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RUNNING HEAD: ATTACHMENT AND HISTORY OF PSYCHOTHERAPY

Adult attachment and history of psychotherapy in a normative sample

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Abstract

The willingness to trust and self-disclose to others, key aspects in the decision to seek psychotherapy, is expected to vary across attachment classifications. The current study examined the association between internal working models of attachment and history of psychotherapy in a middle-class sample of 120 women, who were administered the Adult Attachment Interview and the Mental Health Survey. Findings supported predictions that security of attachment is linked to history of psychotherapy. Specifically, adults classified as Dismissing were less likely than other adults to report a history of psychotherapy, whereas Secure adults reported the highest rates of couples therapy.

Adult attachment and history of psychotherapy in a normative sample

A key feature of attachment theory is the principle of continuity which posits that the way attachment behavior becomes organized in childhood as a strategy for relating to others is carried forward and profoundly influences subsequent behavior in later life (Bowlby, 1980). According to Bowlby (1979), though the organization of attachment behavior develops in infancy and is most obvious in early childhood, it can be observed throughout the life cycle, especially in times of stress and emergency. Considerable agreement exists among attachment theorists that children develop mental representations of themselves, others and relationships (i.e., the internal working model) through repeated interactions with their caregiver and it is this internal working model that is carried forward to influence interpersonal relationships in adulthood (Sroufe, 1986; Sroufe & Fleeson, 1986). Based on Bowlby's contention that attachment behavior is especially activated during stressful periods, Lopez (1995) hypothesized that adult attachment patterns should influence the adaptive mobilization of social support during the stress/coping process. However, the decision to seek social support and more specifically to seek assistance from a mental health professional or benefit from such experiences may depend on the belief that others are capable of providing care and comfort (Bowlby, 1988; Farber, Lippert, & Nevas, 1995; Slade, 1999), a view that is not expected to be consistent across the different attachment categories.

Lopez, Melendez, Sauer, Berger, and Wyssman (1998) found that college students with self-reported dismissive and fearful romantic attachment styles were less willing to seek therapy than students with secure or preoccupied romantic attachment

styles. The current study sought to extend Lopez et al.'s findings regarding the associations between differential help-seeking attitudes and internal working models of attachment in several ways. First, we used an adult sample representative of middle-class women. Second, rather than measuring attitudes toward seeking therapy, we looked at past history of therapy-seeking. Third, we utilized the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985/1996), an in-depth clinical interview, to assess current internal working models of childhood attachment relationships.

The AAI is conceptually distinct from self-report measures of adult attachment style, which measure conscious attitudes regarding close relationships. Bowlby (1980, 1988) originally conceived of internal working models as largely acting outside of awareness. Based on the premise that internal working models consist of “conscious and *unconscious* rules for the organization of information relevant to attachment and *for obtaining or limiting access* to that information (Main, Kaplan, & Cassidy, 1985, p. 92, italics added), the AAI is designed to assess the present state of mind with respect to early attachment-related experiences by means of discourse analysis. Classification of attachment status is determined by the extent to which participants can discuss their experiences openly in a collaborative, balanced, and highly coherent fashion, rather than by the reported quality of those experiences *per se*.

#### Adult Attachment Interview Classifications and Associated Features

Theoretically, as the individual develops through childhood, adolescence and adulthood, a secure attachment organization should act as a buffer against maladaptive responses to stress, allowing individuals to pursue and effectively draw upon support

from friends, family, or mental health practitioners (Riggs & Jacobvitz, 2002). Secure adults generally have a favorable, coherent image of the self, and are flexible and realistic in their approach to interpersonal relationships (e.g., Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987). Having experienced trust and open communication in past relationships, secure individuals are likely to remain relatively open and objective in their interpretation of and response to information (Main & Goldwyn, 1998). Despite the low risk of developing psychological problems, Secure adults, like Secure children, are likely to demonstrate attachment behaviors when distressed. Consequently, when life stressors stretch the limits of their coping capacities, they may seek assistance from counselors, who may be perceived as temporary attachment figures capable of providing a secure base from which to explore present modes of interaction (Bowlby, 1979; Pistole, 1989).

Individuals with insecure attachment strategies, on the other hand, are at risk for the development of psychopathology due to their inability to respond flexibly in unfavorable situations (Carlson & Sroufe, 1995). Cognitive distortions triggered by present-day events that resemble earlier anxiety-provoking interactions promote negative views of others and the self or the formation of multiple contradictory internal models (e.g., others can be trusted and no one can be trusted), which can have a deleterious impact on current behavior, emotion, and thinking (Bowlby, 1980). Unfortunately, due to distrustful attitudes formed in early attachment relationships, which are reinforced by subsequent interactions confirming their insecure internal working models, some insecure individuals may be unwilling to seek social support from friends or mental health

practitioners until motivated by severe, overwhelming distress or possibly coerced by family or legal pressures.

In addition to the Secure category, the AAI classification scheme identifies three insecure attachment classifications: Dismissing, Preoccupied, and Unresolved. Adults classified as Dismissing are likely to minimize feelings and relational bonds, turning away from the self and issues regarding the availability of others, which threaten established defenses (Dozier, 1990). In order to maintain internal working models of the self as invulnerable and of others as untrustworthy or weak, psychological symptoms are likely to involve avoidance, detachment/withdrawal, perfectionism, anger, denial, narcissism, and paranoia (Bowlby, 1979; Carlson & Sroufe, 1995; Crittenden, 1995; Rosenstein & Horowitz, 1996). Dismissing adults may also avoid self-disclosure, over-value secrecy and exhibit compulsively self-reliant or care-giving behaviors (Bowlby, 1980). These characteristics make it improbable that Dismissing individuals would seek assistance from the mental health system.

In contrast, Preoccupied adults experience difficulty managing anxiety in relationships and consequently undermine independent functioning while maximizing or exaggerating emotion and attachment behaviors. Early strategies of heightening attachment behavior, while adaptive for the purpose of maintaining proximity to the attachment figure in infancy and childhood, become maladaptive at older ages when over-dependency interferes with developmental tasks requiring autonomous exploration (Carlson & Sroufe, 1995). Heightened anxiety in relationships may be reflected in the tendency to report more physical maladies (Kobak & Sceery, 1988), impulsive and acting

out behaviors (Crittenden, 1995), an inability to move beyond a preoccupied involvement with relationships or previous attachment experiences, and rapid oscillations in behavior, attitude and discourse (Cassidy & Berlin, 1994). Empirical studies have linked Preoccupied attachment to increased psychological distress and a high incidence of mood disturbance and symptoms of anxiety (e.g., Cole-Detke & Kobak, 1996; Fonagy et al., 1995; Pianta, Egeland, & Adam, 1996).

The fourth AAI classification is the Unresolved category. This classification differs considerably from the fourth category of “fearful-avoidant” attachment style found on many recent self-report measures. First, self-reported “fearful-avoidant” attachment is conceived as a free-standing type of avoidant style associated with negative models of others and self (Bartholomew & Horowitz, 1991), whereas Unresolved attachment reflects not a distinct style *per se*, but rather a lack of resolution to previous experiences of loss or traumatic abuse that underlies the predominant Secure, Dismissing, or Preoccupied organization. Second, rather than denoting a pervasive style of fearfulness in current relationships, the AAI Unresolved classification represents a brief and possibly transient state of disorganization in reasoning or discourse that appears only in relation to childhood loss or trauma. Consequently, the Unresolved classification is always assigned in conjunction with one of the three primary attachment classifications (Secure, Dismissing, Preoccupied), which prevail as overt relational strategies in most ordinary circumstances. Indeed, the clinical utility of the Unresolved classification lies in its ability to detect lapses in reasoning or discourse that cut across all primary attachment classifications, thereby recognizing that loss and trauma can have a tremendous impact

on functioning regardless of an individual's dominant attachment strategy (Riggs & Jacobvitz, 2002).

While the particular form of psychopathology taken will likely be related to the underlying primary category, the Unresolved attachment classification has been linked to emotional distress and substance abuse (Riggs & Jacobvitz, 2002), borderline personality disorder (Fonagy et al., 1995; Fonagy et al., 1996; Patrick, Hobson, Castle, Howard, & Maughan, 1994), psychiatric hospitalization (Adam, Sheldon-Keller, & West, 1996; Allen et al., 1996; van IJzendoorn & Bakermans-Kranenburg, 1996), suicidal ideation (Adam, Hauser, & Borman-Spurrel, 1996; Riggs & Jacobvitz, 2002) and has been suggested as a risk factor for the development of dissociative disorders (Liotti, 1992, 1995), psychopathy (Crittenden, 1995), anxiety and phobias (Main, 1995), and Post Traumatic Stress Disorder (Alexander, 1992). Due to the trauma experience and associated likelihood of severe emotional distress, Unresolved adults are likely to seek or be referred to mental health agencies for a variety of psychological services.

#### Purpose of the Study

The present study was designed to extend previous research linking self-reported romantic attachment style and attitudes toward counseling in a college sample (Lopez et al., 1998) to a normative middle-class population of women. The specific purpose of the study was to empirically explore the theoretical association of internal working models of attachment, measured by the Adult Attachment Interview, and history of psychotherapy. Based on the idea that Dismissing individuals tend to minimize emotional experience and are less likely to seek help when distressed, it was predicted that Dismissing women in

this study would be less likely than other adults to report past experience in therapy. In contrast, although less frequently affected by emotional distress, because Secure adults have a positive view of relationships and adaptively mobilize social support during times of stress, it was expected that they would commonly report past experiences in therapy, particularly couples or family therapy. Preoccupied adults were also expected to report past therapy because they tend to exaggerate emotional responses and turn to others for caretaking. Finally, due to significant disorganization related to childhood loss or trauma that may create a vulnerability to symptoms of severe psychopathology, Unresolved adults were expected to report a history of therapy more often than other adults.

## Method

### *Participants*

The current sample was drawn from a larger longitudinal study investigating the transition to parenthood and family relationships. Participants in the third trimester of a first-time pregnancy were recruited through birthing classes, public service radio announcements, and flyers distributed at maternity stores. In return for their participation in the study, participants were offered a total of \$150 in savings bonds for their children, a videotape of parent-child interactions, and bimonthly newsletters containing updates on the research project. The median family income was \$30,000-45,000 and the mean age of participants was 29.4 years (Range: 16-41). The majority of women reported education beyond the high school level, with 64% earning a bachelor's or graduate degree and another 26% reporting some college or trade/business school coursework. Ethnic distribution was predominantly Caucasian (82.5%), but also included 7.5%

Hispanic, 2.5% African-American, and 7.5% indicating “Other” and/or bi-racial heritage. The current sample consists of 120 women. Five women were not included in the present study because Adult Attachment Interviews were either inaudible or could not be transcribed due to equipment failure. The 120 participants in this study did not differ from the entire sample on any of the demographic characteristics.

### *Procedures and Instruments*

Data used in the present study were collected during a prenatal visit, which was approximately 90 to 120 minutes in length and took place in a laboratory setting where participants completed a consent form and the Mental Health Survey. After completing these measures, participants were individually administered the Adult Attachment Interview (Main & Goldwyn, 1985/1998).

*The Mental Health Survey (MHS).* The Mental Health Survey is a self-report measure designed for the larger longitudinal project to collect information regarding participants’ personal history of psychotherapy and mental health, as well as the history of mental health in participants’ families of origin. Participants were asked to provide information about past experience in therapy and histories of mental for themselves and their families. History of psychotherapy and mental health variables were categorized as present or absent. Affirmative responses to the query regarding past experience in psychotherapy/counseling were followed by requests to indicate the type of therapy (i.e., individual, couple, group, family). Psychotherapy was defined as a formal arrangement with a professional counselor, psychologist or psychiatrist. As a result, responses

indicating that prior counseling was in the context of a self-help group, such as Alcoholics Anonymous, were excluded.

*Adult Attachment Interview* (AAI; Main & Goldwyn, 1985/1998). The Adult Attachment Interview is a semi-structured clinical interview designed to assess adults' representations of their relationships with their parents during childhood. Administered in a relaxed, conversational manner and generally lasting 60 to 90 minutes, the interview focuses on early attachment experiences and interviewees' current states of mind regarding the influences of these experiences on personality and parenting. In the course of the interview, participants are asked to describe their childhood relationships with both parents and/or other significant attachment figures (e.g., step-parents), in particular about their parents' and their own responses when upset, ill, injured, or separated from parents. The interviewer probes the subject's current perception of the effects of these experiences on their development, why their parents may have behaved in the way described, trauma and loss experiences, and changes in their relationships with parents.

Interviews were administered in a university laboratory, audio-taped and later transcribed verbatim, retaining all dysfluencies, grammatical errors, stuttering, mispronunciations, and marking any interruptions and pauses. Interviews are evaluated in terms of probable childhood history with each parent, which is rated on five experience scales: *Loving*, *Rejecting*, *Role Reversing*, *Pressuring to Achieve*, and *Neglecting*. Each scale ranges from 1 to 9, with 1 representing an absence of the particular variable and 9 representing very high levels of the variable. Next, the coder considers the transcript with regard to various aspects of the subject's present state of

mind with respect to attachment-related experiences. These scales include: *Idealization*, *Involved/Involving Anger*, *Dismissing Derogation*, *Lack of Memory*, *Metacognitive Monitoring*, *Passivity of Thought*, and *Fear of Loss* scale.

Specific criteria set forth by Main and Goldwyn (1985/1998) are used to determine if an experience qualified as abusive. For example, physical beatings harsh enough to leave bruises or severely threaten safety and any form of sexual contact would be considered abuse, whereas spankings that did not leave marks and were not reported as painful or frightening would be excluded. After the trauma or loss is established, disorganization and/or disorientation in thinking or discourse when discussing these experiences are rated on the *Unresolved loss* and/or *Unresolved trauma* scales. Adults can be considered "Unresolved" if they receive a 5 or higher rating for lapses in the monitoring of reasoning or discourse in discussions of trauma or loss.

The coder then reviews the transcript for overall *Coherence of Transcript* and *Coherence of Mind*. *Coherence of Transcript* rates the subject's ability to present an integrated and believable narrative. *The Coherence of Mind* scale is closely related to *Coherence of Transcript*, distinguished only by an additional evaluation of the subject's apparent belief systems in relation to the coder's own view of reality. The final step involves evaluating the entire transcript and overall profile of scale scores to assign an attachment classification. As discussed previously, the current AAI classification scheme delineates four major attachment classifications: *Secure*, *Dismissing*, *Preoccupied*, and *Unresolved*. Assignment of major classification is always based on the scores for the

present state of mind scales and not on scores for the childhood experience scales, which only provide a guide to common experiences associated with a particular state of mind.

Coding of the AAIs in this sample was conducted by coders trained for reliability in the use of the Adult Attachment Classification system (Main & Goldwyn, 1985/1998). One half of the transcripts were double-coded. Disagreements between two coders on transcripts in the present study were resolved by conferencing with a third coder. Coders were blind to all hypotheses and had no knowledge of participants' responses on the mental health survey. Inter-rater agreement on overall four-way attachment classification was 81% ( $k = .67$ ) and rose to 84% when considering only the three primary classifications ( $k = .67$ ). One participant was classified as Unresolved in the four-way distribution, but could not be classified in the three-way distribution and consequently was excluded from the three-way analyses.

The AAI has demonstrated adequate test-retest reliability over two months (Bakermans-Kranenburg & van IJzendoorn, 1993) through a year and a half (Fonagy, Steele, & Steele, 1991). Research has established the independence of AAI classifications from social desirability bias (Bakermans-Kranenburg & van IJzendoorn, 1993), memory (Sagi, van IJzendoorn, Scharf, Koren\_karle, Joels, & Mayseless, 1994), and intellectual ability (Steele & Steele, 1994). Waters and his colleagues (Waters, Crowell, Treboux, O'Connor, Posada, & Golby, 1993) also reported that narrative style in the AAI differs from general conversational style when discussing topics unrelated to attachment relationships. The distribution of AAI classifications in a combined sample (i.e., meta-analyses) of 584 non-clinical women remains consistent in samples from

different countries, averaging 16% Dismissing, 55% Secure, 9% Preoccupied, and 19% Unresolved in non-clinical samples (van IJzendoorn & Bakermans-Kranenburg, 1996). A similar distribution was found for men in the meta-analysis of five samples (see Hesse, 1999 for a comprehensive review of the psychometric properties of the AAI).

## Results

### *Preliminary Analyses*

The distribution of AAI classifications for the sample used in the present study is similar to the proportions reported by van IJzendoorn and Bakermans-Kranenburg (1996) in their meta-analysis of 267 non-clinical mothers in the U.S., suggesting that it is unlikely that pregnancy influenced the participants' AAI classification. Using the four-way AAI coding system, Secure women made up 54% of the sample, Dismissing 14%, Preoccupied 8%, and Unresolved 24%. When Unresolved participants were placed in the best fitting primary classification, the resulting three-way distribution yielded 67% Secure, 17% Dismissing, and 16% Preoccupied.

In terms of therapy, 57% (N = 68) of this middle class sample reported previous experience in some type of psychotherapy, with 41% reporting individual therapy, 6% reporting family therapy, 3% reporting group therapy, and 28% reporting couples therapy with their current partner. Low reported incidences of family and group therapy prevented analyses of these variables, although it is interesting to note that all six women reporting family therapy were Secure or Unresolved/Secure and the three women reporting group therapy were Unresolved/Preoccupied.

*AAI Classification and History of Psychotherapy*

The major question addressed in this study concerned the relation of adult attachment classification to previous experience in therapy. Pearson chi-square analyses assessed the relationship of adult attachment classification to history of some form of psychotherapy (i.e., combined individual, family, group, couples therapy), and more specifically, a history of individual or couples therapy. As presented in Table 1, history of some form of psychotherapy was statistically significant in its association with four-way attachment classification (Secure, Dismissing, Preoccupied, Unresolved) in the predicted manner,  $\chi^2(3, 120) = 10.62, p < .01$ . Dismissing adults were less likely than other adults to report previous experience in psychotherapy, whereas Unresolved adults were more likely than other adults to report some form of psychotherapy. Results of four-way chi-square tests were non-significant for individual therapy, but showed a statistically significant association between couples therapy and attachment classification  $\chi^2(3, 120) = 9.63, p < .02$ , with Dismissing adults again less likely than other adults to report couples therapy. However, rather than the Unresolved group, it was the Secure women who reported higher rates of couples therapy than other women.

Similarly, as shown in Table 2, in three-way analyses (Secure, Dismissing, Preoccupied), Dismissing adults were less likely than other adults to report previous experience in some form of psychotherapy  $\chi^2(2, 119) = 6.78, p < .03$ , and couples therapy  $\chi^2(2, 119) = 6.62, p < .04$ . In both cases, Secure adults demonstrated higher rates of reporting previous therapy, whereas the reporting rate of Preoccupied adults was midway between the Dismissing and Secure groups. Results of three-way chi-square analysis for individual therapy were not statistically significant.

*Discussion*

Important theoretical advances have appeared in the past decade regarding the implications of attachment theory for psychotherapy. This study extends previous research linking adult attachment to help-seeking behavior by documenting evidence of associations between history of psychotherapy and internal working models of attachment in a normative adult female sample. As predicted, Dismissing adults in this study were less likely to report experiences in therapy than adults in the other attachment groups. These results are consistent with the idea that Dismissing individuals are less trusting and less likely to seek support from others, and also support previous research showing that avoidant/dismissing tendencies are related to decreased willingness to seek counseling (Lopez et al., 1998) and greater rejection of help from therapists (Dozier, 1990). Although it is possible that Dismissing adults in this sample were simply less willing than other adults to report a history of therapy, from a theoretical standpoint it is logical to presume that Dismissing adults may be more reluctant to seek therapy as a result of distrustful attitudes toward others, the minimization of emotion, and a view of the self as invulnerable.

These results suggest that ways to encourage Dismissing adults to enter and remain in therapy should be thoroughly explored, particularly in light of previous findings reporting that Dismissing adults have demonstrated the capacity for change in internal working models following clinical intervention (Fonagy et al., 1996). Creative methods of identifying and attracting Dismissing adults who might benefit from therapeutic interventions but who are reluctant to seek help need to be developed. For instance, given prior research suggesting that Dismissing attachment is a covariate of

psychophysiological response to stress and a risk factor for physical illness (Carpenter & Kirkpatrick, 1996; Dozier & Kobak, 1992), educational programs for physicians and employers who are likely to observe somatic responses to life stress among these individuals might increase referrals to mental health agencies.

The high rate of therapy-seeking behavior among Unresolved adults is not surprising given the serious disorientation and disorganization of reasoning and discourse demonstrated by these adults on the AAI. The observed link between Unresolved classification and history of psychotherapy is at least partially due to the definitional criteria for lack of resolution scales requiring a history of significant childhood loss or trauma, which are common presenting problems in clinical settings. The emotional and mental disorganization individuals in this classification are likely to experience during times of stress may trigger psychological crises, motivating Unresolved adults to pursue clinical intervention. These results are in contrast to Lopez et al.'s (1998) findings that self-reported "fearful" attachment style is associated with less willingness to seek therapy and lend support for the distinctions made between the two constructs.

Secure adults in this study reported the highest rates of couples therapy. Consistent with theoretical formulations, Secure adults may be more open to pursuing therapeutic intervention when distressed than insecure adults and may be particularly comfortable pursuing couples therapy. The relational approach to problem-solving characterized by seeking social support from others and more specifically cooperating with current romantic partners in these efforts may be a good therapeutic fit for Secure

adults. However, it is also possible that Secure individuals are more likely to disclose a history of therapy than insecure individuals.

Although the findings in this study provide initial support for associations between internal working models of attachment and history of psychotherapy, a few important limitations should be noted. First, the use of a self-report instrument to gather retrospective information about therapy experiences from participants may have introduced subjective bias. In particular, some attachment researchers have suggested that the use of self-report instruments with Dismissing individuals may result in a bias related to defensive strategies designed to minimize emotion and self-evaluation, making self-disclosure less likely (Dozier, 1990; Dozier, Stevenson, Lee, & Villegan, 1991; Kobak & Sceery, 1988; Pianta et al., 1996; Rothbard & Shaver, 1994). In addition, together with the use of a correlational design, the use of a self-report measure does not allow an examination of the temporal or causal relationships between self-reported experiences and current attachment status.

Conversely, the findings are strengthened by the use of the AAI. Conceptually, the AAI comes closer than self-report instruments to measuring Bowlby's (1980) original formulation of internal working models as overlearned rules for evaluating behavior, thoughts, and feelings that eventually come to operate automatically outside of awareness. Specifically, Bowlby (1973, 1980) suggested that aspects of experience that produce anxiety or disorganization are defensively modified and may be separated from conscious processing, which make it less likely that a true picture of experiences will be obtained in self-report instruments. Methodologically, the AAI's interpretive coding

strategy based on discourse properties rather than content, permits the assessment of unconscious attachment strategies. Although self-reported attitudes toward attachment relationships clearly provide valuable information on conscious processes that influence interpersonal relations, it is still open to question whether self-report instruments are capable of accurately assessing insecure internal working models of attachment that are unconscious and not readily accessible for evaluation.

The sample used in the current study presented both advantages and limitations. In this highly educated sample, 90% of which reported some education beyond high school, therapy was a relatively common experience. This sample characteristic afforded a unique opportunity to examine normative patterns of therapy seeking or avoidance among adults with different attachment classifications. Nevertheless, current findings might have been compromised by low cell counts and should therefore be interpreted cautiously. Although the sample may offer a better understanding of the links between therapy and attachment processes among middle-class American women, it is unlikely to be generalizable to other segments of the U.S. population characterized by dissimilar gender or racial composition, cultural background, or socio-economic class. Furthermore, because volunteers were used, self-selection of participants raises the possibility of unknown bias related to the willingness to participate in a two-year study of the transition to parenthood.

Finally, this study relied heavily on the assumption of developmental continuity in attachment organization. That is, based on empirical support for the stability of attachment organization from infancy through adulthood in low-risk samples (Main &

Cassidy, 1988; Hamilton, 2000; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). We presumed that current attachment strategies most likely reflected these adults' attachment strategies earlier in life when they faced stressful circumstances and first sought therapy. However, because the AAI measures current state of mind and the therapy data are retrospective, it is possible that experiences in therapy allowed the secure adults in this sample to achieve security. Consequently, these results need to be interpreted with caution and substantiated with further longitudinal research prospectively tracing help-seeking behavior and changes in attachment organization before and after therapeutic intervention. "Earned security" (Main & Goldwyn, 1998; Pearson, Cohn, Cowan, & Cowan, 1994) is a construct that is in the early stages of investigation and thus lacks clear definition at the present time, but it shows considerable promise in its application to future therapy outcome research.

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Table 1

*Four-way AAI Classification and History of Therapy*

Therapy	Attachment Classification				4-way $\chi^2$	
	<i>n</i>	Secure	Preoccupied	Dismissing		Unresolved
4-way Total	120	65	9	17	29	
Combined Therapy	68	38 (58%)	5 (56%)	4 (24%)	21 (72%)	10.62**
Individual Therapy	48	25(39%)	4 (44%)	4 (24%)	15 (52%)	4.19
Couples Therapy	33	24 (37%)	2 (22%)	0	7 (24%)	9.63*

Note. Percentages represent proportion of relevant column *N* reporting therapy.

\* $p < .05$ , \*\* $p < .01$

Table 2

*Three-way AAI Classification and History of Therapy*

Therapy	Attachment Classification			3-way $\chi^2$	
	<i>n</i>	Secure	Preoccupied		Dismissing
3-way Total	119	80	19	20	
Combined Therapy	67	49 (61%)	12 (63%)	6 (30%)	6.78*
Individual Therapy	47	32 (40%)	9 (47%)	6 (30%)	1.58
Couples Therapy	33	27(34%)	5 (26%)	1 (5%)	6.62*

Note. Percentages represent proportion of relevant column *N* reporting therapy.

\* $p < .05$