ATTACHMENT THEORY

and

THERAPEUTIC RELATIONSHIPS

By

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Thesis submitted in fulfillment of the DPsych in Counselling Psychology
City University, London
Department of Psychology
November 2015

THE FOLLOWING PART OF THIS THESIS HAS BEEN REDACTED FOR DATA PROTECTION/CONFIDENTIALITY REASONS:

pp 165-197: **Section C. Professional practice:** A cognitive analytic approach with a case of anxiety.

pp 274-293: **Appendix 2.** Professional practice appendix.

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pp 265-273: **Appendix 2.** The psychotherapy file.

ACKNOWLEDGEMENTS

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TABLE OF CONTENTS

TITLE of the THESIS:

Attachment Theory and Therapeutic Relationships

SECTION A: PREFACE

SECTION B: RESEARCH

Title: Adult Attachment Styles and Therapeutic Alliance

1-Introduction

5

2-Method

3-Results

4-Discussion

SECTION C: Professional Practice

A Cognitive Analytic Approach with a Case of Anxiety

SECTION D: A Critical Review

Postnatal Depression and Attachment Difficulties

APPENDICES

City University Ethical Approval
Ethical approval letters
Amendments approval letters
Brief letter for psychologists
Invitation letter for participants
Information sheet
Consent form
Contact details form
Experiences in Close Relationship (ECR) Scale
Childhood Experiences Survey (CES)
Working Alliance Inventory (WAI)

Psychotherapy File
Reformulation Letter
Diagrams: Fig. 1, Fig. 2, Fig. 3, Fig. 4, Fig. 5, Fig. 6
Good Bye Letters
Target Problems and Aims scoring sheets
Glossary

SECTION A: PREFACE

Overview

The central theme of this thesis is attachment theory (AT) and its application to therapeutic relationships (Bowlby, 1969a). It links different areas of my practice as a chartered counselling psychologist working with and researching clients in primary care in the NHS.

Since its original formulation, AT has inspired new ways of looking at the function and structure of close relationships (Bowlby, 1969b). Over the last three decades, the theory has been extended to adults (Brennan, Clark & Shaver, 1998; Hazan & Shaver, 1987) and used as a framework to understand the process of therapy and the therapeutic relationship (Cobb & Davila, 2009; Daniel, 2006; Mikulincer & Shaver, 2004,2007). This thesis aims to explore adult attachment issues in therapeutic relationships and contribute to research in counselling psychology.

I initially became interested in AT in the beginning of my career working as a university counsellor and later with clients in primary care as a counselling psychologist. At the time, AT resonated with my personal and professional life as I had moved from Turkey to the UK, and left behind all my personal and professional relationships. Since training as a counselling psychologist, and later as a chartered counselling psychologist, I had lived and worked in different cultures, and with clients from diverse backgrounds. Regardless of the setting in which I worked, it became increasingly clear to me that the theoretical ideas related to attachment had begun to permeate my counselling practice. On the one hand, clients' early attachment experiences seemed to be systematically related to their presenting problems, and on the other hand, the mental residue of these early experiences (internal working models, in attachment theoretical parlance) seemed to influence the nature of the therapeutic relationships I was able to form with my clients. I recognized the impact of early relationships on

adult attachments and how these relationships were projected in the consulting room, illustrating how attachment patterns operated on many levels.

Given these personal experiences, AT (Bowlby, 1969a) seemed to provide an increasingly suitable 'secure base' for my professional endeavours as a counselling psychologist. The theory promised to provide a broad understanding of how interactions in childhood, socio-emotional development and personality development are all interrelated. The theory's influence on psychotherapy, specifically on individual differences in adult attachment patterns, had gained momentum over the last three decades (Bartholomew & Horowitz, 1991; Bretherton & Munholland, 2008; Hazan & Shaver, 1987; Meyer & Pilkonis, 2002) and it seemed logical to focus my doctoral thesis on this theory, as it had seemed like a natural personal and professional fit for a long time. I set out with the hope that working on this project would allow me to deepen my understanding of the theory, of the methodological advances and of the application of the theory to therapeutic relationships, consequently contribute to the practice and knowledge base of counselling psychology.

An additional reason why I chose to focus this thesis on AT is that, in my view, counselling psychologists are surprisingly underrepresented in the attachment theoretical literature. Thus, this thesis represents an effort of one counselling psychologist to join a research field that at present seems to be occupied primarily by other related professional fields. In the wider field of AT and its application to therapeutic relationships, the main body of research contributions has so far come from developmental psychology, clinical psychology and a few from counselling psychology (Mallinckrodt, Coble & Gantt, 1995). In the case of counselling psychology, the research focus has been primarily on the relationship between adult attachment patterns and therapeutic alliance employing the qualitative method, thus missing the systematic quantitative study of the dynamic between the client and therapist (Skourteli & Lennie, 2011). My primary motivation to undertake this research was to make a new contribution by providing an extended understanding of the subject, and

secondly to make a difference by exploring attachment issues in therapy employing a quantitative methodology.

This thesis focuses on three different areas related to the general field of adult attachments in therapeutic relationships, and are all linked to the practice of counselling psychology in primary care. Firstly, there is an empirical study that examined how early attachment-relevant experiences, adult attachment styles, and aspects of the client-therapist relationship might be related to each other. Secondly, there is a case study in which a client with anxious attachment experiences difficulties in relationships. Finally, there is a critical review of the literature on PND and its link with attachment related difficulties. These three sections are summarised below.

SECTION B - Research

Attachment Styles and Therapeutic Alliance

Section B is the research component of the portfolio. This is a quantitative research study that aimed to examine the relationship between current attachment styles, retrospective reports of childhood experiences and the development and quality of the therapeutic alliance in therapy. Adult attachment styles refer to individual differences in the way adults behave in the context of interpersonal relationships. Theory and previous research suggest that attachment styles are associated with the quality of the therapeutic alliance.

In this study, the therapeutic alliance is defined as a multi-dimensional concept, referring to the client's capacity to work purposefully in therapy, their affective bond with the therapist and agreement on the treatment goals and tasks (Gaston, 1990). Some research has already shown that patient attachment styles are associated with the quality of therapeutic alliance and with therapy outcome (Eames & Roth, 2000; Mallinckrodt et al., 1995). The present study aimed to extend the research in this area by examining the association between client attachment styles and the therapeutic alliance among primary care clients.

The research also had a secondary objective, to examine the association between retrospective reports of childhood experience and current self-reported attachment styles. Early experiences with parents have been thought to be one of the most important factors to affect the quality of adult attachments in close relationships and to influence the client's capacity to form a positive working alliance in therapy (Greenson, 1967; Hazan & Shaver, 1987; Strupp, 1974). This study thereby aims to test whether retrospective reports of childhood experiences with parents relate both to current adult attachment style and the therapeutic alliance.

On a practical level, this research may be another step towards the goal of enabling counselling psychologists to individualize their interventions based on knowledge about individual patients' attachment styles and their early experience with parents. It is hoped that this research might help counselling psychologists in their efforts to understand and conceptualise their clients' problems and the process of therapy itself.

SECTION C-Professional Practice

A Cognitive Analytic Approach with a Case of Anxiety

In this section I have presented a case study of a woman client displaying attachment problems in close relationships. This is a reflexive account of a Cognitive Analytic Therapy (CAT) intervention, including discussions regarding the nature of ambivalence and anger in the context of anxious attachment (Ryle, 1990). The rationale for presenting this case is the parallel between CAT and the basic assumptions of AT. Both in AT and the CAT model, there is emphasis on early childhood, quality of attachments between infant and caregiver, attachment patterns in infancy and the impact of early interactions on adult relationships. Ryle (1990) described the clients' problems as self-fulfilling negative assumptions about self and other, the origins of which lie in disturbed attachment patterns in infancy and early childhood. Holmes (2004) describes CAT as 'Bowlbian' (p.147) because both models are theoretically eclectic; the therapist in CAT is active just like the secure base mother, and they both focus on

the process of self-reflection and mirroring which is then internalised as self-reflecting capacity.

Another reason for presenting this case study is to share my experience of using CAT in the NHS as the preferred model: it is time-limited, has dynamic depth and recourse to cognitive tools that make it easily accessible to clients. The presented client study highlights the challenges of working with very anxious clients within time constraints, and illustrates the benefits of employing a structured therapeutic format that offers containment for such clients. This client study was an important learning experience for me as a counselling psychologist practicing CAT in the NHS.

SECTION D – Critical review of the Literature

Postnatal Depression and Attachment Difficulties

In this section, I presented a critical review of the literature on PND that explores the arising attachment problems in the mother-infant relationship and interventions that repair the bond.

PND not only causes so much pain and suffering to the mother, it has a rippling effect on the family, affecting the couple's relationship and their capacity to parent. In my clinical work with mothers suffering from PND I have been witness to their pain and fears which undermined their ability to engage with their infants emotionally. Feeling low and distant from everyone, and experiencing attachment difficulties in interpersonal relationships these mothers experienced difficulties both in seeking and engaging in therapy.

Counselling psychologists working in general practice often see patients with symptoms of depression and anxiety. Information about the nature of PND, its course and severity and long-term effects on the mother and infant would help to promote awareness and understanding, and maximize clinical effectiveness. Knowledge and awareness of attachment difficulties arising from PND and how

these may be reflected in therapy are essential ingredients in promoting sensitive and ethical counselling psychology practice.

Personal Statement

This portfolio reflects both my academic and, equally importantly, my clinical background. Working with clients in the NHS is a privilege and fulfilling endeavour, in that it allows me to contribute to the reduction of suffering. Understanding and developing the therapeutic relationship with clients have always been central in my clinical work as a counselling psychologist. In fact, understanding the factors contributing to the therapeutic alliance has been the main driving force behind this project. I feel the therapist is a central agent of change by which the client may experience a new way of relating and being. When working with the complexities of each case and dealing with the enormity of the research process, I regard the use of supervision and personal reflection as essential and invaluable.

As a counselling psychologist, one is expected to think on one's feet and work sensitively, appropriately - always maintaining a scientific attitude. I have found the process of conducting research, reviewing the literature, reflecting on my client's work and thinking about it from the AT perspective extremely beneficial in terms of my personal and professional development. I have appreciated the opportunity of putting my clinical experience on a scientific platform from which different ideas may emerge and give rise to further research.

References –Section A

Ainsworth, M. S., Blehar, M. C., Waters, E., & Walls, S. (1978). *Patterns of attachment; A psychological study of the strange situation.* Hillsdale, NJ: Lawrence Erlbaum.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2) 226-244.

Bowlby, J. (1969a). *A secure base: Parent child attachment and healthy human development.* New York: Basic Books.

Bowlby, J. (1969b). *Attachment and Loss*: New York: Basic Books; London: Hogarth Press.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In A. Simpson & W.S. Rhodes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guildford Press.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships. In J. Cassidy & P.R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 89-111). New York: Guildford Press.

Cobb, R. J., & Davila, J. (2009). Internal working models and change. In J.H. Obegi & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp.209-233). New York: Guildford Press.

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26*(8), 968-984.

Dryden, W. (Ed.). (1984). *Individual therapy in Britain*. London: Harper & Row.

Eames, V., & Roth, A. (2000). Patient attachment orientation and the working alliance; A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10*, 421-434.

Gaston, L. (1990). The concept of alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy, 27*, 143-153.

Greenson, R. (1967) The technique and practice of Psychoanalysis. New York: International Universities Press.

Hazan, C., & Shaver, P.R. (1987). Romantic love conceptualised as an attachment process*. Journal of Personality and Social Psychology, 52*, 511-524.

Holmes, J. (2004). *John Bowlby & Attachment Theory*. Routledge: London.

Horvath, A. O., & Greenberg, L. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counselling Psychology, 36*, 139-149.

Mallinckrodt, B., Coble, H. M., & Gantt, D. L. (1995). Working alliance, attachment memories, and social competencies of women in brief therapy. *Journal of Counselling Psychology, 42*, 10. 79-84.

Meyer, B., & Pilkonis, P. A. (2002). Attachment style. In J.C. Norcross (Ed.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 367-382). Oxford: Oxford University Press.

Meyer, B. (2005). *Child Experiences Survey*. Unpublished manuscript, City University, London.

Mikulincer, M., & Shaver, P. R. (2004). Security based self representations in adulthood: Contents and processes. In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 159-195). New York: Guildford Press.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guildford Press.

Orlinsky, D. E., Graw, K., & Parks, B. K. (1994). Process and outcome in psychotherapy — Noch Einmal. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change.* New York: Wiley.

Ryle, A. (1990). *Cognitive Analytic Therapy: Active Participation in Change.* Chichester: Wiley.

Skourteli, M. C., & Lennie, C. (2011). The therapeutic relationship from an attachment theory perspective. *Counselling Psychology Review, 26*(1), 20-31.

Strupp, H. H. (1974). Some observations on the fallacy of value-free psychotherapy and empty organism. *Journal of Abnormal Psychology, 893*, 199-201.

Wampold, B. E. (2001). *The great psychotherapy debate; Models, methods, and findings*. Mahwah, New Jersey: Lawrence Erlbaum.

Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe and W. Dryden (Eds*.), Handbook of counselling psychology* (pp. 3-20). London: Sage.

SECTION B: RESEARCH

Title: Adult Attachment Styles and Therapeutic Alliance

Abstract

The aims of this study were to examine the associations between current self-reported attachment styles, retrospective reports of childhood experiences, and the development of the therapeutic alliance. It was hypothesised that anxious and avoidant attachment would be correlated with negative childhood experiences and that both attachment anxiety and avoidance would be inversely correlated with the therapeutic alliance. The third hypothesis stated that negative childhood recollections would correlate inversely with the quality of the therapeutic alliance and that this association would be mediated by adult attachment styles. One hundred adult counselling/psychotherapy clients referred for psychological therapy in primary care were asked to complete the Childhood Experiences Survey (Meyer, 2005) as a measure of retrospective childhood experiences, the Experiences in Close Relationships Scale (Brennan, Clark, & Shaver, 1998) as a measure of adult attachment styles and the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989) as a measure of working alliance. The first hypothesis which stipulated that negative childhood experiences would be correlated with anxious and avoidant attachment style was partially supported. Avoidant attachment style but not anxious attachment style was significantly and moderately strongly associated with rejection experiences as measured by the CES. The second hypothesis, which stated that both anxious and avoidant attachment would be correlated with the therapeutic alliance, was also partially supported. Avoidant attachment but not anxious attachment correlated significantly and inversely, moderately strongly with the therapeutic alliance. The third hypothesis stated that the relationship between childhood experiences recollections and the alliance would be mediated by both attachment anxiety and avoidance. The third hypothesis could not be explored further as childhood experiences did not correlate significantly with the therapeutic alliance. Findings and implications for further research are discussed.

Overview

AT has inspired new ways of looking at the function and structure of close relationships, providing a broad understanding of social-emotional development, personality, and interactions in childhood and adulthood (Cassidy & Shaver, 2008; Fraley & Shaver, 2000; Gillath, Shaver, Baek, & Chun, 2008). Whereas earlier studies focused on childhood attachment, the last thirty years have witnessed an explosion of interest in adult attachment research, particularly in the area of romantic relationships (Brennan et al., 1998; Bretherton & Munholland, 2008; Levy, Ellison, Scott, & Bernecker, 2011; Meyer & Pilkonis, 2002; Mikulincer & Shaver, 2004, 2007). Over the last decade, the research on the clinical applications of AT has grown even more, specifically on individual differences in adult attachment patterns and their effect on therapy process and outcome (Byrd, Patterson & Turchik, 2010; Jordan, 2007; Mallinckrodt, 2010; Marmarosh, Gelso, Markin, Majors, Mallery & Choi, 2009; Romano, Fitzpatrick & Janzen, 2009; Wallin, 2007).

The significance of adult attachment styles in psychotherapeutic studies stems from Bowlby's (1988a) intent to use AT in clinical work, particularly in therapeutic relationships. In the early years of the theory's creation, when Ainsworth (1973), Bowlby's co-worker and co-founder of AT, was testing Bowlby's ideas on attachment empirically she developed the concept of 'attachment figure as a secure base'. This then led to further expansion of the theory, and the emergence of sophisticated methodology measuring individual differences in adult attachment, which in general terms, refer to characteristic ways of feeling and behaving in the context of current interpersonal relationships. Because much of psychotherapy is concerned with helping clients navigate relationships and resolve interpersonal problems (Grosse Holtforth & Grawe, 2002), and because the relationship is itself a fundamentally important aspect of psychotherapy (Norcross, 2011) the relevance of AT to the domain of counselling psychology may appear almost self-evident.

Consistent with this line of reasoning, empirical research has demonstrated that AT is indeed relevant for the field of psychotherapy, and for therapeutic relationships generally. In particular, research on client and therapist adult attachment patterns has increased our understanding of the therapy process and the relationship between client and therapist (Holmes, 1996; Jordan, 2007; Mallinckrodt, Porter & Kivlighan, 2005; Mikulincer, Shaver, & Berant, 2012; Shane & Shane, 2001). Theory and previous research suggest that adult attachment styles, particularly secure attachment is associated with the quality of therapeutic alliance and with therapy outcome (Eames & Roth, 2000; Mallinckrodt, Gantt & Coble, 1995; Shorey & Snyder, 2006) (see also reviews, Daniel, 2006; Meyer & Pilkonis 2002). The present study aimed to extend the research in this area by exploring associations between client attachment styles and the therapeutic alliance among primary care clients. This study attempted to go beyond the existing research by investigating the association between early childhood experiences and current adult attachment, and aimed to test whether retrospective reports of childhood experience with parents relate both to current adult attachment style and the therapeutic alliance. Up until now, these associations have not been empirically examined in this way. That is, no single study has thus far included and shown relationships among (a) a retrospective assessment of early attachment-relevant experiences, (b) a validated measure of adult attachment styles, and (c) a validated measure of the quality of the therapeutic alliance among clients currently undergoing outpatient therapy.

The research section comprises four sections: 1-Introduction, 2- Method, 3-Results, and 4-Discussion. The introduction section consists of four sub-sections: (a) AT and individual differences, (b) AT and therapeutic relationships, (c) empirical evidence regarding attachment and the therapeutic relationship, (d) the final sub-section is on the development of the research question and aims of the research including the principle and secondary research objectives.

1-Introduction

(a) Attachment Theory and Individual Differences

The purpose of the research conducted in this thesis was to illuminate how early attachment-relevant experiences, adult attachment styles, and aspects of the client-therapist relationship might be related to each other. In order to convey more precisely what is meant by this, it will first be necessary to describe, in brief, the history and key tenets of AT, which serve as an overall conceptual framework of the work reported here.

Attachment Theory and its criticisms

An understanding of AT requires a closer look at the life and ideas of its founder, John Bowlby (1969/1997, 1973/1998, 1980/1998). The origins of AT lie at the beginning of Bowlby's professional life working as a child psychiatrist with children and their mothers at the London Child Guidance Clinic during which he began to formulate his thoughts on maternal deprivation (Bretherton, 1992). Although he was an active member of the Psychoanalytic Society, he gradually departed from the orthodox school of psychoanalysis because he believed that infant-mother attachment ('mother love') was rooted in real relationships, not in the unconscious. Supported by his empirical data, Bowlby stated that 'the infant and young child should experience a warm, intimate, and continuous relationship with his mother (permanent mother substitute) in which both find satisfaction and enjoyment' (Bowlby, 1951, p.13). Unlike the conventional psychoanalysis of his time, during which psychoanalysts like Anna Freud (1972) and Melanie Klein (1975) viewed human motivation in terms of the conflict between the life and death instinct, Bowlby (1982) conceptualised psychopathology as the result of real life experiences taking place in a social context, and not solely or primarily in the mind.

Bowlby (1977) believed that the development of personality is influenced by the early relationships between parent and child – and that failure to develop an attachment of any kind early in life would affect all subsequent relationships and lead to personality disturbance. On the negative effects of maternal deprivation,

Holmes cites two quotes from Bowlby: 'In the article published in the 'International Journal of Psycho-Analysis' in 1940, Bowlby presented a 'general theory of the genesis of neurosis', in which environmental factors in the early years of a child's life are causative, especially separation from the mother through death or 'broken home'. 'His World Health Organisation monograph (Bowlby, 1951) and later observations of children separated from their parents enabled him to establish once and for all the importance of environmental trauma as a cause of neurosis and character disturbance' (Holmes, 2004. p.5). These quotations illustrate Bowlby's theoretical and clinical thoughts on the effects of actual family experiences being the most likely cause of emotional disturbance in the child.

Bowlby continued to develop his ideas on attachment while working with children and their mothers at the Tavistock Clinic (Marrone, 2000). His observations confirmed his beliefs that disruption to maternal care, whether in the form of separations, loss or illness, would affect personality. At the time, his clinical work and ideas were supported by the observational studies of the Robertsons, who were social workers and close colleagues of Bowlby (Robertson & Robertson, 1952). They made systematic film footage of children in the hospital, recording their distress at being separated from their mothers throughout their treatment. Not only did these films raise awareness of the effects of loss experienced by children, but they also produced clear evidence for the psychological effects of separation between the young child and its mother (Robertson & Robertson, 1952).

Observational studies by Anna Freud (1949) on war orphans and children in institutional care provided additional evidence of the negative effects of separation, and the distress it caused to the young child. Research on institutional care, adoption and separation put the issue of maternal deprivation and separation anxiety at the centre of AT (Freud & Dann, 1951).

These studies culminated in Bowlby's monumental work *Attachment and Loss* (1969/1997, 1973/1998, 1980/1998), in which two major ideas stand out from the perspective of this study:

1. Infants are attached to their caregivers because of the inborn disposition to seek closeness with a protective other. The infant's strong attachment with its primary caregiver will be its base of exploration, and the infant will depart from the base to explore but when in danger will return to its secure base. Attachment, which is a relational concept, has a survival function as well as a function to facilitate exploration (Elliot & Reis, 2003; Mikulincer et al., 2012).

2. The second major idea that will be examined later in the text is that of the internal working models, which are the mental representations of attachment figures through which the history of specific attachment relationships are integrated into the personality (Bretherton, 1992). The history of children's early interactions with parents shapes the quality of their attachment relationships, their sense of self and how others will respond to them, and these attachment patterns then become the foundation for adult relationships in the future.

Bowlby's thinking was influenced by ethological studies (Harlow & Harlow, 1969; Lorenz, 1981), and in particular by studies on how other mammals rear their young. He noticed in these studies that the social bonds between the mothers and their young did not necessarily form due to feeding, rather from the young running to a place of protection when frightened, or seeking comfort near the mother, and that these various forms of attachment seemed critical to the survival and thriving of mammals. Bowlby (1969) focused on the developmental significance of these innate patterns in mammals, and postulated for humans that infants are born with the primary instinctive drive to be close to their caregivers, seeking comfort and care. The drive facilitates both the survival of the infant and attachment with its primary caregiver. The need to form an attachment is thought to be biological: that is, the infant will attach even if the caregiver does not provide the security and the comfort sought (Bowlby, 1969). The presence of the caregiver almost functions as a trigger for the infant's inborn

need to seek closeness and protection, whether the security and comfort is there or not. The theory includes biological but also cognitive and behavioural aspects of attachment, such that innate intra-psychic structures are manifested in actual behaviour and the development of attachment is an experience of learning (Bretherton, 1991; Rutter, 1981). Through social learning, depending on the caregiver's sensitivity and responsiveness, infants form mental representations of the attachment related interactions and develop distinct patterns of relating (Bretherton, 1991). These attachment patterns increasingly become individualised and form adult attachment styles later in life (Bowlby, 1973; Bretherton & Munholland, 2008).

AT has not been without its criticisms. The historical and social context of Bowlby's ideas of maternal deprivation gave rise to the idealisation of motherhood and family life. At the time when women were starting to find their voices, pushing for equal rights in politics, business and social-life, the theory was seen to put women back to staying at home, shouldering the family responsibility (Contratto, 2002). Moreover, the theory postulated that maternal deprivation caused emotional, intellectual and behavioural damage to the child and could lead to pathological consequences such as delinquency, criminal behaviour and personality disorders (Bowlby, 1951). The deterministic element of the theory has been criticised by feminist writers as sexist and mother blaming (Contratto, 2002; Oakley, 1981), as expressed by Contratto (2002):

> Infant determinism has contributed enormously to women's stress and guilt about doing well by their children. Also, it underlies political debates over childcare, women work force participation, school outcomes, levels of poverty, gun control and drug abuse. There is always the assumption that if parents (read 'mothers') doing their job well we would live in a happier, safer, healthier world. It is a limitation of the ongoing subtle sexism to marginalise the growing literature on the resilience in children. (Contratto, 2002, p.31)

The feminist critique stood against the implication of the exclusivity of the mother-child relationship (Contratto, 2002). In support of this perspective, the anthropological and cultural studies showed that maternal-care is not exclusive and can be shared by a stable group of adults (Kibbutz studies, Scharf, 2001; Mead, 1964). The child can have a hierarchy of attachments: father, grandparents, relatives, and the attachment to the mother is not exclusive, although it is usually the most important. Overall, the feminist perspective gave rise to the discussion of the role of women in society and contributed to the discussion regarding political issues in the AT movement.

In recent years criticisms of AT have come from the field of genetics. With regard to the 'nature versus nurture' debate in psychology, AT is based more on nurture. One of the assumptions of the theory is that the infant will establish a strong attachment with its primary caregiver, and the strength (quality) of this attachment will shape the character of the child and its future interpersonal relationships (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969). Harris (2000) believed that parenting alone did not determine the child's personality. She provided evidence against good nurturing with twin studies (Harris, 1998). Identical twins separated at birth and brought up separately tended to have the same habits, hobbies and way of life which indicated that genetic factors may over ride environmental differences including parenting.

Some researchers in the field of genetics have been exploring the influence of inborn temperament on behaviour (Kagan, 1998, 2009; Kagan & Snidman, 2004; Kochanska, Aksan, & Carlson, 2005). According to the field of genetics, individual differences in personality might be influenced more by a person's genetic make-up than by parental upbringing, as AT suggests. Strong evidence comes from identical twin studies (Harris, 1998; Kagan & Snidman, 2004). Kagan (1998) who emphasised the ongoing influence of inborn temperament in shaping interpersonal relationships also did not agree with AT's basic assumption that parental upbringing determines the child's personality. He believed that the theory not only ignored the temperament of the child, but also the environmental stresses like poverty and peer pressure, which could override the

quality of parenting. For example, growing up in a run-down area could increase the susceptibility of getting involved in criminal activity and the risk of delinquent behaviour in spite of good parenting. Moreover, Kagan, (1998) criticised AT on a different issue, the resilience of children, in that some children are born with certain robustness of personality in being able to cope with the unavoidable traumas and problems in life, and some are not. According to Kagan (1998), AT does not take children's resilience into sufficient account. These were major challenges to AT's assertion that particular parenting styles shaped children's behaviour.

In response to these criticisms, attachment theorists have accepted the important role of inborn temperament and its significance in shaping the character of children (MacKenzie & McDonough, 2009; Sroufe, Egeland, Carlson, & Collins, 2005). In response to the challenge that resilience is primarily genetically determined, the studies by Fonagy (1994), Rutter and Silberg (2002), Sroufe and colleagues (2005) and Yates, Egeland, and Sroufe (2003) showed that attachment-related experiences also influence resilience. In these studies, children with histories of secure attachment tended to deal with traumas such as divorce or death of a parent better than those children whose early childhood experiences with parents lacked care and support. It emerged from the studies that early supportive care continued but stayed dormant during the difficult period until it was rekindled with a positive experience.

In conclusion, then, research in attachment is not divided into biological versus environmental factors, one being more important than the other in shaping the character of children. Instead, contemporary research recognizes the importance of both and aims to explore the interactions between biological factors, parenting styles and attachment (Steele, 2002; Zeanah & Fox, 2004).

AT and individual differences

Bowlby, defined attachment behaviour as 'any form of behaviour that results in a person attaining or retaining proximity to some other differentiated and preferred individual, usually conceived as stronger and/or wiser' (Bowlby,

1973/1998, p.292). According to the theory, attachment can be defined by three key features: firstly, the search for proximity to a preferred individual and a need to maintain it; secondly, the development of a secure base that facilitates exploration and curiosity; and thirdly, the experience of distress on separation and grief at loss. The whole process acts like a system whereby the infant stays close to the caregiver especially where there is threat, and seeks a response from the attachment figure to restore proximity. The emotional closeness, the secure base, is defended against any threat in the form of separation or loss. The physical and emotional closeness to the caregiver generates feelings of safety and security and separation from the caregiver causes distress and insecurity. Although all human beings are born with the capacity to seek proximity and comfort from protective others there are individual differences in the context of relationships from birth on. Positive exchanges with an available and responsive attachment figure promote a sense of secure attachment, and lead to the formation of feelings of security and positive self-image, which are considered to be optimal for successful functioning in relationships and prerequisites for mental health (Bowlby, 1977). Research in this area shows that attachment security is associated with greater psychological well-being, higher self-esteem, and higher work and relationship satisfaction (Mikulincer & Shaver, 2003; Shaver & Mikulincer, 2002). The more the child experiences sensitive and responsive interactions with the caregiver the more positive and empathic adult relationships will be (Bowlby, 1973). Longitudinal studies such as the Minnesota Longitudinal Study of Parents and Children (MSPC, 1975) indicated that children with secure attachment histories tend to be more socially competent, self-assured than children with insecure interactions with parents. They had a greater sense of self-agency and higher capacity to join trusting and non-hostile relationships as adults than those children with insecure attachment histories.

(i) Developing attachment: Sensitive responsiveness

Attachment is a gradual process, occurring through a repertoire of genetically based behaviours e.g. crying, smiling, clinging and acting independently at first then later becoming organised towards the caregiver (Ainsworth, 1973). The attachment system develops over months through interactions that are mediated

by looking, hearing and holding between the infant and caregiver (Berlin et al., 2005; Holmes, 2004). Through sensitive responsiveness, face-to-face interactions and physical and emotional engagement with the infant, gradually a pattern develops (Gowen & Nebrig, 2002; Lier, 1998). The caregiver's sensitive responsiveness to cues from the infant provides a consistent and holding environment, facilitating emotional bonding; lack of responsiveness or even inappropriate responsiveness can be experienced as neglect and can cause distress in the child (Pauli-Pott & Mertesacker, 2009; Tronick & Weinberg, 1997).

According to Ainsworth and colleagues (1978) attunement – the sensitive responsiveness to the infant's needs – largely shapes the infant's attachment. The notion of attunement is about responding to the infant's needs appropriately. For example, energetic, exciting play with an already excited infant will stimulate the infant more and will not be an attuned response, whereas the same response might be more appropriate for a very quiet infant who might need that level of stimulation. It is the sensitivity towards the infant's need, and responding to certain signals elicited by the infant that will give meaning to the attachment between them. These interactions between child and caregiver enable the child to learn about emotions and rules regarding interpersonal relationships (Holmes, 2004). Sroufe (1995) explained this interaction as a form of 'dyadic emotion regulation' on which the infant is heavily dependent, needing the assistance of the caregiver. According to Sroufe (1995), children learn to regulate their emotions by imitating what they hear and see without having a system for doing so in place. Eventually, the child learns self-regulating skills and develops its own means of emotional expression.

(ii) Neurobiological component of attachment

Studies on the central nervous system pathways suggest that there is a neurological connection underlying the reciprocity between infant and caregiver (Schore, 1994; Schore, 2003a, 2003b). The first 18 months appears to be a sensitive life stage in which the quality of the interaction between mother and infant may shape the affect regulation pathways in the brain (Schore, 2001).

According to Schore (2001), during this period, there is a lot of synaptic activity in the right brain, and some of these synaptic connections are discarded and some are reinforced by environmental information. Caregivers regulate the infant's environmental experiences by responding, e.g. smiling, providing appropriate stimulation, playing, and thus regulating the infant's arousal states (Beebe, 2000). Inappropriate under and over stimulation have been linked to neuronal cell death (Perry et al., 1995). According to Schore (2001), maternal sensitivity is crucial for the early brain development of the child, thus shaping the emotional and social development of the infant. Schore (2003a, 2003b) argued that insensitive parenting in early life might lead to 'emotion dysregulation patterns', which he referred to as 'insecure attachment' in the infant. These dysregulated emotions (insecure attachments) tend to continue into adulthood. According to the author, ultimately, the aim of psychotherapy should be about learning new ways to correct 'attachment distress' and effectively change the neural patterns in the right side of the brain that correspond to insecure patterns of attachment. Although the studies on the neurobiology of emotional development are greatly relevant to AT and the development of adult attachment patterns, detailed analyses of these studies are beyond the scope of this project.

(iii) Internal working models

'AT has moved much of its interest away from overt behaviour, towards representational processes, and the interaction of infant and parent in a developing attachment relationship' (Jellema, 2002, p.14). Representational processes of adult attachment reflect the internalised interpersonal interactions based on early repeated patterns of interactive experiences with parents. Over time, these mental representations form a set of beliefs about self and others which are called internal working models of self and other (Bowlby, 1973/1998). Although derived from the psychoanalytic perspective, originating from Freud's 'inner world', Bowlby's internal working models are more in line with Beck, Rush, Shaw and Emery's (1979) cognitive theory than psychoanalytic thought (Freud, 1911). We can understand these working models as cognitive maps or schemas that people have about themselves and their social environment.

According to Bowlby (1973), these two models develop within the individual in relation to each other in a complementary way. If a caregiver provides inconsistent or unresponsive care, the child develops negative models of self and other, expecting others to be unresponsive towards them. If a caregiver responds sensitively and consistently, the child develops positive working models and will think of others as trustworthy and of themselves as worthy of others' positive responsiveness.

Table 1: Working models of self and other (based on Carver & Scheier, 2008)

	Self	Other
Consistent and responsive parenting	Positive Worthy of care	Positive Supportive response from others
Inconsistent or unresponsive parenting	Negative Unworthy of care	Negative Unsupportive response from others

The theory predicts that (Bowlby, 1973) a securely attached child develops an internal working model of the self as worthy of care and comfort, and will therefore expect others to be responsive, caring and nurturing; whereas a child with inconsistent or consistently unresponsive parenting experiences would experience him/herself as unworthy of care, and would expect further disappointment, rejection and ambiguity. These patterns, over time, are thought to take on a life of their own, becoming self-perpetuating and self-fulfilling. The theory stipulates that they come to govern the individual's emotions, expectations and thoughts in close relationships (Ryle & Kerr, 2002). For example, being abandoned in childhood may cause one to expect abandonment from others, to interpret the behaviours of others as rejecting and to behave in ways that may lead to further rejection, thus continuing the pattern (Ryle & Kerr, 2002). These working models may be generalised to new situations and people and become resistant to change as development takes place (Bretherton &

Munholland, 2008; Miller, 1993). Information that does not fit into these models is usually excluded. For example, it is more likely that an avoidantly insecure adult will not expect to be treated well or expect to be praised for good work; instead, such a person might perceive others' actions with caution and interpret their praise as patronising.

(iv) Attachment patterns

Ainsworth and the Strange Situation

The concept of attachment patterns initially arose out of the observational studies of infant-mother interaction (Ainsworth et al., 1978). Ainsworth and colleagues (1978) had conducted series of detailed observations of mother-infant dyads first in Uganda and then in Baltimore to test Bowlby's propositions about human bonding. Bowlby (1988a) proposed that children's early interactions with caretakers shape the quality of their attachment relationships, which then become the foundation for their adult attachment patterns. Ainsworth wanted to capture the quality of the relationship in the mother-infant interaction, and measure the quality of the connection that the child experiences in the interaction with the mother to predict its effect on the child's development. While it was relatively easy to observe and measure how often the baby cried when a stranger approached or whether the infant smiled when greeted by the mother, Ainsworth went beyond measuring simple infant behaviours and devised a semi-standardized laboratory procedure called the 'Strange Situation' which revolutionised attachment research. The Strange Situation is a 20-minute mother-infant interaction that takes place in a laboratory playroom. The infant and the mother are taken to a toy-filled room and are joined by a stranger a few minutes later. The mother leaves the room briefly and then returns. The short separation from the mother was planned to allow observation of the emotional response of the infant at the mother leaving the room and then returning. Researchers assessed how disturbed and anxious the infant became upon separation and how quickly the infant was comforted upon being reunited with the mother. A second separation takes place when the baby is alone in the room. The purpose of the second separation was planned to observe how quickly the infant calmed down and started to explore its

environment, e.g. playing with toys freely. Finally the stranger and the mother return. The semi experimental procedure ultimately allowed the researchers to make inferences about the child's representational world.

The Strange Situation was thought to have evoked separation anxiety in the child. But infant reunion behaviours struck Ainsworth as unexpected, and reminded her of the Robertson's film in which sick children staying in hospital, who were separated from their mothers, reacted in similar ways when reunited with their mothers. Whatever attachment experience the child has had with their caregiver was reflected in how that child responded during their reunion. The baby's response to the reunion was the factor that determined the classification of the attachment relationship with that particular caregiver. Two distinct responses were noted in these studies: (1) children who were active in initiating renewed engagement with the caregiver and (2) those who exhibited anxiety, either actively avoiding their caregivers upon reunion or failing to be comforted by them (Ainsworth et al., 1978). These observations led to the conclusion that there are both secure and anxious ways of relating. After many hours of laboratory observations, Ainsworth and colleagues (1978) identified three main patterns of attachment: secure, avoidant, and ambivalent.

Table 2: Attachment patterns (Ainsworth et al., 1978)

Securely attached	Insecurely attached (anxious ambivalent)	Insecurely attached (anxious-avoidant)
66%	20%	12%

About two-thirds of the infants, - 66% - were found to be securely attached, i.e. they showed appropriate emotional responses at the mother leaving the room and later reuniting with them. Securely attached children reacted somewhat in a distressed way when their mothers left, expressing some anxiety upon separation, but they were quickly comforted on their mother's return. These infants explored their environment freely, playing with toys. Infants with secure

attachment displayed trusting behaviour when united with their mothers, did not seem to worry about being abandoned, and could use their primary caregiver as 'secure base' from which to explore (Ainsworth et al., 1978; Toth, Cicchetti, Rogosch, & Sturge-Apple, 2009). One fifth - 20% - of the children, fit the pattern labelled as anxious-avoidant, and 12% fit the pattern labelled as anxious-ambivalent. Children in these two groups, anxious-ambivalent and avoidant groups, showed two distinct reactions at the mother leaving the room and then returning. Anxious-ambivalent children showed excessive emotion – angry, clingy and distressed behaviour – when the mother left the room, and took a long time to be comforted upon reunion. Anxious-avoidant children on the other hand showed less affect and seemed relatively undisturbed on separation and reunion with the mother. Although the anxious-avoidant children seemed content in the absence of their attachment figure and not particularly interested in reconnecting upon reunion, when physiological measures were taken, these children showed anxiety during separation (Ainsworth et al., 1978; Toth et al., 2009). The classifications of both attachment patterns as secure and insecure, and insecure attachments patterns as anxious and avoidant, have been key to the growth in attachment research, have led to the development of sophisticated measurements to assess attachment styles and have been instrumental in expanding the application of the theory to therapeutic relationships.

Attachment patterns and maternal correlates

Ainsworth and colleagues (1978) were interested in how these attachment patterns were related to maternal sensitivity, and whether particular attachment patterns in infants were correlated with particular maternal attitudes. The mothers of insecure children showed a delayed response to their children's cries; the mothers of avoidant infants responded in an abrupt and interfering way; and the mothers of ambivalent infants tended to resist the infant's attempts at independence. Securely attached children had sensitive, responsive parents who were perceived as available and reliable. These mothers were assessed as loving and affectionate. The secure type is when an infant seeks protection and comfort from the mother and receives care consistently. The avoidant type is when the infant pulls away from their mother and ignores her – the mother is rated as

rejecting. The anxious-ambivalent type is when the infant clings to their mother, and the mother is rated as inconsistent in her care. Ainsworth and colleagues (1978) concluded that consistent responsive parenting leads to the development of a secure attachment pattern; inconsistent parenting to an anxious-ambivalent attachment pattern; and consistent unresponsive parenting to an anxious-avoidant attachment pattern.

A simple table describing these correlates is presented below:

Table 3: Maternal attitudes and infant response according to attachment patterns

	Maternal attitudes	Infant response
Secure attachment	Consistent and loving, reliable, available	Seeks protection and comfort
Avoidant attachment	Abrupt and interfering, unresponsive	Pulls away, ignores the mother
Ambivalent attachment	Resists infant's independence, inconsistent	Clings to the mother

Continuity of attachment

Given a fairly consistent pattern of interactions with attachment figures during childhood, these interactions become part of an individual's personality and govern a person's attachment dynamics in adulthood. Research indicates that these attachment styles are more or less stable across development (Hamilton, 2000; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Studies show that a greater sense of security can be acquired in the course of development as time goes on (Beckwith, Cohen, & Hamilton, 1999; Phelps, Belsky, & Crnic, 1998). In one study, 60 infants were identified as having a secure or insecure

attachment style at 12 months of age, and 72% of these children showed the same attachment style 20 years later (Waters et al., 2000). However, the stability can be negatively affected by life events such as divorce, death of a parent or depression in the parent, which may completely alter the attachment style (Beckwith et al., 1999).

AT postulates that early experiences with parents influence the relationships all through the person's development in late childhood, adolescence, young adulthood and adulthood. Secure attachments formed early in life predict good relationships with peers at school, comfort in close relationships, and expression of emotions in adult romantic relationships (Simpson, Collins, Tran, & Haydon, 2007). Simpson and colleagues (2007) showed in their studies that 'both the experience and expression of emotions in adult romantic relationships were meaningfully linked to attachment-relevant experiences' in childhood (Simpson et al., 2007, p.363). Studies that explored the attachment patterns during different phases of development indicated that adult attachment styles show a developmental continuity from childhood to adulthood (Dwyer, Fredstrom, Rubin, Booth-LaForce, Rose-Krasnor, & Burgess, 2010; Moss, Bureau, Beliveau, Zdebik, & Lepine, 2009; Simpson et al., 2007). Related to the issue of continuity of attachment, Kerns and colleagues (2001, 2008) suggested that there is a developmental process between childhood, adolescent and adulthood attachments, such that each stage serves as a preparation for the next phase. Children with secure attachments are more likely to develop secure attachments with peers during adolescence (Dwyer et al., 2010; Klohnen & Bera, 1998; Simpson et al., 2007), whereas a child with early experiences of neglect and rejection is more likely to have insecure attachments and develop expectations of rejection, and behave in ways that will increase the likelihood of rejection during adolescence (Dwyer et al., 2010).

Since the original publication of the Strange Situation study, the same experimental design has been used in more than thirty studies and all the subsequent studies have confirmed Ainsworth and colleagues' (1978) classification of attachment patterns (van Ijzendoorn & Kroonenberg, 1988; van

Ijzendoorn & Sagi, 1999; Metzger, Erdman, & Ng, 2010; Toth et al., 2009). The next section will briefly review how attachment patterns may be related to culture.

Attachment and Culture

Ainsworth's classification of children's attachment styles has been supported by studies across cultures (Toth et al., 2009; van Ijzendoorn & Sagi, 1999), suggesting that human relatedness presents similarly across cultures. However, apart from Ainsworth's (1973) very early studies in Uganda, most of the attachment research has been conducted with white North American and European populations (Metzger et al., 2010), which brings to mind the question of whether the development of attachment reflects a universal principle or is culture specific. According to Metzger and colleagues (2010), and Wang and Mallinckrodt, (2006), cross cultural studies show that basic concepts of attachment are universal but how individuals develop and express attachment is culture specific, which may have implications for psychotherapy. Wang and Song (2010) who conducted cross-cultural studies argued that it is essential to consider the belief systems, interpersonal norms, social structure and relational status in a culture in order to be able to understand the impact of culture on the development of attachment patterns. According to the authors, cultures differ with respect to childrearing methods and social ideals such as valuing self-appraisal or social cohesion, and these would have an effect on the interpersonal relationships including the therapeutic relationship (Wang & Song, 2010).

Imamoglu and Imamoglu (2010) have also stressed the importance of examining the family relationships in a society and how these may affect the development of attachment patterns. The authors (Imamoglu & Imamoglu, 2010) suggested that cultural attitudes to individuation and relatedness in a society would reveal how attachments develop in that particular culture. For example, Behrens (2010) found that closeness between mother and infant is highly valued in Japanese culture, however, in various studies, relatively high numbers of Japanese children have been categorised as anxious-resistant (Mizuta, Zahn-Waxler, Cole, & Hiruma, 1996; Rothbaum, Kakinuma, Nagoaka, & Azuma, 2007).

According to the authors, (Mizuta et al., 1996; Rothbaum et al., 2000), Japanese children are rarely left by their mothers. The distress the children had exhibited in the 'Strange Situation' studies might have been more likely expressions of distress due to the absence of the mother rather than insecure attachment. Rothbaum and colleagues (2007) questioned the definition of sensitive parenting in Japanese and American cultures. According to Rothbaum and colleagues (2000), sensitive parenting in the United States, implied responding to infants' needs to individuate, whereas in Japan sensitive parenting involved responding to infants' needs for social contact and encouraging children to remain in the larger family unit (Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000). For example, self-expression is associated with secure attachment, but self-expression may not be desirable in collectivist cultures such as Japan where social inhibition is favoured to maintain social harmony (Rothbaum et al., 2000). Are there universal principles with regard to the classification of attachment patterns as suggested by cross-cultural studies of attachment? Rothbaum and colleagues (2000) have challenged the universality assumption:

> The evidence leads us to call into question three core hypotheses of the theory, involving the antecedents (sensitivity), consequences (social competence), and nature (secure base) of attachment. These hypotheses are based on measures that are biased toward Western values and meanings, in that they emphasise aspects of individuation such as autonomy and exploration. (Rothbaum et al., 2000, p. 1095)

The authors recognise that there are cultural differences in the way certain beliefs are highly valued, e.g. autonomy and independence being highly valued in Western cultures and not so much in others. The analysis of the results of cross cultural studies showed that avoidant attachment classification tends to be higher in Western Europe and the United States compared to Israel and Japan, and that ambivalent classification is more common in Israel and Japan (Grossmann et al., 1985; van Ijzendoorn & Kroonberg, 1988; van Ijzendoorn & Sagi, 1999; Wang & Mallinckrodt, 2006). The authors (Rothbaum et al., 2000) recommend that the classification of attachment should reflect culture specific

values and that there should be more research to examine the influence of culture and ethnicity on the development of attachment styles, as well as on the therapy process and outcome. They further stated that, 'We advocate an approach that is grounded in concepts that are most meaningful to the peoples being examined' (Rothbaum et al., 2000, p.1095).

Attachment studies in recent decades: Adult attachment styles

During the 1980s, clinicians studied the changes in the children subjects of the Strange Situation who were by now grown up into adults (Hazan & Shaver, 1987). They conducted empirical studies, though limited, on children classified in childhood whether they were classified similarly in adulthood. (Waters et al., 2000). Ainsworth's attachment patterns were translated into corresponding adult patterns and the terminology used in these scales were changed. The secure/ autonomous adult corresponded to the secure attachment pattern; the preoccupied adult attachment corresponded to the anxious ambivalent attachment pattern; and the dismissing adult corresponded to the anxious-avoidant attachment pattern (Hazan & Shaver, 1987).

Table 4: Comparison between child and adult attachment categorisations

Strange Situation categorisation	Hazan and Shaver categorisation
Secure attachment	Autonomous adult
Anxious-ambivalent	Preoccupied adult attachment
Anxious-avoidant attachment	Dismissing adult attachment

Hazan and Shaver (1987, 1994), who developed the concept of adult romantic attachment in the 1980s, conceptualised love as an attachment process similar to the infant-parent attachment process and suggested that early experiences with caretakers could predict adult attachments within romantic relationships. According to this perspective, the emotional and behavioural dynamics of infant-

caregiver and adult romantic relationships are regulated by the same innate system, which promotes safety and survival. Adults feel the same way as infants – safe and secure – when their partner is accessible and responsive, and extremely distressed upon separation. These studies paved the way for AT's clinical applications, especially on individual differences in adult attachment. New scales for the assessment of adult attachment, e.g. Adult Attachment Interview (AAI) (George, Kaplan, & Main, 1985; Main & Goldwyn, 1991), or self-report questionnaires (Hazan and Shaver, 1987, 1994) were developed. The measurement of adult attachment patterns will be the focus of the next section.

Assessing attachment

Attachment research has evolved from observational studies of infant-caregiver dyads, to self-report scales measuring adult attachment patterns (Ainsworth et al., 1978; Bartholomew & Horowitz, 1991; Brennan et al., 1998). The focus in these studies has been the attachment relationship and what makes the attachment relationship optimal, especially in the formative years of the child. The assessment of attachment behaviour sparked a debate whether it should be based on clinical analysis or empirical research. Clinician and researcher positions expressed by Bowlby clearly differentiate the approaches employed in each position and how both approaches may enrich each other rather than divide them:

> The aim of the practitioner is to take into account as many aspects as he can of each and every clinical problem which he is called upon to deal. This requires him not only to apply any scientific principle that appears relevant but also to draw on such personal experience ... The outlook of the research scientist is quite different. In his efforts to discern general patterns underlying individual variety he ignores the particular and strives to simplify, risking thereby over-simplification. If he is wise he will probably concentrate attention on a limited aspect of a limited problem. If in making his selection he proves sagacious, or simply lucky, he may not only

elucidate the problem selected but also develop ideas applicable to a broader range. (Bowlby, 1988b, p. 40)

The differences Bowlby noted between the two approaches resembles the current debate in counselling psychology, as to whether the focus should be the scientist-practitioner or practitioner-scholar positions, and whether the research employed in counselling psychology should reflect the positivist/empiricist philosophical tradition or 'would be more a tone with existential-phenomenological perspectives' (Martinelli, 2010, p.43). Some would argue that the positivist tradition using a quantitative approach might reduce the phenomena to numerical values and might also fall short of collecting valuable personal data or knowing the personal perspective fully (Toomela, 2008). On the other hand, the quantitative approach has advantages such as precision and replicability, as different researchers can use the same measures and, therefore, compare results more directly than what might be possible within a qualitative approach. Through independent replication of quantitative findings, researchers can then build theories that are supported by stable patterns of empirical findings. Such theories, in turn, can add to the knowledge base of counselling psychology. As suggested by Gelo, Braatman, and Benetka (2008), quantitative and qualitative methodologies need not be dichotomous – they are not at the two extreme ends of a continuum – but rather complimentary.

In the present thesis, I chose to pursue a quantitative approach to the measurement of attachment, but this choice is not meant to indicate in any way the superiority of this approach over a qualitative approach. Rather, the choice of the quantitative method was motivated by the goal of wanting to replicate and extend previous quantitative research. By doing so, the research would enable me to compare my findings to an already existing body of quantitative research in this domain. Having settled on the choice of a quantitative research approach, though, did not by itself answer the question of how attachment should be measured, given that there are numerous quantitative approaches to measuring attachment.

In the field of adult attachment there are two general paths of inquiry and measurements: interview and self-report instruments. "These two traditions use the same concepts, but in different ways and within different research fields" (Daniel, 2006, p.970). " A variety of research strategies have been adopted, resting on different conceptual and methodological assumptions. As a result, an array of measures assessing the quality of the attachment representation in adults suggests diversity in reference to three main factors: relationship domain, level of consciousness, and conceptualisation of representational difference" (Sochos, 2013, p. 90). Interview and self-report measures will be explained in detail below.

(i) Interview methods

Interview methods are basically the narratives of the subjects talking about their past and present relationships, 'eliciting and classifying the subject's state of mind with respect to attachment' with the aim of assessing the adult's internal working models of attachment relationships (Marrone, 2000, p. 88). The earliest semi-structured interview is The Adult Attachment Interview (AAI), (Main & Goldwyn, 1984) which aims to explore the subject's earliest experiences with parents and family: "The extent to which the subject experienced mother or father as loving or unloving, the extent to which the child felt rejected or prematurely pushed to be independent, and the extent to which 'role reversal' may have occurred" (Marrone, 2000, 83-84). The AAI is more likely to capture the non-conscious aspects of the nature of attachment experience, its internal representation which manifests itself in the narrarratives of the participant who is allowed to elaborate freely on the early experiences with parents.

When **the test was** first administered, the authors noted a strong match between the mother's narrative and the infant's attachment pattern. These similarities were coded to predict the classification of the child's attachment (Main & Goldwyn, 1984; Main, Goldwyn, & Hesse 2002). The interview contains 20 questions collecting information from the subjects about their early experiences with parents or other significant attachment figures, traumas and losses, the quality of their parents' relationship with them and, if relevant, with their own

children. "The interviewer follows the subject's phrasing in order to understand the meaning of what he says and to assess the coherence of his narrative" (Marrone, 2000, p. 81). The interview progresses in an empathic way and the focus of the interviewer is the way the subject organises his/her early recollections and thoughts, and how clearly and coherently these are communicated. Narratives about attachment experiences are transcribed and analysed according to coherence and collaboration with the interview process, yielding attachment status as secure, dismissing, preoccupied and disorganised (Hesse, 1999). For example, individuals whose narrative is coherent despite their possible traumatic/deprived past are classified as autonomous or secure. Those with dismissing or avoidant attachment status by contrast tend to offer short stories, idealise early experiences and communicate these experiences in a detached and contradictory manner. Those with preoccupied attachment tend to present a long and usually negative analysis of their life, unable to describe events coherently without being flooded by emotions. Disorganised individuals tend to have incoherence or lapses in their discourse especially when they discuss loss or traumatic experiences. The AAI has been accepted as a reliable research tool (Marrone, 2000). The reliability studies (Bakermans-Kranenburg & Van IJzendoorn, 1993; Benoit & Parker, 1994) and validity studies (Van IJzendoorn, 1992; Van IJzendoorn, 1993) have shown that it is a reliable and valid research tool which aims to define "an adult's state of mind with respect to attachment" (Marrone, 2000,p.88).

Although there appears to be good evidence for the AAI's validity (Crowell et al. 1996; Van Ijzendoorn 1992; Van Ijzendoorn 1993), criticisms regarding its construct validity (Eagle, 1997; Fox, 1995) have generated discussions, whether the self reflecting capacity of the subject and the coherence of the interview can be considered an 'independent and valid evidence' (Sochos, 2013, p. 91) of attachment security. According to Sochos (2013) 'influences of other factors such as the participant's current psychological mental state, their thoughts and beliefs' about the nature of human change are not taken into account and that these may have an effect on the participant's response in the interview.

Another method of interview in the tradition of the AAI is the Reflective Functioning Scale developed by Fonagy, Target, Steele, and Steele (1998). This scale uses the AAI questions but the narratives are analysed differently, measuring reflective functioning – the subject's ability to reflect on their own inner experience and reflect on the minds of others. According to Fonagy and colleagues (1995), the capacity to reflect is a developmental level by which the individual can separate their own mental state and psychic experience from others'. This capacity develops as the result of secure attachment within the child-parent relationship through which the child develops full appreciation of the mind of the other. This is a reciprocal and dialectical process in which the child learns the caregiver's mind through the process of the caregiver's intentions of understanding the child's mind. There develops a parallel capacity to express affective aspects of experience and behaviour between the minds of the caregiver and infant. According to Fonagy and Target, (1997) high reflective functioning relates to secure attachment and high reflective functioning in the parent is found to be a better predictor of secure attachment in the infant as compared with the AAI's prediction of secure attachment.

Kobak, Cole, Ferenz-Gilles, and Fleming (1993) developed a different method of coding of the AAI, a 100-item Q sort called the Adult Attachment Q-sort. The scores are continuous and run on two dimensions; secure-anxious and deactivation-hyperactivation. The secure-anxious dimension reflects the coherence in the interview process and the deactivation and hyperactivation dimension aims to distinguish dismissing tendencies from the preoccupied tendencies when discussing attachment related thoughts, feelings and experiences. The Q-sort can also be converted into three categorical measure of attachment as autonomous, dismissing and preoccupied (Kobak et al., 1993).

Hardy, Aldridge, Davidson, Rowe, and Reilly (2004) have developed another measure for the assessment and formulation of attachment status for clinical use in psychotherapy. Initially, they drafted an attachment-based interview schedule to collect information on client attachment histories, styles, issues and problems. Following various applications, this interview has been refined through group

discussion and client/therapist feedback. The information gathered by the interview schedule helps to build a picture of clients' attachment patterns and behaviours; make an attachment formulation; provide clues as to the model of therapy; provide a focus for therapeutic work, and highlights potential difficulties that may arise in therapy. The authors reported that it is a clinical tool for the assessment of an individual's suitability for psychotherapy.

(ii) Self-report instruments

The other main method of measuring adult attachment is by self-report questionnaires which are easy to administer and score. Origins of self-report questionnaire tradition are in social rather than developmental psychology. They aim to assess adult attachment in the context of romantic adult relationships (Hazan & Shaver, 1987), and ' have attempted to capture attachment style" (Sochos, 2013, p.93), therefore are more likely to reflect the conscious aspect of attachment. They have been used widely, and this has allowed the scales to undergo significant refinement and in the process gain in reliability and validity. However, in spite of their advantages in providing precision, validity and reliability (Brennan et al., 1998; Fraley & Waller, 1998), limitations, e.g. social bias, not accounting for unconscious material, have been recognised (Mikulincer & Shaver, 2007; Obegi & Berant, 2009). In questionnaires, participants' answers may be affected by how they tend to portray themselves as socially acceptable-social bias-, and also by the way questions are asked so that their answers are not what the scale intends to measure. In addition, the answers tend not to account for in-depth unconscious material due to it being prevented by defensive mechanisms such as denial or repression employed by anxious or avoidant attachment clients. Limitations of the self-report scales used in the present study will be fully discussed in the Discussion section in relation to the study's findings.

The self-report scales of romantic attachment have been developed over the last 25 years. Most self-report questionnaires of adult attachment have been developed out of Hazan and Shaver's adult attachment categories, which were based on Ainsworth's initial classifications of secure, ambivalent and avoidant

attachment categories (Brennan et al., 1998; Hazan & Shaver, 1987, 1994; Shaver, Belsky, & Brennan, 2000). The original Hazan and Shaver (1987) measure of romantic attachment was a brief, multi sentence description of three attachment styles: the secure, avoidant and ambivalent styles, which were based on Ainsworth and colleagues' (1978) classification of attachment patterns. The simplicity of Hazan and Shaver's (1987) measurement had been criticised, and as the result of these criticisms, the authors developed a new, Likert-type scale (Hazan & Shaver, 1994). Later, Bartholomew and Horowitz (1991) expanded this measure, developing the four-category attachment categorisation which is based on the working models of self and other as positive or negative (worthy or unworthy of receiving love, and willing or unwilling to provide care and protection). These four categories are on two dimensions – anxious and avoidant. The anxious dimension is thought to reflect people's mental model of the self and the avoidant dimension is thought to reflect the mental model of others. Combinations of these dimensions and positive and negative 'self' and 'other' produce four attachment styles. Secure (positive self and positive other), preoccupied (negative self and positive other), dismissing (positive self and negative other) and fearful (negative self and negative other).
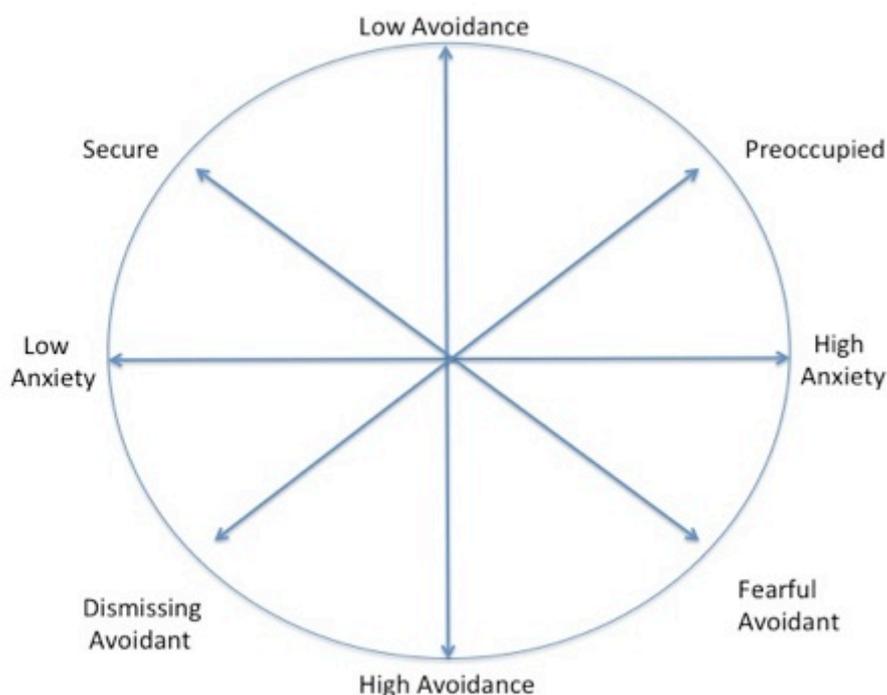
Figure 1: The two-dimensional model of individual differences in attachment organisation (Fraley & Phillips, 2009).

Bartholomew and Horowitz (1991) developed the Relationship Questionnaire to calculate the four attachment styles. Later this questionnaire was expanded (Griffin & Bartholomew, 1994) to have 30 items which measures attachment styles both as categorically and dimensionally. There is also a semi-structured interview (Bartholomew, 1991), similar to the AAI that fits the interview content into the four attachment prototypes.

Brennan and colleagues (1998) have conceptualised adult attachment in terms of two orthogonal dimensions: Avoidance and Anxiety. Similar to the Bartholomew and Horowitz's (1991) model, the anxiety dimension is thought to reflect people's working model of the self – the degree to which a person worries

over a partner not being available in times of need, and fears abandonment. High anxiety refers to anxious or fearful preoccupation with close relationships, and low anxiety relates to confidence in intimate relationships. The avoidant dimension, by contrast, is thought to reflect people's mental model of others and reflects a person's trust versus distrust regarding a partners' goodwill. High avoidance represents defensive dismissal or putting distance in close relationships, and low avoidance represents comfort with closeness and trust in the dependability of others. Individual scores are calculated on both of these two dimensions and determine subject's attachment style as high or low on anxious or avoidant continuums. People who score low on these two dimensions – anxiety and avoidance – are said to be secure with respect to attachment or to have a secure attachment style. In this study, Brennan and colleagues (1998) two-dimensional scale has been used.

It is also possible to examine attachment styles as categorical rather than dimensional variables. Brennan, and colleagues (1998) provided an algorithm, based on cluster analyses, to assign participants to one of four attachment categories (secure, preoccupied, fearful, or dismissing), based on their Experiences in Close Relationships (ECR) scores. It is also possible to group attachment types by simply assigning participants to quadrants depending on whether they scored above or below the logical midpoint on the two attachment dimensions (i.e., high avoidant attachment = score above 4 on a 1 to 7 scale; low anxious attachment = score below 4 on a 1 to 7 scale, etc.). This simplified procedure has been described and applied by Meyer and Pilkonis (2002) and has been used in this study as part of the subsidiary analysis of the data. However, in recent years, researchers working with self-report measures are in agreement that adult attachment patterns are better understood in the dimensional conceptualisation than in its categorical prototypes (Daniel, 2006).

In summary, different measures of attachment have been reviewed above. They appear to assess somewhat different constructs, e.g. reflective functioning measuring specific ways of thinking about one's own and others' mental states and self-reports of romantic attachment measuring current relationships, and

consequently 'partially correlate with each other' (Daniel, 2006). It is suggested that 'self-reports of romantic attachment converge only moderately with the AAI-derived attachment 'states of mind', that these instruments capture somewhat different facets of attachment' (Meyer & Pilkonis, 2002, p.369). If so, which approach is the right way to measure adult attachment? Daniel (2006) commented that:

Since both the interview and self-report traditions have yielded interesting findings in agreement with ideas contained in attachment theory, there seems to be merit in both approaches. Therefore, the most interesting and potentially enlightening question is not which type of measure is right, but how they are related, and what factors explain concordance and nonconcordance of classification on the two types of measures. (p. 972)

Increasing numbers of studies have shown that adult attachment styles are associated with early attachment related experiences with caretakers, and that in turn predict the quality of future adult relationships (Hazan & Shaver, 1994; Marmarosh et al., 2009; Mikulincer & Shaver, 2004). Attachment style is a 'concept' that refers 'to a person's characteristic ways of relating in intimate caregiving and receiving relationships with 'attachment figures', often one's parents, children, and romantic partners' (Levy et al., 2011, p.193). These are systematic patterns of relational expectations, emotions, and behaviours that originate from early experiences with caretakers (Fraley & Shaver, 2000; Shaver & Mikulincer, 2002). Attachment styles are broadly defined as 'people's comfort and confidence in close relationships, their fear of rejection and yearning for intimacy, and their preference for self-sufficiency or interpersonal distance' (Meyer & Pilkonis, 2002, p.367).

In general, securely attached people tend to form stable and committed relationships, preoccupied or anxiously attached people tend to form rather turbulent relationships and avoidantly attached people tend to form brief and relatively uncommitted relationships (Feeney & Noller, 1990; Hazan & Shaver, 1994). Links between adult attachment, especially insecure attachment, and

psychopathology have also been shown in recent years (Bifulco et al., 2006; Dozier et al., 1999; Tereno et al., 2008).

Attachment and psychopathology

Over the last two decades, many clinicians have been intrigued by AT and the research on its clinical applications in psychopathology. An obvious question concerns the link between insecure attachment and the emergence of psychopathology – is there indeed a connection between insecure attachment and psychopathology? Bowlby (1973) predicted the negative effects of separations in child development. He described (1988a) how children respond to interpersonal incidents such as separations or losses from attachment figures by adopting defensive ways to ward off their distress and despair or other attachment related painful thoughts and feelings. For example, abandonment in childhood may cause one to expect rejection from others, which may consequently minimise the importance of intimacy and encourage the avoidance of emotional contact in relationships. However, insecure attachment does not directly cause later psychological disturbance, rather it can be 'conceptualised as patterns of information processing and affect regulation that protects the person from attachment related pain' and may initiate a path that increases the risk of psychopathology (Daniel, 2006, p.972).

As much as there is an emphasis on the reality of failed parent-infant interactions and research evidence, the theory does not consider insecure attachment patterns to be psychopathological (Bifulco, Moran, Ball, & Lillie, 2002; Bowlby, 1977; Carlson & Sroufe, 1995; Meyer & Gillings, 2004). Even in low-risk populations, roughly half of all the children and adults fall into the category of insecure attachment (Dozier, Stovall, & Albus, 1999; van Ijzendorn et al. 1996). People with insecure attachment patterns do not inevitably develop psychological disorders; rather, an insecure attachment pattern increases the probability of psychopathology. For example anxious attachment does not directly cause anxiety related disorders, however, anxious or avoidant attachments have been shown to increase the probability of depression, anxiety and substance abuse (Mickelson, Kessler, & Shaver, 1997). Because many of the

studies are correlation studies, it would be difficult to draw causal conclusions from such research findings. Furthermore, due to the divergence of measures and categorisation of attachment styles it is difficult to replicate the studies to show the connection between specific attachment style and particular disorder (Eng, Heimberg, Hart, Schneider, & Leibowitz, 2001). Moreover, studies also indicate that there may be moderating factors, e.g. poor education or parental conflict underlying the link between insecure attachment in childhood and the subsequent emergence of psychopathology, and potential mediators, e.g. adult attachment between childhood abuse and psychopathology. For example, insecure adult attachment style has been investigated as a potential mediator between childhood adversity and adult depression and anxiety (Bifulco et al., 2002; Whiffen, Judd, & Aube, 1999). Studies have shown that insecure attachment styles predict both major depression and anxiety. Many studies indicate that insecure attachment and adult psychopathology are associated, but a direct causal conclusion cannot be drawn from them.   Instead, a broad conclusion can be made with respect to insecure attachment, such that it is a risk factor for rather than the cause of psychological disorders (Daniel, 2006; Mickelson et al., 1997).

There is one longitudinal study that showed a link between attachment styles and adult psychopathology. Carlson (1998) investigated the relationship between disorganised attachment in childhood and its manifestation in adulthood. Children were measured at 12 and 18 months and later as adults at 17 years and 19 years. The results showed that these children exhibited problem behaviour at 12 and 18 months, and cognitive and affective problems continued throughout their developmental years as assessed at 17 and 19 years of age. Most of these children came from single parent families and poor educational backgrounds. Carlson (1998) reported that these findings might suggest a neurophysiological cause, and that the children who had developed insecure attachments in adulthood might have experienced distortions in the regulation of emotions in the parent-child relationship early on. As the above study showed, insensitive interactions between infant and caregiver in childhood may lead to emotion dysregulation patterns, which might have implications for the

developing mind and could lead to insecure attachments later in adulthood (Schore, 2003a). More of these longitudinal studies are needed to show not only the link between insecure attachment and adult psychopathology, but also how insecure attachment may be related to specific psychological disorders.

The next section will review studies that examined AT and its link to therapeutic relationships.

(b)- AT and Therapeutic Relationships
AT and its relevance for psychotherapy

Bowlby was committed to using AT in clinical work, and as a practicing community psychiatrist he applied it to individual psychotherapy with adults, inspiring academics and researchers to extend the basic research on attachment into therapeutic settings.

AT predicts that when people are in distress or faced with illness or loss, they seek security via an attachment figure who will provide a secure base to explore their distress and bring relief from suffering. According to the theory, any person in a relationship can become an attachment figure provided that they possess the three requirements of an attachment relationship; that they can maintain proximity, alleviate distress, and establish a secure base (Bowlby, 1982). Similarly, the client-therapist relationship can be conceptualised as an attachment relationship. Bowlby (1988a) noted that:

> In providing his client with a secure base from which to explore and express his thoughts and feelings the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world. (p. 140)

Clients, most often vulnerable and distressed, come to therapy, eliciting care-giving behaviours from therapists, and therapists just like sensitive and

accepting mothers respond with warmth, openness and trustworthiness, all dispositions associated with secure attachment (Ackerman & Hilsenroth, 2003). According to Bowlby, one of the tasks of psychotherapy is to enable the client to explore and revise their attachment representations and gain a corrective experience from the therapeutic relationship with the therapist. The quality of the relationship with the therapist who functions as an attachment figure – whether the client is aware of this or not – can alter the client's attachment security (Bowlby, 1988a). 'Sense of attachment security' (Mikulincer & Shaver, 2004, p.159) has a central role in AT, both as an essential ingredient to explore difficult emotions in therapy, and a skill to develop on the part of the therapist in facilitating a secure attachment relationship with their clients (Daniel, 2006). Empirical studies have shown that clients' secure attachment to the therapist as well as the therapists' secure attachment to the client facilitate in-session exploration in therapy (Mallinckrodt et al., 1995, 2005; Romano, Fitzpatrick, & Janzen, 2008).

Therapist as an attachment figure in Attachment Theory

According to Bowlby (1969), emotional closeness and security in relationships provide confidence and strength, and may generate feelings of wellbeing. The relationship with a therapist may offer such security for the client and facilitate the exploration of difficult emotions. Like the reciprocal emotional exchange between parent and child, attunement between therapist and client is an important part of the process in the development of the therapeutic alliance (Stern, 2004). Sonkin (2005) conceptualises the therapist's attunement as being in touch with one's own internal emotional/body experience and being able to pick up non-verbal cues from the client. According to Sonkin (2005), therapists need to be aware of their own internal experience and consider their own attachment styles. Lack of attunement is likely to be picked up by the client and affect their anxiety regarding acceptance and unconditional regard from the therapist.

Researchers have emphasised the importance of therapist attachment patterns in therapy (Black, Hardy, Turpin, & Parry, 2005; Meyer & Pilkonis, 2002;

Mikulincer et al., 2012). Awareness of their own sense of attachment may help therapists to know how effective they can be as a caregiver and provider of a secure base (Mikulincer et al., 2012). Therapists with secure attachment handle ruptures more easily (Eames & Roth, 2000), and respond to clients more empathically than therapists with preoccupied attachment styles-anxious attachment (Rubino, Barker, Roth, & Fearon, 2000). Consequently secure therapists appear to contribute to client security more than insecure therapists (Mikulincer & Shaver, 2007). By increasing awareness of their own attachment patterns, therapists may increase their ability to empathise accurately and respond to clients' needs appropriately, and generally promote secure attachment (Eames & Roth, 2000; Rubino et al., 2000).

The Therapeutic relationship and therapeutic alliance

'The therapeutic relationship in general, and the alliance in particular, is the quintessential common ground shared by most psychotherapies' (Horvath & Bedi 2002, p. 37). The therapeutic relationship is conceptualised differently in different psychological therapies (Feltham, 1999; Gilbert & Leahy, 2007). Some authors believe the therapeutic relationship delivers what the therapy aims to achieve and some believe it is the therapy itself (O'Brian, 2009). Above all, what many researchers agree on is the therapeutic relationship's pivotal role in yielding an effective therapy outcome (Bogart & Tallman, 2010; Norcross, 2011; Wampold, 2010).

(i) The Therapeutic relationship

Not all models of therapy put the therapeutic relationship in the centre of the therapy process. According to Gelso and Carter (1994), the three dimensions, which are the 'centrality', 'real-unreal', and 'mean-end' dimensions, define the differences between models of therapy, namely the psychodynamic, humanistic, and cognitive approaches (e.g. CBT). The three dimensions illustrate to what extent the therapeutic relationship plays a 'central role' in the therapy process and outcome, to what extent the development of the therapeutic relationship is conceptualised as 'real' in the therapy process, and to what extent the

therapeutic relationship is a functional 'means to an end' for the outcome of therapy.

(ii)The Therapeutic alliance

An important dimension of the therapeutic relationship is the working alliance. However, there does not seem to be a universally accepted definition of alliance (Horvath & Luborsky, 1993; Saketopoulou, 1999). For example, Greenson (1967) defined it as 'the patient's capacity to work purposefully in the treatment situation' (p. 192), emphasising the cognitive and motivational resources of the client to carry out specific tasks. Clarkson (2003) defined the working alliance as 'the part of client-psychotherapist relationship that enables the client and therapist to work together even when either or both of them do not want to' (p.10). This definition emphasises the relational aspect of the therapeutic relationship that facilitates therapeutic work.

Historically, much has been debated regarding what is meant by therapeutic alliance. The earliest use of the term, 'therapeutic alliance' lies in the psychoanalytic theory, and was a dynamic concept referring to the client's ability to use the healthy part of the ego to work with the analyst (Freud, 1940; Zetzel, 1956). Zetzel (1956) was the first to introduce the term 'therapeutic alliance' to distinguish the transference relationship from the reality-based relation to the therapist. She suggested that the alliance was a representation of the positive and trusting aspects of the mother-child relationship, and viewed the alliance as being crucial to a successful therapy outcome. Later, Greenson (1967) defined the therapeutic alliance as the capacity of the client and therapist to develop an affective bond between them, and the working alliance depending on the ability of the partners to work purposefully together in the treatment situation. In the 1970s, Luborsky (1976) departed from the psychodynamic origins, emphasising the relational aspects of the interaction between client and therapist. He conceptualised the alliance as a process developing in two stages. The first stage involved the client's anticipation of getting warm and supportive help from the therapist and the therapist providing a caring response. The second stage

involved the actual commitment by the client and therapist to make the therapy work, an exploratory process by nature.

Bordin's (1975, 1989, 1994) model took the concept further away from its dynamic roots, conceptualising the alliance as fundamentally a collaborative effort involving three components: agreement on the goals of therapy, the tasks involved in reaching the goals of therapy and the affective bond between the client and therapist. Bordin's model has been used across different models of therapy because it does not assume a particular viewpoint on the type of therapy necessary to achieve positive therapy outcome (Horvath & Luborsky, 1993).

(iii) Different conceptualisations of therapeutic alliance

There are diverse conceptualisations of the therapeutic alliance, which have been utilised differently according to different schools of therapy (Bordin, 1975; Freud, 1940; Rogers, 1951). Taking a closer look at these views of the relationship across therapy schools can help contextualize this complex and multifaceted construct. Psychoanalytic or psychodynamic approaches recognise therapist and client attachment patterns as central in the therapeutic relationship which becomes the object of exploration and vehicle for change. The 'unreal' dimension of the relationship is high in these approaches, and utilised for exploring the client's memories, fantasies and unmet needs from the past, therefore the relationship itself becomes the medium of change. Theoreticians from Freud onwards emphasised the use of therapist-patient interaction with timely interpretation of transference and resistance that might help to create positive outcome for the client (Freud, 1940). According to this model, the client's transference feelings which involve past memories and experiences would allow the therapist to interpret and give meaning to what was being communicated by the client. In a way the therapist has the authority to work with the relationship in producing an effective therapeutic outcome. Zetzel (1956) was the first to introduce the term 'therapeutic alliance' and conceptualised it as a representation of the positive and trusting aspects of the mother-child relationship.

Within the humanistic/Client-Centred Therapy, Rogers (1951) was a leading figure in starting a movement to focus on the working alliance in therapy. He suggested that the therapist brings about an atmosphere for change by just being there. The therapist's presence creates the 'necessary and sufficient' conditions: genuineness, empathy, and positive regard for therapeutic change, and the therapeutic relationship serves as a means of experiencing oneself in the interaction in new ways (Rogers, 1951). The focus is on the 'real relationship' between the client and therapist. Humanistic therapies (such as Gestalt and Person-Centred Counselling) emphasise the presence of the moment and genuine authentic contact, through which human growth and development can be facilitated, therefore the therapeutic relationship accounts for the change. In these approaches the therapeutic relationship is active, yet it is a 'way of being and not of doing' (Rogers, 1990), experienced only through the implementation of the core conditions (Rogers, 1990). It is a non-directive approach that places much of the responsibility on the client, such that the client's sense of what is needed for change is acknowledged and worked through collaboratively based on the equality of power between the client and therapist. Bowlby's (1969/1997) understanding of the therapeutic alliance is similar to the humanistic school's perspective, but with more cognitive input. The therapist as an attachment figure provides 'a physical and emotional safe haven; they facilitate distress alleviation and are a source of support and comfort' (Mikulincer et al., 2012, p.608). Additionally, they serve as a medium for the client to explore their existing dysfunctional relationship patterns, and to revise and replace them with new corrective emotional experiences (Bowlby, 1988a). The client can use this new interpersonal experience to change the problematic attachment-related beliefs and expectations about relationships, eventually developing security in attachments (Mikulincer & Shaver, 2007).

In the CBT model, the therapeutic relationship is high on the 'mean-end dimension' and low on 'centrality' dimension because, little attention is given to how the therapeutic relationship should develop, and how it can be used to motivate the client to use the skills to create change in behaviour. The technical aspects of the therapy are considered more important (Scott & Dryden, 2003).

According to this perspective cognitive and behavioural change would be achieved by the successful implementation of techniques, and the therapeutic alliance is a means to facilitate the implementation of those techniques (Rector et al., 1999). In this model the emphasis is on the functional aspect of the therapeutic relationship. The collaborative work between the therapist and client is characterised by goal setting and task setting, and showing basic human concern and respect to the client. The therapeutic relationship may not be central to the therapeutic work but the therapist needs to be mindful of how the relationship is affecting the client (Dryden & Feltham, 1992). The therapist initiates a reflective process by which both the client and therapist are encouraged to step back from the content of the counselling to evaluate how strong and satisfactory their working relationship has been developing (Dryden & Feltham, 1992).

Contemporary theories of working alliance are pan-theoretical and offer an interactive model with three components: 1- the affective bond between therapist and client, 2- agreement and shared understanding of the goals of therapy, and 3- agreement on the tasks to achieve the goals of therapy (Bordin, 1994; Horvath & Bedi, 2002). According to Horvath and Bedi (2002):

> The alliance refers to the quality and strength of the collaborative relationship between client and therapist in therapy. This concept is inclusive of: the positive affective bonds between client and therapist, such as mutual trust, liking, respect, and caring. Alliance also encompasses the more cognitive aspects of the relationship; consensus about, and active commitment to, the goals of therapy and to the means by which these goals can be reached. (Horvath & Bedi, 2002, p. 41)

The therapeutic alliance model used in the present study is based on Bordin's model, which is pan-theoretical, widely used and well accepted. It also has the advantage of having a reliable and valid measure.

(iv) The therapeutic alliance and adult attachment styles

'The primary reason the alliance has grown in significance is the consistent finding that the quality of the alliance is related to subsequent therapeutic outcome' (Martin et al., 2000, p.438). A meta-analysis conducted by Horvath and Symonds (1991) concluded that the therapeutic alliance is significantly associated with outcome not only across a number of investigations but also across different types of psychotherapy. Since 1991 there have been five major meta-analyses that have examined the relationship between the therapeutic alliance and therapy outcome in individual psychotherapy and they all indicate that the quality of the therapeutic alliance can predict positive outcome (Diener, Hilsenroth, & Weinberger, 2009; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Horvath et al., 2011; Martin et al., 2000).

The recent meta-analysis conducted by Diener and colleagues (2009) is particularly pertinent for the present study because the authors reviewed the research on the relationship between therapeutic alliance and attachment security. They described their aim in conducting this meta-analysis as:

> 'Insufficient evidence existed to clearly support the utility of tailoring the therapy relationship to patient attachment style' (Ackerman et al., 2001). The present meta-analysis addresses this. We predicted that secure attachment would be positively correlated with alliance, whereas insecure attachment would be negatively correlated with alliance. (Diener et al., 2009, p. 524)

The authors reviewed 12 studies out of 134 abstracts that fulfilled their inclusion criteria to examine the relationship between 'patient reported' therapeutic alliance and adult attachment style. They found that the weighted average of the effect size for the relationship between attachment security and the alliance was r= .17 p<. 0001, indicating a small but statistically significant relationship. 'As suggested by AT, individuals reporting secure attachment styles also report more positive alliances with their therapist, and individuals reporting insecure attachment styles report more negative alliances with their therapist' (Diener et

al., 2009, p. 524). Consistent with AT, then, clients with secure attachment style tend to form stronger alliances with their therapists than those clients with insecure attachment styles, although the magnitude of this relationship was rather weak.

The next section will review research that examined not just whether attachment styles are related to the therapeutic relationship but also to the process and outcome of therapy itself.

(C)- Empirical Studies of Adult Attachment Styles and Psychotherapy

The research examining the multifaceted relationships between attachment styles and psychotherapy has grown over the past two decades (Baldwin, Wampold, & Imel, 2007; Goldfried & Davila, 2005; Norcross, 2011). For the purposes of this study, the review will focus on the links between: 1) client attachment and therapy outcome, (2) the effects of client attachment on therapist behaviour (including client attachment patterns in the context of the therapeutic process) (3) client attachment patterns and therapeutic alliance, and (4) childhood adversity and attachment.

Client attachment and therapy outcome

Studies in this section will examine whether client attachment styles influence therapy outcome, and if so which attachment patterns emerge as a significant predictor of positive outcome. According to AT, it can be expected that clients with secure attachment patterns might engage better with their therapists, and consequently are more likely to contribute positively towards therapeutic change (Bowlby, 1988a). On the other hand, the insecurely attached clients might engage less with their therapists which may consequently hinder a positive therapeutic outcome.

Fonagy and colleagues (1996) investigated the impact of attachment styles on therapy outcome in a longitudinal study. They administered the AAI to a sample of 82 inpatients diagnosed with mood disorders and severe personality disorders. All patients received psychoanalytically orientated individual and group psychotherapy over a period of 9 months. The transcripts were analysed from the client's perspective as to whether they were able to reflect on their internal emotional experience, and reflect on the mind of the other. The attachment classification was made according to the reflective function of the client on the AAI. Results showed that securely attached clients tended to function more favourably than others at the beginning and end of therapy. Surprisingly, the clients classified as dismissive showed relatively greater improvement than the secure and preoccupied clients. Although one might conclude from the study that clients with dismissive attachment benefit more than others from long-term psychoanalytic therapy, it is also possible to interpret the result as 'regression to the mean', where the extreme scores tend to shift to moderate levels when they are assessed at a second time-point (Meyer & Pilkonis, 2002). Fonagy and colleagues (1996) had commented on the unexpected results, suggesting that dismissive clients might have benefited more from long-term psychoanalytic therapy because they might have felt encouraged to talk about the past relationships and the emotional issues they had previously avoided.

The study by Horowitz, Rosenberg and Bartholomew (1993) showed opposite results with regard to dismissive attachment. They found that avoidant clients showed less clinical improvement than secure or anxious clients following individual therapy. They administered the Inventory of Interpersonal Problems (IIP) to 36 clients in brief dynamic psychotherapy and the attachment patterns were inferred from the IIP scores. Clients who scored high on interpersonal problems that were classified as 'dominating', and 'cold' (according to the authors the interpersonal problems that fell into 'dominating' and 'cold' groupings were typical of clients with 'dismissing attachment style' in another study; (Bartholomew & Horowitz, 1991)), benefitted the least from therapy. However, it is difficult to draw a definitive conclusion from this study because of

the small sample size and problematic measurement of the attachment patterns, which were not assessed directly but inferred from the IIP scores.

Meyer, Pilkonis, Proietti, Heape and Egan (2001) investigated the predictive value of attachment dimensions on treatment outcome in 149 psychiatric patients, of which most were outpatients. The authors used a semi-structured psychosocial interview method, which highlighted the content of the narrative, as opposed to the AAI's focus on the form. The interview was followed by consensus ratings of several attachment prototypes (see Pilkonis, 1998). According to this method, a client who reported a high level of comfort in relationships but showed minor problems with recovering from break-ups in relationships would score high on secure attachment, as opposed to AAI's focus on verbal coherence. Over the six-month period, clients with secure attachments showed relative improvement as measured by a global rating of psychosocial functioning, whereas other attachment dimensions were unrelated to outcome. It can be concluded from the study that secure attachment was significantly related to positive treatment outcome, which corresponds to the theoretical prediction.

Mosheim and colleagues (2000) also studied the influence of attachment style on the treatment outcome. They used the German version of Pilkonis' (1998) semi-structured interview method to classify attachment styles among 65 patients in a psychiatric hospital. The results indicated that 'Secure attachment emerged as a significant predictor of therapy-goal attainment over an average treatment duration of seven weeks' (Meyer & Pilkonis, 2002, p. 373). Patients who appeared to be comfortable and confident in relationships were classified as securely attached clients, and they were more likely to benefit from treatment than other groups.

Recent studies examining the link between attachment style and therapy outcome found similar results to the previous studies. Secure attachment has emerged as a predictor of positive therapeutic outcome and insecure attachment has been shown to interfere with positive change (Berant & Obegi, 2009; Byrd et

al., 2010; Levy et al., 2011; Sauer, Anderson, Gormley, Richmond, & Preacco, 2010). Three meta-analysis which consisted of 14 studies, (N= 1467), were reviewed by Levy and colleagues (2011). They examined the association between attachment styles in close relationships and therapy outcome. The result indicated that attachment insecurities were inversely related to therapy outcome, with attachment anxiety showing the effect size of -.46, whereas secure attachment showed a significant positive association with outcome (effect size of .37). Byrd and colleagues (2010) used archival data of 66 psychotherapy clients, treated at a university clinic, to study the working alliance as a mediator of client attachment and therapy outcome. They studied three attachment dimensions; 'Comfort with Closeness, Comfort Depending on Others, and Rejection Anxiety', and their effect on the therapeutic alliance and therapy outcome. They found that 'Comfort with Closeness' and 'Comfort Depending on Others' were significantly related to alliance and outcome. Rejection Anxiety dimension was not significantly related to alliance or outcome. Alliance was a significant partial mediator of the effect of Comfort with Closeness on the outcome of therapy. According to the authors 'the results suggest that multidimensional measures of attachment capture important influences on alliance and psychotherapy and that Comfort with Closeness promotes successful outcome by virtue of its influence on alliance.' (Byrd et al., 2010, p.631). The study by Tasca, Taylor, Bissada, Ritchie, and Balfour (2004) also found that clients with avoidant attachment could not engage well with others and appeared to have benefitted less from group psychotherapy, in a sample of eating disorder clients. Higher rates of dropping out by this group suggest difficulties in engaging and establishing a good working alliance with their therapists, which consequently influences the outcome of their treatment negatively. Sauer and colleagues (2010) examined the association between client and therapist attachment styles, and progress and outcome in therapy. They also confirmed the link between secure attachment and therapy outcome. This study measured how insecurely and securely attached clients responded to their therapists, as measured by a standard therapy progress questionnaire, at the beginning, the third session and end of therapy. Results showed that 'Clients with secure attachments to therapists and those reporting stronger working

alliances reported greater reductions in psychological distress over time' (Sauer et al., 2010, p.708). Secure attachment appeared to have benefitted more from talking out their problems in a trusting relationship with their therapists. On the other hand, anxiously attached clients were more distressed towards the end of their therapy, reflecting their fear of abandonment in close relationships.

The overall research findings in this section appear to indicate that attachment security is associated with therapy outcome, facilitating beneficial therapeutic change, and thus contributing to positive therapy outcome. However differences in measurement, e.g. AAI, semi-structured interviews, and therapeutic modalities, e.g. psychoanalytic therapy, Interpersonal Psychotherapy (IPT), make it difficult to directly compare the results from different studies. For example, there are studies that show therapy modality might influence the therapy outcome in favour of some attachment groups, e.g. avoidant attachment benefitting more from intensive long-term interventions that might facilitate emotional expression for them (Fonagy et al., 1996). In summary, securely attached clients seem to engage better across different therapeutic models (Mosheim et al., 2000; Tasca et al., 2004; Sauer et al., 2010), and the meta-analytic findings increasingly paint a coherent picture of client attachment security and therapy outcome (Diener et al., 2009; Horvath & Symonds, 1991; Horvath, Del Re, Fluckiger, & Symonds, 2011; Martin et al., 2000). There is also some evidence that therapist attachment might interact with the client's attachment style and influence the therapeutic process and outcome (Hardy et al., 2004). This issue will be the focus of the next section.

The Effect of client attachment on therapist behaviour

AT predicts that people respond to others in accordance with their internal working models of attachment (Bowlby, 1988a). Therefore, it can be expected that clients with different attachment styles would elicit responses from their therapists according to their own internal working model of the other. In other words, they would interact with their therapists according to their own expectations of how the therapist would receive them. Studies show that therapists respond flexibly to clients and work differently with them.

Hardy, Aldridge, Davidson, Rowe, Reilly, and Shapiro (1999) examined the therapist's responsiveness to clients with different attachment styles. The classification of attachment styles in this study was formed from the clients' own narratives. The authors asked 16 clients in psychodynamic interpersonal therapy to identify significant events from their therapy sessions. For example, one client described 'exploring my relationships with my father and grandfather' (p. 40), as a significant therapeutic discussion. The authors selected 10 such significant therapeutic events and these were content analysed. The coherent and collaborative narratives were grouped as secure, and others were classified as dismissing or preoccupied attachment styles. The authors found that therapists of clients with dismissing (avoidant) attachment styles struggled to find a coherent joint narrative to facilitate exploring the client's early and painful attachment problems. These clients avoided closeness and could not engage or reflect on their painful past experiences. On the other hand, preoccupied attachment (anxious) style clients were caught up in discussions that involved negative and lengthy interpretation of their past. The therapists were flexible in responding to these clients, adjusted their approach and used supportive and containing interventions. They avoided interpretation and made an effort to meet the client's need to be understood.

Making use of the narratives provided an in depth analysis of the interaction between the therapist and client and added richness to the content, but also presented problems with regard to the comparability of their results with other studies. Although the findings were supportive of the proposed hypotheses that different attachment styles elicit different forms of responsiveness from therapists, it is difficult to compare these results with others due to the difference in the attachment measurement.

The study by Rubino and colleagues (2000) was designed to explore client attachment styles eliciting different responses from their therapists, and the effects of therapist attachment style on managing the ruptures in therapy. The study was conducted on trainee therapists who were asked to observe

videotaped vignettes of simulated rupture episodes with clients and respond to the situation. Therapists' empathy and the depth of intervention was assessed by independent judges. The vignettes included clients classified as secure, dismissing, fearful and preoccupied. Therapists' attachment styles were also assessed with self-report measures. Findings confirmed previous research results and support the hypothesis that client attachment styles tend to elicit different responses from therapists. More anxious therapists tended to respond less empathically than those therapists who were less anxious. Therapists responded with more empathy and with greater depth to the fearful and preoccupied clients than to the secure and dismissing clients. Therapists were drawn more to helping the clients with anxious-attachment (preoccupied clients), reflecting their own difficulties in relationships. Rubino and colleagues (2000) commented on this result, stating that 'more anxious therapists might interpret ruptures as an indication of their clients' intention to leave therapy, and their own sensitivity toward abandonment might diminish their own ability to be empathic', (p. 416).

Although the above study was with videotaped vignettes of simulated therapy interactions between client and therapist, the results were illustrative of the therapists' differential responses to clients with different attachment styles. The results showed that both the client and therapist attachment patterns, reflecting their early relationships with caretakers influence the therapy process.

The overall conclusion of the above studies in this category provides support for the hypothesis that the attachment styles of clients tend to elicit specific responses from therapists. However, it is also possible to deduce from the results that therapists' own attachment styles could have affected how they responded to clients, because they tended to adjust their responses according to their own needs-their level of comfort in relationships- as well as to their clients' attachment styles. The studies showed that more anxious therapists tended to respond less empathically to secure clients than those who were less anxious. Fearful and anxious (preoccupied) clients seemed to elicit more in-depth interventions from anxious therapists. On the other hand, secure therapists

reflecting their comfort in relationships, engaged with all groups of clients in the same way, empathically and sensitively, which seemed to enhance the therapeutic alliance. Both client and therapist attachment patterns seemed to affect the therapeutic process and the therapeutic relationship.

Client attachment patterns and therapeutic alliance

Because of the empirically strong link between therapeutic alliance and therapeutic outcome (Horvath & Bedi, 2002; Horvath et al., 2011), therapeutic alliance and its link to attachment styles have been frequently researched. It is expected that clients with different attachment styles will approach their therapists with varying degrees of emotional commitment and self-disclosure, consequently affecting the development and quality of the working alliance differently. For example, securely attached individuals would feel relatively comfortable in approaching their therapists whereas anxiously-avoidant clients would find it difficult to engage with their therapist. Studies in this area are particularly useful in shedding light on how clients with different attachment patterns function in interpersonal relationships and how this enables them to use the therapeutic relationship for positive outcomes.

Early studies on alliance and attachment patterns indicated that 'comfort with intimacy' appeared to be associated with alliance positively (Mallinckrodt et al., 1995; Kivlighan, Patton, & Foote, 1998; Satterfield & Lyddon, 1995), 'Fear of abandonment' appeared to be correlated with alliance negatively (Mallinckrodt et al., 1995), and 'ability to depend on others,' predicted better therapeutic alliances. The results from the above studies showed that clients with secure attachments form more positive alliances than clients with insecure attachment patterns. In most of these studies the Adult Attachment Scale (AAS) was used (Collins & Read, 1990) which is an 18-item questionnaire that produces three attachment dimensions: 'comfort with closeness, ability to depend on other, and fear of abandonment'. Because these 3 dimensions are not directly convertible to the more widespread categorical or two dimensional attachment measurements it is difficult to compare the results with other studies and make a firm conclusion.

To examine the link between attachment styles and therapeutic alliance, and how the level of comfort or discomfort in relationships would affect the quality of the therapeutic alliance, Mallinckrodt and colleagues (1995) developed a scale called the 'Client Attachment to Therapist Scale' (CATS). The 36-item self-report measure distinguishes the client's attachment to the therapist in three groups: 'secure', 'preoccupied-merger', and 'fearful-avoidant'. According to CATS, the securely attached client would perceive the therapist as emotionally available and responsive; the preoccupied client would perceive the therapist as unsure and therefore would tend to demand a closer relationship and push the boundaries of the therapy; and the avoidant client would perceive the therapist as disapproving or rejecting, therefore would tend to feel threatened in the relationship with the therapist and be reluctant to self disclose.

The authors, Mallinckrodt and colleagues, (1995), conducted a study on 129 outpatients to explore how attachment to therapist, as measured by CATS, is related to the working alliance as measured by Working Alliance Inventory (WAI). Both the 'secure' and 'fearful-avoidant' sub scales of CATS correlated with some aspects of the alliance (Mallinckrodt et al., 1995). On this issue, Meyer and Pilkonis (2002) stated that 'In fact, the magnitude of correlations (around .80) suggested that some CATS scales share a common conceptual core with the working alliance' (p.375). Patients who were securely attached to their therapist perceived them as accepting and supportive, and were more likely to view the alliance as strong. Patients who were attached to their therapist in an avoidant style perceived them as distant, and viewed the alliance as less strong, recalling a greater number of negative family experiences. There was no relationship between preoccupied attachment to the therapist and a total alliance scale.

In a review by Meyer and Pilkonis (2002), it was pointed out that the constructs assessed in CATS (e.g., emotional comfort with the therapist), are different to the ones measured by the ECR scale developed by Brennan and colleagues (1998). In fact, the subscales of CATS related weakly or not at all to self-report measures of romantic attachment (Mallinckrodt et al., 1995). However, according to Meyer

and Pilkonis (2002) 'some of CATS' dimensions relate to early experiences with caregivers (p.375), in that people who had unresponsive and negative relationships with caregivers would likely to perceive their therapists as disapproving and rejecting, and recall a greater number of negative experiences with parents (Mallinckrodt, King, & Coble, 1998). This is consistent with AT, in that people who had difficult relationship experiences with parents would have mental representations of others as difficult, and would reflect these in their relationships, including in their relationship with their therapists.

Romano and colleagues (2008) have assessed associations between client attachment and the development of the working alliance during therapy. This study by Romano and colleagues (2008) is very similar to the present study in that it also examined the association between client attachment styles and therapeutic alliance using the same questionnaires, namely the ECR and WAI. They conducted their study on 59 volunteer clients and 59 trainee therapists who were students enrolled in a counselling course. Overall findings suggested that session depth was related to the client's experience of attachment security with the therapist. The results did not show a significant association between client's attachment style- secure, anxious and avoidant- and total working alliance. Contrary to their expectations, anxious attachment was not associated with the working alliance. However, they did find a negative correlation between avoidant attachment and working alliance, similar to the present study. Unlike the present study, the negative correlation they found between avoidant attachment and alliance was not statistically significant.

In another study, Kanninen, Salo and Punamaki (2000) explored the association between attachment patterns and therapeutic alliance among 36 Palestinian political ex-prisoners. They used a pencil and paper version of AAI by which the clients described, in writing, their relationship with their caretakers and their impressions of how their upbringing had influenced them as adults. Their writings were analysed and classified into three groups; autonomous, dismissing and preoccupied. The participants were offered group or individual therapy for post-traumatic stress in which they were asked to complete the working alliance

questionnaire at the beginning, middle and end of therapy. The results did not show a particular attachment style having a significant effect on the outcome of therapy. However, there was a difference in the development of the therapeutic alliance among the different attachment groups. Securely attached clients showed a stable alliance throughout therapy; preoccupied clients showed a poor alliance in the middle of therapy but a stronger alliance towards the end of therapy; and dismissing clients showed a gradually weakening alliance towards the end of therapy.

The authors suggested that the differences displayed by the different attachment groups might have been due to internal working models. Preoccupied individuals would tend to be cautious with the challenges and various interventions employed by the therapist in the middle of therapy – they would likely to interpret these as confrontations and threats of rejection – and rate the alliance as not strong. Towards the end, however, they would be reassured by the therapist's consistent and supportive response and view their alliance as strong. The internal working model of a client with a dismissing attachment style would be the opposite. They would likely to perceive their alliance as superficially strong at the beginning and in the middle of therapy, but by the end would realise their difficulties in making an emotional contact with the therapist and distance themselves. Consequently they would view the alliance as deteriorating towards the end of therapy (Kanninen et al., 2000). Consistent with theory, clients with secure versus insecure attachment patterns would approach interpersonal relationships in different ways, and consequently their attachment patterns would influence the quality and development of the alliance over time accordingly.

Eames and Roth (2000) examined the relationship between client attachment styles and the quality of the therapeutic alliance on 30 outpatients in a London clinic. They administered the Relationship Scale Questionnaire (RSQ) which measures attachment orientations as secure, preoccupied, dismissive and fearful. In addition, they looked at the link between attachment and frequency of ruptures in the duration of therapy, measuring it at four points. As expected, the

results showed that securely attached clients rated their alliances positively, suggesting that they had formed effective therapeutic relationships, and fearfully attached clients rated their alliances negatively, suggesting that they had formed less effective alliances. Interestingly, opposite to what was expected, both the preoccupied and dismissing clients showed an increase in alliance over time even reaching the level of significance. The researchers questioned the differential reliability in clients' reporting the therapeutic alliance, and questioned the underlying dynamics of their perceptions of the therapeutic alliance. Clients with high need for intimacy and fear of rejection might have strived to be in an alliance with the therapist regardless of the depth of therapeutic work. On the other hand, clients with dismissing attachment styles might have superficially formed strong alliances to avoid genuine emotional engagement (Eames & Roth, 2000). With regard to alliance ruptures, therapists were more likely to report ruptures than clients – they reported more ruptures, especially with the preoccupied attachment style clients, and less ruptures with the dismissing clients. The dismissing attachment style showed lower reports of ruptures both by clients and therapists. A similar result was found in Cassidy and Kobak's (1988) study, namely that the preoccupied attachment style clients reported more ruptures as compared to the dismissing group.

The differences in the interpretation of the therapeutic alliance by different attachment groups might be reflective of their internal working models. The preoccupied clients generally are known to have a negative model of self and a positive model of the other. Therefore, it is expected that preoccupied clients would approach their therapist with caution, inferring rejection when they are challenged in the middle of their therapy. However, this cautious approach would change towards the end of their therapy because of their fear of abandonment, which leads them to view the alliance as unrealistically strong. On the other hand, the dismissing attachment style clients are expected to view the alliance as superficially strong in the beginning of the therapy, and change their perceptions later, as they encounter genuine problems in engaging with their therapists (Eames & Roth, 2000).

A study by Sauer, Lopez and Gormley (2003) investigated the effects of client attachment styles on the therapeutic alliance as measured at three points during the initial phase of therapy. Both clients and therapists rated the therapeutic alliance. They used Simpson's (1990) AAI to assess attachment patterns. The results did not yield any effect of attachment patterns on the alliance. However, it is difficult to draw any conclusions from this study because the sample size was small – 28 clients in all. Moreover, after the second time point, approximately half of the subjects dropped out of therapy, making the interpretation of results even more difficult.

In summary, the evidence suggests that clients' attachment styles influence the therapeutic alliance, and that secure attachment is more positively related to therapeutic alliance than insecure attachment. The result of the meta-analysis of 12 studies also supports the link between secure attachment and working alliance (Diener et al., 2009). It is indicated that attachment insecurity is more likely to disrupt the client-therapist working alliance, and that a more secure attachment can contribute to a more stable and stronger alliance (Byrd et al., 2010; Dolan, Arnkoff, & Glass, 1993; Goldman & Anderson, 2007; Kivlighan et al., 1998). Research assessing clients' attachment styles during therapy has also shown that the development of the therapeutic alliance within the insecurely attached client group fluctuates more as compared to the securely attached group, e.g. preoccupied attachment styles showed gradual strengthening towards the end of therapy, and dismissing attachment styles showed gradual weakening towards the end of therapy. Clients' mental representations of the self and other seem to predict how effective they are at establishing a therapeutic alliance (Mallinckrodt et al., 1995; Eames & Roth, 2000).

Childhood adversity and attachment

AT provides a framework for explaining how adult dysfunctional interpersonal relationships arising from early childhood impact therapy process and outcome. According to the theory, infants' emotional bonds with caregivers determine the development of their working models, and hence the development of secure and insecure attachment styles. Bowlby (1973) predicted the negative effects of

failed parent-infant interactions, and described how such distressing early experiences can lead a person to develop ways to ward off these painful attachment-related thoughts and feelings. Though these defensive ways that the individual adopts are essential for survival, and though they help the individual to cope with attachment-related pain, these are also learned patterns of relating that can make the person more vulnerable and susceptible to future psychological problems. AT has been used as a powerful explanatory model in studies that aim to find an association between negative early parental interaction, attachment styles and development of some psychological disorders, e.g. eating disorders, anxiety and depression (Bifulco Kwon, Jacobs, Moran, Bunn, & Beer, 2006; Bowlby, 1973; Dozier et al., 1999).

Many studies have already indicated that there is a link between childhood adversity in the form of physical, emotional or sexual, abuse and adult psychopathology (Anda et al., 2006; Enns, Cox, & Clara, 2002; Hill, Pickles, Burnside, Byatt, Rollinson, David, & Harvey, 2001; Pederson & Wilson, 2009). Research has also demonstrated that attachment style is related to several mental health disorders (Bifulco et al., 2002; Dozier et al., 1999; Gerlsma & Luteijn, 2000; Murphy & Bates, 1997). However, there has been little research on the link between types of insecure attachment and the development of specific types of psychiatric disorder. Insensitive and inconsistent parenting and various forms of childhood maltreatment (e.g. neglect, abuse) have been related to later adult attachment problems (Bifulco et al., 2002; Whiffen et al., 1999), and with major depressive and anxiety disorders (Bifulco et al., 1998; Harkness & Wildes, 2002). In the study conducted by Bifulco and colleagues (2006), adult attachment style has been examined as a mediator between childhood neglect/abuse and adult depression and anxiety. The authors tested the role of insecure attachment style in predicting new episodes of anxiety and/or major depression in 154 high-risk women who were interviewed twice, five years apart. Results showed that insecure attachment styles predicted both major depression and 'case anxiety' in the follow-up interview. A fearful style was significantly associated with depression and social phobia, and an angry-dismissive style with General Anxiety Disorder. Fearful and dismissive styles

72

were shown to partially mediate the relationship between childhood adversity and depression and anxiety. This study highlights the importance of analysing adult attachment as a mediating factor in the relationship between adverse childhood experiences and adult mental health problems. Studying adult attachment as a mediator provides a 'framework to infer causal pathways in development' (Bifulco et al., 2006, p.804).

In the area of eating disorders, two major reviews (O'Kearney, 1996; Ward, Ramsay, Turnbull, Benedettini, & Treasure, 2000) indicate that insecure attachment is related to eating disorders. However, results regarding the association between type of attachment styles and subtypes of eating disorders are inconsistent. One study (Candelori & Ciocca, 1998) did find an association between avoidant attachment and anorexia nervosa, and between preoccupied attachment and bulimia nervosa, which was later confirmed by a recent review (Soares & Dias, 2007). In eating disorders, the research conducted by Tereno, Soares, Martins, Celani and Sampaio (2008) is particularly important for the present study as they looked at the early relationship with parents and how this related to adult attachment styles and the development of the therapeutic alliance. The associations among these variables were examined between control and clinical groups. They found that attachment anxiety was lower in the control group compared to the other two groups (anorexia and bulimia). The mothers in this group also showed higher security than the mothers of anorectic clients, and they also showed lower avoidance than mothers of the bulimic clients. In the anorectic group, higher attachment security was associated with lower maternal overprotection. The authors stated that 'Compared with the control group, clinical patients did perceive higher anxiety and/or avoidance at their present parental relationships as well as higher overprotection and/or rejection in their past relationships' p. 55). With regards to the therapeutic bond between the therapists and clients in the two groups, the clients in the bulimic group perceived their relationship with their therapists stronger than the clients in the anorectic group. In both groups there was an association between anxiety and avoidance attachment styles, negative parental upbringing and lower quality of therapeutic bond. This study highlights the importance of the quality of early

experiences with parents and their effect on future adult relationships inclusive of the therapeutic relationship. It also illustrates the relevance of AT's clinical applications in some psychological disorders such as eating disorders. AT can be utilised in therapeutic work with such clinical groups in helping clients to become aware of their attachment problems through exploring their attachment histories, and modifying them through a corrective relationship experience with their therapist.

The evidence reviewed here is largely consistent with AT's predictions. Negative relationships with parents and neglect or lack of care during childhood lead to the formation of negative mental representations of the self and others. Childhood adversity appears to facilitate the emergence of insecure attachment, which, in turn, increases the risk for adult psychopathology (Bifulco et al., 2006; Tereno et al., 2008).

Summary

Empirical studies that were cited in the above four sections clearly support the pertinence of adult attachment styles in therapeutic relationships. Research that examined the impact of client attachment on the working alliance found client attachment to be a predictor of both working alliance and therapy outcome (Bachelor, Meunier, Laverdiere, & Gamache, 2010; Byrd et al., 2010; Eames & Roth, 2000; Meyer & Pilkonis, 2002). In accordance with AT, both clients' and therapists' mental representations of themselves and of attachment figures influence the process and outcome of psychotherapy, supporting Bowlby's (1988a) proposition that patterns of early life interactions between caregivers and children affect interpersonal behaviours and expectations in later life. As expected, the research findings point to the advantages of secure attachment. In these studies securely attached individuals tended to form stable and effective alliances with their therapists (Diener et al., 2009; Eames & Roth, 2000; Kanninen et al., 2000). Clients who formed secure attachments to their therapists tended to work more in agreement with their therapists regarding goals and tasks and engage more actively in therapy (Bachelor et al., 2010; Byrd et al., 2010; Mallinckrodt et al., 1995). It has been shown in various studies that

therapists' level of comfort in relationships, their fear of rejection and sensitivity to being criticised, also affect the way they respond to clients (Rubino et al., 2000). With regard to the link between negative early experiences and psychopathology, no causal conclusions can be drawn from the studies. It appears that failed parenting along with various forms of childhood maltreatment influence the individual's sense of trust and self-worth in relationships, and consequently, the development of insecure attachment, which, in turn, increases risk for psychopathology. Negative associations between parental upbringing and attachment and development of specific psychological disorders are in accordance with AT.

(d)- Development of the Research Questions

Aims of the Research

This study aimed at examining the associations among early attachment-related experiences, adult attachment styles and therapeutic alliance in counselling clients in primary care. Are recollections of childhood experiences with parents related to adult attachment styles, and are either these recollections or attachment styles related to the quality of the therapeutic alliance?

The Principal Research Objective

Adult attachment styles are thought to emerge in response to and reflect particular early experiences, as summarised by Meyer and Pilkonis (2002): 'people's comfort and confidence in close relationships, their fear of rejection and yearning for intimacy and their preference for self-sufficiency or interpersonal distance' (p. 367). The term 'attachment styles' has been invoked to refer to more or less stable individual differences in individuals' ways of experiencing and behaving in the context of current close relationships. Studies using self-report scales to measure individual differences in attachment support the idea that attachment styles developed in infancy tend to remain stable across the years (Diehl, Elnick, Bourbeau, & Labouvie-Vief, 1998; Fraley, 2002; Hazan &

Shaver, 1987). Longitudinal studies also provide support for the continuity of childhood attachment into adulthood (Hamilton, 2000; Lewis, Feiring, & Rosenthal, 2000; Toth et al., 2009; Waters et al., 2000; Weinfield, Whaley, & Egeland, 2004).

There are many ways of conceptualising individual differences in adult attachment, and the way such conceptualisations are formulated would most likely differ based on a theorist or practitioner's theoretical and practical orientation. For example, whereas, say, a psychodynamically oriented counselling psychologist might emphasise the role of unconscious conflicts and defence mechanisms in a given client pattern of interpersonal relatedness, a social psychologist, or cognitive behaviour therapist working within the theoretical framework of a quantitative approach, might be more interested in the descriptive questionnaire scores deduced from a client's self report with regard to his or her sense of intimacy versus distance from others. The research literature on adult attachment styles has been dominated by social and personality psychologists working within such quantitative theoretical framework. Although the limitations of this method are manifold-and are explicitly acknowledged here- this research was used as the basis for the methods employed in this study.

Several reliable questionnaires have been developed to measure individual differences in adult attachment styles (Brennan, Clark & Shaver, 1998). I attempted to use psychometrically sound measures to capture relevant aspects of adult attachment patterns in adulthood and of how these patterns are associated with the therapeutic relationship, and a novel questionnaire to capture relevant aspects of the early affective bond in parent-child relationships.

In this study, the therapeutic alliance, which is considered to be one of the greatest contributors for effective therapy (Dryden, 1984; Orlinsky, Grawe, & Parks, 1994; Wampold, 2001), is defined as a multi-dimensional concept, referring to the client's capacity to work purposefully in therapy, their affective bond with the therapist and agreement on the treatment goals and tasks (Gaston,

1990). It is measured by the Working Alliance Inventory, which is based on Bordin's model (Horvath & Greenberg, 1989). This is a pan-theoretical model that is well accepted and widely used and also has the advantage of being a reliable and valid measure. Research shows that clients with secure attachment styles are generally thought to form strong alliances than insecurely attached clients (Eames & Roth, 2000: Mallinckrodt et al., 1995).

Theory and research suggest that attachment styles, particularly secure attachment is associated with the quality of the therapeutic alliance and some research has already shown that patient attachment styles are associated with the quality of therapeutic alliance and with therapy outcome (Eames & Roth, 2000; Mallinckrodt et al., 1995; Mikulincer et al., 2004, 2007). The first research objective of the present study was to extend the research in this area by examining and potentially replicating previously observed associations between adult attachment and the therapeutic alliance. Specifically, it was expected that both anxious and avoidant adult attachment would be inversely related to all three facets of the therapeutic alliance, as captured by the Working Alliance Inventory.

Secondary Research Objective

The research also had a secondary objective, to examine the association between retrospective reports of childhood experiences and current self-reported attachment styles. Early experiences with parents have been thought to be one of the most important factors to affect the quality of adult attachments in close relationships and to influence the client's capacity to form a positive working alliance in therapy (Greenson, 1967; Hazan & Shaver, 1987; Mikulincer & Shaver, 2007; Simpson et al., 2007; Wallin, 2007). In fact, it is a basic tenet of AT that early experiences with attachment figures (usually parents) form the basis for adult attachment styles. Thus, the second research objective aimed to examined a core component of AT in a sample of clients undergoing psychotherapy.

Additional Research Objective: Examine the Validity of a Novel Questionnaire of Childhood Recollections

A separate aim was to investigate the validity of a novel 22-item questionnaire, the Childhood Experiences Survey (CES). This is the first study in which the CES was used. The rationale for using this previously unvalidated questionnaire was that, to my knowledge, at the time this study was conducted, no established, validated questionnaire had existed that focused specifically on those aspects of childhood experiences that are theoretically thought to be differentially linked with anxious and avoidant attachment styles. CES was designed to capture the theoretically pertinent childhood antecedents of adult anxious attachment (i.e., inconsistent parenting recollections) and adult avoidant attachment (i.e., consistently negative/rejecting parenting recollections). Specifically, the CES includes items aiming to capture consistently unresponsive parenting, which is thought to facilitate avoidant attachment (example: "When I was a child it was quite clear to me that my parents did not care about me"). Additionally, it includes items aiming to capture inconsistently responsive parenting, which is thought to facilitate anxious attachment (example: "When I grew up, my parents were always unpredictable - I never quite knew what to expect next"). Further detail on the CES is provided in the Method and Result sections.

It was expected that different CES subscales could be empirically differentiated and would correlate with anxious and avoidant attachment in expected patterns, such that inconsistent/unpredictable parenting would be particularly strongly linked with anxious attachment, whereas cold/rejecting parenting would be particularly strongly linked with avoidant attachment. However, it seemed conceivable that the CES items might not empirically yield these expected subscales. Therefore, a preliminary research goal was to examine the factor structure of the CES. It was expected that this analysis would show that consistently unresponsive parenting and inconsistent parenting items could be differentiated.

Three sets of hypotheses were formulated:

(1) **Childhood recollections and adult attachment:** Anxious and avoidant attachment were hypothesized be correlated with negative childhood experiences (i.e., recollections of rejecting, cold, or unresponsive parenting). Both attachment anxiety and avoidance were expected to correlate directly (positively) with adverse childhood recollections and inversely with positive (e.g., caring parenting) recollections. Furthermore, it was expected that whereas anxious attachment would correlate with items or subscales reflecting inconsistently responsive parenting, avoidant attachment would correlate more strongly with items reflecting consistently unresponsive parenting recollections.

(2) **Attachment and therapeutic alliance**: It was hypothesised that both attachment anxiety and avoidance would be inversely correlated with the therapeutic alliance. Specifically, it was hypothesised that both attachment anxiety and avoidance would be inversely correlated with the goals, tasks and bond subscales of the WAI.

(3) **Childhood experiences, attachment and therapeutic alliance**: It was hypothesised that negative childhood recollections would correlate inversely with the quality of the therapeutic alliance (total WAI and all three subscales), and that this association would be mediated by adult attachment styles. That is, it was hypothesised that the relationship between childhood experience recollections and the alliance would be mediated by both attachment anxiety and avoidance.

2-Method

This section provides an explanation of the research design, research setting/s and participants, procedure and materials as well as the ethical issues that needed to be considered in this study.

Research design

The present study used a naturalistic, non-experimental design in which data were collected as part of routine counselling/psychotherapy treatment in primary care. It was conducted on clients in primary care who were referred for counselling/psychotherapy by their general practitioner to the practice-based psychologist.

(a) The initial research proposal (design)

Prior to the present study being carried out, another research design with the same objectives and hypotheses had been formulated. It had aimed to measure the therapeutic alliance early in therapy at two points, in the 1st and 5th sessions of the therapy process. The pilot study had commenced soon after the approval from the Ethics Committee was received and in three months only 4 out of 30 questionnaires had been received. Therefore, it became necessary to simplify the design without completely abandoning the basic scientific aims.

(b) Altered research design, the present study

The research design was revised and once the necessary amendments had been made, the research proposal was re-submitted for ethical approval from the organisations. Since there were no specific ethical issues relating to the amendments and no substantial changes had been made from the first approved protocol, the amended version was accepted within 2 months.

Ethical considerations

Due to this study being carried out in the NHS and with clients who were in routine psychological care, the clients' well-being was considered the top priority and any potential adverse effects, discomfort, distress or any inconvenience to them had to be considered in the design and data collection stages of the research. Before the study began, ethical approvals were sought from the NHS Central Office for Research Ethics Committees (COREC), South London Wandsworth PCT Research Ethics Committee and the City University Senate Research Ethics Committee (see Appendix 1). Detailed application forms regarding the objectives of the study, contributions to scientific knowledge, benefits and disadvantages to the participants, regulations about storing the data and codes of confidentiality and data protection were completed separately for each organisation.

Research setting/s and participants

The present study took place in 12 General Practices in Wandsworth, South London. Initially, 10 clients were to be recruited from 10 practices. Because it was not possible to recruit 10 clients from very small practices, two more practices were added to the study. A total of 100 adult primary care clients, aged between 21-68 (mean = 38.78, SD = 10.64), were recruited.

The inclusion/exclusion criteria for the present study were: (a) adult age (above 21), (b) currently either a client in counselling/therapy or being evaluated for suitability by their primary care physician, (c) no acute suicidality, (d) ability to complete questionnaires in English, (e) no severe organic diseases or severe mental disorders (e.g. schizophrenia) that would interfere with the participant's ability to complete the questionnaire. No additional constraints or inclusion/exclusion criteria were introduced because the goal of this study was to maximise external validity and generalisability to routine primary care settings. The project was given permission with minimum disruption to the normal functioning of the practice and, more importantly, of the counselling

process and the counselling relationship. Many therapists participated under the condition that data collection should be kept to a feasible minimum. Therefore, it was paramount not to interfere with the routine care process and not to select a small and potentially unrepresentative subset of therapy clients.

I had considered collecting additional information on the socio-demographic and clinical characteristics of the clients, such as symptom profiles, therapeutic process and outcome and style of treatment. However, in preliminary meetings with the staff of the participating general practices, it became clear that it would not have been possible to conduct this study in the given time frame, with the resources available, if such client data were to be collected. The majority of practitioners indicated clearly that they were only willing to participate if the burden to their clients were to be minimised and if no highly sensitive personal data were to be collected from their clients. The preliminary research protocol was repeatedly shared in informal discussions with the participating primary care practitioners, and the final questionnaire was developed in this process. In my opinion, although it would have enriched the research to gather additional socio-demographic and clinical data, there were also clear advantages to limiting data collection to only those key constructs that were specified in the hypotheses. This 'narrow approach' to data collection minimised participant burden and was, thus, considered as advantageous from an ethical standpoint (Bifulco, 2002; Patel, Doku, & Tennakoon, 2003).

Reflecting the typical profile of psychologists/counsellors in primary care in Wandsworth, approximately 90% of the therapists in this study were counselling psychologists and of these, 60% had chartered status and several years of clinical experience in primary care settings. The psychologists'/counsellors' contribution in this study has been about helping the general practitioners to familiarise themselves with the study and informing their clients at the end of their therapy session about the research being conducted in the practice. Counsellors/psychologists were advised to take into account their clients' vulnerable state before informing them about the research (see Appendix 1).

Procedure

Usual Referral System for Psychological Therapies in Primary Care

The referral procedure for psychological therapies in primary care goes through the general practitioner. Self-referring clients see their general practitioner and the general practitioner refers them to the practice-based psychologist. At other times, the general practitioner may recommend that the client see the psychologist and refers them on to the practice based psychologist for an assessment. In either case, the general practitioner who does the referring does the initial screening of clients' suitability for psychological treatment in primary care.

The majority of the clients receive counselling/therapy from the same psychologist who had assessed them. The counsellor/psychologist provides an in-depth assessment to decide on the type and length of therapy that will be provided for the client. Generally, only the clients who have mild to moderate psychological problems are referred for psychological therapies in primary care, although this has been changed to include moderate to severe anxiety and depression, Post Traumatic Stress Disorder and Obsessive Compulsive Disorder, as stated by the National Institute of Clinical Excellence guidelines (NICE, 2008).

(a) Preparatory stage for recruitment of participants

Each of the 12 practices was informed of the study and its methodology and procedure through staff meetings and seminars held by the researcher. Ten psychologists/counsellors from the Psychology Department were invited to take part in the study and to disseminate information to the general practitioners in their own practices. The researcher visited each general practice with the practice psychologist/counsellor to inform them of the study and discuss the procedure and confidentiality issues of the study.

A timetable for each practice was devised. An approximate starting date had to be agreed in advance for each practice because the researcher had to be present

in the practice to conduct the project personally. As soon as 10 clients from one practice were recruited, the general practitioners, psychologists and staff were notified of the end of the data collection in that practice. Then, the investigator moved to the next practice to recruit 10 more clients, and this procedure continued until 100 participants were recruited from 12 general practices.

(b) Recruitment of participants

The first step involved informing the counselling clients about the study. The general practitioner as well as the psychologist in the practice informed each potential client that might participate in the study. Clients were told that a study on relationships, involving attachment styles and childhood experiences was being conducted in their practice, and that it was open to all counselling clients (see Appendix 1 for the brief script). If a client was interested, their counsellor/psychologist directed them to the reception area of the practice where the researcher was present to talk to the interested volunteer and give out the invitation letter and research pack which included the questionnaires.

Research packs contained (see Appendix 1): The invitation letter, the information sheet, the consent form, the three questionnaires (including the Childhood Experiences Survey, Experiences in Close relationships, and Working Alliance Inventory), and the client contact details which included their age, gender, number of therapy sessions and the name of the practice.

The second step involved the client's actual participation in the study. The clients who were interested and willing to participate were taken into a nearby room, made comfortable and given a seat. I made sure that they were not too tired after their counselling session and that they were generally feeling well enough to consider participating in the study. I read the invitation letter together with them, talked to them about the research, answered their questions, reiterated the anonymity and asked them for a second time if they would like to complete the questionnaires. Most clients completed the three questionnaires in the room of the practice after their therapy session. Some took the research pack with

them and brought the completed questionnaires and client details in a sealed envelope to the next session, which usually was the following week. If it was their last counselling session and they were too tired to complete the questionnaires in the practice, they could take the research pack with them and post the completed forms back to me in a stamped and addressed envelope.

The clients' subjective responses to completing the questionnaires were generally quite positive. Many participants appeared to find them interesting, and quite a few said they were longer than expected. A few were inclined to talk about their memories of childhood while completing the questionnaires. A number of participants found the Childhood Experiences Survey (CES) so interesting that they tried to draw me into an interaction by asking my opinion on the items they were unable to decide.

In terms of the Data Protection Act 1998, confidentiality was fully observed. The identity of clients involved in the study has not been disclosed to their general practitioner or to their psychologist. There were no reports of inconvenience or harm to clients, therapists or practice managers including the staff.

Sample size

To estimate an appropriate sample size, a statistical power analysis was employed to ensure that the study would detect an effect that is actually present (Cohen, 1988). Many studies in counselling psychology have not been statistically powerful enough and may have overlooked the predicted presence of important effects (Cohen, 1992). The power analysis was calculated in consultation with my supervisor, Dr. B. Meyer, of City University, London.

The sample size of 100 clients was estimated to provide sufficient statistical power (i.e. power of at least 0.80) to detect clinically meaningful effects between adult attachment styles and the therapeutic alliance. That is, with an estimated effect size of r (Pearson's correlation) of .30 (which constitutes a medium effect; (Hemphill, 2003)) and alpha set at .05 (two-tailed), a sample size of 100 would

yield statistical power of .86, which is conventionally regarded as excellent (Cohen & Cohen, 1983).

Materials

Three questionnaires were used in the study and these are described in detail below.

(1) The Working Alliance Inventory (WAI)

WAI was chosen because it appeared to capture the essence of the construct of theoretical interest – the quality of the therapeutic alliance – and because it is a well-validated instrument and perhaps the most widely used in international research. The WAI was developed by Horvath and Greenberg (Horvath & Greenberg, 1989, 1995). Martin and colleagues (2000) cited Horvath and Greenberg's aim as 'Their goal in creating a new alliance scale was three fold: they wanted to measure alliance factors in all types of therapy, to document the relation between the alliance measure, and to connect the alliance measure to a general theory of therapeutic change (1994)' (p.440). Tracey and Kokotovic (1989) developed a shorter version of WAI, and this version was used in the present study. The three dimensions of the therapeutic alliance measured in the scale are:

- Bond-the emotional bond of trust and attachment between client and therapist
- Goals- the degree of agreement concerning the overall goals of treatment
- Tasks- the degree of agreement concerning the tasks in achieving the goals

Horvath and Greenberg (1989) described these three aspects of the working alliance between a client and a therapist as common to all clinical practices. Therefore, this measurement can be used to evaluate the therapeutic process regardless of theory or techniques. With regard to the reliability and validity of

the WAI, Martin and colleagues (2000) cited that 'Research has shown strong support for the reliability of the WAI scales and some support for its validity (see Horvath, 1994, for a review). For example, Horvath and Greenberg (1989) found that the WAI's reliability ranged from r= .85 to r= .93 and that the scale correlated with a variety of outcome indices' (p.440). This measurement is a 12 item self-report instrument that uses a 7-point Likert rating scale (1=never, 7=always), to yield both an overall score for alliance quality and three sub-scale scores. Individual items are summed for a total score.

(2) Experience in Close Relationships (ECR)

For this study, ECR is chosen over the other attachment measurements because this instrument is now generally considered a more refined measure of attachment styles, anxiety and avoidance dimensions as continuous measures. The ECR was developed by Brennan and colleagues (1998), and it is one of the most recent, most thoroughly validated and sophisticated versions of the first measurement of adult attachment patterns in the context of romantic relationships (Hazan & Shaver, 1987).

Several self-report scales of romantic attachment have been developed over the last 25 years. The original Hazan and Shaver (1987) measure of romantic attachment was a brief, multi sentence description of three attachment styles: the secure, avoidant and ambivalent styles which were based on Ainsworth and colleagues' classification of attachment patterns (Ainsworth et al., 1978). Bartholomew and Horowitz (1991) expanded Hazan and Shaver's (1987) three-category attachment classification model, proposing a four-category attachment classification on two attachment dimensions, anxious and avoidant.

Figure 2.
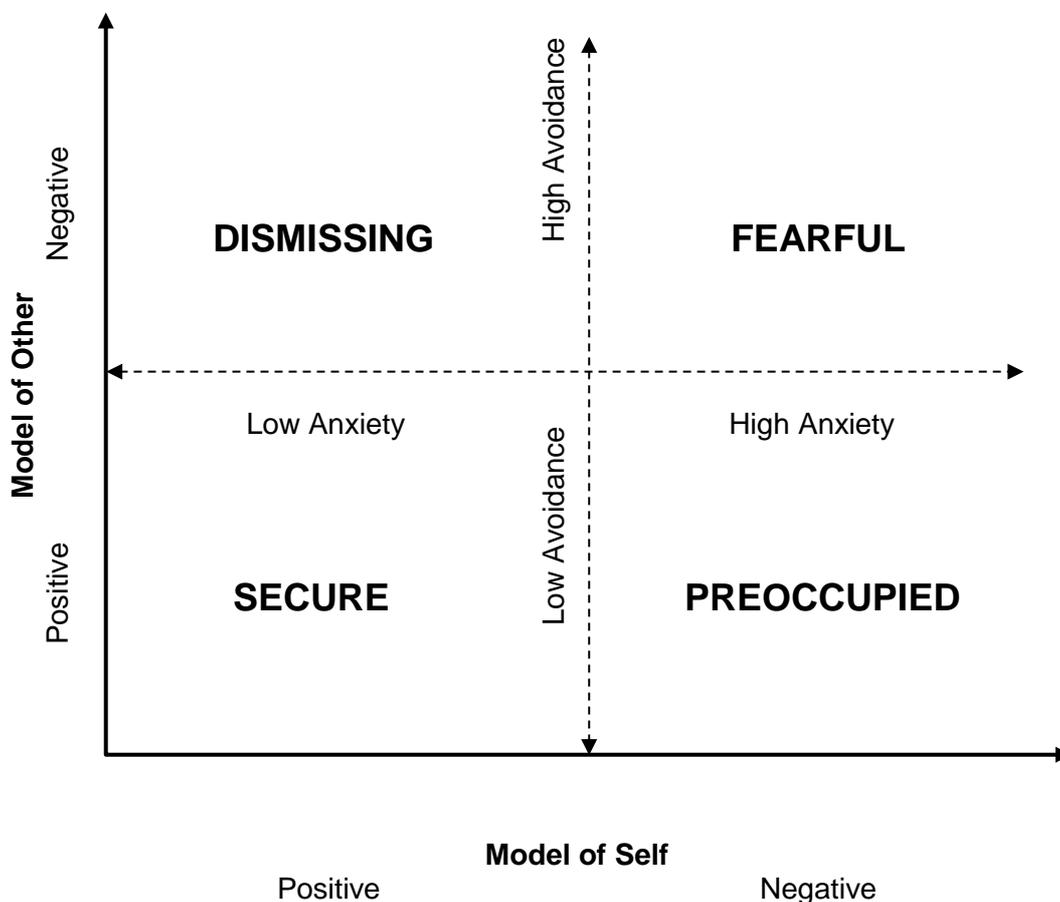
Two-dimentional model of adult attachment styles
    Bartholomew and Horowitz (1991)

The four-category attachment model (Fig. 1) which was developed by Bartholomew and Horowitz (1991) was reframed by Brennan and colleagues in 1998, and conceptualised the attachment avoidance and attachment anxiety on a two dimensional space (Brennan et al., 1998). The new scale was developed from surveys conducted on large number of undergraduates, and from their responses 300 items were drawn to be factor-analysed. Factor analysis identified two dimensions consisting of 18 items each. The Anxiety subscale represents

fears of being abandoned by one's partner, and the Avoidance subscale represents fears of intimacy and emotional closeness.

It is also possible to examine attachment styles as categorical rather than dimensional variables. Brennan and colleagues (1998), provided an algorithm, based on cluster analyses, to assign participants to one of four attachment categories (secure, preoccupied, fearful, and dismissing), based on their ECR scores. Yet another way is to group attachment types by simply assigning participants to quadrants depending on whether they scored above or below the logical midpoint on the two attachment dimensions (i.e. high avoidant attachment = score above 4 on a 1 to 7 scale; low anxious attachment = score below 4 on a 1 to 7 scale, etc.). This simplified procedure has been described and applied by Meyer and Pilkonis (2002) and has been used in this study as part of the subsidiary analysis of the data.

The ECR-R is a 36 item self-report measure and has a 7-point Likert-type rating scale (1=disagree strongly, 4=neutral/mixed, 7= agree strongly). On the questionnaire, 18 items depict the anxiety and the other 18 depict avoidant attachment styles. Respondents are instructed to complete the questionnaire in terms of their opinions about romantic relationships in general, not how a particular relationship is experienced at the moment. Brennan and colleagues (1998) reported internal reliability (coefficient alpha) of .91 and .94, respectively, for the Anxiety and Avoidance subscales. Brennan, Shaver, and Clark (2000) reported retest reliabilities (3-week interval) of .70 for both subscales.

Some sample items from ECR are:
11. I want to get close to my partner, but I keep pulling back.

    Disagree strongly   Neutral/Mixed   Agree strongly

    1   2   3   4   5   6   7

32. I get frustrated if romantic partners are not available when I need them.

    Disagree strongly   Neutral/Mixed   Agree strongly

    1   2   3   4   5   6   7

(3) Childhood Experiences Survey

Childhood Experiences Survey was developed by Dr. B. Meyer and designed to capture the theoretically pertinent childhood antecedents of adult anxious attachment (i.e., inconsistent parenting recollections) and adult avoidant attachment (i.e., consistently negative/rejecting parenting recollections). There is evidence that inconsistent or unpredictable parenting might be linked specifically with anxious attachment, whereas unresponsive or rejecting parenting might be linked specifically with avoidant attachment (for an overview, see Carver & Scheier, 2008). Specifically, the CES includes items aiming to capture consistently unresponsive parenting, which is thought to facilitate avoidant attachment (example: "When I was a child it was quite clear to me that my parents did not care about me"). Additionally, it includes items aiming to capture inconsistently responsive parenting, which is thought to facilitate anxious attachment (example: "When I grew up, my parents were always unpredictable - I never quite knew what to expect next").

It is a 22-item questionnaire which uses a 5-point Likert rating scale (1= very false for me, 5= very true for me). Scoring yields a total for each sub scale: responsive (secure) parenting, inconsistent parenting, rejecting parenting, fear-inducing parenting, and overprotective parenting.

Some sample items from CES:

7. My parents made me feel fearful of them when I was growing up.

9. When I was a child it was quite clear to me that my parents did not care about me.

17. When I grew up, my parents were always unpredictable- I never quite knew what to expect next.

(4) Exploratory factor analysis of the validity of Childhood Experiences Survey:

An exploratory factor analysis (specifically, a principal components analysis [PCA]) was computed to examine the factor structure of the CES. Based on the results of this analysis, two scales were constructed that resulted in two CES-subscales: (1) "rejection experiences" (15 items, Cronbach's alpha = .96) and (2) "safety experiences" (5 items, Cronbach's alpha = .82). These will be discussed in the Results section.

Data Analysis

Descriptive statistics were calculated to determine the mean and standard deviation for each scale and subscale as well as age, gender and number of therapy sessions. Pearson correlation analyses were used to test the hypotheses.

The correlational approach was chosen because this provides a straightforward index of the strength of association among the variables assessed in this study. Correlational methods are regarded as classics in counselling and psychotherapy research and, as described by Cronbach (1957) more than 50 years ago, can be regarded as one of the major traditions within psychological research (Cronbach, 1957). Of course, a major limitation of correlational research is that this approach cannot yield any conclusions with regard to causality. That is, it was clear that it would not be possible to infer from a correlation between, say, childhood experience, attachment and the working alliance, which of these variables 'caused' which other one. However, also described in Cronbach's classic article, it is not always possible or appropriate to use experimental methods (with random assignment to conditions) when investigating real-world clinical phenomena. In this case, one is interested in studying the direction and magnitude of associations among naturally occurring phenomena, the correlational approach was deemed to be the appropriate choice.

Correlations were calculated to measure the association among variables: (a) the childhood experiences variables (b) the attachment style variables and (c) the working alliance variables, with their respective subscales. It was estimated for

the purpose of formulating hypotheses, that strong correlations would have a magnitude of .30, and very strong correlations would have a magnitude of .50 (see Cohen, 1992). Correlations were conducted among the empirically derived subscales and the theory-guided subscales of the CES.

Additional partial correlation analyses were conducted to examine whether the associations among the CES and WAI scales might be influenced by number of sessions and gender. There were two control variables.

Control Variables

   (a) Number of sessions

The number of sessions was used as a statistical control variable in the hypotheses tests because session number might systematically influence client self-report ratings. Therefore, session number might function as a confound variable, which justifies its use as a control variable. Specifically, clients' ratings of the working alliance – but also of childhood recollections and attachment styles – might conceivably differ based on their stage or progress in therapy. As therapy progresses, for example, they might develop better alliances, recall more positive childhood memories, or describe their attachment style as less anxious and less avoidant. Indeed, previous research suggests that attachment styles might shift from less secure to more secure over the course of therapy (Taylor, Rietzschel, Danquah, & Berry, 2015; Travis, Bliwise, Binder, & Horne-Moyer, 2001). Similarly, systematic changes in the alliance over the course of therapy have been reported; for some clients, the alliance stays stable, whereas for others, it increases linearly, shows a U-shaped pattern, or is repeatedly ruptured and then repaired, for example (Kramer, de Roten, Beretta, Michel, & Despland, 2009; Stiles & Goldsmith, 2010). As reported in the Results sections, number of sessions was therefore used as a control variable in hierarchical regression analyses and in partial correlation analyses.

   (b) Gender

In the present study, the sample is made up of 81 females and 19 males, predominantly a female sample. Studies that explore the link between gender

disparities and mental health, including depression, eating disorders, anxiety, and attachment styles and romantic relationships (Feeney et al., 1993; Simpson, 1990) (McCarthy et al., 2012; Trioisi, Massaroni, Cuzzolaro, 2005) show that anxious attachment is over represented among females. Women with eating disorders have a higher frequency of separation anxiety symptoms in childhood and a higher prevalence of insecure styles of adult attachment (Trioisi et al., 2005) compared to males. High levels of female attachment anxiety predicted high levels of male-perpetrated verbal and physical violence (Pearson et al., 2006). Attachment anxiety is found to be associated with depression-negative models of self, beliefs of self as unlovable (Shaver, 2005). The study that explored the influence of attachment style and gender in adolescents' interactions with the opposite sex showed that (Feeney et al., 1993) attachment style and gender role expectations jointly influence relationship development. Because the majority of the sample was female, anxious attachment might have been overrepresented in the sample, the results might have been affected by this issue, therefore, it was necessary to statistically control gender to be able to measure its effects on the independent variable.

Regression analyses were conducted to examine whether parenting recollections would be associated with adult attachment even when controlling for potential confounds, such as the number of therapy sessions and gender.

Results

In total 100 questionnaires were completed. These were made up of 81 females and 19 males. The raw data for the Childhood Experiences Survey (CES), Experience in Close Relationships (ECR) and Working Alliance Inventory (WAI) were put onto a data entry sheet and entered into a database of SPSS.

Preliminary Analysis: Structure of the CES

An exploratory factor analysis (specifically, a principal components analysis [PCA]) was computed to examine the factor structure of the CES. This procedure has been recommended as an appropriate factor-analytic approach "as an initial step" when the goal is to reduce the number of variables to a smaller number of components and learn about the number and nature of factors within a new questionnaire (Tabachnik & Fidell, 2001, p. 612). Varimax rotation (an orthogonal rotation) was used as this is "recommended as a default option" (Tabachnik & Fidell, 2001, p. 615), minimizes the complexity of the factors, and facilitates the interpretability of the findings.

Using the established Eigenvalue > 1 criterion along with the inspection of the Scree-plot to select the number of components, three components were extracted, which explained a total 66.91% of the CES variance. The Scree-plot (Figure 3) is shown below. Inspection of the item loadings suggested that two (not three) factors could be interpreted and formed into meaningful subscales.
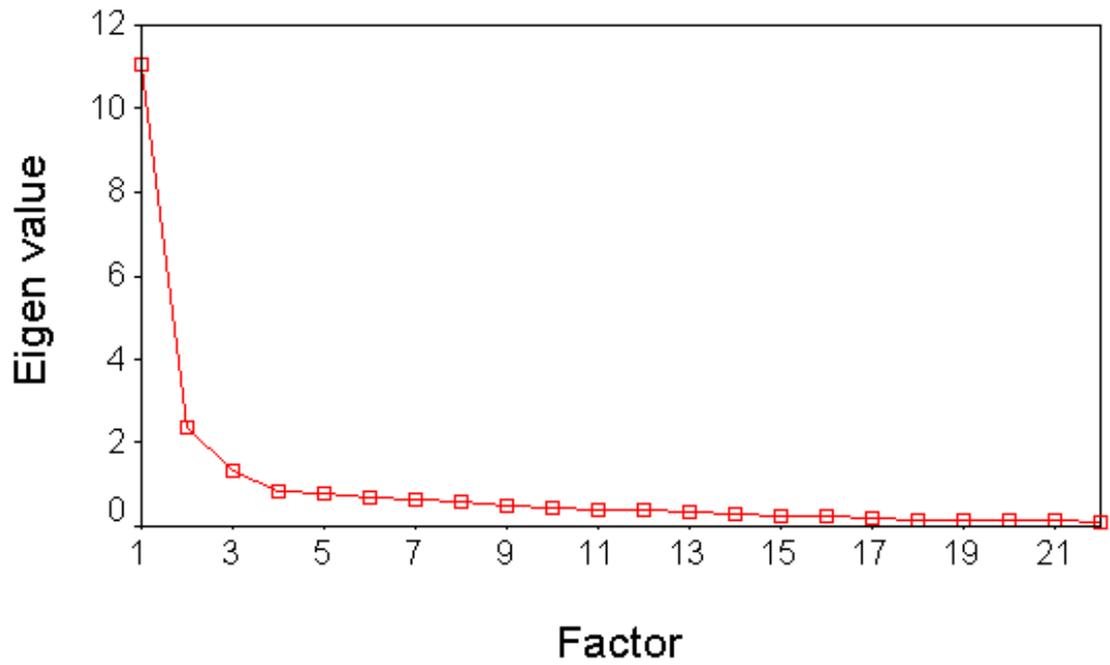
Scree-plot of the CES

The results from this analysis (rotated item loadings) are shown in the Table below.

Table: Principal Components Analysis of the CES, rotated component matrix (and theory-guided item codes)

CES item	PCA Component and Label			Theory-guided subscale (not PCA)
	Rejection experiences	Safety experiences	*(Not interpretable)*	
21. My parents were generally more interested in things and people other than me.	**.85**	-.21	-.11	Cold/ rejecting
19. I used to feel a sense of dread or fright of my parents when I was a child.	**.84**	-.06	.17	Fear-inducing
13. When I was growing up, I remember feeling quite anxious or worried when I had to be with my parents.	**.83**	-.22	.14	Fear-inducing
5. My parents treated me quite awfully when I was a child so I remember being scared of them.	**.80**	-.09	.27	Fear-inducing
15. During my childhood, I remember having to try very hard to win my parents' love and affection - it wasn't something I could take for granted.	**.80**	-.01	.11	Inconsistent
4. Growing up with my parents made me feel as if they were strangers who really did not care much about me.	**.80**	-.31	-.12	Cold/ rejecting
9. When I was a child it was quite clear to me that my parents did not care about me.	**.80**	-.37	-.10	Cold/ rejecting
11. My parents were rather indifferent to me - I'm not sure they really cared whether I existed or not.	**.79**	-.22	-.03	Cold/ rejecting
22. I grew up with a sense of being genuinely loved by my parents.	**-.78**	.37	.16	Secure
7. My parents made me feel fearful of them when I was growing up.	**.75**	-.01	.37	Fear-inducing
12. As a child it was hard for me to know whether my parents really loved me or not.	**.74**	-.33	-.02	Inconsistent
6. I knew I could count on my parents whenever I had a problem as a child.	**-.70**	.46	.13	Secure
1. My parents were always there for me when I needed them.	**-.69**	.42	.24	Secure
17. When I grew up, my parents were always unpredictable - I never quite knew what to expect next.	**.67**	-.20	-.09	Inconsistent
16. I felt secure with my parents - there was no doubt that they loved me deeply and would do anything in case I really needed it.	**-.61**	.45	.10	Secure
10. My parents often made me feel as if I'm safe and protected with them but that the world outside is a harsh and hostile place.	.01	**.80**	-.11	Over-protective
3. I felt comfortable and cosy with my parents, but I also picked up the idea that venturing out into the world could be dangerous and unpleasant.	-.12	**.78**	.04	Over-protective
8. During my childhood, I loved to return to the comfort and safety of my family in order to get away from the harsh outside reality.	-.21	**.74**	-.07	Over-protective
14. When I was growing up, I felt very comfortable at home but I also learned that strangers should be treated with caution.	-.45	**.64**	-.05	Over-protective
20. My parents made me feel loved but they also may have "overprotected" me a bit.	-.26	**.58**	-.09	Over-protective
18. In my childhood, there was often a sense that people outside of my close family couldn't be trusted or were somehow "enemies."	.23	.30	**-.74**	Over-protective
2. My parents were sometimes very nice to me but there were other times when they were quite awful.	.51	.08	**.58**	Inconsistent

Based on the results of this analysis, two scales were constructed by computing the means of the items shown in the table above (after reverse-scoring items with negative loadings). This resulted in two CES-subscales: (1) "rejection experiences" (15 items, Cronbach's alpha = .96) and (2) "safety experiences" (5 items, Cronbach's alpha = .82). Scoring high on "rejection experiences" indicates that clients remember their parents as cold and rejecting, fearing their parents, feeling unloved, and feeling unsure as a child of whether one was loved or not. Scoring high on "safety experiences", by contrast, indicates that clients remember their parents as providing safety, comfort and protection from the potentially dangerous world. These two scales were inversely correlated ($r = -.55$, $p < .001$), as one would expect: Those with more negative, rejecting recollections tended to be less likely to recall their parents as providing a safe haven from a potentially hostile environment.

Advantages of these empirically derived subscales are their clear interpretability, high internal consistency, and the fact they are based on the actual data collected in this study. However, these advantages are balanced by the disadvantage that they do not conform well to the theoretically expected subscale structure, particularly with regard to the differences between inconsistent parenting (a potentially unique correlate of attachment anxiety) and consistently rejecting parenting (a potentially unique correlate of attachment avoidance). Given this concern, subsequent analyses were conducted with both the new empirically derived subscales and theory-guided subscales.

The Table below shows the correlations between the empirically derived subscales and the theory-guided subscales of the CES.

Table 6: Theoretically expected and empirically derived subscales of CES

Theoretically expected subscales	Empirically derived subscales (PCA)	
	Rejection experiences	Safety experiences
Secure and loving parenting (4 items)	-.92	.63
Inconsistent/unpredictable parenting (4 items)	.86	-.39
Cold/rejecting parenting (4 items)	.95	-.51
Fear-inducing parenting (4 items)	.88	-.40
Overprotective parenting (6 items)	-.49	.97

Note: All correlation coefficients are significant at the *p* < .01 level.

As shown in the Table 6 above, the "rejection experiences" subscale was strongly correlated with the theory-guided subscales indicating unloving, cold, and fear-inducing parenting, and less strongly and inversely correlated with "overprotective parenting". The "safety experiences" subscale, by contrast, is strongly liked (and indeed, almost equal with) the "overprotective parenting" subscale. Scoring high on this scale tends to indicate that parents were remembered as generally caring but also as conveying the message that "the outside world is harsh and dangerous place" from which protection is needed.

Descriptive Statistics

Descriptive statistics for the major variables are shown in Table 7

	Mean (SD)	Range	Cronbach's alpha
Childhood Experiences Survey (CES Subscales)			
Empirically derived subscales (PCA)			
Rejection experiences	2.28 (1.13)	1-4.87	.96
Safety experiences	3.01 (1.03)	1-5	.82
Theoretically expected subscales			
Secure and loving parenting (4 items)	3.56 (1.26)	1-5	.90
Inconsistent and unpredictable parenting (4 items)	2.57 (1.15)	1-5	.77
Cold and rejecting parenting (4 items)	2.07 (1.21)	1-5	.92
Fear-inducing parenting (4 items)	2.17 (1.23)	1-5	.91
Overprotective parenting (6 items)	2.92 (.92)	1-5	.77
Adult Attachment Styles (ECR Subscales)			
Anxious Attachment (18 items)	4.35 (1.18)	1-7	.91
Avoidant Attachment (18 items)	3.40 (1.18)	1-7	.92
Working Alliance (WAI Subscales)			
Total alliance (12 items)	5.69 (.95)	1-7	.93
WAI bond (4 items)	5.56 (1.05)	1-7	.85
WAI tasks (4 items)	5.76 (1.02)	1-7	.88
WAI goals (4 items)	5.77 (1.08)	1-7	.83

As shown in Table 7, all scales and subscales used in this study had acceptable (Cronbach's alpha > .70) or even excellent (alpha > .90) levels of internal

consistency reliability. The alpha values of all the scales and subscales were more than .77, generally considered as good and most of the alpha values were found to be around .90, generally considered as excellent.

Table 7 also shows that the clients in this study reported neither extremely positive nor extremely negative childhood experiences, on average. The midpoint of the childhood experiences scale was 2.50. The mean of the rejection experiences subscales was below this midpoint (2.28), indicating that, on average, participants did not strongly endorse having experienced rejection; the mean of the safety experiences subscale, by contrast, was above the midpoint (3.01), suggesting that such experiences were more common, on average. In fact, this mean difference was statistically significant, paired-t (99) = 3.85, $p < .001$.

Looking at the theory-based CES subscales, the mean score for loving and secure parenting was 3.56, inconsistent and unpredictable parenting was 2.57, cold and rejecting parenting was 2.07, fear-inducing parenting 2.17, overprotective parenting was 2.92. Given that the range was 1-5, a mean of 3.56 seems to indicate that, on average, clients tended to slightly agree with having experienced loving and secure parenting; however, as the mean is near the scale midpoint, it also shows that they did not universally endorse secure/loving parenting recollections, nor did they universally endorse the opposite.

When scores were compared on anxious and avoidant dimensions, clients on average, tended to endorse higher anxious rather than avoidant attachment. This difference was, in fact, statistically significant, paired-t (99) = 6.46, $p < .001$.

The descriptive statistics for the WAI subscales show that clients, on average, were quite satisfied with the quality of the therapeutic alliance. The mean for the total alliance was 5.69 (the range was 1-7), which is well above average. It indicated that clients felt that they had established a good relationship with their therapists to be able to work collaboratively. The mean for the working alliance bond subscale was 5.56, for the task subscale was 5.76 and for the goal subscale was 5.77.

Hypotheses Tests: (1) Childhood recollections and adult attachment

a.   Correlation Analyses

To test the first set of hypotheses, which concerned the associations among childhood recollections and adult attachment styles, Pearson correlation coefficients were computed among the CES subscales (both empirically derived and theoretically postulated) and the two attachment ECR-R scales. The results are shown in the Table 8.

Table 8: Correlations among Attachment Styles (ECR-R) and Childhood Experiences (CES)

	Attachment dimensions (ECR-R Subscales)	
	Anxiety	Avoidance
Empirically derived CES subscales		
Rejection experiences	.17	.38**
Safety experiences	.08	-.18
Theoretically postulated CES subscales		
Secure/loving parenting	-.14	-.36**
Inconsistent/unpredictable parenting	.15	.38**
Consistently cold/rejecting parenting	.13	.25*
Fear-inducing parenting	.18	-.13
Overprotective parenting	.12	.36**

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

As shown in the Table 8, avoidant attachment style but not anxious attachment style was significantly and moderately strongly associated with rejection experiences, as measured by the CES. There was no support for the hypothesis that anxious attachment would be correlated with parenting recollections. Furthermore, avoidant attachment style did not correlate significantly with the second CES subscale, safety experiences.

These correlation analyses did not support the hypothesis that the anxiety and avoidance subscales of the ECR-R would correlate differentially with different aspects of childhood recollections, such as inconsistent parenting versus consistently rejecting parenting. In fact, contrary to expectations, the avoidant attachment subscale correlated more strongly with the theoretically derived "inconsistent/unpredictable" CES subscale (r = .38) than with the "consistently

cold/rejecting" subscale (r = .25). Given that the factor analysis of the CES did not support these subscale distinctions, though, the interpretability of these patterns is questionable. A relatively clear conclusion from these analyses is, nevertheless, that recalling one's parents as rather rejecting tended to go along with more pronounced avoidant adult attachment tendencies but not necessarily with more anxious attachment tendencies. Thus, the first set of hypotheses, concerning the associations between childhood recollections and adult attachment styles, received partial support.

b. Regression Analyses

I also computed regression analyses to examine whether parenting recollections would be associated with adult attachment even when controlling for potential confounds, such as the number of therapy sessions and gender.

Two hierarchical, linear multiple regression analysis were conducted: One in which ECR-R attachment avoidance served as the dependent variable, and one in which attachment anxiety served as the dependent variable. In a first step of the regression, the variables session number and gender were entered as a set. In a second step, the variables rejection experiences and safety experiences (that is, the two empirically derived CES subscales) were entered as a set.

In the first of these two analyses, session number and gender did not predict avoidant attachment, $F(2,97) = .50$, $p = .61$. However, rejection experiences and safety experiences together predicted avoidant attachment, F-change $(2, 95) = 7.97$, $p < .01$, R^2-change = .14. Inspection of the regression coefficients showed that, in the final model, only the effect of rejection experiences on attachment avoidance was uniquely significant, $\beta = .41$, $p < .01$. The effect of safety experiences on attachment avoidance was not significant in the final model, $\beta = .05$, $p = .67$.

In the second of these regression analyses, session number and gender did not predict anxious attachment, $F(2,97) = .51$, $p = .60$. However, rejection

experiences and safety experiences together predicted attachment anxiety, F-change $(2, 95) = 3.68$, $p < .03$, R^2-change $= .07$. Inspection of the regression coefficients showed that, in the final model, the effect of rejection experiences on attachment anxiety was significant, $\beta = .31$, $p < .02$, and the effect of safety experiences on attachment anxiety was also significant, $\beta = .24$, $p < .05$.

This latter effect was surprising because *more pronounced* safety experiences were weakly and positively associated with attachment anxiety (when controlling for sessions, gender, and rejection experiences), whereas it might seem intuitively more plausible that recalling *fewer* safety experiences would be linked with attachment anxiety.

Hypotheses Tests: (2) Attachment and therapeutic alliance

a.   Correlation Analyses

To test the second set of hypotheses, which concerned the associations among attachment and the therapeutic alliance, another set of Pearson correlation coefficients was computed.

Table 9 : Correlations among Attachment Styles (ECR-R) and Therapeutic Alliance (WAI)

	Attachment dimensions (ECR-R Subscales)	
	Anxiety	Avoidance
WAI Total Scale	-.13	-.22*
WAI bond subscale	-.10	-.13
WAI tasks subscale	-.10	-.18
WAI goals subscale	-.14	-.29**

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

These analyses showed that attachment avoidance correlated significantly and inversely (moderately strongly) with the therapeutic alliance. Additionally, analyses of the subscales showed that attachment avoidance correlated significantly with the goals subscale but the bond or tasks subscales of the WAI.

b.   Regression Analyses

To test whether these associations would remain significant even when controlling for potential confounds, two hierarchical, linear multiple regression analyses were conducted. Following the logic of the analyses described above (testing the first set of hypotheses), the ECR-R attachment avoidance and anxiety subscales served as dependent variables in these two analyses, respectively. In a first step, session number, and gender were entered as a set of predictors. In a second step, the WAI subscales were entered together as a set of predictors.

In the first of these two analyses, session number and gender again did not predict avoidant attachment, $F (2,97) = .50$, $p = .62$. The WAI subscales together predicted avoidant attachment, F-change $(3, 94) = 3.95$, $p < .02$, R^2-change $= .11$. Inspection of the regression coefficients showed that, in the final model, only the effect of the WAI goals subscale on attachment avoidance was uniquely significant, $\beta = -.46$, $p < .01$. The effects of the other WAI subscales as well as session and gender were not significant in the final model (all $p > .20$).

In the second of these analyses, session number and gender again did not predict attachment anxiety, $F (2,97) = .51$, $p = .61$. Furthermore, the set of WAI subscales did not predict attachment anxiety when entered in Step 2, F-change $(3, 94) = .46$, $p = .71$, R^2-change $= .01$. Inspection of the regression coefficients showed that, in the final model, none of the predictor variables were significantly associated with attachment anxiety.

In summary, these analyses provided partial support for the second set of hypotheses, which concerned the associations among adult attachment and the therapeutic alliance. Evidence suggested that only one of the two attachment dimensions – avoidance – was associated with the alliance, and specifically only with one aspect of the alliance: agreement on therapeutic goals. That is, clients with more pronounced avoidant attachment styles tended to agree less with their therapists' goals, and this association could not be accounted for by differences in session number or gender.

Hypotheses Tests: (3) Childhood experiences, attachment and therapeutic alliance

The analyses reported above yielded several significant associations. Specifically, rejection experiences appeared to be associated with attachment avoidance, and attachment avoidance, in turn, was associated with the goals subscale of the therapeutic alliance. The third hypothesis postulated that the relationship between childhood recollections and the therapeutic alliance would be mediated by adult attachment.

In order to test this hypothesis, a first necessary step was to demonstrate that there was, in fact, a significant association between childhood recollections and the therapeutic alliance (which might or might not be mediated by adult attachment styles). Therefore, correlation coefficients were computed between the CES and WAI scales (see Table).

Table 10: Correlations among Childhood Experiences (CES) and Therapeutic Alliance (WAI)

	Therapeutic Alliance (WAI)			
		WAI Subscales		
	Total WAI	Bond	Tasks	Goals
Empirically derived CES subscales				
Rejection experiences	-.06	.02	-.11	-.08
Safety experiences	.06	.06	.02	.08
Theoretically postulated CES subscales				
Secure/loving parenting	.09	.05	.12	.09
Inconsistent/unpredictable parenting	-.13	-.04	-.19	-.13
Consistently cold/rejecting parenting	-.06	.00	-.10	-.07
Fear-inducing parenting	.03	.14	-.04	-.01
Overprotective parenting	.05	.07	.01	.05

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

These analyses showed that childhood recollections neither correlated significantly with any of the WAI subscales nor with the total WAI scale. Therefore, the hypothesis that childhood recollections would be associated with

the quality of the therapeutic alliance, and that this putative association would be mediated by adult attachment styles, received no support.

Additional partial correlation analyses were conducted to examine whether the associations among the CES and WAI scales might be influenced by number of sessions and gender. Again, none of the correlations attained statistical significance (see Table 10). Therefore, it can be concluded that childhood recollections were not associated with the quality of the therapeutic alliance, regardless of whether number of sessions and gender were used as statistical control variables or not.

Table 11: Partial Correlations among Childhood Experiences (CES) and Therapeutic Alliance (WAI), simultaneously controlling for number of sessions and gender

| | Therapeutic Alliance (WAI) | | | |
| | | WAI Subscales | | |
	Total WAI	Bond	Tasks	Goals
Empirically derived CES subscales				
Rejection experiences	-.08	.01	-.13	-.11
Safety experiences	.09	.07	.04	.12
Theoretically postulated CES subscales				
Secure/loving parenting	.11	.05	.12	.11
Inconsistent/unpredictable parenting	-.12	-.02	-.18	-.13
Consistently cold/rejecting parenting	-.09	-.01	-.12	-.11
Fear-inducing parenting	.02	.15	-.05	-.03
Overprotective parenting	.08	.09	.03	.09

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

To show graphically how childhood recollections, attachment styles, and the alliance were possibly linked with one another, a path model was drawn (see Figure 3). This path model shows that, if anything, the significant associations between rejection experiences and attachment avoidance, as well as between attachment avoidance and the alliance (particularly, the goals subscale), suggest an indirect relationship between certain aspects of childhood recollections and certain aspects of the alliance, but no mediation. That is, clients who recalled their early experiences as more rejecting tended to report more pronounced

attachment avoidance, and those with more such avoidant tendencies tended to form somewhat poorer alliances, especially with respect to agreeing on therapeutic goals. However, recalling rejection experiences did not necessarily indicate that the therapeutic alliance was either better or worse, given that this association was near zero and non-significant.
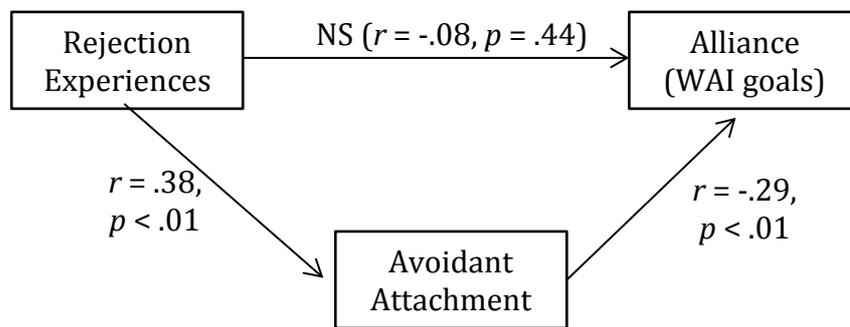
Figure 4: Indirect paths (no mediation) between childhood recollections, adult attachment, and the therapeutic alliance

Subsidiary Analyses

a. Differences in alliance, attachment styles and childhood recollections based on the number of therapy sessions completed.

Additional correlation analyses were conducted to test whether the number of sessions was associated with the therapeutic alliance or with other variables, such as attachment styles or childhood recollections. The results showed positive correlations between number of sessions and the total alliance ($r = .24$, $p < .05$), between sessions and WAI-tasks ($r = .22$, $p < .05$) and between sessions and WAI-goals ($r = .23$, $p < .05$). Thus, there was some evidence that clients developed better alliances as the therapy progressed over time. However, because of the cross-sectional design of the study, causal inferences with regard to the relationship between number of sessions and alliance quality cannot be drawn.

In order to test more directly whether clients in early, middle or late phases of therapy differed in terms of their alliance, attachment styles and childhood recollections, three groups of clients were constructed based on the number of therapy sessions they had completed. Specifically, 26 clients had completed only 1 or 2 sessions and were thus classified as 'early therapy clients'. Fifty-one clients had completed between 3 and 7 sessions and were thus classified as being in the middle phase of therapy. Finally, 23 clients had completed more than 7 sessions and were thus classified as being in the late phase of therapy. Table 12 shows the mean alliance scores, the mean attachment style scores and the mean childhood memory scores of these three groups, as well as the results of significance tests (one-way ANOVA) that examined whether the groups differed in terms of these variables.

The table (Table: 12) shows that none of these group comparisons reached significance at the alpha = .05 level. That is, clients in the early, middle and late phases of therapy did not appear to differ from one another with respect to the quality of the alliance, their attachment styles and their childhood recollections.

Table 12. Group comparisons: Early vs. middle vs. late therapy clients do not differ with respect to alliance, attachment styles and childhood recollections

	Early therapy (n = 26)	Mid-therapy (n = 51)	Late therapy (n = 23)	*F*-value* (2, 97)
Working Alliance (WAI Subscales)				
1. Total alliance (12 items)	5.54 (1.10)	5.61 (.88)	6.04 (.84)	2.15
2. WAI bond (4 items)	5.43 (1.13)	5.44 (.99)	5.97 (1.04)	2.30
3. WAI tasks (4 items)	5.63 (1.29)	5.68 (.91)	6.08 (.88)	1.48
4. WAI goals (4 items)	5.56 (1.25)	5.73 (1.06)	6.09 (.89)	1.55
Adult Attachment Styles (ECR Subscales)				
5. Anxious Attachment (18 items)	4.38 (1.17)	4.46 (1.17)	4.06 (1.19)	.96
6. Avoidant Attachment (18 items)	3.50 (1.21)	3.25 (1.13)	3.64 (1.27)	.98
Childhood Experiences Survey (CES Subscales)				
7. Secure and loving parenting (4 items)	3.94 (1.10)	3.35 (1.26)	3.61 (1.39)	1.96
8. Inconsistent and unpredictable parenting (4 items)	2.37 (1.24)	2.77 (1.03)	2.37 (1.28)	1.94
9. Cold and rejecting parenting (4 items)	1.72 (.88)	2.18 (1.22)	2.20 (1.46)	1.43
10. Fear-inducing parenting (4 items)	1.89 (1.18)	2.24 (1.21)	2.32 (1.31)	.89
11 Overprotective parenting (6 items)	3.26 (.79)	2.81 (.91)	2.79 (1.01)	2.42

* None of the F-values shown here were significant at the p < .05 level.

The cut-off points chosen were admittedly somewhat arbitrary and exploratory, which has now been acknowledged explicitly and further explored. Previous studies have often used the third session, for example, when the "early alliance" was measured (Despland, de Roten, Despars, Stigler, & Perry, 2001; Krupnick et

al., 1996; Principe, Marci, Glick, & Ablon, 2006). However, no such consensus seems to exist with regard to what constitutes "middle" or "late" sessions. Presumably, many psychotherapy studies would not consider sessions 8-12 to be "late" in the course of therapy, as was done here, simply because many therapies extend over a larger number of sessions. In this study, the classification into "early", "mid-therapy", and "late in therapy" was intended to indicate only the *relative therapy stage within the context of this particular study.*

To further explore this issue, I examined whether changing the cut-off values would substantially alter results. I considered three alternative scenarios (Alternative A, B, and C in Table below). In the first Alternative (A), the "early therapy" group was extended to also include session 3. In the second Alternative (B), the "late therapy" group was extended to also include session 7. In the third Alternative (C), the range of observed sessions (1 to 12) was divided into three equal groups, each spanning four sessions. I then computed one way-ANOVAs to examine whether the results would change from the original classification method. However, just as in the original, none of the F-values attained significance at the $p < .05$ level. That is, there were no statistically significant differences between the "early, middle, or late" groups in terms of their alliance ratings (total and three subscales), their attachment style ratings (anxiety and avoidance), and their childhood experiences (I analysed both the new, empirically derived subscales and the original, "theory-guided" CES subscales). Therefore, the conclusion that there are no substantial differences in these variables in this sample among "early, middle or late" phases of therapy appears to be relatively robust or independent from the particular cut-offs used.

Session number	1	2	3	4	5	6	7	8	9	10	11	12
Frequency of clients	7	19	15	17	5	11	3	8	2	7	0	6
Original thesis classification	26			51					23			
Alternative A (extend early)	41				36				23			
Alternative B (extend late)	26			48				26				
Alternative C (equal lengths)	58				27				15			

Table: Alternative classifications of early (green), mid-therapy (orange) or late-therapy (grey)

b. Differences in alliance and childhood recollections among clients in different attachment style categories.

The first two hypotheses stipulated that attachment styles would be correlated with the alliance and with childhood recollections. However, it is also possible to examine attachment styles as categorical rather than dimensional variables. That is, according to Brennan and colleagues (1998), the two ECR-attachment dimensions (anxious and avoidant attachment) can be used to classify or group participants into one of four attachment categories: (1) Secure (low of anxious and avoidant attachment), (2) preoccupied (high on anxious but low on avoidant attachment), (3) fearful (high on both dimensions) and (4) dismissing (high on avoidant but low on anxious attachment). Once participants are categorised in this manner, group comparisons can then be conducted to test whether the four groups differ with respect to the alliance or childhood memories.

Brennan and colleagues (1998) provided an algorithm to assign participants to one of the four attachment categories, based on their ECR scores. However, these algorithms were based on analyses of large groups of US undergraduate students. It is yet unknown whether the same algorithms are applicable to UK

clinical populations. Nevertheless, for exploratory purposes, Brennan and colleagues' (1998) algorithms were applied to the present dataset, yielding the following four attachment categories:

(1) Secure   11 clients
(2) Preoccupied   33 clients
(3) Fearful   49 clients
(4) Dismissing   7 clients

The scattergram below also shows each client's score on the two ECR attachment scales as well as their assignment to one of the four categories based on Brennan and colleagues' (1998) algorithm.

Figure 5: Scatter plot showing each client's score on the ECR anxious and avoidant attachment dimension as well as their assignment to one of four attachment style categories based on Brennan and colleagues' (1998) algorithm.
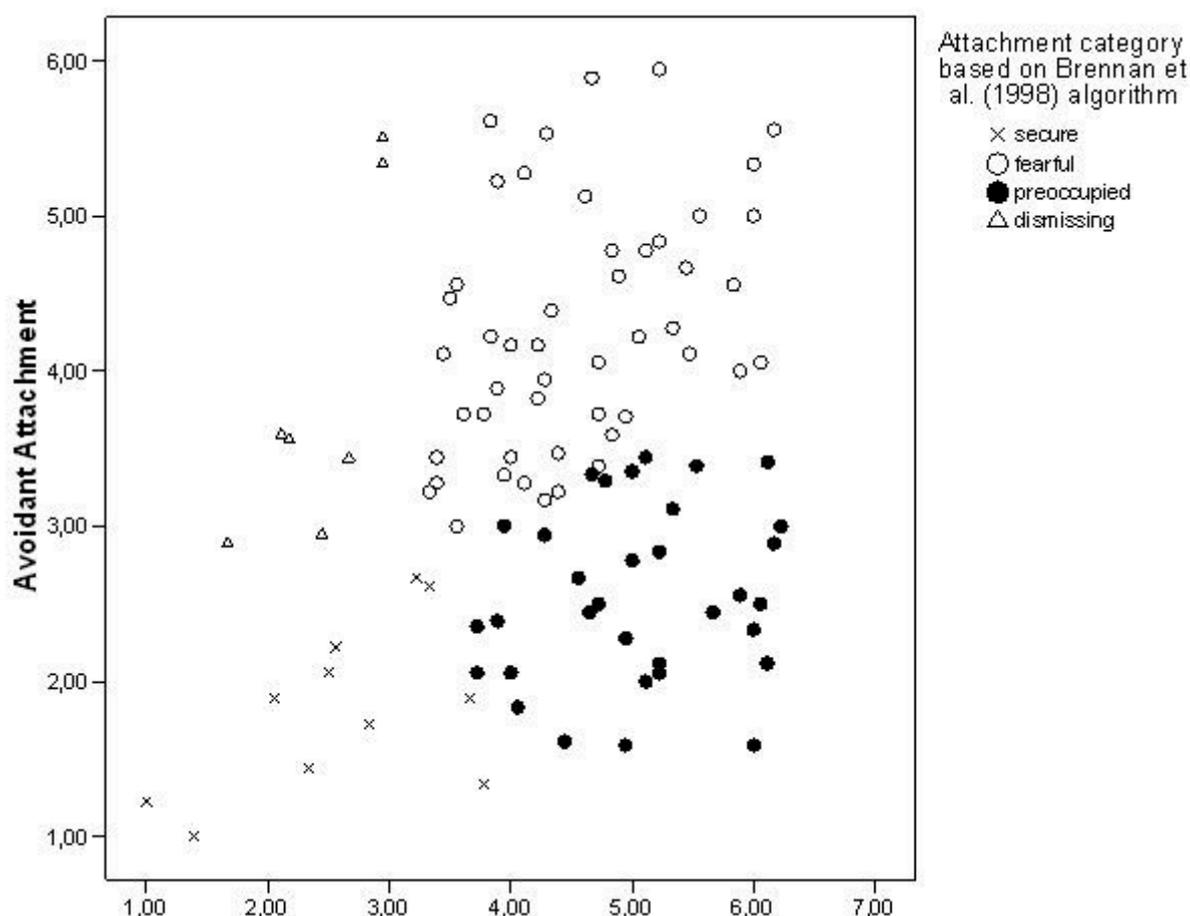
The scatter plot shows that most clients were classified as fearfully attached. The plot also illustrates an obvious shortcoming associated with the categorising of cases based on dimensional scores. That is, two clients with nearly identical scores on both attachment dimensions are sometimes classified as belonging to different attachment categories because they lie just above or below the respective cut-off points. Another potential problem, as mentioned above, is that the cut-off points for these classifications were based on analyses involving US undergraduate students rather than UK clinical samples. Therefore, the validity

of these categorisations has not yet been demonstrated in samples such as the present one.

Another approach to classifying clients based on their ECR anxious and avoidant attachment scores is to simply assign them to one of four quadrants, based on whether their scored above or below the midpoints of each respective Likert scale (i.e. above or below 4 on the 1-7 scales that are used for the ECR anxious and avoidant attachment response scales). This approach has also been used before (Meyer & Pilkonis, 2001). This approach yielded the following classification:

(1) Secure   28 clients
(2) Preoccupied   40 clients
(3) Fearful   24 clients
(4) Dismissing   8 clients

The scatter plot below shows the assignment on this simpler categorisation scheme.

Figure 6: Scatter plot based on the simple cut-off value of 4 on the 1-7 Likert scales.
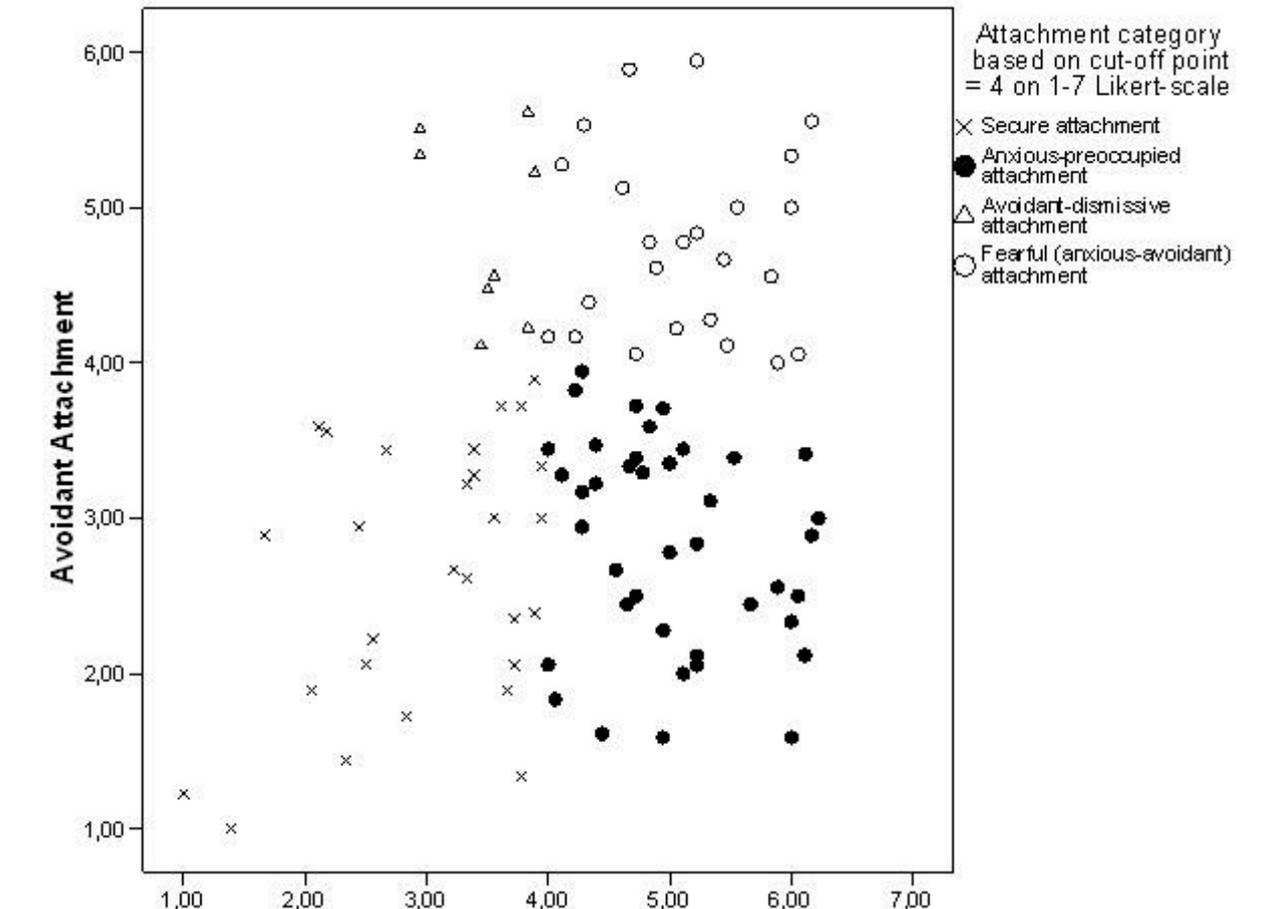
Based on these two classification approaches, group comparisons were conducted to test whether clients with different attachment styles differed in terms of the alliance or in terms of childhood recollections. The results of these one-way ANOVA analyses are summarised in the table below.

Table 14. Group comparisons: Clients in different attachment style categories differ with respect to alliance and childhood recollections (A: Brennan et al. classification algorithm)

	Secure	Preoccupied	Dismissing	Fearful	*F*-value (3, 96)
Working Alliance (WAI Subscales)					
1. Total alliance (12 items)	6.39 (.53)	5.64 (70)	5.93 (1.21)	5.54 (1.06)	2.77*
2. WAI bond (4 items)	6.11 (.96)	5.43 (.99)	5.96 (1.20)	5.46 (1.07)	1.69
3. WAI tasks (4 items)	6.52(.51)	5.72 (.70)	6.04 (1.26)	5.57 (1.18)	2.96*
4. WAI goals (4 items)	6.55 (.51)	5.78 (.88)	5.79 (1.33)	5.58 (1.20)	2.52
Childhood Experiences Survey (CES Subscales)					
7. Secure and loving parenting (4 items)	4.16 (1.25)	3.77 (1.34)	2.79 (1.29)	3.40 (1.15)	2.37
8. Inconsistent and unpredictable parenting (4 items)	1.82 (1.17	2.33 (1.06)	3.11 (1.44)	2.83 (1.08)	3.69*
9. Cold and rejecting parenting (4 items)	1.39 (.96)	1.87 (1.18)	2.71 (1.54)	2.26 (1.18)	2.63
10. Fear-inducing parenting (4 items)	1.52 (.97)	2.18 (1.35)	2.89 (1.52)	2.19 (1.11)	1.89
11. Overprotective parenting (6 items)	2.62 (.65)	3.09 (1.10)	2.38 (.93)	2.95 (.81)	1.62

* p < .05

As can be seen in Table 14 above, there were several significant differences. There was a significant difference between the attachment groups in terms of the total alliance scale (WAI total). A Tukey HSD post-hoc test did not reveal any specific differences between the four attachment groups, however. Similarly, even though the ANOVA suggested significant differences between the groups on the WAI-tasks subscale, the Tukey HSD post-hoc test failed to find specific differences between the groups.

Tukey HSD post-hoc analyses also showed that securely attached clients reported significantly less inconsistent/unpredictable parenting than those with dismissing attachment (there were no other group differences with respect to inconsistent/unpredictable parenting).

In summary, these analyses suggested, as one might expect, that securely attached clients reported more positive childhood memories than those with dismissing attachment. The differences in terms of the alliance were less clear.

A second set of analogous analyses was then conducted with the simplified approach to attachment classification that is shown above (i.e. using the cut-off point of 4 on the ECR Likert-scales). The results of these analyses are shown in the table below.

Table 15. Group comparisons: Clients in different attachment style categories differ with respect to alliance and childhood recollections (B: Cut-off value of 4 on the ECR scales)

	Secure	Preoccupied	Dismissing	Fearful	F-value (3, 96)
Working Alliance (WAI Subscales)					
1. Total alliance (12 items)	6.01 (.83)	5.61 (.76)	5.21 (1.18)	5.64 (1.19)	1.92
2. WAI bond (4 items)	5.68 (1.01)	5.56 (.96)	5.28 (1.11)	5.52 (1.26)	.30
3. WAI tasks (4 items)	6.14 (.92)	5.57 (.80)	5.09 (1.53)	5.84 (1.14	3.16*
4. WAI goals (4 items)	6.20 (.92)	5.70 (.93)	5.25 (1.11)	5.54 (1.34)	2.60
Childhood Experiences Survey (CES Subscales)					
7. Secure and loving parenting (4 items)	3.83 (1.32)	3.74 (1.25)	2.78 (1.29)	3.21 (1.10)	2.44
8. Inconsistent and unpredictable parenting (4 items)	2.22 (1.25)	2.45 (1.07)	3.22 (1.18)	2.97 (1.02)	2.96*
9. Cold and rejecting parenting (4 items)	1.77 (1.20)	1.90 (1.11)	2.97 (1.37)	2.39 (1.20)	3.02*
10. Fear-inducing parenting (4 items)	1.82 (1.07)	2.18 (1.28)	2.75 (1.22)	2.35 (1.26)	1.56
11 Overprotective parenting (6 items)	2.81 (.77)	3.05 (1.05)	2.54 (1.02)	2.97 (.83)	.85

* p < .05

As can be seen in Table 15 above, there were several significant differences. There was a significant difference between the attachment groups in terms of the WAI-tasks subscale. Tukey-HSD post-hoc comparisons indicated that securely attached clients scored higher on the WAI-tasks scale than those with dismissing attachment (there were no other significant differences with respect to the WAI-tasks).

Tukey HSD post-hoc analyses also showed that securely attached clients reported significantly less inconsistent/unpredictable parenting than those with dismissing attachment (there were no other group differences with respect to inconsistent/unpredictable parenting).

With respect to cold and rejecting parenting, securely attached clients scored lower than those with dismissing attachment. Additionally, those with preoccupied attachment also reported less cold/rejecting parenting than those with dismissing attachment. There were no other group differences with respect to cold/rejecting parenting.

In summary, these analyses suggested, as one might expect, that securely attached clients reported more positive childhood memories and, to some extent, were able to form stronger alliances (tasks subscale) than those with the dismissing variant of insecure attachment.

The differences between the two approaches to attachment classification (Brennan and colleagues' algorithm versus the simplified approach using a cut-off value of 4) were not particularly strong. The major difference was that, using the simplified approach, more clients could be classified as securely attached and fewer as fearfully attached. However, this change resulted in only minor differences in terms of the group comparisons involving the alliance and childhood memory scales.

Controlling for Gender

In this sample, 81 of 100 participants were women. This gender imbalance raises the question of whether the findings can be generalized to both women and men. The gender imbalance is not surprising, as such, because – as described in a government report – "women are more likely to report, consult for and be diagnosed with depression and anxiety" in the United Kingdom (Wilkins, 2008). This gender imbalance might have a systematic influence on the results because

gender differences have been reported in some of the variables targeted in this study. For example, according to a meta-analytic review article of 113 samples with more than 60,000 participants, women tend to score higher on attachment anxiety, whereas men tend to score higher on attachment avoidance (Del Giudice, 2011). In this particular sample, there were no statistically significant difference between men and women on attachment anxiety or avoidance, the working alliance, or childhood experiences (CES). However, this might be explained, in part, by the small sample size (only 19 men in this sample) and limited statistical power. Because of these concerns, gender was included as a control variable in the main statistical analyses (i.e., in the hypotheses tests, see Results).

Regression Analyses

A regression analysis was conducted in which childhood experiences (the two empirically derived subscales, rejection experiences and safety experiences), adult attachment style (the ECR attachment anxiety and avoidance scales) as well as gender and number of sessions were simultaneously entered as predictors of the working alliance (total WAI scale). This regression model was statistically significant, F (6, 93) = 2.43, p < .04, R^2 = .14. Inspection of the regression coefficients revealed that both the effects of session number (β = .26, p < .01) and the effect of attachment avoidance (β = -.24, p < .03) were uniquely significant in the prediction of the working alliance, even when simultaneously controlling for gender and attachment anxiety. Thus, clients in later sessions and with relatively less attachment avoidance tended to report better working alliances with their therapists.

Discussion

This chapter includes a discussion of the results generated by this study. The results regarding the hypotheses and the integration of the findings with previous research will be presented and discussed along with the strengths and limitations of the study. Implications for practice and research and conclusions are also included in this section.

A brief summary of the aim of the research, hypotheses and main findings:

The key impetus that gave rise to this study was the clinical applications of Attachment Theory (AT) which provides a model for understanding the adult attachment styles and their impact on the process of therapy (Daniel, 2006; Meyer & Pilkonis, 2002; Mikulincer, Shaver, & Berant, 2012). One of the aims of this research was to examine associations among client attachment patterns and the quality of the therapeutic relationship and, by doing so, potentially replicate previous findings in this area. Beyond that, this study aimed to extend the literature by examining retrospective reports of childhood experiences and linking them with adult attachment patterns as well as the therapeutic alliance.

It was hypothesised that (1) Anxious and avoidant attachment be correlated with negative childhood recollections (i.e., recollections of rejecting, cold, or unresponsive parenting); (2) both attachment anxiety and avoidance would be inversely correlated with the therapeutic alliance; and (3) negative childhood recollections would correlate inversely with the quality of the therapeutic alliance (total WAI and all three subscales) and that this association would be mediated by adult attachment styles.

The results show that the first hypothesis, which stipulated that negative childhood experiences would be correlated with anxious and avoidant attachment style, was partially supported. Avoidant attachment style but not anxious attachment style was significantly and moderately strongly associated

with rejection experiences, as measured by the CES. However, anxious attachment was – contrary to the hypothesis – not significantly associated with any of the childhood recollection subscales, therefore there was no support for the hypothesis that anxious attachment would be correlated with parenting recollections. The second hypothesis, which stated that both anxious and avoidant attachment would be correlated with the therapeutic alliance, was also only partially supported. Specifically, avoidant attachment (but not anxious attachment) correlated significantly and inversely (moderately strongly) with the therapeutic alliance and with the 'goals' subscale of the WAI, indicating that avoidantly attached clients reported poorer alliances and less agreement on the goals of therapy than less avoidantly attached clients. The third hypothesis stipulated that the link between childhood experiences and the alliance would be mediated by attachment style. Analyses showed that memories of early experiences with parents neither correlated significantly with any of the WAI subscales nor with the total alliance score. Therefore, the hypothesis that childhood recollections would be associated with the quality of the therapeutic alliance, and that this association would be mediated by adult attachment styles was not supported and could not be explored further.

Integration of the findings with previous research

(a) Childhood experiences and attachment:

Attachment patterns in adulthood reflect past experiences. Early relationships with parents have been found to shape attachment patterns, which in turn affect relationship experiences and patterns in adult intimate relationships (Bowlby, 1973, 1982). Early observational studies showed that different child rearing styles and the quality of parenting, lead to the development of different internal working models forming distinctly identifiable behaviour patterns in children (Ainsworth, 1973; Ainsworth et al., 1978). Secure attachment has been linked to responsive parenting, anxious-ambivalent with inconsistent parenting and anxious avoidant with rejecting parenting (Ainsworth et al., 1978; Feeney, Noller, & Hanrahan, 1994; Fraley, 2002). A main theme in past research, to

summarise, is that consistently responsive parenting may facilitate secure attachment; inconsistent parenting may facilitate anxious/preoccupied attachment; consistently unresponsive parenting may facilitate avoidant/dismissing attachment; and fearful parenting (traumatic and abusive) may facilitate fearful/disorganised attachment (Feeney & Noller, 1990; Fraley & Shaver, 2000; Hazan & Shaver, 1987; Mikulincer, Gillath, & Shaver, 2002; Waters et al., 2000).

The first hypothesis was partially supported, therefore partially consistent with the previous evidence cited above. The results showed that avoidant attachment was indeed correlated positively with 'cold, rejecting parenting'. For example, participants felt that their parents 'did not care about them' or felt as if their parents 'were strangers and rather indifferent to them'. Thus, in keeping with expectations, avoidantly-attached clients' memories included reports of more negative and less supportive parenting.

Research shows that avoidant attachment develops as the result of unresponsive and unavailable parenting (Ainsworth et al., 1978; Carver & Scheier, 2008). Consistent with the theory, the children who are in close proximity to unresponsive caregivers may learn not to express their distress and show their feelings. Feeling unloved and not needed may be pushed out of consciousness, such that these children learn implicitly to stay away from relationships rather than risking further rejection. They would develop avoidant styles in interpersonal relationships, which may be consistent with an internalised representation - a working model - of themselves as unworthy of love (Mikulincer & Shaver, 2003; Toth et al., 2009). The internalised attachment patterns of being unworthy of love, in turn, may tend to elicit reactions from others that match how they expect to be treated (Batgos & Leadbeater, 1994; Mickelson et al., 1997). The finding in this research with respect to avoidantly attached clients is consistent with such theorising, in that avoidantly attached clients did in fact report more negative parenting experiences and reported having felt unloved and uncared for, which might have contributed to the formation of their dismissing/avoidant attachment.

In contrast to the empirical evidence cited above, this research did not find a link between inconsistent parenting and anxious attachment. Because CES was new and not validated, an exploratory factor analysis was computed that resulted in two CES-subscales: (1) "rejection experiences" and (2) "safety experiences". Pearson correlation coefficients were computed among the CES subscales (both empirically derived and theoretically postulated) and the two attachment ECR-R scales, in fact there was no significant association between anxious attachment and either of empirically derived and theoretically postulated sub scales of childhood recollections.

One reason why this hypothesis was unsupported might be that the anxious attachment, as measured by ECR, might have been more strongly influenced by recent or current experiences in romantic relationships, and may have little to do with early experiences or, particularly, with potentially invalid recollections of early childhood events (Le Poire et al., 1997). According to AT, attachment styles form largely before 18 months, and it is difficult or impossible for people to report accurately on such early experiences, perhaps especially during their psychological treatment. Research has shown that memories formed at such young ages are hard and generally impossible to remember later in life, even though some memory systems among infants are, in fact, sophisticated enough to permit some degree of recollection much later in life (Rovee-Collier, 1999). It is also well known that memories of early life events can be distorted, inaccurate and influenced by later events that have little to do with actual childhood experiences (Garry & Loftus, 1994; Hardt & Rutter, 2004), which points to the need for more longitudinal research regarding the linkages between early childhood events and later attachment in the context of psychotherapy.

Yet another reason for why the hypothesis regarding an association between anxious attachment and childhood recollections was not supported might have been due to the social desirability effect (Nederhof, 1985). That is, participants may have underreported adverse childhood experiences, wanting to appease the researcher or appear as 'normal' or as well adjusted as possible. For example,

consider the first item on the questionnaire: 'My parents were always there for me when I needed them'. This item might easily be regarded as a socially desirable experience, which might have led clients to agree with it merely based on the social desirability motive. Even though there are methods to deal with potential social desirability biases, such as the use of social desirability scales, neutral items or 'bogus pipeline' techniques (Nederhof, 1985), none of these methods were employed in this research, mainly due to feasibility constraints. As a result, it cannot be ruled out that social desirability exerted a systematic effect on the results.

AT stipulates that positive childhood recollections would be associated with secure attachment and vice versa. Interestingly though, the overprotective parenting subscale of the CES which would appear to be a type of negative parenting, was inversely correlated with 'rejection experiences' subscale empirically derived PCA. This suggests that the 'overprotective' parenting style, as measured by CES is perceived in a more positive light than was originally anticipated by the researcher and correlated with safety experiences' subscale of the empirically derived PCA. In line with this reasoning, some participants reported as they were completing the questionnaire, that they had interpreted the 'over-protective parenting' items in a positive light, and that these descriptions seemed to reflect aspects of secure, nurturing early experiences. For example, consider the item: 'During my childhood, I loved to return to the comfort and safety of my family in order to get away from the harsh reality of the outside world'. It appears that the 'comfort and safety' associated with the family in this item is viewed as indicative of positive childhood experiences. The item does not emphasise the problematic aspects of an overprotective parenting style, which conveys to children that the outside world is a harsh and unpleasant environment that is best avoided. In any case, it appears that what the overprotective childhood experiences subscale measures is different from simple 'negative' childhood recollections, and that it deserves to be studied in greater detail in its own right, given the interesting correlations with this scale observed in this study.

(b) Attachment and the alliance:

Empirical evidence shows that client attachment styles are related to the therapeutic alliance: specifically, clients with secure attachment patterns tend to form more positive therapeutic alliances than those with insecure attachment patterns (Mallinckrodt et al., 1995; Kivlighan, et al., 1998; Satterfield & Lyddon, 1995).

With respect to different attachment patterns and how these groups functioned in therapy, the results of previous studies are mixed. For example, in one study, there were no group differences with regard to the ratings of working alliance between the secure, preoccupied and dismissive attachment groups; however, the groups did show differences in the formation of alliance at different points in therapy (Kanninen et al., 2000). The preoccupied attachment group reported a poor alliance in the middle and a more positive alliance towards the end, showing more fluctuation (Kanninen et al., 2000; Kivlighan & Shaughnessy, 2000). In a different study, contrary to expectations, both preoccupied and dismissive attachments were associated with positive alliance, although the reliability of these reports of therapeutic alliance were questioned by the authors (Eames & Roth, 2000). Yet, in another study no relationship was found between preoccupied attachment and total alliance scale (Mallinckrodt et al., 1995). In a study by Romano and colleagues, (2008) similarly to the present study, their results showed no association between anxious attachment and alliance, and showed a negative association between avoidant attachment and working alliance.

In this study, the second hypothesis predicted that both anxious and avoidant attachment would be correlated negatively with the therapeutic alliance. This was partially supported; specifically, avoidant attachment (but not anxious attachment) was correlated significantly and inversely with the total alliance scale and with the 'goals' subscale of the brief Working Alliance Inventory (WAI). Clients with more avoidant attachment styles tended to perceive their alliance as weaker and agree less on the goals of therapy, compared to their less avoidant counterparts. This result was statistically significant and is in accordance with

the theory that clients with a dismissive/avoidant attachment pattern struggle with emotional engagement and find it difficult to form a close alliance. This finding replicates the results of the study by Romano and colleagues' (2008), that attachment avoidance is negatively associated with client-rated working alliance, indicating these clients' difficulties to form constructive working relationships with their therapists.

Although the first part of the hypothesis – avoidant attachment being negatively correlated with alliance - was supported, in our sample, anxious attachment style was not correlated, neither positively nor negatively, with therapeutic alliance. Similar findings have been obtained from research assessing attachment style and alliance and that strong associations were found between avoidant attachment and alliance, but no or lack of association were found between anxious attachment and the therapeutic alliance (Byrd et al., 2010; Goldman & Anderson, 2007; Marmaroush, Gelso, et al., 2009; Romano et al., 2008). A possible reason might be that anxious clients due to having inconsistent available parenting learn to over express their feelings to increase the likelihood of receiving consistent response from the other. Anxious clients have an overriding need to please their therapist to avoid rejection, and consequently become less effective in building good alliances with them. In their frantic placatory efforts they would have failed to make an emotional engagement, working less collaboratively and more superficially on the difficult personal problems, thus agreeing less on therapeutic tasks and goals, leading to a less effective alliance (Mallinckrodt et al., 1995).

Similarly Byrd et al., (2010) did not find any association between rejection anxiety and therapeutic alliance and explained their results with regard to anxious attachment as follows:

> "Rejection anxiety had no appreciable influence on either the alliance or therapy outcome. This finding may, in part, result from the fact that most therapists provide therapy conditions approaching unconditional acceptance and that sustaining a therapeutic relationship depends little on the factors that affect continuity in social relationships, such as

competition with others for the partner's attention, mutual attraction, similar interests, and so forth. The relative unconditional acceptance of the therapist and relatively predict- able course of the therapeutic relationship may largely (but not entirely) alleviate fears of rejection that arise in social relationships, and substantially reduce the impact of this attachment pattern on alliance and outcome. This reasoning is consistent with previous research that found anxiety to be relatively unrelated to working alliance (Kivlighan et al., 1998; Satterfield & Lyddon, 1995) (pg. 635)".

Indeed there might have been other motivational factors, aside from this placatory need, which could have caused the anxious clients to work less efficiently with their therapists. Studies from a psychodynamic perspective have shown that clients' responses to the therapists – transference feelings – may involve attitudes and the experiencing of feelings such as poor Self-Other differentiation, or self devaluation that originate in early childhood, and may be attributable to recollections of parental caregiving (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003), and that these feelings would be projected onto the therapist and consequently impact the alliance. Anxiously attached clients' intense desire for closeness might have caused them to become emotionally confused (Berant et al., 2005) and sought for more negative than positive feedback from the therapist, and affect the therapeutic relationship. An alternative method such as AAI, which makes use of narrative approaches, might have provided access to the mind of the client, and potentially to some less rational processes behind their specific ways of working with their therapist (Hesse, 2008).

In the present study, securely attached clients (as shown in Table 15, the subsidiary analysis of the mean comparisons between alliance and client attachment according to the four attachment groups) scored higher on the WAI-tasks scale than those with dismissing attachment and reported significantly less inconsistent parenting than those with dismissing attachment. These analyses suggested that securely attached clients reported more positive childhood

memories and to some extent were able to form stronger alliances (tasks subscale) than those with the avoidant attachment. This is consistent with the theory and empirical evidence that securely attached clients tend to see their therapists as benign and emotionally supportive and emotionally engage with them to work effectively on therapeutic tasks (Kivlighan et al., 1998; Mallinckrodt et al., 1995; Satterfield & Lyddon, 1995).

(c) Mediation hypothesis

It has been hypothesised that the link between childhood events and current client-therapist relationship might be mediated or explained by attachment styles. In fact, this is a basic assumption of AT: early childhood experiences lead to the formation of stable mental representations (internal working models or attachment styles), which then, in turn, determine how individuals experience and act in the context of adult relationships. The basic logic of these relationships leads quite directly to the hypothesis that the relationship between early childhood experiences and current experiences in therapy would be mediated by clients' attachment styles: early adversity might cause clients to become insecurely attached, and their insecure attachment might cause them to form problematic alliances with their therapists. This was the hypothesis this study aimed to investigate.

Specifically, the third hypothesis stipulated that there would be a link between childhood experiences and the alliance, mediated by anxious and avoidant attachment. It was expected that unresponsive parenting would be associated with avoidant and anxious attachment, which then would be negatively associated with the therapeutic alliance. It was hypothesised that the significant association between positive parenting experiences and a strong working alliance would be statistically mediated by secure (non-anxious and non-avoidant) attachment. Because childhood experiences (empirically derived and theoretically postulated) were not significantly associated with the therapeutic alliance it was not possible to explore whether such a link would be mediated by attachment styles.

The quality of the therapeutic relationship, which Bowlby refers to as the 'secure base', can have indirect benefits for the client. Whether or not the interpersonal relationship with the therapist becomes a means to produce specific outcomes in terms of direct change in behaviour patterns, the emotional engagement with the therapist is expected to generate a qualitatively new experience for the client. The experience of being listened to in itself might make a difference for the client in preparing them to open up more, which can in turn help with building trusting relationships. In this respect, the effect of the therapeutic relationship is indirect: it is believed that 'interpersonal process fulfils a crucial mediating role' (Henry & Strupp, 1994, p.71) between insecure attachment and outcome of therapy. A different quality of interaction from early childhood relationships can offer the client a safe, accepting and empathic relationship, in which fears and threats from the past are discussed and talked about, enabling the client and the therapist to work together (Clarkson, 2003; Jacobs, 2004; Rogers, 1990). Regarding this point, the results with reference to the descriptive statistics in this study illustrate that clients were generally satisfied with their therapeutic relationship. The total therapeutic alliance scores show the clients' overall satisfaction with their therapeutic relationship. The mean of the total therapeutic alliance score was 5.69 (the range was 1-7), which is well above average, which indicated that clients felt that they had established a good relationship with their therapists in order to work collaboratively.

On a different note, the regression analysis in which childhood in which childhood experiences (the two empirically derived subscales, rejection experiences and safety experiences), adult attachment style (the ECR attachment anxiety and avoidance scales) as well as gender and number of sessions were simultaneously entered as predictors of the working alliance (total WAI scale) revealed that both the effects of session number ($\beta = .26$, $p < .01$) and the effect of attachment avoidance ($\beta = -.24$, $p < .03$) were uniquely significant in the prediction of the working alliance, even when simultaneously controlling for gender and attachment anxiety. Thus, clients in later sessions and with relatively

less attachment avoidance tended to report better working alliances with their therapists.

Strengths and limitations of the study

Attachment research aims to look at how the postulates of AT are supported or challenged by research findings (Waters, Crowell, Elliot, Corcoran, & Treboux, 2002). In this study there has been partial support for the general postulate of the theory that clients who feel comfortable in relationships – who do not avoid intimacy or easily feel trapped (i.e. less avoidant attachment) – also tend to form stronger therapeutic alliances.

This study is among the first to examine the associations between attachment styles, therapeutic alliance and early childhood experiences obtained by retrospective reports. By examining the clients' recollections of childhood, this study has been able to establish the link between avoidant attachment and negative unresponsive parenting. Consistent with AT, empirical research (Fraley & Shaver, 2000; Shaver & Mikulincer, 2002) show that comfort with intimacy correlates positively with therapeutic alliance, and fear of abandonment and discomfort with intimacy correlates negatively with alliance (Mallinckrodt et al., 1995).

The other strength of this study is its sampling size and method. A statistical power analysis was employed to ensure that the study would detect an effect of meaningful magnitude, and that such an effect is actually present (Cohen, 1988). The sample size of 100 clients was estimated to be sufficiently large to achieve 80% probability of detecting such effects (i.e. .80 power). Research without adequate statistical power (i.e. with exceedingly small samples) cannot detect important effects, even if such effects exist in the population. For example, the study by Romano and colleagues (2008) found essentially the same correlations using the same measurements (ECR and WAI) as this study, but the correlations in their study did not show significance due to small sample size.

On the other hand, sampling in this study could have been organised better. By obtaining prior information from the psychologists with respect to clients' motivation to participate in the study, and the number of therapy sessions they already had, the effort to recruit participants would have been reduced. This would also have provided evenly spread groups of participants in early, middle and late phases of the therapy. Although some support was established for a relationship between number of sessions and total working alliance – clients developed better alliances as the therapy progressed over time – no significant differences were found between clients in early, middle or late phases of therapy with regard to attachment styles or alliance.

An important limitation of the present study is that it concentrates on the clients' attachment styles only. However, therapy has a dynamic nature in which the interaction between therapist and client involves their own individual attachment histories and mental representations of the self and others. For example this study found a negative association between avoidant client attachment and alliance, and this result might have been affected by therapists' attachment style. An alternative explanation to the problematic alliances between avoidant clients and therapists could be due to the therapists' difficulty to break through the avoidance and connect emotionally with these seemingly distant clients. This lack of connection results in the client's perception of a problematic alliance. Therefore it is important to obtain therapist attachment styles as well as the clients'. Studies show that the therapists' own attachment histories, their fears and anxieties in relationships, may influence the therapeutic relationship as significantly as those of the clients (Maroda, 2010; Meszaros, 2004), and may lead them to interact with clients differently, e.g. less empathetically or more anxiously (Dozier, Cue, & Barnett, 1994; Rubino et al., 2000). Therefore, it seems critically important for future, to consider the therapists' attachment in the study of attachment styles, and how they are related to the development of the therapeutic alliance.

In this study, I attempted to pursue the research question with a quantitative questionnaire approach, and it was hoped that this approach would shed some

light on the research questions at hand. The questionnaire methodology was not judged to be superior to other methodological approaches, such as the qualitative methods of inquiry. Instead, the questionnaire-based quantitative approach was regarded in this research as one – but only one among many – of the options within the rich methodological repertoire that has evolved within and beyond counselling research over the last century. Of course, there are limitations to the correlational questionnaire approach, such as the potential that participants' responses might be biased (e.g. social desirability bias, acquiescence bias). However, these concerns are shared by all questionnaire research, not just research employing correlational statistical analyses. The correlational method was selected here as a flawed (as are all methods) but still useful and appropriate methodological approach.

This study used three self-report questionnaires: two with established validity and reliability (the ECR and WAI) and a novel one (CES) of which its factorial validity has been investigated by the use of exploratory factor analysis and scale reliability testing. Generally, self-reports are a quick and an efficient way of sampling large numbers of participants in a limited time. Although there are advantages of this methodology with respect to feasibility, standardisation of scoring and comparability of results (BACP, 2010; BPS, 2006), there are many limitations of self-report measures (Bifulco, 2002). Being indirect measures of actual clinical practice, they are criticised for not reflecting the reality of therapy. Also information obtained from questionnaires may be inaccurate or incomplete due to social desirability effect and cognitive limitations. There is also some research indicating possible biases in retrospective reporting that adults reporting their own adverse experiences in childhood may involve substantial error because these recollections rely heavily on judgment or interpretation (Hardt & Rutter, 2004). For example, when completing the CES, it might have been difficult to remember the early experiences accurately or remember selectively, as the research in this area provides evidence for memory suggestibility – that people may believe they have experienced or seen something they have not (Garry & Loftus, 1994). In this study, clients may have been biased in such a way that most endorsed being satisfied with their

therapist; perhaps because of an implicit fear that negative evaluations of the alliance would interfere with their own therapeutic care. Additionally, it is possible that their responses were influenced by the fact that they completed the questionnaires in the same practice, and immediately after their therapy session. Although the questionnaires were anonymous, and every effort had been made to assure clients that the results of their questionnaires would remain confidential, it is possible that concern about anonymity might have biased some clients' responses.

Limitations of self-report measures of attachment style have been recognised and discussed by several authors (Crowell & Treboux, 1995; Hesse, 1999; Jacobovitz et al., 2002). It is argued that self-report information may not reveal the unconscious aspects of attachment due to clients' defensive reporting, either the client is not aware of the concerns or do not report them because of social desirability. For example, a client may report that they are not worried about rejection when actually they are worried, or they may not be aware of their discomfort in close relationships and not report it. Researchers using AAI, e.g. Belsky, 2002; Jacobovitz et al., 2002, argue that the narratives of interviewees reflect their attachment patterns inferred from their attachment history, whereas self-reports tap adult's conscious appraisals of themselves and ignore the underlying reasons, meanings and realities of the clients' responses, therefore are limited to indexing conscious mental processes. Consequently the correlations produced may have masked or missed the individual's subjective experiences, thus the reduction of data to numbers results in lost information.

Perhaps additional measures, such as short structured interviews, would have brought depth, the individual's subjective experience to the results obtained by questionnaires. These might have provided insights into the client's internal working models and the motivational factors underlying their attachment preferences. Qualitative and quantitative measures could have been used together and might have provided detailed information about how the interaction might have developed between client and therapist. Having said that,

qualitative measures are also prone to social desirability biases and are known to influence participants' responses (Fisher, 1993; Nederhof, 1985).

Continuing with the issue of self-report measures, the length of the questionnaires presented problems with the possibility of 'over-burdening' the clients, who were suffering from mental/emotional problems or disorders (Patel et al., 2003). This is one of the reasons why data collection was limited to the administration of three questionnaires and the collection of information on the participant's age, gender, and number of therapy sessions they had with their therapist only. Additionally, feedback from the participants indicated that the questionnaires took longer to complete than they had anticipated and some items were difficult to understand. Undoubtedly, it would have been interesting, and more importantly enriching, to obtain detailed information on client pathology and style of treatment but this was not feasible nor deemed appropriate. Obtaining information on participants' treatment or even their symptoms by asking many additional questions and thus introducing new or different outcome measures might have interfered with their treatment and the counselling process. In a review of the ethical principles relevant to conducting research with clients suffering from mental/emotional problems, it was emphasised that 'the number of instruments used should be minimised to prevent excessive participant burden' (Patel et al., 2003, p.231). Indeed, many counselling psychologists participated under the condition that there should be minimal disruption to the normal functioning of the practice and of the counselling process. They were concerned about over burdening their clients with excessive data collection and the disclosed confidential information affecting the counselling relationship. On the other hand, it might have been preferable and possible to obtain additional confidential client information from therapists, however that would have required lengthy procedures for obtaining approval from the Ethics Committees as well as agreement from the therapists.

Some interesting and undoubtedly important participant information, such as socio-economic status (SES) and cultural background was regrettably omitted in the present study. Consequently, the data collected were not sufficient to find out

how the associations between attachment styles and therapeutic alliance might have differed based on culture and socio-economic status, though this would have been merely descriptive information and not outcome data. It would be interesting for future research to employ a mixed methodology including quantitative as well as qualitative data regarding ethnicity and socio-economic status (SES) to investigate the effects of those variables on the formation of relational patterns including the therapeutic relationship.

Implications for practice and research

The present study explored how adult attachments are associated both with early experiences with parents and the therapeutic alliance. Because the therapeutic relationship embodies qualities of an attachment relationship, the results of this study and their relation to the research in adult attachment, particularly the avoidant attachment can potentially inform the practice of counselling psychology, e.g. in case conceptualisation, possibly in the development of strategies for improving the alliance and generation of ideas for the development of specific therapeutic interventions.

Consistent with the theory, previous studies have linked client attachment patterns to differences in the quality and development of the therapeutic alliance and outcome (Daniel, 2006; Meyer & Pilkonis, 2002; Mikulincer & Shane, 2007). Clients with relatively more pronounced avoidant attachment are more likely to have had adverse childhoods which were lacking in sensitive and responsive care, and thereby are more likely to have developed a sense of self unworthy of care (Bernecker et al., 2013; Mikulincer & Shaver, 2007). This in turn may be reflected in the way they view others, including their therapists, as potentially uncaring and sometimes rejecting. Having learned to adopt the attachment figure's view in relationships, the clients with avoidant attachment are more reluctant to enter into relationships, tend to ask for help less, and tend not to discuss attachment-related issues in therapy than those with less pronounced attachment avoidance (Korfmacher, Adam, Ogawa, & Egeland, 1997; Mallinckrodt et al., 1995; Mikulincer et al., 2002; Mikulincer & Shaver, 2003).

The results of this study with respect to avoidant attachment, both in terms of early parenting experiences and therapeutic alliance, support previous research.

General information on what characterises an avoidant attachment pattern is already available from existing research, in that avoidant attachment is characterised by avoidance of intimacy, distrust in the care of others, valuing self-reliance and minimising the importance of close relationships (Bernecker, Levy & Ellison, 2013). Although, these classifications provide an outline of how individuals with different attachment styles generally behave in the context of interpersonal relationships, as most clinicians would agree, it is neither the aim nor easy to assign clients into categories. Avoidantly or not, clients behave more or less around the defining characteristics of their attachment styles, sometimes exhibiting the characteristic tendencies but not always. Therefore specific information regarding the client's attachment style can be inferred from the assessment interview; the therapist needs to be aware of what is indicated in terms of each client's particular way of relating and their history of attachment interactions. When the attachment histories reveal unresponsive and insensitive parenting in childhood during assessment, counselling psychologists can then expect these clients to avoid distressing thoughts and memories regarding early experiences with parents and to feel discomfort in closeness. Recollections of negative experiences in early childhood, particularly unresponsive rejecting experiences with parents, may help therapists with case conceptualisation and provide them with clues of how they can approach avoidantly-attached clients. As this study showed clients with avoidant attachment are more likely to recall negative, rejecting or unresponsive parenting experiences and most often project these feelings on to the therapist and avoid emotional contact. The therapist being mindful of clients' negative experiences in relationships and expectations of distrust in the care of others will ensure comfort and safety when forming a relationship with these clients. Giving them more space – even if it means less interaction and intervening less deeply in the beginning of therapy – will facilitate safety and trust in the relationship (Dozier et al., 1994; Fonagy et al., 1996; Hardy et al., 1999). Based on the results of this study counselling psychologists can expect avoidantly attached clients to work less cooperatively

with therapists and to agree less on therapy aims and goals, consequently forming less effective alliances.

Evidence suggests that a strong therapeutic alliance produces positive outcomes in therapy (Goldfried & Davila, 2005; Hubble et al., 2010; Wampold, 2010). Since adult attachment style has been identified as one of the variables that influences the alliance (Diener & Monroe, 2009; Mallinckrodt et al., 1995), investigating the role of client attachment in the therapeutic relationship will promote our understanding of what essentially improves and maintains it. Knowledge of their clients' particular attachment difficulties in relationships, e.g. avoidance of emotional contact, may guide therapists to develop interventions that will target the arising problems in the alliance and may be used as a strategy for improving the alliance (Castonguay, Constantino, & Grosse Holtforth, 2006). As suggested by Castonguay and colleagues (2006), addressing the problems in the alliance with clients, in particular with insecurely attached clients, and using alliance repair techniques may be beneficial in facilitating a change in the attachment by 'paving the way for corrective relational experiences' (p. 276). The present study has shown that avoidantly attached clients tend to form poor alliances; these clients are more likely to experience problems in engaging with their therapists because they tend to expect others, including their therapists, to be uncaring. Therefore counselling psychologists, once they have identified the avoidant attachment, can employ sensitive and non-confrontational techniques that will ensure safety in enabling these clients to discuss their negative expectations in relationships.

Having an idea of clients' early parenting experiences, in particular rejecting or unresponsive parenting, counselling psychologists may form working hypotheses regarding the client's characteristic detachment in relationships, their tendency to avoid attachment issues and difficulties in making an emotional engagement in therapy, and these may then influence the choice of intervention. For example, some may opt to pursue long-term therapy options with avoidantly attached clients in order to facilitate emotional engagement by slowly drawing their attention to past relationships as determinants of current

difficulties when they have previously avoided such issues (Fonagy et al., 1996). Some others may choose to use different strategies and promote corrective experience using counter-complimentary responses with clients who are dismissive of closeness (Bernier & Dozier, 2002; Slade, 2008). It has been demonstrated that different attachment styles elicit different forms of responsiveness from therapists; in particular, clients with avoidant attachment struggle to form meaningful relationships with therapists therefore therapists tend to employ more active interventions to help them connect emotionally. Further research is perhaps required to examine which clinical strategies and techniques are most suitable for the purpose of correcting avoidant attachment, and whether these interventions may also be affected by therapist attachment. Therefore future research needs to consider both the clients' and therapists' attachment patterns, along with the specific interventions that would be most beneficial for clients presenting different attachment styles.

Summary and conclusions of the study

AT is a theory of lifespan development seeking to describe and account for the affective bond between infants and their caregivers, and how and why these attachments develop and change as people develop and grow.

 AT provides a useful framework for understanding not only the formation and disruption of affectional bonds in children and adults, but also how therapeutic relationships develop and work. Empirical studies of attachment support the relevance of adult attachment to therapeutic process and outcome; many studies have replicated modest but consistent relationships between attachment security and the alliance as well as security and outcome (Dinger, Strack, Sachsse, & Schauenburg, 2009; Goldfried & Davila, 2005; Hubble et al., 2010; Muller & Rozenkranz, 2009; Wampold, 2010). The present research was consistent with many of the previous studies in that similarly modest links were found between some aspects of attachment security and the alliance. However, some of the hypotheses were not supported, for example, those pertaining to the links between childhood recollections and the alliance. There are many possible

reasons that might explain why the relationships between childhood experience, attachment and the therapeutic relationship were only modest in magnitude and somewhat inconsistent, despite the theory's strong appeal. One reason might be that the quantitative research methodology I applied here was inappropriate and could not reveal the complex and perhaps subtle dynamics that the theory actually stipulates. It may well be possible that the questionnaires employed in this research were too crude for their intended purposes and did not allow clients to indicate in a meaningful way what the relationship actually was between their childhood experiences, their adult attachment styles and the relationship with their therapist. Therefore, follow-up studies would be well advised to explore the fruitfulness of a qualitative investigation into the same processes I studied here. For example, such a study could use in-depth qualitative interviews to inquire about clients' current and past relationships with caregivers and other adults, including their therapists.

Empirical research has demonstrated that AT is relevant for psychotherapy and for therapeutic relationships generally (Byrd et al., 2010; Carver & Scheier, 2008; Mallinckrodt et al., 1995; Marmarosh, et al., 2009). The model of therapeutic change proposed by Bowlby (1988a) emphasises the relational aspect of therapy which is particularly relevant for the practice and knowledge base of counselling psychology. Additionally, AT describes the properties of an attachment relationship as compared to other close relationships, therefore depathologising client difficulties (Skourteli, & Lennie,, 2011). Central to the theory is the role of the therapist as a secure base from which an interactive therapeutic process develops and the transformation from insecure attachment representations to secure representations may take place. Consequently the therapeutic relationship has the potential to become a corrective experience for the client, a tool for relationship building and the reconstruction of insecure attachment experiences. If the aims of therapy are to enable the client to understand and strengthen their ability to cope with problems, AT offers a constructive theoretical framework, emphasising client growth and change through the development of the therapeutic relationship. In this study, AT was employed as a conceptual framework within which adult attachments could be empirically

explored. In conclusion, this study provided some empirical evidence that illuminates clinically important associations between adult attachment styles, recollections of childhood experiences and the working alliance in therapy. Some of the findings extend existing research on attachment theory in the context of psychotherapy. It is hoped that further research, in particular prospectively designed studies with more fine-grained measures of early experiences and attachment patterns, will be conducted to explore these findings even more thoroughly.

REFERENCES: Section B

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*: *23*,
1-33.

Ackerman, S.J., Benjamin, L.S., Beutler, L.E., Gelso, C.J., Goldfried, M.R. et al., (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force*. Psychotherapy: Theory, Research, Practice, and Training,* 38,
495-497.

Ainsworth, M. D. S. (1973). The development of infant-mother attachment. In B. M. Caldwell & H. N. Ricciuti (Eds), *Review of child development research* (Vol.3, pp.1-94). Chicago: University of Chicago Press.

Ainsworth, M.S. (1982) 'Attachment: retrospect and prospect', in C.M. Parkes and J. Stevenson-Hinde (eds), *The Place of Attachment in Human Behaviour, London: Tavistock.*

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

Anda, R.T., Felitti, V.J., Bremner, J.D., Walker, J.D. et al. (2006). The enduring effects of abuse and related adverse experiences in childhood: a convergence of evidence from neurobiology and epidemiology. *European Archieves of Psychiatry and Neuroscience.* 256, 174-186.

Bachelor, A., Meunier, G., Laverdiere, O., & Gamache, D. (2010). Client attachment to therapist: Relation to client personality and symptomology and their contributions to the therapeutic alliance. *Psychotherapy: Theory, Research, Practice, Training, 47*, (4), 454-468.

Baldwin, S. A., Wampold, B. E., & Imel, Z. E. (2007). Untangling the alliance-outcome correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, *75*, (6), 842-852.

Baron, R.M., & Kenny, D.A. (1986). The moderator-mediator variable distinction in social psychological research. Conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology*, 51, 1173-1182.

Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*(2), 226-244.

Batgos, J., & Leadbeater, B. J. (1994). Parental attachment, peer relations, and dysphoria in adolescence. In M. B. Sperling & W. H. Bermam (Eds.), *Attachment in adults: Clinical and developmental perspectives* (p. 155-178). New York: Guildford Press.

Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of Depression*. New York: Guildford Press.

Beckwith, L., Cohen, S. E., Hamilton, C. E. (1999). Maternal sensitivity during infancy and subsequent life events relate to attachment representation at early adulthood. *Developmental Psychology, 35*, 693-700.

Beebe, B. (2000). De-constructing parent-infant distress: the microsynchrony of maternal impingement and infant avoidance in the face-face encounter. *Psychoanalytic Enquirer, 20*, 421-440.

Behrens, K. Y. (2010). Amea through the eyes of Japanese mothers: Refining differences and similarities between attachment and amea. In P. Erdman & K. Ng (Eds.), *Attachment: Expanding the cultural connections,* (pp. 55-70). New York: Routledge.

Belsky, J., Jaffee, S., Sligo, J., Woodward, L., & Silva, P.A. (2005). Intergenerational transmission of warm-sensitive-stimulating parenting: A prospective study of mothers and fathers of 3-year-old. *Child Development, 76*, 384-396.

Berant, E., & Obegi, J. H. (2009). Attachment-informed psychotherapy research with adults. In J. H. Obegi & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp. 461-469). New York: Guildford Press.

Berlin, L., Amaya-Jackson, L., & Greenberg, M. (Eds.) (2005). Enhancing early attachments. *Theory, research, intervention, and policy,* New york, N.Y. Guildford Press.

Bernecker, S.L., Levy, K.N. & Ellison, E.D. (2013). A meta-analysis of the relation between patient adult attachment style and the working alliance. *Psychotherapy Research,* 24(1), 12-24.

Bernier, A., & Dozier, M. (2002). The client-counsellor match and the corrective emotional experience: Evidence from interpersonal and attachment research. *Psychotherapy: Theory, research, practice training, 39*(1), 32-43.

Bifulco, A. (2002). Attachment style measurements: A clinical and epistemological perspective. *Attachment and Human Development, 4*(2), 180-188.

Bifulco, A., Kwon, J., Jacobs, C., Moran, P. M., Bunn, A., & Beer, N. (2006). Adult attachment style as mediator between childhood neglect/abuse and adult depression and anxiety. *Social Psychiatry and Psychiatric Epidemiology, 41*, 796-805.

Bifulco, A., Moran, P.M., Ball, C., & Lillie A. (2002). Adult attachment style ll: Its relationship to psychosocial depressive-vulnerability. *Social Psychiatry and Psychiatric Epidemiology 37*, 60-67.

Black, S., Hardy, G., Turpin, T., & Parry, G. (2005). Self-reported attachment styles and therapeutic orientation of therapists and their relationship with reported general alliance quality and problems in therapy. *Psychology and Psychotherapy*, *78*, 363-377.

Boghart, A. C., & Tallman, K. (2010). Clients: The neglected common factor in psychotherapy. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble, *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 83-112). Washington, DC: APA.

Bordin, E.S. (1975). *The working alliance: Basis for a general theory of psychotherapy.* Paper presented at the Society for Psychotherapy Research, Washington, DC.

Bordin, E.S. (1989*). Building therapeutic alliances: The base for integration*. Paper presented at the Society for Psychotherapy Research, Berkeley, CA.

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

Bowlby, J. (1951). Maternal care and mental health. Geneva: *World Health Organisation Monograph Series* (No. 2).

Bowlby, J. (1969). *A secure base: Parent child attachment and healthy human development.* New York: Basic Books.

Bowlby, J. (1969/1997). *Attachment and loss*: Vol. 1. *Attachmen*t. London: Pimlico.

Bowlby, J. (1973). Self-reliance and some conditions that promote it. In R. Gosling (Eds.), *Support, Innovation and Autonomy* (pp. 23-46), London: Tavistock Publications.

Bowlby, J. (1973/1998). *Attachment and loss*: Vol.2. *Separation.* London: Pimlico.

Bowlby, J. (1977). The making and breaking of affectional bonds, I Aetiology and psychopathology in the light of attachment theory, II Some principles of psychotherapy, *British Journal of Psychiatry, 130*, 201-10.

Bowlby, J. (1980/1998). *Attachment and loss:* Vol.3*. Loss.* London: Pimlico.

Bowlby, J. (1982). Attachment and loss: retrospect and prospect. *American Journal of Orthopsychiatry, 52*, 664-78.

Bowlby, J. (1988a). *A secure base: Clinical applications of attachment theory.* London: Routledge.

Bowlby, J. (1988b). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145*, 1-10.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rhodes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guildford Press.

Brennan, K. A., Shaver, P. R. & Clark, C. L. (2000). *Specifying some mediators of attachment-related anxiety and avoidance.* Unpublished manuscript, State University of New York, Brockport, NY.

Bretherton, I. (1991). The roots and growing points of attachment theory. In C. M. Parkes, J. Stevenson-Hinde & P. Marris (Eds.), *Attachment Across the Life-Cycle.* London: Routledge.

Bretherton, I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology, 28*, 759-775.

Bretherton, I., & Munholland, K. A. (2008). Internal working models in attachment relationships. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 89-111). New York, NY: Guildford Press.

British Association for Counselling and Psychotherapy (BACP). (2010). Ethical framework for good practice in counselling and psychotherapy. Rugby: BACP.

British Psychological Society (BPS) .(2006). Code of Ethics and Conduct. Leicester: BPS Publications.

Byrd, K.R., Patterson, C.L., & Turchik, J.A. (2010). Working alliance as a mediator of client attachment dimensions and psychotherapy outcome. *Psychotherapy, 47*, 631-636.

Candelori, C., & Ciocca, A. (1998). Attachment and eating disorders. In A. Ciocca (Ed.), *Psychotherapeutic issues in eating disorders: Model, methods, and results* (pp. 139-153). Rome: Societa Editrice Universo.

Carlson, E. A. (1998). A prospective longitudinal study of attachment disorganization/disorientation. *Child Development, 69*, 1107-1128.

Carlson, E., & Sroufe, A. (1995). Contribution of attachment theory to developmental psychopathology. In D. Ciccetti & D. Cohen (Eds.), *Development and Psychopathology 1, theory and method*, (pp. 581-617). New York: Wiley & Sons.

Carlson, W.A., Sampson, M., & Sroufe, L.A. (2003). Attachment theory and pediatric practice. *Jour of Dev and BehaviourPpediatricks*, 24, 5, 364-379.

Carver, C. S., & Scheier, M. (2008*). Perspectives on personality* (6th ed.). Boston MA: Allyn & Bacon.

Cassidy, J. (2000). Adult romantic attachments: A developmental perspective on individual differences. *Review of General Psychology, 4,* 111-131.

Cassidy, J., & Kobak, R. R. (1998). Avoidance and its relationship with other defensive processes. In J. Belsky & T. Nezworski (Eds*.), Clinical implications of attachment* (pp. 300-323). Hillsdale, NJ: Erlbaum.

Cassidy, J., & Shaver, P. R. (Ed.). (2008). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.) New York: Guildford Press.

Castonguay, L.G., Constantino, M.J. & Grosse Holtforth, M. (2006). The working alliance: Where are we and where we should we go? *Psychotherapy: Theory, research, practice training,* 43.3.271

Clarkson, P. (2003). *The Therapeutic Relationship.* London: Whurr.

Cohen, J. (1988). *Statistical Power Analysis for the Behavioural Sciences* (2nd ed.). Hillsdale, NJ: Erlbaum.

Cohen, J. (1992). A power primer. *Psychological Bulletin, 112*, 155-159.

Cohen, J. & Cohen, P. (1983). *Applied multiple regression/correlation analysis for the behavioral sciences.* Hillsdale, N.J: Erlbaum Associates.

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

Contratto, S. (2002). A feminist critique of attachment theory and evolutionary psychology. In M. Ballou and L.S. Brown (Eds.), *Rethinking mental health and disorders: Feminist perspectives* (Vol. 22, 29-47). New York: Guildford Press.

Corcoran, K., & Fischer, J. (1991). *Measures for Clinical Practice* (3rd ed.). (Vol. 2.). Free Press. New York.

Cronbach, L.J. (1957). The two disciplines of scientific psychology, *American Psychologist, 12*, 671-684.

Daniel, S. I. F. (2006) Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26*, 968-984.

Data Protection Act (1998). *The National Archives.* Retrieved (2010) from www.legislation.gov.uk.

Del Giudice, M. (2011). Sex differences in romantic attachment: A meta-analysis. *Personality and Social Psychology Bulletin, 37*(2), 193-214.

Derlega, V. J., & Hendricks, S. S. (1991). *Psychotherapy as a personal relationship.* New York: Guildford Press.

Despland, J.-N., de Roten, Y., Despars, J., Stigler, M., & Perry, J. C. (2001). Contribution of patient defense mechanisms and therapist interventions to the development of early therapeutic alliance in a brief psychodynamic investigation. *The Journal of psychotherapy practice and research, 10*(3), 155.

Diehl, M., Elnick, A. B., Bourbeau, L. S., & Labouvie-Vief, G. (1998). Adult attachment styles: Their relations to family context and personality*. Journal of Personality and Social Psychology, 74*, 1656-1669.

Diener, M. J. Hilsenroth, M. J., & Weinberger, J. (2009). A primer on meta-analysis of correlation coefficients: The relationship between patient-reported therapeutic alliance and adult attachment style as an illustration. *Psychotherapy Research*, *19*, 519-526.

Dinger, U., Strack, M., Sachsse, T., & Schauenburg, H. (2009). Therapist's attachment, patient's interpersonal problems, and alliance development over time in inpatient psychotherapy. *Psychotherapy, 46*, 277-290.

Dobson, K.S. (2009). (Ed.) *Handbook of Cognitive Behavioural Therapies.* (2nd ed). New York. Guildford Press.

Dolan, R. T., Arnkoff, D. B., & Glass, R. (1993). Client attachment style and the psychotherapist's interpersonal stance. *Psychotherapy, 30*, 408-412.

Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology, 62*(4),793-800.

Dozier, M., Stovall, K. C. & Albus, K. E. (1999). Attachment and psychopathology in adulthood. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory*, *research, and clinical implications* (pp. 497-519). New York: Guilford Press.

Dryden, W., & Feltham, C. (1992). Brief Counselling. Open University Press. Buckingham.

Dwyer, K. M., Fredstorm, B. K., Rubin, K. H., Booth-LaForce, C., Rose-Krasnor, L., & Burgess, K. B. (2010). Attachment, social information processing, and friendship quality of early adolescent girls and boys. *Journal of Social and Personal Relationships, 27*(1), 91-116.

Eames, V., & Roth, A. (2000). Patient attachment orientation and the working alliance: A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research, 10,* 421-434.

Elliot, A. J., & Reis, H. T. (2003). Attachment and exploration in adulthood. *Journal of Personality and Social Psychology, 85*, 317-331.

Eng, W., Heimberg, R., Hart, T., Schneider, F., & Liebowitz,, M. (2001). Attachment in individuals with social anxiety disorder: the relationship among adult attachment styles, social anxiety and depression. *Emotion, 4*, 365-380.

Enns, M. W., Cox, B. J., & Clara, I. (2002). Parental bonding and adult psychopathology results from the US national comorbidity survey. *Psychological Medicine, 32*, 997-1008.

Feeney, J. A., & Noller, P. (1990). Attachment style as a predictor of adult romantic relationships. *Journal of Personality and Social Psychology, 58*, 281-291.

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment. In M. B. Sperling & W. H. Berman (Eds.), *Attachment in adults: Clinical and developmental perspectives* (p. 128-152). Guildford Press.

Feltham, C. (Ed.). (1999). *Understanding the counselling relationship.* London: Sage.

Fisher, R.J. (1993). Social desirability bias and the validity of indirect questioning. Journal of Consumer research, 20(2), 3003-315.

Fonagy, P. (1994). The theory and practice of resilience. *Journal of Child Psychology and Psychiatry, 35*, 231-257.

Fonagy, P., & Target, M. (1997). Attachment and reflective function: Their role in self organization. *Development and Psychopathology, 9*(4), 679-700.

Fonagy, P., Leigh, T., Steele, M., Steele, H., Kennedy, R., Matoon, G., Target, M., & Gerber, A. (1996). The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology*, *64*, 22-31.

Fonagy, P., Target, M., Steele, H., & Steele, M. (1998), *Reflective functioning manual. Version %. For application to Adult Attachment Interviews,* Sub-Department of Clinical Health Psychology, University College London (unpublished manuscript).

Fraley, C. R., & Philips, R. L. (2009). Self-report measures of adult attachment in clinical practice. In J. H. Obegi & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp. 153-180). New York: Guildford Press.

Fraley, C. R., & Shaver, P. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology, 4*, 132-154.

Fraley, R. C. (2002). Attachment stability from infancy to adulthood: Meta-analysis and dynamic modeling of developmental mechanisms. *Personality and Social Psychology Review, 6,* 123-151.

Freud, A. (1949). AQA B *Psychology/ Attachment, Deprivation, & Privation: Bulldogs Bank Study.* Retrieved (2013) from http://aqabpsychology.co.uk

Freud, A. (1972). *Problems of Psychoanalytic Technique and Therapy.* London: The Hogarth Press.

Freud, A., & Dann, S. (1951). An experiment in group upbringing Psychoanalytic Study of the Child 6, 127-168. Reprinted in A. Freud (1969), Indications for child analysis, and other papers, 1945-56 (Chapter 8, pp. 163-229). London: Hogarth Press.

Freud, S. (1911). Formulations regarding the two principles in mental functioning. Papers on Metapsychology: *Papers on Applied Psycho-Analysis.* Collected papers, (Vol. 4, pp. 13-21). London: Hogarth Press & Institute of Psychoanalysis, 1924-1950.

Freud, S. (1940). The dynamics of transference. In J. Starchey (Eds.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 99-108). London: Hogarth Press. (Original work published 1912).

Garry, M. & Loftus, E. (1994). Pseudomemories without hypnosis. *Journal of Clinical and Experimental Hypnosis, 42*(4), 363-378.

Gaston, L. (1990). The concept of the alliance and its role in psychotherapy: Theoretical and empirical considerations. *Psychotherapy.* 27, 143-153.

Gelo, O., Braatmann, D., and Benetka, G. (2008). Quantitative and qualitative research: Beyond the Debate. *Integrative Psychological and Behavioural Science* 42. 266-290.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship; Their Interaction, Unfolding During Treatment. *Journal of Counselling Psychology, 41*(30), 296-306.

George, C. & West, M. (2001). The development and preliminary validation of a new measure of adult attachment: The adult attachment projective. *Attachment and Human Development.* 3, 30-61.

George, C., Kaplan, N., & Main, M. (1985). *An adult attachment interview: Interview protocol.* Unpublished manuscript, Berkeley, University of California.

Gerlsma, C., & Luteijn, F. (2000). Attachment style in the context of clinical and healthy psychology: a proposal for the assessment of valence, incongruence, and accessibility of attachment representations in various working models. *British Journal of Medical Psychology, 73*, 15-34.

Gilbert, P. & Leahy, R. L. (2007). *The therapeutic relationship in the cognitive behavioural psychotherapies.* East Sussex: Routledge.

Gillath, O., Shaver, P. R., Baek, J. M., & Chun, D. S. (2008). Genetic correlates of adult attachment style. *Personality and Social Psychology Bulletin, 34*, 1396-405.

Goldfried, M. R., & Davila, J. (2005). The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 421-430.

Goldman, G. A., & Anderson, T. (2007). Quality of object relations and security of attachment as predictors of early therapeutic alliance. *Journal of Counselling Psychology, 54*, 111-117.

Gowen, J., & Nebrig, J. (2002). *Enhancing early emotional development: Guiding parents of young children.* Baltimore: Paul H Brooks.

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

Grosse Holtsforth, M., & Grawe, K. (2002). Bern Inventory of Treatment Goals: Part
Development and first application of a taxonomy of treatment goal themes. *Psychotherapy Research, 12*(1), 79-99.

Grossman, K., Grossman, K. E. et al., (1985). Maternal sensitivity and newborns orientation responses as related to quality of attachment in northern Germany. In I. Bretherton & E. Walters (Eds.), *Growing points in attachment theory and research. Monographs of the Society for Research in Child Development,* 233-256.

Hamilton, C. E. (2000). Continuity and discontinuity of attachment from infancy through adolescence. *Child Development, 71*, 690-694.

Hardt, J., & Rutter, M. (2004). Validity of retrospective reports of adverse childhood experiences: review of the evidence. *Journal of Child Psychology and Psychiatry, 45*(2), 260-273.

Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C. & Reilly, S. (2004). Assessing and formulating attachment issues and styles in psychotherapy. *British Journal of Psychotherapy, 20*(4). 493-511.

Hardy, G. E., Aldridge, J., Davidson, C., Rowe, C., Reilly, S., & Shapiro, D. A. (1999). Therapist responsiveness to patient attachment styles and issues observed in

patient-identified significant events in psychodynamic-interpersonal psychotherapy. *Psychotherapy Research, 9*, 36-53.

Harlow, H. F. & Harlow, M. K. (1969). Effects of various mother infant relationships on rhesus monkey behaviours. In B. M. Foss (Eds.), *Determinants of Infant Behaviour* IV (pp. 15-36). London: Methuen.

Harris, J. R. (1998). *The Nurture Assumption: Why Children Turn Out the Way They Do*. New York: Free Press. ISBN 978-068-484409-1.

Harris, J.R. (2000). Socialization, personality development, the child's environment. *Developmental Psychology*, 36, 699-710.

Hazan, C., & Diamond, L. M. (2000). The place of attachment in human mating. *Review of General Psychology, 4*, 186-204.

Hazan, C., & Shaver, P. R. (1987). Romantic love conceptualized as an attachment process. *Journal of Personality and Social Psychology, 52*, 511-524.

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

Hemphill, J. F. (2003). Interpreting the magnitude of correlation coefficients. *American Psychologist, 58*(1), 78-79.

Henry, W. P., & Strupp, H. H. (1994). The therapeutic alliance as interpersonal process (Chapter 3). In A. O. Horvath & L. S. Greenberg (Eds). *The working alliance: Theory research and practice.* New York: Wiley & Sons.

Hersoug, A. G., Hoglend, P., Monsen, J. T., & Havik, O. E. (2001). Quality of Working Alliance in Psychotherapy. *Journal of Psychotherapy Practice and Research, 10*, 205-216.

Hesse, E. (1999). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 395: 433). New York: Guildford Press.

Hesse, E. (2008). The adult attachment interview: Historical and current perspectives. In J. Cassidy & P. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications.* New York: Guildford Press.

Hill, J., Pickles, A., Burnside, E., Byatt, M., Rollinson, L., Davis, R., & Harvey, K. (2001). Child sexual abuse, poor parental care, and adult depression: evidence for different mechanism. *British Journal of Psychiatry, 179*, 104-109.

Holmes, J. (1996)*. Attachment, intimacy, autonomy: Using attachment theory in adult psychotherapy*. Northvale, NJ: Aronson.

Holmes, J. (2001). *The search for the secure base*. London: Routledge.

Holmes, J. (2004). *John Bowlby & Attachment Theory*. London: Routledge.

Horowitz, L. M., Rosenberg, S. E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles, and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(4), 549-560.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In J. C. Norcross (Eds.), *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 37-69). London: Oxford University Press.

Horvath, A. O., & Greenberg, L. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counselling Psychology, 36*, 139-149.

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

Horvath, A. O., & Greenberg, L. (1995). Development of the working alliance inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529-556). New York: Guildford Press.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 561-573.

Horvath, A. O., Del Re, C., Fluckiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*, 9-16.

Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B.E. Wampold, & M.A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 23-46). Washington, DC: APA.

Imamoglu, E. O. & Imamoglu, S. (2010). Attachment within a cultural perspective: Relationships with exploration and self orientations. In P. Erdman & K. Ng (Eds.), *Attachment: Expanding the cultural connections,* (pp. 35-54). New York: Routledge.

Jacobs, J. (2004). *Psychodynamic Counselling in Action.* London: Sage.

Jellema, A. (2002*) CAT and attachment theory: Where are we now?* ACAT News, Summer 2002 conference paper, 14-18

Jordan, L. (2007). Attachment-based counselling. Could this be an ABC of psychological therapies? *Counselling Psychology Review, 22*(1), 58-61.

Kagan, J. (1998). *Three Seductive Ideas.* ISBN 0-674-89033-7

Kagan, J. (2009). Two is Better than one. *Association for Psychological Science, 4*, 20-23.

Kagan, J., & Snidman, N. (2004). *The Long shadows of Temperament.* Cambridge, MA: Harvard University Press.

Kanninen, K., Salo, J., & Punamaki, R. L. (2000). Attachment patterns and working alliance in trauma therapy for victims of political violence. *Psychotherapy Research, 10*, 435-449.

Kerns, K. A. (2008). Attachment in Middle Childhood. In J. Cassidy & P. R. Shaver, *Handbook of Attachment: Theory, Research and Clinical applications.* New York: Guildford Press.

Kerns, K. A., Aspelmeier, J. E., Gentzler, A. L., & Grabill, C. M. (2001). Parent-child attachment and monitoring in middle childhood. *Journal of Family Psychology, 15*, 69-81.

Kivlighan Jr., D. M., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counselling Psychology, 45*(3), 274-278.

Kivlighan Jr., D. M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counselling Psychology, 47*(3), 362-371.

Klein, M. (1975). *The Psychoanalysis of Children*. New York: Free Press.

Klohnen, E. C., & Bera, S. (1998). Behavioral and experiential patterns of avoidantly and securely attached women across adulthood: A 31-year longitudinal perspective. *Journal of Personality and Social Psychology, 74*, 211-223.

Kochanska, G., Aksan, N., & Carlson, J., (2005). Temperament, relationships and young children's receptive cooperation with their parents. *Developmental Psychology, 41*(4), 648-660.

Korfmacher, J., Adam, E., Ogawa, J., & Egeland, B. (1997). Adult attachment: Implications for the therapeutic process in a home intervention. *Applied Developmental Science, 1*(1), 43-52.

Kramer, U., de Roten, Y., Beretta, V., Michel, L., & Despland, J.-N. (2009). Alliance patterns over the course of short-term dynamic psychotherapy: the shape of productive relationships. *Psychotherapy Research, 19*(6), 699-706. doi: 10.1080/10503300902956742

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (1996). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. *Journal of Consulting and Clinical Psychology, 64*(3), 532.

Krupnick, J. L., Sotsky, S. M., Simmens, S., Moyer, J., Elkin, I., Watkins, J., & Pilkonis, P. A. (2006). The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the national institute of mental health treatment of depression collaborative research program. *Focus, 4*, 269-277.

Lambert, M. J., & Bergin, A. E. (1994). The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change* (4th ed., pp. 72-113). New York: Wiley & Sons.

Le Poire, B. A., Haynes, J., Driscoll, J., Driver, B. N., Wheelis, T. F., Hyde, M. K., Prochaska, M., & Ramos, L. (1997). Attachment as a function of parental and partner approach-avoidance tendencies. *Human Communication Research, 23*(3), 413-441.

Levy, K. N., Ellison, W. D., Scott, L. N., & Bernecker, S. (2011). Attachment styles. In J. C. Norcross (Eds.), *Psychotherapy relationships that work* (2nd ed., pp. 377-401). New York: Oxford University press.

Lewis, M., Feiring, C., & Rosenthal, S. (2000). Attachment over time. *Child Development, 71*, 707-720.

Lier, L. (1998). Mother-infant relationships in the first year. *Acta Paediatrica Scandinavia Supplementum, 344*(77), 31-42.

Lorenz, K. Z. (1981). *The foundations of ethology.* New York: Springer Verlag.

Lorion, R. P., & Felner, R. D. (1986). Settling the record straight. *American Psychologist, 40*(12), 1418-1419.

Luborsky, L. (1976). Helping alliances in psychotherapy. In J. L. Cleghhorn (Eds.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel.

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

MacKenzie, M. J. & McDonough, S. (2009). Transactions between Perceptions and Reality: Maternal Beliefs and Infant Regulatory Behaviour. In A. Sameroff (Eds.) *The Transactional Model of Development: How children and Contexts Shape Each Other* (pp. 35-54*).* Washington, DC: American Psychological Association.

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

Main, M., & Goldwyn, R. (1984*). Adult attachment scoring and classification system.* Unpublished manuscript, University of California at Berkeley.

Main, M., Goldwyn, R., & Hesse, E. (2002) *Adult attachment scoring and classification systems.* Unpublished manuscript, University of California at Berkeley.

Mallinckrodt, B. (2010). The psychotherapy relationship as attachment: Evidence and implications. *Journal of Personal and Social Relationships, 27*, 262-270.

Mallinckrodt, B., Gantt, D.L., & Coble, H.M. (1995). Attachment patterns in the psychotherapy relationship: Development of the client attachment to therapist scale. *Journal of Counselling Psychology*, 42(3), 307-317.

Mallinckrodt, B., King, J. L., & Coble, H. M. (1998). Family dysfunction, alexithymia, and client attachment to therapist. *Journal of Counselling Psychology*, *45*, 497-504.

Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M., Jr. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy, 42*, 85-100.

Marmarosh, C. L., Gelso, C. J., Markin, R. D., Majors, R., Mallery, C., & Choi, J. (2009). The real relationship in psychotherapy: Relationships to adult attachments, working alliance, transference, and therapy outcome. *Journal of Counselling Psychology, 56*, 337-350.

Maroda, K. J. (2010). *Psychodynamic techniques: Working with emotion in the therapeutic relationship.* New York: Guildford Press.

Marrone, M. (2000). *Attachment and Interaction.* London: Jessica Kingsley Publishers.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relationship of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Martinelli, M. (2010). Being is the new doing: Exploring the philosophical bases of Counselling Psychology. *Counselling Psychology Review, 25*(3), 39-46.

Mead, M. (1964). *Continuities in Cultural Evolution.* New Brunswick, NJ: Transaction Publishers.

Meszaros, J. (2004). Psychoanalysis is a two way street. *International Forum Psychoanalysis, 13*, 105-113.

Metzger, S., Erdman, P., & Ng, K., (2010). Attachment in cross-cultural contexts. In P. Erdman & K. Ng (Eds.), *Attachment: Expanding the cultural connections* (pp.3-12). New York: Routledge.

Meyer, B. (2005). *Child Experiences Survey*. Unpublished manuscript, City University London.

Meyer, B., & Pilkonis, P. A, (2002). Attachment style. In J. C. Norcross (Ed.). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients* (pp. 367-382). London: Oxford University Press.

Meyer, B., Pilkonis, P. A., Proietti, J. M., Heape, C. L., & Egan, M. (2001). Attachment styles and personality disorders as predictors of symptom course. *Journal of Personality Disorders, 15*(5), 371-389.

Meyer, C., & Gillings, K. (2004). Parental bonding and bulimic psychopathology: The mediating role of mistrust/abuse beliefs. *International Journal of Eating Disorders, 35*, 229-233.

Mickelson, K. D., Kessler, R. C., & Shaver, P. R. (1997). Adult attachment in a nationally representative sample. *Journal of Personality and Social Psychology, 73*, 1092-1106.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zenna (Eds.), *Advances in experimental social psychology (Vol.* 35, pp. 53-152). San Diego, CA: Academic Press.

Mikulincer, M., & Shaver, P. R. (2004). Security based self representations in adulthood: Contents and processes. In W. S. Rholes & J. A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 159-195). New York: Guildford Press.

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change.* New York: Guildford Press.

Mikulincer, M., Gillath, O., & Shaver, P. R. (2002). Activation of the attachment system in adulthood: Threat related primes increase accessibility of mental representations of attachment figures. *Journal of Personality and Social Psychology, 83*, 881-895.

Mikulincer, M., Shaver, P. R., & Berant, E. (2012). An Attachment Perspective on Therapeutic Processes and Outcomes. *Journal of Personality, 8*(6), 606-16.

Miller, A. (1993). *The drama of the gifted child and the search for the true self* (R. Ward, trans.). London: Faber & Faber (first published in 1979).

Mizuta, I., Zahn-Waxler, C., Cole, P. M., & Hiruma, N. (1996). A cross-cultural study of preschoolers attachment: Security and sensitivity in Japanese and US dyads. *International Journal Behavioral Development, 19*(1), 141-159.

Mosheim, R., Zachhuber, V., Scharf, L., Hoffman, A., Kemmler, G., Danzl, C., Kinze, J., Biebl, W., & Richter, R. (2000). Quality of attachment and interpersonal problems as possible predictors of inpatient therapy outcome. *Psychotherapist, 45*, 223-229.

Moss, E., Bureau, J. F., Beliveau, M. J., Zdebik, M., & Lepine, S. (2009). Links between children's attachment behaviour at early school age, their attachment-related representations, and behaviour problems in middle childhood. *Internationa Journal Of Behavioral Development, 33*, (2), 155-166.

Muller, R. T. (2010). *Trauma and the avoidant client: Attachment based strategies for healing.* New York: W.W. Norton & Co.

Muller, R. T., & Rosenkranz, S. E. (2009). Attachment and treatment response among adults in inpatient treatment for posttraumatic stress disorder. *Psychotherapy, 46*, 82-96.

Murphy, B., & Bates, G. W. (1997). Adult attachment style and vulnerability to depression. *Personality Individual Differences, 22*, 835-844.

National Institute for Clinical Excellence (NICE). (2008). Retrieved 11 December 2008, from: www.nice.org.uk/Guidance/CG/Published

National Institute for Mental Health (England) (NIMHE). (2002). *Cases for change: Primary care.* London: NIMHE.

Nederhof, A. (1985). Methods of coping with social desirability bias: A review. *European Journal of Social Psychology, 15*, 263-280.

Norcross, J. C. (Ed.). (2001). Empirically supported therapy relationships: Summary report of the Division 29 Task Force. *Psychotherapy*, 38 (4).

Norcross, J. C. (2011). *Psychotherapy relationships that work.* Oxford: Oxford University Press.

O'Brian, M. (2009). Towards integration. In R. Woolfe, S. Strawbridge, B. Douglas & W. Dryden (Eds.), *Handbook of counseling psychology* (3rd ed., pp.173-192). London: Sage.

O'Kearney, R. (1996). Attachment disruption in anorexia nervosa and bulimia nervosa: A review of theory and empirical research. *International Journal of Eating Disorders, 7*, 101-106.

Oakley, A. (1981). *Woman confined: Towards a sociology of childbirth*. Oxford: Martin Robertson.

Orlinsky, D. E., Grawe, K., & Parks, B. K. (1994). Process and outcome in psychotherapy-nocheinmal (Chapter 8). In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behaviour change.* New York: Wiley & Sons.

Patel, M. X., Doku, V., & Tennakoon, L. (2003). Challenges in recruitment of research participants. *Advances in Psychiatric Treatment, 9*, 229-238.

Pauli-Pott, U., & Mertesacker, B. (2009). Affect expression in mother-infant interaction and subsequent attachment development. *Infant Behaviour and Development, 32*, 208-215.

Pederson, C. L., & Wilson, J. F. (2009). Childhood emotional neglect related to post traumatic stress disorder symptoms and body mass index in adult women. *Psychological Reports, 105*, 111-126.

Perry, B.D., Pollard, R., Blakely, T., Baker, W., & Givilante, D. (1995). Childhood trauma, the neurobiology of adaptation and 'use-dependent' development of the brain-how 'states' become 'traits.' *Infant Mental Health Journal*, 16, 271-91.

Phelps, J. L., Belsky, J., & Crnic, K. (1998). Earned security, daily stress, and parenting: A comparison of five alternative models. *Development and Psychopathology, 10*(1), 21-38.

Pilkonis, P. A. (1998). Personality prototypes among depressives: Themes of dependency and autonomy. *Journal of Personality Disorders, 22*(2), 144-152.

Principe, J. M., Marci, C. D., Glick, D. M., & Ablon, J. S. (2006). The relationship among patient contemplation, early alliance, and continuation in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 43*(2), 238.

Rector, A.L., Seeman, M.V., Zanstra, P.E., Solomon, J.E. et al., (1999). Reconciling users' needs and formal requirements: Issues in developing a re-usable ontology for medicine. IEEL Transactions in Information Technology in Bio Medicine, 2(4), 229-242.

Rholes, W.S., & Simpson, J.A. (Eds.). (2004). *Adult attachment: Theory, research, and clinical implications.* New York, NY, US: Guilford Publications.

Rizq, R. (2009). Psychodynamic approaches. In R. Woolfe, S. Strawbridge, B Douglas & W. Dryden (Eds*.), Handbook of counseling psychology* (3rd ed., pp.85-104). London Sage.

Robertson, J., & Robertson, C. (1952). *Film: A Two-Year-Old Goes to Hospital.* London: Tavistock.

Rogers, C. R. (1951). *Client-centered therapy.* Boston, MA: Houghton Mifflin*.*

Rogers, C. R. (1990). *On Becoming a Person: A Therapist's View of Psychotherapy.* London: Constable.

Romano, V., Fitzpatrick, M., & Janzen, J. (2008). The secure base hypothesis: Global attachment, attachment to counsellor, and session exploration in psychotherapy. *Journal of Counselling Psychology, 55*, 495-504.

Romano, V., Fitzpatrick, M., & Janzen, J. (2009). Volunteer client attachment moderates the relationship between trainee therapist attachment and therapist interventions. *Psychotherapy Research, 19*, 666-676.

Rothbaum, F., Kakinuma, M., Nagoaka, R., & Azuma, H. (2007). Attachment and amae: Parent child closeness in the United States and Japan. *Journal of Cross-cultural Psychology, 38*(4), 465-486.

Rothbaum, F., Weisz, J., Pott, M., Miyake, K., & Morelli, G. (2000). Attachment and culture: Security in the United States and Japan. *American Psychologist,* 55(10), 1093-1104.

Rovee-Collier, C. (1999). The development of infant memory. *Current Directions in Psychological Science, 8*(3), 80-85.

Rubino, G., Barker, C., Roth, T., & Fearon, P. (2000). Therapist empathy and depth of interpretation in response to potential alliance ruptures: The role of therapist and patient attachment styles. *Psychotherapy Research, 10*(4), 408-420.

Rutter, D. R., & Durkin, K. (1987). Turn-taking in mother-infant interaction: An examination of vocalization and gaze. *Developmental Psychology, 23*, 54-61.

Rutter, M. (1981). *Maternal Deprivation Reassessed* (2nd ed.). London: Penguin.

Rutter, M., & Silberg, J. (2002). Gene-environment interplay in relation to emotional and behavioral disturbance. *Annual Review in Psychology, 53*, 463-490.

Ryle, A., & Kerr, I.B. (2002). *Introducing Cognitive Analytic Therapy.* Chicester: Wiley & Sons.

Safran, J. D., & Muran, J. C. (Ed.). (1995). The therapeutic alliance [Special issue]. *In Session: Psychotherapy in Practice, I* (1).

Saketopoulou, A. (1999). The psychotherapeutic alliance in psychodynamic psychotherapy: Theoretical conceptualizations and research findings. *Psychotherapy, 36*, 329-342.

Satterfield, W. A., & Lyddon, W. J. (1995). Client attachment and perceptions of the working alliance with counselor trainees. *Journal of Counselling Psychology, 42*(2), 187-189.

Sauer, E. M., Anderson, M. Z., Gormley, B., Richmond, C. J., & Preacco, L. (2010). Client attachment orientations, working alliances and responses to therapy: A psychology training clinic study. *Psychotherapy Research, 20*, 702-711.

Sauer, E. M., Lopez, F. G., & Gormley, B. (2003). Respective contributions of therapist and client attachment orientations to the development of the early working alliance: A preliminary growth modeling study. *Psychotherapy Research, 13*(3), 371-382.

Scharf, M. (2001). A "natural experiment" in Child rearing Ecologies and Adolescents Attachment and Separation Representations. *Child Development, 72*(1), 236-51.

Schore, A. (1994). *Affect Regulation and the Origin of the Self.* Hillsdale, NJ: Lawrence Erlbaum Associates.

Schore, A. (2001). The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal*, 22, 7-66.

Schore, A. (2003a). *Affect dysregulation and disorders of the self.* New York: W.W. Norton & Co.

Schore, A. (2003b) *Affect regulation and repair of the self.* New York: W.W. Norton & Co.

Scott, M. J., & Dryden, W. (2003). The cognitive-behavioural paradigm. In R. Woolfe, W. Dryden, & S. Strawbridge (Eds.), *Handbook of Counselling Psychology* (2nd ed., 156-179.) London: Sage.

Shane, M. G., & Shane, M. (2001). The attachment motivational system as a guide to an effective therapeutic process. *Psychoanalytic Inquiry, 21*(5), 675-687.

Shaver, P. R., & Mikulincer, M. (2002). Attachment related psychodynamics. *Attachment and Human Development, 4*, 133-161.

Shaver, P. R., Belsky, J., & Brennan, K. A. (2000). The Adult Attachment Interview and self-reports of romantic attachment: Association across domains and methods. *Personal Relationships, 7*(1), 25-43.

Shorey, H. S. & Snyder, C. R. (2006). The role of adult attachment styles in psychopathology and psychotherapy outcomes. *Review of General Psychology*, *10*(1),1-20.

Simpson, J.A. (1990). Influence of attachment styles on romantic relationships. *Journal of Personality and Social Psychology.* 59, 5, 971-980.

Simpson, J. A., & Rholes, W. S. (2002). Fearful-avoidance, disorganization, and multiple working models: Some directions for future theory and research. *Attachment and Human Development, 4*, 223-229.

Simpson, J. A., Collins, W. A., Tran, S., and Haydon, K. C. (2007). Attachment and the experience and expression of emotions in romantic relationships: A developmental perspective. *Journal of Consulting and Clinical Psychology, 66*, 174-184.

Skourteli, M. C. & Lennie, C. (2011). The therapeutic relationship from an attachment theory perspective. *Counselling Psychology Review, 26*(1), (20-31).

Slade, A. (2008). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds*.), Handbook of attachment* (pp. 575-594). New York: Guildford Press.

Soares, I., & Dias, P. (2007). Agego y psicopatologia en jovenes y adults. *International Journal of Clinical and Health Psychology, 7*, 177-195.

Solomon, J., & George, C. (1999). The development in attachment in separated and divorced families. *Attachment and Human Development, 1*(1), 2-33.

Sonkin, D. (2005). Attachment theory and psychotherapy. *The Therapist, California Association of Marriage and Family Therapists,* 17(1), 68-77.

Sonkin, D. & Dutton, D (2003). Treating assaultive men from an attachment perspective. In R. Geffner, D. G. Dutton, & D. Sonkin (Eds), *Intimate Violence: Contemporary Treatment Innovations* (pp. 105-133). New York: Haworth Publishing.

Sroufe L. A. (1995). *Emotional development: The organization of emotional life in the early years.* New York, NY: Cambridge University Press.

Sroufe, L. A., Egeland, B., Carlson, E. A., & Collins, W. A. (2005). *The Development of the Person: The Minnesota Study of Risk and Adaptation from Birth to Adulthood.* New York: Guildford Press.

Steele, H. (2002). State of the art: Attachment Theory. *The Psychologist, 15*(10), 518-523.

Some implications of developmental observations for adult psychotherapy. *Infant Mental Health Journal.* Vol. (19), 300-308.

Stern, D., (2004) *The present moment in psychotherapy and everyday life.* New York: W.W. Norton & Co.

Stiles, W. B., & Goldsmith, J. Z. (2010). The alliance over time. In J. C. B. Moran, J. P. (Ed.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 44-62). New York: Guilford Press.

Strauss, B., Lobo-Drost, A., Pilkonis, P.A. (1999). Assessment of attachment styles in adults-First experiences with the German version of an adult attachment prototype rating. *Zeitschrift fur Klinische Psychologie, Psychotherapie ubd Psychiatre,* 49, 223-245.

Tasca, G. A., Taylor, D., Bissada, H., Ritchie, K., & Balfour, L. (2004). Attachment predicts treatment completion in an eating disorder partial hospital program among women with anorexia nervosa. *Journal of Personality Assessment, 83*, 201-212.

Taylor, P., Rietzschel, J., Danquah, A., & Berry, K. (2015). Changes in attachment representations during psychological therapy. *Psychotherapy Research, 25*(2), 222-238.

Tereno, S., Soares, I., Martins, C., Celani, M., & Sampaio, D. (2008). Attachment styles, memories of parental rearing and therapeutic bond: A study with eating disordered patients, their parents and therapists. *European Eating Disorders Review*, *16*, 49-58.

Toomela, A. (2008). Variables in psychology: A critique of quantitative psychology. *Integrative Psychological and Behavioural Science*, 42(3), (insert pages).
Toth, S. L., Cicchetti, D., Rogosch, F. A., & Sturge-Apple, M. (2009). Maternal depression, children's attachment security, and representational development: An organizational perspective. *Child Development, 80*, 192-208.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment, 1*, 207-210.

Travis, L. A., Bliwise, N. G., Binder, J. L., & Horne-Moyer, H. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy. *Psychotherapy, 38*, 149-159.

Tronick, E. Z., & Weineberg, M. K. (1997). Depressed mothers and infants: Failure to form dyadic states of consciousness. In L. Murray & P. Cooper (Eds.), *Postpartum depression and child development* (pp. 54-81). New York: Guildford Press.

van Ijzendoorn, M. H., & Bakermans Kranenburg, M. J. (1996) Attachment representations in mothers, fathers, adolescents, and clinical groups: A meta analytic search for normative data. *Journal of Consulting and Clinical Psychology*, 64(1), 8-21.

van Ijzendoorn, M. H., & Kroonenberg, P. M. (1988). Cross-cultural patterns of attachment: A meta-analysis of the strange situation. *Child Development, 59*, 147-156.

van Ijzendoorn, M. H., & Sagi, A. (1999). Cross-cultural patterns of attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 713-734). New York: Guilford Press.

Wallin, D. (2007). *Attachment in psychotherapy*. New York: Guildford Press.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum.

Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 49-82). Washington, DC: APA.

Wang, C. D., & Song, Y. S. (2010). Adult attachment reconceptualised: A Chinese perspective. In P. Erdman & K. Ng (Eds.), *Attachment: Expanding the cultural connections* (pp. 15-34). New York: Routledge.

Wang, C. D., & Mallinckrodt, B. (2006). Acculturation, attachment, and psychosocial adjustment of Chinese/Taiwanese international studies. *Journal of Counselling Psychology, 53*(4), 422-433.

Ward, A., Ramsay, R., Turnbull, S., Benedettini, M., & Treasure, J. (2000). Attachment patterns in eating disorders: Past in the present. *International Journal of Eating Disorders, 28*, 370-376.

Waters, E., Crowell, J., Elliot, M., Corcoran, D., & Treboux, D. (2002). Bowlby's secure base theory and the social/personality psychology of attachment styles: works in progress. *Attachment and Human Development, 4,* 230-242.

Waters, E., Merrick, S., Treboux, D., Crowell, J., & Albersheim, L. (2000). Attachment security in infancy and early adulthood: A twenty-year longitudinal study. *Child Development, 71*, 884-689.

Weinfield, N. S., Whaley, G. J. L., & Egeland, B. (2004). Continuity, discontinuity, and coherence in attachment from infancy to late adolescence: Sequelae of organization of disorganization. *Attachment and Human Development, 6*(1), 73-97.

Whiffen, V. E., Judd, M. E., Aube, J. A. (1999). Intimate relationships moderate the association between childhood sexual abuse and depression. *Journal of Interpersonal Violence, 14*, 940-954.

Wilkins, P. (2000).Unconditional positive regard reconsidered. *British Journal of Guidance and Counselling,* 28, (1), 23-36.

Wilkins, D. P., S.; Granville, G.; Branney, P. (2008). *The gender and access to health services study*. London: United Kingdom Department of Health.

Woodhouse, S. S., Schlosser, L. Z., Crook, R. E., Ligiero, D. P., & Gelso, C. J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counselling Psychology, 50*, 395-408.

Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe and W. Dryden (Eds.), *Handbook of Counselling Psychology* (pp. 3-20). London: Sage.

Yates, T. M., Egeland, B., & Sroufe, A. (2003). Rethinking Resilience: A developmental process perspective. In S. S. Luthar (Eds.), *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities.* New York: Cambridge University Press.

Zeanah, C. H., & Fox, N. A. (2004). Temperament and attachment disorders. *Journal of Clinical and Child and Adolescent Psychology, 33*, 32-41.

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

Section D: A critical review on
Postnatal depression and attachment

Overview

Childbirth is normally a time for rejoicing and celebration, but for some new mothers the experience of motherhood can be unbearably dark and disturbing. Postnatal depression (PND) is a debilitating condition that diminishes the mother's resources to cope with caring for her baby, and impacts the mother-infant relationship. This is a critical review of the literature on PND that explores the arising attachment problems in the mother-infant relationship and interventions that repair the bond. The first section of the review includes different perspectives on the epidemiology of PND, its possible causes, and the course it takes. The second half of the review focuses on attachment and PND including a review of relevant research on how insecure attachment may contribute to PND, the effects of PND on the mother-child bond and various interventions that repair the bond, and includes a concluding section on how attachment theory can inform therapy for PND.

Counselling psychologists working in general practice often see clients with symptoms of depression and anxiety. Screening for PND can be difficult given the number of symptoms typically associated with having a new baby, e.g. low energy, sleep disturbance, that are also symptoms of major depression. Therefore information on the nature of PND, its course and severity, and long-term effects on the mother and infant would help to promote awareness and understanding of the condition, and maximize clinical effectiveness. PND not only causes pain and suffering to the mother, it has a rippling effect on the family, affecting the couple's relationship and their capacity to parent (Field, 2010; Gunning et al., 2004; Murray, Cooper, Wilson, & Romaniuk, 2003; Paulson, Dauber, & Lieferman, 2006; Righetti-Veltema, Bousquet, & Manzano, 2003). Counselling psychologists in positions of 'practitioner-scientists' engage with the subjectivity and inter-subjectivity of the client (Woolfe, 1996), focusing on the

therapeutic relationship, which is affected by the client's past and current attachment difficulties, including the PND. Knowledge and awareness of attachment difficulties arising from PND and how these may be reflected in therapy are essential ingredients in promoting sensitive and ethical counselling psychology practice.

The nature of PND

PND is a form of depression with characteristics similar to general depression, occurring up to six weeks following childbirth. It is a common condition, with episodes typically lasting two to six months (Kessler et al., 2003; O'Hara, 1997), affecting 10-20% women and their families in the UK every year (Cooper, Murray, Wilson, & Romaniuk, 2003; Royal College of Midwives Survey, 2007). While PND is relatively common with significant social and health implications, it often remains under diagnosed and under-detected (Buist et al., 2005a; Webster, Pritchard, Creedy, & East, 2003). It is suggested that mothers are reluctant to talk about their emotional problems to their health practitioners (Lumley & Austin, 2001), and do not seek help until they reach a breaking point. As suggested by Mauthner (2002), women tend not to reach out to the health professionals either because of the stigma attached to failing to cope with the care of their baby or lack of knowledge on PND. Until these issues are sufficiently explored, the suffering of many women are less likely to be identified and appropriate help would be delivered. Having said that in recent years there is growing awareness of the problem in primary care settings with improved detection and appropriate help and support by the healthcare teams (Buist et al., 2005a).

Symptoms and **Diagnosis**

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (American Psychiatric Association, 1994) provides diagnostic guidelines for mental disorders and defines PND as a form of general depression with a special code for 'postpartum depression'. It is a non-psychotic depression occurring during the first 3-6 months after childbirth and distinguished from 'maternity blues' that may fall into other diagnostic categories (recognised by DSM-IV, (1994)), such as minor depressive disorders, mixed anxiety-depressive disorders or

reactive depression. The signs and symptoms of PND are generally the same as those associated with general depression: low mood, lack of energy and motivation, diminished interest in daily activities, and feelings of worthlessness (Beck, 1996, 2002). Additionally – in my clinical opinion – there is an increased sense of guilt about the mother's ability to comfort and care for her baby. Feelings of inadequacy and the vulnerability of the new-born become overwhelming and unmanageable such that the mother feels the relationship with the infant is undermined by her inability to cope with the situation. The sense of normal functioning is greatly decreased; making simple decisions, planning or concentrating on simple tasks becomes a huge struggle. These women become preoccupied with their sadness and sink into hopelessness (Milgrom, 1999).

Differences in course and severity, as well as the specific manifestations of PND complicate the diagnosis (Beck, 2001). DSM-IV categorisation for PND is four weeks after birth, which is a similar onset for psychotic depression, but research shows that PND develops within two to six months (Beck, 2001; O'Hara, 1997). This dilemma could be due to the difference between clinical practice and a standard diagnostic categorisation system because clinical practice allows for a longer period of symptom development (Cox, 1986). Although PND is increasingly defined in terms of diagnostic criteria, most studies use clinical samples based on the measure of severity of depression rather than the diagnostic criteria (Bick et al., 2002; O'Hara, 1997). To sum up, it is hard to define with clarity when and how PND starts and develops, and whether it will resolve itself or relapse as maternity blues, or alternatively develop into psychotic depression.

Psychosocial risk indicators
The epidemiological studies on PND indicate that there are numerous psychological and social risk factors, the major ones being previous depression, lack of social support, parental conflict, adult attachment style, stressful events and social adversity (Cooper & Murray, 1998; Murray et al., 2003; O'Hara, 1997; Warfa et al., 2014). It is suggested that childbirth can be considered a major

'stressor' – that being a stressful life event (Beck, 2001). Adjusting to the new set of demands that a baby brings, lack of preparation and support, and financial difficulties may all account for the increase in maternal depressive symptoms, and eventually lead to depression (Beck, 2001; Gunning et al., 2004). Previous psychiatric history and severity of anxiety during pregnancy have been associated with depressive symptoms during this period, but they are not sufficient on their own to predict the likelihood of PND (Beck, 2001; Cooper & Murray, 1998). Lack of social support is another major variable linked to PND (Beck, 2001: Cooper & Murray, 1998). The incidence of PND is 20% less likely to occur when compared to those groups without family support (Beck, 2001; Gunning et al., 2004). Rituals and cultural practices may have an important role in the occurrence of PND. Adverse events during labour or delivery in a vulnerable group of women raise the risk of PND (Cooper & Murray, 1998; Hunker, Patrick, & Wisner, 2009; Murray & Cartwright, 1993). Recent meta-analysis shows that insecure adult attachment style is an additional risk factor for PND (Warfa et al., 2014).

None of the potential psychosocial causal factors alone have been supported clearly as the sole causes of PND (Rutter, 1997). Beck (2001) argues that any one of these stressors can impact the onset of PND, but it is more likely that two or more of the risk factors would occur and intensify the depressive symptoms that the mother experiences after the birth of her baby.

Competing Explanations of PND

There are different perspectives of the aetiology of PND: some researchers believe that PND is a natural response to the transition to motherhood (Kruckman & Smith, 2000; Mauthner, 2002), and others believe that it is an illness that sits heavily within the medical model (Bick, et al., 2002). The triggers of PND are thought to be partly biological, social and psychological, and the duration of the illness depends on the individual and society's attitudes to childbirth and the availability of family support – either through traditional means or health care provisions within societies.

Medical model and biological perspective

The evidence presented earlier – diagnosis, occurrence, severity of PND – was from the perspective of the medical/psychological model in which PND is defined as a complex disorder that ranges on a continuum from relatively mild to quite severe (Bick et al., 2002). According to the medical model, mood disruptions that the new mother experiences after giving birth are considered as a condition to be detected, diagnosed and treated (Bick et al., 2002). Biological theories of PND explain the mood disturbances by the hormonal and biochemical changes before, during and after childbirth (Harris, 1994). Biological studies to date have been limited to the immediate childbirth stage and so do not account for the generalised forms of PND, especially those that develop after eight weeks. Extensive research that has been carried out to find a link between steroid hormones in postpartum women and the development of PND has not produced firm evidence to suggest that PND is brought on by hormonal changes (Harris, 1996). According to Murray and Cooper (1997) there is little evidence to support a biological basis to PND.

It appears that explaining PND from a biological perspective only, implies reducing the complexity of the illness to a basic minimum. The most common viewpoint would be that these biological factors must coexist with other psychosocial factors to produce depression.

The feminist perspective

The feminist perspective aims to redefine the parameters of PND. Whilst the medical model offers a biological explanation for the disruption in mood, the feminist approach considers mood disruptions as normal responses to the arrival of a new baby. The basic premise of this approach is the transition to motherhood, which is seen as unique to every mother. It is only understanding the mother's own individual experience and hearing her accounts of the emotional turmoil that will help to overcome the mood disruptions (Nicolson, 1998). This view does not see PND as a pathological condition, instead as a process of growth – transition to motherhood. According to this perspective,

women go through numerous psychological changes in the process of becoming a mother. Some of the changes include loss of independence, increased sense of responsibility, loss of identity, and a grieving reaction to loss (Beck, 2002; Nicolson, 1998). After all, the birth of a child is a life-changing event for the mother, and according to Oakley (1980) it implies 'loss of identity'. Becoming a mother changes the role of women in society, their relationship with the father of the child, and their employment opportunities (Oakley, 1980). It is argued that the maternal role in a patriarchal society still implies that it is the women's responsibility to be the main caregivers of children (Douglas & Michaels, 2004). Additionally, insufficient structural support in place in the community, e.g. day care facilities, can force women to stay at home or take employment that does not accommodate their needs or those of their children (Douglas & Michaels, 2004). It is suggested that depressed mood is a 'normal grief reaction' to all the losses, including the inferior position of motherhood imposed by society (Beck, 2002; Nicolson, 1998; Thurtle, 1995).

Nicolson (1999) argues that:

> ...if (new mother's) losses were taken seriously and women were encouraged to grieve, postpartum depression would be seen by the women and their partners, family and friends as a potentially healthy process towards psychological reintegration and personal growth rather than as a pathological response to a "happy event". (Nicolson, 1999, p. 162)

At the far end of the feminist perspective, some feminist scholars argue that PND does not exist at all. According to this view, mood disruptions should be considered as normal reactions to childbirth and not labelled as 'abnormal'. However, not all feminist scholars agree with the notion that PND is a normal reaction to childbirth, as it negates the very real distress women with PND go through (Mauthner, 1999).

Thurtle (2003) examined the perceptions of first-time mothers and reported that most new mothers enjoyed the experience of giving birth and they did not agree

with the notion that depression was a normal reaction to childbirth. Mauthner (1999) did not agree with the notion of PND as a normal reaction to childbirth and argued that the notion trivialises and minimises women's experiences of depression which mothers themselves feel as terrifying and abnormal.

The feminist perspective offers a different paradigm in which the issues surrounding PND – such as the medicalisation of women's emotionality, the controls placed on women by expert knowledge, medical emphasis on women's bodies, the clash between the idealised 'good mother' and reality of mothering – are debated and challenged. The feminist perspective continues to inspire professionals and researchers in re-evaluating the cultural values, medicalisation of social and structural issues that contribute to PND and promote social change.

The sociological perspective

Researchers who have adopted the sociological perspective argue that cultural attitudes towards motherhood and practices in childbirth may contribute to the onset of depression (Mauthner, 1999; McKenzi et. al., 2004). According to this perspective, health practices and cultural values of the society are utilised to meet the specific needs of women after childbirth (Kruckman & Smith, 1998, 2000). For example, a Japanese custom in which the new mother stays with her own mother for several weeks after giving birth is thought to provide social and practical support for the new mother (Okano, Koshikawa, Nomura, & Tatsunuma, 1992). The rituals following childbirth seem to protect the mother against the development of PND. On the other hand, lack of social support is consistently linked to the onset of PND (Beck, 2001; Webster et al., 2003). It is even suggested by Stern and colleagues (1983) that cultural values held in western societies may in fact increase the likelihood of PND as there is lack of recognition of the role transitions that mothers go through.

Contrasting to the medical model where the focus is on 'diagnosis and treatment', the sociological perspective appears to be organic in its approach, in that emotional difficulties following childbirth are anticipated and not labelled as illness, and that the focus is on support, prevention and cure (Kruckman & Smith,

2000). Rather than viewing PND as a disease, this perspective interprets it as a problem of living that needs to be worked out in the community.

Summary

PND is a common condition that affects 10-20% of women in the early weeks after childbirth, typically lasting two to six months. Whilst the reasons for its occurrence are still unclear, there is little evidence to support a biological basis of PND (Murray & Cooper, 1998). The main risk factors appear to be psychosocial in nature. The prevalence of PND is common across cultures and exists in a wide array of countries (Huang & Mathers, 2001; Kruckman & Smith, 2000). Whether viewed from a medical/biological, feminist, or sociological perspective, the reality of PND remains the same. It is a hugely disturbing and debilitating condition that affects a woman's ability to care for herself and her baby, and impairs the mother-infant relationship.

PND and attachment

The second half of the review includes relevant research on how insecure attachment may contribute to PND, how PND affects the quality of parenting and the child's social cognitive and emotional development. This section also includes various interventions for treatment of PND along with a section on how studies in attachment can inform therapy for PND.

Attachment style and PND

AT predicts that the infant-caregiver relationship functions as the secure base, promoting attachment security in relationships. Sensitive and consistent care, and the empathic attunement facilitate emotional bonding, increase the quality of the interaction and set a precedent for adult attachment relationships (Bowlby, 1988; Cooper & Murray, 1997; Halligan et al, 2007). The development of secure attachment early in life influences the child's representations of self and other, and shapes the internal working model which determines strategies for processing attachment-related thoughts and feelings (Bowlby, 1973, 1980). According to Bifulco and colleagues (2004):

> Insecure attachment strategies primarily involve either minimising the expression of attachment (avoidant styles) or maximising such expression (anxious/enmeshed styles). These strategies relate to maternal behaviours identified, respectively, as distant and withdrawn, or intrusive and punitive-behaviours that are more common in mothers with depression (Bifulco et al., 2004, p. 184).

Research into adult attachment style and depression has gained momentum over the last ten years (Bifulco et al., 2004, 2013; Gerlsma &Luteijn, 2000; O'Hara et al., 2000) and recently this research interest has been extended to studying maternal attachment style in relation to postnatal depression (Warfa et al., 2014). In a systematic review, Warfa and colleagues (2014) examined 20 empirical studies that investigated the relationship between attachment styles and PND symptoms. The sample from these 20 papers represented mothers from a range of locations, mostly from western countries, but a few from the Middle East (Besser, 2002; Kuscu et al., 2008; Akman et al., 2006; Sabuncuoglu & Berkem, 2006). There was clear and consistent evidence, from 19 out of the 20 studies that the adult attachment style of a new mother appeared to be linked with PND, suggesting that insecure attachment might function as a risk factor for PND. Specifically, seven of the studies included in this systematic review found that the anxious attachment style was significantly linked to PND. The three out of seven studies - a cross-cultural study, a longitudinal study and a study highlighting the contextual factors on PND are described below.

Bifulco et al., (2004) conducted a cross-cultural study on European and US populations investigating the link between maternal attachment style and PND, and also with the aim of establishing the reliability of the scale that they have developed, the Attachment Style Interview (ASI). The results indicated that anxious style (enmeshed or fearful) was associated with postnatal disorder and that ASI had achieved a satisfactory reliability.

Kuscu et al., (2008) conducted a study to explore the effects of maternal attachment styles and family support, highlighting contextual factors on

mother's depressive symptoms. They found positive correlations between depression (PND) and maternal ambivalent anxious attachment style. The level of perceived family support also showed a negative correlation with depression. The authors reported that maternal attachment patterns, living with the extended family and existence of family support all have an impact on early postpartum and emotional adaptation, and the implications for screening and preventive interventions for PND were discussed.

McMahon et al., (2005) conducted a longitudinal study on 111 mothers, with the aim of investigating the association between the maternal attachment state of mind and child attachment. Depression was assessed at 4 and 12 months using a diagnostic interview, and the Adult Attachment Interview (AAI) was conducted at 12 months to identify maternal attachment state of mind. The results indicated that the mothers diagnosed as depressed were more likely to have an insecure state of mind regarding attachment. Infants of chronically depressed mothers were more likely to be insecurely attached.

In the review there were two studies that found the fearful attachment style to be predictive of PND (Monk et al., 2008; Wilkonson & Mulachy, 2010). Monk and colleagues' (2008) study investigated 186 women's attachment style in relation to stress during pregnancy and prenatal depression. In the 3rd trimester the women completed self-report questionnaires on attachment style, pregnancy experience, stress and symptoms of depression and anxiety. At 4 months postpartum, a sub sample of 56 women repeated the self-report questionnaires because of their previous high scores on the questionnaires. The results indicated that healthy women (N=130) compared to the women with a psychiatric disorder (56) scored higher on security and lower on attachment fear. There was a significant main effect of fearful attachment style on prenatal depressive symptoms and on PND.

In the review eight studies found both anxious and avoidant or simply 'insecure' styles to be related to maternal PND (Warfa et al., 2014). Two studies were conducted in Turkey and are described below.

Akman et al., (2006) investigated PND, maternal attachment style and infantile colic which is reported to be a common problem in infancy in Turkey. The results indicated that both anxious and avoidant styles were associated with infantile colic, and 62.5 % of mothers whose infants had colic had insecure attachment as compared to 31.1% of mothers whose infants did not have colic. Sabuncuoglu and Berkem (2006) investigated the association between depressive symptoms and attachment style in PND among Turkish women within 2-18 months postpartum. It was reported by the authors that their results confirmed the previous Western studies suggesting a relationship between insecure attachment style and PND. Implications for early identification and treatment of PND in vulnerable women regarding their attachment style were discussed.

In the review by Warfa et al. (2014) anxious attachment style as compared to the avoidant style appeared to be more frequently associated with PND symptoms. The authors speculated that this might be partially explained by the defensive characteristics that avoidant adults tend to exhibit. However, following this logic, mothers with an avoidant attachment style might also be at greater risk for depression than those with a less avoidant styles, but they may not be willing or able to report this on self-report measures, given that characteristically defensive, distancing or non-disclosing style.

The review by Warfa et al., (2014) also found that other factors, such as the mother's age, her employment status, prenatal depression, anxiety, and neuroticism may function as risk factors both for PND and insecure attachment style. In sum, maternal insecure attachment may not only increase the risk for PND, but, along with several other adverse factors and predispositions, may interfere with the formation and maintenance of a secure attachment relationship between mother and infant, pre-empting the development of a secure attachment style later in life. Thus, both insecure attachment and PND could play an important role in the intergenerational transmission of depression.

In the sections that follow, the influence of PND on mother-infant interaction and child development will be reviewed.

PND and its influence on mother-infant interaction and child development

Research on the link between PND and mother-infant interaction indicates that mothers experiencing maternal depression often struggle relating to their babies (Coyl et al., 2002; Crockenberg & Leerkes, 2003). They tend to show inappropriate and negative responses and may feel emotionally detached and withdraw physically from their infants (Barnes, 2007; Puckering et al., 2005). Evidence suggests that lack of responsiveness and/or inappropriate responsiveness from the mother can have negative effects on the child and disrupt the attachment process (Cohn et al., 1990; Field, Healy, Goldstein, & Guthertz, 1990;Righetti-Veltema et al., 2003). Studies on the association between maternal depressive symptoms and negative mother-infant interaction suggest that exposure to maternal depressive symptoms after child-birth and chronically, can cause disruption to the developing attachment relationship and increase risk in children's cognitive and social development (Murray et al., 1996; Righetti-Veltema et al., 2003). Some of these studies are presented below.

Field (2010) reviewed studies that examined the effects of PND on early interaction, parenting and early interventions. The result showed that PND was associated with mother-infant interaction problems. According to this review, mothers with PND appeared to be less sensitive to their infant's needs and exhibited less positive and more negative affect and infants tend to be less responsive towards their mothers, showing less affect, more irritability and less engagement in social relationships. The review also showed that impaired mother-infant relationships in PND were prevalent across different cultures and socioeconomic groups.

The Carter, Garrity-Rokous, Chazan-Cohen, Little and Briggs-Gowan (2001) study examined the role of maternal depression and co-morbidity in early mother infant interactions, infant attachment security, gender differences in

problem behaviours in toddlers, and delays in competencies. Results indicated that the mothers with depression and co-morbid conditions appeared less emotionally available in the mother-infant interaction than mothers with no psychopathology or history of depression only. The above study highlights the importance of co-morbidity as an added risk that intensifies the impact of PND on mother-infant interaction.

Studies that examined the link between PND, negative mother-infant interaction and the child's socio-cognitive development found that there is an association between maternal depression, disrupted mother-infant interaction and impaired cognitive and emotional infant outcome (Murray, 1992; Murray et al., 1996; Murray, Sinclair, Cooper, Ducournau, & Turner, 1999).

Murray and colleagues' (1996) study examined the impact of maternal depression on attachment and infant cognitive and emotional development. The frequency of smiling, imitation and game playing between the mother and baby were observed and recorded at two months, 12 and 19 months. The results showed that there was an association between maternal depressive disorder and impaired cognitive and emotional development in the child assessed at 18 months, and this was mediated by the disturbed mother-infant relationship. The depressed mothers were less sensitively attuned to their infants and more negative with their infants as compared to non-depressed mothers. These disturbances in the infant-mother interaction were predictive of poorer cognitive development measured at 18 months.

The other study that examined the long-term effects of maternal depressive symptoms on 18 month old infants is by Righetti-Veltema and colleagues (2003). Mothers (N=570) were assessed at the last phase of their pregnancy, then at 3 and 18 months after delivery, and 35 mothers who scored 12 and above on the EPDS were selected and matched with 35 women from the control group with regards to age, marital status and profession. The infants were assessed on attachment security and cognitive and socio-emotional development. They found that child development was affected by PND, and more so with the chronicity of

the mother's affective functioning. The mothers with PND were less affectionate and more anxious than the control group, and there was less verbal interaction and play between the mother and infant in the group with PND as compared to the control group. With regard to infant socio-emotional development, the infants of depressed mothers were less responsive to people and their mother, less happy, had smaller attention spans, performed less well on object concept tasks and were more often insecurely attached to their mothers. Infants of the depressed group were more insecurely attached to their mothers and performed less well in cognitive tasks. However, it is difficult to make generalisations from the findings because of its relatively small sample size.

A number of other longitudinal studies have examined the negative effects of PND on the cognitive and emotional development of the child (Milgrom, 1999; Murray et al., 1996; Murray et al., 2003; Sutter-Dallay et al., 2011). These studies have contributed to illustrating the importance of sensitive periods in child development (Toth et al., 2009). For example, with regards to cognitive development, there appears to be a sensitive developmental stage between 2-18 months, and this effect is found to be less at five years of age (Murray & Cooper, 1997).

Toth and colleagues (2009) carried out a large American longitudinal study on the children of depressed and non-depressed mothers (N=135 mother-infant dyads) using the Strange Situation experimental design (Ainsworth, Blehar, Waters, & Walls, 1978). The attachment security in the toddlers was videotaped and assessed at 20 and 36 months. Results showed that attachment classifications differed significantly such that infants of depressed mothers at 20 and 36 months showed significantly less secure attachments with their mothers compared with infants of non-depressed mothers; 17.8% and 13.6% versus 57.4% and 49.1% respectively.

McMahon and colleagues (2006) conducted a similar longitudinal study in Australia, using a similar design in assessing attachment security in a very similar sample of infant-mother dyads. They found similar results to the

American study. To conclude, both of these longitudinal studies indicate that PND has an effect on mother-infant interaction and results demonstrated that depression in mothers is indicative of insecure attachment in infants assessed at 20 and 36 months.

Neurological studies also indicate that the first 18 months is a sensitive life stage in which the quality of the interaction between mother and infant may shape the affect regulation pathways in the brain (Beebe, 2000; Tronick et al., 1982; Schore, 2001)). Maternal sensitivity during this life stage is crucial for the early optimal brain development of the child, and thus shapes the emotional and social development of the infant within the mother-infant interaction (Schore, 2001).

Summary

Empirical evidence on PND and its impact on child development suggests that there is an association between maternal depression and adverse child outcome (Field, 2010). According to the studies cited above direct exposure to severe and long-standing maternal depressive symptoms, less verbal action and lack of engagement with the infant, lack of sensitive and responsive parenting impair the early infant-mother interaction and might lead to infant attachment insecurity and poor performance in cognitive tasks and behavioural problems (Hipwell et al., 2000; Murray et al., 1996, 1999; Toth et al., 2009). The first 18 months appear to be a sensitive life stage in which the development of the mother-infant interaction becomes critical for the child's cognitive and emotional development (Schore, 2001

In conclusion, according to Rutter (1997):

> Research has explicitly recognised that maternal depression is a risk indicator, and not necessarily a risk mechanism. That is, the consistency of the association between maternal depression and disorder in the child across a wide range of studies suggest that it reflects some form of causal process, but nevertheless the research challenge to determine the nature of the risk mechanisms involved remains (p. 296).

Treatment and Management of PND

Different treatments for PND have been developed over the years. For the purposes of this review, these are examined under three headings: 1) behavioural, 2) pharmacological, and 3) psychological interventions. These studies have been presented in a table below.

STUDY	DESIGN/PARTICIPANTS	INTERVENTION AND DELIVERY	RESULTS	LIMITATIONS
Behavioural Treatments				
Field, Grizzle et al., 1996	Randomised controlled trial (RCT) Intervention (n=32) and control groups (n=32) Women with and without PND	Two study groups: (1) 30 min. massage every other day for 5 weeks, (2) 30 min relaxation training every other day for 5 weeks for mood elevation	Relaxation training program had no effect in reducing depressive mood. Massage therapy had a significant effect.	Small sample size. No true control group. Inexplicit randomisation and trial procedures.
Hiscock & Wake, 2002	RCT 156 mothers of infants aged 6-12 months. 78 women in each intervention and control groups assessed at 8 and 16 weeks using EPDS. Power analysis. Intent to treat.	Controlled crying program delivered on weekly basis for 16 weeks. Information on management of sleep problems. Control group received info on normal sleep patterns only.	Controlled crying program along with information on management of sleep problems improved sleep problems significantly.	Small sample size Inexplicit randomisation and trial process. High attrition rate with the massage group.
CBT interventions				
Appleby et al., 1997	RCT Random allocation by computer generated numbers of 87 women postpartum at 6-9 weeks. Groups were assessed at 1, 4, and 12 weeks of treatment	Participants assigned to one of 4 groups; fluoxetine and one CBT, Fluoxetine and six CBT, Placebo and one CBT, Placebo and six CBT	Significant reduction in all groups. Progress was more in groups taking medication and several sessions of CBT	No true control group because all groups had CBT. Sample size got less due to reluctance to take medication.
Cooper et al., 2003	RCT 193 women; control (N=52) and intervention (N=14). CBT-N=43, psychodynamic-N=50, and non-directive counselling-N=48. Depression assessed at 4, 9, 18, and 60 months. Power analysis. Intent to treat.	Three therapeutic intervention groups were compared to the control group- the routine primary care. All interventions were provided at home, weekly from 8 to 18 weeks.	Significant difference between the intervention and control group at post treatment only. Psychodynamic therapy was superior to the other two.	Poor randomisation. Four coloured balls in a bag, and the assignment of each therapy to a different coloured ball made by selecting a ball from the bag.
Chabrol et al., 2002	Quasi-experiemntal design. Pregnant women at risk developing PND assigned to intervention (N=18) and control group (N=30).	5 to 8 one-hour home visits that had 4 different interventions; CBT, psychodynamic, supportive and educational.	The group which had 5-8 one hour weekly home visits providing CBT program made a significant recovery compared to the control group.	Small sample size. Nonrandom group allocation. High initial drop out after group assignment.
Meager & Milgrom, 1996	Pilot randomised controlled trial. 20 women diagnosed with severe PND, 6 months postpartum. CBT (N=16) and waiting-list control group (N=10).	10 weekly 1.5 hour CBT program on 10 women compared to the women on the waiting list control group. Women met outside the program.	Significant reduction in depression scores in the intervention group as compared to the control group.	Small sample size 40% of participants taking medication. 40% of participants dropped out of the program. Possible peer support outside of the group.
Honey et al., 2002	RCT 43 women from mother-baby clinic, using EPDS>12 criteria. Intervention group (N=23) and control (N=22) routine primary care	8 weekly, 2 hour meetings comprising 3 components: (1) CBT on motherhood anxiety; (2) info on PND and eliciting social support; (3) teaching relaxation.	No difference between intervention and control groups in depression scores soon after treatment. But significant difference between the groups after 6 months	Small sample size. Inexplicit randomisation process.
Psychodynamic and interpersonal psychotherapy interventions (IPP)				
Cooper et al., 2003	RCT 193 women; control (N=52) and intervention (N=14). CBT-N=43, psychodynamic-N=50, and non-directive counselling-N=48. Depression assessed at 4, 9, 18, and 60 months. Power analysis. Intent to treat.	Three therapeutic intervention groups were compared to control group- the routine primary care. All interventions were provided at home, weekly from 8 to 18 weeks.	Significant difference between the intervention and control group at post treatment only. Psychodynamic therapy was superior to the other two.	Poor randomisation. Four coloured balls in a bag, and the assignment of each therapy to a different coloured ball made by selecting a ball from the bag.

214

O'Hara et al., 2000	RCT 120 women diagnosed with major depression were allocated to IPT intervention (N=60), and control group (N= 60) using a random numbers table. Power analysis. Intent to treat.	Twelve 60 minutes individual sessions for 12 weeks delivered by trained therapists.	Statistically significant difference between the groups favouring the psychotherapy group, in relationship with children -2 years old and children other than the baby.	Participants were mostly white, educated and married women. Clinical interviewers were not blinded to group allocation
Clark et al., 2003	Quasi-experimental design. 39 women were recruited by healthcare practitioners and allocated to intervention groups (N= 24) and the waiting list control group (N=11).	2 intervention groups; (1) IPT that consisted of 1 hour individual therapy for 12 weeks, (2) mother-infant therapy that consisted of 1.5 hour group sessions for 12 wks	Significant reduction in depression scores within the treatment groups using CES-D but not BDI.	Small sample size. Sequential group assignment. Although data were available for 58 families, only women with BDI scores>16 were included.
Non-directive counselling				
Holden et al., 1989	RCT Group allocation based on random numbers. 50 women screened using EPDS at 6 weeks postpartum.	8 weekly counselling visits at home by health visitors trained in nondirective counselling	Significant group difference. 69 % of the counselling group recovered fully in comparison with 39% of control group.	Small sample size. 3 women in each group were thought to have taken antidepressant medication at a therapeutic level.
Wickberg & Hwang, 1996	RCT 31 women were screened at 8 and 12 weeks using EPDS. 15 women in the counselling 16 in the control group were allocated.	6 weekly 1 hour counselling visits at home by nurses trained in nondirective counselling.	Significant group difference. 80% in the counselling group fully recovered in comparison to 25% in the control group.	Small sample size Inexplicit randomisation process
Social support, peer group				
Fleming et al., 1992	Quasi experimental design 142 depressed and non-depressed women were allocated to a semi structured support group (N=44), group by mail (N=15) and control (N=83).	2 intervention groups: (1) 8 weekly group sessions lasting 2 hours delivered by 2 psychologists; (2) 'group by mail' in which transcripts of the preceding support group were mailed to women.	There were no significant differences between the groups although improvement in mood was noted in all groups.	Non-random allocation Significant differences in group sizes Depressed and non depressed women took part in all study groups
Chen et al., 2000	RCT 60 women recruited using EPDS at 3 weeks and were allocated to intervention and control groups.	4 weekly semi structured group sessions lasting 1.5 to 2 hours were provided by a nurse	Significant group difference with regard to depressive symptomology	Small sample size Inexplicit randomisation process Intervention was not standardised Only 44% of the mothers had returned the screening questionnaire.
Morgan et al., 1997	Single group 34 women recruited using EPDS, including 20 partners	8 weekly 2 hour group sessions and 1 couple session delivered by a nurse and occupational therapist. Telephone support from facilitators	Significant reduction in depression scores	Small sample size No true control group 74% of mothers had spent a week in residential unit. 50% were also receiving additional treatment as well as treated by antidepressant medication.
Mother-infant relationship				

Cicchetti et al., 2000	RCT. Mothers and infants (n=187). Toddler parent psychotherapy (n=43) compared with controls as depressed (n=54) and non-depressed (n=61).	Psychotherapy was delivered weekly, for approximately 57 weeks between child ages 20 months and 3 years.	Significant differences in favour of the psychotherapy group compared with depressed controls. No difference between the psychotherapy group and non-depressed controls.	Inexplicit randomisation process
Glover et al., 2002	RCT Mothers and infants (n=34). Support group only (n=12) as controls compared with infant massage in addition to support group (n=13)	Support group consisted of 30 min per week informal group discussion for 5 weeks. Infant massage consisted of a short period of relaxation followed by 1 hour of massage, in addition to support group for 5 weeks	Significant improvement in mother-infant interaction was reported for the mothers who attended the massage class (n=12) compared with the control group (n=12)	Small sample size Inexplicit randomisation process

Table 1: Studies of various interventions for PND

Behavioural Treatments

Behavioural treatments consist of programmes aimed at developing strategies in improving social skills, enhancing social participation and providing relaxation training for people experiencing depression (Hopko, Lejuez et al., 2003; Lejuez & Hopko, 2001). Basic principles of behaviour therapy have been utilised to develop relaxation training, sleep intervention, and maternal exercise programs, therefore have been indirectly influential in treatments for PND (Field, Grizzle, Scafidi, & Schanberg, 1996).

Behavioural interventions have shown to help with infant sleeping problems and indirectly decrease depressive symptoms of low mood and exhaustion in the mother (Hiscock & Wake, 2002). There are very few randomised controlled trials to measure the effectiveness of this intervention. The study by Hiscock and Wake (2002) which is a RCT, showed that the intervention based on 'controlled crying program and information on management of sleep problems' significantly improved the sleep problems of the infant and lowered depressive mood in the mother, compared to those in the control group. This study was carried out on 156 mothers of infants aged 6-12 months. Women were randomly allocated to intervention and control groups, 78 women in each group. There was a significant difference between the two groups. The 'controlled crying program and information on management of sleep problems' significantly improved the sleep problems of the infant and lowered depressive mood in the mother, compared to those in the control group.

Biochemical/pharmacological treatments

Biochemical theories of depression explain the aetiology of depression as a deficiency in neurotransmitter levels in the brain (Thase & Howland, 1995) and/or fluctuating hormone levels during pregnancy for which oestrogen and progesterone treatments have been advocated (Gregoire et al., 1996). The pharmacological treatments of depression have aimed to correct the chemical

imbalance in the brain and have consequently generated different anti-depressants such as tricylic antidepressants and Selective Serotonin Reuptake Inhibitors (SSRI) to correct it.

Clark (1990) studied the efficacy and relapse outcomes of CBT for depression (general depression) versus drug treatment. With well-conducted CBT it was found that the efficacy of CBT was better than drug treatment maintained for six months. There was less relapse in the CBT treatment group (50%) within two years compared with drug treatment. If however, the drug treatment was maintained for 12 months the CBT did not appear as superior. It seems that well conducted CBT can be as efficacious as the drug therapy with 12 months maintenance. Clark (1990) did not find any evidence for combined treatments of CBT with medication, although the popularity of this approach is growing (Friedman & Thase, 2006; Jama, 2004; Vitiello, 2007).

The evidence for combined treatment of CBT and pharmacotherapy for treatment of depression is growing (Appleby, Warner, Whitton, & Faragher, 1997; Friedman & Thase, 2006; Vitiello, 2007). Some of these studies supported the efficacy of the combined effect of CBT with medication (Sudak, 2011; Jama, 2004; Vitiello, 2007). Other studies did not show any effectiveness of the combined treatment of CBT and pharmacotherapy (Friedman & Thase, 2006). There is no clear-cut evidence that favours either treatment with anti depressants or the combined treatment of medication with CBT for general depression.

Psychological and psychosocial interventions
Interventions in this group include the psychological interventions; CBT, interpersonal psychotherapy (IPT) and psychodynamic therapy, and the psychosocial interventions; non-directive counselling, peer support, and mother-infant interaction interventions.

Cognitive Behaviour Therapy

The clinical evidence for treatment of PND based on CBT is growing (Appleby et al., 1997; Beck, 2002; Cooper et al., 2003; Scott, 1996; Sharp, Hay, Pawlby, Schmucker, Allen, & Kumar, 1995). Several studies, although with methodological limitations, show relative effectiveness of CBT in PND (Dennis, 2004). Five studies involving CBT interventions in the treatment of PND are examined in this review.

Appleby and colleagues (1997) studied the effects of medication plus CBT in a RCT study. Women diagnosed with PND (major depression (N=51) and minor depression (N=36)) postpartum at 6-9 weeks were assigned to one of four groups: 1) fluoxetine and one CBT session, 2) fluoxetine and six CBT sessions, 3) placebo and one CBT session, and 4) placebo and six CBT sessions. Thirty to sixty minute counselling sessions were derived from CBT principles and were delivered by a non-specialist after brief training. Depression was assessed at 1, 4, and 12 weeks of treatment. Results showed that there was a significant reduction in depression in all groups, and progress in the group taking medication was greater than the placebo, and several counselling sessions were found to be more effective than one session of counselling. Although the results showed the effectiveness of CBT, the sample size got smaller due to women being unwilling to take medication and declining to participate. Therefore it is difficult to ascertain the effectiveness of CBT with confidence in this study. More research based on the same design with true control groups and more counselling sessions might highlight the effect of CBT on depression better.

Cooper and colleagues (2003**)** studied the effects of CBT treatment compared with other psychological interventions. One hundred and ninety-three women were randomly assigned to four groups: routine primary care (control group N=52) and three experimental groups. The CBT group (N=43) had focused on problems such as feeding and sleeping, the psychodynamic therapy group (N=50) focused on the mothers' early attachment history, and the non-directive counselling group (N=48) focused on mothers' current feelings. Interventions were carried out at home on a weekly basis for 8-18 weeks. Participants were

assessed using the Edinburgh Postnatal Depression Scale (EPDS) immediately after treatment at 4.5 months, and at 9, 18, and 60 months. There were significant differences between the intervention and the control groups post treatment. In all of the intervention groups, depressive symptomology was reduced significantly. The psychodynamic therapy was superior to the other two modalities, but the treatment effect was not apparent after nine months postpartum.

Chabrol, Teissedre, Saint-Jean, Teisseyre, Roge and Mullet (2002) screened pregnant women and assigned those women at risk of developing PND into two groups, intervention and control groups. The intervention group included CBT, psychodynamic therapy and educational/supportive interventions (N=18 women), and the control group (N=30 women) had no intervention. The group that had 5-8 one-hour weekly home visits providing a CBT program made a significant recovery compared to the control group. Although the study yielded good results showing the relative effectiveness of CBT, the sample size was too small.

Meager and Milgrom (1996) conducted a study involving a 10 week CBT group programme on 20 women diagnosed with severe PND that developed within six months of giving birth. Women who were recruited from local hospitals and health care centres were randomly assigned to either the intervention (N=10), or control group (N= 10) – the control group consisted of women waiting for treatment. The CBT group intervention was administered by clinical psychologists, on a weekly basis for one and a half hours for 10 weeks. The results showed that the intervention group made a statistically significant recovery compared to the control group, but depressive symptoms continued in many women following treatment. There were several shortcomings of this study. Firstly, the sample size was very small. Secondly, 40% of the participants were taking medication, which was not controlled in either group. Also, 40% of participants terminated treatment early. Additionally, the women in the intervention group had peer support outside therapy hours and exchanged phone numbers. This extra input might have improved the results for that group

as well. Medication might have compounded the CBT effect and might have been responsible for the significant difference between the groups.

Honey and colleagues (2002) carried out a RCT study on 45 women recruited from mother and baby clinics. Participants were randomly assigned to an intervention group (N=23, eight week psycho-educational group with three components: CBT techniques related to motherhood anxiety, relaxation, and info on PND) and a control group (N=22, routine primary care home visits). There were no significant differences between the two groups with regard to a decrease in depressive symptomology, immediately assessed after the treatment. However, at follow up six months later, there were significant differences between the groups in the reduction of depression scores in favour of the intervention group.

Psychodynamic and interpersonal psychotherapy interventions
Cooper and colleagues (2003) have conducted a study to evaluate the long-term effects of treatment on PND. This study was presented previously in the CBT section of this review and the result showed that the psychodynamic therapy intervention produced an effect, in terms of remission from depression and that the effect was significantly superior to that of the control group.

Cooper and colleagues (2003) and Milgrom and colleagues (2005) have examined the comparative effectiveness of psychodynamic therapies versus routine primary care management of PND. Other studies explored the effects of psychodynamic and psychoanalytic therapies for depression and PND (Leichsenring, Rabung, & Leibing, 2004; Scott & Watkins, 2004; Taylor, 2008). There is consensus in the broad comparison of psychological therapies versus routine primary care that psychological therapies have been found to be more effective, and psychodynamic therapy was found to be significantly superior to that of the routine management of PND (Cooper et al., 2003; Milgrom et al., 2005).

There are several studies that show the effectiveness of Interpersonal Psychotherapy (IPT) for the treatment of PND. One such study is by O'Hara, Stuart, Gorman and Wenzel (2000), which was conducted on 120 women diagnosed by DSM-IV criteria for major depressive disorder. The women were assigned to two groups randomly; one group was given 12 weekly individual sessions of IPT and the control group was assigned to the waiting list. Every four weeks the groups were measured on depression symptoms and the results showed a statistically significant difference between the groups favouring the intervention group, indicating the effectiveness of IPT for PND.

This was a well designed and carried out study. The sample size was established by power analysis. The main limitation of the study was the background of the participants, who were middle class, white and married women, which automatically excludes the high psychosocial risk factors in the presentation of PND.

Clark, Tluczek and Wenzel (2003) in a quasi-experimental design, examined the effects of IPT and mother-infant therapy interventions for the treatment of PND. The authors used a smaller sample, 39 women, diagnosed with a major depressive disorder and assigned them into intervention and control groups. The intervention group was divided into either IPT (N=11) or mother-infant therapy group (N=13) and the women in the waiting list for therapy formed the control group (N=11). All groups were assessed at the beginning and end of 12 weeks. Intervention groups showed a significant reduction in depressive symptomology compared to the control group using the Centre for Epidemiological Studies Depression Scale (CES-D).

Non-directive counselling

Non-directive counselling, sometimes called 'listening visits', has been a preferred style of intervention by women with PND (Holden, 1987; Nicolson, 1998). Holden, Sagovsky and Cox (1989) conducted a randomised controlled trial on 55 women, with 26 women in the counselling group, receiving eight

weekly counselling visits at home, and 24 women in the control group. The results showed that 69% of women in the counselling group had fully recovered in comparison with only 38% women in the control group.

Wickberg and Hwang (1996) extended the above study and conducted a RCT on 31 Swedish women, with 15 women in the counselling group and 16 in the control group. The results showed that 80% of the women in the intervention group had fully recovered compared to 25% in the control group. Both studies indicated that non-directive counselling, i.e. just being listened to, is significantly effective in the treatment of PND.

The positive results that came out of the non-directive counselling studies indicate the effectiveness of this method for mild to moderate depression. Looking at the intervention from the patient's perspective, non-directive counselling is a non-invasive intervention, allowing the patient to be heard. Most studies examined so far did not obtain information on maternal perceptions, whether the women liked the intervention they were given or not. The only exception was the non-directive counselling study in which the participants reported that talking to their health visitor had been the most important recovery factor (Wickberg & Hwang, 1996).

Social support, peer support

Social support is one of the most important psychosocial risk factors in predicting PND. Health visitors providing prenatal women with educative programs and supporting new mothers at home have reported less depressive symptoms in the mothers after birth (Buist et al., 2007; Turner, Chew-Graham, Folkes, & Sharp, 2010).

A Chinese study examined the effects of a weekly support group on women who were all experiencing PND (Chen, Tseng, Chou, & Wang, 2000). They conducted RCT. Sixty women were recruited in-hospital and participants were randomly allocated to a support group (N=30) in which four weekly group sessions were held, and a control group (N=30). Four weeks after the start of the program,

there was a significant difference between the support group and the control group with regard to presenting depressive symptomatology.

Morgan, Matthey, Barnett and Richardson (1997) carried out a single, group program for women with PND (N=34) and their partners (N=20). The program consisted of eight weekly two-hour sessions including one session for the couple. In the beginning of the program, 66% of women scored over the clinical threshold on the EPDS and by the end of the program it dropped to 22%. A year later, the follow up showed that no participant exhibited depressive symptoms.

Interventions for mother-infant relationship

Interventions that aim to promote both the mother-infant interaction and maternal well-being are on the rise because of the established link between PND and adverse child outcome, and mother-infant interaction having a mediating effect on adverse child outcome (Hart, Field, & del Valle, 1998; Horowitz et al., 2001; Poobalan et al., 2007). According to the review carried out by Poobalan and colleagues (2007), interventions that target mother-infant relationships offer a better chance of improving outcomes for the children of depressed mothers.

Poobalan and colleagues (2007) carried out a systematic review of the studies that examined the impact of treating PND on the quality of the mother-infant relationship. Their database search of the studies was narrowed down to eight randomised controlled trials. The interventions used in the selected studies were varied such as baby massage or coaching mothers, but they all involved therapies that targeted the mother-infant relationship. The outcomes were assessed in children. Out of the eight studies, one study that involved intensive prolonged talking therapy plus other therapeutic interventions showed cognitive improvement in children. The two studies that made use of brief interventions showed improved mother-infant relationships, but did not have an effect on child's cognitive or behavioural development. The rest of the five studies included assessment of the mother-infant interaction only, and all five showed

significant improvements in mother-child relationship irrespective of the type of intervention. The reviewers concluded that cognitive and social development of children of depressed mothers might be improved with interventions that emphasise and target the mother-infant interaction while addressing the mother's needs to alleviate maternal mood.

Puckering and colleagues (2010) carried out a group intervention targeting mother-infant interaction to examine the effectiveness of the program both for the mothers and infants. The intervention was a controlled trial on 17 mothers and their infants who were under one year. The program included CBT work to improve maternal depression, and group work to facilitate mother-infant attunement by using a combination of activities such as baby-massage and infant focused interaction coaching (Puckering, 2004, 2005). The results with regard to maternal mood and mother-infant interaction showed significant differences between control and intervention groups. The changes in the mother-infant relationship included increased interaction, sensitive and appropriate responding to infant needs and increased reciprocity which all implied long-term developmental benefits for the child.

Summary

There is considerable evidence to suggest that different psychological interventions are relatively effective for the treatment of PND, but those targeting the mother-infant relationship have particularly benefitted women, as well as their infants (Dennis, 2004; Forman, O'Hara, Stuart, Gorman, Larsen, & Coy, 2007; Gunlicks & Weissman, 2008). Improved mother-infant interaction as an intervention appeared to have a multi-faceted effect: alleviating maternal mood, changing negative thinking, anticipation and negative responsiveness, increasing positive participation and self efficacy, and consequently benefitting long-term child development (Hart et al., 1998; Horowitz et al., 2001; Glover et al., 2002; O'Hara et al., 2000; Onozawa et al., 2001).

How attachment theory can inform therapy for PND?

According to Daniel (2006):

> The most original contribution of attachment theory to the practice of individual psychotherapy probably lies in the framework it provides for understanding the developmental history and internal dynamics of different forms of relationship difficulties or patterns of attachment (Daniel, 2006, p. 973).

AT predicts an association between parental sensitivity and the children's attachment relationships. Sensitive and responsive caregiving promotes secure relating to self and others and inconsistent and rejecting caregiving corresponds to insecure relating to self and others (Bowlby, 1988). Adult attachment reflects these internalised interpersonal interactions- a set of beliefs about self and other- based on early repeated patterns of interactive experiences with parents.

The driving force behind adopting the concept of adult attachment into psychotherapy must be the growing number of studies showing connection between insecure attachment patterns, psychological problems and psychopathology (Bifulco et al., 2004; Daniel, 2006; Mikulinceret al., 2012). Studies on the link between attachment and postnatal depression (PND) indicated that insecure attachment is an additional risk factor for PND (Bifulco et al., 2004; Warfa et al., 2014) and maternal depressive symptoms tend to have a negative impact on maternal sensitivity therefore the mother-infant relationship. (Murray et al., 1996, 2009; Poobalan et al., (2007). Consistent with this line of reasoning, research regarding adult attachment patterns and therapy process and outcome, childhood attachment studies and intergenerational transmission of attachment patterns, would be relevant in informing therapy for PND.

AT predicts that people respond to others in accordance with their internal working models of attachment (Bowlby, 1988). Therefore, it can be expected that clients as well as therapists with different attachment styles would engage and influence the quality of the therapeutic relationship differently. Clients with insecure attachment style tend to relate differently to their therapists, eliciting responses from their therapists according to their own internal working model of the other, and approaching their therapists with varying degrees of emotional commitment and self-disclosure, consequently affecting the development and quality of the working alliance differently (Byrd et al., 2010; Diener et al., 2009; Kivlighan et al., 1998; Mallinckrodt et al., 1995). For example studies indicate that clients with avoidant and anxious attachment styles tend to function differently with regards to seeking treatment as well as relating to the therapist (Berant & Obegi, 2009; Bifulco et al., 2004). Clients with avoidant attachment tend to ask for help less, and are more reluctant to engage in relationships, and use deactivating strategies, and clients with anxious attachment style might readily enter treatment, tend to disclose more private information, using hyperactivating strategies (Dozier et al. 1994; Korfmacher et al. 1997; Mikulincer & Shaver, 2003).

Studies that examine therapist qualities and client-therapist interaction show that the therapeutic alliance seemed to be enhanced with therapists employing secure or non-complementary strategies, e.g. less deactivating strategies with more deactivating clients, in other words therapists responding in a manner consistent with client's expectations (Dozier et al. 1994; Tyrrell et al. 1999). With regards to different approaches used by therapists, a study examining interventions directed at maternal sensitivity found that depressed mothers with avoidant attachment benefitted more from a video feedback condition than a condition in which video feedback was paired with exploration of childhood experiences, (Bakermans-Kranenburg, Juffer, and van IJzendoorn, 1998). Another study supports this result with regard to avoidant clients preferring less interpersonal engagement with the therapist; avoidant clients with depression did better on cognitive-behavioural approach than interpersonal short-term therapy (McBride et al. 2006). Two studies that examined the impact of

insecurity on therapeutic engagement found that both anxious and avoidant attachment were negatively associated with therapeutic engagement, and that anxiously attached clients appeared to struggle with engagement as much as the avoidantly attached clients (Dozier, 1990; Korfmacher et al. 1997).

All the above studies are relevant to informing therapy for PND. Information on insecure attachment and how it impacts the therapeutic alliance might enable therapists working with women with PND to individualize their interventions and help in their efforts to understand and conceptualise the attachment problems that their clients are experiencing.

Childhood attachment studies that captured and measured the quality of the relationship in the mother-infant interaction indicated that attunement and sensitive responsiveness are the essential elements of infant attachment security (Ainsworth et al. 1978). This information may inform therapy for PND; a therapy that targets the mother-infant relationship may facilitate sustaining the mother's attention to the infant's experience, increase the interaction and reciprocity with the infant, and consequently help to develop attunement (Poobalan et al. 2007). Studies on the interventions for mother-infant relationship for PND demonstrated that mothers could be helped to develop a more sensitive response to the infant, changing their negative responsiveness, and increasing positive participation and self-efficacy (Poobalan et al. 2007; Puckering et al, 2010).

Intergenerational studies of attachment patterns (Main, Kaplan, and Cassidy, 1985; McMahon et al. 2006; van IJzendoorn, 1995) have demonstrated that there is a relationship between adult attachment security, using Adult Attachment Interview (AAI, George, Kaplan, & Main, 1985) and infant security, using the Strange Situation Procedure (SSP, Ainsworth et al. 1978), suggesting that the mother's representation of attachment may influence the infant's attachment style to her. In PND studies, it has been documented that the major threat to a child's future well-being is the mother's own absence of security which may be expressed through mother's depression (Murray et al., 1996, 2009). Information

on intergenerational transmission of attachment styles may inform therapy for PND in helping the depressed mother to examine her own relationship with her parents, especially with her own mother. Helping the mother to gain an insight into her relationships with her own mother would help to impact her current feelings for and relationship with her child. The intergenerational effects of parenting can be explored and this would promote awareness of her own interaction with her own infant and increase revising her insecure representations of attachments. Reflective self-functioning developed by Fonagy et al. (1993) which refers to individuals' ability to think about his or her own mental functioning would be helpful means to exploring past and present experiences with parents and informing the process of therapy for PND.

Maternal insecure attachment along with several other adverse factors and predispositions, may interfere with the formation and maintenance of a secure attachment relationship between mother and infant, pre-empting the development of an insecure attachment style later in life (Warfa et al., 2014). Studies on the link between contextual factors and insecure attachment may inform the delivery of therapy for vulnerable mothers, so that they can be assessed early and given appropriate support and treatment before PND diminishes their capacity to care for themselves and their infants.

Conclusion

To conclude, this review explored the debilitating effect of PND on the mother, the link between attachment and PND and how insecure attachment can contribute to the arising attachment problems in the mother-infant relationship. Further on, tried and effective means of interventions have been reviewed including a section on how AT can inform individual therapy for mothers with maternal depression. With growing research in this area, perhaps the challenge is dissemination of information just as much as new development, so that the trans-generational impact of PND can be better managed.

REFERENCES: Section D

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

Akman, I., Kuscu, M.K., Ozdemir, N., et al. (2006). Mothers' postpartum psychological adjustment and infantile colic. Archives of Disease in Childhood. 91, 417-419.

American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders (4th ed.)*. Washington DC: American Psychiatric Association.

Appleby, L., Warner, R., Whitton, A., & Faragher, B. (1997). A controlled study of fluoxetine and cognitive behavioural counselling in the treatment of postnatal depression. *British Medical Journal. 314*, 932-936.

Bakermans-Kranenburg, M. J., Juffer, F., & van IJzendoorn, M.H. (1998). Interventions with video feedback and attachment discussions: Does type of maternal internal insecurity make a difference? *Infant Mental Health Journal.* 19, 202-219.

Barnes, D. L. (2007). *The journey to parenthood: Myths, reality and what really matters.* Oxford: Radcliffe Publishing.

Beck, C.T. (1996) A meta-analysis of predictors of postpartum depression*. Nursing. Review.* 45, 297-303.

Beck, C. T. (1999). Maternal depression and child behavioural problems: a meta-analysis*. Journal of Advanced Nursing, 29*, 623-629.

Beck, C. T. (2001). Predictors of postpartum depression: An Update. *Nursing Research, 50*, 275-285.

Beck, C. T. (2002). Theoretical perspectives of postpartum depression and their treatment implications. *American Journal of Maternal Child Nursing, 27*, 282-7.

Berant, E., & Obegi, J. H. (2009). Attachment-informed psychotherapy research with adults. In J. H. Obegi & E. Berant (Eds.), *Attachment theory and research in clinical work with adults* (pp. 461-469). New York: Guildford Press.

Besser, A., Priel, B., & Wiznitzer, A. (2002). Childbearing depressive symptomology in high risk pregnancies: the roles of working models and social support. *Personal Relationships.* 9, 395-413.

Bick, D., MacArthur, C., Knowles, H. & Winter, H. (2002). *Postnatal care: Evidence and guidelines for management.* London: Churchill Livingston.

Bifulco, A., Figueiredo, B., Guedeney, N., et al., (2004). Maternal attachment style and depression associated with childbirth: preliminary results from a European and US cross-cultural study. *British Journal of Psychiatry.* 184, 31-37

Bowlby, J. (1973). Self-reliance and some conditions that promote it. In R. Gosling (Eds.), *Support, Innovation and Autonomy* (pp. 23-46), London: Tavistock Publications.

Bowlby, J. (1980/1998). *Attachment and loss:* Vol.3. *Loss.* London: Pimlico.

Bowlby, J. (1988). Developmental psychiatry comes of age. *American Journal of Psychiatry, 145*, 1-10.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rhodes (Eds.), *Attachment theory and close relationships* (pp. 46-76). New York: Guildford Press.

Buist, A. (2005b). Guidelines for the use of SSRIs in pregnant women. *Women's Mental Health, 7*(4), 11-19.

Buist, A., Bilszta, J., Barnett, B., Milgrom, J., Eriksen, J., Condon, J., Hayes, B., & Brooks, J. (2005a). Recognition and management of prenatal depression in general practice. *Australian Family Physicians, 34*(9), 787-790.

Buist, A., Speelman, C., Hayes, B., Reay, R., Milgrom, J., Meyer, D., & Condon, J. (2007). Impact of education on women with prenatal depression. *Journal of Psychosomatic Obstetrics and Gynecology, 28*(1), 49-54.

Byrd, K.R., Patterson, C.L., & Turchik, J.A. (2010). Working alliance as a mediator of client attachment dimensions and psychotherapy outcome. *Psychotherapy, 47*, 631-636.

Carter, A. S., Garrity-Rokous, E. F., Chazan-Cohen, R., Little, C., & Briggs-Gowan, M. J. (2001). Maternal depression and comorbidity: predicting early parenting attachment, security, and toddler emotional problems and competencies. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 18-26.

Cassidy, J., & Kobak, R. R. (1988). Avoidance and its relationship with other defensive processes. In J. Belsky & T. Nezworski (Eds.), *Clinical implications of attachment* (pp. 300-323). Hillsdale, NJ: Erlbaum.

Chabrol, H., Teissedre, F., Saint-Jean, M., Teisseyre, N., Roge, B., & Mullet, E. (2002). Prevention and treatment of postpartum depression: a controlled randomized study on women at risk. *Psychological Medicine, 32*, 1039-1047.

Chen, C. H., Tseng, Y. F., Chou, F. H., & Wang, S. Y. (2000). Effects of support group intervention in postnatally distressed women: a controlled study in Taiwan. *Journal of Psychosomatic Research, 49*, 395-399.

Clark, R., Tluczek A., & Wenzel A. (2003). Psychotherapy for postpartum depression: a preliminary report. *American Journal of Orthopsychiatry, 73*, 441-454.

Clark, D. M. (1990). Cognitive therapy for depression and anxiety: Is it better than drug treatment in the long term? In K. Hawton & P. Cowen (Eds.), *Dilemmas and difficulties in the management of psychiatric patients* (pp. 55-64). New York: Oxford University Press.

Cohn, J. F., Campbell, S., Matia, R., & Hopkins, J. (1990). Face to face interactions of postpartum depressed and non-depressed mother-infant pairs at two months. *Developmental Psychology, 26*, 15-23.

Cooper, P. J., & Murray, L. (1995). Course and recurrence of postnatal depression. Evidence for the specificity of the diagnostic concept. *British Journal of Psychiatry, 166*, 191-195.

Cooper, P. J., & Murray, L. (1997). Effects of postnatal depression on infant development. *Archives of Disease in Childhood, 77*, 97-98.

Cooper, P. J., & Murray, L. (1998). Postnatal depression. *British Medical Journal, 316*, 1884-86.

Cooper, P. J., Murray, L., Wilson, A. & Romaniuk, H. (2003). Controlled trial of the short and long-term effect of psychological treatment of postpartum depression. Impact on Maternal Mood. *British Journal of Psychiatry, 182*, 412-419.

Cooper, P. J., Tomlinson, M., Swartz, L., Landman, M., et al. (2009). Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomised controlled trial. BMJ. 338, doi: http://dx.doi.org/10.1136/bmj

Cooper, P. J., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Postpartum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry, 175*, 554-558.

Cox, J. L., (1986). *Postnatal depression: A guide for health professionals.* Edinburgh: Churchill Livingstone.

Coyl, D. D., Rogman, L. A., & Newland, L. A. (2002). Stress maternal depression and negative mother-infant interactions in relation to infant attachment. *Infant Mental Health Journal, 23*, 145-163.

Crockenberg, S. C., & Leerkes, E. M. (2003). Parental acceptance, postpartum depression, and maternal sensitivity: Mediating and moderating processes. *Journal of Family Psychology, 17,* 80-93.

Daniel, S. I. F. (2006) Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26*, 968-984.

Dennis, C. E. (2004). Treatment of Postpartum Depression, Part 2: A Critical Review of Nonbiological Interventions. *Journal of Clinical Psychiatry, 65*(9) 1252-1265.

Diener, M. J. Hilsenroth, M. J., & Weinberger, J. (2009). A primer on meta-analysis of correlation coefficients: The relationship between patient-reported therapeutic alliance and adult attachment style as an illustration. *Psychotherapy Research*, *19*, 519-526.

Douglas, S.J., & Michaels, M.W. (2004). *The Mommy Myth*: *The idealization of Motherhood and How It Has Undermined Women.* New York: Free Press.

Dozier, M., Cue, C. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology,* 62(4), 793-800.

Dozier, M. (1990). Attachment organisation and treatment use for adults with serious psychopathological disorders. *Development and Psychopathology.* 7, 47-60.

Feeney, J., Alexander, R., Noller, P., & Hohaus, L. (2003). Attachment insecurity, depression, and the transition to parenthood. *Personal Relationships.* 10, 475-493.

Field, T., Healy, B. T., Goldstein, S., & Guthertz, M. (1990). Behaviour-state matching and synchrony in mother-infant interactions in non-depressed vs depressed dyads. *Developmental Psychology, 26,* 7-14.

Field, T. (2010). Postpartum depression effects on early interactions, parenting and safety practices: A review. *American Psychological Association, 33*, 1-6.

Field, T., Grizzle, N., Scafidi, F., & Schanberg, S. (1996). Massage and relaxation therapies, effects on depressed adolescent mothers. *Adolescence, 31*, 903-911.

Fleming, A. S, Klein E., & Corter, C. (1992). The effects of social support on depression, maternal attitudes and behaviour in new mothers. *Journal of Child Psychology and Psychiatry, 33*, 685-698.

Fonagy, P., Steele, M., Moran, G., Steele, H., & Higgett, A. (1993). Measuring the ghost in the nursery: An empirica study of the relation between parents' mental representations of childhood experiences and their infants' security of attachment. *Journal of the American Psychoanalytic Association*, 41, 957-989.

Forman, D. R., O'Hara, M. W., Stuart, S., Gorman, L. L., Larsen, K. E., & Coy, K. C. (2007). Effective treatment for postpartum depression is not sufficient to improve the developing mother-child relationship. *Child Development and Psychopathology, 1,* 585-602*.*

Friedman, E.S., & Thase, M.E. (2006). Cognitive-behavioural therapy for depression and dysthymia. In Stein, D.J., Kupfer, D.J., Schatzberg, A.F., *Textbook of Mood Disorders. (353-371),* American Psychiatric Publication, Washington DC, USA.

George, C., Kaplan, N., & Main, M. (1985). *An adult attachment interview: Interview protocol.* Unpublished manuscript, Berkeley, University of California.

Gerlsma, C., & Luteijn, F. (2000). Attachment style in the context of clinical and healthy psychology: a proposal for the assessment of valence, incongruence, and accessibility of attachment representations in various working models. *British Journal of Medical Psychology, 73*, 15-34.

Glover, V., Onozawa, K., & Hodgkinson, A. (2002). Benefits of infant massage for mothers with postnatal depression. *Seminars in Neonantology, 7*, 495-500.

Gregoire, A.J., Kumar, R., Everitt, B., Henderson, A.F., & Studd, J.W. (1996). Transdermal oestrogen for treatment of severe postnatal depression treatment, Lancet, 6; 347(9006): 930-933.

Gunlicks, M. L., & Weissman, M. M. (2008). Change in child psychopathology with improvement in parental depression. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*, 379-389.

Gunning, M., Conroy, S., Valoriani, V., Figueiredo, B., Kammerer, M. H., Muzik, M., Glatigny-Dallay, E., & Murray, L. (2004). Measurement of mother-infant interaction and the home environment in a European setting: preliminary results from a cross-cultural study. *British Journal of Psychiatry Supplement 46*, 38-44.

Halligan, S. L., Murray, L., Martin, C., & Cooper, P. (2007). Maternal depression and psychiatric outcomes in adolescent offspring: A 13-year longitudinal study. *Journal of Affective Disorder, 97*, 145-154.

Harris, B. (1994). Biological and hormonal aspects of postnatal depressed mood: Working towards strategies for prophylaxis and treatment. *British Journal of Psychiatry, 164*, 288-292.

Harris, B. (1996), Hormonal aspects of Postnatal Depression. *Inter Rev Psychiatry*, 8:27-36.

Hart, S., Field, T., & del Valle, C. (1998). Depressed mothers' interactions with their one-year old infants*. Infant Behaviour and Development, 2193*, 519-525.

Hiscock, H., & Wake, M. (2002). Randomised controlled trial of behavioural infant sleep intervention to improve infant sleep and maternal mood. *British Medical Journal, 324,* 1062-1065*.*

Holden, J. M., Sagovsky, R., & Cox, J. L. (1989). Counselling in general practice setting: controlled study of health visitor intervention in treatment of postnatal depression. *British Medical Journal, 298*, 223-226.

Holden, J.(1987). Postnatal depression: 'She just listened.' *Community Outlook*, 6-10*.*

Honey, K.L., Bennett, P. & Morgan, M.A. (2002). A brief psycho-educational group intervention for postnatal depression. British Journal of Clinical Psychology, 4(Pt. 4): 405-409.

Hopko, D., Lejuez, C.W., LePage, J., Hopko, S. & McNeil, D.W. (2003). A brief behavioural activation treatment for depression. *Behaviour Modification*, 27, 4, 458-469.

Horowitz, J. A., Bell, M., Trybulski, J., Munro, B. H., Moser, D., Hartz, S. A., McCordic, L., & Sokol, E. S. (2001). Prompting responsiveness between mothers with depressive symptoms and their infants. *Journal of Nursing Scholarship, 33*, 323-329.

Huang, Y., & Mathers, N. (2001). Postnatal depression – biological or cultural? A comparative study of postnatal women in the UK and Taiwan. *Journal of Advanced Nursing, 33*, 279-287.

Hunker, D., Patrick, T., & Wisner, K. (2009). Is difficult childbirth related to postpartum maternal outcomes in the early postpartum period? *Archives of Women's Mental Health, 12*, 211-219.

Jama-network (2004). Fluoxetine, CBT, and their combination for adolescents with depression*. Journal of the American Medical Association*. 292, 7.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., Rush, A. J., Walters, E. E., & Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R)*. Journal of the American Medical Association, 289*, 3095-3105.

Kivlighan Jr., D. M., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counselling Psychology, 45*(3), 274-278.

Korfmacher, J., Adam, E., Ogawa, J., & Egeland, B. (1997). Adult attachment: Implications for the therapeutic process in a home intervention. *Applied Developmental Science, 1*(1), 43-52.

Kruckman, L. & Smith, S. (1998). An introduction to postpartum illness. Retrieved in *www.chss.iup.edu/postpartum/preface.htlm*

Kruckman, L. & Smith, S. (2000). 'An introduction to postpartum illness.' *Post partum Support International. Retrieved in www.postpartum.net/in-depth.htlm*

Kumar, R., & Robson, K. (1984). A prospective studies of emotional disorders in child-bearing women. *British Journal of Psychiatry, 144*, 35-47.

Kuscu, M. K., Akman, I, Karabekiroglu, A. Yurdakul, Z. Orhan, l. et al. (2008). Early adverse emotional response to childbirth in Turkey: the impact of maternal attachment styles and family support. *Journal of Psychsomatic Obstetrics and Gynaecology.* 29, 33-38.

Leichsenring, F., Rabung, S., & Leibing, E. (2004). The efficacy of short-term psychodynamic psychotherapy in specific psychiatric disorders: Meta-analysis. *Archives of General Psychiatry, 61*(12), 1208-1216.

Lejuez, C.W., Hopko, D.R., Hopko, S.D. (2001). A brief behavioural activation treatment for depression: Treatment manual. *Behaviour Modification*, 25, 255-286.

Lewinsohn, P. M., & Gotlib, I. H. (1995). Behavioural theory and treatment of depression. In E. E. Beckham & W. R. Leber (Eds.), *Handbook of depression* (pp. 352-375). New York: Guildford Press.

Lumley, J., & Austin, M. (2001). What interventions may reduce postpartum depression. *Current Opinion in Obstetrics and Gynecology, 13*, 605.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. In I. Bretherton & E. Waters(Eds.), Growing points of attachment theory and research. *Monographsof the Society for Research in Child Development* (1-2, Serial No, 209), 50, 66-104.

Mallinckrodt, B. (2010). The psychotherapy relationship as attachment: Evidence and implications. *Journal of Personal and Social Relationships, 27*, 262-270.

Mallinckrodt, B., Gantt, D.L., & Coble, H.M. (1995). Attachment patterns in the psychotherapy relationship: Development of the client attachment to therapist scale. *Journal of Counselling Psychology*, 42(3), 307-317.

Mauthner, N. S. (1999). 'Feeling low and feeling really bad about feeling low'; Women's experiences of motherhood and postpartum depression. *Canadian Psychology*, 1-30.

Mauthner, N.S. (2002). *The Darkest Days of My Life: Stories of Postpartum Depression,* Cambridge, MA: Harvard University Press.

McBride, C., Atkinson, L., Quilty, L. C., & Bagby, R. M. (2006). Attachment as moderator of treatment outcome in major depression: A randomised control trial of interpersonal psychotherapy versus cognitive behaviour therapy. Journal of Consulting and Clinical Psychology. 74, 1041-1054.

McKenzi, K., Patel, V., & Aray, R. (2004). Learning from low-income countries: mental health. *British Medical Journal, 329*, 1138-1140.

McMahon, C. A., Barnett, B., Kowalenko, N. M., & Tennant, C. C. (2005). Maternal attachment state of mind moderates the impact of postnatal depression on infant attachment. *Journal of Child Psychology and Psychiatry, 47*(7), 660-669.

Meager, I., & Milgrom, J. (1996) Group treatment for postpartum depression: a pilot study. *Australian and New Zealand Journal of Psychiatry, 30*, 852-860.

Meredith, P. & Noller, P. (2003). Attachment and infant difficultness in postnatal depression. *Journal of Family Issues.* 24, 668-686.

Mikulincer, M., & Shaver, P. R. (2003). The attachment behavioral system in adulthood: Activation, psychodynamics, and interpersonal processes. In M. P. Zenna (Eds.), *Advances in experimental social psychology (Vol.* 35, pp. 53-152). San Diego, CA: Academic Press.

Milgrom, J. (1999). A 2 year follow up of mothers and infants following postnatal depression. Manuscript submitted for publication.

Milgrom, J., Martin, P. R., & Negri, L. M. (2003). *Treating Postnatal Depression.* Chichester: John Wiley & Sons.

Milgrom, J., Negri, L., Gemmill, A., McNeil, M., & Martin, P., (2005). A randomized controlled trial of psychological interventions for postnatal depression. *British Journal of Clinical Psychology, 44*, 529-542.

Monk, C., Leight, K. L., & Fang, Y. X. (2008). The relationship between women's attachment style and perinatal mood disturbance: implications for screening and treatment. *Archives of Women's Mental Health,* 11, 117-129.

Morgan M., Matthey S, Barnett B., & Richardson, C. (1997). A group programme for postnatally distressed women and their partners. *Journal of Advanced Nursing, 26*, 913-920.

Murray, L. & Cartwright, W. (1993). The role of obstetric factors in postpartum depression. *Journal of Reproductive Infant Psychology*, 11, 215-219.

Murray, L. & Cooper, P.J. (1996). The impact of postpartum depression on child development. *International Review of Psychiatry*, 8, 55.

Murray, L., & Cooper, P. J. (1997). The impact of postpartum depression on child development. *International Review of Psychiatry, 8*, 55-59.

Murray, L., Cooper, P., Wilson, A., & Romaniuk, H. (2003). Mental health of parents caring for infants. *Archives of Women's Health, 6*(2), 571-77.

Murray, L. (1992). The impact of postnatal depression on infant development. *Journal of Child Psychology and Psychiatry, 33*, 561.

Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996). The impact of postnatal depression and associated adversity on early mother infant interaction and later infant outcome. *Child Development, 67*, 2512-2516.

Murray, L., Sinclair, D., Cooper, P. J., Ducournau, P., & Turner, P. (1999). The socio-emotional development of 5-year old children of postnatally depressed mothers. *Journal of Child Psychology and Psychiatry and Allied Disciplines, 40*, 1259-1271.

Nicolson, P. (1998). *Post-Natal Depression.* New York & London: Routledge.

Nicolson, P. (1999). Loss, happiness and postpartum depression: the ultimate paradox. *Canadian Psychology*, 40(2), 162-178.

O'Hara, M. W. (1997). The nature of postpartum depressive disorders. In L. Murray & P. J. Cooper (Eds.), *Postpartum depression and child development* (pp. 3-31). New York: Guildford Press.

O'Hara, M. W., Stuart, S., Gorman, L. L, & Wenzel, A. (2000). Efficacy of interpersonal psychotherapy for postpartum depression. *Archives of General Psychiatry, 57*, 1039-1045.

O'Hara, M. W., & Swain, A. M. (1996). Rates and risks of postpartum depression: a meta-analysis. *International Review of Psychiatry, 8*, 37-54.

Oakley, A. (1980). *Women confined: Towards a Sociology of childbirth*. Oxford: Martin Robertson.

Okano, T., Koshikawa, N., Nomura, T., & Tatsunuma, T. (1992). Cross-cultural study of maternal blues and postpartum depression. Unpublished manuscript.

Onozawa, K., Glover, V., Adams, D., Modi, N., & Kumar, C. (2001). Infant massage improves mother-infant interaction for mothers with postnatal depression. *Journal of Affective Disorders, 63*, 201-07.

Paulson, J. F., Dauber, S., & Lieferman, J. A. (2006). Individual and combined effects of postpartum depression in mothers and fathers on parenting behaviour. *Paediatrics, 118*(2), 659-668.

Poobalan, A.S., Aucott, L.S., Ross, L., Smith, W.C.S., Helm, P.J. & Williams, J.H.G. (2007). Effects of treating postnatal depression on mother-infant interaction and child development. *British Journal of Psychiatry*, 191, 378-386.

Puckering, C., McIntosh, E., Hickey, A. & Longford, J. (2010). *Counselling Psychology Review,* 25, (1), 28-38.

Puckering, C. (2005). Mind the gap! Helping the children of mothers with postnatal depression [Editorial]. *Child: Care, Health and Development, 35*(1), 7-9.

Righetti-Veltema, M., Bousquet, A., & Manzano, J. (2003). Impact of postpartum depressive symptoms on mother and her 18-month old infant. *European Child and Adolescent Psychiatry, 12*(2), 75-83.

Rosenblum, K. L., McDonough, S., Muzik, M., Miller, A., & Sameroff, A. (2002). Maternal representations of the infant: Associations with infant response to the still face. *Child Development, 73*, 999-1015.

Royal College of Midwives Survey (2007). Cited in Social Justice Policy Group (2008), *Breakthrough Britain: The next generation* (Executive Summary, p.3). London: Centre for Social Justice.

Rutter, D. R. (1997). Maternal Depression and Infant Development. In L. Murray & P. Cooper (Eds.), *Postpartum depression and child development* (pp. 296). New York: (Guildford Press).

Sabuncuoglu, O. & Berkem, M. (2006). Relationship between attachment style and depressive symptoms in postpartum women: Findings from Turkey. *Turkish Journal of Psychiatry*. 17, 252-258.

Scharfe, E. (2007).Cause or consequence? Exploring causal links between attachment and depression. *Journal of Social and Clinical Psychology*. 26, 1048-1064.

Schore, A. N. (2001). The effects of a secure attachment relationship on right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal, 22*, 7-66.

Sochos, A. (2013). The defining constituents of adult attachment and their assessment. *Journal of Adult Development*. 20, 87-99.

Scott, J. (1996). Cognitive therapy of affective disorders: A review. *Journal of Affective Disorders, 37*, 1-11.

Scott, J., & Watkins, E. (2004). Brief psychotherapies for depression: current status. *Current Opinion in Psychiatry, 17*(1), 3-7.

Sharp, D., Hay, D. F., Pawlby, S., Schmucker, G., Allen, H., & Kumar, R. (1995). The impact of postnatal depression on boys intellectual development. *Journal of Child Psychology and Psychiatry, 36*, 1315-1337.

Simpson, J. A., Rholes, W. S., Campbell, L., Tran, S., Wilson, C. L. (2003). Adult attachment, the transition to parenthood, and depressive symptoms. *Journal of Personality and Social Psychology.* 84, 1172-1187.

Stern, D. N., Gwen, & Druckman (1983). Multi-disciplinary perspectives on postpartum depression: an anthropological critique. *Social Science and Medicine,* 17, 1027-1041.

Sudak, D.M. (2011). Combining CBT and Medication: An Evidence Based Approach. Neurobiological Evidence and combined treatment (p. 1-10), John Wiley & Sons, Hoboken, New Jersey.

Taylor, D. (2008). Psychoanalytic and psychodynamic therapies for depression; the evidence base. *Advances in Psychiatric Treatment, 14*(16), 401-413.

Thase, M. E., & Howland, R. H. (1995). Biological processes in depression: An updated review and integration. In E.E . Beckham & W. R. Leber (Eds.), *Handbook of depression* (pp. 213-2790). New York: Guildford Press.

Thurtle, V. (1995). Postnatal depression: the relevance of sociological approaches. *Journal of Advanced Nursing, 22*, 416-424.

Thurtle, V. (2003). First time mother's perceptions of motherhood and PND. *Journal of Advanced Nursing, 76*, 261.

Toth, S. L., Cicchetti, D., Rogosch, F. A., & Sturge-Apple, M. (2009). Maternal depression, children's attachment security, and representational development: An organizational perspective. *Child Development, 80*, 192-208.

Turner, K., Chew-Graham, C., Folkes, L., & Sharp, D. (2010). Women's experiences of health visitor delivered listening visits as a treatment for postnatal depression: A Qualitative Study. *Patient Education and Counselling, 78*(2), 234-239.

Tyrell, C. L., Dozier, M., Teague, G. B., & Fallot, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology*. 67, 725-733.

Van IJzendoorn, M. H. (1995). Adult attachment representations, parental responsiveness and infant attachment: A meta-analysis on the predictive validity on the adult attachment interview. *Psychological Bulletin.*117, 387-403.

Vitiello, B. (2007). Research in child and adolescent psychoparmacology:recent accomplishments and new challenges. *Psychopharmacology.* 191, 5-13.

Warfa, N., Harper, M., Nicolais, G., & Bhui, K. (2014). Adult attachment style as a risk factor for maternal postnatal depression: a systematic review. *BMC Psychology*, 2; 56-71.

Webster, J., Pritchard, M. A., Creedy, D., & East, C. (2003). A simplified predictive index for the detection of women at risk for postnatal depression. *Birth, 30*, 101-108.

Wickberg, B., & Hwang, C. P. (1996). Counselling of postnatal depression: a controlled study on a population based Swedish sample. *Journal of Affective Disorders, 39*, 209-216.

Wilkonson, R.B., & Mulcahy, R. (2010). Attachment and interpersonal relationships in postnatal depression. *Journal of Reproductive and Infant Psychology*, 28, 252-265.

Woolfe, R. (1996). The nature of counselling psychology. In R. Woolfe & W. Dryden (Eds.), *Handbook of counselling psychology* (pp. 3-20). London: Sage.

CONCLUSION

"Two enduring strengths of an attachment perspective are that it is anchored by a cohesive theory with considerable explanatory power and that it is paired with a tradition of empirical rigor (Berant & Obegi, 2009, p. 461)". The present thesis –Attachment Theory and therapeutic relationships- has aimed to capitalize on both strengths. The theory provides a conceptual framework that explains how early interactions affect interpersonal adult relationships, including the therapeutic relationship (Bowlby, 1988). The thesis attempted to explore this basic assumption of AT from different perspectives; in the first section, by examining the associations among childhood experiences with parents, adult attachments and the therapeutic relationship in an empirical study, in the second section, by presenting a client study using in-depth analysis of the therapeutic interaction employing Cognitive Analytic Therapy (CAT) (Ryle, 1979) which has similarities with AT, and in the third section by presenting a literature review exploring attachment difficulties arising from postnatal depression (PND). The quantitative study aimed to extend the research in adult attachment and contribute to the knowledge base of counselling psychology. The case study aimed to illustrate AT's relevance to the moment-to-moment clinical interaction with an anxious client and the benefits of employing a structured therapeutic format that offers containment for such clients in the NHS. The third section, the critical review, aimed to promote awareness and understanding of the condition (PND), attachment difficulties experienced by clients, and how these may be reflected in therapy where they are essential ingredients in promoting sensitive and ethical counselling psychology practice in primary care.

Empirical studies of attachment support the relevance of adult attachment to therapeutic process and outcome (Dinger, Strack, Sachsse, & Scauenburg, 2009; Goldfried & Davila, 2005: Hubble et al., 2010: Wampold, 2010). The present study was conducted to examine the associations among adult attachment, retrospective reports of childhood experiences and the therapeutic alliance with an additional aim to validate the CES questionnaire. The results of the present research were consistent with many of the previous studies in that similarly modest links were found between some aspects of attachment security and the

alliance. However some hypotheses were not supported, for example, those pertaining to the links between childhood recollections and the alliance. The research methodology used in this study might have been inappropriate and could not have been instrumental in revealing the complex and perhaps subtle dynamics that the theory actually stipulates. In future studies, a mixed methodology that would incorporate qualitative investigations into clients' current and past relationships with caregivers and other adults, including their therapists, might provide a deeper understanding of the clients' attachment difficulties and therefore their effect on the therapeutic relationship. Additionally, it seems critically important for future research to consider the therapists' attachment style and examine how therapist attachment impacts the therapist- client interaction and the development of the therapeutic alliance.

The case study was a reflective account of Cognitive Analytic Therapy (CAT) intervention, and additionally involved discussions from the perspective of AT with reference to the nature of ambivalence and anger in the context of anxious attachment. This was a primary care referral involving an anxious woman feeling confused, fearful and out of control, displaying the ambivalence of longing for intimacy but at the same time feeling resentful and angry at those whom she perceived as indifferent to her efforts to please them. The conflict between approach and avoidance, moving between self-states e.g. controlled/controlling, seeking approval/ angry had been re-enacted in therapy. With the client's active participation, these thoughts and feelings that had led her to become controlling or controlled, being submissive or reacting angrily were put on diagrams, and revisited in sessions as they occurred. The tools in CAT, including writing letters in therapy actively engaged the client in thinking about the process both within and outside sessions and kept the internalisation of the therapeutic experience fresh (Murdin, 2000). In terms of AT, the memory of the therapist as the attachment figure is thought to have provided the 'secure base' necessary for learning to continue beyond the termination of therapy.

The third section, a critical review of the literature on postnatal depression (PND), explored the arising attachment problems in the mother-infant

relationship and different interventions that aim to alleviate the maternal mood and repair the bond. Studies reviewed indicated that mothers with PND struggle to adapt to motherhood, and tend to experience a sharp decline in their capacities to care for themselves as well as their infants (Murray et al., 1996; Poobalan et al., 2007). Studies on the link between attachment and postnatal depression (PND) indicated that insecure attachment is an additional risk factor for PND (Bifulco et al., 2004; Warfa et al., 2014) and maternal depressive symptoms tend to have a negative impact on maternal sensitivity therefore the mother-infant relationship (Field et al., 2010; Murray et al., 1996; Poobalan et al., 2007). AT provides a framework to understand the developmental history and internal dynamics of different forms of relationship difficulties or patterns of attachment (Daniel, 2006), 2010), thus an AT informed therapy with a depressed mother has the potential to become a means for changing and reconstructing their insecure attachment experiences with others including their infants.

This thesis has given me the opportunity to explore adult attachments empirically, examine the therapeutic relationship with a client systematically, and review the studies on PND from the perspective of AT. The three sections of the thesis are thought to have contributed to the knowledge base of counselling psychology, providing information and understanding of the impact of early attachments on interpersonal relationships including the therapeutic relationship, and therefore promoting a sensitive and ethical counselling psychology practice in primary care. The thesis has provided me with a greater appreciation of AT as a clinical frame of reference both working as a therapist and as a researcher.

REFERENCES: Conclusion

Berant, E., & Obegi, J.H. (2009). Attachment-informed psychotherapy research with adults. In J.H. Obegi, & E. Berant (Eds.), *Attachment Theory and Research in Clinical Work* (pp. 461-483*). New York; Guildford Press.

Bifulco, A., Figueiredo, B., Guedeney, N., et al., (2004). Maternal attachment style and depression associated with childbirth: preliminary results from a European and US cross-cultural study. *British Journal of Psychiatry*. 184, 31-37

Bowlby, J. (1988*). A secure base: Clinical applications of attachment theory*. London: Routledge.

Daniel, S. I. F. (2006) Adult attachment patterns and individual psychotherapy: A review. *Clinical Psychology Review, 26*, 968-984.

Dinger, U., Strack, M., Sachsse, T., & Schauenburg, H. (2009). Therapist's attachment, patient's interpersonal problems, and alliance development over time in inpatient psychotherapy. *Psychotherapy, 46*, 277-290.

Goldfried, M. R., & Davila, J. (2005).The role of relationship and technique in therapeutic change. *Psychotherapy: Theory, Research, Practice, Training, 42*(4), 421-430.

Hubble, M. A., Duncan, B. L., Miller, S. D., & Wampold, B. E. (2010). Introduction. In B. L. Duncan, S. D. Miller, B.E. Wampold, & M.A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 23-46). Washington, DC: APA.

Murdin, L. (2000*). How much is enough? Endings in Psychotherapy and Counselling.* London: Routledge

Murray, L., Fiori-Cowley, A., Hooper, R., & Cooper, P. (1996).The impact of postnatal depression and associated adversity on early mother infant interaction and later infant outcome. *Child Development, 67*, 2512-2516.

Poobalan, A.S., Aucott, L.S., Ross, L., Smith, W.C.S., Helm, P.J. & Williams, J.H.G. (2007). Effects of treating postnatal depression on mother-infant interaction and child development. *British Journal of Psychiatry*, 191, 378-386.

Ryle, A. (1979). The focus in brief interpretive psychotherapy: dilemmas, traps and snags as target problems. *British Journal of Psychiatry, 134*, 46-54.

Skourteli, M. C. & Lennie, C. (2011).The therapeutic relationship from an attachment theory perspective. *Counselling Psychology Review, 26*(1), (20-31).

Wampold, B. E. (2010). The research evidence for common factors models: A historically situated perspective. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp. 49-82). Washington, DC: APA.

Warfa, N., Harper, M., Nicolais, G., & Bhui, K. (2014). Adult attachment style as a risk factor for maternal postnatal depression: a systematic review. *BMC Psychology*, 2; 56-71.

APPENDIX 1

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Academic Development and Services

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Mrs Zehra Boysan
Chartered Counselling Psychologist

████████████████████████

30 November 2006

Dear Mrs Boysan

Re: "Adult Patient Attachment Styles and Working Alliance in Early Therapy"

I am writing to you to confirm that the research proposal detailed above has been granted formal approval from the City University Research Ethics Committee, following Chairs action taken to approve the proposal.

Should you have any further queries relating to this matter then please do not hesitate to contact me. On behalf of the Research Ethics Committee I do hope that the project meets with success and many thanks for your patience.

Kind regards

████████████████████████

Research Studies Co-ordinator
Secretary to Research Ethics Committee

Email:
Tel:

NHS
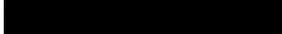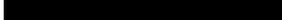
Wandsworth Research Ethics Committee

St George's Hospital
South London REC Office (1) Room 1.14
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Cranmer Terrace
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Telephone: 0208 725 2621

08 November 2006

Mrs. Zehra Boysan
Chartered Counselling Psychologist

█████████████████████████

Dear Mrs. Boysan

Full title of study:	**Adult Patient Attachment Styles and Working Alliance in Early Therapy**
REC reference number:	06/Q0803/139

Thank you for your letter of 23 October 2006, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 03 November 2006. A list of the members who were present at the meeting is attached.

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, providing the wording in the Letter of Invitation is changed in the last sentence to read ".....and consider taking part in this study."

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:

An advisory committee to South West London Strategic Health Authority

Wandsworth Research Ethics Committee

Attendance at Sub-Committee of the REC meeting on 03 November 2006

Committee Members:

Dr C Heron	Consultant Radiologist	Present
Prof G Hall	Consultant Anaesthetist	Present

Document	Version	Date
Application	5.1	19 July 2006
Investigator CV		
Protocol	1	01 July 2006
Covering Letter		20 July 2006
Questionnaire: Childhood Experiences	1	01 July 2006
Questionnaire: Working Alliance Inventory client form	1	01 July 2006
Questionnaire: Experiences in close relationships	1	01 July 2006
Letter of invitation to participant	2	01 October 2006
GP/Consultant Information Sheets	1	01 July 2006
Participant Information Sheet	1	01 July 2006
Participant Information Sheet	2	01 October 2006
Participant Consent Form	2	01 October 2006
Participant Consent Form	1	01 July 2006
Response to Request for Further Information		23 October 2006
Letter from Research Supervisor		29 September 2006
Working Alliance Inventory		
duplicated application form	5.1	19 July 2006
Contact Details Form	1	01 July 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/Q0803/139	Please quote this number on all correspondence

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

Yours sincerely

██████████████

Chair

Email: ████████████████

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

Standard approval conditions

Copy to: Dr Jacqui Farrants
Research Supervisor
Director, Counselling Psychology Programmes
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Mrs Zehra Boysan
Counselling Psychologist

[REDACTED]
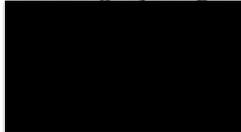
10th January 2006

Dear Mrs Boysan

Re: Wandsworth PCT research approval: 'Adult patient attachment styles and working alliance in early therapy', Ref: W2007/133

Thank you for submitting project registration and approval information for the above study.

Your documentation was submitted to me as Chair of the R&D Committee and I have pleasure in informing you that all the appropriate information was received and that your study has been approved.

The details of your study will be included in our research database. For research governance and management purposes we will require you to forward copies of any annual and final reports, abstracts and publications to the R&D Committee. These should be sent to Wandsworth PCT R&D Committee, c/o Amy Scammell, Research Manager, BRG – Wandsworth Primary Care Research Centre, Wandsworth PCT, Bolingbroke Hospital, Wakehurst Road, London. SW11 6HN.

We will report this project to the National Research Register (NRR) as part of the PCT submission and include this study on the PCT and South West London sector database. Please contact Amy Scammell if you *do not* wish the PCT to report this project to the NRR or include this study on the sector wide database.

We may need to issue you and any associated researchers with honorary contracts to cover this research study and Amy Scammell will be in touch with you regarding this in the next week. Please note that you must not begin your study until any honorary contracts have been issued and approved.

I would like to wish you every success with your study.

Yours sincerely,

[REDACTED]

Chair, Wandsworth PCT R&D Committee

WHN080 mi

Chairman: Melba Wilson   Chief Executive: Helen Walley

RECYCLED PAPER

Christine Heron, Chair
Wandsworth Ethics Committee

███████████████

29 September 2006

Dear Dr. Heron

Adult Patient Attachment Styles and Working Alliance in Early Therapy
REC Ref 06/Q0803/139

I confirm that I fully support the above research to be carried out by Zehra Boysan as part of her Doctorate in Psychology at City University. I believe Zehra to be a committed researcher with the ability to carry out this piece of work. City University will sponsor the research and has the appropriate indemnity insurance to cover the research.

Yours faithfully

Dr Jacqui Farrants
Research Supervisor
Director, Counselling Psychology Programmes

███████████

Dear Colleague

As you know the study titled 'Attachment Styles and Therapeutic Alliance' is underway in your practice. Would you please inform your clients who might be interested in taking part in the study at the end of the therapy session with them?

When you are talking to them about the study it would be helpful if you would include the main points of the study; childhood experiences with parents, current relationships with partners and therapy relationship. The study aims to look at how past and present relationships inclusive of therapy relationships are all related.

I, the researcher, will be around the reception area to answer their questions and give more information about the study.

I appreciate your time and help in supporting me with this project. Thank you.

Zara

Version: 2

Date: October 2006

Invitation Letter

We are conducting a study on counselling experiences of patients who are referred for counselling in Primary Care. The title is **Attachment Styles and Therapeutic Alliance.** The study aims to investigate the counselling relationship between the patient and therapist, and how they relate to each other. It aims to find out whether early childhood experiences influence the way we relate to others as adults and whether these relationship patterns might impact in the context of therapy or counselling.

Your Practice has agreed to help us by providing information to patients who are referred for counselling and who are volunteering to participate in this study. All information is confidential and will not be disclosed to your doctor or counsellor.

We would be grateful if you would review the information in the envelope provided by your General Practitioner and consider taking part in this study.

Thank you for your time.

Zehra Boysan
Chartered Psychologist and Psychotherapist

Patient Information Sheet

Date: February 2008   Version No: 3

Research Title: **Attachment Styles and Therapeutic Alliance**

You are being invited to take part in a research study. Please take time to read the following information carefully and discuss it with others if you wish. Thank you for reading this.

What is this study about?
This study aims to investigate the counselling relationship between the patient and therapist, and how they relate to each other. It aims to find out whether early childhood experiences influence the way we relate to others as adults and whether these relationship patterns might impact in the context of therapy or counselling. How do patients' past and present experiences in relationships influence their counselling relationship?

Why have I been chosen?
This study is open to any patient who is referred for counselling/psychotherapy by their General Practitioner. Your General Practitioner and counsellor/psychologist have agreed to help this study by providing information to patients who are volunteering to participate in the study.

Who is organising the study?
The study is sponsored by City University and will contribute towards Zehra Boysan's doctorate in psychology (DPsych). Zehra Boysan is a chartered psychologist and psychotherapist working in primary care in Wandsworth PCT and she is the prime investigator of this study.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part, simply complete all the forms in the Research Pack and return them in the envelope provided. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What do I have to do?
If you agree to take part, I would like you to complete all the questionnaires in the envelope, read and sign the Consent Form and fill in the Contact Details Form and send all of them back in the stamped addressed envelope or hand it to the Researcher. The questionnaires are anonymous and the questionnaires will not be shown to your psychologist/counsellor or your doctor.

What are the possible benefits of taking part?
There are no direct benefits to you for taking part. However, you will be helping to increase our understanding of an important issue that may improve the future delivery of services for people who are receiving psychological therapies in primary care.

What are the possible disadvantages or risks of taking part? There are no foreseeable risks involved in your participation in this study. However, completing the questionnaires in total will require approximately 30 minutes of your time.

What if something goes wrong?
In the first instance if you have any concerns about this study you should contact:
Zehra Boysan

████████████████████
████████████

Telephone: ████████████
E mail: ██████████████

Or, if these questionnaires cause any emotional discomfort and you need to speak to an independent person, please contact:
Dr Leyla Ziyal........................ ████████████

If there is an aspect of the study which concerns you, you may make a complaint. City University has established a complaints procedure via the Secretary to the Research Ethics Committee. To complain about the study, you need to phone ██████████ You can then ask to speak to the secretary of the Ethics Committee and inform them that the name of the project is 'Attachment Styles and Therapeutic Alliance'.
You can also write to the Secretary:
Dr. Naomi Hammond
Secretary to Senate Ethical Committee
Academic Development and Services
City University
Northampton Square, London EC1V 0HB
Email: ██████████████████

If taking part in this study harms you there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it.

Will my taking part in this study be kept confidential?
All information collected about you during this study will be kept confidential. This includes any information that might be stored on a database. All information about you from this study is governed by the principles of data protection outlined in the Data Protection Act (1998). The data collected in the course of this research may be used for publication in journals. All data will be kept confidentially with complete anonymity and any personal details which may identify you will not be used either verbally in discussions and seminars, or in any written form that the research may take. There are no foreseeable risks involved in your participation in this research. Your participation in this research is completely voluntary, and you may refuse to participate or withdraw from the study at any time without negative consequences

Further information:
For further information or an informal discussion of any aspect of this study please contact Zehra Boysan on the above address, telephone or e mail.

I would like to thank you for your time and considering taking part in this study.

City University London

Wandsworth NHS
Teaching Primary Care Trust

Zehra Boysan
Psychology Department

Title of Project: Attachment styles and therapeutic alliance

Version: 2

Date: October 2006

Name of Lead Researcher: Zehra Boysan

Please initial box

1. I confirm that I have read and understand the information sheet dated July 2006 for the above study and have had the opportunity to ask questions.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my professional or legal rights being affected.

☐

3. I agree to take part in the above study.

☐

OR

5. I do not wish to take part in this study.

☐

_____   _____   _____
Name of Service User   Date   Signature

_____   _____   _____
Name of Person taking consent   Date   Signature

CONTACT DETAILS FORM   Version 2   2008

Please complete and return this Form along with the others in the envelope provided.

Female ………   Male…………….   Date of Birth……………………………

How many therapy sessions did you have?

Name of the Surgery…………………………………………………………………………

Thank you for completing the Form

Instructions:

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. Circle one of the numbers provided for each item, using the scale from 1 (disagree strongly) to 7 (agree strongly):

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

Childhood Experiences Survey

The following questions are about experiences you've had when you were growing up, as a child (before the age of 16).

Most items ask how you felt your parents treated you when you were growing up. If you didn't grow up with both parents, just think about the people that you did grow up with (e.g., maybe in some cases an aunt, uncle, grandparent). In general, think about the parent you felt closest to, in case your memories about your parents are different.

> 1 = Very false for me
> 2 = Somewhat false for me
> 3 = Neither true nor false
> 4 = Somewhat true for me
> 5 = Very true for me

Indicate a number from 1 to 5

1. My parents were always there for me when I needed them. _____

2. My parents were sometimes very nice to me but there were other times when they were quite awful. _____

3. I felt comfortable and cozy with my parents, but I also picked up the idea that venturing out into the world could be dangerous and unpleasant. _____

4. Growing up with my parents made me feel as if they were strangers who really did not care much about me. _____

5. My parents treated me quite awfully when I was a child so I remember being scared of them. _____

6. I knew I could count on my parents whenever I had a problem as a child. _____

7. My parents made me feel fearful of them when I was growing up. _____

8. During my childhood, I loved to return to the comfort and safety of my family in order to get away from the harsh outside reality. _____

9. When I was a child it was quite clear to me that my parents did not care about me. _____

10. My parents often made me feel as if I'm safe and protected with them but that the world outside is a harsh and hostile place. _____

11. My parents were rather indifferent to me - I'm not sure they really cared whether I existed or not. _____

Continue using this response scale:

1 = Very false for me
2 = Somewhat false for me
3 = Neither true nor false
4 = Somewhat true for me
5 = Very true for me

Indicate a
number
from 1 to 5

12. As a child it was hard for me to know whether my parents really loved me or not. _____

13. When I was growing up, I remember feeling quite anxious or worried when I had to be with my parents. _____

14. When I was growing up, I felt very comfortable at home but I also learned that strangers should be treated with caution. _____

15. During my childhood, I remember having to try very hard to win my parents' love and affection - it wasn't something I could take for granted. _____

16. I felt secure with my parents - there was no doubt that they loved me deeply and would do anything in case I really needed it. _____

17. When I grew up, my parents were always unpredictable - I never quite knew what to expect next. _____

18. In my childhood, there was often a sense that people outside of my close family couldn't be trusted or were somehow "enemies." _____

19. I used to feel a sense of dread or fright of my parents when I was a child. _____

20. My parents made me feel loved but they also may have "overprotected" me a bit. _____

21. My parents were generally more interested in things and people other than me. _____

22. I grew up with a sense of being genuinely loved by my parents. _____

WORKING ALLIANCE INVENTORY

Below is a list of statements about your relationship with your therapist. Please consider each item carefully and indicate the level of agreement for each of the following items by circling the number under the statement.

Does not correspond   Corresponds moderately   Corresponds exactly

  1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7

2. What I am doing in therapy gives me new ways of looking at my problem.

    1   2   3   4   5   6   7

3. I believe my therapist likes me.

    1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7

5. I am confident in my therapist's ability to help me.

    1   2   3   4   5   6   7

6. My therapist and I are working towards mutually agreed upon goals.

    1   2   3   4   5   6   7

7. I feel that my therapist appreciates me.

    1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7

9. My therapist and I trust one another.

    1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7

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

    1   2   3   4   5   6   7