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**PSYCHOLOGICAL MINDEDNESS
AND
ADULT ATTACHMENT STYLES**

S. Manley



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**PSYCHOLOGICAL MINDEDNESS
AND
ADULT ATTACHMENT STYLES**

A study of the therapist-client relationship

Thesis submitted in partial fulfilment of the requirements of the
degree of Doctorate in Clinical Psychology (D.Clin.Psy.).

43855 words



SUMMARY

The aims of this study were to examine the relationship between psychological mindedness and adult attachment styles, and to assess the effects of a match or mismatch on these concepts between therapists and their clients. A critical review of the literature highlighted ambiguities in definition and measurement, which this study also aimed to clarify. A pilot study confirmed the validity of the measures chosen for the study and provided preliminary data. The main study consisted of a comparison between a therapist group and a client group on the Psychological Mindedness Scale (PMS), Toronto Alexithymia Scale (TAS-20), Adult Attachment Scale (AAS), and the Hazan and Shaver attachment questionnaire (1987). The attachment dimensions on the AAS were also converted into Bartholomew's (1990) four-category model. A third group provided an unmatched control for the client group.

The methodological limitations of the study, particularly due to the low response rate, further attrition from the client and control groups on follow-up after six months, and confounding factors associated with the groups, meant that only very tentative conclusions could be reached. Psychological mindedness and secure attachment were found to be positively correlated, and alexithymia and insecure attachment (particularly fearful-avoidant) negatively correlated. The therapist group had high levels of psychological mindedness and were mostly securely attached. The literature on 'wounded healers' was discussed in relation to those therapists who were insecurely attached. The client group were more insecurely attached than any of the other groups. Predictions about therapist and client matching on psychological mindedness and attachment styles were unable to be properly tested. The relevance of this study for psychotherapeutic practice, particularly in relation to the impact of similar or different attachment styles in therapists and clients, was discussed. A speculative model suggesting common pathways in the development of psychological mindedness and attachment styles was proposed.

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INTRODUCTION

1. INTRODUCTION

1.1 Background

Throughout the history of psychotherapy there have been many research studies that have attempted to answer the question “which treatment is best suited for which patient with which type of problem?” (e.g. Shapiro & Shapiro, 1982; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975; Smith, Glass, & Miller, 1980; Stiles, Shapiro & Elliot, 1986). So far, a definitive answer has not been found (although the recent review by Roth and Fonagy (1996) suggests that the answer is becoming clearer). Many research studies have also attempted to decide the nature of the therapeutic efficacy of psychotherapy, by studying the relationship aspects of the treatment. This work has highlighted the importance of such factors as “the therapeutic/working alliance” and the non-specific factors of “empathy”, “warmth”, and “genuineness”, (eg. Bergin & Garfield, 1994; Truax & Carkhuff, 1967), although more recent research suggests that these conditions are neither necessary nor sufficient but are facilitative (Bordin, 1979; Gelso & Carter, 1985; Horvath & Symonds, 1991).

The research carried out clearly shows that psychotherapy works (eg. Luborsky, Singer, & Luborsky, 1975, “Everyone has won and all must have prizes”; Stiles et al. 1986, the “equivalence paradox”), but what does this actually mean? This is very difficult to decide, as it all depends on what is meant by ‘psychotherapy’, given that different ‘psychotherapies’ have different underlying philosophies and treatment goals.

As the number of ‘psychotherapies’ is now more than 400 (Kazdin, 1986), accounting for them all satisfactorily is clearly difficult. Research, therefore, tends to focus on the three “core” psychotherapies - psychoanalytic/psychodynamic, cognitive-behavioural, and humanistic. Of these, the psychoanalytic/psychodynamic and humanistic approaches have more in common with each other than the cognitive-behavioural approaches, in that they share similar treatment goals and underlying philosophies, but couched in different terminology.

For the purposes of this research, the definition of psychotherapy used is a very broad one, being 'any form of regular contact between a therapist, using some form of psychological therapy, and their client.' This retains the generic features of the psychotherapeutic relationship that develops between the therapist and his/her client. This relationship is regarded as the vehicle of change for both parties (eg. Bowlby, 1977b, 1988; Derlega, Hendrick, Winstead, & Berg, 1991; Holmes, 1994; Orlinsky, Grawe, & Parks, 1994). It enables the client to gain a greater personal understanding, and the therapist to learn from the client, both about the therapeutic process and about him/herself (e.g. Cashdan, 1988). Given the personal impact of this meeting then, it is inevitable that the personal styles of the two participants are going to contribute in some capacity to the way that the encounter develops, beyond the therapeutic approach adopted (eg. Caine, Wijesinghe, & Winter, 1981; Horvath & Luborsky, 1993; Strupp, 1977).

Despite the huge amount of research on the psychotherapeutic relationship, most of this has focussed on client and/or therapist characteristics. Little research has examined the mutuality of the therapeutic encounter, especially the interactive effects of the personal styles of the therapist and client in psychotherapy. What research there is has been rather inconclusive. This study is an attempt to address this gap in the research literature. Two key concepts have been identified as needing further study, that of psychological mindedness and adult attachment styles.

PSYCHOLOGICAL MINDEDNESS

2. PSYCHOLOGICAL MINDEDNESS

This is widely regarded by most therapists as an essential prerequisite for most forms of psychological therapy, but particularly psychoanalytic psychotherapy. There is also an assumption that the *sine qua non* of being a psychotherapist is characterized by their level of psychological mindedness. Despite the clinical conviction of psychotherapists that high levels of psychological mindedness can lead to more positive outcomes in insight-oriented psychotherapies, there is very little empirical evidence to support this. Few reliable or valid measures of the concept are available, partly perhaps because of the lack of a single operational definition. As the concept of psychological mindedness has also been used synonymously with such terms as insightfulness, reflectiveness, and introspectiveness, (e.g. Appelbaum, 1973), it demands more detailed study.

2.1 Origins of the concept

Psychological mindedness has a long history and can be traced back as far as William James' concept of "tender-minded" (Farber, 1985). The concept has been in the empirical literature since the 1950s, and was one patient variable used in the Psychotherapy Research Project of The Menninger Foundation. It was in this high-profile psychoanalytic centre that a 30-year naturalistic study of psychoanalysis and psychotherapy was set up in 1952-54, and the term then became associated with this project (Wallerstein, 1989). However, the definition used was rather narrow and based on a variable known as 'externalization', which is quite different from subsequent definitions (Greenson, 1973; Kernberg, 1973). Its roots lie in the psychoanalytic field where variants of it have been discussed in the literature under 'indications for psychoanalysis'. Although Freud (1905, 1913, 1937) did not use the term in his writings on indications for psychoanalysis, he referred to many characteristics that would now be subsumed under this heading. More recently the term psychological mindedness has been specifically cited as a key indicator for psychodynamic psychotherapy (eg. Bergin & Garfield, 1994, Coltart, 1988), and regarded as an essential requirement for therapists as well (eg. Farber, 1985).

2.2 Definitions

Eleven definitions have been identified in the literature, with the concept of psychological mindedness being regarded as an interest, ability, tendency, trait, capacity, and attribute.

The early definitions focussed more on the individual, eg. Appelbaum (1973) - "A person's ability to see relationships among thoughts, feelings and actions, with the goal of learning the meaning and causes of his experiences and behaviour" (p.36), and similarly Baekeland and Lundwall (1975) - "Implies the patient's ability to recognize and admit psychological and interpersonal problems, to see himself in psychological terms, to use or to accept the use of psychological constructs, or to at least imagine psychological causes of his symptoms and behaviour" (p.756). Farber (1985) defined it as a trait rather than an ability, and applied it to others as well as the self - "A trait which has as its core the disposition to reflect upon the meaning and motivation of behaviour, thoughts, and feelings in oneself and others" (p.170). He felt that it was likely to be the result of a complex product of the interaction of genetic endowment and a number of environmental influences. Hall (1992) developed a new conceptual model based on what she felt were inconsistencies in the literature. She identified two major dimensions that of Interest/Ability and Intellect/Affect, and combined these to form one model of what she termed 'accurate psychological mindedness', defined as - "reflectivity about psychological processes, relationships, and meanings, and is displayed by an individual to the extent that he or she displays both interest in and ability for such reflectivity, and across both affective and intellectual dimensions"(pp.139-140). Finally Conte, Ratto, and Karasu (1996) offered the following definition, based on the factors identified in their development of a new measure for the concept - "An attribute of an individual that presupposes a degree of access to one's feelings, a willingness to try to understand oneself and others, a belief in the benefit of discussing one's problems, an interest in the meaning and motivation of one's own and other's thoughts, feelings and behaviour, and a capacity for change" (p 254).

2.3 Developmental research

Hatcher, Hatcher, Berlin, Okla and Richards (1990) and Hatcher and Hatcher (1997) assessed the psychological mindedness of children and adolescents using TAT cards. They identified two main strands in the research literature, that of the development of children's "theory of mind", and children's growing understanding of and ability to tolerate painful emotions. The former, was seen as fundamental to the development of psychological mindedness, as it lead to an understanding of self and others. This was thought to be largely genetically determined, involving the developmental capacity to understand the representational activity of the mind, particularly through the development of speech. Much of the research in this area has built upon the cognitive developmental work pioneered by Piaget (1965, 1976, 1981). From this developmental perspective, younger children can only understand themselves and others in unsophisticated ways. Self-understanding is seen as a later development, given the formal operational stage of cognitive development required to achieve the ability to see through one's own conflicts and defences. Psychological mindedness is viewed as "built on both cognitive and emotional skills, and it can be seen as a term characterizing children's ability to make sense of themselves or the world in psychological terms" (Hatcher & Hatcher, 1997, p.66). Thus psychological mindedness is regarded as a complex capacity that is acquired developmentally and influenced by social experience.

Dollinger, Reader, Marnett and Tylenda (1983), Dollinger, Greening and Tylenda (1985) and Dollinger (1997), conducted a series of studies with children and adults, using a word association test. They defined psychological mindedness as the ability to read between the lines of behaviour in relation to the self and others. Thus, it was seen as an ability to understand defence mechanisms. They concluded from their studies that it was a combination of knowledge and vigilance (sagacity) rather than intuitive, empathic understanding (acumen) that led to success at reading between the lines. In other words, the ability to see through others' defence mechanisms was based on knowing what to look for and paying attention to those cues. They felt that this ability was not easily taught. A further finding was that intelligence was a positive predictor of psychological

mindedness about others, although it is not clear whether increased intelligence necessarily leads to increased levels of psychological mindedness.

2.4 Clinical research

Of the clinically relevant research conducted specifically to examine the utility of the concept of psychological mindedness, there is a lack of consistency and clarity regarding the definitions and measures used. For example, Abramowitz and Abramowitz (1974) found that clients who scored high on a measure of psychological mindedness perceived the therapist as more interpersonally skilled, and did better in an insight-oriented group than those clients who scored low on the same measure. However, the results were not significant, non-clinical samples were used, and the measure of psychological mindedness was the Insight Test, which defined psychological mindedness as a skill independent of the person's insight into themselves. They concluded that those individuals with high psychological mindedness were more likely to use the psychological insights offered by the therapist, because they were cognitively more primed for this.

Psychological mindedness was one of the seven variables identified by Sifneos (1968) in assessing motivational criteria for short-term psychotherapy. He found that those who were the most motivated did better than those who were the least motivated, as determined by both therapist and patient statements at the end of therapy. However, psychological mindedness is only one aspect of a patient's motivation for psychotherapy and probably has different effects. A patient can be motivated but not be psychologically minded and vice versa. As with psychological mindedness, motivation has been defined in a variety of ways leading to inconclusive results regarding the role it plays in psychotherapy. Rosenbaum and Horowitz (1983) developed their own measure of motivation, drawing on the findings of previous research. Psychological mindedness was again among the four factors that they identified. They suggested that psychological mindedness was less to do with motivation and more to do with whether or not a person was suitable for insight-oriented psychotherapy, referring more to such attributes as ego strength. They also suggested that psychological mindedness probably reflected

experience and personality, in contrast to the more immediate concerns of patient motivation, and therefore might be too stable to change over a short course of therapy.

Links between ego strength and psychological mindedness, and between other psychotherapeutic variables, have frequently been made in the literature. The concept of ego strength has not been defined consistently, but it is generally thought to include motivation and psychological mindedness in the dimensions that it covers. In a review of the literature on ego strength, Lake (1985) suggested that the notion of personal and social competence, perceived as “the observable outcome of effectively performing ego functions (or adaptive self-management)” (p. 477), provided an operationally defined way of assessing ego strength. Others, (eg. Appelbaum, 1973; Conte, Buckley, Picard & Karasu, 1995) also agreed that psychological mindedness was associated with ego strength. For example, Conte et al. (1995) found high positive correlations between psychological mindedness and ego strength, in particular the three ego functions of mastery-competence, synthetic-integrative functioning, and autonomous functioning. They suggested that psychological mindedness and these ego functions were part of a multifaceted concept that dealt with adaptive functioning and that psychological mindedness might be an additional aspect of ego functioning. In a related study, using the Personality Profile Index, they found that those patients who scored high on psychological mindedness were also above average in assertiveness, sociability, and acceptance. Those who scored low showed high passivity, depression, submission, and rejection. Of interest to this study, the concept of ego strength has been related to attachment style, with securely attached individuals being identified as high on ego strength (Bowlby, 1977a). Low ego strength has also been related to alexithymia (Taylor, Bagby & Parker, 1997).

The quality of the therapeutic alliance in the early stages of psychoanalytic psychotherapy has often been regarded as an important predictor of a successful outcome (Orlinsky et al., 1994). In a study that aimed to identify the differential contribution of a number of variables to patient therapeutic alliance readiness, (object relations, psychological mindedness, hope for success, psychic pain, and intrapsychic flexibility), Ryan and Cicchetti (1985), could account for 41% of the variance in predicting the quality of the

patient's alliance readiness. However, 30% of this was accounted for by the variable 'object relations', with psychological mindedness being among the remaining 11%. Psychological mindedness was defined in this study as the quality of the patient's psychological set towards self and one's difficulties, and was measured using a non-standardized scale developed for the study. It may not, however, have addressed the interpersonal aspects of psychological mindedness, which arguably would have more influence on the development of the initial therapeutic alliance. Other work has made links between the therapeutic alliance and attachment styles (e.g. Horvath & Luborsky, 1993; Mallinckrodt, Gantt & Coble, 1995), which will be discussed later.

Conte, Plutchik, Jung, Picard, Karasu and Lotterman (1990) and Conte et al. (1996), investigated a new measure of psychological mindedness in a study of psychiatric patients attending for psychotherapy. They found that it was related to the number of psychotherapy sessions attended, level of education, and with patients' assessment of their psychosocial symptoms after the end of treatment. However, this latter finding was not replicated in a later study. An interesting finding that emerged was that patients who perceived themselves as high on psychological mindedness also perceived themselves as having received greater benefit from psychotherapy than that noted by either a therapist or an independent rater. Conte et al. (1996) also questioned whether psychological mindedness would be related to transference or the therapeutic alliance. In contrast to some of these findings, McCallum and Piper (1990), using a different measure of psychological mindedness, found no relationship between the concept and age, gender, marital status, employment status, level of education, or measures of psychiatric symptoms and psychological distress. Psychological mindedness was significantly associated with remaining in therapy, and engaging in therapeutic work, but not with therapy outcome. They suggested that psychological mindedness might improve with longer-term therapy, and might also be a useful selection criterion for different forms of therapy.

In a comprehensive review of the literature on psychological mindedness, McCallum and Piper (1997) argued that the concept should be regarded as a stable characteristic. They suggested that its development was influenced by both genetic and environmental factors.

and that ability to be psychologically minded was separate from the motivation to display that ability. They also separated it from insight by regarding it as a process that leads to insight. Citing their own work, they suggested that psychological mindedness and mental health were independent of each other, in that high levels of psychological mindedness did not necessarily protect one from mental ill-health. It was best seen as an intervening variable between certain predictor variables and therapy outcome, and as facilitating engagement in psychodynamic psychotherapy. The ability to be psychologically minded towards oneself was regarded as more difficult than the ability to be psychologically minded towards others. Overall, they felt that psychological mindedness was a healthy attribute, leading to greater insight into oneself and others, and more balance between the positive and negative aspects of oneself.

2.5 Relationship to other concepts

a. Self-consciousness

From the development of a measure of self-consciousness (the Self-Consciousness Scale), Fenigstein, Scheier and Buss (1975) identified private self-consciousness, (defined as awareness of the hidden, internal aspects of the self), and public self-consciousness, (defined as awareness of the external aspects of the self, such as appearance, and social behaviour). Although both self-consciousness and psychological mindedness appear to refer to similar processes, there has not been any research that has compared their relationship. Both are assumed to be of therapeutic value. However, in a review of the literature on self-directed attention, Fenigstein (1997) also argued that increased self-awareness, like increased psychological mindedness, might be psychologically damaging, leading to anxiety, depression and paranoia. He stated that any beneficial therapeutic effects of psychological mindedness were unlikely to be mediated by self-consciousness, given the potentially negative effects of self-directed attention. People either very low or very high in private self-consciousness are likely therefore, to be poor candidates for insight-oriented psychotherapy.

Trudeau and Reich (1995) looked at the relationship between psychological mindedness, as measured by the Psychological Mindedness Scale (PMS), (Conte et al. 1990), mental well-being, and self-consciousness (as measured by Self-Consciousness Scale, Fenigstein et al. 1975) in a sample of college students. They found significant positive relationships between psychological mindedness and mental well-being, and self-consciousness. They also found that as psychological mindedness increased, then so did the level of mental well-being, but self-consciousness decreased. The latter was found to have a negative effect on mental well-being, lending support to Fenigstein (1997). No significant differences were found for age or gender.

b. Personal Intelligence

Gardner (1983, 1993) argued that the standard concept of IQ offered only a limited picture of the potential range of ability and proposed instead that there were at least seven key varieties of intelligence, including personal intelligence. Two kinds of personal intelligence have been identified - intrapersonal intelligence (being able to access one's feelings and use them appropriately), and interpersonal intelligence (being able to accurately empathize with another person). Park and Park (1997) suggested that high personal intelligence, like high psychological mindedness, could have negative consequences. They suggested that children with high psychological mindedness or personal intelligence might suffer more from parenting experiences that were not attuned to their heightened sensitivities. Personal intelligence might have an evolutionary, biological basis whose development could be stifled by an uncaring environment. They argued that there might be a critical period for its development, like the development of language, during which the child began to develop a 'theory of mind' through direct interpersonal experience. If this process were disrupted then the effects might be irreversible. Psychological mindedness was seen, therefore, to be a further development of the skills that children needed to learn to know themselves and others.

Hobson (1994) suggested that a 'theory of mind' developed by the middle of the fourth year because of a biological propensity for interpersonal relatedness. He concluded that

“it is because perceptual-affective processes serve both to connect and to differentiate persons that a child is able to develop a self-reflective and creative mind in accordance with her growing understanding of her own and others’ shareable but distinctive subjective mental states” (p.579). This bears obvious similarities to the work of Park and Park (1997) and Hatcher and Hatcher (1997) cited above, and with attachment theory. The paradox here is that the infant is driven to relate to be separate, as it is only within the context of a secure relationship that he or she can safely explore his or her social and emotional environment.

c. Emotional Intelligence

The model of emotional intelligence was first proposed by Salovey and Meyer (1990) and was described as encompassing the cognitive skills needed to self-regulate and monitor emotions (Goleman, 1995). It has obvious links with the concept of personal intelligence (regarded as more cognitively based than emotional intelligence), and with psychological mindedness. Salovey and Meyer (1990) subsumed Gardner’s personal intelligences in their definition of emotional intelligence and identified five key features of the construct - knowing one’s emotions; managing emotions; motivating oneself; recognizing emotions in others; and handling relationships. There is very little research available yet on this construct as there are no reliable or valid measurement devices, but it would be expected that it would be positively correlated with psychological mindedness.

d. Reflective-Self Function

Fonagy, Steele, Steele, Moran and Higgitt (1991) developed this concept from their work with children and distinguished between two aspects of the self: the pre-reflective or physical self, which simply reflected the world and the self in physical terms, and the reflective or psychological self, which they defined as the capacity to reflect upon both conscious and unconscious mental experiences both in the self and others. Interpersonal relatedness was seen as a natural function of the mind that developed within the context of the infant-caregiver relationship and was seen as a developmental achievement that was

probably reached by the age of six years, given a facilitative early environment. They highlighted the positive effect that secure attachment experiences have on the development of this function and the consequent negative effects of insecure attachment experiences. From their use of the Adult Attachment Interview they developed the Reflective-Self Function Scale to try to reach the key features of this capacity. They suggested that it was related to the concept of psychological mindedness. They saw this however, as a rather outdated concept and limited in its scope, given its restrictive application to the field of psychodynamic psychotherapy. A subtle difference between reflective self function and psychological mindedness is that the former may be more concerned with insight whereas the latter is concerned with the processes that lead to insight. Holmes (1996) suggested that reflective-self function was related to his concept of 'nonattachment', "a nonpossessive, nonambivalent, autonomous, freely entered into attachment, in which the object is held and cherished but not controlled" (p. 84). This seems to represent a level of 'meta-attachment', in which both autonomy and intimacy are attained but neither is possessed. He went on to suggest that this quality was an essential part of the therapist's function, likened to Bion's (1967) stance of 'freedom from memory and desire'.

e. Social Perspective Taking

Menna and Cohen (1997) described social perspective taking as one aspect of social cognition, and similar to psychological mindedness in that it was concerned with the ability to understand the thoughts, feelings, and motives of the self and others. Rooted particularly in Piaget's early work and further developed by Selman (1980), they discussed the developmental progression of perspective taking. The older the child the more perspectives they could focus on, due to their level of maturation and better attentional capacities. These findings are very similar to those reported by Dollinger (1997), in relation to psychological mindedness. Social perspective taking was seen as a genetically determined ability influenced by social experiences. These positive and negative views of self and others are also similar to the work done in attachment theory on the nature of internal working models (Bowlby, 1973), to be discussed later

f. Alexithymia

It has long been recognized that certain patients respond poorly to psychoanalysis and other insight-oriented psychotherapies because of a limited ability to describe and communicate feelings, a lack of fantasy life, and a preoccupation with physical symptoms. These 'non-psychologically minded' individuals have been variously labelled in the literature as infantile personalities (Ruesch, 1948), normopaths (McDougall, 1980), and normotics (Bollas, 1987). Marty and de M'Uzan (1963) first used the term '*pensée opératoire*' (operational thinking) to describe the lack of fantasy life found in patients with physical disease. During the 1970s, psychosomatic and other researchers began systematically to investigate the cognitive and affective style of patients suffering from one or more of the classical psychosomatic diseases (the so-called 'Alexander's Holy Seven'). Sifneos (1973) coined the term alexithymia (from the Greek: a = lack, lexis = word, thymos = emotion). Although these people lacked words for feelings, they could still experience emotions, but did not know what their feelings were. This would often result in them complaining of vague medical problems when really they were experiencing emotional distress. As expected, they were also poor on empathy, which created interpersonal difficulties for them. This absence of the ability to represent the mental and emotional world of the other can be linked to deficits in their development of a 'theory of mind'. Other workers also began to report similar characteristics in patients with eating disorders, drug abuse and post traumatic states (Taylor, 1995), and there was general agreement that the most important features of alexithymia were -

- i. Difficulty in identifying and describing feelings;
- ii. Difficulty in distinguishing between feelings and the bodily sensations that accompany emotional arousal;
- iii. Constricted imaginal processes, as evidenced by a paucity of fantasies,
- iv. An externally orientated cognitive style (Taylor, Bagby & Parker, 1991)

There have been a number of measures of alexithymia but all have suffered from poor reliability and validity due to poor scale construction (Taylor & Taylor, 1997). Previous

examples have included the Beth Israel Hospital Psychosomatic Questionnaire (BIQ), a 17-item forced choice measure completed by an interviewer (Sifneos, 1973) (A modified 12-item version of the BIQ has since been developed and found to have enhanced psychometric properties over the original version (Bagby, Taylor & Parker, 1994b).); the Schalling-Sifneos Personality Scale (SSPS), a 20-item self-report measure (Apfel & Sifneos, 1979); and the Rorschach Alexithymias Indices, based on the Rorschach projective tests (Acklin & Bernat, 1987). A new measure, the Toronto Alexithymia Scale (TAS-20), a 20-item self-report questionnaire, was developed by Taylor, Ryan, and Bagby (1985) as result of the poor reliability and validity of the above measures and is the one used in this study. Details of this measure can be found in the Methods section.

In acknowledging that alexithymic individuals are non-psychologically minded it is important to recognize that they are not simply opposite sides of the same coin. As already discussed, psychological mindedness has traditionally been associated with the set of cognitive and emotional skills that can lead to better outcomes in insight-oriented psychotherapies. Alexithymia is a much narrower concept, concerned exclusively with the processing and regulation of affect, and has not yet been empirically evaluated for its effect on outcome in psychotherapy. However, given that it is strongly and negatively correlated with psychological mindedness, it is not surprising that alexithymic individuals do badly in traditional psychodynamic psychotherapy. Sifneos (1973) has suggested that these people should be treated with supportive rather than exploratory psychotherapy. Alexithymia is also likely to be negatively correlated with the concept of emotional intelligence, although as already mentioned there are no measures of this construct yet. Salovey, Hsee, and Mayer (1993) suggested that severe alexithymia would be placed at the lower end of the construct.

2.6 Summary

The research reviewed above illustrates some of the difficulties in clarifying the nature of the concept of psychological mindedness. It is generally regarded as the complex product of the interaction of nature and nurture, although the evidence for a genetic component

has yet to be demonstrated. It has traditionally been studied within the psychotherapeutic literature and linked to better outcome. As just discussed, it has also been linked to many other similar concepts that have developed outside the psychotherapeutic field. At times they may be referring to the same processes but using different labels to define these. The exception here is that of alexithymia, which has a strong negative correlation with psychological mindedness. It has been discussed at some length because it has been extensively researched and is a key measure that will be used in this study. What clearly emerges from this work is that psychological mindedness, though rooted in the psychotherapeutic milieu, is part of a wider personality trait. There are also similarities between the need for an empathically attuned early environment in the development of psychological mindedness, and the effects of this provision on security of attachment.

2.7 Levels of psychological mindedness in therapists

As mentioned earlier, there is an assumption that high levels of psychological mindedness are the *sine qua non* of being a psychotherapist. For example, Wolitzky and Reuben (1974) developed a study to examine the assumption that high psychological mindedness in the therapist contributed to the effective practice of psychotherapy. In the design of their study, they distinguished between levels of psychological mindedness and the accuracy of appraisals based on this. Their results showed that higher psychological mindedness scores were associated with greater accuracy in personality interpretations. Thus high levels of psychological mindedness in the therapist were regarded as having a positive effect on the practice of psychotherapy. Although generally supporting this contention, other research, suggests that the situation is not so straightforward as this.

Farber (1983), in a study of a heterogenous sample of 60 psychotherapists, mostly working psychodynamically, found that because of their practice, therapists became increasingly psychologically minded, self-aware, and self-assured. In a related study, he suggested that those attracted to psychotherapy as a profession tended to be already psychologically minded, and that this increased because of professional training and practice (Farber, 1985). Farber (1983) argued that there were two modalities of psychological mindedness

essential for effective clinical work, that of emotional knowing and intellectual knowing. He felt that there was a need for therapists to maintain an optimal balance between the two. However, the therapists themselves thought that too high a degree of psychological mindedness could interfere with their natural way of interacting socially and result in a loss of spontaneity.

In a further study of the effects of too high a degree of psychological mindedness, Farber (1989) found that these individuals had greater emotional awareness and nonverbal expressiveness, although were less likely to verbally express their emotions. Individuals with high psychological mindedness were also found to have lower levels of self-esteem, perhaps due to an increased awareness of both positive and negative, pessimistic emotions. As Farber (1989) has commented “highly psychological minded individuals are wiser but also sadder” (p. 216). Overall, however, the positive effects of high psychological mindedness are regarded as more beneficial than the influence of the negative effects

Although psychological mindedness tends to be associated with psychodynamic thinking and therapy, individuals outside the psychodynamic field can also have high levels of psychological mindedness, e.g. writers and artists, (Farber & Golden 1997). A further researchable question concerns whether one’s choice of profession and theoretical orientation is influenced by one’s level of psychological mindedness. The level of psychological mindedness in a range of therapists is one of the main areas that will be examined in this study.

2.8 Measures

Most of the measures that have been developed over the years have attempted to provide a way of assessing levels of psychological mindedness. Most of these have had methodological problems, partly due to the lack of clarity regarding the definition of psychological mindedness, and have therefore been of limited utility.

One of the most widely used measures has been the Psychological Mindedness Scale of the California Personality Inventory (CPI) (Gough, 1957, 1975). One of 18 subscales of the CPI, it was developed as an attempt to measure interpersonal behaviour. The definition of psychological mindedness, however, concerned others rather than the self - "more interested in why people do what they do than in what they do; good judge of how people feel and what they think about things" (p.7) (Conte & Ratto, 1997). Its poor validity and insufficient definition of psychological mindedness were seen as limiting its usefulness. Another common measure of psychological mindedness was the Insight Test (Tolor & Reznikoff, 1960). Insight was measured by determining the degree to which an individual accurately interpreted several hypothetical situations representing the operation of various defence mechanisms. Broadly related to self-awareness, reflectiveness and introspectiveness, it has been used over the past 30 years to link the concept of insight to psychopathology and the outcome of psychotherapy, in a variety of populations. A major concern with the Insight Test however, is again with its definition of psychological mindedness, which is viewed as a skill independent of the person's insight into themselves.

Wolitzky and Reuben (1974) tried to measure psychological mindedness using standard TAT cards, by assessing subjects' psychological interpretations of a person based on that person's TAT stories. This method also unfortunately lacked reliability and validity. Another popular measure reported in the literature is the Self-Consciousness Scale referred to earlier (Fenigstein et al. 1975). This 23-item self-report questionnaire measures private self-consciousness and public self-consciousness, and has been standardized on a sample of 432 college students. Again, however, it lacked appropriate reliability and validity data. McCallum and Piper (1990) developed one of the few measures designed for use with clinical populations. The Psychological Mindedness Assessment Procedure has a standardized video and interview format that is individually administered. The videotape presents a simulated patient-therapist interaction portrayed by actors. It is based on a narrow and more analytic conceptualization of psychological mindedness. Nine levels of psychological mindedness can be differentiated, reflecting basic assumptions of psychodynamic theory. Subjects are rated according to their interpretations of the patient-therapist interaction. Its design and administration, however, limit its practical usefulness.

Given the reported difficulties in measuring psychological mindedness with these measures, a new self-report measure of psychological mindedness (the Psychological Mindedness Scale (PMS) was developed by Conte et al. (1990, 1996) and is the measure chosen for this study. Fuller details of this measure are provided in the Methods section.

ADULT ATTACHMENT STYLES

3. ADULT ATTACHMENT STYLES

The study of attachment styles in adults, particularly in relation to the theory and practice of psychotherapy, is now an increasingly topical area of study, resulting in a growing body of literature. For example, Fonagy et al. (1996) found that much psychiatric disorder was associated with unresolved difficult early relationships, and suggested that most people presenting with psychological problems were likely to be insecurely attached. Much of the research in this area is concerned with applying childhood attachment classifications to adults. One example is the work of Heard and Lake (1986) who have developed the concept of the Attachment Dynamic. This is an attempt to reformulate attachment concepts (eg. feeling secure being equated with the attainment of 'companionable interactions' with peers), so that they will have more applicability to adults. They also wanted to be able to generate hypotheses regarding the aetiology and management of neuroses and personality disorders.

This section will review the development of attachment theory, the literature on adult attachment, and the application of this to psychotherapy.

3.1 Origins of attachment theory

“Attachment theory is a way of conceptualizing the propensity of human beings to make strong affectional bonds to particular others and of explaining the many forms of emotional distress and personality disturbance, including anxiety, anger, depression and emotional detachment, to which unwilling separation and loss give rise.” (Bowlby, 1977a, p.201)

John Bowlby (1969, 1973, 1980), psychoanalyst and founder of attachment theory, was ostracised by the psychoanalytic community because of his preference for studying the influence of the 'real' environment of parental care rather than the traditional study of the inner world of drives, conflicts and defences (Holmes, 1993b). This was despite his Kleinian psychoanalytic schooling. (Of interest is that later studies have suggested that Klein's clinical theorizing may have been valid, being based on studies of children that would now be classified as showing disorganised attachment (Steele & Steele, 1998). It

is also of interest that Klein became increasingly interested in the child's 'real' interactions later in her career). Bowlby was also critical of the lack of scientific rigour that much of psychoanalytic theory was based on, although he agreed with the view that most adult psychopathology could be traced back to very early childhood experiences (Holmes, 1993b). (As his research work progressed however, he began to give credence to the influence of later experiences as well). His clinical work with children culminated in a major WHO report, 'Maternal Care and Mental Health' (Bowlby, 1951), in which he concluded that maternal deprivation, especially during the first three years of life, put children at increased risk for physical and mental illness. At that stage, however, he was yet to develop his new theory to account for these findings.

Attachment theory developed out of this early work of Bowlby's, combined with his growing awareness of evidence emerging from developmental biology and the new science of ethology (Lorenz, 1952). Lorenz's work with imprinting in birds and Harlow's work with monkeys (Harlow, 1958; Harlow & Zimmerman, 1959) showed that affectional bonds could develop unrelated to the satisfaction of hunger needs. Bowlby's (1958, 1969) insights led him to conclude from this that humans needed social interaction that was satisfied by the caregiver being close by and available for support when needed. This was in contrast to the traditional psychoanalytic theory of dependency, where affectional bonds were thought to develop secondarily to the primary drives for food and sex. As attachment behaviour had been found to occur in most species of mammals, he suggested that there was a 'primary attachment relationship' that developed during the first nine months of life whose evolutionary function was to protect from predators (Holmes, 1993b). This view was based on the assumption that human infants were dependent on a caregiver to survive due to their extreme immaturity. (In a similar vein, Muir (1995) has suggested that the transpersonal mode is the earliest mode of relationship and experience of the self, and that infants are programmed to relate to others (see also Hobson, 1994).) Mutual attachment behaviours then evolved to ensure that the infant was provided with the care it needed to ensure its survival.

The attachment behaviour system was seen to be the primary system that became activated when the infant felt anxious or frightened, and was readily available up to the first three years of life. This resulted in a variety of attempts to reestablish physical closeness to the primary attachment figure (proximity). Proximity resulted in the 'secure base phenomenon' - feeling safe and securely attached and so able to engage in 'exploratory behaviour' (Holmes, 1993b). Drawing on control systems theory to describe the dynamics of proximity-seeking behaviour, Bowlby argued that the 'set goal' of proximity was dependent on both internal (emotional) and external (environmental) factors. Physical proximity to the caregiver was maintained through repeated, "goal-corrected", reciprocal experience. This led to the experience of 'felt security' (Bretherton, 1985). Reciprocal experience with the caregiver then resulted in the development of internal working models about whether the self was worthy of care and attention, and of whether the caregiver was caring and responsive. Bowlby believed that these internal working models guided the thoughts, feelings, and behaviours of self and others in subsequent close relationships, and persisted almost unchanged throughout life, forming the basis of personality (Bowlby, 1977a). Maternal deprivation in early childhood was seen as adversely affecting these internal working models. They could become distorted and disrupted by defensive processes, leading to insecure attachment (Bretherton, 1996).

In a further challenge to existing psychoanalytic theory, Bowlby's observations of the behaviour of infants separated from their mothers led him to view anxiety as a normal and healthy reaction to the increased risk of danger it represented. He described a predictable series of normal emotional reactions because of this separation. The first of these was protest (unconsolable crying and searching), followed by despair (a state of passivity and sadness), and emotional detachment (disregard and avoidance of the mother on her return). (Recent work however, is beginning to challenge this formulation of Bowlby's on the grounds of insufficient evidence, and proposing a more complex model to account for the variability found in children's responses to separation experiences (e.g. Barrett, 1997)). Bowlby (1977a) also described four attachment patterns that resulted from parental failures - anxious attachment (no sense of secure base, prone to separation anxiety); compulsive self-reliance (outwardly self-sufficient but inwardly yearning for

affection), compulsive care-giving (emotional needs met through caring for others, probably because of having had to care for mother as a child); and emotional detachment (affectional needs and desires defensively excluded with a 'false self' (Winnicott, 1965) presented to the world).

Attachment theory was empirically tested by Ainsworth and others (Ainsworth, 1969; Ainsworth, Blehar, Waters & Wall, 1978), who developed the experimental 'Strange Situation' test. This was designed to enable the effects of maternal separation and reunion, and so security of attachment, to be observed and rated. A vast amount of research has been generated by this original work that can only be briefly reviewed here. Three typical patterns (and frequencies) of attachment have been observed - secure (65%), insecure-avoidant (20%), and insecure-ambivalent (resistant) (15%). A further category was later identified, that of insecure-disorganised/disoriented (4%) (Bretherton, 1991; Main & Solomon, 1990). The available evidence seems to suggest that cultural factors also play a role in the type of insecure attachment pattern that develops, related to the ways in which emotional issues are dealt with (Steele & Steele, 1994). The Strange Situation test has now become a standardized procedure, and has produced a considerable amount of empirical evidence supporting claims of associations between patterns of prior parent-infant interaction and subsequent Strange Situation behaviour (e.g. Ainsworth et al. 1978; Main & Cassidy, 1988). It has not been without its critics however. For example, Lamb (1987) argued that because attachment status was only usually measured at one time point, and consistency in parenting behaviour was not controlled for, then any individual attachment differences found might be more to do with current parent-child interaction rather than earlier patterns of parent-child interaction. Rutter (1997) has also argued that the use of discrete coding categories in the Strange Situation test may not be the best way to represent attachment experiences.

Further study of the behaviour of mothers in interaction with their children at home (Ainsworth, 1982) showed that secure children had mothers who were more responsive and attuned (Stern, 1985). Insecure-avoidant children had mothers who ignored their child's needs, insecure-ambivalent children had mothers who were inconsistent in their

responses to their child, and insecure-disorganized children had mothers who were neglectful and abusive. This was all consistent with Bowlby's theory. As some commentators have remarked, it is perhaps ironic that the findings of the Strange Situation procedure, and other measures, are now seen as offering empirical support to some of the psychoanalytic concepts that lie at their roots (Eagle, 1997; Steele & Steele, 1998).

Attachment theory has yet to offer a clear place for the role of aggression and sexuality in human behaviour, although some researchers are beginning to pay attention to these areas (e.g. Cassidy, 1998; Erickson, 1993; Sperling, Berman & Fagen, 1992). Eagle (1997) suggested that there were close links between sex and attachment in adults, given that one's stable sexual partner tended also to be the primary attachment figure. He further suggested that later sexual difficulties might be linked to failure to resolve Oedipal issues because of earlier insecure attachment. The role of temperament in attachment is another area that remains equivocal. The available evidence seems to support the view that both temperament and caregiver responsiveness are probably mediated by social support (Hazan & Shaver, 1994). Attachment status would then depend on the 'goodness of fit' between the child, with its unique inherited disposition including temperament, and the unique qualities of the caregiver, with her own attachment history and available support network (Holmes, 1996). In a review of the literature, Rutter (1997) found that temperaments invoking negative emotions were associated with insecure attachments.

3.2 Internal working models

Internal working models refer to the mental representations of the self, attachment figures, and the social world that develop because of the child's attachment experiences. These mental representations of attachment experiences have generated an increasing amount of interest (e.g. Bretherton, 1996). Main, Kaplan and Cassidy (1985) were pivotal in the reconceptualization of individual differences in attachment organization. Instead of individual differences being based on the observation of infants' nonverbal behaviour in the Strange Situation, they were based on the mental representation of the self in relation to attachment. These internal working models are now being studied to gain a greater

understanding of individual differences in attachment organization, particularly about cognitive structures in the mind.

Psychoanalytic theories have always seen the capacity for mental representation as a fundamental structure of the mind. For example, Balint (1964) and Fairbairn (1952) emphasized the important role that the internalisation of the relationship with the primary caregiver played in the development of mental life. Main et al. (1985) believed that internal working models were formed because of the infant's experience of their caregiver's responsiveness to them in the first few months of life. They argued that it was the organization of this generalized attachment relevant behaviour that formed these working models. These models were seen as providing rules for attachment behaviour, including its affective and cognitive components, organized in terms of beliefs about self worth and parental acceptance or rejection. The complexities of this internal organization were recognized by Bowlby (1980) who proposed that multiple working models could develop because of traumatic child-caregiver experiences. As Eagle (1997) pointed out however, it was unlikely that these internal working models would be an exact internal match of the infant's experience of caregiving. The influence of temperament and constitution would result in the caregiving experience being internalised with the infant's response to this.

Collins and Read (1994) have provided a detailed analysis of working models concerning adult attachment, drawing on research from social and cognitive psychology. They suggested that working models became increasingly complex from infancy to adulthood, and that they were best seen as a network of interconnected models built on previous attachment experiences. Thus it was unlikely that there would be a single attachment style once adulthood had been reached. They also argued that attachment security was built on the coherency of organization of these working models. Thus people with a secure attachment style would develop working models of themselves as likeable and friendly and of significant others as reliable and trustworthy. Their self-reliance meant that they would be able to both provide help and accept it when needed (Bowlby, 1973). Those with an anxious style would have working models of themselves as unconfident and not

appreciated and of significant others as unreliable. Individuals with an avoidant style would develop models of themselves as lacking trust and commitment and of significant others as unreliable (e.g. Collins & Allard, in press; Collins & Read, 1990; Feeney & Noller, 1990; Hazan & Shaver, 1987).

Bowlby (1973) believed that working models of attachment operated outside of conscious awareness and were therefore resistant to dramatic change. Individuals would select and create social environments that confirmed their existing representations of self and other. Eagle (1997) has described the benevolent cycle set up by the securely attached and the negative cycle set up by the insecurely attached that serve to maintain attachment patterns and internal working models. He stressed the importance of the ties to early objects, even if they were self-destructive, to maintain some sense of self and security. This is reminiscent of Fairbairn's (1952) oft-quoted remark "better to cling to a bad object than to have none at all", referring to the dangers to the loss of the sense of self rather than just the loss of a secure relationship. As cognitive abilities develop then change becomes more possible, although as Collins and Allard (in press) suggest, the insecurely attached have more rigid, negatively biased working models that make them less likely to change despite positive experiences. Despite these difficulties, Bowlby (1988) suggested that change could come about in psychotherapy through the development of a capacity to think about and reflect upon one's working models and through a "corrective" relationship experience. Similarly, Main (1991) has suggested that change could occur through the process of meta-cognitive monitoring (thinking about thinking) that could be initiated by experiences in psychotherapy. Change can also occur outside psychotherapy of course, as in finding a stable partner (e.g. Rutter & Quinton, 1984).

West (1997) suggested that the dimension of organization/disorganization was more relevant than that of secure/insecure attachment in relation to traumatic experiences, as it better highlighted the major difficulty that traumatised individuals had. Fonagy (1991) described a similar disturbance in borderline personality disorder (BPD) patients who lacked self-reflective capacity (the capacity to mentalize). Their disorganization acted as a defensive barrier against the trauma. West (1997) further suggested that there was

increasing recognition that the need to maintain the coherence of the self was, like attachment, grounded in the biology of human experience. He argued that attachment theory had overlooked the capacity of the self to heal itself. It was this adult capacity that enabled an individual to acquire a coherent attachment history. He felt that unresolved attachment experiences could be reprocessed by the individual and transformed into new meaning. This was achieved through the operation of the self's capacity to reflect on itself. West (1997) believed that this reflective capacity was biologically rooted and either enabled or disabled by the empathic responsiveness of the caregiver. (Interestingly, this has close parallels with the development of psychological mindedness discussed earlier).

3.3 Summary

The concept of working models has helped to provide a link between attachment theory and other psychological theories of development and pathology, and helped to bridge these other theories (e.g. psychoanalytic and cognitive behavioural theories). The mental representations that individuals develop about their attachment relationship experiences are clearly a key feature of how attachment relationships are maintained over time, and provide a focus for effecting change. One of the important functions of internal working models lies in the regulation of emotion and defensive processes. A dysfunction in the regulation of emotion has already been referred to in the discussion of alexithymia that appears to have some similarities with the internal working models underlying insecure attachment. Conversely, psychological mindedness should have some similarities with the internal working models underlying secure attachment. These relationships are the main focus of this study.

3.4 Adult attachment

“Adult attachment is the stable tendency of an individual to make substantial efforts to seek and maintain proximity to and contact with one or a few specific individuals who provide the subjective potential for physical and/or psychological safety and security. This stable tendency is regulated by internal working models of attachment, which are cognitive-affective-motivational schemata built from the individual’s experience in his or her interpersonal world” (Berman & Sperling, 1994, p.8).

Adult versions of attachment have been labelled as attachment styles and are regarded as conceptually and dynamically similar to infant styles (Berman & Sperling, 1994; Shaver & Clark, 1996). Birtchnell (1997) however, argued for the development of alternative interpersonal models to take account of adult attachment experiences. Hazan and Shaver (1994) highlighted how adult attachment differed in several important ways from infant attachment. They suggested that adult relationships were reciprocal rather than complementary and that the primary attachment figure was usually a peer rather than parent, and most often a sexual partner. The motivation for proximity-seeking, therefore, could also be to offer comfort or engage in sexual activity. They suggested that there was a gradual transfer of attachment from parents to peers during development. Similarly, Berman and Sperling (1994), argued that the attachment and caregiving systems were more reciprocal than in parent-child relationships.

Adult attachment styles are commonly labelled Secure, Insecure-Avoidant (Dismissing), and Insecure-Ambivalent (Preoccupied), although there is only unanimous agreement about the distinction between secure and insecure styles. Bartholomew (1997) argued that it was unlikely that the measurement of attachment styles in adults would capture the full range of their attachments and underlying working models. Bartholomew (1990; Bartholomew & Horowitz, 1991) also argued that the single category of avoidant attachment in Hazan and Shaver’s (1987) study only identified those adults who were fearful of attachment compared with the dismissive-avoidant group that she identified based on her study. She therefore proposed a new four-category model of attachment

drawing on Bowlby's theory of working models. This was based on a positive and negative model of self and a positive and negative model of other, along two dimensions of dependency and avoidance of intimacy. Each pattern therefore, represented a prototype - Secure (positive model of self and other, low dependence and low avoidance); Preoccupied (negative model of self and positive model of other, high dependence and low avoidance); Fearful-Avoidant (negative model of self and negative model of other, high dependence and high avoidance); Dismissing-Avoidant (positive model of self and negative model of other, low dependence and high avoidance). Support for this model was obtained through two further studies (both non-clinical samples) using self and friend reports, and by other studies using the model (e.g. Feeney, Noller & Hanrahan, 1994)

Research into adult attachment falls into three main areas -

a. Longitudinal studies

Various studies have examined the stability and predictive value of attachment histories. For example, Fonagy, Steele, Moran, Steele and Higgitt (1993) found mothers' attachment status in pregnancy, as measured by the Adult Attachment Interview (AAI), predicted their child's subsequent attachment pattern at one year with 70% accuracy. There have also been several studies that have followed up children from the Strange Situation (e.g. Ainsworth, 1989; Grossman & Grossman, 1991; Sroufe, 1979). Generally, attachment patterns have been found to remain stable, perhaps needing to be self-perpetuating to maintain some predictability in interpersonal relationships. Main et al. (1985) however, found that some insecure children had freed themselves of their attachment history, and as adults, had produced children who were securely attached. She argued that certain types of later relationships (such as a supportive relationship with a spouse or therapist) may, therefore, help to challenge mental models that have resulted from negative experiences while growing up.

b. Romantic relationship studies

There is growing evidence that adults with different attachment styles differ in the nature and quality of their close relationships (Feeney & Noller, 1990; Hazan & Shaver, 1987). Studies have generally supported Bowlby's idea of positive and negative models of self and others. Hazan and Shaver's (1987) original work on romantic relationships was extended by Collins and Read (1990) and Simpson (1990) who examined the relationship between adult attachment and beliefs about self, the nature of romantic love, and the social world. They found that the more secure the person, the more positive their view of self and the social world, and the more romantic their views of love.

c. Attachment theory and psychotherapy

Jeremy Holmes (1993a, 1993b, 1994, 1996, 1997) has been one of the most prolific of the recent writers and researchers who have tried to apply attachment theory to psychotherapy. Apart from Holmes' work however, the perceived importance of attachment theory as applied to psychotherapy has yet to be realised, despite Bowlby's desire for this. Holmes argued that attachment theory was comparable to Frank's (1973, 1986) work on the 'common factors' approach to the psychotherapies, which asserted that change arose out of the nonspecific factors of the therapeutic relationship. Attachment theory provided a means of understanding how this could lead to change through its insights into secure and insecure parent-child bonding, and the idea of a secure base for children/adult patients enabling exploration of aspects of their environment/inner world safely. Although regarding attachment status as stable and self-perpetuating, Holmes agreed with Bowlby (1988) that the therapeutic relationship could provide the right environmental circumstances for change. The links between good mothering, with responsiveness and attunement to the child's needs (Ainsworth, 1969; Stern, 1985) and good therapist responsiveness has been made by others before (eg. Winnicott's (1971) provision of a holding environment, Bion's (1967) maternal reverie and containment, and Bollas's (1987) transformational function of the mother-therapist) but not in relation to attachment theory. According to Holmes (1993a) the aim of psychotherapy was to help

the client to develop a more coherent narrative of their life, what he called autobiographical competence. If this were successful then it should lead to secure attachment, if not then there would be an insecure defensive stance against either intimacy (avoidant attachment) or autonomy (ambivalent attachment) (Holmes, 1993b).

There is now ample evidence, from Freud onwards, that disturbed family relationships during childhood are at the root of many patients who present for psychotherapy (eg. Birtchnell, 1993; Fonagy et al. 1991, 1996; Horowitz, 1979). In other words, most patients present with interpersonal problems because of being insecurely attached. This raises the question of the relationship between mental health and attachment and the role of the therapeutic relationship in this. Collins & Allard (in press) found that adults with less secure internal working models were at increased risk for interpersonal difficulties, and for depression. In particular, the fearful and preoccupied insecure attachment types have been most vulnerable to poor mental health (Harris, 1997). Although insecure attachment is clearly a risk factor, however, it does not directly cause later psychiatric disorders (Sroufe, 1988). A common assumption is that only secure attachment is normal and therefore more desirable. For some individuals an insecure attachment style may be the most adaptive response to their circumstances (Belsky & Nezworski, 1988). Eagle (1997) suggested that remaining insecurely attached because of psychotherapy could be regarded as a good outcome if the individual were better able to understand themselves and were less troubled by their problems. Perhaps one advantage of secure attachment lies in a better ability to tolerate the loss of a relationship and feel sufficiently comfortable without a significant relationship for extended periods (Bartholomew, 1997). Although a close confiding relationship is regarded as necessary in the provision of a secure base, an adult can presumably still feel secure without a current relationship, given an internal secure base provided earlier in life. This is akin to Winnicott's (1958) 'capacity to be alone' which can only occur because of having been in the secure presence of the other. Secure attachment, however, does not necessarily prevent later mental health problems. This is nicely summed up by a study by Lewis, Feiring, McGuffog and Jaskir, (1984) cited in Lamb (1987) - "infants neither are made invulnerable by secure attachments nor are they doomed by insecure attachments to later psychopathology" (p.134). Perhaps beyond secure

attachment, as a desirable goal in life, lies nonattachment (e.g. Holmes, 1996). Some have argued that much emotional distress can be due to the need to attain attachments to self, things and others, which can drive some individuals to pursue more spiritual practices such as Buddhism, in order to achieve the more desirable state of nonattachment (e.g. Pietroni, (1993)).

Jones (1983) suggested that the ideal psychotherapeutic relationship could be seen as comparable to a secure base within which the patient, feeling securely attached to the therapist, was able to explore his or her inner world. Similarly, Strupp (1973), argued for the need for more specific techniques in psychotherapy, particularly to help the more insecurely attached overcome their resistances to forming a trusting relationship. Within this secure base of therapy, these techniques can be used to help the patient shift from insecure to secure attachment, by enabling them to try new behaviour and gain new meaning. The therapist thus provides a 'corrective emotional experience' (Alexander & French, 1946) for the client, which is regarded as a necessity for change in psychotherapy. This argument for a more attachment-based psychotherapy has also been put forward by other writers (e.g. Holmes, 1997; West & Keller, 1994). Similarly, Mackie (1981) has distinguished between the 'doing to' and 'being with' functions of the therapist, and argued for the need for the therapist to provide a similar attachment experience for the client as the mother does for her infant by 'being with', through both physical and psychological holding.

Mallinckrodt (1991) in reviewing previous research, argued that the working alliance, as a secure base, was crucial to successful outcome regardless of the theoretical underpinnings of the therapy, and cited Horvath & Symonds (1991) who reported significant effect sizes produced from meta-analytic studies. Early experiences of emotional bonds with parents were seen as important factors affecting subsequent adult relationships, and perhaps also the development of the working alliance. Sable (1992, 1994) in discussing the role of attachment in agoraphobia, saw it as a condition of anxious attachment, related to the fear of separation from those with whom the person had formed affectional bonds. Psychotherapy was seen as providing a temporary attachment

relationship within which to explore and understand the experiences, both current and past, that led to anxiety over attachment. She argued that the secure therapeutic bond could provide the conditions for resolving the conflicts generated by inner working models of attachment figures and the self in the past, and current experiences of attachment figures.

3.5 Clients' attachment style and psychotherapy

Evidence is beginning to emerge about the relationship between clients' attachment style and response to particular therapeutic approaches. Fonagy et al. (1996), for example, found that individuals rated as dismissing were more likely to show improvements in psychotherapy, whereas people with a preoccupied attachment style were less accessible to insight-oriented psychotherapy. In contrast, however, Bartholomew and Horowitz (1991) suggested by their study that people with a dismissing attachment style might be less amenable to exploratory therapy. This finding was also supported by a study by Horowitz, Rosenberg and Bartholomew (1993), who found evidence in support of a relationship between attachment styles and interpersonal problems. In particular, they found that patients whose interpersonal problems were primarily in the region of hostile dominance (dismissing attachment style), unlike those of friendly submissiveness (as measured by the Inventory of Interpersonal Problems (IIP)), were less likely to succeed in brief dynamic psychotherapy. They argued, however, that this group might respond better to long-term dynamic psychotherapy, cognitive therapy, pharmacotherapy or group treatment. They also looked at the capacity to describe other people and its relationship to therapeutic outcome and found that those patients who were more successful in brief dynamic psychotherapy could provide clearer and more coherent descriptions of their parents than those who were unsuccessful. They concluded by suggesting that a person's attachment style, interpersonal problems and ability to describe other people were related variables. The more secure the person then the warmer their interpersonal relatedness, and the less defensive and greater clarity of their descriptions of others. They also suggested that clarity in describing others may be one component of the concept of psychological mindedness. Eagle (1997) suggested that the attachment style of the patient should be taken into account when planning any treatment intervention. He argued that the

therapeutic aim with the avoidant/dismissive group might be to undo the 'defensive exclusion' of attachment cues, whereas with the enmeshed/preoccupied group the aim may be more to help the patient let go of relationships and work through mourning. Establishing before treatment the attachment style of the client seems important therefore.

Mallinckrodt et al. (1995) described a study involving the development of a new measure (the Client Attachment to Therapist Scale [CATS]). They found that secure clients developed a positive working alliance, perceived the therapist as emotionally responsive and accepting, and as promoting a secure base; preoccupied clients developed a too early and strong working alliance and wanted too frequent and intense personal contact with the therapist; avoidant-fearful clients developed a poor working alliance and were very mistrustful of the therapist; and reluctant-dismissing clients saw the therapist as emotionally responsive and developed a positive working alliance.

In a related study, Lyddon and Satterfield (1994) examined the relation between the client's working models of attachment and the therapist's assessment of the type of change that may be clinically indicated in cognitive psychotherapy, using the Adult Attachment Scale (AAS) (Collins & Read, 1990). They found that for clients with secure working models (high Depend, low Anxiety on the AAS) first-order change goals (symptom relief) were assessed as suitable. For clients with insecure working models, exhibiting a lack of trust (low Depend on the AAS), and fears of abandonment (high Anxiety on the AAS), second-order change goals (deep, structural change) were deemed to be more suitable. They suggested that the AAS was a viable research measure for assessing different dimensions of clients working models of attachment, and that its results could have implications for the therapist-client relationship and the process of therapy.

Several studies have identified links between attachment status and psychopathology. Alexander (1992) cited several studies supporting the link between insecure attachment and physical and emotional abuse in children. Secure bonding between parents and their children have been argued to be an important factor in incest avoidance (Erickson, 1993). Shaver and Clark (1996) provided evidence supporting the view that abused children

developed fearful avoidant attachment patterns, and Parker (1979) found that neurotic depressives reported less parental care and greater maternal overprotection. Individuals classified as preoccupied have been found to be more prone to disorders of heightened affect such as affective, histrionic, or borderline disorders. Those individuals classified as dismissive have been found prone to substance abuse, disordered eating behaviour, or antisocial behaviour (Burge et al., 1997; Cole-Detke & Kobak, 1996; Pianta, Egeland & Adam, 1996; Rosenstein & Horowitz, 1996). This latter group of disorders have also been associated with alexithymia. Heard and Lake (1986) suggested that because of the failure of support-givers, people developed neurotic symptoms and antisocial tendencies. These defensive strategies were developed to help the individual cope with their severe psychological distress ('dissuagement').

3.6 Levels of attachment in therapists

Although it might be assumed that therapists would be more securely attached, the literature on 'wounded healers', suggests another perspective. For example, Farber (1985) cited several findings from various researchers investigating the motivating factors of mental health workers. Common experiences in their childhood included feeling separate, lonely, rejected, and unloved. Much evidence is supporting the view that many potential therapists are attracted to the profession to resolve their own emotional difficulties (e.g. Ford, 1963; Goldberg, 1986; Guy, 1987; Holt & Luborsky, 1958), some of which might manifest themselves in the compulsive care-giving style identified by Bowlby (1977a). Much of the 'healing' of these personal wounds in therapists takes place during training which often involves a personal therapy component, and through clinical supervision. This should be sufficient to identify those people who would be unsuitable for the profession because of their personal difficulties. However, as Masson (1990) has graphically described, some people go through training and become psychotherapists when clearly they should not.

Taylor and Taylor (1997) argued that outcome could be influenced by the therapist's personality and cognitive style, and that there was value therefore, in assessing levels of

alexithymia (and by implication psychological mindedness) in therapists and in patients. They also suggested that there was a need for more research on the types of attachment patterns of alexithymic individuals. Therapists who are more securely attached have been better able to deal with clients' problems (e.g. Singer & Luborsky, 1977). Despite the findings cited here, there has been little research yet that has examined the attachment styles of therapists, something that this present study aims to redress.

3.7 Summary

There seems ample evidence to support the continuity and similarity of attachment styles across the life-span, although adult attachment styles are more complex, and there is yet no clear theory of adult attachment. Within the clinical literature, what can be stated with some certainty from these studies is that those people with insecure attachments are more prone to interpersonal difficulties. In addition, these are the people who present for psychological help. These are generally regarded as the most robust findings in the adult attachment literature. For example, in a meta-analytic study covering 33 studies that used more than 2000 Adult Attachment Interviews, Van Ijzendoorn & Bakermans-Kranenburg (1996) found a strong over-representation of insecure types of attachment among clinical groups, although there was no clear relationship between the type of clinical disorder and attachment status. What is also becoming clear is that identifying the attachment style of people seeking psychotherapy can provide useful guidelines for the most appropriate treatment approach. The evidence seems to suggest that those people with either a preoccupied (ambivalent) or fearful-avoidant attachment style are less well suited to insight-oriented psychotherapies. The therapeutic relationship in the guise of the working alliance can be seen to provide attachment experiences that can challenge internal working models that are unhealthy for the individual. Links between the development of attachment styles of relating and thinking can also be made with the development of psychological mindedness, particularly with the development of self-reflective functions and security of attachment.

3.8 Measures

Unlike the concept of psychological mindedness, there have been several measures developed to assess different attachment styles. In a review of the literature, Shaver and Clark (1994) identified as many as 20. This has led to some confusion about classification and categorization despite them all being rooted in the same theory. Crowell and Treboux (1995) suggested that two broad categories of studies of adult attachment could be identified - those that focus on individual differences, and those that examine underlying dimensions of attachment. In a wide-ranging review of adult attachment measures, they identified interviews and self-report questionnaires as the two main measures used in the literature. Much concern has been expressed about how well self-report and interview measures correlate. Self-report measures are limited in that they only capture consciously held feelings and perceptions about attachment relationships, whereas evidence from working models suggests that much of our attachment related strategies lie outside conscious awareness. Such self-report measures, nevertheless, have greater practical utility and much work is being done to refine them further.

Of the interview methods, one of the most commonly used measures is the Adult Attachment Interview (AAI) (George, Kaplan & Main, 1985). This is a semi-structured interview developed to study the relationship between current parenting and experiences of being parented, whose aim is to gain access into feelings about current and past attachments and separations. The interviews are rated according to how the person describes their lives. The person is then placed into one of four attachment patterns. The Secure/Autonomous give coherent accounts of their lives and losses; the Insecure/Dismissing have few coherent memories and tend to overidealize; the Insecure/Preoccupied give incoherent accounts and are often tearful in the telling; and an Unresolved classification is used with the other classifications for reports of loss that haven't been resolved.

Of the self-report questionnaires, the Hazan and Shaver (1987) measure was one of the first self-report measures to be developed, and produced categorical placement of

individuals into attachment styles. This was further refined by Collins and Read (1990) who developed the Adult Attachment Scale (AAS) which identified dimensions thought to underlie attachment styles. Both measures have been used in this study and are further elaborated upon in the methods section.

THERAPIST AND CLIENT MATCHING

4. Therapist and Client Matching

4.1 Introduction

Most therapists acknowledge that they do better with some clients than others, but there is little evidence of which therapist-client pairings are most effective. Despite a large literature on therapist-client matching, few of these studies have looked at interaction effects (Berzins, 1977). Of the variables studied in both participants, such as age, gender, marital status, socioeconomic status, YAVIS (Young, Attractive, Verbal, Intelligent, Successful) patients (Schofield, 1964), expectancies, preference values, and personality characteristics, there has been little evidence that any of these are significantly related to therapeutic outcome.

Berzins (1977) found that those therapist-patient pairs that were optimally matched had better outcome scores. The results were not so straightforward as this, however, as he suggested that there were important differences between therapist-patient matches that served to engage the patient in therapy, and those that enabled the patient to continue in therapy. He suggested that a mismatch between therapist and patient on some variables might produce a better outcome for some patients than a match on the same variables. He also argued that there was a need to show that matching was more effective than the normal clinical allocation of cases based on intuition.

Studies looking at similarities in values between therapist and client have produced some further useful findings. For example, Kelly and Strupp (1992) found that those therapist-patient pairs whose values were moderately similar showed the most improvement. Vervaeke, Vertommen and Storms (1997) found that clients were more likely to dropout of therapy when values were dissimilar at the beginning. The more similar patient and therapist values were, the more likelihood there was that a degree of collusion would occur, which could work against positive change for the patient. Similarity in values between therapist and client however, has also been shown to lead to greater rapport (e.g. Kantrowitz, Katz & Paloitto, 1990). Holmes (1996) argued for the importance of

therapists' becoming aware of their own values, and the impact that these could have on therapeutic progress.

This research on values seems to suggest that at least some areas of similarity between therapist and client are important for therapeutic outcome, although it is not clear what values or other variable are the most relevant.

4.2 Therapist and client matching on psychological mindedness

Very little research into the therapeutic effects of therapists and clients being matched on levels of psychological mindedness has been carried out. One study that might be referring to similar factors of the concept of psychological mindedness is that of Calvert, Beutler and Crago (1988). They found that outcomes were better when there was a match between patients who used externalising defences and therapists who used an external focus, and likewise between patients who internalised and therapists who used an internal focus. Tantum (1995) suggested that psychological mindedness might be no more than a set of values rather than a personality trait, and that lack of psychological mindedness would not necessarily mean that the client would not respond. Much depended on the therapist's ability to modify their technique, and presumably their level of psychological mindedness to tune in to their client's needs effectively. This is an important, but neglected area of research, that this study will address.

4.3 Therapist and client matching on attachment style

Of the few studies that have looked at the effect of the interaction of attachment style in therapists and their clients, Dozier, Cue and Barnett (1994) hypothesized that the clinician's therapeutic efficacy was affected by their attachment style. Therapists needed to respond so that they would effectively challenge their clients working models. They argued that this ability might be affected by the therapist's attachment style. In a study designed to assess this, they administered the Adult Attachment Interview to 18 case managers (non-psychotherapists) and their 27 clients (with serious psychopathological

disorders). They found that secure case managers responded more to the dependency needs of dismissing clients than preoccupied clients, thus providing a challenge to their models of the world, whereas insecure case managers responded superficially, and therefore reinforced clients' world views. Furthermore, preoccupied case managers responded in greater depth to preoccupied clients and perceived these clients to have greater dependency needs than dismissing clients. Dismissing clients presented themselves as invulnerable, whereas preoccupied clients presented themselves as needy and dependent. Preoccupied case managers were found to intervene more intensively, whereas dismissing case managers intervened non-intensively despite client characteristics. Secure case managers could be more reflective about their clients and use their countertransference feelings to therapeutic effect. This ability to 'see through' their clients' defences (cf. Dollinger et al. 1985) is perhaps the same as the ability to be psychologically minded. This research suggested that therapist responsiveness to clients was dependent on the interactive factors of the attachment styles of the two groups, and that there was also an independent effect of therapists insecure attachment style.

Hardy, Stiles, Barkham and Startup (1998), using data from the Second Sheffield Psychotherapy Project, found that therapists used more affective and relationship-oriented interventions with anxious-ambivalent (overinvolved) clients than with avoidant (underinvolved) and secure (balanced) clients. Therapists also used more cognitive and behavioural interventions with avoidant than with anxious-ambivalent and secure clients, especially with longer sessions treatments. The alliance and treatment outcome was equivalent across the attachment groups. They suggested that this might have been because of therapists' responding appropriately to clients' varying requirements. The attachment styles of the therapists were not measured however, but even then perhaps the constraints of manualized therapy would have reduced the impact of these.

Bernardi (1998), cited Ammaniti (1997) who reported that research had shown a high frequency of dropouts when patient and therapist were both insecurely attached or dependent. In a similar vein, Holmes (1997) has suggested that the 'fit' between the attachment style of the therapist and patient might be an important determinant of the

outcome of therapy. Referring to Racker's (1968) distinction between complementary and concordant countertransference, he suggested that those therapists who could respond concordantly to an avoidant client by offering attunement, and similarly to an anxious/ambivalent client by offering structure, were more likely to engage their clients. This obviously has implications for the proper matching of therapist and client on attachment styles, and supports some of the findings of the Dozier et al. paper cited earlier.

Evidence from the field of romantic relationships, where much of the adult attachment research has been focussed, may help us to understand the effects that one partner's (or therapist's) attachment style will have on the other partner (or client). Hazan and Shaver (1987), for example, suggested that an anxious/ambivalent person in a relationship with a secure person might pressure that person to act and feel avoidant, whereas an avoidant person in the same relationship might cause the secure partner to act and feel anxious.

4.4 Relationship between psychological mindedness and adult attachment styles

There seem strong links between security of attachment, coherency of autobiographical memory, reflective self-function and psychological mindedness (eg. Fonagy et al. 1991; Horowitz et al. 1993; Main et al. 1985; West, 1997). Eagle (1997) however, has argued against a straightforward relationship between reflective self-function and secure attachment. He asserted that there was no evidence to support the view that greater reflective self-function led to greater security, only that individuals were better able to construct more coherent and plausible narratives. He suggested that this ability was an adaptive one in mothers. Being able to reflect on their own and their infant's mental state, he argued, was more likely to lead to secure attachment because the mother was better able to understand and respond to her infant.

West and Keller (1994) suggested that secure attachments were strongly linked to 'affective authenticity', meaning a degree of openness to one's own feelings and a readiness to respond to another person's feelings. They contrasted this with inauthentic affective communication dominated by defensiveness. Schaffer (1993) has also found a

relationship between security of attachment and low levels of alexithymia.

There would also seem strong links between insecure-avoidant (fearful) attachment, incoherency of autobiographical memory, poor reflective self-function and alexithymia (eg Burge et al. 1997; Fonagy et al. 1996). Based on reports of improvement in psychotherapy, there may be a link between psychological mindedness and insecure (preoccupied (ambivalent)) attachment. There may also be a link between alexithymia and insecure dismissive-avoidant attachment (Fonagy et al. 1996; Horowitz et al. 1993; Mallinckrodt et al. 1995). It is possible that some of the insecure (preoccupied (ambivalent) group may use psychological mindedness as a defensive style (Fogel, 1994) in order to keep the therapist involved with them. Some of the insecure (dismissing-avoidant) group could also be alexithymic, reflecting their avoidance of intimacy. Schaffer (1993) found evidence for a link between alexithymia and a compulsive care-seeking style of insecure attachment, which was defined as a subtype of ambivalent attachment. There was a secondary link between alexithymia and a compulsive self-reliant attachment style, defined as a subtype of avoidant attachment. Despite the contradictory implications here, with preoccupied (ambivalent) attachment being linked with both psychological mindedness and alexithymia, if this group used psychological mindedness as a defence this could serve to mask an underlying alexithymic condition. Similarly, Simpson and Rholes (1994) in a review of studies, have suggested that people with an avoidant attachment style would have difficulties in affect regulation, which is the core difficulty for people with alexithymia.

**RESEARCH QUESTIONS
AND
HYPOTHESES**

5. RESEARCH QUESTIONS AND HYPOTHESES

5.1 Research Questions

In studying these two concepts of psychological mindedness and attachment styles, several research questions are raised -

1. Will therapists be more psychologically minded and more securely attached than either clients or members of the general population?
2. Is there a relationship between psychological mindedness and adult attachment style?
3. Will measures of psychological mindedness and adult attachment style in clients show any change because of time spent in therapy?
4. Does a match or mismatch of psychological mindedness and/or adult attachment style between therapists and their clients have an effect on whether clients remain in therapy?

5.2 Hypotheses

Following on from these research questions, and based on previous research and clinical experience regarding dropout from various forms of psychological therapy, the following hypotheses are proposed -

- 1 Therapists will have higher levels of psychological mindedness and be more securely attached than either a client group or a control group representing members of the general population,

2. Those clients assessed as having high psychological mindedness at the beginning of therapy/the study will tend to have a secure attachment style and be more likely to persist in therapy. Those clients who remain in therapy, as assessed again after six months, will tend to maintain high psychological mindedness and a secure attachment style;
3. Those clients assessed as having low psychological mindedness at the beginning of therapy/the study will tend to have an insecure attachment style and be more likely to drop out of therapy. The clients who do remain in therapy, as assessed again after six months, will show an increase in psychological mindedness and have developed a more secure attachment style;
4. Client and therapist pairs that are matched on level of psychological mindedness and/or attachment styles are less likely to drop out of therapy, as assessed after six months, than those not so matched.

METHOD

6. METHOD

6.1 Measures (for details of these see Appendices)

a. Psychological Mindedness Scale (PMS) (Conte et al. 1990, 1996) (see Appendix A).

This 45-item questionnaire is the most recent of the few self-report instruments that have been designed to measure psychological mindedness. Although primarily designed to measure a patient's suitability for dynamically oriented psychotherapy, it is based on a broad definition of psychological mindedness that includes both self-understanding and an interest in others. As such, it aims to measure those characteristics that are associated with good outcome in psychotherapy. It represents a shortened version of Lotterman's 65-item scale designed to measure suitability for dynamically oriented psychotherapy (A. C. Lotterman, "A Questionnaire Measure of Psychological Mindedness and the Capacity to Benefit from Psychotherapy," © 1993, unpublished), and has mainly been used with psychiatric outpatients. Items are scored on a 4-point scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*), with 21 of the items being reverse scored. A total PM score is obtained by adding together the scores on each item. The PMS has been shown to have good internal consistency (Cronbach's alpha coefficient 0.86 for a population of 69 psychiatric outpatients, which was recomputed in another study of 250 outpatients to 0.87 (Conte et al. 1990)), good stability (test-retest reliability over a 2 week period for a sample of 22 normal adults was 0.92 (Conte et al. 1990)), inconclusive predictive validity, and good construct (discriminant) validity as shown by significant negative correlations with the TAS-20, a measure of non-psychological mindedness (alexithymia) (Bagby et al 1994b). It was chosen as the most suitable measure of psychological mindedness for the present study because of its recent validity and reliability data, and its ease of administration with the three groups;

b. Toronto Alexithymia Scale (TAS-20) (Taylor et al. 1985) (see Appendix B):

This measure is a further development of an earlier 26-item measure (Bagby et al. 1994a, 1994b). It has a three factor structure -

- F1 Difficulty identifying feelings and distinguishing them from the bodily sensations that accompany emotional arousal;
- F2 Difficulty describing feelings to others;
- F3 Externally orientated thinking.

The TAS-20 has been found to have good internal consistency (Cronbach's alpha coefficient 0.81 for a university student derivation sample and 0.83 for a psychiatric outpatient sample, and good stability (test-retest reliability over a 3-week interval for a sample of 72 students was 0.77) (Bagby et al. 1994a). Strong negative correlations with the PMS ($r = -.68, p < .01$) (Bagby et al. 1994b) suggested that the TAS-20 was measuring the inverse of psychological mindedness. Items are scored on a 5-point scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with 5 of the items being reverse scored. A total alexithymia score is obtained by adding the scores on each item, with >61 and ≤ 51 being the cut off scores for alexithymia and non-alexithymia respectively. It was included in this study as it was felt that it would provide a useful validity check for the PMS, and adding further information regarding the relationship between psychological mindedness and adult attachment styles.

c. The Adult Attachment Scale (AAS) (Collins, 1996; Collins & Read, 1990) (see Appendix C);

This 18-item self-report measure was developed to overcome some deficiencies of the Hazan and Shaver (1987) measure, which assumed that the three attachment styles were mutually exclusive. It provides a measure of three dimensions -

Close	the extent to which an individual is comfortable with closeness and intimacy;
Depend	the extent to which an individual believes others can be depended on to be available when needed;
Anxiety	the extent to which an individual feels anxious about such things as being abandoned or unloved.

These dimensions were felt to represent most of the core structures thought to underlie differences in attachment styles, although others (e.g. Feeney et al. 1994) have suggested just two dimensions. Participants had to rate the extent to which each of the 18 statements described their feelings on a scale ranging from *not at all characteristic* (1) to *very characteristic* (5). The AAS has been found to have good internal consistency (Cronbach's alpha coefficient in three samples of undergraduates for the three dimensions - Close (.86), Depend (.76), Anxiety (.83), and moderate stability (test-retest reliability over a 2-month period for a sample of 101 undergraduates was Close (.68), Depend (.71), and Anxiety (.52). Higher scores on the Close and Depend dimensions and lower scores on the Anxiety dimension suggest greater security in the person's working models of attachment; high scores on Anxiety and moderate scores on the Close and Depend dimensions are related to anxious-ambivalent attachments; whereas low scores on the three dimensions of Close, Depend and Anxiety are related to avoidant attachment.

d. The Hazan and Shaver (1987) questionnaire (see Appendix D);

This single-item, self-selection measure was the first to translate the three infant attachment styles identified by Ainsworth et al. (1978) into terms appropriate to adult love. It was designed to identify feelings about the self in relationships, particularly romantic ones. Participants had to indicate which of three short descriptions best described their feelings. Hazan and Shaver (1987) found similar percentages of respondents in each attachment category in their study as those found in infant studies (56% secure, 25% avoidant, 19% anxious/ambivalent). These frequencies have also been found in other adult studies (eg. Collins & Read, 1990; Feeney & Noller, 1990).

The secure style characterizes people who are comfortable with intimacy, dependency, and reciprocity in relationships, and experience low levels of anxiety with loss. The avoidant style includes people who lack trust, and are uncomfortable with intimacy and dependency. People with an ambivalent style desire to be close but feel anxiety about rejection.

The Hazan and Shaver (1987) questionnaire and the AAS are the two measures of attachment used in this study. They were chosen for their practical utility given the design of this study, but also because together they can provide greater validity of measurement. They have both been used quite extensively in other studies, and between them provide both categorical and dimensional measures of attachment status. Although they were designed for use in adult romantic relationships, it is argued that the therapeutic relationship provides a similar intimate adult setting of equal significance. Luborsky, Barber and Crits-Christoph (1992), in summarizing psychotherapy outcome research, argued for the legitimacy of studying the therapeutic relationship using measures derived from the attachment literature. Currently no other self-report measures can be given to both therapists and their clients.

e. Collins (1996) procedure for placing people into one of Bartholomew's (1990) attachment styles.

Collins (1996) has developed a procedure for placing people into one of Bartholomew's (1990) four attachment styles (secure, preoccupied, fearful-avoidant, dismissing-avoidant) based on their scores on the three attachment dimensions (Close, Depend, Anxiety) of the AAS (N. Collins, personal communication, February 10, 1998). Although this method is largely exploratory, it was decided to supplement the attachment measures with this procedure as it would provide further supporting evidence for attachment status.

f. Outcome measure

The main outcome measure used in this study is that of a dropout from treatment. In a major review of dropping out of treatment, Baekeland and Lundwall (1975) found that of

the psychological variables studied, lack of psychological mindedness (important in 24 out of 26 studies) emerged as a significant factor. Other important variables included low therapist-patient similarity and discrepant treatment expectations. In this present study dropout was assessed by asking clients in their follow-up questionnaire whether they were still in therapy, and if not why they had stopped.

- g. General information questionnaire (control group) - (name and address, age, sex, marital status, occupation) (see Appendix H);
- h. Initial general information questionnaire (client group) - (name, address, age, sex, marital status, occupation, previous experience of therapy, name of therapist) (see Appendix K);
- i. General information questionnaire (therapist group) - (name, age, sex, theoretical orientation, years of experience) (see Appendix O);
- j. Follow-up general information questionnaire (client group) - (name of therapist, whether still seeing therapist, how long for, why stopped seeing therapist) (see Appendix R).

6.2 Pilot Study

A pilot study was conducted using a group of 40 post registration health studies students, who each completed the Psychological Mindedness Scale (PMS), the Adult Attachment Scale (AAS), and the Toronto Alexithymia Scale (TAS-20) questionnaires once only (the Hazan and Shaver (1987) questionnaire was a later addition to the study). The demographic characteristics of this group showed that most of them were female in their 20s or 30s. The results for this group are presented later.

6.3 Main Study

6.3.1 Participants

Prior to the commencement of the study, ethics committee approval was obtained from the Department of Psychology, University of Wales, Bangor, and from the two NHS Trusts from which the participants were selected from. Three groups were included in the study -

a. Therapist group

A therapist group was recruited from two sources -

- i. The author met with eight community mental health teams (CMHT's) and described the nature of the study. The main concerns expressed by the therapists at these meetings centred on the ability and appropriateness of their clients participating in the study. This was due to the type of client problem that the CMHT treated, with the focus being particularly on clients with "serious mental illness". Some therapists wanted to be able to use their discretion to not include some clients if they were concerned about the negative impact of the study on them. Therapists didn't voice any objections about their own involvement in the study. Despite these concerns there appeared to be sufficient interest generated from these meetings to warrant sending out 78 packs of questionnaires for the therapists to both complete themselves and hand out to their clients. This however, turned out to be an overestimate of the number of therapists in these teams that were willing or able to participate, with the response rate from the CMHT therapists being only 23% (18).
- ii. To complement this group of therapists working in the secondary psychiatric service, a letter was sent to all 18 counsellors working in GP practices in the area inviting them to participate in the study (see Appendix M). The counsellors had

already been notified that they would be receiving this communication at an earlier professional meeting. The response rate was again poor at 17% (3), with 11 (61%) not replying at all, and 4 (22%) refusing to participate. Concerns expressed by those refusing to participate included questions about the impact of the study on their therapeutic relationship with their clients, and anxieties about revealing personal information about themselves by completing the questionnaires. These 3 counsellors were then included with the other therapists to provide a total therapist sample of 21 (22%).

This total sample of 21 therapists consisted of 5 men and 16 women, ranging in age from 25 to 58 (mean 42.6). Their professional groups included clinical psychologists (5, (24%)), social workers (5, (24%)), psychiatric nurses (hospital and community-based) (5, (24%)), counsellors (3, (14%)), occupational therapists (2, (10%)), and a psychotherapist. There were a range of theoretical approaches represented within this group with 5 (24%) describing themselves as psychodynamic, 5 (24%) as a mixture of eclecticism and cognitive behaviour therapy (CBT), 2 (10%) as purely CBT, and the remaining 9 (43%) as a mixture of eclecticism and various forms of humanism. The number of years the therapists had been qualified ranged from 6 months to 32 years (mean 10.9 years).

b. Client group

The client group was recruited with the agreement of their respective therapists, and consisted of clients who would ordinarily have been seen for some form of psychological therapy from the date of commencement of the study. The selection criteria were that clients should be included in the study if they were about to commence some form of psychological therapy, or had commenced this in the previous month before the start of the study. As already mentioned working practices in the CMHT's that gave priority to clients deemed to have a "serious mental illness" limited the number of potential clients that were available for the study and meant that some clients were included that would not have been according to the selection criteria. Although therapists were encouraged to

adhere to the selection criteria, they were allowed to use their discretion if they were concerned about the impact of the study on the client. In order to match clients to their therapists, the clients were requested to provide the name of their therapist on their initial general information questionnaire (see Appendix K). Therapists were not aware, however, which of their clients had agreed to take part in the study, unless their clients had informed them.

A further source of potential bias was that due to the design of the study it was not possible to know how many clients were asked to take part or refused to participate. The maximum theoretical sample that could have been included in the study was 780 (78 therapists recruiting 10 clients each). With the 21 therapists that agreed to participate the sample size of the client group could have been 210 (21 therapists recruiting 10 clients each). The actual sample consisted of 26 clients (representing a theoretical response rate of 12%), 7 men and 19 women, ranging in age from 21 to 55 (mean 36.6). Ten (40%) were married (including 1 living with a partner), 7 (28%) were single, and eight (32%) were divorced (including 1 separated); one client had left this section blank. Occupations were classified as for the control group. Ten (38.5%) were classified into social class group 1, and 10 (38.5%) were classified into social class group 2, with six (23%) not able to be classified. Length of time seeing a current therapist ranged from 7 days to more than four months, (median 21 days). Six (23%) clients had been seen for longer than the stipulated 1 month (1 having been seen for almost a year) thus potentially skewing the data. It was hoped to provide measures of psychological mindedness and attachment style before involvement in therapy to compare with the effects of being in therapy six months later. Using clients already in therapy may have made their initial measures of psychological mindedness and attachment style less independent from the effects of therapy. It was unlikely, however, that any of the clients would be in intensive psychotherapy, and may not, therefore, have developed as strong a relationship with the therapist. It was hoped then that the inclusion of these clients would not have any adverse effects on the conclusions drawn from these measures. Mallinckrodt et al. (1995) suggested in their study that a minimum of five sessions would be necessary for important features of the therapist-client relationship to emerge. Few of the clients outside of the

selection criteria were being seeing weekly and some were being seen monthly. Most of the clients (16 (62%)) had not had any previous therapy before, (excluding GP consultations), the others having received therapy within the last 12 months (4 (15%)) or two years or more ago (6 (23%)).

c. Control group

A number of attempts were made to recruit a control group for the study. First, the research panel at a local university were contacted as they would have been able to provide a representative sample of the general population. Unfortunately, however, due to financial and administrative problems, this option proved to be unworkable. Next, several large local employers were contacted to try to recruit from their workforce. This option also presented difficulties, with some employers not responding at all. Those that did respond didn't follow up on their initial positive interest in the study and time constraints then reduced the feasibility of this option. A third option considered was to recruit from the workforce of the local NHS Trust, but this wasn't pursued as it was felt that any sample obtained from this source would be unrepresentative. The final option considered was to recruit the control group from the Electoral Role. 200 names and addresses from a major local conurbation were selected randomly from the Role. The first 175 of these were sent letters describing the nature of the study and inviting them to take part (see Appendix F). Of these, only 22 (13%) returned completed questionnaires, which obviously limited the representativeness of the sample. It was not possible to determine the characteristics of the non-responders. The sample consisted of 11 men and 11 women, ranging in age from 18 to 77 (mean 38.4). Fourteen (64%) were married (including 1 living with a partner), 7 (32%) were single, and 1 was divorced. Occupations were classified according to broad social class groupings with a division into two social classes 1 (I and II), and 2 (III, IV, and V) (General Register Office, 1970). Six (27%) were classified into social class group 1, and eleven (50%) were classified into social class group 2, with 5 (23%) unable to be classified.

There were no significant differences between the control and client groups on age, gender, marital status, or occupation.

6.3.2 Procedure

a. Therapist group

The therapist group was asked to contribute to the study by completing the PMS, TAS-20, AAS, Hazan and Shaver measure, and given a consent form, an information sheet and a general information questionnaire, but on only one occasion, at the commencement of the study (see Appendices E, L, M, N and O for details of the consent form, the letter sent to therapists, information sheet, and general information questionnaire respectively). Each therapist was also given 10 sealed envelopes containing the same questionnaires and asked to give these to up to 10 clients that they were either taking on for some form of psychological therapy within the next month, or had taken on within the last month.

b. Client group

The client group were given an envelope by their therapist, containing a covering letter explaining the nature of the study (see Appendix I), copies of the PMS, TAS-20, AAS, Hazan and Shaver measure, a consent form, information sheet, and a general information questionnaire (see Appendices E, J and K for details of the consent form, information sheet and general information questionnaire respectively). The client group were asked to provide their names and addresses so that they could be followed-up in six months time to complete the PMS, TAS-20, AAS, and the Hazan and Shaver measure again, and a further general information questionnaire (see Appendices Q and R for details of the follow-up letter and follow-up general information questionnaire respectively).

c. Control group

The control group was sent an envelope containing a covering letter explaining the nature of the study (see Appendix F), copies of the PMS, TAS-20, AAS, Hazan and Shaver measure, a consent form, information sheet and a general information questionnaire (see Appendices E, G and H for details of the consent form, information sheet, and general information questionnaire respectively). The control group was asked to provide their names and addresses so that they could be followed-up in six months time to complete the PMS, TAS-20, AAS, and the Hazan and Shaver measure again (see Appendix P for details of the follow-up letter).

RESULTS

7. RESULTS

7.1 Pilot study

The pilot study enabled preliminary comparisons among the three measures to be conducted, the results of which are presented in Tables 1 to 3.

Table 1

Means and standard deviations for the pilot group on the PMS, TAS-20 and AAS dimensions ($n = 40$)

	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
<i>M</i>	134.83	45.85	14.85	12.03	18.98	22.03	18.03	14.95
<i>SD</i>	12.6	11.72	6.36	4.00	5.68	4.19	4.37	6.08

Note. TASF1 = difficulty identifying feelings;
 TASF2 = difficulty describing feelings;
 TASF3 = externally oriented thinking.

There were no published norms for the PMS, but the TAS-20 results were very similar to the university student sample used for the cross-validation of the TAS-20 (Mean = 47.39; SD = 10.37), (Bagby et al. 1994a). Using the cutoff scores on the TAS-20 to classify people into alexithymic and nonalexithymic categories (Taylor & Taylor, 1997), 6 (15%) were classified as alexithymic. The results for the AAS were very similar to the undergraduate norms for the AAS (Close: Mean = 21.2; SD = 4.8; Depend: Mean = 18.3, SD = 4.7; Anxiety: Mean = 16.2; SD = 5.1), Collins and Read (1990).

Table 2

Correlations between the PMS, TAS-20 and AAS dimensions for the pilot group ($n = 40$)

Measure	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
PMS	--	-.50**	-.19	-.35*	-.57**	.41**	.32 [†]	-.15
TAS-20		--	.78**	.79**	.64**	-.52**	-.38 [†]	.56**
TASF1			--	.55**	.09	-.17	-.22	.56**
TASF2				--	.31*	-.59**	-.38 [†]	-.52**
TASF3					--	-.47**	-.27	.16
Close						--	.55**	-.26
Depend							--	-.49**
Anxiety								--

* $p < .05$, one-tailed, ** $p < .01$, one-tailed. [†] $p < .05$, two-tailed, ^{††} $p < .01$, two-tailed.

The correlations between the PMS and TAS-20 compared favourably to the university student sample used for the cross-validation of the TAS-20 (PMS/TAS-20 = $-.68$, $p < .01$; PMS/TASF1 = $-.44$, $p < .01$ (weaker in this study); PMS/TASF2 = $-.51$, $p < .01$; PMS/TASF3 = $-.54$, $p < .01$), (Bagby et al. 1994b), and the parameter estimates for the relationships among the three factors (F1/F2 = $.65$, $p < .05$; F1/F3 = $.10$, ns; F2/F3 = $.36$, $p < .05$), (Bagby et al. 1994a).

The PMS and the AAS had not been used together in any published studies before so no comparative correlational data existed. As can be seen from Table 2 psychological mindedness, as measured by the PMS, was significantly positively correlated with the Close and Depend dimensions of the AAS but was unrelated to the Anxiety dimension. The AAS interfactor correlations were higher here than in the original normative study but in the expected direction (Close/Depend = $.38$; Close/Anxiety = $-.08$; Depend/Anxiety = $-.24$), (Collins & Read, 1990). The Close dimension was significantly positively correlated with the Depend dimension, and negatively correlated with the Anxiety dimension. The Depend dimension was significantly negatively correlated with the Anxiety dimension.

The TAS-20 and the AAS had not been used together in any published studies before either so again no comparative correlational data existed. Given that the TAS-20, as a

measure of alexithymia, was inversely correlated with the PMS, a measure of psychological mindedness, then the opposite of the significant relationship found between the PMS and the AAS above should have been found. Table 2 shows that this was the case. The TAS-20 was significantly negatively correlated with the Close and Depend dimensions and significantly positively correlated with the Anxiety dimension of the AAS, with the Close and Anxiety dimensions showing the strongest relationships. The three factors of the TAS-20 were also significantly correlated with the AAS. In particular, F1 (difficulty identifying feelings) was positively correlated with the Anxiety dimension, F2 (difficulty describing feelings) was negatively correlated with the Close, Depend and Anxiety dimensions, and F3 (externally oriented thinking) was negatively correlated with the Close dimension.

Collins' (1996) procedure for creating Bartholomew's (1990) four attachment styles (secure, preoccupied, fearful-avoidant, dismissing-avoidant) based on scores on the three attachment dimensions of the AAS (Close, Depend, Anxiety) was used for the pilot group and produced the following classification - Secure 47.5% (19), Preoccupied (Ambivalent) 17.5% (7), Dismissive-Avoidant 17.5% (7), and Fearful-Avoidant 17.5% (7).

These compared well with the results obtained for a sample of 77 undergraduates in a study by Bartholomew and Horowitz (1991) (Secure - 46.8%, Preoccupied (Ambivalent) - 14.3%, Dismissive-Avoidant - 18.2%, Fearful-Avoidant - 20.8%). They were also compared with the findings of Hazan and Shaver (1987) and their three category classification. Using a self-selected sample of normal adults, Hazan and Shaver (1987) found that 56% could be classified as secure, 25% as avoidant, and 19% as anxious/ambivalent. The results obtained here with the Bartholomew (1990) classification were not that dissimilar if the dismissive-avoidant and fearful-avoidant categories were collapsed into one avoidant category, thus producing a classification of 35%.

The results for the relationship between the PMS, TAS-20 and the Bartholomew model are now presented in Table 3

Table 3

Mean PMS and TAS-20 scores (pilot group) for the four attachment types classified by Bartholomew (1990)

	Attachment style				<i>F</i> (3, 36)
	Secure	Preoccupied (Ambivalent)	Dismissive- Avoidant	Fearful- Avoidant	
Bartholomew's model					
<i>n</i>	19	7	7	7	
PMS	138.26 _a	141.29 _a	132.14 _{a,b}	121.71 _b	4.80**
TAS-20	39.21 _a	47.29 _{a,b}	49.86 _{a,b}	58.43 _b	7.56***
TASF1	12.26 _a	17.43 _a	15.14 _a	19.00 _a	2.76
TASF2	9.32 _a	13.43 _{b,c,d}	14.71 _{b,c,d}	15.29 _{b,c,d}	9.69***
TASF3	17.63 _a	16.43 _{a,b}	20.00 _{a,b}	24.14 _b	3.34*

Note. Separate univariate analyses were conducted for the PMS and TAS-20. PMS scores had a possible range of 45 to 180, TAS-20 scores had a possible range of 20 to 100, TASF1 scores had a possible range of 7 to 35, TASF2 scores has a possible range of 5 to 25, TASF3 scores had a possible range of 8 to 40. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

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

The results in Table 3 indicate that the mean PMS score differed significantly between those people with a secure attachment style and a fearful-avoidant style, as well as between those with a preoccupied (ambivalent) style and a fearful-avoidant style. The mean TAS-20 score differed significantly between those people with secure and fearful-avoidant attachment styles. Of the TAS-20 factors, TASF2 (difficulty describing feelings) differed significantly between the securely attached and those with a preoccupied (ambivalent), dismissive-avoidant, and fearful-avoidant style and TASF3 differed significantly between the secure and fearful-avoidant groups. This pattern of results suggested that those people with a fearful-avoidant style were less psychologically minded than those with either a secure or preoccupied (ambivalent) style.

Overall, the results of the pilot study indicated that the questionnaires to be used in the main study were producing similar results to those obtained in their respective samples. The PMS and TAS-20 were significantly inversely correlated, suggesting that they were

measuring psychological mindedness and alexithymia respectively. The Close, Depend and Anxiety dimensions of the AAS were also as predicted, suggesting that this scale would provide some measure of attachment status. Psychological mindedness as measured by the PMS seemed to be positively related to the Close and Depend dimensions of the AAS (confirmed by significant negative correlations between the TAS-20 and these dimensions), suggesting that those people who were psychologically minded were also comfortable with closeness and able to depend on others. The Anxiety dimension was unrelated to psychological mindedness but significantly positively correlated with the TAS-20 and therefore alexithymia, suggesting that those people who were alexithymic were also anxious about being abandoned or unloved. As the Close and Depend dimensions had been associated with secure attachment, then this suggested that psychological mindedness had some relationship with secure attachment. Similarly, the Anxiety dimension has been associated with insecure attachment, suggesting that alexithymia has some relationship with insecure attachment. The results of the Bartholomew (1990) classification of attachment styles offered further support to these findings.

7.2 Main Study

7.2.1 Relationship between psychological mindedness and adult attachment styles

The results of the pilot study confirmed the validity of the measures and suggested that measures of psychological mindedness were related to measures of attachment style. In particular, they suggested that psychological mindedness was related to security of attachment. To test whether this relationship would be repeated in the main study, the therapist, client, and control groups were combined to form one whole sample and similar correlational analyses and analyses of variance computed between the measures. Tables 4 to 6 give details of the results of correlations among the three groups on the various measures.

Table 4

Correlations between the PMS, TAS-20 and AAS dimensions for the whole sample ($n = 69$)

Measure	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
PMS	--	-.66*	-.48*	-.68*	-.57*	.49†††	.43††	-.22
TAS-20		--	.89*	.91*	.75*	-.58††	-.50††	.34††
TASF1			--	.78*	.43*	-.47††	-.44††	.43††
TASF2				--	.56*	-.66††	-.52††	.35††
TASF3					--	-.37††	-.30†	.05
Close						--	.59**	-.39*
Depend							--	-.50**
Anxiety								--

* $p < .01$, one-tailed, ** $p < .001$, one-tailed.

† $p < .05$, two-tailed, †† $p < .01$, two-tailed, ††† $p < .001$, two-tailed.

As can be seen from Table 4, the PMS and TAS-20 were significantly negatively correlated, as expected. Psychological mindedness, as measured by the PMS, was significantly positively correlated with the Close and Depend dimensions of the AAS but negatively correlated with the Anxiety dimension. The AAS interfactor correlations were again higher here than in the original normative study (Close/Depend = 0.41;

Close/Anxiety = 0.01; Depend/Anxiety = 0.18), (Collins & Read, 1990). The Close dimension was significantly positively correlated with the Depend dimension, and significantly negatively correlated with the Anxiety dimension. Given that the TAS-20, as a measure of alexithymia, was inversely correlated with the PMS, a measure of psychological mindedness, then the opposite of the significant relationship found between the PMS and the AAS above should be found. Table 4 shows that this was the case. The TAS-20 was significantly negatively correlated with the Close and Depend dimensions and significantly positively correlated with the Anxiety dimension of the AAS, with the Close and Anxiety dimensions showing the strongest relationships. The three factors of the TAS-20 were also significantly correlated with the AAS. In particular, F1 (difficulty identifying feelings) was negatively correlated with the Close and Depend dimensions, and positively correlated with the Anxiety dimension, F2 (difficulty describing feelings) was positively correlated with the Close and Depend dimensions, and positively correlated with the Anxiety dimension, and F3 (externally oriented thinking) was negatively correlated with the Close and Depend dimensions, but unrelated to the Anxiety dimension.

To provide more accurate comparisons between each of the measures and the Hazan and Shaver measure and Bartholomew four category model for the whole sample, only those individuals whose attachment style classification was the same on both the Hazan and Shaver measure and Bartholomew four category model were included. Unfortunately, this resulted in a loss of 30.4% (21) of the total sample. Although any loss of data is undesirable, especially with a small sample such as in the present study, it was felt to be an appropriate adjustment to enhance the validity of the results. This selection criteria was repeated with each of the three groups separately as will be seen later. With this smaller whole sample (48) the relationship between the various measures and the Hazan and Shaver measure and Bartholomew four category model was examined. The AAS was tabulated with the Hazan and Shaver measure rather than the Bartholomew model as the latter was derived from the AAS. The PMS and TAS-20 are tabulated with the Bartholomew model. These results are now presented in Tables 5 and 6.

Table 5

Mean Adult Attachment Scale scores (whole sample) for the three attachment types as classified by Hazan and Shaver (1987)

AAS dimension	Attachment style			<i>F</i> (2, 45)
	Secure	Anxious/ Ambivalent	Avoidant	
Hazan and Shaver's measure				
<i>n</i>	23	3	22	
Close	25.26 _a	22.33 _a	15.00 _b	37.74*
Depend	22.22 _a	17.67 _{a,b}	12.73 _b	40.05*
Anxiety	11.30 _a	26.67 _c	19.86 _b	31.10*

Note. Scores had a possible range of 6 to 30. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

* $p < .001$

The results in Table 5 indicate that the Close dimension mean for the securely attached differed significantly from those who had an avoidant attachment style. Similarly, those with an anxious/ambivalent style differed from those with an avoidant style. The Depend dimension mean for the secure group differed from the avoidant group. For the Anxiety dimension the mean for the securely attached differed from those with either an anxious/ambivalent style or avoidant style. Those with an anxious/ambivalent style also differed from those with an avoidant style.

Table 6

Mean PMS and TAS-20 scores (whole sample) for the four attachment types as classified by Bartholomew (1990)

	Attachment style				<i>F</i> (3, 44)
	Secure	Preoccupied (Ambivalent)	Dismissive- Avoidant	Fearful- Avoidant	
Bartholomew's model					
<i>n</i>	23	3	6	16	
PMS	141.70 _a	144.00 _{a,b}	135.33 _{a,b}	130.56 _b	3.06*
TAS-20	39.74 _a	39.33 _{a,b}	53.33 _{a,b}	61.81 _b	9.79**
TASF1	12.13 _a	14.67 _{a,b}	17.00 _{a,b}	23.38 _b	10.44**
TASF2	10.43 _a	11.67 _{a,c}	16.17 _{b,c}	17.69 _{b,c}	9.83**
TASF3	17.17 _a	13.00 _a	20.17 _a	20.88 _a	2.61

Note. Separate univariate analyses were conducted for the PMS and TAS-20. PMS scores had a possible range of 45 to 180. TAS-20 scores had a possible range of 20 to 100, TASF1 scores had a possible range of 7 to 35, TASF2 scores has a possible range of 5 to 25, TASF3 scores had a possible range of 8 to 40. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

* $p < .05$, ** $p < .001$.

Table 6 indicates that the mean PMS scores differed significantly between the secure and the fearful-avoidant group. The TAS-20 and TASF1 means also differed significantly between the secure and fearful-avoidant groups. The TASF2 mean differed between the secure and both avoidant groups.

These results seemed to suggest that security of attachment was more related to psychological mindedness than insecure (avoidant) attachment. Of note again was the high level of psychological mindedness associated with the preoccupied (ambivalent) group, although the numbers were small. The results also suggested that those people who had an insecure (avoidant) attachment style were more likely to be alexithymic than those who were more securely attached. These results matched those found with the pilot group and added further support to the relationship between psychological mindedness and attachment style mentioned earlier.

7.2.2 Levels of psychological mindedness and security of attachment in the therapist, client and control groups

Hypothesis 1 predicted that the therapist group would have higher levels of psychological mindedness and be more securely attached than either the client or control groups. Tables 7 to 10 show the results of the comparisons between the various measures for this.

Table 7

Means and standard deviations for the therapist, client and control groups on the PMS and TAS-20

Measure	Group			<i>F</i> (2, 66)
	Therapist	Client	Control	
<i>n</i>	21	26	22	
PMS				
<i>M</i>	147.38 _a	132.62 _b	134.68 _b	11.87*
<i>SD</i>	7.66	12.40	11.72	
TAS-20				
<i>M</i>	35.81 _a	58.42 _b	47.73 _c	18.06*
<i>SD</i>	8.89	14.88	13.36	
TASF1				
<i>M</i>	12.14 _a	21.50 _b	14.55 _a	14.03*
<i>SD</i>	3.85	7.22	7.12	
TASF2				
<i>M</i>	9.90 _a	16.08 _b	13.09 _{a,b}	9.65*
<i>SD</i>	3.46	5.55	4.91	
TASF3				
<i>M</i>	13.76 _a	20.92 _{b,c}	20.09 _c	15.24*
<i>SD</i>	4.15	4.70	5.24	

Note. Separate univariate analyses were conducted for the PMS and TAS-20. PMS scores had a possible range of 45 to 180. TAS-20 scores had a possible range of 20 to 100, TASF1 scores had a possible range of 7 to 35, TASF2 scores has a possible range of 5 to 25, TASF3 scores had a possible range of 8 to 40. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test. * $p < .001$

The results for the client group were very similar to the psychiatric outpatient sample used for the cross-validation of the TAS-20 (Mean = 54.86; SD = 12.86), (Bagby et al. 1994a), and the (unofficial) norms for the PMS based on data reported for a sample of psychiatric outpatients (Mean = 130.69; SD = 14.10), (Conte et al. 1996), (normative data does not exist for the control and therapist groups).

Table 7 shows that the therapist group mean score on the PMS was significantly larger than either the client or control groups. All three groups differed significantly on the TAS-20, with the client group mean score being greater than either the control or therapist group.

Table 8

Levels of psychological mindedness and alexithymia in the therapist, client and control groups

	Therapist	Client	Control
PMS (High)	15 (71%)	4 (15%)	4 (18%)
PMS (Low)	1 (5%)	14 (54%)	9 (41%)
Alexithymic	0 (0%)	14 (54%)	4 (18%)
Non-Alexithymic	20 (95%)	9 (35%)	16 (73%)

To enable comparisons to be made between low and high psychological mindedness on the PMS, a method of ranking the scores from all the individuals in the client, control and therapist samples (thus treating them as one whole sample) was used (H. R. Conte, personal communication, October 23, 1997). The score obtained by the lowest scoring individual of the top third of the whole sample was used as a cutoff for high psychological mindedness, and that of the highest scoring individual of the bottom third as a cutoff for low psychological mindedness. This resulted in a score of 144 and above on the PMS being regarded as indicating high psychological mindedness, and a score of 131 and below being regarded as indicating low psychological mindedness. As Table 8 shows, each group was then compared with regard to the cutoff on the PMS into high and low psychological mindedness, the differences being significant ($\chi^2(2, n = 47) = 19.72, p <$

.001). The therapist group had higher levels of psychological mindedness than either the control or client groups, and the client group had lower levels of psychological mindedness than the therapist group. Using the cutoff scores on the TAS-20 to classify people into alexithymic and nonalexithymic categories (Taylor & Taylor, 1997), the three groups were classified as shown in Table 8, and again the differences were significant ($\chi^2(2, n = 63) = 20.48, p < .001$). The client group were classified as more alexithymic than either the therapist or control groups.

As Tables 7 and 8 show, the therapist group was significantly more psychologically minded than either the client or control groups. Comparisons of security of attachment between the three groups were then made, based on mean score differences on the AAS dimensions and on the attachment classification according to the Hazan and Shaver measure and Bartholomew model. The results of these comparisons can be seen in Tables 9 and 10.

Table 9

Means and standard deviations for the therapist, client and control groups on the Adult Attachment Scale dimensions

AAS Dimension	Group			<i>F</i> (2, 66)
	Therapist	Client	Control	
<i>n</i>	21	26	22	
Close				
<i>M</i>	22.24 _a	17.89 _b	22.28 _a	5.17*
<i>SD</i>	4.86	6.36	4.84	
Depend				
<i>M</i>	18.81 _a	14.15 _b	18.77 _a	7.35*
<i>SD</i>	4.27	4.54	5.71	
Anxiety				
<i>M</i>	13.67 _a	22.89 _b	15.96 _a	17.95**
<i>SD</i>	3.88	5.22	7.07	

Note. Scores had a possible range of 6 to 30. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

* $p < .01$, ** $p < .001$

The results in Table 9 indicate that the Close, Depend, and Anxiety dimension means for the therapist and control groups all differed significantly from the client group. The mean scores for the therapist and control groups were very similar to the undergraduate norms reported by Collins and Read (1990) (Close: Mean = 21.2; SD = 4.8; Depend: Mean = 18.3; SD = 4.7; Anxiety: Mean = 16.2; SD = 5.1). This pattern of results suggested that the therapist and control groups were comfortable with closeness, able to depend on others, and not worried about being abandoned or unloved (i.e. were more secure). The client group were less comfortable with closeness, less able to depend on others, and very worried about being abandoned or unloved (i.e. were more insecure).

This was confirmed by the attachment classification of the three groups according to the Hazan and Shaver (1987) measure and Bartholomew's four category model (1990) as can be seen in Table 10.

Table 10

Attachment classification for the control, client and therapist group on the Hazan and Shaver (1987) measure and Bartholomew's (1990) four attachment types

Measure	Group			
	Therapist	Client	Control	Whole sample
<i>n</i>	21	26	22	69
Hazan and Shaver				
Secure	61.9%	11.5%	77.3%	47.8%
Avoid	38.1%	61.5%	13.6%	39.1%
Anx/Amb	0.0%	26.9%	9.1%	13.0%
Bartholomew				
Secure	57.1%	7.7%	54.5%	37.7%
Preoccupied (Ambivalent)	4.8%	19.2%	22.7%	15.9%
Dismissive-Avoidant	19.0%	7.7%	9.1%	11.6%
Fearful-Avoidant	19.0%	65.4%	13.6%	34.8%

The Hazan and Shaver classification for the whole sample compared favourably to their reported classification using a self-selected sample of normal adults (56% secure, 25%

avoidant, and 19% anxious/ambivalent)(Hazan & Shaver, 1987). Using the method described by Collins (1996) to convert the AAS dimensions (Close, Depend, Anxiety) into the four attachment types identified by Bartholomew (1990), these classifications were compared with the self-selected attachment classifications provided by the Hazan and Shaver measure. The data have been compared in two ways, both of which provide valid comparisons.

- a. Looking at the distinction between secure and insecure attachment as broad categories, (i.e. subsuming the avoidant and preoccupied (anxious/ambivalent) under the insecure category) then 81% (56) of the total sample (therapists, clients, controls) were classified on Bartholomew's model in the same way as the Hazan and Shaver measure (70% (23) of the secure styles, 89% (24) of the avoidant styles, 100% (9) of the anxious/ambivalent styles).

For the therapist group 77% (10) of the secure styles on the Hazan and Shaver measure (1 was reclassified as preoccupied (ambivalent), 1 as dismissive-avoidant, and 1 as fearful-avoidant) and 75% (6) of the avoidant styles (2 were reclassified as secure, 3 as dismissive-avoidant, and 3 as fearful-avoidant) were similarly classified on the Bartholomew model.

For the client group 33% (1) of the secure styles on the Hazan and Shaver measure (2 were reclassified as preoccupied (ambivalent)); 94% (15) of the avoidant styles (1 was reclassified as secure, 2 as preoccupied (ambivalent), 2 as dismissive-avoidant, 11 as fearful-avoidant); and 100% (7) of the anxious/ambivalent styles were similarly classified on the Bartholomew model.

For the control group 71% (12) of the secure styles on the Hazan and Shaver measure (3 were reclassified as preoccupied (ambivalent), 1 as dismissive-avoidant, 1 as fearful-avoidant); 100% (3) of the avoidant styles; and 100% of the anxious/ambivalent styles were similarly classified on the Bartholomew model.

- b. If the data are examined by comparing similar classifications of insecure attachment, then 70%(48) of the total sample (therapists, clients, controls) were similarly classified (70% (23) secure, 82% (22) avoidant, 33% (3) anxious/ambivalent). The client group were responsible for this reduced comparison, with 86% (6) of their anxious/ambivalent styles being reclassified as fearful-avoidant styles. This may be more a reflection of how this particular group rated themselves than a problem with the Bartholomew classification given the reasonable cross-classifications produced (therapists - 76%; clients - 58%; controls - 77%).

The Hazan and Shaver classifications for the therapist and control groups are proportionately similar to the Hazan and Shaver (1987) norms (56% Secure, 25% Avoidant, 19% Anxious/Ambivalent) from a self-selected sample of normal adults, unlike the client group. The distribution for the three groups on the Hazan and Shaver measure was significant ($\chi^2(4, n = 69) = 25.86, p < .001$). In particular, there was a significant difference between the therapist and client groups on this measure ($\chi^2(2, n = 47) = 15.56, p < .001$), with the therapist group being more securely attached than the client group. There was also a significant difference between the client and control groups on the same measure ($\chi^2(2, n = 48) = 21.29, p < .001$) with the client group being less securely attached than the control group. Of note are the high levels of secure attachment identified by the control and therapist groups, and the higher levels of insecure attachment in the client group, particularly with regard to avoidant attachment. Also of interest is that all of the insecurely attached therapists were in the avoidant category.

The distribution for the three groups on the Bartholomew model was also significant ($\chi^2(6, n = 69) = 25.23, p < .001$). In particular, the therapist and client groups differed significantly ($\chi^2(3, n = 47) = 18.20, p < .001$), with the therapist group again being more securely attached. The client and control groups also differed significantly on this measure ($\chi^2(3, n = 48) = 16.73, p < .001$) with the control group again being more securely attached. These results matched the findings on the Hazan and Shaver measure.

The results of the comparison between the three groups on security of attachment indicated that the therapist group was more securely attached than the client group, but there was no difference in security of attachment when compared with the control group.

Hypothesis 1

(Therapists will have higher levels of psychological mindedness and be more securely attached than either a client group or a control group representing members of the general population).

The results presented here confirmed the higher levels of psychological mindedness in the therapist group compared to the client and control groups. The therapist group was also more securely attached, but only when compared with the client group. Subject to the limitations of the data due to the small sample size and confounding factors associated with the sample, Hypothesis 1 received very tentative support.

Given the differences identified between the three groups on levels of psychological mindedness and attachment style, comparisons between the various measures for each group (therapist, client, control) are now presented separately in order to clarify the nature of these differences.

7.2.3 Therapist Group

There were no significant differences between age, gender, profession, years qualified or theoretical approach and scores on the PMS, TAS-20, AAS, Hazan and Shaver measure or the Bartholomew measure.

Tables 11 to 13 present the results of the correlations and analyses of variance between the various measures for this group.

Table 11

Correlations between the PMS, TAS-20 and AAS dimensions for the therapist group (n=21)

Measure	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
PMS	--	-.22	-.16	-.19	-.16	.05	.37	-.09
TAS-20		--	.83*	.83*	.68*	-.69 ^{††}	-.47 [†]	-.04
TASF1			--	.72*	.26	-.75 ^{††}	-.50 [†]	.14
TASF2				--	.26	-.68 ^{††}	-.33	.00
TASF3					--	-.21	-.26	-.22
Close						--	.62*	-.25
Depend							--	-.31
Anxiety								--

* $p < .01$, one-tailed. [†] $p < .05$, two-tailed, ^{††} $p < .01$, two-tailed.

Unlike the findings of the pilot group, the correlations between the PMS and TAS-20 and its three factors were non-significant and negative but weak for the therapist group, although intercorrelations between the three factors compared favourably with the parameter estimates for the relationships among the three factors (F1/F2 = 0.65; F1/F3 = 0.10; F2/F3 = 0.36), (Bagby et al. 1994a).

The PMS was not significantly related to any of the AAS dimensions, with the strongest relationship being between the PMS and the Depend dimension, unlike the significant relationships found with the pilot group. The AAS interfactor correlations also differed from the original normative study, with the therapist group showing much stronger relationships (Close/Depend = 0.41; Close/Anxiety = 0.01; Depend/Anxiety = 0.18), (Collins & Read, 1990). The Close dimension was significantly positively correlated with the Depend dimension, and negatively correlated with the Anxiety dimension.

The TAS-20 was significantly negatively correlated with the Close and Depend dimensions of the AAS, but the relationship with the Anxiety dimension was much weaker than would be expected. This supported the inconsistent findings between the PMS and the AAS for this group. Two of the three factors of the TAS-20 were also significantly correlated with

the AAS. F1 (difficulty identifying feelings) was negatively correlated with the Close and Depend dimensions, F2 (difficulty describing feelings) was negatively correlated with the Close dimensions, with F3 (externally oriented thinking) showing no significant correlations.

Only the therapists who obtained similar attachment style classifications on the Hazan and Shaver measure and Bartholomew's four category model were included in the following results. Unfortunately, this meant that 24% (5) were lost to the analysis. The relationship between each of the measures and the Hazan and Shaver measure and Bartholomew's model for this therapist sample (16) was then examined. The AAS was tabulated with the Hazan and Shaver measure rather than the Bartholomew model as the latter was derived from the AAS. The PMS and TAS-20 were tabulated with the Bartholomew model. These are now presented in Tables 12 and 13.

Table 12

Mean Adult Attachment Scale scores (therapist group) for the three attachment types as classified by Hazan and Shaver (1987)

AAS dimension	Attachment style			<i>F</i> (1, 14)
	Secure	Anxious/ Ambivalent	Avoidant	
Hazan and Shaver's measure				
<i>n</i>	10	0	6	
Close	25.20 _a	--	17.00 _b	22.40*
Depend	22.50 _a	--	15.00 _b	37.62*
Anxiety	11.70 _a	--	15.00 _a	3.62

Note. Scores had a possible range of 6 to 30. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

-- dashes indicate that no scores were obtained for the anxious/ambivalent category.

* $p < .001$

The results in Table 12 indicate that the Close dimension mean for the securely attached differed significantly from those who had an avoidant attachment style. The Depend dimension mean differed similarly between the secure and the avoidant style. There were

no differences for the Anxiety dimension. Of interest is the fact that none of the therapist group were classified as having an anxious/ambivalent attachment style.

Table 13

Mean PMS and TAS-20 scores (therapist group) for the four attachment types as classified by Bartholomew (1990)

	Attachment style				<i>F</i> (2,13)
	Secure	Preoccupied (Ambivalent)	Dismissive- Avoidant	Fearful- Avoidant	
Bartholomew's model					
<i>n</i>	10	0	3	3	
PMS	148.50	--	147.67	151.67	0.33
TAS-20	32.80	--	45.67	35.00	2.56
TASF1	10.70	--	16.67	14.67	4.07*
TASF2	9.00	--	13.33	9.33	2.10
TASF3	13.10	--	15.67	11.00	1.70

Note. Separate univariate analyses were conducted for the PMS and TAS-20. PMS scores had a possible range of 45 to 180. TAS-20 scores had a possible range of 20 to 100, TASF1 scores had a possible range of 7 to 35, TASF2 scores has a possible range of 5 to 25, TASF3 scores had a possible range of 8 to 40.

-- dashes indicate that no scores were obtained for the preoccupied (ambivalent) category.

* $p < .05$.

Table 13 indicates no difference between security of attachment and mean PMS or TAS-20 scores. Of note are the high levels of psychological mindedness for the secure and insecure attachment classifications.

7.2.4 Client Group

There were no significant differences between age, gender, marital status, or occupation and the PMS, TAS-20, AAS, Hazan and Shaver measure, and the Bartholomew measure. Neither was there a significant relationship between previous experience of therapy and psychological mindedness. Table 14 to 16 present the results of the correlations and analyses of variance between the various measures for this group.

Table 14

Correlations between the PMS, TAS-20 and AAS dimensions for the client group ($n=26$)

Measure	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
PMS	--	-.67**	-.49**	-.72**	-.51**	.55††	.35	.07
TAS-20		--	.88**	.93**	.74**	-.51††	-.12	-.13
TASF1			--	.73**	.39*	-.33	.04	.03
TASF2				--	.63*	-.62††	-.32	.00
TASF3					--	-.39†	-.05	-.46†
Close						--	.47**	-.24
Depend							--	-.30
Anxiety								--

* $p < .05$, one-tailed, ** $p < .01$, one-tailed. † $p < .05$, two-tailed, †† $p < .01$, two-tailed.

The correlations between the PMS and TAS-20 were in the expected direction and confirmed again the significant negative correlation between these two measures. The PMS was significantly positively related to the AAS Close dimension, and non-significantly correlated with the Depend dimension, there being no relationship with the Anxiety dimension. The AAS interfactor correlations differed from the original normative study, with the client group showing much stronger relationships (Close/Depend = 0.41; Close/Anxiety = 0.01; Depend/Anxiety = 0.18), (Collins & Read, 1990).

There was a significant negative relationship between the TAS-20 and the AAS Close dimension, supporting the significant positive relationship found between the PMS and AAS Close dimension. There were also similar significant negative relationships between two of the factors of the TAS-20 and the Close dimension (F2, difficulty describing feelings and F3, externally oriented thinking). Unexpectedly, there was a significant negative relationship between F3 and the Anxiety dimension.

Only those clients who obtained a similar classification on both the Hazan and Shaver measure and Bartholomew's model were included in the following analyses.

Unfortunately, this meant that 42% (11) clients were lost to the analysis. The relationship between each of the measures and the Hazan and Shaver measure and Bartholomew model for the client group was then examined. The AAS was tabulated with the Hazan and Shaver measure rather than the Bartholomew model as the latter was derived from the AAS. The PMS and TAS-20 were tabulated with the Bartholomew model. The results are presented in Tables 15 and 16.

Table 15

Mean Adult Attachment Scale scores (client group) for the three attachment types as classified by Hazan and Shaver (1987)

AAS dimension	Attachment style			<i>F</i> (2,12)
	Secure	Anxious/ Ambivalent	Avoidant	
Hazan and Shaver's measure				
<i>n</i>	1	1	13	
Close	30.00 _a	23.00 _{a,b}	13.85 _b	5.43*
Depend	27.00 _a	15.00 _{a,b}	12.46 _b	7.57**
Anxiety	9.00 _a	27.00 _b	22.23 _b	6.02*

Note. Scores had a possible range of 6 to 30. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

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

As the numbers were very small for the secure and anxious/ambivalent groups statistical comparisons were very limited, however the results fitted the pattern that would be expected with this measure.

Table 16

Mean PMS and TAS-20 scores (client group) for the four attachment types as classified by Bartholomew (1990)

	Attachment style				<i>F</i> (3,11)
	Secure	Preoccupied (Ambivalent)	Dismissive- Avoidant	Fearful- Avoidant	
Bartholomew's measure					
<i>n</i>	1	1	2	11	
PMS	139.00 _{a,b}	158.00 _a	125.50 _b	126.18 _b	6.15*
TAS-20	49.00 _a	27.00 _a	63.00 _b	67.18 _b	6.05*
TASF1	18.00 _a	12.00 _a	19.50 _a	25.55 _a	1.70
TASF2	11.00 _a	6.00 _a	18.50 _b	19.45 _b	4.92*
TASF3	20.00 _a	9.00 _b	25.00 _a	22.36 _a	9.14**

Note. PMS scores had a possible range of 45 to 180. TAS-20 scores had a possible range of 20 to 100, TASF1 scores had a possible range of 7 to 35, TASF2 scores has a possible range of 5 to 25, TASF3 scores had a possible range of 8 to 40. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

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

As the numbers were again very small for the secure and anxious/ambivalent groups statistical comparisons were very limited, however the results fitted the pattern that would be expected with these measures, with low scores on psychological mindedness and high scores on alexithymia for the avoidant attachment styles.

It was hypothesized that those clients high on psychological mindedness would tend to have a secure attachment style, and that conversely, those clients low on psychological mindedness would tend to have an insecure attachment style. Using the cut-off method described earlier for the PMS, only four clients could be classified as being high on psychological mindedness making any statistical comparison meaningless. Of note, however, was the fact that all four of these clients were classified according to the Bartholomew model as having a preoccupied (ambivalent) attachment style (although only one of these was similarly classified on the Hazan and Shaver measure). Eight clients fell in the middle range of psychological mindedness, but none of their scores on the PMS

were significantly related to any of the attachment measures. Of the remaining fourteen clients who scored low on psychological mindedness, again there were no significant relationships between their scores on the PMS and any of the attachment measures.

7.2.5 Control Group

There were no significant differences between age, gender, marital status or occupation and the PMS, TAS-20, AAS, Hazan and Shaver measure or the Bartholomew model, except for a significant finding between being married/living with a partner and secure attachment on the Bartholomew model ($\chi^2(6, n = 22) = 17.05, p < .01$). Tables 17 to 19 present the results of the correlations and analyses of variance between the various measures for this group.

Table 17

Correlations between the PMS, TAS-20 and AAS dimensions for the control group ($n=22$)

Measure	PMS	TAS-20	TASF1	TASF2	TASF3	Close	Depend	Anxiety
PMS	--	-.50*	-.23	-.60**	-.38*	.59††	.40	.07
TAS-20		--	.85**	.86**	.56**	-.45†	-.63††	.15
TASF1			--	.70**	.13	-.21	-.53†	.27
TASF2				--	.27	-.58††	-.63††	.26
TASF3					--	-.31	-.31	-.23
Close						--	.53**	-.22
Depend							--	-.38*
Anxiety								--

* $p < .05$, one-tailed, ** $p < .01$, one-tailed. † $p < .05$, two-tailed, †† $p < .01$, two-tailed.

The correlations between the PMS and TAS-20 were in the expected direction and confirmed again the significant negative correlation between these two measures. The PMS was significantly positively correlated with the Close dimension, non-significantly positively correlated with the Depend dimension and unrelated to the Anxiety dimension. The AAS interfactor correlations were higher here than in the original normative study (Close/Depend = 0.41; Close/Anxiety = 0.01; Depend/Anxiety = 0.18), (Collins & Read,

1990). The Close dimension was significantly positively correlated with the Depend dimension, and non-significantly negatively correlated with the Anxiety dimension. The Depend dimension was significantly negatively correlated with the Anxiety dimension.

There were significant negative relationships between the TAS-20 and the Close and Depend dimensions of the AAS, as well as between Factor 2 (F2) of the TAS-20 and the same dimensions. These were all in the expected direction.

Only those members of the control group who obtained similar attachment classifications on the Hazan and Shaver measure and the Bartholomew four category model were included in the following analyses. Unfortunately, this meant that 23% (5) were lost to this analysis. The relationship between each of the measures and the Hazan and Shaver measure and Bartholomew model for this control group sample (17) was then examined. The AAS was tabulated with the Hazan and Shaver measure rather than the Bartholomew model as the latter was derived from the AAS. The PMS and TAS-20 were tabulated with the Bartholomew model. More detailed results for each of the measures are presented in Tables 18 and 19.

Table 18

Mean Adult Attachment Scale scores (control group) for the three attachment types as classified by Hazan and Shaver (1987)

AAS dimension	Attachment style			F (2, 14)
	Secure	Anxious/ Ambivalent	Avoidant	
Hazan and Shaver's measure				
n	12	2	3	
Close	24.92 _a	22.00 _{a,b}	16.00 _b	8.84*
Depend	21.58 _a	19.00 _{a,b}	9.33 _b	11.08*
Anxiety	11.17 _a	26.50 _b	19.33 _{a,b}	12.42**

Note. Scores had a possible range of 6 to 30. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

* $p < .01$, ** $p < .001$

The results in Table 18 indicate that the Close and Depend dimension means differed significantly between the secure and avoidant groups. The Anxiety dimension mean differed significantly between the secure and anxious/ambivalent groups.

Table 19

Mean PMS and TAS-20 scores (control group) for the four attachment types as classified by Bartholomew (1990)

	Attachment style				<i>F</i> (3, 13)
	Secure	Preoccupied (Ambivalent)	Dismissive- Avoidant	Fearful- Avoidant	
Bartholomew's model					
<i>n</i>	12	2	1	2	
PMS	136.25 _a	137.00 _a	118.00 _a	123.00 _a	1.75
TAS-20	44.75 _a	45.50 _a	57.00 _{a,b}	72.50 _b	4.66*
TASF1	12.83 _a	16.00 _a	13.00 _a	24.50 _a	1.63
TASF2	11.58 _a	14.50 _{a,b}	20.00 _b	20.50 _b	6.41**
TASF3	20.33 _{a,b}	15.00 _a	24.00 _{a,b}	27.50 _b	2.53

Note. Separate univariate analyses were conducted for the PMS and TAS-20. PMS scores had a possible range of 45 to 180. TAS-20 scores had a possible range of 20 to 100. TASF1 scores had a possible range of 7 to 35. TASF2 scores has a possible range of 5 to 25. TASF3 scores had a possible range of 8 to 40. Within each row, means with different subscripts differed significantly at $p < .05$ according to a Bonferroni test.

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

As can be seen from Table 19 the pattern of results for these measures were in the expected direction, with lower levels of psychological mindedness and higher levels of alexithymia for the avoidant groups.

7.3 Psychological mindedness, attachment status, and persistence with therapy at 6 months

Hypotheses 2 and 3 predicted that there would be an increase in psychological mindedness and security of attachment for those clients who were still in therapy after a six month period. Repeat measures on the questionnaires were therefore collected from the client and control groups at this second time point (see Appendices P, Q and R for details of the follow-up letters to the control and client groups, and the follow-up general information questionnaire for the client group respectively).

7.3.1 Control group

Of the 22 controls who had agreed to participate, 13 (59%) returned their second set of questionnaires, and 2 (9%) were returned blank.

There were no significant differences within the control group between the follow-up responders and non-responders on any of the demographic characteristics (age, gender, marital status, occupation) or mean scores on the PMS, TAS-20, AAS, Hazan and Shaver measure, or the Bartholomew model.

Test-retest correlations on the various measures for the 13 control group follow-up responders were calculated and produced the following ratings - PMS (.86), TAS-20 (.78), AAS (Close dimension (.86), Depend dimension (.77), Anxiety dimension (.72)), (all $p < .01$, two-tailed). The PMS test-retest correlation compared very favourably to a test-retest reliability of .92 reported by Conte et al. (1996) over a 2-week period for a sample of 22 normal adults. The TAS-20 test-retest correlation compared very favourably to a reported test-retest reliability over a 3-week interval of .77 for a sample of 72 students (Bagby et al. 1994a). The AAS dimensions' test-retest correlations also compared very favourably to test-retest correlations over a 2-month period reported by Collins & Read (1990) in their original study (Close, .68; Depend, .71; Anxiety, .52). The test-retest correlations for the Hazan and Shaver measure and Bartholomew model were calculated using

Cramer's V (Hazan & Shaver, = .645, $p < .01$; Bartholomew, = .641, $p < .05$). Overall, this data suggested that scores on these questionnaires remained fairly stable over a 6-month period.

7.3.2 Client group

Of the 26 clients who had agreed to participate, 9 (35%) returned their second set of questionnaires, with 2 (8%) being returned blank, and 1 returned by the post office (addressee no longer resident).

There were no significant differences within the client group between the follow-up responders and non-responders on any of the demographic characteristics (age, gender, marital status, occupation), between whether they had experienced previous therapy and length of current therapy, or between mean scores on the PMS, TAS-20, AAS, Hazan and Shaver measure, or the Bartholomew model.

Test-retest correlations on the various measures for the 9 client group follow-up responders were calculated and produced the following ratings - PMS (.29), TAS-20 (.54), AAS (Close dimension (.49), Depend dimension (.14), Anxiety dimension (.76, $p < .05$, two-tailed). The test-retest correlations for the Hazan and Shaver measure and Bartholomew model were calculated using Cramer's V (Hazan & Shaver, = .391, ns; Bartholomew, = .372, ns). Most of the change within the Hazan and Shaver measure and Bartholomew model was due to reclassification within the insecure category, with only one person being reclassified as secure. Of the 9 clients who responded to the follow-up, five were no longer in therapy. The changes in scores on the various measures for those clients who were either no longer in therapy or still in therapy, and the number of sessions they reported to have had, are presented in Table 20.

Table 20

Change in scores on the PMS, TAS-20, AAS dimensions, Hazan and Shaver measure and Bartholomew model for those clients either no longer in therapy or still in therapy at follow-up

Client	Measure							Sessions
	PMS	TAS-20	Close	Depend	Anxiety	H&S	Bartholomew	
1	125→128	69→60	9→13	11→13	22→16	Av→Av	FAv→DAv	5
2	137→156	71→55	20→14	14→18	19→11	Av→Av	FAv→DAv	10
3	158→139	27→62	23→9	15→14	27→28	Aa→Av	P→FAv	5
4	135→126	54→61	17→14	13→12	30→29	Aa→Aa	FAv→FAv	1
5	121→121	76→73	6→7	15→12	18→14	Av→Av	DAv→DAv	5
6	122→156	70→60	15→12	20→12	24→26	Av→Av	FAv→FAv	7
7	122→137	48→41	6→12	10→6	24→25	Av→Av	FAv→FAv	32
8	129→138	57→52	17→21	17→18	25→16	Av→Av	FAv→Sec	18
9	142→164	33→33	23→25	12→23	29→21	Aa→Aa	FAv→P	28

Note. Clients 1 to 5 were no longer in therapy at follow-up. Clients 6 to 9 were still in therapy at follow-up. Numbers separated by an arrow (→) refer to pre- and post- scores.

H&S = Hazan and Shaver measure: Av = Avoidant, Aa = Anxious/ambivalent.

Bartholomew model: FAv = Fearful-avoidant, DAv = Dismissive-avoidant, P = Preoccupied, Sec = Secure.

The data in Table 20 indicate that clients 1, 4 and 5 showed no change on their scores on any of the measures (apart from a drop in score on the Anxiety dimension and subsequent change on the Bartholomew model for client 1) over the 6 months of the study. Analysis of their follow-up questionnaires suggested that clients 1 and 4 stopped therapy because their sessions with the therapist came to an end, whereas client 5 dropped out due to other pressures. Client 2 changed from low to high psychological mindedness, and from alexithymia to non-alexithymia, produced lower scores on the Close and Anxiety dimensions, and moved from a fearful-avoidant to a dismissive-avoidant attachment style. This client discontinued therapy because his/her goal had been reached, although there was a mixed picture here with improvements in self-awareness but no change in insecure attachment status. It could be argued though that the change within insecure attachment from fearful-avoidant to dismissive-avoidant was at least in the right direction of change. Client 3's data seemed to suggest a worse outcome with a decrease in psychological mindedness and subsequent change from non-alexithymia to alexithymia, a much lower

score on the Close dimension, and a change in attachment status from preoccupied (anxious/ambivalent) to fearful-avoidant. This client had to discontinue therapy at the therapist's request and it seemed clear from this data that the client wasn't ready to finish therapy.

Of the four clients who were still in therapy after 6 months, client 6 changed from low to high psychological mindedness, and correspondingly from alexithymia to non-alexithymia, had a drop in score on the Depend dimension, but showed no change on attachment status after only 7 sessions. Client 7 showed an increase in psychological mindedness, and a decrease in alexithymia, an increased score on the Close dimension but a decreased score on the Depend dimension, and again no change in attachment status, this time after 32 sessions. Client 8 showed an increase in psychological mindedness, a decrease in alexithymia, a drop in score on the Anxiety dimension, and a significant change in attachment status from fearful-avoidant to secure (although self-reported attachment status on the Hazan and Shaver measure remained in the avoidant category), after 18 sessions. Finally, client 9 showed an increase in psychological mindedness, remained non-alexithymic, an increase in score on the Depend dimension and a decrease in score on the Anxiety dimension, and a move from fearful-avoidant to preoccupied (ambivalent) attachment style on the Bartholomew model, after 28 sessions.

On the PMS, five (56%) showed an increase in psychological mindedness (3 of these into the high range), 2 a decrease, and 2 no change. On the TAS-20, only 2 showed an decrease in levels of alexithymia, with 2 showing an increase into high levels, and 5 showing no change.

Although the numbers were small, to enable statistical comparisons to be made absolute differences between the pre- and post scores on the PMS, TAS-20 and AAS dimensions were compared between those clients who were no longer in therapy and those who remained in therapy after the 6 month period. T-tests indicated that there were no significant differences between the clients who were no longer in therapy after 6 months and those who were. The data for the clients who were no longer in therapy were very

variable, with 3 showing no change, 1 showing negative change, and only 1 showing any positive change. In comparison, the data for the clients who were still in therapy after 6 months suggested a picture of therapy in progress, with improvements in a number of areas. From these limited results it could be suggested that improvements in psychological mindedness might be easier to promote than improvements in attachment status.

Hypothesis 2

(Those clients assessed as having high psychological mindedness at the beginning of therapy/the study will tend to have a secure attachment style and are more likely to persist in therapy. Those clients who remain in therapy, as assessed again after 6 months, will tend to maintain high psychological mindedness and a secure attachment style).

It was not possible to test this hypothesis as only 1 of the clients who responded after six months had high psychological mindedness. This was client 3 who produced the worst outcome, becoming less psychologically minded and more insecure. One other client, 9, had a PMS score that was very close to the cut-off for high psychological mindedness and, although not having a secure attachment style, changed in the direction predicted by this hypothesis. Only 4 clients from the total sample of clients had a high level of psychological mindedness, and only 3 identified themselves as securely attached thus limiting the testing of this hypothesis.

Hypothesis 3

(Those clients assessed as having low psychological mindedness at the beginning of therapy/the study will tend to have an insecure attachment style and are more likely to drop out of therapy. The clients who do remain in therapy, as assessed again after 6 months, will show an increase in psychological mindedness and have developed a more secure attachment style).

Again there were insufficient numbers in the sample to test this hypothesis in any meaningful way. Of the 5 clients who were no longer in therapy after 6 months, 4 had low levels of psychological mindedness at the beginning of the study, and insecure attachment

styles. Only 1 of these clients appeared to have ended therapy because of improvements having taken place. All of the clients who remained in therapy after 6 months showed improvements in levels of psychological mindedness as predicted. They also had insecure attachment styles at the beginning of the study, some of which became more secure as predicted, and none became less secure.

7.4 Therapist and client matching

Hypothesis 4 predicted that those client and therapist pairs that were matched on levels of psychological mindedness and/or attachment style would be less likely to drop out of therapy, as assessed after 6 months, than those not so matched. Table 21 presents the data relating to this.

Table 21

Comparison of scores on the PMS, TAS-20, AAS dimensions, Hazan and Shaver measure and Bartholomew model for client and therapist pairs (clients either no longer in therapy or still in therapy at follow-up)

Client and therapist pair	Measure						
	PMS	TAS-20	Close	Depend	Anxiety	H&S	Bartholomew
1	125 / 144	69 / 25	9 / 27	11 / 18	22 / 22	Av / Sec	Fav / P
2	137 / 136	71 / 40	20 / 24	14 / 19	19 / 12	Av / Sec	Fav / Sec
3	158 / 151	27 / 31	23 / 25	15 / 21	27 / 15	Aa / Sec	P / Sec
4	135 / 154	54 / 24	17 / 24	13 / 27	30 / 9	Aa / Sec	Fav / Sec
5	121 / 141	76 / 34	6 / 25	15 / 23	18 / 13	Av / Sec	DAv / Sec
6	122 / 137	70 / 35	15 / 19	20 / 12	24 / 13	Av / Sec	Fav / DAv
7	122 / 140	48 / 40	6 / 19	10 / 14	24 / 20	Av / Av	Fav / Fav
8	129 / 140	57 / 40	17 / 19	17 / 14	25 / 20	Av / Av	Fav / Fav
9	142 / 154	33 / 24	23 / 24	12 / 27	29 / 9	Aa / Sec	Fav / Sec

Note. Clients 1 to 5 were no longer in therapy at follow-up. Clients 6 to 9 were still in therapy at follow-up. Numbers separated by a slash (/) refer to client and therapist scores.

H&S = Hazan and Shaver measure, Av = Avoidant, Aa = Anxious/ambivalent, Sec = Secure, Bartholomew model, Fav = Fearful-avoidant, DAv = Dismissive-avoidant, P = Preoccupied, Sec = Secure.

As can be seen from Table 21 only two of the client and therapist pairs, who were no longer in therapy, were matched on levels of psychological mindedness (2 and 3) and none were matched on attachment style. Client 2 also had a much higher alexithymia score, and a higher score on the Anxiety dimension. This client had 10 sessions of therapy and was felt to have reached his/her therapeutic goal. Client 3 was matched on level of alexithymia, thus supporting the matching on psychological mindedness, but had a lower score on the Depend dimension and a higher score on the Anxiety dimension. From this client's perspective, therapy ended prematurely at the therapist's behest. The remaining three clients (1, 4, and 5) were not matched on any of the measures and had variable outcomes in that therapy seemed to end for reasons other than therapeutic goals having been achieved.

All four of those clients who were still in therapy after a six month period were matched on levels of psychological mindedness and/or attachment style. Client and therapist pair 6 were the least well matched as there was a large difference between scores on the alexithymia measure, the client being classified as alexithymic, and a dissimilarity in attachment style according to the Hazan and Shaver measure and Bartholomew model. This client was still in therapy after 7 sessions though only on a monthly basis, but had shown an increase in psychological mindedness. Client and therapist pairs 7 and 8 were less well matched on the psychological mindedness measure, but well matched on attachment style. Client 7 had received 32 weekly sessions at follow-up and showed an increase in psychological mindedness, and client 8 had received 18 fortnightly sessions and also showed an increase in psychological mindedness and some positive changes in attachment style. Finally, client and therapist pair 9 were matched on levels of psychological mindedness but not on attachment style, the therapist being more securely attached. At follow-up, this client had received 28 weekly sessions and had demonstrated an increase in psychological mindedness.

Although the numbers were small, to enable statistical comparisons to be made absolute differences between the client and therapist scores on the PMS, TAS-20 and AAS dimensions were compared between those clients who were no longer in therapy and those

who remained in therapy after the 6 month period. T-tests indicated that there were no significant differences between the clients who were no longer in therapy after 6 months and those who were.

Hypothesis 4

(Client and therapist pairs that are matched on level of psychological mindedness and/or attachment styles are less likely to drop out of therapy, as assessed after 6 months, than those not so matched).

Overall, the results from this small sample of client and therapist pairs suggested that those clients who remained in therapy after 6 months were better matched with their therapists on psychological mindedness and/or attachment style than those clients who were no longer in therapy. Given the small numbers again, it is very difficult to reach any definite conclusions regarding this hypothesis.

DISCUSSION

8. Discussion

8.1 Introduction

The aim of this study was to examine the relationship between two key concepts in the psychotherapeutic literature, that of psychological mindedness and adult attachment. The study of this relationship had been little explored in the literature before, and especially not concerning therapist and client matching on these concepts. This was seen as an exploratory study with the main focus being on discovering relationships between concepts rather than on therapeutic outcomes, but also to explore the potential influence of these variables on persistence with therapy.

Based on the available literature, four research questions were posed which were tested through four hypotheses. The literature review suggested that the use of three questionnaires, the Psychological Mindedness Scale (PMS); the Toronto Alexithymia Scale (TAS-20); the Adult Attachment Scale (AAS), would be appropriate ways of answering these research questions. Prior to the main study, a pilot study was conducted to test the applicability of these questionnaires. The results of this pilot study showed that the questionnaires were measuring what they had previously been reported to have been measuring in their respective validity studies. The pilot study means and correlations were all in the expected directions, thus supporting the use of these questionnaires in the main study as appropriate ways of answering the research questions. Following on from this pilot study, two further attachment classification systems were included in the study to enable adult attachment styles to be identified. These were the Hazan & Shaver questionnaire and the Bartholomew four-category model. The pilot group did not complete the Hazan & Shaver questionnaire, but it was possible to convert their scores on the AAS into Bartholomew's four-category model. Collins (1996) devised a method for placing respondents into one of the four attachment categories in the Bartholomew model (secure, preoccupied, dismissing-avoidant, fearful-avoidant) based on their scores on the three attachment dimensions (Close, Depend, Anxiety) of the AAS. Similar attachment style classification ratios were found for the pilot group as were reported in a study of the

four-category model by Bartholomew and Horowitz (1991) thus supporting the appropriateness of this method of attachment style categorization. The preliminary data from the pilot study therefore confirmed the choice of questionnaires to be used in the main study, and also enabled useful comparisons to be made with the groups from the main study.

The main study involved three groups (therapist, client, control) completing four questionnaires with the Bartholomew categorization being applied in each case. The client and control groups completed their questionnaires on two occasions, six months apart.

8.2 Methodological considerations

Before going on to discuss the findings that emerged from this study, there are a number of methodological considerations that need to be taken into account. One of the major drawbacks of the study concerns the low response rate for all three groups (22% (n = 21) for the therapist group, [theoretically] 12% (n = 26) for the client group, and 13% (n = 22) for the control group). The respondents were a self-selected sample, and as it was not possible to determine the characteristics of the non-respondents, it is difficult to determine how representative each group sample was of their respective populations. Statistical analysis of the data was affected by the need to match respondents attachment classifications on the Hazan and Shaver questionnaire and the Bartholomew four-category model in order to increase the reliability and validity of the findings. This resulted in a loss of 5 (24%) for the therapist group, 11 (42%) for the client group, and 5 (23%) for the control group. The low response rates were further reduced for the client and control groups due to the requirements of the study to follow these groups up six months later. This resulted in a loss of 17 (65%) for the client group, and 9 (41%) for the control group. Selection bias, therefore, needs to be taken into account in interpretation of the results. A study such as this may appeal more to those who are already psychologically minded, leading to systematic bias. This might apply particularly to the control group. Those therapists less securely attached might have been less inclined to participate, given that they were colleagues of the researcher, adding a further confounding factor. The client

group were recruited by their therapists which might have influenced their decision to participate or not, particularly on follow-up. Thus the very nature of the theoretical constructs being studied may well have been the major factors determining participation in the study. The poor response to the study, both in encouraging people to participate at all and particularly to respond again after six months, limits the applicability and generalizability of the findings. The postal design of this questionnaire study was not ideal, especially given the nature of the information that was expected of people. Standardized clinical interviews would probably increase the response rate. There was no information obtained about the type of therapy the clients received, or about their clinical diagnoses. It was difficult to know therefore, whether the type of therapy had a bearing on dropout, whether there were any improvements in symptoms as a result of therapy, and how these related to psychological mindedness and/or attachment styles. This knowledge may have helped to shed more light on the findings here or provided other explanations of them.

Other methodological considerations concern the measures used in the study. Although the Bartholomew model has highlighted the range of attachment styles available, its placement of individuals into one attachment category results in an oversimplification of the reality of adult attachment experiences. As Bartholomew and Horowitz (1991) and others (e.g. Griffin & Bartholomew, 1994; Leiman, 1995; Sperling et al. 1992) have acknowledged, the complexity of adult attachment is likely to be reflected in a range of attachment styles co-existing within the same person. Bartholomew and Horowitz (1991) took account of this in their study by using semi-structured interviews as the basis of assessment, along with other self-report measures, one of which offered attachment descriptions for the four attachment styles based on the Hazan and Shaver measure. Thus an individual could have a generally secure mental representation of a relationship and yet manifest avoidant attachment behaviour within this or other relationships. This means that a lot of individual variability in attachment styles could have been lost by the placing of people into separate styles. Thus one secure person may not have the same interpersonal experiences as another secure person when their range of attachment styles are taken into account. A key issue here is whether attachment security or insecurity refers to an enduring characteristic of an individual or whether it refers to a particular relationship.

The use of the Collins and Read measure, which identifies the underlying dimensions of attachment, may have gone some way to overcome some of the deficiencies of the single category placement method. It may also be that there are other attachment categories than the four that Bartholomew (1990) proposes. For example, Sperling et al. (1992) have suggested that if the roles of anger and hostility within relationships are properly accounted for then this could result in four different adult attachment styles - dependent, avoidant, hostile, and resistant-ambivalent. Simpson and Rholes (1994) also point out that the behaviours displayed by individuals with different attachment styles cannot be separated from the context within which those behaviours are expressed. Thus somebody with an avoidant style will manifest different aspects of the range of behaviours typically associated with that style depending on the situation that they are in. How an avoidant individual presents themselves in a psychotherapeutic relationship may well be different from how they present in the marital relationship.

All of the measures used were self-report and therefore subject to possible misinterpretation and other biases by the respondents. Despite all having good validity and reliability coefficients, self-report data should ideally be supplemented by clinical interview data, which can better assess those factors that lie outside of conscious awareness (Griffin & Bartholomew, 1994). In a study such as this, where respondents are being asked to comment upon somewhat sensitive and personal information about their feelings and relationships, there is even more room for error. In particular, the insecurely attached may answer their self-report questionnaires defensively, and consciously or unconsciously avoid the endorsement of uncomfortable feelings (Alexander, 1992; Rothbard & Shaver, 1994). Or they may be unaware of not being in touch with feelings, as in the case of the alexithymic individuals, and therefore respond inaccurately. Feeney et al. (1994) argue that one drawback of all of the questionnaire measures of adult attachment is that they are dependent upon the respondent either being in, or previously having been in, an intimate relationship. In this study, one or two respondents made this very point on their questionnaires. The original wording of the questionnaires was kept for the purposes of this study, but it might be more appropriate in a future study to orient the questions more toward the particular relationship in question, i.e. the therapeutic relationship for therapist

and client responses. This study tried to overcome these difficulties by the use of a number of measures that offered support to each other. The consistency of the findings is perhaps an indication of the success of these attempts.

8.3 Research Questions

1. Will therapists be more psychologically minded and more securely attached than either clients or members of the general population?

There was a marked contrast between the therapist and client groups on all of the measures in the study. The therapist group obtained the highest scores on the measures of psychological mindedness, with 71% scoring above the high cut-off on the PMS, and 95% scoring below the low cut-off on the TAS-20 for alexithymia. These findings support the previously reported research highlighting the high levels of psychological mindedness that tend to be found in therapists (e.g. Farber, 1983). For the client group 54% scored below the low cut-off on the PMS and a similar percentage scored above the cut-off on the TAS20 for alexithymia. On the basis of these opposite scores it was always going to be difficult to obtain a match on levels of psychological mindedness. The high levels of psychological mindedness in the therapist group, despite the range of professional backgrounds and theoretical approaches (among which there were no significant differences) is perhaps not surprising. It has always been recognized as one of the desirable characteristics for somebody entering the psychotherapy profession, and is often intensified and reinforced by the experience of professional training, supervision and clinical work. It would be expected therefore, by the very nature of the work, that therapists of whatever theoretical persuasion or profession should have the highest levels of psychological mindedness. This has been demonstrated by this study with the pilot, client, and control groups' levels of psychological mindedness being very different to that of the therapists. This implies that the therapist group are untypical of the levels of psychological mindedness to be found in groups of either psychiatric out-patients, undergraduates, or members of the general public. In addition to being the most psychologically minded, the therapist group was also the least alexithymic. According to

their scores on the three factors of the TAS-20 they had no difficulties identifying, describing or reflecting on their feelings.

The therapist and client groups also differed significantly on their attachment styles, with the therapist group being more securely attached. There were, however, no differences between the therapist and control groups in terms of security of attachment. Of interest is the fact that just over a third of the therapist group were insecurely attached, as measured by the matched Hazan and Shaver and Bartholomew results, compared to 93% of the client group. None of these insecurely attached therapists were classified as preoccupied (ambivalent) with all of them being placed into the avoidant category. It is interesting to speculate about the attachment status of therapists. It didn't have any influence on their levels of psychological mindedness as even those therapists who were insecurely attached had high levels of psychological mindedness.

A recognized 'Achilles heel' in therapists has often been highlighted when motivations for choosing the profession of psychotherapy have been studied. This feature has generally been referred to in the literature as the archetypal 'wounded healer'. Studies reviewed in section 3 of this thesis have frequently shown that many people are attracted to the profession because of a desire to resolve emotional problems of their own. These emotional problems have been linked to experiences of isolation and loneliness in childhood, with feelings of unloveableness and rejection. It is possible that many choose psychotherapy as a profession to try to find the closeness and intimacy that they were lacking in childhood. The closeness and intimacy of the therapeutic relationship can provide a safe place to get these needs met without having to become too attached. This description of the emotional difficulties that draws some people to become psychotherapists would fit well with the avoidant attachment style which describes people as feeling uncomfortable with closeness and intimacy. The attachment classification of the therapist group in this study would fit the explanation offered here, and supports the findings that therapists' attachment styles are likely to be either secure or insecure (avoidant). The preoccupied (ambivalent) style (Bowlby's compulsive care-givers) would presumably not be suited to this profession, despite their high levels of psychological

mindedness, because of their anxiety about being abandoned. Given the number and intensity of attachments within psychotherapy, only those therapists who could tolerate the emotional demands placed upon them, either because they are secure within themselves and their relationships with others or because they don't allow themselves to become attached, are going to cope. This then begs the question of whether there would be a difference in effectiveness between these two types of therapists, over and above any other differences that would be present.

Dozier et al. (1994) found in their study that dismissing-avoidant case managers intervened non-intensively regardless of client characteristics. Perhaps this implies that avoidant therapists would tend not to engage with their clients and therefore wouldn't be suited to certain types of client or types of therapeutic approach. Although no differences were found in this study between attachment status and either therapeutic profession or theoretical orientation, it is possible that choice of profession or theoretical orientation could be determined in part by one's attachment status. Holmes (1996) argues that moral development is just as important as the acquisition of technical skills for therapists, and perhaps the same applies to emotional development as reflected in their attachment style. While it was not possible to assess these issues in the present study, they are clearly important areas for further research.

Bearing in mind the limited conclusions that can be reached on the basis of the data, the answer to research question 1 is that this sample of therapists were more psychologically minded than either the client group or the control group in this study. Unsurprisingly, the therapists in this study were more securely attached than the client group. Significantly, however, they were not more securely attached than the control group. These conclusions however, are limited to the samples used in this study and cannot be generalized.

2. Is there a relationship between psychological mindedness and adult attachment style?

This was tested through hypotheses 1 and 2, which partly proposed that high psychological mindedness would be related to secure attachment and low psychological mindedness to insecure attachment. These results were based on the observed relationship between the PMS and TAS-20, as measures of psychological mindedness, and the Hazan and Shaver questionnaire, AAS, and Bartholomew categorization, as measures of adult attachment. Looking at the pilot group and main study whole sample (therapist, client, and control groups combined) there were positive relationships between secure attachment and high psychological mindedness, and between insecure (fearful-avoidant) attachment and low psychological mindedness. These relationships were, however, much stronger for the, more cohesive, pilot group. This pattern of results was also non-significantly evident for the client and control groups separately, but not for the therapist group.

What also emerged were high levels of psychological mindedness for those with a preoccupied (ambivalent) attachment style in both the pilot group and main study whole sample, although this was not significant for the latter group. This again was evident for the client and control groups separately, although the numbers were very small, but not for the therapist group who had no members with a preoccupied (ambivalent) attachment style. Although this wasn't a prediction of the study, on reflection it seems an obvious finding. As this particular attachment style is characterized by a preoccupation with relationships in order to gain the acceptance of valued others, then it is not surprising that they should score high on a measure that accesses "...an interest in the meaning and motivation of one's own and others' thoughts, feelings, and behaviour..." (Conte, et al. 1996, p. 254.). The findings for the TAS-20, a measure of non-psychological mindedness or alexithymia, partly supported these results. In both the pilot group and the main study whole sample, secure attachment was related to low levels of alexithymia and insecure (fearful-avoidant) attachment was related to high levels of alexithymia. This remained true for the client and control groups separately, but not for the therapist group. There was also a tendency for those with an insecure (preoccupied [ambivalent]) attachment style to

have similar low levels of alexithymia to those with a secure attachment style, but this was only clearly evident for the main study (whole sample combined) and control group.

On the AAS, which produces dimensions of attachment rather than attachment styles, further support for the relationship between psychological mindedness and attachment was obtained. For the pilot group and the main study whole sample, the PMS was significantly positively correlated with the Close and Depend dimensions of the AAS. This relationship with the Close dimension was also evident for the client and control groups but not for the therapist group. The relationship with the Depend dimension was non-significantly positively correlated for all three groups. The Anxiety dimension was unrelated to the PMS in either the pilot group or the main study groups. As high scores on the Close and Depend dimensions and low scores on the Anxiety dimension have been related to security of attachment (Collins & Read, 1990), then these results add further support to the suggestion that psychological mindedness and secure attachment are related. The relationship between the TAS-20 and the AAS confirmed these findings, showing significant negative correlations with the Close and Depend dimensions and significant positive correlations with the Anxiety dimension for both the pilot group and the main study (whole sample). The findings for the TAS-20 and Close and Depend dimensions were repeated with the therapist and control groups, but the Anxiety dimension was unrelated in all three groups. For the client group the Depend dimension was also unrelated.

The answer to the second research question again has to be tempered by the methodological limitations of the study. There appears to be a relationship between psychological mindedness and adult attachment style, at least with this limited sample. Hypotheses 2 and 3 can be very tentatively confirmed in that the study has demonstrated that high psychological mindedness and secure attachment are related, as are low psychological mindedness and insecure (especially fearful-avoidant) attachment. As noted, the relationship is not so straightforward; an additional finding was that high psychological mindedness was also related to insecure (preoccupied [ambivalent]) attachment.

3. Will measures of psychological mindedness and adult attachment style in clients show any change as a result of time spent in therapy?

This was again tested through hypotheses 2 and 3, which partly proposed that those clients who were assessed as having high levels of psychological mindedness and secure attachment at the beginning of the study would tend to maintain these over a six month period, and that those clients who were assessed as having low psychological mindedness and insecure attachment at the beginning of the study would show an increase in psychological mindedness and a more secure attachment style. Changes in these measures were assessed in both the client and control groups by obtaining repeat measures after a six month interval. The function of the control group was to ensure that any changes that did take place in the client group could be attributed to the effects of being engaged in some form of psychological therapy, rather than being due to extraneous factors or instabilities in the measures over the six month time period. Unfortunately the numbers in each group who agreed to complete the measures again after the six month interval were much lower than was desirable, making any statistical comparisons very limited (control = 13, client = 9, with five of these no longer in therapy and four still in therapy). However, test-retest correlations for the PMS, TAS-20, AAS, Hazan and Shaver questionnaire, and the Bartholomew model for the control group were more stable than for the client group, apart for the Anxiety dimension of the AAS which remained stable for both groups. These findings suggest that there might have been more change on these measures for the client group. There were insufficient numbers in the client group with high levels of psychological mindedness or secure attachment at the beginning of the study, so it was not possible to say whether or not they would have maintained this as a result of being in therapy. This limited sample did show an increase in their levels of psychological mindedness after six months, perhaps offering some support to Conte et al. (1996) who reported that psychological mindedness tends to be associated with more time spent in therapy. There was very little change in the expected direction for the attachment measures. Attachment style may well need a more intensive period of therapy to evidence any changes, a finding that supports the earlier discussion about the stability of internal working models of attachment. Research evidence suggests that when change from one

insecure attachment type to another occurs, it is more likely to be from avoidant to preoccupied rather than the reverse (e.g. Rothbard & Shaver, 1994; West & Keller, 1994). Only one of the clients in this study showed a change in insecurity of attachment from preoccupied to avoidant.

In answer to this third research question, subject to the small sample size involved in this follow-up, it can be very tentatively stated that measures of psychological mindedness did show an increase as a result of time spent in therapy for those clients with low levels of psychological mindedness at the beginning of the study, whereas measures of adult attachment showed no significant changes from initial insecure attachment.

4. Does a match or mismatch of psychological mindedness and/or adult attachment style between therapists and their clients have an effect on client dropout from therapy?

This was tested through hypothesis 4 which proposed that those client and therapist pairs that are matched are less likely to drop out of therapy than those not so matched. Matching was assessed by comparing scores on the various measures for the therapist and client groups. Dropout was further assessed by the responses clients gave to the question "*What was the reason that you stopped seeing your therapist?*". Once again numbers were very low, with only 5 therapist/client pairs in the 'no longer in therapy' group and 4 therapist/client pairs in the 'still in therapy' group, and limited any useful statistical analysis. However, of the therapist/client pairs that were no longer in therapy only 2 were matched on levels of psychological mindedness and none were matched on attachment style. On the basis of the responses to the question about dropout, 4 of this group appeared to have ended therapy prematurely. In contrast, of the therapist/client pairs that were still in therapy, all four were matched on either psychological mindedness or attachment style.

Taking into account the very small sample available, the tentative answer to the fourth research question is that therapist and client pairs that are matched on psychological mindedness and/or adult attachment style may be more likely to remain in therapy than those not so matched. It wasn't possible to determine the separate or additive effects of matching or mismatching on psychological mindedness or adult attachment style.

8.4 Other Findings

Two other findings emerged from this study and are worthy of further discussion - the frequency and type of insecure attachment in clients, and their levels of alexithymia.

a. Insecure attachment in clients

There were significant differences between the client group and both the therapist and control groups on the Hazan and Shaver and Bartholomew attachment classification systems, and the AAS dimensions, with the client group being more insecurely attached. This was as expected by the literature review discussed earlier in section 3. Using the data from each group that were matched on both the Hazan and Shaver and Bartholomew attachment classification systems, 93% of clients were insecurely attached compared to 38% of the therapist group and 29% of the control group. In particular, the insecure attachment in the client group mainly fell into the avoidant category (93%), with most of this in the fearful-avoidant category (85%) on the Bartholomew attachment classification system. As already noted, most of the people who present to psychiatric services are insecurely attached due to difficulties in establishing satisfactory interpersonal relationships. West and Keller, (1994) suggest that the most important cause of insecure attachment in adulthood lies in the failure to successfully master the loss of an empathic relationship with the primary caregiver. Insecure attachment would seem therefore, to create a vulnerability to the development of pathology, rather than being a disorder in itself. It is not clear whether this type of insecure attachment in this sample of clients is typical of the range of insecure attachment that would be expected with this group, particularly bearing in mind the limited number of clients. What does seem to be

reasonably clear is that fearful-avoidant group of clients tend to respond less well to therapeutic interventions and develop a poor working alliance (e.g. Mallinckrodt et al. 1995). It was not possible to determine how much of a factor this was in relation to therapeutic outcome for the clients in this study, but it is clearly an area that warrants further research.

b. Alexithymia

The measure of alexithymia, the TAS-20, was included in this study as a validity check for the measure of psychological mindedness, the PMS. The concept of alexithymia, however, emerged as having more relevance in its own right than anticipated. As has been shown, apart from their levels of insecure attachment, what also distinguished the client group was their higher scores on the measure of alexithymia. In fact, they obtained the highest scores, and therefore the highest percentage of alexithymia (scoring above the cut-off), when compared to the other groups (client group - 54%; therapist group - 0%; control group - 18%; pilot group - 15%). The client group's scores were, however, very similar to those reported by Bagby et al. (1994a) for a sample of psychiatric outpatients' suggesting that they are within the normal range for the limited sample size in this study, although it is not clear whether the comparisons with the other groups are as would be predicted.

Given the significance of the levels of alexithymia found in this study, further discussion of the concept is warranted. Most of the recent research into the alexithymia construct regards it as a stable personality trait that manifests itself as a disturbance in affect regulation (Taylor et al. 1997). There is also debate in the literature over whether alexithymic characteristics reflect developmental deficits, underlying psychoneurotic conflicts, or the influence of social and cultural factors on emotional expressiveness. The evidence favours a deficit model (Taylor & Taylor, 1997) in that cross-cultural evidence for alexithymia and the TAS-20 found that alexithymia was associated more with the use of immature rather than neurotic defences. Lane and Schwartz (1987) provide a useful model of affect development that lends support to the deficit model. They describe five levels of emotion organization and awareness in their model, hypothesising that the

experience of emotion undergoes a gradual transformation in line with the neurobiological and cognitive development of the individual. The deficit is thought to be in the cognitive processing and regulation of emotions, leading to the suggestion that alexithymia should be seen as a disorder of emotion (affect) regulation (Taylor & Taylor, 1997). Despite it being regarded as a stable trait however, it is acknowledged that reductions in levels of alexithymia can be achieved with the right therapeutic approach, and that it can develop as a state experience in response to trauma. Taylor et al. (1997) cite many research studies reporting correlations between alexithymia and substance abuse, eating disorders, somatization disorders, PTSD and psychoneuroses such as panic disorder, which are seen as developing because of disordered affect regulation. Other findings suggest that alexithymia may be associated with left cerebral activation (right cerebral activation has been associated with use of fantasy and awareness of affective states) (Parker, Taylor and Bagby, 1992). Although the evidence is yet uncertain regarding the neurobiology of alexithymia, it does seem to reflect some deficiency in the coordination of the two cerebral hemispheres (Taylor et al. 1997). Alexithymia is also more likely to develop in families where emotions tend not to be expressed openly (Berenbaum & James, 1994). It has been associated with a reduced ability cognitively to process and modulate emotions, using a modified Stroop colour-naming task (Parker, Bagby, Taylor, Endler and Schmitz, 1993a), and less ability to recognize facial expressions of emotion (Parker, Taylor, Bagby and Acklin, 1993b).

Taylor and Taylor (1997) stress the value of assessing alexithymia in patients before allocation to therapy as they are unlikely to respond well to traditional exploratory therapies and may need modified versions of these approaches. They argue strongly for supportive psychotherapies or combinations of more structured approaches with psychopharmacology. As with the type of insecure attachment in the client group in this study, it is not possible to find out whether the levels of alexithymia in these clients had a bearing on therapeutic outcomes. Again, this is an area well worthy of further research.

8.5 The relationship between psychological mindedness and adult attachment styles using Bartholomew's four-category model

Having looked at the main differences between the therapist and client groups, the findings from this study regarding the relationship between psychological mindedness and adult attachment styles are now considered in relation to Bartholomew's four category model (see Table 22). This classification suggests two types of internal model, one of self and one of others, and is based on the theories put forward by Bowlby (1969, 1973, 1980). In particular, Bowlby (1973) suggested that children develop an internal working model of the other that is concerned with whether the attachment figure is reliably available when needed, and of the self that is concerned with how positively the self is perceived by the attachment figure and others. Bartholomew (1990; Bartholomew & Horowitz, 1991) suggests that four attachment patterns can be derived from the combination of these two models of self and others if they are each dichotomized as positive and negative. She also suggests that the model of self can be further conceptualized in terms of dependency (referring to the need for others approval) and the model of other conceptualized in terms of avoidance of intimacy (referring to expectations of others availability and supportiveness) to produce the four theoretically ideal attachment types.

This four-category model is shown in Table 22, along with the tentative findings from this study of the relationship between psychological mindedness and adult attachment styles. These are based on the consistent pattern of results that were obtained with the whole sample (therapist, client and control groups combined) as well as the pilot group

Table 22

Summary of tentative findings in relation to Bartholomew's four-category model

Model of other (avoidance)	Model of self (dependence)	
	Positive model of self (low dependency)	Negative model of self (high dependency)
Positive model of other (low avoidance)	SECURE <i>psychologically minded</i>	PREOCCUPIED <i>psychologically minded</i>
Negative model of other (high avoidance)	DISMISSING-AVOIDANT <i>moderately psychologically minded and or alexithymic</i>	FEARFUL-AVOIDANT <i>alexithymic</i>

Note. Bold type refers to the original Bartholomew four-category model. Italic type refers to the tentative findings from this study on the measure of psychological mindedness, and the measure of alexithymia.

The secure pattern represents a positive model of the self and other with low dependency and avoidance. Secure individuals are therefore high on autonomy and intimacy and able to use others as a source of support when needed. The tentative findings from this study suggested that the secure pattern was associated with high scores on the PMS (psychological mindedness), and low scores on the TAS-20 (alexithymia). The securely attached may therefore, be more likely to be psychologically minded and able to reflect on their feelings.

The preoccupied (ambivalent) pattern represents a negative model of self with high dependency and a positive model of the other with low avoidance. Preoccupied individuals are preoccupied with their attachment needs and dependent upon others for self validation. The tentative findings from this study suggested that the preoccupied pattern was associated with high scores on the PMS (psychological mindedness), and low scores on the TAS-20 (alexithymia). The preoccupied (ambivalent) person may therefore, be more likely to be psychologically minded. This latter finding is in contrast to that reported in a

study by Schaffer (1993) which found that alexithymia tended to be associated with a compulsive care-seeking style of insecure attachment which was defined as a subtype of ambivalent attachment. This may not be the same as the preoccupied (ambivalent) attachment style described in this study, however, as a different measure of adult attachment was used.

The fearful-avoidant pattern represents a negative model of self and other with high dependency and avoidance. Fearful-avoidant individuals avoid close involvement with others, and develop defensive strategies to protect themselves from feared rejection. In this study the fearful-avoidant pattern was associated with a low score on the PMS (psychological mindedness), and a high score on the TAS-20 (alexithymia). The fearful-avoidant person could be described then, as being alexithymic with difficulties identifying and describing feelings and little fantasy life, perhaps reflecting their defensive stance toward others.

The dismissing-avoidant pattern represents a positive model of self with low dependency and a negative model of other with high avoidance. Dismissive-avoidant individuals avoid close relationships and protect themselves from rejection by developing defensive strategies that maintain a positive self-image and a sense of invulnerability. In this study the dismissing-avoidant pattern was associated with moderate scores on psychological mindedness and alexithymia. The dismissive-avoidant person could therefore be either psychologically minded or alexithymic. Psychological mindedness for this person, in the form of presenting psychologically aware narratives, might be more of a defensive style of relating (Fogel, 1994), to protect them against primitive conflicts and anxieties given their level of self-isolation. Their levels of alexithymia may be due to the lack of experience in regulating emotions, given their avoidance of close relationships.

What emerges from this study is the consistency of the findings despite the very different groups from which the data originated from, and despite the small sample size and possible confounding factors. There would appear to be clear relationships between psychological mindedness and the attachment categories. Individuals with positive models of other,

characterized by the secure and preoccupied (ambivalent) attachment categories, seem to be more likely to be psychologically minded. Individuals with negative models of other, characterized by the avoidant categories, seem to be more likely to be alexithymic. This suggests that psychological mindedness, representing an ability to reflect on one's own and others thoughts, feelings and behaviours, may be enhanced when the other is deemed to be a person who can be relied upon for support when needed, irrespective of whether the self is viewed positively or negatively. A negative model of the other seems more likely to be associated with alexithymia, particularly when the model of the self is negative.

8.6 A suggested model linking the development of psychological mindedness and attachment style

Based on the review of the literature and the findings of this study, it is worth speculating about whether there are common pathways for the development of both psychological mindedness and attachment styles. Both appear to require a facilitating environment in order for their full potential to be realized. Given an appropriately attuned and responsive primary caregiver, the child's natural cognitive, social and emotional development should unfold, leading to feelings of security in the primary attachment relationship. Along with this would be the development of a theory of mind, the capacity to understand one's own and others' minds, the development of a reflective self, and the ability to regulate one's emotions as well as use these in the empathic understanding of others. In this ideal, and oversimplified, view of personal development, one could envisage the child growing up feeling securely attached and feeling comfortable with both autonomy and intimacy. He/she would have developed the capacity for psychological mindedness, and other similar capacities such as healthy self-consciousness, personal intelligence, and emotional intelligence.

Where there was a failure of appropriate attunement, in that there was a lack of 'fit' between the child and its primary caregiver, then the natural development of these capacities would be affected. The pathways here seem to be much more complex with many different possible outcomes. In general though it could be said that these early

failures would lead to insecure attachment and a more defensive stance taken to the world. One would expect as a result of this that the development of a theory of mind might be more limited, or might develop in a less healthy way. Defensive structures would ensure that no stable differentiation of self and other would occur, leading to interpersonal relating that was dominated more by fantasy than reality. Self-reflection might be avoided and the ability to tolerate and regulate affects may be impaired.

The different developmental routes taken by the child as a result of early failures (e.g. unreliable caregiving) may lead to preoccupied (ambivalent) attachment, where autonomy is sacrificed for the sake of intimacy and relationships are dominated by anxiety. There may be too much self-reflection and psychological mindedness, in that self-awareness and the awareness of others becomes coloured by anxieties about losing them. If the developmental route leads to a dismissive-avoidant attachment style (e.g. due to unavailable caregiving), then intimacy may be sacrificed for autonomy. The defensive stance taken by this style of relating would lead to others being shut out of awareness and so self-reflection and psychological mindedness would not be highly developed. It would be expected that they would also be low on personal intelligence, self-consciousness and social perspective taking. Another possible developmental route could lead to a fearful-avoidant attachment style (e.g. due to unavailable and/or rejecting caregiving), where again intimacy may be sacrificed for autonomy. However, this person would want emotional contact with others but be so fearful of it that they avoid close involvement. This fearfulness could lead to a reduced capacity for self-reflection and psychological mindedness, and low levels on the other related capacities. Such an individual would also be more likely to have difficulties regulating their emotional responsiveness to events and be alexithymic because of the immaturity of their defensive structure. This would suggest that the developmental failures had occurred at an early stage, possibly resulting in a “false self” (Winnicott, 1965) being presented to the world.

8.7 Therapeutic Implications

Whatever symptoms these earlier developmental failures may lead onto in later life, it is very important to be able to identify the nature of the early failure in terms of its effects on the individual's style of relating to others. It is clear both from previous literature and the tentative findings of this study that the people who present for psychological help are going to be insecurely attached in some way and have deficits in affect regulation. Their needs are therefore, going to be very different in each case. Holmes (1997) has suggested that avoidant clients need more therapeutic attunement to make up for what was missing earlier on for them, whereas ambivalent clients need a more structured approach that is able to contain their anxieties. Bowlby (1988) and others have recognized the potentialities of the therapeutic relationship to challenge and change internal working models of attachment, and so it would seem to be of fundamental importance that the therapist knows something of the attachment status of their client. Adopting a symptom-based approach may be an insufficient response to the needs of an important, particular group of clients. An attachment-based psychotherapeutic approach would seem to be a more appropriate response for this group, helping individuals to "mourn the loss of that which they never fully experienced but yearned for deeply" (West & Keller, 1994, p. 314). What this research has indicated is the need to take into account the therapist's style of relating as well, which includes both attachment style and level of psychological mindedness. Given the need for a particular therapeutic response to the client's level of functioning, and taking into account this study's findings regarding therapists' attachment styles, a number of important questions are raised. Can, for example, an avoidantly attached therapist provide the necessary attuned response to an avoidantly attached client, or would some collusive, complementary transference-countertransference (cf. Racker, 1968) develop? Can an insecure client experience secure attachment in therapy if he/she has not had this experience before? These questions, and others, could not be answered by this study, but are important areas for further research.

8.8 Conclusion

This study has provided tentative support for the nature of the relationship between psychological mindedness and attachment styles, and much more limited support for the impact of these factors on engagement in therapy and therapist/client matching. The therapeutic relationship has become a central focus for research into the ‘Holy Grail’ of therapeutic effectiveness, and this study is a contribution to this long tradition by offering a new focus for research. Psychological mindedness, and particularly its shadow partner, alexithymia, may have more applicability within the psychotherapy relationship than its traditional links with insight-oriented psychotherapies, especially when the attachment styles of the therapist and client are taken into account. More accurate identification of these important constructs prior to allocation of a particular style of therapy or a particular therapist should contribute to a more productive outcome in psychotherapy.

APPENDICES

APPENDIX A

The Psychological Mindedness Scale (PMS)

Name (Please print) _____

Forty five statements are listed below. Each statement is followed by four phrases:

strongly agree
mostly agree
mostly disagree
strongly disagree

Please place a check (✓) next to the phrase which best describes how you feel about each.

	<u>Strongly</u> <u>Agree</u>	<u>Mostly</u> <u>Agree</u>	<u>Mostly</u> <u>Disagree</u>	<u>Strongly</u> <u>Disagree</u>
1. I would be willing to talk about my personal problems if I thought it might help me or a member of my family.	_____	_____	_____	_____
2. I am always curious about the reasons people behave as they do.	_____	_____	_____	_____
3. I think that most people who are mentally ill have something physically wrong with their brain.	_____	_____	_____	_____
4. When I have a problem, if I talk about it with a friend, I feel a lot better.	_____	_____	_____	_____
5. Often I don't know what I'm feeling.	_____	_____	_____	_____
6. I am willing to change old habits to try a new way of doing things.	_____	_____	_____	_____
7. There are certain problems which I could not discuss outside my immediate family.	_____	_____	_____	_____
8. I often find myself thinking about what made me act in a certain way.	_____	_____	_____	_____
9. Emotional problems can sometimes make you physically sick.	_____	_____	_____	_____
10. When you have problems, talking about them with other people just make them worse.	_____	_____	_____	_____
11. Usually, if I feel an emotion, I can identify it.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
12. If a friend gave me advice about how to do something better, I'd try it out.	_____	_____	_____	_____
13. I am annoyed by someone, whether he is a doctor or not, who wants to know about my personal problems.	_____	_____	_____	_____
14. I find that once I develop a habit, that it is hard to change, even if I know there is another way of doing things that might be better.	_____	_____	_____	_____
15. I think that people who are mentally ill often have problems which began in their childhood.	_____	_____	_____	_____
16. Letting off steam by talking to someone about your problems often makes you feel a lot better.	_____	_____	_____	_____
17. People sometimes say that I act as if I'm having a certain emotion (anger for example) when I am unaware of it.	_____	_____	_____	_____
18. I get annoyed when people give me advice about changing the way I do things.	_____	_____	_____	_____
19. It would not be difficult for me to talk about personal problems with people such as doctors and clergymen.	_____	_____	_____	_____
20. If a good friend of mine suddenly started to insult me, my first reaction might be to try to understand why he was so angry.	_____	_____	_____	_____
21. I think that when a person has crazy thoughts, it is often because he is very anxious and upset.	_____	_____	_____	_____
22. I've never found that talking to other people about my worries helps much.	_____	_____	_____	_____
23. Often, even though I know that I'm having an emotion, I don't know what it is.	_____	_____	_____	_____
24. I like to do things the way I've done them in the past. I don't like to try to change my behavior much.	_____	_____	_____	_____
25. There are some things in my life that I would not discuss with anyone.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
26. Understanding the reasons you have deep down for acting in certain ways is important.	_____	_____	_____	_____
27. At work, if someone suggested a different way of doing a job that might be better, I'd give it a try.	_____	_____	_____	_____
28. I've found that when I talk about my problems to someone else, I come up with ways to solve them that I hadn't thought of before.	_____	_____	_____	_____
29. I am sensitive to the changes in my own feelings.	_____	_____	_____	_____
30. When I learn a new way of doing something, I like to try it out to see if it would work better than what I had been doing before.	_____	_____	_____	_____
31. It is important to be open and honest when you talk about your troubles with someone you trust.	_____	_____	_____	_____
32. I really enjoy trying to figure other people out.	_____	_____	_____	_____
33. I think that most people with mental problems have probably received some kind of injury to their head.	_____	_____	_____	_____
34. Talking about your worries to another person helps you to understand your problems better.	_____	_____	_____	_____
35. I'm usually in touch with my feelings.	_____	_____	_____	_____
36. I like to try new things, even if it involves taking risks.	_____	_____	_____	_____
37. It would be very difficult for me to discuss upsetting or embarrassing aspects of my personal life with people even if I trust them.	_____	_____	_____	_____
38. If I suddenly lost my temper with someone, without knowing exactly why, my first impulse would be to forget about it.	_____	_____	_____	_____

	<u>Strongly Agree</u>	<u>Mostly Agree</u>	<u>Mostly Disagree</u>	<u>Strongly Disagree</u>
39. I think that what a person's environment (family, etc.) is like has little to do with whether he develops mental problems.	_____	_____	_____	_____
40. When you have troubles, talking about them to someone else just makes you more confused.	_____	_____	_____	_____
41. I frequently don't want to delve too deeply into what I'm feeling.	_____	_____	_____	_____
42. I don't like doing things if there is a chance that they won't work out.	_____	_____	_____	_____
43. I think that no matter how hard you try, you'll never really understand what makes people tick.	_____	_____	_____	_____
44. I think that what goes on deep down in a person's mind is important in determining whether he will have a mental illness.	_____	_____	_____	_____
45. Fear of embarrassment or failure doesn't stop me from trying something new.	_____	_____	_____	_____

APPENDIX B

The Toronto Alexithymia Scale (TAS-20)

Using the scale provided as a guide, indicate how much you agree or disagree with each of the following statements by circling the corresponding number. Give only one answer for each statement.

Circle 1 if you **STRONGLY DISAGREE**
 Circle 2 if you **MODERATELY DISAGREE**
 Circle 3 if you **NEITHER DISAGREE NOR AGREE**
 Circle 4 if you **MODERATELY AGREE**
 Circle 5 if you **STRONGLY AGREE**

- | | Strongly
Disagree | Moderately
Disagree | Neither
Disagree
Nor Agree | Moderately
Agree | Strongly
Agree |
|---|----------------------|------------------------|----------------------------------|---------------------|-------------------|
| 1. I am often confused about what emotion I am feeling. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 2. It is difficult for me to find the right words for my feelings. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 3. I have physical sensations that even doctors don't understand. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 4. I am able to describe my feelings easily. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 5. I prefer to analyze problems rather than just describe them. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 6. When I am upset, I don't know if I am sad, frightened, or angry. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 7. I am often puzzled by sensations in my body. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 8. I prefer to just let things happen rather than to understand why they turned out that way. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 9. I have feelings that I can't quite identify. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 10. Being in touch with emotions is essential. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |

- | | Strongly
Disagree | Moderately
Disagree | Neither
Disagree
Nor Agree | Moderately
Agree | Strongly
Agree |
|---|------------------------------|--------------------------------|---|-----------------------------|---------------------------|
| 11. I find it hard to describe how I feel about people. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 12. People tell me to describe my feelings more. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 13. I don't know what's going on inside me. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 14. I often don't know why I am angry. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 15. I prefer talking to people about their daily activities rather than their feelings. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 16. I prefer to watch "light" entertainment shows rather than psychological dramas. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 17. It is difficult for me to reveal my innermost feelings, even to close friends. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 18. I can feel close to someone, even in moments of silence. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 19. I find examination of my feelings useful in solving personal problems. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |
| 20. Looking for hidden meanings in movies or plays distracts from their enjoyment. | 1 _____ | 2 _____ | 3 _____ | 4 _____ | 5 _____ |

APPENDIX C

The revised Adult Attachment Scale (AAS)

Please read each of the following statements and rate the extent to which each describes your feelings, by placing a tick in one of the spaces on the scale ranging from not at all characteristic to very characteristic of you.

Name.....

	Not at all characteristic <u>of me</u>	Not really characteristic <u>of me</u>	Not sure _____	Somewhat characteristic <u>of me</u>	Very characteristic <u>of me</u>
1. I find it relatively easy to get close to others.	_____	_____	_____	_____	_____
2. I find it difficult to allow myself to depend on others.	_____	_____	_____	_____	_____
3. In relationships, I often worry that my partner does not really love me.	_____	_____	_____	_____	_____
4. I find that others are reluctant to get as close as I would like.	_____	_____	_____	_____	_____
5. I am comfortable depending on others.	_____	_____	_____	_____	_____
6. I do <u>not</u> worry about someone getting too close to me.	_____	_____	_____	_____	_____
7. I find that people are never there when you need them.	_____	_____	_____	_____	_____
8. I am somewhat uncomfortable being close to others.	_____	_____	_____	_____	_____
9. In relationships, I often worry that my partner will not want to stay with me.	_____	_____	_____	_____	_____
10. When I show my feelings for others I'm always afraid they will not feel the same about me.	_____	_____	_____	_____	_____
11. I often wonder whether my partner really cares about me.	_____	_____	_____	_____	_____
12. I am comfortable developing close relationships with others.	_____	_____	_____	_____	_____

	Not at all characteristic <u>of me</u>	Not really characteristic <u>of me</u>	Not sure _____	Somewhat characteristic <u>of me</u>	Very characteristic <u>of me</u>
13. I am nervous when anyone gets too close.	_____	_____	_____	_____	_____
14. I know that people will be there when I need them.	_____	_____	_____	_____	_____
15. I want to get close to people but I worry about being hurt by them.	_____	_____	_____	_____	_____
16. I find it difficult to trust others completely.	_____	_____	_____	_____	_____
17. Often, my partner wants me to be closer than I feel comfortable being.	_____	_____	_____	_____	_____
18. I am not sure that I can always depend on others to be there when I need them.	_____	_____	_____	_____	_____

APPENDIX D
The Hazan and Shaver (1987) questionnaire

Which of the following best describes your feelings?

- I find it relatively easy to get close to others and am comfortable depending on them and having them depend on me. I don't often worry about being abandoned or about someone getting too close to me.

- I am somewhat uncomfortable being close to others; I find it difficult to trust them completely, difficult to allow myself to depend on them. I am nervous when anyone gets too close, and often, love partners want me to be more intimate than I feel comfortable being.

- I find that others are reluctant to get as close as I would like. I often worry that my partner doesn't really love me or won't want to stay with me. I want to merge completely with another person, and this desire sometimes scares people away.

**APPENDIX E
Research Consent Form**

RESEARCH CONSENT FORM

(Please cross out as necessary)

Have you read the Information Sheet?.....YES / NO

Have you received enough information about the study?.....YES / NO

Do you understand that you are free to withdraw from the study:

- at any time?
- without having to give a reason?
- and without affecting your future care?.....YES / NO

Do you agree to take part in this study?.....YES / NO

Signed: _____ Date: _____

(NAME - in block letters) _____

APPENDIX F
Letter to members of the control group

PSYCHOLOGICAL THERAPIES DEPARTMENT

Dear Sir/Madam,

We are carrying out research to look at the different ways that people get on with others. You have been randomly selected from the Electoral Role Register to take part in this survey.

Will you take a little time to fill in the enclosed consent form and questionnaires and return them in the reply-paid envelope? This should take no more than about 30 minutes of your time. That is all that is asked of you for the present time. You will then be contacted six months later and asked to fill in the questionnaires again.

All of the information that you provide will be treated strictly confidentially, but I do need to ask that you provide your name and address so that I can contact you again in six month's time.

You do not have to agree to take part in this research. If you have decided not to take part, then please accept my thanks for your time. I would appreciate it if you could then return the blank questionnaires in the reply-paid envelope.

Please remember that even though you have agreed to take part now, you can still change your mind and withdraw from the study at any time.

Thank you very much for your time to think about this study and if you have any questions about it then please contact me on the above number.

Your faithfully,

Steven Manley
Chartered Clinical Psychologist

APPENDIX G

Information Sheet (control group)

INFORMATION SHEET

1. Title of Research

Psychological Mindedness and Attachment Styles

2. Names and Positions of Investigators

- a. Steven Manley, Clinical Psychologist;
- b. Dr. Richard Corney, Clinical Psychologist, (Supervisor of Research).

3. The Nature of the Research Project

We are looking at the different ways that people use to get on with others. We want to see which of these different ways is most helpful when people are getting help for their psychological problems.

You are one of a number of people being asked to take part, and you have been selected entirely at random. Your involvement in this study will enable us to make sure that we can provide the most appropriate form of help to people. The results of this study will then contribute towards improving the quality of psychological help that people receive when they need it.

4. Procedures of the Study

We would like you to fill in 3 questionnaires; once at the beginning of the study and again six months later. We would also like you to fill in a general information questionnaire. All of these questionnaires can be filled in within thirty minutes.

If your preferred language is Welsh, we are sorry that the questionnaires are not translatable into Welsh. We hope you will not mind completing them in English.

5. Benefits and Harms of Procedures

You are not at risk of any harm from this study.

Full information about the results of the study will be available if you request it.

6. Procedures to maintain Confidentiality and Anonymity

All information received will be treated as strictly confidential and will be kept secured in a locked cabinet at all times. Questionnaires and personal details will not be given to any other people except the main investigators, and will only be kept as long as is necessary to complete the analysis of results. All information will then be destroyed following the standard procedures for the disposal of confidential information.

As I need to contact you again in six months time, I do need to ask you to give me your name and address. However, as already mentioned, the rules of confidentiality will be strictly held.

7. Questions/Further Information

If you have any questions or require further information about the study then please contact the following person -

Steven Manley
Clinical Psychologist
Psychological Therapies Department

8. Right to Refuse or Withdraw

You are free to refuse to take part or withdraw at any time.

9. Complaints

If you have any complaints about this research, these should be addressed to the following individual -

APPENDIX H
General information questionnaire (control group)

GENERAL INFORMATION QUESTIONNAIRE

1. **Name**.....
2. **Date of Birth**.....
3. **Male/Female**.....
4. **Marital Status**.....
5. **Occupation**.....

Thank you very much for your cooperation in completing this form, which will be kept confidentially secured.

APPENDIX I
Letter to members of the client group

PSYCHOLOGICAL THERAPIES DEPARTMENT

Dear Sir/Madam,

I am looking at the different ways that people get on with others. Will you take part in this research to help us to see which of these different ways is most helpful when you are getting help? You have been given this envelope either because you have recently seen someone, or are about to see someone, to help you with your difficulties.

Will you take a little time to fill in the enclosed consent form and questionnaires and return them in the reply-paid envelope? This should take no more than about 30 minutes of your time. That is all that is asked of you for the present time. You will then be contacted six months later and asked to fill in the questionnaires again, whether or not you are still receiving help.

All of the information that you provide will be treated strictly confidentially, but I do need to ask that you provide your name and address so that I can contact you again in six month's time. I will also need to let your General Practitioner (GP) know that you are taking part in this research project, as well as your Psychiatrist, if you have one.

You do not have to agree to take part in this research. Neither your present nor any future treatment will be affected by this. If you have decided not to take part, then please accept my thanks for your time. I would appreciate it if you could then return the blank questionnaires in the reply-paid envelope.

Please remember that even though you have agreed to take part now, you can still change your mind and withdraw from the study at any time.

Thank you very much for your time to think about this study and if you have any questions about it then please contact me on the above number.

Your faithfully,

Steven Manley
Chartered Clinical Psychologist

APPENDIX J

Information Sheet (client group)

INFORMATION SHEET

1. Title of Research

Psychological Mindedness and Attachment Styles

2. Names and Positions of Investigators

- a. Steven Manley, Clinical Psychologist;
- b. Dr. Richard Corney, Clinical Psychologist, (Supervisor of Research).

3. The Nature of the Research Project

We are looking at the different ways that people use to get on with others. We want to see which of these different ways is most helpful when people are getting help for their psychological problems.

You are one of a number of people being asked to take part, and you have been selected entirely at random. Only those people who are about to get help for their difficulties, at the time this study begins, are being asked.

4. Procedures of the Study

We would like you to fill in 3 questionnaires; once at the beginning of the study and again six months later. We would also like you to fill in a general information questionnaire. All of these questionnaires can be filled in within thirty minutes.

If your preferred language is Welsh, we are sorry that the questionnaires are not translatable into Welsh. We hope you will not mind completing them in English.

Whether you agree to take part or not, you will still get the same standard of care that you would normally get.

5. Benefits and Harms of Procedures

You are not at risk of any harm from this study.

Full information about the results of the study will be available if you request it.

6. Procedures to maintain Confidentiality and Anonymity

All information received will be treated as strictly confidential and will be kept secured in a locked cabinet at all times. Questionnaires and personal details will not be given to any other people except the main investigators, and will only be kept as long as is necessary to complete the analysis of results. All information will then be destroyed following the standard procedures for the disposal of confidential information.

As I need to contact you again in six months time, I do need to ask you to give me your name and address. However, as already mentioned, the rules of confidentiality will be strictly held.

7. Questions/Further Information

If you have any questions or require further information about the study then please contact the following person -

Steven Manley
Clinical Psychologist
Psychological Therapies Department

8. Right to Refuse or Withdraw

You are free to refuse to take part or withdraw at any time. This will not affect your present or any future treatment.

9. Complaints

If you have any complaints about this research, these should be addressed to the following individuals -

APPENDIX K
Initial general information questionnaire (client group)

GENERAL INFORMATION QUESTIONNAIRE

1. Name.....
2. Address.....
.....
.....
3. Date of Birth.....
4. Male/Female.....
5. Marital Status.....
6. Occupation.....
7. Name of therapist treating you.....
8. How long has your therapist been treating you?.....
9. Name of General Practitioner (GP) and/or Psychiatrist?.....
.....
10. If you have had any previous experience of therapy/counselling before this present one, then please provide details below (when, how long for, who seen) -
.....
.....

Thank you very much for your cooperation in completing this form, which will be kept confidentially secured.

APPENDIX L
Letter to members of the therapist group (CMHT)

PSYCHOLOGICAL THERAPIES DEPARTMENT

Dear Colleague,

Thank you for agreeing to take part in this research project. Enclosed with this letter are 3 psychological questionnaires, a general information questionnaire and a consent form for you to complete. There is also an information sheet with details of the research outlined. The other sealed envelopes, which contain the same questionnaires and an introductory letter, are for you to give out to your clients. This is what I would like you to do-

1. Read through the information sheet and then sign the consent form;
2. Complete the 3 psychological questionnaires and the general information questionnaire. Return these, with the consent form, to me in the enclosed envelope;
3. For the next month, give a sealed envelope to each new client that you agree to see for some form of psychological therapy (this is interpreted widely to include any form of regular contact with a client). I have provided you with 10 envelopes to give out. If you feel that you will not see enough new clients within the month, then you can include new clients that you agreed to see in the previous month if you wish. I suggest that when you give your clients the envelopes you say something like, "These are being given to every new client being seen at the moment as part of a research project. Please have a look to see if you want to take part in it", or some other similar form of words that you would feel comfortable with. Return any unused envelopes to me and let me know if you require more.

That is all that is required of you. I will contact the clients directly from the information that they provide to me in six months time. Thank you very much indeed for your co-operation in this study and do get in touch if you have any further questions. I will be in contact again once the study has been completed to feedback the results.

Yours faithfully,

Steve Manley
Chartered Clinical Psychologist

APPENDIX M
Letter to members of the therapist group (Counsellors)

PSYCHOLOGICAL THERAPIES DEPARTMENT

Re: RESEARCH PROJECT

Dear

You may recall () notifying you last year of my intention to contact all the counsellors regarding participation in a research project. I am writing now to follow this request up, as the project has received ethical committee approval and is ready to begin. I am also including members of the Community Mental Health Teams (CMHT's) in this study and have already visited their bases to recruit them.

Attached to this letter is a description of the project and details of what I am specifically requesting from you. What I suggest is that you read through this in order to decide whether or not you would be willing to take part. (Please note that you are under no obligation whatsoever to take part). If you need more information about the study before making your mind up, then please contact me on the above number and I will be happy to provide it, either over the phone or in person if necessary. (Please note that there is only an answerphone service available on this number after 1.30pm).

The study is due to commence on Wednesday 4th February, and I would very much appreciate it if you could let me know whether or not you would be willing to take part by this date.

If you do agree to participate, then I will send you 10 sealed envelopes to be handed to your clients, each containing the three psychological questionnaires, the information questionnaire, the information sheet and the consent form, as well as a stamped addressed envelope for the clients to return this directly to me. You will also receive your own copies of these questionnaires to complete and return to me.

Many thanks for your time and interest in this study.

I look forward to hearing from you.

Yours sincerely,

Steve Manley
Chartered Clinical Psychologist

APPENDIX N

Information sheet (therapist group)

INFORMATION SHEET

1. Title of Research

Psychological Mindedness and Attachment Styles

2. Names and Positions of Investigators

- a. Steve Manley, Clinical Psychologist;
- b. Dr. Richard Corney, Clinical Psychologist, (Supervisor of Research).

3. The Nature of the Research Project

The purpose of this research project is to investigate the relationship between psychological mindedness and attachment styles in people receiving some form of psychological therapy. It is felt that this relationship can influence how much benefit people get from treatment, and it is hoped that the results will help to ensure that people receive the most appropriate treatment for their difficulties.

You are one of a number of therapists, from a range of professional backgrounds, being asked to participate in this study. You will be aware from the presentation of the research that you are also being asked to give permission for up to fifteen of your clients/patients to be included in the study as well.

4. Procedures of the Study

Each participant, except the therapists, will be asked to complete 3 psychological questionnaires on two occasions; once at the commencement of the study and again at six months later. They will also be asked to complete a further general information questionnaire on one occasion only, at the beginning of the study. You will be asked to complete the same questionnaires on one occasion only, at the beginning of the study. All of these questionnaires can be completed within thirty minutes.

5. Benefits and Harms of Procedures

The procedures have been designed to be as minimally inconvenient as possible and will not result in any participant being at risk of any harm.

Full information about the results of the study will be available to any participant that requests it.

6. Procedures to maintain Confidentiality and Anonymity

All information received will be treated as strictly confidential and will be kept secured in a locked cabinet at all times. Thus completed questionnaires and personal details will not be divulged to any other party except the main investigators, and will only be kept as long as is necessary to complete the analysis of results. All information will then be destroyed following the standard procedures for the disposal of confidential information

Due to the nature of the study, complete anonymity cannot be maintained. Names and/or addresses of participants are required in order to follow the same people up six months after the commencement of the study and to provide personal feedback. Participants are, therefore, being requested to put their names on the questionnaires. However, as already mentioned, the rules of confidentiality will be strictly maintained.

7. Questions/Further Information

If you have any questions or require further information on any aspect related to the study then please contact the following person -

Steve Manley
Clinical Psychologist
Psychological Therapies Department

8. Right to Refuse or Withdraw

Participation in this study is entirely voluntary, and you are free to withdraw at any time without penalty.

9. Complaints

If you have any complaints concerning the conduct of this research, these should be addressed to the following individuals -

APPENDIX O
General information questionnaire (therapist group)

GENERAL INFORMATION QUESTIONNAIRE

1. Name.....
2. Date of Birth.....
3. Male/Female.....
4. Profession.....
5. How would you describe your therapeutic approach?
.....
.....
6. How many years have you been qualified?
.....

Thank you very much for your cooperation in completing this form, which will be kept confidentially secured.

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APPENDIX P
Follow-up letter to members of the control group

PSYCHOLOGICAL THERAPIES DEPARTMENT

Dear Sir/Madam,

Earlier this year you were randomly selected from the Electoral Role Register and asked if you would be willing to take part in a research project looking at the different ways that people get on with others. You kindly agreed to take part in this and completed some questionnaires for me. I told you then that you would be contacted again in six months time to complete the same questionnaires once more. I am writing now to ask if you would be willing to fill in the enclosed questionnaires again and return them in the reply-paid envelope. This will enable me to complete the research.

All of the information that you provide will be treated strictly confidentially, and I will not be contacting you again about this research.

You do not have to continue to take part in this research. If you have decided not to continue, then I would appreciate it if you could return the blank questionnaires in the reply-paid envelope.

Thank you very much for your time and if you have any questions then please contact me on the above number.

Yours faithfully,

Steven Manley
Chartered Clinical Psychologist

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APPENDIX Q
Follow-up letter to members of the client group

PSYCHOLOGICAL THERAPIES DEPARTMENT

Dear Sir/Madam,

Earlier this year you were asked if you would be willing to take part in a research project looking at the different ways that people get on with others. You kindly agreed to take part in this and completed some questionnaires for me. I told you then that you would be contacted again in six months time to complete the same questionnaires once more. I am writing now to ask if you would be willing to fill in the enclosed questionnaires again and return them in the reply-paid envelope. This will enable me to complete the research.

All of the information that you provide will be treated strictly confidentially, and I will not be contacting you again about this research.

You do not have to continue to take part in this research. Neither your present nor any future treatment will be affected by this. If you have decided not to continue then I would appreciate it if you could return the blank questionnaires in the reply-paid envelope.

Thank you very much for your time and if you have any questions then please contact me on the above number.

Yours faithfully,

Steven Manley
Chartered Clinical Psychologist

APPENDIX R
Follow-up general information questionnaire (client group)

GENERAL INFORMATION QUESTIONNAIRE

- 1. Name of therapist.....
- 2. Are you still seeing your therapist?..... YES/NO
- 3. If YES how many times or how many weeks have you been seeing your therapist?
.....
- 4. If NO how many times or how many weeks did you see your therapist for?
.....
- 5. What was the reason that you stopped seeing your therapist?
.....
.....

Thank you very much for your cooperation in completing this form, which will be kept confidentially secured.

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