

Self-reported Anxious- and Avoidant-related attachment correlated to interpersonal problems by patients starting psychotherapy

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Abstract

Attachment theory is an encompassing theory for understanding human reactions to life stressors, such as loss and separation, and interpersonal problems are common reasons for seeking psychotherapy. Psychotherapy may be an opportunity to revise insecure attachment and handle interpersonal problems. This study examined attachment styles and interpersonal problems in a clinical sample of psychotherapy patients ($n = 168$) at the start of psychotherapy. The main aim was to study how self-reported attachment styles, measured by the Attachment Style Questionnaire (ASQ), correlated with interpersonal problems measured using the Inventory of Interpersonal Problems (IIP). Avoidant-related and anxious-related attachment scales correlated positively to the total IIP scores. Inconsistent with findings in non-clinical samples, specific interpersonal problems in the dominant and affiliative parts of the IIP correlated positively to both the anxious-related and the avoidant-related attachment scales. The findings imply that a challenge for the therapist at the start of psychotherapy is to balance providing security with encouraging exploration of feelings, thoughts, and behaviour in the patient's interpersonal problems in current relationships. Exploring individual profiles of attachment styles helps to clarify motives in expressed interpersonal problems.

Keywords: Attachment style; Interpersonal problems; Patients; Psychiatry, Psychotherapy.

Introduction

Psychotherapy has been suggested to revise insecure internal working models of attachment, thereby providing an opportunity to make the exploration, expectations and handling in interpersonal relationships more adaptive (Bowlby, 1988; Holmes, 2001; Lawson,

Barnes, Madkins, & Francois-Lamonte, 2006; Levy, Meehan, Reynoso, Weber, Clarkin & Kernberg, 2006; Tasca, Ritchie, Conrad, Balfour, Gayton, Lybanon, et al., 2006; Travis, Binder, Bliwise & Horne-Moyer, 2001). Attachment theory was developed as an encompassing theory for understanding human reactions to major life stressors such as loss and separation (Bowlby, 1988). A fundamental assumption in attachment theory is that inner working models of attachment styles are developed and internalised from early interactions with caregivers (attachment figures). The gradual formation of internal working models will guide in the person's future formation of patterns in interpersonal behaviour and interpersonal expectation. Adults use different attachment styles especially in parenting and in attachment relevant relationships (Berman & Sperling, 1994; Bowlby, 1988; Davila & Levy, 2006; Main, 2000; Shaver & Miculincer, 2002). "The term 'attachment style' refers to particular internal working models of attachment that determine people's behavioural responses to real or imagined separation and reunion from their attachment figures" (Berman & Sperling, 1994, p. 11). A person's internal model of self and others is reflected in interpersonal behaviour, and thought of as an effect of attachment experiences (Horowitz, 2004).

Different methods have been developed from attachment theory to assess attachment styles in adults, like the Adult Attachment Interview (AAI) and various self-report questionnaires (Fraley & Phillips, 2009; Levy & Kelly, 2009). Brennan, Clark, and Shaver (1998) found that diverse self-reports were tapping the two dimensions of attachment-related avoidance and attachment-related anxiety. Avoidance manifests in deactivating strategies, characterized by deflecting and withdrawing attention from attachment-related thoughts,

feelings, and distressing stimuli. Anxiety manifests in hyper-activating strategies characterized by increased attention to distressing attachment-related stimuli (Miculincer & Shaver, 2007; Shaver & Mikulincer, 2002; Shaver & Mikulincer, 2004). Secure attachment manifests in low or balanced avoidance and anxiety, and is proposed to create conditions for an open trusting interpersonal style and for the possibility to optimally explore one's environment (Grossman, Grossman, Kindler, & Zimmermann, 2008).

Interpersonal problems are often inherent in psychiatric disorders and common reasons for seeking psychotherapy (Horowitz, 1979; Horowitz, 2004; Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988). Interpersonal rigidity - meaning that one type of motive in behaviour is exaggerated at the expense of the other - can be described as maladjusted behaviour. Interpersonal theory emphasizes that human existence is interpersonal from the start and that interpersonal relating is a continuously active condition of mental life and concerns the reciprocity of interpersonal behaviour (Florsheim & McArthur, 2009; Horowitz, 2004; Levenson, 1991; Lyons-Ruth, 2007; Sullivan, 1953). Relying on interpersonal theory, interpersonal problems reported by patients at psychotherapy intake interviews have been examined in the dimensions of affiliation and dominance (Alden, Wiggins, & Pincus, 1990; Horowitz, 2004; Horowitz, et al., 1988).

An important aim in psychotherapy is often to reduce and handle interpersonal problems. Self-reported interpersonal problems and specific attachment profiles have been found to be related in both interview and self-report data (Bartholomew & Horowitz, 1991; Horowitz, Rosenberg, & Bartholomew, 1993; Schmidt & Strauss, 1997; Strauss, Kirchman, Eckert, Lobo-Drost, Marquet, Papenhausen, et al., 2006). The oft-cited studies by Bartholomew and Horowitz (1991) and Horowitz and colleagues (1993) were carried out in a student sample, and showed that attachment-related avoidance correlated positively to interpersonal problems in the subscales associated with dominance, such as Coldness, and negatively to the subscales associated with affiliation, such as Exploitable and Overly expressive. The preoccupied attachment style (high on attachment-related anxiety and low on attachment-related avoidance) related positively to the affiliation interpersonal subscales.

In a study of a treatment-seeking outpatient sample the authors surprisingly, and inconsistent with what they expected from previous research, found that attachment-related avoidance positively correlated to subscales in the affiliation dimension of interpersonal problems (Self-sacrificing and Non-assertive) and that attachment-related anxiety positively correlated to subscales in the dominant dimension of interpersonal problems (Cold, Vindictive, Socially inhibited and Dominant) (Haggerty, Hilsenroth & Vala-Stewart, 2009). The authors raise the question of whether the relationships between

attachment styles and interpersonal problems are more complex in clinical samples. Patients in clinical samples have reported more insecure and unstable attachment styles compared to non-clinical subjects (Bakermans-Kranenburg & van Ijzendoorn, 2009; Fossati, Feeney, Donati, Donini, Novella, Bagnato, et al., 2003; Strauss et al., 2006; van Ijzendoorn & Bakermans-Kranenburg, 1996; Waters, Hamilton, & Weinfield, 2000). The findings by Haggerty and colleagues (2009) were based on a limited sample size. Thus a vital issue is to examine whether attachment styles correlate to interpersonal problems in the same way in a different clinical setting and a larger clinical sample.

Even if few clear-cut connections are found, attachment styles have shown to associate with psychiatric diagnoses such as mood disorders, anxiety disorders, eating disorders, alcohol abuse and personality disorders (Dozier, Stovall, & Albus, 1999; Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, et al., 1996; Fossati et al., 2003). Horowitz (2004) has argued that interpersonal problems are inherent in diagnoses described in DSM-IV Axis I diagnoses and in Personality disorders.

The aim of the present study was to examine self-reported attachment styles, how they relate to each other, and how they relate to interpersonal problems and diagnoses in a clinical sample of patients starting psychotherapy. The research questions were:

- How are attachment styles reported in a clinical compared to a non-clinical sample?
- How are attachment styles correlated to each other?
- What levels of interpersonal problems are reported?
- How do attachment styles relate to interpersonal problems?
- Are attachment styles and interpersonal problems related to diagnoses?

Method

Setting

In Örebro County, Sweden, patients with psychiatric diagnoses may be referred to publicly-funded psychotherapy by psychiatrists in public psychiatric services and by physicians associated with the Social Insurance Administration. An experienced licensed psychotherapist at the Psychotherapy Centre assigns patients to an available psychotherapist with a cognitive behavioural orientation or to a psychotherapist with a psychodynamic orientation, based on the diagnoses according to the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (American Psychiatric Association, 1994), the presentation of the problems, and, occasionally, the patients' preferences in the written referrals. The 32 licensed psychotherapists treating patients included in this study had 5-15 years of training and were employed at the centre or in private practice, partly funded by the centre. Two therapists were trainees

supervised by licensed psychotherapists. The catchment area of the centre has 270 000 inhabitants and the number of referrals to the centre is about 180 per year.

Participants and procedure

The study design was descriptive, based on 168 patients consecutively starting psychotherapy. For the purpose of quality assurance, the intention of the centre was to ask all patients to fill in self-reports assessing attachment styles and interpersonal problems. However, due to heavy workload of the staff, not all patients were asked or reminded. Those who responded were informed about the study and were asked for consent to use the questionnaires and case record data for our research study. Participants gave written informed consent. The inclusion process is shown in Figure 1. A sample of high school and university students ($n = 90$), used by Håkanson and Tengström (1996) in testing the Swedish version of the ASQ (Attachment Style Questionnaire), constitute a reference group in the present study. The study was approved by the Regional Research Ethics Vetting Board in Uppsala, Sweden (Ref. 2004: 14-243). Socio-demographic and clinical characteristics of included patients are shown in Table 1.

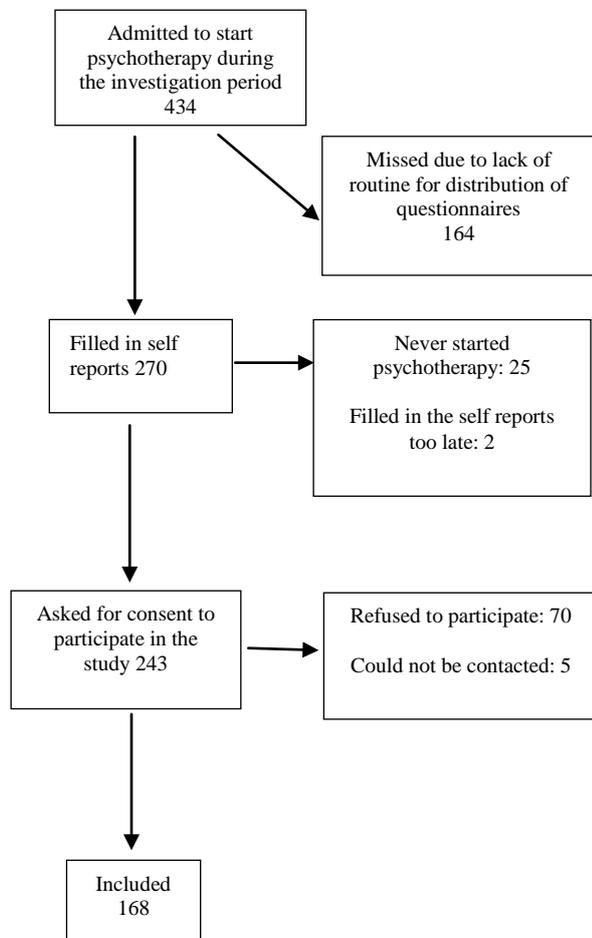


Figure 1. Flow diagram of inclusion process.

Table 1
Socio-Demographic and Clinical Characteristics, in Percentages (n = 168)

Sex		Diagnoses ¹	
Women	78.0	Mood Disorders	31.5
Men	22.0	Anxiety Disorders	31.0
Age		Adjustment Disorders	16.7
18-25 years	10.7	Personality Disorders	6.0
26-39 years	42.9	Others	11.9
40- years	46.4	No diagnosis	
	3.0		
Education		Orientation of therapy ²	
Junior High School	16.1	Cognitive behavioural	32.7
High school	41.1	Psychodynamic	63.1
University	26.8	Mixed ³	4.2
Unreported	16.1		
Employment status			
Employed	51.8		
Unemployed	15.5		
Sick leave	28.6		
Unreported	4.2		

Note. 1) Classified by the treating psychotherapists according to the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (APA, 1994). In 36 case records no DSM-IV-diagnosis was documented. In these cases diagnoses were assessed by the first author (MWG) from descriptions in the records, in collaboration with an experienced psychiatrist.

2) Defined from the type of formal training qualifications of the psychotherapists treating the patients.

3) Cognitive behavioural therapy and Psychodynamic psychotherapy.

Measures

Attachment Style Questionnaire (ASQ) The self-report measure Attachment Style Questionnaire (ASQ) was designed to capture common themes in attachment theory such as dependence, trust, and self-reliance in relationships in general (Feeney, Noller, & Hanrahan, 1994). It is intended to provide a broader-based measure to be used also with individuals having more limited experiences with romantic relationships. The dimensional approach of the ASQ has the advantage not to imply the existence of diametrically opposed types of adult attachment. The ASQ contains 40 items with answers ranging from 1 (*totally disagree*) to 6 (*totally agree*). A factor analysis of responses to the 40 items (Feeney et al., 1994) revealed five scales as the best distribution of the responses: *Confidence (C)*, *Discomfort with Closeness (D)*, *Relationships as Secondary (RS)*, *Need for Approval (NA)*, and *Preoccupation with relationships (PR)*. Administered to 470 Australian students, internal consistency measured by Cronbach's alpha for the five scales ranged from .76 to 0.84. The ASQ showed test-retest stability over a 10-week period ($n = 295$ respondents) with reliability coefficients ranging from .67 to .78 for the five scales (Feeney et al., 1994). The five-factor structure of the

ASQ was replicated in an Italian study tested in both a clinical sample of 487 psychiatric patients and in 605 non-clinical participants. The five-factors were revealed to fall in the two-dimensional factor space of attachment-related avoidance and attachment-related anxiety. The scales *Discomfort with Closeness* and *Relationships as Secondary* were parts of avoidance dimension. *Need for Approval* and *Preoccupation with Relationships* were parts of the anxiety dimension (Fossati et al., 2003).

The ASQ has been translated into Swedish, tested in a sample of high school and university students ($n = 90$) and in a sample of somatic and psychiatric patients ($n = 66$). Internal consistency, measured by Cronbach's alpha for the five scales ranged from .71 to .84. The scales in the Swedish version correlate to each other similarly as in the original version of ASQ. Validity tests showed theoretically predicted results (Håkanson & Tengström, 1996; Tengström & Håkanson, 1997) compared with Structural Analysis of Social Behavior, SASB (Armelius & Öhman, 1990; Benjamin, 1974) and Karolinska Scale of Personality, KSP (Perris, Eisemann, von Knorring & Perris, 1984; Schalling, Åsberg, Edman & Orelund, 1987). Thus a good fitness and maintained validity and reliability between the original version of ASQ and the Swedish version were indicated.

The number of cases excluded from the analyses due to missing values varied from 1-6 between the different ASQ scales.

Inventory of Interpersonal Problems (IIP)

Interpersonal problems were measured by The Inventory of Interpersonal Problems, developed in the U.S. to assess the severity of interpersonal problems in the dimensions of dominance and affiliation. The IIP is an interpersonal circumplex divided in eight sectors (octants), each describing an interpersonal dysfunction (Alden et al., 1990; Gurtman, 1996; Horowitz et al., 1988). It consists of 64 items concerning "things you find hard to do with other people" or "things that you do too much", with response options ranging from 0 (not at

all) to 6 (extremely) in eight subscales.

A Swedish version has been developed to fit Swedish perspectives on interpersonal problems (Stiwne & Rosander, 1999). The original 127 items were translated into Swedish and tested in a clinical sample of help-seeking students ($n = 147$) and in a non-clinical sample of students ($n = 202$). Compared with the American version some items were found in scales close at hand. These differences are understood to result from cultural and linguistic differences. The subscales are Domineering, Vindictive, Cold, Socially Avoidant, Non-assertive, Exploitable, Overly Nurturant and Intrusive. They showed internal consistency, with Cronbach's alpha coefficients ranging from .78 to .91. Higher scores were noted in the help-seeking sample than in the non-clinical sample.

In the present study, a maximum of one missing answer on a subscale was accepted. Consequently, 1-3 cases with two or more answers missing on a scale were excluded from the analyses.

Psychiatric Diagnoses Clients' diagnoses had been provided by the psychotherapists who treated them, following the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV (APA, 1994). In 36 case records no DSM-IV-diagnosis was documented. In these cases diagnoses were assessed by the first author (MWG) from descriptions in the records, in collaboration with an experienced psychiatrist.

Statistical Analyses

Two-sample t-tests were used to analyse differences in attachment styles between the sample of the study and the reference group. Correlations between the ASQ scales, and between the ASQ scales and interpersonal problems, were analysed using Spearman's rho correlation coefficient. ANOVA was used for comparisons between groups of diagnoses. The data

Table 2
ASQ Scale Means (Standard Deviation) in a Non-Clinical Reference Group of Students ($n = 90$) and in the Clinical Sample ($n = 168$)

Scales	M (SD)				
	D	RS	C	NA	PR
Non-clinical sample	3.3 (0.8)	2.1 (0.7)	4.4 (0.8)	3.5 (0.9)	3.5 (0.8)
Clinical sample	4.0 (1.0)	2.7 (0.9)	3.5 (1.0)	4.1 (1.1)	3.9 (1.0)
<i>p</i> -value	< .001	< .001	< .001	< .001	.0028

Note. D = Discomfort with Closeness, RS = Relationships as Secondary, C = Confidence, NA = Need for Approval, PR = Preoccupation with Relationships.

were analysed using SPSS, version 15, and p-values < .05 with a Bonferroni correction were considered significant.

Results

Attachment styles

The patients in this study showed more insecure attachment styles than those in the non-clinical reference group of students (Table 2), used in testing the Swedish version of the ASQ.

Correlations between attachment styles are presented in Table 3. The ASQ scale *Confidence* correlated negatively with all the insecure attachment scales and insecure attachment scales correlated positively to each

Table 3
Correlations Between Attachment Styles According to ASQ (n = 168)

Scales	D	RS	NA	PR
C	-.69*	-.55*	-.57*	-.42*
D		.62*	.51*	.34*
RS			.36*	.24*
NA				.64*

Note. C = Confidence, D = Discomfort with Closeness, RS = Relationships as Secondary, NA = Need for Approval, PR = Preoccupation with Relationships. $p < .005 (.05/10)$

Table 4
Means and Standard Deviations on the IIP Subscales and Correlations between Attachment Styles and Interpersonal Problems (n = 168)

IIP subscales [M (SD)]	[M (SD)]	ASQ scales				
		D	RS	C	NA	PR
Domineering [6.8 (5.2)]		.26	.28*	-.15	.11	.24
Vindictive [7.6 (5.3)]		.38*	.42*	-.29*	.18	.20
Cold [10.6 (6.3)]		.66*	.64*	-.74*	.52*	.36*
Soc A [12.8 (7.9)]		.67*	.57*	-.71*	.52*	.41*
Non A [13.9 (7.8)]		.57*	.43*	-.65*	.66*	.52*
Exploitable [16.0(7.6)]		.43*	.29*	-.47*	.58*	.49*
Overly N [13.4 (6.9)]		.31*	.13	-.25	.53*	.47*
Intrusive [7.1 (5.7)]		.09	.05	.08	.13	.25
Total IIP [87.5 (36.7)]		.63*	.51*	-.59*	.60*	.53*

Note. D = Discomfort with Closeness, RS = Relationships as Secondary, C= Confidence, NA = Need for Approval, PR = Preoccupation with Relationships, Soc A = Socially Avoidant, Non A = Non-assertive, Overly N = Overly Nurturant.

* $p < 0.001 (0.05/45)$

other with the highest positive correlations between *Discomfort with Closeness* and *Relationships as Secondary* (Avoidant-related attachment) and between the scales *Need for Approval* and *Preoccupation with Relationships* (Anxious-related attachment).

Attachment scales and interpersonal problems

The highest reported interpersonal problem scores were found on the subscales Exploitable, Non-assertive, Overly Nurturant, Socially Avoidant and Cold (Table 4).

Secure attachment correlated negatively to interpersonal problems and insecure Avoidant-related and Anxious-related attachment correlated positively to interpersonal problems associated with both dominance and affiliation. As shown in Table 4, the total IIP score correlated positively with all insecure ASQ scales and negatively to *Confidence*. The Avoidant-related attachment scales (*Discomfort with Closeness* and *Relationships as Secondary*) correlated positively to the IIP-subscales Vindictive, Cold, Socially Avoidant and Domineering measuring the dimension of dominance and also to the IIP-subscales Non-assertive, Exploitable and Overly Nurturant measuring the dimension of affiliation. The Anxious-related attachment scales (*Need for Approval* and *Preoccupation with Relationships*) correlated positively to the IIP-subscales Non-assertive, Exploitable and Overly Nurturant, measuring the dimension of affiliation and also to the IIP-subscales Cold and Socially Avoidant measuring the dimension of dominance. The IIP-subscale Intrusive did not significantly correlate to any of the ASQ scales.

Comparisons between diagnostic groups

No statistical differences in scores on ASQ scales and IIP total score between diagnostic groups were found (Table 5).

Discussion

Higher scores of insecure Avoidant and Anxious attachment were found in this clinical sample of patients starting psychotherapy compared to a non-clinical sample of students.

The high scores of insecure attachment styles as well as mixed avoidant and anxious attachment styles reported are consistent with findings in previous studies, where attachment patterns were found to be particularly unstable in clinical samples (Fossati et al., 2003; Strauss et al., 2006; van Ijzendoorn & Bakermans-Kranenburg, 1996; Waters et al., 2000). In an Italian study, also using the ASQ, patients diagnosed with a Personality Disorder showed statistically significant lower scores on *Confidence* and higher scores on all insecure related

Table 5
ASQ Scales and IIP Total Score in Diagnostic Groups

	Mood Disorders <i>M (SD)</i>	Anxiety Disorders <i>M (SD)</i>	Adjustment Disorders <i>M (SD)</i>	Personality Disorders <i>M (SD)</i>	<i>p</i> -value
Discomfort with Closeness	3.9 (1.0)	4.1 (1.0)	4.2 (1.1)	4.4 (0.9)	0.441
Relationships as Secondary	2.6 (1.0)	2.7 (1.0)	3.0 (0.9)	3.0 (0.6)	0.306
Confidence	3.4 (1.0)	3.6 (1.0)	3.8 (1.0)	2.8 (1.0)	0.075
Need for Approval	4.3 (1.1)	4.0 (1.1)	3.9 (1.0)	4.4 (1.1)	0.296
Preoccupation with Relationships	4.0 (1.0)	3.9 (1.0)	3.7 (0.9)	3.6 (0.9)	0.340
IIP total score	92.9 (37.0)	83.2 (38.8)	86.8 (31.2)	111.5 (37.4)	0.135

attachment scales compared to patients with a DSM-IV Axis I diagnosis (Fossati et al., 2003). In our study too, with a smaller sample, there was a tendency towards lower scores on *Confidence* among patients with Personality Disorders ($p = .075$). It might be important in further studies to examine the link between specific personality disorders and specific insecure attachment in psychiatric samples referred to psychotherapy.

The sum total of interpersonal problems, also named the general distress score, has been suggested to represent a more general measure of psychological functioning than interpersonal distress alone (Holtforth, Lutz & Grawe, 2006). Interpersonal problems according to the IIP are regarded as expressing behavioural excesses (too Exploitable, too Overly Nurturant, too Domineering, too Socially Avoidant) and scores on the eight scales indicate frustrated interpersonal motives (Puschner, Bauer, Horowitz, & Kordy, 2005). Consistent with previous research concerning patients at the start of psychotherapy, we found high scores on the interpersonal problem scales, Exploitable, Non-assertive, Overly Nurturant, Socially Avoidant and Cold (Holtforth, et al, 2006; Puschner et al, 2005; Puschner, Kraft & Bauer, 2004).

In our clinical sample, interpersonal problems correlated positively to both Avoidant-related and Anxious-related attachment styles and negatively to *Confidence*. Avoidant-related attachment scales (*Discomfort with Closeness and Relationships as Secondary*) correlated positively not only to the IIP-subcales in the dimension of dominance as found in non-clinical samples, but also positively to the IIP-subcales in the dimension of affiliation, not found in non-clinical samples. Likewise, the Anxious-related attachment scales (*Need for Approval and Preoccupation with Relationships*) correlated positively to IIP-subcales in the dimension of affiliation as found in non-clinical samples and also to IIP-subcales in the dimension of dominance, which has not been found in non-clinical samples (Bartholomew & Horowitz, 1991; Horowitz et al., 1993; Schmidt & Strauss, 1997).

However, our results are consistent with the findings of Haggerty and colleagues (2009). These findings indicate that patients' specific interpersonal problems of being too Non-assertive, too Exploitable, too Overly Nurturant, and too Cold in many cases correlate to internal working models of mixed avoidant and anxious attachment at the start of psychotherapy.

Interpersonal problems have been suggested to show a conflict between an individual's desire to express behaviour, a thought, or a feeling and fear of the consequence of doing so. Horowitz (2004, p. 49), suggests that "Attachment styles help to clarify a person's motive in interpersonal relationships: Does the person want closeness or does the person prefer distance?" In attachment theory, search for security against threats to self-concept and integrity is regarded as an essential motivator.

Methodological considerations and limitations

For the purpose of quality assurance, the intention of the Psychotherapy Centre was to ask all patients to fill in self-reports assessing attachment styles and interpersonal problems. However, due to heavy workload of the staff, not all patients were asked or reminded, and 38% did not fill in the questionnaires. However, since the patients not asked or reminded were not selected in any way, there is no reason to suspect a systematic drop out at this stage of the data collection. When those who did respond were asked for permission to use their data for this research, the acceptance rate was acceptable (69%). Diagnoses were classified and documented by the 32 psychotherapists who treated the patients. Questions could be raised concerning the reliability of the documented diagnoses, for instance that few Axis II diagnoses were documented. However, the diagnostic distribution corresponds to findings in another Swedish study, carried out in a sample of psychotherapy patients, the project STOPP (Lazar, Sandell, & Grant, 2006). Even though only broad diagnostic categories were used in our analyses, real differences between diagnostic groups may have been undetected due to the limited

sample size.

The self-report measure ASQ was developed to ask for attitudes, expectations and experiences in general, not specifying a particular relationship such as a partner or a close friend and therefore has the advantage to be distributed to individuals having more limited experiences with romantic relationships. The five-factor model of the ASQ was revealed to tap the two dimensions of attachment-related Avoidance and attachment-related Anxiety (Fossati et al., 2003). A variety of item sets in self-reports has shown these two dimensions (Brennan et al., 1998), and it is reasonable that findings in this study could be compared to findings of other studies. The tests of the Swedish version of the ASQ and the Swedish version of the IIP, described in the method section, were carried out at the Umeå University and Linköping University in Sweden, (Håkanson & Tengström, 1996; Stiwyne & Rosander, 1999; Tengström & Håkanson, 1997). Although not published in peer-reviewed journals, our judgement is that reliability and validity were accurately tested and presented. A limitation of the study is that in the non-clinical sample used for comparison of attachment styles, the mean age and age range were lower than for the participants of this study, and this may have influenced the fact that we found greater occurrence of insecure attachment styles in our clinical sample.

Attachment styles, interpersonal problems and clinical implications

The high scores of insecure attachment and the positive correlation to interpersonal problems reported in this clinical sample imply that a challenge for the therapist is to balance providing security with encouraging the patient to explore feelings, thoughts, and behaviours in their interpersonal problems. Patients who deactivate and downplay affects in avoidant styles and hyper-activate affects in the anxious styles have been found more difficult to treat than patients with a secure attachment style (Daniel, 2006; Saypol & Farbera, 2010). The dynamic between current interpersonal problems and internalised models of attachment will affect the patient's ability to make use of a fruitful relationship with the therapist, which is relevant to the success of therapy. From the interpersonal perspective, the therapist is required to focus on the quality of the therapist-patient exchanges (Florsheim & McArthur, 2009; Levenson, 1991; Safran & Muran, 2000; Sullivan, 1953). Irrespective of therapy orientation, interventions need to be adjusted to the way a patient seeks for security, both in the therapy relationship and in relevant relationships in the life context. Thinking about the therapy process as an interplay between security seeking and wanting to explore one's environment helps to understand motives in patients' behavioural excesses expressed in specific interpersonal problems, and to form interventions that helps the patient to find adaptive interpersonal

expectations and behaviour. It can also be helpful to identify difficulties in the therapeutic alliance (Obegi, 2008).

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