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Jessica Taylor-Pickford
Parents with Children in Therapy:
Is There A Relationship Between
Parental Attachment Styles and the
Parent-Therapist Alliance?

Abstract

Over 2,000 studies have been completed exploring the working alliance in adult psychotherapy (Horvath & Bedi, 2002); by comparison, only 23 studies have explored the working alliance in psychotherapy with children (Shirk & Karver, 2003). However, the alliance in youth therapy may be more complex than in adult psychotherapy because it also involves the alliance between the child's parent(s) and the therapist (Hawley & Weisz, 2005). The parent-therapist alliance is one of the least emphasized relationships in theoretical or empirical literature referring to child therapy, and was the focus of the current study.

Using a cross-sectional, quantitative research design and a small sample (N=53) of parents with children in therapy at a community mental health clinic, this study explored the relationship between parental attachment tendencies and parental assessment of the parent-therapist working alliance. This study utilized two self-report measures, the Working Alliance Inventory-Revised Short Form and Experiences in Close Relationships-Short Form.

While no correlation was found between attachment patterns and the strength of the working alliance in the entire sample, when parents were placed into groups based on number of sessions attended, a significant, strong negative correlation was found between attachment avoidance and the parent-therapist bond in the mid-range group (attending 11-25 sessions). This suggests that parental attachment style may be related to the formation and strength of the parent-therapist working alliance over time. Clinical implications, study limitations, and suggestions for further research are discussed.

**PARENTS WITH CHILDREN IN THERAPY:
IS THERE A RELATIONSHIP BETWEEN PARENTAL ATTACHMENT
STYLES AND THE PARENT-THERAPIST ALLIANCE?**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

Jessica Taylor-Pickford

Smith College School for Social Work
Northampton, Massachusetts 01063

2011

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CHAPTER I

Introduction

It is a well accepted idea that the working alliance, often called the therapeutic alliance or the helping relationship, between client and therapist is the bedrock of therapeutic work. A strong alliance between client and therapist facilitates greater collaboration, can lead to better outcomes in therapy (Bordin, 1979; Horvath & Luborsky, 1993; Horvath & Symonds, 1991, Norcross, 2002; Orlinsky, Rønnestad, & Willutzki, 2004), and is sometimes considered the healing element in individual psychotherapy across populations (Bordin, 1979). Over 2,000 studies have been completed exploring the working alliance in adult psychotherapy (Horvath & Bedi, 2002); by comparison, only 23 studies have explored the working alliance in psychotherapy with children (Shirk & Karver, 2003). However, the alliance-outcome correlation in youth therapy may be more complex than that which exists in adult psychotherapy because it involves not only the working alliance between child and therapist, but also the alliance between the child's parent(s) and the therapist (Hawley & Weisz, 2005). The parent-therapist alliance is one of the least emphasized relationships in theoretical and empirical literature referring to child therapy. It is for this reason that the parent-therapist alliance is the focus of this research.

It has been suggested that up to 40 percent of the variance in treatment outcomes will be due to client pretreatment qualities and extra-therapeutic influences (Lambert, 1992), such as client ego strength, social context, or previous and current social or familial relationships. Given the importance of the working alliance in therapy outcomes, researchers are exploring pre-treatment conditions or qualities that might affect the formation of a strong working alliance in

client-therapist dyads, with the hopes of increasing the efficacy of therapy (Smith, Msetfi & Gold, 2010). There is a need for similar research regarding the pre-treatment qualities of parents that could have an effect on the formation of the parent-therapist working alliance. This study explored one pre-treatment quality, parental attachment style, and whether a relationship may exist between a parent's internal working model of attachment and the strength of the parent-therapist working alliance in child therapy.

This research employed a quantitative, cross-sectional model of inquiry, utilizing two pre-created and validated self-report measures. Study participants were asked to complete the Working Alliance Inventory-Short Form Revised (WAI-SR) to measure the strength of the parent-therapist alliance, and the Experiences in Close Relationship Scale-Short Form (ECR-S) to measure avoidance and anxiety in close relationships, which is theoretically based on internal working models of attachment. The hypothesis was that parental attachment styles, or the internal working model of attachment, would have an effect, either positive or negative, on the parent's endorsement of the parent-therapist working alliance. The scores on each measure were used to test whether a parent's score on the anxious attachment subscale or avoidant attachment subscale of the ECR-S was correlated with that parent's rating of the parent-therapist alliance on the WAI-SR.

A greater insight into the relationship that may exist between a parent's internal working model of attachment and formation of the parent-therapist working alliance could create greater understanding of one variable that may be indirectly linked to treatment completion (Garcia & Weisz, 2002; Kazdin, Holland & Crowley, 1997), satisfaction (Tolan, Hanish, McKay & Dickey, 2002), and therapeutic change in child therapy. The utilization of theoretical and empirical literature discussing appropriate interventions or methods of engagement for clients with varying

attachment styles, in conjunction with the findings of this study, could be used to identify steps to strengthen the parent-therapist alliance, leading to possible improvements in the clinical care of children in therapeutic settings. The findings may also have limited applicability to other settings and professions working with children and parents, including daycares, schools, or healthcare facilities specializing in the treatment of children.

Chapter II

Literature Review

The review of literature begins with a brief explanation of attachment theory, attachment classifications, and their relation to the client-therapist dyad. This is followed by a description of the working alliance, as well as previous studies linking the internal working model of attachment to the working alliance between client and therapist. Lastly, there is a description of the parent-therapist relationship, with a focus on recent alliance-outcome literature.

Attachment Theory

Originally used to explore the bond between infants and their primary caregivers, the ideas of attachment theory have been expanded in recent years to offer a framework from which to understand adult relationships and “strong affectional bonds to particular others” (Bowlby, 1977, p. 201). Initially, Bowlby hypothesized that the attachment system evolved as a system to keep caregivers in close proximity to their infant under times of distress or threat. However, current understanding of the infant-caregiver attachment suggests that the attachment system, in optimal conditions, allows for the creation of “felt security” within the infant that facilitates comfortable exploration of the self, others and the larger world (Ainsworth, Blehar, Waters & Wall, 1978). Available, responsive caregiving lends itself to the creation of a securely attached infant. Infants with misattuned, unresponsive, or unpredictable caregivers may develop alternative strategies to relieve distress by deactivating or hyperactivating attachment behaviors, such as crying, proximity seeking, or other methods of signaling the caregiver in times of distress.

According to Bowlby (1973), infants and young children internalize their experience with early caregivers, which over time becomes an internal working model for later relationships. Theoretically, these internal working models of attachment have the power to influence a person's expectations, emotions, defenses and relational behavior in all close relationships (Bartholomew & Shaver, 1998). These early attachment experiences, Bowlby (1973) insisted, shape individual expectations about whether or not attachment figures will be available when one attempts to elicit support or protection. In addition, early attachment experiences foster views of the self as someone who is worthy, or not worthy, of protection and support from others during times of distress. Researchers have documented the continuity of attachment behaviors across the lifespan and, more recently, several measures of adult attachment have been created to measure attachment styles in adult romantic relationships (Hazan & Shaver, 1987), caregiver-child dyads (George, Kaplan & Main, 1987; van Ijzendoorn, 1995), the client-therapist relationship (Mallinckrodt, Gantt & Coble, 1995) and close adult relationships more generally (Bartholomew & Horowitz, 1991; Brennan, Clark & Shaver, 1998; Fraley, Waller & Brennan, 2000; Wei, Russell, Mallinckrodt & Vogel, 2007).

Early in attachment research, two distinct traditions of research were initiated to investigate patterns of attachment in adulthood. Both were based on Ainsworth's three patterns of childhood attachment: secure, avoidant and anxious or preoccupied. The first tradition, developed by George et al. (1987), is the Adult Attachment Interview (AAI), which elicits information about childhood relationships with primary caregivers. Initially, the AAI was administered to mothers and the classifications were used to 'postdict' their infant's reactions in the Strange Situation, assuming the internal working model of attachment would affect the caregiver's parenting behaviors, in turn influencing the child's attachment pattern. The second

tradition, developed originally by Hazan and Shaver (1987), is a self-report attachment questionnaire addressing attachment in romantic relationships, hypothesizing that orientations to romantic relationships might be an outgrowth of previous attachment experiences with early caregivers. In 1990, Bartholomew reviewed these two traditions of adult attachment research and found that not only do they focus on different domains of relational experience, but they also reflect differing conceptualizations of adult attachment. The AAI focuses on the dynamics of internal, and presumably unconscious, working models of attachment that are revealed indirectly during an interview about early childhood experiences. Self-report questionnaires measure experiences in close relationships of which the person is more aware and thus can describe fairly accurately (Bartholomew & Shaver, 1998).

Building on the prior attachment traditions described above and their critiques, researchers have proposed an expanded model of adult attachment that includes two forms of the avoidance style (dismissive and fearful). Bartholomew and Horowitz's (1991) Relationship Questionnaire (RQ) and Brennan et al.'s (1998) Experiences in Close Relationships Questionnaire (ECR) describe four prototypical attachment patterns: (1) secure, (2) preoccupied, (3) dismissive, and (4) fearful. Each attachment pattern is defined in terms of two dimensions: level of anxiety in close relationships that is based on an assessment of the self in these relationships, and level of avoidance in close relationships, based on beliefs about others in close relationships. Adults classified as secure are understood to be free and autonomous with regard to attachment relationships, which is indicative of comfort in close relationships (Bowlby, 1973). Individuals classified as preoccupied, which is also described as anxious in Ainsworth and colleague's (1978) classifications, have a tendency to hyperactivate attachment related behavior based on a view of the self as unlovable or unworthy, but they may achieve self-acceptance by

gaining the approval of respected others (Bartholomew & Horowitz, 1991). Individuals with dismissive attachment styles reflect a somewhat positive view of the self and an expectation that others are untrustworthy or rejecting. These individuals protect themselves from disappointment by minimizing the importance of close relationships. Individuals with fearful attachment classification have a negative view of the self and others in close relationships; thus they may be equally as avoidant of close relationships as their dismissive counterparts for somewhat different underlying ideas about relationships (Bartholomew & Horowitz, 1991).

The degree to which clinicians and researchers view the therapeutic relationship as an attachment relationship varies. Many assert that psychotherapy works precisely because it is an attachment relationship (Amini et al., 1996; Bowlby, 1988; Jones, 1983; Obegi, 2008). Therapists utilizing an attachment theory model insist that clients will re-enact internal working models of attachment in the therapeutic relationship, which are then explored, challenged and revised during the course of therapy (Bowlby, 1988), eventually providing a corrective attachment experience (Jones, 1983). However, little empirical data exists to support how these attachment properties manifest themselves in the therapeutic relationship and, given the varying categories of the internal working model of attachment and corresponding relational behavior, this may be difficult to parse out (Parish & Eagle, 2003; Schuengel & van Ijzendoorn, 2001).

The Working Alliance

Despite the lack of empirical research with regards to the client attachment to the therapist, the client-therapist relationship has been a topic of clinical interest since the time of Freud (1913), playing a crucial role in the conceptualization of therapeutic processes and outcomes of therapy with patients in any age group. The therapeutic alliance, often referred to as the working alliance, has been extensively empirically studied. The concept of the working

alliance transcends theoretical orientations and treatment approaches, and a large body of empirical literature links it to positive outcomes in therapy, such as treatment completion, compliance with the expectations of treatment, and therapeutic change (Bordin, 1979; Horvath & Luborsky, 1993; Horvath & Symonds, 1991, Norcross, 2002; Orlinsky et al., 2004).

The working alliance, first conceptualized by Bordin (1979), is the reality-based, dynamic component of the therapeutic relationship, consisting of three parts (Bordin, 1979; Horvath & Greenberg, 1989, Luborsky, 1976). The first portion of the working alliance, which begins at the outset of therapy, is client-therapist agreement on the goals of the therapy. Bordin (1979) suggests this stems from the mutual recognition that the client's frustration or dissatisfaction is the function of his or her own ways of thinking, feeling and acting. To be clear, Bordin (1979) recognizes that social or environmental circumstances may contribute to these frustrations; however, the goal of therapy is to ameliorate the presenting issues through an examination of the client's contributions to these issues. The second portion of the working alliance is made up of the mutual agreement on the tasks or strategies the client and therapist can use to achieve these goals. These include the in-counseling behaviors that each party must see as relevant and efficacious, and agree to complete. The final component is the bond formed between the client and therapist, which involves some level of trust and attachment.

Based on Bordin's concept of the working alliance, Horvath and Greenberg (1989) developed and validated the Working Alliance Inventory (WAI). The WAI is a 36-item questionnaire, measuring satisfaction in all three domains of the working alliance described above. Bordin (1979) recognized that the goals, tasks, and bonds between client and therapist, as well as the emphasis placed on each, will vary greatly based on theoretical orientation of the therapist, the needs of the particular client, modality of therapy, and the phase of treatment.

Despite these differences, Bordin's (1979) working alliance, measured by the WAI, has been linked to outcomes in therapy (Horvath & Symonds, 1991).

Attachment and the Working Alliance

Given the importance of the working alliance in therapy, researchers have explored pre-treatment conditions or client qualities that affect the formation of a working alliance, including client internal working models of attachment, which will be further examined in this study (Smith et al., 2010). Researchers have found that clients with secure attachment models, as described earlier, are better able to become involved in self-exploration, engage in higher rates of self-disclosure, appraise past and current relationships more accurately, and have the capacity to develop a more collaborative relationship with the therapist than their insecure counterparts (Mikulincer & Nachshon, 1991). Given these findings, the relational strengths of adults classified as securely attached would presumably assist patient-therapist dyads in the development of a positive working alliance. Furthermore, it may allow the pair greater flexibility in approaching ruptures that may occur within the alliance (Furman, 1999). Conversely, studies have found that clients with insecure attachment models may be more resistant to forming an alliance with the therapist (Smith et al., 2010). Additionally, clients who have difficulty developing a strong therapeutic alliance with the therapist have been found to be more likely to have difficulties maintaining social relationships, poor past and current family relationships (Mallinckrodt, 1991), and low levels of intrapsychic flexibility (Ryan & Cicchetti, 1985). Based on this previous research, it seems possible that attachment styles influence intrapersonal and interpersonal strengths that could potentially lay the groundwork for a strong working alliance. Additionally, relational deficits of insecurely attached clients could hinder the formation of a

strong working alliance in individual therapy and potentially the parent-therapist alliance in child treatment.

Parent-Therapist Relationship

There has been relatively little empirical work addressing the alliance in youth psychotherapy. A meta-analysis by Shirk and Karver (2003) identified only 23 studies, spanning nearly three decades that addressed this topic. Although the vast majority of clinical practice with children includes parents or caregivers, the meta-analysis draws attention to the lack of empirical literature regarding the parent-therapist relationship (Kazdin, Siegel & Bass, 1990; Shirk & Karver, 2003). The therapeutic relationship with the parent might impact outcomes of treatment in several ways. In treatment that is focused on directly changing parent behavior in order to impact child behavior (Furman, 1957), a parent-therapist alliance will be required as a prerequisite. If treatment is focused on the child, engaging the parent would be important because parents generally are responsible for scheduling and keeping appointments, providing information about the child to the therapist during intake and throughout the course of therapy, as well as encouraging the child's treatment adherence to promote the generalization of treatment gains outside the therapy session (Karver, Handelsman, Fields & Bickman, 2005).

Within the limited empirical literature on the parent-therapist relationship, a stronger parent-therapist alliance has been associated with treatment completion (Garcia & Weisz, 2002; Kazdin et al., 1997), satisfaction (Tolan et al., 2002), and therapeutic change in child psychotherapy. Garcia and Weisz (2002) administered the Reason for Ending Treatment Questionnaire (RETQ) to the parents of 344 children at various clinics and found that parents whose children successfully completed treatment were more likely to feel that the therapist was invested in both the child and parent, and demonstrated competency and effectiveness by "doing

the right things” in the therapy session. This could be loosely linked to the bond and task components of the working alliance (Bordin, 1979; Horvath & Greenberg, 1989). Kazdin et al. (1997) had similar findings in a study of 242 families of children who were referred for treatment due to oppositional, aggressive or anti-social behavior. They suggested that, among other barriers to treatment, parents who reported a poor relationship or alliance between himself or herself and the therapist were correlated with early termination from therapy. Neither study utilized the WAI to measure the therapeutic alliance.

Hawley and Weisz (2005), in a study of 65 youths and their parents attending treatment at a community mental health clinic, found the parent-therapist alliance, and not the youth-therapist alliance, was significantly correlated to the researchers’ measure of retention that included: family participation in therapy, frequency of cancellations and no-shows, and therapist concurrence with treatment termination. Kazdin, Whitley and Marciano (2006) examined the child-therapist and parent-therapist working alliance, among children referred to therapy for oppositional, aggressive or antisocial behavior, at two points during the course of treatment using the WAI. Findings from this study suggest that both the parent-therapist and the child-therapist alliance are correlated to therapeutic changes among the children referred to treatment. Although the specific mechanisms through which alliance operated to create change were not studied, both studies point out the need to investigate pre-treatment characteristics of children and their parents that may serve as predictors of alliance formation and, in turn, therapeutic outcomes in child therapy.

To date, only one study has addressed parent pre-treatment characteristics in relation to the formation of the parent-therapist working alliance. Kazdin and Whitley (2006) measured parent’s pre-treatment social relationships and parent/therapist ratings of the working alliance at

two points in time. Study participants (N=53) had children referred to treatment for oppositional, aggressive and anti-social behavior. The parents were involved in Parent Management Training (PMT) to support them in creating effective parenting practices in the home to alleviate his or her child's presenting concerns. Kazdin and Whitley (2006) hypothesized the parent-therapist alliance would mimic a social relationship, thus the strength of the parent's pre-treatment social network would have an effect on the formation of the working alliance. They found that the combined social relationship measures positively and significantly predicted the strength of the therapeutic alliance for parents in the PMT treatment model. They also found that higher quality alliances were linked to greater improvement in parenting practices, as reported by the treating therapist.

While Kadzin and Whitley's (2006) findings are encouraging, they are limited in a few ways. First, the parent-therapist relationship in PMT may not be reflective of the parent-therapist relationship in other treatment models, where contact with parents may be much less frequent. Thus, findings cannot be generalized to other treatment modalities for children. Additionally, the study was not able to explain why a parent's pre-treatment social relationships would be predictive of formation of the working alliance with the therapist. It seems likely that exploring this relationship through an attachment lens would provide a theoretical framework for understanding this phenomenon.

Current Study

Given the small amount of research on the parent-therapist alliance, fundamental questions remain about the alliance relationship, including the precursors, underpinnings and characteristics of the parent-therapist alliance. Kazdin and Whitley (2006) asserted that the parent-therapist relationship is likely to be reflective of the parent's quality of social

relationships more generally, which could be understood as being based on internal working models of attachment (Bowlby, 1973). It was the purpose of this study to explore the correlation between a parent's internal working models of attachment, which contain longstanding personal views of the self and others in relation, and the strength of the parent-therapist working alliance.

Considering previous studies have linked the strength of the parent-therapist alliance with positive outcomes in child therapy, including treatment completion (Garcia & Weisz, 2002; Kazdin et al., 1997), satisfaction (Tolan et al., 2002) and therapeutic change in child psychotherapy, it seems important to explore parent pre-treatment characteristics that could hinder or facilitate the creation of a strong parent-therapist working alliance.

Chapter III

Methodology

Research Question and Hypotheses

It was the purpose of the current study to explore the parent-therapist alliance through the lens of attachment theory, and to determine what, if any, relationship existed between parental attachment classifications and the strength of the parent-therapist alliance in child therapy. As described in the literature review, infants and young children internalize their experiences with early caregivers. Over time, these early internalized experiences become an internal working model for later relationships (Bowlby, 1973). Early attachment experiences, Bowlby (1973) insisted, shape individual expectations about whether or not others will be available when one attempts to elicit support or protection. In addition, early attachment experiences foster views of the self as someone who is worthy, or not worthy, of protection and support from others during times of distress. As previously noted, beliefs about self and others in relationship have been labeled as attachment anxiety and avoidance, respectively.

This research utilized the theoretical framework of attachment theory, in conjunction with the Kazdin and Whitley (2006) study that found a parent's pre-treatment social relationships positively and significantly predicted the strength of the parent-therapist alliance in the PMT treatment model, it seemed possible that attachment styles may be one factor influencing the formation and strength of the parent-therapist alliance in child therapy. This researcher hypothesized that high levels of attachment avoidance and anxiety will have a negative effect on the parent's evaluation of the parent-therapist alliance.

Study Design

This research employed a quantitative, cross-sectional model of inquiry. This design was chosen over a qualitative study design due to the nature of the questions being explored and the availability of quantitative measures to explore the study variables. In addition, it allowed for the opportunity to recruit a greater number of study participants, who would likely be more willing to complete a short survey at their own convenience, rather than schedule and participate in an interview in person or via phone. Although a longitudinal study design was considered, due to the time constraints of this project it would not have been feasible. In addition, a longitudinal study would have required greater commitment from study participants, treating clinicians, and clinic administrative staff. Thus, a cross-sectional research design was utilized.

Sample and Procedure

Agency

Participants for this research study were drawn from a community mental health clinic with several sites located in a suburban area just outside Denver, Colorado. Although the clinics offer a variety of services to various populations, the primary study sites for this research were the mental health center's two child and family outpatient clinics. Although the study focuses on parents with children in individual therapy, the clinics offer medication management, case management, group therapy, and family therapy services. Clinic clients ranged from ages 5 to 18 years old. Clinic clients engaged in treatment for a variety of reasons, which will be discussed later.

The clinics employed a total of 19 outpatient child therapists whose parents were recruited for this study. Of those 19 therapists, 16 (84%) were female and three (15%) were male. Per therapist self-report, 16 (84%) respondents identified as white, two (11%) identified as

Latino, and the remaining clinician (5%) identified as South Asian. Seven (37%) of the therapists have a doctorate degree (Ph. D or Psy. D), five (26%) are licensed clinical social workers (LCSW), two (11%) are masters level social workers (MSW), and the remaining four (21%) have a masters degree in counseling (LPC, LMFT, MA). Per therapist report, years of experience ranged from 1 to 26, with a mean of 7.7 years, a standard deviation of 6.8, and a median of 7 years. Most of the therapists reported utilizing one, but generally more than one, theoretical orientation in his or her daily practice at the clinic. In total, eight (42%) therapists reported using psychodynamic theories in his or her daily practice, eight (42%) reported using CBT/DBT theories, six (32%) reported utilizing family systems theories, one (5%) utilized solution focused theory and interventions, and two (11%) of the therapists did not respond. See Table 1.

Per therapist estimates, caseload for both clinics was roughly 950. Therapists estimated roughly 275 (29%) of these cases involved mono-lingual Spanish parents, who were likely not able to participate in the research study because the survey was distributed in English only.

Sample

It was not feasible to gain access to a sampling frame from the agency, including a list of clients, client contact information, and information about client caregivers, due to limited access to agency records, concerns regarding participant confidentiality, and the time constraints of this research project. Moreover, time and monetary restraints would not have allowed this researcher to contact every agency parent who fit inclusion criteria for the research study. As such, non-probability convenience sampling techniques were employed to recruit study participants at the clinics when they checked in for the child's appointment at the clinic.

A total of 188 surveys were distributed throughout the recruitment period. A total of 63 were returned to this researcher, with a response rate of 34%. Of these, 53 were utilized for data

analysis. Ten surveys were excluded because respondents did not meet criteria for the study (four surveys), the survey was incomplete (five surveys), or it was returned after the close of the data collection period (one survey).

The sample included parents whose children had attended outpatient treatment with an individual therapist at the clinic for a minimum of four sessions with the current treatment provider. To ensure the largest possible sample size and respect the diversity of families who attend treatment at the clinics where participants were recruited, the term “parent” was expanded to include not only biological and adoptive parents, but also other caregivers who had co-habitated with the child either full or part time throughout the duration of treatment. The inclusion of parents who co-habitate with the child part-time was meant to ensure that the study would be open to parents who might have joint custody of the child in treatment. In addition, caregivers were required to have legal custody of the child for the duration of treatment. Two responses were not included in data analysis because they came from foster parents, who did not have legal custody of the child in treatment and had not co-habitated with the child throughout the duration of treatment.

The children and parents were required to have attended a minimum of four sessions with the current therapist, which included an initial intake session during which the child may or may not have been present. A minimum of four sessions was chosen as an exclusionary criteria because it is in line with current studies utilizing the WAI, which generally begins measurement of the parent-therapist alliance in session four of treatment (Kazdin & Whitley, 2006; Kazdin et al., 2006). No maximum number of sessions attended was identified as exclusionary criteria for the study, in an effort to ensure the largest possible final sample size. Two surveys were

excluded from the study because the respondents had only attended two sessions with the current treatment provider.

Recruitment Procedures

The study followed procedures and used materials approved by two institutional review boards, one at the agency where the study was conducted and the other at Smith College School of Social Work. Over a period of nine weeks, the clinic receptionists recruited parents at the clinic to participate in the study when they checked in for the child's appointment, utilizing talking points about the study provided to them (Appendix A). Protocol required that the receptionists, rather than the child's therapist, introduce the study to parents because it reduced the possibility that parents may feel coerced by the therapist to participate. It also seemed to have fewer implications for fostering biased responses to questions about the parent-therapist relationship, and was a more systematic way of ensuring the survey was being distributed to all parents who might be eligible to participate in the study.

After verbally introducing the study to parents, the clinic receptionist provided potential participants with the survey packet when they were checking in for the child's scheduled appointment. Parents were asked to read through the packet, which included a short cover letter giving directions for study participation (Appendix B), an informed consent letter (Appendix C), a copy of the informed consent letter the participant was instructed to keep for his or her records (Appendix D), and a three-three page study questionnaire (Appendices E-G). In the short cover letter and informed consent, parents were informed of their option to voluntarily complete the survey packet if they met inclusion criteria outlined for the study. In addition, the demographics page included questions that addressed inclusion/exclusion criteria to ensure that participants who self-selected to complete and return the survey were eligible. Parents had the option to

complete the survey in the clinic waiting room during the appointment or at home at his or her convenience. Each participant was provided an envelope for the signed informed consent and completed survey, which they could give to the clinic receptionist to mail or mail it directly to the researcher at a later date.

Measures

The first page of the three page study questionnaire provided to each participant elicited demographic data from participants, as well as collecting data regarding the child's treatment, including presenting concerns, length of treatment, estimated number of sessions, information about parental involvement in sessions, and information regarding communication with the therapist outside of sessions (Appendix E). The second and third pages of the study questionnaire contained alliance and attachment measures that are discussed in greater detail below.

Working Alliance

Currently, there are at least 11 instruments available to measure the working alliance, which vary in perspective (observer, client, or therapist) and theoretical orientation. However, the most widely used measure of the working alliance is Horvath and Greenberg's (1989) Working Alliance Inventory (WAI) and its later permutations. Extensive research has attested to the reliability and validity of this measure in both adult and child psychotherapy (Horvath & Bedi, 2002). Additionally, it is the most commonly used measure in the small number of current empirical studies formally measuring the parent-therapist alliance and outcomes in child therapy (Hawley & Weisz, 2005; Kazdin & Whitley, 2006; Kazdin et al., 2006).

The WAI is based on Bordin's (1979) pantheoretical construct of the working alliance and can be applied across treatment models. The original measure has two parallel measures of report, one for the client and one for the therapist. Each survey contains 36 items rated on a

seven point likert scale (1 = *Seldom*; 7 = *Always*). Items focus on mutual agreement on the tasks of therapy, client-therapist agreement on the overall goals of therapy, and extent to which there is a positive personal attachment between client and therapist (bond). There is no norm for the measure, but higher scores indicate a stronger therapeutic alliance.

The second page of the survey contained Hatcher and Gillaspy's (2006) Working Alliance Inventory-Revised Short Form (WAI-SR) to measure the strength of the parent-therapist working alliance (Appendix F). The WAI-SR is a 12-item questionnaire, utilizing a 5-point likert scale (1 = *Seldom*; 5 = *Always*), which closely parallels the scores obtained on the original WAI, as well as closely reflecting the scores on the three subscales (tasks, bonds, goals). Because this study also contained a measure of attachment, a shorter alliance measure was a strategic choice to maintain participant compliance and motivation to complete and return the survey. Validation of the measure showed far higher psychometric properties, as compared to older revisions (Hatcher & Gillaspy, 2006).

It is important to note that no version of the WAI has been created to specifically measure the parent-therapist alliance. Despite this, versions of the WAI have been given to measure the parent-therapist alliance in recent research studies (Hawley & Weisz, 2005; Kazdin, et al., 2006; Kazdin & Whitley, 2006). Thus, as in previous studies, slight adjustments were made to the wording to suggest that the parent was evaluating the tasks and goals of their child's therapy, rather than those that might be created with an individual therapist (Hawley & Weisz, 2005). Also, no version of the WAI-SR was given to the therapist to rate the parent-therapist alliance. The focus of this study is to obtain information regarding the effects of internal working models of attachment and the parent's view of the working alliance with the child's therapist, since it has been found that the parent's view of the working alliance has possible consequences for the

outcomes of treatment (Garcia & Weisz, 2002; Kazdin et al., 1997; Tolan et al., 2002). Among other alliance-outcome studies in adult populations, the client's appraisal of the working alliance, more than the therapist's, has the strongest association with outcome (Horvath & Symonds, 1991).

Attachment Measure

Numerous measures of attachment, both interview and self-report questionnaires, have been created to classify attachment patterns among adults and children, as well as measuring attachment in specific relationships, such as romantic relationships (Hazan & Shaver, 1987), caregiver-child dyads (George et al., 1987; van Ijzendoorn, 1995), the client-therapist relationship (Mallinckrodt et al., 1995), and close adult relationships more generally (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Wei et al., 2007). Although several attachment interviews exist, it was determined that a self-report measure would best fit within the quantitative research design because it increased feasibility of the study and participation by lessening the time required for participation. It seemed that potential participants would be more likely to complete a short survey than engage in a lengthy personal interview, which was not feasible for this study and had the possibility of uncovering potentially painful memories of the participant's childhood experience.

Brennan, Clark and Shaver's (1998) Experience in Close Relationship (ECR) and Bartholomew and Horowitz's (1991) Relationship Questionnaire (RQ) are self-report measures of attachment measure anxiety and avoidance in relationships based on the views of self and others in relationship. In these measures, higher scores on avoidance subscales indicate discomfort depending on others because the individual believes that others will not help them during times of distress, and higher scores on anxiety subscales indicate a fear of rejection or

abandonment based on a negative assessment of the self (Bartholomew & Horowitz, 1991; Bowlby, 1973; Brennan et al., 1998). Brennan and colleagues' ECR (1998) derived the same attachment style categories (secure, preoccupied, dismissive, fearful), but it is said to have a greater internal validity than the RQ (Fraley & Waller, 1998).

This study utilized Wei et al.'s (2007) ECR-Short Form (ECR-S), which is a streamlined version of the original ECR with only 12 items for self-report (Appendix G). The scale, tested for its reliability, validity and factor structure with six separate samples, proved to be comparable to the original version of the ECR on all accounts (Wei, et al., 2007). Again, choosing a shorter alliance measure was a strategic choice to maintain participant compliance and motivation to complete the survey. The shortened version, like the original, measures anxiety and avoidance in close relationships. Lower scores on both ECR-S subscales indicated the respondent has a more secure attachment style, while higher scores on one or both subscale(s) indicated the respondent has an insecure attachment patterns (preoccupied, dismissive, fearful). Although the original wording of the survey elicited information on close romantic relationships, researchers are encouraged to modify the survey to reflect the type of relationship they are studying. For the purposes of this study, the language of the measure was modified to reflect the experience in close relationships more generally, rather than romantic relationships.

Data Analysis

Data was analyzed using SPSS. Demographic data and information regarding the duration of and participation in treatment was analyzed using means, medians, standard deviations, and percentages for all relevant items. Additionally, a thematic coding system was developed to categorize responses regarding the reasons for entering treatment.

The central hypothesis of this study is based on the assumption that, among parents with children in therapy, greater levels of attachment avoidance or attachment anxiety will have a negative effect on their endorsement of the parent-therapist working alliance. Each measure utilized within the study produced one or more continuous numerical values. For the WAI-SR, single numerical values are produced for each subscale (task, goal and bond), as well as a total score indicating the strength of the working alliance, where higher numbers indicated a more positive assessment of the parent-therapist working alliance. The ECR-S produced two interval level pieces of data, one measured relationship anxiety and the other relationship avoidance. It seems important to note that other versions of the ECR have at times been used to place individuals into categories based on attachment style, using scores on the avoidance and anxiety subscale. However, no such formula has been validated for the ECR-S and the creators of the measure strongly advised against doing so (M. Wei, personal communication, March 20, 2011).

Pearson's correlations were used to test dependence between two quantities in the Pearson product-moment correlation coefficient. Pearson correlation scales were used to test four things: 1) if participant's scores on the anxious attachment subscale of the ECR-S were correlated with scores of the WAI-SR, 2) if participant's scores on the avoidant subscale of the ECR-S were correlated with scores of the WAI-SR, 3) if participant's scores on the anxious attachment subscale of the ECR-S were correlated with bond subscale scores of the WAI-SR, and 4) if participant's scores on the avoidant subscale of the ECR-S were correlated with bond subscale scores of the WAI-SR. Pearson's correlation scores provided information regarding the ways in which these variables may be differentially related.

Luborsky (1976) understood the working alliance to be a dynamic entity that changes over time. Previous research on attachment and the working alliance found that assessment of

the working alliance in insecurely attached individuals tends to fluctuate more over time than in individuals with secure attachment styles (Kanninen, Salo and Punamaki, 2000). Though it was beyond the scope of this study to follow respondents longitudinally, respondents were placed in three groups based on number of sessions in order to explore differences in alliance and attachment patterns that might exist based on the number of sessions with the current therapist. These groups (4-10 sessions, 11-24 sessions, 25 or more sessions) were based on natural breaks in the data collected and selected, particularly because they created groups that were roughly equal in size and large enough for statistical analysis. Analyses of variance (ANOVA) were used to explore group differences between scores on both the WAI-SR and the ECR-S. In addition, Pearson's correlations were utilized within each of the three groups to determine if participant's scores on the ECR-S subscales (avoidance and anxiety) were correlated with the overall WAI-SR score or the participant's score on the WAI-SR bond subscale.

CHAPTER IV

Findings

As previously noted, 188 surveys were distributed over a period of nine weeks. A total of 63 were returned (34%). Fifty-three were complete and turned in prior to end of the data collection period, meeting criteria for inclusion in the current study (28%). Two were excluded because the respondents indicated they were a “foster parent,” which suggested they were not legal guardians and, in both cases, the respondents reported they had not lived with the child throughout the course of treatment at the clinic. Two surveys were also excluded because the respondent’s child had attended fewer than four sessions with the current therapist and the remaining five were excluded because they did not answer one or more items from the WAI-SR or ECR-S; thus, the scores could not be used in the statistical analyses. One survey was returned via mail after the data had already been analyzed and was excluded.

Demographic Survey Data

Parents

Of the 53 survey respondents utilized in the study, 46 (86.8%) were female and seven (13.2%) were male. The respondents ranged in age from 24 to 67, with a mean age of 40.98, a standard deviation of 10.01, and a median of 40. Participants were given the option to select whether they were single, married, divorced, in a committed relationship, or “other” to demonstrate their current relationship status. Twenty-eight (52.8%) indicated they were currently married, 12 (22.6%) indicated they were divorced, six (11.3%) reported they were in a committed relationship, six (11.3%) were single, and one (1.9%) respondent chose other and

indicated they were currently “separated.” A total of 46 (86.8%) respondents indicated they had attended their own therapy, while the remaining seven (13.2%) had not.

Parents responding to the survey were asked to write in their race/ethnicity. Thirty-seven (69.8%) identified as White/Caucasian, six (11.3%) identified as Black/African American, five (9.4%) identified as Hispanic/Latino, and two (3.8%) identified as Native American. In three (5.7%) instances, the respondents indicated more than one of the above categories and these respondents were coded as “Biracial.” See Table 2.

Parents were asked to identify how they were related to the child in treatment by identifying as a biological parent, adoptive parent, stepparent (with legal custody), or as another relative (with legal custody). A fifth category, “other,” was added with room for further explanation. This was added to verify that the respondent was eligible for the study based on inclusion/exclusion criteria and, as previously mentioned, the two respondents who answered as “other” indicated they were a foster parent to the child in treatment and were not included in the study. Of the 53 respondents, 41 (77.4%) identified as a biological parent, six (11.3%) identified as an adoptive parent, and six (11.3%) identified as a relative with legal custody. Respondents were asked to report how many years they had lived with the child in treatment and, when this was compared with the child’s reported age, it was found that 46 (86.8%) of the parents appeared to have lived with the child since birth, while the remaining seven (13.2%) had not.

Children in Therapy

Parents were asked to answer questions that required them to provide demographic information regarding their child in treatment. Per parent report, 25 (47.2%) of the children in treatment were male, while the remaining 28 (52.8%) were female. The children’s ages ranged from 6 to 17, with a mean of 11.08 years old, standard deviation of 3.36, and a median of 10. Of

the 53 children described, 28 (52.8%) were identified as Caucasian/White, four (7.5%) were identified as Black/African American, five (9.4%) were identified as Hispanic/Latino, two (3.8%) were identified as Native American, and the remaining 14 (26.4%) were identified as Biracial. See Table 3.

Treatment Information and Parent Participation

All survey respondents had a child receiving individual therapy from a treatment provider in the clinics where the survey was distributed. Respondents reported their children were in therapy anywhere from 1 month to 84 months, with a mean of 13.68 months, a standard deviation of 15.7, and a median of 9 months. Estimated number of sessions reported by parents ranged from 4 to 140, with a mean of 25.64 sessions, a standard deviation of 25.01, and a median of 18 sessions.

To get a superficial look at the issues that caused the parent to seek therapy for the child, parents were asked to briefly write about the child's presenting concerns. More often than not, parents wrote a brief response containing more than one reason he or she sought therapy for the child. For example, one parent wrote "aggressive behaviors, inappropriate sexual behaviors, issues at school" and another responded "ADHD, anger issues, behavioral issues, physical violence." The variety of responses presented a challenge for coding; however, broad thematic categories for responses were developed that included categories for psychosocial stressors (18.9%), specific behavioral issues (66%), concerns related to school behavior or performance (11.3%), specific diagnoses (67.9%) and trauma (13.2%).

Of parents who responded with specific diagnoses, 14 (26.4%) reported the child had a mood disorder (depression or Bipolar Disorder), nine (17%) reported the child had a diagnosis of ADD/ADHD, five (9.4%) had been diagnosed with an anxiety disorder, and two (3.8%) children

carried a diagnosis of Post-Traumatic Stress Disorder. Other diagnoses of mention were schizophrenia, Asperger's syndrome, fetal alcohol syndrome (FAS), reactive attachment disorder (RAD), pervasive developmental disorder (PDD), and borderline-personality disorder.

Parents also reported specific behavioral concerns as the reason for attending treatment. Of these parents, 15 (28.3%) reported the child had issues with aggression or anger outbursts, four (7.5%) reported the child had made suicide attempts or engaged in self-harming behaviors, three (5.7%) parents reported the child had been displaying sexually inappropriate behavior, two (3.8%) parents reported the child was "oppositional," two (3.8%) parents reported they sought therapy because of the child's "attitude," and another seven (13.2%) reported non-specific "behavioral issues" led them to seek treatment. See Table 4.

Of the 53 respondents, six (11.3%) of the parents reported the child was having issues in school that led them to refer the child to therapy, including "difficulty concentrating," "suspensions," and "removal from class." Another seven (13.2%) respondents reported the child had experienced or witnessed a traumatic event, including domestic violence and sexual abuse, and one child who had experienced a "house fire."

A total of 10 (18.9%) parents reported a variety of psychosocial issues that led them to seek treatment for the child, including six (11.3%) parents who reported that the child was "estranged from" or had been "abandoned by" a biological parent, two (3.8%) parents reported the child was experiencing a "big change" in his or her life, one (1.9%) parent reported the child was "dealing with the death of her father," and another parent (1.9%) referred the child due to the parents' divorce. See Table 4. The variety of responses reflects the variety of clients and client issues that present at a community mental health clinic. However, no further measures of

analysis were explored, as this question did not evoke any particular information that would be useful for the purposes of this study.

Finally, parents were asked to respond to a series of statements about his or her participation in the child's treatment. Parents were instructed to check all that might apply. Of the 53 respondents, two (3.8%) parents indicated they rarely spoke with the child's treatment provider. A total of 23 (43.4%) indicated they did attend an initial intake session, with or without the child present, and another 23 (43.4%) reported they checked in with the child's treatment provider at the beginning or end of the treatment sessions. In addition, 15 (28.3%) respondents indicated they contacted the child's therapist outside of regularly scheduled appointments to discuss issues that were happening in treatment, at home, and in school. The majority of parents indicated they had attended and participated in at least one full session with the child: five (9.4%) reported this occurred "rarely," 11 (20.8%) parents indicated this happened "sometimes," 11 (20.8%) reported this happened "often," and 21 (39.6%) stated they "always" attended and participated in full sessions with the child. While this data provided interesting information in regard to the way parents participated in the child's treatment, it was not the subject of further analysis.

Working Alliance Inventory (WAI-SR)

On the WAI-SR, participants were asked to rate the alliance with the child's therapist using a five point likert scale, in which 1= *Seldom* and 5=*Always*. There are a total of 12 items on the measure, made up of three subscales containing four items each (task, goal and bond). The task subscale items focused on mutual agreement on the tasks of therapy, goal subscale items focused on parent-therapist agreement on the overall goals of therapy, and bond subscale items measured the extent to which there was a positive personal attachment between parent and

therapist. Scores are summed on each subscale and overall. Higher scores were indicative of a stronger working alliance; however, no norms were available for this measure.

Of the 53 respondents used in the study, one hundred percent completed the WAI-SR. Scores on the goal subscale ranged from 7 to 20, with a mean score of 16.62, a standard deviation of 3.6, and a median of 18. Scores on the task subscale ranged from 6 to 20, with a mean score of 15.55, a standard deviation of 3.51, and a median score of 16. Scores on the bond subscale also ranged from 6 to 20, with a mean score of 16.58, a standard deviation of 3.61, and a median score of 18. Overall, WAI-SR scores ranged from 19 to 60 points, with a mean of 48.79, a standard deviation of 9.74 points, and a median score of 50 points (see Table 5).

A one way ANOVA was utilized to determine if there were significant differences in scores on the overall WAI-SR total or the WAI-SR bond subscale total based on the number of sessions attended with the current therapist. Respondents were divided into three categories: Group 1 had attended 4-10 sessions, Group 2 attended 11-24 sessions, and Group 3 had attended 25 or more sessions with the current therapist. No significant differences were found between these groups on the respondent WAI-SR total scores ($p=.225$) or on the respondent WAI-SR bond subscale scores ($p=.084$).

Experiences in Close Relationships (ECR-S)

On the ECR-S, participants were asked to rate his or her experience in close relationships using a seven point likert scale in which 1=*Strongly Disagree*, 4=*Neutral* and 7=*Strongly Agree*. Within the 12 total items, six are geared toward measuring “anxiety” in close relationships and the remaining six were used to measure “avoidance” in close relationships. Scores on each subscale were summed and low scores on both subscales were reflective of a secure attachment

style. No cutoff scores are available to place individuals into attachment style categories, thus correlations were used to examine the relationship between subscales and measures.

All 53 respondents completed the ECR-S. Respondent scores on the anxiety subscale ranged from 6 to 39, with a mean of 20.25 points, a standard deviation of 7.39 points, and a median of 20. Scores on the avoidance subscale ranged from 6 to 29, with a mean of 18.36 points, a standard deviation 5.92, and a median of 18 points (see Table 5). In the Wei et al. (2007) study, they administered the ECR-S as a standalone measure to a sample of undergraduate students (N=65). Respondents from this study had a mean score of 22.45 on the anxiety subscale, with a standard deviation of 7.14, and a mean score of 14.97 on the avoidant subscale, with a standard deviation of 6.40 (Wei et al., 2007, 198). Parents included in the study, when compared to the undergraduate sample, displayed a greater discomfort depending on others, which is theoretically based on an underlying belief that others will not help them during times of distress (attachment avoidance), and a lesser degree of anxiety regarding a fear of rejection or abandonment, that is theoretically based on a negative assessment of the self (attachment anxiety).

A one way ANOVA of variance was utilized to determine if there were significant differences in scores on the ECR-S subscales based on the number of sessions attended with the current therapist. Respondents were divided into three categories: Group 1 had attended 4-10 sessions, Group 2 attended 11-24 sessions, and Group 3 had attended 25 or more sessions with the current therapist. No significant differences were found between these groups on the respondent ECR-S avoidance subscale scores ($p=.234$) or on the respondent ECR-S anxiety subscale scores ($p=.403$).

Relationship Between ECR-S Subscales and WAI-SR

Pearson's correlations were used to test relationships between two quantities in the Pearson product-moment correlation coefficient. Pearson correlation scales were used to test four things: 1) if participant's scores on the anxious attachment subscale of the ECR-S were correlated with scores on the WAI-SR; 2) if participant's scores on the anxious attachment subscale of the ECR-S were correlated with bond subscale scores on the WAI-SR; 3) if participant's scores on the avoidant subscale of the ECR-S were correlated with scores on the WAI-SR; and 4) if participant's scores on the avoidant subscale of the ECR-S were correlated with bond subscale scores on the WAI-SR.

All respondents' scores were used in the correlations. No significant relationship was found between respondent scores on the ECR-S anxiety subscale and respondent scores on the WAI-SR total score ($r=.05$, $n= 53$, $p=.723$) or on the WAI-SR bond subscale score ($r= -.103$, $n=53$, $p= .463$). In addition, there was no significant relationship between respondent scores on the ECR-S avoidance subscale and respondent scores on the WAI-SR total score ($r= -.037$, $n= 53$, $p=.790$) or on the WAI-SR bond subscale score ($r= -.127$, $n=53$, $p= .365$) (see Table 6).

As previously noted, respondents were placed into groups based on the number of sessions attended with the current therapist, where Group 1 had attended 4-10 sessions, Group 2 attended 11-24 sessions, and Group 3 had attended 25 or more sessions with the current therapist. The same correlations were run in each group, comparing the anxiety and avoidance subscales on the ECR-S with the overall WAI-SR total score and the WAI-SR bond subscale score. There were no significant correlations found for the ECR-S subscales and the WAI-SR overall or WAI-SR bond subscale for the parents who had attended between 4 and 10 sessions with the current therapist (Group 1, $n=19$) or parents who had attended 25 or more sessions with

the current therapist (Group 3, $n=19$). However, for parents who had attended 11 to 24 sessions with the current therapist, there was a significant, strong negative correlation between the ECR-S avoidance subscale and WAI-SR bond subscale score ($r= -.641$, $n=14$, $p=.014$, two tailed). The negative correlation suggests that as avoidance on the ECR-S increased, the parent's endorsement of the parent-therapist bond on the WAI-SR was weaker. In other words, less avoidant parents, during sessions 11 through 24 of treatment, endorsed a stronger parent-therapist bond on the WAI-SR (see Table 6).

CHAPTER V

Discussion

It was the purpose of the current study to explore the parent-therapist alliance through the lens of attachment theory, and to determine what, if any, relationship may exist between parental attachment tendencies and the strength of the parent-therapist alliance, as measured by WAI-SR. Overall, correlations suggested there was no significant relationship between the strength of the parent-therapist working alliance, as measured by the WAI-SR, and parental avoidance or anxiety in global attachment relationships measured by the ECR-S. This finding raises a few questions about the nature of the parent-therapist relationship in child therapy that warrant further attention.

Parent-Therapist Relationship as a Working Alliance

It may have been premature to assume that all of the parents in the current study or all parents with children in therapy form an alliance with their child's therapist. The majority of the studies utilizing forms of the Working Alliance Inventory to measure alliance waited until the third or fourth individual session with the current therapist (Hawley & Weisz, 2005; Horvath & Greenberg, 1989; Kanninen et al., 2000). Presumably, this is because it gives the client and therapist time to establish a rapport, as well as time to discuss some of the goals and tasks of therapy (Horvath & Greenberg, 1989). However, it is unclear how this timeframe for the development of the alliance might translate for parents with children in therapy, particularly in a setting such as the community mental health clinic that served as the site for this study, where the clinicians engage with parents in a variety of ways (e.g. little or no participation, parent check-ins, parent participation in partial or full sessions, parent participation in individual sessions with the child therapist).

This researcher attempted to explore the various ways in which parents participated by asking them to select one or more statements that applied to them about participation in the child's treatment. While the majority of participants (90.6%) in the current study indicated they had participated in full sessions with the current child therapist, in which the child may or may not have been present, the exact number of these sessions was not captured in the survey responses. Thus, it is unclear if parents included in the study had participated in three to four full sessions, or spent the equivalent amount of time checking in with the child's therapist. In addition, two parents indicated they had little contact with the child's treatment provider and one could argue that it would be quite difficult, in those cases, for a parent-therapist alliance to have been established. This raises questions about whether alliance formation is possible when a parent typically does not accompany the child to treatment, either because of his or her own time constraints (e.g. parent works all afternoon and the adolescent child takes the bus to therapy appointments, another caregiver transports the child to treatment because the parent is not available to do so) or because therapy occurs in settings in which the parent may not always be present to participate (inpatient units, school-based therapy programs, residential treatment programs).

A premise of this, and other studies examining the parent-therapist relationship, was that the parent-therapist relationship could be fully understood using Bordin's (1979) conceptualization of the working alliance and the WAI measures (Kazdin et al., 2006; Kazdin & Whitley, 2006). Bordin's (1979) model, which includes the task, bond and goal components, was meant to encompass all change-inducing relationships from a variety of models representing various theoretical orientations. However, there has been some criticism of the model, suggesting that alliance theories and the measures derived from them are biased by practitioner and

investigator understanding of the relationship and, as such, variables are frequently limited to those that professionals assert are important in understanding the client-therapist relationship (Bedi, 2006). However, multiple studies have found that the client's understanding of the alliance may not correspond to therapist understanding of the alliance. In addition, clients have identified a number of variables contributing to the formation and strength of the alliance (counselor friendliness, setting, advice, humor, client self-understanding) that are not well accounted for in Bordin's (1979) theory (Bachelor, 1995; Mohr & Woodhouse, 2001). This suggests that factors that contribute to parent-therapist alliance formation in the current study may not have been sufficiently measured by the WAI-SR (Bedi, 2006).

Studies have found there is a relationship between the parent-therapist alliance and outcomes in child therapy (Garcia & Weisz, 2002; Kazdin et al.; 1997; Tolan et al., 2002), so it seems crucial that therapists and counselors working with children and families engage with parents in a way that supports the formation of a strong parent-therapist working alliance, regardless of treatment setting. In addition, child therapists and counselors should consider what other relational variables may be important to the parent-therapist working alliance, including those that may be unique to that particular therapeutic relationship. Future studies, perhaps those that are qualitative and longitudinal in design, should explore the components to the parent-therapist working alliance, how it is formed, and how it is maintained throughout the course of treatment. These studies would benefit from gaining the perspective of not only the child therapist, but also by gathering data from parents with children in therapy.

Child Therapist as an Attachment Figure

This study found no correlation between parental attachment tendencies in close relationships, as measured by the ECR-S, and the strength of the parent-therapist alliance.

However, there are a number of ways to measure attachment styles, including measures for adult romantic relationships (Hazan & Shaver, 1987), caregiver-child dyads (George, Kaplan & Main, 1987; van Ijzendoorn, 1995), the client-therapist relationship (Mallinckrodt, Gantt & Coble, 1995), and close adult relationships more generally (Bartholomew & Horowitz, 1991; Brennan, Clark & Shaver, 1998; Fraley, Waller & Brennan, 2000; Wei, Russell, Mallinckrodt & Vogel, 2007). Previous research has shown the client's attachment to the therapist has a stronger correlation to the quality of the working alliance than do the client's global attachment tendencies in close adult relationships with family members, friends, or romantic partners (Parish & Eagle, 2003; Smith et al., 2010). Theoretically, clients will re-enact internal working models of attachment in the therapeutic relationship, which are then explored, challenged, and revised during the course of therapy (Bowlby, 1988), eventually leading the client to generalize secure attachment tendencies in all close relationships (Jones, 1983). So, throughout the course of individual therapy the client attachment tendencies toward the therapist may be fundamentally different from attachment tendencies in other close relationships. While Kazdin and Whitley's (2006) study found that parental pre-treatment social relationships were significantly correlated to scores on the WAI-SR, for the current study it may have been more appropriate to explore the quality of the parent-therapist attachment (particularly for the 21 parents who reported they "always" attended and participated in full sessions with the child), rather than utilizing a measure, such as the ECR-S, that explores global attachment patterns.

Bowlby (1973) suggested that, in individual therapy, clients will re-enact internal working models of attachment with the therapist, who becomes an attachment figure. However, it may be premature to assert that parents in the current study formed an attachment to the child's therapist. Parish and Eagle (2003) identified nine essential characteristics, based on theoretical

literature, they believed to be present in attachment relationships with both early caregivers and in secure attachment relationships that form between clients and therapists. The researchers asserted that study participants with a secure attachment to the therapist looked up to the therapist (stronger/wiser), turned to the therapist in times of distress, believed the therapist was unique or irreplaceable, and identified that they had strong feelings toward the therapist. In addition, Parish and Eagle (2003) asserted that participants found the therapist to be emotionally responsive, clients evoked mental representations of the therapist in times of distress, and, in general, clients relied on the therapist as a “secure base,” which helped them to feel more confident in their work and exploration outside of therapy.

It is unclear whether or under what conditions the components of an attachment relationship can exist (according to Bowlby’s assertions) in the parent-therapist relationship. As previously noted, parents in this study participated in the child’s treatment in a variety of ways. Some parents did not engage in ongoing, regular contact with the therapist, and it may be likely that some parents did not form an attachment relationship with the child’s therapist or formed only tenuous attachments with therapists. Thus, these parents theoretically could have approached and assessed the parent-therapist relationship with relative freedom from working models of attachment that shape expectations about whether or not others will be available when he or she attempts to elicit support or protection (avoidance), or views of the self as someone who is worthy, or not worthy, of protection and support from others during times of distress (anxiety) that are present in other close relationships (Bowlby, 1973). Or, those parents who may not have formed an attachment relationship with the child’s therapist could have based their assessment of the relationship on the child’s attachment to the therapist. However, the quality of the child’s attachment to the therapist was not explored in this research. In either case, parental

attachment patterns in close relationships would not have been correlated with the formation and quality of the parent-therapist working alliance..

Other lines of research suggest that early attachment patterns may influence the therapy relationship, even when the therapist does not become an attachment figure (Schuengel & van Ijzendoorn, 2001). Parental attachment patterns might influence the strength and formation of the parent-therapist working alliance; however it is certainly only one of many variables that may do so. These variables might include the therapist's skill level, length of time in therapy, perceptions of the therapist, attitudes or beliefs about participation in therapy, treatment involvement, child-therapist alliance, level or type of services provided, symptom improvement, goodness of fit between parent and therapist, the child's attachment tendencies, or even therapist attachment style.

The degree to which parental attachment style affects the parent-therapist relationship remains unclear. Child therapists may benefit from considering parental attachment style, along with a number of other factors, in assessing the strength and formation of the parent-therapist alliance, when they encounter barriers to alliance formation with parent(s) of children in therapy or when ruptures occur in the parent-therapist alliance. Future studies in this area should attempt to adopt methods that control for other factors that could influence the parent-therapist working alliance such as treatment modality, length of participation in treatment and the frequency or type of parental involvement in the child's therapy. Additional research should consider or explore whether an attachment relationship actually exists between the parent and the child's therapist and, if so, under what conditions might this type of relationship develop. This research should also explore the child's attachment to his or her therapist, and how this attachment may

influence the parental attachment to the child therapist or the formation and strength of the parent-therapist working alliance.

Viewing The Parent Therapist Alliance as a Dynamic Entity

Luborsky (1976) suggested that the working alliance is a dynamic, rather than static, entity that responds to the changing demands of therapy as sessions proceed. Although the current study did not measure alliance development over time, this researcher did attempt to account for shifts in the alliance throughout the course of therapy by placing respondents into groups based on number of sessions (Group 1 attended 4-10 sessions, Group 2 attended 11-24 sessions, and Group 3 attended 25 or more sessions) and comparing them. A one-way ANOVA determined there were no significant group differences on overall WAI-SR score, but the p value measuring group differences on WAI-SR bond subscale was nearing significance ($p=.084$). This suggests that parent assessment of the parent-therapist bond may vary based on number of sessions attended with the current therapist.

Horvath and Marx (1990) asserted there was systematic fluctuation within individual treatment dyads that followed a high-low-high pattern. At the beginning of therapy, the alliance is dominated by perceptions of the therapist as caring or supportive (Horvath & Luborsky, 1993). The high-low-high model suggests there may be ruptures in the therapeutic alliance at different times and for different reasons, such as in later phases of treatment when the therapist begins to challenge a client's dysfunctional patterns (Horvath & Luborsky, 1993). Kanninen et al. (2000) found there were no differences in alliance endorsement based on attachment patterns in early phases of therapy with victims of political violence; however, they noted that alliance development over time varied based on client attachment style. The current study's findings also support a high-low-high alliance development that may also be reflective of attachment

tendencies of parents with children in therapy. In particular, there was a significant, strong negative correlation between attachment avoidance and parent assessment of the parent-therapist bond on the WAI-SR among parents whose children had attended 11-25 sessions with the current therapist.

Kanninen et al. (2000) reported that dismissive individuals in their study, who have a high level of attachment avoidance, were characterized as having negative memories of early childhood experiences that they coped with by withdrawing. According to Bowlby (1973), this stems from negative views of whether or not others will be available when the dismissive individual attempts to elicit support or assistance. Dismissive individuals are often described as being more comfortable engaging at a cognitive level, which unconsciously helps them avoid the risk of being made aware of distressing information (Kanninen et al., 2000). Therefore, parents with higher attachment avoidance may have less flexibility in approaching ruptures in the parent-therapist alliance when they occur. Instead, they may distance themselves or hide behind a negative assessment of the parent-therapist bond. Therefore, inevitable ruptures could have a more significant effect on the parent-therapist bond for these parents, when compared to their anxious or secure counterparts, as the findings of this study suggest.

According to the findings of this study, child therapists may benefit from considering how parental attachment patterns may influence alliance development and strength throughout the course of the child's treatment. In particular, clinicians may benefit from being more attuned to shifts in the parent-therapist alliance when they occur by checking in regularly with the parent(s) to elicit information about agreement on treatment goals and tasks of therapy, as well as ruptures that may have occurred in the parent-therapist bond. Future research should explore how

parents and child therapists approach or negotiate inevitable ruptures in the parent-therapist alliance throughout the course of treatment.

Study Limitations

The current research was conducted at a community mental health clinic with an expansive population. Not only was the population demographically representative of the community in which the clinic is based, but study participants reported a variety of reasons for initiating the child's treatment, practitioners reported utilizing a variety of theoretical orientations, and parents reported a number of different ways in which they engaged in the child's treatment. The variability of the sample theoretically made it somewhat easier to make inferences about the generalizability of findings, but it created problems in this research regarding controlling for confounding factors that may have had an influence on the formation and strength of the parent-therapist working alliance. Although an attempt was made to address alternative explanatory variables, such as session number or participation in the child's treatment, in the end the sample size was not large enough to control for these factors or analyze them using multivariate techniques. In addition, there were a number of variables that were not explored that may have had an effect on the strength and formation of the parent-therapist alliance, including the amount of time spent with the child therapist in session or in parent check-ins, parental beliefs or views about therapy efficacy, treatment model, goodness of fit, symptom improvement, therapist attachment style, child attachment style or other parental pre-treatment characteristics.

The low response rate (34%), small sample size (N=53), and convenience sampling techniques also weakened the internal and external validity of the current study because it pointed to the likelihood that there was some bias inherent in the responses based on who was

available, willing, and eligible to participate in the current study. In particular, two scenarios could have led to the inflated WAI-SR scores among study participants, which were quite high for this study. First, parents who had a positive experience with the child's therapist may be more likely to have a more positive view of the clinic in general and other staff members. So, when the clinic receptionist approached those parents, it seems possible they might have been more willing to participate in the study than a parent who had a negative view of the clinic or the child's treatment provider. Second, studies have found that the strength of the parent-therapist alliance in child therapy is correlated with treatment completion (Garcia & Weisz, 2002; Kazdin et al., 1997). The study utilized convenience sampling methods that would not have allowed for the inclusion of parents who terminated the child's therapy prematurely. It seems likely that those parents who were available in the clinic waiting room to participate in the current study would have rated the strength of the parent-therapist alliance higher than their counterparts who had possibly prematurely terminated therapy. It may also be possible that parents with the most anxious or avoidant attachment tendencies may not have sought out therapy for their child, thus they would not have been included in the current study.

In addition, there is always some bias inherent in self-report measures because participants may desire to portray themselves in a socially desirable light (e.g. more engaged in treatment, having more secure relational tendencies or a stronger alliance with the child's therapist). Therefore, respondents' reports may not have been an accurate reflection of the working alliance or attachment tendencies. No therapist scores for the WAI-SR were collected in this study, nor were therapist asked to provide information about the attachment tendencies of the parents participating in the study. Thus, there was no information available to corroborate parental self-reports.

There is always some concern when utilizing pre-created, validated instruments for research, that the instrument is reliably measuring the variable constructs. As previously mentioned, there is some criticism that the client's understanding of the alliance may not correspond to current theoretical conceptualizations of the working alliance (Bedi, 2006). This suggests the factors that contribute to parent-therapist alliance formation may not have been sufficiently measured by the WAI-SR in the current study. In addition, there are two traditions of adult attachment research, and there has been some suggestion that they focus on different domains of relational experience and reflect differing conceptualizations of adult attachment. Attachment interviews focus on the dynamics of internal, and presumably unconscious, working models of attachment that are revealed indirectly during an interview about early childhood experiences (Bartholomew & Shaver, 1998). Perhaps. Self-report questionnaires reportedly measure experiences in close relationships of which the person is more aware and thus can describe fairly accurately (Bartholomew & Shaver, 1998). Perhaps unconscious attachment tendencies, that can be uncovered during an interview, could be correlated to the strength and formation of the parent-therapist working alliance under certain conditions.

Personal biases are always present in research, and this study is not exception. A personal interest in attachment theory, stemming from training in a graduate program that heavily utilizes psychodynamic theory, contributed to the formation and exploration of the current research question. This research focused on only one parental pre-treatment characteristic that theoretically had the potential to affect the parent-therapist working alliance. However, there are numerous other pre-treatment characteristics that require attention in further research.

Further Research

Parental attachment styles and the parent assessment of the parent-therapist working alliance should continue to be a topic of further research in future studies. Small sample size, sample variability, and study design made it difficult to control for confounding variables that could have influenced the parental assessment of the parent-therapist alliance. Further research regarding parental attachment style and the parent-therapist working alliance should attempt to explore or control for confounding variables. This could be done in a variety of ways, including through the study of child therapy models that engage with parents in a specific way (e.g. parent guidance, parent-management training, parent-child interactional therapy) or through the recruitment of a larger sample size that would allow for multivariate data analysis. These studies should utilize sampling techniques that have the potential to recruit parents who have terminated treatment, and a longitudinal study design that measures alliance formation and strength throughout the course of treatment. These studies might also benefit from the collection of data regarding provider skill level, caregiver relationship to the child in treatment, provider attachment style, and provider assessment of the parent-therapist alliance.

Hawley and Weisz (2005) asserted that there is a greater need for alliance research in child therapy, particularly in regards to the parent-therapist alliance. Current theories and measures used to assess the parent-therapist alliance have been adapted from those used to explore the client-therapist relationship in individual treatment. However, this study demonstrated that parents, particularly those in a community mental health clinic, interact with the child's therapist in a variety of ways that may not align with those experienced by a client in individual therapy. Thus, the parent-therapist alliance may be quite different than the client-therapist alliance. Research needs to be done in order to gain a greater understanding of the

parent-therapist alliance in its own right. This exploratory research should include the perspectives of child therapists and parents, to ensure that the conceptualization of the parent-therapist alliance accounts for all the variables that could contribute to the formation and strength of that alliance (Bedi, 2006).

According to one study, 40 percent of the variance in treatment outcomes will be due to client pretreatment qualities and extra-therapeutic influences (Lambert, 1992), such as client ego strength, social context, or previous and current social or familial relationships. Given the importance of the parent-therapist alliance in child therapy outcomes, further research on other variables, including other parental pre-treatment characteristics that may be correlated with the quality, formation or strength of the parent-therapist working alliance in child therapy. Further research in this arena has the potential to increase the efficacy of child therapy. Additionally, it may have limited applicability to other settings and professions working with children and parents, such as daycares, schools, or healthcare facilities.

Conclusion

The parent-therapist alliance is one of the least emphasized relationships in theoretical or empirical literature referring to child therapy, and was the focus of the current study, which explored the relationship between parental attachment tendencies and parental assessment of the parent-therapist working alliance for parents with children receiving individual therapy with clinicians at a community mental health clinic. No correlation was found between attachment patterns and the strength of the working alliance in the entire sample. However, when parents were placed into groups based on number of sessions attended, a significant, strong negative correlation was found between attachment avoidance and the parent-therapist bond for parents with children who had attended 11 to 25 sessions with the current therapist. This suggests that

parental attachment style may be related to the formation and strength of the parent-therapist working alliance over time.

Although the study was limited in several ways, the findings of this study may suggest that child therapists could benefit from considering how parental attachment patterns may influence alliance development and strength throughout the course of the child's treatment. In addition, child therapists and other professionals working with children and families in other settings (e.g. schools, health-care settings, residential treatment facilities) could benefit from checking in regularly with the parent(s) to elicit information about agreement on treatment plans or learning goals, as well as ruptures that may have occurred in the parent-professional relationship.

It is crucial that therapists and counselors working with children and families engage with parents in a way that supports the formation of a strong parent-therapist working alliance, regardless of treatment setting, as studies have found there is a relationship between the parent-therapist alliance and outcomes in child therapy (Garcia & Weisz, 2002; Kazdin et al.; 1997; Tolan et al., 2002). Considering the lack of empirical research on the parent-therapist alliance in child therapy, further research is needed to understand the nature of the parent-therapist alliance, including information about how it is formed and how it is maintained throughout the course of treatment. In addition, given the importance of the parent-therapist alliance on treatment outcomes, further research is needed to explore other parental pre-treatment characteristics that may be related to the formation and strength of the parent-therapist alliance in child therapy.

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Appendix A

Receptionist Recruitment Script

The clinic is working with a graduate student on a study exploring the relationship between a parent's experiences in close relationships and the relationship the parent develops with the child's individual therapist. To participate in the study, you will be asked to complete a short questionnaire, which should take roughly 15-20 minutes. In return, you will have the opportunity to enter a raffle for a \$25 Walmart gift card.

You'll find more information about the study in this packet, along with the survey. You can fill out the survey while you wait today and return it to me in a sealed envelope, or take it with you and mail it directly back to the researcher in a pre-posted envelope.

Participation in this study is voluntary. Whether or not you chose to participate in the study will not affect your child's therapy. Your child's therapist will not know whether or not you have participated in the survey, nor will completed surveys be made available to your child's treatment provider here at the clinic.

Appendix B

Survey Packet Cover Letter

Dear Potential Study Participant:

You are being asked to participate in a study regarding your relationship with your child's individual therapist and how this relates to your personal experiences in close relationships. To participate in this study, you will need to fill out a 3-page questionnaire attached to this form, which should take about 15-20 minutes of your time. In exchange, you will be entered in a raffle with the opportunity to win one of four \$25 Walmart giftcards.

Instructions for Participation:

Please read and sign the Informed Consent Form before completing the survey, which is also included in this packet. You may do this now or take the packet home to complete it at your convenience. You have two options to return the survey and Consent:

- (1) Seal the survey and signed Informed Consent Form in the attached envelope and give it to the clinic receptionist; or
- (2) Mail it directly to this researcher, at your convenience, in a pre-paid envelope that you will find at the clinic desk.

Your participation is voluntary, so you need not fill out any or all of the survey. You can return it to the receptionist sealed in the envelope unused.

Please be aware that no one at the agency, including your child's therapist, will know whether you took the survey nor will they have access to your answers.

Thank you for your time and interest in this matter!

Appendix C

Informed Consent Letter

January 1, 2011

Dear Parent,

My name is Jessica Taylor-Pickford. I am conducting a study to see whether parents' experiences in close relationships are associated with the relationship they form with their child's individual therapist. This research will be used for the completion of a thesis project, which is a requirement for a Master of Social Work degree at the Smith College School for Social Work. In addition, this research may be used in future presentations and publications to professional audiences. It is my hope that the results of the study might help child therapists understand more about developing strong relationships with both children and parents who seek counseling.

Your participation in this study has been requested because your child is attending treatment at [Name of Agency] and has been assigned to an individual therapist. You are eligible to be included in this study if you have: (1) full custody of your child; (2) lived, at least part-time, with your child since the start of treatment; and (3) taken your child to a minimum of four sessions with his/her current therapist. The survey is designed to be completed by only one person. In instances where more than one parent meets the above criteria, each parent must complete and return their own survey.

If you choose to participate, please complete the survey attached to this letter, which should take about 15-20 minutes. It includes 3 sections. The first section asks about basic demographic information. The second is a questionnaire that will ask about your experience with your child's therapist. The third is a short survey about your experiences in relationships in general. After you are done, place the signed Consent and completed survey in the envelope provided. You may return the envelope to the clinic receptionist to mail or you can mail the survey back at your convenience.

Parents who participate in this study and provide a contact email will be entered into a drawing for a \$25 Walmart eGiftcard. A total of four winners will be selected when data collection for this research has ended. Winners will be emailed the \$25 Walmart eGiftcard to the email address provided below. An additional benefit of participation is that you may find it helpful to answer questions that prompt you to think about your relationship with your child's treatment provider.

Please be aware that your child's therapist will not be informed of your participation, and completed surveys will only be available to me. The survey you complete will not be seen or used in any way by staff at [Name of Agency]. Other affiliates of the project, including my research advisor and statistician, will have access to the data you provide once all identifying information has been removed. In future presentations and publications to professional audiences, your identity will be protected; no names or identifying information will be used in

the reporting of the data. Strict confidentiality will be maintained, consistent with federal regulations and the mandates of the social work profession. When the data is no longer needed, it will be destroyed.

Your participation is completely voluntary. You are free to refuse to participate and/or answer specific questions, and to withdraw from the study at any time before April 15, 2011. If you decide to withdraw, all materials pertaining to you will be immediately destroyed. If you have additional questions about the study or wish to withdraw, please feel free to contact me at the contact information below. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me at the number listed below or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Your participation will be greatly appreciated. Thank you for your time and consideration. You will find a copy of this form to keep for your records attached at the end of this packet.

Jessica Taylor-Pickford
(919) 681-1726

YOUR SIGNATURE INDICATES THAT:

- YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION;
- YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND
- YOU AGREE TO PARTICIPATE IN THE STUDY

Participant Signature: _____ Date: _____

Participant Name (please print):

Researcher Signature: _____ Date: _____

If you would like to be entered to win a \$25 Walmart eGiftcard, please include your email address below. Please note that email addresses will only be used to distribute the contest prizes, which can be sent via email. It will not be used for any other purposes.

Participant Email: _____

Appendix D

Informed Consent Copy

PLEASE KEEP THIS COPY FOR YOUR RECORDS

January 1, 2011

Dear Parent,

My name is Jessica Taylor-Pickford. I am conducting a study to see whether parents' experiences in close relationships are associated with the relationship they form with their child's individual therapist. This research will be used for the completion of a thesis project, which is a requirement for a Master of Social Work degree at the Smith College School for Social Work. In addition, this research may be used in future presentations and publications to professional audiences. It is my hope that the results of the study might help child therapists understand more about developing strong relationships with both children and parents who seek counseling.

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If you choose to participate, please complete the survey attached to this letter, which should take about 15-20 minutes. It includes 3 sections. The first section asks about basic demographic information. The second is a questionnaire that will ask about your experience with your child's therapist. The third is a short survey about your experiences in relationships in general. After you are done, place the signed Consent and completed survey in the envelope provided. You may return the envelope to the clinic receptionist to mail or you can mail the survey back at your convenience.

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Please be aware that your child's therapist will not be informed of your participation, and completed surveys will only be available to me. The survey you complete will not be seen or used in any way by staff at [Name of Agency]. Other affiliates of the project, including my

research advisor and statistician, will have access to the data you provide once all identifying information has been removed. In future presentations and publications to professional audiences, your identity will be protected; no names or identifying information will be used in the reporting of the data. Strict confidentiality will be maintained, consistent with federal regulations and the mandates of the social work profession. When the data is no longer needed, it will be destroyed.

Your participation is completely voluntary. You are free to refuse to participate and/or answer specific questions, and to withdraw from the study at any time before April 15, 2011. If you decide to withdraw, all materials pertaining to you will be immediately destroyed. If you have additional questions about the study or wish to withdraw, please feel free to contact me at the contact information below. If you have any concerns about your rights or about any aspect of the study, I encourage you to call me at the number listed below or the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Your participation will be greatly appreciated. Thank you for your time and consideration. You will find a copy of this form to keep for your records attached at the end of this packet.

Jessica Taylor-Pickford
(919) 681-1726

YOUR SIGNATURE INDICATES THAT:

- YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION;
- YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS; AND
- YOU AGREE TO PARTICIPATE IN THE STUDY

Please return original signed copy with your completed survey. This copy is for your records only.

Appendix E

Survey: Participant Demographic Information

Please Answer the following questions about yourself.

1. **Gender:** _____
2. **Age:** _____
3. **Race/Ethnicity:** _____
4. **Marital Status:** Married Divorced In a Committed Relationship
 Single Other: _____
5. Have you ever attended your own individual therapy? Yes No
6. Relationship to your child who is in treatment:
 Biological parent Adoptive parent Step-parent (with legal custody)
 Other relative (with legal custody) Other: _____
7. How long have you lived with your child who is in treatment (in years): _____

Please answer the following information about your child who is in treatment.

1. **Gender:** _____
2. **Age:** _____
3. **Race/Ethnicity:** _____

Please answer the following questions about you and your child's participation in therapy.

1. How long has your child been seeing his/her therapist (in months): _____
2. How many sessions (estimate) has your child had with his/her therapist: _____
3. Briefly describe the issues that led you to seek therapy for your child?

4. What is your role in you child's treatment (check all that apply):

- I rarely speak with my child's mental health provider.
- I attended the initial intake session (with or without my child).
- I briefly check in with my child's mental health provider at the beginning or end of most sessions to discuss what is happening in treatment and/or what is happening at home/school.
- I contact my child's mental health provider outside of regularly scheduled appointments to discuss issues that are happening in treatment and/or at home/school.
- I attend and participate in full sessions with my child and his/her therapist. If so, how often? (circle the best response)

Rarely

Sometimes

Often

Always

Appendix F

Survey: Parent Therapist Alliance Measure (WAI-SR)

Instructions:

Below is a series of statements about experiences people might have with therapy or the therapist. Some items with an underlined space refer directly to your therapist -- as you read the sentences, *mentally* insert the name of your child's therapist in place of _____ in the text. You do not need to fill in the name of the child's therapist on this form. For each statement, please take your time to consider your own experience and then circle the appropriate answer.

1. As a result of these sessions, I am clearer now on how my child or I might be able to change.

Seldom Sometimes Fairly Often Very Often Always

2. What I am doing in my interactions with my child's therapist gives me different ways of looking at problems.

Seldom Sometimes Fairly Often Very Often Always

3. I believe _____ likes me.

Seldom Sometimes Fairly Often Very Often Always

4. _____ and I collaborate on setting goals for my child's therapy.

Seldom Sometimes Fairly Often Very Often Always

5. _____ and I respect each other.

Seldom Sometimes Fairly Often Very Often Always

6. _____ and I are working on mutually agreed upon goals for my child.

Seldom Sometimes Fairly Often Very Often Always

7. I feel that _____ appreciates me.

Seldom Sometimes Fairly Often Very Often Always

8. _____ and I agree on what is important for my child and I to work on.

Seldom Sometimes Fairly Often Very Often Always

9. I feel _____ cares for me, even when I do things s/he does not approve of.

Seldom Sometimes Fairly Often Very Often Always

10. I feel the things I do in my interactions with my child's therapy will help me accomplish the changes that I want.

Seldom Sometimes Fairly Often Very Often Always

11. _____ and I have established a good understanding of the changes that would be good for my child or me.

Seldom Sometimes Fairly Often Very Often Always

12. I believe the way we are working with my child's problem is correct.

Seldom Sometimes Fairly Often Very Often Always

Appendix G

Survey: Attachment Measure (ECR-S)

Instructions:

The following statements concern how you feel in close relationships. I am interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Please mark your answer using the following rating scale:

1	2	3	4	5	6	7
Strongly Disagree	Disagree	Slightly Disagree	Neutral	Slightly Agree	Agree	Strongly Agree
1. It helps to turn to others in times of need.						_____
2. I need a lot of reassurance that I am loved by others.						_____
3. I want to get close to others, but I keep pulling back.						_____
4. I find that others do not get as close as I would like.						_____
5. I turn to others for many things, including comfort and reassurance.						_____
6. My desire to be very close sometimes scares people away.						_____
7. I try to avoid getting close too others.						_____
8. I do not often worry about being abandoned.						_____
9. I usually discuss my problems and concerns with others.						_____
10. I get frustrated if others are not available when I need them.						_____
11. I am nervous when others get too close to me.						_____
12. I worry that others will not care about me as much as I care about them.						_____

Thank you again for your participation.

Appendix H

WAI-SR Permission for Use

[Email Correspondence 10/17/2010]

Dear Jessica,

You are most welcome to use the WAI-SR in your project!

Best wishes,

Bob Hatcher

Robert L. Hatcher, Ph.D.
Director, Wellness Center
Faculty, Graduate Psychology Program
The Graduate Center/ The City University of New York
365 Fifth Avenue, Room 6422
New York, NY 10016
(T) 212-817-7029; (F) 212-817-1602
rhatcher@gc.cuny.edu
<http://web.gc.cuny.edu/wellness/>

Dr. Hatcher-

I am a second year MSW student attending Smith College. The completion of my degree requires the completion of a thesis project. My current project will explore the relationship between parent's internal working model of attachment and their assessment of the working alliance with the child's therapist. A brief description of the study is provided to you below. My hope is to gain permission from you to use the WAI-SR for this project. Thank you for your consideration of this matter.

Best,
Jessica Taylor-Pickford

Appendix I

ECR-S Permission for Use

[Email Correspondence 12/19/2010]

Dear Jessica,

Please feel free to use my scale (see my website for scale and scoring information).

Best wishes for your study!

Meifen

Meifen Wei, Ph.D.
Associate Professor
Department of Psychology
W112 Lagomocino Hall
Iowa State University
515-294-7534 (office)
515-294-6424 (fax)
<http://www.psychology.iastate.edu/~wei/>

Professor Wei,

I am a second year MSW student attending Smith College. The completion of my degree requires the completion of a thesis project. My current project will explore the relationship between parent's internal working model of attachment and their assessment of the working alliance with the child's therapist. A brief description of the study is provided to you below. My hope is to gain permission from you to use the ECR-S for this project. Thank you for your consideration of this matter.

Best,
Jessica Taylor-Pickford

Appendix J

Smith College HSRB Approval Letter



Smith College
Northampton, Massachusetts 01063
T (413) 585-7950
F (413) 585-7994

December 21, 2010

Jessica Taylor-Pickford

Dear Jessica,

Your revised materials have been reviewed and they are fine. If you find that you don't get enough participants and you have to go to plan B, we will quickly review any changes you have to make. We are glad to approve your study and wish you good luck with your recruitment.

Please note the following requirements:

Consent Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

This is an interesting study and should make a useful contribution.

Sincerely,

A handwritten signature in cursive script that reads 'Ann Hartman' followed by a flourish.

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Elissa Baldwin, Research Advisor

Appendix K

Aurora Mental Health HSRB Approval Letter



11059 East Bethany Drive, Suite 200 • Aurora, Colorado 80014 • TEL 303-617-2574 • FAX 303-856-2927

Aurora Research Institute

December 22, 2010

Jessica Taylor – Pickford
Smith College School for Social Work

RE: Aurora Mental Health Center IRB 2010-2011 #5: Parents with Children in Therapy: Parental Attachment Styles and the Parent – Therapist Alliance

Dear Ms Taylor-Pickford:

This is to inform you that the AuMHC Institutional Review Board has reviewed the above-referenced research protocol, patient-subject informed consent and clinician-subject informed consent and approved your proposal and request to use patients from the Aurora Mental Health Center. This approval is contingent on your College's Human Subject's Committee approval. I know this occurred last week.

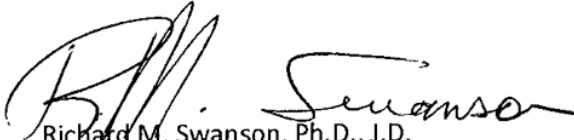
The approval period will begin January 1, 2011 and will end on December 30, 2011.

The Aurora City clinic site approved is: Child and Family Services South
14301 E. Hampden Avenue

Approval will be conditional upon your compliance with the following requirements:

- Use of the approved **Informed Consent Templates**.
- The following must be promptly reported to AuMHC IRB: changes to the study sites and all unanticipated problems that may involve risks or affect the safety or welfare of subjects or others, or that may affect the integrity of the research.
- All protocol amendments and changes to approved research must be submitted to the IRB and not be implemented until approved by the IRB except where necessary to eliminate apparent immediate hazards to the study subjects.

- Compliance with all federal and state laws pertaining to this research and with AuMHC IRB approved protocol.
- The study cannot continue after December 30, 2011 until re-approval by the AuMHC IRB. A Study Renewal Report must be completed and returned to AuMHC IRB prior to the expiration of the approved period.

A handwritten signature in black ink, appearing to read "R.M. Swanson". The signature is fluid and cursive, with the first name "R.M." being more compact and the last name "Swanson" being more extended.

Richard M. Swanson, Ph.D., J.D.
Chair of AuMHC IRB

Copy: Chris Beasley, Psy.D.
Co-Chair
Aurora Mental Health Center IRB

Kathie Snell, Deputy Director
Child and Family South

Holly Cappello, Program Director
Child and Family South

Enclosures

Appendix L

Study Expansion Approval Email

[Email Correspondence 2/4/2011]

Subject: Study Expansion Approved

Please contact Mara Kailin to make the arrangements and get things going.

Richard M. Swanson, Ph.D., J.D.

Director

Aurora Research Institute

11059 E. Bethany Dr., Suite105

Aurora, Co 80014

tel 303-617-2574

and

Clinical Professor

Department of Psychiatry

Health Sciences Center

University of Colorado at Denver

Table 1

Therapist Demographics and Practice Information

N=19	Frequency	Percent
Gender		
Male	3	15.2
Female	16	84.2
Race/Ethnicity		
White/Caucasian	16	84.2
Black/African American	0	0
Hispanic/Latino	2	10.5
Asian	1	5.2
Degree/Licensure		
Doctorate (PhD/PsyD)	7	36.8
Licensed Clinical Social Work (LCSW)	5	26.3
Master of Social Work (MSW)	2	10.5
Licensed Professional Counselor (LPC), Licensed Marriage and Family Therapist (LMFT), Other Master's Degree (MA)	4	21.1
Theoretical Orientation (Note: Some therapists listed more than one)		
Psychodynamic	8	42.2
CBT/DBT	8	42.2
Family Systems	6	31.6
Solution Focused	1	5.2
Missing	2	10.5

Table 2

Sample Demographics (Parent)

N=53	Frequency	Percent
Parent Gender		
Male	7	13.2
Female	46	86.8
Parent Race/Ethnicity		
White/Caucasian	37	69.8
Black/African American	6	11.3
Hispanic/Latino	5	9.4
Native American	2	3.8
Asian	0	0
Biracial	3	5.7
Parent Relationship Status		
Married	28	52.8
Divorced	12	22.6
In a Committed Relationship	6	11.3
Single	6	11.3
Other: Separated	1	1.9
Parent Relation to Child in Treatment		
Biological Parent	41	77.4
Adoptive Parent	6	11.3
Other Relative (with legal custody)	6	11.3

Table 3

Sample Demographics (Child)

N=53	Frequency	Percent
Child Gender		
Male	25	47.2
Female	28	52.8
Child Race/Ethnicity		
White/Caucasian	28	52.8
Black/African American	4	7.5
Hispanic/Latino	5	9.4
Native American	2	3.8
Asian	0	0
Biracial	14	26.4

Table 4

Reasons for Attending Treatment

N=53	Frequency	Percent
Diagnoses	36	67.9
Mood Disorder	14	26.4
Attention Deficit Disorder (ADD/ADHD)	9	17
Anxiety	5	9.4
Post-Traumatic Stress Disorder (PTSD)	2	3.8
Schizophrenia	1	1.9
Asperger's Syndrome	1	1.9
Fetal Alcohol Syndrome (FAS)	1	1.9
Reactive Attachment Disorder (RAD)	1	1.9
Pervasive Developmental Disorder (PDD)	1	1.9
Borderline Personality Disorder (BPD)	1	1.9
Behavioral Issues	35	66
Not Specified	7	13.2
Anger/Aggression	15	28.3
Suicide/Self Harm	4	7.5
Sexual Acting Out	3	5.7
Oppositional	2	3.8
Attitude	2	3.8
Withdrawn	1	1.9
Hyper	1	1.9
Psychosocial Issues	10	18.9
Separation From a Parent	6	11.3
“Big Change”	2	3.8
Grief/Loss	1	1.9
Divorce	1	1.9
School Issues	6	11.3
Difficulty Concentrating	2	3.8
Suspension	1	1.9
Removed From Class	1	1.9
Not Specified	2	3.8
Trauma	7	13.2
Domestic Violence	2	3.8
Sexual Abuse	1	1.9
Other	1	1.9
Not Specified	3	5.7

Table 5

WAI-SR and ECR-S Scores

N=53			
	Mean	<i>SD</i>	Median
WAI-SR			
Total	48.79	9.74	50
Goal Subscale	16.62	3.6	18
Task Subscale	15.55	3.51	16
Bond Subscale	16.58	3.61	18
ECR-S			
Avoidance Subscale	18.36	5.92	18
Anxiety Subscale	20.25	7.39	20

Table 6

Pearson's *r* Correlations: Overall and Group by Session Number

	WAI-SR Total Score			WAI-SR Bond Score		
	<i>r</i>	<i>N</i>	<i>p</i>	<i>r</i>	<i>n</i>	<i>p</i>
All Respondents						
ECR-S Avoidance	-.037	53	.79	-.127	53	.365
ECR-S Anxiety	.050	53	.723	-.103	53	.463
4-10 Sessions						
ECR-S Avoidance	.242	20	.304	.209	20	.377
ECR-S Anxiety	.418	20	.067*	.083	20	.727
11-24 Sessions						
ECR-S Avoidance	-.449	14	.107	-.641	14	.014**
ECR-S Anxiety	-.235	14	.419	-.313	14	.277
25 + Sessions						
ECR-S Avoidance	-.077	19	.754	-.070	19	.777
ECR-S Anxiety	-.269	19	.266	-.32	19	.182

*Approaching significance

**Statistically significant value