

## Attachment and early working alliance in adult psychiatric inpatients

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### Abstract

**Background:** There is an increasing amount of research indicating that patient's attachment style is related to the development of working alliance. The earlier research is based mainly on outpatients or therapy clients.

**Aims:** In this study, we studied the association between adult attachment styles and early working alliance among psychiatric inpatients.

**Method:** The information was gathered using self-report questionnaires (Relationship Questionnaire and Working Alliance Inventory). The participants were 100 inpatients and their 21 case managers from a unit of acute psychiatry.

**Results:** The results showed that adult attachment style was associated with working alliance, but the association was different in men and women. As hypothesized, securely attached women formed stronger emotional and relational alliance (bond) than women with fearful and dismissing attachment styles. Among men, however, not only secure but also fearful attachment was related to strong cognitive aspects of working alliance (task).

**Conclusions:** Learning more about the links between attachment style and working alliance and the meaning of gender in these associations helps us consider the patients' strengths and weaknesses in planning psychotherapy and other interventions.

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**Keywords:** Attachment, working alliance, psychiatric treatment

### Introduction

Attachment theory emphasizes the crucial role of the first attachment experiences in shaping relationships later in life (Bowlby, 1969). According to Bowlby, patterns of attachment develop along with behavioral interactions between the infant and the parent. Attachment behavior serves a child's need for security and, therefore, it is activated especially when he or she is frightened, tired, or ill. In an optimal situation the mother provides her child with a *secure base* (Ainsworth, Blehar, Waters, & Wall, 1978) from which he can explore the environment and to which he can return when needed.

Early attachment experiences are internalized to cognitive-affective structures of attachment, called *working models* (Bowlby, 1969). Working models include expectations

about the availability of the caregiver, and a conception of how acceptable the child feels in the eye of the caregiver (Fonagy, 2001). A securely attached child has internal working models of a responsive, loving, and reliable caregiver, and of oneself as acceptable and worthy of care and attention. Conversely, the internal working models of an insecurely attached child represent the caregiver as consistently or inconsistently unresponsive and emotionally unavailable. In insecure attachment development, a child solves the unsatisfactory attachment either by deactivating strategies of avoiding closeness and denying the importance of attachment (insecure-avoidant attachment), or by hyperactivating strategies of clinging to the caregiver and getting overly anxious about separation (insecure-preoccupied attachment) (Main, 1990). In disorganized/disoriented attachment behavior, a child lacks a clear attachment pattern and oscillates between different attachment strategies (Main & Solomon, 1990).

Childhood patterns of attachment are not carried through as such into adult life, but similar styles are conceptualized in adulthood: *secure-autonomous* (secure), *dismissing* (avoidant), *preoccupied* (ambivalent), or *unresolved/disorganized* attachment style. Marriage is an example of an attachment relationship, which provides a secure base allowing work and exploration and a safe haven in times of need. Adult attachment reflects the original function of attachment in providing safety in the face of threat, such as stress and illness. This study focuses on the adult attachment in one of the most stressful and insecure settings, i.e., when falling acutely mentally ill and entering a psychiatric hospital.

There are two approaches in conceptualizing and measuring the adult attachment: narrative and self-rated. The narrative approach arises from the developmental tradition, using the Adult Attachment Interview (AAI) as a method (George, Kaplan, & Main, 1985). The AAI classification is based on the quality and coherence of narratives about childhood relations and experiences, including illness, separation and trauma. Adults with different attachment styles differ in the quality of childhood experiences with their parents (e.g., loving, rejecting, or role-reversing) and the ways they emotionally and cognitively process their childhood memories (e.g., whether they idealize or belittle attachment relationships, and how coherently they tell about their experiences).

Self-rating approaches arise from the social psychology tradition, and they depict conscious experiences of current attachment relationships. Bartholomew and Horowitz (1991) and Bartholomew (1990) have organized Bowlby's definition of internal working models into a four-category classification of adult attachment, where there is a distinction between two types of avoidant attachment: fearful and dismissing. Attachment patterns are defined in terms of two underlying dimensions – the person's model of the self and the model of the others. A *secure* pattern is defined by positive models of both the self and the others. Secure attachment is also characterized by low anxiety about abandonment, and low avoidance of intimacy. A *fearful* pattern is defined by a negative self and negative other model, indicating high anxiety about abandonment and high avoidance of intimacy. A *dismissing* pattern is defined by positive self model and negative other model (low anxiety and high avoidance), and *preoccupied* pattern by negative self and positive other models (high anxiety and low avoidance). According to Griffin and Bartholomew (1994), each attachment pattern is characterized by distinct ways of emotional regulation and interpersonal behavior. Secure individuals have an internalized sense of self-worth and they are comfortable with intimacy in close relationships. Fearful individuals rely on others for the validation of their self-worth, but on the other hand, evade intimacy in the fear of rejection. Dismissing persons have a high sense of self-worth and they avoid intimacy because of negative expectations and devaluation of close relationships. Preoccupied persons have a low self-worth, but they try to validate it through excessive closeness in personal relationships.

As attachment behavior becomes activated in case of illness (Bowlby, 1988), it is likely to be observable in treatment relationships. For instance in mental health institutions, the forming of positive relationships with staff members may help the patient to seek support and face painful and difficult issues that arise in the treatment, such as earlier traumas (Schuengel & van Ijzendoorn, 2001). However, it is not self-evident that patients develop attachment relationships to the staff. They may seek support from their original attachment network or form attachment relationships with fellow patients.

Attachment patterns are likely to be present especially when forming the therapeutic relationship (Bowlby, 1988; Dozier & Tyrrell, 1998; Slade, 1999). According to Goldberg (2000), psychotherapy can be seen as a possibility for a corrective emotional experience if the therapist can create a secure base where to explore painful memories. The therapist can help the patient to construct a coherent narrative of previously conflicting and confusing experiences. There is an increasing amount of research indicating that attachment is related to therapeutic processes, including working alliance (Parish & Eagle, 2003; Meyer & Pilkonis, 2001; Eames & Roth, 2000). Working alliance is defined as the collaborative and affective relationship between the therapist and the patient. It is considered to be an important general factor in psychotherapy across a variety of theoretical frameworks (Martin, Garske, & Davis, 2000).

Bordin (1979) conceptualized the working alliance as composed of three independent dimensions: the goal, the task, and the bond. The goal and task dimensions reflect the cognitive aspects, whereas the bond dimension reflects the emotional and relational aspects of alliance. The goal dimension refers to agreement on general objectives of the therapy. The task dimension contains the specific actions that have to be taken to reach the goal. The bond refers to affective qualities of the therapeutic relationship (e.g., whether the patient feels understood and respected).

Research shows that securely attached persons form a working alliance characterized by high level on global alliance (Satterfield & Lyddon, 1998) and create especially high levels of emotional and relational alliance (bond dimension) and agreement on goals (Satterfield & Lyddon, 1998) or agreement on both tasks and goals of the therapy (Dolan, Arnkoff, & Glass, 1993). Fearful persons face difficulties in creating the alliance (Parish & Eagle, 2003; Eames & Roth, 2000) and especially in creating the emotional and relational bond with their therapists (Satterfield & Lyddon, 1998). All of these studies have used self-report questionnaires in determining the participants' attachment styles.

There are some gender differences in adult attachment. Dismissing attachment style is more common in men, and preoccupied style is more common in women (Bartholomew & Horowitz, 1991; Feeney, 1999). Studies on patients' attachment styles and working alliance have ignored the role of gender, apparently due to small sample sizes and with predominantly female study populations. We also lack knowledge about the possible gender differences in the link between attachment and working alliance.

The research on patients' attachment styles and working alliance is based mainly on outpatients or therapy clients. In this study, we aim at extending the focus on inpatients of a psychiatric hospital. Learning more about the links between attachment style and working alliance helps us consider the patients' strengths and weaknesses in planning psychotherapy and other interventions. Our research aim is to examine, first, how adult attachment styles are associated with global working alliance and second, whether we can identify attachment specific working alliance profiles regarding goal, task, and bond dimensions of alliance. Further, we will examine the role of a patient's gender in these associations.

We hypothesize, first, that patients with secure attachment have better global working alliance than insecure, especially fearful patients. Second, regarding the different dimensions

of working alliance, patients with secure attachment are likely to show a balanced profile of alliance, having equally high alliance in cognitive (goal and task) and emotional and relational (bond) dimensions. Instead, patients with insecure-preoccupied attachment are likely to have high levels of emotional and relational alliance but low levels of cognitive aspects of alliance. Finally, insecure-dismissing patients are likely to be characterized by high levels of cognitive aspects of alliance and low levels of emotional and relational alliance.

## Method

### *Participants and procedure*

Participants were 100 patients with serious psychiatric disorders and their 21 case managers from a unit of acute psychiatry at Tampere University Hospital, Finland. Of the sample 62% were women and 38% were men. The mean age was 34.5 years (range 19–69). A naturalistic design was used: all the patients who were fully authorized (i.e., were not under custody) were asked to participate in the research. Exclusion criteria were a diagnosed limited intelligence, inadequate language skills in Finnish, or inability to focus adequately on the conversation because of severe psychiatric symptoms. Originally 121 patients were given information about the study by the first author and were asked to participate in it. Twenty-one (17%) of them refused to participate, leaving 100 participants to the sample. According to our drop-out analysis, the share of psychotic patients was greater among those who refused to participate than among those participating in the study ( $\chi^2(1, N=104) = 3.88, p < .05$ ). The participants signed a written consent. The research plan was evaluated and accepted by the Ethical Board of Pirkanmaa Hospital District.

The case managers participated in the study as a part of their usual work. Twelve (57%) of them were women, and nine (43%) were men. Their mean age was 39.7 years (range 24–58). Five case managers had one patient, two had two patients, four had four patients, four had five patients, three had six patients, one had seven patients, one had eight patients and one had eleven patients.

After the third session with the case manager, both the patients and their case managers filled in the Working Alliance Inventory. During their treatment, the first author interviewed the patients individually and administered the Relationship Questionnaire. During the meeting, the patients were encouraged to ask for help if they had any difficulties in understanding the instructions of the questionnaire.

The number of participants in the present study was reduced to 83 for the final analyses. The treatments of five patients terminated before the third meeting with their case-managers leaving alliance questionnaire uncompleted. Five case managers and 12 patients did not fill the alliance questionnaire. One case with extremely high scores on patient-rated working alliance was found to be an outlier and was excluded from the analyses considering the patient-rated alliance.

### *Measures*

*Adult attachment style.* The Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) was used for assessing the participants' attachment styles. The RQ is made up of four paragraphs, each describing a prototypical attachment pattern in relation to close relationships in general (the secure, dismissing, fearful, and preoccupied). The participants were asked to report their degree of correspondence to each prototype using a 4-point scale

(1 = does not describe my view at all, 2 = describes my view a little, 3 = describes my view well, 4 = describes my view very well). The participants evaluated each of the attachment styles separately regarding close relationships with their own and with their opposite sex. Two categorical variables were constructed: attachment style in same sex relationships (SS) and attachment style in opposite sex relationships (OS). Griffin and Bartholomew (1994) have found evidence for the construct and predictive validity of the Relationship Questionnaire.

*Working alliance.* Working alliances of patients and their case managers were assessed by The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), which measures Bordin's (1979) integrative model of alliance. The WAI is a self-report instrument and it has parallel forms for patient and therapist ratings. The questionnaire consists of 36 items which participants rate on a 7-point scale (1 = never, 7 = always) according to the degree to which statements correspond to their experience in the current therapy situation. A global score and three subscales can be derived. The subscales (all consisting of 12 items) reflect emotional and cognitive aspects of alliance: the bond (e.g., "I believe that my case manager is genuinely concerned for my welfare"), the agreement on goals (e.g., "I don't know what to expect as the result of my therapy") and the agreement on tasks (e.g., "I am clear on what my responsibilities are in therapy"). In this study, both the patient and the therapist (here: case manager) ratings were used. Horvath and Greenberg (1989) have shown adequate reliability of WAI scales (between  $r = .85$  to  $r = .93$ ) and provided support for the validity of the WAI.

In this study the reliability analysis was conducted on all items and on three dimensions of alliance (goal, task, and bond). Regarding the global patient-rated alliance the scale reliability (alpha) was 0.85. Scale reliability of patient-rated goal was 0.53, task 0.52, and bond 0.81. In case manager-rated alliance the reliability for global alliance was 0.83, for goal dimension 0.53, task dimension 0.28, and bond dimension 0.80.

## Results

### *Descriptive statistics*

The distribution of the background variables are presented in Table I. Of the participants, 60% were single, 22% were married, and 17% divorced. The majority (55%) of participants had mood disorder as a primary diagnosis. The second largest group (34%) had psychotic disorder as a primary diagnosis. Almost two-thirds (61%) of the participants were hospitalized for the first time. About a quarter (23%) of them had had two or three previous hospitalizations. Most of the patients (89%) were hospitalized voluntarily and about ten percent were treated involuntarily (11%).

### *Attachment styles*

The participants' attachment styles were evaluated separately regarding the same (SS) and the opposite sex (OS) relationships. The distribution of the attachment styles among women and men is presented in Table II. A notable proportion of the participants had two or more equally high scores in the Relationship Questionnaire and was not classifiable to attachment styles. When comparing women's and men's ratings, the differences between attachment classifications were not statistically significant in same sex,  $\chi^2(4, N = 83) = 4.54, p = .34$  opposite sex,  $\chi^2(4, N = 83) = 4.60, p = .33$  attachment styles.

Table I. Percentages and frequencies of background variables.

	%	N
<b>Gender</b>		
Woman	62.7	52
Man	37.3	31
<b>Education</b>		
Legislators, senior officials and managers	1.2	1
Professionals	14.5	12
Technicians and associate professionals	10.8	9
Clerks	7.2	6
Service workers and shop and market sales workers	15.7	13
Craft and related trades workers	7.2	6
Plant and machine operators and assemblers	3.6	3
Elementary occupations	39.8	33
<b>Civil status</b>		
Single	60.2	50
Married	21.7	18
Divorced	16.9	14
Widow	1.2	1
<b>Number of children</b>		
None	60.2	50
1–2	26.6	22
3+	13.2	11
<b>Primary diagnosis</b>		
Mood disorder	54.8	45
Depression	52.4	43
Non-psychotic	45.1	37
Psychotic	7.3	6
Bipolar affective disorder	2.4	2
Neurotic, stress-related and somatoform disorders	3.6	3
Personality disorder	1.0	1
Psychotic disorder	34.2	28
Schizophrenia	11.0	9
Schizoaffective disorder	6.1	5
Other psychotic disorder	17.1	14
Eating disorder	1.2	1
Substance use disorder	3.7	3
Other	1.2	1
<b>Length of hospitalization</b>		
– 30 days	59.0	49
31–60 days	22.9	19
61–90 days	9.6	8
91–120 days	4.8	4
121+ days	2.4	2
<b>Number of previous hospitalizations</b>		
None	61.0	50
1–2	23.2	19
3–4	7.3	6
5–7	8.5	7
<b>Way of admission</b>		
Voluntary	89.2	74
Involuntary	10.8	9

*Attachment style and patient-rated working alliance*

To analyse the effect of attachment style on patient-rated working alliance, a multivariate analysis of variance (MANOVA) was performed. The patient's attachment style and gender were used as independent variables, and working alliance dimensions of goal, task, and bond were the dependent variables. The means and standard deviations of patient-rated working alliance scores according to the attachment styles (in relation to same sex relationships, SS) are presented in Table III. With the use of Roy's criterion, the MANOVA showed an attachment style and gender-interaction effect on patient-rated working alliance,  $F(3, 45) = 5.10, p < .01$ . The main effect of attachment style was approaching significance,  $F(3, 45) = 2.44, p = .076$ . The main effect of gender was not significant.

Because the MANOVA showed an attachment style x gender-interaction, the effect of attachment style was analysed separately for women and men and for their goal, task and bond dimensions of working alliance. These analyses were also performed on the global alliance scores. The results of the one-way ANOVAs are shown in Table III. Among women, the attachment style had a significant effect on the alliance scores on the bond dimension ( $p < .01$ ). Multiple comparisons (LSD) showed that women with secure

Table II. The distribution of attachment styles for Same (SS) and Opposite (OS) Sex Relationships in women and men.

Attachment style	Women (SS)		Men (SS)		Women (OS)		Men (OS)	
	%	N	%	N	%	N	%	N
Secure	25.0	13	25.8	8	7.7	4	22.6	7
Dismissing	5.8	3	9.7	3	1.9	1	0	0
Preoccupied	13.5	7	6.5	2	15.4	8	9.7	3
Fearful	26.9	14	12.9	4	25.0	13	19.4	6
Unclassified	28.8	15	45.2	14	50.0	26	48.4	15

Table III. Means (and standard deviations) of patient-rated working alliance dimensions according to gender and attachment style (SS).

Attachment style	Patient-rated working alliance							
	Goal		Task		Bond		Global	
	Women	Men	Women	Men	Women	Men	Women	Men
Dismissing	44.33 (2.52)	50.00 (5.66)	46.00 (8.54)	44.50 <sup>ab</sup> (0.71)	47.67 <sup>a</sup> (5.77)	53.00 (0.00)	133.67 (4.51)	143.50 (3.54)
Secure	47.92 (6.41)	48.75 (8.10)	45.08 (7.11)	45.48 <sup>a</sup> (5.42)	61.14 <sup>bc</sup> (4.93)	54.50 (9.93)	152.29 (14.64)	145.94 (22.17)
Fearful	47.07 (5.09)	50.75 (2.50)	43.07 (4.14)	49.25 <sup>a</sup> (4.57)	51.80 <sup>ac</sup> (7.04)	57.75 (6.40)	139.87 (11.64)	156.25 (12.53)
Preoccupied	47.03 (8.71)	44.00 (5.66)	47.18 (4.32)	36.00 <sup>b</sup> (0.00)	58.20 <sup>c</sup> (11.66)	43.00 (2.83)	149.16 (24.46)	120.00 (8.49)
F-value	0.27	0.47	0.41	3.51*	5.03**	1.47	2.15	1.77

Note: \* $p < .05$ ; \*\* $p < .01$ .

Means within columns not sharing the same superscript were significantly different at  $p < .05$  (LSD).

attachment formed stronger bond than women with dismissing ( $p < .01$ ) or fearful ( $p < .01$ ) attachment. Also the women with preoccupied attachment showed higher bond dimension than women with dismissing attachment ( $p < .05$ ). The attachment style was not affecting the women's working alliances regarding the goals and tasks of the treatment.

For men, there was a significant effect of attachment style on the alliance scores on the task dimension. Multiple comparisons showed that men with preoccupied attachment had lower scores than securely ( $p < .05$ ) or fearfully ( $p < .01$ ) attached men. For men, this was the only alliance dimension which was affected by the attachment style.

The patient-rated working alliance scores on three different dimensions were also analysed in different attachment styles when the categorization was based on the opposite sex relationships. A MANOVA performed on these data did not show any significant effects.

#### *Attachment style and case manager-rated working alliance*

To analyse the effect of attachment style on case manager-rated working alliance, a multivariate analysis of variance (MANOVA) was performed. The patient's attachment style and gender were used as independent variables, and goal, task and bond dimensions of working alliance as dependent variables. The means and standard deviations of case manager-rated working alliance scores according to attachment styles (in relation to same sex relationships, SS) are presented in Table IV. With the use of Roy's criterion, the MANOVA showed both a significant attachment style main effect,  $F(3, 46) = 4.91, p < .01$  and attachment style and gender-interaction effect,  $F(3, 46) = 3.55, p < .05$  on case manager-rated working alliance. The main effect of gender was not significant.

Because the MANOVA showed an attachment style x gender-interaction, the effect of attachment style on working alliance dimensions and global score were analysed separately for women and men. The results of the one-way ANOVAs are shown in Table IV. Among women, the attachment style did not affect any of the case manager-rated working alliance dimensions. Among men, the attachment style had a significant effect on the alliance scores on global alliance as well as on bond dimension. Multiple comparisons (LSD) showed that

Table IV. Means (and standard deviations) of case manager-rated working alliance dimensions according to gender and attachment style (SS)

Attachment style	Case manager-rated working alliance							
	Goal		Task		Bond		Global	
	Women	Men	Women	Men	Women	Men	Women	Men
Dismissing	38.80 (7.11)	43.33 (5.51)	38.67 (6.43)	42.00 (5.29)	49.00 (9.54)	59.00 <sup>a</sup> (1.73)	126.4 (22.99)	144.33 <sup>a</sup> (11.72)
Secure	45.54 (4.58)	48.38 (5.66)	43.00 (3.44)	44.00 (5.86)	57.15 (7.43)	56.88 <sup>a</sup> (7.64)	145.69 (12.54)	149.25 <sup>b</sup> (15.85)
Fearful	47.36 (5.33)	48.50 (3.70)	44.00 (3.96)	45.50 (3.70)	59.93 (5.99)	65.00 <sup>a</sup> (0.82)	151.29 (12.85)	159.00 <sup>b</sup> (7.35)
Preoccupied	44.57 (6.40)	38.00 (1.41)	41.43 (2.82)	38.00 (4.24)	58.00 (10.38)	43.50 <sup>b</sup> (9.19)	144.00 (18.00)	119.50 <sup>ab</sup> (14.85)
F-value	2.15	2.88	1.96	1.03	1.69	5.42*	2.45	3.86*

Note: \* $p < .05$ ; \*\* $p < .01$ .

Means within columns not sharing the same superscript were significantly different at  $p < .05$  (LSD).

securely and fearfully attached men had higher scores on case manager-rated global alliance than dismissing men ( $p < .05$ ). Furthermore, the preoccupied men had lower scores on case manager-rated bond dimension than secure ( $p < .05$ ), dismissing ( $p < .05$ ) and fearful ( $p < .01$ ) men.

The case manager-rated working alliance scores on three different dimensions were also analysed in different attachment styles when the categorization was based on the opposite sex relationships. A MANOVA performed on these data did not show any significant effects.

#### *Attachment styles and working alliance profiles*

In order to test whether we can identify attachment specific working alliance profiles, we analyzed the data with MANOVA, Repeated measures procedure. The dimension of working alliance (goal, task, and bond) was treated as a within-subject factor and attachment style (dismissing, secure, fearful, and preoccupied) and gender as between-subject factors. Furthermore, because we had alliance scores which were based either on patients' or case managers' ratings and because the attachment classification could be based on same sex or opposite sex relationships, we wanted to test the similarity of the alliance score profiles in all the combinations of these factors. Thus, four MANOVAs (Repeated measures procedure) were run.

The main effects of the alliance profiles were highly significant in all analyses (all  $ps < .001$ ) indicating that the levels of bond, goal and task were generally significantly different. However, against to our hypotheses, neither the main effects of attachment style and gender nor the attachment style and gender-interaction effect were significant in any of the analyses. Thus, there were no differences in the alliance profiles between the attachment groups, no matter whether the alliance scores were based on patients' or case managers' ratings, or whether the attachment classification was based on the same sex or opposite sex relationships.

To illustrate the results, Figure 1 presents the data based on patient-rated working alliance scores according to the same sex attachment styles. Because there was no main effect of gender or attachment style and gender-interaction, the factor of gender was omitted from this analysis. Here, the main effect of the alliance score dimension was highly significant,  $F(2, 48) = 27.65$ ,  $p < .001$ . Post hoc analyses (LSD) showed that the patients scored generally higher on bond dimension than on goal ( $p < .001$ ) and task ( $p < .001$ ) dimensions. Furthermore, the goal dimension was generally higher than the task dimension ( $p < .01$ ). Neither the main effect of the attachment group nor the interaction between the alliance score dimension and attachment group were significant.

## **Discussion**

The aim of this research was to examine the associations between adult attachment styles and working alliance in psychiatric inpatients. We also investigated the possibility of attachment specific working alliance profiles regarding goal, task, and bond dimensions of alliance.

The results confirmed that security of attachment was associated with several positive aspects of patient-rated working alliance. However, the association was different in men and women. In accordance with the hypothesis, securely attached women formed stronger emotional and relational alliance (bond) than women with fearful and dismissing attachment styles. Also preoccupied women showed stronger emotional and relational alliance

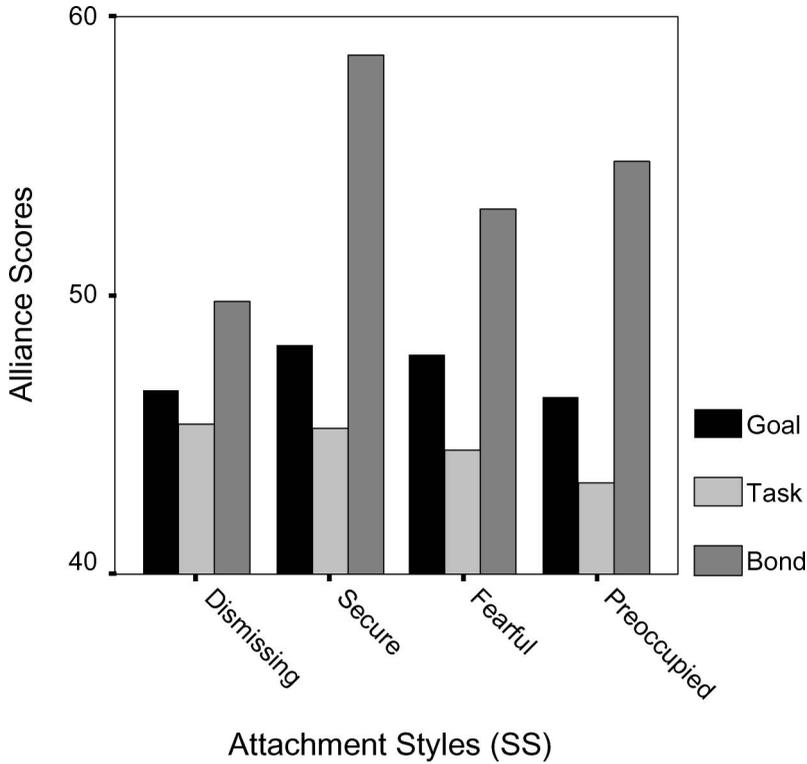


Figure 1. Patient-rated working alliance profiles according to same sex attachment styles,  $n = 54$ .

compared to dismissing women. Although both the secure and the preoccupied women strive for an emotional bond with their case managers, the underlying mechanism may differ. The strong bond of secure women can reflect their positive working model and trust in the benevolence of other people. With their tendency to seek contact and help from the others, the secure women can find it easier to create a trusting and emotionally close relationship with their case managers. On the other hand, with preoccupied women the strong bond may reflect a tendency to form intensive emotional relationships because of the anxiety about abandonment and uncertain self-worth. By intensifying the affective cues to their case managers, the preoccupied female patients may try to assure continuing comfort and care (Slade, 1999).

The results were quite different among men. The attachment style was related to the agreement on tasks of the therapy, i.e., the cognitive aspects of working alliance. Securely and fearfully attached men had better agreement on the tasks of the therapy than preoccupied men. It seems that in our inpatient sample the fearfully attached men represent a very different alliance pattern than what would be expected on the basis of attachment theory. Despite of their negative working model of the self and the others, they are able to set aside their general fear of intimacy when they face the psychological distress of losing mental health. Unlike the dismissing patients who are able to rely on their high self-worth and self-sufficiency, the fearful patients recognize more clearly their need for help and support and, therefore, create a positive cognitive collaboration with their case managers. This was reflected in their agreement on tasks in the building of working alliance.

The informant of working alliance, namely whether it was the patient or the case manager, was important for the dynamics between attachment and working alliance. When evaluated by the case managers, patients' attachment was associated with working alliance only among men. In line with men's own experience of working alliance, securely and fearfully attached men had higher global alliance than dismissing men. Furthermore, in emotional and relational alliance (bond) case-managers evaluated the preoccupied men as having lower alliance than men in other attachment styles. This may reflect the case-managers' reaction to the high demands of preoccupied patients who represent themselves as needy and dependent (Dozier, 1990). It is possible that case-managers feel it more difficult to handle the neediness of preoccupied male patients, because it challenges the cultural stereotype of males being more independent than their female counterparts.

Previous studies on attachment and working alliance are based either solely on patients' alliance reports (e.g., Tyrell et al., 1999; Satterfield & Lyddon, 1995; 1998) or on both patients' and their therapists' reports (Dolan et al., 1993; Eames & Roth, 2000). Our results accord with previous research by indicating that using of different informants yields different results and using multiple informants gives us the richest picture of the dynamics between attachment and alliance.

In this study, the participants rated their attachment style in relation to same sex as well as opposite sex relationships. According to our results there was an association between attachment and alliance only when it was analyzed using the same sex attachment classifications. In previous research the gender of the attachment figure has not been taken into account, and attachment has been measured in relation to close relationships in general (Eames & Roth, 2000; Satterfield & Lyddon, 1995, 1998; Dolan et al., 1993) or in relation to both the therapist and the primary attachment figure (Parish & Eagle, 2003). It is noteworthy that the same sex attachment became so salient in our inpatient group whose mental integrity is in danger. It may be that in their situation the same sex relationships seem less complicated and contradictory source of support than opposite sex relationships.

The proportion of unclassifiable participants regarding attachment styles was high in our sample, namely 34% for same sex and 47% for opposite sex attachment relationships. This proportion was higher than in a sample of Finnish non-clinical adults (Männikkö, 2001). There the proportion of unclassified participants was 27% for the same sex and 32% for the opposite sex relationships. Our results thus accord with the observations that non-classified cases have been over-represented in clinical samples (e.g., Allen, Hauser, & Borman-Spurrell, 1996; Hesse, 1999). Their high share may indicate that in severely ill psychiatric patients the type of attachment may not be adequately described by traditional coding systems (Schuengel & van Ijzendoorn, 2001).

This study increases our understanding of attachment and working alliance and it can be applied to acutely ill psychiatric inpatients. However, there are some threats to the generalizability of the findings. First of all, the high number of unclassifiable subjects refers to a substantial methodological problem in our study design. The number (17%) of the patients who refused to participate further limits the representativeness of our sample. Furthermore, although our sample included a relatively high proportion of psychotic patients (34%), the drop-out analysis showed that their share was higher among the drop-outs than in the final sample. Therefore, cautiousness should be applied to the generalizability of the findings in all types of psychotic patients. Finally, our findings may not be generalized in outpatient therapy settings because case management relationships can be different from those that are created in traditional psychotherapy. It should be noted that also therapist's or case manager's attachment orientation is likely to affect the development

of working alliance (Dozier, Cue, & Barnett, 1994). For example Tyrell, Dozier, Teague, and Falot (1999) have found better working alliances when clients were matched with case managers who were dissimilar to them, thus indicating compensatory dynamics of attachment. Clients who were more deactivating (e.g., avoidant/dismissing) with respect to attachment had better alliances with less deactivating case managers, whereas less deactivating clients worked better with more deactivating case managers.

The study design had several limitations. Although we originally had a relatively large inpatient sample, we lost power of analysis due to the high proportion of unclassified cases. Furthermore, the method of using of self-report questionnaires is susceptible to response biases. Measuring attachment with multiple methods could have provided us with deeper understanding about the relationship between attachment and alliance. Although the internal consistency of our alliance measure (WAI) was good or satisfactory for most of the dimensions, there was a considerable problem with the low scale reliability of the task dimension when rated by the case managers. Our methods can be further criticized for using an earlier version of the Relationship Questionnaire involving paragraph descriptions (Bartholomew & Horowitz, 1991). We chose the paragraph description tool because in the interview procedure it was possible to be used in a reflective and dialogical way. With newly hospitalized psychiatric patients we had to avoid long questionnaires and encourage dialogue instead. Finally, our study design was cross-sectional and we focused on the alliance at the early phase of treatment. Horvath and Luborsky (1993) have suggested that alliance is a dynamic phenomenon with two important phases. Our study handled the first phase, where the initial satisfactory levels of collaboration and trust should be established, and an agreement about the procedures and goals should be reached. The second critical phase comes in when the therapist starts to challenge the patient's old dysfunctional patterns. There the dynamics between attachment and alliance could show a different pattern from the one in our study.

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