Attachment and Working Alliance in Emotionally-Focused Individual Therapy

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Thesis Submitted in Partial Fulfillment of the

Requirements for the Degree of

Master of Arts in Counselling & Spirituality

in the

School of Counselling, Psychotherapy & Spirituality

Faculty of Human Sciences

Saint Paul University

February 2024

Abstract

The purpose of this study was to investigate the relationship between attachment and the working alliance in Emotionally Focused Individual Therapy (EFIT), within a population experiencing mild-to-moderate depression and anxiety. Baseline, midpoint, and post self-report measures of attachment and working alliance were collected from a sample of 36 individuals over 12 to 17 sessions of EFIT and used in correlational and regression analysis. Significant negative correlations were found between attachment avoidance and different factors of working alliance at multiple timepoints, and none with attachment anxiety. Pre-treatment attachment insecurity does not predict weaker working alliances as anticipated. Pre-to-post change in attachment anxiety was significant but was not attributed to the working alliance. Pre-to-post change in attachment avoidance was non-significant but was moderated by the task agreement factor of the working alliance, which accounted for 16% of change in avoidance.

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Acknowledgements

Just as humans develop best within secure attachments, these pages were nurtured by those who cared enough to pause, attend, and guide me while I was writing them. I could not have arrived here without my own community, for whom I am endlessly grateful.

To Dr. Wiebe. I sing your praises every chance I get. I could not have chosen a supervisor more wisely and I am grateful for your willingness to work with me before you knew me, for the way you teach with humility and generosity, and for your confidence in this final product throughout its iterations.

To Dr. Armstrong and Dr. Bilodeau. You each embodied an empathetic, attentive and accepting presence before I had yet seen a client. Thank you for laying this professional foundation for me and thank you for meeting me here again, for your insights, and for closing this chapter together.

To my thesis friends: Elyse, Joelle, and Keltie. Thank you for laughing, stressing, sharing, and occasionally writing with me. You prevented this solitary goal from becoming lonely. To Anna, I am so grateful that we bookended this degree together in supervision, and that I will continue learning with you.

To my partner, Martin. Thank you for your warmth, good humour, and believing in my pursuits wholeheartedly. You keep me grounded (and very well fed) and you remind me that life is brief and might as well be fun. I would be too serious without you.

To my mum and dad and my siblings Sarah (both) and Adam. We don’t choose family, but I am glad you were chosen for me. Thank you for traveling back in time with me to shine light on shadowy places. Beyond the academic accomplishment, this is what I am most grateful for.

Most especially to Madeline and Kieran. Being your aunt is my joy and my inspiration, and when I didn’t want to read anymore, I thought of you and read some more.

To the people and family I chose: Carla, Alison, Maha, and the others I will wish I had included. You were a part of this every time your presence brought reprieve, levity, pleasure, and comfort. Thank you.

Attachment and Working Alliance in EFIT

Depression and Anxiety

Depression and anxiety are the two most diagnosed mental disorders globally (Dobson et al., 2020) and the World Health Organization predicts that depression will be the leading cause of disability worldwide by 2030 (WHO, 2011). Depression and anxiety are strongly correlated with one another, and comorbidity is common (Murphy et al, 2004). Anxiety often precedes a depressive episode and symptomology is typically mixed which necessitates effective treatment to address both (Kalin, 2020; Murphy et al., 2004). Even when treated effectively to symptom remission, recurrence of depression and anxiety is common. Results from the Netherlands Study of Depression and Anxiety (2011) found that following a 3-month symptom-free period, the recurrence rate was 80% for depression and 46% for anxiety within two years. Comorbidity was a predictor of poor diagnostic and symptom trajectories, including the development of a chronic course of either disorder (Penninx et al., 2011).

Rates of depression and anxiety have been steadily climbing in Canada over the past decades (Murphy, 2004; Phillips & Yu, 2021), but never was the prevalence more exigent than during the COVID-19 pandemic (Wong et al., 2021; Cai et al., 2021). In the first year alone between 2019 and 2020, the United States Census observed a threefold increase in depression and anxiety symptoms among adults (Twenge & Joiner, 2020), resulting in a sharp increase in formal diagnosis, antidepressant and benzodiazepine prescriptions, and greater demand and wait times for psychotherapeutic treatment (Gaffney et al., 2021). Canadians experienced similar effects, with 23% of the population screening positive for Generalized Anxiety Disorder or Major Depressive Disorder between February and May 2020, a 4% increase from the previous quarter and only weeks into the first wave of the pandemic (Gov. of Canada, 2022). This collective experience points to a direct need for effective treatments.

Health Impacts

Depression has been shown to lead to systemic inflammation, elevated cortisol levels and inhibited immune response (Fiksdal et al., 2019; Kiecolt-Glaser & Glaser, 2002; Vreeberg et al., 2013). These health factors make those with depression less responsive to vaccines, slower to heal from infections and wounds, and more susceptible to aging and disease processes like cardiovascular and respiratory diseases, arthritis, type 2 diabetes, cancers, and periodontal disease (Kiecolt-Glaser & Glaser, 2002). Moreover, those with depression and anxiety are more likely to have coping behaviours and health habits which put them at greater risk for adverse health outcomes including smoking, excessive alcohol consumption or other substance use, less physical exercise and poor sleep (Kiecolt-Glaser & Glaser, 2002). Anxiety and depression are also known to amplify pain perception and can worsen quality of life for those with chronic health conditions (Battalio et al., 2018). These health factors combined with higher rates of self-harm and suicidality are some of the reasons why chronic depression and anxiety can shorten life expectancy on average (Demyttenaere & Van Duppen, 2019; Kiecolt-Glaser & Glaser, 2002).

Depression and anxiety affect cognitive functioning as well as physical well-being. Older adults are particularly susceptible to the adverse cognitive effects of anxiety and depression, showing more deficits in attention, working memory, and executive functioning than younger adults (Battalio et al., 2018), leading to increased risk for cognitive impairment, vascular dementia, and Alzheimer's disease (Perin et al., 2022).

Social Impacts

Family members may experience the physical, emotional, financial and social strain of being in a relationship with or caretaking for a person with anxiety or depression (Demyttenaere & Van Duppen, 2019). Moreover, marital relationship satisfaction is significantly impacted when

either partner has a diagnosis of anxiety or depression (Aggarwal et al., 2017; Zaider et al., 2010), and both are correlated with higher rates of separation and divorce (Bruce, 1998). Children raised by one or more parents with anxiety or depression are more likely to experience parental hostility and less emotional attunement and availability in childhood (Epkins & Harper, 2016) and are more likely to develop anxiety and depression themselves in adolescence or adulthood (Kendler et al., 2020; Spence et al., 2002).

Part of the strain of anxiety and depression on interpersonal relationships may be related to what social psychologists refer to as "emotional contagion", or the tendency to take on the emotional distress of others (Zaider et al., 2010). Additionally, people with depression or anxiety often engage in ineffective or damaging communication and behavioural patterns and can be met with the rejection or avoidance they fear, thereby creating a cycle which confirms their negativity bias and compounds their personal and relational distress alienating them from others (Segrin, 2010, p. 425-460; Starr et al., 2014). While perceived social support moderates the symptoms of anxiety and depression (Roohafza et al., 2014), these negative social expectations and experiences characteristic of the disorders may be why people with depression or anxiety often report difficulties with social support seeking, and more doubt related to the availability, sincerity, and trustworthiness of others (Segrin, 2010, p. 425-460; Vélez et al., 2016).

Educational, Occupation, and Economic Impacts

Depression and anxiety are linked with poorer school performance in elementary, high school and post-secondary (Awadalla et al., 2020, Owens et al., 2012), in one part due to the interfering role of worry and test anxiety on memory processes and test performance (Owens et al., 2012) as well as social strains and the effects of mood on motivation. Relatedly, students are

more likely to skip classes, fail to complete assignments, and drop out of courses or programs when managing depression and anxiety (Owens et al., 2012).

Along with higher rates of workplace absenteeism, studies show that productivity is lowered when people are at work while managing depressive and anxious symptoms, called workplace presenteeism (Demyttenaere & Van Duppen, 2019). Workplace absenteeism and presenteeism along with the cost of providing treatment through the health care system and compensating short-and-long-term disability are some of the reasons why depression and anxiety represent a significant societal economic burden (Demyttenaere & Van Duppen, 2019).

Predictors and Protective Factors for Developing Depression and Anxiety

The literature on depression and anxiety is vast and includes varied perspectives on its etiology. A purely biomedical perspective would suggest that there are certain genetic and physiological vulnerabilities to developing anxiety or depression, like temperament, levels of important neurotransmitters in the brain, or a nervous system over-responsiveness to threat stimuli for example (Segrin, 2010). It is largely accepted, however, that while people may inherit a biological predisposition, it is the compounding effect of multiple adverse environmental and life factors, and perhaps the lack of certain supports and protective factors, that results in the development of a diagnosable mental illness. These are commonly referred to as risk and resiliency factors and are a topic of much research in the study of psychopathology (Keyes, 2004).

In a recent longitudinal study, Swedish researchers Kendler et al. (2020) isolated the effect of childhood environment in the development of depression later-in-life by studying biological sibling pairs wherein one is adopted out and the other remains with the biological parents. This method allowed the researchers to isolate the effect of divergent rearing

environments: adoptive parents are carefully selected and therefore typically experience low levels of psychiatric and substance use disorders and often provide higher quality parenting environments due to social and economic advantage, as compared to the biological families of adopted children who are often at greater risk for psychiatric and substance use disorders, are generally younger, and typically less economically and educationally privileged (Kendler et al., 2020).

Using biological families where one or both parents had a diagnosis of Major Depressive Disorder and adopted families with no parental history of depression, the researchers followed the children over multiple decades and monitored their access of health services for the assessment or treatment of depression. The results showed that the sibling who was adopted out had a significant 23% reduction in risk for development of depression as compared with siblings raised in the biological family, however this protective effect disappeared when either adoptive parent or a sibling in the adoptive family developed a diagnosis of depression or when there was significant family disruption such as death or divorce.

The findings of this study are interesting when considering the etiology and treatment of depression. First, they demonstrate clearly that the presence of depression in the family home regardless of biology is a risk factor for the development of depression, suggesting that there is something important which occurs (or perhaps which does not occur) between a depressed parent and child which represents a risk factor. This perspective is supported by developmental research (Bernard-Bonnin, 2004; Goodman et al., 2011; Keyes, 2004) as well as by interpersonal theory which explains psychopathology as social in origin and perpetuated by social context and interactions (Joiner et al., 1999).

A second longitudinal study by Wong et al. (2023) investigated depressive symptomology in mixed-gender romantic partnerships over 23 years wherein one partner had a diagnosis of depression at baseline. The researchers found that remaining in partnership with someone with chronic depression increases the depressive symptomology of the other partner and that separation rates are higher. The increased depressive symptomology remained present in the other partner years after separation however, though to a lesser extent. The non-diagnosed partner also exhibited an influence on the symptoms of the depressed partner, likely through negative patterns of interaction and perceptions of the depressed partner. In this way the couples had long-term mutual associations with one another's depressive symptoms, reinforcing the perpetuating interpersonal nature of the diagnosis.

Relationships marked by a certain closeness like the parent-child or adult romantic relationships exert the most influence on the development of depression and anxiety and may serve as a risk or resiliency factor depending upon the relational dynamic (Keyes, 2004; Mikulincer & Shaver, 2007). Other supportive relationships like with friends, coaches, spiritual leaders, etc. may also offer a protective function (Keyes, 2004). To understand the influence of these relationships, we must understand what sets them apart.

Attachment Theory

First researched and developed by psychologists John Bowlby and Mary Ainsworth beginning in the 1950s, attachment theory continues to be a well-researched, respected and utilized way of understanding the relational drives and bonds between human beings, and their importance on individual and collective well-being (Mikulincer & Shaver, 2007). Bowlby's original writings came from his early work with "maladjusted children", where he was one of the first to explore troubled early parent-child experiences and attribute them to the distress or

psychopathology he observed in the children, in essence describing what is now known as the intergenerational transmission of trauma (Mikulincer & Shaver, 2007). Ainsworth (1970) later added to Bowlby's research in her famous Strange Situation study where she observed infant behavioural responses to maternal separation, noting that children responded to the distress of separation in distinct patterns of behaviours which could be categorized.

The core tenet of attachment theory is that human beings are inherently relationship-seeking and naturally oriented to seek closeness and proximity to others (Mikulincer & Shaver, 2007). The presumed biological function of this proximity-seeking is based in the prolonged helplessness of the human infant, who without attachment to a caregiver could not survive (Mikulincer & Shaver, 2007). In attachment theory, the caregivers (most often parents) are called *attachment figure*s and represent a crucial and significant bond for human infants. Beginning in infancy, human beings will organize themselves around their attachment figures, basing their perception of themselves, others, and how best to behave to attain and maintain closeness to their attachment figures (Mikulincer & Shaver, 2007).

Attachment does not end once the child has matured though, and human beings continue to be wired for connection throughout the lifespan (Cassidy & Shaver, 2016). Multiple attachments may be formed in family, work, school, social, spiritual or other contexts, but attachments are considered hierarchical with only a small number of relationships favoured for the characteristics of the bond (Shaver & Mikulincer, 2014). Namely, these favoured attachment figures offer felt safety in the form of availability, protection, comfort, support and relief, which attachment theorists call a *secure bond* (Mikulincer & Shaver, 2007). In western cultures, primary attachment figures in adulthood often become romantic partners (Johnson, 2019; Kluwer et al., 2020). Though these attachment figures are different and the bonds are unique, adults may

project their childhood understanding of what to anticipate from others and how to behave within relationships onto their adult relationships. These processes, widely referred to as internal working models of attachment, are largely unconscious and can represent a point of tension, confusion, or conflict within adult partnerships (Johnson, 2019).

Attachment Security

Bowlby described attachment as a behavioural system which is activated when an individual is experiencing danger through an immediate or imminent threat (Mikulincer & Shaver, 2007). When the system is activated by threat, the individual will feel a physiological response cueing them to seek proximity to their attachment figure to receive protection, support, and soothing. Threats may be obvious such as physical danger, but may also be subtle, interpersonal or attachment specific. For example, being ostracized from a group or the perceived or real separation or loss of an attachment figure (Mikulincer & Shaver, 2007).

When the attachment figure is available and needs for protection, comfort, and caring are met, the attachment behavioural system activation terminates and the individual returns to a felt sense of safety (Mikulincer & Shaver, 2007). This cycle of experiencing threat, seeking proximity to the attachment figure, receiving comfort and care, experiencing felt safety, and returning to normal activities represents a script that the individual uses to inform their understanding of the world and others. This particular script is the *secure base script.* Experientially over time this cycle teaches the individual skills in emotional regulation and trust in oneself and others (Mikulincer & Shaver, 2007, p.12-13).

All people regardless of age are wired to seek proximity to an attachment figure when their attachment system is activated, unless this ingrained process is consistently disrupted (Mikulincer & Shaver, 2007). Someone with a secure base script, generally referred to as

attachment security, will navigate these threats differently than those whose experience of early attachment figures was less optimal.

Attachment Insecurity

When the attachment system is activated by threat and the individual seeks proximity of the attachment figure, but the attachment figure is physically or emotionally unavailable, non-responsive, or ineffective at alleviating the distress, then the attachment system remains activated and the distressed individual becomes preoccupied with the threat and unmet attachment needs for comfort, security, and protection (Mikulincer & Shaver, 2007, p. 19-20). Since directly seeking proximity is not effective, the individual will respond by either hyperactivating or hypoactivating the attachment behavioural system, depending upon which is most effective. Hyperactivating strategies involve escalating signals of distress to garner the attention and protection of the attachment figure, who is often unreliably or intermittently responsive (Mikulincer & Shaver, 2007). The person with hyperactivating strategies learns to be vigilant to threat and the availability of attachment figures and believes they must always express their attachment needs through persistent and escalated protest.

Hypoactivating strategies involve suppressing attachment needs and appearing as though not in distress, which often develops when the attachment figure is disapproving of proximity seeking efforts or even withdraws when attempts are made (Mikulincer & Shaver, 2007). The person with hypoactivating strategies appears as though they are not in distress and that they do not need the comfort and protection of the attachment figure, and may believe these things themselves, so adept are they at downregulating the attachment system to avoid their distress.

Both hyper and hypo-activating strategies are learnt responses that become innate in the way that an individual perceives and regulates their emotional distress and expresses their

attachment-based needs within relationships. They too become part of a script which informs understanding of the world and others, but rather than being called an insecure base script, they are explained in terms of *working models*.

Working Model of Self and Others

The mind is naturally oriented to store patterns and automate responses to manage the daily influx of stimuli and will do so with patterns in attachment figure responses to proximity-seeking efforts. The secure base script is developed from generally consistent and optimal responses to direct proximity-seeking efforts. The more frequently a child experiences the same inconsistent or suboptimal response to direct proximity-seeking efforts, the more ingrained their reliance on an alternative strategy to have their attachment needs met becomes. Beyond behaviours, the child is also encoding mental representations of themself and others (and broadly about relationships) based upon the patterns in their early attachment relationships. Bowlby referred to these representations as the working model of self and others (Collins, 2003; Mikulincer & Shaver, 2007).

The working model of other will include beliefs about whether others are available, sensitive, and responsive when needed, and the working model of self will include beliefs about the self as worthy or unworthy of love and care (Collins, 2003). Working models of self and other are complimentary in that the characterization of one will relate to the other. For example, in the secure base script there is an inherent belief in the trustworthiness and availability of others and the worthiness of the self to receive care, whereas in attachment insecurity there is likely to be a belief that others are unreliable or rejecting, and a complimentary belief that the self is either unworthy of consistent care, or is self-reliant and not in need of caring (Collins, 2003; Vogel & Wei, 2005).

Working models are more flexible and adaptive to change in early childhood, but with consistency they become more rigid and more generalized to relationships beyong the attachment figures (Collins, 2003; Mikulincer & Shaver, 2007). Rigid is not fixed, however, and research also shows that attachment insecurity, including working models of self and other, can be influenced by context and by novel relational experiences, real or even imagined (Byrant & Chan, 2017; Johnson, 2019; Mikulincer & Shaver, 2007; Rowe et al., 2020).

Attachment Dimensions

The concepts of attachment system activation strategies can also be explained in terms of dimensions of attachment security or insecurity. Broadly, security and insecurity represent the two primary categorizations of attachment system organization first observed by Mary Ainsworth in the Strange Situation study. Security is organized around the secure base script, and insecurity is divided into three sub-categories organized around different working models of self and other:

- **Anxious Attachment:** Refers to the preoccupation with threat and attachment figure availability associated with hyperactivation strategies and a working model of others as unreliable and of self as unworthy of caring and vulnerable.
- **Avoidant Attachment:** Refers to the suppression of needs and distress associated with hypoactivation strategies and a working model of others as unavailable and of self as hyper-reliant and without relational needs.
- **Disorganized Attachment:** Refers to a confused presentation of hypo and hyper-activation strategies and an inherent uncertainty as to the availability and trustworthiness of others or the worthiness and competence of the self. This presentations is typically

associated with attachment figures who were at times hostile or dangerous (Mikulincer & Shaver, 2007).

Though people may tend to rely primarily on one global attachment orientation, it is rarely to the complete exclusion of others (Crowell et al., 2016). This is in part because attachment is more context and relationship-specific than previously believed, meaning that a particular context or relationship can elicit different degrees of attachment security than typical of the global attachment orientation (Barry et al., 2007). There is further support for the idea that attachment orientation is malleable in an extensive body of research on *security priming*, which involves imaginal or remembered experiences of attachment security and has been shown to decrease negative affect, increase positive affect, and shifting global attachment orientation towards security with repetition (Byrant & Chan, 2017; Rowe et al., 2020).

Attachment, Depression and Anxiety

Attachment insecurity is associated with higher incidences of both depression and anxiety (Mikulincer & Shaver, 2007, p. 406). This association is theorized to be caused by learnt emotion regulation processes rooted in the attachment-related working models.

Emotion

Out of the immense totality of possible emotions, it is agreed among psychology researchers and theorists that there are a small number of core emotions, which include (with some debate): sadness, anger, fear, joy, shame and surprise (Johnson & Campbell, 2023). William James was one of the first in the field of psychology to observe that emotions have physiological responses and adaptive functions (Johnson & Campbell, 2022). John Bowlby elaborated on the adaptive functions from an attachment-perspective stating that emotions help to orient oneself to personal needs, motives, and priorities and communicate these to others

(Johnson & Campbell, 2022). In essence, emotions are immediate, potent, physiological means of communication between the external and internal worlds.

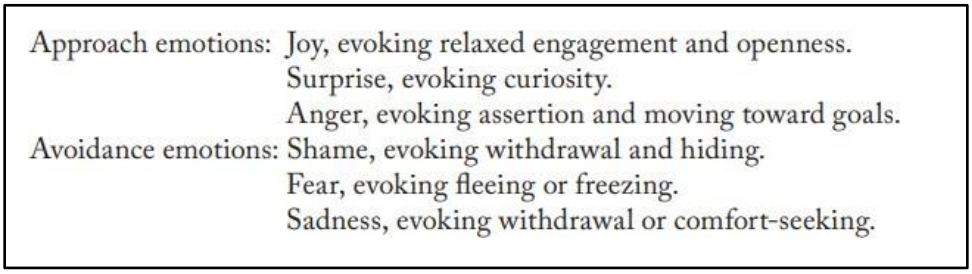
Emotion Regulation

The emotion regulation process involves stimulus, cognition, felt sense, and response (Johnson, 2019; Mikulincer & Shaver, 2007). The stimulus, which may be an external or internal environmental change, is immediately and subconsciously appraised cognitively in relation to personal needs, goals, and concerns, shaped by personal significance and history. Almost instantaneously, the appraisal is followed by physiological changes, like increased blood pressure, muscle tension, or changes to attention (Elkjaer et al., 2023; Mikulincer & Shaver, 2007). Emotion is this "felt sense" experience and its purpose is to signal action which attends to the underlying need, goal or concern. The entire process from stimulus to response is called the emotion-action tendency (Johnson, 2019).

There are broadly two emotion-action tendencies of approach and avoidance in response to different core emotions (see Figure 1) (Johnson, 2019; Johnson & Campbell, 2023). When an emotion is congruent with its action and effectively attends to the underlying need, then the emotion has served its purpose and the system returns to a neutral physiological state (Elkjaer et al., 2023; Johnson, 2019; Johnson & Campbell, 2023; Mikulincer & Shaver, 2007). This represents effective emotion regulation (Elkjaer et al., 2023). Oftentimes, however, there are social or protective reasons that make experiencing or expressing emotion congruently undesirable, in which case alternate regulatory efforts are exerted to postpone, dampen, alter, or amplify the emotion (Mikulincer & Shaver, 2007).

Figure 1

Emotion-Action Tendencies



Note. From A*ttachment Theory in Practice* by Sue Johnson (2019).

Attachment Security and Emotion Regulation

People operating from a secure base script will experience their emotions more consciously and accurately, have the cognitive flexibility to reappraise situations and consider alternative meanings, and the emotion regulation skills to self-soothe and seek support from others as needed (Mikulincer & Shaver, 2007). Most often, their emotion-action tendency is congruent which reinforces the belief that emotions are useful, transient messengers and that they can be managed and communicated with others safely (Johnson, 2019; Mikulincer & Shaver, 2007). This naturally aligns with working models of self as worthy and capable and others as available and trustworthy (Mikulincer & Shaver, 2007).

Attachment Avoidance and Emotion Suppression

The hypoactivating strategies within attachment avoidance are designed to inhibit emotional experiencing to keep the attachment system deactivated. The action tendency may be to downregulate or dissociate from the experience, suppress emotionally infused memories or thoughts, divert attention, and outwardly mask the expression of emotion (Mikulincer & Shaver, 2007). The avoidant response is rooted in the beliefs that interdependence is risky because others are unavailable and rejecting, and so self-reliance is necessary (Mikulincer & Shaver, 2007). This emotional regulation response is characteristic of depression,

which also involves the suppression of emotion, a feeling of isolation, and avoidance of support-seeking.

Hypoactivating strategies are mainly directed at emotions that arise from vulnerability in face of threat, like fear, sadness, anger, shame, guilt, or distress because these are the emotions that naturally drive proximity-seeking behaviours and were likely met with rejection by early attachment figures (Mikulincer & Shaver, 2007). Selective inhibition of emotions is improbable, however, and studies show that any act of emotional suppression affects all emotional experiencing, which may explain the symptoms of anhedonia, or loss of pleasure or joy characteristic of depression (Beblo et al., 2012). Moreover, the fear of interdependence may drive the avoidant response to inhibit expressions of joy or happiness within relationships, to avoid intimacy and the correlated attachment-related threat of rejection (Mikulincer & Shaver, 2007).

Attachment Anxiety and Emotion Amplification

The hyperactivating strategies within attachment anxiety are designed to catch and sustain the attention of attachment figures through intensifying emotions and demands for response (Mikulincer & Shaver, 2007). The action tendencies may be to catastrophize, amplify the threatening nature of benign concerns, exaggerate nonverbal signals of distress like facial expressions, remain vigilant to changes in emotional states, and ruminate on actual or potential threats (Mikulincer & Shaver, 2007). The anxious response is rooted in beliefs that relaxing is dangerous because others are inconsistent, and so remaining vigilant and maintaining efforts to keep the attachment figure's attention is necessary (Mikulincer & Shaver, 2007). This emotion regulation process is characteristic of anxiety, which also involves preoccupation with threat and emotional states.

Though the hyperactivating response implicitly makes a request for proximity through distress signals, the request is often indirect and when attained it rarely soothes the activated attachment system which remains vigilant to the eventual disengagement of the attachment figure (Mikulincer & Shaver, 2007). Further, the fear-based ruminations in anxious attachment overburden cognitive capacity rendering self-reflective processes and reappraisals of situations more challenging (Mikulincer & Shaver, 2007).

Attachment insecurity is an evident perpetuator of depression and anxiety. Shifting the attachment system towards security could prevent, treat, or manage symptoms (Johnson, 2019). Attachment-based therapies utilize the therapeutic relationship to explore attachment histories and process distressing emotion with the goal of introducing flexibility into working models of self and others and internalizing a secure base script (Johnson & Campbell, 2023).

Emotionally-Focused Individual Therapy (EFIT)

EFIT is an attachment-based therapeutic modality which stems from decades of research on Emotionally-Focused Therapy for couples (EFCT). Grounded in a humanistic and systemic approach, the foundational principle of Emotionally-Focused Therapy is that change occurs through relational experiences which foster congruent emotional regulation processes and which through repetition can restructure the attachment system towards security (Johnson, 2019; Wiebe & Johnson, 2016).

Evidence Base

There is a strong evidence base supporting the effectiveness of EFCT as an empirically validated couples' therapy that is unique in its approach to emotion (Furrows & Bradley, 2011; Johnson, 2019). Over relatively short courses of treatment, EFCT has been shown to improve relationship adjustment and resolution of target problems, as well as couple stability, intimacy,

and empathy when compared to more behavioural approaches, and results are most often maintained or improved post-treatment (Wiebe et al., 2017; Wiebe & Johnson, 2016). EFCT researchers have observed the efficacy of the model against more complex populations, including with trauma survivors, couples coping with chronic illness, and with attachment injuries requiring forgiveness (Johnson & Wittenborn, 2012; Wiebe & Johnson, 2016).

As the newest iteration, EFIT has no publicized findings to-date with populations of individuals experiencing depression and anxiety, though current studies are being conducted. A randomized controlled trial by Dessaulles et al. (2003) of heterosexual couples in which the female partner met criteria for Major Depressive Disorder compared pharmacological treatment versus EFCT. Both groups showed improvement in depressive symptoms by end of treatment, however the EFCT group demonstrated additional improvement in relationship adjustment, and persistent gains post-treatment when compared to the control group. Findings from research on a population who met criteria for Social Anxiety Disorder using a therapeutic modality which also centers emotion and experiential processing noted reductions in self-criticism, increased ability to self-reassure, as well as greater expressions of healthy assertive anger (Haberman et al., 2019; Shahar et al., 2017). These, combined with sound theoretical predictions, represent preliminary evidence for the efficacy of EFIT, but further studies are needed.

Processes of Change

EFT is fundamentally an experiential therapy which utilizes present processing of emotions as they occur in session, exploring automatic and reactive responses to uncover hidden primary emotions rooted in attachment fears or longings (Furrow & Bradley, 2011; Johnson, 2021; Johnson, 2019). In EFCT, partners are encouraged to share deeper emotional experiences with one another and coached to respond with attunement and empathy (Johnson & Wiebe,

2016; Johnson, 2021; Johnson, 2019). Through repetition, they develop a felt sense of the emotional regulation inherent in the secure base script and update rigid working models of self and other (Johnson, 2021; Johnson, 2019). EFIT therapists do the same work *within* the client by using imaginal experiences with earlier attachment figures or aspects of self, like a younger part (Johnson, 2021; Johnson, 2019).

EFIT occurs in three stages. The first stage, *stabilization*, involves joining with the client in understanding their presenting problem and formulating treatment goals (Johnson, 2021; Johnson, 2019). The client in this stage will begin to understand how they maintain their depressive or anxious symptomology through patterns in emotional regulation and will become more explicit and specific with their emotional experiences over time (Johnson, 2019). The therapist will choreograph imaginal enactments with important attachment figures from the client's narrative, or with disowned aspects of self, wherein the client uses their newfound emotional language and evolving action tendencies to respond in new ways (Johnson, 2019).

The second stage, *restructuring*, involves continuation of the exploration and enactments begun in the first stage but will become more evocative and intensive, connecting to painful emotions rooted in very rejecting or dismissing figures in the client's past or to despised aspects of self (Johnson, 2021; Johnson, 2019). Emotional responses are heightened or contained so that they are challenging but not overwhelming, and are normalized within an attachment frame (Johnson, 2019). Finally, the third stage, *consolidation*, involves applying new discoveries to current and everyday problems. The client demonstrates a new ability to use their emotion as a compass directing them towards their needs and goals, and implementing new solutions with confidence (Johnson, 2021; Johnson, 2019).

All three stages of EFIT depend on a strong therapeutic relationship which is secure, exploratory, collaborative, and adaptive over therapy (Johnson, 2019). This relationship is commonly referred to in psychotherapy practice and research as the *working alliance* and has been shown to be one of the primary change factors across all therapeutic modalities (Bernecker et al, 2014; Diener & Monroe, 2011; Doran, 2016), but may be particularly relevant to attachment-related injuries and therapies, which center the relationship as an important element of treatment (Johnson, 2021; Johnson, 2019; Johnson & Talitman, 1997).

Working Alliance

The relationship between therapist and client has been a focal point of therapy research and is considered a primary factor in client change (Horvath & Symonds, 1991). Freud first theorized that the therapist-client relationship primarily involves transference processes whereby the client assigns to the therapist unconscious projections from their past in the hopes of resolving them (Fluckiger et al. 2018). Carl Rogers later theorized that an effective therapist brings certain necessary qualities, like unconditional positive regard and empathy, which facilitate change in the client (Horvath & Symonds, 1991). The term working alliance was coined by researcher and psychologist Edward Bordin (1979) to describe the therapeutic relationship as a collaborative process between the therapist and client rather than something which belongs to either individually, and is most commonly used in research on the therapeutic relationship today (Doran, 2016).

The working alliance is comprised of three interrelated collaborative facets: agreement on therapeutic goals, agreement on therapeutic tasks, and the quality of the relational bond (Bordin, 1979; Doran, 2016). This formulation introduced both the concept of client-therapist interdependence and the ability to measure the therapeutic relationship empirically (Horvath & Greenberg, 1989). In the

interceding years studies have contributed strong evidence for the transtheoretical significance of the working alliance on outcomes. There is some mixed reporting on whether the three facets of the working alliance exert unique influence on outcomes, but what is well-reported is that overall weaker working alliances are associated with higher rates of premature psychotherapy dropout (Sharf et al., 2010), while stronger working alliances are associated with positive therapeutic outcomes regardless of theoretical orientation, treatment course, or presenting problem (Bernecker et al, 2014; Diener & Monroe, 2011; Doran, 2016).

Attachment and the Working Alliance

Research has confirmed what could be anticipated about the relationship between adult attachment and the development and strength of the working alliance: client attachment security is associated with stronger working alliances than client attachment insecurity (Bernecker et al., 2014; Diener & Monroe, 2011). The average therapist caseload is likely to have greater proportions of individuals with attachment insecurity as compared to the general population, however, and so exploring nuances in attachment insecurity is beneficial to psychotherapists in the field (Bernecker et al., 2014). The wariness of or pressing need for intimacy associated with attachment insecurity make the development of early working alliances more involved (Diener & Monroe, 2011), and render them more vulnerable to rupture (Eames & Rothe, 2000). Rather than preclude the formation of working alliances, though, this knowledge can present opportunities to expose relational patterns and attend to them in a direct and non-threatening manner (Diener & Monroe, 2011).

Studies are mixed on the separate influence of attachment avoidance and anxiety, and both appear to impact the working alliance equally (Bernecker et al., 2014). The authors Bernecker et al. (2014) theorize that this may relate to different relational fears affecting

alliances through separate pathways but with comparable effect. Those with greater attachment avoidance may perceive the therapeutic process, and therefore the therapist, as infringing upon them or probing too deeply, and those with greater attachment anxiety may be dissatisfied with the level of support provided or be more sensitive to rupture. Conversely, it may be that therapists naturally attune to moment-to-moment client presentation and respond accordingly, therefore unknowingly attending to different presentations of attachment insecurity and moderating their effects on the working alliance equally (Bernicker et al., 2014; Eames & Roth, 2000). Experienced therapists in a qualitative study by Daly & Mallinckrodt (2009) explicitly outline some of the ways in which they tailor the therapeutic process dependent upon a client's anxious or avoidant attachment presentations, including more time spent in an initial "engagement" phase of therapy, more attention to relational factors like boundaries, ruptures and repair, and careful preparation for termination. These are some of the ways that therapists are able to develop secure bonds regardless of client's overall attachment insecurity (Slade & Holmes, 2019).

The bond subscale and the secure base concept are closely related and potentially overlapping processes. Both describe the emotional-relational space from which the therapist and client collaboratively negotiate and agree upon the more cognitive elements of the tasks and goals of therapy. Bordin and Bowlby use slightly different language to describe the "bonds" within their theories though (Pérez-Rojas et al., 2019). Bordin (1994) describes a "liking, trust, and respect for one another, and a sense of common commitment and shared understanding", reminiscent perhaps of a more adult-to-adult version of Bowlby's secure bond between attachment figure and child, described as a "safe haven" in times of need, providing protection, comfort, support, and relief (Mikulincer & Shaver, 2007). To complicate further, some

understand the bond between therapist and client as the “real relationship”, i.e. the mutual appreciation of one another as individuals, separate from therapeutic work (Pérez-Rojas et al., 2019). Differentiating between these concepts may be hairsplitting, and what remains foremost is that the three components of the working alliance together facilitate therapeutic change and are deserving of consideration when working with individuals with attachment insecurity.

The Current Study

The working alliance has been shown to be one of the greatest predictors of positive outcome in psychotherapy generally, and EFT specifically (Johnson & Talitman, 1997) and is the foundation of each of the three stages of EFIT. The current study aims to investigate the relationship between the working alliance and attachment in EFIT, within a population experiencing mild-to-moderate depression and anxiety.

Hypotheses

1. The total working alliance and subscale scores will be significantly negatively correlated with attachment insecurity as measured by higher levels of attachment anxiety and attachment avoidance at baseline, midpoint, and post.
2. Greater attachment security as measured by lower levels of attachment anxiety and attachment avoidance at baseline will significantly predict increased working alliance scores at midpoint and post.
3. Greater working alliance scores at midpoint will significantly predict positive change in attachment security (i.e., decreases in attachment anxiety and attachment avoidance) between baseline and post.

Methods

Research Design

This study utilizes data from a randomized controlled trial (RCT) carried out across three study sites (Ottawa, Denver, Victoria) comparing a treatment group (*n*=36) and a wait-list control (*n*=38). The wait-list control group received an empirically validated online transdiagnostic cognitive-behavioural treatment for depression and anxiety following a 15-week wait period. The treatment group received approximately 15 sessions of EFIT. Therapy was carried out by twenty-two experienced EFT therapists in private practice trained in the EFIT model. The participants completed self-report measures following each therapy session and during the follow-up phase of the study. We used data collected from the treatment group for this study.

Recruitment of Participants

Participants were recruited (*n*=36) through university and psychotherapeutic networks via posters, email and social media. Interested participants experiencing symptoms of depression or anxiety were invited to contact the research coordinator via email. All interested participants were screened over-the-phone and if preliminarily eligible were invited for an in-person initial study assessment to determine final eligibility.

Treatment

Twenty-two experienced EFT therapists trained in the EFIT model provided 12-17 sessions of EFIT treatment to approximately 2 clients each. Therapy was conducted in private practices in each of the study sites in Ottawa, Ontario; Victoria, British Columbia; and Denver, Colorado. Covid-19 pandemic restrictions temporarily interrupted all sessions for approximately one week of treatment until the study received Research Ethics Board approval to continue

therapy services virtually. 16% (*n*=6) of participants started in-person therapy (*M* = 5.17 (3.06) in-person sessions) prior to transitioning to virtual. Fidelity to the treatment model was assured through weekly supervision and coding of session video recordings. Therapists asked clients to complete a brief ~15-minute questionnaire online after each session using a study tablet.

Participants

A summary of socio-demographic characteristics of the 36 participants can be found in Table 1. The average age of participants was 34 years old and most were female (67%), Caucasian (72%) and heterosexual (75%). Over half (67%) were in committed relationships and about a third (33%) had children. Most (69%) had experienced psychotherapy or counselling in the past.

Table 1

Socio-demographic Characteristics of Participants at Baseline

	Total sample (*N* = 36)
Variable	N (%)
Age (Mean, SD)	34.19 (11.58)
Sex	
Female	24 (66.7%)
Male	12 (33.3%)
In Committed Romantic Relationship	24 (66.7%)
Have Children	12 (33.3%)
Ethnic Background	
Caucasian	26 (72.2%)
Asian	6 (16.6%)
Hispanic	2 (5.6%)
Indigenous	1 (2.8%)
Sexual Orientation	
Heterosexual	27 (75%)
Gay/lesbian	1 (2.8%)
Bisexual/pansexual	5 (13.9%)
Queer	1 (2.8%)
Income	
Under $20,000	5 (13.9%)
$20,000 - $50,000	9 (25%)
$50,000 - $100,000	10 (27.8%)
More than $100,000	12 (33.3%)

Note. *N* = individuals

Measures

Three measures were used to assess depressive and anxious symptoms (the ADIS-5, BDI-II, and BAI) and one measure each to assess attachment orientation and working alliance (the ECR and WAI). We used initial measures as baseline scores and repeated the measures for comparison at later timepoints.

The Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5)

The ADIS-5 is a structured interview that helps clinicians diagnose psychological disorders based on DSM-5 criteria and make differential diagnoses. It is a widely used measure for clinical research, which possesses good validity and reliability, and was used in the initial assessment to determine whether interested participants met the criteria for a diagnosis of depression or anxiety. (Brown & Barlow, 2014; Brown et al., 2001).

The Beck Depression Inventory II (BDI-2)

The BDI-2 is a 21-item self-report questionnaire used to assess the severity of depressive symptoms (e.g., sadness, guilt, crying, suicidal thoughts, etc.). Participants select statements relating to different themes which best represent their mood over the past two weeks. Each statement has a corresponding numerical value, and the sum of all statements is calculated for scoring purposes. A score of 0-13 indicates minimal depression, 14-19 indicates mild depression, 20-28 indicates moderate depression, and a score above 29 indicates severe depression (BDI-2; Beck, Steer, & Brown, 1996). Participants in the treatment group completed this questionnaire in paper format at baseline, session 5 and 7, and post.

The Beck Anxiety Inventory (BAI)

The BAI is a 21-item self-report questionnaire used to assess common symptoms of anxiety (e.g., rapid heartbeat, sweating, numbness, trembling, etc.). Participants are presented

with a list of common symptoms of anxiety and are asked to note how much they experienced each over the past week from a four item Likert scale ("not at all", "mildly", "moderately", and "severely") which correlate to numerical values for scoring purposes. The sum of all 21 items is calculated for the total score; a score of 0-21 indicated low anxiety, 22-35 indicates moderate anxiety, and a score of 36 and above indicates potentially concerning levels of anxiety (BAI; Beck, Epstein, Brown, & Steer, 1988). Participants in the treatment group completed this questionnaire in paper format at baseline, session 5 and 7, and post.

Both Beck inventories have been widely used in clinical research and have demonstrated good reliability and validity (Beck et al., 1988; Dozois, et al., 1998). Cronbach's alpha reliabilities in the current study for the BDI were high: baseline a = .91, midpoint 1 a = .84, midpoint 2 a = .92, post a = .9, as well as for the BAI: baseline a = .91, midpoint 1 a = .89, midpoint 2 a = .93, post a = .94.

Experiences in Close Relationships Questionnaire (ECR)

The ECR is a 36-item measure of individual attachment to romantic partners, along two scales of 18 items correlating to the dimensions of attachment anxiety and attachment avoidance (ECR; Brennan, Clark, & Shaver, 1998). The questionnaire is scored on a 7-point Likert scale (1=strongly disagree, 7=strongly agree). For the purposes of this study, approval was received to change wording within the measure from "romantic partners" to "loved ones" for broader investigation.

The ECR is a widely used measure of adult romantic attachment and has demonstrated discernible two-factor validity on subscales of anxiety and avoidance and strong internal reliability (α=0.95 and α=0.93 respectively), providing evidence that the model accurately and reliably measures these two distinct subscales (Graham & Unterschute, 2015; Sibley & Liu, 2004). The test-retest reliability of the ECR is notably stable over short assessment periods (86% shared variance over a 6-week period), demonstrating that it provides a reliable and consistent

measure of global attachment orientation without significant measurement error over short periods of time (Sibley & Liu, 2004).

The internal reliability measures of the current study ranged between α=0.72 and α=0.91 for anxiety and α=0.57 and α=0.84 for avoidance. The range for anxiety represents acceptable to excellent internal consistency reliability. The higher end of the range for avoidance is good, however the lower end of the range for avoidance represents questionable internal reliability consistency (α = < .70). The two findings that fell below the acceptable range were in sessions 15 and 16 where listwise deletion resulted in 50% and 74% of data being excluded for reliability testing in these two sessions. It is likely that participant attrition skewed the results for these sessions, and given that the alpha levels for all previous sessions were acceptable-to-good (α = .70-.90) we determined that there was adequate internal reliability consistency among the ECR avoidance items in the current study.

Working Alliance Inventory (WAI)

The WAI is a 12-item clinical tool which measures the three elements of 1) agreement on tasks for therapy, 2) agreement on goals for therapy, and 3) the development of a strong therapeutic relationship (WAI; Horvath & Greenberg, 1989). The questionnaire is scored on a 5-point Likert scale which rates the client's perception of the therapeutic relationship.

There is consistent evidence of moderate-to-strong positive intercorrelations between the subscales of the WAI, which warrants clinical and statistical consideration (Falkenström et al., 2015; Horvath & Greenberg, 1989). Most confirmatory factor analyses confirm a three-factor structure, while observing that the correlation between Task and Goal is notably high (close to α=.90) (Falkenström et al., 2015; Horvath & Greenberg, 1989), although some studies promote a two-factor structure which combines Task and Goal for this reason (Falkenström et al., 2015).

Given the magnitude of studies conducted of the WAI and using the WAI, it is generally accepted to possess adequate validity, measuring three distinct although highly related concepts (Falkenström et al., 2015). The WAI possesses adequate overall internal consistency reliability (α=.93) as well as on individual subscales in the literature (Horvath & Greenberg, 1989). The overall internal consistency reliability across total and subscales in the current study was α=0.917, indicating excellent internal consistency

Statistical Analysis

We performed all analyses using SPSS version 29. We used descriptive functions to explore participant characteristics including demographic data, and bivariate correlations to explore the strength and direction of linear relationships between variables (Field, 2013; Frost, 2019).

To investigate the predictive relationship between baseline attachment security and working alliance we used linear regressions. We computed residual change scores for attachment anxiety and attachment avoidance between baseline and post for use in linear regressions investigating the relationship between midpoint working alliance and change in attachment security over the course of treatment.

Preliminary Data Screening

Prior to analysis, we screened data for plausibility and missing values (Tabachnick & Fidell, 2013). We confirmed plausibility using minimum and maximum values and mean scores. A Missing Values Analysis showed that the percentage of missing data ranged from 5.3%-15.8%. Percentages were highest for post values which can be attributed to participant attrition, but the results of the chi square test showed that the data was missing completely at random: χ^2 =13.64 (30, n = 36), α=.99. Missing data reduces statistical power and can introduce bias into analysis (Field, 2013), so we used regression based multiple imputations to complete the dataset prior to analyses.

Normality

We inspected continuous measures of all relevant variables to assess normality through standardized skewness (z-skew) and standardized kurtosis (z-kurt) scores. Scores with a critical value above 3.29 or below -3.29 indicated significant skewness or kurtosis (Tabachnick & Fidell, 2013). Visual inspection of histograms and Q-Q plots confirmed that some variables were negatively skewed and leptokurtic, notably those for the WAI bond at midpoint and post and WAI goals at post. This indicates a greater proportion of individuals reporting high WAI scores, which is not unusual for research using the working alliance (Meier, 2022). Regardless, none of the variables exceeded either critical value for skewness or kurtosis and we determined the data to be adequately normally distributed.

Univariate outliers

We assessed the presence of univariate outliers using standardized z-scores. Standardized scores above 3.29 or below -3.29 would be considered outliers (Tabachnick & Fidell, 2013). No values exceeded these critical limits, and we determined that the data had no significant univariate outliers.

Results

Sample Attachment Findings

Table 2 shows the mean ECR scores for avoidance and anxiety among the sample at baseline, midpoint, and post. The mean avoidance scores for the study sample are higher than the ECR norms for avoidance (M = 2.93, SD = 1.18) while anxiety is roughly comparable to ECR norms (M = 3.64, SD = 1.33), which are taken from an online survey sample of over 22,000

(Fraley, 2005).

We investigated change in attachment between baseline and post using paired samples t-tests which showed significant reductions in attachment anxiety ($t(31) = 4.904$, $p = <.001$), and non-significant reductions in attachment anxiety ($t(31) = 1.890$, $p = .068$).

Table 2

Mean ECR Scores

	Total sample ($N = 36$)
Variable	
Avoidance (Mean, SD)	
Baseline	3.81, 0.73
Midpoint	3.63, 0.73
Post	3.44, 0.73
Anxiety (Mean, SD)	
Baseline	4.04, 1.29
Midpoint	3.76, 1.20
Post	3.53, 1.01

Note. N = individuals

Sample Working Alliance Findings

Table 3 shows the mean WAI scores among the sample at baseline, midpoint, and post. The maximum total score possible on the WAI is 60, which is broken down equally into a possible score of 20 on each subscale. These scores would indicate perfect agreement on tasks, goals, and bond of therapy. The results from the study show high scores across all three subscales and improvement throughout treatment, most notably in the task subscale.

Paired samples t-tests showed significant increases between baseline and post total and subscale WAI scores at the $p = <.001$ level: WAI total $t(34) = -6.432$, $p = <.001$, WAI Goals $t(34) = -4.100$, $p = <.001$, WAI Task $t(34) = -.7256$, $p = <.001$, and WAI Bond ($t(34) = -5.794$, $p=<.001$.

Table 3

Mean WAI Scores and Percentage of Agreement

	Total sample (N = 36)	
Variable	Mean, SD	%
Total		
Baseline	43.26, 8.62	72%
Midpoint	49.09, 7.93	82%
Post	52.93, 6.43	88%
Goal		
Baseline	14.38, 4.04	72%
Midpoint	16.04, 3.66	80%
Post	17.38, 2.90	87%
Task		
Baseline	12.62, 2.98	63%
Midpoint	14.80, 3.31	74%
Post	16.53, 2.92	83%
Bond		
Baseline	16.26, 2.85	81%
Midpoint	18.25, 2.26	91%
Post	19.10, 1.46	96%

Note. N = individuals, % = % client agreement with measure statements of working alliance out of a possible 100%

Hypothesis 1

A series of Pearson correlations were computed to assess the relationship between attachment (mean ECR scores on both subscales at each timepoint) and working alliance (mean total and subscale WAI scores at each timepoint).

Table 4

Significant Correlations between Attachment (ECR) and Working Alliance (WAI)

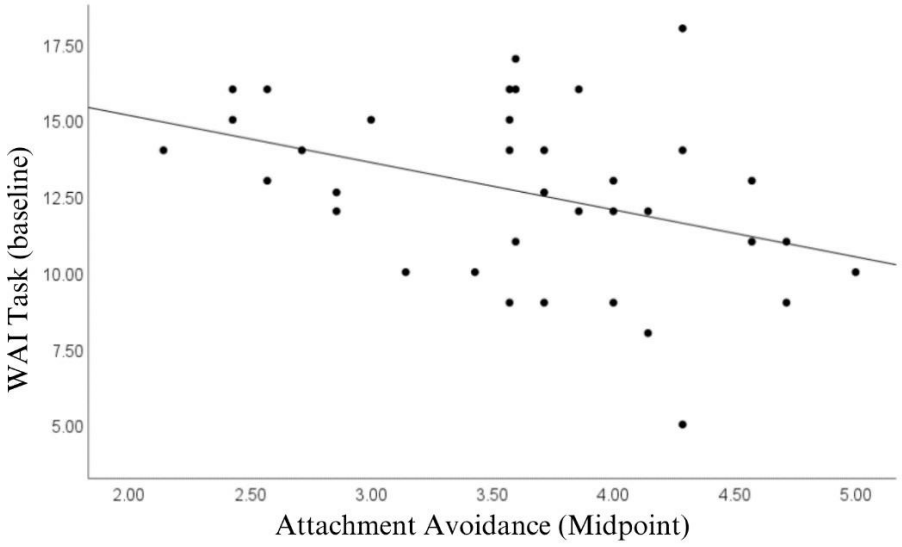
	Total sample (N = 36)	
Variables	Avoidance - midpoint	Avoidance - post
Task - baseline	-.388*	-.392*
Task - midpoint	-.408*	-.426**
Goal - midpoint	-.382*	-
Total - midpoint	-.390*	-

Note. * $p < 0.05$ level (2-tailed). ** $p < 0.01$ level (2-tailed).

Significant relationships not reported include different timepoints of the same measure, and between subscales of the WAI, which is anticipated and not relevant to the current study hypotheses. We found one moderately significant positive correlation between attachment avoidance and anxiety at midpoint ($r(34) = .353$, $p=.035$). There were no significant correlations between attachment anxiety and any WAI scores at any timepoint, nor between attachment avoidance and any timepoint of the WAI bond subscale.

Figure 2

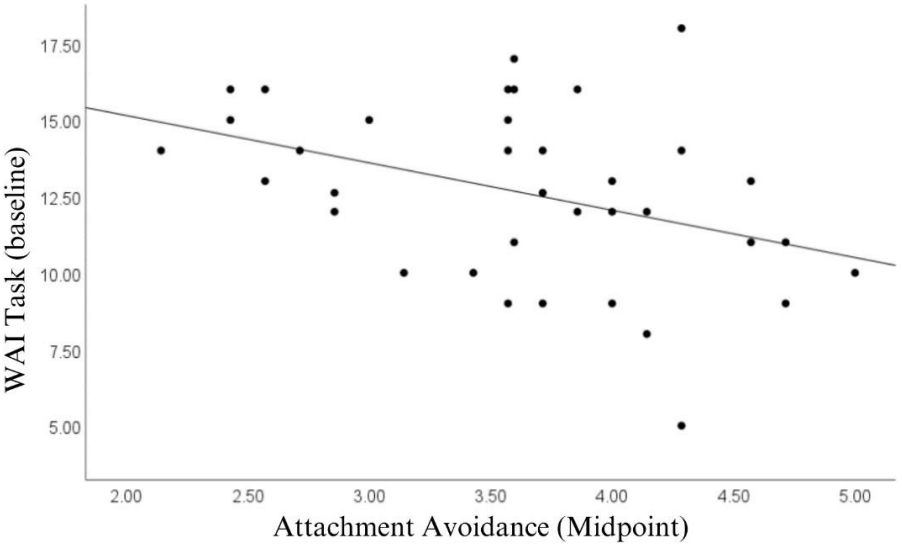
Scatterplot of ECR Avoidance at Midpoint and WAI Task at Baseline



Note. $r(34) = -0.39$, $p=.02$

Figure 3

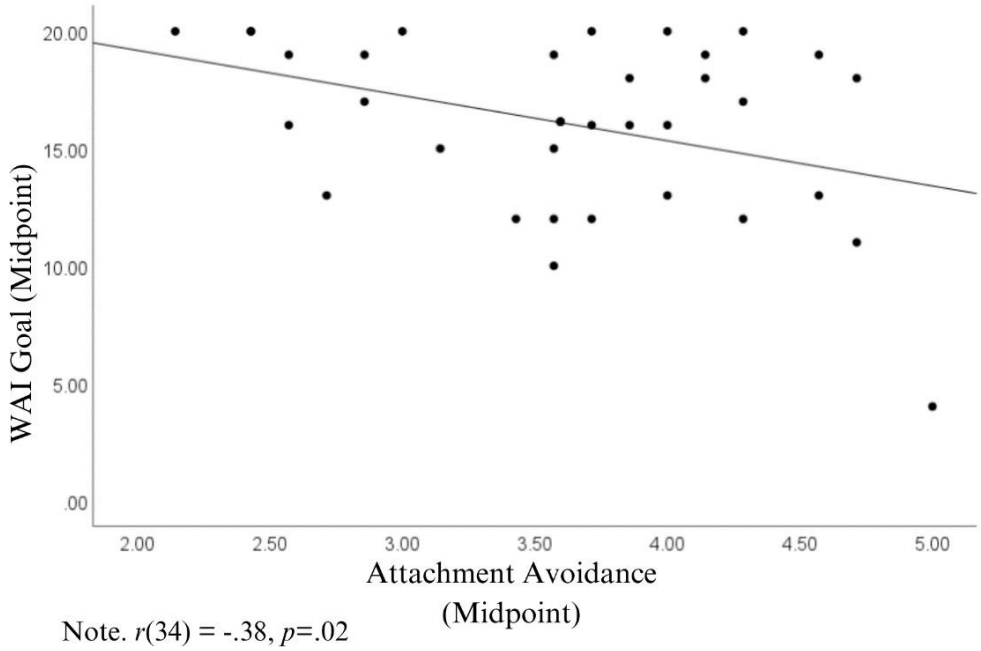
Scatterplot of ECR Avoidance at Midpoint and WAI Task at Baseline



Note. $r(34) = -0.39$, $p=.02$

Figure 4

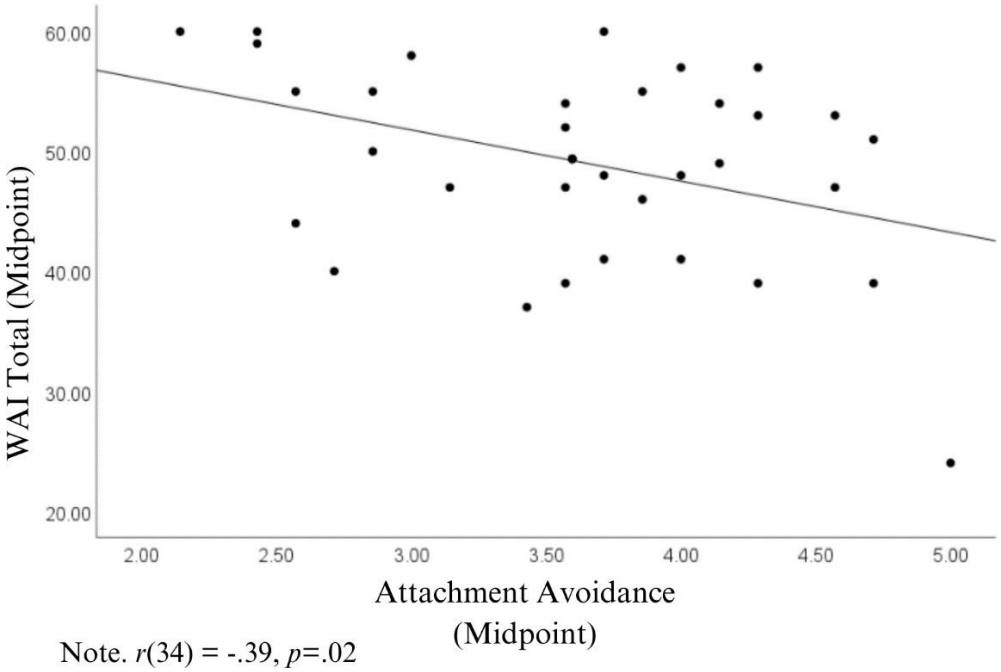
Scatterplot of ECR Avoidance at Midpoint and WAI Goal at Midpoint



Note. $r(34) = -.38$, $p=.02$

Figure 5

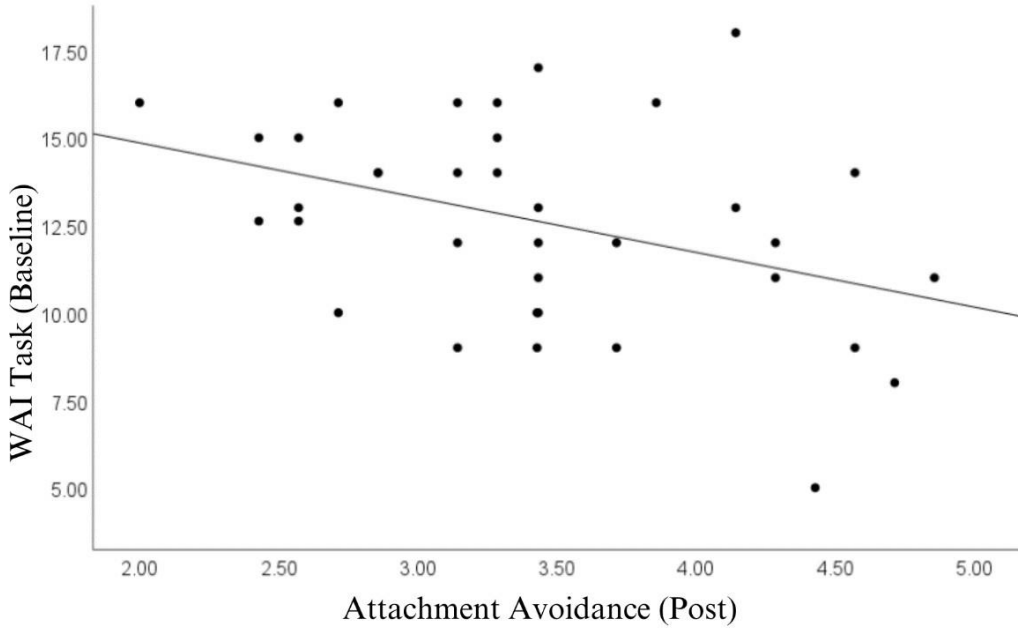
Scatterplot of ECR Avoidance at Midpoint and WAI Total at Midpoint



Note. $r(34) = -.39$, $p=.02$

Figure 6

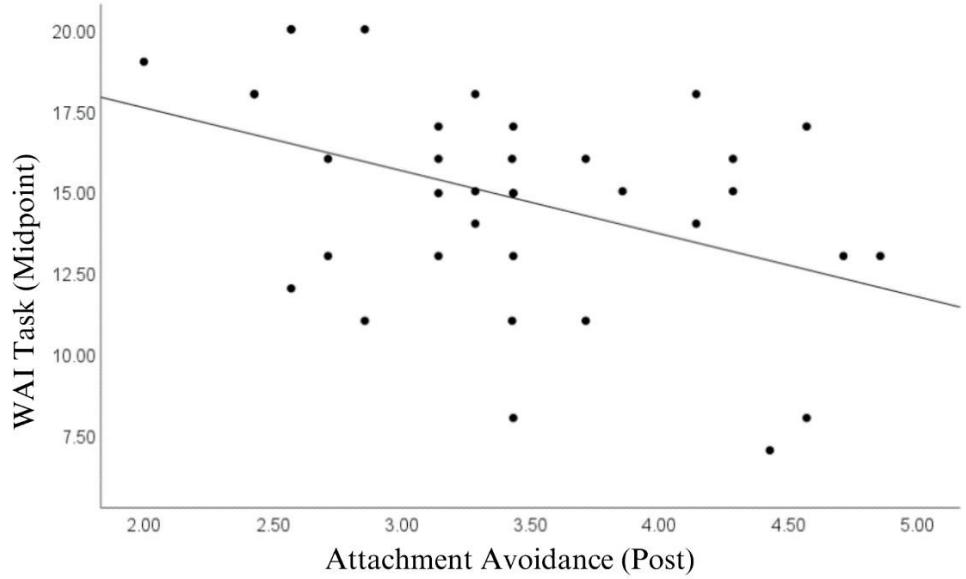
Scatterplot of ECR Avoidance at Post and WAI Task at Baseline



Note. $r(34) = -.39$, $p=.02$

Figure 7

Scatterplot of ECR Avoidance at Post and WAI Task at Midpoint



Note. $r(34) = -.43$, $p=.010$

Hypothesis 2

We performed linear regressions using ECR anxiety and avoidance scores at baseline as predictors for total and subscale WAI scores at midpoint and post. Hypothesis two was not supported as there were no statistically significant regressions detected.

Table 5

Nonsignificant Linear Regressions of Baseline Attachment Predicting Working Alliance

	Independent Variables							
	ECR Avoidance (baseline)				ECR Anxiety (baseline)			
Dependent Variables	*B*	*SE*	*t-test*	*p*	*B*	*SE*	*t-test*	*p*
WAI Total (midpoint)	-1.13	1.91	-0.59	.56	-0.24	1.09	-0.21	.83
WAI Total (post)	-0.52	1.55	-0.33	.74	-0.29	0.88	-0.33	.75
WAI Task (midpoint)	-0.87	0.79	-1.01	.32	0.26	0.45	0.57	.57
WAI Task (post)	-0.33	0.70	-0.47	.64	0.15	0.40	0.38	.71
WAI Goal (midpoint)	-0.64	0.88	-0.73	.47	-0.30	0.50	-0.60	.55
WAI Goal (post)	-0.51	0.74	-0.74	.47	-0.14	0.40	-0.35	.72
WAI Bond (midpoint)	0.30	0.54	0.57	.57	-0.19	0.31	-0.62	.54
WAI Bond (post)	0.27	0.35	0.78	.44	-0.29	0.25	-1.58	.14

Notes. B= unstandardized B and p <0.001

Hypothesis 3

Hypothesis three was partially supported by a single significant regression where the WAI task subscale at midpoint predicted 16% of the variation in attachment avoidance between baseline and post ($F(1, 34) = 6.481$, $p = .016$). There were no other statistically significant regressions.

Discussion

Previous research has noted that client attachment insecurity negatively impacts the working alliance, which is correlated with therapeutic outcomes (Bernecker et al, 2014; Diener & Monroe, 2011; Doran, 2016). This provides support that addressing attachment insecurity is optimal for better therapeutic outcomes regardless of modality. Studies of both working alliance and attachment are extensive, but this represents the first study of each within the context of EFIT, an attachment-oriented therapy.

Attachment Change

We found reductions in attachment insecurity in the current study. The reduction in attachment anxiety was significant, while the reduction in attachment avoidance was not. The literature confirms that client attachment may change in psychotherapy treatment, although not consistently across studies, and that avoidance may be particularly resistant to change (Fraley, 2002; Taylor et al., 2015; Slade & Holmes, 2019). A systematic review of the literature on attachment changes in therapy demonstrated that clients tend to report reduction in attachment anxiety through therapy, but no change in avoidance (Taylor et al., 2015). One study of EFCT for couples who had experienced attachment injuries observed that individual attachment did not change throughout therapy, even when the couples identified the attachment injury as resolved, and distress as significantly reduced within the couple (Makinen & Johnson, 2006). Research on an attachment-oriented couples therapy for relational dissatisfaction found that over just 6 sessions couples did experience reductions in individual attachment insecurity but noted that attachment anxiety changed more in the first three sessions and then plateaued, whereas attachment avoidance did not change until the last three sessions (Seedall et al., 2015).

Travis et al. (2001) studied change in attachment patterns among individuals in a short course of psychodynamic therapy and found that 66% of clients changed attachment patterns throughout therapy, but the majority moved from one insecure attachment orientation to another.

The 24% who changed from insecure to secure attachment were those who exhibited the least severe symptoms pre-treatment, although the rate of change was the same for those who did not attain security. This study notably had only two individuals with an initial avoidant attachment orientation, one of whom remained categorized as avoidant at the end of treatment, while the other was categorized as secure. Unfortunately, study samples often have lower number of participants with attachment avoidance, likely due to their lower help-seeking behaviour (Dozier, 1990).

These varying results in attachment change through therapy could be explained by the findings in a longitudinal study by Fraley (2002) modeling the dynamics of attachment stability and change across the lifespan. The author found that there is a moderate degree of stability in attachment orientation across the lifespan, which is best explained as a prototype model, whereby current experiences are biased by past experiences, and easily incorporated into existing prototypical beliefs about the self and others. Nonetheless, the author observed that attachment can fluctuate over the lifespan in response to new contexts, but change is limited around a set-point formulated in childhood. Further, he stated that short-term or generalized treatments may elicit only transient change in attachment security while in therapy, and that long-term attachment change would likely require persistent, intentional attachment-based corrective experiences over a longer-term therapy (Fraley, 2002). The sample in the current study had higher than normal levels of attachment avoidance compared with the general population, while attachment anxiety was comparable (Fraley, 2005). This may also explain why the reductions in attachment avoidance did not reach significance, either because there was insufficient time in the study or because attachment change is limited around as was found by Fraley (2002).

All the studies cited are attachment-based therapies which may explain the attachment changes that were observed in most. There are limited studies of non-attachment-oriented psychotherapy modalities which investigate change in attachment as a therapeutic outcome, so

the speculation that change occurs more in attachment- oriented therapies is theoretical. Additionally, few studies, including those cited, have follow-up or longitudinal data available to confirm the persistence of the reported attachment change after therapy.

Many attachment researchers explain the variation in findings on attachment change (and on other therapy processes and outcomes) as a combination of the characteristics of insecure attachment orientations and/or the therapist's responsiveness to attachment insecurity in clients, including attending to the working alliance through attuned, timely, and corrective responses to transference-processes (Bernecker et al., 2014; Daly & Mallinckrodt, 2009; Diener & Monroe, 2011; Taylor et al., 2015; Slade & Holmes, 2019). Other mediating factors frequently mentioned in the literature include the therapist's experience, the therapist's global attachment orientation, and the client-therapist attachment "match" (these studies differ on whether complimentary or opposing attachment orientations are more beneficial for clients in terms of working alliance development or attachment change) (Slade & Holmes, 2019; Degnan et al., 2011). Few studies have investigated the role of non-relational variables promoting change in attachment in therapy; however, a study of therapy for individuals with borderline personality disorder identified higher mentalizing (or reflective functioning) ability of clients at baseline as a predictor of attachment security at termination (Tmej et al., 2018). It may be that other variables which influence attachment change in therapy are under researched, offering an additional explanation for the variation in research findings.

An important caveat when discussing attachment change in therapy, is that there is limited research which directly connects change in security with better clinical outcomes (Daniel, 2006). Studies conflict on the impact of attachment insecurity on therapeutic outcomes generally, with some reporting that anxiety limits outcomes whereas avoidance has no correlation with outcomes, others finding that any attachment insecurity limits outcomes (Slade & Holmes, 2019), and others still finding minimal to no correlation between attachment

insecurity and outcomes (Levy et al., 2014). The theoretical and statistical evidence for improved clinical outcomes in EFT is substantive, but studies have not yet explored the relationship between attachment system reorganization and clinical outcomes, though this is the theory of change. Nonetheless, there is sufficient evidence to support that attachment insecurity negatively impacts therapeutic processes including the formation of the working alliance and can limit clinical outcomes (Bernecker et al., 2014; Diener & Monroe, 2011; Taylor et al., 2015; Slade & Holmes, 2019).

Existing literature supports the current study finding of reduced change in avoidance compared with anxiety (Taylor et al., 2015). Avoidance seems to change less immediately in therapy (Seedall et al., 2015) and to a lesser extent (Taylor et al., 2015), which is likely explained by the avoidant tendency to suppress attachment needs and emotion. The research provides theoretical support, however, that attending to the working alliance through an attachment-perspective may result in reductions in client attachment insecurity (Daly & Mallinckrodt, 2009; Taylor et al., 2015; Slade & Holmes, 2019).

Attachment & The Working Alliance

The literature on attachment and working alliance is extensive. Meta-analyses conclude that client attachment security is associated with easier working alliance formation and consistently stronger working alliance ratings throughout therapy (Bernecker et al, 2014; Daniel, 2006; Diener & Monroe, 2011). The relationship between attachment insecurity and the working alliance varies between studies, and across different timepoints of therapy, but there is consensus that these is a possible mutual influence between the two, with greater attachment insecurity exerting a negative pressure on the working alliance, and greater working alliance potentially moderating attachment insecurity (Bernecker et al, 2014; Daniel, 2006; Diener & Monroe, 2011).

Kivlighan & Shaughnessy (2000) studied the development of the working alliance over

time and discovered three common patterns: stable alliance, linear alliance growth, and a high-low-high pattern which they named quadratic alliance growth. The high-low-high pattern was most strongly associated with positive clinical outcomes, including reduction in interpersonal problems. The theory behind this finding is that it is mirrored by the rupture-and- repair process in therapy, which is considered importantly therapeutic, representing a corrective relational experience (Kivlighan & Shaughnessy, 2000).

A study by Kanninen et al. (2000) investigating the effects of client attachment on the development of working alliance in trauma therapy with 36 Palestinian political ex-prisoners found similar patterns of working alliance formation and correlated these with client attachment orientations. They found no difference in initial alliance scoring between attachment groupings, but notable difference in later sessions. The secure and anxiously oriented groupings both had similar high-low-high patterns to alliance, but the fall and rise of ratings were steeper in the anxious group than the secure group. The avoidantly attached group demonstrated a stable working alliance pattern, dropping off near the end of therapy. The authors theorize that the more extreme highs and lows of the anxiously attached group mirror the characteristic of amplifying emotional highs and lows, and the reduction in alliance among the avoidantly attached group mirrors a protective dismissal of the importance of the relationship as termination approaches (Kanninen et al., 2000). Eames & Roth (2000) tracked patterns of rupture and repair in different attachment presentations and reported significantly more ruptures with clients with more anxious tendencies and significantly fewer with clients with more avoidant tendencies, confirming that the working alliance development is more tumultuous in attachment anxiety.

The current study differs from the research cited in the absence of significant correlations between attachment anxiety and the working alliance, where we anticipated negative relationships based on the literature, as well as the complete absence of a significant predictive relationship between baseline attachment and working alliance development. Attachment anxiety and pre-treatment attachment insecurity did not negatively impact the development of the

working alliance in the current study.

Previous research has highlighted the difficulty of engaging those with higher attachment avoidance in therapy (Dozier, 1990; Slade & Holmes, 2019; Taylor et al., 2015). A study of attachment-related patterns in treatment use among individuals with significant psychopathology found that clients with higher avoidance tend not to seek help, make use of available resources, or self-disclose openly to treatment providers (Dozier, 1990). A meta-analysis of attachment and psychotherapy processes reported weaker alliances and negative transference with attachment avoidance, but that when therapists heightened emotion in session the clients found the sessions more helpful (Slade & Holmes, 2019). These findings are consistent with the suppression of emotion and attachment needs characteristic of attachment avoidance.

Though pre-treatment attachment insecurity did not predict weaker working alliances, the WAI task factor at midpoint accounted for 16% of the change observed in attachment avoidance between baseline and post. This is not the first study to find an isolated effect of the task or combined task and goal factors of the WAI on therapy outcomes. One early study of EFCT also observed that the task factor of the working alliance was significantly associated with outcomes where the other factors were not (Johnson & Talitman, 1997). Two studies of obsessive-compulsive disorder treatment using exposures (Hagen et al., 2016; Wheaton et al., 2016), and one study of CBT for the treatment of depression (Andrusyna, 2001) all found that the task and goal factors of the WAI were the most predictive of outcomes.

Another study comparing client and therapist ratings of working alliance in 48 client-therapist dyads over 14 sessions, showed that therapists and clients consistently rated the bond subscale the highest with minimal disagreement, but frequently reported notable differences in ratings of the task and goal subscales. The researchers found that client-rated agreement on the task factor was most correlated with session impact, particularly in earlier sessions (Fitzpatrick et al., 2007). WAI task is the only baseline variable in the current study with a significant negative

correlation, which provides support to attending to this factor in early sessions of EFIT as well, specifically in the presence of attachment avoidance.

EFIT Considerations

EFIT centers the working alliance as the foundation of therapeutic treatment and frame challenges in working alliance in terms of attachment insecurity (Johnson, 2019). The research on attachment and psychotherapy state that therapists operating from an attachment approach are attuned to signs of client attachment insecurity, like patterns of emotion regulation and expression, ruptures in the alliance, and verbalized or implicit beliefs based in working models of self and other (Daly & Mallinckrodt, 2009; Daniel, 2006; Slade & Holmes, 2019; Eames & Roth, 2000).

Researchers Daly & Mallinckrodt (2009) studied experienced therapists' responses to client attachment insecurity and stated that therapists become “authentic chameleons”, tailoring the therapeutic relationship to the clients’ needs. The therapists in this study consistently describe responding to signs of attachment insecurity with purposeful relational distancing depending upon the presentation of their clients, initially matching their attachment orientation by adjusting their relational proximity and emotion regulation style to establish client engagement and a strong working alliance.

It’s likely that EFIT therapists operating from an attachment-oriented approach similarly attend to attachment insecurity effectively in early sessions during working alliance formation. Additionally, the current study was conducted by therapists already experienced in using EFT who received regular supervision, so findings may attest to therapists who are particularly adept at mitigating the effect of attachment insecurity on the working alliance. These reasonings could explain the complete absence of significant correlations between baseline attachment insecurity and working alliance development. They could also explain the overall reductions in attachment insecurity, and the absence of any significant correlations between attachment insecurity and the working alliance bond factor specifically.

The therapists in the study by Mallinckrodt & Daly (2009) used a counterconditioning approach with clients in later sessions to contain or amplify emotion in opposition to the client's usual attachment patterns. Similarly, in later sessions they used relational distancing to intentionally modulate their proximity to clients, withdrawing somewhat from those with more attachment anxiety (while still providing acceptance and support) to promote more self-agency and competency, and drawing nearer to those with more attachment avoidance (without overwhelming) to promote more interdependency and vulnerability. They describe the alliance in this working phase of therapy as more strained than during the initial engagement phase or the consolidation phase that follows, with the potential for more transference, client expression of negative affect, and ruptures to the alliance. Rather than being concerned by these processes, the therapists in this study use them as an opportunity for further exploration of the client's attachment histories, needs, and fears – and the corrective experience of relationship repair in session. They recognize a strong working alliance not just as a necessary condition for effective therapy, but a therapeutic tool itself that may be used to support the fostering of attachment security through therapy.

EFIT is designed in three stages of therapy (stabilization, restructuring, and consolidation) that match the ones described by the therapists in this study by Mallinckrodt & Daly (2009). The second stage of EFIT has a similar purposeful heightening of intensity as emotions are deepened and imaginal experiences become more evocative (Johnson, 2019). These three-stage approaches map against the high-low-high pattern of working alliance development that is associated with optimal clinical outcomes in the previously cited study by Kivlighan & Shaughnessy (2000). There is a seemingly inherent acknowledgment among attachment-oriented therapists that pressure applied to the attachment system is oftentimes useful for attachment reorganization when employed deliberately and conscientiously to an alliance that is already well-established (Daly & Mallinckrodt, 2009; Johnson, 2019).

The numerous significant negative correlations between midpoint working alliance and

attachment avoidance may be indicative of a strain experienced in the middle phase of therapy, however this midpoint strain does not result in greater changes in attachment avoidance. It is those with attachment anxiety who experienced significant reductions in insecurity throughout the study, though the change does not appear associated with the working alliance. Instead, there is a significant correlation between greater agreement on the tasks of therapy at midpoint and change in attachment avoidance. Task is interestingly also the only baseline variable which is significantly negatively correlated with attachment avoidance at midpoint and post. It is possible that there is a bidirectional relationship between the tasks of EFIT and attachment avoidance, where greater avoidance has a negative association with task agreement, but greater task agreement has a positive association with reduction in avoidance.

It's worth exploring the tasks of EFIT to understand these findings. EFIT interventions are grounded in exploring attachment histories and drawing parallels to current experiences alongside present processing of emotions. Arguably the most defined task of EFIT may be the choreographing of interactions with aspects of self or imagined others, but many are more abstract and experiential in nature. There are no explicitly prescribed therapeutic tasks assigned for clients to complete between sessions of EFIT.

Based on this description of the tasks of EFIT, there are several potential explanations for the significant negative correlations between the WAI task factors and attachment avoidance, as well as the absence of the same for attachment anxiety. First, these interventions may be more congruent with the preoccupation with attachments and emotion in attachment anxiety but feel foreign or even be accompanied by a degree of fear or aversion within the context of attachment avoidance. Similarly, the overarching goal of reorganizing the attachment system towards secure relationship with self and others may be accompanied by skepticism from the avoidant orientation who feels safest with hyper-independence and suppression of attachment needs, explaining the significant negative correlation with WAI goals and avoidance.

Secondly, it may be that those with attachment avoidance dismiss the relational and

interpersonal benefits of therapy and place more importance on the utility of interventions and the overall aim. As EFIT is less task-precise and more relational than other modalities used for the treatment of depression and anxiety, those with attachment avoidance may not recognize the tasks as such unless this is made explicit. It may be that EFIT therapists prioritize the experiential approach to therapy and spend less time providing explicit psychoeducation regarding the interventions or attaining express agreement.

These are some reasons why those with attachment avoidance may find the tasks of EFIT particularly challenging, however, the literature supports that those with attachment avoidance find sessions most useful when therapists leverage emotionally charged moments (Slade & Holmes, 2019). This aligns with the therapists in the previously cited study by Daly & Mallinckrodt who seek to restructure the avoidant attachment system by amplifying emotion and increasing relational proximity, counter to their usual patterns (2009). The tasks of EFIT are designed to amplify emotions, meaning that they are particularly suited to the treatment of attachment avoidance, but the current study findings suggest that this is only so when supported by a strong working alliance, particularly a high degree of task agreement.

Attachment Change, Depression & Anxiety

A previous outcome study utilizing the data from the randomized-controlled trial found that EFIT wa an overall successful therapeutic modality for the treatment of depression and anxiety compared against the control group (Wiebe et al., 2024). The treatment group, which also represented the sample in the current study, experienced reductions in symptoms of depression and anxiety both, where the control group experienced worsening of symptoms. The researchers found that the reduction in depression as measured on the Beck Inventory of Depression (BDI-2; Beck, Steer, & Brown, 1996) was significant, whereas the reduction in anxiety as measured on the Beck Inventory of Anxiety (BAI; Beck, Epstein, Brown, & Steer, 1988) was non-significant (Wiebe et al., 2024).

These findings are interesting considering the relationship between the hypo-and-hyperactivation of the attachment system in avoidance and anxiety and the parallel processes of emotion regulation associated with depression and anxiety described in the literature. Given this, we may have anticipated that the findings from this outcome study would map against the findings of the current study, with changes in attachment avoidance shifting in tandem with changes in depressive symptoms and the same with attachment anxiety and anxious symptoms. In fact the findings of this previous study and our own are inverse, with significant reductions in attachment anxiety but not avoidance and significant reductions in depressive symptoms but not anxious.

It may be that even non-significant reductions in attachment avoidance can meaningfully improve depressive symptoms. Those with higher avoidance may disregard the severity of their own distress and even a moderate amount of acknowledgment, as would occur in the tasks of EFIT, can represent a significant shift in well-being. This could explain and provide additional support for the benefit of task-agreement for this population. Another explanation may be that treating any attachment insecurity is an effective treatment for the symptoms of depression regardless of the specific insecure orientation. Studies on the treatment of comorbid depression and anxiety found that treatments focused on one typically do result in concurrent reductions in the other regardless of modality or intent (Wietx, et al., 2018), and this could extend to the current study findings that the treatment of attachment anxiety results in significant reductions in both anxiety and depression.

Since EFIT is shown to be an effective treatment for depression and anxiety and the mechanism of change is theorized to be shifting the attachment system towards more security, there is support in the current study for emphasizing task agreement in order to shift attachment avoidance specifically towards more security for the overall effectiveness of the modality in a population with depression and anxiety.

Clinical Implications

The study has many clinically relevant findings. It provides some support that attachment may change in EFIT and that change in avoidance is particularly supported by the working alliance task agreement. It provides clinical rationale for identifying attachment insecurity early in therapy to anticipate adjustments in working alliance development.

Working with clients with insecure attachments can be challenging. Therapists working with clients with higher attachment avoidance in particular report at times feeling inadequate, discouraged, rejected and frustrated by their client's presentation in sessions (Daly & Mallinckrodt, 2009). The current study provides reassurance that therapeutic bonds can form despite attachment insecurity. In fact, the findings point to the important distinction between disagreement about tasks and goals, versus the appreciation of the therapeutic bond. The literature supports that relationship-specific attachments may develop in therapy despite a client's overall attachment orientation (Levy et al., 2014; Slade & Holmes, 2019), which was also demonstrated in the current study. This is supported by an attachment approach to working alliance development.

Principally, the current study provides evidence for the importance of task-clarity and attaining express agreement on the tasks of therapy, particularly for those who demonstrate more attachment avoidance. Therapists are encouraged to understand how the tasks of therapy may be experienced by clients based on their presentation of attachment insecurity, and to engage clients with more avoidance in task and goal discussions beginning in early sessions and continuing throughout treatment, particularly when utilizing an emotionally focused, attachment-oriented approach such as EFIT.

Strengths

A primary strength of this study is that it is one of the first studies of EFIT generally, and the first to research attachment and working alliance within EFIT. The use of EFIT offers a unique research opportunity to investigate the influence of attachment on the working alliance in

an attachment-oriented therapy. The sample comprised participants with depression and anxiety which permits the study of their comorbidity, common in the population but often missing in research.

This study emphasizes clinical utility. Therapists see a larger proportion of individuals with high levels of attachment insecurity in practice compared with population averages (Bernecker et al., 2014) and these presentations can be straining on even experiences therapists (Daly & Mallinckrodt, 2009). The current study adds to the body of knowledge on attachment insecurity and the working alliance, providing insights and practical implications relevant to EFIT therapists and others. The research on attachment change demonstrates that avoidance is more resistant to change in psychotherapy (Taylor et al., 2015), and the current study findings provide evidence-based recommendations for reducing avoidance specifically.

The study builds upon previous EFT research related to the task factor predicting outcomes (Johnson & Talitman, 1997) and offers a factor-level exploration of the WAI and the ECR. The language used in the ECR was adapted with permission from “romantic partner” to “loved ones” which means this study explored adult attachment more holistically, where previous research has often focused on adult romantic partnerships to the exclusion of other potentially meaningful attachments.

Limitations

The current study has several limitations. First, the population was mostly Caucasian and heterosexual, meaning that the sample was relatively homogeneous, and the findings cannot be generalized. Additionally, the study lacks follow-up or longitudinal data to assess whether changes observed in attachment are sustained after treatment.

The study was limited to the use of client self-report measures. As a result, the study is also limited in exploration of the findings, specifically around the development of task agreement in session, and the mechanisms of change of EFIT tasks on attachment avoidance. Attachment and the working alliance are both difficult variables to isolate in research and the study cannot

rule out confounding variables which may be distorting or masking effects. Lastly, discussion on the potential mediating influence of EFIT on attachment and working alliance in the current study is tentative and theoretical and requires further research.

Future Research

Replication of the current study is recommended within different populations for generalizability and validity. Future research could include follow-up or longitudinal data to assess the sustained effects of attachment change beyond treatment.

Further research could include a task analysis tracking in-session interventions of EFIT and the impact on clients of different attachment orientations to provide guidance for EFIT therapists to increase task agreement among clients with more attachment avoidance. Comparing the findings of the current study with data from the randomized controlled trial control group could explore the hypothetical influence of EFIT on overall change in attachment as well as the mitigating effect of EFIT on attachment insecurity and the development of the working alliance in the current study. Future research could include other variables which may mediate the influence of attachment in EFIT, such as the therapist's own attachment orientation and its interaction with that of the client, or non-relational factors within the client.

The scope of the current study did not include potential correlations between change in attachment and change in depressive or anxious symptomology. Little research evidence exists confirming the theory that reducing attachment insecurity reduces psychopathology, and this would be a clinically useful and logical follow-up to the current study.

Conclusion

Research on attachment is mixed on the impacts of attachment insecurity on the working alliance, and whether attachment security can increase in therapy (Bernecker et al., 2014; Daly & Mallinckrodt, 2009; Diener & Monroe, 2011; Taylor et al., 2015; Slade & Holmes, 2019). The current study contributes to these research gaps. First, the significant reductions in attachment

anxiety observed in this study provides evidence that attachment is not a fixed state but can shift and move within a therapy context over a relatively short period of time. Secondly, it offers evidence that the negative impact of attachment insecurity on the working alliance is not ubiquitous. The current study found some negative correlations to suggest that there is justified cause to consider attachment insecurity in the development of working alliances but found no predictive effect whatsoever that pre-treatment attachment insecurity invariably impedes the development of a working alliance in EFIT. This finding is reassuring to therapists in the field and promising for EFIT as an emerging modality. Future research will hopefully explain the in-session processes of EFIT which may be mediating attachment and the working alliance. Lastly, this study offers highly practical and applicable recommendations for therapists who wish to increase security among clients with attachment avoidance, which previous research has shown is more challenging than with anxiety (Taylor et al., 2015). The study findings demonstrate that task agreement can be used as potential intervention for reducing avoidance. This finding is applicable across modalities, although future research may confirm that EFIT is particularly apt for treating attachment insecurity in individuals.

Table of Tables

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