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Rupture and Repair in the Therapeutic Alliance: An Attachment Perspective.

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Submitted in partial fulfillment of the requirements of the Higher Diploma in Psychotherapy and Counselling in Dublin Business School

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May 2020

Acknowledgments

I would like to thank my lecturer, Dr. Grainne Donohue, for her guidance and support throughout the year.

I would also like to thank my supervisor, Stephen McCoy, for his patience and valuable feedback throughout the process of writing this dissertation.

Abstract

Research has consistently demonstrated that the quality of the relationship between a therapist and their client, often referred to as the therapeutic alliance, has been shown to be a reliable predictor of positive therapeutic outcome. Equally, weakened alliances have been found to be correlated with unilateral termination by clients. It is therefore important to understand the factors that contribute to the quality of the alliance, and the factors influencing alliance ruptures and repair processes when they occur. There is considerable evidence that clients with secure attachment styles are found to have stronger alliances with their therapists, while the alliances of those with insecure attachment styles are weaker. Recent developments in rupture repair research suggest that attachment style may play a role in a client's ability to engage in rupture repair processes. This study aims to explore rupture and repair in the therapeutic alliance from an attachment perspective.

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Introduction

Research has consistently shown that the quality of the relationship between a therapist and their client, often referred to as the working alliance or the therapeutic alliance, has been shown to be a reliable predictor of positive therapeutic outcome for clients. (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000) Though the concept of the alliance has its roots in the school of psychodynamics, with Freud (1912) being the first to refer to the significance of the relationship between therapist and patient, it is now seen as a prerequisite for change across all treatment modalities. The concept has been developed and redefined over the years as different researchers (Zetzel, 1956; Greenson, 1965; Luborsky, 1976, cited in Horvath & Luborksky, 1993) have drawn distinctions between the transferential elements and "real" elements of the relationship, however, Bordin (1979) proposed a transtheoretical conceptualization of the alliance which is generally accepted as encompassing both the conscious and unconscious processes at play, and is widely used in alliance research today. He defines the alliance as the degree of collaboration between therapist and client regarding the tasks and goals of the therapy, as well as the quality of the personal bond between them.

Knowing that the quality of the therapeutic alliance is correlated to positive outcome, the next natural question is to consider what the variables which contribute to a positive alliance are. Research conducted by Mallinckrodt (1991) found that an individual's ability to form a working alliance with their therapist was affected by the quality of their early experiences with their parents, while research by Goldman and Anderson (2007) found that the more comfortable that a client was with closeness and emotional intimacy with others, the higher they rated the alliance with their therapist. Attachment theory provides a framework through which we can understand how an individual's early experiences with their primary caregivers can influence their later relationships

and contribute to enduring patterns of how they relate to others and to themselves. (Bowlby, 1982) There has been considerable research investigating the relationship between attachment style and alliance quality. A meta-analysis of studies conducted by Diener and Monroe (2011) investigated this relationship and found that individuals with more secure attachment styles demonstrated stronger alliances, while the alliances of those with more insecure attachment styles were weaker.

Just as alliance quality has been found to be a robust predictor of positive outcome across modalities, weakened alliances have been found to be correlated with unilateral termination by the patient. (Horvath & Bedi, 2002; Martin, Garske, & Davis, 2000) Therefore, research has also necessarily focused on investigating ruptures in the alliance, and the processes involved in repairing them when they occur (Safran, Muran, Samstag & Stevens, 2002) Ruptures are thought to occur as a result of both therapist and client contributions. On some occasions these contributions are relatively straight-forward, such as a badly timed intervention by the therapist. However, on other occasions the intrapsychic processes and enduring relational patterns of the client are more significantly at play. The resolution of ruptures can provide opportunities for the client to acknowledge disowned parts of themselves and learn to negotiate their needs for agency with their relatedness to others. (Safran, 1993b, cited in Safran & Muran, 1996)

Aims and Objectives

The aim of this study is to explore rupture and repair in the therapeutic alliance from an attachment perspective. The first objective of the study is to investigate the impact of client attachment style on the therapeutic alliance. The literature relevant to this objective will be covered in Chapter 1. Chapters 2 and 3 will highlight the research relevant in addressing the studies second objective, which is to explore how client attachment style may impact alliance ruptures and repair processes.

Chapter 1 –Attachment Style and the Therapeutic Alliance

1.1 Attachment Theory

Attachment theory, with its origins in developmental research, proposes a framework for understanding the development of emotional attachments in childhood and throughout adulthood. John Bowlby's theory suggests that through interactions with caregivers in infancy, children develop internal working models of the self and of others. These models act as templates, containing beliefs about relationships with attachment figures which ultimately determine the individual's expectations, perceptions and behaviours in relationships throughout their lives. These models remain relatively fixed and determine how the child predicts and relates to the world. (Bowlby, 1982)

Holmes (1993) describes the development of attachment in his book about Bowlby's work. If a child's caregiver provides stability, is predictable and consistent the child should develop a secure attachment. A securely attached child will have developed an internal model of the caregiver, or other, as reliable, responsive and loving towards them. Their model of the self will be one that is worthy of love, care and attention. If a caregiver does not provide this stability and predictability, the child may develop an insecure attachment. The insecurely attached child may perceive the world around them as a dangerous place and feel the need to treat others with caution. Their model of self will be equally bleak, considering themselves ineffective and unworthy of love.

Bowlby's theory was further developed through the work of Mary Ainsworth and her colleagues (Ainsworth, Blehar, Walters & Wall, 2015) in their Strange Situation study. They conducted a laboratory procedure consisting of a series of separations and reunions between infants and their caregivers and found that the infants usually seek proximity to the caregiver in one of three ways,

resulting in three classifications of attachment style; secure, insecure-avoidant and insecure-ambivalent. Further research by Bartholomew and Horowitz (1991) considered the impact of combinations of positive and negative internal models of self and other on attachment. This study resulted in the identification of four categories of attachment: secure, (positive self and other), anxious-preoccupied, (negative self, positive other), avoidant-fearful, (negative self, negative other) and avoidant-dismissing, (positive self, negative other).

1.2 Attachment and the Quality of the Alliance

The findings of Diener and Monroe's (2011) meta-analysis, that attachment style is correlated with alliance quality, are consistent with attachment theory's emphasis on the enduring nature of relationships patterns. They note in their discussion that though none of the studies the papers they included in their analysis used methodology which would permit causal inferences, their findings do suggest contiguity between general patterns of relational functioning outside of therapy and the quality of the therapeutic alliance in it. They also found that there was a stronger relationship between patient-attachment and their self-report of the alliance than therapists report of the alliance. They suggested that this could indicate that patients may perceive the working alliance in ways that are more similar to their general attachment style than do their therapists.

A study by Eames and Roth (2000) investigated the relationship between attachment style and the quality and development of the alliance over time. Self-report methods measured both attachment and the quality of the alliance, and they found some evidence that patient attachment orientation may be related to alliance development in the early phase of therapy. They found that fearfulness in attachment was associated with lower alliance ratings, while security was associated with higher, suggesting that attachment systems characterised by anxiety about attachment or avoidance of intimacy may hinder alliance development. They also found that the preoccupied attachment

dimension was significantly associated with alliance ratings over time and suggested that, despite high anxiety, the strong drive for intimacy by individuals with this attachment classification may enable them to develop a stronger alliance over time. Surprisingly, there were similar findings in relation to the dismissing orientation, and they suggested the possibility that this could be due to a degree of denial characteristic of this attachment style.

A study by Finnish researchers Kanninen, Salo and Punamaki (2000, cited in Meyer and Pilkonis, 2001) also explored the connection between attachment and alliance. They found that though attachment did not affect outcome, differences were observed in the formation of the therapeutic alliance. Securely attached patients were able to form relatively stable alliances throughout the treatment, whereas those with preoccupied attachment reported a poor alliance in the middle but very strong alliance later in therapy. In contrast to this, those with a dismissing attachment orientation reported a deteriorating alliance towards the end of therapy.

1.3 The Alliance as an Attachment Relationship

The evidence presented above indicates the accuracy of attachment theory's assumption that for both the securely and insecurely attached child, the working-models established in infancy will be brought to bear on all other relationships. Those with inconsistent or adverse experiences with attachment figures in childhood are thought to develop negative expectations in relationships, responding to emotional intimacy with either anxiety or withdrawal. It appears that Bowlby was correct in his suggestion that these attachment differences in adulthood may be especially apparent in the therapeutic relationship, as the therapist embodies some key features of an attachment figure. (Bowlby, 1988)

Researchers have undertaken investigations into the ways in which the therapist functions as an attachment figure for clients in psychotherapy. A study by Parish and Eagle, (2003), examined the extent to which defining components of attachment are active in therapy relationships. They used a self-report measure called the Components of Attachment Questionnaire, (CAQ; Parish, 2000, cited in Parish & Eagle, 2003), which is based on the essential characteristics of attachment relationships identified in the theoretical literature, and with it assessed which aspects of attachment were prominent in their participants relationships with their therapists. They found that the relationship that forms in long-term psychotherapy clearly has many qualities of an attachment relationship. They also used another self-report measure of attachment style called the Relationship Questionnaire, (RQ; Bartholomew & Horowitz, 1991), and found positive correlations between secure attachment and overall attachment to therapist, as well as finding negative correlations between insecure attachment and overall attachment to therapist.

Mallinckrodt also discusses the essential elements of attachment bonds, as outlined by Mikulincer and Shaver (2007), and cites further research arguing that each of these elements has a parallel in the psychotherapy relationship. (Daniel, 2006; Obegi & Berant, 2009) These elements are specified as follows (i) the client regards the therapist as stronger and wiser (ii) the client seeks proximity through emotional connection and regular meetings; (iii) the client relies upon the therapist as a safe haven when they feel under threat; (iv) the client derives a felt sense of security from their therapist, they provide a secure base for exploration within and outside the therapy room; (v) and the client experiences separation anxiety when they anticipate the loss of their therapist. (Mallinckrodt, 2010)

A study by Mallinckrodt, Porter, & Kivlighan, (2005), found that client's secure attachment to their therapist was found to be associated with greater depth and ease of exploration during

sessions, while avoidant-fearful attachment were found to be negatively associated with these factors. This is consistent with Bowlby's (1988) contention that the secure attachment to the therapist may be used as a secure base for the client's psychological exploration.

Mallinckrodt (2000, cited in Mallinckrodt, 2010, p. 264) suggests that many adults come to therapy having found themselves unable to build and maintain healthy relationships in adulthood as they were unable to acquire the skills necessary to do so through healthy development in childhood, and the maladaptive patterns contributing to their interpersonal problems quickly become apparent within the therapeutic relationship, interfering with the development of a secure attachment to the therapist. Achieving the functional elements of a secure attachment, such as the secure base for exploration, may be essential goals for the therapist, however, the client may be unwilling, or unable, to seek the appropriate level of emotional proximity necessary for these to develop.

Mallinckrodt goes on to describe how among the approaches that make use of an attachment bond to facilitate change, for the therapy to be effective it requires that the five elements be present to a moderate degree, rather than being weak, should the client be resistant, or overly intense. Mikulincer and Shaver (2007, pp. 32-33) describe how those who have failed to receive comfort from their caregiver, and whose primary security-seeking strategies have failed, (those with insecure attachments), will engage in one of two "secondary strategies". Those who rely on a hyperactivating strategy magnify their expression of distress, monitor attachment figures closely for potential signs of abandonment and seek out close proximity to a potential source of comfort, often manifesting as emotional dependency. In contrast, those who rely on a deactivating strategy make great efforts to divert their attention from attachment related thoughts and feelings, as well as stimuli that evoke their distress. These individuals tend to avoid emotional intimacy. In psychotherapy, the deactivating strategy manifests in the client's resistance to the emergence of

the five elements, while a hyperactivating strategy will lead to the client's magnification of the intensity of the elements. These strategies correspond generally to the anxious and avoidant attachment categories. (Mallinckrodt, 2010). The therapist can facilitate what is termed a corrective emotional experience through the management of the relationship through the different phases of therapy. essentially reshaping their internal working models as they develop a sense of security. Daly and Mallinckrodt (2009), suggest that this can be done by managing the level of therapeutic distance in the relationship, where the level of distance required to engage the client initially is increased or decreased as appropriate during the course of the work.

Chapter 2: Rupture and Repair in the Alliance

2.1 Ruptures in the Therapeutic Alliance

If we are to take Bordin's (1979) definition of the alliance as the degree of collaboration regarding the tasks and goals of therapy, as well as the quality of the therapeutic bond, then a rupture in the alliance may result from a strain in any of these domains. (Safran & Muran, 2000, cited in Miller-Bottome, Talia, Safran & Muran, 2017). Two of the leading researchers in the field of ruptures and their resolution, Jeremy Safran and John Muran, (2006), define a rupture as a tension or breakdown in this collaborative relationship between patient and therapist. They emphasise that not all disagreements are ruptures, as therapist and client can disagree and still work in collaboration with each other. (Eubanks, Muran & Safran, 2015) Though this definition retains the closest link to the traditional conceptualization of the alliance, Safran and Muran (2006) did not feel that it was necessarily an all-encompassing one, and they found that as therapists they were interested in the process of exploring ruptures as reflections of patients' difficulties in negotiating authentic relatedness. They therefore also use a broader definition to include the collaboration aspect as well as "poor quality of relatedness".

Earlier in their research career, Safran and Muran (1996, p.447) referred to ruptures as "patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration." An individual's perception of the meaning of other people's actions is organised by core cognitive structures which develop based on early life experience. (Safran, Crocker, McMain, Murray, 1990) Safran and Muran suggested ruptures in the alliance may emerge when the therapist, unknowingly, ends up participating in maladaptive interpersonal cycles which resemble the client's other interactions, consequently confirming the client's "dysfunctional

interpersonal schemas or generalised representations of self-other interactions."(Safran, 1990a, 1990b, cited in Safran & Muran, 1996, p.447)

Ruptures vary in intensity from relatively minor tensions to major breakdowns in collaboration, understanding or communication., and one or both parties may be only vaguely aware of the more minor or subtle ruptures, (Safran, Muran & Eubanks-Carter, 2011). They can also vary in terms of duration and frequency, depending on the therapist-client dyad, and some may not significantly obstruct the therapeutic process while others, in more extreme cases, can lead to drop-out or treatment failure. (Safran & Muran, 1996) The alliance inevitably involves moments of misattunement or tension, and successfully working through these events can be potentially transformative, allowing for significant therapeutic change to occur. (Safran, Muran & Eubanks-Carter, 2011) Through exploring, understanding and resolving ruptures, the therapist can provide the client with new, constructive interpersonal experience which can lead to an adaptation of their interpersonal schemas (Safran, 1993a, cited in Safran & Muran, 1996)

Safran and Muran describe two types of markers which indicate a rupture to the therapist, these are withdrawal and confrontation markers. They suggest the neurotic trends identified by Karen Horney (1950) for use to differentiate between these subtypes; in ruptures indicated by withdrawal markers, the client either moves *away* from the therapist by, for example, avoiding their questions, denial, minimal responses of abstract communication; or they move *toward* the therapist, but in a manner which denies a part of their own experience, potentially by being overly compliant or appeasing, or presenting with a split between content of speech and affect, therefore withdrawing from the work of the therapy. Alternatively, with confrontation ruptures, the client moves *against* the therapist. This may happen through an expression of anger or dissatisfaction, rejecting interventions, becoming defensive, or by attempting to control the therapist and session by making

demands. Ruptures may also include elements of both types. From a therapeutic perspective, even the most subtle fluctuation in quality of relatedness can be worth exploring with the client, and can facilitate a resolution process which facilitates an important change in their relational schema and self-defeating patterns of relating to both self and others. (Safran & Muran, 2006)

The following is an excerpt adapted from a session transcript used in one of Safran and Muran's studies on ruptures. (1996, p. 456) It provides an example of a withdrawal rupture as the client presents with a split between content and affect and withdraws from directly expressing the true nature of their feelings.

T: Hello. Happy birthday.

P: Uh, yeah. I guess. I don't think it's a big deal really.

T: Mmhmm.

P: Everyone's always nice to you when it's your birthday, so ...

T: Uhuh. So I'll be nice to you. (both laugh)

P: Yeah. Don't pull that crap you usually pull, (smiles)

T: What's going on for you inside? I'm aware of a smile on your face as you say that, but I'm not sure if you're joking.

P: Well. I guess I'm a little irritated.

T: What are your irritated about?

P: Well, you know, we've talked about it before, (smiles again) You won't tell me what I should do.

T: I'm aware of your smile again. What are you experiencing?

P: Well, I guess I'm a little uncomfortable.

T: What are you uncomfortable about?

P: Well, maybe I'm feeling a little angry.

T: And your discomfort?

P: I guess I'm afraid of your reaction.

T: How might I react?

P: You might get pissed off at me.

T: Anything else?

P: Well . . . you might give up on me as a hopeless case and want to wash your hands of me

2.2 Repair Processes

Safran and Muran have conducted several studies involving intensive examinations of the processes involved in rupture resolution. (Safran & Muran, 1996; Safran, Muran & Samstag, 1994; Safran, Crocker, McMain & Murray, 1990) Their research led them to the development of a stage process model of rupture resolution, which they tested and revised over several years. The first stage is when the therapist recognizes that a rupture has occurred and attempts to disengage from it by inviting the client to explore the event in the here and now. Following this, the second stage involves the therapist and client exploring the nuances of their perceptions of the rupture. The exploration at this point may lead to feelings and concerns arising in the patient that they will be rejected by the therapist after having expressed their experience, leading them to try to avoid further exploration of the rupture. The third stage involves the therapist and patient exploring these avoidance maneuvers and their function, Finally, in stage four, they both move toward clarifying the underlying wish or need that is beneath the client's problematic interpersonal behaviour.

This final stage is largely dependent on the type of rupture that has occurred. Moving to stage four in the resolution of ruptures marked with withdrawal generally involves helping the client to move towards clearer expressions of self-assertion, perhaps by learning to express their needs. Resolution in the fourth stage of a rupture marked by confrontation usually involves helping the client gain access to more vulnerable feelings in order to clarify the underlying wish. (Safran & Muran, 2000, cited in Eubanks, Muran & Safran, 2010)

The following excerpt is a continuation of the session transcript above. While the first excerpt was from the beginning of the session, this one is further on in the middle of the session.

P: I don't see how this is helping. I want you to take charge of things rather than leaving it all up to me. (smiles)

T: What are you experiencing?

P: I feel embarrassed.

T: What are you embarrassed about?

P: It's like I'm asking you for help.

T: Can you try this as an experiment? Try asking me for help and see what it feels like.

P: I want you to help me. I need your help, (sadness in voice)

T: What are you in contact with?

P: It's true. I feel embarrassed about it, but it's true. I want your help, (begins to cry)

T: That really touches some sadness inside of you.

P: Yeah.

(Safran & Muran, 1996, p. 456)

This case example demonstrates the application of Safran and Muran's model of resolution. They note in their discussion that the resolution process is, naturally, often more circular, repetitive, and nonlinear in real life. At the start of the session, we can observe the therapist engaging in the first stage by focussing the client on their present experience, highlighting the disconnect between their smile and words. There is some movement between the stages throughout; the client explores the rupture and identifies their irritation (S2) before looking further and identifying that there is an avoidance of a potentially negative response from the therapist (S3). Later, at the start of the second excerpt, a rupture appears again, and moving through the stages uncovers underlying feelings of shame and embarrassment that are being avoided, before the client is finally able to enter the final stage and assert their feeling that they wish to be helped or cared for by the therapist.

It is important for therapists to be aware that clients may have these negative feelings and experiences in therapy that they are reluctant to explore as they are worried about the therapist's reaction or perception of them. Therapists should be aware of the subtle hints of these feelings and

provide a space where they can be expressed safely. It is important that therapists respond in a non-defensive fashion, taking responsibility for their contributions where necessary, and validating the client's experience in order to avoid the interpersonal complementarity (Safran, Muran, Samstag & Stevens, 2001) that can perpetuate the client's dysfunctional internal schemas. On some occasions, following the stages and the expression of the clients underlying wish or need, a change in the task or goal of therapy may be sufficient to resolve a rupture, while in others further investigation of the patients experience may be required. It may be useful on occasion for the therapist to explicitly establish links between the rupture event and characteristic interpersonal patterns of the patients' life, though these interpretations should be given with caution so as not to provoke defensiveness in the client. (Safran, Muran & Eubanks-Carter, 2011)

Chapter 3 – Attachment and Rupture Repair Processes

There has been limited research into the impact of client attachment orientation on alliance ruptures and repair processes. Research conducted by Eames and Roth (2000) into the relationship between adult client attachment orientation and the early alliance focussed part of the study specifically on alliance ruptures. Their results suggested that high preoccupation/low dismissingness (or high anxiety/low avoidance) may be related to the experience of more tension in the therapeutic alliance. A study by Wiseman and Tishby (2017) found some evidence that therapists rupture resolution ratings were related to patient's positive self and other representations, though they emphasised the need for further research in the area due to the small number of sessions analysed in their study.

Coutinho, Ribeiro and Safran (2009) highlight client characteristics which may be more frequently associated with different types of rupture markers. They suggest that clients who privilege the need for relatedness to others and develop an anxious dependence on them, submitting their own desires and needs in order to maintain proximity, are more likely to exhibit withdrawal markers. Those clients that privilege the need for self-agency and developing self-reliance, who may sacrifice their needs for proximity and care, sometimes presenting themselves in a controlling or dominating way, are likely to exhibit confrontation markers more frequently. These characteristics correspond with the internal models of self and other and behaviours associated with anxious and avoidant/dismissing attachment styles.

The rupture repair strategies developed by Safran and Muran are now widely embraced amongst researchers in the field, however, despite the many strengths of their model, including its transtheoretical applications, a significant limitation is that it does not account for differences in

a client's capacity to engage in the repair process. (Miller-Bottome, Talia, Eubanks, Safran & Muran, 2019) Following their work, there has been further research conducted investigating how client attachment may contribute to rupture frequency and repair. (Miller-Bottome et. al., 2017; Miller-Bottome et. al., 2019)

This research has endeavoured to show that both secure and insecure clients may experience alliance ruptures, but their abilities to participate in resolving such ruptures differ markedly. A significant feature of this work is its use of the Patient Attachment Coding System (PACS) (Talia, Miller-Bottome & Daniel, 2017) as a measure of client in session attachment. The PACS is a transcript-based instrument which shows that attachment classifications manifest in psychotherapy as distinct ways of communicating about present internal experience. It was developed from the discovery of several in-session discourse characteristics which were shown to be statistically associated with patient's pre-treatment Adult Attachment interview (AAI; George, Kaplan & Main, 1996) classifications. The AAI has consistently been found to be a reliable tool for measuring attachment orientation in research, (Hesse, 2008) and the three classifications assigned through the PACS have been validated as reliable indicators of clients' three AAI classifications. Using the PACS provides information regarding the ways in which attachment plays out in therapy sessions and allows for the prediction of which sorts of in-session processes will be associated with different attachment classifications.

In the 2017 study by Miller-Bottome and her colleagues, transcripts of secure, avoidant and preoccupied clients' sessions were reviewed, and characteristic communication patterns were highlighted. Clients with secure PACS classifications were shown to be capable of conveying their present internal experience openly and can allow the therapist to collaborate with them in defining and elaborating on their experience. Avoidant clients are more likely to decline requests

for them to express their here and now experience or downplay the magnitude or importance of any experience that has been implied by the therapist. Preoccupied clients tend to share their experience in a one-sided, exaggerated, or confusing way that leaves little room for the therapist to respond, or they actively disregard he therapist's interventions. This tends to limit the extent to which the therapist can collaborate with them in making meaning of their experience.

Overlaps can be observed between the communication styles of secure clients and the tasks of rupture resolution laid out in Safran and Muran's stage model. Repair involves the exploration of the client's experience of the rupture, focusing on the expression of negative feelings of anger or vulnerability, and the need for self-assertion. These are the kinds of communications that secure clients engage in in psychotherapy. Due to the fact that the communication styles of avoidant and preoccupied clients may present obstacles to collaborative exploration of here and now internal experience, the rupture resolution process can be compromised in significant ways.

Following this study, another sought to prove the researchers' hypothesis that when ruptures occur, high levels of PACS secure in session attachment will be associated with higher ratings of resolution between client and therapist, while higher levels of PACS avoidant and preoccupied in session attachment will be associated with lower resolution ratings. (Miler-Bottome et. al. 2019) Results showed a strong predictive relationship between PACS security and both client-rated and therapist-rated resolution over the course of treatment, with higher levels of security associated with higher resolution ratings. Their hypothesis regarding avoidant and preoccupied clients was not supported by the results, however, they emphasised that this does not mean these in session markers are irrelevant to rupture-repair processes, and their study suggests that it is the relative proportion of secure markers to insecure that predicts repair.

Discussion and Conclusion

This study sought to explore ruptures and repair processes in the therapeutic alliance from an attachment perspective. It is clear from the literature presented that client attachment style has a significant impact on the quality of the alliance and how it may change over time. This is as a result of the interpersonal patterns which develop due to the internal working models of self and other developed through early experiences with caregivers.

The internal working models of those with secure attachment reflect trust in others and the adequacy and goodness of self, as well as the desire for interpersonal connection. These individuals are more likely to be able to form a strong bond with their therapists, allowing for collaboration in the goals and tasks of the therapy process. Those who have developed an insecure attachment are more likely to distrust the motives and intentions of others, have negative representations of the self, display a weariness of engaging intimately with others and have a greater need for reassurance of their love and availability. These characteristics mean that these individuals have a more difficult time cultivating the bond with their therapists, agreeing on the goals of treatment and the tasks necessary to collaboratively achieve these goals. (Diener & Monroe, 2011) Evidence presented in this study demonstrates exactly how the therapist can serve as an attachment figure for their clients, and how the internal models brought to the relationship by the client can impact upon the development of the essential elements of a secure attachment relationship with the therapist which are necessary to achieve positive outcome.

There is some limited evidence suggesting that attachment style has an impact on the frequency of ruptures within the relationship. Research has also suggested that the types of rupture markers which occur in the alliance can be related to client characteristics which correspond with

attachment styles. More research is required in this area to validate the link between insecure attachment and the frequency of ruptures, as well as looking at how ruptures may develop and present themselves in the alliances of those with specific attachment styles. However, the literature reviewed here would suggest that insecure attachment may play a role in rupture development. If ruptures occur at times when the client is uncomfortable with revealing their true selves, expressing their wishes and needs, and are concerned with how others will respond to them, then it seems likely they are influenced by their internal working models of self and other.

The recent evidence presented relating to attachment and characteristic communication styles is valuable progress in the research around rupture repair processes. Focussing on the communicative tendencies of individuals with different attachment styles has allowed for the generation of hypotheses and beginnings of investigations which focus on how the different attachment classifications may promote or inhibit a client's ability to engage in repair processes. It may be beneficial to conduct further studies testing the relationship between these communication styles and success or failure of resolution strategies. Additionally, future research could focus on the development of resolution strategies tailored to the in session communication patterns of avoidant and preoccupied clients, as researchers involved in these studies suggest that the use of particular approaches with these clients may serve to intensify ruptures rather than resolve them. (Miller-Bottome et. al., 2019).

The literature presented pertaining to attachment and the alliance, and the literature relating to rupture resolution, both highlight the significance of internal working models, or dysfunctional interpersonal schemas, on the course of the therapeutic process. The theoretical frameworks highlighted in the first two chapters of this study describe how the therapist can facilitate positive therapeutic change for their clients. The appropriate management of therapeutic distance, and the

resolution of ruptures when they occur, both provide new experiences for the client which differ from those they had early in life. Positive therapeutic change can occur as the client's working models of self and other are modified, as they experience the other as accepting, supportive, warm and safe, and experience themselves as capable of asserting and expressing themselves and worthy of being seen, heard and accepted. It is vital, then, that therapists should have an understanding of how the attachment characteristics which clients bring to the alliance may promote or hinder this process.

References

Ainsworth, M., Blehar, M. C., Waters, E. & Wall, S. N. (2015). *Patterns of Attachment: A Psychological Study of the Strange Situation*. (Classic Ed.) New York: Psychology Press.

Bartholomew, K. & Horowitz, L. M. (1991). Attachment Styles Among Young Adults: A Test of a Four-Category Model. *Journal of Personality and Social Psychology.* 51(2), 226-244. Retrieved April 15th, 2020, from https://pdfs.semanticscholar.org/6b60/00ae9911fa9f9ec6345048b5a20501bdcedf.pdf.

Bowlby, J. (1982). *Attachment and Loss Vol. 1: Attachment*. (2nd ed.) New York: Basic Books.

Bowlby, J. (1988). *A Secure Base: Clinical Applications of Attachment Theory*. New York: Brunner- Routledge.

Coutinho, J., Ribeiro, E. & Safran, J. (2009). Resolution of ruptures in therapeutic alliance: Its role on chanfe processes according to a relational approach. *Análise Psicológica*. 4(27), 479-491. Retrieved 8th May, 2020 from https://pdfs.semanticscholar.org/6526/302a20bd27bda44048702d601018cc3198e0.pdf?_ga=2.13640244.226459648.1587760103-1570402742.1586885368.

Daly, K. D., Mallinckrodt, B. (2009). Experienced Therapists' Approach to Psychotherapy for Adults with Attachment Avoidance or Attachment Anxiety. *Journal of Counselling Psychology.* 56(4), 549-563. Retrieved 21st April, 2020, from https://www.researchgate.net/publication/232445640_Experienced_Therapists'_Approach_to_Psychotherapy_for_Adults_With_Attachment_Avoidance_or_Attachment_Anxiety.

Daniel, S. I. F. (2006). Adult attachment patterns and individual psychotherapy: A Review. *Clinical Psychology Review*. 26(8), 968-984. Retrieved 7th May, 2020, from https://www.researchgate.net/publication/7232789_Adult_Attachment_Patterns_and_Individual_Psychotherapy_A_Review.

Diener, M. & Monroe, J. (2011) The Relationship Between Adult Attachment Style and Therapeutic Alliance in Individual Psychotherapy: A Meta-Analytic Review. *Psychotherapy Theory Research Practice Training*. 48(3), 237-48. Retrieved April 15th, 2020, from https://www.researchgate.net/publication/51158374_The_Relationship_Between_Adult_Attachment_Style_and_Therapeutic_Alliance_in_Individual_Psychotherapy_A_Meta-Analytic_Review#fullTextFileContent.

Eames, V. & Roth, A. (2000). Patient Attachment Orientation and the Early Working Alliance: A Study of Patient and Therapist Reports of Alliance Quality and Ruptures. *Psychotherapy Research.* 10 (4) 421-434. Retrieved 30th April, 2020 from https://pdfs.semanticscholar.org/ac9f/fc5d6c9fc0eb2cda4c77242c195cb5be9574.pdf

Eubanks, C. F., Muran, J. C. & Safran, J (2015). Rupture Resolution Rating System (3Rs): Manual. Brief Psychotherapy Research Program: Mount Sinai-Beth Israel Medical Centre. Retrieved 4th Amy, 2020, from https://www.researchgate.net/publication/270581021_RUPTURE_RESOLUTION_RATING_SYSTEM_3RS_MANUAL#fullTextFileContent.

Eubanks, C. F., Muran, J. C. & Safran, J. (2010). Alliance Ruptures & Resolution. In Muran, J. C. & Barber, J. P. (Eds.), *The Therapeutic Alliance: An Evidence-Based Guide to Practice*. (pp. 74-94), New York: Guilford Press.

Freud, S. (1912). The Dynamics of Transference. *Standard Edition* (Vol. 12). [Electronic version]. Retrieved from PEP Archive database.

George, C., Kaplan, N. & Main, M. (1996). Adult Attachment Interview. (3rd ed.) Unpublished Manuscript. Berkeley: Department of Psychology, University of California. Retrieved 8th May, 2020, from http://library.allanschore.com/docs/AAIProtocol.pdf.

Goldman, G. A. & Anderson, T. (2007). Quality of Object Relations and Security of Attachment as Predictors of Early therapeutic Alliance. *Journal of Counselling Psychology*. 54(2), 111-117. Retrieved 5th May, 2020, from https://psycnet.apa.org/record/2007-04178-001.

Hesse, E. (2008). The Adult Attachment Interview: Protocol, Mehod of Analysis, and Empirical Studies. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of Attachment: Theory, Research and Clinical Applications*. (2nd ed.) (pp. 552-598) New York: Guilford Press.

Holmes, J. (1993). *John Bowlby and Attachment Theory* [Dawsonera version] Retrieved 17th December, 2019 from: https://www.dawsonera.com/readonline/9780203136805

Horvath, A. O. & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*. 61(4), 561-573. Retrieved 8th May, 2020, from https://www.researchgate.net/publication/14828157_The_role_of_the_therapeutic_alliance_in_Psychotherapy.

Horvath, A. O. & Symonds, B. D., (1991). Relation Between Working Alliance and Outcome in Psychotherapy: A Meta-Analysis. *Journal of Counselling Psychology*. 38(2), 139-149. Retrieved 3rd May, 2020, from https://psycnet.apa.org/record/1991-22095-001.

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

Mallinckrodt, B. (1991). Clients' representations of childhood emotional bonds with parents, social support, and formation of the working alliance. *Journal of Counselling Psychology.* 38(4), 401-409. Retrieved 8th May, 2020, from https://psycnet.apa.org/record/1992-06262-001.

Mallinckrodt, B. (2010). The psychotherapy relationship as attachment: Evidence and implications. *Journal of Social and Personal Relationships.* 27(2), 262-270. Retrieved April 15th, 2020, from https://www.researchgate.net/publication/249719006_The_psychotherapy_relationship_as_attachment_Evidence_and_implications.

Mallinckrodt, B., Porter, M. J., Kivlighan Jr., D. M. (2005). Client Attachment to Therapist, Depth of In-Session Exploration, and Object Relations in Brief Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training.* 42(1), 85-100. Retrieved 21st April, 2020, from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.901.8597&rep=rep1&type=pdf.

Martin, D. J., Garske, J. P., Davis, M. K. (2000). Relation of the therapeutic relationship with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology.* 68(3), 438-450. Retrieved 3rd May, 2020, from https://psycnet.apa.org/record/2000-15699-009.

Meyer, B. & Pilkonis, P. A. (2001). Attachment Style. *Psychotherapy*. 38(4) 466-472. Retrieved 14th April, 2020, from:

https://www.researchgate.net/profile/Paul_Pilkonis/publication/230777439_Attachment_style/links/53ee0d330cf23733e80b2489.pdf.

Mikuliner, M., Shaver, P. R. (2007). *Attachment in Adulthood: Structure, Dynamics, and Change*. New York: Guilford Press.

Miller-Bottome, M., Talia, A., Eubanks, C. F., Safran, J. & Muran, J. C. (2019). Secure in-session attachment predicts rupture resolution: Negotiating a secure base. *Psychoanalytic Psychology.* 36(2), 132-138. Retrieved 8th May, 2020, from http://web.a.ebscohost.com/ehost/detail/detail?vid=2&sid=b0fad38d-aa54-45ac-8901-ad23b8a40844%40sdc-v-sessmgr01&bdata=JkF1dGhUeXBlPWlwLHNoaWIsY29va2llLHVybCZzaXRlPWVob3N0LWxpdmU%3d#AN=2019-20593-004&db=pdh&anchor=c43.

Miller-Bottome, M., Talia, A., Safran, J. D. & Muran, J. C. (2017). Resolving Alliance Ruptures from an Attachment informed Perspective. *Psychoanalytic Psychology*. Advance Online Publication. Retrieved 5th May, 2020, from https://www.researchgate.net/publication/316975639_Resolving_Alliance_Ruptures_from_an_Attachment-Informed_Perspective.

Parish, M. & Eagle, M. N. (2003). Attachment to therapist. *Psychoanalytic Psychology.* (20)2, 271-286. Retrieved April 15th, 2020, from https://www.researchgate.net/publication/232472294_Attachment_to_the_therapist.

Safran, J. & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Counselling and Clinical Psychology*. 64(3), 447-458. Retrieved 27th April, 2020 from

https://www.researchgate.net/publication/263923005_The_resolution_of_ruptures_in_the_therapeutic_alliance.

Safran, J. D. & Muran, J. C. (2006). Has the Concept of the Therapeutic Alliance Outlived its Uselfulness? *Psychotherpay: Theory, Research, Practice, Training.* 44(3), 286-291. Retrieved 9th May, 2020 from http://www.safranlab.net/uploads/7/6/4/6/7646935/has_the_concept_of_the_alliance_outlived.pdf.

Safran, J. D., Muran, J. C. & Samstag, L. W. (1994). Resolving Therapeutic Alliance Ruptures: A Task Analytic Investigation. In A. O. Horvath & L. S. Greenberg (Eds.) *The Working Alliance: Theory, research and practice.* (pp. 225-255) New Jersey: John Wiley & Sons.

Safran, J. D., Muran, J. C., Eubanks-Carter, C. (2011). Repairing alliance Ruptures. *Psychotherapy*. 48(1), 80-87. Retrieved 27th April, 2020, from http://www.safranlab.net/uploads/7/6/4/6/7646935/repairing_alliance_ruptures._psychotherapy_2011.pdf

Safran, J., Crocker, P., McMain, S., Murray, P. (1990). Therapeutic alliance rupture as therapy event for empirical investigation. *Psychotherapy Research and Practice*. 27(2), 154-165. Retrieved 27th April, 2020, from https://www.researchgate.net/publication/232457552_Therapeutic_alliance_rupture_as_therapy_event_for_empirical_investigation#fullTextFileContent

Safran, J. D., Muran, J. C., Samstag, L. W. and Stevens, C. (2002). Repairing alliance ruptures. In Norcross, J. R. (Ed.), *Psychotherapy Relationships That Work* (pp. 235–254). New York: Oxford University.

Talia, A., Miller-Bottome, M., Daniel, S. I. F. (2017). Assessing Attachment in Psychotherapy: Validation Study of the Patient Attachment Coding System. *Clinical Psychology & Psychotherapy*. Retrieved 8th May, 2020, from https://www.researchgate.net/publication/282879320_Assessing_Attachment_in_Psychotherapy_Validation_Study_of_the_Patient_Attachment_Coding_System.

Wiseman, H. & Tishby, O. (2017). Applying relationship anecdotes paradigm interviews to study client-therapist relationship narratives: Core conflictual relationship theme analyses. *Psychotherapy Research.* 27(3), 283-299. Retrieved 10th May, 2020, from https://www.tandfonline.com/doi/abs/10.1080/10503307.2016.1271958.