A Portfolio of Academic, Therapeutic Practice and Research Work

Including an investigation of

The effects of therapists’ attachment dimensions on the working alliance

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Statement of Anonymity and Confidentiality

Throughout this portfolio, names of all clients and research participants have been replaced with pseudonyms and other identifying information has been altered or omitted in order to preserve their anonymity and confidentiality.
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Abstract

This portfolio contains my academic, therapeutic practice and research work. It consists of three dossiers which reflect my personal and professional development as a counselling psychologist. The academic dossier contains three selected theoretical essays. The first essay discusses the patient’s transference in light of attachment theory, looking at the differences when compared to the purely libidinal psychoanalytic view of transference. The second essay makes a critique on the use of standard psychopathological classifications in understanding human distress and discusses the example of the so-called Schizoid Personality Disorder. Implications for counselling psychology practice are also discussed in this essay. The third essay critically reviews the literature on how the therapeutic relationship is perceived in Cognitive Behavioural Therapy (CBT). Additionally, this essay discusses how counselling psychologists who work with CBT can understand and utilise the therapeutic relationship as an “intervention” in their therapeutic practice, from an attachment theory perspective. The therapeutic practice dossier contains a description of my three different clinical placements during my training as a counselling psychologist and it also includes my final clinical paper which offers a reflective account of my personal-professional experience and development. Finally, the research dossier contains three pieces of work, a review of the literature and two empirical research studies. The first piece of work, reviews the existing literature on the effects of therapists’ attachment organisation on the process and outcome of therapy. The second piece of work is a quantitative study that examines the role of therapeutic caregiving in the relationship between therapists’ attachment dimensions and the working alliance. Finally, the last study explores the attachment-caregiving therapeutic relationship by investigating whether clients’ attachment dimensions moderate, and therapists’ caregiving mediate, the effects of therapists’ attachment dimensions on the working alliance.
Introduction to the Portfolio

The purpose of this introduction is to reflect upon my personal and professional experience which led me into psychotherapeutic and counselling psychology training. I also hope that this introduction will facilitate the reader’s understanding of how my academic and research interests were formed at the time of my training and ultimately contributed in the development of my evolving identity as a scientist-practitioner counselling psychologist.

Some reflections on why I chose to do a doctorate in counselling psychology

Initially, one of the reasons that attracted me to doctorate level training was my “thirst” to expand my academic knowledge. Furthermore, I wanted to obtain a qualification which would keep me in academia, in order to continue learning. This “thirst” for knowledge was obvious in the earlier years of my life, as from my parents’ descriptions I was a curious child who always wanted to know more about things around me. I remember myself, as a quiet observer of my family, friends and others, and particularly being interested in wanting to understand more about why people are so different and how those differences affected their relationships. This curiosity guided me throughout school and my aim was to study at university one day. My tendency towards education was also reinforced by my parents’ continuous support to grow in this area. Therefore, eight years ago I found myself travelling to Greece, the land of Plato, Socrates and Aristotle, to study psychology. This is how my journey into understanding the human experience began.

During my undergraduate psychology degree, I was introduced to different psychological theories of human development and personality. Due to the emphasis of the course on the clinical aspects of psychology, I had several lectures on “abnormal psychology” which provided a comprehensive understanding of human psychopathology. The enthusiasm and passion that I saw in my lecturers continued to stimulate my curiosity on the clinical applications of psychology. My research supervisor’s influence, a clinical psychologist and psychoanalyst, with whom I worked over a period of three years, was the catalyst in my final decision to study psychotherapeutic psychology. Now, with hindsight, I can see how those
opportunities met and satisfied my needs in understanding human experience and relationships.

Throughout the four years of my undergraduate degree, I completed two different mandatory clinical placements and other four voluntary placements, which gave me the opportunity to observe in practice some of the theoretical notions I have been taught. However, the observational nature of my placements was not enough for me to actually experience and apply theory in practice. Towards the end of my degree, I was already convinced that I wanted to specialise in psychotherapeutic psychology but I needed to have some prior clinical experience. Therefore, soon after I completed my undergraduate degree I undertook a year’s placement as assistant psychologist in a psychiatric department of a general hospital in Greece.

As an assistant psychologist, I had the opportunity to carry out psychological assessments using different psychometric tests and also to observe how other practitioners, such as psychiatrists and clinical psychologists, worked with clients. During this period, while undertaking a counselling skills course, I also worked therapeutically with three clients under supervision and the focus of my work was to provide them with a space to reflect upon their life’s situation. These three people reported that they benefited from our sessions and felt relief as they had the opportunity to speak to someone, they felt safe in doing so and also felt listened to. Listening closely to their feedback, I was trying to understand what made those people feel safe when talking to me, a stranger to them. At the same time I was wondering what was stopping them from talking to their close others. My supervisor advised me, that one of the reasons they felt safe with me was because I provided them with something really important, unconditional positive regard, which was probably missing from their lives. I felt very privileged that the clients trusted me and this has also helped me embrace the concept of the therapeutic relationship and value its importance, at a time when my ‘main’ therapeutic skills and ‘techniques’ were empathic understanding and reflection.

Becoming more interested on the function of the therapeutic relationship in psychological therapy, I spent many supervision hours discussing it. My supervisor suggested some reading and from this I discovered different theories about how the relationship can be used therapeutically. Theoretically this was useful, but practically I realised that it required skills that were beyond my clinical expertise and knowledge.
Via the counselling skills course, I was introduced to counselling psychology. Getting to know more about counselling psychology, I was fascinated with the emphasis given to the use of the therapeutic relationship in understanding and working with human distress. As I was also very interested in research, by reading the existing counselling literature, I began to develop some research ideas to explore further. Towards the end of my placement, I decided that a postgraduate training which combined research, theory and practice, could fulfil my personal and professional needs. Therefore, I pursued further training in counselling psychology.

**Academic Dossier**

The academic dossier contains a selection of three academic essays which I wrote during the second and third year of my training and these reflect my theoretical interests at the time. Writing these essays enabled me to understand further some theoretical notions and also informed and facilitated my therapeutic practice.

The first essay entitled “Conceptualising the patient’s transference in light of attachment theory”, was written during my second year of training. At the time, I was working in a psychotherapy department and practicing psychodynamic therapy, and transference was a topic that was often discussed in the team meetings. With this essay I wanted to understand more about transference as there was something that did not sit comfortably with me listening to other professionals’ discussions. Firstly, this concerned the core of the classical psychoanalytic view on transference, which is seen as a repetition of repressed infantile neurosis and as a relationship distortion, and secondly about the role of the therapist in the patient’s transference. Therefore, in this essay I attempted to provide an overview of the classical Freudian theory on the function of transference and then to discuss transference in light of attachment theory. This essay helped me understand my clients’ transference from a relational point of view and also understand my own role in that, as therapy is a co-created process.

The second essay entitled “A critique on the use of standard psychopathological classifications in understanding human distress: The example of Schizoid Personality Disorder”, was written during my third year of training. In this essay I made a critique on the use of standard psychopathological classifications in understanding human distress and discussed the paradigm of schizoid personality disorder in non-conventional psychiatric terms. More specifically, I discussed and
explored a formulation-driven approach coming from the basic tenets of attachment theory, in understanding people's experience that may be labelled as schizoid. Additionally, I discussed its implications on counselling psychology practice, keeping an integrative stance and finally mentioned the importance of embedding a formulation-driven approach in the standard psychopathological manuals. This essay helped me conceptualise human distress from a different angle from that of the medical model, and crystallise my views on psychopathology. Finally, I believe that this essay has also reminded me of my humanistic values and helped me gain a greater compassion in understanding the underlying processes of people who experience psychological distress.

In the third essay entitled "Working in and on the therapeutic relationship in Cognitive Behavioural Therapy from an attachment theory perspective", I explored the role of the therapeutic relationship in CBT. This essay was written during my third year of training. At the time, I was troubled by the fact that in our CBT lectures I was not entirely able to grasp the functions of the therapeutic relationship in CBT. Therefore, with this essay I reviewed the literature on how the therapeutic relationship is perceived and used in CBT. Additionally, I discussed how counselling psychologists who work with CBT can understand and utilise the therapeutic relationship as an "intervention" from a more relational perspective, that of attachment theory. Writing this essay enabled me to understand how as an integrative therapist I can still use the therapeutic relationship when practicing CBT.

**Therapeutic Dossier**

The therapeutic practice dossier contains a description of my three different clinical placements during my training as a counselling psychologist. This description includes information about the type of service and duration of my placement, my activities and responsibilities within each placement, my therapeutic orientation, the client population I worked with and the supervision I received. Additionally, this dossier includes my final clinical paper which offers a reflective account of my personal and professional growth and experience as a counselling psychologist.
Research Dossier

The research dossier contains three pieces of work: a literature review and two empirical research projects. My research work over the course of my training in psychotherapeutic and counselling psychology has focused on the effects of therapists' attachment organisation on the working alliance.

After I began to work therapeutically with adults as an assistant psychologist in Greece, I became particularly interested in understanding how my own personality characteristics affected my relationships with clients. I believed that the same observations that had guided me as a child, how our differences as individuals can affect our interactions with others, might be relevant for the therapeutic relationship. When I began this course I knew that I wanted to pursue these observations and questions in my doctoral research, but it was difficult to decide exactly what the topic should be, and how to accomplish it. The first lecture on the course inspired my final decision about the form my research topic would take. After discussing our learning styles, at the end of the lecture, we were given a task to think about how we engage with people as this would be the topic of our following meeting. I recalled that in my undergraduate dissertation I had used attachment theory to explain the association between individuals' ways of engaging in relationships and psychological separation. Therefore, I wondered if the topic could focus on how our attachment organisation affects the therapeutic relationship.

In my first year's research, I explored the existing literature on the effects of therapists' attachment organisations on the process and outcome of therapy. Initially it was difficult to find many relevant studies and I began with seven. Interestingly, although researchers started to study this area in the mid 1990s, it is only in the last eight years that they have expanded upon the topic. Findings from the 14 reviewed studies showed that therapists' attachment could influence the process and outcome of therapy. In particular, the majority of these studies found that a secure attachment style or dimension in therapists had a positive association to the working alliance, whereas insecure attachment styles associated negatively to both the process and outcome of therapy. The implications for psychotherapeutic practice, and future research, seemed promising. Nevertheless, it was suggested that the relationship between therapists' attachment organisation and the process of therapy might be more complex than we think. Additionally, as this topic was still in its infancy, the need for
more empirical studies was evident. Therefore, wanting to contribute to the existing literature and, more importantly, to understand more about the causal inferences of this relationship, I began to think about my next year’s project.

Building upon my literature review, I decided that for my second year’s research project I would explore the factors which could explain the relationship between therapists’ attachment organisation and the working alliance. Therefore, I examined the role of therapists’ caregiving on the relationship between therapists’ attachment dimensions and the working alliance. Findings from this study were initially consistent with the existing literature, that therapists’ attachment organisation is activated in the therapeutic encounter and affects the therapeutic alliance but, more importantly, it was found that therapists’ caregiving mediated this relationship. This could partially explain the relationship between therapists’ attachment dimensions and the working alliance, contributing to our understanding that therapists’ attachment organisation, depending on the levels of their attachment anxiety or avoidance, can influence their therapeutic caregiving behaviours which then affect the working alliance negatively or positively. Implications for practice were also discussed in this study.

From my previous study, many questions were left unanswered and I was particularly interested in the attachment-caregiving dynamics in the therapeutic relationship. More specifically, I wondered if therapists’ caregiving was activated differently with clients who had different or similar attachment dimensions to their own, and whether this could explain the effects of therapists’ attachment dimensions on the working alliance. Therefore, in my third year’s research study I explored the effects of therapists’ attachment dimensions on the working alliance by investigating whether clients’ attachment dimensions moderated, and therapists’ caregiving mediated, this relationship. Findings showed that interesting attachment-caregiving dynamics were created in the therapeutic encounter and affected the therapeutic alliance. More specifically, it was found that when therapists with high attachment anxiety were matched with clients who had moderate to high levels of attachment anxiety, reported less effective therapeutic caregiving which then affected the working alliance negatively. Finally, when therapists’ with low attachment anxiety were matched with clients with low to moderate attachment avoidance, they reported an effective therapeutic caregiving which then affected the working alliance
positively. Implications for psychotherapeutic practice were also discussed in this study.

I believe that exploring this topic during the three years of my training, gave me the opportunity to answer some of my initial questions. In addition, it helped me to gain a deeper understanding of how my own attachment-caregiving processes affect the ways I engage with clients and finally to recognise the importance of the therapist's use of self.
Introduction to the Academic Dossier

This dossier includes three theoretical essays written throughout my training. The first essay discusses the patient’s transference from an attachment theory perspective, looking at the differences when compared to the classical psychoanalytic view on transference. The second essay addresses issues about the use of psychopathological classifications in understanding human distress and discusses the example of the so-called Schizoid Personality Disorder in light of a formulation-driven approach. Finally, the third essay discusses how the therapeutic relationship is perceived in Cognitive Behavioural Therapy (CBT) and how it can be understood and used in clinical practice from an attachment theory perspective.
Essay 1

Conceptualising the patient’s transference in light of attachment theory

It is generally acknowledged that Freud gave us powerful insights in understanding the human “psyche” and psychological distress. However, a shift has occurred from the drive theory to the relational theories when conceptualising and working with some therapeutic processes, hence it can be said that we have moved on from Freud. In this paper I will discuss the concept of transference in light of attachment theory, a relational theory that integrates both theory and research in guiding clinical practice.

The Freudian concept of transference

The concept of transference was originated by Freud and used for the first time in 1895 in the “Studies of Hysteria” where he believed that transference was a form of resistance (Mijolla, 2005). However, it was only with the analysis of “Dora” in 1905 that Freud began to understand the significance of transference and some years later, he wrote a paper to explain how transference was important in understanding the patient’s behaviour towards the therapist (Freud, 1912).

Transference is a phenomenon characterised by the unconscious redirection of feelings from one person to another, and it is argued that in the therapeutic relationship the patient directs their positive or negative feelings onto the therapist by replacing a person from their past (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). For the patient, this experience feels “real” as they are totally unaware of transferring “new editions” of impulses and “phantasies” to the therapist (Lemma, 2003). Freud also suggested that libidinal energy is shifted in this transaction and that transference has its base in infantile neurosis (Freud, 1912). Clearly, the transference in Freudian terms is a repetition of the past, where early experiences based on the patient’s Oedipus complex are repressed. In addition, as these experiences cannot be expressed, they are acted out in the therapeutic encounter. By using this concept, transference is seen as a distortion of the “real” relationship between the therapist and the patient and it is thought to be therapeutically important for the patient when the therapist understands and interprets this phenomenon.
Post-Freudian theorists and clinicians, particularly those coming from the object-relations school, believe that transference is not a relationship distortion that is based on sexual or erotic wishes resulting from the unresolved Oedipus complex. They rather believe that transference is an actual experienced relationship from the past and the enactment of that internalised relationship with the therapist in the "here and now" (Hinshelwood, 1989). Attachment theory is closer to the object-relations school's theory on transference.

Approaching Transference from an attachment perspective

Bowlby's theoretical conceptualisations and clinical experience, and Ainsworth's pioneering empirical work, established the attachment theory which provides a framework in understanding human relationships (Bowlby, 1969, 1973, 1980; Ainsworth, Blehar, Waters, & Wall, 1978). Attachment theory asserts that the infant forms an attachment-bond to their caregiver (usually the mother) and this bond is based on the infant's needs for safety, security and protection. According to the quality of their caregiver's response, the child starts to develop his/her concept of the self and his/her expectations of others. These early attachment experiences are internalised and incorporated into the Internal Working Models (IWMs), which are thought to be universal and transferrable in adulthood (Bowlby, 1988). The theory of the IWMs can provide us with an understanding of how an individual's past relational experiences can guide their emotional responses in adult relationships and give us hints on how these may appear in the form of transference.

Cortina and Marrone (2005) proposed that transference from an attachment theory perspective can be redefined as the unconscious expectations, attributions, beliefs and attitudes that are embodied in the patient's IWMs and affect all relationships. Therefore, in the therapeutic relationship as the patient attaches to the therapist, the patient's transference-based expectations towards the therapist are activated and can be explored and understood by their IWMs or attachment styles (Holmes, 1996; Mallinckrodt, Gantt, & Coble, 1995).

Four major attachment styles were identified in adulthood, the "secure-autonomous", the "insecure-dismissive", the "insecure-preoccupied" and the "insecure-unresolved/disorganised" (Steele & Steele, 2008). Obegi and Berant (2009) argued that as attachment insecurity was found to be a risk factor that contributes to
mental health problems, working with patients who have an insecure attachment style may be a therapeutic challenge. Therefore, it is interesting to focus on the characteristics of the three insecure attachment styles and to what can be expected in the transference. It is important to note that as each patient is unique, the examples that follow must be seen only as possible tendencies of the patient's transference expectations towards the therapist in the therapeutic relationship.

**Dismissive attachment**

Dismissively attached patients often have short transcripts and they may have difficulty in trusting others. In order to prevent themselves from becoming upset or disorganised, they tend to keep out of awareness childhood attachment experiences that are coloured by rejection or neglect. Nevertheless, when they decide to disclose something there is an idealised presentation of childhood. Additionally, when they report difficulties in relationships, their effects are minimised or normalised with little or no specific memories to support those experiences. Generally, dismissive patients present themselves as invulnerable, self-reliant and disconnected from their feelings.

In the transference, as dismissively attached patients feel uncomfortable with intimacy, the closeness with the therapist might represent a threat of rejection, similar to experiences in their past relationships. Therefore, by using different methods they will ensure that the therapist does not become close and too important to them. For example, they may be resistant to transference interpretations or be less inclined to accept the therapist’s empathic reflections. In more extreme circumstances, dismissively attached patients may report that the therapist has little to offer them or that therapy is insignificant and even commenting that if they were not in therapy they would be spending their time more creatively. On the other hand, they could idealise the therapist, in such ways as to protect themselves from strong and upsetting feelings. It is important for therapists to understand that the minimisation of feelings and the avoidant/dismissive stance that these patients have towards the therapeutic relationship, and the therapist, perhaps indicate an attempt to defend against the pain of further rejection.
Preoccupied attachment

Patients with a preoccupied state of mind, often have transcripts that are lengthy, confused, conflicted, vague or angry. Generally, they present with unfavourable memories of childhood and attachment experiences, which left them unloved, misunderstood and hurt. They also seem to be overwhelmed by their feelings when they talk about these memories. Afraid of independence and having problems in believing that they can rely on themselves, they may be fearful of asserting themselves or too willing to please. In addition, they are preoccupied about the availability of others, searching for evidence to provide proof to sustain their beliefs. However, driven by their fear of others’ unavailability, there is often a desire to come closer to, or “merge” with, others by being absorbed in finding ways to avoid distance.

In the transference, they may perceive the therapist as unavailable in the same way their significant others may have been, unreliably responsive, in the past. Thus, in order to receive the therapist’s full attention they may appear helpless and exaggerate their distress. Other attempts to diminish distance and to get closer to the therapist are mirrored in their need to be the “perfect” patient. However, by presenting with a readiness to engage in the therapeutic relationship, this might be less an indication of their ability to collaborate and more a sign of their desire to comply and please. In order to avoid their unconscious fantasy of rejection and abandonment, they may seek reassurance or wanting the therapist to agree with them. Additionally, as they may be preoccupied with the therapist, they will be asking very personal questions. Therefore, it is understood that therapists are regularly “tested” for their availability from these patients and it can be useful to understand this need for closeness as a defence against the distance and the fear of abandonment experienced in past relationships.

Unresolved/disorganised attachment

Unresolved/disorganised patients may have been brought-up in a disorganised environment where attachment relationships have been traumatic, painful, unsafe or abusive. These patients often speak in an unusual way with lapses in reasoning, or in discourse, regarding trauma and loss, presenting with a mixed insecure preoccupied and dismissive state of mind. In the preoccupied mode they appear as “needy” of a
close relationship, but because they fear rejection, humiliation and abandonment, they find it difficult to become close to others. This is how they shift into the dismissive mode where their main coping strategy becomes the avoidance of intimacy. There is often a pattern of "all or nothing" and "black or white" thinking, which results in unrealistic and unstable experiences of the self and others. Finally, as unresolved/disorganised patients are overwhelmed by memories of past experiences, and as they fear that past trauma will be repeated in current relationships, they may try to make reality seem less real by "spacing-out" and dissociating.

In sessions, as unresolved/disorganised patients are afraid of the therapist, there can be a lot of silences and, often, sudden shifts in therapy may occur as they move from one insecure state of mind into another. By using defences like dissociation and projective identification, and trying to avoid the painful past, the unresolved/disorganised patients unconsciously recreate the old unsafe relationships, which are then brought alive in the relationship with the therapist. Furthermore, as they cannot tolerate a secure relationship, where the therapist is empathic and attuned to their pain, it is possible that these patients will report that they have re-experienced old threats. Therefore, they may perceive the relationship with their therapist as stormy, unstable and extraordinarily difficult. In addition, when they are in crisis they may desperately and angrily request the therapist's help, while at the same time being in denial, they will say that they do not need therapy or the therapist. Finally, when the therapist is trying to contain painful feelings or even when they interpret transference, unresolved/disorganised patients may find this unhelpful, controlling or intrusive.

With knowledge of the patients' attachment styles, therapists can become more aware of the transference and hence the kind of relationship that patients with different attachment styles can tolerate or try to develop with them. Using attachment theory in their clinical practice, therapists can tailor their interventions to the patients' actual needs. In addition, by working in and on the transference, therapists can facilitate the patient's understanding of their transferential expectations and reactions towards them. Therapists can provide patients with specific examples as to how these transferential patterns have been played out in their here and now relationship. Ultimately, this can enable patients firstly to become more aware of how their unhelpful relational patterns are re-enacted in other relationships outside of the
therapeutic room, and secondly to become more flexible and open to reflect and revisit their maladaptive attachment styles. This is the essence and the meaning of the corrective emotional experience that Bowlby (1988) suggested, which can be achieved by providing a secure base for the patient from where they can explore and understand their transference reactions and finally revisit their insecure attachment styles.

Transference as a co-created process

From an attachment theory perspective, it can be understood that in the process of transference the patient has an idiosyncratic way of perceiving and relating to the therapist based on their attachment styles. However, perhaps the patient not only expects the therapist to be similar to their “transference objects”, but they may also be seeking-out real signs that can place the therapist in such expectations. In classical psychoanalysis, this is understood as a distorted relationship, because the patient is incapable of accurately perceiving the therapist as a real person. Therefore, any signs that the patient looks for to place the therapist in their expectations, are seen as distortions. It was also claimed that the analyst should serve as a blank screen so that transference can occur in order to be analysed and understood. For that reason, it can be argued that from a purely classical psychoanalytic perspective, what happens in the therapeutic relationship comes entirely from the patient’s history and is distinct from the therapist’s actual impact (Wallin, 2007). However, the notion of the blank screen is problematic because therapists are never neutral.

Attachment theory’s conceptualisations about the therapists’ role in patients’ transference, finds the intersubjective theory as an ally. In intersubjective theory, it is claimed that the subjective states of two individuals are always shared in a conscious or an unconscious way (Natterson & Friedman, 1995). Therefore, the therapeutic relationship from an attachment-intersubjective perspective is a co-created process and thus a reciprocal interaction between the client and the therapist takes place. In this co-created relationship, the therapist is not a blank screen but an active participant who, as Gelso and Hayes (1998) suggest, affects and is affected by the patient’s experience. Hence, it can be understood that the therapist may also bring in some ways their own personal values which may have then an impact on the patient’s transference (Bowlby, 1973; Cortina & Marrone, 2005; Holmes, 1996).
Initially, it was theorised, and then confirmed by empirical studies, that the patients’ attachment styles are activated in therapy and affect their therapists’ countertransference (Hardy, Aldridge, Davidson, Rowe, Reilly, & Shapiro 1999; Kiesler, 2001; Mallinckrodt et al., 1995). However, later studies showed that, therapists’ responses and countertransference behaviours towards clients, are not only evoked by the clients’ attachment styles and transference, but also it can originate from the therapists’ own attachment styles (Dozier, Cue, & Barnett, 1994; Mohr, Gelso, & Hill, 2005; Rubino, Barker, Roth, & Fearon, 2000). Therefore, it can be understood that the way therapists relate to patients, understand and respond to them, and generally how they behave, listen, talk or even stay silent, can reinforce the patients’ transference expectations towards therapists. This mutual and reciprocal influence, places the therapist somewhat closer to the centre of the patient’s transference. Thus, the transference from an attachment-intersubjective perspective is no longer considered as a distorted relationship. This is because the patient’s views of their therapist have a plausible basis and the patient’s transference is, to some extent, also determined by the real signs they find in the therapeutic relationship (Wallin, 2007).

The therapist’s personal characteristics, including their conscious and unconscious behaviours or even some elements of the therapeutic frame, are more than just a propensity to affect the patient’s internal object representations. For example, when a patient of mine said that she was afraid to be in therapy with me because I am a man, the question raised in my mind was, what was it about my gender that she found so fearful? The answer could be found in the previous abusive experiences she had with men, who became the abusive objects in her life. In the sessions, she reported feeling vulnerable by remembering, discussing and exploring painful experiences with me, while at other times she seemed to really need the space to discuss them. Her subjective experience, felt real for her but it felt like a distorted transference relationship for me, at least in the beginning. What led me to that conclusion was that while at times she was able to discuss painful experiences and afterwards feel some kind of relief at other times I observed that my expression of empathy and congruence was not enough for her. This evoked in me three different kinds of countertransference feelings towards her, sympathy, fear and irritation. Discussing her in supervision, when looking at my countertransference reactions, I
realised that perhaps it was not only her transference and unresolved/disorganised state of mind that made her so fearful with me, but possibly she found some real signs for experiencing me as an "abusive object". After bringing this to her attention, she said that the times I remained silent and was just looking at her, I looked annoyed and she felt afraid of me. I recalled that the times I remained silent were mostly the times I did not know how to respond to her when she was bringing the issue of the abuse into the room and that I was afraid, as if I was about to open a "Pandora's box". At other times, in my silence, I was perhaps communicating my irritation because when empathising or making interpretations, she seemed to build a massive wall between us. It is possible that at the time we were both caught into a transference-countertransference dynamic, where her attachment styles, and my own, contributed to this.

Conclusion

The shift from the libidinal view of transference to the more object-relational, as well as intersubjective-relational, is the core of understanding transference from an attachment theory perspective. Under this concept, transference is no longer viewed as a repetition of repressed infantile neurosis. Instead, as Wallin (2007) stated: "Transference is thus a matter of selective attention and sensitivity" (p. 176). Therefore, it can be understood that transference occurs because this is how the patient has learnt to experience relationships. These experiences are encoded in the patient's memories, which are activated in the therapeutic relationship and can be understood by their attachment styles. Working in and on the transference and using the here and now therapeutic relationship, therapists can facilitate the patient's awareness by enabling them to reflect on their experience and revisit their insecure attachment styles and their unhelpful transference. Finally, as attachment theory gives considerable attention on the therapist's impact on therapy processes, transference is no longer perceived as a relationship distortion. This highlights the importance of understanding the patient's transference in the co-created nature of the therapeutic relationship and may be of particular interest to practitioners who work mainly from a relational perspective like counselling psychologists.
References


A critique on the use of standard psychopathological classifications in understanding human distress: The example of “Schizoid Personality Disorder”

There is an ongoing debate about how practitioners understand “mental disorders” in terms of assessment, formulation and treatment. The current diagnostic procedures are defined by rule-based classifications that largely rely on symptom clusters, such as DSM and ICD, and are influenced by the medical model which supports the concept of nosology (Jablensky & Kendell, 2002). Under this notion, psychological difficulties are seen as pathological and therefore questions are raised about what is “normal” and “abnormal”. The aim of this paper is to make a critique on the use of standard psychopathological classifications in understanding human distress and the example of so-called Schizoid Personality Disorder (Schizoid PD) will be discussed in non-conventional psychiatric terms. A formulation-driven approach which derives from the basic tenets of attachment theory will be utilised to understand Schizoid PD, and implications for counselling psychology practice will also be considered.

Psychiatric classifications and human distress

Existing empirical studies related to human biology and psychology, but also philosophically-rooted notions such as the “body and mind problem”, imply that humans are beings with complex and different needs. Due to this complexity, humans have a developmental cognitive tendency to construct different meanings in their lives by classifying and naming objects (Towse & Cowan, 2005). Perhaps without this ability, it might have been very difficult to cope with the demands of everyday life and as Golsworthy (2004) suggests, we try to produce meanings by categorising things so that our world becomes more manageable. In line with this, categorisation applies in the field of psychopathology and underpins the psychiatric classifications of mental disorders because understanding and “treating” human distress is seen as complex and difficult (Fulford, Thorton, & Graham, 2006).

It is suggested that diagnostic manuals are a necessary frame of reference in the field of mental health, because they provide a common language to clinicians
worldwide in producing clinically meaningful information about people’s difficulties, which can then lead to specific interventions aiming to target symptomatology (Berganza, Mezzich, & Pouncey, 2005). Despite the agreement between these diagnostic systems in identifying symptoms and classifying mental disorders, it can be argued that they lack a formulation-driven approach and also, with the publication of new research, they become outdated. Inflexible use of those atheoretical classifications, can (mis)label people as “mentally ill” without acknowledging what is behind the manifestation of their presented symptoms and difficulties.

In other branches of medicine the process of classifying, diagnosing and treating illnesses can be much more straightforward than in the field of psychiatry (Fulford et al., 2006). One aspect of the problem here is the definition of the term mental disorder and what can be defined as such, especially when the behaviour is the main instrument used in diagnosing mental disorders (Golsworthy, 2004). DSM-IV defines a mental disorder as:

... a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. ... Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological, or biological dysfunction in the individual. (American Psychiatric Association [APA], 1994; p.xxi)

Some assumptions that derive from the above definition are that mental disorders are facts people struggle with and symptoms, whatever the original cause, can be classified in such terms defining a normal and abnormal behaviour or psychological state. These assumptions can create great uncertainty to a lay person who can assume just by reading one of those manuals that they suffer from a disorder of mind or that they are psychologically “unstable”.

A major limitation of the standard psychopathological classifications is that they only present with a list of symptoms and clusters, neither providing any understanding, nor addressing the aetiology of symptoms and disorders. Even statistically, the categorical system which is used to diagnose mental disorders proves to be problematic as to what is normal and abnormal is not discretely classified
(Lopez et al., 2006). Therefore, it can be argued that the meaning attached on constructs like psychiatric disorders or mental illness tends to pathologise human experience. The definition of a mental disorder becomes more blurred when we talk about personality disorders as directly, or indirectly, it is implied that there is a "faulty" personality and a disordered behaviour which causes problems in interpersonal relationships (Perris, 2000). The rest of the paper will focus on a discussion around Schizoid PD in DSM-IV terms, and how attachment theory can be utilised by counselling psychologists to understand a person’s distress when presenting with such difficulties.

The paradigm of Schizoid PD

In plain language, DSM-IV defines a personality disorder as a steady long-held pattern of beliefs and behaviours that cause difficulties in maintaining emotions, thoughts, behaviours and interpersonal relationships at a socially acceptable level. But what constitutes the socially acceptable and is that socially acceptable the same in different countries and cultures? Why does DSM-IV assume that personality traits are absolute determinants? What methods are valid and reliable to assess if a personality trait is inflexible or maladaptive? And finally, is a personality disorder really an illness? These questions have plagued practitioners for many years and must be carefully considered before classifying people in such discrete categories.

A person to be diagnosed with Schizoid PD in DSM-IV terms must meet the following criteria:

A. A pervasive pattern of detachment from social relationships and a restricted range of expression of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

(1) neither desires nor enjoys close relationships, including being part of a family
(2) almost always chooses solitary activities
(3) has little, if any, interest in having sexual experiences with another person
(4) takes pleasure in few, if any, activities
(5) lacks close friends or confidants other than first degree relatives
(6) appears indifferent to the praise or criticism of others
(7) emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of schizophrenia, a mood disorder with psychotic features, another psychotic disorder, or a pervasive developmental disorder, and is not due to the direct physiological effects of a general medical condition. (APA, 1994; p.641)

My first impression after reading the above points was that the combination of words Schizoid and Personality Disorder have a negative connotation. Furthermore, after carefully rereading those symptoms, I realised that they can lead to misleading assumptions such as: Schizoid PD begins only in early adulthood, the person has limited or no sexual drives and interests, little or nothing can give them pleasure and that they seem apathetic in the praise or criticism of others. Finally, that list of symptoms seems dry as there is no explanation about their aetiology. As the main feature of Schizoid PD is withdrawal from relationships, accompanied by decreased affect regulatory strategies, attachment theory could possibly provide a grounded framework in understanding the nature of these difficulties.

**Understanding and redefining Schizoid PD in non-conventional psychiatric terms from an attachment perspective**

Attachment theory is a well-established theory of close relationships, development and psychopathology which can enlighten us, as to whether a person may experience psychological distress from a relational point of view (Obegi & Berant, 2009). Unlike DSM, which in my opinion never intended to appreciate the significance of the individual’s phenomenology, attachment theory values not only the present, but also the past, and the developmental context in which a person’s difficulties may have developed. Disorders are seen as expressions of an internal pain coming from difficulties experienced in interactions with attachment figures and therefore symptoms are signals of that pain, serving a specific function (Crittenden, 2005). From this stance, a valid assessment and formulation can lead to appropriate therapeutic interventions tailored to the individual’s needs. This approach is highly respected in counselling psychology, as it can provide an understanding of the person’s phenomenology and enhance our clinical work, which mainly focuses in and on the therapeutic relationship. Working with the therapeutic relationship is
considered as highly important, especially for people whose distress is associated with inflexible longstanding personality traits and relational difficulties (Young, Klosko, & Weishaar, 2003; Wallin, 2007).

From an attachment theory perspective, our interactions with primary caregivers shape our perceptions of the world, our responses to others and also the ways we learn to regulate emotions. Children at times of need, distress and danger tend to seek proximity from their caregivers in order to elicit protection and security. When an attachment figure is unavailable, rejecting or inconsistently responsive to the child’s needs, the distress increases and as their world feels unreliable and unsafe they develop an insecure attachment. Therefore, to cope with distress they may adopt a secondary attachment strategy which takes two forms: hyperactivation or deactivation (Ainsworth, Blehar, Waters, & Wall, 1978). Bowlby (1982) suggested that these experiences are internalised and stored in memory and finally become schemas or Internal Working Models of attachment (IWMs) and affect regulation, which are activated in new situations and relationships.

Empirical research has revealed that, insecure attachment and the use of secondary attachment strategies by adults, are risk factors for mental health problems and that Schizoid PD is associated with an insecure attachment and particularly with attachment avoidance (Dignam, Parry, & Berk, 2010; Haggerty, Hilsenroth, & Vala-Steward, 2009; Sherry, Lyddon, & Henson, 2007; Shorey & Snyder, 2006). Attachment avoidance is related to an excessive need for self-reliance and fear of depending on others, avoidance of emotional closeness and social withdrawal (Brennan, Clark, & Shaver, 1998). People with attachment avoidance make use of the “deactivating strategy” which can provide a rationale for the Schizoid PD symptoms. As Main, Kaplan, and Cassidy (1985) proposed, in the co-created nature of the parent-child relationship there is a projection of “dismissing rules” from parents (i.e., the child should not express any physical or emotional needs) and an internalisation of those rules by children. Therefore, facing rejection, children characterised by attachment avoidance may have learnt to give up on their proximity-seeking efforts and by using suppression, avoidance and minimisation of the pain (deactivating strategy) they try to regulate their emotions.

The use of deactivating strategy lies between the individual’s conscious and unconscious IWMs that shape their inner and interpersonal experience (Wallin, 2007).
The conscious model is about a good, strong and complete sense of self while others are seen as untrustworthy. The unconscious model is about a flawed, dependent and helpless self while others are rejecting and punitive. As previously mentioned, attachment relationships are powerful enough to inform our self-image and our perceptions of others and the world, hence from the continuous interactions with our caregivers, and later on from our interactions with close others, we learn what to expect. Consequently, individuals with attachment avoidance may use the deactivating strategy as they may believe that others are no good to trust or will reject their needs, just like their primary caregivers.

Reframing the DSM-IV’s criteria for Schizoid PD into a more tentative presentation derived from attachment theory, could mean, that individuals who present with such difficulties may tend to keep relationships at a distance, choosing to be more self-reliant as they feel discomfort with intimacy and interdependence. They may have a desire for some degree of contact but as they fear rejection or emotional “traumatisation” they may be reluctant to pursue steady or long-term romantic, sexual and other relationships, and by keeping others “at arms length” they “survive” from the emotional closeness of those relationships. Finally as they may have learnt to devalue emotions in times of pain, they may experience some difficulties in regulating and demonstrating some of their emotions giving the impression to others, who are different from them, of a distant, detached and unemotional person.

Attachment theory describes personality functioning in a nonpathological way and provides a coherent aetiology of the distress of people who are diagnosed by Schizoid PD in DSM-IV terms. In addition, attachment research with its recent developments, suggests that the IWMs are best captured in dimensional rather than categorical terms (Fraley & Waller, 1998). According to this, the different ways of relating and regulating difficult emotions represents a logical adaptive functioning, e.g., all of us have the need sometimes not to express feelings or even withdraw from relationships. However, if these characteristics tend to be excessive and cause persistent difficulties to a person, they may lead to psychological distress which lies somewhere at the other end of the continuum. In addition, it is suggested that our attachment experiences inform rather than define our future relationships and as we form more than one relationship our IWMs may differ from one relationship to another (Shaver & Mikulincer, 2009). As we have multiple social roles in our lives,
our interactions with different people shape the choice of particular actions, thoughts and behaviours. Therefore, it can be understood that a person with schizoid tendencies may have good interactions and relationships with people at some level.

All these are in accordance with McRay's and Costa's (2003) definition of personality traits which are seen as only dispositions and not absolute determinants, confirming that the traditional categorical classification systems wrongly assume that personality disorders are stable and absolute facts of human nature. Not giving the proper attention to understanding why people behave as they do, psychopathological classifications can never capture the complexity and uniqueness of human experience (Ivey & Ivey, 1998). Counselling psychology is a branch of scientific and applied psychology that resists dogma and takes such issues seriously by formulating that psychological distress is a product of interacting systems (Boucher, 2010).

**Implications for practice**

Knowing that schizoid clients may present as self-reliant and detached, they may approach the therapist in a distant way, often being reluctant to express any emotions and believing that the therapist will be unavailable, rejecting or intrusive. Working in and on the therapeutic relationship can be very reparative for them because the core of their distress is relational. Therefore, counselling psychologists informed by attachment theory, will aim to construct a secure relationship within such emerging relational patterns will be understood and reworked. But to achieve this, there is a need for adaptation, sensitivity, responsiveness, flexibility and integration, all which are components of sensitive therapeutic caregiving from the part of the therapist (Fitch & Pistole, 2010; Parpottas, 2010).

CBT with its rich repertoire of techniques can be utilised to motivate schizoid clients to actively participate in their therapy. This is because emotions can be very frightening, especially in the beginning of therapy, and threats associated with closeness and dependence on the therapist may be evoked by the frame of therapy. In this way, therapists can work “in style” (Slade, 2008), meaning that they can work at a more cognitive level which schizoid clients, like dismissively attached clients, can respond to well. As therapy continues, clients can be prepared for deeper work and the key here, as Wallin (2007) suggests, is to follow the affect. Therapists can then work “out of style” (Slade, 2008), meaning that they can work in more affective ways in
order to respond to schizoid clients' underlying emotional needs by challenging their deactivating strategy and attachment avoidance.

The use of Rogerian conditions are essential throughout the process, especially attunement and empathic understanding, as in this way clients can learn more adaptive strategies for affect regulation. However, as therapy gradually exposes schizoid clients to their unintegrated emotional experience, which can become the most challenging task of therapy, they may use their deactivating strategy and related defences to protect themselves. Here a more psychodynamic approach can be appropriate, with the analysis of transference, empathic confrontation and appropriate work with the client's defences, all showing the "royal road" in understanding clients' unconscious IWMs. As known from psychoanalysis, whatever these clients are reluctant to feel, it will often be evoked in their therapists. Therefore, our countertransference is an important "tool" throughout the process of therapy as it can guide us to the client's unintegrated experience.

Although attachment theory is not an independent psychotherapeutic approach, it is a theory about relationships which can inform our formulation of the client's distress, and our interventions, by placing the therapeutic relationship at the heart of therapy. However, some caution must be stressed on the use of ideas that derive from the basic tenets of attachment theory. As each person is different and their distress differs in nature and degree, our formulation must always be a tentative working hypothesis based on their specific experiences and difficulties. Therefore, the previous implications for practice must be seen as tentative ideas and suggestions and not a "treatment plan" that suits every client.

Conclusion

For many years the stigma of being "crazy" was attached to any difficulty related to mental health and perhaps the standard psychopathological classifications still give this impression. Although the current diagnostic systems have been developed for classification purposes, they just label "clinical phenomena", specific attitudes and behaviours (Ivey & Ivey, 1998). The present paper took a different perspective in understanding psychological distress, utilising attachment theory to formulate hypotheses about the symptomatology of Schizoid PD in non-conventional psychiatric terms and provide implications for counselling psychology practice.
Important inferences that derive from this paper are that whatever a mental disorder is, it does not reflect facts about individuals. The lack of clarity on why some people experience a specific disorder leaves the traditional diagnostic classifications incomplete. After all, mental illness is only a construct that people developed to understand such phenomena (Golsworthy, 2004). A need for revision is apparent in the standard psychopathological manuals and perhaps the inclusion of a formulation-driven approach is essential as it can bring together a systematic organisation of symptoms and a comprehensive understanding of their aetiology.
References


Essay 3

Working in and on the therapeutic relationship in Cognitive Behavioural Therapy from an attachment theory perspective

It is generally accepted that the therapeutic relationship is one of the most fundamental aspects of therapy and one of the best predictors of therapy outcome (Gelso & Carter, 1994; Stevens, Muran, Safran, Gorman, & Winston, 2007). However, it may be argued that Cognitive Behavioural Therapy (CBT) has given more attention to techniques and “in doing therapy” rather than the therapeutic relationship. Although through the different waves of CBT the views on how to work with the therapeutic relationship have changed (Sanders & Wills, 2005), there is still an impression that the therapeutic relationship is necessary but not sufficient itself to bring about change. Therefore, the aim of this paper is to briefly review how the therapeutic relationship is operating in CBT and furthermore to understand how attachment theory can inform the practice of counselling psychologists who work with CBT, by bringing the focus of the work more in and on the therapeutic relationship. For the purpose of this paper, I will discuss an example from my clinical work with a client who I have named Tom (a pseudonym is used and all personal details were altered for confidentiality reasons).

Cognitive and behavioural views on the therapeutic relationship

In the first wave of behavioural therapy, the importance of the therapeutic relationship was devalued and received much less attention than the technical aspects of therapy (Scott & Dryden, 2003). Behavioural therapists believed that the outcome of therapy depended mainly on specific techniques and assumed that the relationship between the client and the therapist was a rather “neutral stimulus” which had only minimal impact on treatment efficacy (Kohlenberg, 2000). Only after the second, and now the third, wave of CBT, therapists have gradually begun to consider working more with the therapeutic relationship itself.

The second wave of CBT gave birth to cognitive therapy and its primary founder Aaron Beck stated the importance of collaborative empiricism (Beck, Rush, Shaw, & Emery, 1979). The idea of collaborative empiricism was mainly constructed
around the view that in an environment of mutual collaboration, the client provides the data to be investigated and a genuinely warm, empathic and open therapist helps the client to discover and change distorted, unrealistic and unhelpful thoughts and beliefs (Blackburn & Twaddle, 1996). However, the cognitive change would be achieved by the successful implementation of specific techniques while a good therapeutic alliance was thought to facilitate the implementation of those techniques (Rector, Zuroff, & Segal, 1999). Under this view, the collaborative nature of the therapeutic relationship is primarily used in delivering and accomplishing specific techniques methodically and efficiently and this was a quite common approach in many models under the umbrella of CBT.

Looking closer at Beck’s and his colleagues’ writings, arguably it seems that something really important was overlooked. They mentioned that therapists might be taking a large risk if they ignore the therapeutic relationship, because beyond the techniques and principles of CBT, the relationship is still an important interaction between two human beings who are trying to accomplish a very important task: that of psychological therapy (Beck et al., 1979). Unfortunately, although they cautioned therapists they did not elaborate further on this either by implementing in their theory concepts on the processes involved in the therapeutic relationship, or even explicitly incorporating the therapeutic relationship into cognitive and behavioural interventions. Overlooking aspects of the therapeutic relationship, CBT theoreticians ended-up by talking and emphasising more on the technique. As a result, only a few theoretical papers, empirical studies and books have addressed issues around the complexities of the therapeutic relationship, or even how it can be utilised as an intervention itself in CBT.

The treatment of long term psychological problems, like personality disorders, brought a shift in how CBT perceived the therapeutic relationship. In addition, influences from other frameworks, such as the interpersonal, emphasised how the therapeutic relationship could be utilised in practice (Newman, 1998). Jeremy Safran, contributed majorly to CBT by placing the therapeutic relationship at the heart of psychological therapy as another way of understanding clients’ wider relationships and psychological difficulties. From an interpersonal point of view, the client’s dysfunctional relational patterns are manifested in the therapeutic relationship, not only affecting their psychological wellbeing, but also the relationship with their
therapist (Blackburn & Twaddle, 1996). According to Safran and Segal (1996), this is something that needs to be addressed in order to help the client integrate their experience of the self and others. Initially, the therapist tests the client's experience (thoughts and feelings) of the therapist, and their relationship, and then the therapist talks about how they experience the client. This can provide invaluable insights around issues as to why the client often feels "stuck" with their difficulties which are repeated in the therapeutic relationship in similar ways as in their broader relationships. Under the scope of the interpersonal framework, it is implied that interpersonal relationships are powerful enough to affect psychological change and hence, perhaps the therapy relationship can be therapeutic in itself.

The previous ideas have been questioned by some CBT authors and practitioners who advocated that, although the therapeutic relationship is necessary, it is not sufficient itself to bring about the therapeutic change (see in Dobson, 2003). These critiques may be quite robust, especially in the current trend of evidence-based practice, where CBT manuals and protocols demonstrate the effectiveness of specific techniques on therapy outcome (National Institute for Health and Clinical Excellence, 2008; Wright, 2006). At the same time, when practitioners and theoreticians are trying to defend their model and also when therapy becomes "manualistic", only resistance and inflexibility is created. The result might be that a very interesting theory, like CBT, is devalued and more importantly the interaction between two people, who are trying to understand human experience, becomes less human and more mechanistic. To avoid this, perhaps therapists who use a pluralistic practice, like counselling psychologists, need to question the underlying assumptions and the status quo of how the "therapeutic change" and the therapeutic relationship are perceived in conventional CBT terms. After all, as Boucher (2010) stated: "... counselling psychology resists theoretical dogma, repeatedly questioning its own assumptions in an attempt to gain a richer perspective on what it is to be human" (p. 160).

Moving towards working in and on the therapeutic relationship in CBT from an attachment theory perspective

In counselling psychology, our work is underpinned by a phenomenological approach tailored to the individual's difficulties and unique subjective experiences (Woolfe, Dryden, & Strawbridge, 2003). Counselling psychology is interpersonal,
relational and flexible and this means that in order to meet an individual’s needs and experiences we may need to keep a more pluralistic perspective in our work. This can be done by bringing the focus of the work directly in and on the therapeutic relationship, while the techniques can follow. Having said this, the rest of this paper will touch upon issues that are less frequently addressed in CBT, such as understanding how transference and countertransference, from an attachment theory perspective, can influence the therapeutic relationship and how these processes can be incorporated into cognitive-behavioural interventions.

From their continuous experiences in relationships, individuals discover themselves and their world, and thus they build their self-concept and their views about others. These experiences, memories, schemas, mental structures and processes are internalised and incorporated in what attachment theory describes as Internal Working Models (IWMs) of self and others which enable individuals to construe and construct their relationships (Shaver & Mikulincer, 2009). In addition, it is suggested that an individual may hold multiple IWMs relating to different people, and because IWMs are dimensional and hierarchically constructed, individuals may think and behave differently depending on which IWM is triggered at the time (Bowlby, 1988). It can therefore be understood that, a client’s perception of themselves and others in relationships may come from a dynamic interaction between their past and current experiences which can then affect every relationship in their lives, including the therapeutic relationship.

It is generally accepted that, the therapeutic relationship contains many qualities of an attachment relationship and hence clients’ IWMs are activated in the therapeutic relationship (Parish & Eagle, 2003; Wallin, 2007). At times, clients explicitly report how they view themselves in relation to their therapists; other times, specific feelings, thoughts and reactions are evoked in therapists without any verbal communication and what happens in the room might seem out of context. In both occasions, this can occur in the process of transference which is a unique aspect of the therapeutic relationship (Gelso & Carter, 1994). Understanding transference in terms of attachment theory can be very useful when working with CBT. Attachment theory suggests that although clients may approach the therapeutic relationship having a set of assumptions and rules about relationships in general (global IWMs), they also develop specific thoughts and behaviours towards the therapist in the moment.
(context-specific IWMs) (Shaver & Mikulincer, 2009). Being aware of both the client’s global and context-specific IWMs, gives therapists a broader view of transference and how it may relate to clients’ difficulties. Ultimately, therapists have the opportunity to understand and explore with the client the way(s) they relate to the therapist. This can provide insights that the therapeutic relationship may be affected in similar way(s) to the way their other relationships are affected, and perhaps this may also be how their difficulties are caused or maintained. The following example shows how my client’s global and context-specific IWMs were activated in the therapeutic relationship in the form of transference.

When I started working with Tom, he had a difficulty with repeating sentences (his formal psychiatric diagnosis was OCD). Tom’s global IWMs could be seen as preoccupied attachment, while in therapy he was fluctuating between a preoccupied and dismissive attachment to me: at times he was talking in the same detached tone of voice, not getting into details about his difficulties and being vague about his thoughts and feelings, while at other times he was feeling extremely anxious, compulsively repeating sentences and then agitatedly asking reassurance from me. This was a recurrent pattern in our sessions, where he would either withdraw into himself, dismissing me and his problems, or become very anxious, repeating sentences and seeking reassurance. After discussing with him what was going on in the room, he told me that he was feeling embarrassed and angry with himself. He also reported that he believed that I was unable to understand him and when I did not reassure him he was feeling that I was critical and rejecting. Without challenging his beliefs at that point, we explored the meaning he was giving to these beliefs. He told me that something similar was happening back home with his brother. His brother was not giving Tom any attention and Tom was getting angry with himself and his brother, and as a result he was feeling ‘incompetent’, ‘ignored’ and ‘unnoticed’. However, being afraid of his brother’s reactions, he never verbalised his anger and after suppressing his thoughts and feelings, he was feeling an ‘urge’ to repeat sentences which resulted in a tension between the two brothers. Tom told me that he found it difficult to talk about his thoughts and feelings with me because he believed that I would not understand him. He also thought that if he did, he could have caused some kind of inconvenience between us and that I would decide not to see him again.
Although transference is not, and should not be, the main focus of our work in CBT, working with this concept we may be more able to understand the client’s phenomenology and difficulties from a relational perspective. By creating a secure base, both client and therapist can accept what is happening in the moment (validation and containment) and eventually this will enable clients to become more aware of the process and understand how it relates to their difficulties. Then, by utilising cognitive techniques the client’s negative automatic thoughts, core beliefs or assumptions, could be tested and this will eventually offer a different outlook (or modification in CBT terms) to unhelpful thinking patterns and maladaptive IWMs. In this way we do not only facilitate the application of CBT techniques but we directly work in and on the transference, using the therapeutic relationship as an intervention.

As the therapeutic relationship, like other attachment relationships, is co-created perhaps it is not only influenced by the client’s IWMs and transferential reactions to the therapist, but also from the therapist’s IWMs. In the past, insight-oriented (i.e., psychoanalytic) and action-oriented (i.e., CBT) psychotherapies’ views on whether therapists’ personal characteristics were determining factors of the process and outcome of therapy, were contradictory. Research around this topic was either modest or very general (Spilken, Jacobs, Martin, James, & Knitzer, 1969). While some studies share the assumption that in “manualised” therapies, the therapist’s personality does not interfere in the psychotherapeutic process (Fitzpatrick, 1997), nowadays a growing body of literature confirms that the therapist’s professional and personal characteristics can influence the therapeutic alliance (Henry & Strupp, 1994).

Attachment theory and research indicate that except for the clients’ IWMs, the therapists’ IWMs affect the working alliance (Daniel, 2006). For example, Rubino and her colleagues (2000) found that therapists with high attachment anxiety experience more difficulties in handling alliance ruptures because their worry of being rejected is triggered by those ruptures. To manage those threats to their security, anxiously attached therapists may intensify their affect in establishing closeness with clients and therefore they fail to be empathic and handle those ruptures therapeutically. On the other hand, as therapists with high attachment avoidance may be less comfortable with intimacy, they may perceive the closeness of the therapeutic relationship but also their clients’ distress as very intrusive. Therefore, to deal with those threats to their security they may divert their attention away from being
emotionally too close with clients, devaluing their clients' real needs and responding to them less empathically (Trusty, Ng, & Watts, 2005).

While clients' IWMs are activated in therapy in the form of transference, one could argue that the therapists' countertransference is a simple reaction towards clients' transference. If this is the case, how is it possible then that therapists' IWMs can be triggered and affect the therapeutic alliance? A recent study showed that therapists' attachment dimensions influence therapists' caregiving (i.e., sensitivity, responsiveness and flexibility) which mediates the relationship between therapists' attachment dimensions and working alliance (Parpottas, 2010). This suggests that therapists' countertransference towards clients is not merely a reaction to clients' IWMs and transference, but it may also be a reaction coming from therapists' IWMs. Therefore, it is understood that therapists' IWMs may translate into caregiving behaviours which then affect the therapeutic alliance.

In the example with Tom, he was feeling very angry with himself and me but being unable to put it into words resulted in me feeling very irritated. At the same time I was being put off by his constant attempt to elicit reassurance and I found myself becoming unempathic towards him. This was something that kept me preoccupied and affected our alliance. The intensity of my countertransferential feelings and reactions were partly evoked by Tom's IWMs and partly by my IWMs. What gave me this impression was that when I meet with clients whose IWMs are similar to Tom's I often have similar reactions towards them.

Being aware of our countertransference, and how in the previous example my IWMs influenced my therapeutic caregiving, and consequently the therapeutic alliance, is a very essential aspect of therapy. As Wallin (2007) states “our own capacity to be mindful may be critical to our efforts to be of help to our patients” (p. 7), the emphasis here is on the importance of supervision and personal therapy which can enhance the therapist's use of self. What initially led Tom to discover that he was angry with himself and frustrated with me was the use of my countertransference. After discussing Tom in supervision, I was able to share with him that I felt some kind of irritation in the room. However, it was only by using supervision and personal therapy, that I realised that my feelings and thoughts were partly evoked by Tom's transference and partly from my own IWMs (attachment avoidance), and also how I could have used these in a way that could be therapeutic and make sense to Tom.
Although the “use of self” can be a very valuable “tool” in understanding the client’s presenting difficulties and working directly in and on the therapeutic relationship, CBT has not embraced this concept (MacLaren, 2008). Being mindful enough of our and our clients’ state of mind in respect to attachment, we can become more attuned and provide a safe base for the client to explore their internal world which will ultimately endorse the “corrective emotional experience” (Wallin, 2007).

Conclusion

The therapeutic relationship is a unique “relational space” where the existence of two people comes together and narratives are co-created. As counselling psychologists, we work towards what is thought to be therapeutic by “staying with” the individual’s experience and also by paying attention to our internal and external processes. CBT is a therapeutic approach with extremely useful conceptualisations and techniques but the therapeutic relationship and its processes, like transference and countertransference, were minimally or rarely regarded. Attachment theory can offer to CBT a thoughtful approach to these issues, aiming to strengthen its practice. On the other hand, it must be acknowledged that nowadays CBT practitioners and theoreticians have begun to take these issues more into consideration (see in Gilbert & Leahy, 2007). This is really important, especially at a time where the future of psychological therapies might seem a bit hazy, as pressures to deliver therapy, in the UK-public sector at least, are threatening the relational aspect of psychological therapy. Therapy is a space where “other meets otherness” (Boucher, 2010; p.165), therefore in the immediacy of this powerful reciprocal therapeutic relationship the client’s presented difficulties and underlying needs, can be understood in meaningful and constructive ways.
References


Introduction to the Therapeutic Practice Dossier

The therapeutic practice dossier relates to my clinical practice and contains descriptions of the different placements I have undertaken during my training, including the duration, client population and type of supervision, as well as other associated professional activities. This dossier also includes my final clinical paper, which provides the reader with a more in-depth account of my personal progress and evolving identity as a Counselling Psychologist. Names of all clients have been replaced with pseudonyms and personal information has been altered or omitted, in order to preserve their anonymity and confidentiality.

Client studies-process reports were written on my individual work with a number of clients throughout the three years of my training and a log book was kept of all work undertaken. These form part of the attachment file and appendices available to the exam board.
Description of Clinical Placements

First year placement: University Counselling Service
October 2008 – July 2009

My first year placement took place in a University Counselling Service, located in South-East England. The counselling service staff consisted of two psychologists, five counsellors, three study advisers, two peer-support counsellors, a mental health adviser and two secretaries. Therapists’ psychotherapeutic approaches were integrative, systemic, CBT, psychodynamic and existential.

The counselling service received referrals from the University GP Surgery and from university tutors, but clients could also refer themselves directly to the service. Within the service, clients completed an intake form and the Clinical Outcomes in Routine Evaluation (CORE) and after its completion, clients were placed in the waiting list. The service offered mainly short-term counselling to university students and staff, on average six weekly sessions. Longer-term therapy was also offered in line with the clients’ psychological needs. Additionally, online counselling and group-based interventions like assertiveness training, anxiety management and emotional intelligence workshops, were available to clients. Finally, the service provided liaison to the medical service through the mental health adviser.

In this placement, I worked on a short-term individual basis with young adult-clients and I was supervised by a chartered counselling psychologist. The client-group varied in gender, cultural background and socio-economic status. The clients I worked with, presented mainly with difficulties such as depression and anxiety and my therapeutic approach was integrative with person-centred and CBT influences.

I participated in weekly business and clinical meetings of the team which lasted for one hour. In the first half of the meeting, all the counselling team was gathered to discuss business-issues and in the second half only therapists were present and discussed clinical issues. I also participated in four educational presentations which included: a presentation on CBT skills, a presentation on health and social anxiety, a presentation on inter-cultural psychology and a presentation on DBT for personality disorders. I also attended a three-hours training course on a computerised CBT programme called ‘Beating the Blues’.
Two combined client studies-process reports were written on my individual work with two different clients during this time, and a log book was kept of all work undertaken. These form part of the appendices available to the exam board.
Second year placement: NHS Psychotherapy Department
September 2009 – August 2010

My second year placement took place in a psychotherapy department, part of a large NHS trust located in South-East England. The psychotherapy team consisted of two psychiatrists in psychoanalytic psychotherapy, two consultant adult psychoanalytic psychotherapists, a consultant group analyst, a principal adult psychoanalytic psychotherapist and two secretaries.

The service offered both short and long term individual and group psychodynamic psychotherapy to clients who were usually referred by their GP, Community Mental Health Teams or from other health and social care professionals. The service also offered the “Mentalization-Based Group Therapy” for clients with a diagnosis of borderline personality disorder and also the “Young People’s Group” for people aged from 18 to their mid-twenties. Within the service, clients completed an intake questionnaire and they were assessed by a consultant psychotherapist. They were then placed on a waiting list before being allocated to an available psychotherapist.

In this placement, I worked both on a short-term and long-term individual basis with clients and I was supervised by two consultant adult psychotherapists. Supervision took place on a weekly basis and I was presenting verbatim transcripts for each client. The clients I worked with presented with complex interpersonal difficulties and my therapeutic approach was psychodynamic.

I participated in weekly clinical meetings which lasted for one hour. In clinical meetings each member of the psychotherapy team presented a client. I had the opportunity to present two clients and I received valuable comments and feedback from the team. In December 2009 the service was going through some changes and it was decided that a computerised record system would replace the clients’ files. All the information about clients, such as demographics, assessments, tests and even progress notes needed to be put on a computer system called RiO. I attended a two-day RiO-training in November 2009.

As part of my duties in the psychotherapy department, I wrote formal letters and reports such as assessment and discharge reports to the professionals who referred the clients I worked with (i.e., psychiatrists, care coordinators and GPs). I also wrote
progress notes for each client on RiO, which were monitored and validated by my supervisor.

Three' combined client studies-process reports were written on my individual work with three different clients during this time, and a log book was kept of all the work undertaken. These form part of the appendices available to the exam board.

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1 The third client study-process report was presented in my re-sit viva.
Third year placement: NHS Community Mental Health Recovery Service
(previously known as Community Mental Health Team)
September 2010 – September 2011

My third year placement took place in a Community Mental Health Recovery Service (CMHRS), part of a large NHS trust located in South-East England, where adult clients with "severe and enduring mental health problems" were referred through psychiatric services and GP surgeries. The team was led by a team manager and consisted of three consultant psychiatrists, eight Community Psychiatric Nurses (CPN), one psychologist, three Social Workers (SW), one Occupational Therapist (OT), three Mental Health Workers (MHW), one approved mental health professional, four secretaries and receptionists.

During my placement, the CMHRS provided clients with an assessment of their clinical and social needs, using a multidisciplinary approach, which led to the creation of a "care plan" specifically designed and tailored to each client's individual needs. The care plan included assessment, medication and on-going support from CPNs, MHWs, SWs and OTs. Psychological therapy was also available to clients over a period and time agreed by the client and psychologist, in line with the clients' individual needs. Finally, the service offered short-term CBT oriented groups such as anxiety management and assertiveness groups and also the Wellness Recovery Action Plan group (WRAP) which is a programme designed to aid clients' recovery.

In this placement, I worked with clients mainly on a short-term individual basis. Additionally, I co-facilitated one anxiety management and one assertiveness group and facilitated another two anxiety management groups and two WRAP groups. I was supervised by a chartered counselling psychologist on a weekly basis. The clients I worked with in my third year placement, presented with complex psychological difficulties such as anxiety, depression, social anxiety, OCD, personality disorders, psychosis and paranoid schizophrenia. My therapeutic approach was mostly integrative (i.e. person-centred, psychodynamic and CBT) and informed by attachment theory.

In addition, I had the opportunity to observe how other professionals within the team worked with clients. For example, I observed a psychiatric evaluation carried out by a psychiatrist and a psychological assessment carried out by my supervisor,
who also observed me in assessing two clients. In addition, I went on a home visit
with a SW and finally I observed a CPN working on-duty.

I participated in weekly clinical meetings which lasted for a two and a half
hours. In the clinical meetings all members of the multidisciplinary team discussed
new assessments and discharges, risk assessments and reviews of clients who were
placed on the risk list, considered complex cases and clients' feedback, complements
and complaints. On June 2011, I attended a team away-day for the redesign of the
CMHRS.

As part of my duties in the CMHRS, I wrote formal letters and reports such as
assessment reports, discharge reports and referral reports to those who were involved
in the clients' care (i.e., psychiatrists, care coordinators and GPs). These reports were
written for all clients I worked with in this placement. I also wrote progress notes for
each client on RiO, which were monitored and validated by my supervisor. In
addition, I had the opportunity to contact practitioners from other services in order to
gather more information about clients who were referred to me for psychological
therapy. Together with my supervisor, I assessed and referred a client to the
personality disorders service and another to the psychotherapy service. Finally, as part
of my responsibilities in the CMHRS as a psychologist, I provided consultation under
supervision to other mental health professionals such as CPNs, SWs and MHWs
around issues of psychological understanding of clients' presenting difficulties and on
aspects related to psychotherapeutic interventions which they could use with some of
their clients.

Two combined client studies-process reports were written on my individual
work with two different clients during my placement at the CMHRS, and a log book
was kept of all the work undertaken. These form part of the appendices available to
the exam board.
Final Clinical Paper: My quest in understanding human experience via the path of counselling psychology

While writing this paper I found myself considering whether my journey to become a counselling psychologist has finally reached its end; but I am aware that as one journey ends another begins. In this paper I will focus on four areas that, I believe, have been a major influence on my personal and professional development, that of theory, practice, supervision and personal therapy. It feels that five thousand words may be too little to capture my whole experience and perhaps other areas that were also important in my development, could be missed. Therefore, the interested reader is invited to read my research dossier of this portfolio, for more personal reflections about how research has shaped my experience, and also the academic dossier to see the areas I was interested in and expanded on at the time of my training.

Stepping into “the unthought known”

Soon after I finished my psychology degree in Greece, I was convinced that I wanted to specialise in applied psychotherapeutic psychology. I believe that the reasons for my choice were both conscious and unconscious, but at that time I only knew I wanted to do it because of the interesting lectures in “abnormal psychology” and the fascinating theoretical concepts on human development and personality that stimulated my curiosity to learn more about the nature of human distress. It was only later, when I embarked on personal therapy, that I realised my desire to help others in distress was perhaps a masked unconscious desire to help me understand my environment and its relationship to myself. Therefore, I believe my journey into understanding human experience, began several years ago, even before thinking about studying psychology or training as a counselling psychologist.

Taking the step to come to the UK was a major one for me, as at the time I was very settled in my personal life. My research supervisor, who was the director of the clinical psychology programme, suggested that I think seriously about applying for clinical psychology training in Greece. However, I felt that I was still “thirsty” for knowledge and I was unsure if that particular course could fulfil my personal and professional needs. Looking through the professional practice guidelines of the British Psychological Society for Counselling Psychology, I was very intrigued by the
statement: “Counselling Psychology draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology” (DoCP, 2005; p. 1). In addition, the “Handbook of counselling psychology” (Woolfe, Dryden, & Strawbridge, 2003) with its different views on how mental illness and human experience can be approached and understood in the context of the therapeutic relationship, was influential in my decision to pursue counselling psychology training in the UK. Therefore, after applying and being accepted onto the Surrey course, I felt that a dream had been fulfilled; even though at the same time I was stepping into “unknown waters”.

The unknown was frightening, and when I came to the UK I thought I needed to be strong and therefore pushed away feelings of sadness, anxiety, fear, anger and guilt. But I was not doing this just for myself or because starting a new life was difficult, nor because I was in a new country alone—although working in a different language proved to be a major struggle for me—. After all, I have travelled that road before in my life; first when I went to do my military service for two years at the age of 18 and then immediately afterwards I went to live and study in Greece for five years. I believe I was also trying to protect my significant others from similar feelings. After spending endless hours in my therapy exploring this, I began to crystallise that the notion of protecting my loved-ones by pushing my feelings away was a recurrent theme in my life. It was my state of mind, a “survival thing”, and something so automatic that I was mostly unaware that it was happening. Joining this course and engaging in personal psychoanalytic psychotherapy was like stepping into what Bollas (1987) calls “the unthought known”, something we know, but are unable to think and put into words for a variety of reasons. The relevance of this in the current paper is enormous because by being unaware of, and unable to put into words, things I knew about myself is a theme that was reflected in my clinical work, and which also contributed to failing my first year viva.

My initial therapeutic work and the theme of “protection”

For my first year placement I worked in a university counselling service, where clients were offered brief counselling; on average six sessions. Although it was quite a busy service, with many pressures coming from above (e.g., economic cuts and the need for evidence-based practice), I felt protected by my supervisor. She
made arrangements so I could have the same clinical room each week and she also allowed me more flexibility than the resident therapists, in how many sessions I could offer to clients based on my learning needs (I was able to offer from eight to 12 sessions). That “shield” of protection was very important as the consistency, flexibility and containment made it a safe working environment at a difficult transitional time for me, when other aspects of my life felt less stable.

The initial workshops during the first year of the course were about learning the basic therapeutic skills with a focus on developing a therapeutic relationship. Also the theoretical lectures were on person-centred theory and although theory made sense, as intellectually I was able to grasp the six necessary and sufficient conditions for psychological change (Sanders, 2006), I was struggling to apply it to some clients. My work with clients in the first year was an attempt to integrate person-centred and Cognitive Behavioural Therapy (CBT) but my interventions were not always clearly representative of my chosen models, especially in my process reports. That was partly due to the demands and needs of the counselling service (e.g., oriented in offering clients brief-focused therapy), partly due to my initial struggle with language and partly due to my own anxiety about “doing” therapy and my need to demonstrate that I had “mastered” some of the basic therapeutic skills.

Two or three months after I started seeing clients, I was feeling that although the core conditions were necessary, perhaps they were not sufficient to bring about psychological change and that I needed to do something differently. Therefore I began to move into the “safety” of CBT, were I felt I could offer something more “concrete” to my clients. It was interesting at the time that I did not ask myself why there were clients I could work with by just “staying with” their experience, while with others it was more difficult. For example, Miss T. (Process report, appendix 1), is indicative of my attempt to “stay with” the client by giving her space to explore her world and also my difficulty of being totally attuned to her. I did not want to interrupt her because I thought she would feel deprived by me just as she felt with her parents. I also mistakenly perceived that she was doing all the work by herself and that by just responding with the classic “Uhum” I was showing my unconditional positive regard. I still remember a comment from the person who assessed my report, who said that maybe I was trying too hard. However, I did not ask what she meant by that, and passing the assessment felt sufficient at the time. With hindsight, yes, I was trying too
hard, and as a result I could not see that some of the similarities between me and my clients were getting in the way. Also I now realise that I was protecting my clients from their own emotions, which prevented me to “stay with” their experience or pay the appropriate attention to process. At times this led to my interventions becoming vague and without purpose, as with Miss F (Process report, appendix 2) who I will discuss below.

My impatience/anxiety was growing and it was obvious in supervision. It was noticed several times that I needed to “remain with” clients’ experience, even when working with CBT. But I could not really explain what was happening and found it hard to listen to what had been said. Normally, when I am warned about something that needs to be considered for my own good I listen carefully, but on this occasion this was not the case. Perhaps this was something not explored in supervision or in my personal therapy. Around that time, I also found out that my supervisor was leaving the service at the end of June and also a very good friend of mine decided to leave the UK and move back in Cyprus. Academically, the work was growing and it was hectic. I was struggling and I believe the anxiety around the themes of separation and loss activated my defences but I did not recognise my need for support. With hindsight, I did not say anything, afraid that I would be seen as incompetent or incapable, especially as the end of the first year was approaching. Instead, I took on more clients, determined to prove my competence, but I was becoming psychologically and physically exhausted.

Unable to “stay with” my own emotions, it was even more difficult to “stay with” the clients’ feelings and experience. Instead, I coped by offering solutions, focusing on clients’ strengths and always trying to end on a positive note, as if talking about the emotion around separation and loss was harmful for them. I struggled to choose a client and a session for the second process report and the viva, and eventually I decided to present Miss F. I went into the viva confused and tired, as I had not slept the previous night. I was extremely anxious and sensed that something was wrong. But it was too late; my “internal saboteur” was already set (Fairbairn, 1954). I remember the examiners asking me questions and not being able to provide them with an answer. I was feeling stuck and at times defensive. I failed the viva and the comments were that the client’s needs were overlooked in the report as well as in the viva discussion. In addition, they noticed that I “failed to demonstrate the basic
counselling skills and an understanding of their use", that there was “complete absence of process awareness” and finally “very limited attention to the client’s moment to moment needs and feelings” (see Viva feedback in attachment file).

With hindsight, I can see now why it was impossible for me to fully grasp congruence and immediacy but also to stay with the “here and now”. The fact that I was personally incongruent made it difficult to remain focused on process and to be attuned to Miss F’s actual needs. My research, which was on how therapists’ attachment organisation affects the process and outcome of therapy, was one of the sources I used for reflection. Research findings showed that people with higher attachment avoidance use minimisation of affect as their main strategy in dealing with difficult emotions (Brennan, Clark, & Shaver, 1998). Similarly, avoidant therapists may pay less attention to process and on the dynamics of the therapeutic relationship, and they may be less receptive, accurate and consistent in understanding and responding to their clients’ feelings, presenting issues and underlying needs (Obegi & Berant, 2009). This made me question how my own attachment organisation prevented me from attending to my own and some of my clients’ deepest inner experiences and feelings. I was protecting both myself and Miss F from our respective emotions.

However, whilst these insights are extremely important to acknowledge, and drove my development, I do not want to diminish the importance of my work with other clients, which would imply that my first year was “all bad practice”. I had good feedback from my supervisor and I could see improvements in my clients: some of them became more insightful and others made changes at a cognitive and a behavioural level. There were reasons for failing my process report and without any doubt it was a valuable source of learning more about myself. The recommendations from the board of examiners were that I could continue and proceed into the next year and re-write a process report with a new client which would then be discussed and examined in a new viva. This was a relief, as if they were saying: you are not totally incompetent but you need to get something out of this if you wish to continue.

**Working in and on the therapeutic relationship**

After failing the viva, I realised I needed time to relax, recover and reflect. What had happened began not only to raise my awareness but also led me to question
myself: do I still want to do this? Did they make the right choice by accepting me onto this course? Do I deserve to be here? Do my clients deserve to have someone like me? I questioned my own philosophy about life, and struggled with feelings of anger, blame, shame and sadness. However, there was also a sense of relief: I was finally in touch with my feelings, not only able to name them but also own them and not run away from them. I was able to realise my struggle with them and thus my need for support. I needed to search, find and use my secure base (Holmes, 2001).

I entered the second year with my confidence low. I spent hours in my therapy talking about it. The process was long and painful. I disclosed to my therapist that this year, although I was talking about my experiences, it was more like talking “at” my self and “at” her rather than “talking it through” with her. I remember saying: “All your interpretations make sense, but I am rejecting them because if I accept them many things will come up and I am afraid that I will hurt you”. She smiled and in a calm and soothing but rather serious tone she said “I think you’ve been protecting me very well so far and probably we were both drawn into that... but as you can see I am still here”. At that point she really touched a very “sensitive nerve”. I was in the transference and we could both see that what I was doing with my mother for several years, as well as with many other people in my relationships, I was repeating with her; protecting her from my feelings. After a year or so in therapy, my analysis began to make much more sense as I was less resistant and more open to challenge my defences. In addition, my own personal therapy became a mutual “learning arena” where I could also learn from my therapist how to be a therapist.

Starting my second year placement in an NHS psychotherapy department, I was given two clients to start with, and another three through the year. I used supervision to work on the areas I needed to develop, which were to attend to therapy dynamics and process, attend to my internal processes and find ways to use myself in my clinical work. To gain a better understanding of what was happening in sessions between me and my clients, I was presenting a verbatim transcript every week in supervision for each client. I was also encouraged to talk about my feelings towards clients (countertransference), but also about the feelings that arose in the supervisory room when discussing clients in order to recognise any parallel processes (Jacobs, 2004) which could provide insights in understanding the clients’ internal world. Therefore, I began to develop my “internal supervisor” (Casement, 1997) which was...
helpful in maintaining my awareness of process, particularly the times I was not in the supervisory room, but also in recognising, accepting and facing my mistakes and learning from them.

In formulating clients' difficulties, I found attachment theory (Obegi & Berant, 2009; Wallin, 2007) useful. Particularly, having an understanding of the clients' attachment organisation was another way of orienting me in how clients' interpersonal behaviours were played out in the therapeutic room, influencing the therapeutic relationship as well as their other relationships. During the course this year, I was also exposed to other psychoanalytic ideas and concepts but I was not exactly sure how to integrate those into practice. Supervision kept me focused on working more in the here and now relationship with clients, to be patient and to recognise that actually when I am in the room the client's experience comes first and theory follows. As I gradually learnt to observe how my feelings were guiding my interventions, I realised that my countertransference was a powerful "tool" in getting closer to clients' unintegrated feelings, experiences and (ph) fantasies, but also in getting more in touch with my own "dismissed" feelings. This was the only way to understand theoretical notions like Klein's "projective identification", "persecutory anxiety" and "splitting" (Gomez, 1997) or how to use Malan's (1999) "triangle of conflict" when working with defences and internal conflicts.

The work done in supervision and personal therapy, resulted in feeling more in touch with my own feelings, more present in the room and more able to listen to my clients and be attuned to their actual needs. Hence, I could work in and on the transference and use the therapeutic relationship and myself as therapeutic tools. For example, when Mrs Smith (Process report, appendix 3), whose main coping strategy was to keep emotions "at bay" and others "at arms length" (avoidance/dismissive attachment), was talking about something difficult she did not show any obvious emotion which left me feeling extremely angry and then guilty for feeling this way (projective identification). After putting those feelings into words, Mrs Smith began to talk about her anger towards her attachment figures, and how afraid she was of being abandoned if she expressed any of those feelings (persecutory anxiety). My work with Mrs Smith "taught" me that I needed to appreciate my feelings more because they could firstly aid a human being connect with unintegrated parts of
themselves, and with another person, and secondly help me understand how I connect with others and myself.

Working in and on the transference was also rewarding for some clients, like Ms Daniels (Process report, appendix 4) who became more aware of her relational patterns and how those affected her mood and her life. She believed that both of her marriages failed because both husbands did not care about her and also because they failed to provide her with love and attention. As she spoke very fast in the sessions and presented in a helpless way, I became quite bored but also irritated with her and I stopped listening. At other times she was coming across as “needy”, wanting me to find solutions to her problems or asking me personal questions which made me withdraw even more. As she was quite vigilant, she picked that up and said that I seemed distant and that this made her nervous. In the transference I was becoming like her husbands and working through that, she was more able to distinguish between reality and fantasy by how she was eliciting that reaction from me and hence become more aware of her relational styles. I also came to understand how my countertransference was influencing the therapeutic relationship, which also made me wonder if I have similar reactions to others who have similar attachment styles to Ms Daniels.

After a year of reflection and “staying with” feelings, I began to understand and value the importance of working with the therapeutic relationship and how to use myself in my work with clients. Additionally, I realised how containment, which was not always easy, was the essence of developing healthier emotional regulation strategies and integration of the self, for my clients and myself. With this mind-set I went into my second viva, being more able to discuss openly my work and my development, without the “unthought known” impacting negatively as it did in the first viva, and I passed. The examiners’ surprise and their comment that they were not sure if they were talking to the same person who failed the viva nine months ago, was something that stayed with me that day. It was clear to them, and to me, that I had improved, but still there was plenty of room to develop. Through this experience I discovered that I needed to fail, fall, rise and grow in order to continue my journey.
Learning to “be with” CBT and gradually developing as a counselling psychologist

My third year placement was in an NHS Community Mental Health Recovery Service (CMHRS), where clients with “severe and enduring mental health problems” were referred for psychological therapy through psychiatric services. This year I was faced with the “reality” of a bureaucratic system, where it felt for me that the human experience could have been easily lost in all that paper work. I also joined a multidisciplinary team whose philosophy, driven by the medical model, was to treat “patients” and reduce symptomatology. The only psychologist there, a counselling psychologist (my supervisor), was making huge efforts to “educate” other practitioners that although clients (“service users”) suffer from psychological difficulties (“mental illnesses”), our work is not just to label phenomena and reduce symptomatology but also to try and capture the phenomenology of really distressing human experiences.

When I joined the team many structural changes were due to take place throughout the year. During March and May the majority of the staff-members in the service were interviewed and some of them, including my supervisor, were faced with the danger of losing their jobs. “Chaos” is the only word that comes in mind when I think about the context of my third year placement. It was inevitable that I was going to be affected by all these issues, facing the danger of not being entirely focused on my work. However, I worked through this, by bringing my worries to supervision which were explored and finally contained.

The transition from the psychodynamic to the CBT year was not easy. This was because the psychodynamic thinking fitted really well with my own personal style. Also I did not want to lose “touch” with the client’s experience, as I viewed CBT as a “manualised” approach where more attention is paid “in doing therapy”, focusing on techniques rather than “being with” the individual’s experience. Perhaps, I also linked CBT with failing the viva, thinking that because the focus of CBT would have been mainly on thoughts, it could have prevented me from paying attention to process and thus could have taken me back to square one, where I would protect my clients from their feelings. However, acknowledging that the therapeutic relationship could still be used in CBT as an “arena in which people behave according to their
beliefs about relationships" (Sanders & Wills, 2005; p.60), made me challenge my own beliefs and automatic thoughts concerning my relationship with CBT.

My fears and worries proved wrong after experiencing the model in the room. I could still pay attention to process and use the concept of transference in a CBT way by working with clients' beliefs and feelings about themselves and others. This made me realise that it is more how we understand and apply the theory in the room that makes therapy mechanistic or not. However, I must admit that recording sessions for my CBT process reports was an anxiety provoking situation for three reasons. Firstly, it was difficult to find clients to agree to record our sessions; secondly recording was not appropriate as the majority of clients I was working with had a formal diagnosis of "paranoid schizophrenia" and finally, I could see that having to be so directive and focused in tasks of therapy did not match my own style.

I was, nevertheless, about to discover that a structured CBT approach with all those handouts and techniques was very beneficial for some clients, like Mr Hill who presented with social anxiety (Process report, appendix 7). At the end of his therapy he reported that he was more able than before to understand some of his "unspoken" difficult feelings because he was writing them on a piece of paper. Also by recognising his automatic thoughts and thinking errors, and linking them with his behaviour, it became easier for him to understand and start challenging the ways he was relating to others. I believe this may have contributed to the fact that I was working with the therapeutic relationship where Mr Hill could test directly his beliefs about our relationship and try to experience something different, which could have also been applied in his other relationships.

In the CMHRS I also worked with clients who were labelled as "difficult" to engage or change, often referred by other mental health practitioners who had already worked with them and felt they could not get anywhere. Most clients had a diagnosis of schizophrenia or psychosis and as classic CBT was not appropriate, I found some ideas from the person-based cognitive therapy for distressing psychosis really useful (Chadwick, 2006). My work with them was a flexible integrative approach, where I was using attachment theory in formulating the origin of their difficulties and utilising the core person-centred skills to build a trusting relationship and stay with their experience. Also, cognitive interventions like the "ABC model" were used mainly in finding the meaning that clients attached to their voices and their beliefs about
themselves, rather than challenging paranoid thoughts or hallucinations. This could offer them potential alternatives without increasing their defences.

Two of my other roles within the CMHRS were to become involved with group work (i.e., anxiety management, assertiveness and Wellness Recovery Action Plan groups) both as a co-therapist and as the leading-therapist, and finally to provide consultation to other mental health professionals. My first role was an opportunity to expand on my clinical experience with groups, but also as a counselling psychologist to “keep an eye” on process and dynamics in these psycho-educational and mostly practical CBT oriented groups which were run by an occupational therapist. My second role was to provide consultation to other professionals and my supervisor supported me throughout. As people became aware of my practice they were keener to seek my clinical opinion on issues like psychological understanding of their clients’ difficulties and underlying needs.

This placement was a different experience from the previous two as it helped me gather all my experiences from my clinical work so far and think more about my professional identity. Supervision allowed space to see how myself, my clients and their relationships, my supervisor, the context of the placement, other wider social aspects and finally the relationship between all these, can be used in understanding clients’ unintegrated and sometimes dissociated and very traumatic experiences. I also had the opportunity to experience the integration of different theories (i.e., person-centred, psychoanalytic and CBT) in my work and learn more about my relationship with practice and theory. Last but not least, I had opportunities to work in the same way as a qualified psychologist, which not only gave me a foretaste of my future as a qualified counselling psychologist, but also an opportunity to recognise that I can successfully accomplish this role.

Conclusion

Throughout my training as a counselling psychologist, I have learnt that therapy is much more than a place where the therapist uses techniques to facilitate the client’s “change”. Therapy is the “being with” the person’s experience where in a “good enough” therapeutic relationship the “other meets otherness” (Boucher, 2010). This was something, which for my own reasons, I initially struggled to capture, but
after years of hard work and through training, supervision and personal therapy I finally internalised and embodied.

Over the three years I came across various theories of understanding and working with human distress, and realised that in the main, all of them refer to similar or the same concepts using a different language. I found attachment theory not only to be the link between these theories but also the base from where I could see the essential relational quality of therapy. However, attachment theory is not primarily a clinical theory, but rather a developmental theory, which can guide my interventions either those defined as person-centred, psychoanalytic or CBT. When I am working at my best, I am integrative and although my work is informed by theory and research, when I am in the room with clients it is as myself, not Bowlby, Rogers, Beck or anyone else. In my endeavour I always need to remember to remain open to my experience, my clients’ experience and the one we co-create.

I believe I am at the stage now where I feel ready to move on from being a trainee to being a qualified counselling psychologist, a scientist-practitioner, who has grown personally and professionally and is about to continue his never-ending quest in understanding human experience. However, this does not mean that I hold all the answers or that I have become the “perfect” therapist. In my practice there is no such thing as the perfect therapist, rather someone who always endeavours to capture the essence of the human nature.
References


Introduction to the Research Dossier

This dossier contains a literature review and two research reports conducted during the three years of my training. The literature review explores the effects of therapists' attachment organisation on the process and outcome of therapy. The first research report is a quantitative study that examines the role of therapeutic caregiving in the relationship between therapists' attachment dimensions and the working alliance. Finally, the second research report is also a quantitative study that explores the attachment-caregiving therapeutic relationship by investigating whether clients' attachment dimensions moderate, and therapists' caregiving mediate, the effects of therapists' attachment dimensions on the working alliance.
Effects of therapists' attachment organisation on the process and outcome of therapy: A review of the empirical literature

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Abstract

The last two decades, in particular, have witnessed an increased interest in the clinical implications of attachment theory in individual adult psychotherapy. By and large, the majority of empirical studies on the importance of adult attachment patterns in individual psychotherapy have focused on exploring the effect of clients’ attachment organisation. Gradually, more researchers became more interested in the role of therapists’ attachment organisation. The present paper reviewed the existing literature on the effects of therapists’ attachment organisation on the process and outcome of therapy. In particular, 14 known studies were reviewed, exploring how trainee and qualified therapists’, as well as other clinicians’, attachment styles could influence the working alliance; the depth of their interventions; their emotional empathy and psychological mindedness; their countertransference behaviours towards clients and finally the outcome of therapy. Overall, findings from these studies showed that a secure attachment organisation in therapists could positively affect the process and outcome of therapy, whilst an insecure attachment organisation was negatively associated with both process and outcome of therapy. Nevertheless, a few studies provided us with different results. The findings, the methodological characteristics and limitations of the 14 reviewed studies are discussed throughout this paper. Finally, building on findings from the existing studies, research hypotheses for future research are made.

Keywords: attachment theory; individual adult psychotherapy; therapists’ attachment styles; process and outcome of therapy.
Introduction

Since the publication of Bowlby’s trilogy on attachment theory, many researchers and scholars have been inspired to gain a better understanding of the function of close relationships. The earlier studies, focused on exploring the relationships between infants and their caregivers (Ainsworth, 1969, 1989; Ainsworth, Blehar, Watters, & Wall, 1978; Hamilton, 2000; Main & Cassidy, 1988; Sroufe, 1983), whilst the later studies explored how adult attachment patterns can influence romantic relationships (Collins, 1996; Collins & Read, 1990; Hazan & Shaver, 1990). Nowadays, more scholars and researchers turn their attention on the clinical implications of attachment theory in individual psychotherapy with adults. More specifically, researchers interested in the individuals’ state of mind with respect to attachment, have focused on exploring the effects of adult attachment patterns on the process and outcome of therapy (Bernier & Dozier, 2002; Preschken & Johnson, 1997).

The majority of the existing empirical studies investigating the relationship between adult attachment and therapy have focused on the effects of clients’ attachment styles on the process and outcome of therapy. These studies have shown that clients with different attachment styles can engage differently in therapy, with securely attached clients reporting stronger working alliances with their therapists than insecurely attached clients, and finally a significant relationship between secure attachment in clients and therapy outcome was found (for a review see Daniel, 2006). On the basis of these findings, it can be argued that the clients’ attachment styles are important factors that can influence the psychotherapeutic process and outcome. As the therapeutic relationship is a process that involves two (or more) people, and as clients’ attachment styles have an important role in this, it would reasonably be
expected that therapists' attachment styles may have its own role on the process and outcome of therapy.

Bowlby (1988) declared that the therapist can be seen as a surrogate caregiver for the client, and their role in providing a secure base for the client to explore their thoughts and feelings can be affected by the therapist's attachment organisation. Although it can be understood that the therapists' attachment organisation in therapy may be as important as the clients, fewer studies have explored this relationship. Therefore, the purpose of this paper is to review the existing studies in order to conceptualise how the therapists' attachment styles can influence the process and outcome of therapy. This review is divided into different sections. Firstly, the earlier studies, which are the starting point of later empirical studies in exploring the effect of the therapists' attachment organisation in individual psychotherapy, will be mentioned briefly. The following three sections, will focus on studies that explored the effects of qualified therapists', trainee therapists' and other clinicians' attachment styles respectively, on the process and outcome of therapy. Finally, drawing upon findings from the existing studies, research hypotheses that can be tested in future empirical studies will be made.

The earlier studies that led to investigation of the effects of therapists’ attachment styles on the process and outcome of therapy

It has been suggested that therapists' early relational experiences and personal qualities, can determine their abilities to form therapeutic alliances with clients and also can have an impact on the outcome of therapy (Luborsky, McLellan, Woody, O’Brien, & Auerbach, 1985; Lambert, 1989). One of the earlier studies that attempted to explore how therapists’ personal qualities affect the outcome of therapy was the
study of Arizmendi, Beutler, Crago, and Hagaman (1985). Findings from this study indicated that therapists who had positive views on their interpersonal security, attachment, social responsibility and self control, were feeling more productive when working with clients and as a result, clients were implicitly encouraged by their therapists to experience the therapeutic change. In contrast, therapists who had a more negative value-system were negatively perceived by clients and this seemed ineffective in facilitating a positive therapeutic change.

Results from the previous study were confirmed by three later studies which showed that therapists’ internal representations of past relationships, as measured by the therapists’ “introjects” (the conscious and unconscious repertoire of ways of treating the self based on internalised past experiences), had a strong influence on their clinical work. More specifically, it was found that therapists with hostile and controlling introjects had weaker therapeutic alliances and poorer therapy outcomes with their clients rather than therapists with less disaffiliative introjects (Hendry, Schact, & Strupp, 1986, 1990; Hendry, Strupp, Butler, Schacht, & Binder, 1993). These four studies can be seen as the starting point in confirming the theoretical proposition that perhaps therapists’ attachment organisation can influence the process and outcome of therapy; and this was the basis that later studies built upon to further investigate this topic.

Studies investigating the effect of qualified therapists’ attachment styles on the process and outcome of therapy

Dunkle and Friedlander (1996) examined whether therapists’ level of experience and personal characteristics could predict the working alliance in early treatment. Seventy-three psychodynamic, eclectic, CBT, interpersonal and humanistic
oriented therapists, working in university settings in the United States, and 73 of their clients participated in this study. The INTREX questionnaire was utilised to assess therapists' introjects, the Adult Attachment Scale (AAS) to assess therapists' attachment styles, and the Social Provisions Scale (SPS) to assess therapists' quality of social support network. Their professional experience was measured by a single question, and to assess the working alliance, clients completed the short version of the Working Alliance Inventory (WAI-S). The researchers found that clients were more likely to report a stronger emotional bond early in therapy if their therapists reported less hostility, more social support and greater comfort with closeness. In addition, results indicated that when therapists were less anxiously attached they could have stronger alliances with their clients and finally no significant effect of therapists' experience on the working alliance was found. These results confirmed previous findings that therapists, like clients, can bring to the therapeutic relationship their early relational experiences (captured by their introjects and attachment organisation) which can affect their therapeutic interactions and more specifically the working alliance (Arizmendi et al., 1985; Hendry et al., 1986, 1990; Hendry, Strupp et al., 1993). Additionally, this was one of the first attempts in finding that a less anxious attachment style in therapists was associated with a strong working alliance. Some of the restrictions of this study were that the nature of its design could not permit any strong causal inferences and also that the results could relate, only to therapists working in university settings and with young adults.

Given that the attachment patterns of therapists could derive from early childhood experiences and in turn affect their therapeutic behaviours, an interesting study by Leiper and Casares (2000) explored how clinical psychologists' early experiences could influence their attachment styles and their therapeutic work. The
authors hypothesised that therapists' early experiences might be one of the reasons for choosing this profession which could affect their work with certain clients. To investigate their hypothesis, they explored the attachment organisation of 196 British clinical psychologists and its relationship to their clinical practice. The majority of participants worked in adult services, while others worked in child, older adult, learning disability, forensic and other services; their chosen therapeutic orientations were eclectic, CBT, psychodynamic/analytic, behavioural and systemic. The Adult Attachment Categorisation (AAC) and the Adult Reciprocal Attachment Questionnaire (ARAQ) were used to assess psychologists' attachment styles. The Taxonomy of Early Loss (TEL) was used to assess psychologists' early experiences. The authors found that insecurely attached clinical psychologists who scored higher on the self-reliance and angry withdrawal scales, experienced more early loss events and more unempathic parental responses. Furthermore, it was reported that these clinical psychologists had difficulties working with mildly disturbed clients, experienced more professional problems, felt less supported at work and finally that work interfered in their personal life.

The results of this study suggested that insecure attachment styles derive from early childhood experiences and may interfere with clinical psychologists' work with clients. One important limitation of this study was the low internal consistency of the angry withdrawal scale (i.e., $a = .54$), which must be taken into account when interpreting results related to that attachment scale. Additionally, it can be argued that had the authors run, and reported, further analyses to examine the effect of specialty on the relationship between clinical psychologists' attachment styles and their clinical practice, clearer inferences could have been drawn. This is because it is unclear whether the final results apply to the clinical psychologists of the sample who work in
adult, child, older adult, learning disability, forensic or other services. Finally, it can be understood that the results of this study may better apply to clinical psychologists rather than therapists in general.

The study of Black, Hardy, Turpin, and Parry (2005) investigated the relationship between therapists’ attachment styles, general alliance and their experienced problems in therapy. The sample consisted of 491 British Psychodynamic/analytic, CBT, CAT, integrative, eclectic and humanistic psychotherapists. The psychotherapists’ attachment styles were assessed with the Attachment Style Questionnaire (ASQ), the therapeutic alliance with the Agnew Relationship Measure (ARM) and finally, problems in therapy were measured with the Problem Check List (PCL). Findings from this study showed that securely attached psychotherapists reported better general alliances with their clients than insecurely attached psychotherapists, who reported poorer general alliances. Also, insecurely attached psychotherapists, who had higher ratings in the scale need for approval (this scale is related conceptually to anxious attachment), reported more problems in therapy than securely attached psychotherapists. The findings from this study are consistent with previous findings that perhaps securely attached therapists are more able to build stronger therapeutic relationships with their clients than insecurely attached therapists (e.g., Dunkle & Frieldander, 1996).

Although this study could have enhanced our understanding of the relationship between psychotherapists’ attachment styles, working alliance and problems in therapy, the authors did not elaborate on what kind of problems insecurely attached psychotherapists might face. It can be hypothesised that these problems may relate to difficulties in handling alliance ruptures or with difficulties in understanding and responding to clients’ underlying needs. Another important limitation of this study
was that the alliance ratings were taken only from the psychotherapists' perspective and it is argued by Hovarth & Symonds (1991) that the client's ratings of the alliance can be a better measure of the working alliance than the therapist's ratings. Furthermore, due to the fact that the client-version of the ARM was not used and as the data were mostly correlational, strong causal inferences cannot be fully supported in this study. Finally, because the participants were only psychotherapists, who may have had more training than other therapists and counsellors, this may restrict the generalisability of results to all therapists.

The study of Bruck, Winston, Aderholt, and Muran (2006), explored the association between therapists' attachment styles and in-session process and therapy outcome. The participants in this study were forty-six psychiatrists, psychologists and social workers trained in CBT and Short-Term Dynamic Psychotherapy (STDP), as well as 26 patients (20 out of 46 patients dropped out from treatment) from a medical centre in the United States. The authors used the INTREX questionnaire to assess therapists' introjects, and the Relationship Scale Questionnaire (RSQ) to assess therapists' attachment styles. The measures for the process of therapy were the Inventory of Interpersonal Problems (IIP), the Patient and Therapist Target Complaints (PTTC), the WAI-S and the Session Evaluation Questionnaire (SEQ), which were completed by both therapists and patients. For the outcome of therapy, patients completed the Global Severity Index (GSI) of the SCL-90-R and both therapists and patients completed the Global Assessment Scale (GAS) and the Post Session Questionnaire (PSQ). The results showed that therapists with affiliative introjects and secure attachment styles, reported better in-process measures and their patients showed improvement in therapy over therapists with autonomous introjects.
In addition, it was found that the therapeutic alliance and therapy outcome were negatively associated with a fearful, preoccupied and dismissive style in therapists. This study confirmed previous theoretical notions and empirical findings that perhaps a more secure attachment in therapists is associated with a good working alliance and therapeutic outcomes; however it suffered from important limitations. The first limitation comes from the fact that the authors failed to report the internal consistency of their scales, which may hinder the validity of their results especially if the internal consistency was low. In addition, the small sample of participants cannot allow generalisation of the findings and therefore, must be cautiously interpreted. Finally, the authors failed to report the therapists’ attachment styles, and which patients dropped out from the study. Importantly, this could have provided a better understanding of the final conclusions and especially if the therapists’ attachment styles had any role in the drop-out of their patients.

A more recent study that focused on understanding the impact of psychotherapists’ attachment representations on the development of the therapeutic alliance was the study of Dinger, Strack, Sachsse, and Schauenburg (2009). In this study, the authors recruited 12 psychotherapists (six of them were still on postgraduate clinical training at the time of the study) who treated 281 inpatients with a range of clinical diagnoses (i.e., depressive disorders, anxiety, eating disorders, somatoform disorders, adjustment/stress and obsessive-compulsive disorder, with 20.6% having an additional personality disorder) at a psychotherapy unit of a German university hospital. Psychotherapists’ attachment styles were classified with the Adult Attachment Interview (AAI) and the 281 patients completed the Inpatient Experience Scale (IES) to evaluate the therapeutic alliance to their individual therapist and the IIP for their interpersonal problems. Findings showed that psychotherapists’ preoccupied
attachment was associated to lower levels of alliance quality and confirmed results from previous studies that perhaps attachment insecurity in therapists, and more specifically attachment anxiety, related to weaker working alliances (Bruck et al., 2006; Dunkle & Friedlander, 1996).

The findings of this study must be carefully interpreted due to several reasons. First of all, as the authors also reported, most of the associations found in their study were small and reached only an alpha level of .10. This shows absence of statistically robust results and in combination with the very small sample of psychotherapist-participants restricts generalisability of their findings. The authors also reported that, the IES, which was used to measure the therapeutic alliance, has not been validated with other established measures of alliance and for this reason the results may be cautiously interpreted. Another caution in interpreting the findings might be the fact that the authors did not mention whether they had run any analyses to show possible differences between qualified and trainee psychotherapists; instead they generalised their results for the whole sample of psychotherapists, regardless of their professional status. Finally as the main therapeutic orientation of participants in this study was the psychodynamic/analytic model and also the alliance ratings were taken from inpatients, the findings may not be applicable for therapists who either use different therapeutic orientations in their clinical work with clients, or therapists who do not work in an inpatient service.

Studies assessing the effect of trainee therapists’ attachment styles on the process of therapy

The study of Rubino, Barker, Roth, and Fearon (2000) focused in exploring the relationship between trainee therapists’ attachment styles and the resolution of
ruptures in the therapeutic alliance. The sample of this study consisted of 77 British clinical psychology graduate students who completed the RSQ for their attachment styles. In addition, four clinical vignettes were given to participants to assess their empathy levels and the depth of their interventions. Their verbal responses were transcribed and rated by the principal investigator of the study and two trainee clinical psychologists using post-vignette measures such as the Response Empathy Scale (RES) and the Depth of Interpretation Scale (DIS). The authors found that more anxiously attached trainee clinical psychologists demonstrated less empathic responses than secure trainees, and also that they were less empathic with fearful and secure patients. Finally, participants’ attachment styles were found not to affect the depth of their interventions. Findings from this study may suggest that lower levels of empathy can affect the quality of the therapeutic relationship, and that possibly higher attachment anxiety in trainee therapists can prevent them firstly, from recognising and tolerating alliance ruptures and secondly, from being empathic with clients who are different from them in terms of their attachment organisation.

Although this study explored the effects of trainee therapists’ attachment styles on processes of therapy, ratings of the therapists’ empathy and depth of interventions were taken from a single response, which derived from four video vignettes with professional actors role-playing clients. Hence, participants did not have the opportunity to form an actual therapeutic relationship with real clients. Finally, the therapists’ scores on empathy and the depth of their interventions were rated from the perspective of independent investigators, who were also trainees. Perhaps different results could have been obtained if those responses were rated either by more experienced investigators, or by the participants’ clinical supervisors, or even
by clients. Therefore, these limitations should be taken into account before interpreting and generalising these results.

Interesting findings, as concerns the relationship between trainee therapists’ attachment anxiety and working alliance, have been found in the study of Sauer, Lopez, and Gormley (2003). This study investigated the contribution of trainee therapists’ and their clients’ attachment patterns on the early therapeutic alliance. The researchers initially recruited 20 trainee therapists who were asked to recruit one or more of their clients, but only 13 therapists and 17 clients completed the questionnaires. Clients received brief psychodynamic, eclectic, CBT and systemic therapy in university counselling centres and in community counselling agencies in the United States. The questionnaires used in this study were the Adult Attachment Inventory (AAInv) for the attachment styles and the WAI for the working alliance, which were completed by both therapists and clients. The ratings of the participants’ attachment styles were completed after the first session, while ratings of the working alliance were completed after the first, the fourth and the seventh session. It was found that anxiously attached therapists had very good working alliances with their clients in the initial session but in the next sessions their alliance scores were significantly lower. The results from this study must be very carefully interpreted and generalised due to the very small sample size and also the low internal consistency of the therapists’ attachment anxiety scale of the AAInv (i.e., $a = .51$).

The study of Sauer et al. (2003) can make us wonder whether anxiously attached trainee therapists actually can provide clients with a secure base to explore their internal world and achieve the therapeutic change, throughout the process of therapy. Tentatively it can be hypothesised that perhaps in the initial stages of therapy, anxiously attached trainee therapists may work harder in trying to make the
client feel good about the relationship and perhaps that is why clients gave higher ratings of the working alliance in this study. However, as trainee therapists’ attachment anxiety could have interfered in the therapeutic relationship, it might have affected their empathic understanding and reflection towards clients as found by Rubino et al. (2000). Perhaps that is why clients gave lower ratings of the working alliance in later sessions. Nevertheless, these must be seen as tentative hypotheses and more empirical studies are needed to explore this relationship further.

Another study, that of Trusty, Ng, and Watts (2005) which explored the effects of trainee counsellors on emotional empathy, provided us with interesting and different results from the already known studies in this area. The sample of the study consisted of 143 trainee counsellors from the United States who completed self-report questionnaires like the Emotional Empathy (EE) and the ASQ for their attachment styles. The authors found that lower attachment avoidance and higher attachment anxiety in trainee therapists were associated with higher levels of empathy. These findings suggest that more anxiously attached trainee therapists than avoidant therapists, may have higher levels of empathy with their clients. Although the findings may be different from previous findings, that anxiously attached trainee therapists may have lower levels of empathy (Rubino et al., 2000), it can be understood that when they are compared with avoidant trainees, anxiously attached trainee therapists may be more empathic towards their clients. The authors discussed their findings in light of the “wounded healer” concept and suggested that because anxiously attached therapists are attuned to their own issues and anxieties they are more attuned to their clients’ emotions and vulnerabilities than avoidant therapists, who minimise their emotions and vulnerabilities.
Before interpreting and generalising these results, some important facts must be taken into consideration. Firstly, the low reliability (i.e., $a = .59$) in the relationship as secondary subscale of the ASQ (this scale relates to avoidant attachment) raises questions about the internal consistency of the scale and the final results. Secondly, all participants were trainees in their initial stages of training and greater attention at this stage, rather than in other stages of training, is given on processes like the emotional empathy. Hence, perhaps because novice anxiously attached trainees were trying harder to master the "skill" of empathy at the initial stage of their training, they may have demonstrated this when completing the questionnaires. Thirdly, the questionnaire used to measure empathy was not specifically designed to capture therapists' empathy towards clients, but rather their empathy levels towards "others" in general. Not knowing if the researchers altered any of the items referring to clients rather than others in general, the results must be cautiously interpreted. Finally, a statement by Trusty et al. (2005) that "... attachment theory does not readily transfer to counselors and counseling as some assumed" (p. 74) needs some attention. Although Trusty and his colleagues mentioned that their previous statement must not be generalised based on their findings, perhaps they mistakenly assumed that attachment theory may not be applicable to aspects of therapy processes such as the emotional empathy. This is because throughout their paper they referred to attachment theory and research to explore their topic and also due to the fact that they did not mention any of the previous studies of Rubino et al. (2000) or Sauer et al. (2003) that could have assisted them in interpreting their findings.

The study of Ligiero and Gelso (2002) was the only study that has not found any relationship between trainee therapists' attachment styles and the therapeutic relationship. In this study, the authors examined the relationship between trainee
therapists' attachment styles, countertransference behaviours and the working alliance. Fifty trainee counselling and clinical psychologists and their 46 supervisors participated in this study, which was conducted in the United States. The Relationship Questionnaire (RQ) for the attachment styles was completed by the trainees, the Countertransference Index (CTI) and the Inventory of Countertransference Behaviour (ICB) for the countertransference behaviours were completed by their supervisors and finally the WAI-S for the working alliance was completed by both trainees and supervisors. The results indicated that trainee therapists' attachment styles did not relate either to countertransference behaviours or to the working alliance, as rated by trainees or their supervisors. The authors argued that because the therapist does not see the client as an attachment figure, the therapist's attachment styles are not activated in therapy and thus cannot influence the therapeutic relationship. They also argued that therapists' attachment styles may not be good predictors of the working alliance and countertransference behaviours towards clients, leading perhaps to similar assertions as in the study of Trusty et al. (2005) that attachment theory may not be applicable for understanding some counselling processes.

The results from the study of Ligiero & Gelso (2002) must be cautiously interpreted and generalised not only due to the small sample of participants but also for other reasons. For instance, the working alliance ratings were collected from both the therapists' and their supervisors' perspective. As more than half the sample of the supervisors were doctoral students, it can be argued that being less experienced supervisors, doctoral students' ratings might have been less accurate than the more experienced or qualified supervisors' ratings who participated in the study. Additionally, the ratings of the working alliance and countertransference were assessed based on clients with whom trainee therapists worked on short-term contract.
Perhaps, different results would have been obtained if trainees had presented long-term clients. Finally, the psychometric properties of the questionnaires measuring countertransferential behaviours were relatively new instruments and needed further examination.

A later study in the United States by Mohr, Gelso, and Hill (2005), explored the relationship between trainee counsellors’ and their clients’ attachment organisation, session evaluation and countertransference behaviour in first counselling sessions. The participants of this study were 93 clients and 27 trainee counsellors who completed the Experiences in Close Relationships (ECR) for their attachment styles and the SEQ for the session evaluation, while the trainee counsellors’ 12 supervisors completed the Countertransference Behavior Measure (CBM) to assess trainees’ countertransference. The findings showed no effect of trainee counsellors’ attachment styles on session evaluations but it was found that dismissively attached trainee counsellors were more likely than others to engage in hostile countertransference behaviours with their clients. Additionally, it was found that when dismissively attached trainee counsellors were matched with preoccupied clients, they showed more hostile and distancing countertransference behaviours.

The findings from this study seemed to disconfirm the results from the study of Ligiero and Gelso (2002) that trainee therapists’ attachment styles did not relate to their countertransference behaviours towards clients. However, the small number of trainee counsellors that participated in the study may restrict generalisability of its findings. Additionally, because the CBM was a new countertransference measure which was developed for the purpose of this study, 12 people cannot be considered as an adequate number of participants for conducting a factor analysis in order to develop a questionnaire. Finally, because the ratings of session evaluation and trainee
counsellors’ countertransference behaviours were taken only from the first session, the relevance of these findings may not be applicable to other counselling sessions except the first.

Studies of the effect of other clinicians’ attachment styles on the process and outcome of therapy

Some studies approached the topic on the effects of therapists’ attachment patterns on the therapy process and outcome, by exploring “other” clinicians’ attachment styles. An interesting study which offered support to the notion that clinicians’ attachment styles may influence the process of therapy is the study of Dozier, Cue, and Barnett (1994). Dozier and her colleagues investigated the relationship between 18 case managers’ attachment strategies, who were working in a mental health centre in the United States, and their ability to use clinical intervention strategies with their 27 clients who were diagnosed with severe psychopathological disorders (e.g., paranoid schizophrenia). All case managers’ and clients’ attachment styles were assessed by the AAI and also the authors conducted a 5-10 minutes recorded interview with clinicians to assess their interventions with their clients. All qualitative data were coded and transformed for quantitative analysis. The results from this study showed that, clinicians with secure attachment styles seemed to be more able to understand and respond to dismissive and preoccupied clients’ needs. On the other hand, insecure clinicians reported being confused and less able to understand the underlying needs of dismissive clients. In addition, insecure clinicians could not make good use of their countertransference as they were responding to the obvious needs of preoccupied clients rather to their underlying needs. These results illustrated
how countertransferential issues can be activated from the clinicians’ attachment patterns, interfere in their interventions and affect the process of therapy.

Although the results from this study can provide us with some evidence about the role of clinicians’ attachment styles in the therapy process, due to their limitations they must be cautiously interpreted and generalised. First of all, the sample was small and the client-case manager dyads were inconsistent. Secondly, due to the fact that client-participants were exclusively clients diagnosed by severe mental disorders, the results may not be applicable to the general population of clients. Finally, a very important limitation of this study is the fact that the clinicians were case managers and not therapists. This may restrict the generalisability of the findings to all therapists, as most of the case managers who participated in the study had limited training and experience in psychotherapy and their interventions may not be considered as purely psychotherapy interventions.

Five years later, a study in the United States by Tyrell, Dozier, Teague, and Fallot (1999) examined the therapeutic outcome by matching 21 clinicians and their 54 patients in terms of their attachment styles. In this study the participants were again case managers and psychiatric patients. Both groups of participants were administered the AAI and the WAI and also patients completed the Quality for Life Inventory (QLI), the Beck Depression Inventory (BDI) and the GAF to measure therapy outcomes. The findings demonstrated that, when there is a complementary match between clients’ and clinicians’ attachment styles, there is a positive quality in the therapeutic relationship. This study confirmed previous findings that secure case managers can have better working alliances with their clients (Dozier et al., 1994). However, the most impressive finding of this study was the match between preoccupied and avoiding dyads, where preoccupied clients seemed to have
productive relationships and better therapy outcomes with dismissive case managers and vice versa.

On the basis of the findings from the study of Tyrell et al. (1999) it can be understood that preoccupied and dismissive clinicians may work as efficiently as secure clinicians and have good therapeutic outcomes but perhaps, only when preoccupied clinicians work with dismissive clients and vice versa. It seems that matching clients and clinicians in ways that balance their interpersonal and emotional strategies can affect positively the therapeutic process and outcome. Unfortunately, these findings have not been confirmed by any other study and due to some limitations, such as the small sample size and the fact that clinicians were case managers and not therapists, and the clients were psychiatric patients, they must be cautiously generalised to therapists and to all patients.

Finally, two more studies, one in the Netherlands (Zegers, Schuengel, van IJzerdoorn, 
Janssens, 2006) and one in the United Kingdom (Berry, Shah, Cook, Geater, Barrowclough, & Wearder, 2008) examined how the professional caregivers’ attachment styles could impact their relationship with patients. In the Dutch study the AAI was used to assess the 33 mentors’ and 81 patients’ attachment styles, the Dutch Forensic Staff-Patient Interactions Inventory (DFSI) to measure the staff-patient interactions and the Psychological Availability and Reliance on Adult scale (PARA) to assess the patients’ psychological availability and reliance on the mentors. The results showed that, secure mentors, unlike insecure mentors, were perceived as more available over time by preoccupied and dismissive patients, who reported that they could rely on them more in times of need and distress (Zegers et al., 2006). In the UK study, 20 psychiatric nurses and support workers completed the Staff Attachment Style Questionnaire (SASQ) which was specifically designed for this study to assess
the staff's attachment styles, and the Staff-Patient Relationships and Psychological Mindedness scale (FMSS) to assess the staff's thoughts and feelings about patients. Additionally, staff and the 26 patients (diagnosed by psychotic disorders) completed the IIP for the clients' interpersonal problems. The results from this study indicated that higher attachment avoidance in staff was associated with greater discrepancies in staff and patient ratings of the patients' interpersonal problems and with poorer staff psychological mindedness. In addition, staff with less anxious and avoidant attachment styles seemed more able to develop more positive therapeutic relationships with patients than insecurely attached staff (Berry et al., 2008). Although both these studies confirmed previous findings, they raised similar important limitations, just like in the two previous studies of Dozier et al. (1994) and Tyrell et al. (1999).

Summary of findings

From the 14 known studies exploring the role of therapists' attachment patterns in individual therapy with adults, 13 of them found that therapists' attachment styles may have a significantly important effect on the process and outcome of therapy (i.e., Black et al., 2005; Berry et al., 2008; Bruck et al., 2006; Dinger et al., 2009; Dozier et al., 1994; Dunkle & Friedlander, 1996; Leiper & Casares, 2000; Mohr et al., 2005; Rubino et al., 2000; Sauer et al., 2003; Trusty et al., 2005; Tyrell et al., 1999; Zegers et al., 2006). Only one study, that of Ligiero and Gelso (2002), did not find any effect of the therapists' attachment styles on the process of therapy. Reviewing the existing studies which explored the effects of therapists' attachment patterns on the process and outcome of therapy, it can be understood that their findings can be divided into three streams.
According to the first stream of findings, therapists' attachment security-insecurity can define individual differences, firstly in how therapists develop and maintain a good therapeutic relationship and secondly in the overall effectiveness of therapy. In particular, these findings indicated that when therapists have a secure attachment organisation, they may be quite sufficient to form strong emotional bonds with their clients early in therapy and maintain good general working alliances through time. In addition, some of the reviewed studies showed that securely attached therapists may be more empathic and more able to understand and respond to clients' needs effectively by using their countertransference and also they may be perceived as more available over time than insecurely attached therapists. Ultimately, as some other studies showed, clients of securely attached therapists can rely on them more in times of need and distress, they can function better in therapy and finally they can show improvement at the end of therapy.

On the contrary, some studies showed that insecurely attached therapists may have difficulties working with some clients, they may experience more problems in therapy, and they may be more confused and less able to understand and respond to their clients' underlying needs. This was associated with generally poorer therapeutic alliances when compared with securely attached therapists. Additionally, it was found that anxiously attached trainee therapists may demonstrate less empathic responses than securely attached trainee therapists, which may prevent them from recognising and repairing alliance ruptures and negatively affect the quality of their working alliances with clients. Similarly, it was found that avoidant therapists may have problems in fully capturing the clients' interpersonal problems and also, as they may engage in hostile countertransference behaviours with their clients, they may not be able to maintain a positive therapeutic relationship. Finally, as some of the reviewed
studies found, the effect of the two insecure attachment styles in therapists may also negatively affect the outcome of therapy.

The second stream may be opposite to the first, proposing that some insecurely attached therapists may have good working alliances and outcomes with their clients, but only under specific conditions. Such findings were found, mostly, in studies with trainee-participants and case manager-participants. More specifically, it was found that anxiously attached trainee therapists may have good working alliances with their clients but this was only in the initial stages of therapy. Additionally, it was found that anxiously attached trainees may have higher levels of empathy but only in comparison to avoidant trainee therapists. The studies with case managers showed that a complementary match between anxiously attached clinicians and avoidant clients, and vice versa, may result in good therapeutic alliances and positive outcomes. Arguably, it can be said that, the findings that form this second stream, could suggest that the relationship between therapists' attachment styles, process and outcome of therapy is not as straightforward or as simple as we may believe.

Finally, from the third stream of findings, which is quite different from the other two, it can be suggested that perhaps therapists' attachment styles may not be activated in the therapeutic room and that they do not affect the process of therapy. However, only one study resulted in such conclusions and once again the participants were trainee therapists. In this study, Ligiero and Gelso (2002) suggested that because therapists do not perceive clients as attachment figures, this may be one possible reason why their attachment styles are not activated in therapy. More empirical studies are needed to investigate such findings.

Arguably, when these findings from all the three streams are taken together, it can be suggested that the relationship between therapists' attachment and the process
of therapy is not as simple as we assume because other factors will interfere in this relationship. Thus, a need for more empirical studies on the topic is evident, and particularly studies to investigate not only the simple, but also the more complex causal links in the relationship between therapists’ attachment organisation, process and outcome of therapy.

Methodological dilemmas of the reviewed studies

It can reasonably be said that, exploring the construct of attachment organisation in psychotherapeutic processes, is not an easy task due to their complex nature. The different research tactics of the existing empirical studies can make the systematic review more difficult and these methodological dilemmas need attention. For instance, the majority of the reviewed studies were conducted in the United States (i.e., eight), with fewer in Europe (i.e., four in the United Kingdom, one in Germany and one in Holland) and none from other continents. This may restrict the cross-cultural replicability of the findings.

In addition, the different methods of assessing the process and outcome of therapy can make it difficult to compare the reviewed studies. For example, there was no great consistency in the way therapists’ attachment was measured, with the majority of studies using different self-report questionnaires and only a few studies using semi-structure interviews. This may lead to another debatable issue when conducting empirical studies: that of conceptualising attachment organisation in categorical (i.e., secure, preoccupied, dismissive, fearful styles) or in dimensional terms (i.e., attachment avoidance and anxiety). Perhaps agreement on common methods in assessing and conceptualising the constructs of therapists’ attachment, but
also assessing therapy processes (e.g., working alliance measured in single sessions versus over time) and outcomes, is essential.

Another two patterns of limitations that were observed and must be noted, are the number of participants in the reviewed studies and the way of interpreting findings. The number of participants in nine out of 14 studies was less than 51 participants and in the other five studies the numbers ranged between 73 and 491 participants. Taking this issue together with problems concerning the internal consistency of the used measures in some studies, may contribute in restrictions in interpreting some of the findings. Therefore, another important issue that must be considered is the interpretation and generalisability of the existing findings. Although it was observed that some authors drew attention to the issue that readers must be cautious in generalising findings, other authors did not consider this. Particularly, not much thought was given in some studies that their findings may be differently applied in different therapist-populations (i.e., trainees and qualified therapists, psychologists, counsellors, psychotherapists and other clinicians who work therapeutically with clients) and in different client-populations (i.e., clients who received therapy in university settings, in psychiatric and psychotherapy departments or from the private sector).

Finally, in some studies the interpretation of findings might have gone beyond the estimation of simple causal effects. This is easily done when a rich and interesting theory like attachment theory is the main source of interpreting research findings. However, on the basis of the existing findings, because the relationship between therapists’ attachment organisation, process and outcome of therapy may not be simple, a need for more complex causal analyses, like mediation and moderation analyses, seems necessary. With such analyses, the previous findings can be
confirmed, validated and explained in more depth and also other theoretical
propositions can be empirically tested to enhance our understanding of the role of
therapists’ attachment organisation in individual therapy with adults.

**Building on theory and research to form future research hypotheses**

Attachment theory proposes that therapists’ attachment styles can be a very
important factor which can influence the therapeutic process and outcome. Ideally, if
the therapist is more securely attached than the client, this can predict their ability to
establish good therapeutic relationships. As Slade (1999) also suggested, the
therapist’s attachment security may enable them to remain open to their own
experience and to the patient’s experience, and this can be the basis of a healthy and
successful psychotherapy. These theoretical propositions were confirmed by the
majority of the existing empirical studies; however comparatively little attention has
been directed towards exploring the possible causal links between therapists’
attachment and the process of therapy. One question that arises from this might be:
how one could explain the relationship between the therapists’ attachment styles and
the process of therapy?

It is known that all important relationships are affected by the dynamics of
attachment processes (Bowlby, 1988). When these dynamics are activated in the
therapeutic relationship, a strong emotional connection arises between the client and
therapist. The client, as the “care-seeker”, naturally feels the need to turn to the
therapist for comfort and support in times of distress and the therapist, as the potential
“caregiver”, responds to the clients’ distressing cues, as in the relationship between a
mother and a child (Bowlby, 1980; Slade, 1999). An answer perhaps to the previous
question might be that as the therapists’ internal working models of attachment are
activated in therapy, they may be translated into different therapeutic caregiving behaviours towards clients which can then affect the quality of the therapeutic relationship.

The caregiving system is reciprocal and complementary to the attachment system (Bowlby, 1988; George & Solomon, 2008). Longitudinal studies suggested that an individual’s attachment styles were initially formed by their experience of being cared for and consequently this can determine their own caregiving behaviours (Belsky, 1999; Berlin & Cassidy, 1999; Feeney, 1999; Hazan & Zeifman, 1999; Howes, 1999; Weinfield, Sroufe, Egeland, & Carlson, 1999). Perhaps, the same can be hypothesised for therapists as it was found that therapists’ internal representations of past relationships influenced their therapeutic behaviours and clinical work (Hendry et al., 1986, 1990; Hendry, Strupp et al., 1993). Additionally, Leiper and Casares (2000) found that therapists’ early relational experiences influenced therapists’ attachment styles, and other studies found an association between therapists’ attachment styles and countertransference behaviours, which seemed to influence their capacity to respond to clients therapeutically and effectively (Dozier et al., 1994; Mohr et al., 2005). Therefore, it can be understood that to have an effect on the process of therapy, and thus on the therapeutic outcome, different therapists’ attachment organisations will influence their understanding of clients’ distress and translate into somewhat different therapeutic caregiving responses.

Gathering together all the findings and theoretical propositions, the model of the “Therapeutic Attachment-Caregiving Processes”, can be hypothesised (see Figure 1). This model consists of some therapists’ attachment and caregiving characteristics and behaviours that may arise in the therapeutic encounter. It is possible that this model can theoretically explain the relationship between therapists’ attachment
organisation, process and outcome of therapy. However, more research is clearly needed to explore the usefulness and validation of this model.

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<tr>
<th>Sensitive Therapeutic Attachment-Caregiving</th>
<th>Anxious Therapeutic Attachment-Caregiving</th>
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<tbody>
<tr>
<td><strong>Attachment characteristics:</strong></td>
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<tr>
<td>Comfortable with intimacy, autonomy and closeness. Positive views on self and clients. Confident in their ability to help.</td>
<td>Preoccupied with relationships and higher attachment anxiety. Unsure about the therapeutic relationship and afraid of not being a 'good' therapist.</td>
</tr>
<tr>
<td><strong>Caregiving characteristics/behaviours:</strong></td>
<td><strong>Caregiving characteristics/behaviours:</strong></td>
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<tr>
<td>Attends to clients' experience, understands the obvious and underlying needs of clients, open and self-reflective. Effective use of countertransference. Objective and available, warm, sincere. Facilitates expression of affect, empathic, appropriate use of self-disclosure. Supportive and works in collaboration with clients. Accurate and sensitive interpretation. Interested in the client and is an active participant in the therapeutic relationship.</td>
<td>Some times gets too close with clients. Seems very friendly. Inappropriate self-disclosure. They can be supportive but collaboration varies as they may do the work for the client or become overly protective. Stronger countertransference reactions. Feeling tense and worried which can make them less empathic. Difficulties with structuring the therapy and keep boundaries.</td>
</tr>
<tr>
<td><strong>Distant Therapeutic Attachment-Caregiving</strong></td>
<td><strong>Fearful Therapeutic Attachment-Caregiving</strong></td>
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<td><strong>Attachment characteristics:</strong></td>
</tr>
<tr>
<td><strong>Caregiving characteristics/behaviours:</strong></td>
<td><strong>Caregiving characteristics/behaviours:</strong></td>
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<tr>
<td>Less warm, can be rigid and aloof with clients. Difficulties in developing emotional bond. At times can be defensive and less empathic. Appears as less involved in the psychotherapeutic process, perceived as less understanding. Not good use of countertransference.</td>
<td>Devote little attention to affect. Over-involved in their countertransference. Using distancing strategies in the therapeutic room to minimise distance with the client while other times becomes very close to clients. Less empathic, difficulties in structuring sessions and maintaining appropriate boundaries. Less sensitive and accurate in their interventions.</td>
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Figure 1. The model of Therapeutic Attachment-Caregiving Processes

Based on these theoretical propositions and also previous empirical findings some hypotheses that can be tested in future studies are: (1) Therapists’ attachment styles/dimensions will predict the working alliance, with attachment avoidance and similarly attachment anxiety, predicting weaker working alliances with their clients; (2) Therapists’ attachment styles/dimensions will correlate with therapeutic
caregiving, and more specifically attachment avoidance and attachment anxiety will negatively correlate with therapeutic caregiving; (3) The therapeutic caregiving will mediate the relationship between therapists’ attachment styles/dimensions and the working alliance; (4) Clients’ attachment styles/dimensions will moderate the relationship between therapists’ attachment styles/dimensions and the working alliance; (5) The working alliance will mediate the relationship between clients’ and therapists’ attachment styles/dimensions and outcome of therapy.

Limitations of this literature review

The studies that were included in this literature review were only those available from the research database EBSCOhost and also only those written in the English language. It is possible that some studies may have been missed, firstly because they were not yet published, secondly because we did not have access to them and thirdly because they were not written in English. In addition, the discussion and conclusions from this literature review were based only on studies investigating the effects of therapists’ attachment organisation on the process and outcome in adult individual therapy. Hence, studies looking at similar effects in group therapy, family therapy, therapy with children or older adults, were not included in this review and we do not know if and how these studies could have contributed to our understanding.

Conclusion

This review indicates that the literature on adult attachment patterns in individual therapy is continuously growing and except for the clients’ attachment organisation, the therapists’ attachment organisation can influence significantly the process and outcome of therapy. From the 14 reviewed studies, it is suggested that
Attachment security in therapists, compared to therapists' attachment insecurity, might be an important factor that can positively associate with some therapeutic processes, predict good therapeutic alliances and finally more successful therapeutic outcomes. However, as some studies have showed, this may not always be the case, which suggests that further research is needed to explore the complex relationship between therapists' attachment organisation, process and outcome of therapy.
[Reflections on the Use of Self]

I believe that the therapeutic relationship is one of the most interesting topics in the psychotherapeutic literature and especially in the field of counselling psychology. From my personal experience as assistant psychologist in the psychiatric department of Athens General Hospital, I have learnt to value the importance of the relationship between the clinician and the client and specifically the bond and the quality of the working alliance. At a period when I was not trained to provide “actual” therapy, as I had limited training in the therapeutic skills, I discovered that the relationship by itself could be a “healing” process as my first clients reported feeling “better” after our sessions. In addition, the opportunity to observe different clinicians in their work with clients, made me realise some differences in how each person develops a therapeutic relationship with different clients.

The field of counselling psychology is rich in theoretical, research and clinical applications of both the therapeutic relationship and the outcome of therapy. The psychoanalytic influences from my first research supervisor, when studying for my bachelor degree, and my dissertation on psychological separation of university students, motivated me to search for a topic from a psychodynamic perspective. I found that attachment theory was appropriate for exploring issues in the therapeutic encounter. As I mentioned before, the observation of different clinicians’ work made me wonder about their different approaches on building a relationship with clients and how that could influence the process and outcome of therapy. I was not sure if the differences on building therapeutic relationships were because of their therapeutic approach, interventions or their personal characteristics. That made me wonder about my own ability of developing therapeutic relationships and more importantly how I could provide a secure space for the client to tell their story.
The opportunity that I was given to start something new in my doctorate, was very fascinating but at the same I was wondering why I chosen this topic, as it is said that a person's interests and experiences inevitably shape their chosen research topic. This made me think for example, that the topic of my bachelor degree dissertation on psychological separation might have been very relevant to my research interests that time as I was trying to gain my independency from my parents. That was the first actual time that I was separated from my own family and began to live independently. Now that I started working with clients, I am interested in how my own personality characteristics may interfere in my work with clients.

My topic, on the influence of therapists' attachment organisation on the process and outcome of therapy, it was something recent in the available literature. The majority of available studies were looking at the influence of clients' attachment styles on the process of therapy and also almost half of the studies that interested me were not accessible from the library system. Therefore, writing this literature review was not an easy thing to do. I felt that I could not write a literature review with only six studies, and many times I thought about changing my topic and finding another one, more accessible and "easier". With the help of my supervisor, I finally found the proper structure for my literature review, and from the continuous support that I had from him I felt motivated to continue. It was really easy for me to lose focus but with the right structure and being able to separate my own ideas and biases, the process became more manageable.

Although the "journey" of writing this literature review was long, causing anxiety and frustration at times, it was also fascinating. I needed to remind myself that I was writing in a language different from my own and to try not to become over preoccupied with the difficulties this created. I remember myself to constantly worry
if I got it right because I was not used to writing in a different language from mine or if I would finish it on time. The entire process was very tiring and there were also times when it was difficult to continue writing. At the same time I remained focused, because I had chosen to do something that really interested me and which deserved all my attention. The first piece of my thesis is now complete and I feel enthusiastic to proceed to the next stage of conducting empirical studies and really glad that I chose to do this. After all, it is the journey that counts and not the destination, and for me the real journey has just begun!


Appendix 1. Journal of Attachment & Human Development. Instructions for authors
Instructions for Authors

Papers will be considered providing that they have not previously been published or submitted simultaneously elsewhere for publication.

EMPIRICAL REPORTS

1) The paper should conform to APA standards, with a legible abstract (100-150 words), followed by sections that include an introduction, method, results, and discussion.

THEORY/REVIEW PAPERS

2) The paper should make an original, testable and/or useful extension/revision to theory and previous literature concerning attachment processes and human development.

CLINICAL CASE-STUDIES

3) Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

ALL SUBMISSIONS

should include an abstract, and ordinarily be about 6,000 words in length, not exceeding 7500 words in total, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.
E-mail submissions to the Editor are preferred; please send an electronic copy of your manuscript to steelehgnewschool.edu.

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Appendix 2. Details of the use of computer-based literature search facilities
From the EBSCOhost page of the Surrey university library
(http://web.ebscohost.com/ehost/search?vid=1&hid=103&sid=9c01f6e4-d60a-45c7-ac09-08cfdbeac289%40sessionmgr108), I chose the PsychINFO online database typing the words:

- The influence of therapist’s attachment styles in therapy
- The influence of therapist’s attachment styles in therapeutic relationship
- The influence of therapist’s attachment styles in therapy outcome

I downloaded the articles and after reading them, I found more relevant articles from the references. Then I typed the specific name of the article that I was interested, in the Google Scholar and at the same time in the PsychINFO online database. Articles were then downloaded either from Google Scholar or PsychINFO. Articles that could not be downloaded from these databases were purchased using the interlibrary loans from the library of University of Surrey.
EMPIRICAL RESEARCH

Effects of therapists’ attachment dimensions and therapeutic caregiving on the working alliance

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Psych.D in Psychotherapeutic & Counselling Psychology, University of Surrey,

Guildford, UK

(July 2010)
Abstract

Both theory and research support the notion that therapists' attachment organisation influences the process of therapy; however, little research has examined the possible causal links in this relationship. The present study examined the effects of therapists' attachment dimensions on one process variable, the working alliance, and whether these are mediated by therapists' caregiving. One hundred and thirty-nine therapists from the private sector in the United Kingdom completed self-report measures of their adult attachment dimensions (i.e., anxiety and avoidance), their overall therapeutic caregiving (i.e., sensitivity, responsiveness, flexibility and total caregiving), and their working alliance with a specific client. Except for attachment anxiety not predicting caregiving responsiveness, the two attachment dimensions were significant negative predictors of all different aspects of therapeutic caregiving, and of the working alliance. In addition, therapists' caregiving was a significant mediator between therapists' attachment dimensions and the working alliance. In particular, all the subfactors as well as the total factor of caregiving mediated the relationship between therapists' attachment avoidance and the working alliance and, with the exception of caregiving responsiveness, between therapists' attachment anxiety and the working alliance. It is argued that depending on their attachment dimensions, therapists' caregiving is differently activated in the therapeutic relationship in ways that then affects the process of therapy. Results are discussed in light of attachment theory and implications for future research and psychotherapeutic practice are considered.

Keywords: therapists' attachment dimensions; therapeutic caregiving; working alliance; psychotherapeutic practice.
Introduction

Following Bowlby’s work many authors have argued that therapists’ attachment organisation can influence the process and outcome of therapy, a proposition that is clearly supported by the existing empirical literature (Black, Hardy, Turpin, & Parry, 2005; Bruck, Winston, Aderhold, & Muran, 2006; Dinger, Struck, Sachsse, & Sahuenburg, 2009; Dozier, Cue, & Barnett, 1994; Dunkle & Friedlander, 2006; Leiper & Casares, 2000; Rubino, Barker, Roth, & Fearon, 2000). However, comparatively little attention has been directed towards exploring the possible causal links between therapists’ attachment and the process of therapy. The present study investigates whether therapeutic caregiving mediates the relationship between therapists’ attachment dimensions and the working alliance.

Since its inception, attachment theory has become a grounded and comprehensive psychological theory of development, motivation, personality and psychopathology (Obegi & Berant, 2009). The last two decades have witnessed an increased interest in how attachment theory can inform and be applied to our understanding of interpersonal relationships in clinical work with adults (Holmes, 2001; Main, 1996; Wallin, 2007). In the main, empirical studies on the importance of attachment dimensions in individual therapy with adults have focused on exploring how clients’ attachment dimensions affect the process of therapy. However, a shift in the literature is occurring and the therapist is seen as an active participant who affects and is affected by the client’s experience in the therapeutic relationship (Gelso & Hayes, 1998). Therefore, more researchers now turn their interest to explore how therapists’ attachment dimensions may also affect the process of therapy.

The majority of these authors report that securely attached therapists tend to have stronger working alliances with their clients than insecurely attached therapists
Some have also found that securely attached therapists can experience fewer problems in work settings and they tend to have less ruptures in the therapeutic relationship than insecurely attached therapists (Black et al., 2005; Leiper & Casares, 2000). There are, however, studies which provide us with different findings and paint a different picture, suggesting that the relationship between therapists' attachment and the process of therapy can be rather complex. For instance, there is evidence that anxiously attached trainee therapists can have higher levels of empathy than avoidant therapists (Trusty, Ng, & Watts, 2005) and that anxiously attached trainee therapists also tend to have good working alliances, at least at the beginning of therapy (Sauer, 2000; Sauer, Lopez, & Gormley, 2003). These exceptions may be part of the reason why some researchers have not found any significant relationship between therapists’ attachment styles and their working alliance with clients (Britton, 2006; Crook-Lyon, Gelso, Fisher, & Silva, 2007; Ligiero & Gelso, 2002).

Overall findings thus far suggest that therapists' attachment organisation influences the process of therapy but also that the relationship between specific aspects of these variables may vary. It also seems reasonable to hypothesise that this relationship might not be as straightforward, because of the mediating role of other factors. It is quite obvious, for example, that to have an effect on the working alliance, different therapists’ attachment dimensions must translate into somewhat different perceptions, and therapeutic responses to clients (i.e., different therapeutic caregiving). Key questions then are: (1) which therapeutic caregiving capacities in particular can explain the effects of therapists’ attachment dimensions on the working
alliance? (2) Are the effects of therapists’ attachment avoidance and anxiety mediated by the same or by different therapeutic caregiving capacities?

Attachment theory has mainly focused on understanding attachment-related processes in caregiver-child relationships, and has given comparatively less attention to understanding the caregiving system in its own right (George & Solomon, 2008). In brief, when a child is in distress, the caregiver naturally perceives that the child is in real or potential danger and as a result they respond to the child’s signals for comfort and protection. The caregiving system is thus activated in response to the child’s attachment system and consists of a set of behaviours designed to promote care, proximity, protection and comfort to the distressed child (Cassidy, 2008). According to George and Solomon (2008) to provide protection, and hence to act as safe haven and secure base for the child, the caregiver must be able to: (a) sensibly notice and accurately perceive attachment-related signals, (b) respond to them appropriately and at the right time, and (c) tailor their responses to the child’s signals and needs. Therefore, the parents’ role as caregivers is met through these specific caregiving capacities and most importantly it is these capacities that vary within their own attachment orientations (Bowlby, 1982).

Turning our attention to the psychotherapeutic process, it is generally said that the therapeutic relationship contains many qualities of an attachment relationship (Jansen, Fitzpatrick, & Drapeau, 2008; Mallinckrodt, Gantt, & Coble, 1995; Mallinckrodt, 2000; Parish & Eagle, 2003). Clients tend to start therapy and turn to their therapist in moments of heightened distress, aiming to elicit care and comfort (Bowlby, 1988). The therapist can then act as an attachment figure and their own caregiving system might be then activated in response to the clients’ attachment signals. Fitch and Pistole (2006) suggested that as the client develops an attachment
bond to the therapist, the therapist in return develops a caregiving bond with the client. These authors have also developed a self-report questionnaire to measure therapists’ caregiving and found that through therapeutic capacities such as sensitivity, responsiveness and flexibility, therapists meet their role as an attachment-caregiver figure to the client (Fitch & Pistole, 2010). This way, therapists come to act as a secure base and safe haven in exploring the clients’ world, understanding the contextual factors of their distress and providing protection from internal and external threats of distress to promote healthy affect regulation and emotional development.

The concept of the therapeutic caregiving is new and little is known about its relationship with therapists’ attachment dimensions and the process of therapy. However, as the theory of the caregiving system is consistent with attachment theory, it can be hypothesised that there is an association between therapists’ attachment and their therapeutic caregiving. In particular, the levels of therapists’ attachment anxiety or avoidance can influence the quality and effectiveness of their therapeutic caregiving (i.e., levels of sensitivity, responsiveness and flexibility). Therefore, it can also be reasonably hypothesised that the effects of the therapists’ attachment on the working alliance are mediated by the therapists’ caregiving.

Research hypotheses

On the basis of existing research and theory three main hypotheses are made:

Hypothesis 1: Therapists’ attachment avoidance, and also attachment anxiety, will significantly and negatively correlate with therapeutic caregiving.

Hypothesis 2: Therapists’ attachment avoidance, and also attachment anxiety, will significantly and negatively predict their working alliance with clients.
Hypothesis 3: The therapeutic caregiving and its specific aspects, namely sensitivity, responsiveness and flexibility will mediate the relationship between therapists’ attachment dimensions and total working alliance.

Finally, consideration will also be given to the fact that the majority of studies in literature talk about the importance of conceptualising attachment styles rather than attachment dimensions. Therefore, a more exploratory stance will be taken with regard to the effect of the therapists’ attachment styles on the working alliance.

Method

Participants

Overall 139 therapists working individually with adults were recruited from the private sector in the United Kingdom (i.e., therapists in private practice and therapists working in private organisations such as university counselling centres and private counselling services). Of the 139 participants 33 were men (24%) and 106 women (76%), with a mean age of 42.7 years ($SD = 12.5$; age range: 23–74 years). Therapists’ ethnicity was as follows: 81 white-British (58.3%), five white-Irish (3.6%), 45 from “other” white background (32.4%), one black British-African (0.7%), two Asian-British (1.4%), two Chinese (1.4%), two from another ethnic background (1.4%) and one refused to provide information (0.7%).

Twenty-one participants (15.1%) identified themselves as qualified counselling psychologists and 39 as trainee counselling psychologists (28.1%); 22 as qualified counsellors (15.8%) and nine as trainee counsellors (6.4%); 23 as qualified psychotherapists (16.5%) and 10 as trainee psychotherapists (7.2%); seven as qualified nurses practising psychotherapy (5%); three as qualified social workers practising psychotherapy (2.2%); two as psychiatrists practising psychotherapy...
Participants reported the following therapeutic orientations used in their clinical practice: 63 integrative (45.3%); 21 person-centred (15.1%); 17 psychoanalytic/psychodynamic (12.2%); seven CBT (5%); four systemic (2.9%) and 27 therapists (19.4%) reported using "other" therapeutic approaches (i.e., existential, shamanic, gestalt, psychosynthesis, solution-focused, transpersonal, relational, schema therapy and hypnotherapy). The vast majority of participants (97.1%) were working under supervision and 132 were or had been in personal therapy themselves (95%). Forty participants (28.8%) were working short-term and 99 participants (71.2%) long-term with the clients with whom they measured their working alliances.

Procedure

After being granted a favourable ethical opinion by the University of Surrey Ethics Committee, about 150 recruiting emails were sent to universities, training institutes, professional bodies, associations, societies and councils across the United Kingdom describing the aims of the study and asking them to forward the message to their members. Participation was voluntary and anonymous; however, there were few restrictions in participating in this study. These restrictions were that therapists working only with families, children, groups and clients diagnosed by any psychiatric mental condition could not participate. In addition, therapists working in the NHS would not be able to participate as we did not pursue an NHS REC approval. The questionnaires were completed online by the therapists as no client was recruited for this study. Additionally, therapists were instructed to complete the Working Alliance Inventory (WAI) with a specific client in mind, one with whom they have worked for more than three sessions. This was because previous research
indicates that the working alliance is usually already established by the third session (Ligiero & Gelso, 2002). Data were collected through a secure online platform, which was created for the purpose of this study by the University of Surrey, and were preserved in accordance with the Data Protection Act (1998) and then erased a year after its extraction.

**Measures**

*Demographics questionnaire:* This questionnaire consists of nine questions asking about participants' gender, age, ethnic origin, professional specialty, therapeutic orientation, years of clinical experience after completion of training, personal therapy, supervision and contracted duration of therapy.

*Therapists' attachment dimensions:* Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998). This questionnaire is a 36-item self-report measure which was created to assess adult attachment dimensions. According to Fraley, Waller, and Brennan (2000), the ECR benefits from better psychometric properties than other commonly used adult attachment self-report measures. The ECR is designed to assess two continuous dimensions of adult attachment: Avoidance (e.g., "I prefer not to be too close to others") and Anxiety (e.g., "I worry about being rejected or abandoned"). Items are scored on a 7-point Likert scale (1 = disagree strongly, 4 = neutral/mixed, 7 = agree strongly) and higher scores indicate greater attachment avoidance or anxiety, respectively. Brennan et al. (1998) reported good internal consistency for the ECR with Cronbach’s alpha .91 for anxiety and .94 for avoidance. Cronbach’s alpha in the present study was .92 for anxiety .90 for avoidance.

*Working alliance:* Working alliance Inventory Short form (WAI-S; Tracey & Kokotovic, 1989). The WAI-S is a 12-item questionnaire, the shorter version of the
36-item questionnaire (Hovarth & Greenberg, 1989), which measures Bordin’s (1979) integrative model of alliance and is used to assess both therapists’ and clients’ perceptions of the strength of the working alliance. The WAI-S measures the total working alliance (e.g., “We agree on what is important for my client to work” and “My client and I have built a mutual trust”) and each item is rated on a 7-point Likert scale (1 = never to 7 = always). In the present study only therapists completed this questionnaire and only the total score was used. Ligiero and Gelso (2002) reported good internal consistency for WAI-S total working alliance with Cronbach’s alpha .90. In the present study Cronbach’s alpha was .87 for total working alliance.

**Therapeutic caregiving:** The Counselor Caregiving Questionnaire (CCQ; Fitch & Pistole, 2010) is used to assess counsellors’ therapeutic caregiving. This questionnaire consists of 25 items rated on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree) which relate to one factor/scale, that of total caregiving, and to three subfactors/subscales: Sensitivity (e.g., “It is easy for me to be in tune with the client’s feelings about closeness”), Responsiveness (e.g., “I am reliable and responsive to clients exploring their own world”) and Flexibility (e.g., “It’s important for me to recognise when a client wants more closeness or distance”). Fitch and Pistole (2010) reported good internal consistency for CCQ with Cronbach’s alpha .79 for Sensitivity, .71 for Responsiveness, .70 for Flexibility and .85 for total caregiving. Cronbach’s alpha in the present study was .73 for Sensitivity, .73 for Responsiveness, .78 for Flexibility and .87 for total caregiving.

**Data Analysis**

Pearson correlation coefficients were calculated to explore the association between therapists’ attachment dimensions, therapeutic caregiving and the working
alliance. A regression analysis was then conducted to investigate if therapists’
attachment dimensions predict the working alliance. Additionally, to explore the
relationship between therapists’ attachment styles, working alliance and therapeutic
caregiving, we repeated the correlation and regression analyses using the four
attachment classifications (i.e., secure, preoccupied, dismissive and fearful) as the
independent variables. Finally, to test whether therapeutic caregiving mediates the
relationship between therapists’ attachment dimensions and working alliance, we
followed the recent recommendations in testing mediation effects using the
Bootstrapping re-sampling method (Preacher & Hayes, 2004). This particular method
of conducting a mediation analysis does not require the normality assumption to be
met, and is recommended for sample sizes that are not considered to be large or very
large (N<200 or N<500). Bootstrapping is a method that repeats sampling from the
same data set thousands of times, and from the re-sampled data set calculates the
confidence intervals of the indirect effect which are then sorted from low to high
(Preacher & Hayes, 2004). If the value of zero does not fall within the 95%
confidence intervals then the indirect effect is considered significantly different from
zero at a value of \( p < .05 \), indicating the existence of mediation.

Results

Before preliminary and primary analyses were performed, we examined the
distribution of our data by using the criterion of skewness, divided by the standard
error of skewness, and we found that our data met the requirements of normality and
linearity.
**Preliminary investigations**

We conducted preliminary analyses to explore whether any of the demographic variables had an effect on any of the main variables (i.e., attachment dimensions, working alliance and therapeutic caregiving). These analyses showed no effect of gender, age, years of clinical experience after completion of training, supervision or contracted duration of therapy on any of the main variables. In addition, because of the low numbers in some cells, meaningful preliminary analyses could not be run for ethnicity, professional specialty, therapeutic orientation and whether therapists were or had been in personal therapy themselves.

Significant differences were found between trainees and qualified therapists on avoidance anxiety \( t(137) = -2.69, p < .01, d = .46 \) with trainees \( M = 3.54, SD = 1.03 \) having higher scores than qualified therapists \( M = 3.08, SD = 0.97 \), and on caregiving sensitivity \( t(137) = 2.94, p < .01, d = .51 \) with qualified therapists \( M = 31.41, SD = 5.15 \) having higher scores than trainees \( M = 28.95, SD = 4.50 \).

Therefore, the variable of status (trainees/qualified therapists) was partialed out in the regression and mediation analyses that included the variables of attachment anxiety and caregiving sensitivity to reduce the *error term* (Dancey & Reidy, 2004).

**Primary analyses**

*Correlations:* Pearson correlation coefficients indicated that therapists’ attachment avoidance and attachment anxiety significantly and negatively correlated with the working alliance. With no correlation between attachment anxiety and responsiveness, the two attachment dimensions also significantly and negatively correlated with all scales of therapeutic caregiving (sensitivity, responsiveness, flexibility and total caregiving) (Table 1).
Table 1. Summary of correlations, Means, and Standard Deviations of therapists’ attachment dimensions, working alliance and therapeutic caregiving

<table>
<thead>
<tr>
<th>Variable</th>
<th>$M$</th>
<th>$SD$</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Avoidance</td>
<td>2.92</td>
<td>0.87</td>
<td>-</td>
<td>.515**</td>
<td>-.397**</td>
<td>-.303**</td>
<td>-.278**</td>
<td>-.232**</td>
<td>-.314**</td>
</tr>
<tr>
<td>2. Anxiety</td>
<td>3.27</td>
<td>1.02</td>
<td>-</td>
<td>-.439**</td>
<td>-.365**</td>
<td>-.135</td>
<td>-.191*</td>
<td>-.249**</td>
<td></td>
</tr>
<tr>
<td>3. Working alliance</td>
<td>5.48</td>
<td>0.71</td>
<td>-</td>
<td>.418**</td>
<td>.427**</td>
<td>.380**</td>
<td>.483**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Sensitivity</td>
<td>30.37</td>
<td>5.02</td>
<td>-</td>
<td>.397**</td>
<td>.423**</td>
<td>.665**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Responsiveness</td>
<td>47.71</td>
<td>6.76</td>
<td>-</td>
<td>.730**</td>
<td>.873**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Flexibility</td>
<td>53.07</td>
<td>7.70</td>
<td>-</td>
<td>.900**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Tot. Caregiving</td>
<td>131.15</td>
<td>16.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note. *Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed)

We then explored if therapists’ attachment styles influenced the working alliance. Since there are no validated cut-off values for ECR dimension-scores to give the attachment styles, two cluster analyses were conducted according to guidelines suggested by Hair, Anderson, Tatham, and Black (1995) and used by Brennan et al. (1998). In the present study, cluster analyses were used to help us classify our participants into one of the four attachment styles deriving from the two-dimensional model of attachment. A hierarchical clustering analysis (i.e., Ward’s method, with squared Euclidean distance) was used to obtain initial cluster centres. Then these clusters were used in a second non-hierarchical cluster analysis (i.e., K-Means, with an optimisation method of assigning cases to clusters). This procedure revealed four clusters (see Table 2), where participants in the first group scored high on both avoidance and anxiety (fearful 23.7%), those in the second group scored high on both avoidance and anxiety (secure 26.6%) whilst participants in the third group scored low on avoidance and high on anxiety (preoccupied 30.2%) and finally those in the last group scored high on avoidance and low on anxiety (dismissive 19.4%).
Table 2. Means and standard deviations for the two-dimensional four-category model of attachment

<table>
<thead>
<tr>
<th>Attachment Styles</th>
<th>Secure</th>
<th>Preoccupied</th>
<th>Dismissive</th>
<th>Fearful</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dimensions N</td>
<td>N=37</td>
<td>N=42</td>
<td>N=27</td>
<td>N=33</td>
<td>N=139</td>
</tr>
<tr>
<td></td>
<td>(26.6%)</td>
<td>(30.2%)</td>
<td>(19.4%)</td>
<td>(23.7%)</td>
<td>(100%)</td>
</tr>
<tr>
<td>Avoidance M (SD)</td>
<td>1.97 (0.47)</td>
<td>2.64 (0.44)</td>
<td>3.60 (0.48)</td>
<td>3.77 (0.58)</td>
<td>2.92 (0.87)</td>
</tr>
<tr>
<td>Anxiety M (SD)</td>
<td>2.03 (0.47)</td>
<td>3.62 (0.41)</td>
<td>2.95 (0.51)</td>
<td>4.49 (0.48)</td>
<td>3.27 (1.02)</td>
</tr>
</tbody>
</table>

Following the cluster analysis, a discriminant analysis was performed in which the cluster numbers were used as the dependent variables, and anxiety and avoidance scores as the independent variables, to determine whether the four groups obtained by the cluster analysis was a good split of the participants. The model obtained by the discriminant analysis predicted a 91.4% correct classification of participants. Finally, Pearson correlation coefficients were computed again to explore the relationship between therapists’ attachment styles therapeutic caregiving and the working alliance. It was confirmed that the attachment styles significantly correlated with the working alliance. Additionally, significant correlations between attachment styles and therapeutic caregiving were observed only between the secure attachment style, which positively correlated with sensitivity and total caregiving, and the fearful attachment style which negatively correlated with the total caregiving and all its subscales (Table 3).

Table 3. Correlations between attachment styles, therapeutic caregiving and working alliance

<table>
<thead>
<tr>
<th>Working alliance</th>
<th>Sensitivity</th>
<th>Responsiveness</th>
<th>Flexibility</th>
<th>Total Caregiving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure</td>
<td>.517**</td>
<td>.326**</td>
<td>.165</td>
<td>.139</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>-.233**</td>
<td>-.099</td>
<td>.166</td>
<td>.140</td>
</tr>
<tr>
<td>Dismissive</td>
<td>-.169*</td>
<td>.033</td>
<td>-.132</td>
<td>-.019</td>
</tr>
<tr>
<td>Fearful</td>
<td>-.226**</td>
<td>-.297**</td>
<td>-.228**</td>
<td>-.265**</td>
</tr>
</tbody>
</table>

Note. *p < .05 **p < .001
Regression analyses: Both therapists’ attachment dimensions and therapists’ attachment styles were found to significantly predict the working alliance (Table 4).

Table 4. Regression analyses predicting working alliance

<table>
<thead>
<tr>
<th>Predictors</th>
<th>Outcome Variable</th>
<th>R^2</th>
<th>Adj. R^2</th>
<th>t</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>W.A.</td>
<td>.158</td>
<td>.152</td>
<td>-5.064***</td>
<td>-0.314</td>
<td>0.062</td>
<td>-0.397</td>
<td>[-0.437, -0.191]</td>
</tr>
<tr>
<td>Anxiety</td>
<td>W.A.</td>
<td>.194</td>
<td>.182</td>
<td>-5.445***</td>
<td>-0.292</td>
<td>0.054</td>
<td>-0.431</td>
<td>[-0.398, -0.186]</td>
</tr>
<tr>
<td>Secure</td>
<td>W.A.</td>
<td>.278</td>
<td>.273</td>
<td>7.264***</td>
<td>0.846</td>
<td>0.116</td>
<td>0.527</td>
<td>[0.615, 1.076]</td>
</tr>
<tr>
<td>Preoccupied</td>
<td>W.A.</td>
<td>.055</td>
<td>.048</td>
<td>-2.812**</td>
<td>-0.456</td>
<td>0.162</td>
<td>-0.234</td>
<td>[-0.777, -0.135]</td>
</tr>
<tr>
<td>Dismissive</td>
<td>W.A.</td>
<td>.033</td>
<td>.026</td>
<td>-2.172*</td>
<td>-0.406</td>
<td>0.187</td>
<td>-0.182</td>
<td>[-0.775, -0.036]</td>
</tr>
<tr>
<td>Fearful</td>
<td>W.A.</td>
<td>.051</td>
<td>.044</td>
<td>-2.711**</td>
<td>-0.400</td>
<td>0.148</td>
<td>-0.226</td>
<td>[-0.692, -0.108]</td>
</tr>
</tbody>
</table>

Note: *p < .05, **p < .01, ***p < .001; 'Controlling for therapists' status. W.A. = working alliance; CI = confidence intervals

Mediation Analyses: Four mediation analyses examined the indirect effect between therapists’ attachment avoidance and the working alliance. Additionally, three mediation analyses examined the indirect effect between therapists’ attachment anxiety and the working alliance and because caregiving responsiveness was unrelated to attachment anxiety, it was not included in these mediation analyses. As therapists’ attachment dimensions were better predictors of the working alliance and explained more of the variance than the therapists’ attachment styles, it was more meaningful to only run mediation analyses using the attachment dimensions as the independent variables. Mediation analyses showed significant indirect effect on all occasions, suggesting that therapeutic caregiving mediated the relationship between therapists’ attachment dimensions and the working alliance (Table 5).
Table 5. Summary of indirect effects for attachment dimensions and working alliance

<table>
<thead>
<tr>
<th>X</th>
<th>M</th>
<th>Y</th>
<th>F (df)</th>
<th>$R^2$</th>
<th>$\beta$</th>
<th>95% CI</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>Tot. Caregiving</td>
<td>W.A.</td>
<td>29.120 (2, 136)*</td>
<td>.30</td>
<td>-0.098</td>
<td>[-0.0448, -0.1785]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Sensitivity*</td>
<td>W.A.</td>
<td>15.511 (3, 135)*</td>
<td>.26</td>
<td>-0.072</td>
<td>[-0.0291, -0.1435]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Responsiveness</td>
<td>W.A.</td>
<td>24.652 (2, 136)*</td>
<td>.26</td>
<td>-0.075</td>
<td>[-0.0261, -0.1498]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Flexibility</td>
<td>W.A.</td>
<td>22.125 (2, 136)*</td>
<td>.25</td>
<td>-0.055</td>
<td>[-0.0141, -0.1255]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Anxiety*</td>
<td>Tot. Caregiving</td>
<td>W.A.</td>
<td>23.533 (3, 135)*</td>
<td>.34</td>
<td>-0.069</td>
<td>[-0.0183, -0.1362]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Anxiety*</td>
<td>Sensitivity</td>
<td>W.A.</td>
<td>16.611 (3, 135)*</td>
<td>.27</td>
<td>-0.066</td>
<td>[-0.0265, -0.1282]</td>
<td>$p&lt;.05$</td>
</tr>
<tr>
<td>Anxiety*</td>
<td>Flexibility</td>
<td>W.A.</td>
<td>18.245 (3, 135)*</td>
<td>.29</td>
<td>-0.046</td>
<td>[-0.0094, -0.1065]</td>
<td>$p&lt;.05$</td>
</tr>
</tbody>
</table>

Note. *Controlling for therapists' status; W.A. = working alliance; X = predictor; M = mediator; Y = outcome variable; $\beta$ = unstandardised coefficient; CI = confidence intervals; Sig = significance. All values are based on bias-corrected bootstrap estimation; 5000 bootstrap samples. *$p < .001$

Discussion

This study examined the effects of therapists’ attachment dimensions and therapeutic caregiving on the working alliance. To our knowledge, this is the first study to examine whether therapists’ caregiving mediates the effect of therapists’ attachment dimensions on the working alliance. Consistent with previous findings, our study indicates that therapists who scored higher on attachment avoidance, and similarly therapists who scored higher on attachment anxiety, reported significantly weaker working alliances with their clients. In addition, we found a negative association between therapists’ attachment dimensions and therapeutic caregiving and, most interestingly, that the therapeutic caregiving mediated the relationship between therapists’ attachment dimensions and the working alliance. Overall, our findings indicate that less effective therapeutic caregiving may be an important part of the explanation why therapists with higher attachment avoidance or anxiety (insecure attachment organisation) tend to report weaker working alliances with their clients.
Correlations between therapists’ attachment dimensions and therapeutic caregiving

Our first hypothesis was fulfilled inasmuch as therapists’ attachment dimensions correlated negatively with their therapeutic caregiving. These findings suggest that insecurely attached therapists tend to report less effective caregiving behaviours with their clients. In particular, therapists with higher attachment avoidance, and also therapists with higher attachment anxiety, may be less accurate in perceiving clients’ signals of distress, feelings and thoughts as they scored lower in the sensitivity scale of caregiving. In addition, a low but still significant negative association between the two attachment dimensions and scores on the flexibility scale of caregiving, suggests that in a sufficiently large number of cases their responses towards their clients’ might not be based on their clients’ actual needs. A significant, albeit low, negative correlation was also found between attachment avoidance and caregiving responsiveness, indicating that avoidant therapists may be less successful, consistent and accurate in providing reasonable and appropriate responses to clients’ attachment-related cues. The non-significant association between attachment anxiety and caregiving responsiveness suggests that anxiety may not have a similar effect on therapists’ tendency to promptly respond to their clients’ distress cues.

We are not aware of other studies exploring the relationship between therapists’ attachment dimensions and therapeutic caregiving, and therefore we do not have a valid stand-point to compare our findings. However, there are parallel findings from studies exploring attachment-caregiving processes in adult romantic relationships. More specifically, these studies show the existence of a negative association between insecure attachment and effective caregiving, indicating that attachment security/insecurity in adult romantic relationships can define individual differences in caregiving (Carnelley, Pietromonaco, & Jaffe, 1996; Feneey, 1999;
Collins & Feneey, 2000; Kunce & Shaver, 1994; Simpson, Rholes, & Nellingan, 1992). Therefore, as suggested by our results, it seems reasonable that higher attachment avoidance or anxiety in therapists, possibly resulting from their own early experiences of being cared for, can negatively influence their caregiving behaviours which are activated and manifested within the therapeutic relationship.

While finding that therapists’ attachment anxiety was not significantly correlated to their capacity to respond promptly to their clients’ distress cues, there are indications from previous studies that anxiously attached therapists may have difficulties in responding to their clients and they experience more problems in sessions (Black et al., 2005; Dozier et al., 1994; Dinger et al., 2009). Nevertheless, our results suggest that an anxious attachment organisation in therapists may hinder their caregiving sensitivity (i.e., perceiving these needs accurately) and flexibility (i.e., tailoring their interventions to the clients’ needs) towards clients. As caregiving sensitivity and flexibility may be analogous to empathy, it can be said that our findings confirm the study that found a negative correlation between therapists’ attachment anxiety and empathy (Rubino et al., 2005).

The caregiving behavioural system’s goal is to respond to the dependent others’ needs for help and protection (George & Solomon, 2008) and according to Bowlby (1982), caregiving has a protective and supportive function for others who are not only chronically dependent on the caregiver but also to those who are temporarily in need (e.g., clients). As therapists can be seen as having the role of the caregiver in the therapeutic relationship, from our results it can be understood that not only their attachment is activated but also their caregiving system. This may suggest that, therapists’ previous experiences of being cared for can influence their internal
working models of attachment which in turn can affect their internal models of caregiving and thus their therapeutic caregiving behaviours and capacities.

**Therapists’ attachment as a predictor of working alliance**

Our second hypothesis, namely, that therapists’ attachment dimensions would significantly predict the working alliance was also supported in that both therapists’ attachment avoidance and anxiety were significant negative predictors of the working alliance. A secondary finding of an exploratory nature was that the attachment styles, coming from the two-dimensional construct of attachment, also predicted the working alliance. The secure style predicted significantly stronger working alliances whilst the preoccupied, the dismissive and the fearful styles predicted significantly weaker alliances. It is important to note that these results are consistent with previous studies that found that insecure attachment organisation in therapists is negatively associated with the working alliance (Berry et al., 2008; Bruck et. al., 2006; Dinger et al., 2009; Dunkle & Friedlander, 1996; Sack, 1996; Tyrrell et al., 1999). On the basis of our findings, it can be said that therapists’ attachment representations can affect not only their ability to understand their own and their clients’ behaviours, thoughts and feelings but also their perceptions of the working alliance.

Research indicates that securely attached people explain relationship events in more positive ways (Collins, 1996). Interestingly, findings from previous studies exploring the effects of therapists’ attachment organisation on the therapeutic relationship, indicate that as securely attached therapists are more comfortable with intimacy and have the ability to form closer relationships with their clients, they may be more confident in their ability to act as a secure base for their clients and have better therapeutic alliances (Black et al., 2005; Diamond, Stovall-McClough, Clarkin,
Therefore, from our findings it can be understood that because securely attached therapists (those who scored lower on attachment avoidance and anxiety) may have an internalised positive sense of self-worth, but also a positive image about their clients, they may also have more positive perceptions about the therapeutic alliance with their clients in comparison to insecure therapists.

Attachment avoidance is associated with an excessive need for self-reliance and fear of depending on others, avoidance of emotional closeness, social withdrawal and generally a negative image of others but also a positive self-image (Brennan et al., 1998). This avoidant attachment organisation in therapists may be triggered by the closeness of the therapeutic relationship. In fact, some studies found that therapists higher in attachment avoidance may experience more difficulties in developing and maintaining strong working alliances with their clients than securely attached therapists (Bruck et al., 2006; Dunkle & Friedlander, 1996). Our findings are consistent with these findings and hence it can be understood that dismissively attached therapists' avoidant strategy can negatively affect their perceptions of the working alliance with their clients.

Attachment anxiety is associated with fear of rejection, excessive need for approval from others, worry and concern about being neglected and abandoned (Brennan et al., 1998). As therapists higher in attachment anxiety may have a negative self-image, they may worry about their ability as therapists and also about their capacities of forming good working alliances. In addition, Diamond and colleagues (2003) found that preoccupied therapists believe that their professional reputation depends on the outcome of treatment and thus they can be preoccupied with the client's treatment progress. On occasions where the client might be more withdrawn

& Levy, 2003; Dunkle & Friedlander, 1996). Therefore, from our findings it can be understood that because securely attached therapists (those who scored lower on attachment avoidance and anxiety) may have an internalised positive sense of self-worth, but also a positive image about their clients, they may also have more positive perceptions about the therapeutic alliance with their clients in comparison to insecure therapists.

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or even critical towards them, or the process of therapy, therapists with high
attachment anxiety may be afraid that their clients are judging them and that they will
leave them. As this situation may trigger their own sensitivity of abandonment, which
is characteristic of a preoccupied state of mind, it can negatively influence their
perceptions of the working alliance (Dinger et al., 2009), something that was
confirmed by our results.

The mediation of therapists' attachment dimensions and working alliance

We found that it was significant that trainees were more anxiously attached
than qualified therapists, and also that their therapeutic caregiving sensitivity was less
effective than qualified therapists. This result was to be expected, as it is possible that
the qualified therapists of our sample might have reworked their insecure attachment
dimensions, and also enhanced their caregiving skills through personal therapy,
supervision, experience and other available resources. After partialling out the effect
of status from the mediation analyses that included attachment anxiety and/or
caregiving sensitivity, the therapeutic caregiving was found to be a significant
mediator between therapists' attachment dimensions and the working alliance, which
supports our third and last hypothesis. It can be argued that this finding can answer, at
least partially, questions as to why and how do therapists' attachment dimensions
affect the working alliance. The following general model of the relationship between
therapists' attachment dimensions, their therapeutic caregiving (sensitivity,
responsiveness and flexibility) and the working alliance is suggested (see Figure 1).
While this is the first study to explore the therapists’ caregiving in mediating the relationship between therapists’ attachment dimensions and their working alliance with clients, its results are consistent and expand on those from a number of other studies. Berry and colleagues (2008), for instance, found that clinicians’ higher attachment avoidance is associated with greater discrepancies in their perceptions of patients’ interpersonal problems and also with poorer psychological mindedness. Other researchers reported that therapists with higher attachment avoidance intervene in less depth and may demonstrate less empathic responses towards their clients (Dozier et al., 1994; Trusty et al., 2005). In addition, Wallin (2007) suggested that therapists who lean toward the dismissing attachment dimension may demonstrate cold, withdrawn or controlling countertransference behaviours towards clients, and Mohr et al. (2005) found that dismissively attached trainee therapists tend to exhibit more hostile countertransference behaviours.

Our findings confirm and provide a rationale to all these studies. In particular, therapists with higher attachment avoidance reported lower caregiving sensitivity,
responsiveness and flexibility which then affected the working alliance negatively. Basically this suggests that therapists with higher attachment avoidance may be somewhat inaccurate in perceiving clients' internal and external signals of distressing feelings and thoughts, and thus are less effective in responding to clients consistently and accurately. This may be due to the fact that therapists with higher attachment avoidance are fearful of emotional closeness and perceive the therapeutic relationship as intrusive. To deal with those threats to their security they may use attachment deactivating-distancing strategies, or what Solomon and George (1996) called "distanced protection". Therefore, their therapeutic caregiving can be affected and driven by countertransference reactions they become less able to understand and intervene effectively. This, in turn, naturally reduces the strength of the working alliance.

Therapists with higher attachment anxiety also reported less effective caregiving behaviours related to sensitivity and flexibility, which then affected the working alliance negatively. Rubino and colleagues (2000), in a study with trainees, found that anxiously attached therapists may demonstrate less empathic responses towards clients than securely attached therapists. In addition, Dozier et al. (1994) found that preoccupied case managers had stronger countertransference reactions which resulted in perceiving greater dependency needs in clients and therefore intervening more intensively. Similarly, Obegi and Berant (2009) suggested that therapists' higher attachment anxiety can affect their countertransference, as they can become overly protective with clients and thus less able to respond flexibly as the relationship deepens. Some theorists have even proposed that preoccupied therapists' fears of abandonment and preoccupation with relationships can reinforce their strong emotional countertransferential reactions and behaviours towards clients (i.e., being
overly supportive and agreeing too often with the client rather than helping them recognise their own resources in how to cope with distress) (Friedman & Gelso, 2000; Wallin, 2007).

Our results not only confirm these findings and theoretical notions but also suggest that anxiously attached therapists' countertransference may make it more difficult for them to keep a sensitive and flexible therapeutic caregiving. This could then lead to weaker working alliances with their clients. On this basis it could be argued that because therapists with higher attachment anxiety may approach the therapeutic relationship being worried about their therapeutic ability, wanting to be liked and seen as good therapists, this can affect their therapeutic caregiving. In particular, being less accurate in perceiving clients' signals of distress may prevent them from seeing the "bigger picture" of their clients' underlying needs, which could negatively affect their working alliance. This is confirmed by the results of our research that less effective caregiving flexibility can negatively affect the working alliance and therefore it seems likely that anxiously attached therapists' responses might be based on their own countertransference, rather than their clients' actual needs.

This seems to be different for therapists with lower attachment avoidance and anxiety, who reported more positive views of the working alliance with their clients. Their secure state of mind within their relationships can affect not only the way they understand but also the way they respond therapeutically to clients. Holding an effective caregiving model, which Solomon and George (1996) named as "close protection", they can be more sensitive and thus more empathic and more receptive in understanding the clients' distressing signals, feelings and thoughts. In a collaborative approach, the securely attached therapists' behaviours that relate to caregiving
responsiveness can allow them to respond to their clients' related attachment issues in an open, flexible and non-defensive way. As Slade (2008) mentioned, a secure attachment in therapists can determine more flexible responses to their clients when necessary and appropriate, something that was confirmed by our findings. This means that being more open to their experience, and due to their higher caregiving flexibility, therapists with lower attachment avoidance and anxiety can use their countertransference more effectively in order to mirror and contain clients' distress. Therefore, based on our findings, it can be argued that in the therapeutic relationship the therapists' secure attachment organisation activates their therapeutic caregiving which then affects positively the working alliance with their clients.

The findings from the current study can also support the theoretical model of the Therapeutic Attachment-Caregiving Processes that was proposed in a literature review (Parpottas, 2009). The four groups represent four different therapeutic caregiving styles and capacities which come from a therapist's attachment dimensions (avoidance-anxiety): the sensitive therapeutic attachment-caregiving, the anxious-compulsive therapeutic attachment-caregiving, the distant-controlling therapeutic attachment-caregiving and the mixed controlling-compulsive therapeutic attachment-caregiving (see Figure 2). More specifically, it can be hypothesised that therapists who have lower attachment anxiety and avoidance may hold a more sensitive therapeutic caregiving which reflects higher sensitivity, responsiveness and flexibility towards clients' needs. Therapists with higher attachment anxiety may hold an anxious-compulsive therapeutic caregiving which reflects both a higher over-involvement in a clients' therapy and a less effective caregiving with moderate to low sensitivity, responsiveness and flexibility. Therapists with higher attachment avoidance may hold a distant-controlling therapeutic caregiving with less effective
caregiving capacities that reflect moderate to low sensitivity, responsiveness and flexibility. Finally, the mixed controlling-compulsive therapeutic caregiving may be a combination of the previous two insecure attachment-caregiving strategies and which reflect low caregiving sensitivity, responsiveness and flexibility. Nevertheless, as the TA-CP is a new model and more work is needed for its validity, it must be interpreted very carefully.

<table>
<thead>
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<th>Attachment Anxiety</th>
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<tbody>
<tr>
<td>Low</td>
<td>Sensitive TA-C</td>
</tr>
<tr>
<td></td>
<td>Effective caregiving, High Sensitivity, Responsiveness and Flexibility</td>
</tr>
<tr>
<td>High</td>
<td>Anxious-Compulsive TA-C</td>
</tr>
<tr>
<td></td>
<td>Less effective caregiving, Moderate Sensitivity, moderate-low Responsiveness and Flexibility. Perhaps use of Compulsive caregiving</td>
</tr>
<tr>
<td>Low</td>
<td>Distant-Controlling TA-C</td>
</tr>
<tr>
<td></td>
<td>Less effective caregiving, Moderate Sensitivity, low Responsiveness and Flexibility. Perhaps use of Controlling caregiving</td>
</tr>
<tr>
<td>High</td>
<td>Mixed Controlling-Compulsive TA-C</td>
</tr>
<tr>
<td></td>
<td>Less effective caregiving, Low Sensitivity, Responsiveness and Flexibility. Perhaps use of Compulsive and Controlling caregiving</td>
</tr>
</tbody>
</table>

Figure 2. The model of Therapeutic Attachment-Caregiving Processes (TA-CP)

Limitations and research recommendations

There are a number of limitations that must be taken into account when interpreting these findings. Firstly and importantly, as the current study was conducted in the United Kingdom, with a majority of White-European therapists, it may restrict a cross-cultural replicability of the findings. Secondly, the use of self-report questionnaires is always debatable as to whether such measures can adequately capture the complexities of human behaviour and personality. For instance, the CCQ is a new instrument and its psychometric properties may need further examination and hence more research is needed to explore further the correlation between therapists’ attachment and caregiving. We also used a self-report questionnaire to assess...
therapists' attachment dimensions and perhaps different results might have been obtained if another self-report questionnaire of adult attachment or even a different assessment method had been used. Griffin and Bartholomew (1994) suggested that results coming from self-report measures should be validated with an interview. Therefore, measuring attachment in multiple methods could have been the most desirable but also the most difficult and time-consuming method. Nevertheless, our results are in line with studies conducted in different countries and using different assessment methods (for a review see Daniel, 2006; Parpottas, 2009).

Another limitation is that we assessed only self-reported perceptions of the alliance rather than actual behaviours and our data were collected only at one point. Although we instructed therapists to complete the WAI-S after the third session, we do not know exactly at which point of therapy they rated the working alliance. This can be an important limitation as the alliance varies through the different phases of therapy (Hovarth & Luborsky, 1993). For example, further research including this information, would be needed to test more in depth the hypothesis that anxiously attached therapists can still achieve a good working alliance at the beginning of therapy but not as therapy progresses. It can be therefore understood, that collecting data at different stages would have been the most desirable method.

To our knowledge, this is the first study to investigate possible causal links between therapists' attachment and working alliance using caregiving as a mediator. One may also argue that strong causal inferences cannot be fully supported because our data were collected only from the therapists' perspective when it has been found that clients' ratings of the working alliance can be a better measure than therapists' ratings (Hovarth & Symonds, 1991). Additionally, because we are unaware which of their clients the therapists chose to have in mind when they completed the WAI, we
are wondering if those clients' attachment dimensions could also have affected the working alliance and the therapists' caregiving. As this study has focused solely on understanding therapists' attachment-caregiving processes we note that the contribution of clients' attachment dimensions must not be overlooked in future studies. As the therapeutic relationship is co-created, it would be interesting for future research to explore how possible interactions between clients' and therapists' attachment-caregiving dimensions can affect the working alliance.

Another important issue that must draw the attention of researchers, especially when conducting studies on adult attachment, is how adult attachment organisation should be assessed and conceptualised. When we used the attachment styles to examine their relationship with the working alliance, we found that although they correlated with the working alliance, those correlations were statistically weaker than the correlations between the attachment dimensions and working alliance. Additionally, we found that only the secure and fearful attachment styles, and not the preoccupied or dismissive styles, correlated with some aspects of the therapeutic caregiving and this can be seen as conflicting to the correlation that was found between the attachment dimensions (anxiety and avoidance) and therapeutic caregiving. Moreover, the attachment styles explained lower variance in predicting the working alliance than the attachment dimensions. Therefore, it can be argued that the results in our study that were based on the dimensional rather than categorical model of attachment, can be more consistent with what was expected based on theory and previous studies. Although the issue of how to conceptualise and assess attachment organisation is an ongoing debate in the attachment literature, it was reported that when using self-report questionnaires for research purposes a dimensional system might be more appropriate than the categorical (Cassidy &
We suggest that researchers must be aware of the different psychometric properties and limitations of each method of assessing individuals’ attachment organisations before employing them for research purposes.

**Implications for practice**

This study offers some implications for therapists’ clinical work as it can enhance awareness of issues related to the therapeutic use of self. Therapists should be aware of how their attachment dimensions might inform their responses towards clients and how such caregiving behaviours can affect the development and maintenance of the working alliance. Blind spots in therapy are inevitable and therapists must always strive to be aware of them. It is important that they make a distinction between countertransferential reactions evoked mainly by clients and countertransferential reactions that rise primarily from their own attachment avoidance or anxiety. Therapists with higher attachment avoidance must be aware of their distancing strategies as they may find difficulties in connecting with clients emotionally. Likewise, therapists with higher attachment anxiety must be aware of their own worry of rejection and abandonment, used to minimise distance, as it can affect their working alliances negatively. Both these strategies can be counterproductive when perceiving and responding to clients’ actual needs with flexibility.

In this context, personal therapy and supervision can provide invaluable information to increase therapists’ awareness of their effective and less effective personal strategies for affect regulation, and their helpful and less helpful ways of relating to others. Therefore, personal therapy can help therapists not only to
understand how they exhibit those strategies in their personal relationships, but also in
the therapeutic relationship with their clients. Supervision can provide very useful
insights as supervisors can draw from attachment theory while understanding and
attending to their supervisees’ attachment dimensions. This can help supervisees
improve and use their therapeutic caregiving skills in developing and maintaining
better working alliances with their clients.

Regardless of their level of experience or expertise, therapists’ continuous
personal and professional development is vital for their learning, clinical practice and
personal growth. Their development can include further psychotherapeutic training,
personal/group supervision, and attendance at seminars and scientific conferences.
Additionally, by continuously studying recent research publications, useful insights
can be gained and implemented in their psychotherapeutic work which will strengthen
their therapeutic relationships with clients.

Conclusions

According to attachment theory, the relationship between the therapist and the
client is a non-reciprocal caregiving-attachment relationship, where the therapist
develops a caregiving-bond with the client and the client an attachment-bond with the
therapist (Fitch & Pistole, 2006). Although some authors suggested that the
caregiving system must be equally considered when exploring attachment
relationships, more researchers and theorists have primarily focused on understanding
the attachment system in the therapeutic relationship (Reizer & Mikulincer, 2007).
This study was an attempt to provide an inclusive understanding of those two systems
and how they affect the process of therapy from the perspective of therapists. Our
results support the idea that therapists’ attachment dimensions are activated in the
psychotherapeutic process and affect the working alliance through their therapeutic caregiving.

However, not only must all the previous interpretations be seen as tentative but it is also important to keep in mind that not all therapists with higher attachment avoidance or anxiety are deemed to have ineffective caregiving or weak working alliances with all their clients. These therapists may have the ability to hold an effective caregiving model with some clients but they may lack the motivation or intentional resources of being effective on a consistent basis with others. Therefore, it can be understood that the variation between the effectiveness of therapists' caregiving may also depend on clients' attachment dimensions or other factors that need to be explored. From the lenses of attachment theory, insecure attachment and also ineffective caregiving, are not fixed and can change in time either because of life experiences, therapy and/or supervision.

Despite the limitations of the present study, to our knowledge this is the first study to investigate possible mediators of the relationship between therapists' attachment dimensions and the working alliance. We found that attachment anxiety and avoidance affect therapists' caregiving and specifically their reports of how they perceive, respond and adapt to their clients' needs. For this reason therapists' attachment dimensions affect their reports of the quality of the ensuing working alliance. Although caregiving was found to be a significant mediator between therapists' attachment and working alliance, and helped us understand more about this relationship, it does not mean that additional variables cannot contribute to our understanding. Because of the consistency between these results and those from other studies, we conclude that our findings point out the importance of the role played by therapists' attachment-caregiving tendencies on the process of therapy.
[Reflections on the Use of Self]

[I find myself writing this reflection having mixed feelings; very tired but at the same time pleased and proud of this empirical work. The whole process seemed a very long journey; from the time spent designing the study and sending it to the Ethics Committee for approval, together with the data collection and statistical analysis to finally writing and discussing the results, I am pretty sure that this experience is something I will not forget. I feel that this piece of work has given me not only the opportunity to discover and understand my area of research in more depth but also the possible implications of the findings in my clinical work as counselling psychologist. The purpose of this research was to provide a better understanding for therapists, who work psychotherapeutically with clients, and of how our attachment and therapeutic caregiving can affect the working alliance. Now that I have finished this study, I am wondering how those findings can inform my clinical work. Also having in mind the limitations of the study, I am wondering how to design my next-year-study and attempt to find some answers to the questions that have arisen after finishing this piece of work. I believe that we will always have lots of questions on such topics but it feels that we must always strive to find possible answers, even if we know that not everything can be answered.

A big part of this study comes from questions that I had, and still have, about myself as a trainee counselling psychologist. After failing the first year viva I had to come to terms with a new experience, which was in many ways “unforgettable”. It was a really challenging period as I found myself trying to understand what went wrong. Through the year I have been trying to find ways to develop myself using personal therapy, supervision and other available resources. I believe that this piece of work has been an added aid in answering my questions. One of those questions was
how my attachment was influencing my work with clients and also how I could use all the available resources to develop further. I have to admit that this was not easy and there were frustrations and disappointments in learning that the process of personal and professional development is an ongoing process.

From my literature review, I came to realise that our attachment can affect the way we are working with clients. However, exploring how therapists’ attachment influences the working alliance was already something common in the literature and I felt that something was “missing”. In the existing literature different researchers used different methods to explore this topic and thus the results were implying that the actual relationship between therapists’ attachment and working alliance is more complex than at first thought. I questioned whether it is possible that our attachment can be activated in the room when the client is not an attachment object for us. Generally it is said that therapists’ attachment objects are usually their parents, partners, friends, therapists and supervisors. At the same time I was thinking that what we do and how we do it in the room is something that could affect the working alliance and also somehow relate to our attachment.

Reading very thoroughly the theory of attachment I found a term, which many authors accept and to which researchers and clinicians have not given the appropriate attention. This was the concept of caregiving which I hoped would back up my formulations. However, I had to adjust the theory of caregiving which is mainly associated with parenting and romantic relationships, to the psychotherapeutic process. Then I had to find the right tools to assess therapists’ caregiving and finally to put everything down and explore if therapists’ caregiving was something that could explain why therapists’ attachment affects the working alliance.
I discussed my thoughts with my supervisor and he suggested that I explore this relationship using a mediation analysis. I felt that this was an unknown path and was unsure how this could possibly help me find a solution. After exhaustingly reading many papers on mediation analysis, I discovered that this method was the most appropriate to test my hypotheses. As far as we knew, our study was going to be the first to explore possible causal links of the relationship between therapists’ attachment and working alliance. Therefore, I was doubtful, as once again I was faced with a similar issue to the previous year: no available studies on this topic and only some studies that explored the relationship of attachment and caregiving in parental and romantic relationships.

With the help of my supervisor we designed the present study and I was able to test my hypotheses. This also motivated me to contact experts in the field of attachment and get their advice and suggestions as concerns theoretical and methodological issues. Consequently, I was more clear in my mind about which measure I should use to assess therapists’ attachment and why. This process of searching and contacting other scientists in the field, led me to find the proper instrument to assess therapists’ caregiving and complete my study.

Once again, I believe that the whole process of completing this study was a valuable experience. Even though this study has limitations that must be taken into account, the results are still important. I am proud of this work as together with my supervisor, who was a continuous source of support and encouragement, I believe we have contributed to the attachment and psychotherapeutic literature.]
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11th February 2010

Dear Panagiotis,

Reference: 408-PSY-10
Title of Project: "The effects of therapist's attachment styles and care-giving behaviours on the working alliance"

Thank you for your submission of the above proposal.

I am pleased to advise that this proposal has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee provided that the following conditions are adhered to:

- The information sheet and consent form should appear as if they were on University headed paper.
- There is a lack of clarity in the information sheet concerning whether the study is anonymous or confidential. I assume that the study will be anonymous because the applicant will not know the names of the people to whom professional bodies, training institutes and universities forward details about the study. I would like the applicant to confirm this and, if so, amend the information sheet accordingly.
- Why is there no debrief sheet and what if the participants want to withdraw their data at a later date? Clarification is required.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Dr Adrian Coyle
Chair’s Action

Ref: 408-PSY-10
Name of Student: PANAGIOTIS PARTPOTTAS
Title of Project: “The effects of therapist’s attachment styles and care-giving behaviours on the working alliance”
Supervisor: Dr Ricardo Draghi-Lorenz
Date of submission: 22 January 2010
Date of re-submission:

The above Project has been submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: [Signature]
Dr Adrian Coyle
Chair

Dated: 11th Feb 2010
Dear Panagiotis

Thank you for confirming that you have addressed the conditions of ethical approval and you can now proceed with your study.

You may use the letter giving your proposal a favourable ethical opinion and attach your revised documentation as evidence that you have adhered to the conditions of ethical approval as stated therein.

Good luck with your project!

Kind regards

Julie Earl
Secretary and Administrator FAHS Ethics Committee
Appendix 2. Permission to use Counselor Caregiving Questionnaire
Hi Panagiotis,

Thank you for your interest in the Counselor Caregiving Questionnaire. You may definitely use the instrument in your dissertation, as it is closely aligned with my research interests and seems to fit into your topic area.

We have just begun classes here at my university, and I have some administrative items to do from over the break. Would it work for you if I were to send the materials to you tomorrow? I will send the instrument and the psychometric properties/data. In using the instrument, I ask that you provide us with your data so we can use it to review the validation and reliability of the instrument.

Best,

Jenelle

Jenelle C. Fitch, Ph.D.
Assistant Professor
Texas Woman's University
Department of Psychology & Philosophy
P.O. Box 425470
Denton, TX 76204-5470
940.898.2312 (office)
940.898.2301 (fax)

From: P.Parpottas@surrey.ac.uk
Sent: Wednesday, January 20, 2010 9:02 AM
To: Fitch, Jenelle
Subject: Information about The counselor caregiving questionnaire

Dear Dr Fitch,

my name is Panagiotis Parpottas and I am currently enrolled in the 2nd year of the Psych.D Psychotherapeutic & Counselling Psychology course of Surrey University in the UK. I am currently undertaking a quantitative study as part of my doctorate thesis with title "The effects of therapist's attachment dimensions and caregiving behaviours on the working alliance". Searching for questionnaires that measure the therapist's caregiving, I found the paper: "Fitch, J. C., & Pistole, M. C. (2006, August). The counselor caregiving questionnaire (CCQ): An exploratory pilot study. Poster presented at the annual meeting of the American Psychological Association, New Orleans, LA." and I was wondering if I could use the questionnaire in my study with your permission.

I would be grateful if you could send me the questionnaire, the scores and any relevant information that can be useful.

Should you want further information, feel free to contact my supervisor Dr Riccardo Draghi-Lorenz. His email is r.draghi-lorenz@surrey.ac.uk

Yours sincerely

Panagiotis Parpottas
Psych.D (cand.) Psychotherapeutic & Counselling Psychology
Department of Psychology
University of Surrey
Appendix 3. Information for participants, consent form, questionnaires and debriefing sheet
Information Sheet for participants

Dear participant,

This study aims to investigate the effects of therapists’ attachment and caregiving on the working alliance. This study involves only professionals who are working therapeutically with individual clients/patients (Psychiatrists, Clinical Psychologists, Counselling psychologists, Psychotherapists, Nurses, Social workers, Counsellors or others). If you are a therapist working in the NHS or a therapist working only with children, families, groups and patients diagnosed with a psychiatric mental condition (psychotic spectrum) you should not participate in this study.

Please notice that NO CLIENT/PATIENT is recruited in this study, though you are advised to think of one of your clients/patients when you will complete the working alliance inventory. NO information is required about the CLIENT/PATIENT.

Your participation is voluntary and anonymous. Your name will not appear anywhere as the required information in the demographics questionnaire require minimum information and does not ask any personal information that can reveal your identity. Also I will not ask or have any access to lists that could possibly include information about your name or other relevant information from the people in your institute/organization/university or association who were asked to forward you this information sheet. The data will be protected in the strictest confidence, and in accordance with the Data Protection Act (1998). Also in recognizing your answers, code numbers will be used instead of names and the results will be reported for the whole sample and not independently for each participant. Finally, you can withdraw your data whenever you want without penalties.

Once you tick that you have read this information and the consent form it means that you agree to participate in the study and you can continue with the survey. It is asked for you to complete 5 questionnaires and the whole process takes about 10 to 15 minutes. The first questionnaire includes general demographic data. The second questionnaire is about therapist’s attachment styles, the third questionnaire about the working alliance, and finally the fourth and fifth about the caregiving behaviours. More instructions about each questionnaire are included in the next section.

You can contact me for any enquiries by sending me an email: p.parpottas@surrey.ac.uk . You can also contact my supervisor: r.draghi-lorenz@surrey.ac.uk (Dr Riccardo Draghi-Lorenz, Director of Psych.D in Psychotherapeutic & Counselling Psychology, Department of Psychology, University of Surrey).

I would be very grateful for your support and time in participating.

Many thanks

Panagiotis Parpottas
Counselling Psychologist In Training
Psych.D (Cand.) Psychotherapeutic & Counselling Psychology
Department of Psychology
University of Surrey
Consent Form

- I voluntarily agree to take part in the study on “Effects of therapists’ attachment and therapeutic caregiving on the working alliance”

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose, location and likely duration of the study, and of what I will be expected to do.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

☐ Yes

☐ No
Demographics Questionnaire

Answer all questions by checking the following boxes or fill the spaces where appropriate

1) Gender:
   - [ ] Male
   - [x] Female

2) Age:

3) Ethnic Origin:
   - [ ] White – British
   - [ ] White – Irish
   - [x] Other White Background
   - [ ] Black or Black British – Caribbean
   - [ ] Black or Black British – African
   - [x] Other Black Background
   - [ ] Asian or Asian British – Indian
   - [ ] Asian or Asian British – Pakistani
   - [ ] Information Refused
   - [ ] Other Asian or Asian British Background
   - [x] Chinese
   - [x] Mixed – White & Black Caribbean
   - [ ] Mixed – White & Black African
   - [ ] Mixed – White & Asian
   - [ ] Other Mixed Background
   - [ ] Other Ethnic Background
   - [ ] Not Known

4) Therapeutic orientation:
   - [ ] Psychoanalytic/Psyodynamic
   - [ ] CBT
   - [ ] Behavioural
   - [ ] Systemic
   - [ ] Humanistic
   - [ ] Integrative
   - [ ] Other

5) Qualification-specialty

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<td>[ ]</td>
<td>[x]</td>
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<tr>
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<tr>
<td>Nurse</td>
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(Please be sure that you also check the answer No if it's not representative of your Qualification)

If you have not recognized any of the above qualifications-specialties please clarify any others: ...........
Do you have any further training in psychotherapy?
- Yes
- No

Trainees: Your year of training:
- 1
- 2
- 3
- 4
- 5+

6) Years of experience since qualification: .......... 

7) Are you engaged in personal therapy (or sometime in the past)?
- Yes
- No

8) Is your clinical/psychotherapeutic practice supervised?
- Yes
- No

9) Are you working in short term or long term with this client/patient?
- Short term
- Long term
Experiences in Close Relationships Scale

The following statements concern how you generally feel in close relationships. Respond to each statement by indicating how much you agree or disagree with it. There are no right or wrong answers. Work quickly your first impressions are the ones we would like to see:

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<td>1</td>
<td>Disagree strongly</td>
<td>2</td>
<td>Neutral/mixed</td>
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1. I prefer not to show others how I feel deep down.
2. I worry about being rejected or abandoned.
3. I am very comfortable being close to other people.
4. I worry a lot about my relationships.
5. Just when someone starts to get close to me I find myself pulling away.
6. I worry that others won’t care about me as much as I care about them.
7. I get uncomfortable when someone wants to be very close to me.
8. I worry a fair amount about losing close others.
9. I don’t feel comfortable opening up to others.
10. I often wish that close others’ feelings for me were as strong as my feelings for them.
11. I want to get close to others, but I keep pulling back.
12. I want to get very close to others, and this sometimes scares them away.
13. I am nervous when another person gets too close to me.
15. I feel comfortable sharing my private thoughts and feelings with others.
16. My desire to be very close sometimes scares people away.
17. I try to avoid getting too close to others.
18. I need a lot of reassurance that close others really care about me.
19. I find it relatively easy to get close to others.
20. Sometimes I feel that I try to force others to show more feeling, more commitment to our relationship than they otherwise would.
21. I find it difficult to allow myself to depend on close others.
22. I do not often worry about being abandoned.
23. I prefer not to be too close to others.
24. If I can’t get close others to show interest in me, I get upset or angry.
25. I tell my close others just about everything.
26. I find that close others don’t want to get as close as I would like.
27. I usually discuss my problems and concerns with close others.
28. When I don’t have close others around, I feel somewhat anxious and insecure.
29. I feel comfortable depending on others.
30. I get frustrated when close others are not around as much as I would like.
31. I don’t mind asking close others for comfort, advice, or help.
32. I get frustrated if close others are not available when I need them.
33. It helps to turn to close others in times of need.
34. When other people disapprove of me, I feel really bad about myself.
35. I turn to close others for many things, including comfort and reassurance.
36. I resent it when my close others spend time away from me.
Instructions:
These are sentences that describe some of the different ways you might think or feel about your client. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

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

1. My client and I agree about the steps to be taken to improve his situation.

2. My client and I both feel confident about the usefulness of our current activity in counselling.

3. I believe my client likes me.

4. I have doubts about what we are trying to accomplish in counselling.

5. I am confident in my ability to help my client.

6. We are working towards mutually agreed upon goals.

7. I appreciate my client as a person.

8. We agree on what is important for my client to work on.

9. My client and I have built a mutual trust.

10. My client and I have different ideas on what his real problems are.

11. We have established a good understanding between us of the kind of changes that would be good for my client.

12. My client believes the way we are working with her problem is correct.
Counselor Caregiving Questionnaire

Think about your clients, past or present. Think about the people, your relationship with them, the setting, the therapeutic issues, your successes, your failures; also recall the most memorable clients, those who were most difficult for you, those with whom you were most confident. Then answer the items below with your most general response.

Rate the extent to which you agree or disagree with the following statements. There are no right or wrong answers; just do the best that you can.

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1. I usually know when the client needs my assistance.
2. I concentrate on being there for my client.
3. Leaning forward can respond to the client’s need for support or reassurance.
4. One of the worst things a therapist can do is to be distant with a client.
5. It’s important to facilitate the client’s comfort with appropriate closeness both in and outside of therapy.
6. When a client is clearly upset, I try to be closer or more distant, depending on the particular client.
7. My interventions are designed to respond to the legitimate closeness and security needs of the client.
8. It is easy for me to be in tune with the client’s feelings about closeness.
9. When being more distant or close than usual, I monitor the client’s reactions closely.
10. I sometimes do not provide my clients with enough emotional support.
11. The therapist should try to be available to the client’s closeness and security needs.
12. It’s important for me to recognize when a client wants more closeness or distance.
13. I am not very good at “tuning in” to my client’s feelings about closeness or distance.
14. It is essential to remain psychologically present when clients talk about separation.
15. I modify interventions according to whether clients can perceive me as trustworthy.
16. I can always tell when my client needs comforting, even if he or she doesn’t ask for it.
17. I sometimes misread or miss my client’s signals for help and support.
18. It is important for clients to know that I am there when they need me.
19. It is important that each client feels that we are working together, even when I have to adapt my style.
20. I am reliable and responsive to clients exploring their own world.
21. I prefer that my interventions convey that I understand the client’s needs and issues.
22. I believe my clients would say that I can be relied on.
23. I recognize that some clients feel close to me, even though they act distant.
24. My clients can rely on my providing guidance when they want it.
25. I can handle alliance ruptures fairly easily.
Many thanks for your time and co-operation.

The main objective of the study in which you just participated was to investigate the effects of therapist's attachment styles and caregiving behaviours on the process of therapy. The rationale of doing this study is to explore what mediates the relationship between therapist's attachment styles and working alliance. Also this study can be an opportunity to address issues related with the therapists' training and to promote an awareness of understanding important issues about the process of therapy drawing from attachment theory.

It is the purpose of this study to explore if the variable of therapists' caregiving behaviours can mediate the relationship between therapists attachment styles and working alliance. In this way, it is hoped that our hypothesis that the caregiving behaviours can mediate this relationship will be rigorously tested.

Your contribution to this study is therefore very valuable and very much appreciated. Without you, our research would be impossible. Your responses will be used to help answer our questions. These are questions that have plagued the psychotherapeutic research related with attachment theory for a long time now and more specifically research that look the therapists' attachment styles.

If, for whatever reason, you later decide that you no longer want your responses to be part of this study, then please contact me to have your data removed from the study and destroyed. As a final point, all data collected in this study will be analysed in an aggregated form and your responses will not be singled out thus only averaged results will be reported in any future publications.

If you would like more information, or have any further questions about any aspect of this study, then please feel free to contact Panagiotis Parpottas.

Email: p.parpottas@surrey.ac.uk
pparpottas@hotmail.com

Address: University of Surrey
Department of Psychology
Guildford
Surrey
GU2 7XH
Appendix 4. Journal of Attachment & Human Development. Instructions for authors
Instructions for Authors

Papers will be considered providing that they have not previously been published or submitted simultaneously elsewhere for publication.

**EMPIRICAL REPORTS**

1) The paper should conform to APA standards, with a legible abstract (100-150 words), followed by sections that include an introduction, method, results, and discussion.

**THEORY/REVIEW PAPERS**

2) The paper should make an original, testable and/or useful extension/revision to theory and previous literature concerning attachment processes and human development.

**CLINICAL CASE-STUDIES**

3) Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

**ALL SUBMISSIONS**

should include an abstract, and ordinarily be about 6,000 words in length, not exceeding 7500 words in total, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.
E-mail submissions to the Editor are preferred; please send an electronic copy of your manuscript to steeleh@newschool.edu.

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Appendix 5. Details of the use of computer-based literature search facilities
Most of the articles that I have used in the present study were used in the last year's literature review and downloaded from the EBSCOhost page of the Surrey University library. However, I run again a new search for more recent articles on the influence of therapist's attachment on the process of therapy but also to find articles about therapists' caregiving. I chose the PsychINFO online database, typing the words:

- The influence of therapist's attachment on process of therapy
- The influence of therapist's attachment styles on therapeutic relationship
- The influence of therapist's attachment styles on the working alliance
- Therapist's caregiving behaviours
- Therapist's caregiving and working alliance

After finding some articles about caregiving, I contacted Dr Fitch from the Purdue University in USA as I was interested to use her questionnaire “Counselor's Caregiving Questionnaire”. I also contacted Dr Chris Fraley from the University of Illinois to ask his opinion about the ECR scoring and how to compute the attachment styles. Finally, I contacted Dr Andrew Hayes from the Ohio State University for some guidance about the bootstrapping method in conducting mediation analysis.
Exploring the attachment-caregiving therapeutic relationship: How therapists-clients attachment dimensions and therapists’ caregiving influence the working alliance

Panagiotis Parpottas

Psych. D in Psychotherapeutic & Counselling Psychology, University of Surrey, Guildford, UK

(June 2011)
Abstract

This study examined the effects of therapists’ attachment dimensions on the working alliance by investigating whether clients’ attachment dimensions moderate, and therapists’ caregiving, mediate this relationship. One hundred and twenty-seven therapists from the private sector in the United Kingdom, completed self-report measures of their adult attachment dimensions, their assessment and evaluation of a client’s attachment dimensions, and their specific therapeutic caregiving and total working alliance with that client. Results indicated that both therapists’ attachment dimensions (i.e., higher avoidance and higher anxiety) were significant negative predictors of the working alliance and also this relationship was moderated by clients’ attachment dimensions and mediated by therapists’ caregiving. Overall, our results suggested that under specific conditions, when therapists were matched with clients who had similar attachment dimensions to their own, they reported less effective therapeutic caregiving which then affected the working alliance negatively. On the other hand, when therapists were matched with clients who had dissimilar attachment dimensions to their own, they reported an effective therapeutic caregiving which then affected the working alliance positively. Results are discussed in light of attachment theory and implications for future research and psychotherapeutic practice are considered.

Keywords: therapists’ and clients’ attachment dimensions; therapeutic caregiving; working alliance; moderation; mediation; psychotherapeutic practice.
Introduction

It is generally accepted that clients’ and therapists’ personality characteristics and interpersonal styles can influence the process of therapy (Bernier & Dozier, 2002). From an attachment theory perspective, a growing body of empirical research has provided some support to the previous notion, with researchers investigating the effects of adult attachment patterns on psychotherapy process (Daniel, 2006). However, the majority of these studies have focused on the effects of clients’ attachment patterns on the process of therapy while fewer studies looked at the relationship between therapists’ attachment and the therapy process (Mohr, Gelso, & Hill, 2005). Therefore, the current study builds upon previous research to explore how therapists’ attachment dimensions influence the working alliance. In particular, to understand more about the possible causal links of the relationship between therapists’ attachment dimensions and the working alliance, the clients’ attachment dimensions and therapists’ caregiving will be examined as to whether they moderate and/or mediate this relationship.

As already mentioned, the majority of empirical studies in the literature have focused on how clients’ attachment patterns affect the therapeutic relationship. These studies showed that securely attached clients tend to report stronger working alliances with their therapists than insecurely attached clients, and also that clients’ attachment insecurity is a negative predictor of the alliance (Dolan, Arnkoff, & Glass, 1993; Eames & Roth, 2000; Goldman & Anderson, 2007; Justitz, 2002; Kalogerakos, 2009; Kivligham, Patton, & Foote, 1998; Parish & Eagle, 2003; Mallinckrodt, Coble, & Grant, 1995; Meier, Donmall, Barrowclough, McEdluff, & Heller, 2005; Reis & Grenyer, 2004; Satterfield & Lyddon, 1998; Skourteli & Lennie, 2011; Storer, 2010). On the other hand, a few studies provided us with entirely different results which
contradict previous findings. For example, some studies found that clients' insecure attachment (i.e., preoccupied, dismissive and fearful styles) predicted the working alliance positively (Bair, 2008; Eames & Roth, 2000). Unlike all the above studies, some studies have failed to find any significant relationship between clients' attachment and working alliance (Hardy, Stiles, Barckham, & Startup, 1998; Britton, 2006; Frehling, 2005; Sauer, Lopez, & Gormley, 2003).

From this brief overview, the studies investigating the effects of clients' attachment on the process of therapy point to the overall conclusion that attachment security, with few exceptions, is a good predictor of the working alliance. Similarly, it was reasonably hypothesised that therapists' attachment security would positively predict the therapeutic alliance. This assertion was actually confirmed with findings indicating that securely attached therapists report stronger working alliances with their clients than insecurely attached therapists (Black, Hardy, Turpin, & Parry, 2005; Bruck, Winston, Aderhold, & Muran, 2006; Dozier, Cue, & Barnett, 1994; Dunkle & Friedlander, 1996; Mohr et al., 2005; Sack, 1996; Tyrrell, Dozier, Teague, & Fallot, 1999. Nevertheless, some studies, unexpectedly, did not find any significant relationship between therapists' attachment styles and the process of therapy (Britton, 2006; Ligiero & Gelso, 2002) or found that anxiously attached trainee therapists had good working alliances with their clients (Sauer, 2000; Sauer et al., 2003). The later findings must not be misinterpreted or disregarded, especially after similar findings have been found in studies exploring the relationship between clients' attachment and the process of therapy. Arguably, this may lead to a hypothesis that the relationship between therapists' attachment and the working alliance may be much more complex than we think.
Due to the gap which was created in the literature, some attachment scholars and researchers have attempted to understand the complex effects of therapists' attachment on the therapeutic relationship, adopting a relatively new theoretical approach that of the therapeutic caregiving. They conceptualised the therapeutic relationship as a non-reciprocal attachment-caregiving relationship, where the client develops an attachment bond to the therapist and the therapist in return, develops a caregiving bond with the client (Fitch & Pistole, 2006, 2010). In particular, when the client turns to their therapist in moments of heightened distress, aiming to elicit care and comfort, the therapist acts as an attachment figure for the client and hence the therapist’s caregiving system might then be activated in response to the client’s attachment signals. Therefore, it was proposed that when exploring the effects of therapists’ attachment on the therapeutic relationship, the therapists’ caregiving towards clients must also be taken into consideration.

Even though attachment scholars frequently referred to the concept of the “therapeutic” caregiving (see in Bowlby, 1989; Cassidy & Shaver, 2008), it is only recently that researchers have devoted the appropriate attention to empirically investigate its function and association with therapists’ attachment dimensions and the working alliance. Findings from the first ever study to investigate the relationship between therapists’ attachment dimensions, therapists’ caregiving and the working alliance, showed initially that therapists’ attachment dimensions predicted their therapeutic caregiving and then that the therapeutic caregiving mediated the relationship between therapists’ attachment dimensions and the working alliance (Parpottas, 2010). More specifically, it was found that therapists with higher attachment anxiety or avoidance reported less effective therapeutic caregiving.
behaviours towards clients (i.e., less able in perceiving, responding and adapting to their clients’ needs) which then affected negatively the working alliance.

The findings from the above study suggested that there is an indirect relationship between therapists’ attachment dimensions and working alliance, and that therapists’ caregiving can explain this relationship. However, we were left with many unanswered questions such as: is the therapeutic caregiving influenced only by therapists’ attachment dimensions or also by clients’ attachment dimensions? Is it possible that therapists can have less effective caregiving with some clients but more effective with others? If therapists’ caregiving is differently activated for clients with different attachment dimensions, is it also possible to affect the working alliance differently? Therefore, these are some questions we will attempt to answer in the current study.

Unfortunately, none of the existing studies in the literature have previously explored any of these specific questions. Nevertheless, three studies explored the interaction effects of therapists’ and clients’ attachment on the working alliance and perhaps their findings can help us form some hypotheses in our attempt to answer our questions. For example, Dozier et al. (1994) found that when compared to insecurely attached case managers, securely attached case managers intervened more effectively with preoccupied and dismissively attached clients. This suggests that dissimilarity in attachment security between case managers and clients may associate with different effectiveness in case managers’ interventions. Interestingly, Tyrrell et al. (1999) found that when preoccupied case managers were matched with dismissive clients (and vice versa) had better working alliances, rather than when preoccupied case managers were matched with preoccupied clients (or dismissive case managers with dismissive clients). Their findings suggest that perhaps dissimilarity, rather than
similarity, in insecurely attached therapeutic dyads could predict better working alliances. This assertion was confirmed in the study of Borsanyi (2001) where it was found that similarity between therapists' and clients' insecure attachment styles, and particularly when both were avoidant, was indeed associated with weaker working alliances.

From these three studies, it can be argued that the unique combination of clients' and therapists' attachment organisation can affect the working alliance differently. In addition, it can be hypothesised that therapists' caregiving can explain these effects. Therefore, the current study will attempt to answer questions that have been raised before by exploring if clients' attachment dimensions moderate the relationship between therapists' attachment dimensions and working alliance and finally if therapists' caregiving mediates this relationship (Figure 1).

![Figure 1. The proposed conceptual mediated moderation model](image)

Based on previous studies, we developed the following hypotheses:

**Hypothesis 1**: Therapists' attachment dimensions will predict the working alliance, with higher attachment anxiety and avoidance predicting significantly weaker working alliances.
Hypothesis 2: Therapists’ caregiving will mediate the relationship between therapists’ attachment dimensions and the working alliance.

Hypothesis 3: Clients’ attachment dimensions will moderate the relationship between therapists’ attachment dimensions and the working alliance. More specifically, we hypothesised that: (a) the interaction between therapists’ and clients’ attachment anxiety will predict a weak working alliance; (b) the interaction between therapists’ and clients’ attachment avoidance will predict a weak working alliance; (c) the interaction between therapists’ attachment anxiety and clients’ attachment avoidance will predict a strong working alliance, and (d) the interaction between therapists’ attachment avoidance and clients’ attachment anxiety will predict a strong working alliance.

Hypothesis 4: The interaction effects of therapists’ and clients’ attachment dimensions on the working alliance will be mediated by the therapists’ caregiving. In particular, the interaction effects of therapists and clients with similar attachment dimensions on the working alliance will be mediated by less effective therapeutic caregiving, while the interaction effects of therapists-clients with dissimilar attachment dimensions on the working alliance will be mediated by an effective therapeutic caregiving.

Method

Participants

Overall 127 therapists working individually with adults were recruited from the private sector in the United Kingdom (i.e., therapists in private practice and therapists working in private organisations such as university counselling centres and private counselling services). Of the 127 participants, 33 were men (26%) and 94 women (74%), with a mean age 42.87 (SD = 13.9; age range: 25–69 years).
Therapists’ ethnicity was as follows: 69 white-British (54.3%), three Asian-British (2.4%), 51 from “other” white background (40.2%), two from “other” Asian background (1.6%) and two from another ethnic background (1.6%).

Eleven participants (8.7%) identified themselves as qualified counselling psychologists and 44 as trainee counselling psychologists (34.6%); two as qualified counsellors (1.6%) and three as trainee counsellors (2.4%); 51 as qualified psychotherapists (40.2%) and 10 as trainee psychotherapists (7.9%); one as qualified social worker practicing psychotherapy (0.8%); one as psychiatrist practicing psychotherapy (0.8%) and four as “other” therapists (3.1%). The therapeutic orientations of the sample were: 32 integrative (25.2%); seven humanistic (5.5%); 20 psychoanalytic/psychodynamic (15.7%); eight CBT (6.3%), four systemic (7.1%), 12 existential (9.4%) and 39 therapists (30.7%) reported using “other” therapeutic approaches (i.e., neurolinguistic psychotherapy, experiential constructivist, psychosynthesis, transactional analysis, transpersonal psychotherapy and gestalt). The vast majority of participants (98.4%) were working under supervision, 124 had been in personal therapy themselves (97.6%) and 71 were still in personal therapy (55.9%).

Thirty-eight of the clients therapists chose to think about were men (29.9%) and 89 women (70.1%) with a mean age of 40.6 (SD = 13.26; age range: 18–79). Clients’ ethnicity was as follows: 104 white-British (81.9%), three Asian-British (2.4%), one black-British (0.8%), two from “other” British background (1.6%) 13 from “other” white background (10.2%), three from another ethnic background (2.4%) and one from a “not known” ethnic background (0.8%). Sixty-three clients (49.6%) had a formal psychiatric diagnosis (i.e., BPD 11%, Psychosis 4.7%, Depression 16.5%, Bipolar 3.9%, OCD 3.9%, Social anxiety 1.6%, General anxiety 1.6%, Anorexia 1.6%, Agoraphobia 1.6%, ADHD 0.8%, Alcohol dependence 0.8%,
PTSD 0.8% and Depression together with anxiety 3.1%) whereas 59 clients (46.5%) did not have a specific diagnosis; for five (3.9%) clients it was unknown if they had a diagnosis. Finally, 35 therapists (27.6%) reported working short-term and 92 (72.4%) long-term with their clients and at the time of study 16 dyads (12.6%) were at the early stage of therapy, 74 (58.3%) at mid-stage and 37 (29.1%) at the last stage of therapy.

Procedure

After being granted a favourable ethical opinion by the University of Surrey Ethics Committee, recruiting emails were sent to UK universities, training institutes, professional bodies, associations, societies and councils, describing the aims of the study and asking them to post the research advert onto their websites and also to forward an information sheet to their members. Participation was voluntary and anonymous and only therapists working in private practice and private organisations participated in this study. Therapists working in the NHS or only with children or groups were excluded from this study, firstly because we did not pursue an NHS REC approval and secondly because we wanted to investigate adult attachment dimensions in individual therapy as the attachment dynamics between therapists and child-clients or groups may be different. Therapists who were interested to participate could access the survey following the instructions on the information sheet. No client was recruited for this study and therapists were instructed to complete the TECAD, CCQ and WAI with a specific client in mind, one with whom they have worked for more than three sessions. The criterion of three sessions was chosen because previous research indicates that the working alliance is usually already established by the third session (Ligiero & Gelso, 2002). Data were collected through a secure online platform, which
was created for the purpose of this study by the University of Surrey, were preserved in accordance with the Data Protection Act (1998) and then erased a year after its extraction.

**Measures**

*Demographics questionnaire:* This questionnaire consists of nine questions asking about therapists' gender, age, ethnic origin, specialty, therapeutic orientation, total years of training and total years of experience after completion of training, if therapists had been in the past or were at the time of the study on personal therapy and finally if their clinical work with the specific client they have chosen to think about was supervised. In addition, seven questions were asking about the clients' gender, age, ethnic origin, contracted duration of therapy, current stage of therapy and existence of diagnosis.

*Therapists' attachment dimensions:* Experiences in Close Relationships (ECR; Brennan, Clark, & Shaver, 1998). This is a 36-item self-report measure of adult attachment. According to Fraley, Waller, and Brennan (2000), ECR benefits from better psychometric properties than other commonly used adult attachment self-report measures. The ECR is designed to assess two continuous dimensions of adult attachment: *Avoidance* (e.g., “I prefer not to be too close to others”) and *Anxiety* (e.g., “I worry about being rejected or abandoned”). Items are scored on a 7-point Likert scale (1 = disagree strongly, 4 = neutral/mixed, 7 = agree strongly) and higher scores indicate greater attachment avoidance or anxiety, respectively. Brennan et al. (1998) reported good internal consistency for the ECR with Cronbach's alpha .91 for anxiety and .94 for avoidance. Cronbach's alpha in the present study was .91 for anxiety .89 for avoidance.
Working alliance: Working alliance Inventory Short form (WAI-S; Tracey & Kokotovic, 1989). This is a 12-item questionnaire, which measures Bordin’s (1979) integrative model of alliance and is used to assess both therapists’ and clients’ perceptions of the strength of the total working alliance. The WAI-S contains the same three subscales as the longer one (Hovarth & Greenberg, 1989): agreement on tasks (e.g., “We agree on what is important for my client to work”), development of bond (e.g., “My client and I have built a mutual trust”) and agreement on goals (e.g., “We are working towards mutually agreed upon goals”). Each item is rated on a 7-point Likert scale (1 = never to 7 = always). In the present study only therapists completed the WAI-S and also only the total score was used. Tracey and Kokotovic (1989) reported good internal consistency for WAI-S total working alliance with Cronbach’s alpha .95. In the present study the Cronbach’s alpha was .92 for the total alliance.

Therapeutic caregiving: Counselor Caregiving Questionnaire (CCQ; Fitch & Pistole, 2010). The CCQ is used to assess therapists’ general caregiving. For the purpose of this study, we slightly modified the questions to assess therapists’ specific caregiving. We changed words that were referring to how therapists generally feel, think and behave with all their clients to how they are with the specific client they had in mind. The CCQ consists of 25 items rated on a 7-point Likert scale (1 = strongly disagree to 7 = strongly agree) that relate to one factor/scale the total caregiving and to three subfactors/subscales: Sensitivity (e.g., “It is easy for me to be in tune with my client’s feelings about closeness”), Responsiveness (e.g., “I am reliable and responsive in my client exploring his/her own world”) and Flexibility (e.g., “It’s important for me to recognize when my client wants more closeness or distance”). In the present study only the total caregiving score was used. Fitch and Pistole (2010) reported good
internal consistency for CCQ with Cronbach's alpha .85 for total caregiving. Cronbach's alpha in the present study was .81 for total caregiving.

 Clients' attachment dimensions: Therapist's Evaluation of Client’s Attachment Dimensions (TECAD; Parpottas, 2011). This questionnaire was created for the purpose of this study and is based on items deriving from the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) and two self-report measures of adult attachment such as: the ECR (Brennan et al., 1998) and the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991). The TECAD is a 17-item questionnaire designed to allow therapists assess and evaluate their clients’ attachment dimensions. Items are scored on a 7-point Likert scale (1 = not at all like my client, 4 = somewhat like my client, 7 = very much like my client) with higher scores indicating greater attachment avoidance or anxiety, respectively. A factor analysis revealed two continuous dimensions to assess attachment avoidance (e.g., “My client tends to keep relationships at a distance as s/he feels discomfort with intimacy”) and attachment anxiety (e.g., “My client wants to be completely emotionally intimate with others”). There are no previous psychometric properties for TECAD as it was piloted during this study. However, after conducting a reliability analysis the internal consistency of this questionnaire was good with Cronbach’s alpha .82 for attachment anxiety and .83 for attachment avoidance.

Data Analysis

Initially, a Principal Components Analysis (PCA) was conducted for the TECAD. After that, we conducted preliminary analyses firstly to examine the distribution of our data (normality is met when skewness divided by the standard error of skewness gives a value smaller than the critical value 1.96) and secondly to
investigate if any of therapists’ and clients’ demographic variables had an effect on
the dependent variable (working alliance) in order to partial them out from our
primary analyses to reduce the error term (Dancey & Reidy, 2004).

Primary analyses included correlation, regression, mediation and moderation
analyses. Pearson correlation coefficients were calculated to explore the association of
therapists’ attachment dimensions with therapeutic caregiving and the working
alliance and a regression analysis was then conducted to investigate if therapists’
attachment dimensions predicted the working alliance (hypothesis 1). To test the
indirect effect of the relationship between therapists’ attachment dimensions and
working alliance, a mediation analysis was then conducted (hypothesis 2). We
followed the recent recommendations in testing mediation effects using the
Bootstrapping re-sampling method (Preacher & Hayes, 2004). This particular method
of conducting a mediation analysis does not requires the normality assumption to be
met, and is recommended for sample sizes that are not considered to be large or very
large (N<200 or N<500). Bootstrapping is a method that repeats sampling from the
same data set thousands of times, and from the re-sampled data set calculates the
confidence intervals of the indirect effect which are then sorted from low to high
(Preacher & Hayes, 2004). If the value of zero does not fall within the 95%
confidence intervals then the indirect effect is considered significantly different from
zero at a value of \( p < .05 \), indicating the existence of mediation.

To examine possible moderation effects of clients’ attachment dimensions on
the relationship between therapists’ attachment dimensions and the working alliance
(hypothesis 3), a moderated hierarchical regression analysis was used (Jaccard,
Turrisi, & Wan, 1990). In this analysis, to eliminate multicollinearity problems the
predictor and moderator variables are centred prior to analyses and an interaction term
is then created by multiplying the two centred variables. Subsequently, the two
variables are entered in the first block of a hierarchical regression and their interaction
term is then entered in the second block. Two conditions must be met for the
existence of moderation effects: firstly to observe a significant increase in $R^2$ and
secondly the interaction term to significantly predict the dependent variable.

Finally, we explored the indirect effects of the relationship between the
interaction effects of therapists’ and clients’ attachment dimensions on the working
alliance, with therapists’ caregiving as a potential mediator (hypothesis 4). Based on
the paper of Preacher, Rucker, and Hayes (2007), this could be termed mediated
moderation analysis and the Bootstrapping re-sampling method is recommended to
test such effects.

Results

Factor analysis

To measure the clients’ attachment dimensions from the therapists’
perspective the TECAD was created. The first phase of the TECAD’s development
included reviewing the relevant literature on clients’ attachment patterns. After
looking at some items from the ECR, the RQ and the AAI, the first draft of TECAD
was created. In the second phase, the initial questionnaire was sent to three academics
and qualified psychologists, colleagues of the author, to review the items and check
for clarity, biases and other possible problems. The feedback and related suggestions
were received and considered (minor changes in wording of instructions and some
items) and then the final version of TECAD was created.

The 17 items of TECAD were subjected to PCA using SPSS version 18. Prior
to performing PCA, the suitability of data for factor analysis was assessed. Inspection
of the correlation matrix revealed that the majority of coefficients had a value of .3 and above, but not greater than .9 so as to cause problems of singularity in the data. In addition, the Kaiser-Meyer-Oklin value was .738, exceeding the recommended value of .6 (Pallant, 2007), and the Bartlett's test of Sphericity reached statistical significance ($p < .001$), supporting the factorability of the correlation matrix. Finally, the PCA revealed the presence of two components/factors explaining a total of 46.01% of the variance, with component 1 contributing 25.89% and component 2 contributing 20.12%. After a varimax rotation, all loadings in the two factors were in the range of .5 and above, except of one (see Table 1), which indicates as Field (2005) suggested that they were "good enough" for a sample between 100-200 participants.
Table 1. Therapist Evaluation of Clients’ Attachment Dimensions (TECAD) and subscales’ factor loadings and communalities

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item text</th>
<th>Factor loading</th>
<th>Communalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>My client tends to deny difficulties in relationships or minimizes those difficulties because talking about them can bring up difficult or painful feelings</td>
<td>.730</td>
<td>.535</td>
</tr>
<tr>
<td>14</td>
<td>Sometimes my client gives me the impression that s/he is reluctant to talk about ‘threatening’ feelings</td>
<td>.722</td>
<td>.560</td>
</tr>
<tr>
<td>18</td>
<td>My client finds it difficult to be reflective of her/his emotional experience and her/his main strategy of coping with distress is minimization of affect</td>
<td>.708</td>
<td>.505</td>
</tr>
<tr>
<td>12</td>
<td>My client often tries to block negative emotions and thoughts by inhibiting or masking both verbal and non verbal expressions</td>
<td>.680</td>
<td>.514</td>
</tr>
<tr>
<td>6</td>
<td>My client prefers to rely mainly on her/himself as it is very important to her/him to be independent and self-sufficient</td>
<td>.663</td>
<td>.509</td>
</tr>
<tr>
<td>1</td>
<td>My client wants to be completely emotionally intimate with others</td>
<td>-.613</td>
<td>.597</td>
</tr>
<tr>
<td>8</td>
<td>My client tends to keep relationships at a distance as s/he feels discomfort with intimacy</td>
<td>.603</td>
<td>.371</td>
</tr>
<tr>
<td>16</td>
<td>When my client talks about feelings of hurt, distress, loss, needing or dependence on others s/he often talks abstractly</td>
<td>.560</td>
<td>.314</td>
</tr>
<tr>
<td>4</td>
<td>My client prefers not to depend on others or have others depend on her/him</td>
<td>.534</td>
<td>.306</td>
</tr>
</tbody>
</table>

**Factor 1: Attachment Avoidance (9 items)**

<table>
<thead>
<tr>
<th>Item no.</th>
<th>Item text</th>
<th>Factor loading</th>
<th>Communalities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>My client wants to be completely emotionally intimate with others</td>
<td>.470</td>
<td>.597</td>
</tr>
<tr>
<td>13</td>
<td>My client is pessimistic about his/her ability to manage distress as s/he underestimates her/his own strengths s/he often needs others to help or ‘rescue’ her/him</td>
<td>.792</td>
<td>.630</td>
</tr>
<tr>
<td>17</td>
<td>My client finds it difficult to be reflective of her/his emotional experience and her/his main strategy of coping with distress is maximization of affect</td>
<td>.751</td>
<td>.600</td>
</tr>
<tr>
<td>11</td>
<td>My client presents as vulnerable to pain and s/he is often prone to signaling or expressing her/his distress in an exaggerated manner</td>
<td>.729</td>
<td>.537</td>
</tr>
<tr>
<td>9</td>
<td>My client often talks about themes of neglect, rejection and abandonment</td>
<td>.637</td>
<td>.419</td>
</tr>
<tr>
<td>5</td>
<td>My client worries a lot that others don’t value or care about her/him as much as s/he does</td>
<td>.631</td>
<td>.443</td>
</tr>
<tr>
<td>15</td>
<td>My client often shifts attention toward internal indicators of distress and tends to emphasize on her/his sense of helplessness and vulnerability</td>
<td>.573</td>
<td>.366</td>
</tr>
<tr>
<td>3</td>
<td>My client is preoccupied about others’ availability and responsiveness</td>
<td>.541</td>
<td>.335</td>
</tr>
<tr>
<td>7</td>
<td>My client feels uncomfortable being without close relationships</td>
<td>.517</td>
<td>.300</td>
</tr>
</tbody>
</table>

**Factor 2: Attachment Anxiety (9 items)**

Note. N=127; *Item should be reversed keyedi

**Preliminary investigations**

After examining the distribution of our data, we conducted exploratory analyses to investigate if any of therapists’ and clients’ demographic variables had an effect on the dependent variable (working alliance). From all the demographic...
variables for both therapists and clients, only therapists’ gender had an effect on the working alliance. An independent-sample t-test showed a significant difference between therapists’ gender, where women had significantly higher scores on the working alliance than men (Table 2). Therefore, the variable of therapists’ gender was partialed out from primary analyses.

Table 2. Differences between therapists’ gender and working alliance

<table>
<thead>
<tr>
<th>Variable</th>
<th>Women</th>
<th>Men</th>
<th>F</th>
<th>p</th>
<th>t(df=125)</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Working alliance</td>
<td>5.28</td>
<td>0.87</td>
<td>4.78</td>
<td>0.94</td>
<td>0.923</td>
<td>-2.759**</td>
</tr>
</tbody>
</table>

Note. N=127; *p<.05; Cohen’s d = effect size

Primary analyses

Correlations: Pearson correlation coefficients indicated that the working alliance and therapeutic caregiving significantly and negatively correlated with therapists’ attachment anxiety and avoidance (Table 3).

Table 3. Summary of correlations, Means, and Standard Deviations of therapists’ attachment dimensions, working alliance and therapeutic caregiving

<table>
<thead>
<tr>
<th>Variables</th>
<th>M</th>
<th>SD</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. T.Av</td>
<td>2.86</td>
<td>0.87</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. T.Anx</td>
<td>2.94</td>
<td>0.94</td>
<td>.232**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. WAI</td>
<td>5.15</td>
<td>0.91</td>
<td>-.229**</td>
<td>-.322**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Caregiving</td>
<td>128.39</td>
<td>13.94</td>
<td>-.278**</td>
<td>-.271**</td>
<td>.594**</td>
<td></td>
</tr>
</tbody>
</table>

Note. *Controlling for therapists’ gender; T.Av = Therapists’ attachment avoidance; T.Anx = Therapists’ attachment anxiety; WAI = Working alliance.
*Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed)
Regression analyses: Both therapists' attachment dimensions were found to significantly predict the working alliance after controlling for therapists' gender (Table 4).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Outcome</th>
<th>R²</th>
<th>Adj. R²</th>
<th>t</th>
<th>B</th>
<th>SEB</th>
<th>β</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.Av</td>
<td>W.A.</td>
<td>.107</td>
<td>.092</td>
<td>-2.617*</td>
<td>-0.234</td>
<td>0.089</td>
<td>-0.222</td>
<td>[-0.411, -0.057]</td>
</tr>
<tr>
<td>T.Anx</td>
<td>W.A.</td>
<td>.155</td>
<td>.141</td>
<td>-3.781**</td>
<td>-0.304</td>
<td>0.080</td>
<td>-0.313</td>
<td>[-0.463, -0.145]</td>
</tr>
</tbody>
</table>

Note. N = 127: 'Controlling for therapists' gender; T.Av = therapists' attachment avoidance; T.Anx = therapists' attachment anxiety; W.A. = working alliance; CI = confidence interval. *p < .01 **p < .001

Mediation analyses: Two mediation analyses examined the indirect effect between attachment avoidance and working alliance, and between attachment anxiety and working alliance. Mediation analyses showed significant indirect effect for attachment avoidance explaining the 39% of the variance and also for attachment anxiety explaining the 42% of the variance, suggesting that therapeutic caregiving mediated the relationship between therapists' attachment dimensions and working alliance (Table 5).

<table>
<thead>
<tr>
<th>X</th>
<th>M</th>
<th>Y</th>
<th>F(df)</th>
<th>R²</th>
<th>β</th>
<th>95% CI</th>
<th>Sig</th>
</tr>
</thead>
<tbody>
<tr>
<td>T.Av</td>
<td>Caregiving</td>
<td>W.A.</td>
<td>26.608(3, 123)*</td>
<td>.394</td>
<td>-0.071</td>
<td>[-0.2922, -0.0591]</td>
<td>*p &lt; .05</td>
</tr>
<tr>
<td>T.Anx</td>
<td>Caregiving</td>
<td>W.A.</td>
<td>29.162(3, 123)*</td>
<td>.416</td>
<td>-0.164</td>
<td>[-0.2353, -0.0594]</td>
<td>*p &lt; .05</td>
</tr>
</tbody>
</table>

Note. N = 127: 'Controlling for therapists' gender; T.Av = therapists' attachment avoidance; T.Anx = therapists' attachment anxiety; W.A. = working alliance; X = predictor; M = mediator; Y = outcome variable; β = unstandardised coefficient; CI = confidence intervals; Sig = significance. All values are based on bias-corrected bootstrap estimation: 5000 bootstrap samples. *p < .001

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Mediated moderation analyses: Initially, we examined whether clients’ attachment dimensions affected the direction or strength of the relation between therapists’ attachment dimensions and working alliance by conducting four moderation analyses: (a) therapists’ attachment anxiety X clients’ attachment anxiety, (b) therapists’ attachment avoidance X clients’ attachment avoidance, (c) therapists’ attachment anxiety X clients’ attachment avoidance and (d) therapists’ attachment avoidance X clients’ attachment anxiety. Finally, we examined whether therapists’ caregiving mediated the relationship between any of these four interactions and the working alliance.

Significant results were found only for (a) and (c). A significant $R^2$ change ($\Delta R^2 = .034$) was observed when the interaction variable of therapists’ and clients’ attachment anxiety was introduced, with a significant negative effect on the working alliance (see step 1 and 2 in Table 6). To test which levels of clients’ attachment anxiety moderated the relationship between therapists’ attachment anxiety and the working alliance, the moderator values were examined at ±1 standard deviation from the mean (Aiken & West, 1991). The test indicated that only when clients had moderate to high levels of attachment anxiety, therapists’ attachment anxiety negatively predicted the working alliance (see bottom of Table 6). In addition, therapists’ caregiving mediated the interaction effects of therapists’ and clients’ attachment anxiety on the working alliance, and this accounted for the 43% of the variance (see step 3 in Table 6). Results indicate that when clients have relatively moderate to high scores on attachment anxiety, therapists’ higher attachment anxiety seems to affect negatively the working alliance and this is mediated by therapists’ less effective caregiving.
Table 6. Summary of mediated moderation analysis for therapists' and clients' attachment anxiety and working alliance

<table>
<thead>
<tr>
<th>Variables</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$F$ (df) of change</th>
<th>$t$</th>
<th>$B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Anx</td>
<td>.155</td>
<td>.098</td>
<td>7.126 (2, 123)**</td>
<td>-3.655***</td>
<td>-0.311</td>
<td>-0.320</td>
</tr>
<tr>
<td>C. Anx</td>
<td></td>
<td></td>
<td></td>
<td>-0.254</td>
<td>0.016</td>
<td>0.022</td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Anx</td>
<td>.190</td>
<td>.034</td>
<td>5.162 (1, 122)*</td>
<td>-3.153**</td>
<td>-0.270</td>
<td>-0.277</td>
</tr>
<tr>
<td>C. Anx</td>
<td></td>
<td></td>
<td></td>
<td>0.403</td>
<td>0.025</td>
<td>0.035</td>
</tr>
<tr>
<td>T. Anx X C. Anx</td>
<td></td>
<td></td>
<td></td>
<td>-2.272*</td>
<td>-0.129</td>
<td>-0.192</td>
</tr>
<tr>
<td><strong>Step 3</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Anx</td>
<td>.426</td>
<td>.237</td>
<td>49.902 (1, 121)***</td>
<td>-1.931</td>
<td>-0.144</td>
<td>-0.148</td>
</tr>
<tr>
<td>C. Anx</td>
<td></td>
<td></td>
<td></td>
<td>0.024</td>
<td>0.001</td>
<td>0.002</td>
</tr>
<tr>
<td>T. Anx X C. Anx</td>
<td></td>
<td></td>
<td></td>
<td>-1.490</td>
<td>-0.073</td>
<td>-0.108</td>
</tr>
<tr>
<td>Caregiving</td>
<td></td>
<td></td>
<td></td>
<td>7.064***</td>
<td>0.034</td>
<td>0.526</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C. Anx</th>
<th>b</th>
<th>SE</th>
<th>z</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>-1.265</td>
<td>-0.106</td>
<td>0.123</td>
<td>-0.863</td>
<td>.390</td>
</tr>
<tr>
<td>0.00</td>
<td>-0.269</td>
<td>0.086</td>
<td>-3.153</td>
<td>.002</td>
</tr>
<tr>
<td>1.265</td>
<td>-0.434</td>
<td>0.099</td>
<td>-4.355</td>
<td>.000</td>
</tr>
</tbody>
</table>

Note. *Controlling for therapists' gender. T. Anx = therapists' attachment anxiety. C. Anx = clients' attachment anxiety. WA = working alliance DV = dependent variable; *$p < .05$ **$p < .01$ ***$p < .001$

A significant $R$ square change ($\Delta R^2 = .080$) was also observed when the interaction variable of therapists' attachment anxiety and clients' attachment avoidance was introduced, with a significant positive effect on the working alliance (see step 1 and step 2 in Table 7). To test which levels of clients' attachment avoidance moderated the relationship between therapists' attachment anxiety and the working alliance, the moderator values were again examined at ±1 standard deviation from the mean. The test indicated that only when clients had low to moderate levels of attachment avoidance, therapists' attachment anxiety positively predicted the working alliance (see bottom of Table 7). Additionally, therapists' caregiving mediated the interaction effects of therapists' attachment anxiety and clients' attachment avoidance on the working alliance and this accounted for the 45% of the variance (see step 3 in
Table 7). Results indicate that when clients have relatively low to moderate levels of attachment avoidance, therapists' lower attachment anxiety seems to affect the working alliance positively and this is mediated by therapists' effective caregiving.

Table 7. Summary of mediated moderation analysis for therapists' attachment anxiety and clients' attachment avoidance and working alliance

<table>
<thead>
<tr>
<th>Variables</th>
<th>$R^2$</th>
<th>$AR^2$</th>
<th>$F$ (df) of change</th>
<th>$t$</th>
<th>$B$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1$^a$</td>
<td>.169</td>
<td>.112</td>
<td>8.294 (2, 123)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Anx</td>
<td></td>
<td></td>
<td></td>
<td>-3.729***</td>
<td>-0.299</td>
<td>-0.307</td>
</tr>
<tr>
<td>C. Av</td>
<td></td>
<td></td>
<td></td>
<td>-1.469</td>
<td>-0.088</td>
<td>-0.121</td>
</tr>
<tr>
<td>Step 2$^a$</td>
<td>.249</td>
<td>.080</td>
<td>12.942 (1, 122)***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T. Anx</td>
<td></td>
<td></td>
<td></td>
<td>-3.043**</td>
<td>-0.238</td>
<td>-0.245</td>
</tr>
<tr>
<td>C. Av</td>
<td></td>
<td></td>
<td></td>
<td>-1.317</td>
<td>-0.075</td>
<td>0.104</td>
</tr>
<tr>
<td>T. Anx X C. Av</td>
<td></td>
<td></td>
<td></td>
<td>3.597***</td>
<td>0.223</td>
<td>0.297</td>
</tr>
<tr>
<td>Step 3$^a$</td>
<td>.452</td>
<td>.203</td>
<td>44.797 (1, 121)***</td>
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<td>T. Anx</td>
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<tr>
<td>T. Anx X C. Av</td>
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<td>2.352*</td>
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<tr>
<td>Caregiving</td>
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<td></td>
<td></td>
<td>6.693***</td>
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Conditional effects at C. Av = mean +/- 1SD (DV = W.A.)

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</table>

Note: *Controlling for therapists' gender; T. Anx = therapists' attachment anxiety; C. Av = clients' attachment avoidance; W.A. = working alliance; DV = dependent variable; $^{*}p < .05$ $^{**}p < .01$ $^{***}p < .001$

Discussion

This study examined the effects of therapists' attachment dimensions on the working alliance by investigating whether clients' attachment dimensions moderate, and therapists' caregiving mediate this relationship. To our knowledge, this is the first study to examine the relationship between therapists' attachment dimensions and the
working alliance using this particular methodology. Our results confirmed findings from a previous study that therapists' caregiving mediates the relationship between therapists' attachment dimensions and the working alliance, but more importantly, we found that clients' attachment dimensions are significant moderators that could change the direction and/or the strength of this relationship. Overall, our results showed that under specific conditions, when therapists were matched with clients who had similar attachment dimensions to their own, they reported less effective caregiving which then affected the working alliance negatively. On the other hand, when therapists were matched with clients who had dissimilar attachment dimensions to their own, they reported effective caregiving which then affected the working alliance positively.

Confirming the existence of a relationship between therapists’ attachment dimensions and working alliance through therapists’ caregiving

Our first hypothesis, namely, that therapists' attachment dimensions would significantly predict the working alliance was fulfilled in that both therapists' attachment avoidance and anxiety were significant negative predictors of the working alliance. These results are consistent with previous studies that found that therapists' insecure attachment is negatively associated with the working alliance (Berry, Shah, Cook, Geater, Barrowclough, & Wearder, 2008; Black et al., 2005; Bruck et al., 2006; Dinger, Strack, Sachsse, & Schauenburg, 2009; Parpottas, 2010; Dunkle & Friedlander, 1996). Being uncomfortable with intimacy, people with higher attachment avoidance may try to maximise distance in relationships by devaluing distressing feelings, whereas, being afraid of rejection, people with higher attachment anxiety may show an excessive need for approval from others by trying to minimise
distance in relationships (Obegi & Berant, 2009). Our results indicate that similar defenses and coping strategies for highly anxious and avoidant therapists, may be activated in the therapeutic room with clients, and thus affect the development and maintenance of the working alliance negatively.

We then explored if therapists’ caregiving mediated the relationship between therapists’ insecure attachment dimensions and working alliance and since our findings confirmed this, our second hypothesis was also supported. In line with findings from a previous study (Parpottas, 2010) insecurely attached therapists reported significantly weaker working alliances due to less effective therapeutic caregiving (see Figure 2). This seems to suggest that therapists’ higher attachment anxiety or avoidance, affects their therapeutic caregiving as they become inaccurate in perceiving clients’ internal and external signals of distress and also less effective in responding to them consistently and accurately, which naturally then reduces the strength of the working alliance.

![Diagram](Figure 2. The proposed mediation model of the relationship between therapists’ attachment dimensions and working alliance)
The interaction effects of therapists' and clients' attachment dimensions on the
working alliance through therapists' caregiving

After confirming that therapists with higher attachment anxiety or avoidance
reported weaker working alliances, due to less effective therapeutic caregiving, our
next task was to investigate if the same occurred when therapists were matched with
clients who had similar or dissimilar attachment dimensions to their own.

Our third hypothesis, that clients' attachment dimensions would moderate the
relationship between therapists' attachment dimensions and the working alliance, was
partially supported as we found significant effects only for certain interactions. More
specifically, when clients' anxious attachment dimension moderated therapists'
anxious attachment dimension, there was a significant negative effect on the working
alliance. On the other hand, when clients' avoidant attachment dimension moderated
therapists' avoidant attachment dimension, there was still a negative effect on the
working alliance but it did not reach statistical significance. Furthermore, when
clients' avoidant attachment dimension moderated therapists' anxious attachment
dimension, there was a significant positive effect on the working alliance. Finally,
when clients' anxious attachment dimension moderated therapists' avoidant
attachment dimension, there was still a positive effect on the working alliance but it
did not reach statistical significance. It is important to note that these results are
consistent with previous studies which found either that similarity in the therapeutic
dyad's attachment patterns predicts weaker working alliances (Borsanyi, 2001) or that
dissimilarity predicts stronger working alliances (Tyrrell et al., 1999). To understand
these results in more depth, we ran a mediated moderation analysis.

Our fourth and last hypothesis was confirmed as we found that therapists'
caregiving mediated the relationship between the interaction effects of therapists' and
clients' attachment dimensions on the working alliance. Particularly, results from the mediated moderation analysis showed that when therapists with higher attachment anxiety were matched with moderate to high anxiously attached clients, they reported weaker working alliances and this was mediated by less effective therapeutic caregiving (Figure 3).

![Diagram](image)

*Figure 3. The proposed conceptual mediated moderation model for therapists' attachment anxiety and clients' attachment anxiety*

It can be understood that in the anxiously attached therapeutic dyads the "role-reversal" relationship may apply (Clulow, 2009), which means that the anxiously attached clients’ dependency needs will be allowed rather than challenged. This happens as the anxiously attached therapist may be drawn into these dynamics because of their own countertransference reactions towards anxiously attached clients’ transference, which will affect their caregiving behaviours towards these clients. For example, it was suggested that to obtain more attention and caregiving from their therapists, and thus to avoid rejection, anxiously attached clients may exaggerate their needs or distress, developing dependency on the therapist who is perceived as stronger and wiser (Dozier & Tyrrell, 1998; Mallinckrodt, 2010; Obegi,
2008; Shorey & Snyder, 2006). In response to this, it was also found that anxiously attached therapists' countertransference might “pull” them back from challenging their clients’ “needy” behaviour as they think that clients will protest, or worse, leave therapy and thus reject them (Dinger et al., 2009; Friedman & Gelso, 2000; Obegi & Berant, 2009; Wallin, 2007). In other words, anxiously attached therapists’ own fears of abandonment and preoccupation with relationships will reinforce strong emotional countertransferential reactions and behaviours towards these clients. As a result these therapists may try to work very hard with clients and this was confirmed in the study of Diamond, Stovall-McClough, Clarkin, and Levy (2003) where it was found that therapists with higher attachment anxiety tend to believe that being good therapists depends on how well they perform in therapy. Therefore, as the anxiously attached therapists are trying hard to meet all those emotional demands that anxiously attached clients are placing upon them it can lead to frustration and lack of empathy as confirmed in the study of Rubino, Barker, Roth, and Fearon (2000).

Our results not only confirm findings from other studies but also suggest that a similarity in an anxiously attached therapeutic dyad may create a co-dependent relationship, where highly anxiously attached therapists’ countertransference creates a difficulty in keeping a sensitive, responsive and flexible therapeutic caregiving towards their moderate to high anxiously attached clients. On this basis it could be argued that the therapist may discourage their clients’ autonomy and as a result clients may not be able to recognise their own resources in how to cope with distress. Therefore being less accurate in perceiving clients’ signals of distress may prevent therapists from seeing and responding to the “bigger picture” of their clients’ underlying needs, which will naturally then affect their working alliance negatively.
Another finding from the mediated moderation analysis showed that, when therapists with low attachment anxiety were matched with low to moderate avoidant clients, they reported strong working alliances and this was mediated by effective therapeutic caregiving (Figure 4).

![Diagram](image)

Figure 4. The proposed conceptual mediated moderation for therapists' attachment anxiety and clients' attachment avoidance

This finding suggests that dissimilarity in the dyad and especially when the therapist has low tendencies of attachment anxiety and the client has a low to moderate avoidant attachment, the therapist is more able to have a sensitive, responsive and flexible caregiving towards this client which then enhances the working alliance. Our results are not only in line with previous findings (e.g., Dozier et al., 1994; Tyrrell et al., 1999) but also provide a rationale for them. For example, clients who have a low to moderate avoidant attachment can have tendencies towards self-reliance. Therefore, as it was theoretically suggested and empirically confirmed, at times of heightened distress clients with avoidant attachment may keep the conversation with the therapist at a superficial level and try to minimise distressing feelings (Banai, Mikulincer, & Shaver, 2005; Letwith, 2011). This can be a signal that negative transferential and countertransferential behaviours will follow but therapists
with low attachment anxiety will not fall into that “trap”. From our findings it seems that therapists who score lower in attachment anxiety will not get caught into the avoidant clients’ transferential expectations nor will they develop a negative countertransference towards them, but they will remain open to their experience. This suggests that they will be able to use effectively their therapeutic caregiving sensitivity to empathically understand the avoidant clients’ actual feelings and underlying needs, such as their need for emotional closeness and dependency. Also, using their therapeutic caregiving responsiveness they may gently challenge and disconfirm the avoidant clients’ distancing and deactivating strategies and consequently, by responding to clients’ underlying needs appropriately, and at the right time, they can promote the corrective emotional experience. This was also something confirmed by other researchers and authors (Hardy et al., 1998; Mallinckrodt, 2010). Ultimately, from our findings it can be understood that when therapists with low attachment anxiety work with clients who have a low to moderate avoidant attachment, they may be able to create a secure base where the client feels safe to explore and challenge their distancing attachment strategies.

Limitations and research recommendations

A number of limitations must be mentioned and considered before interpreting our findings. The current study was conducted in the United Kingdom and as the majority of participants were white-British therapists, and clients, there must be a restriction in the cross-cultural replicability of our findings. In addition, the therapists’ and clients’ attachment dimensions, the therapeutic caregiving and the working alliance were assessed with specific self-report questionnaires and our data were collected only at one point in therapy. Perhaps different results might have been
obtained had other questionnaires or different assessment methods were utilised. Consequently, it is worth noting that the TECAD is a new scale with no previous psychometric properties and it needs further examination; the same might apply for the CCQ. Finally, our data were collected only from the therapist’s perspective and perhaps different findings would emerge if clients participated in this study; therefore one may argue that strong causal inferences cannot be fully supported in our study.

This study has focused in understanding therapists’ and clients’ global attachment dimensions and therapists’ specific caregiving towards clients. Nowadays, more researchers have begun to investigate relationship-specific models of attachment, such as the client’s attachment to the therapist (Bachelor, Meunier, Laverdiere, & Gamache, 2010), which taken together with relationship-global models of attachment there is a possibility of providing us with a better understanding of how attachment processes influence the working alliance. Finally, researchers should identify more moderator and mediator variables which can contribute to our understanding of the effects of attachment-caregiving processes on the therapeutic relationship.

**Implications for practice**

The findings from our study highlight the importance of the implication of attachment theory and research in therapists’ clinical work. More specifically, therapists should be aware how their clients’ attachment dimensions might inform their caregiving responses. For example, therapists must pay particular attention to the anxiously attached client’s tendency to exaggerate their distress, not to be pulled into finding answers for the client or intervene too intensively. On the other hand, a client with avoidant attachment may present as emotionally uninvolved and reluctant to
engage in the therapeutic process, hence the therapists should be aware not to intervene less intensively or be overwhelmed by strong negative reactions towards the client. Being aware of the different attachment-caregiving dynamics in the therapeutic relationship can help therapists distinguish between countertransferential reactions evoked mainly by clients, and caregiving tendencies that rise primarily from their own attachment avoidance or anxiety. For instance, therapists with higher attachment avoidance may have a difficulty in connecting emotionally with clients due to their distancing strategies, and likewise, therapists with higher attachment anxiety may be over-involved with clients due to their strategy to minimise distance. Both these strategies may prevent therapists from understanding and responding effectively to clients and this may affect the therapeutic relationship negatively.

It can be therefore understood that, supervision can provide important information to increase supervisees’ awareness of the dynamics in the therapeutic relationship, in order to improve the use of their therapeutic caregiving “skills”, and hence to adapt their interventions towards their client’s actual needs; this can help them develop and maintain better therapeutic alliances with clients, which may result in a better therapeutic outcome. Finally, therapists’ own personal therapy can be a vital aspect of their personal and professional development. This is because therapists can gain a deeper understanding of their strategies for affect regulation, and also their interpersonal strategies of relating to others, as these may interfere in their relationships with clients and affect the process of therapy negatively.

Conclusions

According to attachment theory, the therapeutic relationship contains many qualities of an attachment-caregiving relationship (Mallinckrodt et al., 1995; Skourteli
However, most empirical studies have focused on exploring either how clients’ or therapists’ attachment styles/dimensions affect the psychotherapeutic process. The present study was an attempt to explore and understand possible moderator and mediator effects of clients’ attachment dimensions and therapists’ caregiving on the relationship between the therapists’ attachment dimensions and the process of therapy. Despite the limitations of this study, to our knowledge this is the first study to investigate possible mediated moderation effects of the relationship between therapists’ attachment dimensions and working alliance.

Our findings suggest that variation between the effectiveness of therapists’ caregiving and the working alliance depends not only on their own attachment dimensions, but also on their clients’ attachment dimensions. More specifically, we found that when therapists have high attachment anxiety and are matched with clients who have a moderate to high attachment anxiety, they develop less effective caregiving and thus report weaker working alliances. In addition, when therapists with low attachment anxiety are matched with clients who have a low to moderate attachment avoidance, they develop effective caregiving and thus report stronger working alliances. To conclude, our results support the idea that attachment-caregiving processes are activated in the psychotherapeutic process and affect the working alliance, demonstrating the importance of the role played by therapists’ and clients’ attachment-caregiving tendencies in the development and maintenance of the working alliance.
[Reflections on the Use of Self]

[As I reach the end of this paper, I wonder whether its completion marks the end of this particular piece of research, and thus the end of my journey. I imagine that this is a reaction, not only to the end of my study, but also because the topic of explaining and understanding personal processes in the therapeutic relationship is very complex. This is the final piece of research that I will submit as a student and certainly one that I shall miss. The pressure of preparing papers to a specific deadline, and their detailed design, has been a way of life for me for the last three years and I am very proud of my results. I feel that my final year's study has taken a unique and different form from previous years. It is the culmination of three years' systematic and collective work and I have gained many insights which can inform not only my clinical work with clients, but which have also contributed to my personal growth, in that I now understand more about myself, and my everyday relationships with people.

When I finished my second year's study, I was left with many unanswered questions. My results showed that therapists' attachment dimensions are activated in the room with clients and particularly, that insecurely attached therapists had less effective caregiving which negatively affected their working alliance. By observing not only my own work with clients, but also that of others on placement, as well as in our group supervision, I tried to analyse the times we feel 'stuck' with some clients and why this can impact upon the quality of our working alliances. I cannot speak for others, but I believe that my personal history of relationships affects the way I relate to others and also with clients in the therapeutic room.

The findings of this study made perfect sense to me as I could see that my attachment tendencies were affecting my caregiving, thus impacting on the working
alliance both positively or negatively. However, it cannot be said that the same thing happened with every client. Therefore, I did not believe that it was entirely my own attachment dimensions that were affecting my caregiving and the working alliance with clients. As counselling psychologists, we always see the therapeutic relationship as a co-created one. Rogers (Sanders, 2006) said where two people are in psychological contact, each person affects the other. Therefore, the unique combination of both participants' attachment dimensions could affect therapists' caregiving, and thus the working alliance. This could also happen among dyads with different and similar attachment organisations.

Initially, when I began thinking about this year's study, I wanted to make it more inclusive. Therefore, I decided to investigate how the global and specific attachment dimensions of both therapists and clients were affecting the process and outcome of therapy. My plan seemed an ambitious one, as it needed to be achieved in just one year. Considerable time, effort and money have been spent on its design, gathering materials and making contact with people. Although I was given the 'green light' from the ethical committee to continue with the study, unfortunately some of the organisations, who initially agreed to take part, did not maintain their interest. In the light of the economic crisis and ensuing cuts, this can happen and I had to try a different path by using email contacts. Only two therapists responded in four months which was frustrating and disappointing and resulted in me having to change my topic into its current form.

It has been a long process, but with continuous support from my supervisor and with the help of colleagues, I was able to design a new questionnaire: the TECAD. Using this I was able to gather information about clients' attachment dimensions from therapists' observations and perspective without interfering in the
complex dynamics of the therapeutic relationship, or lessening the importance of an
exciting topic. I decided to follow a specific methodology to investigate my research
questions and hypotheses, that of mediated moderation analysis; a complex and new
statistical analysis for me. However, it was only when I put it into practice that I
gained full understanding and, positively, I have mastered another statistical technique
which has enhanced my research skills in quantitative methods.

The results from the current study are important, firstly because the findings
from my second year's study were confirmed and validated, and secondly, they were
in line with, and helped to explain previous findings in attachment literature. In
addition, these findings can provide insights for both theory and practice and can be
used to design future studies. I believe that I have found answers to some of my
personal questions about what happens within the dynamics of an attachment-
caregiving therapeutic relationship. I am more curious about understanding the
therapeutic relationships I form with my clients from an attachment theory
perspective and believe that findings, not only from this study, but also from
attachment literature in general, are now embedded in my clinical practice.]
References


psychology, 64(3), 355–363. doi: 10.1002/jclp.20456


Fitch, J. C., & Pistole, M. C. (2010). Development and use of CCQ. Unpublished manuscript, Department of education, Purdue University.


Hardy, G. E., Stiles, W. B., Barkham, M., & Startup, M. (1998). Therapist responsiveness to client interpersonal and cognitive styles as predictors of


Storer, L. J. (2010). *Therapeutic alliance with adolescent clients: The role of attachment style and parent-adolescent agreement regarding targets of therapy and problem severity* (Unpublished Master of science). College of Arts and Sciences of Ohio University, OH.


Appendix 1. Ethical Approval
Dear Panagiotis

Reference: 505-PSY-10 RS
Title of Project: “Exploring the therapeutic care-giving attachment relationship: How the interaction effects of therapists’ and clients’ global attachment dimensions, the client’s specific attachment to therapist and the therapist’s specific care-giving to client influence the working alliance and outcome of therapy.”

Thank you for your re-submission of the above proposal.

The Faculty of Arts and Human Sciences Ethics Committee has given a favourable ethical opinion.

If there are any significant changes to this proposal you may need to consider requesting scrutiny by the Faculty Ethics Committee.

Yours sincerely

[Signature]

Dr Adrian Coyle
Chair
Chair's Action

Ref: 505-PSY-10 RS
Name of Student: PANAGIOTIS PARPOTTAS
Title of Project: “Exploring the therapeutic care-giving attachment relationship: How the interaction effects of therapists' and clients' global attachment dimensions, the client's specific attachment to therapist and the therapist's specific care-giving to client influence the working alliance and outcome of therapy”.

Supervisor: Dr Riccardo Draghi-Lorenz
Date of submission: 19th October 2010
Date of re-submission: 23rd November 2010

The above Project has been re-submitted to the FAHS Ethics Committee.

Favourable ethical approval has now been granted.

Signed: [Signature]
Chair
Dated: 23rd Nov 2010
Appendix 2. Recruiting email, information for participants, consent form, questionnaires and debriefing sheet
Dear sir/madam,

My name is Panagiotis Parpottas and I am a trainee Counselling Psychologist from University of Surrey and I hope that you might be interested in taking part in my final Doctoral research: "Exploring the attachment-caregiving therapeutic relationship: How therapists-clients attachment dimensions and therapists' caregiving influence the working alliance". I am looking to recruit qualified and trainee therapists who are working individually with clients to complete an online survey which takes maximum 20 minutes. NO CLIENT/PATIENT is recruited in this study, however, you are advised to think about one of your clients/patients when you complete the questionnaires.

This project has been given a favourable ethical opinion by the University of Surrey Ethics Committee and is supervised by Dr Riccardo Draghi-Lorenz, Director of Psych.D in Psychotherapeutic & Counselling Psychology, University of Surrey.

If you are interested in participating, please click the hyperlink below for more information and to access the survey:

http://www.fahs.surrey.ac.uk/survey/Interaction/

For any enquiries please contact me: p.parpottas@surrey.ac.uk - pparpottas@hotmail.com or my supervisor r.draghi-lorenz@surrey.ac.uk.

Kind regards

Panagiotis Parpottas
Counselling Psychologist "InTraining"
PsychD (cand.) Psychotherapeutic & Counselling Psychology
Department of Psychology
University of Surrey
Exploring the attachment-caregiving therapeutic relationship: How therapists-clients attachment dimensions and therapists’ caregiving influence the working alliance

Dear Participant,

You are being invited to take part in a research study. Your decision to take part in this study is entirely voluntary and you are under no obligation to do so and your care will not be affected in any way. Before you decide whether or not to take part in this study it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the research study?
The purpose of this study is to explore the caregiving-attachment processes in the therapeutic relationship. Our aim is to investigate how the effects of therapists’ and clients’ attachment dimensions affect the therapist’s caregiving processes which can also influence the process of therapy and particularly the working alliance.

Why have I been chosen to take part in this study?
Qualified and trainee therapists in the UK who work individually with adults are invited to participate in this study. Therapists working only in the NHS should not participate as we do not hold an NHS REC approval.

Who has reviewed the study?
This project has been given a favourable ethical opinion by the University of Surrey Ethics Committee.

What will happen to me if I take part?
If you agree to participate you can access the study by clicking the hyperlink in the email you have received. You will be asked to complete a battery of five questionnaires: the Demographics Questionnaire, the Experiences in Close Relationships Scale (ECR), the Therapist Evaluation of Client Attachment Dimensions (TECAD), the Counsellor Caregiving Questionnaire (CCQ), and the Working Alliance Inventory (WAI). Please notice that NO CLIENT/PATIENT is recruited in this study, however, you are advised to think of one of your clients/patients when you complete the questionnaires. The completion of questionnaires takes approximately 10 to 20 minutes.

What are the possible risks and benefits of taking part?
We use self-report questionnaires that were used in previous studies and none has mentioned any risk issues, so it is unlikely that you will experience any distress. However, it is possible that you might become a little tired from doing the survey. The knowledge gained from this study may help us address issues related to therapists’
training and practice and understand important issues about the therapeutic relationship drawing from attachment theory which may enrich your clinical practice and personal development. If you would like to get a brief summary of the results when the study is completed please feel free to contact me.

Confidentiality
Your participation is voluntary and anonymous and in recognizing your answers, code numbers will be used instead of names. The demographics questionnaire requires minimum information as we do not ask for personal information that can reveal your or your client’s identity. Please notice that you are free to withdraw your participation whenever you want without penalties. The data collected in this study will be protected in the strictest confidence, and in accordance with the Data Protection Act (1998) http://www.legislation.gov.uk/ukpga/1998/29/contents and finally the results will be reported for the whole sample and not independently for each participant.

What will happen to the results of this study?
The final report will be assessed by academics at the University of Surrey and I also intend to publish the results of this study for scientific purposes.

Should you have any enquiries please contact me, my email address is: p.parpottas@surrey.ac.uk and pparpottas@hotmail.com. You can also contact my supervisor Dr Riccardo Draghi-Lorenz, Director of Psych.D in Psychotherapeutic & Counselling Psychology, University of Surrey: r.draghi-lorenz@surrey.ac.uk.

Kind regards

Panagiotis Parpottas
Counselling Psychologist “In Training”
Psych.D (Cand.) Psychotherapeutic & Counselling Psychology
Department of Psychology
University of Surrey
Dear participant,

This study is designed to investigate how the interaction of therapists' and their clients' attachment dimensions influence the process of therapy. Therapists will complete a battery of five questionnaires: the Demographics Questionnaire, the Experiences in Close Relationships Scale (ECR), the Therapist Evaluation of Client Attachment Dimensions (TECAD), the Counsellor Caregiving Questionnaire (CCQ) and the Working Alliance Inventory (WAI). Please notice that NO CLIENT/PATIENT is recruited in this study, however, you are advised to think of one of your clients/patients when you complete the questionnaires.

Your participation is voluntary and anonymous and in recognizing your answers, code numbers will be used instead of names. The demographics questionnaire requires minimum information as we do not ask for personal information that can reveal your or your client's identity. You should know that therapists working only in the NHS will not be contacted to participate in this study as we do not hold an NHS REC approval. Please notice that you are free to withdraw your participation whenever you want without penalties. The data collected in this study will be protected in the strictest confidence, and in accordance with the Data Protection Act (1998) http://www.legislation.gov.uk/ukpga/1998/29/contents and finally the results will be reported for the whole sample and not independently for each participant.

Once you have read this information you can proceed in the next section where you can find the consent form. If you agree to participate you can continue with the survey and more instructions about each questionnaire can be found in the next section. The completion of questionnaires takes approximately 10 to 15 minutes.

This project has been given a favourable ethical opinion by the University of Surrey Ethics Committee.

Should you have any enquiries please contact me, my email address is: p.parpottas@surrey.ac.uk and pparpottas@hotmail.com. You can also contact my supervisor Dr Riccardo Draghi-Lorenz, Director of Psych.D in Psychotherapeutic & Counselling Psychology, University of Surrey: r.draghi-lorenz@surrey.ac.uk.

Yours Sincerely

Panagiotis Parpottas
Counselling Psychologist “In Training”
Psych.D (Cand.) Psychotherapeutic & Counselling Psychology
Department of Psychology
University of Surrey
Consent Form

- I voluntarily agree to take part in the study "Exploring the therapeutic caregiving-attachment relationship: How the interaction effects of therapists' and clients' caregiving-attachment dimensions influence process of therapy"

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigators of the nature, purpose of the study and of what I will be expected to do. I have been advised about any discomfort and possible ill-effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of the study and have understood the advice and information given as a result.

- I agree to comply with any instruction given to me during the study and to cooperate fully with the investigators.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Do you agree to go on?

Yes

No
Demographics Questionnaire

Please answer all questions.

1) Gender: Male    Female

2) Age: .......... 

3) Ethnic Origin: White British    Black British    Asian British
     Other British Background    White other    Black other
     Asian other    Other Ethnic Background    Not Known

4) Qualification-Specialty: Qualified    Trainee

Psychiatrist
Clinical Psychologist
Counselling psychologist
Psychotherapist
Counsellor
Social worker
Nurse
Other: ....

5) If you are a trainee what is your current year of training: ...... (Only for trainees)

6) Therapeutic orientation: Psychoanalytic/Psychodynamic
       CBT
       Systemic
       Existential
       Humanistic
       Integrative
       Other

7) Total years of post-graduate or therapeutic training: .......... (Only for seniors)
8) Years of experience since qualification: ........... (Only for seniors)

9) a) Have you ever engaged in personal therapy? Yes No
   b) Are you currently receiving any personal therapy? Yes No

10) Is your clinical/psychotherapeutic practice supervised? Yes No

Choose one of your clients to think about in order to complete the questionnaires. The client you will choose to think about should be one that you are currently working with and have seen in more than three sessions.

11) Client's Gender  Male  Female

12) Client's Age:....... 

13) Client's Ethnic origin: White British Black British
    Asian British
    Other British Background White other
    Black other
    Asian other Other Ethnic Background Not Known

14) Are you working in short term or long term with your presented client?
    Short term  Long term

15) In which stage of therapy are you now: Early stage of therapy, mid-therapy, in the last stage of therapy

16) Does your client have any formal or informal diagnosis of a mental health disorder? Yes No Not Known
    If yes please briefly clarify(e.g. OCD, Personality disorder, psychosis etc.): ...............
Experiences in Close Relationships Scale

The following statements concern how you generally feel in close relationships. Respond to each statement by indicating how much you agree or disagree with it. There are no right or wrong answers. Work quickly your first impressions are the ones we would like to see:

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<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<td>Disagree strongly</td>
<td>Neutral</td>
<td>Agree strongly</td>
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1. I prefer not to show others how I feel deep down.
2. I worry about being rejected or abandoned.
3. I am very comfortable being close to other people.
4. I worry a lot about my relationships.
5. Just when someone starts to get close to me I find myself pulling away.
6. I worry that others won’t care about me as much as I care about them.
7. I get uncomfortable when someone wants to be very close to me.
8. I worry a fair amount about losing close others.
9. I don’t feel comfortable opening up to others.
10. I often wish that close others’ feelings for me were as strong as my feelings for them.
11. I want to get close to others, but I keep pulling back.
12. I want to get very close to others, and this sometimes scares them away.
13. I am nervous when another person gets too close to me.
15. I feel comfortable sharing my private thoughts and feelings with others.
16. My desire to be very close sometimes scares people away.
17. I try to avoid getting too close to others.
18. I need a lot of reassurance that close others really care about me.
19. I find it relatively easy to get close to others.
20. Sometimes I feel that I try to force others to show more feeling, more commitment to our relationship than they otherwise would.
21. I find it difficult to allow myself to depend on close others.
22. I do not often worry about being abandoned.
23. I prefer not to be too close to others.
24. If I can’t get close others to show interest in me, I get upset or angry.
25. I tell my close others just about everything.
26. I find that close others don’t want to get as close as I would like.
27. I usually discuss my problems and concerns with close others.
28. When I don’t have close others around, I feel somewhat anxious and insecure.
29. I feel comfortable depending on others.
30. I get frustrated when close others are not around as much as I would like.
31. I don’t mind asking close others for comfort, advice, or help.
32. I get frustrated if close others are not available when I need them.
33. It helps to turn to close others in times of need.
34. When other people disapprove of me, I feel really bad about myself.
35. I turn to close others for many things, including comfort and reassurance.
36. I resent it when my close others spend time away from me.
Therapist Evaluation of Client Attachment Dimensions

The following statements describe how your client generally feels in her/his relationships with close others and also how s/he copes with distress. We acknowledge that this may not be the most accurate description of your client’s global attachment dimensions but we encourage you to read and rate the statements to the extent to which you think is closest to your client.

1. My client wants to be completely emotionally intimate with others
2. My client is preoccupied about others’ availability and responsiveness
3. My client prefers not to depend on others or have others depend on her/him
4. My client worries a lot that others don’t value or care about her/him as much as s/he does
5. My client prefers to rely mainly on her/himself as it is very important to her/him to be independent and self-sufficient
6. My client feels uncomfortable being without close relationships
7. My client tends to keep relationships in distance as s/he feels discomfort with intimacy
8. My client often talks about themes of neglect, rejection and abandonment
9. My client tends to deny difficulties in relationships or minimizes those difficulties because talking about them can bring up difficult or painful feelings
10. My client presents as vulnerable to pain and s/he is often prone to signaling or expressing her/his distress in an exaggerated manner
11. My client often tries to block negative emotions and thoughts by inhibiting or masking both verbal and non verbal expressions
12. My client is pessimistic about his/her ability to manage distress as s/he underestimates her/his own strengths s/he often needs others to help or ‘rescue’ her/him
13. Sometimes my client gives me the impression that s/he is reluctant to talk about ‘threatening’ feelings
14. My client often shifts attention toward internal indicators of distress and tends to emphasize on her/his sense of helplessness and vulnerability
15. When my client talks about feelings of hurt, distress, loss, needing or dependence on others s/he often talks abstractly
16. My client finds it difficult to be reflective of her/his emotional experience and her/his main strategy of coping with distress is maximization of affect
17. My client finds it difficult to be reflective of her/his emotional experience and her/his main strategy of coping with distress is minimization of affect
Counselor Caregiving Questionnaire

Think about your client, your current relationship with him/her, the setting, the therapeutic issues, your successes, your failures. Rate the extent to which you agree or disagree with the following statements answering the items below with your most general response. There are no right or wrong answers.

Strongly Disagree   1 2 3 4 5 6 7   Strongly Agree

1. I usually know when my client needs my assistance.
2. I concentrate on being there for my client.
3. Leaning forward can respond to my client’s need for support or reassurance.
4. One of the worst things a therapist can do is to be distant with a client.
5. It’s important to facilitate my client’s comfort with appropriate closeness both in and outside of therapy.
6. When my client is clearly upset, I try to be closer or more distant, depending on the particular client.
7. My interventions are designed to respond to the legitimate closeness and security needs of my client.
8. It is easy for me to be in tune with my client’s feelings about closeness.
9. When being more distant or close than usual, I monitor my client’s reactions closely.
10. I sometimes do not provide my client with enough emotional support.
11. The therapist should try to be available to the client’s closeness and security needs.
12. It’s important for me to recognize when my client wants more closeness or distance.
13. I am not very good at “tuning in” to my client’s feelings about closeness or distance.
14. It is essential to remain psychologically present when my client talks about separation.
15. I modify interventions according to whether my client can perceive me as trustworthy.
16. I can always tell when my client needs comforting, even if he or she doesn’t ask for it.
17. I sometimes misread or miss my client’s signals for help and support.
18. It is important for my client to know that I am there when s/he needs me.
19. It is important that my client feels that we are working together, even when I have to adapt my style.
20. I am reliable and responsive my client exploring his/her own world.
21. I prefer that my interventions convey that I understand my client’s needs and issues.
22. I believe my client would say that I can be relied on.
23. I recognize that my client feels close to me, even though s/he acts distant.
24. My client can rely on my providing guidance when s/he wants it.
25. I can handle alliance ruptures fairly easily with this client.
Working Alliance Inventory

Instructions:
These are sentences that describe some of the different ways you might think or feel about your client. If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

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

1. My client and I agree about the steps to be taken to improve his situation.

2. My client and I both feel confident about the usefulness of our current activity in counselling.

3. I believe my client likes me.

4. I have doubts about what we are trying to accomplish in counselling.

5. I am confident in my ability to help my client.

6. We are working towards mutually agreed upon goals.

7. I appreciate my client as a person.

8. We agree on what is important for my client to work on.

9. My client and I have built a mutual trust.

10. My client and I have different ideas on what his real problems are.

11. We have established a good understanding between us of the kind of changes that would be good for my client.

12. My client believes the way we are working with her problem is correct.
Many thanks for your time and co-operation

The main objective of the study in which you just participated was to investigate how the effects of therapists’ and clients’ attachment dimensions and caregiving processes influence the process of therapy. The rationale of this study is to explore the caregiving-attachment processes in the therapeutic relationship which gives the opportunity to address issues related to therapists’ training and practice but also to promote awareness in understanding important issues about the therapeutic relationship drawing from attachment theory.

It is the purpose of this study to explore if the variables of therapists’ specific caregiving to clients mediate the relationship between therapists and clients attachment dimensions and working alliance. In this way, it is hoped that our hypotheses will be rigorously tested.

Your contribution to this study is therefore very valuable and very much appreciated. Without you, our research would be impossible and your responses will be used to help answer our questions.

As a final point, you should know that all data collected in this study will be analysed in an aggregated form and your responses will not be singled out and therefore only averaged results will be reported in any future publications. If you would like more information, or have any further questions about any aspect of this study please feel free to contact me.

Email: p.parpottas@surrey.ac.uk
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Yours Sincerely

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Appendix 3. Journal of Attachment & Human Development. Instructions for authors
Instructions for Authors

Papers will be considered providing that they have not previously been published or submitted simultaneously elsewhere for publication.

EMPIRICAL REPORTS

1) The paper should conform to APA standards, with a legible abstract (100-150 words), followed by sections that include an introduction, method, results, and discussion.

THEORY/REVIEW PAPERS

2) The paper should make an original, testable and/or useful extension/revision to theory and previous literature concerning attachment processes and human development.

CLINICAL CASE-STUDIES

3) Authors should provide an account of previous clinical theory in an organized and up-to-date manner distinct from the clinical case material. Further, the clinical case material should occupy no more than a third of the paper. The first third should include only relevant background theory, while the final third should aim to discuss the descriptive presentation of the clinical case material against the background of existing theories and/or modifications needed to accommodate the clinical material.

ALL SUBMISSIONS

should include an abstract, and ordinarily be about 6,000 words in length, not exceeding 7500 words in total, though occasionally longer papers are considered. In order to facilitate blind peer review, authors are encouraged to prepare a cover sheet that includes identifying details not included in the manuscript which will be sent out for review, less the cover sheet.
E-mail submissions to the Editor are preferred; please send an electronic copy of your manuscript to steeleh@newschool.edu.

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D. *Italic initial cap only*. Text runs on  
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Note: This is a note. (ranged left under table) |
| Figures                | (Figure 1) in text.  
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Note: This is a note. (ranged left under figure) |
| Displayed quotations   | Indented left and right, smaller font (over 40  
words, or when appropriate) |
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| Equations              | Equation (1) in text  
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Appendix 4. Details of the use of computer-based literature search facilities
Most of the articles that I have used in the present study were used in the previous two studies and downloaded from the EBSCOhost page of the Surrey University library. However, I run again a new search for more recent articles up-to-date on the influence of therapist's attachment on the process of therapy, therapists' caregiving and interaction effects. I chose the PsychINFO online database, typing the words:

- The influence of therapist’s attachment on process of therapy
- The influence of therapist’s attachment styles on the working alliance
- Therapist's caregiving and working alliance
- Moderation effects of clients’ attachment styles on working alliance
- Clients’ and therapists’ interaction effects on the process of therapy