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# **ATTACHMENT AND PSYCHOTHERAPY**

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“Portfolio submitted in partial fulfilment of the DPsych in Counselling Psychology,  
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## **Declaration**

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## **SECTION A**

# **INTRODUCTION TO THE PORTFOLIO**

## Overview

The values underpinning counselling psychology can at times seem to be threatened by the dominant market forces which permeate the areas in which we work. The centrality of the therapeutic relationship to our work can seem undermined by the increasing emphasis on “one size fits all” therapies where the person of the therapist is seemingly absent. How do we reconcile our belief in “being with” rather than “doing to” a patient when the emphasis would seem to be on delivering evidence-based interventions, for specific medically diagnosed conditions, monitoring outcome in terms of symptom reduction, and all within a short time span with scant regard for individual need. There is emphasis on what works best for which patient ignoring the individuality of either the therapist or the patient.

The three components of this portfolio are related theoretically in that each considers the therapeutic relationship and the therapist’s contribution to its development and maintenance. Attachment theory was used as a lens through which to view the process and to frame understanding.

Each component represents aspects of my personal development as a counselling psychologist. The client study, written as a trainee, is especially concerned with the development of my capacity as a reflective practitioner as I used both supervision and a personal journal to reflect upon the work. Through my experiences in psychoanalytic psychotherapy I was developing greater self-awareness and insight. Taken together, these experiences of reflection made me

question the role of attachment in psychotherapy and this developed into the research component for this degree.

The critical literature review grew out of my experience as a trial therapist in a randomised controlled trial of CBT for the prevention of relapse in psychosis. I had for some time been interested in the work of Frieda Fromm-Reichman and Sullivan together with Bion and Winnicott and found myself frustrated by the predominance of CBT for psychosis. In the therapies I was involved in, I thought that attachment related difficulties recurred frequently and yet the model did not appear to address them. With other therapists involved in the trial, we considered the difficulties in engaging psychosis patients in therapy, and yet we never talked about the experience of being with someone who was terrified of intimacy or the impact such patients had on ourselves. I experienced again the conflicting thoughts and feelings: evidence-based practice said one thing, and yet the subjective experience of therapies seemed to say another.

And finally, the research component focused on therapist and patient attachment styles and their impact on the working alliance and outcome. It has been argued that the identity and professional roles of counselling psychologists have to be examined in relation to the political, economic and social systems in which they practice (Strawbridge and Woolfe, 1996). In the last few years, we have seen a considerable increase in the demand for psychological therapies (Hague and Cohen, 2005) together with initiatives such as Improving Access to Psychological Therapies (Turpin *et al*, 2006) with emphasis on the cost-effectiveness of CBT (Layard, 2007). Within secondary and tertiary level psychology services, there is increasing emphasis on outcome evaluation in a system where “payment by results” is becoming a reality

(Turpin, 2009). Whilst it may be implicit, there often seems to be more concern that evaluation measures are completed and that waiting lists are managed, than a client is met in a mutual relationship. Norcross reminds us that the therapist is frequently absent from evidence-based psychotherapy (Norcross, 2002) and yet there is a need to be aware of our own histories and the ways in which these impact on our relationships, including those with clients.

### ***1. The research component***

The impact of attachment style of either therapist or patient on the establishment of the therapeutic relationship, resolution of alliance ruptures and on the interventions the therapist uses, is well-researched. Both therapist and patient bring with them their past experiences, either good or bad, of relating and being close to another. Some of these patterns of relating will be unconscious and as such unavailable for evaluation. Others will be accessible through the use of attachment measure questionnaires. Moreover, individuals' experience of relatedness within a therapy session can be explored through validated questionnaires about the therapeutic alliance.

There is conflicting empirical evidence for an interactional effect between therapist and patient attachment patterns. Whilst three studies appear to demonstrate an interactional effect (Dozier, Cue, & Barnett, 1994; Rubino, Barker, Roth, & Fearon, 2000; Tyrrell, Dozier, Teague, & Fallot, 1999) shown by the in-session behaviour of therapists, Sauer *et al* (2003) found no interactional effects. Neither the Dozier *et al* study nor the Tyrrell *et al* study involved psychologists or psychotherapists but case managers who had not had therapy training. It is possible that mediating factors in interactional effect might be personal therapy or therapeutic training. Rubino *et al*

(2000), studied trainee psychologists and utilised a video-vignette format with actors playing the roles of patient. Personal therapy and therapeutic training might again be mediating factors.

Whilst it might be assumed that more secure patients will have better outcomes, most patients are likely to have insecure patterns of attachment. There is some evidence (Fonagy *et al* 1996), that different patterns of insecurity are associated with varying outcomes. It is possible that patients with different attachment patterns might benefit from different models of therapy.

### ***Current Study***

This study explores the interactional effects of attachment patterns of therapists and patients on outcome and questioning whether this is mediated by the therapeutic alliance. A quantitative methodology is being used in which various reliable and well-validated self-report measures are used to measure the participants' attachment style and their perceptions of the therapeutic alliance. Outcome is measured by completion of the CORE-OM, a well-validated outcome measure used increasingly frequently in NHS psychotherapy services. Although quantitative methodologies can be criticised for their emphasis on measurement, there is a case for exploring attachment relationships in this way. Whilst not denying the richness and complexity of human relationships, it is seen that ways of being in relationship are repeated over an individual's lifetime and can be captured by self-report measures which offer a valid and reliable form of measurement. Although some of the rich material which might have been elicited from interviewing participants will

be foregone, a quantitative approach utilizing self-report measures will be more cost-effective, more time-effective and less intrusive.

## ***2. The client study component***

This client study has been included with the aim of showing the development of self as a reflective practitioner through supervision and personal reflection – a movement from reflection-on-action towards reflection-in-action (Schon, 1983). Supervision provided me with a space to reflect on the work I was engaged in with this patient, to facilitate the integration of theory and practice and to develop self-awareness. My supervisor encouraged me to practice cognitive therapy techniques myself, a method which permits the trainee “to look in depth at the implications for themselves, for their clients, and for cognitive theory” (Bennett-Levy, 2003, p. 210). I was already keeping a reflective journal and this has been likened by Bolton (2003) to the development of Casement’s internal supervisor (1990; cited Bolton, 2003).

This study presents a short-term cognitive behavioural therapy for PTSD, demonstrating evidence-based practice. Questioning the medical model and the utility of psychiatric diagnoses, counselling psychology has always emphasised the subjective experience of the client. Whilst this therapy focused on the symptoms of PTSD and was successful in terms of symptom reduction, I felt that the real work of therapy was in the establishment of a sound therapeutic relationship, which in attachment theory functioned as a “secure base”. During this therapy, with the use of supervision, I discovered the importance of the therapy relationship within CBT. Attachment theory also offered a means of understanding the way the patient stayed within a violent relationship and I began to explore the literature on attachment and violence. This later became integrated into my professional practice.

### ***3. The critical literature review***

The aim of this review was to examine psychodynamic psychotherapies for psychosis at a time when CBT models predominated. To achieve this it was necessary to question the modernist research paradigm with its emphasis on randomised controlled trials resulting in a predominance of CBT evidence. Written whilst I was working as a trial therapist for a Randomised Controlled Trial (RCT), the need to adhere to a manualized therapy made me concentrate on therapeutic technique whilst feeling that something was being lost within the therapy. Evidence based practice has informed the compilation of the NICE guidelines for psychiatrically diagnosed disorders. As the evidence is strongest for CBT, CBT has been designated the therapy of choice for psychosis and yet, as this review shows, there is some excellent and successful work being done within other models. Practice based evidence also generates knowledge and these case studies and naturalistic studies from within a psychoanalytic framework provoke thought and invite comment.

Evidence supporting CBT-type interventions for schizophrenia is insufficiently strong to justify limiting psychological interventions to these models (Shapiro & Paley, 2002), yet practitioners seem reluctant to research the efficacy and effectiveness of psychodynamic approaches (Martindale *et al*, 2002; Shapiro & Paley, 2002; Tarrier *et al*, 2002).

The predominance of research into some models rather than others (Roth & Parry, 1997) once again draws attention to the continuing debate about RCTs. RCTs

ensure clinical accountability by establishing empirical evidence for psychological treatments for particular patients in specific circumstances (Shapiro, 1995). Seen as the “gold standard” for investigating treatment efficacy, RCTs are not without their critics or methodological limitations and yet are still held in awe by research and service funders (Shapiro, 1995). Processes of change may occur out of sight of researchers and therapists and outcome studies may not necessarily measure the specific changes that distinguish between treatments. Non-specific factors associated with outcome remain unidentified (Shapiro & Paley, 2002). It has been claimed (Roth & Parry, 1997) that whilst psychological therapies have been shown to be efficacious, there is little evidence for the efficacy of specific models used in specific conditions.

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## **SECTION B**

### **RESEARCH THESIS**

#### **ATTACHMENT AND PSYCHOTHERAPY**

## Abstract

The aim of this study was to explore the relationship between therapy outcome, the therapeutic alliance and both patient and therapist attachment styles. 14 therapists and 27 patients participated. 78.57% ( $n = 11$ ) therapists and 29.63% ( $n = 8$ ) patients were classified as securely attached by self-report measures.

It was predicted that more patients of secure therapists would show clinically significant improvement as determined by CORE-OM scores. However, 21.05% of patients with a secure attachment style therapist compared to 40% of patients with a dismissing attachment style therapist showed clinically significant improvement. Short-term therapies of once-weekly intensity enabled dismissing style patients to restore their defences, reduce distress and show clinically significant change in terms of reduction of symptomatology.

There did not appear to be an association between attachment style of either therapist or patient and overall ratings of the alliance in this study. However, changes in both therapist and client ratings of the ARM subscales for Confidence and Openness between Time 1 and Time 2 suggested that therapist and client were beginning to perceive the alliance more similarly as therapy progressed. Mediation of the relationship between attachment style and therapeutic outcome by the therapeutic alliance was not found to be significant.

A significant finding in this study was that patient participants were more likely to have only brothers and no sisters (51.9%,  $n = 14$ ),  $X^2 = 13.15$ ,  $df = 3$ ,  $p = 0.004$ .

# **Chapter 1**

## **Attachment Theory and Its Origins**

*“From the cradle to the grave”*

*Bowlby, 1977*

Attachment theory is not just a theory of infant development but a theory that encompasses lifetime development. Bowlby defined attachment behaviour as:

Any form of behaviour that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued, or sick and is assuaged by comforting and caregiving.

*Bowlby, 1988, pp 29.*

Bowlby also emphasized the importance of an attachment figure for providing a secure base for the infant and later the adult, from which they can safely explore their world and to which they can return. Attachment theory, whilst initially highlighting the normative function of an attachment behavioural system, also enables the conceptualisation of individual differences.

This chapter considers the development of attachment theory, from Bowlby's normative theory, and the focus on individual differences by Mary Ainsworth ending with an overview of the measurement of adult attachment styles through both Main's Adult Attachment Interview and the development of self-report questionnaires.

### ***1.1 Maternal Deprivation***

Attachment theory grew out of Bowlby's work with children who had been separated from their families. The work of Anna Freud on evacuees and Rene Spitz on orphans influenced Bowlby's ideas on the importance of family relationships for both normal and pathological development. Bowlby's work on maladapted and delinquent children culminated in *Maternal Care and Mental Health*, the 1951 report for the World Health Organisation on the mental health of homeless children in post-war Europe (Bowlby, 1951).

At this time, Bowlby collaborated with James Robertson who was making the documentary film, "A Two-Year Old Goes to Hospital" – a film which highlighted the suffering endured by children when separated from their caregivers and later became instrumental in changing hospital practice (Robertson, 1953). The film, when presented in 1953, was not well-received by the British Psychoanalytical Society who argued that a child of this age could not mourn but their distress was due to unconscious fantasies regarding the mother's pregnancy.

#### ***1.1.2 Origins of Attachment Theory***

Three classic papers were presented by Bowlby, predating his seminal trilogy, "Attachment and Loss". In *The nature of the child's tie to his mother* (Bowlby, 1958), Bowlby argued that an infant's instinctual responses function to bind infant to mother and mother to infant. The following year, in *Separation anxiety* (Bowlby, 1959), Bowlby argued that a threatening situation can trigger escape and attachment

behaviours in the absence of the attachment figure. This paper continued Robertson's 1953 observations, built on the work done by Heinicke (1956, 1965) on parent-child separations and that of Harlow's preliminary work on primates (1958). Bowlby also challenged the accepted psychoanalytical belief that maternal over gratification was dangerous to the developing infant, arguing that pseudo affection and over protectiveness might mask unconscious maternal hostility. He went on to postulate that pseudo independence is a defence against separation anxiety. In *Grief and mourning in infancy and childhood* (1960) Bowlby challenged Anna Freud's belief that incomplete ego development in infants precludes mourning by claiming that grieving and mourning processes in children occur with the continued absence of an attachment figure. This work stimulated the interest of Colin Parkes in his work on adult grief and subsequently, Kubler-Ross's work on death and dying and the phases of dying.

### ***1.1.3 "Attachment and Loss"***

Bowlby's theory of attachment was enriched by the work of Mary Ainsworth on the Ganda project (1963, 1967; cited Bowlby, 1969). Ainsworth brought experimental research methodologies together with observational, naturalistic studies and a child development orientation to Bowlby's study of attachment behaviour. Her methodology, considered unusual at that time, involved looking at patterns of meaningful behaviour within natural contexts, rather than focusing on counting occurrences of particular behaviours. The Ganda project data also gave information on individual differences in mother-child interactions.

The first volume of Bowlby's seminal trilogy, *Attachment and Loss* was published in 1969. Bowlby wanted to develop a new theory of motivation and behavioural control and this led to preliminary work in *Attachment*. His theoretical claims were backed with the then current scientific research, citing the influence of work by ethnologists such as Lorenz, Tinbergen and Hinde (cited Bowlby, 1969). Arguing that proximity to an attachment figure has evolutionary functions of protecting an infant from danger, he emphasised how this is not derived from motivational systems related to mating or feeding.

Bowlby thought that the development of the attachment system would continue throughout the preschool years as the child gains greater insight into parental motives and plans. The child now considers the response required from the parent and plans how to achieve this, gradually developing the capacity to take another's perspective and adjust her own actions within this "goal-corrected partnership" .

In *Separation: Anxiety and Anger* (1973), Bowlby revised Freud's 1926 theory of signal anxiety and formulated new ways of thinking about Freud's 1923 and 1940 theories of motivation. Bowlby postulated an epigenetic model of personality. He suggested that humans are driven to achieve a dynamic balance between familiar, stress-relieving behaviours such as proximity to attachment figures and home environment, and the antithetical exploratory behaviours. Anger occurs in response to frustration and will communicate to the attachment figure that something is wrong. Bowlby's work suggested that children experience quite violent fantasies when they eventually return to parents after long separations. Bretherton suggested (1995) that these fantasies are residual Kleinian ideas in Bowlby's thinking.

In *Loss: Sadness and Depression* (1980) Bowlby discussed the problems of grief and mourning and the defensive processes which arise. He also developed his theory on Internal Working Models which derived from psychoanalytic theories, particularly those of the British Object Relations theorists.

Bowlby's work on attachment theory was taken forward by Mary Ainsworth and her graduate students. Attachment behaviour was seen to be a normal developmental process in children both in the work by Erickson, Sroufe and Egeland (1985) and by Main, Kaplan and Cassidy (1985).

#### ***1.1.4 Internal Working Models***

Turning to the inner world of Freudian theory, Bowlby developed the concept of an *internal working model of self and attachment figure* which he thought was achieved through interpersonal interaction patterns. For Bowlby "the concept of working models ... is no more than a way of describing, in terms compatible with systems theory, ideas traditionally described in such terms as 'introjection of an object' (good or bad) and 'self image'" (Bowlby, 1973, p. 204).

This dynamic working model enabled the child to predict their attachment figure's most likely behaviour and for them to adapt their response appropriately. Bowlby also clarified the way in which attachment patterns are inter-generationally transmitted. He stated that the concepts of self would be derived from experiences with an attachment figure. Contradictory or incompatible aspects of reality can be accommodated within Bowlby's multiple models.

Internal working models (IWMs) are central to attachment theory. Bowlby drew on ethnology, evolutionary biology and the emerging cognitive information processing sciences to develop his ideas of an internal representation of relationships. Writing from an evolutionary stance, Craik (1943) claimed that organisms which were capable of forming internal representations of their environment increased their potential for survival. He stated that not all aspects of reality needed to be represented but that the relation-structure would enable evaluation of possible alternative behaviours:

If the organism carries a “small-scale model” of external reality and of its own possible actions within its head, it is able to try out various alternatives, conclude which is the best of them, react to future situations before they arise, utilize the knowledge of past events in dealing with the present and future, and in every way to react in a much fuller, safer and more competent manner to the emergencies which face it. (Craik, 1943, pp.61).

In choosing to use Craik’s metaphor of “internal working model” Bowlby wanted to describe a model which was adaptive and could be updated, rejecting other metaphors which appeared to imply a static state. Models which are not updated appear arrested at a developmental point with levels of self-awareness and interpersonal awareness similarly arrested.

Bowlby’s model most closely resembles Sullivan’s (1953) and Fairbairn’s (1952) theories of object relations. Further work by ego psychologist, Edith Jacobson (1964) postulated an internal image of self and objects with good and bad

valences, depending on gratification or frustration. Using the term “representation” she described a model incorporating inner and external worlds which were subject to distortion and modification. Fonagy (1999) argues that in some ways her model is more sophisticated than that of Bowlby.

Bowlby drew on information-processing theories to clarify the seeming stability of the internal working model and the defensive distortions. As patterns of relating become habitual, they become less accessible to awareness. Due to expectancy of reciprocity, dyadic relational patterns are more resistant to alteration (Bowlby, 1980). Defensive exclusion leads to a split in internal working models with subsequent lack of accommodation of the model to external reality (Bowlby, 1980). However, the affective quality of internal working models may change as, for example, when environmental stressors diminish and a parent becomes more able to respond sensitively (Bretherton and Munholland, 1999), although defensive features of IWMs might make this updating more difficult.

Drawing on the work of Tulving (1972) on episodic and semantic memory, Bowlby furthered our understanding of repressive and dissociative phenomena and pathological grief. Bowlby postulated that there was an executive structure which accounted for regulation of competing behavioural systems. This type of defensive exclusion might occur, for example, when a child knows something that the parent wishes they did not know but continues to deny. In this situation, the child will continue to maintain two sets of models which remain unconnected and incompatible. Multiple models allow contradictory or incompatible aspects of reality to be accommodated. Bowlby (1980) and later Stern (1985), show how language can either communicate or miscommunicate when verbal information on interpersonal

events is at odds with the child's nonverbal experience thus causing concordance or discordance within the IWM.

Attachment patterns can be considered defence mechanisms enabling the child to cope with the particular parent she interacts with (Fonagy *et al*,1996). Internal representations represent both sides of the relationship, for example, a child who has internal representation of caregiver as rejecting and critical will form a complementary IWM of self as unacceptable and unworthy (Sroufe and Fleeson, 1986). Supportive parents allow autonomy and will talk about their own models of self, of child and others and show the child that working models are open to being questioned and revised.

The conceptualisation of internal working models was further developed by Stern (1994) in his work on the “*emerging moment*” and the experience of intersubjectivity. This takes IWMs a little bit closer to the mental model postulated by Johnson-Laird (1983). A cognitive psychologist, Johnson-Laird (1983) argued that mental models were constructed on the basis of perception, knowledge and understanding resulting in a conclusion which can be reality tested by the seeking of alternative disconfirmatory models. He considered the concept of internal working models within an evolutionary framework suggesting that it allows individual insight and permits behavioural planning. Such a mental model offers structural correspondence between reality and what is represented and is essential for a model which aims to guide behaviour.

The study of event representation enables us to understand IWMs more fully (Bretherton, Ridgeway and Cassidy, 1990) and such theories fit with Bowlby's

theory as they are a “configurational and dynamic approach” to the process of memory. Representational processes are determined by event schemata or scripts in which repeated examples of life events are summarised but the concept of scripts is arguably imprecise and thus unable to explain the relationship to autobiographical memory, the creation of new scripts and the place of affect in event representation (Bretherton *et al*, 1990). Revision by Schank (1982) is more useful as it permits accessing information from both episodic and autobiographical memories along with associated affect and allows reprocessing, cross-indexing and summarising. There is however a blurring of the episodic/semantic memory distinction proposed by Tulving (1972, 1983). According to this model, new event schemata are processed in light of existing schemata although defensive information processing will impact on selective information processing, and development will be altered into non-optimal channels.

Internal working models have, however, been criticised for “undue vagueness” which makes it difficult to empirically test them (Hinde 1988; Rutter 1995). However, more recent psychoneurobiological evidence is beginning to show how the development of the right hemisphere of the brain is directly affected by attachment relationships (Schorer, 1994). It is beyond the scope of this study to explore the extensive emerging literature on psychoneurobiological research but Schorer goes on to argue that the internal working model, with encoded strategies of affect regulation, is stored within the right brain (Schorer, 1994).

#### **1.1.5 Mary Ainsworth**

Ainsworth and her colleagues identified patterns of attachment in infants which were most pronounced on reunion with mother following brief separation.

Whilst The Strange Situation research has been criticised over the years for the falseness of the situation creating the infant distress, the Ainsworth data compared favourably to extensive home observations. This work highlighted the importance of maternal sensitive responsiveness. Ainsworth's classification system enabled empirical study of Bowlby's theory (Slade, 1999) which thus moved along a different path away from being basically a clinical development theory. The assumption that attachment quality can be classified is central to attachment research.

## ***1.2 Developmental Perspectives***

Whilst initially attachment patterns in infancy are associated with a specific attachment relationship, they gradually become the property of the individual rather than a specific relational dyad (Bowlby, 1973). Internal working models lead an individual to have expectations of reciprocity and guide the manner in which the individual engages with another. An insecure pattern of attachment associated with expectations of hurt and rejection will often cause the individual to be closed and avoidant of intimacy thus eliciting rebuff and non-understanding.

It has been said that attachment theory is not only a theory of psychopathology but also a theory of normal development (Sroufe, Carlson, Levy and Egeland, 1999). Attachment has a role in the subsequent development of psychopathology either increasing the risk of future difficulties or operating as a protective factor, and arguably understanding childhood psychopathology might enhance the study of attachment.

Developmental psychopathology is complex, with multiple pathways to and from disorders and attachment insecurity is unlikely to be the sole cause (Greenberg, 1999). Neither should it be used to account for the entire child-parent relationship (Solomon and George, 1999). Both the continuity of attachment status and the empirical evidence suggesting that intervening life events can change an expected outcome of infant attachment, are consistent with Bowlby's model where attachment processes show plasticity as an individual's life "turns at each and every stage of the journey on an interaction between the organism as it has developed up to that moment and the environment in which it then finds itself." (Bowlby, 1973, pp. 412).

Whilst early experiences colour later experiences, those earlier experiences will be transformed by later events. Adverse early attachment experiences can be overcome by later good experiences resulting in "earned-security" of attachment. Individuals with earned-security have been shown to be just as resilient in parenting under stressful situations as continuously securely attached individuals, thus breaking the cycle of intergenerational transmission of inadequate parenting (Phelps, Belsky and Crnic, 1998). The beginnings of formal operational thought enable children to reflect on and re-evaluate previous experiences which they are then able to integrate (Main, Kaplan and Cassidy, 1985). Many early experiences exist in a preverbal period of life and are inaccessible to verbal recall, and thus not easily modified by later experiences (Sroufe *et al*, 1999).

Attachment behaviour is elicited in those situations which the child perceives as threatening, stressful or fearful. Later, situations which evoke memories of such states will also trigger attachment behaviours (Solomon and George, 1999). Attachment is strongly linked with childhood disruptive behaviour, dissociative

symptoms, aggression and violence (Fonagy *et al*, 1997; Lyons Ruth and Jacobvitz, 1999). Fonagy *et al* (1997) showed that early attachment insecurity is associated with adolescent delinquency and adult criminality. The authors postulate that internal working models of specific attachment figures are generalised during adolescence allowing different attachment relationships. Mentalising ability, made possible by the early experiences of attachment security, creates awareness of others' mental states and facilitates appropriate social behaviour. Failure to develop mentalising capacity creates difficulties in appreciating the needs and feelings of others and there is a concomitant lack of social bonding towards institutions such as schools and peers. Children with avoidant attachment style appeared most likely to follow this developmental path (Fonagy *et al*, 1997). The ability to cope with anger, anxiety and sadness requires the capacity to use "secure-base figures" and more mature defences (Greenberg, 1999) whilst disorganised attachment behaviours have been seen to reflect inadequate strategies for coping with stress with the noted presence of increased salivary cortisol levels (Lyons Ruth and Jacobvitz, 1999).

Attachment disorganisation appears to occur within specific relationships rather than as a function of an individual's traits (Lyons Ruth and Jacobvitz, 1999). Infants who had been classified as disorganised in relationship with one parent were not always so with the other in a study by Main and Solomon (1990).

### ***1.2.1 Mary Main: Adult Attachment Interview***

The Adult Attachment Interview (AAI) is a structured, semi-clinical interview comprising 15 questions (Main, 1991) which looks at an individual's "descriptions of early relationships and attachment related events for the adult's sense of the way

these relationships and events had affected his or her adult personality; by probing for both specific corroborative and contradictory memories of parents and the relationship with parents” (Main *et al*, 1985, p. 98).

The Adult Attachment Interview was originally developed and used within the Berkeley Longitudinal Study (George *et al*, 1985; Main *et al*, 1985). Whilst Ainsworth *et al* (1978) focused on the differences in infants’ behaviour, Main *et al* (1985), postulated that mental processes were equally different in adults and their work focused on the level of representation. Main and her colleagues explored relationships between parent’s early attachment experiences and the attachment pattern of their infants (George, Kaplan and Main, 1985), finding that the attachment patterns of these were analogous to their infants’ behaviour patterns in Ainsworth’s Strange Situation (1978). The Adult Attachment Interview (AAI) has been described as being able to surprise the unconscious (George *et al*, 1985), eliciting adults’ thoughts about attachment relationships and providing a window onto their internal working models or states of mind (Main, 1995). Discourse analysis of the interviews allows both conscious and unconscious aspects of attachment representations to be brought to light. The AAI does not assess secure-base behaviour in adults (Crowell, Fraley and Shaver, 1999) nor an adult’s security of attachment to a second person (Hesse, 1999) but rather assesses an individual’s state of mind in relation to attachment. The AAI has excellent predictive power for the behaviour of the infants of these individuals’ on the Strange Situation task (Steele, Steele and Fonagy, 1996) and also has wide cultural validity (van Ijzendoorn, 1995).

Main *et al* (1985) found three patterns of attachment in adults which appeared to parallel those identified in infants in the Strange Situation – autonomous/secure,

dismissing and preoccupied. They also found further patterns of attachment – unresolved for trauma and later, an unclassifiable style in which individuals showed considerable dismissing or preoccupied speech or were otherwise incoherent (Hesse, 1996).

Individuals classified as secure/autonomous are seen to be characterised by internal consistency of narrative, displaying apparently truthful descriptions of relationships with parents in both childhood and in the present; their narratives appear coherent and organized and they appear able to collaboratively discuss both the positive and the negative aspects of relationships together with congruent emotional expression. Individuals classified as dismissing appear to either devalue the importance of attachment relationships or to talk about them in an idealised way. Frequently these individuals claim they remember little from childhood. By contrast, individuals classified as having preoccupied states of mind for attachment relationships, talk openly and expressively, although their narrative is confused, incoherent and chaotic.

Slade (1999) argued that Main's work on the classification of adult attachment patterns and the importance of representation altered the course of attachment research. Main found that attachment patterns were related, not to the actual events individuals had experienced, but rather the ways in which these events were mentally represented and talked about. The ability to coherently and collaboratively represent past experiences is arguably highly significant for adult security of attachment and is strongly predictive of infant security (Slade, 1999). A mother's capacity to mentally represent an individual child is a determinant in that child's security of attachment, with low concordance in the attachment security of

each sibling (van Ijzendoorn *et al*, 2000). When there has been trauma and adversity within the mother's history, there is a stronger association between maternal reflective function and child security (Fonagy *et al*, 1995) with intergenerational transmission reduced with increased maternal capacity to reflect on her own history. Mothers who demonstrate high reflective functioning on the AAI, have been shown to have high reflective functioning on the Parent Development Interview in which maternal representations of the child are explored (Slade, 2001). More recent work by Steele, Steele, Jacobvitz and Sroufe (2008) has again drawn attention to the ways in which clinicians can access valuable information by using the AAI. The authors suggest that the AAI introduces the individual to the idea that therapeutic experience means "being with someone who is able to hear, believe, and understand a great range of difficult stories about family experience" (Steele *et al*, 2008, p.12) which can be a profound experience. Steele *et al* also argued that use of the AAI enables observation of a patient's reflective function and their potential to engage in psychotherapy.

### **1.2.2 Reflective Function**

Work on metacognitive monitoring (Main, 1991) and reflective functioning (Fonagy *et al*, 1995) has been important for the understanding of intergenerational transmission of security or insecurity of attachment. The original concept of reflective functioning developed from Main's theory of metacognitive monitoring of interpersonal experiences (Main, 1991) and has been defined as "the plausible interpretation of one's own and others' behaviour in terms of underlying mental states" (Bateman and Fonagy, 2004, p.74). Fonagy and colleagues have extended

this work with the concept of mentalisation encompassing the philosophical *theory of mind* tradition.

In looking at the Bateman and Fonagy (2004) definition of mentalising, Holmes (2005) unpacks aspects of the concept which are inter-related. There is an equivalence between responses which are self-referential and hostile-intrusive (Holmes, 2005; Lyons-Ruth and Jacobvitz, 1999). Bion's schematized theory of thinking (1962, 1983) demonstrates the ways in which an infant needs thoughts to be contained by a mother with the ability to think these thoughts, accepting projections and later returning them in such a way that the infant can tolerate thinking. Fonagy and Target (1997) claimed a distinction between pretend and equivalence modes of thinking which compares with Bion's barrier between conscious and unconscious thought (Holmes 2005). Mentalising is a marker for secure attachment.

It is through therapy that a patient can be enabled to move from an "equivalence" position to one where "as if" is possible, from "unmentalised transference" to "mentalisation" (Holmes, 2005). Transference can be thought of as arising from internal working models which are in effect "experientially based templates that are carried forward in development" (Cortina & Marrone, 2003, p.30)

Whilst both the models of Bion and Fonagy encompass affect regulation, that of Fonagy, like that of Winnicott (1965), emphasises the interacting subjectivities of mother and child. This contrasts with Bion's model which although interpersonal, allots a somewhat passive role for the mother.

Diamond *et al*, (2003) have studied the therapeutic relationship using the AAI. Analysis of the reflective function in these transcripts suggests that reflective function improves during the course of therapy, good outcomes appear associated with therapists whose scores are not too far ahead of or behind their patients and that the therapist's degree of reflective function varies with each patient (Diamond *et al*, 2003). Patient-therapist dyads appear to create a specific attachment environment with a particular capacity for mentalisation.

Consideration of the interactive processes between care-giver and child, therapist and patient, lead to speculation about patient capacity to complete questionnaires regarding the working alliance in empirical studies of psychotherapy (see Chapters 3 & 4). If, as argued by Bateman and Fonagy (2004), mentalising capacity involves attribution of meaning to one's own and others' actions and thoughts, the completion of measures such as the Agnew Relationship Measure or the Working Alliance Inventory, eliciting patients' thoughts about their therapists and therapy sessions, will reflect this capacity.

If the process of development parallels the capacity to mentalise in an ideal situation, the therapy process will similarly see increase in both self-mentalising ability and the capacity to conceptualise other's mentalising. This might be an explanation for the frequently observed increased alliance quality over therapy and again might contribute to the dilemma of when to administer alliance measures. Completion of alliance measures immediately following a psychotherapy session might incur a carry-over effect from the therapist in the session which will make it

easier for the patient. Conversely some distress at leaving a therapeutic session might impact on a patient's capacity to mentalise as this is frequently compromised in attachment related situations.

### ***1.3 Social Psychology Perspectives***

Another line of research developed within social psychology where romantic relationships and attachment patterns were explored.

#### ***1.3.1 Measurement of Adult Attachment: Self-report Measures***

Whilst the Adult Attachment Interview probes for individual's states of mind for childhood attachment experiences, self-report measures elicit thoughts and feelings about adult relationships.

Hazan and Shaver (1987) argued that the three attachment categories of Ainsworth *et al*'s (1978) Strange Situation continued throughout adolescence and were involved in the establishment of romantic relationships. A single-item measure was developed in which the three categories – secure, avoidant and anxious-ambivalent – were presented as descriptions. Participants, having chosen the description which was most characteristic of themselves, then completed questions relating to experiences of romantic love, mental models of self and others and memories of childhood attachment experiences. Hazan and Shaver found similar distribution of attachment patterns to those found by Ainsworth *et al*. Security of attachment was associated with greater caring and intimacy and experiences of

understanding in romantic relationships whilst insecure participants reported higher levels of loneliness.

Other measures developed at this time included Collins and Read (1990) 18-item questionnaire, the Revised Adult Attachment Scales (AAS) which measured three underlying dimensions of attachment: comfort with closeness (Close), ability to depend on other (Depend) and fear of abandonment (Anxiety). The authors argued that this obtained greater sensitivity of measurement and greater precision of attachment style definition than did Hazan and Shaver. Also Simpson (1990) and Simpson, Rholes and Nelligan (1992) developed a 13-item questionnaire, the Adult Attachment Scale (AAS) which measured two independent dimensions – Avoidance and Anxiety.

Bartholomew (1990) and Bartholomew and Horowitz (1991) noted an inconsistency between the conceptualisation of avoidance by Main *et al* (1985) and that of Hazan and Shaver (1987). Hazan and Shaver's avoidant attachment prototype, seen in the context of a romantic attachment, appeared more vulnerable, tearful and conscious of emotional pain. This contrasted with the avoidant style described by Main which seemed less overtly emotional, more defended and utilising strategies of denial. Arguing that conceptually distinct patterns of avoidance are lost when a single avoidant detached category is used, Bartholomew and Horowitz (1991) proposed a four-group model of attachment style in adulthood, demonstrating that all styles were associated with a specific profile of interpersonal problems based on both self-report and friend report. It was shown that attachment style with peers correlated with ratings of attachment to family.

When two levels of self-image are combined with two levels of other-image, four categories logically emerge. The model derived has four “cells” representing a “theoretical ideal” and individuals can be approximately categorized to some degree (see Figure 1, p.43). The dimensions of the model can be seen in terms of avoidance of intimacy and dependency. Differences in interpersonal problems are associated with each attachment style, and there was a consistency for both self and friend reports (Bartholomew and Horowitz, 1991). The authors concluded that these studies confirmed both the distinct dimensions of self and other models and that these dimensions independently vary.

The Relationship Questionnaire (RQ) is a self-report instrument assessing adult attachment within the four-category model developed by Bartholomew (1990, 1991). Based on the work of John Bowlby (1973), Bartholomew proposed that there were two types of internal working model – an internal model of the self and an internal model of others. By conceptualising each model as having positive or negative dichotomies, four possible styles of attachment were theoretically possible. Secure and Fearful-Avoidant attachment patterns correspond to Bartholomew’s Style A and Style B respectively. Styles C and D correspond to preoccupied and dismissing-avoidant attachment patterns respectively.

This model includes the dismissing-avoidant category from the Adult Attachment Interview (Ainsworth *et al*, 1978) which the Hazan and Shaver 1987 model did not include. Bartholomew located the four categories into a two dimensional model unlike either Ainsworth or Hazan and Shaver. The measure was not intended as an assessment of adults’ retrospective childhood attachment but of

adult close peer relationships. The measure has most frequently been used with young adult friendships or romantic relationships.

Test re-test stability over an 8 month period was moderate (Scharfe and Bartholomew, 1994). The Relationship Questionnaire has been shown to be the only self-report measure of attachment free from self-deceptive biases (Leak and Parsons, 2001). In a study comparing The Relationship Questionnaire with the Revised Adult Attachment Scale (RAAS; Collins and Read, 1990), Adult Attachment Scale (AAS; Simpson, 1990), Relationship Scales Questionnaire (RSQ; Griffin and Bartholomew, 1994) and The Attachment Style Questionnaire (ASQ; Feeney and Noller, 1990), the Relationship Questionnaire was found to be twice as likely to classify participants as fearful (Stein *et al*, 2002). The authors suggest that this might be due to what they term a “hedge word” – *sometimes* – which occurs in the description *‘I sometimes worry that others don’t value me as much as I value them’*.

The importance of Bartholomew’s distinction between fearful and dismissing types of avoidant attachment has considerable empirical support (e.g. Brennan, Clark and Shaver, 1998; Bartholomew and Horowitz, 1991; Horowitz, Rosenberg and Bartholomew, 1993).

Brennan, Clark and Shaver (1998) conceptualised adult attachment in terms of two dimensions – Avoidance and Anxiety. By combining high and low scores on these dimensions, four different prototypes are obtained which have a conceptual correspondence with Bartholomew’s four types. Their Experiences in Close

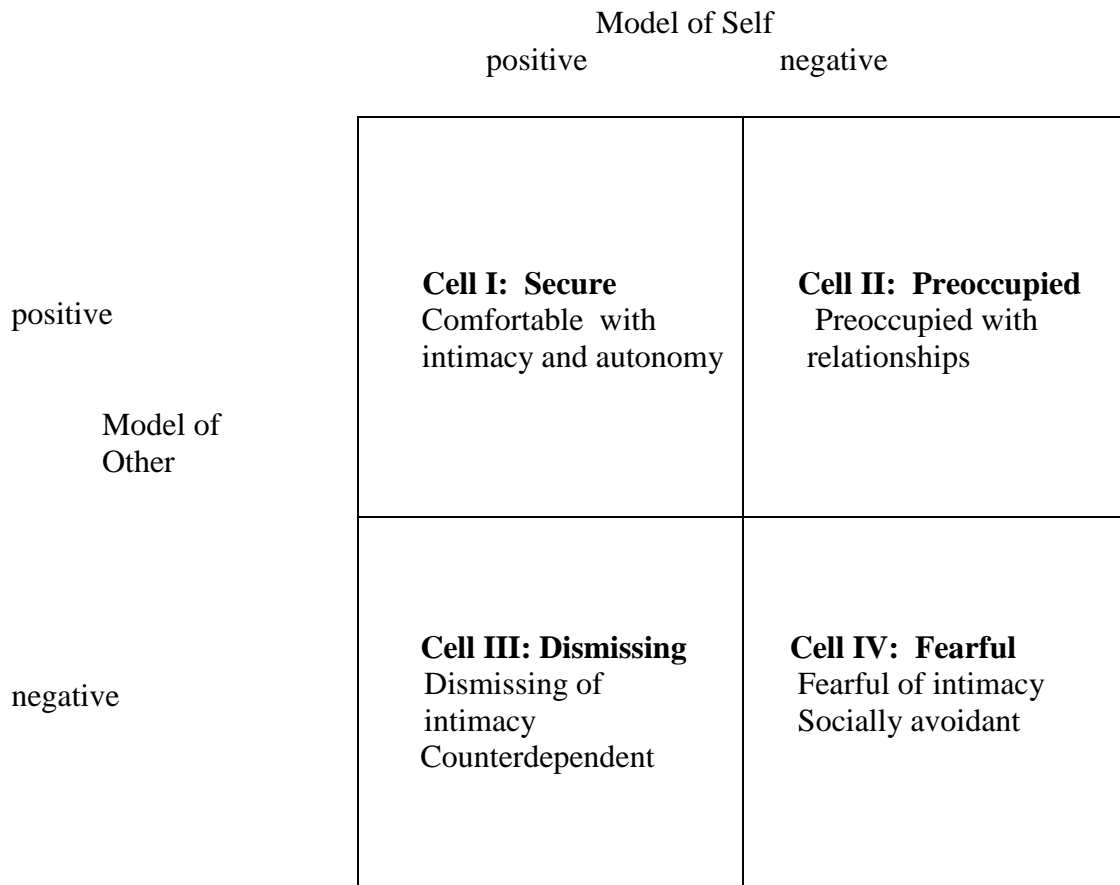


Figure 1. Bartholomew's (1990) four-category diagram.

Relationships (ECR) is a 36 item self-report attachment measure where the items derive from factor analysis of most of the pre-existing self-report measures of adult romantic attachment. It measures adult attachment within romantic relationships.

Brennan *et al* (1998) expressed a retrospective opinion that more attention should have been paid by Hazan and Shaver to Ainsworth *et al*'s (1978) summary of results. Brennan *et al* argue that Ainsworth indicated that attachment types could be seen as two-dimensional spatial regions. These dimensions were Avoidance and Anxiety. It was this conceptualisation of an underlying two-dimensional structure

that inspired Bartholomew's realisation that four rather than three conceptual patterns were possible.

The factor analysis of 60 named attachment constructs (Brennan *et al*, 1998) enabled the identification of two factors which corresponded to the Anxiety and Avoidance dimensions. Clustering, on the basis of scores on these two dimensions, revealed four groups conceptually corresponding to Bartholomew's four types. Hierarchical cluster analysis provided a cluster centre then non-hierarchical analyses were done to optimise cluster fitting. These distinct groups resembled secure, fearful, preoccupied and dismissing categories as described by Bartholomew.

There has been much academic argument as to whether adult attachment patterns should be conceptualised as types or dimensions (Fonagy, 1999; Fraley and Waller, 1998; Griffin and Bartholomew, 1994; Hazan and Shaver, 1994; Rutter, 1995) with Fraley and Waller suggesting that researchers use dimensional measurement rather than categorical. Empirical research demonstrates low correspondence between assessment of attachment styles by self-report questionnaires and the assessment of internal working models by interview (Crowell, Fraley, Shaver, 1999; Bartholomew and Shaver, 1998). Bartholomew and Shaver (1998) suggested that there is a continuum which ranges from the Adult Attachment Interview (a categorically coded measure focusing on parenting issues) through the parental attachment and peer/romantic interviews and questionnaires of Bartholomew to Hazan and Shaver's self-report measure. Measures lying near to one another on this continuum appear to be more highly empirically related (Bartholomew and Shaver, 1998), although Stein *et al* (2002) did not find high levels of agreement between measures which were conceptually similar.

#### ***1.4 Summary***

In this chapter, the beginnings of attachment theory were examined. Bowlby emphasised the importance of an attachment figure for the provision of a secure base for first the infant and later the adult, from which they can safely explore their world and which offers a place of safety to which they can return. The development of Bowlby's concept of Internal Working Models was explored showing how internal representation of self and caregiver enables the infant to interpret and predict caregivers' behaviour and thus plan their own response. Whilst it was argued that IWMs are unconscious structures, it was seen that some elements were conscious and more easily accessible than others. From this arises the question as to whether IWMs can be measured by instruments such as the Relationship Questionnaire (Bartholomew and Horowitz, 1991) or the Experiences in Close Relationships (Brennan, Clark and Shaver, 1998) and whether IWMs will impact on completion of such measures as the Agnew Relationship Measure (Agnew-Davies *et al*, 1998) within psychotherapy research.

## Chapter 2

### Attachment Theory and Psychotherapy

*“less under the spell of forgotten miseries and better  
able to recognize companions in the present for what they are.”*

*(Bowlby, 1988, pp. 155)*

Bowlby (1988) saw the emotional availability of the therapist as a core factor in psychotherapeutic outcome. The therapist's own history of attachment will impact on their emotional availability. Many therapists have experienced considerable early loss, which they have faced and overcome and patients will use therapists' "attachment dramas" in diverse ways (Slade, 1999). Differing responses to patients' various attachment styles may reflect therapists' earliest emotional experiences. Arietta Slade points out that the caring experience may be reminiscent of earlier experiences for therapists and that within therapy caring suggests that there is an emotional connection from therapist to patient which will, depending on the security of attachment of the therapist, form a sense of safety and connection (Slade, 1999). With an insecure therapist, this caring capacity can be distorted.

Difficulties in establishing and maintaining a therapeutic alliance then will reflect not only the patient's earliest experiences of care but that of the therapist. In discussing a model of psychological development and psychotherapy, Harris (2004) highlights the need for "responsive empathy" in facilitating therapeutic change. When working in the transference, the therapist needs to maintain empathic sensitivity whilst challenging initial internal working models (Harris, 2004).

It is argued that such internal resources enabling sensitive and appropriate responses are a result of security of attachment in a therapist.

Affect is linked to the concept of internal working models of attachment theory (Pines and Marrone 2003) and sensitive responsiveness includes tact as well as empathy (Stern 1985). Highlighting the importance of the therapist's own history of sensitive responsiveness from their primary carers and later their own therapists, Pines and Marrone suggest that the ability to respond empathically to patients will be unconsciously influenced by this prior experience. Adverse attachment histories which have not been adequately worked through will adversely impact on the therapist's ability to care for their patient. Defining empathy as "the capacity to perceive the other's feeling states as if one were in the other's position" (Pines and Marrone, 2003, p. 44), they argue that empathy alone is not sensitive responsiveness which involves mother making responses to facilitate her infant's emotional regulation. As seen in the previous chapter, various measures of attachment style have been developed and have been used in research studies looking into the impact attachment style has on seeking for and acceptance of help.

This chapter explores the ways in which both therapists' and patients' attachment styles impact on psychotherapeutic process by reviewing empirical evidence. Empirical studies looking at attachment style and its impact on the establishment and maintenance of the working alliance are discussed in Chapter 4.

## ***2.1 Patients' Attachment Style and Psychotherapy***

Research has demonstrated the links between insecurity of attachment and psychopathology. Dozier (1990) investigated the association of psychopathology and attachment style using patient self-report and clinician rated use of treatment. The Adult Attachment Interview was given to 42 participants with psychopathological disorders and clinicians rated treatment use by responding to researchers' questions (see Table 1, p. 49). Four areas of functioning were explored by means of two stated questions per area - compliance with prescribed treatment regimen (the frequency of attending appointments and compliance with medication), the extent to which clients sought out or rejected treatment (whether clients demanded more than provided by the treatment or asked for or rejected additional appointments), the extent of clients' self-disclosure (whether clients talked about significant problems and the extent to which they acknowledged feelings of anger and distress) and lastly, the general use of treatment (engagement and degree of benefit). All responses were rated on continuous rating scales with definite end anchors.

Higher security was associated with affective disorders in contrast to thought disorders, gender correlated with the avoidance-preoccupation dimension and men demonstrated greater avoidant tendencies in comparison to women although this did not reach significance. The attachment dimensions of security/anxiety and avoidance/preoccupation were correlated with the four areas of functioning.

Table 1

*Empirical Studies of Patient Attachment Style and Psychotherapy*

Author	N	Measures	Results
Dozier, 1990	42	AA I <sup>1</sup> Clinician ratings of client functioning in 4 areas	Secure tendencies associated with greater compliance, $r = .37, p < .05$ . Stronger avoidant tendencies less likely to seek and more likely to reject treatment than stronger preoccupied tendencies, $r = .55, p < .01$ . Preoccupied strategies associated with more disclosure than avoidant strategies, $r = .50, p < .01$ . Stronger avoidant tendencies poorer uses of treatment than stronger preoccupied tendencies, $r = .32, p < .05$ . Gender correlated with the avoidance-preoccupation dimension ( $r(38) = .34, p < .05$ )
Korfmacher <i>et al</i> 1997	55	AA I Clinician question- naires re client participation	Secure mothers more committed, able to accept help, able to express feelings. Dismissing women less emotionally committed to treatment, preferring companionable support. Declined crisis working stressing self-reliance. Unresolved mothers less committed, participated less fully, more negative interactions with facilitators and within group. Required more crisis intervention.
Hardy <i>et al</i> 1999	16	HATs <sup>2</sup> BSR <sup>3</sup> AAI derived classification	Attachment themes: loss/rejection; conflict/danger; closeness/proximity Therapist responses: containment; reflecting; interpreting challenging Therapists responded with reflection to preoccupied attachment styles Therapists responded with interpretation to dismissing attachment styles

<sup>1</sup>Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)<sup>2</sup>Helpful Aspects of Therapy (HATs; Llewelyn, 1988)<sup>3</sup>Brief Structured Recall (BSR; Elliott & Shapiro, 1988)

Secure tendencies were associated with more compliance with the treatment programme. Clients with stronger avoidant tendencies were less likely to seek out and more likely to reject treatment and less able to be self-disclosing, making poorer use of treatment than those with stronger preoccupied tendencies. Greater preoccupied strategies were associated with more disclosure. Greater attachment anxiety is related to greater ease with self-disclosure within therapy whilst more avoidant attached patients show greater self-concealment (Dozier, 1990).

The clients in this study were in a residential facility and the treatment use was rated by clinicians with whom they had daily contact. The ratings for treatment use would necessarily be subjective and arguably present only a limited view of any client's behaviour.

Treatment non-compliance was also found to be associated with patients with greater avoidant tendencies by Korfmacher, Adam, Ogawa, and Egeland (1997). In a preventative intervention programme involving 55 "at risk" mothers, secure mothers were more committed to the treatment programme and were able to accept more help (see Table 1, p.49). Whilst dismissing women appeared less emotionally committed to the treatment programme and preferred a more companionable support, women with an unresolved attachment style were more likely to require crisis intervention and were less emotionally committed than secure women. The AAI was used to determine clients' attachment status.

Patients' attachment style affects therapist's behaviour as dismissing patients push the therapist away, depriving themselves of needed help (Dozier, 1990),

evoking strong countertransference responses as therapists struggle with feeling pushed out, rejected and helpless (Slade, 1999). Countertransference reactions might include sadistically forcing the patient to acknowledge painful feelings prematurely or avoiding confronting transference concerns (Slade, 1999).

The impact of patients' interpersonal style on the therapeutic process was analysed by Hardy *et al* (1999) who hypothesised that therapist response to attachment issues would be mediated by patient attachment style (see Table 1, p.49). In order to study change processes in detail, selections of "therapy dialogue" (Hardy *et al*, 1999, p. 39) were made based on client-identified significant therapy events. After each therapy session, clients completed the Helpful Aspects of Therapy forms (HATs; Llewelyn, 1988) describing in their own words, "the most helpful and hindering events" of the preceding therapy session. These were rated using a three point scale ranging from "no relationship difficulty" to "clear relationship difficulty". Clients were then interviewed using Brief Structured Recall to locate the identified "helpful event" on the session audio tape. Content analysis of sessional transcripts identified client attachment style, attachment issues and therapist responsiveness to these issues of loss/rejection, conflict or danger and need for closeness. Therapist responses were categorised as being containment, reflection or interpretation. The dialogical model of Elliott (1995; cited Hardy *et al*, 1999) was used whereby therapists and researchers work together to analyse events. Clients' speech patterns were classified rather than the patients themselves. Only helpful events of those patients who had improved were analysed and the authors argue that, whilst this meant they had a homogenous sample, the results might have been very different for those patients who did not improve. With preoccupied attachment styles, therapists responded with reflection of feelings, whilst they responded with emotional

interpretation to dismissing styles (Hardy *et al*, 1999). Support is taken from the findings of Hardy, Stiles, Barkham, and Startup (1998; reviewed Chapter 4) that over-involved patients attempted to elicit more psychodynamic or interpersonal interventions in contrast to dismissing patients who tried to elicit more CBT interventions. There was no report of therapist characteristics which, as can be seen from other studies, might have contributed to their findings.

## ***2.2 Therapist Attachment Style and Psychotherapy***

Therapists' clinical effectiveness in challenging clients' internal working models is mediated by their own attachment style (Dozier, Cue and Barnett, 1994) and their perception of their client's attachment status and needs (Dolan, Arnkoff and Glass, 1993). The effect of therapists' attachment styles on treatment outcome is now emerging (Dozier and Tyrell, 1998; Leiper and Casares, 2000; Tyrell, Dozier, Teague and Fallot, 1999).

First of all research demonstrates the impact of therapist attachment patterns on engagement of patient (Black, Hardy, Turpin, and Parry, 2005; Dunkle and Friedlander; 1996; Leiper and Casares, 2000; Sauer, Lopez, and Gormley, 2003).

Leiper and Casares (2000) studied attachment organization of a random sample of clinical psychologists ( $n = 196$ ) and found that therapists were significantly higher on compulsive care giving compared to angry withdrawal (see Table 2,p.54) The amount of early loss experienced by therapists was significantly associated with attachment styles, with loss higher for the insecure group. Attachment insecurity in therapists was also associated with reported greater

difficulty in therapeutic practice as measured by a Clinical Practice Questionnaire based on the Common Core Questionnaire (Orlinsky *et al*, 1999), with insecure therapists more likely to locate difficulty within themselves. Whilst no significant difference was found between approach used by secure or insecure groups, there was a significant difference on level of early loss experience with “loss” highest for those using an analytic approach. More secure therapists than insecure therapists had been in therapy, mostly analytic. Loss scores were significantly higher for those who reported previous experience of therapy. Secure therapists with previous therapy experience reported significantly more early loss than those who were secure but had not had therapy. In attachment theory, this could be considered “earned security”.

The findings of Leiper and Casares can be considered in relation to those of Sauer *et al* (2003) who argued that therapist attachment insecurity might be associated with problematic clinical intervention and/or difficulties building the working alliance (see Section 2.3, p.55 & Table 3, p.57). An unexpected finding in their 2003 study was the highly significant positive association between therapist attachment anxiety and patients’ ratings of the first session alliance. They suggested that anxious therapists with negative models of self and positive models of others might be better at seeing variation in others and responding accordingly as they are “highly invested in establishing connections” (Sauer *et al*, 2003). Black *et al* (2005) also found therapeutic orientation was significant (see Ch. 4.4, p. 82). Psychodynamic therapists reported significantly more problems in therapy than either CBT or CAT therapists which might reflect the focus on interpersonal and relationship issues or the theoretical framework within which therapy occurred.

Table 2  
*Empirical Studies of Therapist Attachment Style and Psychotherapy*

Author	N	Measure	Results
Dozier <i>et al</i> 1994	27	AAI <sup>1</sup> Depth of intervention (manual)	Insecure CMs responded in greater depth to more preoccupied clients, $r(14) = -.64, p < .05$ . Secure CMs responded in greater depth to less preoccupied clients, $r(13) = -.32$ ( <i>ns trend</i> ). Insecure CMs saw that preoccupied clients had greater dependency needs than dismissing clients, $r(14) = .80, p < .01$ .
Leiper <i>et al</i> 2000	196	Common Core Question- naire <sup>2</sup> AAC <sup>3</sup> ARAQ <sup>4</sup> TEL <sup>5</sup>	Insecure therapists experienced more difficulty in therapeutic practice $X^2(2) = 11.21, p < .01$ . Avoidant more than ambivalent group ( $U = 185.0, p < .05$ ). Between groups difference for degree to which difficulty located in therapist $X^2(2) = 6.98, p < .05$ with Insecure group more likely to locate difficulty in themselves ( $U = 201.5, p < .05$ ). Analytic therapists more early loss $X^2(5) = 15.6, p < .01$ & unempathic parental responses ( $X^2(5) = 32.4, p < .0001$ )
Rubino <i>et al</i> 2000	73	RSQ <sup>6</sup> Response Empathy <sup>7</sup> DIS <sup>8</sup>	Empathy and depth of interpretation intercorrelated ( $r = .69$ ). Patient main effect for Empathy ratings ( $F(3,70) = 5.77, p = .001$ ) with main effect of attachment-anxiety ( $F(1,72) = 4.04, p = .048$ ). More anxious therapists responded less empathically than less anxious therapists. Less anxious therapists varied empathy levels across patient groups ( $F(3, 69) = 4.500, p = .006$ ), more empathic to fearful than dismissing or secure patients, and more to preoccupied than to dismissing.

<sup>1</sup>Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)

<sup>2</sup>Common Core Questionnaire<sup>2</sup> (CCQ; Orlinsky et al 1999)

<sup>3</sup>Adult Attachment Categorization (AAC; Hazan and Shaver, 1987)

<sup>4</sup>Adult Reciprocal Attachment Questionnaire<sup>4</sup> (ARAQ; West *et al*, 1994)

<sup>5</sup>Taxonomy of Early Loss (TEL; Burton, 1994)

<sup>6</sup>Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994)

<sup>7</sup>Response Empathy (Goodman, 1972)

<sup>8</sup>Depth of Interpretation Scale (DIS; Harway *et al*, 1953)

The therapist's own relational history will contribute to countertransferential experiences and ability to deal with these (Dunkle and Friedlander; 1996; Leiper and Casares, 2000; Ligiero and Gelso, 2002). Security of attachment in clinicians gives them internal resources enabling them to respond appropriately and sensitively to their clients (Dozier, Cue and Barnett 1994; Harris, 2004). Therapists need sufficient ego strength and flexibility if they are to provide effective interventions (Tyrell *et al*, 1999) and therapist attachment style is associated with their capacity for empathic response (Rubino, Barker, Roth, and Fearon, 2000), (see Tables 2, p.54 & 3, p. 57 & section 2.3, p.55). Countertransference management enables the therapist to provide non-complementary responses to the patient's attachment strategies (Dozier *et al*, 1994) which is an important way in which the therapy relationship is different from the patient's other relationships.

### ***2.3 Interactional Effects of Patient and Therapist Attachment Styles***

Therapists' and clients' attachment needs interact within the matrix of transference-countertransference, impacting on the process of therapy and potentially affecting outcome. Most research reviewed tends to concentrate on either therapist or patient attachment styles with only a small number of researchers considering the interactional effects. (Dozier *et al*, 1994; Rubino *et al*, 2000; Sauer *et al*, 2003 Tyrell *et al*, 1999).

Whilst Sauer *et al* (2003) found no interaction effects, Rubino *et al* (2000) found that there was a trend for anxious therapists to respond less empathically than less anxious therapists (see Table 3, p.57). Their results showed that less anxious therapists were able to vary their levels of empathy across the patient groups, showing greater empathy to fearful rather than dismissing or secure patients. Rubino *et al* operationalised Depth of Interpretation as the extent to which therapists elaborated on patient responses. Deeper interpretations were made to fearful patients in comparison to those made to secure or dismissing patients. Participants were psychologists in training and patients were role-played by actors. Assessment of empathic intervention was based on a response to a videotape.

Complementarity in treatment was studied by Dozier *et al* (1994). Dozier *et al* explored whether there was a relationship between clinician attachment strategies and their ability to respond therapeutically to their clients. Attachment style was measured by AAI. The Depth of Intervention Score was developed by coding each of the 28 intervention items on a scale ranging from low to high intervention depth. During telephone interviews, 18 case managers (who had not undergone psychotherapy training) were asked to talk about the issues that had arisen within their most recent session with their patients (27 patients). Subsequently, these taped interviews were analysed and the interventions coded for Type of Contact (Discussion, Help, Skills, Support, Listening, Checking-in or General).

Table 3

*Empirical Studies of Interactional Effects of Patient and Therapist Attachment Style*

Author	N	Measures	Results
Dozier <i>et al</i> 1994	27	AAI <sup>1</sup> Depth of intervention – based on manual	More insecure CMs responded in greater depth to more preoccupied clients, $r(14) = -.64, p < .05$ . More secure CMs responded in greater depth to less preoccupied clients, $r(13) = -.32$ ( <i>ns</i> trend). More insecure CMs saw that preoccupied clients had greater dependency needs than dismissing clients, $r(14) = .80, p < .01$ .
Tyrrell <i>et al</i> 1999	54	AAI WAI <sup>2</sup> GAF <sup>3</sup> QLI <sup>4</sup>	Less deactivating case managers rated more deactivating clients higher on global functioning than less deactivating clients, $r(25) = .24$ ; Non-significant trend. More deactivating case managers rated more deactivating clients lower on global functioning than less deactivating clients, $r(25) = -.31$ . Non-significant trend.
Rubino <i>et al</i> 2000	73	RSQ <sup>5</sup> RE <sup>6</sup> DIS <sup>7</sup>	Empathy and depth of interpretation intercorrelated $r = .69$ . Patient main effect for Empathy ratings ( $F(3,70) = 5.77, p = .001$ ) with main effect of attachment-anxiety ( $F(1,72) = 4.04, p = .048$ ) - more anxious therapists responded less empathically than did less anxious therapists.  Less anxious therapists varied their levels of empathy across patient groups ( $F(3, 69) = 4.500, p = .006$ ), responding more empathically to fearful rather than dismissing or secure patients, and more to preoccupied than to dismissing. Depth ratings showed no therapist main effect or therapist by patient interaction. Strong main effect for patient ( $F(3,70) = 26.25, p < .001$ ). Post-hoc pairwise comparisons showed that therapists made deeper responses to the fearful patient than to the secure or dismissing patients.
Sauer <i>et al</i> 2003	17	WAI AAI	Client and therapist WAI ratings significantly related at T1 ( $r = .42, p < .05$ ) and T2 ( $r = .62, p < .05$ ) but not T3 ( $r = .10$ ). Therapist attachment anxiety positively correlated with client WAI ratings at Time 1 ( $r = .40, p < .05$ ) but significant negative effects over time.

<sup>1</sup>Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)<sup>2</sup>Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)<sup>3</sup>Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1987) <sup>4</sup>Quality of Life Interview (QLI; Lehman, 1988)<sup>5</sup>Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994)<sup>6</sup>Response Empathy (RE; Goodman, 1972)<sup>7</sup>Depth of Interpretation Scale (DIS; Harway, Dittman, Raush, Bordin & Rigler, 1953)

More secure case managers responded more to the dependency needs of dismissing clients than those of preoccupied clients, thus giving a new relationship experience. The authors suggest that this might indicate a greater ability to use countertransference in contrast to the preoccupied/dismissing clinicians who either responded with too much or too little intensity to the client's relational expectancy and thus failed to challenge these clients' relationship models.

Dissimilarity of client and clinician on the deactivating/hyperactivating dimension was found by Tyrrell *et al* (1999) to give the best therapeutic outcomes (see Table 3, p. 57). More deactivating patients functioned better and were more satisfied with their lives following intervention with more hyperactivating case managers, whilst the more hyperactivating patients functioned better with greater life satisfaction when case managers were more deactivating. However no significant effects for depression scores were found by the authors. It needs to be remembered that these clinicians were not therapists but case managers and the work was not psychotherapy.

#### ***2.4 Attachment Style, Psychotherapy and Outcome***

Empirical evidence for the impact of attachment style on therapeutic outcome is emerging. Horowitz, Rosenberg, and Bartholomew (1993) studied 36 patients in brief psychodynamic psychotherapy and found that those with a "dismissing" attachment style had a poorer outcome than other attachment styles

Table 4 *Attachment style and outcome*

Author	N	Measure	Results
Horowitz <i>et al</i> 1996	36  77	IIP <sup>1</sup>  RQ <sup>2</sup> IIP	Problems from the “exploitable” octant (90%) most improvement. Problems from “cold”, “vindictive” and “dominating” least improvement. Attachment style and interpersonal problems were associated. Interpersonal hostility associated with dismissing group. Overly expressive subscale associated with preoccupied group. Unassertiveness and social inhibition associated with fearful group.
Borman Spurrell 1996	54	AAI <sup>3</sup>	Secure patients significantly greater improvement with either model of therapy when compared to insecure group. Greater improvement of preoccupied clients with CBT than with interpersonal psychotherapy. Dismissing patients did equally well in both therapies.
Fonagy <i>et al</i> 1996	82	AAI GAF <sup>4</sup> RSF <sup>5</sup>	Dismissing patients improved more than preoccupied or free-autonomous patients, $X^2(2) = 14.9, p < .001$ . Attachment classification & final GAF score significant in ANCOVA, $F(2,79) = 4.28, p < .02$ .
Meyer <i>et al</i> 2001	149	AP <sup>6</sup> Ham-D <sup>7</sup> Ham-A <sup>8</sup> SCLR90 <sup>9</sup> GAF	Secure attachment predicted greater positive changes in GAF & HAM-A scores at Time 2 (.38, $p < .01$ ; -.21, $p < .01$ ) Symptom severity of borderline PD at Time 1 predicted less improvement in HAM-D (.24, $p < .05$ ) and GAF (-.23, $p < .05$ )
Mosheim <i>et al</i> 2000	65	AP IIP	Attachment security significant predictor of goal attainment. Autocratic interpersonal style correlated with abrupt termination
Saatsi <i>et al</i> 2007	94	BDI <sup>10</sup> IIP	Secure interpersonal style associated with better outcome $F(1, 78) = 3.17, p < .05$ . Secure group most clients with clinically significant and reliable change $X^2(2, N = 88) = 11.90$ .

<sup>1</sup> Inventory of Interpersonal Problems (IIP; Horowitz *et al*, 1988)

<sup>2</sup> Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991)

<sup>3</sup> Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)

<sup>4</sup> Global Assessment of Functioning Scale (GAF; American Psychiatric Association, 1987)

<sup>5</sup> The Reflective-Self Function Scale (RSF; Fonagy *et al* 1991)

<sup>6</sup> Attachment Prototypes (AP; Pilkonis 1988)

<sup>7</sup> Hamilton Rating Scale for Depression (HAM-D; Hamilton, 1960)

<sup>8</sup> Hamilton Rating Scale for Anxiety (HAM-A; Hamilton, 1959)

<sup>9</sup> Revised Symptoms Checklist-90 (SCL-90-R; Derogatis, 1983)

<sup>10</sup> Beck Depression Inventory (BDI; Beck & Steer, 1987)

(See Table 4, p.59). Likely attachment style was inferred through the use of the Inventory of Interpersonal Problems (IIP; Horowitz *et al*, 1988), a self-report questionnaire that allows the plotting of problems within octants. Patients whose responses could be located within the “cold”, “dominating” and “vindictive” octants made less improvement through therapy than patients whose responses were plotted in different octants. Bartholomew and Horowitz (1991) had previously explored these octants in the development of the scales and on the basis of this work, concluded that the “cold”, “dominating” and “vindictive” octants corresponded to a dismissing attachment style. Another study utilising the IIP was that of Saatsi, Hardy and Cahill (2007) who also found that more dismissing interpersonal style was associated with poorer outcome (see Table 4, p.59), [this is reviewed more extensively in Chap. 4.].

Dismissing attachment style was associated with better outcome in the Fonagy *et al* (1996) study of inpatients at the Cassell Hospital in London (see Table 4, p. 59). Fonagy *et al* evaluated the effectiveness of psychoanalytic psychotherapy with patients with severe personality disorder. 82 patients participated and psychotherapy lasted approximately one year. Patients were also exposed to the therapeutic milieu environment and group analysis. Whilst patients determined as securely attached by AAI functioned better at intake and outcome, those with a dismissing attachment style appeared to make the most therapeutic gains. Although this can be argued as a regression to the mean (Fonagy *et al*, 1996), it might also reflect a greater willingness to consider the effects of past relationships on current difficulties in a patient group who have previously avoided thinking about intimate relationships.

Whilst the results of Fonagy *et al*'s study are in contrast to those of Horowitz *et al*, an unpublished study by Borman Spurrell (1996) again showed that dismissing patients appear to do well in therapy (see Table 4, p. 59). Patients' attachment style was ascertained by the AAI. Participants were 54 patients meeting diagnostic criteria for binge eating disorder and engaged in either cognitive behavioural group therapy or interpersonal group therapy. Preoccupied patients had better outcomes following cognitive behavioural psychotherapy in comparison with interpersonal psychotherapy. Dismissing patients had good outcomes in both models of therapy.

Another way of describing attachment relationships is by the concepts of "deactivation" - diverting attention from attachment related topics in order to minimise the importance of early attachment relationships - and "hyperactivating" associated with preoccupation with attachment relationships.

Meyer, Pilkonis, Pioletti, Heape, and Egan, (2001) hypothesised that personality disorder and attachment styles would predict symptom course over time. They claimed that attachment style and personality disorders overlap conceptually as both concepts have evolutionary roots, reflect adaptive strategies for survival and reproductive fitness and both can potentially undermine psychotherapeutic success.

This naturalistic, prospective study involved 149 participants (see Table 4, p.59). The Pilkonis Attachment Prototypes Methodology (Pilkonis, 1988) was used to assess attachment prototypes. Whilst Attachment Prototypes differentiate secure from insecure patterns of attachment, it involves a greater number of insecure categories. The treatment protocol included psychotherapy, pharmacotherapy, or both with follow-up at 6 and 12 months.

Symptoms improved over the 6 month period whilst attachment and personality disorder remained relatively stable which weakly supported the hypothesis. Secure attachment at assessment was a strong predictor of changes in psychosocial functioning whilst self-reported symptom changes were not predicted by personality disorder or attachment scale ratings. More changes in global functioning were predicted by secure attachment and lesser changes in depressive symptoms were associated with and therefore predicted by borderline features.

The Attachment Prototype methodology (Pilkonis 1988) was used by Mosheim *et al*, (2000) as the basis for their attachment rating – the EBPR (see Table 4). In this study, 65 inpatients completed both the attachment rating and the Inventory of Interpersonal Problems (Horowitz *et al*, 1988). Only attachment security was a significant predictor of patients' goal attainment over an average therapy duration of 7 weeks. Autocratic interpersonal behaviour was found to be significantly correlated with abrupt termination of therapy. Whilst Meyer and colleagues (2001) suggest that it is hard to reconcile the results from the Mosheim study with those of Fonagy and colleagues (1996), a temporal element might be involved – in the Mosheim study, therapies were brief with a Mean of 7 weeks whilst in the Fonagy study, the average length of stay at the tertiary centre was 9.4 months (range 6 months to 1 year) and during this time patients received individual and group psychoanalytic psychotherapy within a therapeutic community.

Empirical evidence suggests that dissimilarity of clinician and client in interpersonal style is associated with improved process and outcome in therapy. Bernier and Dozier (2002) focused on corrective emotional experience, defining the concept as a period of experiential relearning which enables changes in inflexible

relational patterns. The authors proposed that a non-complementary client-counsellor match would facilitate a corrective emotional experience which they argue is a key factor of therapeutic change with models of brief psychodynamic therapy.

#### ***2.4.1 Changes in Attachment Style***

Changes in patients' attachment style during time-limited psychodynamic psychotherapy were explored by Travis, Bliwise, Binder, Horne-Moyer, (2001). Attachment style was measured by the Bartholomew Attachment Rating Scale (Bartholomew and Horowitz, 1991). Results showed that a significant number of patients moved from insecure to secure attachment classification (see Table 5, p.64) . However, most changes in attachment status appeared to be a move from one type of insecure pattern to another. At outcome, secure attachment style patients had significantly less symptomatology than did the three other groups of clients with insecure attachment styles. GAS scores were significantly lower for preoccupied clients in comparison to other insecure or secure client groups.

Diamond, Stovall, McClough, Clarkin and Levy (2003) reported on a longitudinal study of seventeen patients, engaged in Transference Focused Psychotherapy for Borderline Personality Disorder (BPD) (see Table 5, 64). They explored the ways attachment style and reflective function capacity impacted on therapeutic process and outcome. An adaptation of the AAI (George, Kaplan, and Main, 1985), the Patient-Therapist Attachment Interview (PT-AAI), was used to

Table 5  
*Empirical Studies of Changes in attachment Style*

Author	N	Measure	Results
Travis <i>et al</i> 2001	28	ARS <sup>1</sup> GAS <sup>2</sup>	Outcome GAS lower for secure attachment than insecure attachment styles, $t(28) = 3.6, p < .05$ . Preoccupied style lower GAS in than other insecure or secure client groups, $t(28) = -2.48, p < .05$ .
Woodhouse <i>et al</i> 2003	51	CATS <sup>3</sup> MITS <sup>4</sup> TSC-TI <sup>5</sup> PCSQ <sup>6</sup>	Level of security of attachment to therapist positively correlated with time in treatment ( $r = .35, p < .05$ ) Secure and preoccupied attachment positively related to negative transference and amount of transference
Parish & Eagle 2003	105	CAQ <sup>7</sup> WAI <sup>8</sup> RQ <sup>9</sup>	Overall attachment to therapist correlated with WAI ( $r = .56, p < .001$ ). Dismissing attachment negatively correlated with overall attachment to therapist ( $r = -.31, p < .001$ ). CAQ Secure base component correlated with WAI ( $r = .65, p < .001$ ). CAQ Availability component significant predictor of WAI ( $r = .65, p < .001$ ). RQ secure dimension correlated with Secure base component ( $r = .22, p < .05$ ), Safe Haven component ( $r = .38, p < .01$ ), and Perceived Availability component ( $r = .25, p < .01$ )
Diamond <i>et al</i> 2003	10	AAI <sup>10</sup> PT-AAI <sup>11</sup>	At 1 yr: 3 patients moved from insecure to secure patterns, 4 patients made little change, 3 patients moved from classified <i>insecure</i> to <i>cannot classify</i> . ↑ narrative coherence, ↑ reflective function No resolution for loss or trauma

<sup>1</sup> Attachment Rating Scale (ARS; Bartholomew and Horowitz, 1991)

<sup>2</sup> Global Assessment Scale (GAS; Endicott *et al*, 1976)

<sup>3</sup> Client Attachment to Therapist Scale (CATS; Mallinckrodt *et al*, 1995)

<sup>4</sup> Missouri Identifying Transference Scale (MITS; Multon *et al*, 1996)

<sup>5</sup> Therapy Session Checklist-Transference Items (TSC-TI; Graff and Luborsky, 1977)

<sup>6</sup> Parent Caregiving Style Questionnaire (PCSQ; Hazan and Shaver, 1986)

<sup>7</sup> Client Attachment Questionnaire (CAQ; Parish, 2000)

<sup>8</sup> Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)

<sup>9</sup> Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1990)

<sup>10</sup> Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)

<sup>11</sup> Patient-Therapist AAI (PT-AAI; Diamond *et al*, 2003)

capture the quality of the attachment between patient and therapist and any changes over the course of therapy. The AAI was administered at 4 months and again at 1 year, whilst the PT-AAI was given at 1 year. Preliminary findings on a subset of ten patients showed that six out of the ten patients were classified as unresolved with respect to loss and/or trauma at 4 months (see Table 5, p.64). Four of these six shifted to organised secure or insecure state of mind at 1 year, three patients moved from insecure to secure patterns, four patients made little change whilst three patients moved from classified *insecure* to *cannot classify*. The *cannot classify* category is usually indicative of psychopathology but in this study Diamond *et al* argue that it might be indicative of a transformative period, as previously dismissing patients become aware of their attachment needs (see section 2.4.2 for further discussion).

#### **2.4.2 Attachment to the Therapist**

Psychotherapy patients can see their therapist as an attachment figure and this takes place within Bowlby's concept of a "secure base". Therapists need to have sufficient ego strength to challenge patient's relational beliefs – their internal working models – which will arise from their own attachment security. Challenging internal working models including perception of therapist is reminiscent of focus on the transference with transference interpretations.

Shane and Shane (2001) argue that the therapeutic secure base is an "important positive new experience" (p. 679), and can be recognised by increased self-esteem and positive affect, increased self-reflection and greater openness and comfort with the therapist, and acknowledgement of the importance of therapist and therapy. The therapist will also experience positive changes through the

establishment of a secure base, with increasing sense of mutuality and openness (Shane and Shane, 2001).

When Bowlby talked about transference he suggested that patients make “forecasts” about the therapist based on childhood established internal working models. Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) examined the relationships between the client’s attachment to their therapist and the therapist’s perception of the transference (see Table 5, p. 64). Whilst secure or preoccupied attachment were positively associated with both negative transference and the amount of transference, avoidant attachment was not correlated with any type of transference. Insecurity of attachment to the therapist was correlated with greater negative recollections of caregiving by parental figures. Woodhouse *et al* also found that more secure attachment to the therapist was associated with higher amounts of negative transference which they suggest might reflect the client’s capacity to use the Secure base for exploration of negative expectations of other. Woodhouse *et al* highlight the importance of Bowlby’s 1988 statement that attachment to an individual arises within the context of a specific relationship which serves as a secure base. Security does not mean that patients see their therapists realistically but rather that the Secure base enables the emergence of negative transferential material. Secure attachment is associated with higher reflective functioning – greater awareness of and greater capacity to reflect on own and others’ inner states and behaviours (Hesse, 1999; Slade, 1999).

A framework of Attachment theory was used by Szajnberg and Crittenden (1997) for evaluating early transference and for conceptualizing patient/therapist working models of attachment. Like Main (cited Slade, 1999) they question whether

an individual could have elements of both insecure and secure attachment and explore how this might impact on an analyst's response to a patient, arguing that two analysts, both with secure attachment might respond very differently to a particular patient's patterns of relating due to differing dimensional profiles. This argument is supported by Griffin and Bartholomew's (1994) statement that attachment measures must capture the interpersonal and intrapersonal nuances that exist for persons of the same dominant category.

Parish and Eagle (2003) found that duration of therapy and frequency of sessions was associated with the number of attachment components in the therapeutic relationship (see Table 5, p.64). Multiple regression analysis found that CAQ Secure base component was highly correlated with the Working Alliance Inventory and Availability emerged as significant predictors of the WAI.

Scores on RQ Secure dimension significantly correlated with scores on Secure base component, the Safe Haven component, and the Perceived Availability component. Patients with secure attachment style were more able to use the therapist as a Secure base and experience the therapist as a safe and available figure.

An increase in reflective functioning capacity in patients with borderline personality disorder was found by Diamond *et al* (2003) following one year transference-focused psychotherapy. There was also a move from insecure to secure-autonomous classification on the Adult Attachment Interview (AAI; George, Kaplan and Main, 1985) with greater narrative coherence although no improvement for resolution of loss or trauma. Increased narrative coherence might not mean that

patients are securely attached (Eagle, 2006) or able to relate to a current attachment figure without perpetuating self-destructive behaviours (Levy, Kelly, Meehan, Reynoso, & Weber, 2006). Increased reflective function might indicate a greater capacity to explore one's state of mind relating to attachment rather than an actual change.

The Patient-Therapist Adult Attachment Interview (PT-AAI) was used by Diamond *et al* (2003) to measure changes in reflective function over the course of one year's therapy (see Table 5, p. 64). Attachment within the psychotherapeutic relationship is bi-directional and Diamond *et al* explored the therapist's reflective function, showing how both patient and therapist influence each others' reflective capacity. For one patient-therapist dyad, the level of reflectivity remained low throughout therapy, which is argued to be unhelpful in instigating psychic change. Another therapist appeared to adjust his mentalization to the level of the patient. Diamond *et al* conclude the therapist should be slightly ahead of, but not too far ahead of, the patient in mentalisation capacity for the best outcomes.

The development of greater awareness of emotional needs and previous hurt might also impact on completion of other self-report outcome measures such as the CORE-OM. Those previously defended against thoughts and feelings will become more accessible through therapy and the development of greater reflective functioning. This often results in higher scores on post-therapy CORE-OMs which might erroneously be taken as "reliable deterioration" (Jacobson and Truax, 1991) and a concern that therapy or therapist has not been effective.

## 2.5 Summary

In this chapter, patient and therapist attachment styles were considered in relation to psychotherapy. Difficulties with treatment compliance, help seeking behaviours and capacity to be self-disclosing were associated with a dismissing-avoidant attachment style (Dozier, 1990). Whilst dissimilarity of therapists and patients on deactivating/hyperactivating dimension has been seen to be associated with better outcomes in a study where the clinicians were not trained therapists (Tyrrell *et al*, 1999), this might not be so with psychotherapists. It raises the question whether the impact of therapeutic training and personal therapy will moderate this association.

Therapists' security of attachment, ego strength and flexibility were seen to be essential for engagement of patients within therapy, for the provision of a Secure base, for effective challenging of patients' relational models, for sensitive and deep interventions and for successful countertransference management. Whilst the evidence for interactional effects between patient and therapist attachment styles is mixed, it is possible that concordance of security in therapist/patient dyad will give better therapeutic outcomes.

Again the empirical evidence for outcome and association with attachment style appears mixed. Studies which found that dismissing patients achieved better outcomes tended to be of greater duration, intensity and depth.

## Chapter 3

### The Working Alliance

*“The inescapable fact of the matter is that the therapist is a person, however much he may strive to make himself an instrument of his patient’s treatment.”*

*Orlinsky and Howard, (1977)*

The therapist is frequently absent from evidence-based psychotherapy although there is a considerable body of research which shows the importance of the therapy relationship for successful psychotherapeutic outcome (Norcross, 2002). Norcross argues that there is a neglect of the therapy relationship and therapist interpersonal skills in validation studies of treatment efficacy. Whilst manuals and reports state the importance of the therapy relationship, few ever specify which therapist behaviours contribute to establishing and maintaining a beneficial relationship (Norcross, 2002).

In this chapter, the concept of the working alliance is explored, briefly looking at the development of measurement of the alliance within psychotherapy and considering some of the empirical evidence that locates it as a critical factor in outcome.

### ***3.1 Origins of the Concept***

The concept of the working alliance began with Freud (1912) who suggested that there was an “analyst” in the patient who supports the healing within therapy. Freud described a “reality-based collaboration” between analyst and patient, distinguishing between the distorted transference relationship and a more collaborative, affectionate, friendly and conscious relationship. For, as Freud stated, ‘It remains the first aim of treatment to attach him (the patient) to it (the process of analysis) and to the person of the doctor’ (Freud, 1913, pp. 139).

Freud (1912, p.139) also draws attention to the importance of the analyst’s attitude: “If one exhibits a serious interest in him (the patient), he will of himself form such an attachment (to the person of the therapist)”. Freud viewed the alliance as facilitative, recognising its importance for successful analytic interpretations, enabling the patient to use such interpretations, and the analyst to formulate further interpretations. The alliance may be conceptualised as providing the optimum context within which interventions can be mutative.

This view of the alliance as facilitative is seen again in the work of Sterba (1934) who described the working alliance as an Ego alliance where a “reasonable part” of the patient is allied with a reasonable part of the therapist. Described as an ego-observing process rather than a transference relationship, Sterba saw maturity of ego-functioning and identification with analyst as necessary conditions for its development.

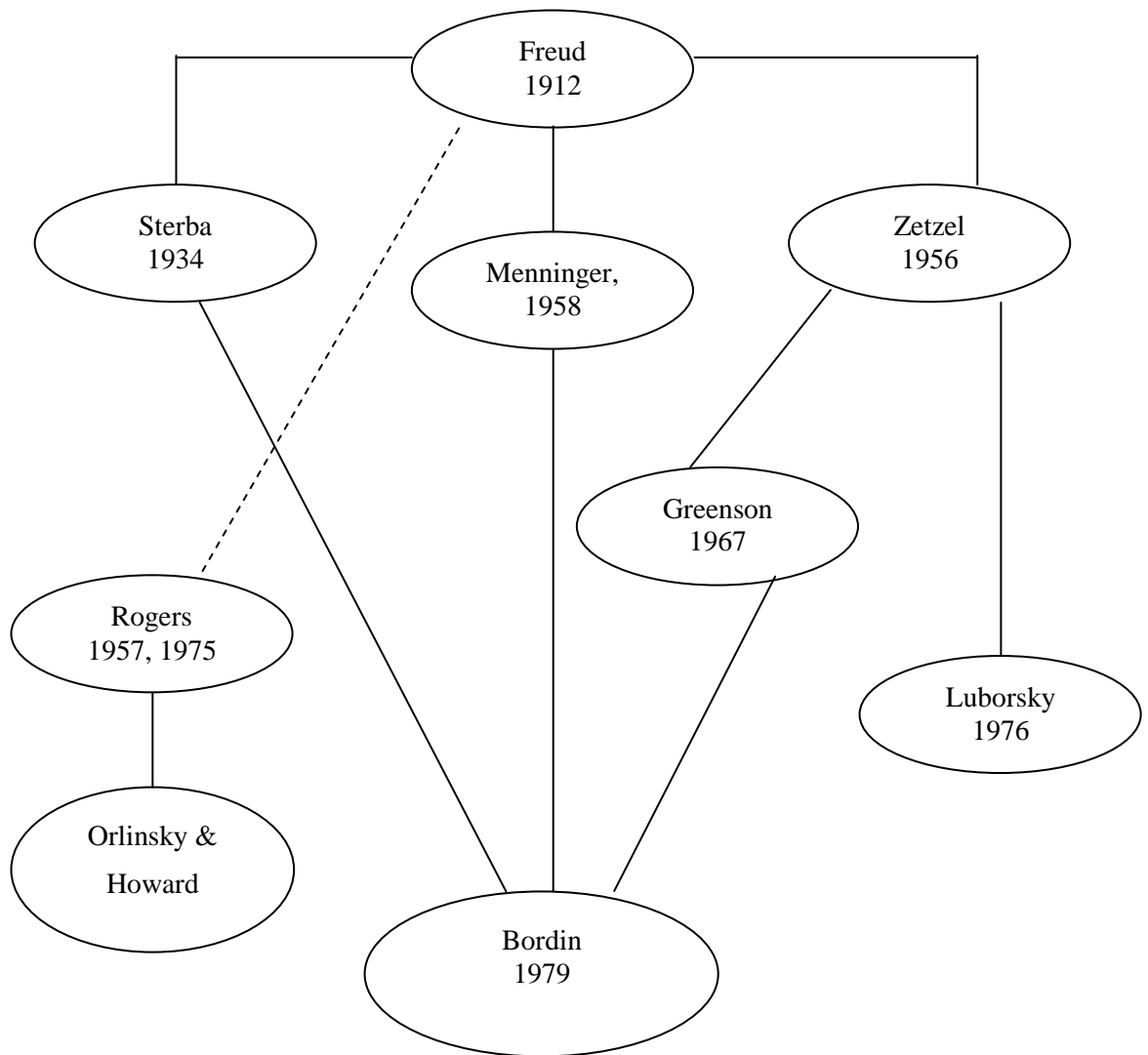


Figure 2 Development of the Concept of the Alliance

Zetzel's (1956) "therapeutic alliance" was facilitative and conceptualized as a repeat of the satisfying aspects of an earlier mother/infant relationship with an attachment to and identification with the analyst. Zetzel focused more on the technical aspects of the alliance in furthering successful analysis, arguing that it allows the patient to step away and differentiate transference distortion and the real relationship. She believed that, in a successful analysis, there are times when the

relationship is dominated by the transference and others times when it is the alliance that comes to prominence. Like Sterba (1934), Zetzel also drew attention to those patients with immature ego functioning for whom analysts might need to adapt their techniques in order to facilitate engagement. Patients who do not trust easily might need more supportive interventions to develop attachment to therapist and subsequent ability to work in therapy. This foreshadows the work of Bowlby (1988) on attachment and psychotherapy, and Bateman and Fonagy (2004) on mentalising capacity.

Moving away from the psychoanalytic framework of Freud, Sterba and Zetzel, Rogers' (1957) person-centred framework held that the alliance is the main ingredient in psychotherapeutic change and the relationship is curative in itself. Rogers claimed that the therapist-offered conditions of empathy, congruence and maintenance of unconditional positive regard were necessary and sufficient conditions for patient improvements. These conditions are not, however, a definition of the relationship but describe components of effective therapy rather than the therapist-patient interaction (Gelso and Carter, 1994). Other research on the Rogerian concepts of empathy, congruence and unconditional positive regard demonstrated that it is the patient's rather than the therapist's perception of the alliance that is associated with effective therapeutic outcome (Mitchell, Bozart and Krauft, 1977).

1967 saw a return to a more psychoanalytic framework for conceptualising the working alliance with Greenson's view that whilst the alliance was facilitative, it was not the main condition for psychotherapeutic outcome (Greenson, 1965). In

developing Zetzel's (1956) and Sterba's (1934) work, Greenson described a working alliance, a reality-based collaboration, as the patient's capacity to work on the task of therapy. Greenson proposed a three component model – transference, working alliance and the real relationship. This therapeutic alliance, which relates to the ability of therapist and patient to forge an affectionate bond, included affectionate, realistic feelings towards the therapist (Greenson, 1965). He acknowledged the difference of this from the transferential relationship with its misperceptions. Greenson suggested that the alliance enables the patient to remain working in therapy when transferential feelings are intense thus echoing Zetzel's ideas about enabling the patient to step back and observe the relationship and again foreshadowing Bateman and Fonagy's work on mentalising. This alliance is intrapersonal in theoretical framework.

Taking the alliance further from its dynamic beginnings, Luborsky (1976) took in relational elements of other therapies. Luborsky regarded the alliance as facilitative and he conceptualised it as a bridge between conscious/reasonable and unconscious/transferential positions. He argued that the alliance developed in two stages. Initially the patient believes the therapist will help and the therapist provides a warm holding relationship. The second stage incorporates the patient's investment in therapy, their continued motivation and ownership of process. Luborsky also suggested that the patient's perception of the therapist's helpfulness is part of the alliance although this might be argued to be distorted by transference.

The theoretical discussions regarding the role of the alliance were brought together by Bordin's (1979) pantheoretical interpersonal model. Bordin, whilst

seeing the alliance as facilitative, was more aligned with seeing it as an active ingredient of therapy. Bordin differentiated between the two traditions that had previously contributed to the development of the concept of a working alliance. One strand emanated from the idea of alliance between analyst and the patient's rational ego (Sterba, 1934) and the importance of the therapeutic contract (Menninger, 1958). A second strand emerged from the work of Zetzel (1956) and Greenson (1965) highlighting the importance of the real relationship in psychoanalytic therapies. Bordin postulated a pantheoretical concept including the effective components of the therapeutic relationship and called this the working alliance. Bordin's conceptualisation moved further away from the alliance's dynamic roots than did Luborsky's. He suggested it is basically collaborative with three components – the bond between patient and therapist, the agreement on goals and the agreement on tasks. The bond element captures the affective component described by Freud, Zetzel and Greenson whilst the goal and task agreement can be thought to be more cognitive and collaborative.

Bordin argued, as had Freud, Sterba and Zetzel, that successful therapy becomes possible because the alliance “makes it possible for the patient to accept and follow treatment faithfully” (Bordin, 1980, p. 3). He also proposed that, over time in therapy, the strength of the alliance would wax and wane with the repair of ruptures an essential part of the therapy process, an idea later elaborated by Safran (1993) and Safran and Muran, (1996).

The interactional effects of patient and therapist needs were seen by Bordin to be an important part in the development of the quality of the working alliance. Suggesting that personal characteristics of the therapist would possibly draw them

more to one therapeutic model than another, Bordin argued that any differences in the alliance might reflect either patients' or therapists' capacity to cope with that particular alliance. Others have argued that the relationship between patient and analyst is entirely transference and, as such, there is no validity in a concept such as a working alliance (Brenner, 1979). Indeed, Curtis (1979) argues that in espousing the concept of a working alliance, there is a risk that focus in analysis might move away from the core analytic concepts of unconscious intrapsychic conflict, free association and interpretation of transference and resistance.

Gaston's comprehensive review (1990) identified four reasonably independent dimensions which form the alliance: the patient's capacity to work in therapy, the affective bond between patient and therapist, the therapist's empathic understanding and involvement, and the agreement of patient and therapist on the treatment goals and tasks. Whilst this mostly corresponds to the Bordin pantheoretical construct, Gaston includes separately the empathy, understanding and involvement of the therapist.

### ***3.2 Measurement of the Alliance***

Over time, various measures of the alliance have been developed to reflect theoretical understanding of its conceptualisations. These have been extensively reviewed elsewhere (Martin *et al*, 2000; Elvins and Green, 2008). Whilst the alliance measurement scales were developed independently by various research groups, they are highly correlated (e.g. Hatcher & Barends, 1996).

The Working Alliance Inventory (WAI; Horvath and Greenberg, 1989) was designed to capture the three dimensions of Bordin's working alliance – the bond, the agreement on goals and agreement on tasks. Patient, therapist and observer versions of the form were developed.

For some the distinction between working alliance and transference relationship is false (Brenner 1979; Curtis, 1979) and indeed, Bordin argued that measures of the working alliance could be “heavily loaded with transference” (Bordin, 1994, p.16). Others have highlighted the fact that, although studies often use different measurement scales to rate the alliance, therapists and patients seem to consistently rate it highly. Tyron, Blackwell and Hammel (2008) examined studies ranging over a seventeen year period in which the working alliance was rated by both therapists and clients. They found that, on average, therapists tended to use solely the top 30% of rating scale points of any instrument, whilst their clients used only the top 20% suggesting that both might have difficulty in discriminating lower rating points of scales including the Agnew Relationship Measure (ARM; Agnew-Davies *et al*, 1998) and the Working Alliance Inventory (WAI; Horvath and Greenberg, 1989). The authors suggest that this finding might occur due to lower rated alliances being associated with premature drop-out: in other words, the client had discontinued therapy before the alliance could be rated. Alternatively, response distortions including acquiescence or social desirability (Lanyon and Goodstein, 1997) might be the cause. Tyron *et al* conclude that if both therapists and clients used the full range of points on any scale, a less restricted range of alliance scores would result and this could lead to a larger relationship between alliance and outcome.

### **3.3 Association alliance and outcome**

Empirical evidence shows association between the working alliance and therapy outcome. Three major reviews consider this substantial body of research; Horvath and Symonds (1991) found an overall effect size of .26 ( $n$  24), and Martin, Garske and Davis (2000) found an overall effect size of .22 ( $n$  79). Horvath and Bedi (2002) found that the average relation between the alliance and outcome was .21 (weighted by sample size). The median effect size was .25.

Horvath and Bedi considered potential moderators in the alliance-outcome relationship. They suggest that in empirical research, the alliance is necessarily operationalised by the actual alliance measure used. However, they did not find statistically significant differences across studies. Therapist-rated outcome was slightly more related to alliances than either client or observer rated outcome. Client and observer rated alliance have similar relationships to outcome although therapist-rated alliance and outcome appear less related. Although alliance –outcome assessments arise from the same source, bias due to halo effect does not appear (Horvath and Bedi, 2002). Most alliance measurements were taken early between sessions 1 and 5: Early: ES ( $n$  130) .22; Mid: ES ( $n$  38) .19; Late: ES ( $n$  42) .25; Multiple measurement averaged: ( $n$  68) .26

The relationship between alliance and outcome has been shown to be moderated by both client and therapist factors. Severity of disorder may diminish the quality of the alliance (Gaston, Thompson, Gallagher, Cournoyer and Gagnon, 1998; Zuroff *et al*, 2000) whilst in other studies there was less difference between severe and less-severe disorder in patients (Gaston, Marmar, Thompson and Gallagher ,

1991; Joyce and Piper, 1998; Orlinsky, Grawe and Parks, 1994). Experience of therapists interacts with severe disorder and alliance quality (Kivlighan, Patton and Foote, 1998).

Patients' ability to form an alliance is affected by the quality of object relations (Henry and Strupp, 1994; Hersoug *et al*, 2001) and attachment style (e.g. Eames and Roth; 2000; Rubino, Baker, Roth and Fearon, 2000; Satterfield and Lyddon, 1995; Sauer, Lopez and Gormley, 2003).

The therapist brings qualities to the development of the alliance and whilst some may be the result of training, others will bear the imprint of the therapist's earliest history of relationships (Black *et al*, 2005; Dunkle and Friedlander, 1996; Rubino *et al* , 2000).

The ability to respond sensitively and appropriately to a patient, and to maintain this sensitive responsiveness when dysfunctional relational patterns emerge, reflects the therapist's interpersonal skills. Interpersonal skills will enable the therapist to deal effectively with negative transferences and to recognise and repair ruptures to the alliance (Leiper and Casares, 2000; Safran and Muran, 1996; Safran, Muran, Samstag and Stevens, 2002). The capacity to show understanding of a patient's subjective experience and the ability to respond empathically with sensitivity to a patient's tolerance for this kind of intervention contribute to the quality of the alliance (Diamond *et al*, 2003; Zuroff *et al*, 2000). Negative therapist behaviours in response to difficulties within the therapy relationship reflect the loss of sensitivity and can appear as prematurely given interpretations (Henry *et al*,

1994), coldness and withdrawal (Hersoug *et al*, 2000) and irritability (Sexton, 1996). The relationship between therapist experience and the alliance has been found to vary across studies. Dunkle and Friedlander (1996) found that whilst experience of therapist was not predictive of outcome on goals and tasks, personal characteristics were associated with early stage emotional bond. Kivlighan *et al*, (1998) found however, that patient attachment style moderated the relationship between counsellor experience and outcome. Therapists with more experience appear to be more able to form a good alliance with patients with intimacy difficulties (Kivlighan *et al*, 1998) which might reflect their increased ability to recognise and repair alliance ruptures.

Henry and Strupp (1994) suggested that therapist's earliest relational histories may create difficulties in that they create a "destructive interpersonal process" which involved therapist self-directed hostility as well as hostile and controlling behaviour towards patients. These intrapersonal difficulties have been studied by researchers including Dunkle and Friedlander (1996) and Leiper and Casares (2000).

A positive alliance has been associated with complementarity of patient and therapist with interactions that are complementary rather than competitive, autonomy-encouraging rather than controlling (Henry and Strupp, 1994).

Whilst collaboration is seen as one of the basic aspects of the working alliance, Horvath and Bedi highlight the paucity of empirical evidence which would allow us to conclude a causal relationship. Alliance measures used in the evaluation of the working alliance tend to focus on the felt experience of collaboration and questions of objectivity and reliability are raised.

### ***3.4 Timing of Alliance Measurement***

The quality of the alliance fluctuates over time (Bordin, 1981; Horvath *et al*, 1993; Stiles *et al*, 1998) which highlights the dilemma of timing alliance measurement. Evidence supports the advisability of early measurement – Horvath and Bedi (2002) claim that there is “critical window” in sessions 3-5 and that, if the alliance is not established by session 5, then successful outcome is less likely. Kivlighan and Shaughnessy (1995) found, however, that later alliance measurement is related to client-rated therapeutic outcome with Stiles *et al* (1998) also finding it more strongly correlated with outcome, and arguing that early alliance-outcome correlation reflects early outcome changes. There are two phases to the development of the working alliance (Horvath *et al*, 1993) with a period of establishment during sessions 1-5 or Type 1, and a second phase, Type 2, where the patient’s resistance is confronted leading to variations in alliance strength. Late ratings have shown large and significant client and therapist correlations (Kivlighan and Shaughnessy, 1995) which suggest that, over time, clients and therapists come to perceive the quality of the alliance similarly.

Within therapy the exploration of problems associated with establishing and maintaining the alliance can help patients change. The inevitable ruptures in the therapeutic alliance provide important opportunities for both patient and therapist to clarify characteristic patterns of perception and relating (Safran 1993). Alliance ruptures are part of the human existential dilemma for, whilst we may desire interpersonal connection, we have to face the reality of our separateness (Safran 1993). Healthy developmental processes enable the individual to accept the independent existence of the other.

Empathic and affective misattunement occurs within mother-infant dyads and for optimal development, such misattunements must be dealt with. Repeated movement between misattunement and repair enables infants to develop adaptive interpersonal skills. Within therapy, interpersonal difficulties lead to alliance ruptures but by learning how to repair such ruptures alongside the therapist, the patient will begin to experience themselves as someone who can “negotiate relatedness” (Safran, 1993). The therapist’s ability to repair alliance ruptures has been shown to be associated with attachment style of therapist (Rubino, Barker, Roth and Fearon, 2000). Therapists with hostile introjects appear more likely to respond countertherapeutically rather than repair the rupture (Henry and Strupp, 1994).

Whilst agreement on goals and tasks, development of a bond reflecting care and trust, and the sense of collaboration may be associated with early stages of therapies, there are likely to be changes in a mature therapy where the ability to reflect critically and thoughtfully on the therapist-patient here-and-now relationship becomes part of the therapeutic discourse.

### ***3.5 Summary***

Whilst some writers have conceptualised the alliance as representing just one construct (Sterba, 1934; Zetzel, 1956), others have argued that it comprises several independent dimensions (Bordin, 1979; Luborsky, 1976). Definitions of the alliance vary with some seeing it as the patient’s bond with the therapist and their perception of the therapist’s helpfulness (Luborsky, 1976) whilst others claim that the alliance should be defined in terms of the patient’s collaboration with the therapeutic tasks

(Bordin, 1979). Lack of consensus regarding definition and conceptualisation is mirrored by the variety of names used to describe the different aspects – therapeutic alliance, working alliance, therapeutic bond and helping alliance.

The debate continues as to whether the alliance is interpersonal or intrapersonal, and the extent to which therapists' own relational histories and personalities interact and influence the alliance (Henry and Strupp, 1994). Whilst the alliance has usually been conceptualised as something different to and separate from technique, it is through therapeutic technique that a patient becomes engaged in the work of therapy allowing the emergence of an alliance between patient and therapist. (Black, Hardy, Turpin, and Parry, 2005; Dunkle and Friedlander; 1996; Leiper and Casares, 2000; Sauer, Lopez, and Gormley, 2003 ). Empathic understanding, reflection of feelings and the encouragement of hope enable the patient to feel listened to and understood and facilitate engagement.

Acknowledgement of both patients' and therapists' history of relating and its impact on the alliance can be explored further using the framework of attachment theory.

## Chapter 4

### Attachment Style and the Working Alliance

*“The first (task) is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of life, past and present ...” Bowlby 1988, pp 156*

Bowlby (1988) described five tasks for psychotherapy, the first of which was for the therapist to act as a Secure base to enable the patient's self-exploration to occur and to encourage them during exploration. This concept of a Secure base was similar to that of Winnicott's "holding" (1965) and Bion's "containing" (1962/1983). By examining past, current and transference relationships, Bowlby suggested that the patient is helped to reconstruct her working models of self and attachment figures and is "less under the spell of forgotten miseries and better able to recognise companions in the present for what they are." (Bowlby, 1988, pp.155). There is an implicit assumption that the therapist is able to function as a "secure base" (Eagle, 2006) and is able to be emotionally available for the patient to use as an attachment figure. Therapists bring with them old patterns of relating and within the intensity of the therapeutic relationship, may struggle not only with their patient's maladaptive relational strategies but also with their own counter-transference vulnerabilities. More recent studies (e.g. Bateman and Fonagy, 2004) have emphasised the importance of emotion regulation and mentalisation as a protective factor for individuals who have endured harsh childhood experiences. Seen as an extension of internal working models, mentalisation is essential for social interaction and enables survival of misattunement and failures of parenting. Mentalisation capacity allows patients to cope with alliance ruptures within therapy.

In this chapter, the impact of either therapists' or patients' attachment style on the establishment, maintenance and repair of the therapeutic alliance is explored.

#### ***4.1 The Establishment of the Working Alliance***

The patient's comfort with intimacy is associated with a positive alliance (Kivlighan, Patton, and Foote, 1998; Mallinckrodt, Coble, and Gantt, 1995). Mallinckrodt *et al* (1995) predicted that adult social competencies would affect the quality of the working alliance (see Table 6). A correlational questionnaire design was used with convenience sampling which arguably introduces the possibility of self-select bias and lower generalizability. No information was provided on therapists' characteristics which could be a confounding variable.

Only moderate support was found for the hypothesis that positive memories of parental attachment would be associated with high levels of social competencies as measured by completion of the social subscale of The Self-Efficacy Scale (Sherer, *et al*, 1982). Attachment memories and working alliance were strongly associated with paternal bonds being stronger predictors of alliance than maternal bonds. Patients' estimates of their ability to form attachments in adulthood, ascertained by The Adult Attachment Scale (AAS; Collins & Read, 1990) were found to be good predictors of their capacity to form a working alliance.

Table 6

*Empirical Studies Attachment, Development and Maintenance Working Alliance*

Author	N	Measure	Results
Mallinckrodt <i>et al</i> 1995	76	WAI <sup>1</sup> AAS <sup>2</sup>	Client willingness to be closely attached predictive of positive alliance ( $\beta$ .30, $t$ (62) = 2.44, $p$ < .05). Client fears of abandonment predictive of poor working alliance ( $\beta$ -.37, $t$ (62) = 3.66, $p$ < .01).
Satterfield & Lyddon 1995	60	AAS WAI	Depend dimension (AAS) positively correlated with global working alliance score, $r$ = .31, $p$ < .01.
Kivlighan <i>et al</i> 1998	40	WAI AAS	Moderation by Client attachment style on relationship between Therapist experience and Client perception of working alliance. Client scores on Close & Depend scales significantly related to total WAI, $r$ = .35, $p$ < .05 & $r$ = .38, $p$ < .05. Hierarchical regression: Close dimension significant, $t$ (32) = 3.30, $p$ < .01; Experience by Close dimension $t$ (32) = 3.82, $p$ < .01
Dunkle & Friedlander 1996	73	WAI Intrex <sup>3</sup> AAS	Clients whose therapists claimed less self-directed hostility, more social support & more comfort with intimacy, more likely to report strong emotional bond in early phases of treatment, $R$ = .57, $R^2$ = .32, $F$ (6,66) = 5.17, $p$ < .0002. Client perception of WAI 'goal' & 'task' not associated with therapist experience.
Kanninen <i>et al</i> 2000	50	AAI <sup>4</sup> WAI	No differences between attachment groups in early alliance ratings. Secure group: alliance dropped in middle of therapy, increased to initial level by the end. Pre-occupied group: alliance steep decrease in the middle then increased more steeply at the end of therapy. Dismissive group: alliance remained the same over therapy decreasing at end.
Saatsi <i>et al</i> 2007	94	BDI <sup>5</sup> IIP <sup>6</sup> WAI	Secure interpersonal style predicted client-rated alliance ( $F$ (1, 85) = 5.91. $p$ < .05) Secure interpersonal style affected BDI final score ( $\Delta r^2$ = .06, ( $F$ (1, 79) = 5.81. $p$ < .05) Client rated alliance predicted outcome over pretherapy status ( $\Delta r^2$ = .23, ( $F$ (1, 79) = 27.93. $p$ < .001).

<sup>1</sup>Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)<sup>2</sup>Adult Attachment Scale (AAS; Collins & Read, 1990)<sup>3</sup>INTREX Introject Questionnaire (Benjamin, 1982,1983)<sup>4</sup>Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)<sup>5</sup>Beck Depression Inventory (BDI; Beck & Steer, 1987)<sup>6</sup>Inventory of Interpersonal Problems (IIP; Horowitz *et al*, 1988)

Although both Kivlighan, Patton, and Foote, (1998) and Mallinckrodt *et al* (1995) concluded that the patient's comfort with intimacy was associated with a positive alliance, Satterfield and Lyddon (1995) argued that the patient's perception of the availability and dependability of the therapist might be more important in the formation of the early alliance (see Table 6, p. 86). Examining the relationship between the three dimensions of client attachment and their ratings of the working alliance, the alliance was assessed at the third session using the WAI. Attachment classification was done through use of the Adult Attachment Scale. Satterfield and Lyddon found that the Depend dimension of the AAS was positively correlated with the global working alliance score. Clients' negative evaluation of the working alliance during the early phase was associated with a lack of trust.

In a study in which therapists' interpersonal style was not explored, Saatsi, Hardy and Cahill (2007) hypothesised that the alliance would mediate the relationship between patient interpersonal style and therapy outcome (see Table 6, p. 86). In a study of 94 patients, they found that there were significant differences between interpersonal groups (assessed by completion of IIP) on the final BDI scores, with the secure group having the largest proportion of patients who showed clinically significant and reliable change. However, it is worth noting that they also found significant between- group differences for intake scores on the Beck Depression Inventory (BDI; Beck & Steer, 1987). Using Scheffé's post hoc range test, Saatsi *et al* found that the secure group ( $M = 24$ ,  $SD = 8.76$ ) had significantly lower pre-therapy BDI scores than either the avoidant group ( $M = 33.15$ ,  $SD = 9.16$ ,  $p < .005$ ) or the ambivalent ( $M = 35.72$ ,  $SD = 9.62$ ,  $p < .001$ ).

Between-group differences in the Working Alliance Inventory ratings just failed to reach significance, although Secure group clients appeared to rate the alliance higher than the insecure groups. Whilst the alliance was associated with outcome for the entire client sample, and for the avoidant and the ambivalent groups, it did not reach significance for the secure group. The alliance mediated the relationship between interpersonal style and outcome with secure interpersonal style predicting and affecting outcome, and client-rated alliance predicting outcome.

#### ***4.2 Therapists' Experience and the Working Alliance***

In view of contradictory findings relating to counsellor experience and working alliance, (Mallinckrodt *et al*, 1995; Dunkle and Friedlander, 1996), Kivlighan, Patton, and Foote, (1998) hypothesised that client attachment status would moderate the relationship between counsellor experience and client-perceived working alliance (see Table 6, p.86). The authors acknowledged the limitations of the study in terms of correlational design, self-report measures and non-randomisation. The 40 counsellors were classified according to experience, following Dunkle and Friedlander's operationalisation of experience as a continuous variable showing clinicians' years of clinical practice. No agreed definition of experience seems to exist in the literature (Kivlighan, Patton, and Foote, 1998) and it might be argued that there is a confabulation of experience with professional training and years of clinical practice. The Adult Attachment Scale (AAS; Collins & Read, 1990) was given before therapy and the Working Alliance Inventory (WAI; Horvath & Greenberg, 1986, 1989) was given following session 3. In this study therapists did

not complete the WAI, so there appeared to be no consideration of what therapists bring to the development of the alliance. The relationship between counsellor experience and client perception of working alliance was moderated by client attachment style. Discomfort with intimacy in clients was associated with positive perception of the alliance. Clients' scores on Close and Depend scales were significantly related to total WAI. More experienced counsellors got better outcomes than less experienced counsellors when challenging patients.

In a study looking at the impact of therapists' characteristics on alliance development, Dunkle and Friedlander (1996) found that clients whose therapists reported less self-directed hostility, more social support and greater comfort with intimacy were more likely to report a strong emotional bond in early phases of treatment (see Table 6, p. 86). The authors argued that this might mean that hostility is communicated in some way to clients. Therapists' experience was not found to be predictive of clients' ratings on goal and task when these were rated in the early stages of alliance development. Dunkle and Friedlander acknowledge that *ex post facto* design does not allow causal inferences, that interactional effects were not measured and their study had a low response rate. However, it did draw attention to the ways in which therapist characteristics might be more important in the early stages when the bond was being developed although the attachment style of patients was not ascertained.

### ***4.3 Development of the Working Alliance***

Kanninen, Salo, and Punamäki (2000) studied the nature of political torture and the subsequent impairment of survivors' ability to trust others, and its impact on the establishment and development of the alliance (see Table 6). Whilst Kanninen *et al* found no difference between the three attachment groups and relationship to the therapeutic alliance at the beginning of the trauma therapy, the results suggest that the alliance developed differently across groups. In secure patients, the alliance dropped in the middle but increased to the initial level by the end of therapy whilst in preoccupied patients, the alliance decreased steeply in the middle and then increased even more steeply towards the end. With dismissive patients, however, the alliance remained the same across therapy until it decreased at the end. Attachment style was measured using an adaptation of the Adult Attachment Interview and the WAI was used to assess alliance after session 3, middle and last sessions. Kanninen *et al* suggest that early development of the alliance might be determined by therapists' "reality-based action" whilst over time, the alliance was influenced by patients' habitual ways of relating. It is possible that the early establishment of a working alliance reflects therapist characteristics which were not ascertained in this study but which were studied in Dunkle and Friedlander (1996) (see section 4.2, p.88) and Rubino *et al* (2000) who found that attachment anxiety in therapists was related to the alliance at the beginning of therapy (see Ch. 2.3 p.55 and Table 2, p.54).

#### ***4.4 Difficulties Within the Alliance***

Eames and Roth (2000) explored whether attachment style was associated with ratings of the quality and development of the alliance over time and whether attachment style was associated with frequency of rupture reports (see Table 7, p.94). A naturalistic design utilising data-collection as part of treatment-as-usual was used involving eleven therapists, nine of whom were qualified, and thirty patients. The Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) and the WAI were used and ruptures measured by an unpublished self-report measure based on one developed by Safran. The WAI and Rupture measure were given at the end of sessions 2, 3, 4, and 5 and therapists also completed the measures at these times.

Fearful attachment was negatively correlated with alliance. Patient-ratings were significant for the WAI Task subscale at session 3, and then at session 5 for the Global Alliance score and for the Goal and Task subscales. Therapist ratings of the Goal subscale were significant at session 2. Secure attachment was positively correlated with the alliance, with therapist-rated Global Alliance score and therapist-rated Bond subscale both reaching significance at session 5. The Preoccupied/enmeshed style was negatively correlated with the alliance but this failed to reach statistical significance. The Dismissing dimension was positively correlated with the alliance with significant patient-ratings for the Goal subscale at session 3. Therapists reported more ruptures than patients – reporting tension in 43% sessions compared to patient reports of 17% sessions - and there was a highly significant positive correlation between preoccupied attachment style and rate of therapist reported ruptures. There was a significant negative correlation between

dismissing attachment style and rate of therapist reports of alliance ruptures.

Correlation between patient-reported ruptures and attachment dimensions did not reach statistical significance. These results were inconclusive and Eames and Roth suggest that high preoccupation/low dismissingness might be associated with higher awareness of tension in the therapeutic alliance.

Fearful attachment style was associated with lower alliance ratings and security of attachment with higher therapist-rated alliance. This was congruent with Satterfield and Lyddon's (1998) findings that the development of the alliance might be impaired by attachment anxiety and avoidance of intimacy (see Section 4.1, p.85). Eames and Roth suggest that their results might indicate that attachment concerns become more important to the development of the alliance over time which was found to be so in the 2000 study by Kanninen *et al* (see Section 4.3, p.90). Small sample size and opportunistic sampling limit generalisability and therapists' attachment style was not measured.

Hardy, Stiles, Barkham and Startup (1998) argued that clients' interpersonal styles are reciprocal and may have powerful effects on treatment (see Table 7, p.94). They operationalised interpersonal style as over-involved (anxious-ambivalent) or under-involved (avoidant) based on Hazan and Shaver's (1987) classification of attachment style. Hardy *et al* (1998) claimed that alliance quality and outcome can be predicted by the therapists' "appropriate responsiveness" to clients' needs. Over-involved patients were thought to form intense early attachments to therapists whilst underinvolved patients may engage slowly; poor alliances and outcomes would reflect responsiveness failures. The Therapist Session Intentions (TSI; Stiles *et al*, 1996) was used to ascertain therapeutic intentions. The TSI comprises nineteen

items forming seven scales or “foci of intentions” which are Treatment Context, Session Structure, Affect, Obstacles, Encouraging Change, Behaviour and Cognition-Insight. It is completed by therapists immediately following each session to elicit a retrospective classification of the therapist’s interventions from the therapist’s perspective. The TSI can be used with a wide range of theoretical approaches. Results showed that therapists reported significantly more use of TSI Obstacles with over-involved patients – the Obstacles items relate to therapists’ efforts to work with alliance ruptures or to confront other interpersonal difficulties within the therapy. With over-involved patients, therapists made significantly more use of Affect items – TSI Affect items include use of experiential work and the encouragement of patients’ emotional experiencing.

In this study, CB Therapy was more behavioural in emphasis than cognitive therapy (Hardy, *et al*, 1998) whilst PI Therapy was based on Hobson’s Conversational Model (Hobson, 1985; cited Hardy, *et al*, 1998). In CB treatments, therapists used more behavioural or cognitive interventions with underinvolved patients (Hardy, *et al*, 1998). Using the Session Evaluation Questionnaire (SEQ; Stiles *et al*, 1994), the impact of therapy sessions was assessed in terms of depth and smoothness, and by post-session evaluation of therapists’ levels of positivity and arousal. The only significant interaction was a 3-way interaction on SEQ Depth subscale. This subscale measures the perception of sessions as “powerful” or “valuable”. The post-session mood of therapists differed depending on the patients’

Table 7  
Difficulties Within Working Alliance

Author	N	Measure	Results
Hardy <i>et al</i> 1998	11 4  79	Hazan & Shaver's style. <sup>1</sup> TSI <sup>2</sup> SPRS <sup>3</sup> ARM <sup>4</sup>	More use TSI Obstacles focus, $F(2, 102) = 5.42, p = .006$ , & TSI Affect focus, $F(2, 102) = 2.97, p = .056$ with over-involved patients. No significant main effects of interpersonal style on Client or Therapist ARM scale scores. Interpersonal Style x duration interaction effect on clients' openness, $F(2, 65) = 5.01, p = .009$ . Therapist perception of openness, $F(2, 65) = 2.55, p = .085$ . Underinvolved Client significantly higher in 16 session condition, $F(1, 16) = 7.50, p = .015$ (client ratings), $F(1, 16) = 4.60, p = .048$ (Th. ratings). 3-way interactions on Client & Therapist rated ARM Partnership scale, $F(2, 65) = 3.99, p = .023$ , for Client, and $F(2, 65) = 3.44, p = .038$ for Therapist, and on Therapist rated ARM Client Initiative scale, $F(2, 65) = 4.33, p = .017$ .
Eames & Roth 2000	30	RSQ <sup>5</sup> WAI <sup>6</sup> Ruptures unpub. self-report measure	Fearful attachment negatively correlated with alliance – Client ratings session 3 'Task' $R = -.46, p < .05$ . Session 5 global alliance score, $R = -.52, p < .05$ , 'goal', $R = -.49, p < .05$ task, $R = -.48, p < .05$ . Therapist ratings 'goal' session 2, $R = -.40, p < .05$ . Secure attachment positively correlated with alliance – Therapist rated global alliance score significant session 5, $R = .42, p < .05$ , & Therapist rated 'bond' session 5, $R = .44, p < .05$ . Dismissing attachment positively correlated with alliance, significant session 3 for Client ratings of 'goal', $R = .45, p < .05$ . Preoccupied and Dismissing attachment associated with improvement in alliance ratings over time. Preoccupied attachment associated with Therapist reported ruptures, $R = .50, p < .01$ . Dismissing attachment negatively correlated with Therapist reported ruptures, $R = -.42, p < .05$ .
Black <i>et al</i> 2005	49 1	ASQ <sup>7</sup> ARM PCL <sup>8</sup>	Therapist secure attachment correlated with Therapist reported general good alliance, (confidence scale & mean ARM score), $r = .441, p < .001$ . Therapist insecure attachment correlated with number therapist reported therapy problems. Discomfort with closeness, $r(459) = .252, p < .001$ , Relationships as secondary, $r(463) = .165, p < .001$ . Need for approval, $r(464) = .165, p < .001$ , Preoccupation with relationships, $r(464) = .322, p < .001$ . Therapeutic orientation predicted general alliance score (psychodynamic or not), $\beta = -.024, p < .001$ .

<sup>1</sup>Hazan and Shaver's classification of attachment style.

<sup>2</sup>Therapist Session Intentions (TSI; Stiles *et al* 1996)

<sup>3</sup>Sheffield Psychotherapy Rating Scale (SPRS; Shapiro & Startup, 1992)

<sup>4</sup>Agnew Relationship Measure (ARM; Agnew-Davies *et al*, 1998)

<sup>5</sup>Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994)

<sup>6</sup>Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)

<sup>7</sup>Attachment Style Questionnaire (ASQ; Feeney *et al*, 1994)

<sup>8</sup>Therapist Problem Checklist (PCL; Shroder, 1999)

interpersonal styles and on whether CB or PI therapy used. Interpersonal Style by Treatment Interactions was significant. Therapists felt “relatively” positive after sessions with overinvolved patients in the PI Therapy condition, and with underinvolved and balanced patients after sessions of CB Therapy.

There was a trend for therapists to state that they felt more aroused after sessions with overinvolved or balanced patients in the PI Therapy condition. Whilst there were no significant main effects of interpersonal style on Agnew Relationship Measure (ARM; Agnew-Davies *et al*, 1998) scales, there was a significant style by duration interaction effect on openness. Outcomes were similar for patients with different interpersonal styles who were receiving different treatments. Hardy *et al* argued that this might reflect appropriate responsiveness of therapists. They also postulate that underinvolved patients appeared to benefit from a 16-session format (rather than a 12-session one) in that they had more freedom to learn how to express themselves. There was no discussion of therapists’ interpersonal style apart from discussion about appropriate responsiveness. It could be argued that negative evaluation of the alliance might reflect the difficulties a patient has in experiencing their attachment figure as a secure base. Insecure attachment strategies might put considerable pressure on the therapist to respond in a complementary way and their own attachment histories will impact on their ability to respond sensitively (Slade, 1999; Pines and Marrone, 2003).

Black, Hardy, Turpin and Parry (2005) explored the relationship between the attachment style of therapists, therapeutic orientation, therapeutic alliance and therapist-reported problems in therapy (see Table 7, p.94). 491 psychotherapists participated. Attachment style was measured by the Attachment Style Questionnaire

(ASQ; Feeney *et al*, 1994) and the working alliance was measured by the Agnew Relationship Measure (ARM; Agnew-Davies *et al*, 1998). Therapist reported problems were determined by completion of the Therapist Problem Checklist (PCL; Shroder, 1999). When therapists completed the ARM, they were not allowed for Ethics Committee reasons, to have a particular client in mind but rather to answer “in general”. Therapists who reported more secure attachment relationships had better general alliances with their clients. Meyer *et al* (2001) also found that therapists with higher insecure attachment scores predicted poorer general therapeutic alliance and the results from the Black *et al* (2005) study support this. Preoccupation with relationships was associated with poorer alliance scores. Therapists who reported more insecure attachment relationships also reported more problems in therapy and Black *et al* found significant correlations between PCL and four insecure styles of attachment with “need for approval” associated with high reported problems.

Black *et al* (2005) found that psychodynamic orientation of therapists was predictive of less positive alliance ratings and of therapists reporting more problems within the alliance. The authors argue that this might reflect the more relationship focused model and the greater awareness these therapists brought to evaluating the quality of the alliance.

#### ***4.5 Countertransference Management and the Working Alliance***

Research focusing on therapist attachment styles and their relationship with countertransference behaviours and the working alliance, used supervisors’ perception and ratings of both. Friedman and Gelso (2000) claimed that both positive and negative countertransference were detrimental to therapy process: the

first by meeting the therapist's needs and diverting attention away from patients' conflicts, the second by causing the therapist to be punitive or critical. Developing this theory, Ligiero and Gelso (2002) predicted that both positive and negative countertransference behaviours and levels of therapist attachment insecurity would be negatively associated with quality of working alliance (see Table 8, p.100).

Participants were 50 therapists in training together with their 46 supervisors. The working alliance was measured by WAI-short version and attachment style measured by the Relationship Questionnaire (RQ; Bartholomew and Horowitz, 1991).

Countertransference behaviours were measured by The ICB (ICB; Friedman and Gelso, 2000). Data was analysed using bivariate correlational analyses. The authors found that therapist attachment style did not correlate with either the quality of the working alliance or countertransference behaviours. Ligiero and Gelso argue that an explanation for this finding is that therapists do not see the client as an attachment figure so their attachment style is not activated during therapy and will not impact on establishment of the alliance or countertransference behaviours. However, others have argued that the therapists' countertransference will reflect their earliest experiences of caring/being cared for and as many therapists have endured considerable early loss, these feelings can be painful (Pines and Marrone, 2003). Negative countertransference was associated with poorer working alliances, and positive countertransference was associated with the weak bond of the working alliance. Disagreement between supervisors and therapists regarding bond component of the WAI was predictive of positive and negative countertransference behaviours as measured by the ICB (ICB; Friedman and Gelso, 2000), which Ligiero and Gelso suggest might be due to therapists having a distorted perception of

the bond. The distorted perception might, however, reflect the therapist's internal working model and is thus a product of their attachment style.

In discussing the limitations of their study, Ligiero and Gelso highlight that the supervisors were doctoral students and thus relatively inexperienced as supervisors. Ligiero and Gelso also stated that they believed the therapists' session audiotapes had been listened to by the supervisors. However, no mention is made of either analysis or ratings.

#### ***4.6 Interactional Effects of Attachment Styles***

The relationship between client and therapist attachment styles and the establishment and maintenance of the working alliance was explored by Sauer, Lopez, and Gormley, (2003). The WAI was used to measure the alliance ratings after Sessions 1, 4 and 7. Adult attachment style was measured by the Adult Attachment Inventory. The study used a naturalistic design in which data was collected during treatment-as-usual. Therapist participants were recruited from graduate level training programmes, university counselling centres and from the wider community. Therapists then recruited one or more patients from their assigned practice. Only the 13 therapists and 17 patients with complete data were included in analyses. Changes in the development of the alliance over three time points were analysed using hierarchical linear modelling (see Table 8, p.100). The results from this preliminary growth modelling were consistent with studies that demonstrated that there is a relationship between client and therapist adult attachment style and the development of the early working alliance.

Attachment anxiety in therapists appeared to be specifically related to the development of the early alliance. Therapist AAI scores did not predict client dropout when analysed using *t*-test and comparison of patients who dropped out of therapy with those who completed did not differ significantly on measures of initial AAI or WAI as analysed by *t*-test. Intercorrelations demonstrated that client and therapist working alliance ratings were significantly related at Time 1 and Time 2 but not Time 3 whilst therapist attachment anxiety was positively correlated with client WAI ratings at Time 1. Over the three time points, average working alliance ratings by both client and therapist increased.

Clients whose therapists showed greater attachment related anxiety, reported higher levels of connection and sense of collaboration during the first session and Sauer *et al* postulated that therapists with anxious attachment style, with negative models of self and positive models of others might be better at seeing variation in others and responding accordingly as they are “highly invested in establishing connections” (Sauer *et al*, 2003, pp.379). This echoes Rubino *et al*’s (2000) finding of a relationship between therapists’ attachment anxiety and early alliance (see Ch.2. 3 p.55 and Table 2, p.54). In Sauer *et al*, only therapists’ attachment anxiety had a significant negative effect on client working alliances over time. Whilst initial ratings of alliance suggest a significant positive effect, measurement over time showed that there was a significant negative effect which is congruent with attachment theory.

Table 8

*Empirical Studies of Interactional Effects*

Author	N	Measure	Results
Sauer <i>et al</i> 2003	17	WAI <sup>1</sup> AAI <sup>2</sup>	Client and therapist WAI ratings significantly related at Time 1 ( $r = .42, p < .05$ ) and Time 2 ( $r = .62, p < .05$ ) but not Time 3 ( $r = .10$ ). Therapist attachment anxiety positively correlated with client WAI ratings at Time 1 ( $r = .40, p < .05$ ) but significant negative effects over time.
Tyrrell <i>et al</i> 1999	54	AAI WAI	Less deactivating case managers had stronger alliances with more deactivating clients than with less deactivating clients, $r(25) = .53, p < .01$ . Deactivating case managers had weaker alliances with more deactivating clients than with less deactivating clients, $r(25) = -.31$ , nonsignificant trend
Rubino <i>et al</i> 2000	73	RSQ <sup>3</sup> Response Empathy <sup>4</sup> DIS <sup>5</sup>	Empathy and depth of interpretation intercorrelated ( $r = .69$ ). Patient main effect for Empathy ratings ( $F(3,70) = 5.77, p = .001$ ) with main effect of attachment-anxiety ( $F(1,72) = 4.04, p = .048$ ). More anxious therapists responded less empathically than less anxious therapists. Less anxious therapists varied empathy levels across patient groups ( $F(3, 69) = 4.500, p = .006$ ), more empathic to fearful than dismissing or secure patients, and more to preoccupied than to dismissing.
Ligiero & Gelso 2002	50	WAI RQ <sup>6</sup> CT <sup>7</sup>	Therapist attachment style not related to any WAI subscales or to positive countertransference behaviours Therapist insecurity of attachment was not found to be related to negative countertransference behaviours. Security in therapists inversely related to negative countertransference behaviours, $r = -.28, p < .05$ .

<sup>1</sup>Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)<sup>2</sup>Adult Attachment Interview (AAI; George, Kaplan & Main, 1985)<sup>3</sup>Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994)<sup>4</sup>Response Empathy (Goodman, 1972)<sup>5</sup>Depth of Interpretation Scale (DIS; Harway *et al*, 1953)<sup>6</sup>Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1990)<sup>7</sup>The Countertransference Index (CT; Hayes, Riker & Ingram, 1997)

Tyrrell, Dozier, Teague, and Fallot, (1999) argued that differences in treatment relationships reflect either the differences in internal organisation of relationships held by individuals or in the different states of mind of individuals (see Table 8, p.100). Both clinician and client completed the AAI and the WAI. The authors conceptualise deactivation within the context of the dimensions of the AAI: “deactivating states of mind are associated with diverting attention from attachment related topics in order to minimise the importance of early attachment relationships” and “hyperactivating attachment states of mind are associated with being preoccupied with attachment relationships”.

Tyrrell *et al* (1999) predicted that dyadic regulation of emotion (Sroufe 1996, cited Tyrrell *et al*, 1999) within case management would be affected by the interaction of clinician-patient states of mind. Clients’ characteristic ways of emotional processing would be challenged by dissimilarity of clinicians’ of states of mind with subsequent learning of new ways of emotion regulation and approaching interpersonal relationships. Emotion regulation *per se* was not measured but was hypothesised to be a mediating variable thus explaining the way in which attachment style impacts on treatment outcome.

The results showed that more deactivating clients formed better working alliances with less deactivating case managers in comparison to less deactivating clients who worked better with more deactivating case managers. Tyrrell *et al* concluded that this shows the importance of clinicians and clients being matched in such a way as to balance each other’s interpersonal strategies. However, it might be argued that this demonstrates clearly the importance of clinician training to develop awareness of this and to develop skills in appropriate intervention. Length of

treatment and diagnosis were not found to be significant predictors of either attachment dimensions or treatment variables which is unlike Fonagy *et al*, (1996) (see Section 2.4, p.58) and a later study by Hardy *et al* (1998) where the results suggested that underinvolved patients appeared to benefit from longer therapies (see Section 4.4, p.91). Tyrrell *et al* also suggested that the length of treatment relationship (at least 7 months) had enabled clinicians to create a secure base for their clients.

Tyrrell *et al* state that the dissimilarity between clinician and client in terms of deactivation/hyperactivation is supported by Bowlby's argument that the clinician has the important task of disconfirming a patient's usual and expected interpersonal and emotional strategies. Dissimilarity of patient and therapist was associated with higher client ratings of the alliance which might have been different if the alliance had been assessed earlier in treatment (Tyrrell *et al*, 1999).

#### **4.7 Summary**

This chapter looked at the growing evidence which shows the relationship between attachment styles and the working alliance. Secure attachment style is associated with high levels of global alliance (Black *et al*, 2005; Meyer and Pilkonis, 2001; Satterfield and Lyddon, 1998), high level ratings on the emotional and relational alliance (Bond dimension) (Satterfield and Lyddon, 1998) and with high levels on goal agreement (Satterfield and Lyddon, 1998) and goal and task agreement (Dolan, Arnkoff and Glass, 1993). Fearful attachment style is associated with difficulties in establishing the alliance (Parish and Eagle, 2003; Eames and Roth, 2000) and in establishing the emotional and relational bond (Satterfield and Lyddon, 1998).

Whilst therapists with less self-directed hostility rated the emotional bond more highly (Dunkle and Friedlander, 1996), psychoanalytic orientation of therapists was predictive of less positive alliance ratings and of therapists reporting more problems within the alliance (Black *et al*, 2005).

Whilst therapists' clinical experience does not appear to be associated with the quality of the alliance, there is some evidence that more experienced therapists are more able to confront challenging patients and repair ruptures. Whilst insecurity of attachment in therapist might impact on the long term engagement and process of psychotherapy (Slade, 1999; Pines and Marrone, 2003), insecure therapists have been shown to establish a good alliance initially which might be due to their own anxieties about abandonment and rejection. Dismissing patients appear to benefit from longer therapies as this gives them more time in which to learn how to express themselves (Hardy *et al*, 1998).

## **Chapter 5**

### **Method**

This chapter describes the design of the research study and then discusses the sampling procedures used and the underlying rationale for choosing the research site. Methods of data collection, recording and analysis are then described and finally, the methodological limitations of the study will be addressed.

#### ***5.1 Research questions and hypotheses***

Whilst there is considerable empirical evidence to support the argument that patient or therapist attachment style impacts on both the process and outcome of psychotherapy, fewer studies have considered the interactional effects and these give mixed findings. It is still uncertain exactly how either therapist or patient attachment style impacts on therapeutic outcome or whether there is an interactional effect.

There is empirical evidence supporting an association between the working alliance and therapeutic outcome and suggesting that there is a relationship between attachment style and establishment, maintenance and repair of the alliance. This association can be captured by the use of a measure such as the Agnew Relationship Measure. It has been shown that, over time, therapists' and patients' ratings of the alliance become more alike and it is possible that this is related to attachment style.

The questions relating to attachment style of either patient and therapist and outcome were reframed in such a way that they could be tested. In relation to alliance ratings, the literature suggested that over time, patients and therapists come

to see the alliance more similarly. To test this idea, it was hypothesised that similarly attached therapists and patients would have more concordant and higher ratings of the alliance than would other dyads.

No other studies have combined measurement of both therapist and patient attachment styles, looking for an interactional effect on outcome and proposing that such a relationship might be mediated by the quality of the therapeutic alliance. This could be visualised as a mediation model whereby the change in patients' mental state over the course of therapy could be seen as being mediated by the quality of the dyadic therapeutic alliance. Within this conceptual framework, both therapist and patient attachment style was seen as impacting on the establishment, maintenance and development of the alliance.

The change in mental state of the patient was assumed to be measurable by the use of outcome measures such as the CORE-OM which measures distress pre-therapy and then again post-therapy.

**Hypothesis 1:** It is proposed that secure attachment style of therapist will be positively correlated with good outcome, defined as clinically significant change as measured by CORE-OM.

**Hypothesis 2:** It is proposed that concordant secure/secure attachment style patient/therapist dyads will have far higher concordant alliance at outcome evaluation than other dyads.

These hypotheses lead to the proposal that the relationship between attachment style and outcome is mediated by the therapeutic alliance as defined by Bordin (1979). The interactional effects of therapist and patient attachment style will impact on the establishment, maintenance and repair of the alliance which thus mediates the relationship between attachment style and outcome.

**Hypothesis 3:** It is proposed that the association between attachment style and psychotherapeutic outcome will be mediated by the therapeutic alliance.

This theory can be conveyed schematically:

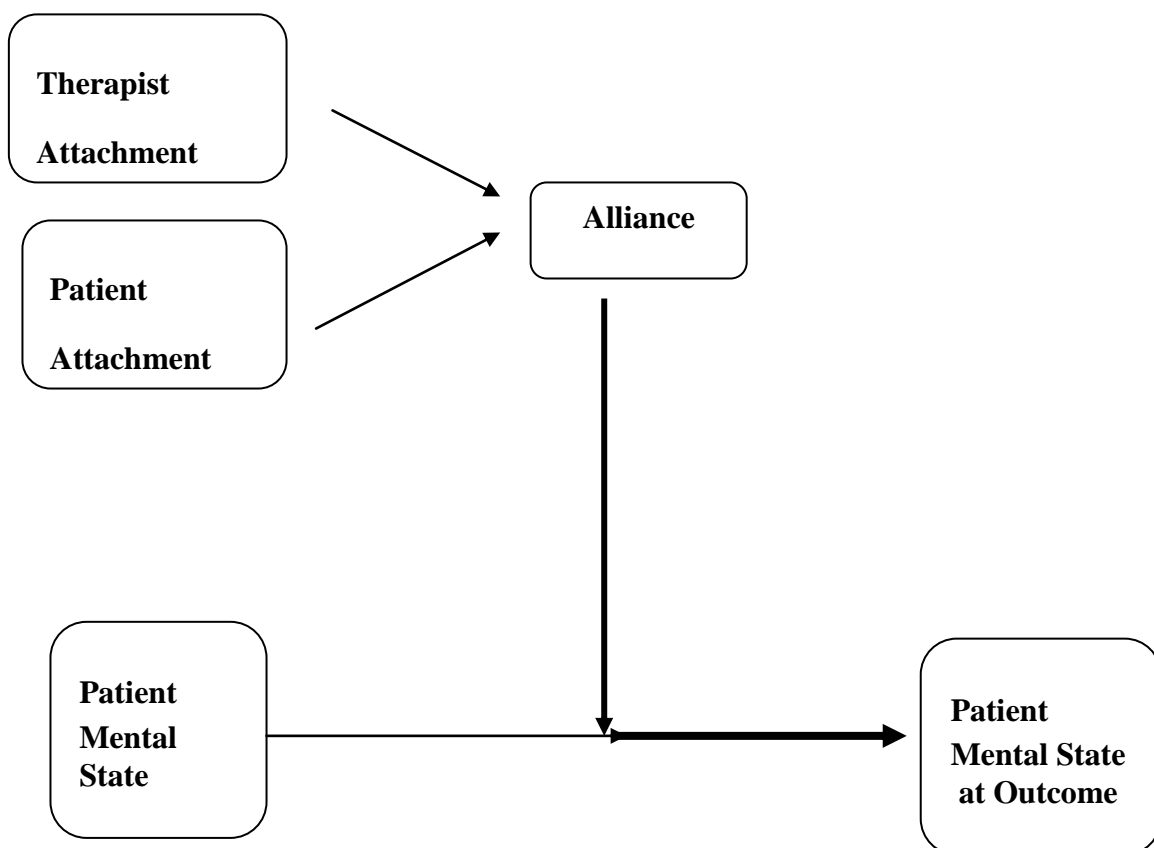


Figure 3 Schematic representation of theory

## **5.2 Design**

The study used a naturalistic design in which allocation of participants to a group was on the basis of attachment style. Data from therapists was collected prior to therapy commencing and at predetermined points during therapy with a particular patient. Data from patients was collected at specified points during treatment as usual. A quantitative methodology was used in which various reliable and well-validated self-report measures were used to measure the participants' experiences of relating and thus determine their attachment style. Although quantitative methodologies can be criticised for their emphasis on measurement, there is a case for exploring attachment relationships in this way. Whilst not denying the richness and complexity of human relationships, it is seen that ways of being in relationship are repeated over an individual's lifetime and can be captured by self-report measures which offer a valid and reliable form of measurement. Although some of the rich material which might have been elicited from interviewing participants will be foregone, a quantitative approach utilizing self-report measures will be more cost-effective, more time-effective and less intrusive.

## **Variables**

The dependent variables were therapy outcome as measured by the CORE-OM. (Hypothesis 1) and the rating of the therapeutic alliance as measured by the Agnew Relationship Measure (Hypothesis 2). The independent, predictor variable was the attachment status of therapist (Hypothesis 1) and the attachment status of patient and therapist (Hypothesis 2). The influence of attachment style on outcome was hypothesized to be mediated by the therapeutic alliance.

### 5.3 Operationalisation of Concepts

**Therapist:** A chartered clinical/counselling psychologist or a registered psychotherapist who offers psychotherapy.

**Patient:** An individual who has been offered psychotherapeutic intervention.

**Therapeutic Alliance:** The pantheoretical model proposed by Bordin (1979) informed this study. In this study, the therapeutic alliance was considered to be a collaborative relationship between therapist and patient which enables the work of therapy to proceed and which is based on trust, warmth, respect and understanding of the tasks of therapy. It is a relationship in which both therapist and patient are agreed as to the work which is to be done and assumes that, although a subjective construct, the alliance manifests both observable psychological and behavioural elements. It is assumed, that patient and therapist will have perspectives on the alliance and that there will be both unconscious and conscious processes at work.

**Therapeutic Outcome:** For the purposes of this study, positive therapeutic outcome is defined as clinically significant and reliable change as determined by measurement on the CORE-OM. The concept of “Reliable Change”, initially postulated by Jacobson, Follette and Revenstorf (1984), describes the change between pre-treatment and end-of-treatment scores on a given measure which, if greater than would be expected by measurement error, constitutes statistically significant change which is therefore reliable. Jacobson *et al* proposed calculations using the reliability of a given measure which would then account for measurement error. Christensen and Mendoza (1985) suggested corrections for Jacobson *et al*’s calculations. The resulting calculation for criterion for reliable change is  $1.96 \times SD1 \times \sqrt{2 \times (1 - rel)}$ , where *SD1* equals the pre-therapy mean score. This formula is

based on change that will happen less than 5% of the time by measurement unreliability alone.

Jacobson and Truax (1991) suggest that we think of psychotherapy process and outcome as when a client (considered to be part of a dysfunctional population) enters therapy and, as a result of that therapeutic intervention, leaves therapy no longer part of that dysfunctional population. They offer a definition of clinically significant change as “*the level of functioning subsequent to therapy places that client closer to the mean of the functional population than it does to the mean of the dysfunctional population.*” (Jacobson & Truax, 1991, p.13). Jacobson and Truax argue that demonstrating a statistical effect does not tell us about psychotherapy efficacy and they go on to draw attention to the confusion inherent in Smith, Glass, and Miller’s (1980) meta-analysis of psychotherapeutic outcome in which they based their conclusion that therapy was beneficial on demonstrated effect sizes. Jacobson and Truax state that effect size and efficacy have been confabulated by Smith *et al* and argue that to be effective, psychotherapy must “meet standards of efficacy set by consumers, clinicians and researchers” (p.12).

Characterising clinically significant treatment response as “*returning to normal functioning*” might be too strict criteria although consumers of mental health services might like to know how often “normal functioning” is achieved (Jacobson *et al*, 1999). Kazdin (1999) questions the meaning of clinical significance reminding us that some important therapeutic changes are not associated with changes in symptoms. The importance of impact of change on an individual’s functioning in everyday life is highlighted by Kazdin. Although the participants in this study had moderate to severe difficulties and it might seem unreasonable to expect “clinically

significant change”, this cut-off was retained in order to test the hypothesis that the patients of secure therapists had better outcomes.

**Attachment Style:** The pattern of relating to another as reported through self-completion questionnaires and determined by validated published self-report measures. Whilst attachment style is measured at the beginning of therapy, this study is not looking at changes in attachment patterns which may be related to the therapeutic intervention.

#### ***5.4 Participants***

##### ***Sampling***

Random selection in relation to sampling is most related to external validity and generalizability. However, when populations might be difficult to either find or recruit, non-random, purposive sampling can be used. Its major weakness is the bias which might be introduced by the availability of willing participants who might differ in some way to those not found.

##### ***Therapist participants***

Psychologists and psychotherapists were initially identified through mailing lists from the NHS Trust and were approached via direct mail. This had a very poor response rate as did advertisements in a professional journal. Further potential participants in private practice were identified through colleagues. A packet of questionnaires was sent to each identified therapist together with an explanatory letter. If interested in taking part in the study, therapists were asked to sign the enclosed consent forms and to complete and return the completed questionnaires.

Therapists who consented to participating and who returned the completed questionnaires were asked to approach their next three new patients and involve them in the project. All therapist participants were assured of confidentiality of disclosed information and numerical identity coding was used. Therapist participants remained anonymous to the researcher being identified solely by numerical code.

### ***Patient Participants***

Patient participants, identified and initially approached by their therapists, were given detailed information and asked to sign a consent form. They were free to withdraw at any time. Patient exclusion criteria were in place – age below 18 years and above 65 years, diagnosis of schizophrenia with positive symptoms of psychosis, diagnosed learning disability and current untreated substance abuse. All participants were assured of confidentiality of disclosed information and numerical identity coding was used. Patient participants remained anonymous to the researcher being identified solely by numerical code.

## ***5.5 Instrumentation***

### **Experiences in Close Relationships (ECR)**

The ECR (Brennan, Clark and Shaver, 1998) is a 36 item self-report attachment measure where the items derive from factor analysis of most of the pre-existing self-report measures of adult romantic attachment. It measures adult attachment within romantic relationships. Participants are asked to complete the self-report measure by reading each of the 36 items and deciding the extent to which this is true of them on a Lickert scale (1 ... very like me, 7 ... very unlike me). The ECR is scored by summing the scores for all items within each scale. Negatively worded

responses are “reverse keyed”. Scores are obtained on 2 subscales – Anxiety and Avoidance.

**External validity:** The Avoidance Scale has high correlation with scales measuring avoidance and discomfort with closeness. The Anxiety Scale has high correlation with scales measuring anxiety and preoccupation with attachment, fear of rejection and jealousy. Whilst the Avoidance and Anxiety Scales correlate highly with patient factors,  $r = .95$  in each instance, they are nearly uncorrelated themselves,  $r = .11$ . The combined scales score gives the attachment clusters as defined by Bartholomew. Internal consistencies of Anxiety and Avoidance are .91 and .94 respectively.

### **The Relationship Questionnaire (RQ)**

The Relationship Questionnaire (RQ) is a self-report instrument assessing adult attachment within the four-category model developed by Bartholomew (1990, 1991). Based on the work of John Bowlby (1973), Bartholomew proposed that there were two types of internal working model – an internal model of the self and an internal model of others. Designed to obtain continuous ratings of patterns of attachment, these can be obtained by making linear combinations of the ratings. To achieve results corresponding to the anxiety dimension discussed by other research, calculation was reversed [(fearful plus preoccupied) minus (secure plus dismissing)] to arrive at self model. The forced choice paragraph acted as a counterbalancing effect thus reducing order effects of the Lickert rated scales.

**Test, re-test stability:** Test re-test stability over an 8 month period was moderate (Scharfe and Bartholomew, 1994). The Relationship Questionnaire has been shown

to be the only self-report measure of attachment free from self-deceptive biases (Leak and Parsons, 2001).

### **Agnew Relationship Measure (ARM)**

Using existing scales, Agnew-Davies *et al* created a group of items reflecting qualities of client, qualities of therapist and qualities of the relationship between client and therapist. Any items reflecting technique of early outcome were dropped. Following further refinement, a final version of the scale comprised 28 items on parallel forms rated on a 7 point Lickert scale. The instructions ask for respondents to focus on a “single recent session” recognizing that the relationship might change during therapy. In evaluating the ARM, Agnew-Davies *et al* found that Bond and Partnership were related statistically and might be considered the feeling and action parts of the same component of the alliance. The Confidence scale showed differences which Agnew-Davies suggests might be due to clients regarding professional competence as part of the Emotional bond whereas therapists rate Bond and personal competence separately. The ARM assesses 5 dimensions of the therapeutic alliance: Bond, Partnership, Confidence, Openness, and Client Initiative – and can be used to rate the alliance by both therapist and patient after every session of either psychodynamic or cognitive behavioural therapy.

The convergent validity of the Agnew Relationship Measure (ARM) and the Working Alliance Inventory (WAI) was assessed by Stiles *et al* (2002) showing that the ARM’s core alliance scales (Bond, Partnership and Confidence) were variously correlated with the WAI’s scales (Bond, Tasks and Goals) giving support to the suggestion that they measure some of the same core constructs. The ARM captured some aspects of the alliance not measured by the WAI such as the freedom to

disclose within therapy. The advantages of the ARM are its use of content arising from previous work, a simple format, language used and the parallel forms for therapist and client (Stiles *et al*, 2002). The convergent validity of the ARM and the WAI was assessed at two levels – the dyad level (correlations of means across therapist-client pairs) and the session level (correlations of deviation scores across sessions within dyads). The characteristics of client-therapist pairs averaged across sessions reflected in dyad-level means. Stiles *et al*, (1998) suggest the alliance should be considered as a dyad-level variable when it is used to predict outcome.

**Scoring:** Therapists and their patients complete parallel forms using a 7 point Lickert scale, ranging from 1 (strongly disagree), 4 (neutral) to 7 (strongly agree). Raw scores were obtained by calculating the means of constituent items (scored 1-7, reversed keyed for negatively worded items). Correlations of means across therapist-patient dyads can be obtained for each of the alliance dimensions of Bond, Partnership, Confidence and Openness. Internal consistency is acceptable on scales for bond, partnership, confidence and openness –  $\alpha$  .77- .87.

### **CECA-Q: Family Relationships in Childhood**

The Childhood Experience of Care and Abuse Questionnaire (CECA-Q) is a retrospective childhood questionnaire for adults to complete. This questionnaire was originally developed to mirror the well-validated CECA interview measure. Whilst mirroring the main components of CECA interview, the CECA-Q can be used as a research instrument or in a large survey (Bifulco, Bernazzani, Moran and Jacobs, 2005). Internal scale consistency was satisfactory for antipathy and neglect scales,  $\alpha$  = .81 and .80 respectively. Test-retest for care and abuse scales was

satisfactory. Associations between CECA-Q scales and parallel interview scales reach statistical significance and cut-offs for high sensitivity and specificity were determined.

**Validity:** Validation studies (Smith *et al*, 2002) demonstrated high degree of reliability over time and agreement between ratings on interview and questionnaire. From these studies it appears that the CECA-Q is both a reliable and valid measure of childhood adversity.

**Design:** In developing the questionnaire, items were taken directly from the interview schedule. A final version was achieved following piloting and adjustment of questions. Sections were now included on parental loss, parental care, physical abuse, sexual abuse and support.

**Parental Care 16 items:** Antipathy and neglect were each assessed by 8 items using a 5 point Lickert Scale. Mother/surrogate mother and father/surrogate father were rated separately. If, during childhood there had been more than one parental figure, respondents are asked to select the one with whom they lived the longest or the one they found the most difficult to live with. Respondents are required to identify the relation to the parental figure selected. Scoring included reversal of some rating and summing.

**Physical abuse:** A general screening question introduced the section: “When you were a child or teenager were you ever hit repeatedly with an implement (such as belt or stick) or punched, kicked or burnt by someone in the household? (yes or no).” Respondents who answered yes, are then asked to complete 4 questions to elicit characteristics of physical punishment. Mother and father figures are rated separately. Scores were summed.

## CORE-OM

This measure was designed to meet the need for a measure assessing efficacy and effectiveness of psychological therapies. It is a 34-item self-report questionnaire comprising domains of subjective well-being, symptoms, function and risk (Evans *et al*, 2002). As an instrument, it is acceptable to both clinical and non-clinical populations, with a completion rate of 80% and 91% respectively. All items are answered on a 5-point scale and be either hand-scored or computer scanned. A mean item score is calculated by summing the total items marked and dividing this by 34 (when no items are missing), giving a mean item total ranging from 0-4.

**Internal Consistency:** Cronbach's coefficient  $\alpha$  (Cronbach, 1951) showed internal reliability of all domains to be high,  $\alpha > 0.75$  and  $< 0.95$ . The large sample sizes gave precise value estimates shown by confidence intervals.

**Test-retest Stability:** Test re-test correlations were highest within domains. The risk domain, comprising small length and items which were situationally reactive, showed the least stability at 0.64. Other scores exhibited stabilities ranging from 0.87-0.91.

**Convergent Validity:** Convergent validity was highest when compared to conceptually close instruments such as Beck Depression Inventory (Beck *et al*, 1961, 1996) or the Symptom Checklist-90-revised (Derogatis, 1983).

**Distinguishing clinical and non-clinical populations:** Discrimination between clinical and non-clinical populations is the main validity requirement of an outcome measure. Large, highly significant differences were seen on all domains: 1.65 – 1.66 Cohen's effect size. Internal consistency for samples showed no statistically significant differences for samples where English was a second language. There was a small but statistically significant gender difference; this was smaller in the clinical population.

## Reliable and Clinically Significant Change

The CORE-OM measures reliable and clinically significant individual change rather than group mean change (Evans *et al.* 2002). Individuals whose score is representative of a clinical population pre-therapy (i.e. being above the clinical cut-off 1.29 females, 1.19 males) and whose score post-therapy is representative of the general population (i.e. below the cut-off), are deemed to have made a clinically significant change. This follows Jacobson and Truax's (1991) assertion that clinically significant change moves an individual from a clinical to a non-clinical population. This cut-off was taken from calculating the CORE-OM score that most adequately distinguished membership of a general population (lower score) or membership of a clinical population (higher score) (Barkham *et al.*, 2005). The formula used was:

$$\frac{\text{mean}_{\text{clin}} \text{SD}_{\text{norm}} + \text{mean}_{\text{norm}} \text{SD}_{\text{clin}}}{\text{SD}_{\text{norm}} + \text{SD}_{\text{clin}}}$$

Reliable change was calculated using the coefficient  $\alpha$  values of 0.94 for the internal reliability of this data and the resulting calculation for criterion for reliable change is:  $1.96 \times \text{SD1} \times \sqrt{2 \times \sqrt{(1-\text{rel})}}$  where  $\text{SD1}$  equals the pre-therapy mean CORE-OM score and where reliability equals 0.94. This formula is based on change that will happen less than 5% of the time by unreliability of the measure alone. Patients who were below the cut-off at the commencement of therapy cannot be defined as “recovering” through therapy as they were already “healthy” (CORE Partnership, 2007).

## ***5.6 Procedure***

### ***5.6.1 Access***

The research site initially chosen was a large NHS mental health trust in South London. It covers four large London boroughs and includes inner city areas of extreme deprivation as well as middle-class residential areas. It was chosen because it is representative of NHS mental health trusts, has a wide and varied provision of psychotherapy services and employs clinical psychologists, counselling psychologists and psychotherapists. Access to the site and to patients and therapists was negotiated via the Heads of Psychological Services of each borough within the NHS Trust. Ethical clearance was granted by the Ethics Committee of Lewisham NHS Trust (Appendix 1). Other therapists taking part in the study worked outside this NHS Trust and were seeing patients privately.

Data Protection issues were addressed and provision made to ensure that all access to the research records was secure and in accordance with the Data Protection Act, 1998. An Information Leaflet (Appendix 2) was given to each therapist prior to obtaining their Informed Consent (Appendix 3). Therapists who had agreed to participate were asked to discuss the study with their patients, give them the Patient Information Leaflet (Appendix 4) and allow them time to consider participation in the study. Patients were then asked to sign a Consent Form (Appendix 5). Total anonymity of both staff and patients was maintained by the allocation of numerical coding to all participants. At no time were patients' names known to the researcher. Therapists who responded to the initial mailing were thereafter anonymous to the researcher. Treatment was neither offered nor withheld in response to the research generated data. All patients initially approached had previously been offered a psychological intervention which, as they were assured,

would proceed regardless of participation in this study. Patients and therapists were free to withdraw from the study at anytime without giving any reason. Therapists were encouraged to let the researcher know when patients dropped out of therapy.

### **5.6.2 Administration**

2 groups were created on the basis of attachment status of participants - “concordant” therapist-patient dyads and “non-concordant” therapist-patient dyads. In the first instance, responding therapists completed a Professional and Demographic Questionnaire (Appendix 6), the CECA-Q (Appendix 7), the Experiences in Close Relationships (Appendix 8) and Relationship Questionnaire (Appendix 9) and were given a categorical attachment classification together with a dimensional score based on responses to and scoring of the Relationship Questionnaire and the Experiences in Close Relationships respectively. Therapists scoring below 4 on the ECR “Anxiety” and “Avoidance” dimension were deemed “securely attached” and those scoring 4 or above were deemed “insecurely attached”. Therapists were provided with envelopes addressed to the researcher in which to return their completed questionnaires.

Secondly, each therapist had one or more patients who agreed to participate in the study. Each patient participant completed a Demographic Questionnaire (Appendix 10), the ECR and the RQ and all forms were returned directly to the researcher in addressed envelopes in accordance with Ethics Committee stipulations. Therapists were not aware of their patients’ responses to these questionnaires. Patient participants were given a categorical attachment classification together with a dimensional score based on responses to and scoring of the Relationship

Questionnaire and the Experiences in Close Relationships respectively. Patients scoring below 4 on the ECR “Anxiety” and “Avoidance” dimension were deemed “securely attached” and those scoring 4 or above were deemed “insecurely attached”.

When both therapist and their patient were classified as securely attached, the resulting dyad formed part of the concordant/secure group. Other combinations formed part of the non-concordant group or concordant insecure group (NCCN). In this way two groups of dyads were defined by their attachment characteristics.

The CORE-OM (Appendix 11) was administered to patient participants at the beginning of therapy and again at the last session or session 40 in open-ended therapies. This is routinely administered within this NHS Trust and these NHS patients gave consent for the data to be shared with the researcher. All completed CORE-OM forms at both time points were returned directly to the researcher.

The Agnew Relationship Measure (ARM) was administered after session 5 (Appendices 12 and 13) and both therapist and client completed parallel copies of the measure, away from each other and returned directly to the researcher. At no point did the therapist see the patient’s rating and the patient was assured that the completed forms would not be shown to their therapist. Therapists and patients again completed the ARM at therapy ending. In open-ended therapies, therapists and patients completed the ARM at session 40. The same conditions were again in place. Patients placed their completed ARM forms in envelopes addressed to the researcher for direct return in accordance with Ethics Committee stipulation.

### 5.7 Data Analysis

Relationships between therapists' professional and demographic variables, attachment style and working alliance ratings were explored by correlational analyses. These were repeated for the patient demographic variables, attachment style and working alliance ratings.

Differences in pre and last session/session 40 CORE-OM scores were analysed using t-tests for both the whole patient sample and then again for each patient attachment style group. Finally, patients were grouped according to their therapists' attachment style and CORE-OM scores analysed.

One-way Anova was used to test for between group differences in pre and last session/session 40 CORE-OM scores for both patient and therapist groups.

Patients' clinically significant and reliable change following therapy was examined. A criterion for reliable change was calculated based on the coefficient alpha 0.94 for the internal reliability of this data. The formula  $1.96 \times SD1 \times \sqrt{2 \times \sqrt{(1-rel)}}$ , where *SD1* equals the pre-therapy CORE-OM standard deviation and where reliability equals 0.94 was used.

The ratings of the Agnew Relationship Measure were analysed at both the dyad and the sessional level. One-way Anova was used to explore associations between attachment style and ratings of the ARM.

As all variables were measured on a continuous scale, linear regression was used to examine the association between ECR patient measures and final session CORE-OM values. Firstly, the association between each of the two ECR dimensions of Anxiety and Avoidance, and the final session CORE-OM values was examined without considering any other variables. Secondly, multiple linear regression was used to analyse the same associations, this time adjusting for the overall patient and therapist ARM scores at Time 1. In addition, the change in CORE-OM scores from pre therapy to post-therapy/ 40<sup>th</sup> session was calculated, and a similar set of analyses was performed using the same methods. Linear regression was used to examine the association between the ECR dimensional measures and the CORE-OM scores, both in a simple comparison (unadjusted analysis) and adjusted for the overall ARM scores.

### ***5.8 Methodological Limitations***

Whilst quantitative research is frequently criticized for its epistemological and ontological positions, it has been suggested (Bryman, 2001) that it can be independent of these assumptions. The association with theory driven hypothesis testing (Bryman, 2001) does not preclude the use of quantitative methods in more exploratory work such as teasing out relationships between variables and subsequently going on to generate theories. Random selection in relation to sampling is most related to external validity and generalizability. However, when populations might be difficult to either find or recruit, non-random, purposive sampling can be used. Its major weakness is the bias which might be introduced by the availability of willing participants who might differ in some way to those not found.

## Chapter 6

### Results

#### *6.1 Descriptive Statistics*

##### *6.1.1 Therapist Participants*

38 therapists agreed to participate in the study, but only 21 returned completed questionnaires. Reasons given for initial agreement but non-return of questionnaires included pressure of work, anxieties about impact of questionnaire completion on patients, retirement, realisation that their patients were not appropriate and working solely with groups. Several therapists declined to offer a reason. Seven of those who returned questionnaires were unable to return patient data. One therapist moved to another area, one gave up psychology, one psychologist went on maternity leave and four stated they were unable to find suitable patients.

Participating therapists ( $n = 14$ ) were aged between 29 and 67 years, Mean = 43.83 (men) and 37.50 (women). Professional and social characteristics of therapists are presented in Table 9 (p.124). 57.1% therapists were female ( $n = 8$ ) and 42.9% were male ( $n = 6$ ), 71.42% ( $n = 10$ ) identified as white British. 71.42% ( $n = 10$ ) therapists were married, 7.14% ( $n = 1$ ) cohabiting, 7.14% ( $n = 1$ ) cohabiting after a previous marriage, 7.14% ( $n = 1$ ) were single and 7.14% ( $n = 1$ ) were separated.

Post-qualification experience was from 1 year to 32 years, Mean = 10.83 years, Standard Deviation 8.68 (male) and mean = 8.5 years, Standard Deviation 13.35 (female).

Table 9

*Professional and Social Characteristics of Therapists*

	<i>Therapists</i>			
	<i>Male</i>		<i>Female</i>	
Age	<i>M</i> = 43.83	<i>SD</i> 8.68	<i>M</i> = 37.50	<i>SD</i> 13.35
Years experience	<i>M</i> = 10.83	<i>SD</i> 8.68	<i>M</i> = 8.5	<i>SD</i> 13.35
	<i>N</i>	%	<i>N</i>	%
Gender	6	42.9	8	57.10
Marital status				
Married	5	35.71	5	35.71
Cohabiting			1	7.14
Cohabiting after divorce			1	7.14
Separated	1	7.14		
Single			1	7.14
Core profession				
Psychologist	4	28.57	5	35.71
Social worker	1	7.14		
Nurse			1	7.14
Psychotherapist	1	7.14	1	14.29
Personal therapy				
Psychoanalytic	4	28.57	4	28.57
CAT			3	21.43
Existential	1	7.14		
None	1	7.14	2	14.29
Theoretical orientation				
Psychoanalytic	3	21.43	3	21.43
Cognitive	1	7.14	4	28.57
Phenomenological	1	7.14		
Integrative	1	7.14	1	7.14

64.28% ( $n = 9$ ) therapists identified their core profession as psychologist, of which 3 were counselling psychologists and 6 were clinical psychologists. 21.43% ( $n = 3$ ) therapists identified their core profession as psychotherapist, 7.14% ( $n = 1$ ) as social worker and 7.14% as nurse ( $n = 1$ ). 57.1% ( $n = 8$ ) therapists had doctoral degrees, 21.4% ( $n = 3$ ) had masters degrees, 14.3% ( $n = 2$ ) stated they did not have relevant degrees. 64.28% ( $n = 9$ ) therapists were chartered psychologists with the British Psychological Society (BPS), 28.6% ( $n = 4$ ) were registered with United Kingdom Council for Psychotherapy (UKCP), 21.43% ( $n = 3$ ) were members of the British Confederation of Psychotherapy (BCP). 14.3% ( $n = 2$ ) were registered with the British Association of Behavioural and Cognitive Psychotherapy (BABCP).

78.57% ( $n = 11$ ) therapists had been in personal therapy. 72.72% ( $n = 8$ ) of these had been in at least twice weekly psychoanalytic psychotherapy for 2 to 13 years, Mean = 10.0 years. 9.10% ( $n = 1$ ) had had existential psychotherapy, 27.27% ( $n = 3$ ) had had Cognitive Analytic Therapy (one of these had also been in psychoanalytic psychotherapy)

42.9% ( $n = 6$ ) therapists described their theoretical orientation as psychoanalytic, 35.7% ( $n = 5$ ) as cognitive, 14.3% ( $n = 2$ ) as integrative and 7.1% ( $n = 1$ ) as phenomenological.

28.57% (3 cognitive and 1 psychoanalytic psychotherapist) used only one model. 71.43% therapists ( $n = 10$ ) stated that they regularly used more than one model in their practice and these models are presented graphically above in Figure 4. 57.14% ( $n = 8$ ) therapists used CBT, 42.86% ( $n = 6$ ) therapists used psychodynamic therapies, 7.14% ( $n = 1$ ) worked within a group analytic framework, 21.43% ( $n = 3$ )

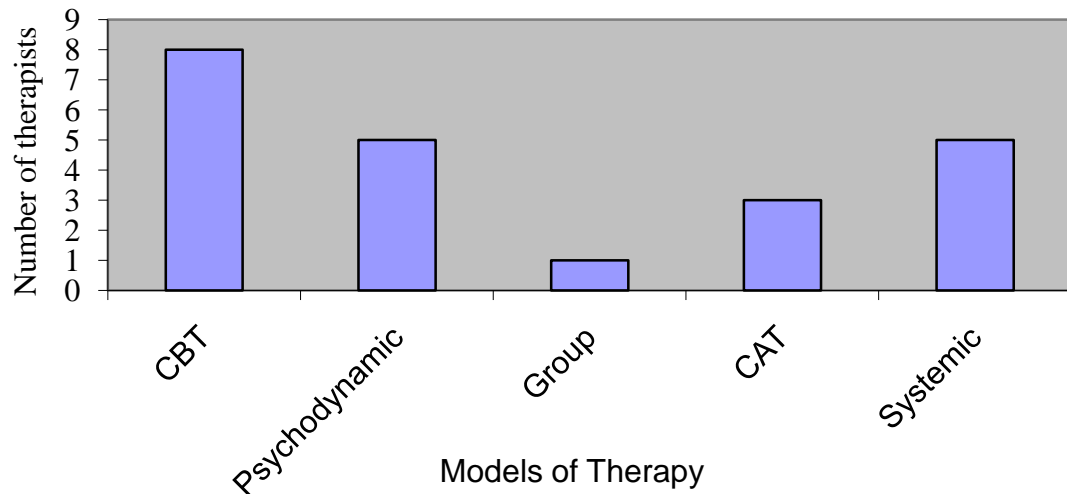


Figure 4

#### *Models of Therapy Used*

therapists regularly used CAT and 28.57% ( $n = 4$ ) worked systemically. 64.3% ( $n = 9$ ) therapists practised solely within the NHS and 14.3% ( $n = 2$ ) therapists were in private practice. 21.43% ( $n = 3$ ) therapists worked in both private practice and in the NHS. All therapists stated that they might see patients aged between 18 and 65 years.

All therapists saw patients for individual psychotherapy, 57.14% ( $n = 8$ ) therapists also conducted groups and 35.71% ( $n = 5$ ) worked with families.

Therapists were not asked to state the model of therapy used with a particular patient. This was partly due to an assumption that many therapists would not wish it to be known that a specific therapy had been eclectic or integrative. It would also have made it more difficult in some cases to preserve therapists' anonymity.

Scores from the CECA-Q are presented below in Table 10. Maternal antipathy mean 27.79 (range 13-39); Paternal antipathy mean 29.43 (range 8-40);

Maternal neglect mean 32.93 (range 18-40; Paternal neglect mean 29.86 (range 17-40). 4 (28.57%) therapists had experienced physical abuse of some severity from mothers (Mean 3, range 2-4), and 3 of them had also experienced similar abuse from fathers (Mean 2).

Table 10

*CECA-Q, Means and Standard Deviations*

CECA-Q	Mean	Std. Deviation
maternal antipathy	27.79	8.69
paternal antipathy	29.43	11.27
maternal neglect	32.93	7.10
paternal neglect	29.86	9.00
physical abuse	1.29	2.13

### **6.1.2 Patient Participants**

There was no patient attrition from therapy once participation agreed. However, 3 patients declined to participate and did not complete any questionnaires and 1 patient was unable to complete the ECR as she felt she had never had any form of intimate relationship. Demographic information on patient participants is presented in Table 11 (p.129). 27 patients, 14.8% male ( $n = 4$ ), 85.2% female ( $n=23$ ) participated in the study, ages ranging from 23 to 63, Mean = 40.96. 3.70% ( $n = 1$ , male), and 37.04% ( $n = 10$ , female) patients were single, 7.41% ( $n = 2$ , male) and 33.33% ( $n = 9$ , female) were married, 3.70% ( $n = 1$ , male) and 11.11% ( $n = 3$ , female) were cohabiting and 3.70% ( $n = 1$ , female) cohabiting after divorce. 14.8% ( $n = 2$ , male) and 40.76% ( $n = 13$ , female) had one or more children. 14.8%

male patients ( $n = 2$ ) and 22.20% female patients ( $n = 8$ ) were in paid full-time employment whilst 11.11% female patients ( $n = 3$ ) were in paid part-time employment.

1 female patient was an only-child (3.70%), 51.9% had at least 1 brother but no sisters ( $n = 14$ , 3 men, 11 women), 25.9% ( $n = 7$ , 1 man and 6 women) had at least 1 sister but no brothers and 18.52% ( $n = 5$ , all women) had brothers and sisters.

18.52% ( $n = 5$ ) patients cited their partners as main support figure, 3.70% ( $n = 1$ ) stated that mother was their sole support figure, 22.22% ( $n = 6$ ) listed a friend, 22.22% ( $n = 6$ ) listed more than one support figure (this included mothers, friends and partners) and 29.63% ( $n = 8$ , 2 men and 6 women) stated that they had no-one to talk to if they had a problem. 6 of these 8 patients without someone in whom they felt they could confide, came from families where they had only brothers and no sisters.

33.33% ( $n = 9$ ) owned their homes, 29.63% ( $n = 8$ ) lived in privately rented accommodation whilst 18.52% ( $n = 5$ ) were renting council accommodation. 4 stated that their property was neither owned nor rented whilst not giving further information. 55.56% ( $n = 15$ ) lived in flats, 44.44% ( $n = 12$ ) in houses.

Patient participants in this study were more likely to have brothers but no sisters, and more likely to be female. Most patients without a support network came from the brothers only subgroup.

Table 11

*Demographic Information on Patient Participants*

	Patients			
	Male		Female	
	N	%	N	%
Age				
Gender	4	14.80	23	85.20
Marital status				
Married	2	7.40	9	33.33
Cohabiting	1	3.70	3	11.11
Cohabiting after divorce			1	3.70
Separated				
Single	1	3.70	10	37.04
Children	4	14.80	10	40.76
Employment				
Full-time	4	14.80	6	22.20
Part-time				
Siblings				
Both Brothers and sisters			5	18.52
Brothers only	3	11.10	11	40.74
Sisters only	1	3.70	6	22.22
No siblings			1	3.70
Support figures				
None	2	7.40	6	22.22
At least 1	2	7.40	13	62.97

### 6.1.3 Therapist and Patient Attachment Style

Means and Standard Deviations for therapists' scores on the ECR, as seen below in Table 12, gave scores for Avoidance dimension Mean = 2.21, SD 1.04, and for Anxiety dimension Mean = 3.01, SD 0.72. Thus 78.57% ( $n = 11$ ) therapists were classified as "secure", with 14.29% ( $n = 2$ ) classified as avoidant and 7.14% ( $n = 1$ ) as preoccupied.

Table 12

#### *Patients' and Therapists' Attachment Styles*

	Therapist Participants		Patient Participants	
	Mean	SD	Mean	SD
ECR avoidance dimension	2.21	1.04	3.41	1.21
ECR anxiety dimension	3.01	.72	3.95	1.05

Therapists' scores on the Bartholomew and Horowitz Relationship Questionnaire gave both categorical and dimensional scores. From their choices on the forced paragraph choice, 71.43% ( $n = 10$ ) therapists were categorised as "secure", 14.29% ( $n = 2$ ) as "dismissing avoidant" (one of these therapists was classified as "secure" on the ECR) and 14.29% ( $n = 2$ ) as "fearful" (one therapist was classified as "preoccupied" on the ECR). Using the dimensional scores on the RQ gave models of self and models of other for each therapist. 57.14% ( $n = 8$ ) therapists had a *positive self, positive other* profile. 28.57% ( $n = 4$ ) had a *positive*

*self, negative other* profile, 7.14% ( $n = 1$ ) had a *negative self, positive other* profile (this therapist was categorized as “secure” through forced choice paragraphs and “secure” on the ECR) and lastly, one therapist’s profile placed them on the divisions between *positive/negative other and positive/negative self*.

Means and Standard Deviations for patients’ scores on the ECR, as seen in Table 12 (p. 130) gave scores for Avoidance dimension Mean = 3.41, SD 1.21, and for Anxiety dimension Mean = 3.95, SD 1.05. Thus 29.63% ( $n = 8$ ) patients were classified as “secure”, with 14.82% ( $n = 4$ ) classified as “dismissing”, 14.82% as “fearful” ( $n = 4$ ) and 40.74% ( $n = 11$ ) as “preoccupied”.

Patients’ scores on the Bartholomew and Horowitz Relationship Questionnaire gave both categorical and dimensional scores. From their choices on the forced paragraph choice, 11.11% ( $n = 3$ ) patients were categorised as “secure”, 14.82% ( $n = 4$ ) as “dismissing avoidant”, 62.96% ( $n = 17$ ) as “fearful”, and 11.11% ( $n = 3$ ) as “preoccupied”. Many patients categorised as “fearful” with the RQ had not been so the ECR. Six had been “preoccupied”, six had been “secure” and three “dismissing”. Only two patients were classified as “fearful” on both ECR and RQ. Using the dimensional scores on the RQ gave models of self and models of other for each patient. 14.82% ( $n = 4$ ) patients had a *positive self, positive other* profile. 22.22% ( $n = 6$ ) had a *positive self, negative other* profile, 48.15% ( $n = 13$ ) had a *negative self, positive other* profile and 14.82% ( $n = 4$ ) had a *negative self, negative other* profile.

## 6.2 Preliminary Analyses

### 6.2.1 Series of Correlational Analyses

A series of correlational analyses were done to explore relationships between therapist professional and social background variables and attachment and working alliance measures. These were repeated for the patient demographic variables and attachment and working alliance measures.

Correlations of Therapists' Demographic characteristics and Attachment Dimensions are presented in Table 13 (p. 133). Age was significantly correlated with years of clinical experience,  $r = 0.957, p < 0.01$ , and negatively correlated with attachment anxiety,  $r = -.620, p < 0.05$ . Personal therapy was negatively correlated with age,  $r = -.540, p < 0.05$ , and with years of clinical experience,  $r = -.574, p < 0.05$ . Years of clinical experience was negatively correlated with attachment anxiety,  $r = -.556, p < 0.05$ .

Correlations between subscales of the CECA-Q are presented in Table 14 (p. 133). Maternal antipathy was significantly associated with Paternal antipathy,  $r = .597, p < 0.05$ , and with Maternal neglect,  $r = .756, p < 0.01$ . Paternal antipathy was also correlated with Maternal Neglect,  $r = .566, p < 0.05$  and Paternal Neglect,  $r = .746, p < 0.01$ . Both Maternal and Paternal neglect were negatively correlated with physical abuse,  $r = -.695, p < 0.01$  and  $r = -.618, p < 0.05$  respectively. However, only Maternal Neglect was negatively associated with ECR avoidance dimension,  $r = -.621, p < 0.05$ . The correlation between Physical abuse and ECR avoidance was highly significant,  $r = .873, p < 0.01$ .

Table 13

*Correlations Therapists' Characteristics and Attachment Dimension (N = 14)*

	Age	Gender	Personal therapy	Years clinical practice	ECR avoidance	ECR anxiety
Age		-.279	-.540*	.957**	.139	-.620*
Gender			.099	-.134	-.049	.351
Personal therapy				-.574*	-.342	.123
Years clinical practice					.141	-.556*
ECR avoidance						.114
ECR anxiety						

\* Correlation is significant at the 0.05 level (2-tailed)

\*\* Correlation is significant at the 0.01 level (2-tailed)

Table 14

*Correlations Therapist CECA-Q and Attachment Dimensions (N = 14)*

	Maternal antipathy	Paternal antipathy	Maternal neglect	Paternal neglect	Physical abuse	ECR avoidance	ECR anxiety
Maternal antipathy		.597*	.756**	.475	-.425	-.466	-.339
Paternal antipathy			.566*	.746**	-.508	-.459	-.202
Maternal neglect				.548*	-.695**	-.621*	.154
Paternal neglect					-.618*	-.504	.212
Physical abuse						.873**	-.172
ECR avoidance							.114
ECR anxiety							

\* Correlation is significant at the 0.05 level (2-tailed)

\*\* Correlation is significant at the 0.01 level (2-tailed)

### ***6.2.2 Analyses of Patients and Their Siblings***

Patient participants in this sample were more likely to have brothers only and no sisters (51.9%,  $n = 14$ ). There was a significant difference in siblings, with greater observed frequency of “brothers, no sisters”,  $X^2 = 13.15$ ,  $df = 3$ ,  $p = 0.004$ . When this was analysed further in terms of attachment style groupings, it showed that the attachment styles of these participants were secure,  $n = 3$ , preoccupied,  $n = 6$ , fearful,  $n = 3$  and dismissing,  $n = 2$ . Statistical analyses using chi-square showed that whilst more “brothers only” patients than one would expect had a preoccupied attachment style, this did not reach significance,  $X^2 = 2.57$ ,  $df = 3$ ,  $p > 0.05$ .

### ***6.2.3 Analysis of Patients, Gender and Brothers Only***

Only 4 of the 27 participating patients were male. Of these, 3 reported that they had “brothers only” with one man having 5 older brothers. 2 of these men stated that they had no-one other than their therapist with whom they could talk about any problems.

### ***6.2.4 Analysis of Patients, Siblings and Lack of Support Network***

Statistical analysis of patients, siblings and lack of support network was not possible due to small sample size. 8 patients stated that they had no support network and that, excepting their current therapist, they had no-one with whom they could talk if they had a problem of some sort. 6 of these 8 patients came

from the “brothers only” category. 4 “brothers only” participants had older brothers, whilst 2 had younger brothers. In two cases, the brothers were only one year younger. 3 preoccupied attachment style patients (all women) were both in the brothers only group and reported that they had no support figure.

### 6.3 Outcome as Measured by CORE-OM

Table 15

*Mean CORE-OM Scores, Pre- and Post-Therapy by Patient Attachment Style*

Patient attachment style	Pre-therapy CORE-OM		Post-therapy CORE-OM		Effect size	
	<i>N</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	<i>d</i>
Secure	8	1.59	0.93	1.05	0.62	.69
Preoccupied	11	1.49	0.70	1.30	0.73	.27
Fearful	4	1.66	0.74	1.32	0.44	.56
Dismissing	4	1.96	0.86	1.32	0.61	.86
All groups	27	1.61	0.77	1.23	0.61	.54

This sample of patients ( $n = 27$ ) showed overall significant improvement, with mean pre-therapy CORE-OM score of 1.61 and mean last-session CORE-OM score of 1.23,  $t = 4.14$ ,  $df = 26$ ,  $p < 0.001$ ,  $d = 0.54$ . The effect size is conventionally considered a medium effect size (Cohen, 1992). Table 15 above presents the means and standard deviations of CORE-OM scores.

One-way ANOVAs did not show any significant between-group differences for pre-therapy CORE-OM scores for the different attachment styles.

Means and Standard Deviations of CORE-OM scores grouped by Patient attachment style are also presented in Table 15 (p. 135). A One-way ANOVAs was used to test for between group differences in last-session CORE-OM scores but this did not reach significance.

The scores from the CORE-OM were then explored further in relation to the therapists' attachment style. Mean and Standard Deviations from pre and post therapy CORE-OM scores are presented below in Table 16.

Table 16

*Mean CORE-OM Scores, Pre- and Post-therapy by Their Therapists Attachment Style*

Therapist attachment style	Pre-therapy CORE-OM			Post-therapy CORE-OM		Effect size
	<i>N</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	<i>d</i>
Secure	19	1.61	0.77	1.24	0.62	0.52
Preoccupied	3	1.61	1.28	1.49	0.91	0.10
Fearful	0					
Dismissing	5	1.65	0.60	1.06	0.56	1.02

A medium effect size of 0.52 was found for the patients of secure attachment style therapists. A very large effect size of 1.02 was found for the patients of Dismissing attachment style therapists.

Further analysis with One-way ANOVAs showed no significant between-group differences.

Dismissing attachment style patients and the patients of dismissing attachment style therapists made the most improvement as measured by CORE-OM.

### ***6.3.1 Changes in Clinical Significance***

It was predicted that more patients of secure therapists would show clinically significant improvement as determined by CORE-OM scores.

At the beginning of therapy, 8 patients were below the clinical threshold described by Jacobson and Truax (1991) whilst 19 patients were above this cut-off level. The means, standard deviations and effect sizes for these groups is shown in Table 17 (p.139).

An effect size (Cohen's *d*) of 0.88 (conventionally seen as a large effect) was seen for the group with CORE-OM scores greater than 1.29 (female) or 1.19 (male) at the commencement of therapy. The group of patient whose initial CORE-OM scores were below 1.29 (female) or 1.19 (male) were classified as a

non-clinical group. The difference between the means for pre and post therapy CORE-OM scores for this group was small with an effect size (Cohen's *d*) 0.25.

Table 17

*Mean CORE-OM Scores, Pre- and Post-therapy by Clinical Cut-off*

	<i>N</i>	Pre-therapy CORE-OM		Post-therapy CORE-OM		Effect size
		Mean	<i>SD</i>	Mean	<i>SD</i>	
Below cut-off	8	0.75	0.29	0.67	0.35	0.25
Above cut-off	19	1.98	0.59	1.47	0.56	0.88

Changes in patients' CORE-OM scores were categorised as being above the clinical cut-off (1.29 females, 1.19 males) (representative of a clinical population) pre-therapy to being below the cut-off (representative of the general population) post-therapy. These results are shown in Table 18 (p.140) and presented graphically in Figure 5 (p.140).

Changes in clinical significance were explored for each attachment style group and results shown in Table 18. 50% of Dismissing group patients, 37.5% Secure and 10% Preoccupied group achieved a clinically significant change over the course of therapy although the total numbers were small.

Table 18  
*Change in Clinical Significance by Patient Attachment Style*

Pre status	Post status	Secure		Preoccupied		Fearful		Dismissing	
		<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Clinical	Non-clinical	3	37.5	1	9.09			2	50
Clinical	Clinical	3	37.5	6	54.55	3	75	1	25
Non-clinical	Clinical			1	9.09				
Non-clinical	Non-clinical	2	25	3	27.27	1	25	1	25
Total		8	100	11	100	4	100	4	100

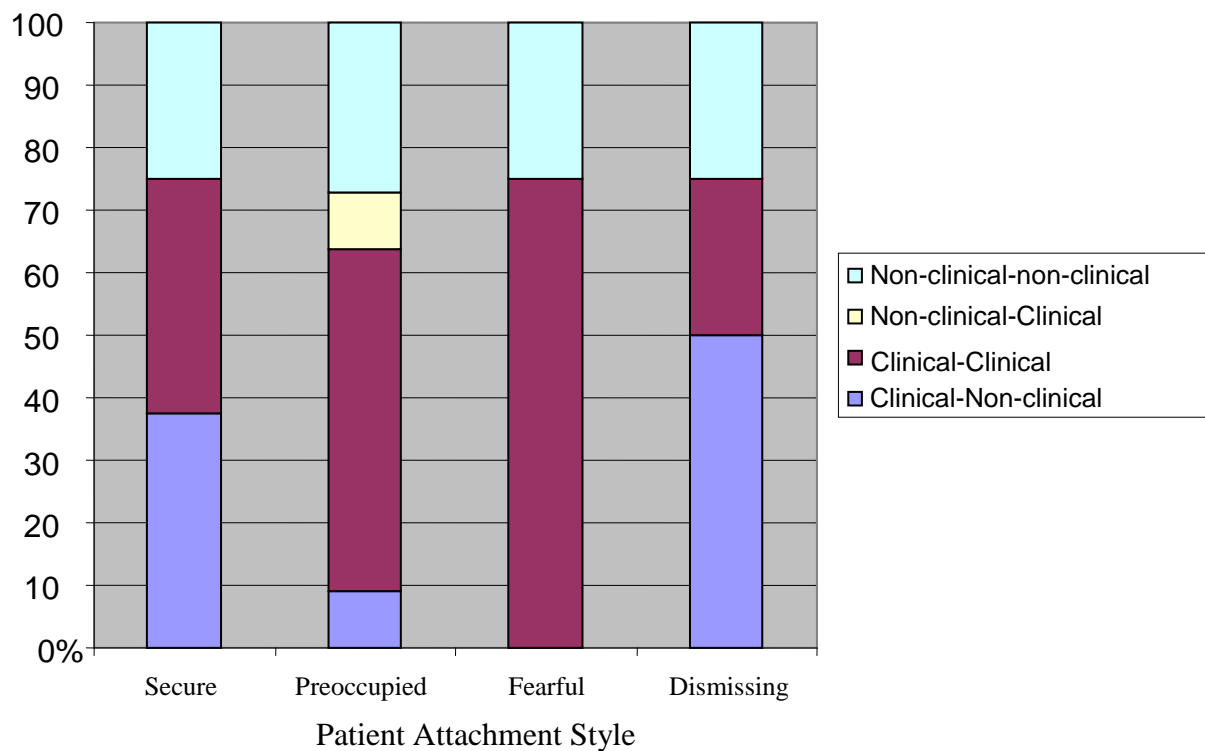


Figure 5 *Change in Clinical Significance*

Patients' change in clinical significance following therapy was examined in relation to their therapists' attachment style and presented below in Table 19. Few patients made a change from clinical status to non-clinical status. 21.05% of patients with a Secure attachment style therapist compared to 40% of patients with a Dismissing attachment style therapist went from clinical to non-clinical status. 47.37% of patients with a Secure attachment style therapist compared to 40% of patients with a Dismissing attachment style therapist remained within clinical status at end of therapy measurement.

Over the course of therapy, more dismissing group patients and patients of dismissing therapists made a clinically significant change as measured by the CORE-OM. It was not possible to reject the null hypothesis.

Table 19

*Change in Clinical Significance by Their Therapists' Attachment Style*

Patient		Therapist Attachment Style					
Clinical cut-off		Secure		Preoccupied		Dismissing	
Pre	Post	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Clinical	Non-clinical	4	21.05			2	40
Clinical	Clinical	9	47.37	2	66.67	2	40
Non-clinical	Clinical	1	5.26				
Non-clinical	Non-clinical	5	26.32	1	33.33	1	20
Total		19	100	3	100	5	100

### 6.3.2 Reliable Change by Attachment Style

A criterion for reliable change was calculated based on the coefficient alpha 0.94 for the internal reliability of this data. The formula  $1.96 \times SD_1 \times \sqrt{2 \times (1 - \text{rel})}$ , where  $SD_1$  equals the pre-therapy CORE-OM standard deviation and where reliability equals 0.94. This formula is based on change that will happen less than 5% of the time by measurement unreliability alone. Calculations for each attachment style group gave varying levels to determine reliable change and these are presented below in Table 20 and were used for further analyses.

Table 20  
*Reliable Change Criterion for Attachment Groups*

	Pre CORE-OM Mean	SD	Post CORE-OM Mean	difference	Reliable change
Secure	1.59	0.93	1.05	0.54	0.63
Preoccupied	1.49	0.70	1.31	0.18	0.48
Fearful	1.66	0.74	1.32	0.34	0.50
Dismissing	1.96	0.86	1.31	0.64	0.58

75% of Dismissing style patients made a “reliable improvement” compared to 62.5% Secure style patients. 18.18% of Preoccupied and 50% Fearful group patients made “reliable improvement”. 1 Preoccupied patient was classified as having “reliably deteriorated”. These results are presented in Table 21 (p. 142) and again, graphically, in Figures 6 and 7 (p. 142& 143).

Table 21  
*Reliable Change by Patient Attachment Style*

Change	Patient Attachment style							
	Secure		Preoccupied		Fearful		Dismissing	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Reliable improvement	5	62.5	2	18.18	2	50	3	75
Non-reliable improvement			6	54.55	1	25		
Non-reliable deterioration	3	37.5	2	18.18	1	25	1	25
Reliable deterioration			1	9.09				
Total	8	100	11	100	4	100	4	100

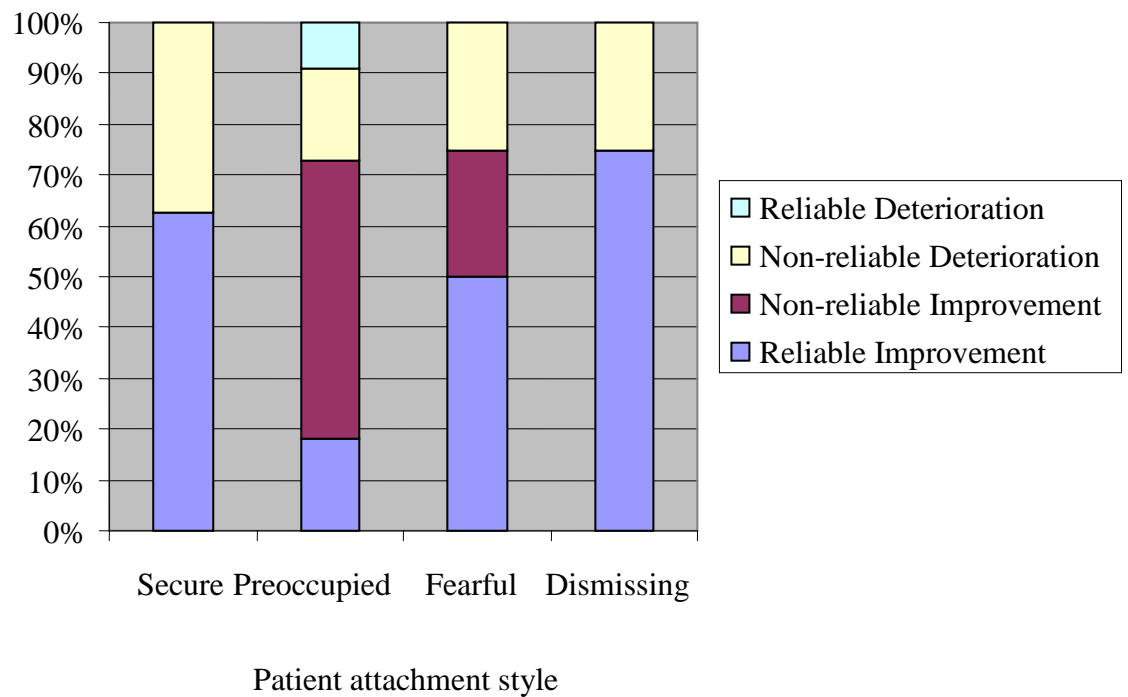


Figure 6 *Reliable Change as Shown by CORE-OM*

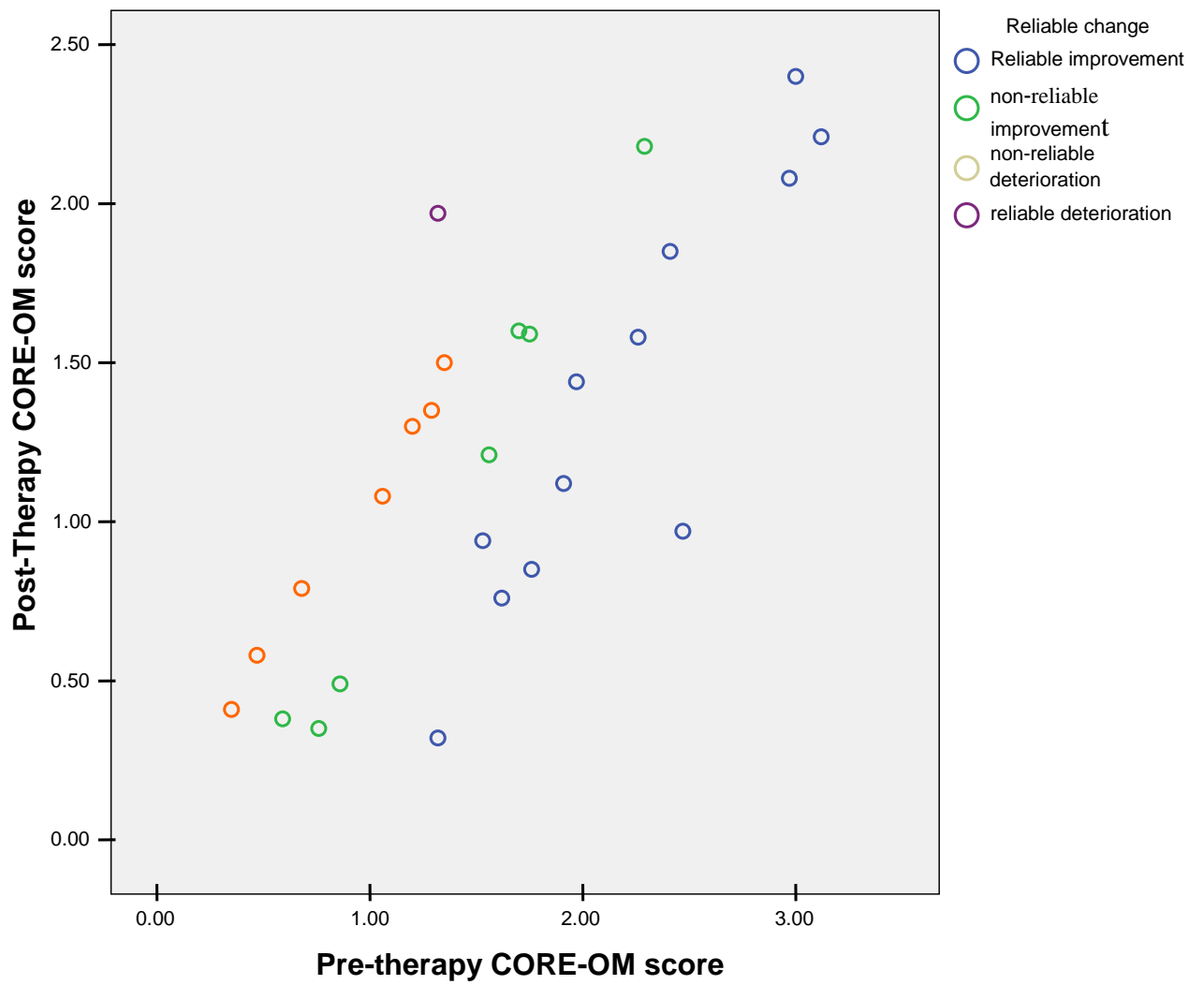


Figure 7 *Reliable Change in Relation to Pre-therapy CORE-OM Scores*

The classification of “reliable change” in patients was further explored in relation to therapists’ attachment style and the results presented in Table 22 (p. 144).

36.84% of the patients seen by Secure attachment style therapists made a “reliable improvement” compared to 33.33% seen by Preoccupied attachment style therapists and 40% of those seen by Dismissing attachment style therapists. 31.58% of patients with a secure attachment style therapist made a “non-reliable improvement” compared to 60% of the patients seen by Dismissing attachment style therapists. None of the patients seen by Dismissing attachment style therapists were classified as having “reliably” or “non-reliably” deteriorated.

Table 22

*Reliable Change by Therapist Attachment Style*

Change	Therapist Attachment Style							
	Secure		Preoccupied		Fearful		Dismissing	
	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%	<i>N</i>	%
Reliable improvement	7	36.84	1	33.33	-	-	2	40
Non-reliable improvement	6	31.58	-	-	-	-	3	60
Non-reliable deterioration	5	26.32	2	66.67	-	-	-	-
Reliable deterioration	1	5.26	-	-	-	-	-	-
Total	19	100	3	100	-	-	5	100

It was predicted that more patients of secure therapists would show “reliable improvement” than patients of insecure therapists. This hypothesis was not

supported.

Over the course of therapy, more dismissing group patients and patients of dismissing therapists made a reliable change as measured by the CORE-OM,

#### ***6.4 Therapeutic Alliance Ratings***

It was predicted that concordant secure/secure attachment style patient/therapist dyads would have far higher concordant alliance at outcome evaluation than other dyads.

Only complete data for patient and therapist dyads ( $n = 25$ ) was included in analysis of the therapeutic alliance ratings as measured by the Agnew Relationship Measure at Time 1, (session 5) and again at Time 2, (end of therapy or session 40, whichever was sooner). Two dyads were excluded from the analyses due to missing data.

Means and Standard Deviations for the Global alliance scores are presented below in Table 23. Therapists appeared to remain relatively consistent over the course of therapy in their rating of the alliance. Patients rated the alliance more highly at both Time 1 and Time 2 than did their therapists.

Table 23  
Means and Standard Deviations for Global Alliance Scores

		Agnew Relationship Measure Global Score						
		<u>Time 1</u>		<u>Time 2</u>				
	<i>N</i>	Mean	<i>SD</i>	Mean	<i>SD</i>	<i>t</i>	<i>df</i>	sig
Therapist	25	62.96	8.33	62.64	9.98	0.19	24	0.85
Patient	25	74.00	10.46	75.64	9.82	0.95	24	0.35

Differences between Time 1 and Time 2 Global alliance scores were not found to be significant for either therapists or their patients using *t* - test.

Differences between therapists' and patients' Global Alliance scores at Time 1 were significant,  $t = 4.7139$ ,  $df = 24$ ,  $p < 0.001$ , and again at Time 2,  $t = 4.9241$ ,  $df = 24$ ,  $p < 0.001$ .

Scores from the four subscales of the Agnew Relationship Measure were analysed. Means and Standard Deviations at Time 1 and Time 2 from the therapists' ratings are presented in Table 24 (p. 147). Ratings of the Bond, Partnership and Confidence subscales were slightly lower at Time 2 than at Time 1. The rating of the Openness subscale was lower than that of Bond, Partnership and Confidence at both assessment points.

Patients' ratings of the Agnew Relationship Measure Subscales was analysed next. Means and Standard Deviations are presented in Table 24 (p.148). In all subscales, there was a slight increase in mean ratings at Time 2.

The patient ratings of the Openness subscale at both time points were lower than those for other subscales.

Analysis of the Agnew Relationship Measure subscales at Time 1 showed significant differences between therapist ratings and patient ratings for all subscales: Bond:  $t = 2.6598$ ,  $df = 24$ ,  $p < 0.05$ , Partnership:  $t = 2.3943$ ,  $df = 24$ ,  $p < 0.05$ , Confidence:  $t = 5.7162$ ,  $df = 24$ ,  $p < 0.001$ , Openness:  $t = 3.7979$ ,  $df = 24$ ,  $p < 0.001$ .

Table 24

*Means and Standard Deviations Patient and Therapist Ratings of Alliance*

ARM	Therapist Ratings		Patient Ratings		$t$	$df$	sig
Time 1	M	SD	M	SD			
Global	62.96	8.33	74.00	10.46	4.72	24	***
Bond	17.40	3.66	19.44	2.26	2.66	24	*
Partnership	16.88	1.90	18.80	3.38	2.39	24	*
Confidence	16.04	2.48	19.20	2.48	5.72	24	***
Openness	12.46	4.12	16.48	4.43	3.80	24	***
Time 2							
Global	62.64	9.98	75.64	9.82	4.92	24	***
Bond	17.12	3.40	19.80	1.94	3.05	24	**
Partnership	16.72	3.01	19.44	3.19	3.38	24	**
Confidence	15.92	3.05	19.72	2.07	3.73	24	***
Openness	12.88	4.17	16.56	4.93	3.46	24	**

\* significant at the 0.05 level (2-tailed)

\*\* significant at the 0.01 level (2-tailed)

\*\*\* significant at the 0.001 level (2-tailed)

Analysis of the Agnew Relationship Measure subscales at Time 2 showed significant differences between therapist ratings and patient ratings for all

subscales: Bond:  $t = 3.0494$ ,  $df\ 24$ ,  $p < 0.05$ , Partnership:  $t = 3.3790$ ,  $df\ 24$ ,  $p < 0.05$ , Confidence:  $t = 3.7297$ ,  $df\ 24$ ,  $p < 0.001$ , Openness:  $t = 3.4582$ ,  $df\ 24$ ,  $p < 0.05$ .

Whilst the difference between therapist and patient ratings of the Confidence subscale remained significant at both Time 1 and at Time 2, there was a slight decrease in the degree of significance over time: Time 1,  $p = 0.0001$  and Time 2,  $p = 0.001$ .

Again, the difference between therapist and patient ratings of the Openness subscale remained significant at both Time 1 and at Time 2, there was a slight decrease in the degree of significance over time: Time 1,  $p = 0.0009$  and Time 2,  $p = 0.0020$ .

#### ***6.4.1 Attachment Style and Ratings of the Therapeutic Alliance***

One-way ANOVAs did not show any significant associations between therapist attachment style and therapist ratings of the alliance.

One-way ANOVAs did not show any significant associations between therapist attachment style and patient ratings of the alliance at the 95% confidence level. A between-attachment style group difference did approach significance for patients' ratings of the Openness subscale at Time 2,  $F(2,22) = 2.969$ ,  $p = 0.072$ . Patients of Dismissing attachment style therapists had a lower mean compared to patients of Preoccupied style therapists.

One-way ANOVAs did not show any significant associations between patient attachment style and either patient or therapist ratings of the alliance at the 95% confidence level. Patient attachment style appeared to be associated with therapist ratings of the Confidence subscale at both Time 1 and Time 2, although this just approached significance. Table 25 (p. 150) presents these results: Time 1:  $F(3,21) = 2.935, p = 0.057$ ; Time 2:  $F(3,21) = 2.704, p = 0.071$ . Therapists of secure style patients rated the Confidence subscale lower (mean 13.43) than therapists of insecure attachment style patients (mean Preoccupied, 16.78, Fearful 17.50, Dismissing 16.60).

Table 25

*Analysis of Variance, Therapist Ratings of ARM "Confidence" Subscale*

	Sum of Squares	<i>df</i>	Mean Square	<i>F</i>	Sig
Between Groups					
Time 1	43.410	3	14.470	2.94	0.057
Between Groups					
Time 2	62.370	3	20.790	2.70	0.071

One-way ANOVAs showed that there was a between-groups difference for therapists' experience and therapists' ratings of the Confidence subscale. This approached significance,  $F(6,18) = 2.220, p = 0.089$ . Therapists who had only one year post-qualification experience ( $n = 2$ ) and those who had 4 years experience ( $n = 7$ ) rated the Confidence subscale lower than other therapists.

Patient attachment style appeared to be associated with patient ratings of the Openness subscale at Time 2 although this just approached significance,  $F(3,21) = 2.590, p = 0.08$  (see Table 26, p. 151). Fearful and Dismissing style patients rated their capacity to be open lower than did either Secure or Preoccupied style patients.

Table 26

*Analysis of Variance, Patient Ratings of ARM "Openness" Subscale*

	Sum of Squares	df	Mean Square	F	Sig
Between Groups	162.037	3	54.012	2.60	.080

## 6.5 Linear Regression

As all variables were measured on a continuous scale, linear regression was used to examine the association between ECR patient measures and final session CORE-OM values.

Two sets of analyses were performed. Firstly, the association between each of the two ECR dimensions of Anxiety and Avoidance, and the final session CORE-OM values were examined without considering any other variables. Secondly, the same associations were examined, this time adjusting for the overall patient and therapist ARM scores at Time 1. This second analysis was performed using multiple linear regression. In addition, the change in CORE-OM scores from pre therapy to post-therapy/ 40<sup>th</sup> session were calculated, and a similar set of analyses was performed using the same methods.

Linear regression was used to examine the association between the ECR dimensional measures and the CORE-OM scores, both in a simple comparison (unadjusted analysis) and adjusted for the overall ARM scores.

The summary of the analysis is presented below in Table 27. The figures reported are the regression coefficients, and their associated 95% confidence intervals. These figures represent the change in the outcome score when the explanatory factor increases by one-unit (for example, for ECR avoidance upon the post CORE-OM scores, the regression coefficient indicates the change in the post scores when ECR avoidance goes up by one unit). The *p*-values indicating the significance of the results are also reported.

Table 27  
*Linear Regression Results*

Score type	Factor	Analysis	Coefficient (95% CI)	P-value
Post scores	ECR avoidance	Unadjusted	0.08 (-0.14, 0.30)	0.45
		Adjusted	0.07 (-0.17,0.31)	0.56
	ECR anxiety	Unadjusted	0.15 (-0.09,0.04)	0.21
		Adjusted	0.12 (-0.16,0.40)	0.39
Changes in scores	ECR avoidance	Unadjusted	-0.07 (-0.23, 0.10)	0.42
		Adjusted	-0.09 (-0.27,0.09)	0.32
(Pre to Post)	ECR anxiety	Unadjusted	0.04 (-0.15,0.24)	0.64
		Adjusted	0.04 (-0.18,0.27)	0.70

The analysis results indicated no evidence of a statistically significant effect of either ECR avoidance or ECR anxiety upon either the post CORE-OM scores, or upon the change in CORE-OM values from pre to post. The results were similar when the unadjusted results were examined or whether the results accounting for the ARM scores were examined.

The subsequent Figures 8 and 9 (pp. 152 & 153) give scatter plots which illustrate the relationships between ECR avoidance and anxiety with the post CORE-OM scores. These show little association between the measures, which backs up the results of the statistical analyses.

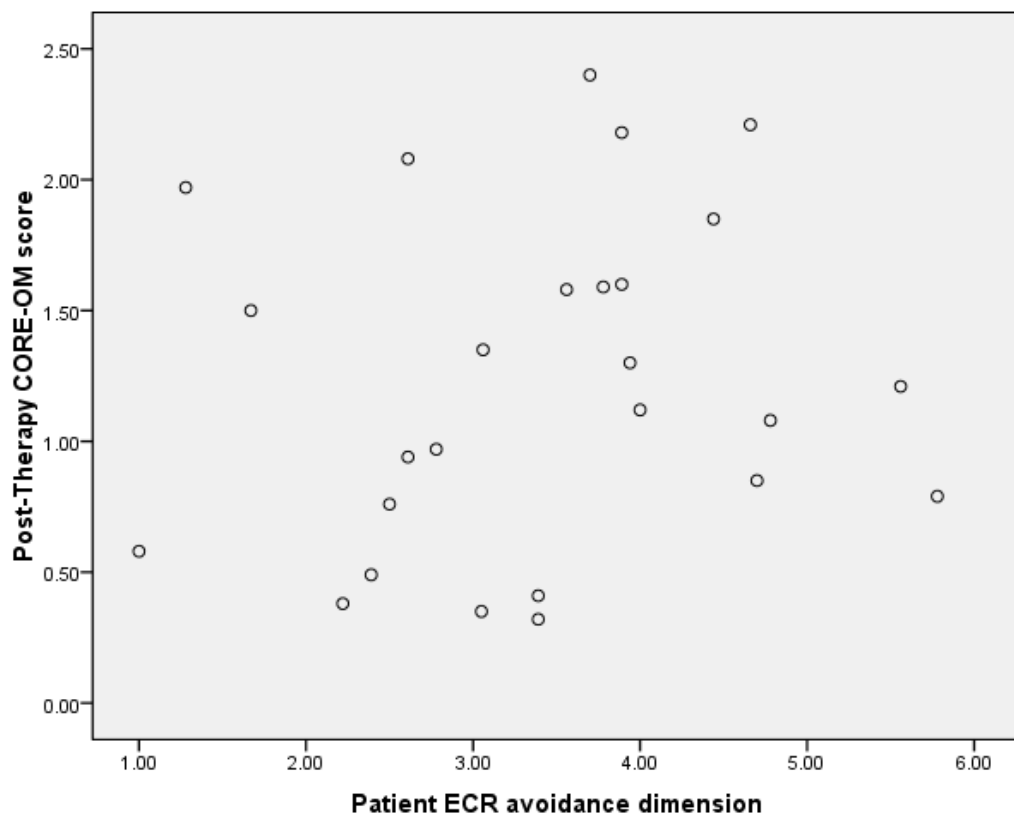


Figure 8  
*Relationship of ECR Avoidance With the Post CORE-OM Scores*

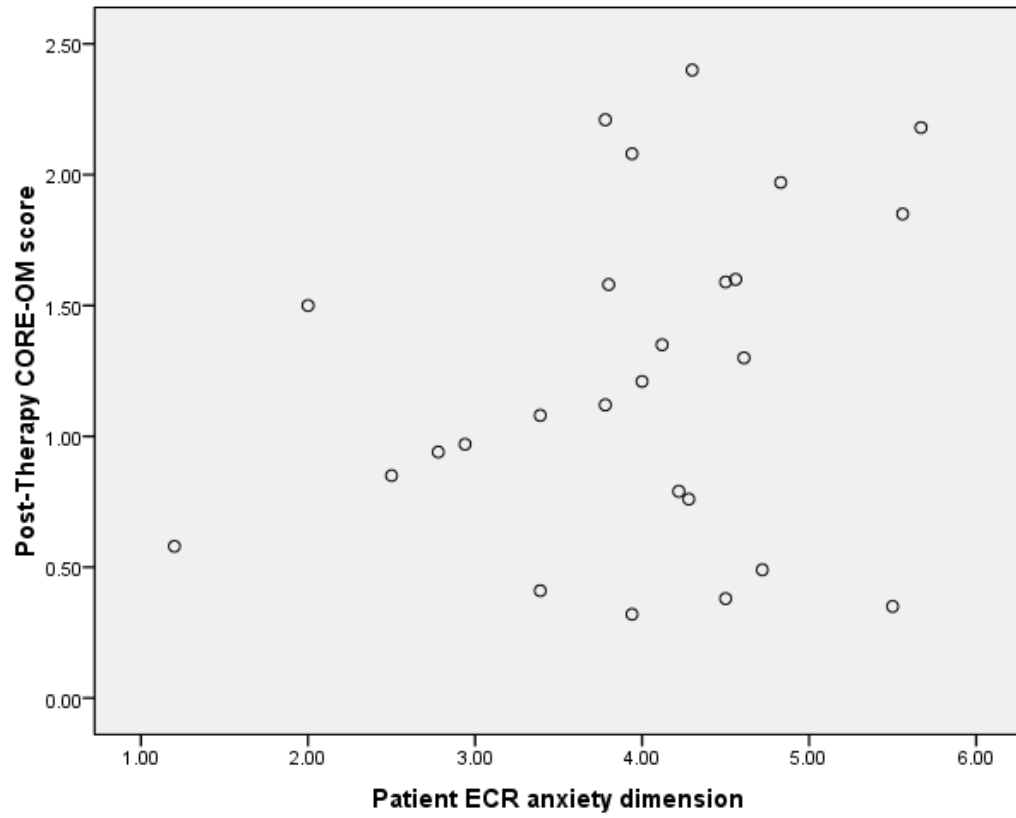


Figure 9  
*Relationship of ECR Anxiety With the Post CORE-OM Scores*

## **Chapter 7**

### **Discussion**

This study proposed that the association of attachment and outcome is mediated by the therapeutic alliance. It also hypothesised that security of attachment in therapists would be associated with more clinically significant and reliable change in their patients and that concordant secure/secure attachment style patient/therapist dyads would have far higher concordant alliance at outcome evaluation than other dyads.

Although it was not possible to reject the null hypotheses, other findings emerged which can contribute to understanding the relationship of attachment and psychotherapeutic process. This study found that patients with dismissing attachment style and the patients of therapists with dismissing attachment style were more likely to make a clinically significant and reliable improvement than other patients. It has been previously argued (Section 5.8) that quantitative methods, whilst concerned with hypotheses testing can also be used creatively to explore unexpected findings within a study by teasing out relationships between variables. This creates the opportunity to revisit and revise the theory behind the hypotheses and to pursue the ways in “which the findings ... suggest new departures and theoretical contributions” (Bryman, 2001, p.435). Original findings in this study were that Dismissing attachment style was found to be associated with both patient and therapist ratings of the Openness subscale of the Agnew Relationship Measure and that therapists of securely attached patients made lower ratings of the alliance subscale for Confidence. A particularly interesting and unexpected finding was that patients were more likely to have

only brothers and no sisters and that this sub-group was less likely to have a support network in whom they could confide.

This chapter explores the findings from the data analysis, considers the theoretical implications for the attachment process in therapy and for the practice of counselling psychology.

## ***7. New ways of looking at the impact of attachment within therapy***

Short-term therapies of once-weekly intensity enable dismissing style patients to restore their defences, reduce distress and show clinically significant change in terms of reduction of symptomatology. Therapists who are categorised as dismissing style are also more effective in short-term, once-weekly therapies as their capacity to contain emotional distress appears to enable them to resist getting overly embroiled in preoccupied patients' affective dysregulation or to challenge dismissing patients' defences prematurely. This suggests that the experience of personal therapy for therapists enables them to work through their own adverse attachment histories, deriving greater emotional resilience together with the capacity to offer sensitive responsiveness to their patients.

### ***7.1 Participants***

#### ***7.1.1 Recruitment of Therapists***

Many people declined to participate. Considerable anxiety appeared to be engendered by invitations to participate. Whilst some of the reasons given were understandable, such as professional association with researcher, others appeared spurious. One argument given against participating was that the therapy

relationship is complex and that the use of self-report questionnaires would not capture unconscious processes. Some expressed concerns that the use of a questionnaire would impact detrimentally on the therapeutic relationship. Others argued that the CORE-OM is a symptom-based measure and reduced therapy outcome to the measurement of diminishing symptomatology, ignoring the complexity of inter and intrapersonal process. Thinking about those therapists who declined to participate, it can be argued that there was a fear of being exposed and evaluated which was justified by other more acceptable reasons for non-participation. The resulting sample was not random and arguably not representative of therapists. It has been argued (Bryman, 2001) that participants might only become involved in a particular study due to strong allegiance to the concepts being explored, thus introducing bias. Although this might be true for some of the participants in this study, others agreed to participate for altruistic reasons as they had only recently completed their own research studies and appreciated the recruitment difficulties. To participate in such a study, where not only personal but professional information was disclosed, required considerable self belief and trust in the researcher. It is possible that the resulting sample of therapists had more self-confidence in their clinical practice which would impact on completion of measures such as the Agnew Relationship Measure by both their patients and themselves.

### ***7.1.2 Orientation of Therapists***

Whilst 42.9% ( $n = 6$ ) therapists described their theoretical orientation as psychoanalytic, 35.7% ( $n = 5$ ) as cognitive, 14.3% ( $n = 2$ ) as integrative and 7.1% ( $n = 1$ ) as phenomenological, 71.43% therapists ( $n = 10$ ) also stated that

they practised regularly using other models. This may reflect the pragmatism and flexibility required within NHS practice rather than being reflective of individuals' preferences. Whilst there appear to be no fixed theoretical points of reference for a modern therapist in a post-modern world (Holmes and Bateman, 2002), it could be argued that an integration of approaches would encompass cognitive and psychoanalytic theoretical overlap and would be beneficial in clinical application. Unfortunately the majority of therapists did not report which model of therapy was used with a particular patient. It was not therefore possible to analyse any associations between attachment, outcome and model of therapy as previously explored by researchers (e.g. Borman Spurrell, 1996; Saatsi, Hardy and Cahill, 2007). Anecdotal information suggests that 40.74% ( $n = 11$ ) of therapies were eclectic or integrative, 29.63% ( $n = 8$ ) were psychoanalytic psychotherapy and 29.63% ( $n = 8$ ) were CBT. This research studied therapists and patients within individual therapy so no group or family modalities were used.

### ***7.1.3 Personal Therapy***

Eleven therapists had been in personal therapy. Nine of these therapists had been in psychoanalytic psychotherapy for four or more years. Whilst a personal therapy is a requirement of psychotherapy training and counselling psychology training, it is not so for clinical psychology. Six clinical psychologists took part in this study, of whom three had been in psychoanalytic psychotherapy for two or more years. The three clinical psychologists who had not been in personal therapy, all practised solely within a CBT model and all rated themselves as "securely attached" on both the Relationship Questionnaire

and the Experiences of Close Relationships questionnaire. The three therapists who rated themselves as “insecurely attached” had all been in psychoanalytic psychotherapy (Mean 8.6 years).

Personal therapy was negatively correlated with age and with years of clinical experience which might reflect changes in training emphasis or the recent trend away from more exploratory therapeutic orientations. It is possible that with professional experience comes a growing realisation of one’s own vulnerabilities or areas of difficulty which impact on therapeutic work. Personal therapy of a sufficient depth and duration will have enabled the working through of adverse attachment histories thus preventing adverse impact on the therapist’s capacity to provide a “secure base” or “responsive empathy” (Harris, 2004).

For some therapists in this study, a personal therapy may have enabled them to move from insecurity of attachment to being securely attached: the “earned security” described by Phelps *et al* (1998). This follows the modification of Bowlby’s internal working models, allowing an assessment of their attachment security which better reflects the current reality. Some therapists will have had histories of early loss, neglect and abuse which will adversely affect their capacity to respond sensitively to their patients unless worked through in personal therapy. Such histories can be captured by questionnaires such as the CECA-Q. As Slade (1999) argued, the caring experience within therapy might remind therapists of their earliest experiences and Pines and Marrone (2003), in agreement with this, add that the therapist’s experiences with their own therapist

contribute to their capacity to offer their patients safety and emotional connection or a “secure base”.

#### ***7.1.4 CECA-Q Responses***

All of the therapists who had experienced some childhood physical abuse had been in psychoanalytic psychotherapy.

The significant association of Maternal antipathy with Paternal antipathy suggests that within some therapists’ families of origin, there was little experience of warmth or consistent affection. The three insecure attachment style therapists and the securely attached therapist who had experienced physical abuse, all reported greater antipathy from either one or both parents.

The significant association of Maternal Neglect with the ECR avoidance dimension is understandable in terms of attachment theory as the neglected child gives up on expecting emotional reciprocity and care, and plays down the importance of attachment relationships. Such difficulties with intimacy could impact on the establishment of the therapeutic alliance and might contribute to patients of such therapists finding it harder to be disclosing and feel safe. It seems as though this occurred in this current study. The two dismissing attachment style therapists had experienced physical abuse from both father and mother and had endured either maternal or paternal neglect. Both therapists had patients whose evaluations of the alliance Openness subscale decreased considerably over the course of therapy (see Section 8.5.7, p. 190). It is possible

that the patients did not feel able to express their feelings within that last session and this might reflect their perception of their therapist's availability.

The correlation between Physical abuse and ECR avoidance was highly significant although, as highlighted in the Chapter 7, the total number of therapists who had experienced physical abuse was only four. Comparison of Mean scores on both the CECA-Q and ECR avoidance dimension does suggest a relationship between physical abuse and attachment avoidance. Mean ECR avoidance dimension was 3.24 for abused therapists compared to the whole sample Mean of 1.6. Two therapists who had endured physical abuse could be categorised as Dismissing-avoidant. One therapist, however, was securely attached but with a negative-self, positive other score on the RQ dimensional score.

## ***7.2 Attachment Style of Participants***

Whilst the capacity to form a relationship with the therapist appears to be empirically associated with attachment, it does not seem to be an association that is captured by the self-report questionnaires used in this study. This raises questions about the utility of these same questionnaires in research into psychotherapeutic process. Although they are both well-validated instruments, their use was based on the assumption that their operationalisation of attachment was important within therapy. And yet it is difficult to say that attachment is not important when dismissing patients did so much better.

The experience of personal therapeutic work will have enabled therapists to work through their own attachment histories. They are likely to have developed strengths and depths of self-awareness which enhanced their technical skills. The capacity to establish a sound alliance which will serve as a secure base is then less related to attachment style but rather to the working through of adverse attachment histories. Therapists who have had therapy of sufficient depth and intensity can draw on their experiences of affect regulation with their therapists to provide effective emotional regulation to their patients.

### ***7.2.1 Attachment Style of Therapists***

Stein *et al* (2002) argued that the Relationship Questionnaire is twice as likely as other measures to classify participants as fearful. This study found some anomalies in self-rated attachment style across the two measures, the Relationship Questionnaire and the Experiences in Close Relationships. Due to the small number of participants in each attachment category, it was not possible to analyse the categorical scores for the RQ. ECR scores were used in all analyses.

The majority of therapists rated themselves as secure attachment style on the Relationship Questionnaire and this was also seen in the scores on the ECR. The total numbers of therapist participants was small and made it difficult to see whether there was significant association between therapist attachment style and outcome or ratings of the alliance. Whilst the Relationship Questionnaire has been shown to be the only self-report measure of attachment free from self-

deceptive biases (Leak and Parsons, 2001), it is always possible that the desire to respond in a socially acceptable way affected responses.

Ten therapists rated themselves as secure attachment style on the RQ whereas eleven did so on the ECR. One therapist was Dismissing attachment style on the RQ but then Secure attachment style on the ECR. Three therapists rated themselves as “insecurely attached” on both the RQ and the ECR. The scores for one therapist placed them as “dismissing” on both measures, for one their scores gave a “dismissing” style on the ECR whilst on the RQ they were categorised as “fearful”. The third therapist’s scores categorised them as “preoccupied” on the ECR whilst they were “fearful” on the RQ. This needs to be considered in association with Stein *et al*’s (2002) argument that the Relationship Questionnaire is twice as likely as other measures to classify participants as fearful.

### **7.2.2 Attachment Style of Patients**

The variation between RQ categorization and ECR classification was even more pronounced when the patient participants’ responses were explored. Seventeen patients were categorized as fearful attachment style on the RQ whilst only two remained fearful according to the scores from the ECR. Six fearful attachment style respondents changed to preoccupied attachment style on the ECR, six gave responses that placed them within the secure attachment style group and three fearful participants were dismissing style on the ECR.

Brennan *et al* (1998) used scores on the Anxiety and Avoidance dimensions as a basis for clustering, which revealed four distinct groups resembling the secure, fearful, preoccupied and dismissing categories as described by Bartholomew (Bartholomew and Horowitz, 1991). However, it does not seem as though the four categories capture the same feelings about intimate relationships.

### **7.3 *Patients and Siblings***

Only one participant in this sample was an “only-child”. 51.85% ( $n = 14$ , 3 men, 11 women) patient participants had only brothers. There appeared to be no other data from similar patient groups with which to compare this sample. Statistical analyses did not show any significant relationship which might be due to the small sample. This might be an interesting area to study further with a larger sample size.

#### **7.3.1 *Patients and Support Networks***

Eight patients stated that they had no-one, excepting the therapist, with whom they would feel able to discuss any problems. The lack of support these patients had in their lives might be related to difficulties they experienced in initiating and maintaining close, confiding relationships. Six of these eight patients also had only brothers and no sisters and it raises thoughts about whether in childhood, these patients had been unable to experience such intimate relationships and had never learnt the pleasure of emotional reciprocity.

Insecurity of attachment in the earliest years of childhood is associated with later difficulties at school and within peer relationships. These children have expectations of others in relationships which reflect the internal working models formed in their earliest attachment relationships. It seems likely that difficulties in making and sustaining friendships in early childhood would continue through adolescence and into adult life. Whilst this might not be so for all insecure children, six insecure attachment style participants in this study did not feel they had any supportive figure with whom to discuss any problems. Whilst it seems likely that their insecurity of attachment has impacted on their capacity to create satisfying and supportive friendships, it is not necessarily a causative factor. It does not automatically mean that these individuals do not have any friends or partners. It seems to imply that the respondents felt that there was no-one in whom they could confide and this might reflect their internal working models and their lack of trust in others, not expecting to find understanding or help in times of need.

The fact that six of the eight participants without a supportive figure also came from the sibling group of “brothers only” warranted further exploration. It raises the question as to whether the impact of having an older brother was somehow detrimental to these girls’ development. Children’s earliest relationships with their siblings have been shown to impact on their social development and their later relationships. Conflict and co-operation with siblings facilitates the child’s learning about the thoughts, feelings and intentions of others. A child’s interest in mother’s relationship with other siblings is a basis for their social understanding (Dunn and Plomin, 1990). It might be that mothers, already struggling with boisterous boys had little time for their small daughters.

Conversely, mothers might have been overly involved with their daughters and feared separation and any signs of independence (three of these women were preoccupied).

#### **7.4 Measures Of Outcome**

Over the course of their therapies, the sample of patients in this study showed overall significant improvement, with mean pre-therapy CORE-OM score of 1.61 and mean last-session CORE-OM score of 1.23,  $t = 4.14$ ,  $df = 26$ ,  $p < 0.001$ ,  $d = 0.54$ . The effect size is conventionally considered a medium effect size (Cohen, 1992).

##### **7.4.1 Therapist Security and Outcome**

It was predicted that secure therapists would have more patients who made clinically significant improvement (as measured by the CORE-OM) when compared to patients of insecure therapists. This hypothesis was not supported. Only three of the fourteen participating therapists were “insecurely attached” on self-report measures which made statistical analyses difficult and may obscure any relationship between attachment style of therapists and patient outcomes.

When the scores were explored to ascertain associations with therapist’s attachment styles, a medium effect size of 0.52 was found for the patients of secure attachment style therapists. The very large effect size of 1.02, found for the patients of dismissing attachment style therapists, might reflect the small

number ( $n = 2$ ) of such therapists. The fact that Analysis of Variance did not show significant between-group differences might be due to the small sample size.

21.05% patients of secure therapists made a clinically significant change compared to 40% patients of dismissing style therapists. However, the total numbers of both patients and therapists were too small to find statistically significant results. There did appear to be a trend.

The decision to retain the “clinically significant change” cut-off was arguably too strict given the sample population who had in many cases longstanding difficulties of moderate to severe degree. It is questionable whether expecting “*returning to normal functioning*” (Jacobson *et al*, 1999) is realistic even though many purchasers of mental health services appear to be moving towards this kind of evaluation. Many of the therapies were of very short duration and as Lambert, Hansen, Finch (2001) found in their extensive review, this will be inadequate for the majority of patients to achieve “clinically significant change”. This will be explored further in Section 7.4.5 when association of outcome and duration of therapies is considered.

When the results for “reliable improvement” are considered, a slightly higher percentage of patients seen by dismissing attachment style therapists showed “reliable improvement” (40%) than did patients of either Secure attachment style therapists (36.84%) or preoccupied style therapists (31.58%). The similarities in percentages might indicate that professional training of this

experienced group of therapists and personal therapy moderated the impact which attachment style might have had on outcome. Dismissing style therapists did not have any secure attachment style patients but saw two fearful, one dismissing and two preoccupied. Both these therapists practised within an integrative model and both had been in twice weekly psychoanalytic psychotherapy (Mean 8.5 years).

Whilst it has been argued that secure attachment style patients are more able to use the therapist as a secure base and to experience the therapist as a safe and available figure (Parish and Eagle, 2003), this assumes that the therapist has the capacity to be emotionally available and able to be used in this way. Insecure therapists have been found to experience more difficulties within therapeutic practice and to be more likely to locate difficulty within themselves (Leiper and Casares, 2000). Therapists rated as insecure attachment style in this study had had considerable personal psychoanalytic psychotherapy. Whilst they remained “dismissing” or “preoccupied” according to the self-report measures, it has to be remembered that questions relate to intimate relationships in general and might not adequately reflect the therapists’ capacity for intimacy within therapy relationships.

Dismissing therapists arguably can contain and put to one side their own feelings. It is possible that their own awareness of the difficulties of tolerating intense and painful feelings developed through their personal therapy. This might make them less likely to stir up patients beyond the tolerable limits within a short-term therapy. Whether these therapists would be equally effective in long term therapies of several times weekly is less certain. It is quite possible that

they might have more difficulties with dismissing patients. Whilst they might easily empathise with their emotional difficulties, they might collude with the patients' maladaptive patterns of relating being unable to challenge them. If these difficulties and associated adverse early attachment histories have been worked through in the therapist's own therapy, these problems will be less likely to occur.

It can be argued that preoccupied therapists might find highly emotional patients hard to contain as their own feelings are activated and they get drawn into the maladaptive patterns of relating. Such therapists might be more effective if they were working in a more structured way. Conversely, these therapists could become frustrated by a more emotionally distant patient and seek an affective response of which the patient is not yet capable and which leaves the patient feeling attacked and misunderstood.

#### ***7.4.2 Security of Patient and Outcome***

Overall there was a moderate effect size of 0.54 for change as measured by the CORE-OM over the course of therapy. When this was examined in relation to patients' attachment style, both dismissing and secure attachment style patients appeared to do well with therapy although one-way ANOVA did not show any significant between-group differences, possibly due to the small sample size. Large effect sizes were seen for the dismissing group (0.86), medium effect sizes for the secure (0.69) and the fearful group (0.56) and a small effect size for the preoccupied group (0.27).

Whilst Dismissing patients achieved better outcomes as measured by the CORE-OM, this instrument only measures symptom reduction and quality of life; it does not measure intrapsychic change. It can be argued that the improvement in terms of reduced symptomatology implies that the initial distress has been contained and ameliorated by therapy. Therapy has served as a means to shore up the defences of these dismissing patients, enabling them to feel more able to cope. It has not, however, altered their attachment style and presumably not their expectations of relationships although these are assumptions rather than empirically supported facts. By sensitivity towards their patients' avoidant style, these therapists have been effective in brief therapies. Longer therapies will be needed if such patients are to be enabled to change.

Looking at the preoccupied patients, one might ask why they did not do so well in terms of outcome. For many of these patients, there is often a confusion of thoughts and feelings, times when they are unsure just whose thoughts they are thinking and whose feelings they are experiencing. Their preoccupation with earlier relationships and their high emotion elicited within therapy can often cause them to develop intense and entangled relationships with their therapists. In such situations, the capacity of the therapist to withstand such emotional pressure is vital. For therapists, this capacity may have resulted from their own therapy during which they will have worked through their own attachment histories.

Arguably, these patients should not have been in short-term therapies as many will have borderline personality structures.

It has been argued that Dismissing attachment style in patients is associated with reluctance in accessing help or greater rejection of treatment (Dozier, 1990), and less emotional commitment to treatment programmes (Korfmacher *et al*, 1997). This rejection of treatment in dismissing patients was not seen in this current study which used highly trained therapists, very experienced in establishing and maintaining a therapeutic relationship. The majority of therapists were self-rated as secure attachment style, and most had been in psychoanalytic psychotherapy of sufficient duration and depth to have worked through early adverse attachment histories.

Others have found that security of attachment predicted better outcome in terms of symptom reduction (Meyer *et al*, 2001; Saatsi *et al*, 2007) or goal attainment (Mosheim *et al*, 2000). In this current study, dismissing patients remained committed to the therapy and there was no attrition, a similar finding to that of Saatsi *et al* (2007). They also appeared to make more improvement which had also been a statistically significant finding in the Fonagy *et al* 1996 study where dismissing patients improved more than Preoccupied or Free-autonomous patients ( $\text{Chi-square } (2) = 14.9, p < .001$ ). However patients with a “dismissing” attachment style were reported as having a poorer outcome in brief psychodynamic psychotherapy (Horowitz, Rosenberg, and Bartholomew, 1996). Whilst other researchers (e.g. Hardy *et al*, 1998) have wondered whether dismissing patients might do better with a more cognitively oriented model, this was not so in this study. Although the overall numbers were too small to analyse statistically, two of the four patients had CBT, one had psychoanalytically-based

therapy, and one was in long-term psychoanalytic psychotherapy (the second CORE-OM being completed at session 40).

It has been previously argued that “dismissing” patients push therapists away (Slade, 1999) and that therapists can feel rejected and become punitive, responding to countertransference pressure (Dozier *et al*, 1994; Ligiero and Gelso, 2000). The therapists in this study appeared to be able to manage countertransference reactions, to respond to patients in a non-complementary manner (Bernier and Dozier, 2002) and to manage and repair the alliance in such a way that patients were enabled to remain within therapy.

In terms of “reliable change”, 75% of dismissing style patients made a “reliable improvement” compared to 62.5% Secure style patient, 18.18% of preoccupied and 50% fearful group patients. This was unlike Saatsi *et al* (2007) who found that 93% of secure interpersonal style patients showed clinically significant and reliable change, whilst only 52.5% avoidant and 38.5% ambivalent patients did so. This has to be considered in relation to the socio-economic status of participants.

Often studies select patients meeting specific diagnostic criteria. This study used a naturalistic design, with therapists recruiting patients from their regular practice. Most patients participating in this study had moderate to severe mental health difficulties and were being seen within community mental health teams (CMHTs). This has to be compared to participants drawn from university

counselling centres (e.g. Kivlighan *et al*, 1998; Mallinckrodt *et al*, 1995). Many patients in the current study had problems that were severe and longstanding.

The CMHTs were within areas of high socio-economic deprivation and a considerable number of patients participating reported that they were unemployed. Only ten patients were in full-time employment and three were employed part-time. Other studies (e.g. Hardy *et al*, 1998; Hardy *et al*, 1999; Stiles *et al*, 1998; Saatsi *et al*, 2007) have stated that their patient participants were “professional, managerial or white-collar”. Many patients in the current study lived in council or housing association accommodation, often living in “studio” flats. Their lives were often financially and socially difficult with little support and considerable external pressures. Whilst the CORE-OM measures symptomatology, many patients might have had ongoing social stressors in addition to intrapsychic distress and these would not have been ameliorated by psychological therapy. Whilst therapy might hope to increase resilience and self-efficacy, it cannot directly improve socio-economic deprivation.

The numbers were small and it is not possible to say for certain what would have happened with a larger sample size. There does appear to be a trend for “dismissing” patients to improve the most in terms of reliable change as determined by the CORE-OM. However, it is not certain whether this group would have shown such improvement in terms of overcoming interpersonal difficulties which would have been captured by a measure such as the Inventory of Interpersonal Problems (IIP; Horowitz *et al*, 1988), and which were used by

Saatsi *et al* (2007) in their study finding that Secure patients had better outcomes than other attachment style groups.

In this current study there appeared to be no association between attachment style and model of therapy when that was stated. The dismissing attachment style patients appeared to do well with psychoanalytic psychotherapy or with CBT, a finding similar to that of Borman Spurrell (1996). Within a group modality, Borman Spurrell found that preoccupied patients had better outcomes following cognitive behavioural psychotherapy in comparison with interpersonal psychotherapy whilst dismissing patients had good outcomes in both models of therapy.

Most therapists were self-rated as secure attachment style while, based on patient completed questionnaires, most patients were insecure attachment styles. Unlike Tyrrell *et al* (1999), all the therapists in this study were highly trained and experienced therapists, the majority of whom had been in personal analytic therapies of considerable duration. Their training and most likely current practice, would have involved intensive supervision. Personal insight and subsequent ability to deal with countertransference would make them less likely to remain drawn into countertherapeutic enactments. In the Tyrrell *et al* study, clinicians were not therapists but case managers and the work was not psychotherapy so that the non-complementary of either style of interpersonal relating might have become more important with the case management work.

This study found no association between symptom course and secure attachment which is as Fonagy *et al* found (1996) in the Cassell study where the insecure-dismissive style patients had the best response to treatment. Meyer *et al* (2001) only found a very weak association between attachment security and symptom course. Both the Meyer *et al* and Fonagy *et al* studies involved participants with severe personality disorders. Whilst the current study did not collect data on individual diagnoses, most of the patients were seen within NHS secondary or tertiary services and it can be assumed that they had enduring difficulties. Many patients are given primary Axis 1 diagnoses in accordance with the *Diagnostic and statistical manual of mental disorders* (DSM IV; APA, 1994) and the Axis 2 diagnosis remains unstated. It is likely that the patient sample in this study is more similar to the samples in Meyer *et al* and Fonagy *et al* than to studies where the patient sample was drawn from a population of counselling patients within university or community settings.

#### **7.4.3 Associations of Outcome with Therapist Experience**

Statistical analyses did not show any association between outcome and therapist experience. This was unlike the Kivlighan study where the relationship between therapist experience and patient perception of the working alliance was found to be moderated by patient attachment style. The literature on association between outcome and therapist experience is contradictory (Mallinckrodt *et al*, 1995; Dunkle and Friedlander, 1996; Kivlighan, *et al*, 1998). As previously stated (Section 8.4.2), this group of therapist participants were experienced clinicians. Training had been of many years duration and the Mean years of clinical practice was, for female therapists, 8.5 years, S.D. 13.35 and for male

therapists, Mean 10.83 years, S.D. 8.68. Some participating therapists were practising as psychologists, but had engaged in further psychotherapy training whilst other participants were psychotherapists. Eleven of the fourteen therapists had had their own personal therapies of considerable duration.

More experienced therapists are more able to challenge patients more effectively (Kivlighan *et al*, 1998) and more able to repair alliance ruptures (Hardy, *et al* 1998). Whilst this current study did not evaluate technical ability in this way, there was no patient attrition once therapy commenced which suggests that this group of therapists were expert in establishing, maintaining and repairing a therapeutic alliance. This also suggests that, at least to some extent, these therapists were able to manage countertransference and resist destructive enactments (Dozier *et al*, 1994; Slade, 1999; Tyrrell *et al*, 1999).

#### **7.4.4 Initial CORE-OM**

At the beginning of therapy, eight patients were below the clinical threshold described by Jacobson and Truax (1991) whilst nineteen patients were above this cut-off level. The clinical cut-off levels for the CORE-OM were used, thus patients ( $n = 8$ ) whose initial CORE-OM scores were below 1.29 (female) or 1.19 (male) were classified as a non-clinical group. The difference between the means for pre and post therapy CORE-OM scores for this group gave a small effect size (Cohen's  $d$ ) of 0.25. Patients ( $n = 19$ ) with CORE-OM scores greater than 1.29 (female) or 1.19 (male) at the commencement of therapy were considered above the cut-off level and thus a clinical group. The difference

between the means for pre and post therapy CORE-OM scores for this group gave a large effect size (Cohen's *d*) of 0.88.

One-way ANOVA did not show any significant differences between attachment groups and initial CORE-OM scores which suggests that, regardless of attachment style, patients were very similar in terms of overall distress as measured by the CORE-OM at the commencement of therapy.

There is a reported 80% improvement rate for patients whose initial CORE-OM scores are 1.5 or above (CORE Partnership, 2007), although recovery decreases sharply as severity (as defined by scores on CORE-OM) increases. Several patients within this study had initial CORE-OM scores which can be categorised as “below caseness” – the patient does not have a score which places them in a clinical category. Patients with an initial CORE-OM mean score of between 0.6 and 1 have been described as “low level” (CORE Partnership, 2007), and cannot “recover” as they are not part of a clinical group to begin with. There is reportedly only a one-third chance that they will improve. Similarly, those patients described as “healthy” i.e. with an initial CORE-OM score of less than 0.6 have a four time higher chance of their score deteriorating than improving. Again, they cannot “recover” as they are already “healthy” (CORE Partnership, 2007). Whilst there is an argument for not accepting patients below the cut-off for therapy, it must be borne in mind that some patients with longstanding problems still present with low initial scores.

Seven patients had an initial CORE-OM below-caseness. This might reflect minimization of distress and difficulties, something Dozier (1990) found in patients with more avoidant tendencies. However, the below-caseness sample in this study were not all classified as dismissing-avoidant: Attachment style of these patients was secure 2; preoccupied 3; fearful 1; dismissing 1. Other reasons might have contributed to their low ratings of overall distress. For some patients, it might reflect events within their social environment just prior to completing the questionnaire, for others it might reflect their lack of insight into their own mental states. These patients may have had longstanding mental health problems given that three were seen within secondary level mental health services which might mean that they are familiar with coping with distress. It needs to be remembered that the CORE-OM asks patients to report on their distress in the preceding week only. In the case of the two who were seen in private practice, whilst it cannot be assumed that they also had longstanding problems, it is possible that their difficulties were less well captured by this measure and measures of interpersonal difficulties would have been more appropriate.

Frequently there is a period of waiting between assessment for and commencement of therapy. All of the CORE-OM pre-therapy were completed at the first session of therapy rather than at assessment. The promise of therapy made at assessment, of help soon to come, creates hope (Brown and Harris, 1978) and might contribute to the apparent below-caseness of some patients.

Those patients who appeared to “deteriorate” over the course of therapy or those who did not make a “reliable change” may have benefited from therapy in ways not captured by the CORE-OM. Previously defended against thoughts and feelings will possibly become more accessible through therapy and the development of greater reflective functioning will show itself through greater awareness and acceptance of distress. Again, completion of final session CORE-OM can be affected by factors other than the efficacy of the therapy. Some patients will be anxious at ending therapy and facing the loss of an important relationship and this might be reflected in an increase in reported distress. For others the increase in symptoms might be an indication that a different model of therapy or a longer duration might have been advisable.

#### ***7.4.5 Association of Outcome with Length of Therapy***

Most of the therapists in this study offered short-term therapies, Mean number of sessions of therapy was 14.6 (range 7-40). Six patients were in either longer-term or open-ended therapy and thus completed the Time 2 ARM at session 40.

In the Lambert, Hansen, Finch study (2001), 50% patients required 21 sessions of treatment before they met the criteria for “clinically significant improvement”, 75% met the criteria for “clinically significant improvement” only after receiving 40 plus sessions. These authors also thought that even this duration would be inadequate for some patients. This was a large study ( $n = 6072$ ) and whilst it did not specifically cite the CORE-OM, it did maintain Jacobson *et al*’s concept of “clinical change”. Given the brevity of many of the

therapies in this current study, it seems with hindsight that maintaining the criteria for “clinically significant change” was restrictive.

Duration of therapy has been linked with outcome in other studies. Hardy *et al* found that underinvolved patients appeared to benefit more from the 16-session format than a 12-session one which seemed to give them more freedom to learn how to express themselves - patients in the slightly longer therapies had tended to begin to be more disclosing to their therapists.

#### **7.4 Measures of alliance**

The hypothesis in this study that concordant secure/secure attachment style patient/therapist dyads would have far higher concordant alliance at outcome evaluation than other dyads was not supported.

##### **7.5.1 Concordance of Alliance Ratings**

Previous research has shown that Secure attachment style is associated with high levels of Global alliance (Satterfield and Lyddon, 1998), high level ratings on the emotional and relational alliance (Bond dimension) (Satterfield and Lyddon, 1998) and with high levels on Goal agreement (Satterfield and Lyddon, 1998) and Goal and Task agreement (Dolan, Arnkoff and Glass, 1993).

There did not appear to be an association between attachment style of either therapist or patient and overall ratings of alliance in this study. This was also a finding in the studies of Hardy *et al* (1998) and Ligiero and Gelso (2002) although contrary to Tyrrell *et al*'s (1999) study where less deactivating case

managers had stronger alliances with more deactivating clients than with less deactivating clients. It was also unlike the Sauer *et al* (2003) study where Client and therapist WAI ratings were significantly related at Time 1 and Time 2 but not Time 3 and where therapist attachment anxiety positively correlated with client WAI ratings at Time 1. In this current study seven therapist participants had levels of anxiety (as measured by the ECR anxiety dimension) greater than 3 but less than 4, whilst one therapist's anxiety dimension was greater than 4. More than half the therapists were therefore quite anxious in respect to intimate relationships.

Kivlighan and Shaughnessy, (1995) found large and significant client and therapist correlations suggesting that, over time, clients and therapists come to perceive the quality of the alliance similarly. In the current study, degree of significance for differences between therapist and client ratings of the ARM subscales for Confidence and Openness decreased between Time 1 and Time 2 suggesting that therapist and client were beginning to perceive the alliance more similarly. This is discussed more fully in Sections 8.5.6 and 8.5.7. It is possible that with a larger sample of patients and therapists, there would have been more indication of a move towards concordant ratings of the alliance. It is also likely that the relative brief duration of most of the therapies in this study (Mean 14.6 sessions, range 7-40) impacted on this relationship. Longer term therapies would have perhaps allowed the working through of transference distortions and seen a more realistic appraisal of therapists and therapy.

### 7.5.2 *Changes in Alliance Ratings Across Levels*

In a recent review examining 63 studies, it was found that both patients and therapists tend to rate the therapeutic alliance highly (Tyron, Blackwell & Hammel, 2008). In evaluating the alliance, patients have been found to use only the top 30% of rating points i.e. they generally do not use the lower 5 points of a 7-point Lickert scale (Hatcher and Gillaspay, 2006). Tyron *et al* (2008) found that clients' and therapists' average percentage of maximum possible ratings on the Agnew Relationship Measure were in the 70s, thus showing that, on average, both patient and therapist used only the top 30% of rating scale points. Whilst this current study also found that patients' mean ratings of the Global alliance of the Agnew Relationship Measure were in the 70s ( $M = 74$ ,  $SD 10.46$  at Time 1;  $M = 75.64$ ,  $SD 9.82$  at Time 2), therapist mean ratings were in the 60s ( $M = 62.96$ ,  $SD 8.33$  at Time 1;  $M = 62.64$ ,  $SD 9.98$  at Time 2) suggesting that therapist participants made more use of the range of rating points.

Unlike Sauer *et al* (2003) this study did not find a significant positive association between therapist attachment anxiety and patients ratings of the first session alliance. Sauer *et al* argued that anxious therapists might have considerable investment in creating an early connection with their patients and possibly better at seeing variation in others and responding accordingly. Sauer *et al* used therapists from graduate training programmes who would have been considerably less experienced than the therapists in this study. However, in the current study, the one therapist who was preoccupied attachment style and with the highest score on the Anxiety dimension of the ECR, did have three patients who had very high scores on the fifth session ARM and again at the final session

ARM. If the ARM had been completed at the first session, it is possible that a similar association would have been found.

Perception of the alliance and thus subsequent ratings might be distorted by transference. Bowlby wrote that part of the function of therapy was to enable patients to be “better able to recognise companions in the present for what they are.” (Bowlby, 1988, pp.155). As these distortions are understood and worked through, the patient will more realistically appraise the alliance and rate accordingly. The development of mentalising capacity (Bateman and Fonagy, 2004) over the course of therapy will lead to an increase in both self-mentalising ability and the capacity to conceptualise other’s mentalising.

Patient-therapist dyads appear to create a specific attachment environment with a particular capacity for mentalisation and the therapist’s degree of reflective function varies with each patient (Diamond *et al*, 2003). Many therapists in the current study were unable to recruit more than one patient participant and there were insufficient numbers to analyse the variation in alliance ratings between patients of the same therapist.

### **7.5.3 Therapist Ratings of Alliance**

Therapists appeared to be fairly consistent in their ratings across time and across patients. Their mean ratings of ARM at Time 1 were 62.96 and at Time 2 were 62.64. This suggests that therapists used a wider variety of available rating scale points than therapists in studies examined by Tyron *et al* (2008).

As there were no drop-outs once therapy had begun, it can be assumed that dyads had established a sound enough alliance for patients to continue within their therapies. It has been argued that in challenging clients' internal working models, a therapist's clinical effectiveness will be mediated by their own attachment style (Dozier *et al*, 1994). The therapists in the current study were however, trained to work psychotherapeutically and were experienced. This suggests that they were able to challenge patients effectively and with understanding. However, as many of the therapies were short-term, it might be argued that the relationship was never exposed to the pressures of longer open-ended therapy. Therapists routinely working within a short time-limited model are accustomed to the need to establish a sound, collaborative relationship where there is explicit agreement on the goals and tasks of therapy and where patient and therapist are agreed on the focus for this short piece of work.

Whether dismissing style therapists would have struggled to maintain the therapeutic relationship within a longer term psychotherapy as argued by Satterfield and Lyddon (1998) and Sauer *et al*, (2003) cannot be said. Arguably these therapists were categorised as dismissing by their responses to self-report questionnaires. The difference between intimate romantic relationships and the intimacy of the therapeutic relationship might have been more adequately captured by other self-report measures or interviews.

There was no significant association of orientation of therapists and ratings of the alliance unlike some previous studies where psychodynamic

orientation of therapists was predictive of less positive alliance ratings and of therapists reporting more problems within the alliance (Black *et al*, 2005).

However, the therapists in Black *et al*'s study did not complete any measures with a specific patient in mind, nor were patients involved in the study. Black *et al* argued that psychoanalytically orientated therapists might bring greater critical awareness to evaluating the quality of the alliance

#### **7.5.4 Patient Ratings of Alliance**

There was a tendency for patients to rate the alliance and their therapists highly. The mean ratings of global alliance by patient participants in this study was 74.00 at Time 1 and then 75.64 at Time 2. At Time 1, thirteen patients rated two or more subscales at the maximum 21, with three patients rating all subscales at this high level. At Time 2, fifteen patients rated two or more subscales at the maximum 21, with six of these rating all subscales at this high level. Three patients rated all subscales at Time 1 and Time 2 at maximum level. All three were patients of the same therapist. Another therapist had two patients who increased their ratings to maximum at Time 2. One increased their Openness rating by 10 points whilst the second increased their rating of the Confidence subscale by 2 points. A sixth patient making maximum ratings at Time 2, increased their rating of the Bond subscale by one point over the two time points. As argued by Tyron *et al* (2008) this would seem to indicate that patients used only the top 30% of rating scale points. Tyron *et al* suggest that this may reflect response distortions such as social desirability or dissonance reduction or might be due to lower rating patients dropping out of therapy prior to measurement. In

this study, no patients dropped out of therapy either prior to Time 1 measurement or between Time 1 and Time 2 measurement.

High ratings of the alliance might reflect the relief and satisfaction patients have found in their therapies as they experience being listened to and understood (Steele *et al*, 2008). It might be a genuine evaluation of both therapist and their capacity to create a secure base from which the patient can begin to explore their difficulties.

The ARM also asks questions about the patient's relationship with the therapist and it can be very hard for some patients in therapy to criticise their therapists which could account for the quite high ratings at the beginning of therapy. Kivlighan, Patton, and Foote, (1998) found that discomfort with intimacy in clients was associated with positive perception of the alliance. Time 2 ratings might reflect unacknowledged anger at therapy ending and disappointment at the therapist which is hidden and which manifests as idealisation and high ratings.

Alternatively, and keeping in mind that the therapies were short, time-limited and focused, the patients might have reasonably felt satisfied and grateful. Seven patients whose rating of the alliance included maximum ratings of two or more subscales made "reliable improvement" as shown by pre and post therapy changes on the CORE-OM – four of these made a "clinically significant change" over the course of their therapies. Three therapies were CBT and one integrative psychotherapy. All therapies were of 12 sessions or less.

### **7.5.5 Confidence Subscale**

Overall, the therapists of six patients rated the alliance subscale for confidence low, at 14 or below, at Time 1. Two of the therapists of these patients rated the subscale higher at Time 2. The therapist of one patient slightly lowered their rating at Time 2, from 14 to 13.

Two therapists rated the subscale at Time 1 as 15 and both rated it at Time 2 as 14. Both patients were insecure attachment style.

However, the group of seven secure attachment style patients (one other was excluded from this analyses due to incomplete data for the ARM) included in this analyses appeared to be the cause of the statistically significant variance. Five of these seven patients had therapists who rated the alliance subscale for confidence lower at Time 2. These seven patients were seen by five therapists with two therapists each seeing two patients.

The first therapist (Secure attachment style), saw two patients, both secure attachment style, in short-term CBT, and in both cases rated the subscale for confidence low at Time 1 and very low at Time 2. The first of these patients rated their confidence at maximum 21 points at both Time 1 and Time 2 (compared to therapist's ratings of 15 and 13 respectively). This patient made a "clinically significant improvement", moving from a clinical to a non-clinical classification. The second patient rated Confidence as 14 at Time 1 and 17 at

Time 2 (compared with therapist ratings of 10 and 7) showed “reliable improvement” over therapy although remained within a clinical population.

The second therapist (Preoccupied attachment style) saw three patients, two of whom were secure attachment style and one preoccupied attachment style. All therapies were brief psychodynamically based. In all cases, the patients of this therapist rated all subscales, including that for Confidence, at the maximum rate of 21 points. For the two Secure attachment style patients, the therapist ratings varied. With one patient, Time 1 ratings by therapist were 15 and at Time 2, 19. This patient showed a non-reliable deterioration as measured by the CORE-OM (Pre-therapy 0.47, post-therapy 0.58) but was “below caseness” at beginning and end of therapy. For the other patient, the therapist rated the Confidence subscale at Time 1 as 16 and then at Time 2 as 14. This patient showed a non-reliable deterioration on the CORE-OM (Pre-therapy 1.35 post-therapy 1.5) and remained just within a clinical population. With the Preoccupied attachment style patient, there was a slight decrease in the Confidence rating by the therapist at Time 2 (from 15 to 14) although the patient made a clinically significant and reliable change with pre-therapy CORE-OM 3.00 and post-therapy 2.4.

Another therapist, Secure attachment style, rated their Secure attachment style patient on the Confidence subscale at Time 1 as 12 (patient rating 18) decreasing to 11 at Time 2 (Patient rating 21). This patient also made a clinically significant change and moved to a non-clinical population following a planned 12 session CBT (pre-Core 1.53 and post core 0.94).

The final therapist seeing a Secure attachment style patient, rated the Confidence subscale at Time 1 as 16 (patient rating 21) and at Time 2, as 14 (patient rating 21). This patient showed a large “reliable improvement” although remaining part of a clinical population (Pre-therapy 2.97, post-therapy 2.08, change of 0.89).

Therapists of secure patients appeared to rate the ARM confidence subscale lower than therapists of insecure patients. The Confidence subscale rates patient optimism and respect for the therapist’s professional competence (Stiles *et al*, 2002). It must be remembered that whilst the questions in this subscale relate to the therapists’ perception of their patients’ beliefs and experiences, the completion also depends to a great extent on therapists’ self-belief which might be shaken through experiences within that particular therapy. It does not necessarily mean that a therapist is generally lacking in self-confidence and can be considered an artefact of a particular therapeutic relationship. Therapists’ feelings of “not being good enough” or despondency might reflect projections from patients and might contribute to their lowered ratings if these feelings have not been worked through. Less secure patients might idealize their therapists and this would possibly be something of which therapists were aware and which might be reflected in their evaluation of the alliance. The questions which elicited low ratings were “*My professional skills are impressive to my client*” and “*I feel confident in myself and my techniques*”.

Less experienced therapists might be less secure within their practice and less certain of their ability to work within a specified model. It might be a realistic appraisal of the difficulties they believe they have experienced within that therapy and their sense of the patient's awareness of those same difficulties. Alternatively it might reflect their earliest relational histories, so that they have created a "destructive interpersonal process" (Henry and Strupp, 1994) with self-directed hostility and a greater likelihood, as found by Leiper and Casares (2000), of locating any therapeutic difficulties within themselves.

It would be interesting to study further this apparent association between a patient's security of attachment and their therapist's low rating of the Confidence subscale. Post-therapy interviews of therapists and patients might be more revealing, eliciting thoughts and feelings not captured by the self-report measure.

#### **7.5.6 *Openness Subscale***

There was considerable variation in ratings of the Openness subscale of the ARM at both Time 1 and at Time 2 and this suggests that most therapists and patients used a wide range of rating points on this subscale.

Ratings by therapists who worked within a psychoanalytic theoretical framework, most likely reflect their attention to the patient's capacity to be open and their awareness of unconscious processes which could inhibit patient's openness.

The majority ( $n = 19$ ) of ratings by therapists increased by a few points at Time 2. Patients showed considerable variation in changes in ratings over the two Time points. Nine remained the same, eight decreased and seven made higher ratings at Time 2.

Three patients who decreased their openness ratings at time 2 were in dyads where this decrease brought their ratings more in line with those of their therapist. The attachment style of these dyads was fearful patient/dismissing therapist, fearful patient/secure therapist and dismissing patient/dismissing therapist.

At Time 2, (end of therapy/session 40), Fearful and Dismissing style patients rated their capacity to be open lower than did either Secure or Preoccupied style patients and this just approached significance with Analysis of Variance. This finding is similar to that of Dozier (1990) who found that clients with greater avoidant tendencies were less likely to self-disclose, whilst greater preoccupied strategies were associated with more disclosure. Whilst Hardy *et al* (1998) found no significant main effects for interpersonal style on either therapists' or clients' ratings of the ARM Global Alliance, there was a significant main effect for Interpersonal Style by duration on clients' openness and therapists' perception of openness: under-involved or avoidant clients had higher openness ratings by both therapist and clients in the 16-session format.

Again, it must be remembered that the wording of the ARM makes it clear to participants that the form being completed relates to the session they have just

had. Variations in the Openness subscale ratings showed that Dismissing style patients felt less able to be “open” within their therapies at the last session.

Whilst it is possible that they have in mind other sessions as well, it can only be conjectured as to what they felt unable to disclose within this session – and perhaps, what they felt their therapist could not bear to hear.

However, as this changed over the course of therapy, it might reflect an increasing self-awareness of patient in that they began to realise the difficulties they experience in intimate relationships. Another way of thinking about this result is perhaps in relation to patients becoming aware that they do not trust their therapists, do not see them as a secure base and are thus unable to be open in their interaction. There is an assumption with this measure that openness refers to verbal disclosure whereas it could encompass felt safety.

#### ***7.5.7 Timing of Alliance Measurements***

In six dyads, the Time 2 ARM was given at session 40 rather than the end of therapy as these therapies were either open-ended or of greater than one year duration. It might be argued that this will not impact on the completion of the measure as the relationship will be well-established. However, patients who know they will return to their therapist the following day or week will view the alliance in a different way to those rating a final session. Whilst there was little difference between end-of-therapy and session 40 ratings, two patients completing the measure at session 40 rated the alliance low which might reflect perceived difficulties within the alliance at that time.

## **7.6 Mediation Model**

The hypothesis that the association between attachment style of patients and therapeutic outcome would be mediated by the therapeutic alliance was not supported. This might have been due to the small sample size. Potentially it might reflect some patient characteristic not measured and present in this sample and not in earlier studies.

The alliance was rated at Time 1, session 5 and again at Time 2, end of therapy or session 40. Earlier measurement of the alliance might have given a statistical result. The literature does not appear to support this. Neither Kivlighan and Shaughnessy (1995) nor Stiles *et al* (1998) found stronger correlation of early alliance measures with outcome. Indeed, Stiles *et al* (1998) found later session alliance measurement to be more strongly correlated with outcome.

## **7.7 Comments and Limitations**

### **7.7.1 Design**

The original design used power analysis to determine the number of participants. The sample was considerably smaller than required for the design resulting in subsequent loss of statistical power. Alternative analyses had to be done. There were problems with recruitment and a number of therapists changed their mind about participating.

The resulting sample was not random and many participating therapists were interested in attachment theory and related research or knew the researcher. It is not possible to know what non-respondents were in terms of attachment

style and it might be that anxieties about self-disclosure and confidentiality deterred more insecure therapists from participating.

The actual type of therapy each patient received was not known although it could be inferred from the therapist's demographic professional questionnaire – in retrospect, this would have been useful information to have elicited in relation to each patient. However, there might have been a reluctance to actually state using an eclectic or integrative approach so it is possible that little would have been gained from the inclusion of such a question.

When looking at the attachment style questionnaires, it is important to consider Griffin and Bartholomew's 1994 statement that self-report measures are possibly subject to respondent misinterpretation and bias. The addition of clinical interview data would enrich self-report acquired data.

The completion of some self-report questionnaires can elicit defensive, unconscious or conscious, avoidance of acknowledging uncomfortable feelings (Rothbard and Shaver, 1994) and this would inevitably impact on patients' and therapists' self-ratings. It is not possible to know to what extent this compromised the validity of the current study although others have commented on the lack of self-bias in the Relationship Questionnaire (Leak and Parsons, 2001).

### **7.7.2 Completion of ARM**

Several therapist participants commented spontaneously on difficulties experienced in completing the ARM at any session. This took the shape of annotating the form. Some therapists expressed concerns that their rating of questions would be completely at variance to their patients. Anxieties appeared to arise specifically around whether patients would rate the alliance less highly than their therapists. It did seem as though therapists were concerned about being evaluated and believed that any discrepancies in alliance ratings reflected the quality of their professional skills.

### **7.7.3 Management**

None of the therapists who stated that their theoretical orientation and main or sole model of therapy practised was CBT, experienced any difficulties in either recruiting patients or managing the completion of any measures of the study. They returned all questionnaires and forms filled out completely and accurately as did their patients. There appeared to be a gender effect in that several male therapists appeared to struggle with the management of their participation – losing or muddling up forms, and needing support and reminders in order to continue participation. This did not appear related to theoretical orientation.

### ***7.8 Implications for Counselling Psychology***

Bury & Strauss (2006) have asked us to consider how the humanistic values which underpin counselling psychologists' philosophy of practice can be accommodated within the mental health settings in which many of us work. To generate research studies that question the therapist's role in therapy and which take measures which at first glance appear contrary to counselling psychology's values, and use them, enables a fresh perspective on evaluation. Counselling psychology emphasizes the centrality of the therapeutic relationship and the importance of the therapist in establishing and maintaining this relationship. This presumes the use of self and an acceptance of subjectivity. British Psychological Society guidelines (BPS, 2004) state that it is essential that all psychologists, not just counselling psychologists, appreciate the vital importance of self-awareness and the need to reflect on practice. Arguably counselling psychologists and psychotherapists extend this self-awareness to an acceptance of intersubjectivity within a mutual relationship with their patients.

This research study explored the impact attachment histories might have on both the therapeutic alliance and on psychotherapeutic outcome. Therapists' and patients' attachment styles were considered in a proposed model that acknowledged the importance of both. The therapeutic relationship involves authenticity, mutuality and emphasises the subjective experience of patients. It involves "being with" rather than "doing to" and this capacity to "be with" another individual has its roots in the therapist's own emotional history. The emphasis on "being with" highlights the centrality of the self of the psychologist in the helping process. There is a need to understand our own histories and the

ways in which these impact on our relationships – the way our being impacts on our therapies and our patients. One fact that emerged from this study was the number of therapists who had undergone psychoanalytic psychotherapy. It was argued that such personal therapeutic work could have been a moderating factor in the association of attachment style and therapeutic outcome. Therapists with a history of adverse attachment histories had worked through these experiences in therapy and had gained greater self-awareness and a capacity for empathy and sensitive responsiveness towards patients which they might otherwise have lacked. The experience of emotional containment offered by their own therapists had given them resources on which to draw during therapeutic encounters in later years. Further studies could focus on the relationship between counselling psychologists' attachment style and engagement in personal therapy, exploring how this has impacted on their personal experiences of working psychotherapeutically.

As Crane and McArthur Hafen (2002) have argued, this research originated within the integration of consumption and production of research. Although working within a service where evidence-based practice is held in esteem, this research attempted to explore real therapists in real therapies where the patients were not selected to meet imposed research criteria. Arguably this means the research loses some of its rigor and thus its generalisability. This study found that less experienced therapists believed that their patients had less confidence in them. This reminds us of the work needed within supervision to support newly qualified therapists. Qualitative studies might look at the role of supervision in helping less secure therapists develop greater confidence. Some therapists of

secure patients also thought that their patients had less confidence in them and were not so impressed by their technical skills. Future qualitative studies might focus on both therapists' and patients' thoughts and feelings on this question in order to capture a greater understanding of a particular therapeutic relationship.

Polkinghorne (1992) stated that "The psychology of practice accepts the concept of equifinality – that the same result can be achieved through a variety of approaches" (p.160) and this research utilised a naturalistic design in which therapy was done "as usual" without recourse to manuals or specified models. Whilst many therapists maintained a firmly held theoretical orientation, it can be seen from this same study that many of these therapists acknowledge that they frequently use more than one model in their regular practice.

Polkinghorne argued (1992) that practitioners' beliefs are epistemologically conflictual as they apparently hold the modernist belief that their theory is a reflection of a psychological reality whilst simultaneously demonstrating a postmodernist belief in their clinical practice seeming to value individual difference and understanding. In this study, many therapists declined to participate stating that they did not agree with the underlying theoretical assumptions. Others felt that the use of measures such as the CORE-OM and the ARM were intrusive and reductionist and that by using such measures, the researcher was somehow betraying fundamental values. Several practitioners cited their scepticism that such measures could be useful, as they were unable to take into account the unconscious processes which contribute to the alliance.

Therapists were loathe to participate in this study which resulted in considerable recruitment difficulties causing a small sample. This impacted upon analyses with subsequent loss of power and potential to generalise. Many therapists express hurt and anger at the predominance of CBT in recent NICE guidelines and yet the seeming reluctance to engage in research contributes to the limited evidence base for therapies other than CBT. It is important that we all accept some responsibility for research into the areas of our practice. The paucity of an accepted evidence base for therapies other than CBT is only partially explained by arguing about randomised controlled trials (RCTs). If practitioners are not prepared to take part in research studies that are not RCTs, then opportunities will be lost to create a more balanced evidence base.

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# Appendix 1

## Ethics Committee Approval

### Lewisham Local Research Ethics Committee

University Hospital Lewisham  
1st Floor Research Centre  
Lewisham High Street  
London  
SE13 6LH

Telephone: 020 8333 3135  
Facsimile: 020 8314 0626

04 September 2006

Tirril Harris  
Socio-medical research group  
Dept Social Psychiatry, HSRD Institute of Psychiatry  
St Thomas' Hospital Campus, Lambeth Palace Road, London  
SE1 7EH

Dear Harris

**Full title of study:** Attachment and Relationship to Psychotherapeutic Outcome  
**REC reference number:** 06/Q0701/33

Thank you for your letter of 17 August 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

#### Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for [other] Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

#### Conditions of approval

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	version 1	12 April 2006
Investigator CV		11 April 2006
Protocol	version 1	27 July 2005
Covering Letter		11 April 2006
Questionnaire	4	

	Questionnaire res - version 1	
Letter of invitation to participant	Patient & Therapist version 1 Jan 06	
Participant Information Sheet	Therapist version 1 Feb 06	
Participant Consent Form	Patient & Therapist version 1 Jan 06	
Response to Request for Further Information	PIS & Consent Form, Statistical Information, Copy of CORE + Recruitment details	01 August 2006
Response to Request for Further Information	Response to recruitment issues + PIS & Consent	17 August 2006
Jo McKay CV		11 April 2006
SLAM Approval Form		06 February 2006

#### Research governance approval

You should arrange for the R&D department at all relevant NHS care organisations to be notified that the research will be taking place, and provide a copy of the REC application, the protocol and this letter.

All researchers and research collaborators who will be participating in the research must obtain final research governance approval before commencing any research procedures. Where a substantive contract is not held with the care organisation, it may be necessary for an honorary contract to be issued before approval for the research can be given.

#### Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**06/Q0701/33** Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely



SF1 list of approved sites

## Appendix 2

### Participants' Information Sheet (Therapist)

Dear

This letter is to ask you if you would like to participate in a research study looking at attachment style and its impact on both the therapeutic alliance and therapeutic outcome. Whilst we know that psychotherapy helps many people, we are trying to understand more about the ways in which they work.

Participation in the project would involve completing 4 questionnaires (enclosed) which explore your experiences of relationships and include a demographic questionnaire. I appreciate that the CECA-Q is a complex questionnaire asking very personal questions, but I would be very grateful if you could manage to complete it. If you decide to participate, we will ask you to involve your next 3 patients beginning a therapy of 40 sessions or less. This involvement would consist of giving each patient the attachment measure questionnaires to complete and also for both you and your patients to complete the Agnew Relationship Measure at the end of session 5 and then again at the end of therapy.

I appreciate reservations you might have on behalf of your patients and have included a copy of the information sheet for patients which might be useful to you. If you have further questions you wish to discuss, please contact me at the above telephone numbers or by email. If you do decide to participate in the study, any information you provide will be confidential and seen only by the researcher. You will remain anonymous to the researcher who will allocate a number code to your questionnaires.

You may feel that you would like more information and the opportunity to discuss this letter.

You can contact me by telephoning the above number and if I am not available, you can leave a message and I will get back to you. I can also be contacted via email – [Jo.McKay@slam.nhs.uk](mailto:Jo.McKay@slam.nhs.uk).

Yours sincerely

Jo McKay  
Chartered Psychologist

## Appendix 3

### Participants' Consent Form (Therapist)

Centre Number:

Direct Line:

Study Number: 06/Q0701/33

Therapist Identification Number for this trial:

## CONSENT FORM

**Title of Project: Attachment and Relationship to Psychotherapeutic Outcome**

Name of Researcher: Jo McKay, Chartered Psychologist

**Please initial box**

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. ☐
3. I understand that data collected during the study will be looked at only by the researchers ☐
4. I agree to take part in the above study. ☐

\_\_\_\_\_  
Name of Therapist

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Name of Person taking consent  
(if different from researcher)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Researcher

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## Appendix 4

### Participants' Information Sheet (Patient)

*Dear Sir/Madam*

This letter is to ask you if you would like to participate in a research study looking at people's experiences of therapy. Whilst we know that "talking therapies" help many people, we are trying to understand more about the ways in which they work.

Participation in the project would involve completing 4 questionnaires at different times during your therapy. Initially you would complete 2 questionnaires (which take about 15 minutes) asking about your thoughts and feelings about relationships. The other two questionnaires would be given to you after your 5<sup>th</sup> session with your therapist and again at the end of therapy. These questionnaires are a bit different and ask you about your feelings about the therapy session you have just had. These two questionnaires take about five minutes each to complete and you will be asked to complete them away from the room in which you have therapy. The replies you make will not be shown to your therapist and you will be asked to leave the completed form in the provided envelope.

Patients receiving talking therapies are routinely asked to complete a questionnaire called the CORE – this usually happens at the start of therapy and again at the end. By agreeing to take part in this study, you are also agreeing to allow the researcher access to these completed questionnaires.

It is entirely up to you whether you take part. Whatever you decide to do, your therapy sessions will not be affected – even if you decide that you don't want to complete the forms, you will still go ahead with the original offer of therapy.

If you do decide to participate in the study, any information you provide will be confidential and seen only by the researcher – all questionnaires will be returned directly to the researcher. You will remain anonymous to the researcher who will allocate a number code to your questionnaires. Any information given will not be disclosed to either your therapist or clinical team. You are also free to withdraw from participating in the project at any time without giving a reason and without your therapy being affected.

You may feel that you would like more information and the opportunity to discuss this letter. You can contact me by telephoning on the above number and if I am not available, you can leave a message and I will get back to you.

Yours sincerely  
Jo McKay  
Chartered Psychologist

**Appendix 5**  
**Participants' Consent Form (Patient)**

Centre Number:           :

Study Number:           06/Q0701/33

**Direct Line:**

Patient Identification Number for this trial:

**CONSENT FORM**

**Title of Project:**

**Attachment and Relationship to Psychotherapeutic Outcome**

Name of Researcher: Jo McKay, Chartered Psychologist

**Please initial box**

1. I confirm that I have read and understand the information sheet dated ..... (version .....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
  
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
  
3. I understand that data collected during the study will be looked at only by the researchers ☐
4. I agree to my GP being informed of my participation in the study. ☐
  
5. I agree to take part in the above study. ☐

Name of Patient	Date	Signature

Name of Person taking consent (if different from researcher)	Date	Signature

Researcher	Date	Signature

## Appendix 6

### Attachment and Relationship to Psychotherapeutic Outcome

#### Demographic Questionnaire (therapist version)

*All information remains confidential and anonymous*

For office use only: version Feb2006

Therapist Code:

---

Please tick responses that apply

Age: .....  
.....

Gender: Male ..... Female

**Marital Status:**

single	.....	separated/divorced
cohabiting	.....	remarried/cohabiting after
widowhood	.....	cohabiting after divorce/separation
Married	.....	
Widowed	.....	

**Ethnicity:** *please see attached ethnicity identification sheet*

.....  
*and write chosen code*

**Professional Identification:**

**Core Profession:** .....

**Higher Education:** Subject Studied: .....

**Professional Training:** *(please specify)*

Type: ..... Years:  
.....

**Organizational Affiliation:** *(please tick all that apply)*

UKCP ..... BABCP .....

BPS ..... BCP .....

Other *(please specify)* .....

**Past Experiences of Personal Therapy:**

**Model:** Psychoanalytic ..... Cognitive ..... Other (*please specify*)  
.....

**Intensity:** Weekly ..... 2xweekly ..... 3 or more x  
weekly .....

**Duration:** Years .....  
If less than 1 year, number of sessions .....

**Professional Practice:**

**Theoretical Orientation:**

Psychoanalytic ..... Group Analytic .....

Cognitive ..... Systemic .....

Other (*please specify*) .....

**Years of Therapeutic Practice:** .....

**Do you regularly use more than 1 model of psychotherapy:** Yes ...No .....

If yes, please give details  
.....

**Number of patients normally seen in a typical week** .....

**Treatment Settings:** NHS ..... Private .....  
Other (*please specify*) .....

**Treatment Modalities:** Individual ..... Group .....  
Family ..... Other .....

**Age Groups treated:**

18-24 ..... 25-34 ..... 35-44 ..... 45-54 ..... 55-64 ..... 65+  
.....

**Is your work:** Time limited: ..... Open-ended: .....

*Thank you for completing this questionnaire*

## Appendix 7

### Childhood Experiences of Care and Abuse (CECA-Q)

Please complete as many sections as you feel able to

#### 1. PARENTAL LOSS

Please circle or write in answer:

<p>Did either parent die before you were aged 17?</p> <p>If YES: what age were you?</p> <p>Have you ever been separated from either parent for one year or more before age 17?</p>	Mother	Father
	YES/NO	YES/NO
	AGE	AGE
	YES/NO	YES/NO

IF NO SEPARATION THEN SKIP TO 2 OVERLEAF

IF SEPARATED:	MOTHER	FATHER
At what age were you first separated?	Age	Age
How long was this separation?	Years	years
What was the reason for separation? (Please circle)		
Parent's illness	YES/NO	YES/NO
Parent's work	YES/NO	YES/NO
Parent's divorce/separation	YES/NO	YES/NO
Abandoned by parent or never knew parent	YES/NO	YES/NO
Other reason	YES/NO	YES/NO

*Please describe your experience*

.....

## 2. AS YOU REMEMBER YOUR MOTHER FIGURE IN YOUR FIRST 17 YEARS

Please circle the appropriate number.

If you had more than one mother figure, choose the one you were with longest, or the one you found most difficult to live with.

### WHICH MOTHER FIGURE ARE YOU DESCRIBING BELOW?

1. natural mother
2. step-mother/father's live-in partner
3. other relative e.g. aunty, grandmother
4. other non-relative e.g. foster mother, godmother
5. other (describe) .....

	YES DEFINITELY		UNSURE	NO NOT AT ALL	
She was very difficult to please .....	1	2	3	4	5
She was concerned about my worries .....	1	2	3	4	5
She was interested in how I did at school .....	1	2	3	4	5
She made me feel unwanted .....	1	2	3	4	5
She tried to make me feel better when I was upset	1	2	3	4	5
She was very critical of me	1	2	3	4	5
.....					
She would leave me unsupervised before I was 10 years old	1	2	3	4	5
.....					
She would usually have time to talk to me .....	1	2	3	4	5
She would hit me	1	2	3	4	5
.....					
At times she made me feel I was a nuisance .....	1	2	3	4	5
She often picked on me unfairly .....	1	2	3	4	5
She was there if I needed her .....	1	2	3	4	5
She was interested in who my friends were .....	1	2	3	4	5
She was concerned about my whereabouts .....	1	2	3	4	5
She cared for me when I was ill .....	1	2	3	4	5
She neglected my basic needs	1	2	3	4	5
(eg clothes and food) .....					
She did not like me as much as my brothers and sisters	1	2	3	4	5
.....					
(leave blank if no siblings)					

Do you want to add anything about your mother?

.....

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### 3. AS YOU REMEMBER YOUR FATHER FIGURE IN YOUR FIRST 17 YEARS

Please circle the appropriate number.

If you had more than one father figure, choose the one you were with longest, or the one you found most difficult to live with. If you had no father in the household, then leave out this section.

#### WHICH FATHER FIGURE ARE YOU DESCRIBING BELOW?

6. natural father
7. step-father/mother's live-in partner
8. other relative e.g. uncle, grandfather
9. other non-relative e.g. foster father, godfather
10. other (describe) .....

	YES DEFINITELY		UNSURE	NO NOT AT ALL	
He was very difficult to please .....	1	2	3	4	5
He was concerned about my worries .....	1	2	3	4	5
He was interested in how I did at school .....	1	2	3	4	5
He made me feel unwanted .....	1	2	3	4	5
He tried to make me feel better when I was upset	1	2	3	4	5
He was very critical of me .....	1	2	3	4	5
.....					
He would leave me unsupervised before I was 10 years old	1	2	3	4	5
.....					
He would usually have time to talk to me .....	1	2	3	4	5
He would hit me .....	1	2	3	4	5
.....					
At times he made me feel I was a nuisance .....	1	2	3	4	5
He often picked on me unfairly .....	1	2	3	4	5
He was there if I needed him .....	1	2	3	4	5
He was interested in who my friends were .....	1	2	3	4	5
He was concerned about my whereabouts .....	1	2	3	4	5
He cared for me when I was ill .....	1	2	3	4	5
He neglected my basic needs	1	2	3	4	5
(eg clothes and food) .....					
He did not like me as much as my brothers and sisters	1	2	3	4	5
.....					
(leave blank if no siblings)					

Do you want to add anything about your father?

.....

.....

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#### 4. PHYSICAL PUNISHMENT BEFORE AGE 17 BY PARENT FIGURE OR OTHER HOUSEHOLD MEMBER

When you were a child or teenager were you ever hit repeatedly with an implement (such as a belt or stick) or punched, kicked or burnt by someone in the household? YES/NO

<b><i>IF YES</i></b>	<b>MOTHER FIGURE</b>	<b>FATHER FIGURE</b>
How old were you when it began?	<b>Age</b>	<b>Age</b>
Did the hitting happen on more than one occasion?	<b>YES/NO</b>	<b>YES/NO</b>
How were you hit?	<b>1. Belt or stick 2. Punched/kicked 3. Hit with hand 4. Other</b>	<b>1. Belt or stick 2. Punched/kicked 3. Hit with hand 4. Other</b>
Were you ever injured e.g. bruises, black eyes, broken limbs?	<b>YES/NO</b>	<b>YES/NO</b>
Was this person so angry they seemed out of control?	<b>YES/NO</b>	<b>YES/NO</b>

Can you describe these experiences?

.....  
 .....

Did you experience this from anyone else in the household? YES/NO

#### **IF YES: DESCRIBE BELOW**

.....  
 .....  
 .....  
 .....

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## Appendix 8

### Experiences in Close Relationships Inventory (ECR) Brennan, Clark, & Shaver (1998).

The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

Disagree	Strongly	Neutral /Mixed	Agree	Strongly
1	2	3	4	5
6	7			
___	1.	I prefer not to show a partner how I feel deep down.		
___	2.	I worry about being abandoned.		
___	3.	I am very comfortable being close to romantic partners.		
___	4.	I worry a lot about my relationships.		
___	5.	Just when my partner starts to get close to me I find myself pulling away.		
___	6.	I worry that romantic partners won't care about me as much as I care about them.		
___	7.	I get uncomfortable when a romantic partner wants to be very close.		
___	8.	I worry a fair amount about losing my partner.		
___	9.	I don't feel comfortable opening up to romantic partners.		
___	10.	I often wish that my partner's feelings for me were as strong as my feelings for him/her.		
___	11.	I want to get close to my partner, but I keep pulling back.		
___	12.	I often want to merge completely with romantic partners, and this sometimes scares them away.		
___	13.	I am nervous when partners get too close to me.		
___	14.	I worry about being alone.		
___	15.	I feel comfortable sharing my private thoughts and feelings with my partner.		
___	16.	My desire to be very close sometimes scares people away.		
___	17.	I try to avoid getting too close to my partner.		
___	18.	I need a lot of reassurance that I am loved by my partner.		
___	19.	I find it relatively easy to get close to my partner.		
___	20.	Sometimes I feel that I force my partners to show more feeling, more commitment.		
___	21.	I find it difficult to allow myself to depend on romantic partners.		
___	22.	I do not often worry about being abandoned.		
___	23.	I prefer not to be too close to romantic partners.		
___	24.	If I can't get my partner to show interest in me, I get upset or angry.		
___	25.	I tell my partner just about everything.		
___	26.	I find that my partner(s) don't want to get as close as I would like.		
___	27.	I usually discuss my problems and concerns with my partner.		
___	28.	When I'm not involved in a relationship, I feel somewhat anxious and insecure.		
___	29.	I feel comfortable depending on romantic partners.		
___	30.	I get frustrated when my partner is not around as much as I would like.		
___	31.	I don't mind asking romantic partners for comfort, advice, or help.		
___	32.	I get frustrated if romantic partners are not available when I need them.		
___	33.	It helps to turn to my romantic partner in times of need.		
___	34.	When romantic partners disapprove of me, I feel really bad about myself.		
___	35.	I turn to my partner for many things, including comfort and reassurance.		
	36.	I resent it when my partner spends time away from me		

## Appendix 9

### RELATIONSHIP QUESTIONNAIRE

Bartholomew, K & Horowitz, L.M. (1991).

1. *Following are descriptions of four general relationship styles that people often report. Please read each description and CIRCLE the letter corresponding to the style that best describes you or is closest to the way you generally are in your close relationships.*

- A. It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me.
- B. I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others.
- C. I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them.
- D. I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me.

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

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

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

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

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

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

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

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

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

## Appendix 10

### *Attachment and Relationship to Psychotherapeutic Outcome*

#### Demographic Questionnaire (patient version)

*All information remains confidential*

For office use only: version Feb2006

*Patient Code:*

Please tick responses that apply

**Age:** ..... **Gender:** Male ..... Female  
 .....

**Marital Status:**

single	.....	separated/divorced	.....
cohabiting	.....	remarried/cohabiting after widowhood	.....
Married	.....	cohabiting after divorce/separation	.....
Widowed	.....		

**Do you have children?** Yes / No

**If yes, please give details**

.....

**Do you have brothers:** yes/no ; **or sisters:** yes/no

**If yes, please give ages**

.....

**Employment:**

**Are you in paid work?** Yes / No Full-time .....Part-time .....

**Do you supervise/manage other employees?** Yes / No

**Accommodation:**

**Do you live in** Flat ..... House ..... hostel .....  
 other (*please give details*)  
 .....

**Is your home** owner occupied ..... Private rental .....

Council rental ..... other .....

If you had a problem of some sort, who would you talk to about it apart from your therapist?

## Appendix 11

### CLINICAL OUTCOMES IN ROUTINE EVALUATION Outcome Measure (CORE-OM)

**Important – please read first.**

This form has 34 statements about how you have been OVER THE LAST WEEK. Please read each statement and think how often you felt that way last week. Then tick the box which is closest to it.

	Not at all	Only Occasionally	Sometimes	Often	Most or all of the time	
Over the last week:						
1. I have felt terribly alone and isolated	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
2. I have felt tense, anxious or nervous	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
3. I have felt I have someone to turn to for support when needed	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
4. I have felt OK about myself	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> W
5. I have felt totally lacking energy and enthusiasm	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
6. I have been physically violent to others	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
7. I have felt able to cope when things go wrong	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
8. I have been troubled by aches, pains or other physical problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
9. I have thought of hurting myself	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
10. Talking to people has felt too much for me	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> F
11. Tension and anxiety have prevented me doing important things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
12. I have been happy with the things I have done	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> F
13. I have been disturbed by unwanted thoughts and feelings	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
14. I have felt like crying	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
15. I have felt panic or terror	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P
16. I have made plans to end my life	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> R
17. I have felt overwhelmed by my problems	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> W
18. I have had difficulty getting to sleep or staying asleep	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> P

## Appendix 11 page 2

- |   |   |   |
|---|---|---|
| 19. I have felt warmth or affection for someone                           | <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> | F |
| 20. My problems have been impossible to put to one side                   | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | P |
| 21. I have been able to do most things I needed to                        | <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> | F |
| 22. I have threatened or intimidated another person                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | R |
| 23. I have felt despairing or hopeless                                    | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | P |
| 24. I have thought it would be better if I were dead                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | R |
| 25. I have felt criticised by other people                                | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | F |
| 26. I have thought I have no friends                                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | F |
| 27. I have felt unhappy   | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | P |
| 28. Unwanted images or memories have been distressing me                  | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | P |
| 29. I have been irritable when with other people                          | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | F |
| 30. I have thought I am to blame for my problems and difficulties         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | P |
| 31. I have felt optimistic about my future                                | <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> | W |
| 32. I have achieved the things I wanted to                                | <input type="checkbox"/> 4 <input type="checkbox"/> 3 <input type="checkbox"/> 2 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> | F |
| 33. I have felt humiliated or shamed by other people                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | F |
| 34. I have hurt myself physically or taken dangerous risks with my health | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> | R |

TOTAL SCORES ☐ ☐ ☐ ☐ ☐ ☐

### MEAN SCORES

(Total score for each dimension divided by  
number of items completed in that dimension)

☐ ☐ ☐ ☐ ☐ ☐

(W)

(P)

(F)

(R)

All

All  
items minus R

**THANK YOU FOR YOUR TIME IN COMPLETING THIS  
QUESTIONNAIRE**

**Appendix 12**  
**ARM – Client's scale**

**Client No:**

**Session:**

**Date:**

Thinking about today's meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

		Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1	I feel friendly towards my therapist	1	2	3	4	5	6	7
2	My therapist is supportive	1	2	3	4	5	6	7
3	My therapist seems bored/impatient with me	1	2	3	4	5	6	7
4	My therapist follows his/her own plans, ignoring my views on how to proceed	1	2	3	4	5	6	7
5	My therapist and I agree about how to work together	1	2	3	4	5	6	7
6	My therapist and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
7	I have confidence in my therapist and his/her techniques	1	2	3	4	5	6	7
8	My therapist's professional skills are impressive	1	2	3	4	5	6	7
9	My therapist is confident in his/herself and his/her techniques	1	2	3	4	5	6	7
10	I am worried about embarrassing myself with my therapist	1	2	3	4	5	6	7
11	I keep some important things to myself, not sharing them with my therapist	1	2	3	4	5	6	7
12	I feel I can openly express my thoughts and feelings to my therapist	1	2	3	4	5	6	7

March 2003

## Appendix 13

### *ARM – Therapist's scale*

**Client No:**

**Session:**

**Date:**

Thinking about today's meeting, please indicate how strongly you agreed or disagreed with each statement by circling the appropriate number.

		Strongly disagree	Moderately disagree	Slightly disagree	Neutral	Slightly agree	Moderately agree	Strongly agree
1	My client is friendly towards me	1	2	3	4	5	6	7
2	I feel supportive	1	2	3	4	5	6	7
3	I feel bored/impatient with my client	1	2	3	4	5	6	7
4	I follow my own plans, ignoring my client's views on how to proceed	1	2	3	4	5	6	7
5	My client and I agree about how to work together	1	2	3	4	5	6	7
6	My client and I have difficulty working jointly as a partnership	1	2	3	4	5	6	7
7	My client has confidence in me and my techniques	1	2	3	4	5	6	7
8	My professional skills are impressive to my client	1	2	3	4	5	6	7
9	I feel confident in myself and my techniques	1	2	3	4	5	6	7
10	My client is worried about embarrassing her/himself with me	1	2	3	4	5	6	7
11	My client keeps some important things to her/himself, not sharing them with me	1	2	3	4	5	6	7
12	My client feels they can openly express his/her thoughts and feelings to me	1	2	3	4	5	6	7

March 2003

## **SECTION C**

### **CLIENT STUDY**

#### **SUCCESSFUL EXPOSURE**

#### **CBT FOR PTSD**

## **Introduction and the Start of Therapy**

I decided to choose this patient as, in retrospect, I think that Lara's therapy marked an important point in my development as a therapist. I believe that I was now integrating theoretical and practical experience in an independent, confident manner. Alongside this, my experiences in both supervision and personal therapy were also facilitating my personal self-awareness.

### ***Summary of Theoretical Orientation***

The cognitive behavioural model proposes that emotional and behavioural difficulties can be caused by the way individuals interpret and give meaning to the events within their lives (Beck, 1976; Beck & Freeman, 1990). Central to the model is the concept of schemas or core beliefs - cognitive structures formed through an individual's exposure to early, possibly adverse events. Schemas are used to organise one's understanding of self, world and future (Young, 1990). Cognitive behavioural therapy aims to identify and subsequently modify automatic thoughts, dysfunctional cognitions and core maladaptive schemas through the use of socratic questioning and Beck *et al* (1979) wrote "Questions must be carefully timed and phrased so as to help the patient recognize and consider his notions reflectively – to weigh his thoughts with objectivity." Padesky later emphasized how socratic questions could be used to 'guide discovery' enabling the client to see new possibilities rather than as a technique to 'change minds' (Padesky, 1993).

Ehlers and Clark's (2000) cognitive model of PTSD postulates the relevance of negative appraisals and subsequent coping strategies in the development of the disorder. Patients with PTSD fear future events even though the trauma is in the past (Ehlers & Clark, 2000). Ehlers and Clark identified the experience of mental defeat as being important in contributing to PTSD development – individuals with previous experience of traumatization are more prone to PTSD as they already hold negative self-beliefs about their efficacy in self-protection. Lack of temporal context for the trauma memory causes a failure of integration into autobiographical memory and subsequent difficulties in intentional recall occur alongside unintentional, cue-driven recall without conscious awareness of triggering events. The memories tend to be poorly elaborated.

### ***The Context for the Work***

Lara was seen at a Community Mental Health Centre in a residential area of south-east London. It is a well-established Centre with a multi-disciplinary team, crisis and home treatment teams and with facilities for seeing patients for psychological therapies.

### ***The Referral***

Lara was referred by a Clinical Health Psychologist at a Pain Management Unit (PMU). Five years previously Lara had been involved in a serious road traffic accident which had been caused by her boyfriend's dangerous driving. Lara, who was a passenger in the car, sustained serious injuries and had intractable pain. Following a four week residential programme for pain

management, Lara had developed good coping strategies and diminished experiences of pain. The PMU team thought that residual Post-Traumatic Stress Disorder was exacerbating Lara's pain and delaying her full recovery. She was therefore referred for assessment of her suitability for psychological intervention.

### ***The Presenting Problem***

Lara was thin and looked tense and tired. She complained of being tormented by flashbacks to the accident telling me that she might suddenly smell petrol and as this intensified, she would begin to see the crashed car and experience the pressure of metal on her legs and back; at other times, she would hear a fire engine in the street and this would trigger a flashback in the form of a "film" like image of being cut from the car. Lara also experienced frequent panic attacks and feelings of powerlessness. When travelling in cars, she found herself bracing her body as though there was going to be an impact. Lara avoided situations where she might be exposed to events which triggered memories. The resulting tension and stress was exacerbating the pain she experienced in her neck and shoulders.

### ***Assessment and Formulation***

An initial 50 minute assessment session was offered to Lara in order to determine whether psychotherapy was the most appropriate treatment for her difficulties. During this time Lara's expectations of therapy were elicited – she wanted to learn strategies for making her daily life easier to cope with – and her potential to engage with therapy was assessed. Lara appeared highly motivated

to make changes and also appeared open to new ideas, seemed able to reflect on her cognitions, emotions and behaviour and had considerable self-awareness.

Lara met the criteria for DSM-IV Posttraumatic Stress Disorder (APA, 1994) and had experienced PTSD symptoms for five years. Ehlers and Clark (2000) suggest that during the assessment stage it is necessary to identify the main cognitive themes to focus on in therapy. Socratic questioning was used to facilitate guided discovery. By exploring images and thoughts associated with high distress, it became possible to identify these main cognitive themes. Continued guided discovery enabled Lara to explore her beliefs about her symptoms and to articulate her fears for the future and her thoughts about other people's behaviour. During the assessment stage we were able to identify problematic behavioural strategies by talking about how Lara currently tried to cope with the trauma, the activities she avoided, her ruminations and the ways in which she dealt with intrusive thoughts, images and feelings. Through guided discovery, Lara was helped to articulate her fear that if she allowed herself to think about the actual car crash, she would go mad.

### ***Second Assessment Session***

A second assessment session was arranged thus allowing discussion within supervision to determine the most appropriate course of treatment. This session focused on psychoeducation – initial work was done on the way trauma memory and intrusive thoughts and images relate. A thought suppression experiment was done to demonstrate the way in which trying to push thoughts out of mind has the opposite effect.

The rationale behind the therapy was explained to Lara and followed the method described by Ehlers and Clark (2000) – to develop her understanding that her symptoms are a common reaction to a traumatic event, that her usual coping strategies might be maintaining her symptoms in this case and that therapy will involve fully processing the trauma.

### ***Negotiating a Contract and Therapeutic Aims***

During this session the proposed length of the therapy was discussed with Lara. Lara appeared suitable for short term therapy – she had considerable insight into her difficulties and appeared motivated to co-operate with therapy which made psychotherapy a viable choice of treatment (Beck, 1995). Lara hoped to travel in the near future and felt that longer-term therapy was not an option and expressed a preference for short, time-limited therapy. Twenty weekly sessions of 50 minutes duration were offered. As Lara had experienced a deprived childhood and had difficulties relating to fears of rejection and abandonment, it was anticipated that the termination phase of therapy would be especially important. It was planned to offer two follow-up sessions at 3 and 6 months. This would give Lara time to gain confidence in utilising learnt strategies and also enable the therapist to complete the issues surrounding termination (Beck, 1995).

Collaborative goal setting is central to the cognitive behavioural approach (Beck *et al.*, 1990) and Lara and I spent time formulating the goals for therapy.

**The therapeutic aims were:**

- The development of cognitive strategies to deal with traumatic memories without recourse to avoidance
- To help Lara resume her pre-trauma level of functioning by facing feared situations through graded exposure and through cognitive restructuring of negative appraisals of trauma sequelae
- To reduce the anger and hypervigilance resulting from the trauma
- To begin to connect with others again and to make plans for the future
- To learn strategies to prevent relapse, self-soothe in order to tolerate difficult feelings and to become more assertive

***Summary Biographical Details of Client***

Lara was 30 years old and worked as a photographer. She told me that her relationship with her boyfriend had ended after the car accident and she now lived alone in her own house. Lara described the relationship as verbally and physically abusive, and Lara felt let down and hurt by this man following the accident during which time he had not visited her in hospital nor offered any help when she returned home. Lara was the youngest of three siblings – two older brothers lived in the United States and in north England. Her mother, aged 60 years, was alive and living in Kent. Lara described her mother as an alcoholic who had been physically and emotionally abusive towards all her children throughout their childhood. Lara told me that her father had died when she was thirteen, although he had left the family when she was 7 years old. She said that he had been a homosexual who underwent gender reassignment surgery but subsequently went on to develop AIDs. Lara stated that he had returned to the

family home in the terminal stage of his illness. Ostensibly his ex-wife was caring for him, but Lara told me that in reality she did all the nursing.

### ***Formulation***

Early childhood experiences of emotional and physical deprivation led Lara to premature self-reliance and her experiences of wanting care had frequently met with rejection. She had developed core beliefs about herself and others which reflected this:

**SELF:** “I’m pathetic; I am basically worthless, deserving bad things to happen”,

**WORLD:** “It’s dangerous to trust people, they always hurt you, abandon you or let you down”.

**FUTURE:** I’ll never be loved for myself.

Lara believed that if she asked for help she was bad and weak and she therefore avoided relying on others for assistance, believing that she must always do everything for herself. Believing that if she could not do something perfectly, she was a failure, Lara had to constantly strive for perfection, whilst berating herself for her inevitable “failure” to live up to her own high expectations.

Her current difficulties associated with PTSD were maintained by these strongly held beliefs. Mistrusting others and believing that to be vulnerable and to need help meant that she was weak, Lara had isolated herself refusing to seek assistance. Whilst yearning for care and love, Lara had experienced disappointment both in childhood and adult life resulting in beliefs that “others will always let you down” and the despair she felt was reflected in “I’ll always be like this”.

## The Development of the Therapy

The therapeutic plan and main techniques used

<b>Therapeutic Plan</b>		<b>Techniques</b>
<b>1-4</b>	Reactivation of social and pleasant activities	Socratic questioning
<b>Reclaiming her life</b>		Guided discovery
<b>Relaxation</b>	Identification problematic beliefs	Continua
	Development of alternative perspectives	Progressive muscular relaxation /Visualization Self-soothing strategies
<b>5-12</b>	Construction of coherent & emotionally congruent trauma narrative	Socratic questioning
<b>Reliving Traumatic Event</b>		Guided discovery
<b>Cognitive Restructuring</b>	Identification specific appraisals and elicit meanings	Reliving in presence of therapist; imaginal reliving
	Find alternative perspectives	Writing trauma narrative
	Discrimination between 'then' and 'now'	Distress monitoring
<b>13-18</b>	Hierarchy of feared and avoided situations	Graded exposure booklets of photos, tapes of car crash sounds, video films of car crashes
<b>In vivo Exposure</b>	Drop safety behaviours and over-generalization	
	Establishing time perspective	Accompanied visits to the site of the crash
	Correct problematic appraisals	Socratic questioning
<b>19-20</b>	Review of therapy techniques and tools	Attribution of progress to client throughout therapy
<b>Relapse prevention</b>	Becoming own therapist	Socratic questioning
<b>Ending</b>	Thoughts about ending	Guided discovery
	Previous experiences of loss	Develop coping plans

## ***Key Content Issues***

### **Sessions 1-4**

To facilitate her sense of moving forward with life (Ehlers and Clark, 2000) and as lack of social support has been identified as being associated with poor treatment response (Tarrier and Humphreys, 2003), Lara was encouraged to reengage with friends and social activities. Behavioural experiments were developed following guided discovery to explore potentially manageable activities.

Lara had sustained serious back and neck injuries as a result of the accident. Although she had had some intensive pain management input prior to the PTSD therapy, she was depressed and unable to adapt fully to a life where she was unable to engage in previous sporting activities which formed the basis of her social life.

Lara expressed the thought that “unless I can do all the sports I did previously, I will be unable to enjoy life and will become fat and unfit.” Using guided discovery she worked on achieving an alternative perspective – “my body has been injured and there are some sports that I can no longer do, but I can do some activities which I might enjoy and which might improve my mood”.

Lara had previously enjoyed and excelled at swimming but had been reluctant to try again as her belief “I must be excellent at something or else there is no point” had prevented her from even going to the pool. We used guided discovery and continua techniques to challenge this. She decided that she would

try, predicting that “If I go swimming each day, I will feel better rather than worse”. Padesky argues that the combination of continuum methods and guided discovery facilitates small core belief changes which, over time, lead to substantial schema shifts (Padesky, 1994). For the next week, Lara went swimming each day for about 20 minutes and reported at her next session that she had felt less depressed. Lara realised that although she could no longer swim as strongly or as fast as previously, she could derive some enjoyment from the activity. It also enabled her to challenge her perception that all sports were now impossible to do.

Lara’s ability to access social support appeared impaired – she found it hard to show her vulnerability and allow others to help whilst at the same time, she yearned to be cared for. Her reported history of emotional and physical deprivation in childhood had led her to premature self-reliance and her experiences of wanting care had frequently met with rejection. It seemed essential that Lara re-engaged with social networks and worked on modifying her expectations of social interactions. Lara held strong assumptions about being pathetic which were contributing to her depression and to her social isolation. Lara suffered a lot of pain and restricted movement and her family seemed to be unsupportive which was a familiar pattern. Lara believed that “If I tell anyone how hard I am finding it to cope alone, they will think I am pathetic”. Through guided discovery Lara developed an alternative perspective – “some people might like to know how awful I feel and might be in a position to help me. Not everyone is going to be like A.”

Lara told a close friend how much pain she was in, how bad she felt at not being able to cope alone and how she kept berating herself for being pathetic. The friend said she had not realized that Lara was in so much pain and distress and asked how she could help her practically. She also suggested that Lara telephoned her whenever she felt lonely and distressed. She said that she did not think Lara was pathetic.

Lara now risked asking another friend. Although the strength of Lara's conviction in this new belief increased each time, it seemed very hard for Lara to give up the old belief about herself because it had predated the accident.

Lara needed coping strategies to increase a sense of efficacy in dealing with her fears and to help reduce arousal levels when exposed to the traumatic memories during reliving within therapy (Harvey *et al*, 2003). During the time at the PMU, Lara had learnt relaxation skills and she continued practising these. As she was particularly interested in Eastern meditation practice and martial arts, we explored this within sessions and she decided to try qi gong and tai chi as well as mindfulness meditation which has been shown to be useful in both stress reduction and pain relief (Kabat-Zinn *et al*, 1987). Lara then decided to take up tai chi to develop her relaxation skills and to replace the much-loved kickboxing. Building on this work, we used some of the self-soothing skills (Linehan, 1993) within and between the sessions.

## **Sessions 5-12**

Lara was encouraged to develop a narrative of the traumatic experience which incorporated not only details of the accident but included sensory cues and affective responses. This was done within sessions 5-12 encouraging Lara to access the suppressed emotions.

Lara believed that if she talked about the accident in detail within the therapy, she would go “mad” which, for her, meant that she would lose control of her feelings and behaviours. An alternative perspective was found through Socratic questioning -“I will be able to tolerate my emotional distress when I talk about the accident. I will not lose control and become mad. My feelings cannot hurt me”. Lara predicted that when she talked about the accident with her therapist, she would get very upset and scared. She acknowledged that with the therapist’s help, she would be able to soothe her distress by the time the session ended.

Lara understood that her intrusive thoughts and flashbacks might increase temporarily and she worked with the therapist on developing self-soothing strategies and her capacity to tolerate distressing thoughts. Lara then described the accident in detail to her therapist. During the experiment, Lara stated that her distress was about 90% and although she was crying and scared, she was able to continue the session. Afterwards, Lara reflected that she was not as upset as she thought she would be and she was very surprised at how well she had been able to cope with her response. The reliving of the trauma within the session used visualization and socratic questioning to gently draw out the negative appraisals

and strong emotion. Following such an exercise, further guided discovery enabled identification of problematic thoughts and facilitated cognitive restructuring by finding alternative perspectives. Examples of appraisals Lara held included “I’m weak and pathetic”, “I’m making a fool of myself”, “I should be able to deal with this” and “I shouldn’t expect help” . Gradually she began to consider alternative perspectives such as “Given what has happened to me, it is understandable that I am tearful and frightened”. Each session of “reliving” began by looking at previously developed alternative perspectives so that Lara could be encouraged to incorporate them in her “reliving” and begin to answer her own thoughts and develop a more compassionate stance towards herself. Each session finished with facilitated self-soothing to enable Lara to leave the therapy session feeling in control and safe.

After session 6, homework focusing on this work involved repeatedly writing the trauma narrative at a set time each day (Resick and Schnicke, 1993). To encourage Lara’s sense of self-efficacy, she rated her emotional response to these tasks (Appendix 2) and was delighted when, after only a few days practice, she began to feel less aroused when accessing the memory.

Although cognitive restructuring was beginning to be helpful in challenging appraisals of the trauma and its associated symptoms, Lara was struggling to restructure more longstanding beliefs about herself. Lara believed that whenever anything bad happened “its always my fault”, “I am basically bad, worthless and deserve bad things to happen”, and “Its dangerous to trust people, they always hurt you, abandon you or let you down”. Although socratic

questioning facilitated guided discovery, these sad and difficult beliefs were too firmly held. It seemed likely that a longer therapy might be needed to enable Lara to find more compassionate, realistic beliefs about the world and herself.

### **Session 13-18**

By engaging in vivo exposure to situations, smells, sounds associated with the trauma, the individual is enabled to see that the trauma is in the past (Ehlers and Clark, 2000) and a hierarchy of feared and avoided situations was drawn up with Lara. Various techniques were used including prepared booklets of photos of crashed cars, listening to tapes of car crash sounds, watching video films of car crashes and watching TV news programmes without avoidance. Finally, visits were made to the site of the crash accompanied by the psychologist. A programme of continued graded exposure was devised in order to help Lara travel in a car. Lara collaborated in drawing up the hierarchy and finding materials such as photographs, newspaper articles, fictional and documentary film footage etc. A recording of various “crash” impacts was made by the therapist. The benefits of exposure are partially due to the reduction in anxiety when it is seen that the avoided situations does not necessarily cause symptom exacerbation. It also encourages corrective information to be integrated into the trauma memory and enhances self-efficacy through the self-directed use of the exposure material.

In order to evaluate the success of this stage of work, all experiments were discussed within sessions prior to attempting as homework. Using guided discovery, Lara was encouraged to predict possible difficulties to completing the

task and to develop an alternative perspective. She would anticipate the level of distress she might feel prior to attempting a task and then, following completion, rate her actual level of distress. Finally, each “experiment” was evaluated by Lara. These evaluations could then be discussed within therapy and any new things learned, incorporated into the planning of the next exposure experiment.

### ***Changes in the Therapeutic Process Over Time***

Lara was highly motivated to work on her difficulties. During the first two or three sessions, Lara eagerly collaborated in therapy and diligently did homework tasks. At times it seemed as though she was trying too hard and I was concerned that she was struggling with her perfectionist belief. However, as the relationship deepened and the therapy progressed, Lara became more truly collaborative and assertive within the sessions.

The first few sessions felt very didactic with Lara keen to deal with her distressing symptoms and looking to me as an expert with the knowledge that would “cure” her. I felt uncomfortable with this role and encouraged Lara to engage in a genuinely collaborative relationship in which I did not have all the answers but one in which we could jointly discover what the trauma meant to her. We were then able to move forward seeking ways of coping with the symptoms.

However, Lara found it difficult to trust others and this exerted a natural pacing on our work together. During the middle phase of therapy, we spent time talking about her childhood and the ways in which she had formed self-limiting

and destructive beliefs about herself, others and the world. This phase was emotionally intense and I wondered whether it might be advisable to extend the therapy beyond the agreed sessions. Supervision drew my attention to my countertransference and to the importance in holding the boundaries of the contract with this woman who had experienced intrusiveness and violence.

During this time, Lara became very sad and tearful and felt helpless and unable to eat. I was very concerned about her and found myself alternately frustrated and sad. It often felt very cruel to encourage her to connect with friends between sessions and to practice self-soothing and mindfulness skills rather than allow her to depend on me as therapist.

As Lara became more adept at recognising her self-limiting beliefs and behaviours in day-to-day life, she became less distressed and the sessions less volatile. The use of diary monitoring now developed as Lara began to take pleasure in a truly creative diary writing which facilitated her self-understanding.

### ***Making use of Supervision***

My initial difficulties and subsequent use of supervision focused on Lara's suitability for short-term therapy in view of her history of deprivation. It has been shown (Stern, 1993) that patients with a history of deprivation of nurturance do better with longer-term therapies enabling them time to "warm-up" and develop trust. However, after discussion within supervision, I decided to

offer a twenty session therapy as Lara had expressed a preference for shorter therapy.

When, during the middle phase of the therapy, Lara's self-destructive self-beliefs were identified, I used supervision to discuss my concerns about the need for a longer therapy. My supervisor encouraged me to balance Lara's immediate needs with her need to experience the containment of holding the boundaries firmly and maintaining the original contract. He also reminded me of the realistic achievements we might reasonably make throughout the therapy and the need for me to accept that I could only be good-enough and not perfect. Supervision provided a space for me to think about some of the intense emotional material that was now part of the therapy. We discussed again the desirability of extended follow-up sessions and, as the evidence for the benefit of this is limited (Fennell & Teasdale, 1987), decided to just offer two.

Within CBT, transference and countertransference problems are predicted from the conceptualization. This can then be shared with the patient and by using guided discovery, the patient's possible responses to difficulties within the therapy can be elicited. Cognitive models of countertransference postulate that it is usually an unhelpful reaction to the patient, that it may reflect the therapist's schemas and could arise through "therapist-patient schema conflict" (Leahy, 2001). It has also been argued (Young *et al*, 2003) that when patient's and therapist's schemas overlap, overidentification can take place. Young *et al* go on to suggest that the therapist might endeavour to overcompensate if their schemas are triggered by the patient. During supervision, I was able to consider what

might be happening within the therapy with reference to my own self-beliefs and my need to accept “good-enough” rather than perfection in myself.

I struggled at times with using the CBT model and having expressed the thought that a psychodynamic approach might enable me to use the relationship more effectively, my supervisor helped me to see that CBT could allow me the flexibility to tackle these issues along with other transferential issues. Whilst some cognitive literature seems to ignore the therapeutic relationship, my supervisor drew my attention to the work of Safran (1999, 2000), Young (2003) and Leahy (2001) on the therapeutic relationship within cognitive therapy and I was able to use some of these ideas.

### ***The Conclusion of the Therapy***

#### ***The Therapeutic Ending (sessions 19-20)***

Gustafson (1995) draws attention to the fact that in focusing upon the therapeutic relationship as therapy ends, it is possible that neither patient nor therapist will pay sufficient attention to the realities of the world in which the patient lives. Holding this injunction in mind, throughout this brief therapy intervention, I endeavoured to encourage Lara to reconnect with friends and to begin to think about her difficult relationships with her family. Lara tentatively approached her brothers and asked for their help in caring for their mother, expressing her own needs in a new way. She was surprised by the way they responded and began to relate to these men in a different way.

I had taken opportunities to reinforce the idea that progress and change was due to Lara's efforts and perseverance (Beck *et al*, 1990). The tools and techniques learned (Socratic questioning, guided discovery, identifying alternative perspectives, monitoring and scheduling activities, problem solving) were documented and would provide a very useful resource for Lara in her work as her own therapist.

Cognitive therapy is usually brief and structured, with explicit reference to time thus minimizing a regressive transference. To maintain awareness of the time-limit of therapy, we had been naming the number of each session (Mann, 1973). However, core beliefs about abandonment and others' trustworthiness will be painfully triggered during the ending phase for most patients. The increase in levels of difficulties during this time can be anticipated and linked to the impending ending. As we reached session 6 Lara began to express concern that the problems remained and that the therapy was not going to be long enough to help her. Whilst validating her distress and fear, I restated the therapy contract and encouraged her to be her own therapist and maintain her newly found assertiveness and self-esteem by social connection. During this time, Lara once again experienced intense and dramatic mood swings and was able to bring her anger into the sessions and claim that the therapy was not helping her. Again, Socratic questioning elicited the thoughts she was having about termination. Whilst I acknowledged these real fears, through guided discovery we were able to elicit alternative responses. During one session we thought about possible setbacks that Lara anticipated and we reviewed the therapy and prepared a relapse prevention plan collaboratively. Lara especially liked the idea of setting aside time to be her own therapist. By collaboratively developing relapse

prevention strategies during these difficult times, Lara began to feel more self-assured and competent and returned to regularly practising relaxation and self-soothing skills. This stability and increased self-esteem enabled her to acknowledge not only her sadness and fear at the loss of the therapeutic support, her disappointments at the failings of both therapy and therapist but also to delight in the very real achievements she had made.

Although it was a planned ending, there was an emotional response from both therapist and patient. I felt able to tell Lara honestly how much I would miss our sessions and to express my hopes that she would continue our work together in her self-therapy.

### ***Evaluation of the Work***

It is impossible to say with total confidence whether a patient gets better because of psychotherapeutic interventions (Bateman *et al*, 2000) or because of something else within their lives. Whilst the quality of the therapeutic alliance has been shown to be very important in effectiveness of psychodynamic therapies (Horvath & Symonds, 1991), it also contributes to the success of cognitive behavioural therapies (Castonguay *et al*, 1996; Safran & Muran, 2000).

Although I was concerned that Lara needed more than twenty sessions, it seemed that the short therapy was effective in reducing the PTSD symptoms. At the end of therapy, Lara no longer experienced flashbacks of any sort, was able to watch news items and films in which there was a car crash and travel as a

passenger in a car. She had applied for a provisional driving licence. As Lara was so highly motivated to change, she made good use of the therapy and developed good cognitive skills. Lara was very committed to becoming her own therapist and had persisted in addressing the underlying assumptions behind her maladaptive schemas that had previously prevented her from breaking out of the abusive cycle.

#### Follow-up

Follow-up sessions were arranged for 3 and 6 months. In the end, Lara did not attend the 3 month session as she was away travelling. At the 6-month follow-up, Lara stated that she had had no PTSD symptoms for 3 months and was able to normalize experiences, had sold her house, found a new job, begun a professional course and claimed a better relationship with her mother and brothers. She had continued with her relaxation programme and was persevering with qi gong and yoga.

#### ***Liaison with Other Professionals***

Contact was maintained throughout therapy with both the referring psychologist and Lara's GP. Communication was by letter. I also discussed the therapy with my supervisor.

#### ***Learning From the Therapeutic Work***

Although I based my therapeutic plan on research evidence, I found that, in practice, it did not necessarily work for this particular patient. For example,

the work of Resick and Schnicke (1993) showed that repeatedly writing the trauma narrative helped the patient. Lara dutifully wrote, rated and rewrote the narrative four times on the first day and five times on the second day. She then “confessed” at the second session that it took too long so she had modified the technique and now wrote it once and then read it. This did appear to work for her. Whilst the theory stated one thing, practice seemed to show another.

A strong therapeutic alliance is essential to cognitive behavioural therapy (Beck *et al* 1990 Safran *et al* 1990), so strengthening the therapist-client relationship is important. I now began to integrate this knowledge with my own experience of the theory and practice of psychodynamic therapies. I found myself increasingly aware of how the transferential relationship impacted on the process of therapy irrespective of model. I felt able to name these issues as they arose and found, that by this transparency, we were able to work towards repairing any ruptures in the therapeutic alliance (Safran & Muran, 2000).

### ***Learning From the Case About Yourself as a Therapist***

I chose this patient because, in retrospect, the therapy seemed to mark a milestone in my personal and professional development. This was a short-term, discrete piece of work with a successful outcome. It was very rewarding as Lara made tremendous improvements. Whilst I was aware of the dangers of needing one’s patients to get well in order to feel confident as a therapist, I realized how good this made me feel and how it boosted my confidence. During the period I was seeing Lara, I was becoming increasingly less dependent on external

validation of my own clinical work. My tendency to be self-critical, to deny my own inner wisdom and to accept what others say diminished considerably. I feel this was often reflected in my work with Lara where I felt able to be flexible, to try things out and to reflect on why something had not worked without fearing that I would be judged negatively. My greater self-confidence has enabled me to be more relaxed and I feel that this is reflected in the therapy outcome.

I also felt more strongly than I had done previously, that I need the opportunities to work both cognitively and psychodynamically – I like working with either model and found through this therapy, that the psychodynamic work has enhanced my cognitive skills.

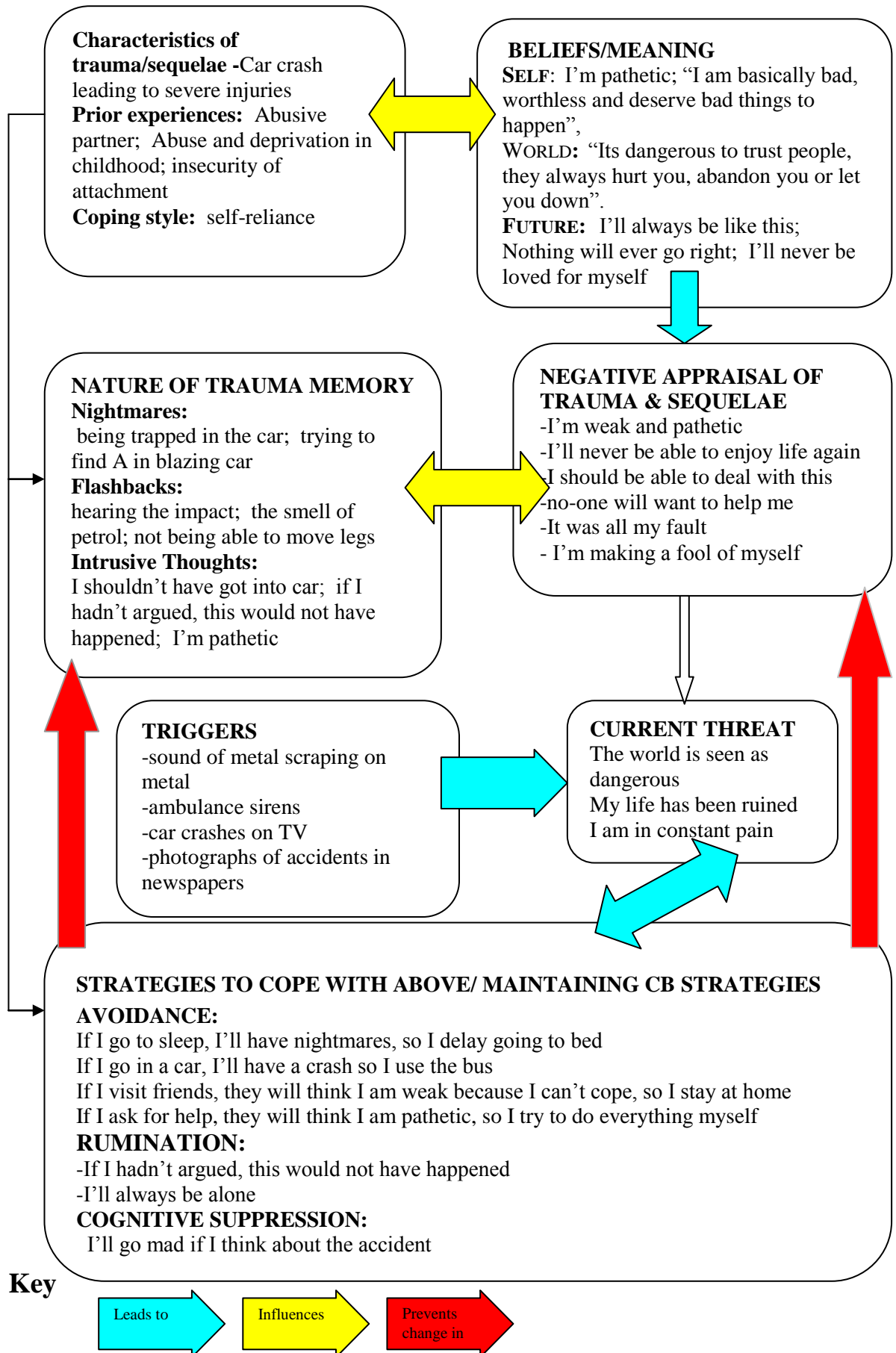
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## Appendix 1

### CONCEPTUALIZATION USING PTSD MODEL



## Appendix 2

### Trauma Writing

#### Instructions

Write the trauma narrative each day. Decide in advance on a particular time to do this – don't do it near bedtime. When you have written the narrative out, write down a number from 0-10 that describes how you are feeling 0-very low, 8-pretty good, 10-great. Rewrite the narrative over and over for about 20 minutes, recording your rating each time. Only stop writing and rating when your last rating is better than your worst for this day.

Week 1	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
1	1	1	3	4	5	6	6
2	1	2	0	0	3	4	2
3	2	0	1	2	2	4	3
4	4	2	2	3	4	5	4
5		5	5	6	6	7	5
Week 2							
1	7	6	6	8	7	6	8
2	3	4	5	6	4	5	5
3	4	4	5	7	8	6	5
4	5	7	7			7	8

## **Appendix 3**

### **Graded Exposure Schedule**

1. Pictures of vehicles involved in car crashes
2. Pictures of cars with people trapped inside
3. Isolated pictures of injured people
4. Comedy films including crashes
5. Isolated sounds of impact of crash
6. Film of crash

### **Material was presented as:**

Booklets of pictures

Newspaper cuttings

Videos

Audio cassettes of “sounds” of car crashes, ambulance, police car and fire engine sirens

All material recorded from copyright free internet archives

Patient also used television, magazine and newspaper opportunities to increase her exposure to feared stimuli.

## **SECTION D**

### **CRITICAL LITERATURE REVIEW**

**DARE WE LISTEN?  
CAN WE AFFORD NOT TO?  
PSYCHODYNAMIC PSYCHOTHERAPY FOR  
PSYCHOSIS**

The terrible loneliness of psychosis contrasts with the individual's desperate fear of connection. Far from having no feelings as so often stated, schizophrenic patients endure chronic terror and utilise defenses against that terror (Karon, 1992). As a defense against separation anxiety, the schizophrenic patient denies wishes for attachment and appears indifferent to object relations (Burnham, 1965). To truly understand the person with schizophrenia, we must confront facts about life and human beings that we would prefer not to know, or to even know once more. Karon (Karon, 1992) suggests that if the therapist "dares to listen carefully", schizophrenia not only makes psychological sense but appears an inevitable consequence of that person's experiences.

Karon (1992) writes:

"Balancing between fear and loneliness is the best description of what it feels like to be schizophrenic. But that is what the rest of us do not want to understand."

To be alongside this fear and loneliness creates such emotional impact on the therapist that, for some, it is unbearable and retreat from understanding must occur (Karon, 1992; Kline, Becker, and Giese, 1992). Bowlby (1980) argued that early attachment experiences are internalised and then, as working models, impact on interpersonal relationships in adulthood. Childhood insecurity of attachment is associated with later low self-esteem and impaired sense of self. Difficulties in forming and maintaining relationships impacts on recovery from psychosis (Drayton, Birchwood, and Trower, 1998; Berry, Wearden, and Barrowclough, 2007) and are implicated in the establishment and maintenance of the therapeutic alliance within psychotherapy.

## ***Introduction***

Is the predominance of cognitive behavioural therapy for psychosis in this country the result of efficacy, effectiveness or expediency? In recent years, research has tended to focus on cognitive behavioural approaches. This review aims to examine recent studies of psychodynamic psychotherapy with patients with psychosis to see whether the paucity of research reflects practice or research paradigms.

## ***Cognitive Approaches***

Recent research trends into psychotherapy for patients with psychosis have focused on cognitive behavioural models. Aspects of psychotic experience have been investigated including the influence of emotion on hallucinations and delusions (Freeman & Garety, 2003), and the development and maintenance of persecutory delusions and auditory hallucinations (Freeman *et al*, 2001; Garety *et al*, 2001). Emotional disturbance contributes to both the development and maintenance of psychotic symptoms (Fowler *et al*, 1995; Freeman & Garety, 2003) with some researchers suggesting such delusions are defences against threats to the self (Bentall *et al*, 1994). Focus is also on the development and implementation of cognitive behavioural therapy for psychosis (Kuipers *et al*, 1998; Tarrier *et al*, 1998; Garety *et al*, 2000) with current models highlighting the importance of empathy and the careful development of the therapeutic alliance (Fowler *et al*, 1995; Garety *et al*, 2000).

### ***Psychoanalytic Accounts of Psychosis***

The development of psychoanalytic understanding of psychosis extends over many years and is well described in Reilly, 1997. Freud (1914 ) described how conflictual demands overwhelm a fragile ego impairing functioning with the loss of ego boundaries and subsequent disturbed reality testing and predominance of primary process thinking. The development of self and object representations is impaired through integrative deficits. Attacks on linking (Bion, 1967) with expulsion of the split-off fragments to establish safety contribute to psychotic defence mechanisms.

Melanie Klein (1946) suggested that terror of annihilation leads the infant to resort to splitting, projective identification and idealisation. Inability to deal with this paranoid-schizoid position leads to persistent use of primitive defense mechanisms and more recently, Migone (1995) has linked the concept of ‘expressed emotion’ with the phases of projective identification. The regression seen in psychotic states was conceptualised by Winnicott (1965) as an attempt to find the previously lacking “facilitating environment” and Bion’s later work on staff containment of patients’ projections (1967) developed understanding of the ways in which a supportive environment could enable patients to feel understood.

### ***Psychodynamic Psychotherapy***

Studies of psychodynamic psychotherapy for psychosis have been described as inferior to other treatments (Tarrier *et al*, 2002) or even as potentially damaging (Mueser & Berenbaum, 1990). Martindale *et al* (2000)

however argued that many of these studies were methodologically flawed rather than unsound or ineffective practice.

Within schizophrenia research, recent reviews on efficacy of family interventions (Burbato, 2000; Huxley et al, 2000) demonstrate only small differences between study outcomes and the benefits of CBT become less obvious when there is longer-term follow-up (Dickerson, 2000). Others have contended that the evidence is insubstantial and based on incomplete or inadequate literature (Tarrier *et al*, 2002).

The use of manuals reduces therapist variability (Elkin, 1999), and enables assessment of therapist adherence to treatment approach. Unless studies provide evidence of therapist adherence, any differences or similarities in treatment effectiveness, cannot be considered to be due to treatment itself (Startup & Shapiro, 1993). Using the same therapists for all conditions or models of treatment reduces variability in therapist personality, experience and training (Startup & Shapiro, 1993).

## **Method**

### ***Search Strategies***

Studies were selected from:

*Psychinfo* using key words – *schizophrenia, psychosis, psychodynamic, psychoanalytic, psychotherapy* in the title, abstract and subject headings for the

period between 1990 and 2004. Initially, the search was restricted to *clinical trials* in but this was expanded to permit access to a wider range of studies.

Reviews on the subject published in English between 1990 and 2004

A hand-search was carried out for the period 1990 and 2004.

### ***Criteria for Inclusion***

Studies included in this review were those published between 1990 and 2004, that describe a method of psychotherapy which is psychodynamic or psychodynamically based and that demonstrate assessment of patients and evaluation psychotherapy outcome.

Whilst it has been argued (Mueser & Berenbaum, 1990) that efficacy of clinical treatment should be evaluated in terms of effect on established outcome criteria, this review is including studies where concepts such as *ego strength* and *insight* are evaluated.

## **Results**

This review seeks to investigate the apparent predominance of research into CBT over that for psychodynamic psychotherapy. Few studies into psychodynamic psychotherapy for psychosis were found when searches were restricted to clinical trials. Studies were found when wider searches were made. Eighteen studies met the above criteria. In view of the methodological difficulties associated with evaluation of heterogeneous studies, it was decided to group the selected studies into i) psychodynamic psychotherapies ii) integrative/multi-modal psychotherapies iii) single case studies iv) group psychotherapy.

### ***Individual Psychodynamic Psychotherapies***

Four studies, three retrospective (Rund, 1990; Cullberg, 1991; Varvin, 1991) and one experimental (Siani & Siciliani, 2002) were included. All studies evaluated the impact of intensive psychodynamic psychotherapy on patients who met DSM III-R, ICD-8, ICD-10 criteria for schizophrenia or other psychosis.

Intensity of psychodynamic psychotherapy ranged from once weekly to four times weekly. Duration of therapy ranged from one to twelve years. In the comparison of differences between a recovered group and a non-recovered group, (Cullberg, 1991), it was observed that the duration of therapy for the recovered group ranged from 1-11 years, mean 6.5, whilst the non-recovered group ranged from 2-12 years, mean 8.6.

Rund (1990) looked for similarities in premorbid adjustment, family interaction, hospitalisation and treatment of fully-recovered schizophrenics and asked whether psychotherapy is necessary for full recovery. A retrospective, case-control strategy was used, incorporating semi-structured interviews. Ten patients, five men, five women comprised the sample of whom three patients met full diagnostic criteria for recovery. Patients were referred to the project by clinicians.

Six of the ten patients had had group psychotherapy, eight had been in individual psychodynamic psychotherapy and six had experience of

social/occupational therapy. Psychotherapy ranged from four to ten years at an unspecified intensity. Eight patients attributed their recovery in part to psychotherapy and the relationship with the psychotherapist (Rund, 1990). Two established outcome measures of patient functioning were used to evaluate changes in level of functioning. On the UCLA Social Adjustment Scale the recovered patients had a mean score 19.1 (range 10-31) and on The Global Assessment Scale the recovered patients had a mean score 70 (range 50-80). The smallness of the sample makes generalisability limited.

Varvin(1991) investigated the characteristics and background variables of patients with schizophrenia who benefited from psychotherapy. Diagnosis (DSM-III and ICD-8) was applied retrospectively using patients' records. The patient sample comprised ten men and seventeen women and the study covered a ten year period.

Psychodynamic psychotherapy was conducted by experienced psychotherapists at an intensity of one to four sessions weekly (Varvin,1991). Eight patients also took part in systematic family therapy. It is not possible to evaluate with certainty whether the psychotherapy caused observed changes as there was no control group. Neither is it possible to evaluate the impact of the milieu environment. Validated measures of outcome were used the Health Sickness Rating Scale, the Strauss-Carpenter Level of Functioning Scale, the Social Adjustment Scale, the Integration-Sealing Over Scale, and the Psychotherapy Outcome Scale. Evaluation of longitudinal outcome

(Varvin,1991) showed that one group comprising nine women showed greater adjustment than the other group of eight women and ten men. Cross-sectional data showed that the same group had better scores on the Health-Sickness Rating Scale. The two psychodynamic scales correlated well with HSRS and SCLFS. The patients who seem to benefit the least had also experienced more moves to other units and this could be a confounding variable through loss of continuity of care.

The therapeutic alliance seemed to be a key factor in the therapies of patients who benefited the most (Varvin,1991). The small sample size limits generalizability, and a larger sample in a controlled study would allow analysis to separate effects of variables such as lack of continuity and poor premorbid adjustment on outcome.

Cullberg (Cullberg, 1991) investigated the clinical differences between patients with schizophrenia (DSM-III-R) who made a full-recovery and those who did not. Both groups received intensive psychotherapeutic treatment with daily or weekly contact . The sample comprised a “recovered” group of eight patients (six male, two female) and a “non-recovered” group of ten patients (eight male, two females). There was a slight age difference at first admission with the “non-recovered group” having a mean 21.5 compared to the “recovered group” with a mean 19.

No information is given about the psychotherapists. Psychotherapy duration was: “recovered group” 6.5 years mean (range 1-11); “non-recovered group” 8.6 years mean (range 2-12). Independent psychiatric evaluation of symptoms gave a high correspondence with the research team’s scores (Cullberg, 1991).

Well-validated outcome measures were used. The Fenton-McGlashan Prognostic Scale has high internal validity. The recovered group showed significantly more confusion ( $p<0.005$ ) in the early stages of their illness (Cullberg, 1991). Significant differences were also found in the non-recovered group’s greater experiences of auditory hallucinations ( $p<0.05$ ) and visual hallucinations ( $p<0.05$ ). Results should be cautiously considered indicative as the sample is small with limited generalisability and the hospital records were of variable quality (Cullberg, 1991).

Siani and Siciliani investigated the effectiveness of Kohutian psychoanalysis in conjunction with medication (Siani & Siciliani, 2002) and evaluated outcome using the Karolinska Psychodynamic Profile. This enables structural and psychodynamic facets of personality and self to be measured (Martindale *et al*, 2002) although it does not allow external measurements of change to be made thus disallowing comparison with other measures.

This was an experimental case-control study with a control group who received only medication. The control group received ten consultations over two

years which makes it more difficult to say with certainty that it was the psychotherapy that caused changes in the Psychotherapy Group rather than the additional contact. However, there was a selective bias, acknowledged by the authors, in that only outpatients were enrolled in the study (Siani & Siciliani, 2002). There was no randomisation. The small sample limits the generalizability of the results.

Data suggests that empathic understanding strengthened the working alliance and that countertransference management enabled the avoidance of narcissistic injury to the patient (Siani & Siciliani, 2002). The therapy focused on object relations, defences and socially related self-esteem with less verbalisation of insight than is traditional. Only one therapist was involved and whilst this controls for some aspects of therapist variability on outcome, it might also conversely account for others.

The Psychotherapy Group showed significant improvement on KAPP items for intimacy/reciprocity; dependency/controlling in object relations; frustration tolerance/coping; impulse control; coping with aggressiveness; sense of belonging.

In summary, psychodynamic psychotherapy outcome was positively evaluated with improvements on social adjustment, affect regulation, intimacy and reciprocity. The importance of the therapeutic alliance (Rund, 1990; Siani

& Siciliani, 2002; Varvin,1991), and continuity of care (Varvin,1991) were highlighted .

### ***Integrative/Multi-modal Approaches***

Five studies were reviewed and these were characterised by their multi-level, multi-modal approaches. All studies spanned longer time periods ranging from three years (Hogarty *et al*, 1997) to the thirty year project described by Alanen (Alanen, 1991). Evaluation and comparison of these complex and long studies is difficult.

Based on the assumption that individual-specific, frequently interpersonal, stress causes affective dysregulation (Hogarty *et al*, 1995, 1997; Fenton, 1997), Personal Therapy uses a variety of interventions to facilitate social and personal adjustment by increase in self-awareness and development of adaptive strategies to increase affective self-monitoring and self-control and thus prevent third-year relapse (Hogarty *et al*, 1997). The three year randomised controlled trial (Hogarty *et al*, 1997) investigated the effectiveness of individual therapy for patients with schizophrenia, particularly looking at the relapse profiles. The concept of relapse was operationalised as being the remission of positive symptoms leading to symptom exacerbation (Hogarty *et al*, 1997) .

The trial grouped 115 patients according to whether they lived alone or with families/friends. Trial I: patients living with families, patients randomised

to Supportive Therapy, Personal Therapy, Family Psychoeducation or a combination of Personal Therapy and Family Psychoeducation. Trial II: patients who lived alone, randomisation to Personal Therapy or Supportive Therapy.

Therapy was of three years duration and at an intensity of monthly, 30-45 minute sessions. The therapists were experienced psychiatric nurses and clinical psychologists. In the Supportive Therapy condition, therapists were the same nurses who did either Personal Therapy or Family Psychoeducation in other conditions. Medication was given at the minimum effective neuroleptic dose.

Evaluations were made at six monthly intervals over the three year period using well-validated outcome measures - The Social Adjustment Scale and The Personal Adjustment Scale. The results were favourable for Personal Therapy. 8% patients remained in the Basic Phase, 38% entered but did not progress beyond the Intermediate Stage and 54% progressed to the Advanced Phase. There were pervasive effects on social adjustment independent of relapse prevention in which Personal Therapy had greater effectiveness in prevention of psychotic relapse. The important main effects were seen in years two and three.

Efficacy of Personal Therapy in relapse reduction is associated with residential status, with patients living with their families experiencing fewer relapses. There were significant demographic differences between the two trials: Trial 2 patients had experienced longer illness, more hospitalisations and

included more divorced and separated patients. Trial 1 patients comprised more first-episode patients. The study discusses the apparent failure to achieve distribution of certain characteristics across groups (Hogarty *et al*, 1997) with Trial 2 comprising the most ill group. Psychotherapy is difficult for any patient especially if they have inadequate social support and this might have contributed to their higher relapse rate. The lack of significant differences between Supportive Therapy and Personal Therapy in Trial 2 could be due to therapist variability. Although the therapies were manualised and treatment adherence claimed, there is no mention of analysis of audiotapes of sessions.

Social Adjustment improvements plateaued at twelve months for patients in Supportive Therapy or Family Psychoeducation, whilst the Personal Therapy groups continued improving in years two and three. The study addresses the idea of levels of intervention and subsequently, individualised interventions.

The Turku Schizophrenia Project (Alanen, 1991) was an integrated need-adapted treatment. It was a non-randomised treatment allocation with a naturalistic follow-through utilising a cohort design. Throughout the development of the model, it has been possible to compare outcomes of different stages and cohorts (Alanen, 1991). However, it is difficult to make comparisons between cohorts as, over the years, there have been changes in diagnostic criteria.

Psychodynamic psychotherapy, systemic psychodynamic family therapy and a therapeutic community formed the basis of the treatment programme.

Cullberg *et al*'s pilot study for the Swedish multi-centre Parachute Project (Cullberg *et al*, 2002) investigated the effectiveness of psychosocially based "need-adapted care" in comparison to a "care-as-usual" patient sample from four years previously. The six principles of "need-adapted care" are described as being: early intervention; crisis and psychotherapeutic approach; family orientation; continuity and easy accessibility; optimal, lowest dose neuroleptic medication; need-adapted overnight care.

The patient sample was matched in terms of age, gender and diagnostic distribution (DSM-IV: American Psychiatric Association, 1994). Patients in the retrospective comparison group had received standard care which included supportive psychotherapy, medication and inpatient care at the time of their first episode of psychosis between 1991-1992 (Cullberg *et al*, 2002). Intensive psychotherapy had not been available. An initial supportive, individual crisis intervention, was followed by intensive, individual psychodynamic or cognitive psychotherapy depending on patients' needs. Intensity was between one and two sessions weekly, duration for up to a year or longer. Supportive and/or family psychoeducation is given where needed. Five psychodynamic psychotherapists and cognitive therapists took part in delivery of psychotherapy.

Outcome measures were validated, frequently used scales. The Global Assessment of Functioning (GAF: American Psychiatric Association, 1994) assesses mental functioning with a score greater than 40 suggesting overt psychosis and less than 60 suggesting the need for psychiatric help. GAF for the schizophrenia group mean 55 and for the non-schizophrenia group mean 75. The Brief Psychiatric Rating Scale (BPRS: Ventura *et al*, 1993) scores positive symptoms (suspiciousness, hallucinations, unusual thought content) and negative symptoms (self-neglect, blunted affect, emotional withdrawal). BPRS scores for the schizophrenia-group showed that 39% were symptom free at follow-up; in the non-schizophrenia-group 79% were symptom free at follow-up. Assessments were only made at follow-up for the project group. The project group had lower consumption of medication, lower rate of hospitalisation and fewer members were receiving a sick pension (Cullberg *et al*, 2002).

This treatment regime was cost-effective (Cullberg *et al*, 2002) with decreased expenditure on medication, hospitalisation and receipt of sick pension. It is difficult to define the effective intervention in multi-modal treatments. 50% of the comparison group had also refused to see the research team (Cullberg *et al*, 2002) and data was collected from hospital records with the possibility of variability in quality and accuracy.

Johannessen *et al* 's study (2002) is ongoing and includes multi-level, multi-modal approaches incorporating supportive psychodynamic psychotherapy. The project aims to reduce duration of untreated psychosis (DUP) which is

operationalised as “the time between onset of psychotic symptoms and hospitalisation for psychosis or initiation of adequate treatment” (Johannessen *et al* , 2002, p.218). A second aim is to investigate the short and long-term outcomes for these patients if they are offered an integrated programme of care including 2 years intensive psychotherapy together with family psychoeducation. The main emphasis of this project is comparison of “early detected” cases compared with “detected as usual” cases. The design is prospective, longitudinal, multi-centre (three areas), quasi-experimental but with no randomisation.

Criteria for inclusion in the project are DSM-IV diagnosis schizophrenia, schizoaffective disorder, schizotypal disorder, delusional disorder, psychotic disorder (DSM-IV: American Psychiatric Association, 1994). A score above 4 on the Positive and Negative Syndrome Scale (PANSS) is also required. The psychotherapist co-ordinates and is responsible for the overall treatment planning and the active outreach approach. Psychodynamic psychotherapy is for a minimum of 2 years with an experienced psychotherapist and the importance of continuity and avoidance of frequent relationship breaks is stressed (Johannessen *et al*, 2002). Psychoeducative family work is also used if needed.

This is an ongoing project, the results are preliminary and effect on clinical outcome is as yet unknown. Historical comparison with the 1993-94 pilot study shows reduction in DUP from mean 114.2 to 17.2 (median 26-12).

Jackson and Cawley evaluated the feasibility of running a unit on psychodynamic principles and investigated whether patients are sufficiently contained within such a milieu (Jackson & Cawley, 1992). An Experimental unit (10-12 beds) and Associate unit (10-12 beds) were studied. 150 patients were involved in the study over a period of thirteen years. All the patients had diagnoses in accordance with ICD-9 criteria: twenty seven schizophrenia, fifteen other psychosis; thirty four personality disorders; thirty six miscellaneous including Anorexia Nervosa.

A psychodynamic milieu comprised daily community group, twice weekly patient groups and a weekly staff group. Long-term, intensive psychoanalytic psychotherapy was delivered by psychiatric registrars/psychotherapists. Six patients had formal psychoanalysis.

All but one patient did well with psychoanalytic work. Psychoanalytic understanding was seen to enhance staff relationships and facilitate understanding of patients' behaviours.

In summary, patients receiving psychotherapy appeared to do well although in multi-modal approaches it is difficult to say with certainty which interventions are effective. Areas of interest highlighted by these studies include duration of therapy and the therapeutic alliance, therapist variability including adherence and the effect of social environments on outcome.

### *Single Case Studies*

Four studies were reviewed one of which (Davenport, 2000) described two case studies. Three of the four studies focused on therapy with psychotic patients whilst one looked retrospectively at the therapy of a fully recovered patient (Levander & Cullberg, 1993). Outcome evaluation was made by therapists (Niels, 1993; Hingley, 1997; by researcher interviews of patient and therapist (Levander & Cullberg, 1993) and by published outcome evaluation scales (Davenport, 2000). Duration of therapy ranged from forty sessions CAT (Kerr, 2003) to seven years psychoanalytic psychotherapy (Levander & Cullberg, 1993).

Levander & Cullberg's retrospective case study (Levander & Cullberg, 1993) presents material extracted from a larger study (Cullberg, 1991) and gives rich insight into the psychotherapy process. It is an exploration of a successful outcome in psychotherapy and involved interviews by both authors of therapist and patient. Access was obtained to the therapist's written material.

Although there is necessarily limited generalizability from a single case-study, it appears that the therapist's affirmative rather than confrontational style facilitated engagement and ego-strengthening. Changes in the patient's functioning were assessed: now living independently, working full-time, enjoys a social network and good relationship with parents. Affective traits were present although the patient remained fearful of intimacy.

Nields' exploratory, process study investigated the effect of psychotherapy on a psychotic man (Nields, 1993). It gives a real feeling of the experience of therapy and highlights areas of interest for future research especially the benefits of a longer therapy relationship, the subsequent attachment and the experience of separation.

Subjective evaluation of changes in the patient's functioning might have been enhanced by the use of either process or outcome evaluation scales. More details regarding the therapist would allow consideration of therapist characteristics as non-specific factors impacting on outcome.

Hingley (Hingley, 1997) reviewed outcome research and psychodynamic practice. The incorporation of a case-study gives rich material and improvement in relating to others appears to have been facilitated by the use of less intensive, more supportive psychotherapy.

The development of a more established ego and greater understanding of inner conflicts, fears and emotions led to improvements in self-esteem, assertiveness, expression of negative feelings, sense of own separate identity, a decrease in reliance on delusions of grandeur and less sensitivity to others' reactions (Hingley, 1997).

It is possible that the case-study would be enhanced and more reliably evaluated if some process or outcome measures had been used. As a single case-

study, there is limited generalizability to a wider patient population. The self-psychology orientation of the psychotherapy links with the work of Siani & Siciliani (Siani & Siciliani, 2002), who also found this style to be beneficial when working with patients with psychosis.

Psychodynamic-interpersonal therapy is a dialogical model of psychotherapy (Davenport, 2000) which aims to develop, within a therapy relationship, a mutual feeling language that can facilitate understanding of relationship difficulties. It can be clearly differentiated from cognitive therapy and Interpersonal therapy (Margison *et al*, 2000). The focus is on using the “here and now” experiences of the patient in such a way that affectivity is kept to a bearable level (Davenport, 2000). These case studies were taken from a larger multi-modal project and consequently it is not possible to be certain which changes are attributable to psychotherapy.

Outcome evaluation measures used have limited psychometric properties when used for repeated measures single case design (Davenport, 2000). Ratings were made by nursing staff and were independent of the therapist although the latter was aware of the scores. The Krawiecka Goldberg Vaughan Scale for Schizophrenia is a well-validated, standardised measure of psychopathology. Improvement was seen in both patients – decrease from 24 to 14 (pt 1) and from 12 to 5 (pt 2). The Social Behaviour Schedule assesses social functioning and the “severe problem behaviour” subscale (strong correlation with need for high intensity inpatient care) was used. Results for both patients showed improvement with decrease in score from 8 to 2 (pt 1) and from 9 to 4 (pt 2).

Pronounced social function disturbance in both patients decreased but residual difficulties remained in the social anxiety field (Davenport, 2000). There was also improvement in The Deviant Behaviour Subscale of the REHAB scale (Davenport, 2000). This subscale measures behaviours which make community placement difficult. Score improvements were from 4 to 0 (pt 1) and from 5 to 0 (pt 2). These scales measure extreme behaviours and are less sensitive to changes in social role. The assessment tools add some objective evaluation which increases the understanding of the progress these two patients through psychotherapy.

Davenport (2002) also acknowledges the adaptive and maladaptive carry-over effect from therapy to the ward environment and also the contribution of the milieu ward environment to non-specific facilitating conditions. These patients had previously been unable to engage with cognitive behavioural therapy but appeared to benefit from Psychodynamic-Interpersonal Psychotherapy's emphasis on early empathy and the focus on establishment of secure boundaries to enable the patient to feel contained. This study also highlights the importance of institutional dynamics and the staff-patient interrelationships which can adversely affect inpatient experiences.

In summary, it appeared that individual psychodynamic psychotherapy led to improvement in ability to communicate and relate to therapist and others. Residual difficulties were observed in area of social anxiety (Davenport, 2000) whilst in four cases improvement was seen in affect regulation and expression.

Areas of particular interest for further discussion are therapy duration, attachment to therapist and separation difficulties. Institutional dynamics were also highlighted in the group of studies.

### ***Group Therapy***

In Kanas' review of the effectiveness of group therapy for schizophrenia, meta-analysis was thought to be inappropriate due to the variability of the studies and the inadequate presentation of their statistics (Kanas, 1990). Criteria for inclusion in the review are clearly stated and consideration given to the parameters of diagnosis in the included studies. Kanas, states that there is a loss of "statistical rigor" due to the inability to use meta-analytic technique.

In the exploration of group process, eleven male inpatients took part in twelve weeks of three times weekly group psychotherapy. Using the Hill-Interaction Matrix G Process Measure (Hill, 1960; 1965), group content and work style was explored and the results compared with a normative sample. Whilst there was a confrontive work style, the group resistance was low comprising 1-5% overall group activity. Therapist activity was moderate (26% of time) and overall there was a significant correlation ranking with the original 1985 study (Kanas, 1990).

A further process study of an integrative group approach (Kanas, 2002) included in and out-patient studies of twelve male and eight female patients. The two therapists were not described. Group intensity was twice weekly sessions of 45 minutes. Ten sessions were evaluated.

The group process was evaluated using the Group Climate Questionnaire (GCQ-S; MacKenzie, 1983) by two therapists whose rankings were consensual. In comparison to the American Veterans Affairs Group, there were significant score differences in anxiety dimension. Conflict dimension and avoiding dimension scores were lower but not significant. There was a non-significant difference in engaged dimension. Content topics included hallucinations, delusions, improving schizophrenia, the need to talk about issues congruent with their needs and with the goals of the group.

In summary, group therapy appears to benefit some patients with schizophrenia .

## **Discussion**

### ***Methodological Limitations***

Many of the studies have methodological limitations including non-randomisation, small sample size and practical difficulties controlling for medication and non-specific contacts.

Whilst there were defined treatment populations in all studies except the single case-studies, only one (Hogarty *et al*, 1997) used randomisation. Less information was given about selection of patients for single-case studies. True

randomisation is difficult to achieve and does not necessarily ensure generalisability (Roth & Parry, 1997). Diagnostically homogenous patients will not be representative (Roth & Parry, 1997; Ablon & Jones, 2002) and patient variance will not be necessarily controlled as personality characteristics and interactional styles are stronger predictors of outcome than technique (Ablon & Jones, 2002). Shapiro (1995) citing Howard *et al*, 1995, argues that patients who manage to persevere through a treatment programme are not a random sample of any population. Inadequate sample sizes in many comparative outcome studies affect statistical power.

Outcome measure reliability varied across the studies. Some studies utilised well-known rating scales (Rund, 1990; Cullberg, 1991; Varvin, 1991; Hogarty *et al*, 1997; Cullberg *et al*, 2002; Davenport, 2000) whilst others measured outcome by subjective therapist or patient self-report. The Karolinska Psychodynamic Profile (Siani & Siciliani, 2002) is a relatively new outcome measure with good inter-rater reliability and test-retest reliability. Comparison between studies was difficult due to the variability of scales.

Randomisation is compromised by attrition. The one randomised trial (Hogarty *et al*, 1997) found that over three years of the study, only twenty seven patients (18%) ended prematurely, twenty four were treatment non-compliant and three left for administrative reasons. Eighteen of the twenty-four treatment-associated terminations came from the no-personal-therapy conditions. Financial reimbursement was given to patients to facilitate attendance and may have

affected treatment compliance. Other studies either did not present attrition statistics or were single case-studies.

Research into psychotherapeutic efficacy for psychosis has to contend with practical difficulties in simultaneous treatments such as medication and case-management. Most of the patients in the reviewed studies were taking some neuroleptic medication. Whilst some of the studies gave detailed descriptions of medication (Hingley, 1997; Davenport, 2000; Cullberg *et al*, 2002) only a very few studies controlled either dose or type of drug (Hogarty *et al*, 1997; Johannessen *et al*, 2002). These difficulties are not specific to psychodynamic approaches and have been highlighted by studies of Cognitive Behavioural Therapy (Haddock *et al*, 1998; Dickerson, 2000) and Family Interventions (Barbato & D'Avanzo, 2000).

Only one study (Hogarty *et al*, 1997) stated that manuals were used to ensure therapist adherence and thus reduce therapist variability (Elkin, 1999). Without evidence of therapist adherence, any differences or similarities in treatment effectiveness, cannot be considered to be due to treatment itself (Startup & Shapiro, 1993). Adherence may not equate, however, with therapeutic adequacy (Elkin, 1999) as it has been shown that manualisation can lead to the therapist experiencing problems in dealing with the therapeutic relationship in both Cognitive Behavioural Therapy (Castonguay, 1996, cited Elkin, 1999) and psychodynamic therapy (Henry *et al*, 1993, cited Elkin, 1999).

If it is not possible to control psychotherapy process even when there is high therapist model adherence, the underlying premise behind RCTs is unable to be met. Treatments cannot therefore be reliably validated (Ablon & Jones, 2002) and it is argued that empirical studies of change processes should replace empirical validation of treatment effectiveness.

## **Factors Involved in Outcome**

### ***Therapeutic Alliance***

It is the therapist's responsibility to develop the therapeutic alliance (Karon, 1988) and their ability to do so is an essential factor in positive outcome. The therapeutic relationship was cited as being associated with positive outcome in many studies (Rund, 1990; Cullberg, 1991; Varvin, 1991; Davenport, 2000; Johannessen, 2002). Martindale (2002) suggests an outcome tool which could measure the therapeutic dyad's capacity for engagement is needed. This could also identify those factors which inhibit the tasks of therapy. A measure of the therapeutic alliance or "treatment connectedness" was used by Hogarty *et al* (1997) and showed that 90% of 710 patient assessments indicated a moderate to high connectedness.

### ***Longer Therapies and Continuity of Care***

Longer term psychotherapy is beneficial for some groups of people with schizophrenia (Levander & Cullberg, 1993; Cullberg *et al*, 2002; Hogarty *et al*, 1997; Nields, 1993; Johannessen *et al*, 2002) and continuity of treatment and

therapist appears to be associated with good outcome (Varvin, 1991; Hogarty *et al*, 1997). The regular rotation of staff within mental health services makes it difficult for patients to develop the supportive relationships they need to help them deal with a disorder that has a long and complex course (Martindale *et al*, 2002).

### ***Therapist Variability***

The therapist's role is important when two treatments are compared (Elkin, 1999). It has also been highlighted that therapists who choose or are chosen to do research therapy may be different in some ways to other therapists (Elkin, 1999). Therapists' clinical effectiveness is mediated by their attachment style (e.g. Black, Hardy, Turpin, and Parry, 2005; Dozier, Cue & Barnett, 1994; ) and it has been argued that attachment fit between therapist and patient has an effect on outcome (Alanen (1997; Holmes, 2001). Non-specific factors associated with outcome remain unidentified (Paley & Shapiro, 2002) and it is possible that therapist attachment style is such a factor.

Burnham (1965) states that separation anxiety makes it essential that the patient is able to develop trust in the therapist as a "reliable object". Whilst the therapeutic frame provides this consistency, brief, planned separations and subsequent reunions help the patient learn to tolerate separation. Such psychotherapeutic techniques are only possible in longer therapies and where there is continuity of therapist.

### ***Institutional Dynamics***

Caring for patients with psychosis can create difficulties for staff as they get drawn into maladaptive patterns of relating. Psychoanalytic understanding enhances staff relationships and facilitates understanding of patients' behaviours. (Jackson & Cawley, 1992; Kline *et al*, 1992; Davenport, 2000). Careful supervision and staff groups act as "container" for unbearable staff anxiety (Jackson & Cawley, 1992) and greater psychoanalytic understanding of psychosis brings theoretical coherence to staff interventions (Kline *et al*, 1992)

### **Conclusions**

It has been advocated (Margison & Mace, 1997) that we become aware of the need for a continually evolving theoretical base for psychotherapy. The question has been raised (Shapiro, 1995) as to whether we need more therapies or perhaps a better understanding of the therapy processes within existing models. This review has highlighted some areas where greater understanding might benefit both patients and therapists.

The therapist's impact on both therapy and outcome has been acknowledged (Luborsky *et al*, 1985; Karon, 1992; Elkin, 1999; Dozier, Cue & Barnett, 1994; Holmes, 2001) and several reviewed studies cited the relevance of the therapeutic alliance to an effective outcome (Rund, 1990; Cullberg, 1991; Varvin, 1991; Davenport, 2000; Johannessen, 2002). It seems as though therapist attachment style might impact on effectiveness and it is

possible that this might be especially relevant to psychotherapy with patients with psychosis and separation anxiety.

The phase of illness and phase of treatment for which specific psychotherapies are most effective is not clearly identified yet (Dickerson, 2000). The multi-modal, multi-level approaches show that psychodynamic psychotherapies should take their place alongside the more prominent cognitive models. However, the recent NICE guidelines (xxxx) state that cognitive behavioural therapies and family interventions are the treatment of choice, a decision based on the perceived superiority of randomised controlled trials.

If patients are to be offered psychological interventions effective in creating lasting change then cognitive therapists must own their limitations as well as their strengths (Holmes, 2000). They would then be in a position to argue with funders that integrative and long-term therapies are also needed.

The ability to engage in longer psychotherapies with these patients demands great therapist resilience and the ability and desire to understand (Karon, 1992). Given the financial costs to society in caring for patients with enduring mental health problems, can we afford to ignore apparently effective psychotherapies simply because they have not been researched through a randomised controlled trial?

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