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Insecure Attachment and Therapeutic Bond as Mediators of Social, Relational, and Social Distress and Interpersonal Problems in Adult Females with Childhood Sexual Abuse History

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ABSTRACT

Establishing trust is an important part of building the therapeutic relationships and achieving the goal of effective trauma treatment for individuals who have experienced childhood sexual abuse. The current study explored the associations between attachment style, therapeutic bond, distress, and interpersonal problems. This study investigated whether attachment style and therapeutic bond mediated the association between the level of early treatment emotional distress and later treatment interpersonal problems among two groups: clients reporting histories of childhood sexual abuse and clients not reporting histories of childhood sexual abuse. Research indicates that disruption of attachment security as well as the therapeutic relationship is common in survivors of childhood sexual abuse. We explored the mediating role of insecure attachment and the therapeutic bond on the predictive relationship between early treatment emotional distress and the interpersonal difficulties that one experiences in their daily life. For clients with histories of child sexual abuse, the model showed that anxious attachment and avoidant attachment mediated the associations between emotional distress and interpersonal relations. Therapeutic bond was not a significant mediator. For clients without histories of sexual abuse, results showed significant association between emotional distress and interpersonal relations, but insecure attachment or therapeutic bond did not mediate this relationship.

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Adult Survivor; sexual Abuse; attachment; therapeutic Bond; therapeutic Alliance; interpersonal; anxious; avoidant

Examining Attachment Styles and Therapeutic Bond as Mediators of Emotional Distress and Interpersonal Issues in People with Childhood Sexual Abuse History Child sexual abuse (CSA) impacts the lives of children and adults, contributing to a variety of problems later in life, including behavioral, emotional, cognitive, academic, social, and biological issues (Choudhary et al., 2019). It is well documented that CSA survivors' have increased risk of experiencing adverse long-term consequences with mental health (e.g., depression, anxiety, PTSD), emotional regulation, suicidal ideation, relationship challenges, and

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emotional and sexual victimization (Afifi et al., 2016; Finkelhor et al., 2013). And while the exact prevalence of CSA is difficult to estimate due to variations in CSA definitions and likely failure to report (Vaillancourt-Morel et al., 2016), the Centers for Disease Control (Felitti et al., 1998) estimates are that within the United States, 20.7% of the total population, and 24.7% of the total female population have experienced CSA in their lifetime. Considering the widespread nature of CSA and its negative impact on long-term wellness across multiple domains (Hodges and Myers (2010); Sigurdardottir et al. (2016), there is a need for mental health professionals to understand the relationships between CSA symptoms within clinical populations in order to promote more successful outcomes.

Anxious and avoidant attachment

One feature commonly associated with CSA is the development of insecure attachment as an adult (Cyr et al., 2010). Due to the nature of childhood sexual abuse (CSA), survivors are at increased risk of developing insecure attachment styles when compared to the general population (Nelson et al., 2019). Anxious attachment often manifests as insecurity, persistent fear of rejection, and intense desire for intimacy (Shaver & Mikulincer, 2008), and is associated with impulsivity, low emotional regulation, and displaced aggression (Mikulincer, 1998). Avoidant attachment often manifests as a disengagement from the relationship process, such that close relationships are inhibited due to the relational distance maintained by the avoidant attached individual (Ainsworth et al., 1978).

Attachment and interpersonal problems

Across studies, attachment style plays an important role in determining the quality of individuals' interpersonal relationships and degree of interpersonal problems. According to Göstas et al. (2012), individuals presenting with a higher capacity for establishing secure attachments reported higher quality of relationship and fewer interpersonal problems, while individuals reporting higher capacity for establishing anxious or avoidant attachments, and therefore less secure attachments, reported more interpersonal problems. Faraji, Farokhzad, and Sabet (2019) showed that significant relationships exist among attachment style and interpersonal problems, and that the less secure the attachment style, the more interpersonal problems. In addition, Keating et al. (2018) found that the relationship between attachment style and interpersonal problems was mediated by improved emotional processing, while Haggerty et al. (2009) showed that levels of secure attachment were negatively correlated with certain measures of interpersonal problems, including

being dominant, vindictive, cold, socially inhibited, and nonassertive. Clinical populations were used in both studies.

There is a positive correlation between interpersonal/relationship problems and overall emotional distress. One of the most common assessments used to measure overall functioning, the Outcomes Questionnaire-45 (OQ-45; Lambert et al., 1996), include an Interpersonal Relationship subscale to assess current functioning, Due to the increased susceptibility to interpersonal problems that arises with insecure attachment, and that research supports relationship support as an important dimension of overall wellness, it would seem logical to address interpersonal problems as a goal for treatment for survivors of CSA.

The role of social and relationship support in mitigating symptoms of emotional distress is well documented in the research literature. For example, feeling emotionally/psychologically unsupported was a key predictor of psychological distress and burnout, while feeling supported reduced this risk (McLuckie et al., 2018). Similarly, according to Watson-Singleton's (2017) study with 158 African American Women that investigated emotional support as a mediator, perceived emotional support partially mediated the relationship between Strong Black Woman schema and emotional distress. Thus, evidence reflects that relationship support is protective against emotional distress and that insecurely attached clients with CSA histories struggle with interpersonal problems, thereby limiting their perceived relationship support. Consequently, an important area to explore is the relationship that forms within the counseling relationship: the therapeutic alliance.

Therapeutic alliance

The alliance is an umbrella term that represents the properties of treatment related to therapist–client interaction and relationship (Murphy & Hutton, 2018). Bordin's (1979) definition of therapeutic working alliance has been used in many studies exploring the relationship between the alliance and treatment outcome. According to Bordin, the working alliance between the client and the therapist is the key to the change process and consists of three components: 1) agreement on *goals* for therapy, 2) the *tasks* assigned to client and therapist according to therapists' approach to therapy, and 3) deep *bonds* of trust and attachment between the client and the therapist. In treatment of trauma-related disorders, a strong therapeutic alliance can play an important factor to facilitate adherence to treatment (Keller et al., 2010). However, interpersonal trauma, especially childhood abuse, may hinder the development of therapeutic alliance between clients and therapists.

Of particular importance to the present study is the bond portion of the alliance. The therapeutic *bond* between client and therapist refers to the affective and trusting relationship between client and therapist as individuals. Early experiences such as abuse and exploitation may result in

issues in interpersonal relationships due to challenges in building trust (Lawson et al., 2013). Consistently, survivors of childhood trauma often experience challenges in preserving the therapeutic bond with their therapists. In a study with 76 females who were in treatment for posttraumatic stress due to child abuse histories, Lawson et al. (2017) found that the therapeutic bond mediated the relationship between interpersonal relation problems and dissociation. Considering the importance of trust between therapists and clients to create strong therapeutic bond, greater interpersonal issues that potentially arose from childhood trauma predicted greater dissociation. The authors concluded that therapeutic bond between clients and therapists should be one of the central parts of trauma treatment related to child abuse.

Purpose of the study

Increasingly, researchers have focused on the role of client attachment style in therapy outcomes (Levy et al., 2018), and evidence suggests that securely attached clients generally have more favorable therapy outcomes when compared to insecurely attached clients. In addition, evidence supports that higher levels of insecure attachment predict less successful outcomes in therapy, possibly due to challenges in developing a working therapeutic alliance or dropping out of therapy prematurely (Levy et al., 2018). Evidence also indicates that the type of insecure attachment, whether anxious or avoidant, plays a part in the development and maintenance of symptom distress (Carlson, 1998) and whether symptom distress increases or decreases in response to therapy (Levy et al., 2018). In addition, although the therapeutic bond between the client and the therapist can play a significant role in successful treatment of trauma-related to CSA, there are limited studies that explore the relationship between bond, attachment, interpersonal problems, and overall presenting clinical symptoms. Although the relationship between attachment and the alliance would appear to be a given, research on this relationship is equivocal (Diener & Monroe, 2011; Smith et al., 2010). The degree to which each may function as mediators, especially between early stage emotion distress and later stage interpersonal problems with CSA clients, has yet to be examined.

The primary goal of this study was to examine whether early stage attachment style (anxious and avoidant) and/or the therapeutic bond mediated the relationship between early stage emotion distress (symptom distress, social role, and quality of life) and late-stage interpersonal problems among a clinical sample of female clients reporting a history of CSA. In addition, this study used a comparison group of women not reporting a history of abuse but participating in a similar treatment, relationship-based CBT, to explore the same relationship variables.

Methodology

Participants

Data for this study were collected over a 3½-year period in a university training clinic. Only women were included in the study, as women comprised approximately 94% of the clients seeking services in the clinic. All women presenting for treatment (*n* = 275) were invited to participate in a study that examined relationship factors and treatment. Of these, 243 began the study with 137 competing data collection across three points in treatment: early, middle, and one of final three sessions. Of those who completed data collection, 56 reported being victims of CSA and 38 reported having experienced no abuse in either childhood or adulthood. The remaining 43 reported various types of abuse that occurred in adulthood such as rape, sexual abuse by and intimate partner, intimacy partner violence, and psychological/emotional abuse.

Various types of abuse were reported based on a checklist in which each participant checked either yes or no to various types of abuse: Childhood Sexual Abuse, Childhood Physical Abuse, Childhood Emotional/Psychological Abuse, Witnessed Interparental Violence, Sexual Abuse Beyond Age 17, and Intimate Partner Violence.

In the CSA group, 10 identified as African American, 40 identified as Caucasian, 5 identified as Hispanic, and 1 identified as Native American. Their ages ranged from 18 to 60, with years of education ranging from 12 to 16 (*M* = 12.5). There were 45 currently in a relationship, while 47 had one or more children. In the no abuse group, 9 identified as African American, 22 identified as Caucasian, 6 identified as Hispanic, and1 identified as Native American. Their ages ranged from 18 to 52, with years of education ranging from 12 to 16 (*M* = 13.4). There were 32 currently in a relationship, while 29 had one or more children. The trauma group participants were included in the study if they (a) had a history of childhood sexual and/or physical abuse by a parent and/or caregiver; (b) had no current diagnosis or history of organic mental disorder, schizophrenia, or paranoid disorder; (c) were literate in English; and (d) were between the ages of 18 and 70 years. All participants completed a consent form approved by the university Institutional Review Board. Of the 56 therapists, six were male. Ages ranged from 24 to 39 (*M* = 27.5). Forty identified as Caucasian, eight identified as African American, and eight identified as Hispanic. Eight therapists were doctoral students in school psychology and 48 were master's students in a clinical mental health counseling program. All were in their second or third practicum.

Instruments

The 5-item bond scale of the *Individual Therapy Alliance: Revised/Shortened* (ITA-RS; Pinsof et al., 2008) was used to assess the therapeutic bond. Each

item is rated on a 7-point Likert scale, ranging from 1 (completely agree) to 7 (completely disagree). Scores are the average of all 5-items, with higher scores indicating a stronger relational bond (Pinsof et al., 2008). The alpha coefficients were .76 for the current sample. Confirmatory factor analysis supported the existence of tasks, goals, and bonds scales (Pinsof et al., 2008). The ITA-RS indicated good construct validity for the bonds scale as it was associated with improved well-being and decreased symptoms.

Interpersonal functioning was assessed with the 32-item *Inventory of Interpersonal Problems- Short Form* (IIP-SF; Soldz et al., 1995) and corresponds to the circumplex model of interpersonal functioning. The IIP-SF is comprised of eight subscales: Domineering, Vindictive, Overly Cold, Socially Avoidant, Nonassertive, Exploitable, Overly Nurturant, and Intrusive. We used the total score (combination of all eight scales) from the third administration (.91 alpha coefficient). Higher scores indicate more interpersonal problems.

The 45-item *Outcome Questionnaire-45* (OQ-45; Lambert et al., 996) total score from the first administration was used to assess client progress in therapy based on three aspects of a client's life: subjective symptom distress (primarily depression and anxiety), interpersonal relations, and social role performance on such life tasks as family, work, and school. Each item is rated on a 5-point Likert scale ranging from 0 (never) to 4 (almost always). Higher scores correspond to greater levels of distress related to depression, anxiety, interpersonal functioning, and performance in social role. To establish concurrent validity, the OQ-45 was found to be significantly correlated with the *Symptom Checklist-90* and the *Inventory of Interpersonal Problems* (Lambert et al., 1996). The alpha coefficients for the total score was .91 for the current sample.

The 36-item *Experiences in Close Relations-Revised* (ECR-R; Fraley et al., 2000) was used to measure two adult romantic attachment dimensions from the first administration: Avoidance and Anxiety. In general, avoidant individuals find discomfort with intimacy and seek independence, whereas anxious individuals tend to fear rejection and abandonment. Each item is rated on a 7-point Likert scale ranging from 1 (Strongly Disagree) to 7 (Strongly Agree). Scores are the average of all items for each 18-item subscale, with higher scores indicating greater avoidance and anxiety (Fraley et al., 2000). The alpha coefficients for the Avoidant and Anxiety scales were .88 and .90, respectively, for the current sample.

The104-item *Detailed Assessment of Posttraumatic Stress* (DAPS; Briere, 2001) assesses for a probable diagnosis of PTSD based on the criterion symptoms of reexperiencing, avoidance, and hyperarousal (DSM-IV-TR criteria 309.81) and related symptoms. Raw scores for all DAPS scales are converted to T-scores. A score above 65 is considered clinically significant. The DAPS provides information on clients' history of exposure to 13 types of traumatic experiences (e.g., sexual and physical abuse) and 12 scales related to trauma. Alpha coefficients for the 12 scales ranged from .69 to .93 for the current sample.

Procedures

All data were collected from participants in three phases of treatment within a range of sessions: early (session 3 or 4), middle (between sessions 6 and 8), and later (between sessions 16 and 24). Number of sessions ranged from 16 to 28, with a mean of 19 sessions. The bond data were collected during the early phase (i.e., either the third or fourth sessions), the approximate time at which the literature indicates that the alliance becomes more stable (Horvath et al., 2011; Martin et al., 2000). Further, we used the data collected during the early phase for general level of distress (OQ-45 total distress) and the anxiety and avoidance attachment dimensions (ECR-R), and interpersonal functioning (IIP-SF) from the third administration during the final phase of treatment. The CSA group received integrated relationship and trauma-based Cognitive Behavioral Therapy (CBT) (Courtois & Ford, 2013), while the non-abuse group received relationship-based CBT without middle phase memory processing, largely targeting depression and/or anxiety. Therapists received individual and/or group supervision from the second author. Supervision included attention to trauma-informed cultural competence (Brown, 2008).

The treatment model for the CSA group largely followed a three-phase treatment model: early phase focused on stabilization, safety, and coping skill development for self-regulation; middle phase focused on memory and emotional processing; and the later phase emphasized integration and generalization of skills and new learning (Ford & Cloitre, 2009). Although treatment emphasized skill building (e.g., grounding, mindfulness breathing) and trauma processing (e.g., life narratives, development, and rereading of a trauma narrative), attention to and processing of the ongoing client–therapist relationship was central.

Statistical analysis

For the primary analysis, we used Hayes (2013) bootstrapping multiple mediation method. Hayes' approach to mediation was preferred over Sobel's (1982) method of estimated standard error and Baron and Kenny (1986) causal steps method because Hayes' method employs bias corrected and accelerated (BCa) confidence intervals (CI). This method possesses greater power to detect a mediated effect. Further, Hayes' method does not require large samples or the assumption of normality of the sampling distribution due to use of bootstrapping. This method also provides acceptable control over type I error (MacKinnon et al., 2004). The mediation analyses were conducted using Hayes (2013) macro for the Statistical Package for the Social Sciences (SPSS). The 95% CI for the estimate of the mediated effect was obtained with 5,000 bootstrap resamples to create BCa CI to estimate the total direct effect (i.e., effect of X on Y) and the specific indirect (i.e., mediation) effect for each individual alliance dimension, while

simultaneously controlling for the other alliance dimensions. A mediation effect is determined to be significant at the .05 level if the CI does not include zero. We did not control for multiple analyses.

Results

Of the 56 CSA participants, four experienced one type of abuse, 10 experienced two types, 10 experienced three types, while 32 experienced four or more types. All women reported ongoing abuse lasting months to years. The majority met criteria for probable PTSD ($n = 44$) or subclinical ($n = 8$; met criteria for two of three symptoms of DSM-IV) levels of PTSD based on the Detailed Assessment of Posttraumatic Stress (Briere, 2001). Further, they reported the following types of interpersonal abuse: Childhood Sexual Abuse (100.0%); Childhood Physical Abuse (89.3%); Childhood Emotional/Psychological Abuse (100%); Witnessed Interparental Violence (71.5%); Sexual Abuse Beyond Age 17 (85.7%); Experienced Intimate Partner Violence (82.1%); Experienced Multiple Types of Abuse (94.6%); and Exposure to Complex Trauma Stressors (92.9%).

Preliminary results

The CSA group ($n = 56$) was compared with the non-abuse group ($n = 38$) on all variables from the early phase data. Results indicated an overall significant difference between the two groups, $F(6, 87) = 6.33$, $p < .0001$, $n2 = .27$. All five variable measures were significantly different between the two groups with the CSA group reporting significantly higher attachment-related anxiety, attachment-related avoidance, Total Distress (symptom, interpersonal, and social role distress), and interpersonal problems. The non-abuse group reported a significantly higher bond with their therapists (see Table 1).

Bivariate correlations assessed relationships between the five variables for each group from early phase data (see Tables 2 and 3). For the non-abuse group, higher symptom, interpersonal, and social role distress (OQ-45 Total Distress) were significantly associated with higher attachment-related anxiety, attachment-related avoidance, and more severe interpersonal problems. Further, higher attachment-related anxiety was significantly associated with higher attachment-related avoidance and more severe interpersonal problems. For the CSA group, higher symptom, interpersonal, and social role distress were significantly associated with higher attachment-related anxiety, attachment-related avoidance, and more severe interpersonal problems. Additionally, higher levels of attachment-related anxiety were significantly associated with more severe interpersonal problems. Also higher attachment-related avoidance was significantly related to more severe interpersonal problems. Finally, a higher bond between client and therapist was significantly related to less severe interpersonal problems.

Table 1. CSA compared to no abuse on all variables.

Instrument	CSA Mean (*SD*)	No Abuse Mean (*SD*)	*n2*
OQ	84.2 (32.0)	57.2 (25.7)	.17aa
ECR Anxiety	4.6 (1.2)	3.8 (1.4)	.09aa
ECR Avoidant	3.6 (1.1)	2.7 (.97)	.16aa
Bond	5.9 (1.3)	6.6 (.68)	.09aa
IIP	4.8 (1.2)	3.8 (1.4)	.12aa

OQ = Outcome Questionnaire 45 early phase; ECR Anxiety = Emotions in Close Relationships-Anxious Attachment early phase; ECR Avoidant = Emotions in Close Relationships-Avoidant Attachment early phase; Bond early phase; IIP = Inventory of Interpersonal Problems-Short Form.

p <.05; ***p* <.01

Table 2. Bivariate correlations for non-abuse group (n = 38).

Instrument	1	2	3	4
OQ	–	–	–	–
ECR Anxiety	.41a	–	–	–
ECR Avoidant	.08	.34a	–	–
Bond	−.26	−.29	−.08	–
IIP	.58aa	.58aa	.22	−.32

p <.05; ***p* <.01

Table 3. Bivariate correlations for child sexual abuse group (n = 56).

Instrument	1	2	3	4
OQ	–	–	–	–
ECR Anxiety	.48aa	–	–	–
ECR Avoidance	.27a	−.05	–	–
Bond	−.22	−.10	−.12	–
IIP	.56aa	.43aa	.37aa	−.28a

p <.05; ***p* <.01

Primary results

The primary analyses addressed the major aim of the study – do attachment-related anxiety, attachment-related avoidance, and the client-therapist bond mediate the relationship between clients' early phase symptom, interpersonal, and social role distress and final phase interpersonal problems in each group. Two mediation models were tested, one for each group. The same variables were employed for each group. The predictor was the early phase symptom, interpersonal and social role distress (OQ-45 total). The criteria variable was the late phase interpersonal problems (IIP-SF). The mediation variables were early phase attachment-related anxiety (ECR-R), attachment-related avoidance (ECR-R), and the client-therapist bond (ITA-RS). Figure 1 displays the mediation model used for this analysis.

For the CSA group, there was a direct effect of early phase symptom, interpersonal, and social role distress (OQ-45 total) on late phase interpersonal problems (IIP-SF), 95% BCa CI (.0016 to .0217). Further, there

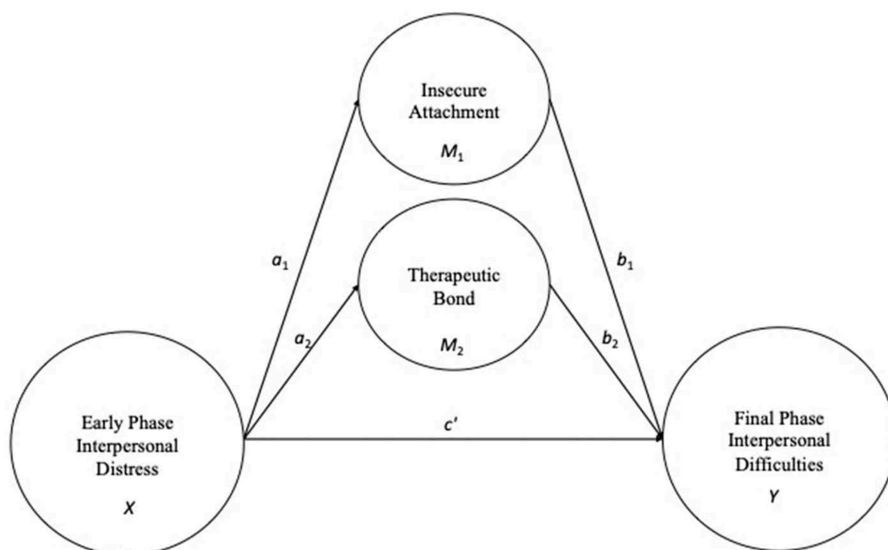

Figure 1. Mediation model.

was a total indirect effect, 95% BCa CI (.0027 to .0164). Of the three mediators, attachment-related anxiety and attachment-related avoidance (ECR-R) produced a significant indirect effect, 95% BCa (CIs of .0003 to .0113 and .0001 to .0092, respectively), indicating that these scales significantly mediated the association between early phase symptom, interpersonal, and social role distress (OQ-45 Total Distress) and late phase interpersonal problems (IIP-SF). The bond (ITA-RS) did not produce a significant mediation effect, 95% BCa CI (−.0003 to .0051). The variable coefficients indicated that more early phase symptom, interpersonal, and social role distress (OQ-45 Total) were associated with higher early phase attachment-related anxiety and attachment-related avoidance (ECR-R), which in turn were associated with more severe interpersonal problems (IIP-SF). Finally, examination of pairwise contrasts of indirect effects indicated no significant difference between the two attachment dimensions (ECR-R) with respect to their indirect effects as mediators. That is, neither of the two attachment dimensions had a significantly greater impact as a mediator than the other. Overall, the full regression model was significant, $F(5, 50) = 9.78$, $p < .0001$, $R2 = .44$.

For the non-abuse group, there was a significant direct effect of early phase symptom, interpersonal, and social role distress (OQ-45) on late phase interpersonal problems (IIP-SF), 95% BCa CI (.0079 to .0396). However, neither the total indirect effect nor any of the three mediators were significant (ECR-R Anxiety; ERC-R Avoidant; ITA-RS). Overall, the full regression model was significant, $F(5, 50) = 5.94$, $p < .001$, $R2 = .43$.

Discussion

This study explored the mediating affect of anxious attachment, avoidant attachment, and therapeutic bond (all measured at early treatment phase) on the relationship between early phase OQ-45 Total Score (symptom distress, interpersonal distress, and social role distress) and late phase interpersonal problems, among a clinical sample of adult female clients who had reported a history of child sexual abuse (n = 56). For comparison, we ran an identical mediation analysis with a sample of female clients who reported no abuse history (n = 38). The preliminary analysis supported previous research on the long-term effects of CSA for adult survivors, in that the CSA group scored significantly higher on all assessments other than therapeutic bond, including OQ-45 Total Distress score, anxious attachment, avoidant attachment, and interpersonal problems. Previous researchers have consistently reported that experiencing CSA leaves survivors vulnerable to elevated levels of emotional and clinical symptom distress (Nguyen-Feng et al., 2017), insecure attachment (Murphy et al., 2016), and interpersonal problems (Rumstein-McKean & Hunsley, 2001). Therefore, we anticipated this result.

The preliminary analysis revealed that therapeutic bond was significantly higher for the no abuse group, which when considered with differences in reported insecure attachment between the two groups, supports previous findings that clients with more secure attachment styles bond with their therapists more quickly (Levy et al., 2018). Another finding from the preliminary analysis was that the CSA group reported higher levels of interpersonal problems in the final phase of treatment, which again supports previous findings that individuals with insecure attachment styles commonly present with more interpersonal and relational challenges (Göstas et al., 2012). The preliminary analysis was in line with what we expected and corresponded with previous findings indicating that survivors of CSA experience higher levels of insecure attachment, overall clinical symptoms, and interpersonal problems when compared to a non-abuse sample, while also experiencing lower levels of reported therapeutic bond.

Both samples had statistically significant direct effects between OQ-45 Total Distress and interpersonal problems, meaning that Total Distress predicted some of the variance observed in interpersonal problems. This finding makes conceptual sense when considering the make-up of the OQ-45 subscales, which include a relationship subscale. In fact, concurrent validity of the OQ-45 was partly established using the IPP (Lambert et al., 1996). Some of the explained variance between the predictor and criterion variables could be due to covariance between the OQ-45 and IPP, which was used to assess interpersonal problems.

Results of the mediation analysis partially supported our hypothesis. We expected that with the CSA group, anxious attachment, avoidant attachment,

and therapeutic bond would mediate the relationship between OQ-45 Total Distress and interpersonal problems. However, while anxious attachment and avoidant attachment mediated the relationship at a significant level, therapeutic bond did not. This finding is particularly interesting because the non-abuse dataset generated no significant mediators when run through the same mediation analysis.

One explanation for this finding is that when compared to the non-abuse group, the elevated levels of anxious and avoidant attachment experienced by the CSA group were significant predictors for IPP and were significantly predicted by OQ-45 Total Distress. When factored into the overall mediation analysis, levels of insecure attachment, as defined by anxious and avoidant styles, accounted for more of the variance explained by the OQ-45 than with the no-abuse group. What this result generally suggests is that anxious and avoidant attachment plays a larger role in the therapy process for clients with histories of CSA, and may contribute more to self-reported interpersonal problems than for non-abuse clients. This result is consistent with the research evidence indicating that survivors of CSA are more vulnerable to developing insecure attachments when compared to the general population and that insecure attachment may play a contributing role in CSA survivors' experience of interpersonal problems.

The therapeutic bond was not a significant mediator for either group, which was unexpected. Considering the role insecure attachment played in mediating Total Distress and interpersonal problems, and that the therapeutic relationship is often an extension of one's attachment style and influenced by interpersonal problems, we expected that both groups would include therapeutic bond as a significant mediator, but this was not the case. One possible explanation for this finding could be that therapeutic bond was assessed during the first phase of treatment, so within the first few sessions, meaning that the bond may not have yet developed across the total sample in a way that reliably predicted interpersonal problems or could be predicted by the OQ-45 Total Distress. Future studies might consider including measures of therapeutic bond later taken from later phases of treatment to see assess the stability of early phase bond assessments.

Buchheim et al. (2017) found that clients with borderline personality disorder shifted from insecure attachment to more secure attachments following Transference-Focused Psychotherapy. Another explanation might be that bond is not practically connected to the variables included in this study. Perhaps therapeutic bond is not influenced so much by attachment style or interpersonal problems, but is instead influence by other variables, such as client-counselor attachment compatibility (Diamond et al., 2003), the client's current stage of change and coping style (Norcross & Wampold, 2011), or familiarity with the overall counseling process, such as the purpose, mechanisms, and expectations of counseling (Tryon & Winograd, 2011). Further

research is needed to better understand the factors influencing therapeutic bond and its development throughout treatment.

Limitations

There are limitations to this study that may influence the generalizability of the results. Although they were under supervision, novice therapists seeing the clients in both groups might have produced results that can be different from experienced therapists working with these clients. Additionally, all participants in both non-abuse and abuse groups were female, which hinders generalizability of the results to male clients. Another potential limitation of this study was the difference between sample sizes in non-abuse and CSA groups. We attempted to control for this limitation by using Hayes (2013) bootstrapping multiple mediation model, which employs bias corrected and accelerated confidence intervals, as well as not requiring large samples to conduct necessary analyses.

While the ECR-R measures secure, anxious, and avoidant attachment styles, disorganized attachment was not included in this study. Future research could also examine disorganized attachment as a mediating variable. Measuring the therapeutic bond in the earlier phases of the treatment process might have influenced the results, as the relationship between clients and therapists develop and get stronger by time. Future research is needed to examine whether or not there will be a difference in findings if therapeutic bond is measured mid-point or in later phases of treatment. Finally, the confidence intervals for the insecure attachment style, while indicating the presence of a mediating relationship, were still close to zero, raising the question as to whether insecure attachment was a meaningful mediator in the overall model. Replication of this study may provide clarity regarding the strength of the mediation model between these variables, and increasing the sample size might also increase the overall power of the analysis and improve the ability to detect significant mediation.

Clinical implications

Clinical implications for this study include the vital role that attachment plays in treatment of CSA, attachment style compatibility between therapists and clients, and the potential role of therapeutic working alliance throughout the therapy process. According to Bowlby (1977), therapists have the responsibility to provide clients with a temporary attachment figure that allows clients to explore themselves and their relationships with others in their lives. Considering that in our study insecure attachment (anxious and avoidant) was a mediator for OQ-45 Total Score and interpersonal problems, and previous research shows that higher levels of interpersonal problems lead to poor relationships and decreased support (Göstas et al., 2012), focusing on insecure attachment styles and related

issues in session with individuals who have histories of CSA can play an important role in providing optimal environment for clients to work on their traumatic experiences. Additionally, therapists bring their own attachment styles into the session and they need to be aware of attachment-related communication between themselves and their clients in order to provide better opportunities for improved working alliance (O'Connor et al., 2019).

Although therapeutic bond did not mediate the relationship between OQ-45 Total Score and interpersonal problems in our study, participants with no-abuse history reported stronger bond to their therapists compared to CSA group. It is difficult to ignore the relationship trust violations that CSA survivors experienced in their past and the potential impact of these experiences on future interpersonal problems. Thus, building, maintaining, and repairing the therapeutic bond throughout the therapy process should still be an important consideration for therapists (Lawson et al., 2017) and this study should be replicated with therapeutic bond measurement toward the end of the treatment process to further explore the mediating effect of therapeutic bond between OQ-45 Total Score and interpersonal problems.

Disclosure of Interest

No authors had any financial or personal relationships that might bias this work.

Ethical Standards and informed consent

All procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation [institutional and national] and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients for being included in the study.

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