Attachment and psychosis
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Attachment style and working alliance in staff and patients with psychosis

Nikie Korver-Nieberg, Carin J Meijer, Maarten WJ Koeter, Lieuwe de Haan

Psychology and Psychotherapy; Theory, Research and Practice, submitted for publication
Abstract

Objectives
Working alliance between patients with psychosis and psychiatric staff is related to treatment outcome. Attachment style is a mechanism underlying interpersonal relationships which may influence working alliance. Previous research showed patient attachment style to be related but the role of staff attachment style is currently understudied. We examined whether attachment styles of both patients and staff were related to working alliance, whether their attachment styles interacted and whether patients and staff differed in perspectives on alliance.

Design
Cross-sectional

Method
Participants were 71 patients with recent onset psychosis, mean age 27 (SD = 6), mostly male (78%), and 26 psychiatric staff members of an early intervention psychosis team, mean age 34 (SD = 9), mostly female (69%). Measures of insecure attachment styles (PAM) and working alliance (WAI-S) were administered in both samples and psychotic experiences (CAPE) in the patient sample.

Results
Insecure attachment styles of both patients and staff were negatively associated with the quality of alliance. Higher avoidant attachment levels in both therapist and patients, was associated with poorer alliance. Patients rated working alliance lower than staff.

Conclusions
Attachment styles of patients and staff, as well as their interaction are important for the perceived working alliance.
Especially avoidant attachment styles of both patient and caregiver may negatively affect (perceived) working alliance. Staff tended to rate the quality of alliance as better than patients. Attachment style of psychiatric staff should be taken into consideration in creating optimal working alliance, which in turn is needed for acquiring positive treatment outcome.

Practitioner Points:
1. Knowledge of attachment patterns in both patients with psychosis and psychiatric staff provides insight into interpersonal difficulties in therapeutic relationships which negatively influences treatment outcome.
2. A pre-treatment attachment measure may be useful in finding the best match of patient-staff pairs to increase the possibility of positive treatment outcome or to gain insight in possible interpersonal difficulties which may arise in treatment.
3. Awareness in psychiatric staff of the patients’ and more importantly their own attachment style would be useful in creating an optimal working alliance.
Introduction

The quality of the therapeutic ‘alliance’, which refers to the collaborative bond between patient and therapist, is an important predictor of therapy outcome (Horvath & Symonds, 1991), independent of the type of therapy provided (Martin, Garske, & Davis, 2000). In patients with psychosis the quality of the therapeutic alliance was found to be associated with symptoms, quality of life, treatment adherence and rehabilitation (Davis & Lysaker, 2007; Lysaker, Davis, Buck, Outcalt, & Ringer, 2011). Individuals with psychosis often experience difficulties in forming and maintaining interpersonal relationships, including those with therapists.

Attachment style is a concept that may help understand mechanisms underlying social interaction. Attachment style incorporates thoughts, feelings and behaviours about self and others and is related to social functioning, psychopathology and interpersonal difficulties in adult life (Berry, Wearden, Barrowclough, & Liversidge, 2006; Berry, Band, Corcoran, Barrowclough, & Wearden, 2007). As psychiatric staff often play a key role in the lives of patients with psychosis (Berry, Wearden, & Barrowclough, 2007) they can be considered as attachment figures (Adshead, 1998). Studying attachment in patients with psychosis could be of great interest in order to gain insight into factors that influence the therapeutic alliance, and consequently the outcome of therapy. However, since all relationships are two-sided, both patients and therapists affect the quality of the alliance. Therefore, not only patient attachment style but also therapist attachment style should be evaluated.

Consequently, the aim of this study is threefold; to investigate whether (1) attachment style of both patients and staff is related to the quality of therapeutic alliance as viewed from both perspectives, (2) patient-staff attachment styles interact to affect the quality of the alliance, and (3) patients and staff have different perspectives on the quality of alliance and whether attachment style can account for these differences.

Methods

Participants

Both patients and psychiatric staff members were recruited through the ‘Early Intervention Psychosis’ teams (‘vroegere interventie psychose VIP’) in Amsterdam, the Netherlands. The VIP teams offer three years intensive outreaching outpatient care to people who develop a first episode of a psychotic disorder. Teams are multidisciplinary, including psychiatrists, residents, nurses, job coaches, social workers and ‘hands-on’ experts, who work together to provide care on a wide range of life domains. The VIP project goals are (1) frequent contact with patient and family members and continuity of care (2) to minimize duration of untreated psychosis, symptomatology and number of hospitalizations, (3) to increase treatment compliance, and (4) improve social functioning.

Patient inclusion criteria for entering the VIP project were: premorbid IQ > 80, Amsterdam resident, age between 16 and 40, a psychotic disorder according to the DSM-IV-TR (APA, 2000), duration of treatment directed at psychosis for less than six months at baseline.
assessment. DSM-IV diagnosis was based on the Comprehensive Assessment of Symptoms and History (CASH; (Andreasen, Flaum, & Arndt, 1992)) and information from referring clinicians. Additional inclusion criteria for the present study: good command of the Dutch language, able and willing to give written informed consent.

**Instruments**

**Working Alliance.** Bordin (1979) conceptualized working- or therapeutic alliance as a collaborative relationship that involves a mixture of three characteristics; (1) client and therapist agreement on *goals* of treatment, (2) client and therapist agreement on *tasks* required to achieve these goals and (3) the development of a personal bond between client and therapist, based on trust, respect, confidence and personal attachment (which is considered as a requirement for achieving treatment goals). To assess Bordins’ model, Horvath and Greenberg developed the ‘Working Alliance Inventory (Horvath & Greenberg, 1989), which has become the most widely used instrument in working alliance assessment (2). Others developed a short version of the WAI (WAI-S; (Tracey & Kokotovic, 1989); Dutch translation WAV-12,(Stinckens, Ulburghs, & Claes, 2009), with good psychometric properties. The instrument consists of twelve statements rated on a 5-point scale, anchored 1 (‘never’) to 5 (‘always’), that are divided into three subscales: ‘therapeutic bond’, agreement on ‘tasks’ and agreement on ‘goals’. Sum scores were calculated for the total and subscales with higher scores indicating a better quality of alliance. The WAI-S includes both a client and a therapist form. The WAI proved to be valid across a variety of different diagnoses (Horvath & Greenberg, 1989). The shortened version has been assessed in schizophrenia samples before (Couture et al., 2006; Davis & Lysaker, 2004). Chronbach’s alphas for the current study were: total WAI-S client form α=.91; therapist form α=.86.

**Attachment.** Two dimensions have been proposed as the best way to measure adult attachment: anxiety and avoidance (Brennan, Clark, & Shaver, 1998). *Attachment anxiety* is defined as having a negative view of self, fear that others will reject and abandon them in times of need, combined with an intense need to receive approval from others (Berry, Wearden, Barrowclough, & Liversidge, 2006; Daniel, 2006).

*Attachment avoidance* is defined as having a negative view about others and feelings of discomfort when close to others, together with social withdrawal and an intense need for self-reliance or a fear of depending on others (Berry, Wearden, Barrowclough, & Liversidge, 2006; Daniel, 2006).

To assess both dimensions the ‘Psychosis Attachment Measure’ (PAM; Berry, Wearden, Barrowclough, & Liversidge, 2006), Dutch translation (Korver-Nieberg et al, submitted) was used. A 15 item questionnaire referring to thoughts, feelings and behaviours, rated on a 4-point likert scale with 0 “not at all” and 3 “very much” with higher scores reflecting higher levels of attachment insecurity. Seven items reflect attachment avoidance and the other eight reflect attachment anxiety. Previous research has shown the PAM to have good reliability and validity in clinical and non-clinical samples (Berry et al., 2006; Berry et al., 2008).
Symptomatology. The Community Assessment of Psychic Experiences (CAPE; Stefanis et al., 2002) was used to assess the frequency and distress of psychotic like experiences. This 42 item questionnaire assesses positive, negative and depressive symptoms experienced over the last week. For the present study only the positive and negative scales were used. Mean total scores ranged from 0 to 3.

Procedure
Prior to the onset of the study all staff members were briefed and requested to inform their patients by distributing folders. When both staff member and patient were willing to participate, an assessment was scheduled after their next session. After signing informed consent, both staff member and patient were asked to fill out the self-report questionnaires. For anonymity reasons and to reduce social desirability, it was made clear that the staff members were blind to the patients’ ratings and vice versa. In addition, patients and staff members filled out the questionnaires in separate rooms. After participants responded to the questionnaires, these were placed in a sealed envelope in their presence. To reduce potential selection bias, staff members were encouraged not to select patients in advance. Due to the smaller number of staff members as compared to the patient sample, staff members were requested to participate a maximum of five times, rating the alliance with a different patient each time. Patients took part a maximum of two times (rating working alliance with two different staff members). When patients participated a second time, with a between assessment interval of more than one week they were asked to fill out the CAPE again.

Analyses
Pearson correlations were used to assess associations with working alliance and possible confounders such as psychotic symptoms, gender, age and frequency of contact. Independent t-tests were performed to assess the differences in PAM scores between patients and staff.

To assess whether attachment style, as assessed with the PAM (both anxious and avoidant attachment scales) could account for the variance in the working alliance, as assessed with the WAI, we used a multiple regression analysis with WAI as dependent and PAM subscales as predictor variables. Age, gender, frequency of contact between patient and staff and duration of treatment/VIP inclusion were included as covariates. The ‘dependence’ in the data caused by the fact that (some) patients and staff members participated several times, was taken into account by using a covariance pattern model with a compound symmetry variance-covariance matrix.

To assess whether the specific combination of staff and patient attachment style had an effect on the quality of alliance the regression model was extended with an interaction term for staff attachment style and patient attachment style. This resulted in four different regression analyses; (1) attachment anxiety of both patient and staff member and their interaction as dependent variables, (2) attachment avoidance of both and their interaction as dependent variables, (3) attachment anxiety of the patient, attachment avoidance of the staff member and their interaction as dependent variables and (4) attachment anxiety of
the staff member, attachment avoidance of the patient and their interaction as dependent variables. Paired t-tests were used to test the differences between ratings on the WAI between patients and staff members.

All analyses were performed with the mixed model module of SPSS 18.

**Results**

**Sample characteristics**

A total of 71 patients were included, of which 8 participated twice, the second time rating the alliance with a different staff member. Mean age was 27 years (SD: 6; range 18-44) and the majority were male (78%). Mean duration of treatment in the VIP teams was 19 months (SD: 13; range 2-50) and mean frequency of contact with a VIP staff member was 2 times a month ranging from once a week to once a month. Diagnoses were schizophrenia (45%), psychosis not otherwise specified (13%), schizoaffective disorder (5%), bipolar disorder with psychotic symptoms (8%), depressive disorder with psychotic symptoms (2%) and other psychotic disorders (27%). A total of 26 psychiatric staff members were included of which the majority participated several times, rating the alliance with different patients. All disciplines were included; two staff members represented different disciplines (e.g. job coach and nurse). Mean age of staff members was 34 years (SD: 9; range 20-55) and 69% were female. Mean duration of VIP employment was 22 months (SD: 16; range 3-57).

Means and standard deviations of the WAI, PAM and CAPE scores are presented in table 1.

<table>
<thead>
<tr>
<th></th>
<th>Patients Mean (SD)</th>
<th>Care workers Mean (SD)</th>
<th>Differences t(df)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WAI-S¹</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41.9 (8.7)</td>
<td>44.1 (6.3)</td>
<td>-2.2(78)</td>
<td>.03</td>
</tr>
<tr>
<td>Task</td>
<td>13.5 (3.1)</td>
<td>13.5 (3.1)</td>
<td>0.3 (78)</td>
<td>.78</td>
</tr>
<tr>
<td>Goal</td>
<td>13.2 (3.4)</td>
<td>13.5 (2.6)</td>
<td>-0.8 (78)</td>
<td>.46</td>
</tr>
<tr>
<td>Bond</td>
<td>15.2 (3.2)</td>
<td>17.1 (2.0)</td>
<td>-4.9(78)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td><strong>PAM²</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
<td>0.8 (0.6)</td>
<td>0.4 (0.2)</td>
<td>4.8(92)</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Avoidance</td>
<td>1.4 (0.5)</td>
<td>1.1 (0.3)</td>
<td>3.1(93)</td>
<td>.003</td>
</tr>
<tr>
<td><strong>CAPE³</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive symptoms</td>
<td>0.3 (0.4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Negative symptoms</td>
<td>0.7 (0.5)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Working Alliance Inventory-Short version, ² Psychosis Attachment Measure, ³ Community Assessment of Psychic Experiences
No significant correlations were found between self-rated positive symptoms, negative symptoms and working alliance. Negative correlations were found between patient age and WAI scale agreement about 'tasks' ($r = -.30, p = .01$), and total working alliance ($r = -.30, p = .028$) as rated by patients. Frequency of contact was negatively correlated to the WAI 'bond' subscale rated by patients ($r = -.30, p = .036$). Age of staff was negatively correlated to the bond subscale rated by staff ($r = -.30, p = .02$). Gender was associated with working alliance as rated by staff ($r = .40, p = .01$); staff rated the quality of alliance lower for male patients compared to females ($78 = -3.4, p = .001$). In terms of effect size (Cohen, 1988) all these correlations indicated medium effects. No statistical significant correlations were found between working alliance and gender of staff members. Psychotic symptoms and gender of staff were not considered potential confounding factors because they were not related to the outcome variable.

Working alliance and attachment

Patients’ ratings of working alliance: ‘task’, ‘goal’, ‘bond’ subscales and total scores. Table 2 presents the results of attachment style as predictor of working alliance as rated by patients. Patient attachment anxiety was positively related to WAI subscales task and goal as well as to WAI total score. Patient attachment avoidance was negatively related to task and bond subscales and WAI total score. In addition, age of the patient was negatively associated with the task subscale and WAI total score.

Staff attachment anxiety was negatively associated with the bond subscale. Staff attachment avoidance was negatively associated with the goal subscale.

Staff ratings of working alliance: ‘task’, ‘goal’ and ‘bond’ subscales and total scores. Table 3 presents the results of attachment styles as predictors of working alliance rated

### Table 2. Univariate predictors of the Patient WAI

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Task Subscale</th>
<th>Goal Subscale</th>
<th>Bond Subscale</th>
<th>Total WAI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>p</td>
<td>B (SE)</td>
<td>p</td>
</tr>
<tr>
<td>Patient Attachment Style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anxiety</td>
<td>1.3 (0.6)</td>
<td>.036</td>
<td>1.3 (0.7)</td>
<td>.070</td>
</tr>
<tr>
<td>- Avoidance</td>
<td>-1.8 (0.7)</td>
<td>.020</td>
<td>-1.4 (0.9)</td>
<td>.129</td>
</tr>
<tr>
<td>Staff Attachment Style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anxiety</td>
<td>-3.0 (1.6)</td>
<td>.083</td>
<td>-3.2 (1.5)</td>
<td>.053</td>
</tr>
<tr>
<td>- Avoidance</td>
<td>-1.7 (1.1)</td>
<td>.128</td>
<td>-2.1 (1.0)</td>
<td>.048</td>
</tr>
<tr>
<td>Frequency of contact</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Age patient</td>
<td>-0.2 (0.1)</td>
<td>.004</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

1Linear mixed model regression analyses (adjusted for multiple participations)
2Not included as covariate in regression model as variable was not significantly related to outcome
by staff. Staff rated WAI subscales task, goal and total WAI score lower for male patients compared to females.

**Interactions of attachment styles as predictors of working alliance**

Table 4 presents interactions between patient and staff member attachment styles as predictor of working alliance. A significant patient avoidance by staff avoidance interaction effect was found for lower scores on the task subscale as rated by both patient and staff and lower scores on goal and total WAI scales, as rated by staff. The other attachment style combinations interaction terms did not reach statistical significance.

<table>
<thead>
<tr>
<th>Predictor</th>
<th>Task Subscale</th>
<th>Goal Subscale</th>
<th>Bond Subscale</th>
<th>Total WAI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Attachment Style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anxiety</td>
<td>0.6 (0.6)</td>
<td>0.9 (0.5)</td>
<td>0.5 (0.4)</td>
<td>1.9 (1.3)</td>
</tr>
<tr>
<td>- Avoidance</td>
<td>-1.2 (0.7)</td>
<td>-0.8 (0.7)</td>
<td>-0.6 (0.4)</td>
<td>-2.7 (1.5)</td>
</tr>
<tr>
<td>Staff Attachment Style</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Anxiety</td>
<td>-2.8 (1.9)</td>
<td>-2.6 (1.3)</td>
<td>-0.01 (1.7)</td>
<td>-5.1 (3.7)</td>
</tr>
<tr>
<td>- Avoidance</td>
<td>-0.8 (1.2)</td>
<td>-0.9 (0.9)</td>
<td>-0.6 (1.1)</td>
<td>-1.6 (2.5)</td>
</tr>
<tr>
<td>Gender patient</td>
<td>-2.1 (0.9)</td>
<td>-1.9 (0.7)</td>
<td>-0.7 (0.5)</td>
<td>-5.0 (1.8)</td>
</tr>
</tbody>
</table>

1linear mixed model regression analyses (adjusted for multiple participations)

**Rating differences between patients and staff on working alliance**

Patients rated the quality of the working alliance, and specifically the quality of the therapeutic 'bond' significantly lower than staff members (Table 1). To assess whether attachment style accounted for these discrepancies in ratings, we subtracted the scores of patients from staff members on the WAI bond subscale and used this difference score as the dependent variable in a multiple regression analysis with staff and patient attachment styles as predictors.

**Discussion**

The main goal of the present study was to improve our understanding of factors that are related to the working alliance between patients with recent onset psychosis and psychiatric staff. This is of interest since the strength of the working alliance is found to be a robust predictor of therapy outcome (Horvath & Symonds, 1991). As the concept of adult attachment pre-eminently concerns interpersonal functioning, its' relation to the strength of therapeutic alliance was assessed. Previous research focused mainly on patient attachment styles and would benefit from including therapist characteristics (Smith, Msetfi, & Golding, 2010), as
relationships are two-sided and both attachment patterns may affect this relationship. Our first aim was to assess associations between attachment insecurity of both patients and staff and the working alliance rated separately by patients and staff.

**Attachment and patients’ perspectives of working alliance**

A salient finding was that when patients rated the quality of alliance, not only their own attachment style, but also staff attachment style was found to be associated with working alliance. Staff attachment anxiety was found to be negatively associated with all three domains of working alliance and staff attachment avoidance was associated with 'agreement on treatment goals'.

Because attachment anxiety is associated with a negative self-image, an individual with high levels of attachment anxiety may come across as insecure and vulnerable. Staff attachment anxiety may undermine patients trust in the abilities of staff members and therefore affect the quality of working alliance. Individuals with a more avoidant attachment style on the other hand tend to rely more on self than on others and could therefore come across as more distant or unresponsive, which may lead to problems with (creating) a satisfactory working relation.

Interestingly though, we found differential effects of patient en staff attachment anxiety on working alliance, as higher levels of attachment anxiety in patients were positively related with quality of the alliance when rated by the patient. It may be that the characteristics of attachment anxiety in patients (dependency on others and a need for approval) may to some extent be constructive in the development of a collaborative alliance. Whereas individuals with high levels of attachment avoidance, who tend to distrust others, may plausibly be disruptive in forming an alliance. The fact that higher levels of attachment anxiety in patients seem to have a positive effect whereas higher levels in staff are related to a negative effect on working alliance may be explained by their different roles. A staff member is expected to provide care with a secure, strong and stable state of mind. When a staff member comes across as insecure or dependent, this may adversely affect perceived strength of working

<table>
<thead>
<tr>
<th></th>
<th>Therapist WAI</th>
<th>Patient WAI</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>B (SE)</td>
<td>p</td>
</tr>
<tr>
<td>Avoidance*Avoidance</td>
<td>-5.3 (1.8)</td>
<td>.006</td>
</tr>
<tr>
<td>Staff Avoidance</td>
<td>7.8 (2.9)</td>
<td>.008</td>
</tr>
<tr>
<td>Patient Avoidance</td>
<td>5.5 (2.3)</td>
<td>.019</td>
</tr>
<tr>
<td>Avoidance*Avoidance</td>
<td>-4.9 (1.7)</td>
<td>.006</td>
</tr>
<tr>
<td>Staff Avoidance</td>
<td>7.3 (2.6)</td>
<td>.005</td>
</tr>
<tr>
<td>Patient Avoidance</td>
<td>5.3 (2.1)</td>
<td>.014</td>
</tr>
<tr>
<td>Avoidance*Avoidance</td>
<td>-10.3 (3.9)</td>
<td>.012</td>
</tr>
<tr>
<td>Staff Avoidance</td>
<td>15.6 (6.1)</td>
<td>.005</td>
</tr>
<tr>
<td>Patient Avoidance</td>
<td>10.6 (4.9)</td>
<td>.014</td>
</tr>
</tbody>
</table>

*linear mixed model regression analyses (adjusted for multiple participations)
alliance. On the other hand patients are more or less expected to be vulnerable and insecure as they are ones seeking help. These findings indicate that insecure attachment styles of both patients and staff are related to the quality of alliance and that attachment anxiety in staff members has a more unfavourable impact on the alliance than attachment anxiety in patients. A previous study by Berry and colleagues (Berry et al., 2008) showed that higher levels of staff avoidant attachment was related to more discrepancy between patient and staff perceptions of patients’ interpersonal difficulties as well as to difficulties in making psychological inferences about the causes of patients’ behaviour. This suggests that staff’s perceptions about patients’ levels of need and staffs’ ‘psychological mindedness’ may be influenced by their attachment style. Overall these findings suggest an important role for attachment styles of patients and staff to consider in therapeutic relationships.

The above findings are of particular interest since patient ratings of alliance have been found to have more predictive value with regard to treatment outcome than staff ratings (Bachelor, 1991; Smith, Msetfi, & Golding, 2010). Staff ratings remain of interest however, as the discrepancy between the ratings may have clinical relevance.

**Attachment and staff’ perspectives of working alliance**

When staff evaluated the strength of working alliance, attachment style appeared to play less of a role compared to patients’ evaluations. They rated the quality of alliance more negatively for patients with avoidant attachment levels. In addition higher levels of staff attachment anxiety, was associated with poorer agreement on goals. The findings indicate that staff members’ perspective of the alliance with patients is less influenced neither by their own nor patients’ attachment style, compared to the quality of alliance as perceived by patients. This is not surprising since staff members may expect social interaction difficulties as part of the illness and may therefore attribute this to a lesser extent in terms of unproductive alliance. The lack of agreement between patient and staff perspectives on the quality of alliance may provide insight into why certain difficulties and miscommunication issues in treatment arise.

**Patient-Staff Attachment styles interactions**

The second aim was to assess whether patient-staff attachment styles interact to influence the quality of alliance. This is important to consider when trying to build an alliance in treatment. A previous study (Tyrrell, Dozier, Teague, & Fallot, 1999) found matching patients with higher levels of avoidant attachment to therapists with lower levels of avoidant strategies may be beneficial in terms of working alliance. The authors suggest that patients and therapists should be matched on having dissimilar attachment strategies. This way, therapists can disconfirm patients’ interpersonal strategies and facilitate emotional change (Bowlby, 1988). The current findings support this theory by showing that higher levels of avoidant attachment of both therapist and patients is associated with poorer quality of working alliance. In this respect, a pre-treatment attachment measure, as also suggested by Smith and colleagues (2010) may be useful to either find a better match of patient- staff pairs or to anticipate the difficulties that may arise when trying to form a therapeutic alliance when both patient and staff member have higher levels of avoidant attachment.
Differences in perspectives on working alliance

The third aim was to assess whether patients and staff perspectives on the quality of their working alliance differed. Results indicate that staff rated the quality of the therapeutic bond higher than patients did. The discrepancy between the perspectives is in line with previous research (Barrowclough, Meier, Beardmore, & Emsley, 2010; Couture et al., 2006; Lysaker, Davis, Buck, Outcalt, & Ringer, 2011), however the direction of the perspectives in the current findings are opposite and therefore in contrast with previous findings in psychotic samples where staff tended to rate the quality of alliance lower than patients.

A number of explanations may account for these discrepancies. The higher ratings from staff members may be a direct consequence of a response tendency. The small sample size of the staff members required multiple participations. Even though each rating of alliance was concerning a different patient, the tendency to be positive could not be controlled for in paired t-tests. Another explanation may be that our patient sample was younger of age compared to previous studies, which could account for more positive staff ratings or conversely more negative patient ratings. Perhaps for staff there is more to achieve when patients are young, as it is early in the illness and the prospect is more hopeful than in chronic patients. Whereas for young patients it is the first time the illness has presented itself which can be very confusing and invalidating and could therefore relate to a more ambivalent perspective. In addition it may be that the tendency for staff to rate the quality of working alliance higher than patients was influenced by increased awareness of their own attachment style making them more aware of their share in a two-sided relationship. Usually the focus in research is only on patient characteristics. A recent study (Owens, Haddock, & Berry, 2012) found patients to rate the alliance lower than staff as well and suggest the ratings may reflect a social desirability bias. Another possible explanation was that attachment style could explain the discrepancies in ratings, especially since these appear within the ‘bond’ subscale of the working alliance. Results point in the direction that higher levels of staff’ avoidant attachment may have led patients to rate the bond with staff as poorer, but should be interpreted with caution, as this finding did not reach significance, which could be due to power problems since the sample size was small. Nevertheless it is important for staff to consider how they might be perceived and how this affects the quality of alliance from the perspective of the patient.

Finally we found associations between patient characteristics and working alliance. Older patients tended to be less likely to agree on tasks necessary to achieve treatments goals. In addition, staff members tended to view the alliance as less favourable for male patients compared to female patients.

Limitations

A major limitation in this study is its’ cross sectional design. Future research should therefore focus on a longitudinal study in which patients and therapists are followed throughout the duration of the treatment, with pre-, during and post treatment assessments and include outcome variables. A second limitation is the heterogeneity of disciplines within the staff sample. The sample size was too small to study the different disciplines separately.
et al. (Blackburn, Berry, & Cohen, 2010) suggest that help seeking patients form an alliance with a team or hospital as an entity, as patients are in contact with many professionals with different disciplines and develop attachment to a service rather than to an individual staff member. They found that patients with insecure attachment patterns had more difficulties in developing secure attachment to services. Future research should investigate whether attachment to services has predictive value for the therapy outcome.

Thirdly, we cannot rule out a selection bias. As mentioned in the method section it was stressed to the staff not to pick their ‘favourite patients’ for this study in order to reduce selection bias. It may be expected however that participating in the current study may acquire a certain level of attachment security, which may in turn lead to selection bias.

Regarding the patient participants, it is likely that the patient group with currently active psychotic symptoms were not part of this study. A fourth limitation is the use of self-report questionnaires, which may have led to social desirability bias, especially with regard to rating the alliance immediately after seeing your patient or member of staff. The attachment measure assesses general expectations about relationships with key people in their lives and not specifically with the staff member. Berry et al. however showed that specific and general measures of attachment correlate highly in psychosis (Berry, Wearden, & Barrowclough, 2007).

**Concluding remarks**

We think that including staff attachment patterns contributes to our understanding of the therapeutic relationship. The current findings suggest that more awareness in psychiatric staff of the patients’ and more importantly their own attachment style would be useful in creating an optimal working alliance. Moreover, more severe attachment anxiety or attachment avoidance in staff is not favourable for the working alliance as perceived by patients. Future research should focus on including these attachment patterns from both sides in larger samples with a longitudinal design, in order to improve our knowledge concerning forming and maintaining working alliance with psychotic patients.
References


