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Measuring Patients' Attachment Avoidance in Psychotherapy: Development of the Attachment Avoidance in Therapy Scale (AATS)

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Abstract

A new scale measuring patient-therapist attachment avoidance was developed. Attachment Avoidance in Therapy Scale is a new measure based on the Bartholomew model of adult attachment (Bartholomew & Horowitz, 1991) and the Experience in Close Relationships Scale (Brennan, Clark, & Shaver, 1998) to measure patients' attachment avoidance towards therapists. With 112 patient-therapist dyads participating in the study, validation of a preliminary scale – measuring both attachment anxiety and attachment avoidance in therapy – took place using therapists' evaluations of patients' relational behavior and patients' self-reports about their attitude toward psychotherapy. Analysis of the data revealed six underlying scales. Results showed all six scales to be reliable. Validation of scales measuring attachment anxiety failed. The importance of Attachment Avoidance in Therapy Scale and its subscales is discussed.

Keywords: attachment, psychotherapy relationship, avoidance, measurement, self-report

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Ever since its birth 50 years ago, attachment theory has never been as popular as it is nowadays. This homecoming of the theory of John Bowlby (1977) enriches psychotherapy practice and research to a great extent. Bowlby (1969) has formerly emphasized the life span relevance of attachment in the first volume of his famous trilogy on this topic. Although the development of this special bond takes place in infancy and childhood, adult expressions of attachment needs are not to be considered regressive, since their importance lasts "from cradle to the grave" (Bowlby, 1969, p. 208). Accordingly, it is relevant to speak of attachment beyond childhood. Research in adult attachment includes phenomena such as religiousness, broad range of interpersonal relations (friendship, adult romantic relationships, therapeutic bond etc.), and connections between attachment insecurity and both childhood and adult psychopathology.

Social Personality Approach to Adult Attachment

In the beginning, the social personality approach to adult attachment (as an alternative to the developmental point of view) focused on interpersonal relations. Nevertheless, since the 1990s, more and more studies have been published about the possible relations between attachment styles and intrapsychic functioning. Using the five common characteristics of psychodynamic theories (Westen, 1998), Shaver and Mikulincer (2005) presented attachment theory as a contemporary psychodynamic approach. Empirical findings considering the functioning of adult attachment have been found to be in accordance with hypotheses proposed by psychodynamic theory.

Moreover, studies of intrapsychic correlations of adult attachment are beginning to form a new model concerning the dynamics of adult attachment (Mikulincer & Shaver, 2008).

In this model, the dynamics of adult attachment is presented in three modules. The first module is responsible for monitoring and evaluating threatening events that are stress-related. The availability of a caring and responsive attachment figure is monitored by the second module. The third part of this model is responsible for organizing secondary strategies (i.e. deactivating or hyperactivating strategies) in order to manage anxiety stemming from feeling insecure in the absence of a sensitive attachment figure. According to this model, it is clearly understandable how individual differences in adult attachment evolve.

One of the most widely known models of individual differences in adult attachment is the bi-dimensional, four-category model of Bartholomew (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994). This model was based on the working hypothesis of Bowlby (1973) which suggests two underlying representations regulating attachment behavior. If these representations of self and of significant others are considered bivalent (being either positive or negative), their combination leads to four categories:

1. *secure* individuals are able to manage both intimacy and autonomy;
2. *preoccupied* people's mental capacity is totally preoccupied with worries about relationships;
3. *dismissing-avoidant* personalities are reluctant to create a dependent and intimate relationship, therefore they devaluate others;
4. *fearful-avoidant* individuals fear intimacy and are socially avoidant.

These categories are organized around two dimensions. The dimension connected to the representation of significant others is called avoidance of intimacy. The dimension connected to representation of self is called separation anxiety. The relation of dimensions to categories is presented in Figure 1.

Bartholomew and Horowitz (1991, p. 240) summarized the results of the validation of their model as follows:

> "results of this research confirm that the valence of both self-models and models of others are separate, important dimensions of an adult's orientation to close relationships and that the two dimensions can vary independently".

The model presented above is not only of theoretical importance but is the base for different scales measuring individual differences in adult attachment. The Experience in Close Relationships Scale (Brennan, Clark, & Shaver, 1998) is one of the most widely used measures. The scale has excellent internal reliability characteristics, with Cronbach's alphas ranging from .87 to .94 for the two dimensions in the original (Brennan et al., 1998) and the Hungarian version (Nagy, 2005). Validity of the scale and its dimensions is proved by the high correlations of the two dimensions with their parent factor developed from nearly 60 attachment-relevant scales (Brennan et al., 1998).

The Psychotherapy Relationship as Attachment

Relationships are of high priority in attachment theory, in psychotherapy practice, and possibly in quite instrumental and computerized therapeutic methods as well (see e.g., Andersson & Cuijpers, 2008, for the efficacy enhancing effect of therapeutic support for computerized CBT).

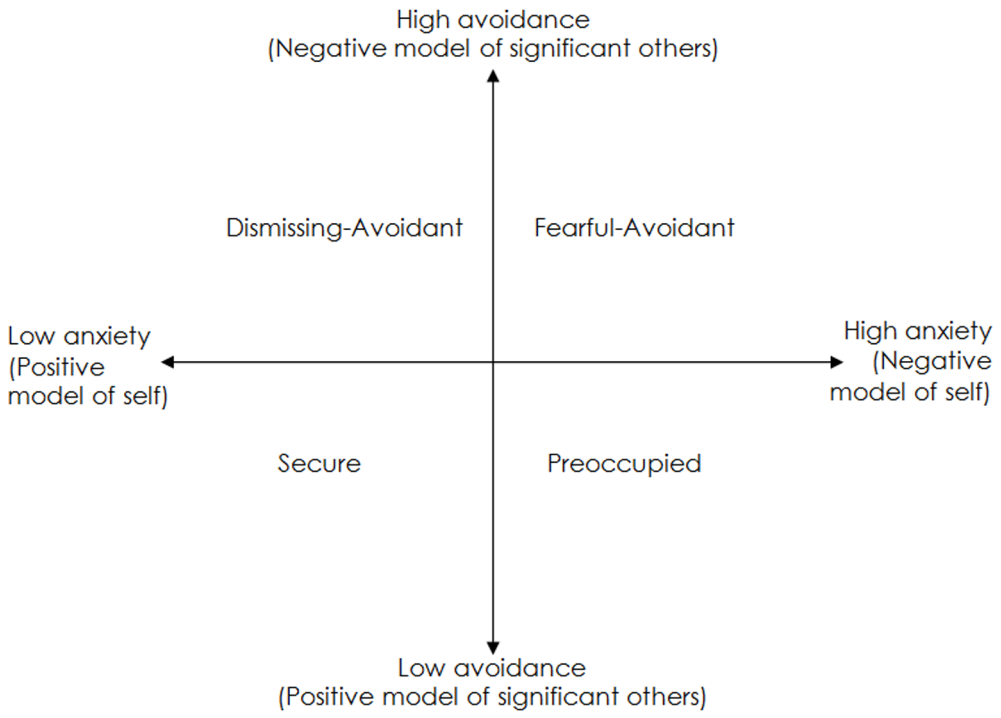

Figure 1. Two dimensions and four categories of adult attachment (based on Griffin & Bartholomew, 1994).

For Bowlby the clinical propagation of his theory was always of great significance (Ainsworth & Bowlby, 1991). The Maudsley presentation (Bowlby, 1977) played an important part in the dissemination of attachment theory among psychotherapists who work with adult patients. In this presentation five tasks of the therapist were addressed that can help patients realize, evaluate and transform their working models of attachment. These five tasks are as follows:

1. Providing a secure base for the patient. The existence of this secure base enables the patient to explore inner and outer reality, past and present environment, even if it is highly distressing.
2. Being a companion to the patient on these explorative journeys.
3. Encouraging the patient to analyze the therapeutic relationship.
4. Supporting the patient in exploring the relevance of former attachments in the formation of actual perceptions and expectations.
5. Encouraging the patient to evaluate his modes of relating and whether they are in accordance with present wishes and future plans. Through the use of this evaluation, which is possibly followed by restructuring, the patient is freed from rigid thinking and acting.

These statements do not form an original method in psychotherapy, they are rather the reformulation of therapeutic work in attachment terms. At the same time, the five tasks implicitly present the therapeutic relationship as attachment. This attachment nature of the patient-therapist bond was empirically tested by Parish and Eagle (2003). Guided by theoretical deduction, they composed the Components of Attachment Questionnaire that measures the intensity of nine components of attachment. In their study, participants, who were involved in a romantic relationship and regularly visiting a therapist, were asked to rate the same statements referring first to their romantic relationship and then to their therapeutic relationship. Thinking of their therapists, participants rated

all nine components over mid-point. Moreover, the 'significant other as wiser/stronger' and 'availability' components were significantly more characteristic for therapists than for romantic partners, whereas the 'secure base' component showed the same non-significant pattern. Consequently, therapists were considered to be attachment figures for their patients.

Farber, Lippert, and Nevas (1995) reviewed therapists' attachment functions. First, they described therapists as stronger and wiser personalities. The facilitating and cooperating competencies of therapists were emphasized in contrast to the traditional role of doctors. Although it strengthens the bond between patient and therapist in most cases, the cooperative attitude of the therapist can be an obstacle for patients with low socioeconomic status who are accustomed to more traditional, more hierarchical settings. Second, therapists were seen as means of psychological survival for some patients. Third, the uniqueness of attachment to therapists was highlighted by patients' hesitation to visit a surrogate therapist even in the case of their therapist's longer absence. Fourth, authors regard patients' evocation of memories about the therapist or the therapeutic setting, especially in case of successful therapies, as evidence of the long term effects of attachment. These mental representations serve attachment functions in the physical absence of the therapist. Fifth, intensive positive emotions present at the beginning of therapy and sadness and/or anger evoked because of temporal and emotional boundaries, were considered to be the analogues of positive emotions accompanying formation of attachment, and then heavy protest upon separation in childhood.

The above statements are empirically proven as well. Patients use their therapist as a safe haven, since memories of them are most likely to be summoned in times of high distress (Geller & Farber, 1993) and summoned representations bring feelings of security and acceptance (Rosenzweig, Farber, & Geller, 1996). In studying the August-phenomenon (August is the month when most of the therapists in USA go on a 4-week holiday), Barchat (1989 cited by Mikulincer & Shaver, 2007) observed that the month-long separation from the therapist evokes patients' yearning for him or her accompanied by anger, sadness or fear. These effects are very similar to those described by Bowlby (1969) in case of infants and children separated from their caregivers.

Measurement of Patient-Therapist Attachment Quality in the Social Personality Tradition

Measurement of attachment in adulthood – including patient-therapist attachment – has been linked to the developmental approach for a long time. Although the findings of studies using interviews are very promising (e.g., the Patient-Therapist Attachment Interview; Diamond, Stovall-McClough, Clarkin, & Levy, 2003), these methods are very costly because of the training required and the face-to-face administration.

In the social personality approach, Mallinckrodt, Gantt, and Coble (1995) developed an instrument called the Client's Attachment to Therapist Scale measuring three dimensions of attachment in psychotherapy: security, avoidance/fearfulness and preoccupation/merger. Analysis of data from ratings of these factors and ratings of working alliance resulted in four clusters resembling the four adult attachment styles of the Bartholomew model. Despite superficial resemblance, patterns of the four variables in each cluster (i.e. high vs. low scores on working alliance and the three factors of attachment in psychotherapy) are not in accordance with results of former research on attachment theory. On the other hand, Robbins (1995) commenting on the development of the instrument criticizing authors for having scales with low internal reliability.

Given the lack of success in former trials to measure patient-therapist attachment correctly (both psychometrically and conceptually), the purpose of our study was to develop a valid and reliable measure for patient-therapist attachment, which is in accordance with the widespread Bartholomew model of adult attachment (for details see above and Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994).

Method

Instrument Development

Adapting an existing, theoretically grounded scale to the distinctive characteristics of the psychotherapy setting and psychotherapy relationship was of high priority for us. So, our choice was the Experience in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) which has excellent psychometric qualities and is available in Hungarian (Nagy, 2005). The theoretical background of this measure was presented earlier in this paper (see the Bartholomew model). Adapting this measure to the psychotherapy relationship is not in itself a novelty since, in his online comment, Chris Fraley (2005) encourages the transformation of the revised version of ECR to other possible attachment-related situations (e.g., the psychotherapy relationship).

Reformulation of the scale fitting the psychotherapy setting was achieved by changing the word 'partner' to 'therapist' in each of the 36 items. Four of the statements were still incompatible with the properties of the psychotherapy setting or relationship, so these statements were slightly altered to fit the specific conditions. With these alterations we obtained a 36-item scale labeled temporarily as the Attachment in Therapy Scale (ATS). According to instruction, psychotherapy patients were asked to rate their degree of agreement (1 = totally disagree; 7 = totally agree) with the statements, by reference to the whole process of their current psychotherapy.

Participants

Selection criteria for participants were twofold: (1) psychotherapy patients should be older than 18; (2) psychotherapy should be lasting for at least three months, but shouldn't be in the phase of termination. The decision about the second criterion was entrusted to psychotherapists. Since at the time of the study no instrument measuring the therapeutic relation had been available in Hungarian, therapists were included in the study as informants and expert raters of their patients' interpersonal behavior in therapy. This information was then used for the validation process.

112 patients (76 women) and 22 therapists (19 women) participated in the study. Mean age of patients was 36.21 years (SD: 11.17 years), 87 of the patients completed at least secondary school education. Considering diagnosis, the sample was very heterogeneous. 27 patients were treated for substance dependence, 19 patients had a single or comorbid DSM-IV Axis II diagnosis (personality disorder), 59 patients had a single or multiple DSM-IV Axis I diagnoses different from substance abuse. In 8 cases diagnosis was missing. Out of the 22 therapists, 5 had psychotherapy qualification; other therapists were either psychiatrists or clinical psychologists. The average duration of the psychotherapies at the moment of the study was 66.82 weeks (SD: 83.4 weeks). The methods used in psychotherapies were supportive psychotherapy (46 therapies), the Minnesota Model (26 therapies), and diverse other methods (40 therapies). Psychotherapy sessions were scheduled weekly most of the times (83 therapies). Heterogeneity or large variance is not common to studies in psychotherapy research and it is fully in accordance with the idea of therapeutic attachment being developed independently of age, sex, method of therapy etc.

Instruments

Data collected about patients referred to sex, age, level of education (provided by patients), DSM-IV diagnosis (provided by therapists). Data collected about therapists referred to sex and level of psychotherapy training (provided by therapists). Data collected about psychotherapy referred to: duration of psychotherapy in progress; frequency of sessions; method of psychotherapy (provided by therapists).

The Attachment in Therapy Scale. Patients reported their experience of the psychotherapy in progress on the previously mentioned self-report scale (see Table A1 for items).

Patients' psychotherapy attitude. Patients' psychotherapy attitude was measured by their degree of agreement with three statements derived from the psychotherapy research literature as important mediating variables for the therapy's outcome. These statements were aimed at grasping (1) the positive effects of psychotherapy on their everyday lives (usefulness; Miller, Duncan, Brown, Sparks, & Claud, 2003); (2) the pleasantness of the time spent with the psychotherapist (Stiles, 1980); and (3) the hope in recovery, hope in successful problem-solving with the help of psychotherapy (Trijsburg, Colijn, & Holmes, 2005).

Therapists' ratings of patients' therapeutic attachment. Therapists rated their patients' attachment in psychotherapy on two statements representing avoidant and anxious behavior in psychotherapy respectively. These statements were altered forms of descriptions for anxious and avoidant attachment used by Hazan and Shaver (1987) in their pioneering study of adult attachment.

Procedure

Listed measures printed in a booklet were disseminated in psychotherapy ambulances and wards in South-Western Hungary. Patients completed measures either individually in their homes or in small groups at the wards. Therapists completed their booklets individually. After completion, both patients and therapists returned their booklets in a closed envelop. Patient and therapist booklets were matched through an identification code derived from the patients' names and date of birth, which guaranteed anonymity, but enabled us to pair up therapist and patient data. Both therapists and patients gave their informed consent for their participation, in agreement with current ethical guidelines. Patients completed the Attachment in Therapy Scale (ATS) once again one week after initial participation.

Results

Internal Structure of ATS

Scoring for items with reversed scoring in the original Experience in Close Relationships Scale (Brennan, Clark, & Shaver, 1998) was reversed before factor analysis to reach best fit of the newly developed scale to the Bartholomew model of adult attachment. Still, in the data analysis we preferred EFA over CFA because the scale was transferred to a completely new situation and we didn't want to prevent new dimensions (e.g., a dimension measuring attachment security directly) from emerging. Out of the 36 items of ATS, three were excluded from later analysis because of low communality (< .25). The remaining 33 items proved to be eligible for using principal axis factoring (KMO = .78), which produced eight factors with varimax rotation. Out of these eight factors, six were taken into account. The selection of these six factors was based on the following rules: (1) the number of items belonging to each factor should be more than two; (2) they should be conceptually appropriate for interpretation. Two factors were omitted from further analysis because only two items loading on these factors was judged to be

hazardous for internal reliability. The remaining six factors accounted for 46.45 per cent of total variance. Attachment in Therapy Scale (ATS) items, factors and factor loadings are presented in Table A1. Factors were named in accordance to the theoretical summary of Wei, Russell, Mallinckrodt, and Vogel (2007).

Items and Factor Structure of The Attachment in Therapy Scale

Since the purpose of the study was to develop a measure of therapeutic attachment fitting into an existing model of adult attachment (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994), we wanted to prove this fit not only on a theoretical ground, but also statistically. To do this, we gathered avoidance items into a superfactor and anxiety items into another one. Cronbach's alphas (indicated in Table 1.) for these higher order factors were computed and found satisfactory.

Table 1

Psychometric Properties of Attachment in Therapy Scale (ATS) Superfactors and Scales

Scales	*M*	*SD*	Range	Cronbach's Alpha (α)	No. of items	Test-retest reliability (r)
ANXIETY SF	34.05	15.92	16-80	.89	16[a]	.92
Excessive worry	14.30	7.75	6-38	.82	6[a]	.89
Lack of fit	12.97	7.01	7-35	.82	7[a]	.84
Need for reassurance	8.96	5.38	4-26	.79	4	.86
AVOIDANCE SF	27.67	10.70	13-72	.79	13	.79
Reluctance to self-disclosure	9.29	5.02	5-32	.76	5	.64
Avoidance of closeness	11.13	5.77	5-25	.78	5	.83
Excessive self-reliance	7.20	3.54	3-18	.69	3	.74

Note. SF = Superfactor.

[a]Both 'Excessive worry' and 'Lack of fit' scales contain item no. 4. For Anxiety total score should not be added two times.

Psychometric Properties of ATS

Means and standard deviations for the ATS subscales are presented in Table 1 together with internal consistency and test-retest reliability. Correlation between the two superfactors was $r = .26$ ($p < .01$).

Validity of ATS

Evidence of concurrent validity tested with Pearson's correlation is presented in Table 2.

Correlations are low to moderate between self-reported and therapist-rated attachment avoidance in therapy, and no correlation was found between self-reported and therapist-rated attachment anxiety in therapy. The correlation between patient-rated therapy attitude and attachment avoidance proved to be low to moderate, and attachment anxiety in therapy as measured in this study proved to be independent of patients' attitude toward psychotherapy.

Discussion

The internal structure of the Attachment in Therapy Scale appears to be similar to that of the Bartholomew model, and results were also satisfactory considering the psychometric characteristics of the measure. Our results are in accordance with ideas derived from adult attachment literature by Wei and colleagues (2007). In their opinion, both attachment avoidance and attachment anxiety can be further split into three scales each. We also found a

Table 2

Pearson's Correlations of Attachment in Therapy Scale Superfactors (SF) and Scales With Other Measures

Scales	TRAV	TRAN	SRUT	SRPT	SRHP
ANXIETY SF	-	-.04	-.02	-.04	-.17
Excessive worry	-	-.01	-.01	-.10	-.12
Lack of fit	-	-.05	-.18	-.17	-.12
Need for reassurance	-	-.04	-.02	-.02	-.17
AVOIDANCE SF	.48**	-	-.32**	-.28**	-.37**
Reluctance to self-disclosure	.39**	-	-.23*	-.10	-.29**
Avoidance of closeness	.40**	-	-.24**	-.30**	-.22**
Excessive self-reliance	.25**	-	-.25**	-.21*	-.35**

Note. TRAV = Therapists' ratings of clients' avoidance in therapy; TRAN = Therapists' ratings of clients' anxiety in therapy; SRUT = Self-rated usefulness of therapy; SRPT = Self-rated pleasantness of therapy sessions; SRHP = Self-rated hope in problem solving / recovery; SF: Superfactor.
*p < .05. **p < .01. ***p < .001.

meaningful structure of six factors underlying the item pool referring to the psychotherapy setting and relationship. It means that a more detailed measurement of attachment is possible as it is an issue of concern common to those studying adult attachment.

These six factors can also be of great interest for practicing psychotherapists because all of them describe patients relating to their therapists in terms of distance regulation. Distance regulation was present from the very beginning of attachment theory (Bowlby, 1969) and it has also been an important aspect of modern psychodynamic theories based on infant research (e.g., Stern, 1985). According to these theories, the role of the therapist is much more similar to an affect-regulating significant other (Stern, 1998) than to an interpreter of unconsciously motivated behaviours and effects. In our opinion, this newly developed measure (ATS) is conceptually suitable to measure therapeutic relations in terms of mutual regulations.

Results referring the validity of the ATS scales are promising for measuring attachment avoidance in therapy, but therapeutic attachment anxiety showed no correlation either with therapists' ratings of their clients' mode of relating or with patients' self-reported attitude toward therapy in our study.

Given the nature of our results, lack of success in validating therapeutic attachment anxiety has to be discussed. Internal reliability indices for these scales are equivalent or show even higher reliability than those for therapeutic attachment avoidance scales; therefore, problems in understanding can be excluded. On the one hand, lack of correlation between therapeutic attachment anxiety and therapists' ratings of the same construct must be accounted for. Attachment avoidance in therapy – e.g., patient's reluctance to self-disclosure – is more readily observable for therapists. In contrast, attachment anxiety – being linked to representations of self and emotions (e.g., worry about losing the therapist) – in itself is not necessarily manifested on the surface. Rather, uttering ambivalence and worries is connected with the dimension of attachment avoidance as represented in the scale of reluctance to self-disclosure (e.g., item 27; see Table A1). In future studies of attachment anxiety in therapy, a validation distinct from therapists' ratings should be used.

On the other hand, lack of relation between therapeutic attachment anxiety and attitude toward psychotherapy can be explained based on attachment theory's ideas about change in psychotherapy. According to Bowlby (see

Dozier & Tyrrell, 1998 for a summary), the aim of psychotherapy is to change the internal working models of the patient. These representations refer either to self or to significant others (i.e. attachment figures like psychotherapists). While effective psychotherapy leads to change in both representations, these can occur at different points during the therapy. Whereas attachment avoidance ought to be overcome in the first phase of therapy, where positive transference and forming a working alliance takes place, anxiety over separation from therapist is mostly worked through in the termination phase. Accordingly, in the intermediate phase of the therapy, individual variances in therapeutic attachment anxiety (representation of self) are more likely to be the results of former experiences, while representation of the therapist as a significant other (therapeutic attachment avoidance) is more likely to have already been accommodated to the perceived characteristics of the therapist. This hypothetical explanation could be tested with a replication of the study with patients who are terminating therapy or with those who have already terminated their therapy several months ago.

Although some questions remain open concerning the measurement of patient-therapist attachment, a reliable and valid measure of therapeutic attachment avoidance has been developed. This measure – called Attachment Avoidance in Therapy Scale (AATS) – is certainly of importance given the fact that Hayes, Wilson, Gifford, Follette, and Strosahl (1996) describe the general phenomenon of experiential avoidance as a probable functional diagnostic dimension. Moreover, our study proved attachment avoidance not only to be a valuable predictor of psychotherapy motivation (Riggs, Jacobovitz, & Hazen, 2002), but also a valuable source of information concerning the possible outcome of psychotherapy.

Notes

1) For AATS use items of Attachment Avoidance in Therapy superfactor from ATS in ascending order (see Table A1).

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Appendix

Table A1

Items and Factor Structure of Attachment in Therapy Scale

Item no.	Item text	Factor loading of items
SUPERFACTOR I. – ATTACHMENT ANXIETY IN THERAPY[a]		
Factor 1: Excessive worry about losing the therapist		
8	I worry a fair amount about losing my therapist.	.74
14	I worry about being without my therapist.	.70
2	I worry about being abandoned by my therapist.	.62
30	I get frustrated when my therapist is not around as much as I would like.	.50
28	When my therapist is not by my side, I feel somewhat anxious and insecure.	.44
4	I worry a lot about the relationship with my therapist.	.42
Factor 3: Lack of fit in closeness		
12	I often want to merge completely with my therapist, and this sometimes scares her/him away.	.61
16	My desire to be very close sometimes scares my therapist away.	.60
6	I worry that my therapist won't care about me as much as I care about her/him.	.55
5	Just when my therapist starts to get close to me I find myself pulling away.	.52
11	I want to get close to my therapist, but I keep pulling back.	.49
26	I find that my therapist doesn't want to get as close as I would like.	.42
4	I worry a lot about the relationship with my therapist.	.41
Factor 5: Excessive need for emotional reassurance		
20	Sometimes I feel that I force my therapist to show more feeling, more commitment.	.68

Item no.	Item text	Factor loading of items
24	If I can't get my therapist to show interest in me, I get upset or angry.	.63
18	I need a lot of reassurance that I am liked by my therapist.	.52
10	I often wish that my therapist's feelings for me were as strong as my feelings for her/him.	.50
SUPERFACTOR II. – ATTACHMENT AVOIDANCE IN THERAPY		
Factor 2: Reluctance to self-disclosure		
27	I usually discuss my problems and concerns with my therapist. (R)	.78
25	I tell my therapist just about everything. (R)	.62
15	I feel comfortable sharing my private thoughts and feelings with my therapist. (R)	.56
31	I don't mind asking my therapist for comfort, advice, or help. (R)	.52
9	I don't feel comfortable opening up to my therapist.	.42
Factor 4: Avoidance of closeness		
17	I try to avoid getting too close to my therapist.	.81
23	I prefer not to be too close to my therapist.	.69
19	I find it relatively easy to get close to my therapist. (R)	.57
13	I am nervous when my therapist gets too close to me.	.45
7	I get uncomfortable when my therapist wants to be very close.	.43
Factor 6: Excessive self-reliance		
29	I feel comfortable depending on my therapist. (R)	.85
33	It helps to turn to my therapist in times of need. (R)	.61
35	I turn to my therapist for many things, including comfort and reassurance. (R)	.45

Note. (R): Items should be reverse keyed.

[a]For total score add item 4 only once.

About the Authors

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