exact F (2,70) = 7.67, <.01). Inspection of the means suggested that the insecure group (M = 4.22, s.d. = .19) responded overall more deeply than the secure group (M = 4.08, s.d. = .18). In contrast, the secure group (M = 2.67, s.d. = .11) responded overall more empathically than the insecure group (M = 2.41, s.d. = .11). However, when depth and empathy were explored individually, there were no significant main effects with depth and only a trend with empathy. Inspection of the means also revealed that both groups produced overall moderately empathic and deep responses.

Multivariate tests (i.e. with empathy and depth combined) showed no interaction effects between patients' attachment style and participants' attachment group (Wilks' Lambda = .88, Exact F (6,66) = 1,47, p .20). In other words, there were no differences between the two groups in the profile of their responses to the four patients. Both groups seemed to respond more empathically and more deeply to the preoccupied and fearful patients and less empathically and less deeply to the secure and dismissing patients. Nonetheless, when empathy and depth were considered individually, there was a significant interaction effect with empathy (p <.05), but not with depth. Multivariate simple effects analyses (i.e. with depth and empathy combined) suggested that the two attachment groups responded differently to the fearful (Wilks' Lambda = .91, Exact F (2,70) = 3.39, p <.05), dismissing (Wilks' Lambda = .88, Exact F (2,70) = 4,69, p <.05) and secure patients, although for this patient the effect was only marginally significant (Wilks' Lambda = .93, Exact F (2,70) = 2.70, p .07). Pairwise comparisons indicated that the insecure group was significantly less empathic towards the fearful (p .05), secure (p .05) and dismissing patient (p .07) than the secure group, although for the dismissing patient this effect was only marginally significant.

As no interaction effects were observed with depth and empathy combined, it is important to interpret this finding with caution and as the possible result of a sampling error. Table 6 and Figure 1 present the mean empathy ratings by attachment group across the four patients, while Table 7 and Figure 2 present the mean depth ratings by attachment group across the four patients.

Table 6

Empathy ratings by attachment group across the four patients

	Preoccupied		**Fearful**		**Dismissing**		**Secure**		**Average**	
	M	SD	M	SD	M	SD	M	SD	M	SD
Secure	2.63	(.76)	2.96	(.94)	2.51	(.74)	2.57	(.73)	2.67	(.79)
Insecure	2.68	(.94)	2.53	(.91)	2.20	(.74)	2.25	(.62)	2.41	(.80)

Note. Ratings ranged from 1 = not at all empathic to 5 = very empathic

Figure 1

<u>Mean empathy ratings by attachment group across the four patients</u>

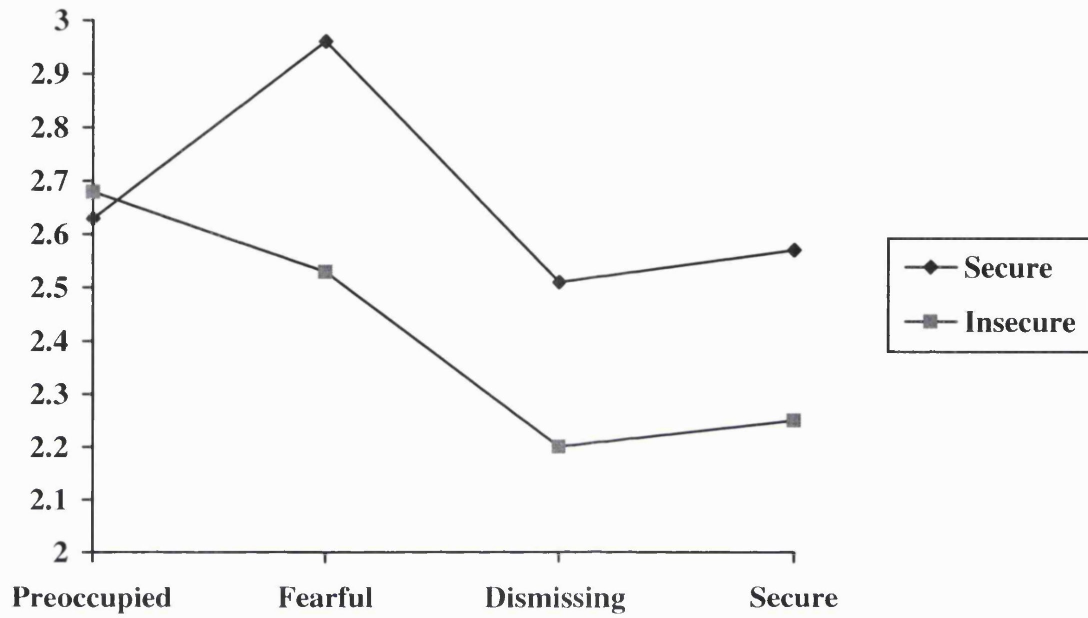


Table 7

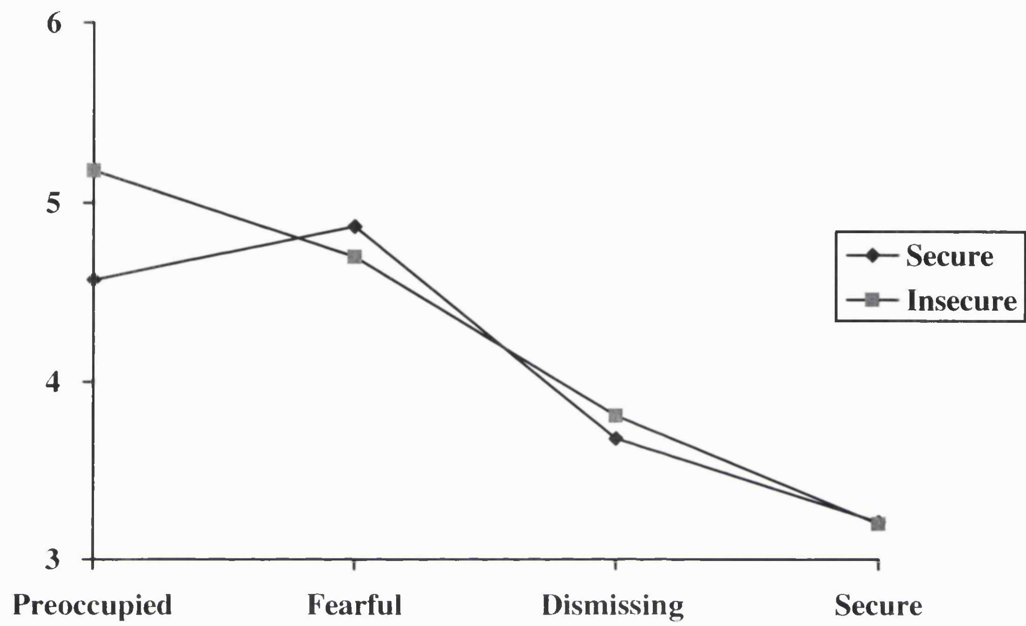
Depth ratings by attachment group across the four patients

	Preoccupied		Fearful		Dismissing		Secure		Average	
	M	SD	M	SD	M	SD	M	SD	M	SD
Secure	4.57	(1.48)	4.87	(2.01)	3.68	(1.21)	3.21	(1.00)	4.08	(1.42)
Insecure	5.18	(1.79)	4.70	(1.97)	3.81	(1.50)	3.20	(1.00)	4.22	(1.56)

Note. Ratings ranged from 1 = superficial to 9 = deep.

Figure 2

Mean depth ratings by attachment group across the four patients



To summarise, participants responded with different levels of empathy and depth to the four patients; specifically, the secure and dismissing patients seemed to elicit less deep and less empathic responses. Although there was a significant main effect of participants' attachment group with depth and empathy combined, only a trend with empathy in the predicted direction was observed when the two dependent variables were explored individually. Thus, it was not possible to confidently reject the null hypothesis that secure participants would not respond more empathically than insecure ones.

There were no interaction effects between the patient's attachment style and participants' attachment group when empathy and depth were explored together. However, when empathy and depth were explored individually, an interaction effect with empathy was observed. The insecure group responded less empathically than the secure group to the fearful, dismissing and secure patients, although this effect was only marginally significant for the latter two. As fearfulness was one of the distinguishing features of the insecure attachment group, it was possible to reject the null hypothesis that fearful participants would not be less empathic towards the fearful patient. It was not possible to reject this hypothesis for the preoccupied patient. However, it is important to be cautious about drawing any definite conclusion from these results, because no interaction effects were observed when depth and empathy were explored together. Thus, the subsequent finding of an interaction effect with empathy might be due to a sampling error.

RESEARCH QUESTION 2:
THE EFFECTS OF TRAINING ON PARTICIPANTS' RESPONSES

This question explored whether attachment style and parental bonds affect trainees' responses as they progress through their training; and specifically, whether the responses of third year trainees displaying insecure attachment features would be more or less empathic and deep than those produced by participants with similar characteristics in their first and second year of training.

Empathy and depth were combined and entered into a 2 x 3 x 4 doubly multivariate repeated measures Anova with the patient's attachment style as within-subjects factor and participants' attachment and year groups as between-subjects factors. Multivariate tests showed that the responses varied across the three year groups, although this effect was only marginally significant (Wilks' Lambda = .87, Exact F (4,132) = 2,33, p .06). When depth and empathy were considered individually, there was a significant difference across the years in response depth ($p < .05$) but only a trend for response empathy. Pairwise comparisons suggested that third year participants responded overall more empathically than first year ones ($p < .05$). No significant differences in response empathy were observed between first year participants and second year ones and third year participants and second year ones. Third year participants also responded overall more deeply than first year ones ($p < .01$) and second year ones (p .07), although the latter effect was only marginally significant. There were no significant differences in response depth between first and second year participants. Table 8 presents the mean empathy and depth ratings across the three year groups.

Table 8

Empathy and depth ratings across the three year groups

	First year		Second year		Third year	
	M	SD	M	SD	M	SD
Empathy[a]	2.35	(.63)	2.59	(.89)	2.77	(.83)
Depth[b]	3.78	(1.37)	4.13	(1.49)	4.66	(1.54)

a. Ratings ranged from 1 = not at all empathic to 5 = very empathic

b. Ratings ranged from 1 = superficial to 9 = deep.

Multivariate simple effects analyses (i.e. with depth and empathy combined) revealed that the three year groups responded differently to the dismissing (Wilks' Lambda = .87, Exact $F (4,132) = 2.45$, p .05) and the secure patients (Wilks' Lambda = .84, Exact $F (4,132) = 3.08$, $p < .05$). This analysis was followed-up by pairwise comparisons to identify which factor (i.e. empathy or depth) and which year group this difference was relevant to.

Empathy

Pairwise comparisons with empathy revealed that first year participants responded less empathically than third year ones to the dismissing patient ($p < .05$). There were no significant differences in response empathy towards this patient between first and second year participants and second and third year participants. First year participants also responded less empathically than third year ones to the secure patient ($p < .05$). No significant differences of this type were observed between first and second year participants and second and third year participants. Table 9 gives the mean empathy ratings by year group across the four patients; these means are also plotted in Figure 3.

Depth

Pairwise comparisons also revealed that first year participants responded significantly less deeply to the dismissing patient than second ($p < .05$) and third year ones ($p < .01$). There were no significant differences between the responses that second and third year participants gave to this patient. First year participants also responded significantly less deeply than third year ones to the secure patient ($p < .01$). There were no significant differences between the responses that first and second year participants and second and third year participants gave to this patient. Table 10 shows the mean depth ratings by year group across the four patients; these means are also plotted in Figure 4.

Table 9

Empathy ratings by year group across the four patients

	Preoccupied		**Fearful**		**Dismissing**		**Secure**		**Average**	
	M	SD	M	SD	M	SD	M	SD	M	SD
First year	2.41	(.74)	2.64	(.72)	2.12	(.53)	2.22	(.55)	2.35	(.63)
Second year	2.79	(.85)	2.81	(1.09)	2.41	(.87)	2.36	(.74)	2.59	(.89)
Third year	2.80	(.93)	2.85	(1.03)	2.63	(.79)	2.78	(.72)	2.77	(.83)

Note. Ratings ranged from 1 = not at all empathic to 5 = very empathic

Figure 3

Mean empathy ratings by year group across the four patients

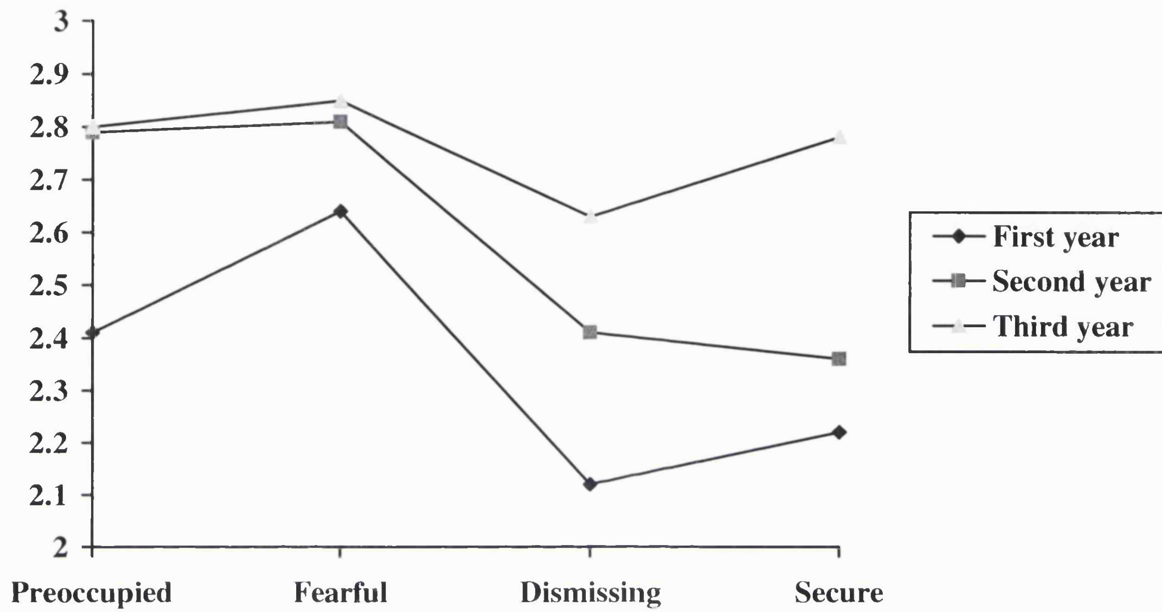


Table 10

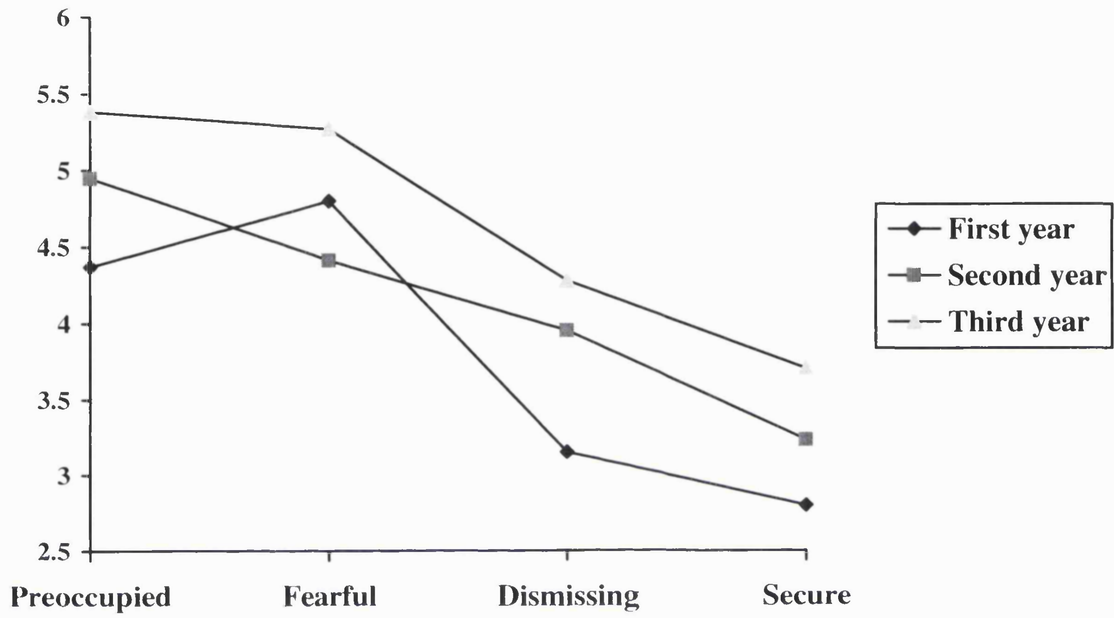
Depth ratings by year group across the four patients

	Preoccupied		Fearful		Dismissing		Secure		Average	
	M	SD	M	SD	M	SD	M	SD	M	SD
First year	4.37	(1.51)	4.80	(2.14)	3.15	(1.24)	2.80	(.60)	3.78	(1.37)
Second year	4.95	(1.70)	4.41	(1.82)	3.95	(1.17)	3.23	(1.05)	4.13	(1.49)
Third year	5.38	(.90)	5.27	(1.96)	4.28	(1.46)	3.70	(1.13)	4.66	(1.54)

Note. Ratings ranged from 1 = superficial to 9 = deep.

Figure 4

Mean depth ratings by year group across the four patients



Multivariate tests revealed a two-way interaction effect between participants' security and year group, in that the responses varied across the three years and between the two attachment groups (Wilks' Lambda = .88, Exact F (4,132) = 2,23, p .07), although this effect was only marginally significant. When depth and empathy were explored individually, there was a significant interaction effect with depth ($p < .05$) and a marginally significant effect for empathy (p .06).

Multivariate simple effects analyses (i.e. with depth and empathy combined) suggested that the responses of the insecure participants varies across the three year groups (Wilks' Lambda = .86, Exact F (4,13) = 2,64, $p < .05$). This variation across the years was not observed for the secure group. Pairwise comparisons were carried out to explore this finding further; these tests indicated that insecure third year participants responded overall more empathically than insecure second year ones (p .05). There were no significant differences in response empathy between insecure first and second year participants and insecure first and third year participants. These comparisons also revealed that insecure third year participants responded more deeply than insecure first ($p < .05$) and second year participants ($p < .01$). No such differences were observed between insecure first and second year participants.

Although there was no variation in the responses produced by the secure participants across the three year groups with empathy and depth combined, pairwise comparisons suggested that secure second year participants responded more empathically than secure first year ones (p .01). No significant differences in response empathy were observed between secure first year participants and secure third year ones and secure third year participants and secure second year participants. These comparisons also indicated that secure second year participants responded overall more deeply than secure first year ones ($p < .05$). There were no significant differences in response depth between secure first year participants and secure third year ones and secure second year

participants and secure third year participants. Table 11 and 12 give the mean empathy and depth ratings by attachment group across the three year groups.

Table 11

Empathy ratings by attachment group across the three years

	First year		Second year		Third year	
	M	SD	M	SD	M	SD
Secure	2.34	(.60)	2.97	(.86)	2.77	(.80)
Insecure	2.36	(.69)	2.21	(.74)	2.77	(.96)

Note. Ratings ranged from 1 = not at all empathic to 5 = very empathic

Table 12

Depth ratings by attachment group across the three years

	First year		Second year		Third year	
	M	SD	M	SD	M	SD
Secure	3.61	(1.28)	4.48	(1.51)	4.26	(1.28)
Insecure	3.99	(1.48)	3.79	(1.30)	5.15	(1.60)

Note. Ratings ranged from 1 = superficial to 9 = deep

Multivariate tests showed no evidence for a three-way interaction effect between participants' year group, participants' attachment group and the patient's attachment style (Wilks' Lambda =.78, Exact F (12,126) = 1.34, p .19). When depth and empathy were explored individually, there was a non-significant interaction effect with empathy and a trend with depth. Although only a trend with depth was observed, this finding was explored further by means of pairwise comparisons.

Preoccupied patient

Second year participants from the secure group responded significantly more deeply to the preoccupied patient than first (p .01) and third year participants from the same group (p .06); although the difference between second and third year participants was only marginally significant. There were no significant differences between third and first year participants in response depth. Third year participants from the insecure group responded significantly more deeply to the preoccupied patient than second ($p <.01$) and first year participants ($p <.01$) from the same group. No significant differences were observed between first and second year participants from the insecure group.

Fearful patient

There were no significant differences in response depth between secure first year participants and secure second year ones, secure first year participants and secure third year ones, and secure second year participants and secure third year ones. However, third year participants from the insecure group responded significantly more deeply to the fearful patient than second year ones from the same group (p .05). No significant differences in response depth were observed between insecure first year participants and

insecure second year ones and between insecure third year participants and insecure first year ones.

Dismissing patient

Secure second year participants responded more deeply than secure first year ones ($p < .05$) to the dismissing patient. The difference in response depth between secure third and secure first year participants was marginally significant (p .07), with the former responding more deeply than the latter. There were no significant differences between secure second year participants and secure third year ones. Insecure third year participants responded more deeply to the dismissing patient than insecure first year ones ($p < .05$). There were no significant differences between insecure first and second year participants and between insecure third year participants and insecure second year ones.

Secure patient

Secure third year participants responded more deeply to the secure patient than secure first year ones ($p < .05$). There were no significant differences between secure first year participants and secure second year ones and secure third year participants and secure second year ones. Insecure third year participants responded more deeply to the secure patient than insecure first year ones ($p < .05$). There were no significant differences between insecure first year participants and insecure second year ones and between insecure second year participants and insecure third year ones.

Figure 5 plots the mean depth ratings of the secure group across the four patients for the three year groups. Figure 6 plots the mean depth ratings of the insecure group across the four patients for the three year groups.

Figure 5

Mean depth ratings across the four patients for the three year groups - (secure attachment group)

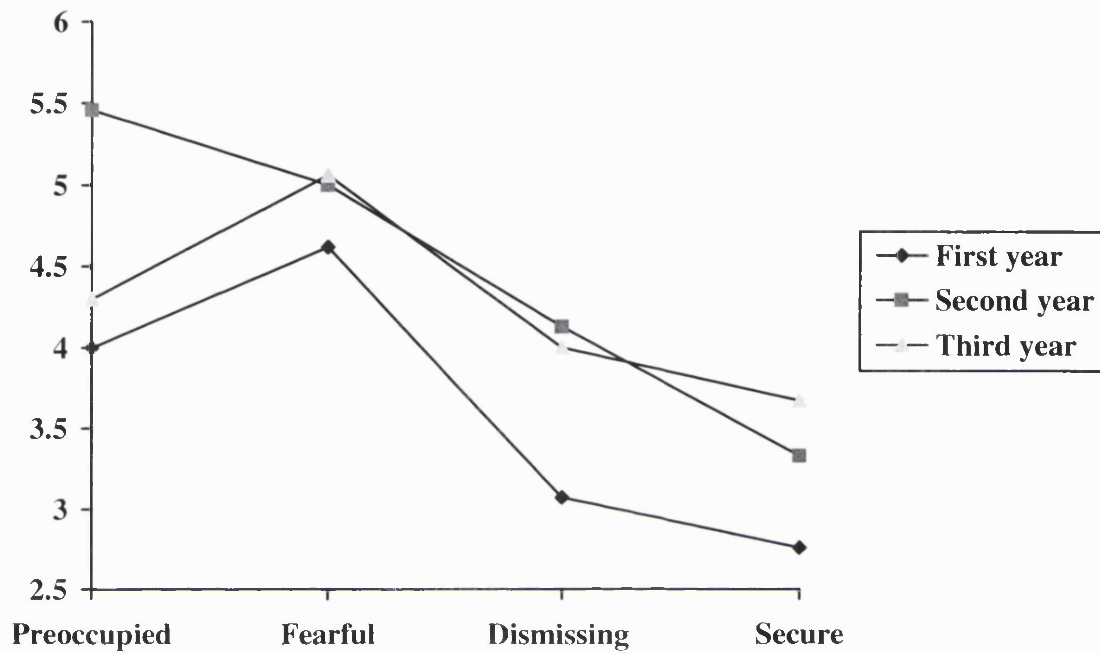
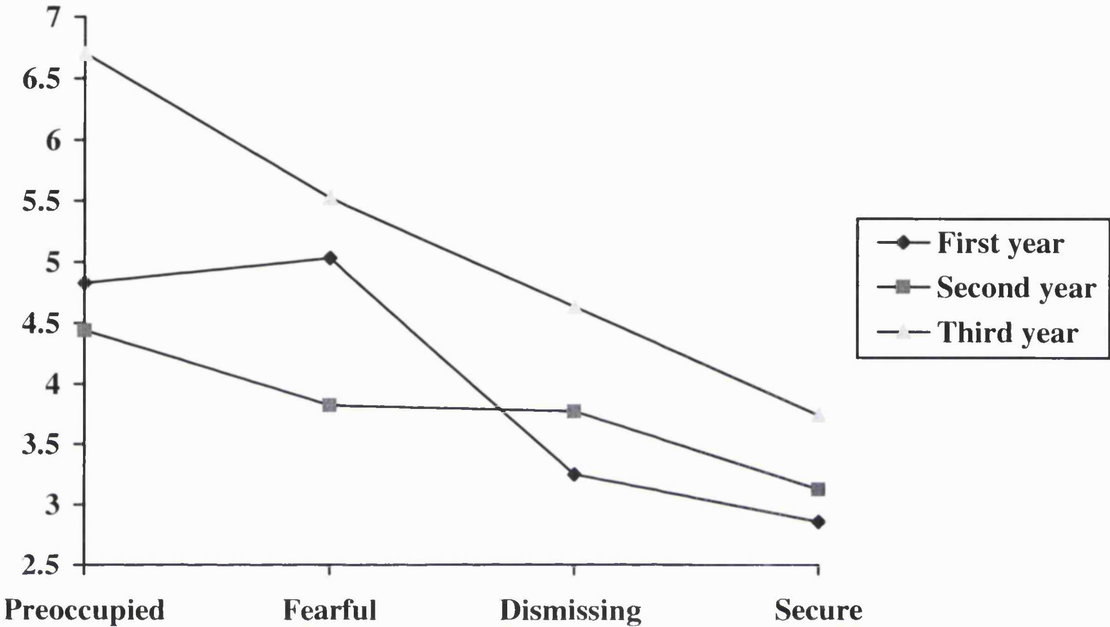


Figure 6

Mean depth ratings across the four patients for the three year groups - (insecure attachment group)



To summarise, there was a marginally significant two-way interaction effect between participants' attachment group and year group with empathy and depth combined. This was significant with depth and marginally significant with empathy. Specifically, insecure third year participants responded overall more deeply than insecure first and second year participants and overall more empathically than insecure second year participants. This suggests that training may have moderated the effects of participants' security, at least on the depth of their responses. The picture was more complex for the secure group, as secure second year participants responded overall more deeply and more empathically than secure first year ones, but no such differences were observed between secure first year participants and secure third year ones. However, as the multivariate tests had shown no interaction effects for the secure group, no definite conclusions about the influence of training on this group's responses can be reached.

No three-way interaction effects between participants' year group, participants' attachment group and the patient's attachment style were observed with empathy and depth combined. When depth and empathy where explored individually, a trend with depth and a non-significant effect with empathy were observed. These results do not permit to reach any conclusions as to whether training and attachment group interacted to influence participants' responses to patients displaying different attachment styles.

It was not possible to explore whether primary orientation affected the depth and empathy of participants' responses, because most trainees chose Cognitive-Behavioural and Eclectic models as their primary orientation and very few identified alternative approaches (e.g. Psychodynamic, Systemic, Humanistic) as such (see Table 4).

SUMMARY OF MAIN FINDINGS

This study is consistent with Bartholomew's observation that 50% of individuals from normal samples tend to classify as secure, with the rest distributed across the three insecure prototypes.

Research question 1

- Participants responded differently to the four patients; specifically, dismissing and secure patients received less deep and less empathic responses than preoccupied and fearful patients.

- There was a main effect of participants' attachment group with empathy and depth combined; the insecure group responded overall more deeply than the secure group, while the secure group responded overall more empathically than the insecure group. However, when depth and empathy were explored individually, there were no significant effects with depth and only a trend with empathy. Thus, although a trend in the predicted direction was observed, the null hypothesis could not be rejected with confidence.

- No interaction effects between participants' attachment group and the patient's attachment style were observed with empathy and depth combined. However, such effects were present when the two variables were explored individually. Specifically, the insecure group responded less empathically than the secure one to the fearful patient. Therefore, there seemed to be some patient-therapist match effects in the predicted direction, although these were not observed for the preoccupied patient.

Research question 2

- Participants' responses varied across the three year groups, although this effect was only marginally significant. Specifically, third year participants produced deeper responses than second and first year participants and more empathic responses than first year participants.

- The three year groups responded differently to the dismissing and the secure patient. Specifically, first year participants responded less deeply than third and second year ones to the dismissing patient and less deeply than third year participants to the secure one. First year participants also responded less empathically than third year ones to these two patients.

- There was a marginally significant two-way interaction effect between participants' insecurity and year group with empathy and depth combined. When these two variables were explored individually, these effects were found to be significant with depth and marginally significant with empathy. Specifically, insecure third year participants responded overall more empathically than insecure second year ones and more deeply than insecure second and first year participants. These results suggest that training might have moderated the effects of attachment style on insecure participants' ability to be explorative and perhaps also to be empathic.

- There were no significant three-way interaction effects between year group, participants' attachment group and the patient's attachment style with empathy and depth combined, and only a trend was observed with empathy alone. Thus, no conclusions can be reached as to whether training moderated the effects of participants' attachment styles on their responses to securely and insecurely attached patients.

CHAPTER 4

DISCUSSION

This study explored the impact of therapists' self-reported attachment styles and parental bonds on the way in which they resolved conflicts within the therapeutic alliance. The study used a video vignette method to simulate ruptures in the alliance. A group of Clinical Psychologists in Training from three consecutive years responded to statements made by four patients displaying different attachment styles (one secure and three insecure). The responses were subsequently rated in terms of their depth and empathy.

Participants clustered into two groups: 1) the 'secure group', characterised by positive parenting (i.e. high parental care and low paternal protection), security, low fearfulness and low preoccupation and 2) the 'insecure group' characterised by less positive parenting (i.e. lower parental care and higher protection), lower security, higher fearfulness and higher preoccupation. There were approximately 50% of participants in each group.

When empathy and depth were explored together, there was a significant difference between the responses produced by the two attachment groups; however, only a trend for empathy in the predicted direction was observed when these two variables were explored individually. Specifically, there was a trend for the secure group to respond overall more empathically than the insecure group. When the patient's attachment style was also considered, an interaction effect was observed for empathy but not for depth, indicating that the patient's attachment style influenced the empathy of the responses given by the two attachment groups. The insecure group responded less empathically than the secure one to the fearful patient. Therefore, there seemed to be some patient-therapist match effects in the predicted direction.

Participants' responses varied across the three year groups. Specifically, third year participants produced deeper responses than second and first year ones and more empathic responses than first year ones. Second and third year participants responded

more deeply than first year ones to the dismissing patient and third year participants responded more deeply than first year ones to the secure patient. Third year participants also responded more empathically than first year participants to these two patients.

There was a significant two-way interaction between participants' insecurity and year group for depth and a marginally significant one for empathy. Specifically, insecure third year participants responded overall more deeply than insecure first and second year ones and overall more empathically than insecure second year participants. These findings suggest that training improved insecure participants' ability to be explorative and perhaps, also to be empathic.

There was no evidence for a three-way interaction between participants' attachment group, year group and the patient's attachment style with empathy and depth combined. When empathy and depth were considered individually, only a trend for empathy was found. These results do not permit to draw any definite conclusions about the effects of training on participants' ability to be empathic towards and be explorative with patients displaying secure and insecure attachment styles.

Patterns of attachment styles and parental bonds in the sample

The finding that approximately half of the participants classified as secure and the remaining half as insecure, is consistent with Bartholomew's finding (1997) that 50% of individuals from non-clinical samples are usually found to be secure, with the remaining 50% being distributed across the insecure attachment styles. However, in this sample the dismissing prototype did not distinguish between the two attachment groups. This is somewhat surprising because 50 (70%) participants scored high on dismissiveness (i.e. average score > 2.5). This finding might be in line with Hazan & Shaver's (1987) hypothesis that, due to defensiveness, the dismissing style can be difficult to assess with self-report measures. It is also possible that participants from both groups rated themselves as high on dismissiveness because the characteristics

typical of this attachment style (e.g. independence and self-reliance) are socially desirable within western cultures.

Despite the ongoing debate about the relative advantages of categorical and dimensional approaches to the measurement of adult attachment, the cluster and factor analyses carried out in this study were consistent with evidence suggesting that these approaches tend to generate similar information (Feeney & Noller, 1996). Two dimensions are often found to underlie the various attachment styles, i.e. 'comfort with closeness' and 'anxiety over relationships'. Feeney (1995) argued that comfort with closeness usually separates dismissing and fearful individuals from secure and preoccupied ones and anxiety over relationships usually separates preoccupied and fearful individuals from secure and dismissing ones. As in this sample fearful and preoccupied individuals fell into the same category, separate from individuals who were high on security, the two attachment groups seemed to differ in terms of their anxiety over relationships, rather than in terms of their comfort with closeness.

In this study, maternal protection did not distinguish between the two attachment groups and there was a greater difference between the two groups in terms of paternal than of maternal scores. This finding might relate to the fact that the majority of participants in the study were female. Mallinckrodt et al (1995) found that, in a sample of female patients receiving counselling, bonds with fathers, but not bonds with mothers, were significantly associated with secure attachments in adulthood. The authors speculated that the gender of the child and that of the parent are likely to interact to influence the child's social and emotional development.

The finding that approximately half of the sample reported negative parental bonds is consistent with some of the literature on the childhood and family characteristics of therapists. In a review of this literature, Cushway (1996) proposed that negative experiences with carers may predispose the child to a career in professional helping and that a desire to overcome some of these early conflicts may also play a substantial role in his/her career choice.

Moreover, the finding that participants' quality of early bonds co-occurred with security/insecurity scores is consistent with other research with non-clinical populations suggesting that early bonds with parents influence later adjustment in close relationships. For example, a study by Flaherty & Richman (1986), using medical students, found that self-reported parental care was significantly related to perceptions of social support networks in adulthood; the authors concluded that parental care might influence a person's ability to form supportive relationships in adulthood.

Although, in the current study, the level of participants' psychological distress was not directly assessed, it could be assumed that most participants were functioning sufficiently well to be able to withstand the demands of the course. Thus, the current findings on participants' parental characteristics are consistent with Parker & Gladstone's (1996) conclusion that negative experiences with parents do not necessarily result in adult emotional problems, but might create a vulnerability to psychological dysfunction, which may or may not result in later difficulties.

Relationship between attachment style and responses

The results showed that, when empathy and depth were considered together, the two attachment groups generated qualitatively different responses. Specifically, the insecure group seemed to respond overall more deeply than the secure group and the secure group overall more empathically than the insecure group; however, when depth and empathy were considered individually, only a trend for empathy in the predicted direction was observed. Also, the difference in empathy scores between the two attachment groups was not very marked and the overall levels of empathy in both groups were perhaps more modest than one would expect in a sample of professional helpers. The moderate levels of empathy observed in this sample may be related to a probable loss of spontaneity and responsiveness, generated as a consequence of

requesting participants to respond to either aggressive or defensive comments made by patients with whom they did not have a real relationship.

However, these results suggest that participants' attachment styles did have some influence on their ability to empathise with patients' concerns. The finding that secure participants were more empathic than insecure ones is consistent with research on the relationship between individuals' personality characteristics and attachment styles. Horowitz et al (1993), who assessed attachment styles and interpersonal problems in a sample of students, found that secure individuals tended to view themselves and be viewed by peers as warm and sensitive. Preoccupied individuals viewed themselves as overly expressive about their own problems and concerns and were perceived as domineering and competitive by their peers. Finally, fearful individuals regarded themselves as unassertive and introverted and were also perceived as such by their peers. Thus, participants from the secure attachment group (i.e. high in security, low in fearfulness and low in preoccupation) might have displayed personality characteristics which made it easier for them to empathise with patients' concerns.

The work of Fonagy et al (1991) has demonstrated that parents' ability to be attuned to their child's needs depends either on their positive attachment histories or on their ability to reflect on both the child's emotional states and their own expectations of relationships. As the relationship between the patient and the therapist has often been compared to the parent-child relationship, the insecure group's lower response empathy might be indicative of a less developed capacity to reflect on their own and other people's emotional states; this could have originated from exposure to low levels of parental care in childhood, which was one of the distinguishing features of the insecure attachment group. However, as both attachment groups demonstrated adequate empathy, most participants' reflective-self function is likely to be reasonably well developed and secure participants' slightly greater ability to generate empathic responses may be related to their more positive attachment histories.

The humanistic school has traditionally assigned a central role to empathy, viewing it as one of the necessary and sufficient conditions for change in therapy (Rogers, 1957). Moreover, some psychoanalytic literature regards empathy as essential for the establishment of the therapeutic alliance (Meissner, 1996), a claim which has been corroborated by empirical evidence suggesting a link between the therapist's empathy and the strength of the therapeutic alliance (Bachelor, 1991; Green, 1996). Thus, although the strength of the alliance could not be measured in this study, in a real therapy situation, the lower levels of empathy shown by insecure participants might affect the quality of the alliance, or at least the bond component of the alliance. As the working alliance has been shown to predict therapy outcome (Horvath & Symonds, 1991), it is also possible that insecure participants' lower ability to generate strongly empathic responses may ultimately have some effect on their effectiveness as therapists.

Safran et al (1994) proposed that the therapist's empathy mediates therapy progress and outcome by enabling patients to express difficult feelings about the therapeutic relationship, thus facilitating the resolution of ruptures in the therapeutic alliance. These authors also suggested that a first step in rupture resolution involves the therapist empathising with patients' given experiences and exploring their relevance to the here and now of the therapeutic relationship. This resolution method has been found to be associated with high alliance ratings (Castonguay et al, 1996).

Safran et al (1994) speculated that anxiety about abandonment, which is one of the distinguishing features of the fearful prototype, might be associated with patients' difficulties with tolerating ruptures in the alliance. In the same way, insecure participants, who scored higher on fearfulness than secure ones, might have perceived the ruptures as an indication that patients intended to leave therapy and their own sensitivity towards abandonment might have complicated their ability to empathise with patients' conflicts. Safran et al's idea is consistent with Collins & Read's (1994) hypothesis that attachment style affects individuals' primary and secondary appraisal of situations. Primary appraisal refers to the immediate emotional response to an

attachment-related event and is affected by the person's attachment history. This initial emotional response is likely to impact on individuals' further information processing, e.g. what they attend to in situation, what memories will be activated etc. Secondary appraisal refers to individuals' tendency to interpret their experiences in line with their attachment styles; for example, preoccupied persons may interpret their partner's failure to comfort them as a clear sign that she/he wants to leave them. Thus, in a real therapy setting, insecure participants' attachment histories are likely to affect their emotional response to and interpretation of ruptures in the alliance, which may in turn impact on their ability to resolve them and ultimately affect the quality of the therapeutic alliance.

Contrary to the initial prediction, participants' attachment styles did not seem to affect the depth of their responses. These results seem to contradict Kantrowitz et al's (1989) finding that a similarity between patients' and therapists' conflicts affected therapists ability to encourage exploration of these conflicts. However, Kantrowitz et al (1989) specified that 'blind spots' occurred only when therapists were unaware of these dynamics. The work of Fonagy et al (1991, 1995) on the moderating effects of a person's ability to think about their attachment experiences suggests that response depth may not have been affected by participants' attachment styles because both attachment groups were able to reflect on their expectations in close relationships; this ability may have helped them to control these expectations when responding to patients. As attachment style was assessed by means of a self-report instrument, it is possible that most participants were aware of their expectations in close relationships. However, it is difficult to establish in retrospect whether participants were aware that these expectations influenced their behaviour towards patients and whether they were attempting to control them.

Exploration has been regarded, together with empathy, as one of the factors influencing the therapeutic alliance and therefore therapy progress and outcome (Bachelor, 1996; Gaston et al, 1998). Thus, it is possible that, in a real therapy situation, the impeding effects of 'empathic failure' (Kohut, 1984) would be

moderated by insecure participants' ability to use explorative interpretations. However, it has been argued that, when working with fragile patients, therapists should use explorative techniques together with supportive, empathic ones, as the latter often pave the way for the former. Thus, empathy needs to be present, in order for exploratory comments to be tolerated and experienced as useful by the patient (Gabbard et al, 1994).

However, the lack of differences between the two attachment groups in terms of the depth of their responses could also be partially related to the method used in this study to assess depth. Most participants in the sample were either Cognitive-Behavioural or Eclectic in orientation and therefore not very likely to produce psychoanalytic style interpretations[2] (i.e. responses that would fall into the 'deep' category of the Depth of Interpretation Scale) which may have reduced the response variation within both groups. The predominance of Cognitive-Behavioural and Eclectic orientations in the sample also explains why participants from both groups tended to use moderate, rather than deep interpretations. There is evidence that moderate interpretations lead to less resistance and to more exploration than deep and superficial ones (Speisman, 1959). Horvath & Luborsky (1993), who summarised some more recent research on therapy process and the therapist's interpretations, concluded that addressing current difficulties in the therapeutic relationship (i.e. the main focus of moderate interpretations) is more likely to lead to rupture resolution than focusing on past issues (i.e. the main focus of deep interpretations). Moreover, Safran et al (1994) viewed moderate exploration (i.e. focusing on the here and now of the therapeutic relationship) as the first step, together with empathy, towards rupture resolution. Therefore, although insecure participants were overall less empathic than secure ones, their equal ability to be explorative might, in real therapy situations, facilitate the resolution of ruptures in the alliance.

[2] In this discussion the word 'interpretation' is used to mean 'exploration', rather than strictly psychoanalytic interpretative work.

It is important to be cautious about drawing any definite conclusions from these results because, when empathy and depth were considered individually, there were no significant effects for depth and only a trend in the predicted direction for empathy. However, these results are a starting point for generating hypotheses about the phenomena that may be operating in more naturalistic therapy situations.

Therapist-patient match effects

The results also showed that the two attachment groups responded with different degrees of empathy to patients displaying different attachment styles. The insecure group responded less empathically than the secure group to the fearful, secure and dismissing patients. As the insecure group scored higher on fearfulness than the secure group, these results could be viewed as suggesting the presence of some therapist-patient match effects in the predicted direction. It is possible that insecure participants were adopting the same interpersonal strategy as the fearful patient, which resulted in their inability to respond empathically to her compulsion to distance herself from therapy and the therapist. This is consistent with Tyrrell et al's (1998) finding that case managers' attachment strategies in close relationships (i.e. deactivation vs. hyperactivation) predicted the quality of their relationship with patients using similar or different strategies. Specifically, less deactivating case managers formed stronger alliances with more deactivating ones and vice versa. Deactivating strategies have been associated with a need to maintain distance from others (Kobak, Cole, Ferenz-Gillies & Fleming, 1993; Kobak & Sceery, 1988), a tactic that fearful individuals often employ to avoid rejection and abandonment (Bartholomew, 1997).

Contrary to the initial prediction, no therapist-patient match effects were observed for the preoccupied patient, despite preoccupation being one of the features distinguishing the secure from the insecure group. This finding may be related to insecure participants' anxieties about rejection and abandonment not being activated

by the preoccupied patient who, unlike the fearful and dismissing patients, did not appear as withdrawn or rejecting. Again, contrary to the initial prediction, the insecure group responded less empathically than the secure group to the dismissing and secure patients, although the differences between the two groups' responses to these patients were only marginally significant. These findings can again be explained in terms of the anxieties about abandonment and rejection that the dismissing patient's confrontation rupture and the secure patient's withdrawal rupture evoked in insecure participants; these participants' emotional reactions to the material may have diminished their ability to produce strongly empathic responses.

However, understanding the unexpected findings solely as originating from insecure participants' fears of abandonment and rejection assumes that fearfulness was more salient than preoccupation in influencing the responses of the insecure group. The possibility that insecure participants' responses may have been particularly influenced by their fearfulness is consistent with research suggesting that fearful individuals have attachment characteristics which suggest extreme insecurity, e.g. a fear of intimacy, a lack of confidence in themselves and others, anxieties about their relationships and about others' approval (Feeney, Noller & Hanrahan, 1994). However, some of the unpredicted results could also be due to confounding factors such as differences in the quality of the acting. Some participants commented that the actor playing the preoccupied patient, for whom no therapist-patient match effects were observed, was less convincing than the other ones. In contrast, some participants regarded the actress who played the fearful patient as the most convincing.

Although it is important to interpret these results with caution, because no significant effects were found with empathy and depth combined and these two variables were highly correlated, these findings suggest that a similarity between the therapist and the patient, in terms of their strategies in close relationships, might affect the therapist's responses to the patient. The current findings also indicate that it may be too simplistic to conceptualise the therapist-patient match merely in terms of attachment style; perhaps, the anxieties that patients displaying certain interpersonal

strategies evoke in the therapist play a greater role in determining the quality of his/her responses.

The finding that the insecure group responded less empathically to patients who presented as less needy than the preoccupied patient (i.e. the fearful, dismissing and secure patients) is reminiscent of social psychological research suggesting that, in social interactions, individuals tend to elicit reactions from others that are consistent with their expectations (Snyder, Tanke & Bersheid, 1977). Dozier & Tyrrell (1998) elaborated on this idea by suggesting that in social interactions, people feel compelled to respond to others in a way that is complementary with these individuals' internal working models. For example, individuals who present as vulnerable tend to elicit caring responses, while individuals who present as self-reliant and independent tend not to. Obviously, it is important that therapists are able to resist this temptation in order to provide a corrective emotional experience to the patient. In this study, insecure participants appeared less able than the secure ones to respond with equal levels of empathy to patients who presented as distant or invulnerable; this suggests that, during real therapy sessions, insecure participants might have difficulties with resisting the patient's pull to respond in a way that is complementary with his/her working models (Dozier et al, 1994).

In retrospect, the initial prediction was too specific because participants did not categorise into four neat categories but into two broad ones, i.e. secure with adequate parenting and insecure with less adequate parenting. On the other hand, it is possible that the highly specific therapist-patient match effects predicted by the original hypothesis would be more easily identifiable in a naturalistic situation.

No therapist-patient match effects were observed for response depth. This could be seen as contradicting the work suggesting that a similarity between the conflicts experienced by the patient and those experienced by the therapist can result in the therapist's inability to facilitate the exploration of these issues (Kantrowitz et al, 1989). However, it is important to note that Kantrowitz et al researched the exploration of conflicts within the context of long-term psychoanalytic treatment;

perhaps a single, isolated response does not capture the phenomenon observed by these authors, which, might have been observed had participants' responses been monitored over time.

Effects of clinical training

In this study, third year participants (independent of their attachment group) responded more deeply but not more empathically than the other two year groups. Thus, clinical training seemed to help participants to develop their interpretation/exploration skills but not their empathy skills. The lack of variation in empathy across the three year groups observed in this study is consistent with research on the effects of Clinical Psychology training on the development of therapy skills. Shiffman (1987), who followed a group of trainee Clinical Psychologists through their training, found that third year trainees did not show more facilitative skills (i.e. empathy and acceptance) than first year ones. Shiffman (1987) attributed the lack of training effects to the stringent selection criteria for clinical training and also to self-selection, as psychology graduates applying for clinical training tend to possess better interviewing skills than other psychology graduates. Shiffman also found that the use of interpretations did not increase as trainees progressed through their training. This contrasts with the current finding that participants' responses became deeper over time. However, the current finding and Shiffman's one cannot be directly compared because the judges in Shiffman's study were asked to allocate participants' responses to one of several categories, including 'interpretation', but not to rate these in terms of their depth.

In the current study, third year participants (independent of their attachment group) responded more deeply than second and first year ones to the dismissing patient and more deeply than first year participants to the secure patient. These results can be viewed as suggesting that training can help therapists to develop an ability to

see beyond the patient's most obvious needs and to intervene deeply with clients who do not seem to need or welcome any exploration (Dozier et al, 1994).

Training seemed to moderate the effects of participants' attachment styles on their ability to be explorative with and empathic towards patients, although this effect was only marginally significant for empathy. Specifically, insecure third year participants responded overall more deeply than insecure first and second year ones and more empathically than insecure second year participants. This finding needs to be interpreted with caution because the training effect was only a marginally significant with empathy and depth combined, and these two variables were found to be highly correlated. However, these results suggest that training can help insecure trainees to develop a skill which has been found to play an important role in therapy process and in the establishment of the therapeutic alliance (Gaston et al, 1998; Bachelor, 1991). The training effects observed in the secure group are more difficult to explain; although, secure second year participants were more explorative than secure first year ones, contrary to what would be expected, there were no such differences between secure first and third year participants. As no training effects for the secure group were observed with depth and empathy combined, this finding may not have a lot of significance. However, it may also indicate the presence of not-controlled for cohort effects. As inspection of the means suggested that both attachment groups tended to respond more deeply as they progressed through training, the finding of no differences between the responses of secure first and third year participants may be due to the former being an exceptionally explorative group, perhaps due to personal or professional experience.

There was no conclusive evidence for a training effect on empathy; it is possible that such an effect would have been more evident were specific training in empathy provided as part of the UCL academic programme. At the moment, trainees are expected to develop their empathy skills on clinical placements, but no intensive training in empathy skills is provided as part of the academic programme. The academic part of the course places more emphasis on helping trainees to develop

formulation skills, mainly through group work and clinical seminars. This could be expected to affect trainees' ability to think deeply about patients' conflicts, but not necessarily to communicate empathy. It has been suggested that teaching trainees skills such as reflective listening, rapport building and empathy in the early phases of their training, results in novice therapists being as able as more experienced therapists to develop a bond with patients (Mallinckrodt & Nelson, 1991).

It is possible that the absence of training effects on empathy might also be partially related to the rating procedure adopted in this study. Shapiro (1968) found that a number of empathy cues are visual and, for convenience, the current judges rated transcripts of the responses. Thus, it is possible that some important information was lost in this process and that this might have affected the results. This may also partially explain the observation of what was merely a trend for the insecure group to be less empathic than the secure group, despite the responses of the two groups being significantly different when empathy and depth were explored together. However, the absence of training effects on empathy could also be due to training resulting in therapists being temporarily more focused on the development of technique, to the detriment of personal qualities such as empathy. This is consistent with some of the findings of a study by Henry, Strupp, Butler, Schacht & Binder (1993). The authors evaluated the efficacy of a manualised training programme and found that, while the programme enabled therapists to improve their intervention skills, it also produced an increase in 'negative interpersonal transactions' between patients and therapists. As therapists are likely to integrate their personal skills with more technical ones once they have mastered the latter, it is possible that, in this study, failure to find a training effect on empathy merely reflects the stage in training participants were at.

LIMITATIONS OF THE STUDY

Validity of the results

It is possible that the current findings might have been affected by the design adopted in this study. A high proportion of participants found the experimental situation (i.e. being asked to respond to video-taped patients in the presence of the investigator and having their responses tape-recorded) anxiety provoking. Despite reassurance from the investigator, some participants also felt that their therapeutic skills were under evaluation and this might have impacted on their performance. Sexton, Hembre & Kvarme (1996) found that the therapist's tension was associated with low patient alliance ratings and speculated that tension might prevent therapists emotionally engaging with patients. Given the overall modest levels of empathy observed in this study, this possibility cannot be ruled out. As noted earlier, empathy levels would probably have been higher in a more naturalistic setting. However, it could also be argued that, in this study, social desirability might have ameliorated the quality of participants' responses, and that these may have been even less empathic in a real therapy situation.

It is important to be cautious about making assumptions about the quality of the therapeutic alliance and therapy outcome on the basis of one single, isolated response. It is possible that, in a real therapy situation, an unempathic, shallow response would be followed by more empathic and explorative ones, thus moderating the effects of the initial one. Also, the design of the current study did not allow the establishment of the impact that the responses would have had on therapy progress.

Moreover, in this study, participants did not form a real relationship with patients and the video clips were rather short, which raise questions regarding the extent to which participants' expectations in close relationships were activated. Also, in a real therapy situation therapists would have access to more information about patients and this, in the context of an ongoing relationship, would probably enhance the quality of their responses.

It is possible that the training effects observed here, could be mere cohort effects; for example, some idiosyncratic characteristics of the insecure third year participants might have contributed to the greater depth of their responses, as well as, or more than training. A longitudinal design, rather than a cross-sectional one, would have provided a better picture of the impact of increasing training on the therapeutic skills of the same group of trainees. Unfortunately, due to the limited time available to complete this research, it was not possible to utilise this design. A group of psychology graduates not receiving clinical training should have been included in the sample, to control for effects due simply to the passing of time, rather than to training. Again, due to the limited time available this option was not regarded as feasible because it would have doubled the number of interviews to be carried out. Another uncontrolled for variable was whether some participants were receiving psychotherapy at the time of participation in the study, or had received psychotherapy in the past. Therapy is likely to increase individuals' awareness of their own conflicts and perhaps also their ability to produce therapeutic responses. Thus, being or having been in therapy may have acted as a confounding factor.

Finally, participants' comments about the actors' competence suggest that there were discrepancies in terms of their individual levels of acting ability, which might have influenced participants' responses. The actors' ability, level of training and experience should have been controlled for. Unfortunately, the limited resources available restricted the investigator's choice to the four actors who agreed to participate for a minimal fee.

Generalisability of the results

It is important to be cautious about extending the results obtained with this sample to Clinical Psychologists in general, because participants were still in training and it might be that different results would have been obtained with more experienced therapists. There is some evidence that therapists' personality characteristics change as

a consequence of practising psychotherapy. Perlman (1973) explored overtime changes in empathy, genuineness and non-possessive warmth in a sample of trainee Clinical Psychologists. Trainees were assessed twice, once at the beginning of their training and once 9 months later. Three independent judges rated tape-recorded therapy segments in terms of the 3 variables mentioned above. The study also utilised a control group of trainees who had contact with patients but no experience of supervised psychotherapy. The results indicated that, when assessed on the second occasion, the experimental group showed a greater increase in empathy, non possessive warmth and genuineness than the control group. One of the problems with this study is that the judges only examined a limited and selected sample of participants' clinical work, which might not have been representative of their work in general. However, although participants were not qualified Clinical Psychologists, the study suggests that increasing levels of psychotherapy experience might result in personal growth. Thus, it is possible that no differences between the two attachment groups would have been observed, had a broader range of participants taken part in the study.

Finally, most participants were either CBT or Eclectic in their orientation, which suggests that, while this sample may not be representative of therapists in general, it was perhaps representative of Clinical Psychologists as a whole.

Despite its shortcomings, the experimental design utilised in this study permitted to explore highly specific therapy processes within a limited period of time and with limited resources available. Moreover, this design permitted to control for confounding effects that might have been more difficult to control for in more naturalistic settings (e.g. participants being exposed to different material, for different amounts of time etc.)

Problems with the instruments

RSQ

The attachment information generated by means of the RSQ was somewhat difficult to interpret because some participants scored high on more than one attachment dimension. This highlighted some of the potential difficulties with assessing adult attachment by means of self-report instruments, as individuals do not tend to classify themselves into well-defined categories. It is possible that different results would have been obtained had a different measure of adult attachment been employed. There is in fact evidence of a less than perfect correspondence between self-report measures and more reliable interview methods, e.g. the Adult Attachment Interview (AAI). Crowell et al (1999) explored the relationship between the Relationships Questionnaire (RQ - Bartholomew & Horowitz, 1991), one of the self-report measures of adult attachment from which the RSQ derives, and the AAI, which is supposed to tap into unconscious working models. The results showed that although 81% of those participants who classified as secure with the AAI also scored as secure on the RQ, only 42% of participants who classified as insecure with the AAI reported themselves as insecure on the RQ. The authors interpreted these results as indicating that the AAI and the RQ do not assess the same constructs and suggested that the RQ (and by implication the RSQ) is more likely to measure social competence in current close relationships, rather than attachment style as understood within the tradition of the 'strange situation'. It is also possible that the behaviours assessed by the RSQ (e.g. comfort with closeness, a desire for distance or intimacy) are influenced by a variety of factors such as the individual's personal characteristics, social circumstances and quality of current close relationships. For example, situations such as relationship crises are likely to affect attachment scores on self-report questionnaires like the RSQ (Harris, 1997). This claim is consistent with the findings of a 4-year prospective study by Kirkpatrick & Hazan (1994), which indicated that individuals' relationship experiences affect the stability of their attachment style, as

measured by a three-category self-report questionnaire. In this study, relationship break-ups were associated with change from a secure to an insecure attachment. This is possibly because during crises (i.e. when there is a threat of a separation) individuals might be more aware of aspects of themselves and their attachment strategies than at more stable times. Thus, the point in time when adult attachment style is measured might be significant. Unfortunately, in this study, no information about participants' current relationships was collected. The studies by Crowell et al (1999) and Kirkpatrick & Hazan (1994) suggest that different, and perhaps more meaningful, results may have been obtained had this study employed a more reliable method of measuring adult attachment (e.g. the AAI).

Another problem with the RSQ, as it was utilised in this study, is that participants were requested to comment on their behaviour in various close relationships (e.g. friendships, sexual relationships and relationships with parents/siblings). However, some participants felt they behaved differently in these different relationships. Participants' comments are consistent with Collins & Read's (1994) proposition that adults might develop different working models for their role as friend, daughter, spouse etc.. The authors viewed adult representations of attachment as organised in a network of interconnected models, with a general model of self and others in relation to attachment at the top of the hierarchy. This model is supposed to contain information about the individual's history of relationships with peers and caretakers and to apply to a range of relationships, without describing any of them in detail. The general model would be followed in the hierarchy by models corresponding to specific types of relationships (e.g. parent, spouse) and finally by models corresponding to specific relationships (e.g. John, Sue etc.). Although the current study aimed to tap into participants' general model of self and others, their comments raise doubts about the extent to which this was achieved. Perhaps, for some participants, the RSQ only elicited information about specific relationships rather than about the more general model of relationships.

A study by Siegert et al (1995) suggested a more fundamental problem with the construct validity of the RSQ. The authors entered the RSQ items into a series of factor analyses and found no evidence for the factors which are meant to underlie the four subscales (i.e. secure, preoccupied, fearful and dismissing). Apart from the dismissing subscale, the items from the other subscales were found to be spread across the four factors. A subsequent two-factor solution analysis identified the presence of two dimensions, which the authors termed 'closeness/independence' and 'security/insecurity'. These findings suggest that further research on the construct validity of the RSQ is needed and also raise questions regarding the meaning of some of the results obtained in this study, e.g. those on therapist-patient match effects.

PBI

It is unclear to what extent the PBI generated information about the real quality of early bonds between participants and their caregivers. Although the studies with siblings cited in the method chapter (Parker, 1981, 1983) suggested that the PBI is a good measure of actual as well as perceived parenting, retrospective self-reports are inevitably vulnerable to biases and distortions. For example, participants' memories of their childhood might have been affected by their mood at the time of completing the questionnaire and/or their current relationship with their parents might have biased their memory of their early bonds. In their study with established couples, Scharfe & Bartholomew (1998) found that current attachment patterns biased participants' memories of their past ones, assessed 8 months previously. Although this study did not utilise the PBI, it nonetheless suggests that reconstructive biases may be in operation when individuals are asked to assess their early bonds with their parents in retrospect.

Individuals might also defend against negative memories of their relationship with their parents through repression or denial (Main et al, 1985). Thus, as with the RSQ, the PBI is unlikely to tap into unconscious or difficult memories. It could also

be argued that asking participants to rate their relationship with their parents over 16 years might be misleading; for example, if the parents underwent a situational or personal change at some point during this period, their relationship with their child might also have improved or deteriorated; however, the PBI only generates an overall and possibly oversimplified picture of a person's early parental bonds.

IMPLICATIONS OF THE FINDINGS AND FUTURE DIRECTIONS

Approximately half of the current sample classified as insecure with anomalous parenting and these characteristics seemed to affect the quality of their responses to securely and insecurely attached patients. This finding suggests the importance for Clinical Psychologists in Training to be aware of their own conflicts and difficulties. Kantrowitz (1995) argued that blind spots during therapy are inevitable, although experienced therapists are less likely than novices to experience them. She also pointed out that the therapist's ability to recognise the occurrence of these blind spots, and therefore to acknowledge his/her own limitations, can result in therapy progress. While Clinical Psychologists are usually tolerant of vulnerability in patients, they do not seem to demonstrate the same tolerance towards vulnerability in themselves (Cushway, Watson & Appleby, 1998). McCourt (1999) warned against the potential dangers of denying one's vulnerability and suggests that adequate supervision, professional development and self-awareness play a central role in the provision of a good service to patients. Like parental attunement, therapists' attunement is likely to derive from a capacity, not only to be aware of their own conflicts, but also to reflect on them and exert control over their attachment strategies during therapy (Fonagy et al, 1991, 1995). The current findings also suggest that it might be important for training courses to explicitly acknowledge the importance of self-awareness and self-reflection and to normalise the possible existence of vulnerabilities and limitations among trainees. Moreover, although personal therapy is not usually required by

Clinical Psychology training courses in the UK, therapy might help some trainees to attain greater self-awareness and further develop their reflective-self function. Despite the evidence for the impact of personal therapy on therapists' clinical effectiveness being inconclusive (Beutler et al, 1994), it has been argued that there may be training benefits from being at the receiving end of therapy (Cushway, 1996). For example, there is some evidence that therapy may contribute to the acquisition of therapy skills. Peebles (1980) asked independent judges to rate the tape-recorded therapy sessions of a sample of Clinical Psychology trainees in terms of accurate empathy, non-possessive warmth and genuineness. Participants also completed a questionnaire about their own therapy. The results showed the existence of a positive correlation between number of hours in therapy and empathy and genuineness. Despite the oversimplified exploration of the contributions of therapy (i.e. in terms of hours spent in therapy), this study suggests that self-exploration through personal therapy can impact on the therapist's ability to be attuned to patients' concerns.

The current study also found modest levels of empathy in both attachment groups and that clinical training per se did not enhance empathy skills. It is possible that more intensive, systematic training in empathy skills would moderate the effects of attachment style on trainees' responses and also increase overall levels of empathy. Although Shiffman (1987) did not find any effects of Clinical Psychology training per se, he reported that those trainees who had completed an elective module on interpersonal processes in psychotherapy, which involved practising interviewing skills during role-plays, were rated as significantly more empathic and accepting than trainees who had only received the normal training. Aronson et al (1982) obtained similar results when evaluating the effectiveness of an intensive training programme undertaken by a group of American trainee Clinical Psychologists. The results showed that the programme helped trainees to develop an ability to produce empathic responses and to discriminate between empathic and unempathic responses; this ability remained stable during a subsequent period on clinical placement. In contrast, mere exposure to academic work did not affect trainees' communication skills. Despite

some shortcomings (e.g. artificial assessment of trainees' empathy), the study suggests that empathy skills are more likely to develop with systematic training than as a result of academic or clinical work alone. As noted earlier, UCL trainees are expected to learn most of their clinical skills (including empathy) on placement. Although small group work involving role-plays is sometimes included in the academic part of the course, no structured feedback on trainees' performance during these short exercises is usually given. Thus the inclusion of intensive empathy skills training in the academic programme might help trainees to enhance and consolidate the empathy skills learned on placement.

Bohart & Greenberg (1997) argued that it might not be sufficient merely to teach therapists how to respond empathically. These authors believe that empathy involves an interest in the other person's world and an emotional, rather than an intellectual, understanding of what it would be like to be the patient. Thus, they suggest that therapists should be trained to achieve an accurate awareness of their own and their patients' emotions. Whether the development of such an ability can easily be achieved through training programmes or would necessitate exploration during personal therapy is open to debate.

Given the artificiality of the design employed in this study and that some of the main and interaction effects were only marginally significant, it would be important to replicate these findings in a naturalistic setting. This would probably be a time-consuming enterprise, but would clarify whether participants' responses actually affect rupture resolution and how. However, the results obtained in a non-controlled, naturalistic setting would perhaps be more difficult to interpret than the current ones.

As some research has suggested that therapists change as a result of practising psychotherapy (Perlman, 1973), it would be interesting to compare the performance of a group of experienced Clinical Psychologists to that of a group of Clinical Psychologists in Training; this design would also control for some of the confounding factors that might have been operating in this study, e.g. performance anxiety.

The accuracy and timing of the therapist's empathy and interpretations have been found to affect therapy process (Book, 1988; Greenberg & Goldman, 1988) and the therapeutic alliance (Bond, Banon & Grenier, 1998; Crits-Christoph, Barber & Kurcias, 1993). Therefore, it might be useful to complement the current results with an understanding of the accuracy and timing of participants' responses.

Some research could be carried out to explore the contribution of attachment style to the understanding of situations like clinical supervision. Watkins (1995) argued that clinical supervision can bring up issues about autonomy, dependency, authority and individuation and that insecurely attached psychotherapy trainees can find this situation challenging. The author discussed the implications for supervisors working with supervisees who display compulsive self-reliance attachment features and are therefore resistant to any input or suggestions. This stance can, of course, prevent the trainee from learning new skills and might also be damaging to patients. However, empirical evidence is needed to clarify this point and also to generate information about the behaviour of supervisees displaying over-dependent attachment features. Such research could also explore the impact that a match between supervisors' and supervisees' attachment strategies can have on the supervisory relationship and on trainees' skill acquisition.

CONCLUSIONS

This study was an exploratory investigation of the impact of both the patient's and the therapist's attachment style on the therapist's ability to resolve ruptures in the therapeutic alliance. Although the contribution of the therapist's attachment style to the therapeutic relationship is a relatively under-researched area, this study demonstrates its relevance and importance. The current study showed that participants' attachment styles affected the quality of their responses to ruptures in the therapeutic alliance; specifically, there was some suggestion that insecure participants produced responses which were overall less empathic than those produced by secure ones, which provided some tentative evidence for the initial prediction.

The study also suggested the presence of an interaction between the patient's and the therapist's attachment style, with insecure participants responding less empathically than the secure ones to the fearful patient. This provided some evidence for the existence of some therapist-patient match effects in the predicted direction. It was suggested that the therapist-patient match may best be conceived in terms of the anxieties that some of the patient's attachment behaviours might evoke in a therapist with similar attachment strategies, rather than in terms of the patient's and the therapist's attachment style per se.

There was also some indication that training ameliorated the effects of attachment style on insecure participants' ability to be explorative; the evidence for a training effect on empathy was not conclusive. This could be because the UCL training programme does not provide any specific training in empathy but also because an individual's ability to be empathic may be more deeply rooted in his/her personality make-up than in his/her ability to be explorative and therefore more resistant to change as a result of training. Trainees' ability to be empathic could be enhanced through systematic training in empathy skills and/or through personal growth achieved during personal therapy.

It is important to be cautious about drawing definite conclusions on the basis of these results because some of the main and interaction effects were only marginally significant. Thus further work in this area is necessary, perhaps in a more naturalistic setting and with more experienced therapists, to clarify the validity of these results. It would also be interesting to explore the relevance of these findings to situations that, like therapy, are reminiscent of the parent-child relationship and therefore likely to reawaken early attachment experiences, e.g. the supervisor-supervisee relationship.

This study aimed to explore complex therapy dynamics which may be difficult to capture. Although the current findings need further validation, the study nonetheless suggests that Clinical Psychologists, like other human beings, are susceptible to repeating their usual patterns of relating in the therapy room, unless they are able to recognise their expectations in close relationships and to reflect on them, thus ultimately controlling their influence when interacting with patients.

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APPENDICES

Appendix 1:

Ethical approval letter

The University College London Hospitals

The Joint UCL/UCLH Committees on the Ethics of Human Research

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Dr T Roth
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18 March 1998

Dear Dr Roth

Study No: 98/0049 *(Please quote in all correspondence)*
Title: **Therapist's style and understanding of clients' difficulties**

The above application was reviewed and agreed at the last ethics committee meeting on the 12th March. You may go ahead with your study.

Please note that it is important that you notify the Committee of any adverse events or changes (name of investigator etc) relating to this project. You should also notify the Committee on completion of the project, or indeed if the project is abandoned. **Please remember to quote the above number in any correspondence.**

Yours sincerely

Professor André McLean
Chairman

University College London Hospitals is an NHS Trust incorporating The Eastman Dental Hospital, The Hospital for Tropical Diseases, The Middlesex Hospital, The National Hospital for Neurology & Neurosurgery, The United Elizabeth Garrett Anderson Hospital and Hospital for Women, Soho, and University College Hospital.

Appendix 2:

Information sheet

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

General Enquiries: 0171-380 7897
Clinical Tutor Team: 0171-391 1258
UCL: 0171-387 7050
Code from overseas: +44 171
Fax: 0171-916 1989

Confidential

INFORMATION SHEET

Study title: Therapist's style and understanding of clients' difficulties.

PURPOSE

I am inviting you to participate in a study which will look at how therapists' personal style influences their understanding of clients' difficulties.

The study aims to investigate: 1) the extent to which the personal style of therapists in training influences the way in which they react to videotaped patients 2) whether training influences the way in which they react to the same patients.

WHAT'S INVOLVED?

If you agree to participate in the study, you will be asked to complete two questionnaires about your view of your relationships with important others. You will then watch four brief videotapes of four different 'patients' (played by actors) interacting with their therapist. After each videotape, you will be asked to imagine that you are the patient's therapist and be briefly interviewed about your impressions of the client. The interview will be tape recorded and later scored by the investigator and by an independent rater.

The study will take approximately one hour. The investigator will see you at UCL, at a time convenient to you. **All your identifying details and any disclosed information will be kept entirely confidential.**

If you have any questions you would like to ask regarding the study, feel free to do so now. Alternatively, you can contact one of the investigators on the above number.

INVESTIGATORS

Gabriella Rubino/Dr Tony Roth
Sub-Department of Clinical Health Psychology
Gower Street
London WC1E 6BT

You do not have to take part in this study if you do not want to. If you decide to take part, you may withdraw at any time without having to give a reason. All proposals for research using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

Appendix 3:

Consent form

Sub-Department of Clinical Health Psychology

UNIVERSITY COLLEGE LONDON

GOWER STREET LONDON WC1E 6BT

General Enquiries: 0171-380 7897
Clinical Tutor Team: 0171-391 1258
UCL: 0171-387 7050
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Fax: 0171-916 1989

Confidential

CONSENT FORM

Study title: Therapist's style and understanding of clients' difficulties.

Investigators: Dr Tony Roth, Sub-department of clinical health psychology, UCL
Gabriella Rubino, Sub-department of clinical health psychology, UCL

Please complete the following: **Delete as necessary**

1) Have you read the information sheet about this study? **YES/NO**

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

3) Have you received satisfactory answers to all your questions? **YES/NO**

4) Have you received enough information about this study? **YES/NO**

5) Do you understand that you are free to withdraw from this study at any time and without giving a reason for withdrawing? **YES/NO**

6) Which investigator have you spoken to? ______________________

7) Do you agree to participate in this study? **YES/NO**

Signed: ______________________ Date: __________

Name (Block letters): ______________________

Investigator: ______________________

All proposals using human subjects are reviewed by an ethics committee before they can proceed. This proposal was reviewed by the Joint UCL/UCLH Committees on the Ethics of Human Research.

Appendix 4:

Relationship Scales Questionnaire (RSQ)

CONFIDENTIAL

RSQ

Please, read each of the statements presented below and then choose a number from the scale, indicating the extent to which each of the statements is relevant to your usual way of relating to persons close to you.

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

/-------/-------/-------/-------/

	Rating
1. I find it difficult to depend on other people	_____
2. It is very important to me to feel independent	_____
3. I find it easy to get emotionally close to others	_____
4. I want to merge completely with another person	_____
5. I worry that I will be hurt if I allow myself to become too close to others	_____
6. I am comfortable without close emotional relationships	_____
7. I am not sure that I can always depend on others to be there when I need them	_____
8. I want to be completely emotionally intimate with others	_____
9. I worry about being alone	_____
10. I am comfortable depending on other people	_____
11. I often worry that romantic partners do not really love me	_____

(PTO)

12. I find it difficult to trust others completely _____

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

14. I want emotionally close relationships _____

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

16. I worry that others do not value me as much as I value them _____

17. People are never there when you need them _____

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

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

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

21. I often worry that romantic partners will not want to stay with me _____

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

23. I worry about being abandoned _____

24. I am uncomfortable being close to others _____

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

26. I prefer not to depend on others _____

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

28. I worry about having others not accept me _____

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

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

Appendix 5:

Parental Bonding Instrument (PBI)
(mother and father versions)

CONFIDENTIAL **CODE No:**

PBI

This questionnaire lists various attitudes and behaviours of parents. As you remember your **mother** in your first 16 years could you place a tick in the most appropriate brackets next to each question.

	Very like	Moderately like	Moderately unlike	Very unlike
1. Spoke to me with a warm and friendly voice	( )	( )	( )	( )
2. Did not help me as much as I needed	( )	( )	( )	( )
3. Let me do those things I liked doing	( )	( )	( )	( )
4. Seemed emotionally cold to me	( )	( )	( )	( )
5. Appeared to understand my problems & worries	( )	( )	( )	( )
6. Was affectionate to me	( )	( )	( )	( )
7. Liked me to make my own decisions	( )	( )	( )	( )
8. Did not want me to grow up	( )	( )	( )	( )
9. Tried to control everything I did	( )	( )	( )	( )
10. Invaded my privacy	( )	( )	( )	( )
11. Enjoyed talking things over with me	( )	( )	( )	( )
12. Frequently smiled at me	( )	( )	( )	( )
13. Tended to baby me	( )	( )	( )	( )
14. Did not seem to understand what I needed or wanted	( )	( )	( )	( )
15. Let me decide things for myself	( )	( )	( )	( )
16. Made me feel I wasn't wanted	( )	( )	( )	( )
17. Could make me feel better when I was upset	( )	( )	( )	( )
18. Did not talk with me very much	( )	( )	( )	( )
19. Tried to make me dependent on her	( )	( )	( )	( )
20. Felt I could not look after myself unless she was around	( )	( )	( )	( )
21. Gave me as much freedom as I wanted	( )	( )	( )	( )
22. Let me go out as often as I wanted	( )	( )	( )	( )
23. Was overprotective of me	( )	( )	( )	( )
24. Did not praise me	( )	( )	( )	( )
25. Let me dress in any way I pleased	( )	( )	( )	( )

CONFIDENTIAL **CODE No:**

PBI

This questionnaire lists various attitudes and behaviours of parents. As you remember your **father** in your first 16 years could you place a tick in the most appropriate brackets next to each question.

	Very like	Moderately like	Moderately unlike	Very unlike
1. Spoke to me with a warm and friendly voice	( )	( )	( )	( )
2. Did not help me as much as I needed	( )	( )	( )	( )
3. Let me do those things I liked doing	( )	( )	( )	( )
4. Seemed emotionally cold to me	( )	( )	( )	( )
5. Appeared to understand my problems & worries	( )	( )	( )	( )
6. Was affectionate to me	( )	( )	( )	( )
7. Liked me to make my own decisions	( )	( )	( )	( )
8. Did not want me to grow up	( )	( )	( )	( )
9. Tried to control everything I did	( )	( )	( )	( )
10. Invaded my privacy	( )	( )	( )	( )
11. Enjoyed talking things over with me	( )	( )	( )	( )
12. Frequently smiled at me	( )	( )	( )	( )
13. Tended to baby me	( )	( )	( )	( )
14. Did not seem to understand what I needed or wanted	( )	( )	( )	( )
15. Let me decide things for myself	( )	( )	( )	( )
16. Made me feel I wasn't wanted	( )	( )	( )	( )
17. Could make me feel better when I was upset	( )	( )	( )	( )
18. Did not talk with me very much	( )	( )	( )	( )
19. Tried to make me dependent on her	( )	( )	( )	( )
20. Felt I could not look after myself unless she was around	( )	( )	( )	( )
21. Gave me as much freedom as I wanted	( )	( )	( )	( )
22. Let me go out as often as I wanted	( )	( )	( )	( )
23. Was overprotective of me	( )	( )	( )	( )
24. Did not praise me	( )	( )	( )	( )
25. Let me dress in any way I pleased	( )	( )	( )	( )

Appendix 6:

Demographic information sheet

DEMOGRAPHIC INFORMATION

CODE No ______

1. AGE

1. 21-24
2. 25-29
3. 30-35
4. 36 and above (please specify) ______________

2. GENDER

1. Male
2. Female

3. YEAR OF STUDY

1. I
2. II
3. III

4. PREFERRED PSYCHOLOGICAL MODEL(S)
(you can circle up to three items. Please, identify your 1st, 2nd and 3rd choices if you have more than one preferred model)

1. Cognitive-Behavioural
2. Systemic
3. Psychodynamic
4. Humanistic
5. Eclectic
6. Other (please specify) ________________________________

5. CLINICAL EXPERIENCE BEFORE TRAINING

1. 0-6 months
2. 1-2 years
3. 3-4 years
4. 5-6 years
5. Other (please specify) ___________________

Appendix 7:

Post-video interview

I am now going to show you a video about a patient interacting with his/her therapist. Only the patient will appear on the screen. The video will last approximately 2 minutes and will end with the patient making a statement, which I want you to listen to carefully. When I stop the videotape I would like you to immediately talk out loud as if you were briefly responding to a statement made by a real patient.

POST-VIDEO INTERVIEW

1) What were you trying to do when you made that response?

2) How did you feel just before you made your response?

3) What else were you feeling when the patient was talking?

4) How did you feel about the patient?

5) How would you describe the patient's central difficulties?

Appendix 8:

Preoccupied patient's background history

VIGNETTE A

Steve is 27 years old and has been in therapy for the last **2 months**. He became depressed soon after his partner of 1 year left him. He wanted to get married to Julia but felt that she was not sufficiently committed to the relationship. In the period before the break-up, Julia often told him that he was suffocating her and that he should stop seeking reassurance about the relationship all the time. Steve apologised but would soon fall into the same trap again. He told the therapist that he resented having been 'dumped' by Julia.

As a child, Steve had felt unloved and neglected by his parents, who frequently argued in his presence. He recalled having to console his mother after these arguments. Steve's mother often told him that her husband was a 'bastard', who had done nothing but ruin her life. Steve's parents went through an acrimonious divorce when he was 7 years old and he went to live with his mother. After the divorce, Steve's mother embarked on a series of unsuccessful relationships and was often depressed and suicidal when they ended. Steve tended to console and support his mother but felt strongly that these efforts were never reciprocated by her, who was rarely 'there for him'. Steve recalled that, as a child, he had often sat on his bed crying silently during the night and that, on these occasions, nobody had ever acknowledged his distress.

Appendix 9:

Fearful patient's background history

VIGNETTE B

Sarah is 36 years old and has been in therapy for **2 months**. She became depressed after Jack, her partner of one year, left her following an acrimonious argument. Sarah had really wanted this relationship to work out: all her previous relationships had been rather tumultuous and characterised by frequent break-ups and reconciliations. During therapy she described her worries about being rejected by others. She pointed out that she had never become too close to Jack for fear that she would not be able to cope should he decide to leave her.

During therapy, Sarah revealed that her parents had died in a car accident when she was four years old. Her maternal grandparents, to whom she was very close, felt that they could not look after her and arranged for Sarah to go to live with her paternal grandparents. Sarah reported that the relationship between her grandparents was very difficult and that she remembered distinctively her grandfather often returning home drunk and physically and verbally abusing her grandmother. Sarah felt that her grandparents had brought her up 'because they had to' and commented that they had never shown any real interest in or love towards her. Her grandfather used to threaten Sarah to throw her out of the house when she misbehaved. For years, Sarah lived in constant fear that this would happen and that she would be left alone.

Appendix 10:

Dismissing patient's background history

VIGNETTE C

Claire is 31 years old and has been in therapy for **2 months** to resolve her depression, which emerged after her partner of one year left her. Claire commented that she had always made it clear to Simon that she wanted to be independent and that she expected him to accept this and to behave in the same way. She often arranged to meet Simon and then made other plans at the last minute, without letting him know. Her unreliability annoyed Simon very much, who eventually told Claire that he 'had had enough' and left her. Claire reported having been surprised by Simon's decision and commented that she could not understand his fuss about her being too distant. She described Simon as 'a bit of a loser' and as 'pathetic'.

Claire initially described her childhood as 'very good' but could not specify what had been good about it and could not recall any specific memories. After considerable probing, it emerged that her parents had been extremely unavailable when she was growing up. They ran their own business from home and always worked very long hours. Claire was allowed to sit in their office upstairs, providing she did not make any noise or ask them any questions. She could not recall ever being read a bedtime story or being praised for her school performance. Her parents were always very indifferent towards one another and Claire could not remember ever having been hugged or kissed by them. Claire speculated that her family environment had contributed to the development of her independence and of her tendency to count on nobody else but herself.

Appendix 11:

Secure patient's background history

VIGNETTE D

David is 29 years old and has been in therapy for **2 months**. He became depressed soon after him and Lynne, his partner of one year, split up. Lynne and David had got engaged approximately two months before they broke up. Although their relationship had been on the whole harmonious, things had recently deteriorated. David was working very long hours on an important project, which he hoped would lead to a promotion. In contrast, Lynne, who had been made redundant some months before, was unemployed and was having difficulties finding another job. Lynne and David spent most of their time together bickering and seemed to have lost interest in one another. In the end, Lynne decided that she wanted to be by herself for a while and they agreed to have a break.

During therapy, David revealed that, due to financial constraints, both his parents had to work very long hours when he was growing up. His grandmother used to look after him and his siblings when his parents were at work. David described both his parents and his grandmother as 'strict but loving and caring' and remembered feeling very close to them and especially to his grandmother. His parents used to spend most of their spare time with the children and David vividly recalled the family trips to the seaside. David was visibly upset when he disclosed that his grandmother had died suddenly a few days after his engagement to Lynne.

Appendix 12:

Preoccupied patient's video script

VIGNETTE A

Therapist: how have you been since I last saw you?

Steve: well, I don't know ...... let me think ..... what have I done? The weeks go by so quickly ... I rang my mum for a chat on thursday, but she wasn't in ..... she's never in these days ... she has probably got a new boyfriend ... I bet she'll come crying on my shoulder when it's over ... as if I haven't got enough on my plate!

Therapist: have you thought about Julia at all ?

Steve: yes, I have thought about the way she has treated me .... all I needed was a bit of love and affection and look what I got ... don't you think that she has been unfair to me?

Therapist: you seem to feel strongly that this is the case ..... maybe we should discuss these feelings and their meaning in greater detail ....

Steve: well, I told you how I feel .... she is not very considerate ..... like my mum ... and my dad .... people never treat me right ......

Therapist: uhm ... I wonder if you feel the same way about me sometimes ....

Steve: well .... I don't know .... (long silence) .... I have to make such an effort with people ..... but you .... well, I think you are here to help me, aren't you? .... You see .... don't get me wrong, you have been quite helpful to me ..... and **I do like you ... . I really wish you liked me (silence) ...... do you?**

Appendix 13:

Fearful patient's video script

VIGNETTE B

Therapist: how have you been since I last saw you?

Sarah: I have been feeling very depressed, as usual ...... I really wish I could forget Jack and enjoy being by myself for a while but ..... well, I also worry that I will be alone forever .

Therapist: is this something that is on your mind at the moment?

Sarah: Yes, all the time .... I don't want to be alone but at the same time I can't (silence) ...... I met this man last week and he asked for my telephone number. I quite fancied the idea of seeing him again but ...... I was unsure whether I could trust him .... I had images of us arguing and him leaving me ... so I just said I was already seeing someone else.

Therapist: these seem to be recurrent fears .... do you know where they might be coming from?

Sarah: well, ... I'm not sure .... perhaps ...... well, it's difficult for me to talk or even think about certain feelings ......

Therapist: I wonder whether you sometimes find it difficult to trust me with your feelings?

Sarah: ..... well, maybe that's it .... you always ask so many questions ... I don't like to imagine what you think of me (silence) .... I don't know .... **I'm not sure whether you care enough about me .... maybe it's best if we leave it.**

Appendix 14:

Dismissing patient's video script

VIGNETTE C

Therapist: how have you been since I last saw you?

Claire: well, more or less the same ...... let me think ..... something did happen last week .... I saw Simon with someone else .....

Therapist: how did that make you feel?

Claire: well ..... what do you think? How dare he go out with someone else so soon .... after all his talk about wanting to be close to me .....what an hypocrite!

Therapist: the ending of this relationship seems to have brought up some strong feelings .....

Claire: well, how would you feel if you didn't think there was a problem in your relationship and all of a sudden your partner left you giving pathetic excuses? I'm quite puzzled to be honest with you and a bit annoyed too ....

Therapist: Do you think that you might have in any way contributed to the break-up of this relationship?

Claire: I can't believe you are asking me that! ....You don't seem to understand that Simon is the one who decided to leave me .... everything was hunky-dory as far as I was concerned!!!!!! I think I'm better off without that wimp anyway ..... **I can't see how talking about my feelings towards Simon and the break-up can help my depression .... coming here is a bloody waste of time .....**

Appendix 15:

Secure patient's video script

VIGNETTE D

Therapist: how have you been since I last saw you?

David: well .... I went out with friends twice and I visited my parents at the week-end .... although I have not just sat around hoping that Lynne would call me ...... well, I still feel quite sad ......

Therapist: have you thought about Lynne a lot?

David: yes, I still miss her (silence) ... things aren't easy for me at the moment ......

Therapist: what specifically about this event do you find difficult to handle?

David: well .... I've told you how painful it is not knowing whether Lynne and I will patch things up ..... still .... I can see that this is not the best time for us to get back together ... there's too much going on ....

Therapist: I wonder whether the ending of this relationship has reminded you of another important loss ...

David: I see what you are getting at .... I think you are right .... losing not only Lynne but also my grandmother has really hit me....... I know I need to work through the loss of my grandmother .... but I wonder whether thinking about it would be helpful, really.... **Sometimes I think too much about things ...... Perhaps I'm depressed because I think too much ..... isn't it better not to think about things sometimes?**

Appendix 16:

Empathy Scale

How much was the participant **empathic**, that is tuned into what the client was saying, understood his/her feelings and responded sensitively?

1 Not at all empathic

2 Slightly empathic

3 Somewhat empathic

4 Moderately empathic

5 Very much empathic

Appendix 17:

Depth of interpretation Scale

How **deep** was the participant's response?

1. The participant merely repeats the material of which the patient is fully aware

2. Restatement of material of which the patient is aware

3. Implied focusing with regard to material of which the patient is aware

4. The participant connects for the patient two aspects of the content of the patient's previous statement

5. Reformulation of the patient's behaviour during the interview in a way not explicitly recognised previously by the patient

6. The participant comments on the patient's bodily and facial expressions as manifestations of the patient's feelings

7. The participant uses the patient's preceding statement to exemplify a process that has been building up during the interview and of which the patient is seemingly unaware

8. The participant speculates as to a possible childhood situation that might relate to the patient's current feeling

9. The participant's response deals with inferences about material completely removed from the patient's awareness

Appendix 18:

Responses coded at each level of empathy

Rating 1:

UC2015 (Responding to the fearful patient)

'Maybe it's best if we leave it ...... '

Rating 2:

UC3042 (Responding to the secure patient)

'How do you think that it would help not to think about things?'

Rating 3:

UC1054 (Responding to the dismissing patient)

'It sounds as if you are feeling very angry at the moment ... I wonder whether your anger towards Simon is ..... whether you have felt that way towards people before ...'

Rating 4:

UC3002 (Responding to the preoccupied patient)

'It's clearly difficult for you ... you have talked a lot about the relationships that you have had and wanting to seek intimacy in these close relationships and I'm wondering if that's a bit wanting to find that in therapy .... '

Rating 5:[3]

UC1055 (Responding to the fearful patient)

'It sounds to me that perhaps you are worried about whether you can trust me and at the moment maybe you are trying to leave me before I leave you, before therapy ends, we have discussed this before ..... your fear that keeps recurring, your worry that you might be abandoned or rejected ....

[3] This response was rated as '5' by one rater and as '4' by the other two.

Appendix 19:

Responses coded at each level of depth

Rating 1:

UC1066 (Responding to the dismissing patient)

'Coming here is a waste of time, you think?'

Rating 2:

UC3001 (Responding to the secure patient)

'Sometimes people do find it quite helpful not to think about things but sometimes people do find it helpful to think about things ....'

Rating 3:

UC2009 (responding to the preoccupied patient)

'Is there anything that makes you feel that I don't like you?'

Rating 4:

UC2021 (Responding to the fearful patient)

'Maybe it's not surprising that you wonder about these things, given the experiences that you have had recently .... and this seems to be something that we need to spend some more time thinking about, if you feel comfortable with doing that ....'

Rating 5:

UC3026 (Responding to the secure patient)

'You seem worried that you are thinking too much ...... and perhaps you are angry because I'm making you do something that you don't think is particularly useful ....'

Rating 6:

None responses were coded at this level

Rating 7:

UC1061 (Responding to the preoccupied patient)

'I wonder whether you needing to know whether I like you is a general feeling in life ...... whether you often feel the need to know whether people like you and doubt very much that they do ...'

Rating 8:

UC2024 (Responding to the dismissing patient)

'It seems as if you find it difficult to talk to people about these strong feelings that you have and see it as a waste of time ..... I was wondering whether this is similar to how you felt about approaching your parents when you were upset about something .....'

Rating 9:

UC3019 (Responding to the fearful patient)

'It sounds like you are quite concerned about what people think about you, their feelings towards you and that makes it difficult for you to become close to other people and trust them ...'