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The effects of client attachment styles and therapeutic alliance on treatment outcome

Dayle Louisa Hill

THE EFFECTS OF CLIENT ATTACHMENT STYLES AND THERAPEUTIC ALLIANCE ON TREATMENT OUTCOME

A Thesis

Presented to the

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In Partial Fulfillment

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Master of Science

in

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ABSTRACT

The purpose of this study was to evaluate changes in symptoms of psychological distress and psychological well-being in clients being seen at a community mental health center as a function of the strength of the client-therapist working alliance and of the client's attachment to the therapist. It was anticipated that Secure attachment styles and strong working alliances would be associated with positive treatment outcomes (i.e., decreases in symptoms of psychological distress and increases in psychological well-being) over the course of therapy. It was also expected that Dismissing and Preoccupied attachment styles would be associated with negative treatment outcomes (i.e., little or few decreases in symptoms of psychological distress and little or few increases in psychological well-being) over the course of therapy. The results of this study were all in the expected direction. Positive outcomes were associated with Secure attachment styles and strong working alliances while negative outcomes were associated with Dismissing and Preoccupied attachment styles. However, probably due to sample size (N=13), few of these associations reached statistical significance. These findings suggest that the quality of the therapeutic relationship, including the client's ability to form a

secure attachment to the therapist and to establish a strong working alliance with his/her therapist has significant implications for treatment outcome. This study has gone beyond previous studies by including a measure of psychological well-being in addition to psychological distress to assess treatment outcome, and by assessing attachment styles and working alliances simultaneously. Recommendations for further research with these issues (using larger sample sizes, while also taking into account the therapist's own attachment styles and his/her treatment approach or treatment orientation) are indicated.

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INTRODUCTION

There is growing interest in the therapist-client relationship as it relates to treatment outcome (Hartley & Strupp, 1983; Greenberg & Pinsoff, 1986; Ryff, 1989; Gaston, 1991; Hamblin, et al., 1993; Blaauw & Emmelkamp, 1994; Dozer, Cue, & Barnett, 1994; Mallinckrodt, Coble, & Gantt, 1995). Much of this interest is focused on two areas: the working alliance and client attachment styles.

The Working Alliance

Until two decades ago, there was ambiguity among researchers with regard to the working alliance. Since Freud's (1913/1958) original idea that the client's attachment to the therapist was based on his or her transference reactions, there have been many important and diverse changes to the original beliefs concerning this bond.

Carl Roger's theory (1951, 1958) was highly influential in establishing new beliefs about the therapeutic alliance. His definitions of the active components of the therapist/client relationship (i.e., empathy, unconditional positive regard, and congruence) were deemed both necessary and sufficient by many (Rogers, Gendlin, Keisler,& Truax, 1957). Unfortunately, this theory was based on the fact that therapeutic gains depended

entirely on the abilities of therapists, which has since been proven to be significant, but insufficient to client change (Gelso & Carter, 1985; Parloff, Waskow, & Wolfe, 1978; Mitchell, Bozarth, & Krauft, 1977).

In the late 1960s, another theory on the therapeutic alliance emerged. This theory was based on the concept of cognitive dissonance (Cartwright, 1965), and it defined the therapist/client relationship as one based on a client's perceived attributions toward his/her therapist. There were two different conceptual factors in relation to client's feelings and/or behavior: 1) whether the therapist had the power to influence, and 2) whether this power stemmed from the client's perceived view of the therapist's Attractiveness, Trustworthiness, and Expertness. Unfortunately this theory has been deemed difficult to prove (Horvath & Greenberg, 1989). In order to design a study on perceived attractiveness of therapists, there would have to be an initial evaluation of such, which would involve a beauty contest; an endeavor that would be highly impractical and at the very least unethical. In addition, previous research based on this theory was developed entirely on the client's initial perceptions of the therapist, and completely ignored the issue of how a therapist may come to be seen as attractive, trustworthy, and expert over the

course of therapy (LaCrosse, 1977; LaCross & Barak, 1976).

In 1975, E.S. Bordin published the first of several papers reconceptualizing the previous notions of the client/therapist working alliance. He clearly delineated the difference between client transference and the positive joining of counselor and client to facilitate change in the therapeutic setting (Bordin, 1975, 1976, 1980). Bordin defined a strong working alliance as having three components: 1) mutual agreements and understanding regarding the goals sought in the change process, 2) the tasks of each of the partners, and 3) the bonds required to sustain the changes. Bordin's concepts of bond, goal, and task involve collaboration and depend on the degree of agreement between therapist and client. This stance is in direct opposition to the previous alternative views that relied either on the client's perceptions of the therapist's qualities, or on the attitude and behavior of the therapist which ignored the mutuality of the therapeutic relationship. Additionally, Bordin did not view the working alliance as a sufficient condition; rather, he saw it as a vehicle that facilitated the success of specific therapeutic interventions. Finally, Bordin believed that alliance configurations may depend on the particular phase of counseling and not on the specific therapeutic orientation

of the therapist (Bordin, 1980).

In 1989, Horvath and Greenberg developed the Working Alliance Inventory (WAI). Based on Bordin's theory, the inventory defined and measured the three components that Bordin originally developed as constructs of the therapeutic alliance (goals, tasks, and bonds). This valid and reliable instrument has given way to more recent, and useful research and is rapidly proving to be a critical component in evaluating the psychotherapy process across a variety of therapeutic orientations (Horvath & Greenberg, 1989).

Current literature suggests that clients with strong alliances (i.e., where the therapist and client have successfully attained a collaborative relationship defined by mutual respect, trust and shared control; e.g., Teyber, 1997), have had more successful treatment outcomes than those with weak alliances (i.e., a less secure relationship with the therapist which prevents a mutual agreement on goals, responsibilities and expectations within the therapeutic setting; e.g., Horvath & Symonds, 1991).

A comprehensive literature review of 24 studies investigating the relationship between the working alliance and treatment outcome was conducted by Horvath and Symonds (1991). The analysis used studies conforming to high design standards (i.e., therapists were experienced, and procedures

were done in clinically valid settings). A wide variety of orientations were included as well. Distinctions between therapist-reported alliance, client-reported alliance, and observer-reported alliance in relation to treatment outcome were analyzed. This investigation found that clients' and observers' ratings of working alliances were more positively correlated with treatment outcomes than therapists' ratings. The overall quality of the working alliance was found to be predictive of positive treatment outcome across orientations. This meta-analysis confirmed that the working alliance is a viable and robust variable linking therapy process to treatment outcome.

Gaston et al. (1994) conducted a study investigating whether alliance, technique, and the interaction of both predicts treatment outcome in short-term and long-term dynamic psychotherapy. The researchers were interested in the impact of exploratory interventions (i.e., technical strategies that address patients' reactions as being problematic and are likely to provoke some anxiety in patients), and supportive interventions (i.e., interventions attempting to support or attain a patient's sense of self, and likely to reduce anxiety), and short-term therapy (six months) versus long-term therapy (two years) on the working alliance. The results indicated that the interaction of the

working alliance and the two types of therapeutic interventions were found to account for significant amounts of variance in outcome. Specifically, Gaston et al. (1994) found that patients encountering difficulties in establishing a working alliance benefitted from supportive interventions. Patients having "good-enough" alliances with their therapists benefitted more from exploratory interventions. Further, the findings indicated that in short-term therapy, the working alliance contributed to a reduction of symptoms in patients, and in long-term therapy, working alliance ratings were significantly associated with reduced interpersonal problems for patients (Gaston, Piper, Debbane & Garant, 1994).

The therapeutic alliance was also investigated by Klee et al. (1990) at the Michigan State University Psychological Clinic. Using 32 adult patients who were being seen for brief therapy, the predictability of the establishment of a therapeutic alliance in the first session was investigated in relation to the maintenance of such an alliance throughout the course of therapy and to the treatment outcome. The results confirmed Klee's hypothesis that patients who formed a working alliance in the first session maintained the alliance and had more positive treatment outcomes than patients who did not establish this alliance

during their initial session. Another hypothesis was also examined in the study which looked at good prognosis versus poor prognosis. Specifically, it was anticipated that patients who were determined to have a good prognosis for forming a therapeutic alliance (defined as those who possessed a capacity for relatedness) would benefit more from treatment, compared with those having a poor prognosis (defined as those who lacked interpersonal relatedness skills; intimacy problems and inability to trust in relationships). The findings however, did not support this assumption, indicating that the establishment of the therapeutic alliance was not necessarily predicted by patients' capacity for interpersonal relatedness. This implies that the strength of the therapeutic alliance does not rely only on client variables, but rather that the therapist's stance plays an important role in the formation of a working alliance. This idea would confirm Bordin's original idea that a strong alliance is collaborative (Klee, et al, 1990).

Attachment Theory

In addition to the working alliance, therapists have come to recognize that the way in which clients establish interpersonal attachments have great implications for their psychological health. Attachment refers to the affective

ties and relational patterns people develop through early experiences with their parental caregivers. Ideally, attachment functions to bring a sense of comfort, safety, protection, and a secure base from which to explore one's environment. Secure attachments are determined by the emotional availability and consistent responsiveness of children's attachment figure/s. Invariably, young children will experience distress and marked separation anxiety when their attachment figure is unaccessible. If this physical or emotional unavailability is experienced repeatedly, the child begins to develop an insecure attachment system and internal working models of relationships that are either anxiously ambivalent or avoidant (Bowlby, 1969; 1973).

As discussed in his article "Becoming Attached", Robert Karen states that researchers such as Ainsworth, Bowlby, and Main have illustrated the importance of attachment in psychological development. Originally, three styles of attachment were identified for children; Secure, Anxious/Ambivalent, and Avoidant. Until the late 1960s, attachment behavior was assessed via long and tedious home visits. Mary Ainsworth and Barbara Wittig developed the "Strange Situation" procedure in 1969. This provided researchers with a laboratory procedure that facilitated the exploration of patterns of attachment behavior in young

children. Ainsworth's ingenious study created a method for dramatically activating the young participant's attachment patterns which in turn made assessment faster and more efficient as opposed to earlier, more cumbersome home visit observations (Karen, 1994; Ainsworth & Wittig, 1969). In a more recent study, a fourth category was identified. The newly defined category was termed "Disorganized" (Main & Soloman, 1986; 1990).

Only in recent years, however, have researchers begun to apply Bowlby's model to adults in general, and to psychotherapy in particular. It is now believed that three of the four attachment styles play themselves out throughout the lifespan and influence marital, partner, and peer relationships (Little, 1964; Weiss, 1975; 1978; 1979). According to Bowlby (1978), attachment behaviors and the corresponding emotional reactions associated with the three principal attachment styles are evident throughout an individual's lifespan. This was apparent after the development of the Berkeley Adult Attachment Interview (AAI) by Carol George, Nancy Kaplan, and Mary Main (1987). They found that adult attachment styles were directly parallel to Ainsworth's childhood attachment categories. The interview was designed to not only discover what one's early attachment experiences were like, but also to determine how

one felt and thought about the experiences now. That is, how would an individual represent attachment figures in his/her mind, what was the internal working model or cognitive schema for self and others in relationships? The AAI was also designed to assess whether or not an individual has free access to painful attachment memories, and with this access, was he/she willing to or capable of examining, remembering, and expressing them realistically, or were problematic attachment patterns defended against by idealization and splitting defenses. More specifically, the three categories determined from the AAI were: a) Secure-Autonomous, i.e., adults who presented a realistic picture of their parents, that is, childhoods that were not necessarily trouble free, and those that had at least one parent that provided them with a secure base, b) Dismissing of Attachment, i.e., adults who were unwilling to take attachment issues seriously, had trouble remembering their childhoods, and disliked looking inward, and c) Pre-occupied with Early Attachments; adults who spoke of hurtful childhoods with intense emotion, whose childhoods were characterized by efforts to please their parents, and by having their roles reversed (parentification; Karen, 1994).

More specific to treatment outcome studies is the recent development of the Client Attachment to Therapist

scale (Mallinckrodt et al., 1995). The scale categorizes clients into three parallel attachment styles (Secure, Avoidant-Fearful, Pre-occupied-Merger), and focuses on their working models in relation to the therapeutic relationship.

In the therapeutic relationship, clients entering therapy with secure attachment styles will be able to trust their therapists in realistic ways. They are capable of emotional intimacy, and can express their needs and emotions comfortably in their interpersonal relationships. Generally, they are optimistic about life, flexible in their coping strategies and able to perceive others realistically. When in emotional distress, their symptoms tend to be mild and transient, and generally only present themselves during times of significant situational stress. Theoretically, securely attached clients will ask for support when it is needed and are readily helped or comforted by others (Bowlby, 1978; Pistole, 1989; Mallinckrodt et al., 1995).

In contrast, clients with a Preoccupied-Merger (Anxious/ Ambivalent) attachment style tend to be immature, overdependent, and present strong yearnings for love and support. They seem to be needy and have a wish to merge with their therapists, while simultaneously distrusting or misinterpreting therapists' caring interventions as temporary, unreliable or insincere. These clients are

likely to present in treatment with symptoms of anxiety and depression which may be accompanied by shame or guilt. In extreme cases, they may be prone to suicidal gestures as an attempt to gain closeness to others; a behavior which is often evident in borderline clients (Bowlby, 1978; Pistole, 1989; Mallinckrodt et al., 1995).

Finally, those clients with Avoidant-Fearful (Dismissing) attachment styles tend to deny any desire for love and affection, or any need for emotional support or help from others. They are afraid of dependence on others and uncomfortable with the dependence or emotional needs of others on themselves. Some parallel attached clients may develop compulsive caretaking behaviors which will play out in the therapeutic relationship (i.e., the client will attempt to take care of the therapist). This caretaking is used as a defense against the therapist getting too close. In relationships where they have succeeded in their caretaking efforts, these clients will then become angry and resentful at having their own needs go unmet. In terms of emotional distress, they are likely to experience depression and somatic symptoms (Bowlby, 1978; Pistole, 1989; Mallinckrodt et al., 1995).

In 1992, Mallinckrodt surveyed 253 psychology undergraduates assessing their current social support

system, social self-efficacy, and their memories of care and protection (i.e., were they neglected and/or prevented from individuating) with their parents. Mallinckrodt found evidence that secure parental bonds were positively related to social self-efficacy. Specifically, the students whose parents were consistently emotionally responsive, attentive, and warm had more social self-efficacy than students whose parents were intrusive, controlling, and resistant to their emancipation. Additionally, students with more social self-efficacy had a more stable social support system (Mallinckrodt, 1992). These findings coincide with the Ainsworth and Wittig strange situation study (1969) which discovered that securely attached children had parents who were attentive, responsive and warm, and that anxious/ambivalent attached children had parents who were intrusive, controlling, and overprotective. Generally speaking, this study implies that in order to develop a stable social network of peers, it is of primary importance for one to have experienced a secure attachment with parental caregivers.

A study done by Dozier et al. (1994) examined the effect of the clinicians own attachment issues on therapeutic interventions. There were 27 volunteer clients and 18 case managers participating in the study. The

clients were selected randomly from a larger study that was investigating the effectiveness of case management at several mental health centers (two urban and two rural areas of Texas, and an inner-city of Washington, DC). Clients also were required to have had one continuous manager for the 6-month duration of the larger study. The participating case managers had an average of 4.3 years experience. Seven case managers had bachelor's degrees in psychology, seven had master's degrees in social work or psychology, and four were working toward master's degrees in social work. Attachment styles of both clients and case managers were assessed using the AAI. Trained examiners measured the depth of the interventions. The examiners conducted 5-10 minute interviews with case managers using a coding manual which was created to help define the depth of the intervention. For example, when client anger was discussed and responded to, it was coded as high, whereas when clinicians checked to determine whether the client had received food stamps, it was coded as low. During the interviews, case managers were asked to describe all of the issues that arose with the client and to discuss why they handled their interaction as they did. Dozier et al. found that case managers who had a Secure attachment style attended and responded to the underlying needs of their

clients, regardless of the client's attachment. In contrast, the insecurely attached clinicians tended to feel the pull of their clients' attachment styles and react according to their clients' expectations. Thus Dismissing or Preoccupied case managers tended to intervene on a more superficial manner with their Dismissing clients, and treated their Preoccupied clients as fragile and helpless, which in turn recapitulated their clients' core relational conflicts. The results of this study imply that securely attached therapists are more effective with their clients. This confirms that both the therapist's and the client's attachment models are important to the therapeutic process (Dozier et al., 1994). Although, the present study is not assessing therapist attachment style, Dozier's study does provide information which highlights the significance of attachment histories to all interpersonal relationships.

Lyddon and Satterfield (1994) conducted a study looking at client working models of attachment and therapist assessment of clients' problems and goals of treatment. The assessment was categorized into two types: a) First-order change, that is, problems are related to life events, and therapeutic goals are directed at symptom relief and a re-establishment of emotional equilibrium, versus b) Second-order change, defining clients' problems as more pervasive

and developmental in nature; core beliefs about self and the world are no longer viable, treatment goals focus more on developmental concerns. The findings indicated that problems and goals of clients with secure attachment styles were assessed by their therapists as being of a first-order nature, whereas problems and goals of clients with more insecure working models of the world were assessed as being congruent with second-order conceptualizations (Lyddon & Satterfield, 1994). As implied by this research, clients having secure attachment styles tend to have less pervasive problems and may require shorter-term therapy than those with more insecure attachment styles. This also supports the belief that attachment working models are highly relevant to the therapeutic process.

Based on Bowlby's work, therapists and researchers have come to believe that clients' relational experiences throughout their lives tend to be patterned or organized to recreate the same repetitive relational themes. These interpersonal coping styles will impact both how clients attach to their therapist and the quality of the working alliance they establish with their therapists. In other words, clients who have had difficult and maladaptive attachment histories with their parents develop a problematic cognitive schema for relationships that lead to

recurrent difficulties in their current interpersonal relationships. In parallel, they will also tend to have similar difficulties in forming a collaborative alliance with their therapists (Teyber, 1997).

In 1995, Mallinckrodt et al. investigated current social competence and memories of attachment bonds with parents in relation to the formation of the working alliance for women in brief therapy. Participants were all women who were seen at a university outpatient hospital-based clinic, and a training clinic for a counseling psychology program. The participants were selected from a community sample (i.e., most were not students at the university). The female clients were given four different instruments: 1) The Parental Bonding Instrument (PBI; Parker, Tupling & Brown, 1979) which measured their early beliefs about parental care and overprotection (memories of a parent who was intrusively controlling and reluctant to allow the client to gain autonomy), 2) The Adult Attachment Scale (AAS; Collins & Read, 1990), which measured client's relationship building skills and style of forming close attachments, 3) The Social subscale of the Self-Efficacy scale (Sherer, Maddux, Mercadante, Prentice-Dunn, Jacobs & Rogers, 1982) which measured client's interpersonal competency in peer relationships, and 4) The Working

Alliance Inventory (WAI; Horvath & Greenberg, 1986; 1989). The findings indicated that for those women, there was a strong association between remembering their fathers as warm and emotionally expressive had a higher capacity to depend on others for emotional nurturance. Memories of fathers as intrusive and controlling were negatively associated with a willingness to allow emotional closeness in adult attachments. Additionally, parental bonds were found to be related to the working alliance: secure attachment bonds with fathers being the strongest predictors. Clients with memories of fathers as warm and emotionally expressive had the strongest working alliance with their therapists. Those with the poorest alliances tended to characterize their fathers as intrusive, controlling and resistant to their daughters' emancipation and autonomy, parental characteristics often seen in children who have developed anxious/ambivalent attachment patterns (Karen, 1994). Finally, client self-estimates of their ability to form adult attachments were found to be good predictors of their ability to form working alliances (Mallinckrodt et al., 1995). This further supports the fact that client attachment issues will somewhat affect the quality of the working alliance they establish with their therapists. It should be noted that this study did not specify the gender

of the student therapists.

Satterfield and Lyddon (1995) investigated the relationship between client attachment and client ratings of the working alliance during the initial phase of treatment. Sixty first-time clients received services from graduate students at a university-based counseling clinic. Clients were given two instruments: 1) The AAS (Collins & Read, 1990), and 2) The WAI (Horvath & Greenberg, 1986; 1989). The results indicated that clients whose internal working models were characterized by a lack of trust in the availability and dependability of others (note characteristics of a preoccupied or dismissing attachment style), tended to evaluate the counseling relationship in negative terms. However, clients who felt they could rely on the availability and dependability of their therapists (skills of securely attached individuals), tended to form a stronger working alliance in the early phases of counseling (Satterfield & Lyddon, 1995). This study again supports the importance of Bordin's idea that collaboration between therapist and client is a necessary component in forming a working alliance. Further, a preoccupied or dismissing attachment style will result in a weaker alliance for therapist and client compared with the working alliance formed between therapist and a securely attached individual.

SUMMARY

In sum, recent research has linked the working alliance to positive treatment outcomes. For example, Gaston et al. (1994) looked at psychological symptoms using the Depression-Anxiety scale of the Psychiatric Status Schedule (Spitzer, Endicott, & Cohen, 1967) and the Interpersonal Behavior Scale (Piper, Debbane, & Garant, 1977). Gaston et al. found that those patients who had established a strong working alliance with their therapist in short-term therapy experienced a reduction of symptoms, while those in long-term therapy who had a strong working alliance experienced a reduction in interpersonal problems. Similarly, Klee et al. (1990) reported an association between working alliance and positive treatment outcome using the SCL-90-R (Derogatis, 1983; Derogatis et al., 1976). Klee et al. found that patients who established a working alliance in the first session were able to maintain this alliance throughout treatment as well as have a greater reduction of symptoms compared with those who did not achieve a working alliance in their initial session.

The relationship between attachment styles and the working alliance has also been investigated. Dozier et al. (1994) investigated case managers' own attachment histories and their relationship in the clinical setting and found

significant differences in intervention depths for clinicians across the three different attachment styles. For example, securely attached case managers attended and responded to clients' core issues and underlying needs. Further, they were able to use their own countertransference feelings in determining clients' eliciting behaviors and then provided clients with new and corrective interpersonal experiences. In contrast to this, the more insecure case managers failed to challenge clients' models of relationships, responding in ways which confirmed clients' expectations of others. In other words, case managers with Dismissing or Preoccupied attachment styles were consistent in recapitulating their clients' interpersonal conflicts (Dozier et al., 1994). Similarly, Lyddon and Satterfield (1994) looked at the relationship between client attachment styles and the client's ratings of the working alliance and found that clients having a Preoccupied or Dismissing attachment style perceived the working alliance in negative terms. Most importantly, Mallinckrodt et al. (1995) looked at social competency for women in brief therapy and reported that secure attachment memories were predictive of a strong working alliance.

These recent investigations suggest that the overall quality of the working alliance is predictive of a positive

treatment outcome (Klee et al., 1990; Horvath & Symonds, 1991; Gaston et al., 1994). In addition, adult attachment styles seem to play a significant role in clients' ability to form and maintain a working alliance. Specifically, clients who have secure attachment styles appear to be able to form stronger working alliances (Mallinckrodt et al., 1995; Satterfield & Lyddon, 1995). Based on this research, it appears that both clients' attachment styles and working alliance impact treatment outcome. Although most studies on the working alliance and adult attachment have looked at treatment outcome by measuring symptoms, few have accomplished this in the arena of psychological well-being or have assessed both client psychological symptoms and well-being in the same study. In addition, few have evaluated the relative contribution of client attachment styles and working alliance to treatment outcome.

Thus, the purpose of the present study is to investigate the relationship between adult attachment styles on treatment outcome (changes in psychological well-being and psychological symptoms) for clients during the course of therapy. Further investigation will be to look at the relationship between the working alliance and treatment outcome.

HYPOTHESES

In light of earlier findings, it is anticipated that in the current study: 1) Secure attachment styles would be associated with decreases in psychological distress and increases in psychological well-being; 2) Dismissing attachment styles would be associated with no change or increases in psychological distress and decreases in psychological well-being; 3) Preoccupied attachment styles would be associated with no change or increases in psychological distress and decreases in psychological well-being; 4) strong working alliances would be associated with decreases in psychological distress and increases in psychological well-being; and 5) Strong working alliances will be positively associated with a Secure attachment style and negatively associated with Dismissing and Preoccupied attachment styles.

METHOD

Participants

The study included 13 volunteer clients, both male and female, who sought treatment at California State University San Bernardino's Psychology Department Training Clinic, and who agreed to participate. All participants received therapy from first-Year M.S. Counseling students.

Materials

Five different questionnaires were used in this study: 1) the Working Alliance Inventory (Horvath & Greenberg, 1986, 1989) was used to assess the therapeutic alliance, 2) the Client Attachment to Therapist scale (Mallinckrodt et al., 1995) was used to determine clients' attachment styles, 3) the Scales of Psychological Well-being (Ryff, 1989) was used to assess clients' psychological well-being, 4) the Symptom Check List (SCL-90-R; Derogatis 1983) was administered to participating clients in order to assess their psychological distress, and 5) a standardized demographic questionnaire was used to identify pertinent demographic information for clients.

Working Alliance Inventory

The Working Alliance Inventory (WAI; Appendix A) developed by Horvath & Greenberg (1986), is a 36 item questionnaire which taps three primary dimensions, comprised

of: a) the emotional bond of trust and attachment for the client, b) the client's feelings concerning the overall goals of treatment, and c) the client's feelings concerning the tasks relevant for achieving these goals. There are 12 items in each subscale. The subjects rate, on a 7-point Likert scale (1=never to 7=always) the extent to which that item applies to them. The dimensions are based on Bordin's working alliance theory. The range of scores for the entire scale is from 36 to 252, and the range of scores for each subscale is 12 to 84. According to the four conditions of validity specified by Campbell and Fiske (1959), the WAI presented with good construct validity. This has been established through multitrait and multimethod analyses demonstrated by Horvath & Greenberg (1989). The results of their analysis found that all of the WAI scales met the first and fourth conditions and the Task and Goal scales met the second. It should be noted however that none of the scales conformed to the third requirement because of the high inter-correlations among the subscales. Horvath and Greenberg (1991) also analyzed 18 studies for reliability. There were 34 reliability indices reported which resulted in an estimated average reliability of .86.

Client Attachment to Therapist Scale

The Client Attachment to Therapist Scale (CATS;

Appendix B), developed by Mallinckrodt et al. (1995), includes the clients' behaviors and perceptions aimed at maintaining psychological closeness to their therapist. These behaviors and perceptions are based on attachment theorists' view that clients' internal working models of relationships were shaped by early developmental experiences. The CAT is a 36 item questionnaire which consists of three subscales: a) Secure (14 items) which assesses the extent to which the client experiences the therapist as sensitive, responsive, and safe; b) Anxious-Ambivalent (12 items) which taps the extent to which the client experiences the therapist as disapproving, dishonest, unsafe for personal disclosures; and c) Preoccupied-Merger (10 items) which taps the extent to which the client is preoccupied with the therapist and longs for more contact. The items are rated on a 6-point Likert scale (1=strongly disagree to 6=strongly agree). The subscales are based on Bowlby's attachment theory (1969). The range of scores for the entire scales is from 36 to 216. The range of scores for each subscale is: a) Secure = 14 to 84, b) Anxious-Ambivalent, and c) Preoccupied-Merger = 10 to 60. High scores indicate more components of that particular attachment style. Scores were averaged to see which style has the highest average and that style was considered the

client's predominant attachment style. Internal consistency and retest reliability coefficients for all subscales were greater than .63 (Mallinckrodt et al., 1995).

Scales of Psychological Well-Being

The Scales of Psychological Well-Being (Appendix C) developed by Ryff (1989), is an 84 item questionnaire which consists of six subscales rated on a 6-point Likert scale (1=strongly disagree to 6=strongly agree). The overall range of scores is 84 to 504. Each subscale is described as follows:

a) Autonomy subscale: 14 items, a high scorer is determined to be self-determining and independent. In contrast, a low scorer is concerned about the expectations and evaluations of others. The scale's range of scores is 14 to 84. The internal consistency (coefficient alpha) = .83, and correlation with the 20-item parent scale = .97.

b) Environmental Mastery subscale: 14 items, a high scorer has a sense of mastery and competence in managing the environment. In contrast, a low scorer has difficulty managing everyday affairs. The range of scores is 14 to 84. The internal consistency (coefficient alpha) = .86, and correlation with the 20-item parent scale = .98.

c) Personal Growth subscale: 14 item scale, a high scorer has a feeling of continued development and a low scorer has a sense of personal stagnation. The range of scores is 14 to 84. The internal consistency (coefficient alpha) = .85, and correlation with the 20-item parent scale = .97.

d) Positive Relations With Others subscale: 14 item scale, a high scorer has warm, satisfying, and trusting relations with others. In contrast, a low scorer has few close and trusting relationships with others. The range of scores is 14 to 84. The internal consistency (coefficient alpha) = .88, and correlation with the 20-item parent scale = .98.

e) Purpose In Life subscale: 14 item scale, a high scorer has goals in life and a sense of directedness. A low scorer lacks a sense of meaning in life. The range of scores is 14 to 84. The internal consistency (coefficient alpha) = .88, and correlation with the 20-item parent scale = .98.

f) Self Acceptance subscale: 14 item scale, a high scorer possesses a positive attitude toward self, and a low scorer feels dissatisfied with self. The range of scores is 14 to 84. The internal consistency (coefficient alpha) = .91, and correlation with the

20-item parent scale = .99.

Symptom Checklist

The SCL-90-R (Appendix D) is a self-report inventory designed to reflect the current psychological symptom status of participants (Derogatis, 1983). It is a 90 item questionnaire where participants rate items on a 5-point Likert scale (1=not at all to 5=extremely often) indicating the degree to which the symptoms have distressed the participant. For the present study, respondents were instructed to rate problems and complaints with regard to the distress they had experienced in the past four weeks. The SCL-90-R yields scores for depression, paranoia, somatization, irritable anxiety, and anxiety with agoraphobia, as well as an overall distress score. For the purpose of this study, the overall distress score was used. The range of scores for the SCL-90-R is 90 to 450. The coefficient alpha and test-retest reliability have been calculated at .84 (Derogatis, 1983; Derogatis, Rickels, & Rock 1976).

Demographic Questionnaire

A demographic questionnaire (Appendix E) was used to obtain information on participants pertinent to this study. The following dimensions were included: a) gender, b) age, c) education, d) income, e) type of work, f) living

arrangements, g) ethnicity, and h) reason for therapy.

Procedure

The prospective volunteers were clients seeking therapy at the Community Counseling Center. At their initial intake, all clients were asked if they would be willing to participate in a study assessing the therapy relationship and its impact on treatment outcome. They were informed that participation was strictly voluntary and was in no way be a requirement for the receival of treatment at the Center. They were told that they would be asked to complete a paper and pencil questionnaire at two times during their therapy process (pre-test and post-test), and that the questionnaire would focus on psychological symptoms, psychological well-being, and the therapist-client relationship. Twenty five clients were asked to participate and twenty three initially agreed to participate. They were subsequently contacted by an investigator within the time frame of the first three therapy sessions (pre-test). The study was again described, they were asked to sign the "Informed Consent" form (Appendix F), and participants were then given the questionnaires. Participants were allowed to complete the questionnaire on their own time and asked to return it within seven (7) days. The investigator made arrangements to collect the completed forms from the

participants at which time a "Debriefing Statement" (Appendix G) was given to them.

The completed forms and questionnaires were kept on file in a secured area (locked cabinet). In order to maintain client confidentiality, there was no personal identification on the questionnaires. A participant identification number was assigned in order to link participants to the pre-test and post-test data. The numbers were assigned to each volunteer and this number was written on the corresponding questionnaires. The number was used as the only identifier. Each participant had a data card which contained the name of the participant and his or her corresponding number. The data cards were kept in a locked file cabinet for reference only and were the only way of identifying subject name and number for future administrations of the questionnaires. Project staff were the only ones to have access to the locked cabinet where the collected data was stored.

Throughout the course of the present study, 12 participants decided to withdraw. So the withdrawal rate of the study was 44 percent. The investigator pulled the data cards of these participants and filed them in a folder marked "Withdrawals" in the locked cabinet.

During the end phase of the therapy process (sessions 8

to 10; post-test), the investigator contacted the participants and arranged to administer the questionnaires a second time. The participants were again allowed to complete the questionnaire on their own time and asked to return it within seven days. The investigator made arrangements to acquire the completed questionnaires and provided the participants with another copy of the "Debriefing Statement" (Appendix G).

Design and Analyses

A quasi experimental, within subjects, correlational and pre-test/post-test design was used to test the proposed hypotheses. The two independent variables were: 1) Working Alliance, and 2) Client Attachment Style. The strength of the Working alliance was determined by the scores of the Working Alliance Inventory (WAI; Appendix A; Horvath & Greenberg, 1986; 1989). The three types of the client attachment styles were identified as Secure, Preoccupied-Merger, and Dismissing. These were determined by the scores on the Client Attachment to Therapist Scale (Appendix B; Mallinckrodt et al., 1995). There were two dependent variables: 1) Psychological Well-Being, and 2) Psychological Distress. These were assessed at the beginning and end of therapy and the change scores on the dependent variables were analyzed. The first dependent

variable identified the amount of change in the well-being scores. The well-being scores were determined by the Scales of Psychological Well-Being (Appendix C; Ryff, 1989). The second dependent variable identified the amount of change in symptoms for clients which was based on their responses to the Symptom Check List-90-R (Appendix D; Derogatis, 1983).

A Correlational analysis was used to determine the relationship between client attachment styles and the working alliance on changes in psychological well-being and changes in psychological symptoms. Each variable was measured according to degree of change in both well-being and symptoms from the beginning to the end of treatment (pre-test/post-test). The degree of change in well-being was determined by subtracting the scores obtained at pre-test (the beginning of treatment) from scores obtained at post-test (the end of treatment). In contrast, the degree of change in symptoms was determined by subtracting the scores obtained at post-test (the end of treatment) from scores obtained at pre-test (the beginning of treatment.

RESULTS

The race and gender characteristics of participants are presented in Table 1.

Table 1

Race and Gender

Description	N
Gender	
Male	2
Female	11
Race	
Latino	1
African Am.	2
Caucasian	10

As shown in Table 1, participants included 2 men and 11 women. Of these, one was Latino, 2 African American, and 10 caucasian. The average age of the participants was 39 (Std dev = 9.84), and their mean years of education was 15 (Std dev = 2.64).

Increases in psychological well-being and distress for each participant are presented in Table 2.

Table 2

Increases in Psychological Well-Being and Psychological Distress for Participants

Participants	Increases in Well-being	Increases in Distress
1	-14.00	+50.00
2	-12.00	+11.00
3	+5.00	+8.00
4	+9.00	-1.00
5	+9.00	-2.00
6	+12.00	-4.00
7	+18.00	-10.00
8	+30.00	-18.00
9	+51.00	-19.00
10	+54.00	-46.00
11	+60.00	-47.00
12	+115.00	-95.00
13	+125.00	-97.00

As shown in Table 2, two clients actually showed decreases in psychological well-being, three others showed

minimal increases in well-being, and the rest showed increases in well-being over the course of therapy (the minuses represent decreases in well-being and the pluses represent increases). Table 2 also shows that three participants had an increase in psychological distress, three others showed minimal decreases in distress, and the rest showed an obvious decrease in distress over the course of therapy (the minuses represent decreases in psychological symptoms and the pluses represent increases).

The results of the relationship between psychological well-being, psychological distress, attachment styles, and working alliance are presented in Table 3.

Table 3

The Relationship Between Psychological Well-Being, Psychological Distress, Attachment Styles, and Working Alliance

Codes:

CWB = Changes in Well-Being
CDS = Changes in Distress
DIS = Dismissing
PRE = Preoccupied
SEC = Secure
W/A = Working Alliance

	CWB	CDS	DIS	PRE	SEC	W/A
CWB		.926***	-.354	-.337	.338	.387
CDS			-.549*	-.371	.374	.457
DIS				.411	-.680**	-.817***
PRE					-.555*	-.217
SEC						.785***

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

Table 3 shows the correlations between psychological well-being, psychological distress, attachment styles and

working alliance. All the associations were in the expected direction although they were not all statistically significant.

Psychological Well-Being

Increases in psychological well-being were significantly associated with decreases in psycholgocial distress ($r=.926$, $p<.001$). In addition, increases in psychological well-being were positively associated with Secure attachments and strong working alliances while negatively associated with Dismissing and Preoccupied attachments.

Psychological Distress

In addition to the significant association between psychological distress and psychological well being, increases in psychological distress also significantly associated with having a dismissing attachment style ($r=-.549$, $p<.05$).

Working Alliance

There was a strong positive association between a strong working alliance and Secure attachment style ($r=.785$, $p<.001$). In addition, weaker alliances were significantly associated with having a Dismissing attachment style ($r=-.817$, $p<.001$)

Client Attachment Styles

Finally the relationship between the clients' attachment styles suggest that those with a high Dismissing style were significantly less secure ($r=-.68$, $p<.01$). Similarly those with a high preoccupied style were also significantly less secure ($r=-.555$, $p<.05$).

DISCUSSION

The results of this study, while in the expected direction, yielded few statistically significant findings. Regardless of the small sample size (N=13), the strength of the associations between psychological distress, psychological well-being, attachment style and working alliance, were impressive and warrant discussion.

As anticipated, a secure attachment style was strongly, although not statistically, associated with increased psychological well-being and decreased psychological distress. Further, as expected, both Dismissing and Preoccupied attachment styles were associated with decreased psychological well-being and increased psychological distress. These associations, however, were significant only for the Dismissing attachment style and psychological distress. As expected, the association between a Dismissing attachment style and a decrease in strength of the working alliance were significant as well as the association between a Secure attachment and an increase in strength of the working alliance. Further, the strength of the working alliance was associated with increased psychological well-being and decreased psychological distress. Finally, the associations between all of the client attachment styles suggest that clients who were predominantly Dismissing and

Preoccupied were significantly less secure, which was also as expected.

While all clients will have aspects of all three attachment styles in their personality, one style will usually predominate. Thus, it is important to recognize that the relative level of each style (Secure, Preoccupied, or Dismissing) will affect how clients cope during periods of high personal stress. For example, even though a client's personality may have Secure attachment components, if his or her primary style is Dismissing or Avoidant, he or she will tend to revert back to the primary attachment style during stressful periods. In other words, clients who are primarily Preoccupied or Dismissing will be unable to ask for help, isolate, avoid, and so on, when they are distressed, even though they may display more secure behaviors when their lives are stable. This is not only important for therapists to recognize, but providing clients with an awareness of their primary attachment styles could help some of them cope more effectively. Similarly, when clients make changes in their maladaptive coping styles, they often revert back to them during stress. When this happens, clients tend to blame themselves and feel discouraged. By addressing this, therapists can normalize and help clients understand this tendency, which in turn

will promote a more positive self-image for them. Further, when therapists are able to recognize clients' attachment styles, they are more prepared to deal with their own countertransference issues, and are able to formulate working hypotheses which will allow them to intervene accordingly.

The strength of the working alliance, as expected, was found to be predictive in regard to treatment outcome. Understandably, therapy would be more productive if therapists attended to the importance of establishing and maintaining this alliance with their clients. In addition, the findings of the present study suggest that therapists attend to clients' attachment styles and conceptualize how they might impact the working alliance.

Although the present study used actual clients seeking treatment, caution must be taken when generalizing the findings to other counseling settings and services, particularly in light of the fact that all of the therapists involved were trainees. It is also important to note that not all of the beginning therapists were trained in the same way. The individual differences, styles and orientations of each supervisor should be addressed and controlled for in future studies. Further, an important topic in future studies is to control for the therapist's attachment style

as well. Dozier, et al. (1994) found that case managers' different attachments styles effected their depth of interventions. Accordingly, it would be expected that therapists' different styles could effect the changes in clients well-being and symptoms.

Although this study provides initial support for the idea that the working alliance and client attachment styles will predict treatment outcome, clearly there is a need to conduct this study with a larger sample. It would also be important to control for the different orientations of supervisors (i.e., use orientation as a matching variable for grouping) which could confound trainees' intervention choices and the relative emphasis they may place on developing the treatment relationship. Further, it would be very useful to assess the effect of therapists' own attachment style on the working alliance and how the match between the therapist's and client's attachment styles might impact treatment outcome. Finally, conducting a longer term study to see how these constructs affect the retention of clients in therapy would be helpful.

In conclusion, our preliminary research indicates that the working alliance and attachment styles may effect treatment outcome for clients. Although a more comprehensive study, with a larger sample which takes into

account both client and therapist variables is needed, the trends in the present study suggest that trainees could benefit from awareness of their clients' attachment styles and that developing the skill to form therapeutic bonds with their clients might be central to the client's improvement over the course of treatment.

Appendix A

Working Alliance Inventory (WAI)

Please respond to each of the following items by circling the number that most closely corresponds to what you believe is accurate for you, on a scale ranging from (1) strongly disagree to (6) strongly agree.

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

1.	Sometimes I change the way I act or think to be more like those around me	1	2	3	4	5	6
2.	In general, I feel I am in charge of the situation in which I live	1	2	3	4	5	6
3.	I am not interested in activities that will expand my horizons	1	2	3	4	5	6
4.	Most people see me as loving and affectionate	1	2	3	4	5	6
5.	I feel good when I think of what I've done in the past & what I hope to do in the future	1	2	3	4	5	6
6.	When I look at the story of my life. I am pleased with how things have turned out	1	2	3	4	5	6
7.	I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people	1	2	3	4	5	6
8.	The demands of everyday life often get me down	1	2	3	4	5	6
9.	In general, I feel that I continue to learn more about myself as time goes by	1	2	3	4	5	6

10.	Maintaining close relationships has been difficult & frustrating for me	1	2	3	4	5	6
11.	I live life one day at a time & don't really think about the future	1	2	3	4	5	6
12.	In general, I feel confident & positive about myself	1	2	3	4	5	6
13.	My decisions are not usually influenced by what everyone else is doing	1	2	3	4	5	6
14.	I do not fit very well with the people & the community around me	1	2	3	4	5	6
15.	I am the kind of person who likes to give new things a try	1	2	3	4	5	6
16.	I often feel lonely because I have few close friends with whom to share my concerns	1	2	3	4	5	6
17.	I tend to focus on the present, because the future nearly always brings me problems	1	2	3	4	5	6
18.	I feel like many of the people I know have gotten more out of life than I have	1	2	3	4	5	6
19.	I tend to worry about what other people think of me	1	2	3	4	5	6
20.	I am quite good at managing the many responsibilities of my daily life	1	2	3	4	5	6
21.	I don't want to try new ways of doing things--my life is fine the way it is	1	2	3	4	5	6
22.	I enjoy personal & mutual conversations with family members or close friends	1	2	3	4	5	6

23.	I have a sense of direction & purpose in life	1	2	3	4	5	6
24.	Given the opportunity, there are many things about myself that I would change	1	2	3	4	5	6
25.	Being happy with myself is more important to me than having others approve of me	1	2	3	4	5	6
26.	I often feel overwhelmed by my responsibilities	1	2	3	4	5	6
27.	I think it is important to have new experiences that challenge how you think about yourself & the world	1	2	3	4	5	6
28.	It is important to me to be a good listener when close friends talk to me about their problems	1	2	3	4	5	6
29.	My daily activities often seem trivial & unimportant to me	1	2	3	4	5	6
30.	I like most aspects of my personality	1	2	3	4	5	6
31.	I tend to be influenced by people with strong opinions	1	2	3	4	5	6
32.	If I were unhappy with my living situation, I would take effective steps to change it	1	2	3	4	5	6
33.	When I think about it, I haven't really improved much as a person over the years	1	2	3	4	5	6
34.	I don't have many people who want to listen when I need to talk	1	2	3	4	5	6
35.	I don't have a good sense of what it is I'm trying to accomplish in life	1	2	3	4	5	6

36. I made some mistakes in the past, but I feel that all in all everything has worked out for the best 1 2 3 4 5 6

37. People rarely talk me into doing things I don't want to do 1 2 3 4 5 6

38. I generally do a good job of taking care of my personal finances & affairs 1 2 3 4 5 6

39. In my view, people of every age are able to continue growing & developing 1 2 3 4 5 6

40. I feel like I get a lot out of my friendships 1 2 3 4 5 6

41. I used to set goals for myself, but that now seems like a waste of time 1 2 3 4 5 6

42. In many ways, I feel disappointed about my achievements in life 1 2 3 4 5 6

43. It is more important to me to "fit in" with others than to stand alone on my principles 1 2 3 4 5 6

44. I find it stressful that I can't keep up with all of the things I have to do each day 1 2 3 4 5 6

45. With time, I have gained a lot of insight about life that has made me a stronger, more capable person 1 2 3 4 5 6

46. It seems to me that most other people have more friends than I do 1 2 3 4 5 6

47. I enjoy making plans for the future & working to make them a reality 1 2 3 4 5 6

48. For the most part, I am proud of who I am & the life I lead 1 2 3 4 5 6

49. I have confidence in my own opinions, even if they are contrary to the general consensus 1 2 3 4 5 6

50. I am good at juggling my time so that I can fit everything in that needs to get done 1 2 3 4 5 6

51. I have a sense that I have developed a lot as a person over time 1 2 3 4 5 6

52. People would describe me as a giving person, willing to share my time with others 1 2 3 4 5 6

53. I am an active person in carrying out the plans I set for myself 1 2 3 4 5 6

54. I envy many people for the lives they lead 1 2 3 4 5 6

55. It's difficult for me to voice my own opinions on controversial matters 1 2 3 4 5 6

56. My daily life is busy, but I derive a sense of satisfaction from keeping up with everything 1 2 3 4 5 6

57. I do not enjoy being in new situations that require me to change my old familiar ways of doing things 1 2 3 4 5 6

58. I have not experienced many warm & trusting relationships with others 1 2 3 4 5 6

59. Some people wander aimlessly through life, but I am not one of them 1 2 3 4 5 6

60. My attitude about myself is probably not as positive as most people feel about themselves 1 2 3 4 5 6

61. I often change my mind about decisions if my friends or family disagree 1 2 3 4 5 6

62. I get frustrated when trying to plan my daily activities because I never accomplish the things I set out to do 1 2 3 4 5 6

63. For me, life has been a continuous process of learning, changing, & growth 1 2 3 4 5 6

64. I often feel like I'm on the outside looking in when it comes to friendships 1 2 3 4 5 6

65. I sometimes feel as if I've done all there is to do in life 1 2 3 4 5 6

66. Many days I wake up feeling discouraged about how I have lived my life 1 2 3 4 5 6

67. My efforts to find the kinds of activities & relationships that I need have been quite successful 1 2 3 4 5 6

68. I enjoy seeing how my views have changed & matured over the years 1 2 3 4 5 6

69. I know that I can trust my friends and they know they can trust me 1 2 3 4 5 6

70. My aims in life have been more a source of satisfaction than frustration to me 1 2 3 4 5 6

71. The past had its ups and downs, but in general I wouldn't want to change it 1 2 3 4 5 6

72. I'm concerned about how other people evaluate the choices I've made in my life 1 2 3 4 5 6

73. I am not the kind of person who gives in to social pressures to think or act in certain ways 1 2 3 4 5 6

74. I have difficulty arranging my life in a way that is satisfying to me 1 2 3 4 5 6

75. I gave up trying to make big improvements or changes in my life a long time ago 1 2 3 4 5 6

76. I find it difficult to really open up when I talk to others 1 2 3 4 5 6

77. I find it satisfying to think about what I have accomplished in life 1 2 3 4 5 6

78. When I compare myself to friends & acquaintances, it makes me feel good about who I am 1 2 3 4 5 6

79. I judge myself by what I think is important, not by the values of what others think is important 1 2 3 4 5 6

80. I have been able to build a home & lifestyle for myself that is much to my liking 1 2 3 4 5 6

81. There is truth to the saying that you can't teach an old dog new tricks 1 2 3 4 5 6

82. My friends and I sympathize with each others' problems 1 2 3 4 5 6

83. In the final analysis, I'm not so sure that my life adds up to much 1 2 3 4 5 6

84. Everyone has their weaknesses, but I seem to have more than my share 1 2 3 4 5 6

Appendix B

Client Attachment To Therapist Scale (CAT)

Please respond to the following statements based on how you currently feel about your counselor. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

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

1.	I don't get enough emotional support from my counselor	1	2	3	4	5	6
2.	My counselor is sensitive to my needs	1	2	3	4	5	6
3.	I think my counselor disapproves of me	1	2	3	4	5	6
4.	I yearn to be "at one" with my counselor	1	2	3	4	5	6
5.	My counselor is dependable	1	2	3	4	5	6
6.	Talking over my problems with my counselor makes me feel ashamed or foolish	1	2	3	4	5	6
7.	I wish my counselor could be with me on a daily basis	1	2	3	4	5	6
8.	I feel that somehow things will work out OK for me when I am with my counselor	1	2	3	4	5	6
9.	I know I could tell my counselor anything and s/he would not reject me	1	2	3	4	5	6
10.	I would like my counselor to feel closer to me	1	2	3	4	5	6
11.	My counselor isn't giving me enough attention	1	2	3	4	5	6
12.	I don't like to share my feelings with my counselor	1	2	3	4	5	6

13.	I'd like to know more about my counselor as a person	1	2	3	4	5	6
14.	When I show my feelings, my counselor responds in a helpful way	1	2	3	4	5	6
15.	I feel humiliated in my counseling sessions	1	2	3	4	5	6
16.	I think about calling my counselor at home	1	2	3	4	5	6
17.	I don't know how to expect my counselor to react from session to session	1	2	3	4	5	6
18.	Sometimes I'm afraid that if I don't please my counselor, s/he will reject me	1	2	3	4	5	6
19.	I think about being my counselor's favorite client	1	2	3	4	5	6
20.	I can tell that my counselor enjoys working with me	1	2	3	4	5	6
21.	I suspect my counselor probably isn't honest with me	1	2	3	4	5	6
22.	I wish there were a way I could spend more time with my counselor	1	2	3	4	5	6
23.	I resent having to handle problems on my own when my counselor could be more helpful	1	2	3	4	5	6
24.	My counselor wants to know more about me than I am comfortable talking about	1	2	3	4	5	6
25.	I wish I could do something for my counselor too	1	2	3	4	5	6
26.	My counselor helps me to look closely at the frightening or troubling things that have happened to me	1	2	3	4	5	6
27.	I feel safe with my counselor	1	2	3	4	5	6

28.	I wish my counselor were not my counselor so that we could be friends	1	2	3	4	5	6
29.	My counselor is a comforting presence to me when I am upset	1	2	3	4	5	6
30.	My counselor treats me more like a child than an adult	1	2	3	4	5	6
31.	I often wonder about my counselor's other clients	1	2	3	4	5	6
32.	I know my counselor will understand the things that bother me	1	2	3	4	5	6
33.	It's hard for me to trust my counselor	1	2	3	4	5	6
34.	I feel sure that my counselor enjoys working with me	1	2	3	4	5	6
35.	I'm not certain that my counselor is all that concerned about me	1	2	3	4	5	6
36.	When I'm with my counselor, I feel I am his/her highest priority	1	2	3	4	5	6

Appendix C

Scales of Psychological Well-Being

Please respond to the following statements based on how you currently feel about your counselor. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

		Never			Sometimes			Always
1.	I feel uncomfortable with my counselor	1	2	3	4	5	6	7
2.	My counselor & I agree about the things I will need to do in therapy to help improve my situation	1	2	3	4	5	6	7
3.	I am worried about the outcome of these sessions	1	2	3	4	5	6	7
4.	What I am doing in therapy gives me new ways of looking at my problem	1	2	3	4	5	6	7
5.	My counselor & I understand each other	1	2	3	4	5	6	7
6.	My counselor perceives accurately what my goals are	1	2	3	4	5	6	7
7.	I find what I am doing in therapy confusing	1	2	3	4	5	6	7
8.	I believe my counselor likes me	1	2	3	4	5	6	7
9.	I wish my counselor & I could clarify the purpose of our sessions	1	2	3	4	5	6	7
10.	I disagree with my counselor about what I ought to get out of therapy	1	2	3	4	5	6	7
11.	I believe the time my counselor & I are spending together is not spent efficiently	1	2	3	4	5	6	7

12. My counselor does not understand what I am trying to accomplish in therapy	1	2	3	4	5	6	7
13. I am clear on what my responsibilities are in therapy	1	2	3	4	5	6	7
14. The goals of these sessions are important to me	1	2	3	4	5	6	7
15. I find what my counselor & I are doing in therapy unrelated to my concerns	1	2	3	4	5	6	7
16. I feel that the things I do in therapy will help me to accomplish the changes that I want	1	2	3	4	5	6	7
17. I believe my counselor is genuinely concerned for my welfare	1	2	3	4	5	6	7
18. I am clear as to what my counselor wants me to do in these sessions	1	2	3	4	5	6	7
19. My counselor & I respect each other	1	2	3	4	5	6	7
20. I feel that my counselor is not totally honest with me about his/her feelings towards me	1	2	3	4	5	6	7
21. I am confident in my counselor's ability to help me	1	2	3	4	5	6	7
22. My counselor & I are working towards mutually agreed upon goals	1	2	3	4	5	6	7
23. I feel that my counselor appreciates me	1	2	3	4	5	6	7
24. We agree on what is important for me to work on	1	2	3	4	5	6	7

25.	As a result of these sessions I am clearer as to how I might be able to change	1	2	3	4	5	6	7
26.	My counselor & I trust one another	1	2	3	4	5	6	7
27.	My counselor & I have different ideas on what my problems are	1	2	3	4	5	6	7
28.	My relationship with my counselor is very important to me	1	2	3	4	5	6	7
29.	I have the feeling that if I say or do the wrong things, my counselor will stop working with me	1	2	3	4	5	6	7
30.	My counselor & I collaborate on setting goals for my therapy	1	2	3	4	5	6	7
31.	I am frustrated by the things I am doing in therapy	1	2	3	4	5	6	7
32.	We have established a good understanding of the kind of changes that would be good for me	1	2	3	4	5	6	7
33.	The things that my counselor is asking me to do don't make sense	1	2	3	4	5	6	7
34.	I don't know what to expect as the result of my therapy	1	2	3	4	5	6	7
35.	I believe the way we are working with my problem is correct	1	2	3	4	5	6	7
36.	I feel my counselor cares about me even when I do things that he/she does not approve of	1	2	3	4	5	6	7

Appendix D

Symptom Checklist (SCL-90-R)

Here is a list of things people sometimes report experiencing. Please circle how often you have experienced each of the following in the last four (4) weeks.

HOW OFTEN DID YOU FEEL OR EXPERIENCE:	Not At All				Extremely Often
1. Headaches	1	2	3	4	5
2. Nervousness or shakiness inside	1	2	3	4	5
3. Repeated unpleasant thoughts that won't leave your mind	1	2	3	4	5
4. Faintness or dizziness	1	2	3	4	5
5. Loss of sexual interest or pleasure	1	2	3	4	5
6. Feeling critical of others	1	2	3	4	5
7. The idea that someone else can control your thoughts	1	2	3	4	5
8. Feeling others are to blame for most of your troubles	1	2	3	4	5
9. Trouble remembering things	1	2	3	4	5
10. Worried about sloppiness or carelessness	1	2	3	4	5
11. Feeling easily annoyed or irritable	1	2	3	4	5
12. Pains in heart or chest	1	2	3	4	5
13. Feeling afraid in open spaces or in streets	1	2	3	4	5
14. Feeling low in energy or slowed down	1	2	3	4	5
15. Thoughts of ending your life	1	2	3	4	5

16.	Hearing voices that other people do not hear	1	2	3	4	5
17.	Trembling	1	2	3	4	5
18.	Feeling that most people cannot be trusted	1	2	3	4	5
19.	Poor appetite	1	2	3	4	5
20.	Crying easily	1	2	3	4	5
21.	Feeling shy & uneasy with the opposite sex	1	2	3	4	5
22.	Feeling of being trapped or caught	1	2	3	4	5
23.	Suddenly scared for no reason	1	2	3	4	5
24.	Temper outbursts you could not control	1	2	3	4	5
25.	Feeling afraid to go out of your house alone	1	2	3	4	5
26.	Blaming yourself for things	1	2	3	4	5
27.	Pains in lower back	1	2	3	4	5
28.	Feeling blocked in getting things done	1	2	3	4	5
29.	Feeling lonely	1	2	3	4	5
30.	Feeling blue	1	2	3	4	5
31.	Worrying too much about things	1	2	3	4	5
32.	Feeling no interest in things	1	2	3	4	5
33.	Feeling fearful	1	2	3	4	5
34.	Your feelings being easily hurt	1	2	3	4	5
35.	Other people being aware of your private thoughts.	1	2	3	4	5

36.	Feeling others do not understand you or are unsympathetic	1	2	3	4	5
37.	Feeling that people are unfriendly or dislike you	1	2	3	4	5
38.	Having to do things very slowly to insure correctness	1	2	3	4	5
39.	Heart pounding or racing	1	2	3	4	5
40.	Nausea or upset stomach	1	2	3	4	5
41.	Feeling inferior to others	1	2	3	4	5
42.	Soreness of your muscles	1	2	3	4	5
43.	Feeling that you are watched or talked about by others	1	2	3	4	5
44.	Trouble falling asleep	1	2	3	4	5
45.	Having to check and double-check what you do	1	2	3	4	5
46.	Difficulty making decisions	1	2	3	4	5
47.	Feeling afraid to travel on buses, subways or trains	1	2	3	4	5
48.	Trouble getting your breath	1	2	3	4	5
49.	Hot or cold spells	1	2	3	4	5
50.	Having to avoid things, because they frighten you	1	2	3	4	5
51.	Your mind going blank	1	2	3	4	5
52.	Numbness or tingling in parts of your body	1	2	3	4	5
53.	A lump in your throat	1	2	3	4	5
54.	Feeling hopeless about the future	1	2	3	4	5
55.	Trouble concentrating	1	2	3	4	5

56.	Feeling weak in parts of your body	1	2	3	4	5
57.	Feeling tense or keyed up	1	2	3	4	5
58.	heavy feelings in your arms or legs	1	2	3	4	5
59.	Thoughts of death or dying	1	2	3	4	5
60.	Overeating	1	2	3	4	5
61.	Feeling uneasy when people are watching or talking about you	1	2	3	4	5
62.	Having thoughts that are not your own	1	2	3	4	5
63.	Having urges to beat, injure or harm someone	1	2	3	4	5
64.	Awakening in the early morning	1	2	3	4	5
65.	Having to repeat actions such as touching or washing	1	2	3	4	5
66.	Sleep that is restless or disturbed	1	2	3	4	5
67.	Having urges to break or smash things	1	2	3	4	5
68.	Having ideas or beliefs that others do not share	1	2	3	4	5
69.	Feeling very self-conscious with others	1	2	3	4	5
70.	Feeling uneasy in crowds such as shopping or at movies	1	2	3	4	5
71.	Feeling everything is an effort	1	2	3	4	5
72.	Spells of terror panic	1	2	3	4	5
73.	Feeling uncomfortable about eating or drinking in public	1	2	3	4	5

74.	Getting into frequent arguments	1	2	3	4	5
75.	Feeling nervous when you are left alone	1	2	3	4	5
76.	Others not giving you proper credit for achievements	1	2	3	4	5
77.	Feeling alone even when you are with people	1	2	3	4	5
78.	Feeling so restless you couldn't sit still	1	2	3	4	5
79.	Feelings of worthlessness	1	2	3	4	5
80.	The feeling something bad is going to happen to you	1	2	3	4	5
81.	Shouting or throwing things	1	2	3	4	5
82.	Feeling afraid you will faint in public	1	2	3	4	5
83.	Feeling people will take advantage of you if you let them	1	2	3	4	5
84.	Having thoughts about sex that bother you a lot	1	2	3	4	5
85.	The idea that you should be punished for your sins	1	2	3	4	5
86.	Thoughts & images of a frightening nature	1	2	3	4	5
87.	The idea that something serious is wrong with your body	1	2	3	4	5
88.	Never feeling close to another person	1	2	3	4	5
89.	Feelings of guilt	1	2	3	4	5
90.	The idea that something is wrong with your mind	1	2	3	4	5

Appendix E

Demographic Questionnaire

PLEASE NOTE THAT YOUR RESPONSES ARE STRICTLY CONFIDENTIAL. PLEASE TRY TO ANSWER AS MANY QUESTIONS AS POSSIBLE TO THE BEST OF YOUR KNOWLEDGE. THANK YOU FOR YOUR PARTICIPATION.

1. Your gender (circle one) a. male b. female

2. Your age at last birthday _____

3. What is your highest educational level (grade) _____
   If appropriate, what is your partner's highest educational level (grade) _____
   If you live with your parents, please give this information for:
   a. your father _____ b. your mother _____

4. What do you think your family's yearly income is (your best estimate. Please circle the number which applies:

   1. $5,000/yr or less ($416/mo or less)
   2. $5,000/yr to $9,999/yr ($417/mo to $832/mo)
   3. $10,000/yr to $14,000/yr ($833/mo to $1249/mo)
   4. $15,000/yr to $19,000/yr ($1250/mo to 1249/mo)
   5. $20,000/yr to 29,999/yr ($1667/mo to $2499/mo)
   6. $30,000/yr to $50,999/yr ($2500/mo to $4166/mo)
   7. $50,000/yr or more (4167/mo or more)

5. What kind of work do you do _____
   What kind of work does your partner do (if applicable) _____
   If you live with your parents:
   What kind of work does your father do _____
   What kind of work does your mother do _____

6. Which of the following best describes your birth family's racial background?
   1. African-American _____
   2. Latino, Chicano, or Hispanic _____
   3. White _____
   4. Asian _____
   5. Native American _____
   6. Other (please specify _____ _____

7. Please state briefly why you are seeking therapy

Appendix F

Informed Consent

INFORMED CONSENT

TREATMENT OUTCOME

The purpose of the study you are volunteering for is to assess the relationship you have with your therapist and how you respond to therapy. It is hoped that the will help therapists be more effective and helpful to their clients. You will be asked to complete a paper and pencil questionnaire, which will focus on your psychological symptoms, your psychological well-being, and your relationship with your therapist. You will be asked to fill out a questionnaire on these issues at three points in the therapy process: 1) sessions 1-3, 2) sessions 8-10, and 3) sessions 16-20; the amount of time required in filling out the questionnaire will be approximately 20 or 30 minutes each time. The duration of this study will be from session 1 to session 20, a maximum of 5 months. A graduate student will administer the questionnaires. Your therapist will NOT be given any information on your specific responses. These responses are confidential.

Your name will NOT be included on the survey and YOUR ANONYMITY WILL BE MAINTAINED AT ALL TIMES. The questionnaires will be kept in a locked cabinet, available only to the researchers.

All questions you may have will be answered. You may refuse to answer any questions at any time. You can withdraw from the study at any time. There will be no penalty (i.e., You can continue to receive therapy at the Counseling Center) even if you choose to withdraw from the study.

The of this study, if published, will be done with provision that all identifying information be withheld. If you have any questions about this study, you may call Dr. Faith McClure (909) 880-5598 or Dr. Edward Teyber (909) 880-5592, Psychology Department California State University, San Bernardino, CA 92407.

This research study has been approved by the Institutional Review Board (IRB) of California State University San Bernardino. If you have questions about research subjects' rights or in the event of a research-related injury, you may

contact the IRB (909) 880-5027.

I acknowledge understanding of the nature and purpose of this study and freely consent to participate.

Place a check mark here ____ Today's Date: _____

Appendix G

Debriefing Form

DEBRIEFING

Thank you for participating in this study. As indicated in the informed consent form, the purpose of this study is to assess the relationship you have with your therapist and how you respond to therapy. At various times, we will ask you about symptoms you might have, how satisfied you are with how you feel, and about your relationship with your therapist. Your therapist will NOT have this information about your responses. We hope that this study will help us identify ways to make therapy more beneficial.

If any of the questions asked were disturbing to you, please discuss these with your therapist. You may also call Dr. Faith McClure [(909) 880-5598] or Dr. Edward Teyber [(909) 880-5592], Psychology Department, California State University, San Bernardino, 5500 University Parkway, San Bernardino, CA 92407, if you have any questions or concerns.

There are also support groups in the community, most of which provide free group support. Information about available support groups near your home may be obtained by calling the California Self-Help Center, toll free (800) 222-link.

Dr.'s McClure & Teyber may also be contacted if you would like a copy of the from this study when it is completed.

REFERENCES

Ainsworth, M.D. (19772). Attachment and dependency: A comparison. In J.L. Gerwirtz (Ed.), Attachment and Dependency. Washington, DC: V.H. Winston and Sons.

Blaauw, E., & Emmelkamp, P. (1994). The therapeutic relationship: A study on the value of the Therapist Client Rating Scale. Behavior and Cognitive Psychotherapy, 22, 25-35.

Bordin, E.S. (1975). The Working Alliance: Basis For a General Theory of Psychotherapy. Paper presented at a symposium of the American Psychological Association, Washington, DC.

Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. Psychotherapy, 16, 252-260.

Bordin, E.S. (1980). Of Human Bonds That Bind or Free. Presidential address delivered at a meeting of the Society for Psychotherapy Research, Pacific Grove, CA.

Bowlby, J. (1969). Attachment. New york: Basic Books.

Bowlby, J. (1973). Separation: Anxiety and anger. New York: Basic Books.

Bowlby, J. (1978). Attachment theory and its therapeutic implications. In S.C. Feinstein and P.L. Giovachini (Eds.), Adolescent psychiatry. Vol. VI: Development and clinical studies (pp. 5-33). Chicago: University of Chicago Press.

Campbell, D.T., & Fiske, D.W. (1959). Convergent and discriminant validation by the multitrait-multimethod matrix. Psychological Bulletin, 56, 81-105.

Cartwright, D.S. (1965). Influence, Leadership, control. In J.G. March (Ed.), Handbook of Organizations. Chicago: Rand McNally.

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

Derogatis, L.R. (1983). The SCL-90 scoring, administration and procedures, manual I (for the revised version). Baltimore: Johns Hopkins University School of Medicine, Clinical Psychometrics Research Unit.

Derogatis, L.R. Rickels, K., & Rock, A.F. (1976). The SCL-90 and the MMPI: A step in the validation of a new self-report scale. British Journal of Psychiatry, 128, 280-289.

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

Freud, S. (1958). On the beginning of treatment: Further recommendations on the technique of psychoanalysis. In J. Strachey (Ed. and Trans.), The Standard Edition of the Complete Psychological Works of Sigmund Freud, 12, 122-144. London: Hogarth Press. (Original work published 1913).

Gaston, L. (1991). Reliability and criterion-related validity of the California Psychotherapy Alliance Scales-patient version. Journal of Consulting and Clinical Psychology, 3, 68-74.

Gaston, L., Piper, W., Debbane, E., & Garant, J. (1994). Alliance and technique for predicting outcome in short- and long- term analytic therapy. Psychotherapy Research, 4, 121-135.

Gelso, C.J., & Carter, J.A. (1985). The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. The Counseling Psychologist, 3, 155-243.

Hartley, D.E., & Strupp, H.H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. In Masling, J. (Ed.), Empirical Studies of Psychoanalytic Theories, Vol.1. New York:Lawrence Erlbaum Associates.

Horvath, A., & Greenberg, L. (1986). In Greenberg & Pinsoff, The Psychotherapeutic Process: A Research Handbook. New York:Guilford.

Horvath, A., & Greenberg, L. (1989). Development and

validation of the Working Alliance Inventory. Journal of Counseling Psychology, 36, 223-232.

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

Karen, R. (1990). Becoming Attached. Atlantic Monthly, (Feb.), 35-70.

Karen, R. (1994). Becoming Attached. New York NY: Basic Books.

Klee, A.M., Abeles, N., & Muller, R.T. (1990). Therapeutic alliance: Early indicators, course, and outcome. Psychotherapy, 27, 166-174.

LaCrosse, M.B. (1977). Comparative perceptions of counselor behavior: A replication and extension. Journal of Counseling Psychology, 29, 464-471.

LaCrosse, M.B., & Barak, A. (1976). Differential perception of counselor behavior. Journal of Counseling Psychology, 23, 170-172.

Little, R. (1964). Buddy relations and combat performance. In M. Janowitz (Ed.), The New Military. New York:Russel Sage.

Lyddon, W., & Satterfield, W. (1994). Relation of client attachment to therapist first- and second-order assessments. Journal of Cognitive Psychotherapy: An International Quarterly, 8, 233-242.

Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized/disoriented attachment pattern: Procedures, findings and implications for the classification of behavior. In T.B. Brazelton & M. Yogman (Eds.), Affective Development In Infancy, 95-124. Norwood, NJ: Ablex.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In M. Greenberg, D. Cicchetti, & M. Cummings (Eds.), Attachment In The Preschool Years: Theory, Research, And Intervention, 121-160. Chicago: University of Chicago Press.

Mallinckrodt, B. (1991). Client's representations of childhood emotional bonds with parents, social support, and formation of the working alliance. Journal of Counseling Psychology, 38, 401-409.

Mallinckrodt, B. (1992). Childhood emotional bonds with parents, development of adult social competencies, and availability of social support. Journal of Counseling Psychology, 4, 453-461.

Mallinckrodt, B., Coble, H.M., & Gantt, D.L. (1995). Attachment patterns in the psychotherapy relationship: Development of Client Attachment to Therapist Scale. Journal of Consulting Psychology, 42, 307-317.

McClure, F.H., & Teyber, E. (1996). Child and Adolescent Therapy: A Multicultural-Relational Approach. Texas:Harcourt Brace.

Mitchell, K.M., Bozarth, J.D. & Krauft, C.C. (1977). A reappraisal of the therapeutic effectiveness of accurate empathy, non-possessive warmth and genuineness. In A.S. Gurman & A.M. Razin (Eds.), Effective Psychotherapy: A Handbook of Research, 482- 503. New York: Pergamon Press.

Parker, G., Tupling, H., & Brown, L.B. (1979). A parental bonding instrument. British Journal of Medical Psychology, 52, 1-10.

Parloff, M.B., Waskow, I.E., & Wolfe, B.E. (1978). Research on therapist variables in relation to process and outcome. In S.L. Garfiend & A.R. Bergin (Eds.), Handbook of Psychotherapy and Behavior Change, 233-282. New York: Wiley.

Piper, W.E., Debbane, E.G., & Garant, J. (1977). An outcome study of group psychotherapy. Archives of General Psychiatry, 34, 264-274.

Rogers, C.R. (1951). Client Centered Therapy. Cambridge, Mass.: Riverside Press.

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

Rogers, C.R., Gendlin, G.T., Kiesler, D.V., & Truax, L.B.

(1967). The Therapeutic Relationship and Its Impact: A Study of Psychotherapy With Schizophrenics. Madison, Wisc.: University of Wisconsin Press.

Ryff, C.D. (1989). Happiness is everything, or is it? Explorations on the meaning of psychological well-being. Journal of Personal and Social Psychology, 57, 1069-1081.

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

Scherer, M., Maddux, J.E., Mercadante, B., Prentice-Dunn, S., Jacobs, B., & Rogers, R.W. (1982). The Self-Efficacy Scale: Construction and Validation. Psychological Reports, 51, 663-671.

Spitzer, R.L., Endicott, J.E., & Cohen, G.M. (1967). Psychiatric status schedule. New York: New York State Department of Mental Hygiene.

Teyber, E. (1997). Interpersonal Process In Psychotherapy: A Relational Approach, third edition. California: Brooks/Cole.

Weiss, J. (1993). How Psychotherapy Works: Process and Technique. New York:Guilford Press.

Weiss, R. (1975). Marital Separation. New York:Basic Books.

Weiss, R. (1978). Couples relationships. In M. Corbin (Ed.), The Couple. New York:Penguin Books.

Weiss R. (1979). Going It Alone: The Family Life and Social Situation of the Single Parent. New York:Basic Books.

Weiss, R. (1984). Attachment in adult life. In Parkes & Stevenson-Hinde, The Place of Attachment in Human Behavior. New York:Basic Books.