ATTACHMENT AND THE INTERPERSONAL PROCESS OF PSYCHOTHERAPY

A Dissertation in
Counseling Psychology

by

Jennifer A. Hardy

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

August 2010
The dissertation of Jennifer A. Hardy was reviewed and approved* by the following:

Susan S. Woodhouse
Assistant Professor of Counseling Psychology
Dissertation Advisor
Chair of the Committee

Jeffrey A. Hayes
Professor of Counseling Psychology

Benjamin D. Locke
Affiliate Assistant Professor of Counseling and Clinical Psychology

Denis Gerstorf
Assistant Professor of Human Development

Spencer G. Niles
Department Head
Department of Counselor Education, Counseling Psychology, and Rehabilitation Services

*Signatures are on file in the Graduate School.
ABSTRACT

This study examined factors associated with client attachment to the therapist in short-term psychotherapy, specifically therapist and client general attachment as well as perceptions of the interpersonal dynamics within early therapy sessions. A total of 53 therapists and 79 clients from university clinics participated, resulting in 52 therapist-client pairings. First, it was hypothesized that secure attachment to therapist would be negatively related to both therapist and client attachment insecurity (i.e., anxiety and avoidance) and positively related to client ratings of both client and therapist in-session affiliation. In addition, client ratings of therapist affiliation were hypothesized to moderate the relations between both client attachment avoidance and anxiety and secure attachment to therapist. As expected, secure attachment to the therapist was inversely related to therapist attachment anxiety and positively related to client ratings of therapist affiliation. Contrary to expectation, client attachment insecurity, therapist attachment avoidance, and client ratings of client in-session affiliation were not related to secure attachment to therapist. Therapist affiliation was found to moderate the relation between client attachment avoidance (but not attachment anxiety) and secure attachment to therapist. Second, it was hypothesized that preoccupied-merger attachment to therapist would be positively related to both therapist and client attachment anxiety and negatively related to client ratings of both client and therapist in-session autonomy. In addition, therapist attachment anxiety and therapist in-session autonomy were hypothesized to moderate the relation between client attachment anxiety and preoccupied-merger attachment to therapist. As expected, preoccupied-merger attachment to the therapist was positively related to therapist attachment anxiety. Contrary to expectation, client
attachment anxiety and client ratings of both client and therapist in-session autonomy were not related to preoccupied-merger attachment to therapist. No support for the moderational models was found. Third, it was hypothesized that avoidant-fearful attachment to therapist would be positively related to client and therapist attachment avoidance as well as negatively related to both client attachment anxiety and client ratings of both therapist and client affiliation. Also, client ratings of therapist affiliation and client attachment anxiety were hypothesized to moderate the relations between client attachment avoidance and avoidant-fearful attachment to therapist. As predicted, avoidant-fearful attachment to the therapist was inversely related to client ratings of client in-session affiliation and positively related to client attachment avoidance. Contrary to expectation, client attachment anxiety, therapist attachment avoidance, and client ratings of therapist in-session affiliation were not related to avoidant-fearful attachment to therapist. No support for the moderational models was found. Finally, several planned post-hoc analyses were conducted to explore relations between the various attachment constructs (therapist general attachment, client general attachment, and attachment to therapist) and each of the in-session ratings of affiliation and autonomy. Avoidant-fearful attachment to therapist was negatively related to client ratings of their own affiliative behaviors in session. Client general attachment anxiety was inversely related to therapist ratings of their own autonomous behaviors in therapy. In sum, results highlighted the importance of therapist general attachment anxiety and client perceptions of therapist in-session affiliative behaviors on client attachment to the therapist, emphasizing the importance of therapist factors in the psychotherapy relationship.
# TABLE OF CONTENTS

List of Tables...............................................................................................................ix
List of Figures..............................................................................................................xi
ACKNOWLEDGEMENTS............................................................................................xii

Chapter 1. INTRODUCTION.............................................................................................1
  Attachment in Psychotherapy.........................................................................................3
  Structural Analysis of Social Behavior..........................................................................7
    The Psychotherapy Relationship and SASB.................................................................9
  The Present Study........................................................................................................10
  Research Questions and Hypotheses............................................................................11
  Planned Post-Hoc Analyses..........................................................................................14

Chapter 2. LITERATURE REVIEW..................................................................................15
  Attachment in Adulthood...............................................................................................16
    Attachment to Other Important Figures.................................................................17
    Conceptualizations of Adult Romantic Attachment................................................19
    Research on Attachment and Interpersonal Functioning.........................................21
    Attachment in Psychotherapy...................................................................................23
  Structural Analysis of Social Behavior.........................................................................35
    Description of SASB.................................................................................................37
    Understanding Attachment with SASB.................................................................42
    The Psychotherapy Relationship and SASB.............................................................44
  Attachment Theory and SASB....................................................................................46
    Research Using Both Attachment and SASB..........................................................47
Chapter 5. DISCUSSION...........................................................................................................105

Secure Attachment to Therapist..........................................................................................105

Preoccupied-Merger Attachment to Therapist.................................................................111

Avoidant-Fearful Attachment to Therapist.........................................................................115

Planned SASB Post-Hoc Analyses.......................................................................................118

Limitations.............................................................................................................................123

Research Implications........................................................................................................127

Practice Implications..........................................................................................................129

Appendix A: Client Demographic Questionnaire...............................................................134

Appendix B: Therapist Demographic Questionnaire.........................................................135

Appendix C: Experiences in Close Relationships Scale- Short Form (ECR-S)............136

Appendix D: SASB Intrex Questionnaire- Short Form.......................................................137

Appendix E: Client Attachment to Therapist Scale (CATS).............................................138

Appendix F: Cedar Clinic Client Consent Form.................................................................139

Appendix G: CAPS/Cedar Client Implied Consent Form................................................141

Appendix H: Cedar Clinic Therapist Consent Form.........................................................143

Appendix I: CAPS Therapist Consent Form..................................................................145

Appendix J: Initial Client Recruitment Email Script.......................................................147

Appendix K: Final Client Recruitment Email Script.........................................................148

Appendix L: Therapist Recruitment Script......................................................................149

Appendix M: Therapist Initial Paperwork Reminder Email Script.................................150

Appendix N: Client Recruitment Reminder Script.........................................................151

Appendix O: Client Upcoming Fourth Session Email Script...........................................152
Appendix P: Therapist Upcoming Fourth Session Email Script……………………….153
Appendix Q: Client Fourth Session Survey Link Email Script………………………..154
Appendix R: Client Reminder to Complete Second Survey Email Script…………….155
References…………………………………………………………………………………………158
## LIST OF TABLES

Table 1: Differences between Master’s Students and Non-Master’s Students ........64

Table 2: Descriptive statistics for Experiences in Close Relationships-Short Form, 
   Client Attachment to Therapist Scale, and Structural Analysis of Social 
   Behavior Intrex Questionnaire ............................................................78

Table 3: Intercorrelations among predictor and outcome variables among 
   therapy dyads ......................................................................................81

Table 4: Intercorrelations among SASB affiliation ratings within 
   therapy dyads ......................................................................................82

Table 5: Intercorrelations among SASB autonomy ratings within 
   therapy dyads ......................................................................................82

Table 6: Summary of Hierarchical Regression Analysis Predicting Secure CATS ....86

Table 7: Summary of Hierarchical Regression Analysis Predicting 
   Preoccupied-Merger CATS .................................................................91

Table 8: Summary of Hierarchical Regression Analysis Predicting 
   Avoidant-Fearful CATS ........................................................................93

Table 9: Summary of Regression Analysis Predicting Therapist Ratings of 
   Therapist Autonomy .............................................................................96

Table 10: Summary of Regression Analysis Predicting Therapist Ratings of 
   Client Affiliation ..................................................................................97

Table 11: Summary of Regression Analysis Predicting Client Ratings of 
   Client Affiliation .................................................................................99
Table 12: Summary of Regression Analysis Predicting Client Ratings of Therapist Affiliation

Table 13: Summary of Regression Analysis Predicting Client Ratings of Client Autonomy

Table 14: Summary of Regression Analysis Predicting Client Ratings of Therapist Autonomy

Table 15: Summary of Exploratory Post Hoc Analysis Predicting Therapist Ratings of Client Affiliation

Table 16: Summary of Exploratory Post Hoc Analysis Predicting Therapist Ratings of Therapist Autonomy
LIST OF FIGURES

Figure 1: The Structural Analysis of Social Behavior Two-Word Cluster Model……..157

Figure 2: Means Plot for Interaction Effect between Client General Attachment Anxiety and Client SASB Intrex Ratings of Therapist Affiliation to Predict Secure CATS Attachment to Therapist…………………………….89
ACKNOWLEDGEMENTS

I would first like to express my appreciation to my advisor, Dr. Susan Woodhouse. I feel blessed to have worked with an advisor who sincerely cared about me both personally and professionally. Thank you for your patience, diligence, and listening ear. It has always been nice having you in my corner.

I would also like to thank my committee members, Dr. Jeff Hayes for his unfailing belief in my potential, Dr. Ben Locke for his creative methodological suggestions that enabled my study to be conducted at CAPS, and Dr. Denis Gerstorf for offering his statistical expertise.

I am also appreciative of the Penn State College of Education Alumni Society for providing me with a grant that covered some of my dissertation research expenses.

Thank you also to the staff at the Cedar Clinic and CAPS for allowing me to conduct research at your sites. In particular, I would like to thank Lynne Gilham, Mark Patishnock, Priscilla Rojas, Kasie Pletcher, and Marie Land for their assistance in coordinating my study. My project would certainly not have been possible without your help.

I consider myself blessed to have been surrounded by supportive cohorts during my time at Penn State. Thank you to Dr. Christina Schendel, Megan Marks, MinJung Doh, and Dan Elreda. For as difficult as our program was, I know that it would have been exponentially more difficult without our teamwork. Also, I feel honored to have spent my internship year with the “love cohort:” Dr. Natalie Hernandez Depalma, Nadia D’Iuso, and Dr. Ryan Weatherford. Going into my internship experience, I didn’t think that I would have found such great friends like I have found in each of you.
Finally, I would like to thank my family who has always supported my academic pursuits. Thank you to my mom who talked me through my anxieties at some of my most difficult times in the program. I don’t think that you had any idea how many hours you would spend talking with me about comps! I thank you for every minute. And lastly, thank you to my husband, Claude, not only for making the sacrifice to move to Central Pennsylvania but also for your love, patience, and understanding. You are a wonderful partner, and I am so excited for the next stage in our life.
Attachment and the Interpersonal Process of Psychotherapy

Chapter 1

Introduction

Bowlby (1973) theorized that humans are driven to develop bonds with their caregivers in order to increase their survival. Children work to maintain proximity to primary caregivers, becoming distressed when separated. The caregiver serves as a secure base when the child explores the environment as well as a safe haven to which the child can return when hurt, scared, sick, or tired (Bowlby). If caregivers are generally able to respond congruently, children develop a sense of security with regard to their attachment figures. With time, individuals develop stable expectations about the physical and emotional availability of each of their caregivers. These patterns are encoded as mental representations of self and relationships to form internal working models (Bowlby, 1982, 1988). The internal working models developed through these early relationships impact the expectations and beliefs that an individual will have within other significant relationships (e.g., with their romantic partners, children, therapists; Fraley & Shaver, 2000).

Various conceptualizations of attachment styles in adulthood have been developed. Brennan, Clark, and Shaver (1998) analyzed all the extant self-report attachment measurements and two underlying attachment dimensions emerged: anxiety and avoidance. Attachment anxiety is defined as the level to which individuals seek closeness and protection while also being sensitive to signs of rejection and abandonment (Fraley & Shaver, 2000). Research regarding individuals high in attachment anxiety suggests that these individuals continually seek to activate their attachment systems to
ensure that their inconsistently available attachment figures will come to their aid (see Mikulincer & Shaver, 2007, for a review). As a result, these individuals report increased affect intensity and expressiveness, higher levels of distress, and lower self-esteem than individuals with minimal attachment anxiety (Horowitz, Rosenberg, & Bartholomew, 1993; Pietromonaco & Barrett, 1997). The second attachment dimension, avoidance, is seen as the degree to which individuals are uncomfortable depending on attachment figures, preferring to maintain emotional distance (Fraley & Shaver). Attachment avoidance has been empirically linked to minimizing the importance of interpersonal closeness (Mikulincer & Selinger, 2001; Collins, Guichard, Ford, & Feeney, 2004), fear of and discomfort with intimacy (Doi & Thelen, 1993; Greenfield & Thelen, 1997; Hudson & Ward, 1997), and restricted emotional expression (Collins & Read, 1990; Tucker & Anders, 1999; Bradford, Feeney, & Campbell, 2002; Wei, Russell, & Zahalik, 2005).

Substantial theoretical and empirical work has examined attachment categorically (e.g., Dunkle & Friedlander, 1996; Kivlighan, Patton, & Foote, 1998; Mallinckrodt, Coble, & Gantt, 1995; Satterfield & Lyddon, 1995), so it is important to be able examine parallels between work that has relied on categories of attachment and newer work that relies on attachment dimensions. The attachment categories can be translated dimensionally as follows: secure (low attachment anxiety, low attachment avoidance), preoccupied (high attachment anxiety, low attachment avoidance), dismissing-avoidant (low attachment anxiety, high attachment avoidance), and fearful-avoidant (high attachment anxiety, high attachment avoidance; Mikulincer, Shaver, & Pereg, 2003). The
subsequent review of the literature will utilize a dimensional approach and translate older findings using a categorical approach into the current dimensional language.

**Attachment in Psychotherapy**

One of Bowlby’s original intentions when developing attachment theory was to assist clinicians when working with patients and their families by providing a theory that “informs rather than defines intervention and clinical theory” (1988; Slade, 1999, p. 577). Accordingly, he proposed a model of therapeutic change that involved understanding current relationship patterns and early experiences with caregivers, examining how these patterns are evident in the psychotherapeutic relationship, and identifying new patterns of relating with others (Bowlby). Within all of these tasks, the therapist is called to be both a secure base to explore early relationship dynamics and a safe haven for the client in distress (Bowlby).

Bowlby conceptualized the therapist as an attachment figure for the client for several reasons. First, the client typically enters therapy with some level of distress, a condition that activates one’s attachment system. Second, the therapist is usually viewed by the client as “stronger and wiser,” someone from whom they are soliciting support and help. Third, the relationship is asymmetrical, with the therapist adopting the role of caregiver for the client, much like the client’s early relationships. Fourth, Bowlby proposed that the therapist’s emotional availability is a healing agent for the client. In fact, this emotional availability can be a corrective experience for clients, empowering them to shift their internal working models and expectations about attachment relationships (Dozier & Tyrrell, 1988). Furthermore, the relationship is theorized to be able to help clients shift their attachment styles in meaningful ways (Bowlby, 1988).
Research has largely supported theory regarding the influence of attachment style on the therapeutic relationship. Both attachment anxiety and avoidance are negatively related to the development of a strong working alliance whereas attachment security (low attachment anxiety and avoidance) is positively related to working alliance ratings (Dozier, 1990; Korfmacher, Adam, Ogawa, & Egeland, 1997; Eames & Roth, 2000; Reis & Grenyer, 2004). Thus, clients who are comfortable with intimacy and are able to trust others are significantly more likely to build strong working alliances with their therapists. However, the research also suggests that significant changes in these attachment dimensions are possible over the course of therapy and that these changes are related to positive shifts in interpersonal functioning (Travis, Binder, Bliwise, & Horne-Moyer, 2001; Levy et al., 2006). These findings suggest that therapy provides a corrective experience and that the therapist serves as a secure base for the client.

Even though therapists are not receiving care from their clients, attachment theorists suggest that therapist attachment styles impact their comfort as a caregiver for their clients (Bowlby, 1988; Slade, 1999; Mikulincer & Shaver, 2007). Attachment is conceptualized as the psychological foundation underlying caregiving (Collins & Feeney, 2000). Not only are we influenced by our caregivers in terms of the development of our own attachment, but they also served as models that will influence our later caregiving styles (Collins & Feeney). In essence, attachment security (low attachment anxiety and avoidance) allows therapists to focus on empathetically caring for their clients rather than concentrating on their own needs and concerns (Mikulincer & Shaver). They are comfortable with closeness during distress (in contrast to those with high attachment avoidance) and generally view themselves as efficacious (unlike those with high
attachment anxiety; Mikulincer & Shaver). These qualities allow them to reach out and effectively help others in crisis (Mikulincer & Shaver). As a result, they are able to provide their clients with a therapeutic environment, serving both as safe haven and secure base. Though only limited research has been conducted examining the relationship between therapist attachment and psychotherapy process variables, the research to date supports the idea that therapist attachment styles are activated in session (see Mikulincer & Shaver, for a review). For example, therapist attachment anxiety has been found to be related to lower working alliance ratings, decreased session smoothness, and increased problems reported in therapy (Rozov, 2002; Sauer, Lopez, & Gormley, 2003; Black, Hardy, Turpin, & Parry, 2005; Bruck, Winston, Aderhold, & Muran, 2006). Additionally, therapists without significant attachment anxiety and avoidance were less likely to have negative countertransference in their therapy relationships (Ligiéro & Gelso, 2002).

Given the direct effects observed for both client and therapist attachment styles, one could wonder how these attachment styles would interact in session. For example, how would the relationship quality vary for clients high in attachment anxiety paired with a secure therapist (a therapist low in attachment anxiety and avoidance) as opposed to a therapist high in attachment avoidance? Two studies have directly examined the interaction between therapist and client attachment styles. First, Dozier, Cue and Barnett (1994) examined this question, finding that insecure therapists struggle not only to maintain a healthy relationship with their clients but also to ensure that their personal experiences do not interfere with the process of therapy. Additionally, therapists high in attachment anxiety and/or avoidance tended to respond to “the most obvious presentation of needs” rather than underlying issues (Dozier et al., p. 798). In contrast they found that
clinicians who did not have significant attachment anxiety and avoidance were able to
provide their clients with a corrective emotional experience. In essence, it appears as
though clinicians low in attachment anxiety and avoidance are more flexible in their
manner of interacting with clients, resulting in interventions focused on dependency
needs much more often with clients high in attachment avoidance than those high in
attachment anxiety (Dozier et al.).

A second study regarding the interaction between therapist and client attachment
style examined how countertransference varied based on attachment (Mohr, Gelso, &
Hill, 2005). Psychotherapists high in attachment avoidance were more likely to use
distancing and hostile countertransference with clients high in attachment anxiety
compared to clients high in attachment avoidance. It appears as though clients high in
attachment anxiety may have been responding to their therapist in a way that did not
allow the therapist to maintain emotional distance. In contrast, therapists high in
attachment anxiety were more likely to use hostile countertransference with clients high
in attachment avoidance in comparison to clients high in attachment anxiety. In this case,
the opposite appears to be true. The clinician high in attachment anxiety seeks closeness
but is unable to obtain that from a client who seeks to maintain interpersonal distance,
resulting in frustration and hostility from the therapist (Mohr et al.). In sum, the two
studies point to the importance of examining both client and therapist attachment in
psychotherapy.

A final line of psychotherapy research on attachment styles is beginning to
examine the manner in which clients attach to their therapist. Mallinckrodt, Gantt, and
Coble (1995) developed a scale to assess the nature of the client’s attachment to therapist
based on the four characteristics of an attachment bond: secure base, safe haven, proximity seeking, and emotion regulation. Subsequent research on the Client Attachment to Therapist Scale (CATS) found that a preoccupied-merger attachment to therapist (high attachment anxiety and low attachment avoidance) was negatively related to session exploration and working alliance reports, whereas a secure attachment to therapist (low attachment anxiety and attachment avoidance) was positively related to session exploration (Mallinckrodt, Porter, & Kivlighan, 2005). The authors theorized that session exploration may tap into the client’s interpretation of the therapist as a secure base.

Thus, research has found that attachment to the therapist and general attachment are both linked to interpersonal behavior in the psychotherapy relationship. Given this association, it is important to understand how attachment is connected to therapist and client interpersonal perceptions within the therapeutic relationship. The Structural Analysis of Social Behavior (SASB) provides a conceptual framework for understanding interpersonal and intrapsychic interactions and perceptions of those interactions. Through SASB, perceptions of relational patterns specific to attachment anxiety and avoidance can be identified. Also, SASB provides an opportunity to examine the interaction between therapist and client attachment and the subsequent impact of that interaction effect on the psychotherapy relationship, for example on clients’ attachment to the therapist.

**Structural Analysis of Social Behavior**

Structural Analysis of Social Behavior (SASB) was developed as a means to visually describe interpersonal and intrapersonal interactions (Benjamin, 1974). SASB was intended to provide a common metric in both empirical and clinical work by
operationalizing interpersonal and intrapsychic behaviors (Benjamin). Rooted in interpersonal theory, Benjamin based the structure of her model on the work of Sullivan (1953), Leary (1957), and Schaefer (1965). Adopting the ideas of John Bowlby, Benjamin proposed that attachment was an essential human need necessary for survival (1993). Inherent in the model was the assumption that individuals develop interpersonal patterns based on early experiences with caregivers (Benjamin, 1974). These processes become unconscious and relatively stable both over time and across important relationships (Benjamin, 1993).

SASB consists of three interrelated surfaces with two dimensions on each surface, affiliation and interdependence (see Figure 1). Affiliation is the horizontal axis that runs from love to hate. The vertical dimension, interdependence, involves how behaviors vary in terms of differentiation and enmeshment (Henry, 1996). Because each surface contains the same dimensions, they are designed to conceptually overlap one another (Benjamin, 1974). The first surface, the transitive surface, consists of interpersonal behaviors that are directed toward other individuals. The second surface, the intransitive surface, includes behaviors that are interpersonal reactions to others. The third surface, the introject, contains actions directed toward the self based on early experiences. Thus, interpersonal interactions occur across the transitive and intransitive surfaces which may overtime influence the individual’s intrapsychic behavior (e.g., self-treatment). Finally, individuals may spend more of their time on one surface in comparison to another. For example, research has found that therapist behaviors are disproportionately on the transitive surface (e.g., caregiving behaviors) with the client primarily responding on the intransitive
The psychotherapy relationship and SASB. The research conducted using SASB has provided clinically useful information about how early relationships influence the therapeutic relationship. Affiliative behavior has been positively related to working alliance contributions (Coady & Marziali, 1994; Bruck et al., 2006) as well as therapist and client describing therapy as effective, smooth, and deep in content (Rudy, McLemore, & Gorsuch, 1985; Henry, Schacht, & Strupp, 1986; Bruck et al.). While interactions during psychotherapy are typically affiliative, disaffiliation, when present, is negatively related to outcome including symptom increases (Rudy et al.; Henry et al., 1986; Henry, Schacht, Strupp, Butler, & Binder, 1993; Schut et al., 2005).

In addition to exploring the role of affiliation in therapy, researchers have examined introject change over the course of treatment, finding that client introject ratings become increasingly similar to client ratings of the therapy relationship (Quintana & Meara, 1990). Thus, therapists who establish an affiliative working relationship with their clients appear to provide a context to explore different means of interacting with others that ultimately affects their clients’ relationships with significant others as well as their own self-concept and treatment of self.

Finally, some research has also considered attachment constructs in relation to affiliation. When therapist and client introjects are both affiliative (the SASB representation of healthy attachment), working alliance ratings and evaluations of sessions (i.e., depth and smoothness) are positively impacted (Dunkle & Friedlander, 1996; Bruck et al., 2006). Also, therapists low in attachment anxiety and avoidance have
been found to establish positive working relationships that contribute the client’s ability to develop an emotional bond with the therapist (Dunkle & Friedlander). Finally, therapists who treat themselves in disaffiliative ways were found to be less likely to develop a therapy relationship characterized by trust and closeness (Dunkle & Friedlander).

The Present Study

The present study examines the relations between client attachment with their therapists (Secure, Preoccupied-Merger, and Avoidant-Fearful) and several possible contributing factors including: therapist general attachment anxiety and avoidance, client general attachment anxiety and avoidance, affiliation within the psychotherapy relationship as rated by the client, and autonomy within the psychotherapy relationship as rated by the client. The present study focused on the clients’ perceptions of the therapeutic relationship because it was theorized that the clients’ perspective would be most closely related to the clients’ attachment to the therapist. Because perceptions of relationships are impacted by attachment styles, the present study enabled clients to provide their perspective on the relationship using SASB ratings (affiliation and autonomy).

The study attempted to correct for methodological limitations in earlier research. First, most research to date have examined only one member of the therapy dyad, typically the client. In the current study, both therapist and client attachment styles as well as their interactions were considered. Second, the research conducted on both SASB constructs and attachment styles have not utilized the most up-to-date attachment measure which assesses the dimensions of attachment anxiety and avoidance. Given the
increased statistical power of the dimensional approach, it is greatly preferred over the previous categorical approach (Fraley & Waller, 1998). While two-dimensional measures of adult attachment have been developed, no such instrument yet exists that assesses client attachment to therapist. Rather, client attachment to therapist has been conceptualized using a three-dimensional approach in which clients possess degrees of Secure, Preoccupied-Merger, and Avoidant-Fearful attachment to their therapist (although as will be described below, the three dimensions of attachment to therapist can be conceptualized in terms of attachment anxiety and avoidance). As a result, the subsequent hypotheses reflect both sets of descriptors, depending on whether general adult attachment or attachment to therapist is being referred to. Third, the psychotherapy research using SASB has generally utilized only the introject surface, relying on inference to examine the interpersonal psychotherapy process. Clearly, it would be more beneficial to have clients actually rate the relational dynamics rather than relying on inference.

**Research Questions and Hypotheses**

The purpose of the current study was to answer several research questions. In order to examine these questions, specific hypotheses were also developed.

*Predicting level of secure attachment to the therapist from attachment and SASB.*

To what degree do attachment styles (both therapist and client) impact the level with which a client is securely attached to their therapist? Do client ratings of the therapist and client in the psychotherapy relationship (using SASB) relate to the development of a secure client attachment to therapist? In order to test these questions, five hypotheses were developed:
1. Client general attachment anxiety and client general attachment avoidance will be negatively related to level of secure attachment to therapist.

2. Therapist general attachment anxiety and therapist general attachment avoidance will be negatively related to level of secure attachment to therapist.

3. Client and therapist affiliation, each rated by the client, will be positively related to level of secure attachment to therapist.

4. Therapist affiliation (as rated by the client) will moderate the relation between client general attachment anxiety and level of secure attachment to therapist.

5. Therapist affiliation (as rated by the client) will moderate the relation between client general attachment avoidance and level of secure attachment to therapist.

*Predicting level of preoccupied-merger attachment to the therapist from attachment and SASB.* Are therapist and client attachment styles (general attachment avoidance and anxiety) related to the degree to which clients form a preoccupied-merger attachment to their therapist? Also, are client SASB ratings of the psychotherapy relationship related to the development of a preoccupied-merger client attachment to therapist? Four hypotheses were created in order to examine these research questions.

1. Client general attachment anxiety and therapist general attachment anxiety will be positively related to level of preoccupied-merger attachment to therapist.

2. Therapist and client autonomy (as rated by the client) will both be negatively related to level of preoccupied-merger attachment to therapist.
3. Therapist general attachment anxiety will moderate the relationship between client general attachment anxiety and level of preoccupied-merger attachment to therapist.

4. Therapist autonomy (as rated by the client) will moderate the relationship between client general attachment anxiety and level of preoccupied-merger attachment to therapist.

**Predicting level of avoidant-fearful attachment to the therapist from attachment and SASB.** To what extent are therapist and client attachment styles related to the degree of an avoidant-fearful attachment to their therapist? Do client ratings of the psychotherapy relationship (using SASB) relate to the development of an avoidant-fearful client attachment to therapist? A final set of hypotheses was designed to answer these research questions.

1. Client general attachment anxiety will be negatively related to level of avoidant-fearful attachment to therapist.

2. Client general attachment avoidance and therapist general attachment avoidance will be positively related to level of avoidant-fearful attachment to therapist.

3. Client and therapist affiliation (as rated by the client) will be negatively related to level of avoidant-fearful attachment to therapist.

4. Therapist affiliation (as rated by the client) will moderate the relation between client general attachment avoidance and level of avoidant-fearful attachment to therapist.
5. Client general attachment anxiety will moderate the relation between client general attachment avoidance and level of avoidant-fearful attachment to therapist.

**Planned Post-Hoc Analyses**

Because only limited empirical research has examined the relations between attachment dimensions and SASB constructs (affiliation and autonomy), a series of planned post-hoc analyses were also conducted. These post hoc analyses assessed the degree to which attachment, as well as the interaction between therapist and client attachment styles, predicted therapist perceptions of their therapy relationships. These relations have not previously been examined, at least insofar as could be ascertained through a thorough literature search. Each SASB construct (client SASB Intrex ratings of therapist affiliation and autonomy, client SASB Intrex ratings of their own affiliation and autonomy, therapist SASB Intrex ratings of client affiliation and autonomy, therapists SASB Intrex rating of their own affiliation and autonomy) were considered independently in terms of variance explained by the four attachment constructs (client general attachment anxiety and avoidance, therapist general attachment anxiety and avoidance). Thus, these analyses explored to what degree internal working models (i.e., client and therapist general attachment) impacts ratings of the interpersonal process of psychotherapy. All two way interaction effects were also examined. Due to the exploratory nature of these post-hoc analyses, no hypotheses were specified.
Chapter 2

Literature Review

Central to attachment theory is the proposition that humans are predisposed to maintain relationships with individuals who can provide protection and security (Bowlby, 1973). During infancy and childhood, this evolutionary drive to maintain proximity to caregivers increases the likelihood that the infant will survive and thrive. Attachment behaviors are characterized by at least one of four defining features including: proximity maintenance, separation distress, safe haven, and secure base. Humans desire to maintain proximity to primary caregivers and will experience distress when separated. This distress is a protective response aimed at securing the caregiver’s return. Also, the caregiver serves as a secure base when exploring the environment as well as a safe haven to return to when hurt, scared, sick, or tired.

Over time, infants develop relatively stable expectations about how each of their caregivers will respond to their distress (e.g., my mother is inconsistently there for me, my father is comfortable with my distress). Ideally, the caregiver is able to respond to distress with congruent emotions and behaviors, conveying to the child that the caregiver is both physically and emotionally accessible during distress. When this occurs, the child develops a sense of security with regard to their attachment figure. Regardless of the level of security developed, these early relationship patterns are relatively stable over time and influence the child’s completion of developmental tasks such as social competence (Bowlby, 1973).

In addition, Bowlby proposed that patterns developed with early caregivers are encoded as mental representations of self and relationships (1982, 1988). These internal
working models influence the individual’s beliefs about the availability of others and their worthiness to receive care from “the cradle to the grave” not only in their interactions with primary caregivers but also in other caregiving-careseeking relationships such as with romantic partners (Bowlby, 1979, 1988; Simpson & Rholes, 1998). Finally, the theory is not intended to account for all of human behavior and personality, focused instead on interactions related to distress, safety, and exploration (Bowlby, 1982).

Attachment in Adulthood

The first measure of adult attachment, the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1984, 1985, 1996; Main & Goldwyn, 1984, 1998; Main, Kaplan, & Cassidy, 1985; Main & Solomon, 1990), was developed in order to predict the infant’s behavior during the Strange Situation scenario, a behavioral assessment that occurs between 12 and 20 months of age and categorizes infants into an attachment type (Ainsworth, Blehar, Waters, & Wall, 1978). The AAI assesses the adult’s general state of mind with regard to attachment and is based on responses to an interview that asks primarily about experiences with early caregivers. Individuals are assessed according to how they have organized and stored information about primary caregivers, focusing on understanding unconscious internal working models related to early experiences. Individuals are classified as secure-autonomous, preoccupied, dismissing-avoidant, or unresolved with respect to loss or abuse in their state of mind (Main & Goldwyn, 1998). An individual classified as secure-autonomous provides a coherent narrative and is able to maintain a sense of collaboration with the researcher. An individual who is able to structure the dialog in this fashion will be classified as secure regardless of how positive
or negative their early experiences were. In contrast, preoccupied adults lack the coherence of security and are preoccupied with their past experiences, often displaying anger as well as passivity of speech during the interview. Also, the preoccupied classification is given when individuals are unable to maintain acceptable conversational norms, usually by relating excessively long narratives. Next, an individual classified as dismissing also provides an incoherent narrative, relating generalized histories without the ability to support these descriptions with examples. In contrast to preoccupied individuals, interviews with dismissing individuals are excessively brief and their descriptions of early caregivers are generally positive (though unsupported). Despite variance in coherence, the preceding three attachment classifications are considered organized in nature. In contrast, individuals classified as unresolved display marked lapses of reasoning while relating stories about past abuse or loss, such as discussing a deceased caregiver as if he or she were still alive. These individuals may otherwise relate their narrative in ways similar to one of the other classification categories.

**Attachment to Other Important Figures**

In contrast to the AAI’s focus on early relationships, another line of adult attachment research has examined attachment to other important figures such as romantic partners and close friends. To some extent, theoretical and empirical overlap exists because of the similarities that exist between pair-bonds and infant-caregiver relationships. First, the emotional and behavioral dynamics within these relationships are believed to be managed by the same biological system (Hazan & Shaver, 1990). Just as a child will seek a caregiver when feeling sick or hurt, adults also seek out their partners as a source of comfort and support (Fraley & Shaver, 2000). The concept of “secure base”
has been observed within pair-bond relationships, with adults generally feeling safer when their partner is readily available (Fraley & Shaver). Second, the individual differences that have been empirically observed in infant-caregiver relationships are similar to the differences that have been observed in pair-bonds (Hazan & Shaver, 1987). In fact, the first assessment of romantic attachment developed by Hazan and Shaver was developed directly from the conceptualization of infant attachment. Third, working models regarding the availability of caregivers first developed during early relationships continue to influence the expectations and beliefs that one holds regarding attachment relationships throughout the lifespan. These internal working models are relatively resistant to change, assimilating discrepant information more readily than accommodating to it (Fraley & Shaver).

Though conceptual similarities are apparent, the nature of adult romantic attachment is also distinctively different from infant-caregiver bonds. For example, romantic love is conceptualized as involving the interaction between attachment, caregiving, and sex (Fraley & Shaver, 2000). Unlike infant-caregiver relationships, adults in romantic relationships will hold at various times either the role of caregiver or careseeker. When one is sick, stressed, or otherwise in need of assistance, the other partner will respond with some degree of care, concern and protection. Thus the asymmetrical infant-caregiver relationship is replaced with a reciprocal, mutual relationship (Hazan & Zeifman, 1999). Additionally, the behavioral systems of attachment and sex are distinct and yet interrelated (Fraley & Shaver). For example, the types of sexual relationships sought by an individual will likely be influenced by their attachment styles. A person who typically avoids emotional closeness in attachment
relationships may desire sexual experiences that do not involve emotional commitment and intimacy.

_Conceptualizations of Adult Romantic Attachment_

As previously mentioned, adult attachment measurement was initially created to be parallel to the categorical infant classification systems of the Strange Situation (Ainsworth et al., 1978). Initial assessments of adult attachment relied on a categorical approach to attachment and involved individuals selecting one of three paragraphs that best represented their experiences in close relationships (Hazan & Shaver, 1987). Based on their selection, individuals were classified as possessing one of three “prototypes:” a secure, avoidant, or anxious-ambivalent attachment style. Individuals classified with a secure attachment style are comfortable with both intimacy and interdependence as well as generally able to cope with stressors in a productive manner. The anxious-ambivalent categorization suggests that the individual seeks closeness and intimacy but also fears abandonment and rejection by their attachment figures. Finally, individuals classified as avoidant generally are uncomfortable with intimacy and relying on others (Hazan & Shaver). Given the rudimentary nature of this first measure, researchers continued to refine adult attachment measurement.

Of note, Bartholomew (1990) proposed that the avoidance category captured two distinct groups of individuals and therefore should be divided into two categories: dismissing-avoidance and fearful-avoidance. Dismissing-avoidance is characterized by excessive self-reliance and downplaying of attachment relationships. In contrast, fearful-avoidant individuals desire closeness and intimacy but avoid close relationships due to a lack of trust in others and fears of rejection. Finally, Bartholomew adopted the term
“preoccupied” from the Adult Attachment Interview (Main & Goldwyn, 1984) terminology in order to describe individuals who would be classified as anxious-ambivalent under Hazan and Shaver’s system.

Over time, several different instruments were developed to measure adult attachment using a dimensional approach. In order to develop a consistent means of measuring adult attachment, Brennan, Clark, and Shaver (1998) created a new scale based on a factor analysis of the items of all of the available attachment measurements. Two attachment dimensions emerged from the items retained: anxiety and avoidance. Attachment anxiety is defined as the level to which individuals are preoccupied with seeking closeness and protection while also being sensitive to signs of rejection and abandonment (Fraley & Shaver, 2000). Attachment avoidance is seen as the degree to which individuals are uncomfortable depending on attachment figures, preferring to maintain emotional distance (Fraley & Shaver). One strength of a dimensional conceptualization is the recognition that individuals possess degrees of both attachment anxiety and avoidance. From a measurement perspective, dimensions allow for greater statistical power in detecting differences in attachment (Fraley & Waller, 1998). Fraley and Waller also demonstrated that the dimensional model was a better fit to nature than the categorical model. Much of the theoretical and empirical work has examined attachment categorically, but the attachment categories can be plotted dimensionally as follows: secure (low anxiety, low avoidance), preoccupied (high anxiety, low avoidance), dismissing-avoidance (low anxiety, high avoidance), and fearful-avoidance (high anxiety, high avoidance; Mikulincer, Shaver, & Pereg, 2003). Similarly, the AAI categories described previously have also been translated dimensionally: secure-autonomous (low
anxiety, low avoidance), preoccupied (high anxiety, low avoidance), and dismissing-avoidant (low anxiety, high avoidance; see Mikulincer & Shaver, 2007, for a review). The subsequent review of the literature utilizes a dimensional approach and translates older findings using a categorical approach into the current dimensional language.

Research on Attachment and Interpersonal Functioning

An extensive body of research has developed regarding the relations between attachment and a variety of aspects of interpersonal functioning. Attachment anxiety has been related to interpersonal rigidity stemming from an emphasis on obtaining love and support in relationships (Mikulincer, 1998; Collins, Guichard, Ford, & Feeney, 2004; Mikulincer & Selinger, 2001). In fact, attachment anxiety is associated with dependency needs (Alonzo-Arbiol, Shaver, & Yarnoz, 2002; Pincus & Gurtman, 1995) and difficulties in asserting oneself (see, Mikulincer & Shaver, 2007, for a review).

Consistent with theory, individuals high in attachment anxiety are more sensitive to the rejection of others (Downey & Feldman, 1996; Taubman-Ben-Ari, Findler, & Mikulincer, 2002), resulting in significant rumination about possible rejection (Baldwin & Kay, 2003; Baldwin & Meunier, 1999) and concerted efforts to avoid abandonment (Vorauer, Cameron, Holmes, & Pearce, 2003). As a result of this rejection sensitivity, individuals high in attachment anxiety excessively seek reassurances from others (Davila, 2001; Shaver, Schachner, & Mikulincer, 2005). In sum, ambivalence develops out of the conflict between seeking support from others and fearing the rejection of others, resulting in behaviors that may seem to contradict each other (Mikulincer & Shaver). It appears as though individuals high in attachment anxiety continually seek to activate their attachment system in order to ensure that their inconsistently available attachment figures
will come to their aid. As a result, these individuals report increased affect intensity and expressiveness, higher levels of distress, and lower self-esteem than individuals with minimal attachment anxiety (Horowitz, Rosenberg, & Bartholomew, 1993; Pietromonaco & Barrett, 1997). Despite their efforts to secure care and closeness, individuals high in attachment anxiety often describe themselves as lonely (see Mikulincer & Shaver, for a review).

Attachment avoidance, on the other hand, has been empirically linked to minimizing the importance of interpersonal closeness (Collins et al., 2004; Mikulincer & Selinger, 2001) in favor of dominance and control in relationships (Mikulincer, 1998). This seems to stem from an overall fear of and discomfort with intimacy (Doi & Thelen, 1993; Greenfield & Thelen, 1997; Hudson & Ward, 1997). Additionally, individuals high in attachment avoidance display restricted emotional expression (Bradford, Feeney, & Campbell, 2002; Collins & Read, 1990; Tucker & Anders, 1999; Wei, Russell, & Zahalik, 2005) and increased emotional control (Feeney, 1995, 1999; Kotler, Buzzwell, Romeo, & Bowland, 1994; Tacon, Caldera, & Bell, 2001). Despite the fact that they are making concerted efforts to maintain emotional distance, individuals high in attachment avoidance also report low relationship satisfaction (Horowitz, Rosenberg, & Bartholomew, 1993; Pietromonaco & Barrett, 1997) and significant loneliness (see Mikulincer & Shaver, 2007, for a review). Interpersonally, individuals high in attachment avoidance describe themselves as hostile and cold (Horowitz et al.; Pietromonaco & Barrett), introverted and unagreeable (see Mikulincer & Shaver, for a review), and preferring to be alone not necessarily because of shyness (Bartholomew & Horowitz, 1991; Cyranowski et al., 2002; Duggan & Brennan, 1994; Griffin & Bartholomew, 1994;
Shaver et al., 1996). Finally, individuals high in attachment avoidance experience significantly more anger when supporting their stressed partner than less attachment avoidant individuals perhaps because of their tendency to pull away from others when they are distressed (Rholes, Simpson, & Oriña, 1999). Thus, the research suggests that individuals high in attachment avoidance seek and secure emotional distance despite the negative psychological and interpersonal consequences that they also report.

**Attachment in Psychotherapy**

A key purpose of Bowlby’s theory was to assist clinicians by providing a theoretical framework that “informs rather than defines intervention and clinical theory” (1988; Slade, 1999, p. 577). He proposed that therapeutic change involved first identifying and understanding current relationship patterns as well as early experiences with significant caregivers. Second, the clinician assists the client in examining how these interpersonal patterns are enacted in the psychotherapeutic relationship. Finally, clients work to develop new patterns of interacting and relating with others. Therapists support clients through all of these stages by serving both as a secure base from which clients can explore early relationship dynamics and as safe haven to comfort the client in distress (Bowlby).

Bowlby (1988) provided several reasons for conceptualizing the therapist as an attachment figure for clients. First, attachment systems are activated when individuals are in distress. Because clients generally enter therapy in distress, Bowlby suggested that client attachment systems are activated in therapy. As a result, clients are more likely to relate to their therapists in ways similar to other attachment figures in their life. Next, therapists are typically considered to be sources of help and support by clients, suggesting
that they may relate to their therapists as they have with other caregivers. Third, the relationship is asymmetrical. Not only do therapists adopt a caregiver role for their clients, but they also ensure that their sessions are focused on client needs. Fourth, Bowlby theorized that the therapist’s emotional availability is a healing agent for the client. This emotional availability has been considered to be a corrective experience for clients because it assists them in shifting their internal working models and interpersonal styles (Dozier & Tyrrell, 1988). Despite the relatively short duration of the therapy relationship, the essential characteristics of attachment relationships are present.

Not only is therapy viewed as an attachment-activating relationship for clients, but it is also considered to be impacted by therapist attachment. “Only when a degree of safety is attained and a sense of security is restored can most people perceive others to be not only sources of security and support but also human beings who need and deserve comfort and support themselves” (Mikulincer & Shaver, 2007, p. 329). It is this sense of security that allows therapists to focus their attention on caring for their clients’ needs rather than being consumed by their own fears and concerns. Therapists with low attachment anxiety and avoidance are comfortable with the intimacy and interdependence of the therapy relationship and possess the self-efficacy needed to confidently provide care (Mikulincer & Shaver). In contrast, insecure therapists will likely struggle to give effective care (George & Solomon, 1999). For therapists with high attachment anxiety, it may be difficult to establish appropriate therapeutic boundaries because of their strong desire for closeness (Mikulincer & Shaver). Further, their caregiving intentions may be motivated by unmet personal needs for closeness and acceptance rather than purely to help their clients (Mikulincer & Shaver). In terms of therapists with high attachment
avoidance, they may struggle with the intimacy of therapy (Mikulincer & Shaver). This intimacy may be especially intolerable when a client is very distressed, with the therapist responding with pity rather than empathetic understanding (Mikulincer & Shaver).

*Theoretical examples of attachment styles in psychotherapy.* It may be helpful to consider an example of how a client high in attachment avoidance may present in psychotherapy as well as possible reactions that the therapist may experience in relation to this type of client. The therapist will struggle to develop rapport and a strong working alliance with clients high in attachment avoidance because of their tendency to dismiss the need for attachment relationships (Dozier & Bates, 2004). These clients have learned to pull away from others when in distress, even though their interpersonal style may engender a strong sense of loneliness (Dozier & Bates). Clients high in attachment avoidance rely on rationality and logic when coping with stress, appearing to have minimal access to their emotional experiencing (Slade, 2004). The central task for the therapist is to help the client high in attachment avoidance gain understanding of their emotions and how past experiences may have affected them emotionally (Slade, 1999). Given the emotionally restrictive and distant nature of clients high in attachment avoidance, therapists may find themselves feeling “intrusive, melodramatic, helpless, ridiculous, and excluded” as a result of their attempts to make emotional connections with the client who consistently dismisses or ignores such connections (Slade, 1999, p. 588).

The client high in attachment anxiety will present to counseling in a markedly different manner from the client high in attachment avoidance. In contrast to clients high in attachment avoidance, clients high in attachment anxiety present to therapy with an
openness to discuss past difficulties and current symptomatology. Furthermore, these clients may experience overwhelming emotions during session (Slade, 1999). The struggle for the therapist is different; it is the struggle of focusing the client on working through their presenting and underlying issues (Dozier & Bates, 2004). Whereas the expression of anger may feel productive with other clients, this anger may take on an unproductive and ruminative nature with clients high in attachment anxiety (Dozier & Bates). Thus, the therapist must assist the client high in attachment anxiety in developing ways to regulate and organize their sometimes overwhelming emotions (Slade). When working with these clients countertransference reactions such as feeling “swamped, angry, helpless, confused, and dysregulated” may arise for the clinician, not only because of the emotional intensity characteristic of clients high in attachment anxiety, but also because of the client’s insatiable desire for interpersonal closeness (Slade, p. 588).

Unlike clients with issues of attachment anxiety or avoidance, clients low in both of the insecure dimensions of attachment (secure clients) will be able to establish a collaborative relationship with their therapist, engage in the process of therapy, and make productive steps toward goal-attainment (Dozier & Bates, 2004). It is believed theoretically that these clients are better able to not only acknowledge their distress but also take steps toward seeking help and beginning a therapeutic relationship (Dozier & Bates). Also, clients low in both attachment anxiety and avoidance effectively establish a strong working alliance with their therapist in part because these clients are able to discuss themselves in a non-defensive, open manner (Dozier & Bates).

Research examining client attachment styles in psychotherapy. Two bodies of research will be reviewed with regard to client attachment styles in the psychotherapeutic
relationship. First, the research that examines the impact of client attachment styles on working alliance will be discussed. Second, the relationship between client attachment styles and symptom change during the course of therapy will be summarized.

Working alliance has been a topic of extensive psychotherapy research, with this emphasis extending to understanding the dynamics of the working alliance in the context of client attachment styles. A strong working alliance involves the therapist and client working together toward therapeutic goals and includes a relationship characterized by trust, respect, and mutual regard (Gelso & Carter, 1985). Both attachment anxiety and avoidance have been found to be negatively related to working alliance ratings. These negative ratings occurred for clients with high attachment anxiety despite clinicians also perceiving them as reaching out for help (Bruck, Winston, Aderholt, & Muran, 2006; Dozier, 1990; Eames & Roth, 2000; Mallinckrodt, Coble, & Gantt, 1995). Attachment avoidance has also been negatively related to working alliance, with clients rated as rejecting of treatment (Dolan, Arnkoff, & Glass, 1993; Dozier; Kivlighan, Jr., Patton, & Foote, 1998; Mallinckrodt et al.; Parish & Eagle, 2003; Satterfield & Lyddon, 1995, 1998). In contrast, attachment security (when both attachment anxiety and avoidance are low) is positively related to working alliance and engagement in therapy (Dozier; Eames & Roth; Korfmacher, Adam, Ogawa, & Egeland, 1997; Reis & Grenyer, 2004). Thus, clients who are comfortable with intimacy and are able to trust others are significantly more likely to build strong working alliances with their therapists. Finally, Kanninen, Salo, and Punamaki (2000) examined how working alliance trajectories may differ by attachment style, finding that attachment anxiety was related to poor alliance during the middle stages but that working alliance sharply increased by the end of therapy.
Attachment avoidance was related to working alliance deterioration by the end of therapy. In contrast, clients who did not possess significant amounts of either attachment anxiety or avoidance maintained stable, positive therapeutic relationships.

Another complexity in working with clients high in either attachment anxiety or avoidance is symptom presentation. First, links have been established between attachment insecurity and psychopathology (Brennan & Shaver, 1998; Fonagy et al., 1996; Shorey & Snyder, 2006) as well as longer times for symptom remission (Cyranowski et al., 2002; Meyer, Pilkonis, Proietti, Heape, & Egan, 2001). In fact when both attachment anxiety and avoidance are elevated, clients reported significantly less symptom reduction than other clients (Reis & Grenyer, 2004). Second, symptom reporting seems to differ as a result of attachment style with clients high in attachment anxiety self-reporting significantly more symptoms than when rated by others (Dozier & Lee, 1995; Pianta, Egeland, & Adam, 1996). Third, McBride, Atkinson, Quilty, & Bagby (2006) found that depressed clients rated as high in attachment avoidance responded more favorably to cognitive-behavioral therapy than interpersonal therapy, with the authors hypothesizing that this may have been due to a focus on cognition rather than affect.

Finally, several authors have examined change in degree of attachment anxiety and avoidance. Reductions in attachment anxiety and avoidance appeared to be a positive and possible component of therapeutic change, related to significantly less psychological symptoms and significantly higher overall functioning than those who did not see a positive change in their attachment style (Levy et al., 2006; Tasca, Balfour, Ritchie, & Bissada, 2007; Travis, Binder, Bliwise, & Horne-Moyer, 2001). Attachment anxiety
seemed to be more malleable when compared to avoidance, with clients reporting significant decreases in attachment anxiety over the course of treatment (McBride et al., 2006; Tasca et al.).

Thus, the research suggests that attachment anxiety and avoidance are related to difficulties in psychotherapy. Not only are they negatively related to the development of a strong working alliance, but they are also linked to increased psychological symptoms. However, the research also suggests that significant changes in these attachment dimensions are possible over the course of therapy and that these changes are related to positive shifts in interpersonal functioning.

*Examining therapist attachment styles in psychotherapy.* Unlike the client who presents to psychotherapy in distress and in need of help, the psychotherapist is responsible for assisting the client through this distress. As described earlier, the psychotherapist must be an emotionally available caregiver, serving as a safe haven and secure base for the client. Attachment security is the foundation for caregiving functions such as empathy and altruistic helping (Collins & Feeney, 2006). “The therapist strives to be reliable, attentive, and sympathetically responsive to his patient’s exploration, and so far as he can, to see and feel the world through his patient’s eyes, namely to be empathetic” (Bowlby, 1988, p. 152). The therapist’s ability and willingness to be an emotionally available caregiver will be based in part upon their early attachment experiences (Slade, 1999). In other words, their caregiving style is influenced by how they were cared for in early relationships. Thus, therapists who had emotionally unavailable caregivers may find themselves struggling to connect with their distressed clients on an affective level. Furthermore, therapy involves attachment-activating
experiences such as loss, separation, and reunion. Just as termination of a therapeutic relationship may bring up feelings of loss, abandonment, and rejection in the client, so might the therapist experience attachment-related reactions (Slade). Though not as much empirical attention has been focused on the role of the therapist’s attachment system in comparison to the client, the research to date has largely supported theory, as described below.

Therapist attachment anxiety has been found to be related to lower working alliance ratings, decreased session smoothness, and increased problems reported in therapy (Black, Hardy, Turpin, & Parry, 2005; Bruck et al, 2006; Ruzov, 2002; Sauer, Lopez, & Gormley, 2003). Black et al. (2005) found that low levels of both attachment anxiety and avoidance explained a significant amount of variance in working alliance ratings. Additionally, therapists without significant attachment anxiety and avoidance were less likely to have negative countertransference in their therapy relationships (Ligiéro & Gelso, 2002). In a study of group therapists, Marmarosh and colleagues (2006) found that therapist attachment anxiety was related to perceptions of their clients as rejecting of them. Although the limited empirical research largely supports the proposition that therapist attachment styles are activated, at least one study failed to find a significant relationship between therapist attachment style and subsequent working alliance (Ligiéro & Gelso).

Research on client and therapist attachment interactions. Though the previous research has been able to test and support attachment theory as important in both client and therapist ratings of the therapeutic relationship, there has been relatively little attention paid to the interaction between client and therapist attachment. For example,
although client attachment avoidance has been negatively related to working alliance ratings, it is not clear how the relation between attachment avoidance and working alliance may be influenced by the attachment style of the therapist. Despite the relative lack of research in this area, several studies have been conducted to date addressing these questions.

Countertransference has been found to depend on the interaction between therapist and client attachment styles. Clinicians high in attachment avoidance are more likely to use distancing and hostile countertransference with clients high in attachment anxiety compared to clients high in attachment avoidance (Mohr, Gelso, & Hill, 2005). It appears as though these clients may have been responding to their therapist in a way that did not allow the therapist to maintain emotional distance. In contrast, clinicians high in attachment anxiety were more likely to use hostile countertransference with clients high in attachment avoidance in comparison to clients high in attachment anxiety. In this case, the opposite appears to be true. The clinician high in attachment anxiety seeks closeness but is unable to obtain that from a client who seeks to maintain interpersonal distance (Mohr et al.). Fearing rejection, these clinicians may be more likely to express their frustration with this therapeutic relationship. Finally, clinicians high on both attachment anxiety and avoidance were more likely to use distancing countertransference with clients high in attachment anxiety than with clients high in attachment avoidance (Mohr et al.). Individuals with both attachment anxiety and avoidance desire closeness but also fear intimacy. As a result, these clinicians sought to maintain distance despite their clients’ attempts at closeness.
Clients high in attachment anxiety are perceived as having more dependency needs than clients high in attachment avoidance when rated by insecure clinicians (Dozier et al., 1994). Clients high in attachment anxiety are generally responded to more deeply by their insecure therapists than by secure therapists, suggesting that insecure therapists are more likely than secure therapist to seek closeness and merger with clients high in attachment anxiety (Dozier et al.; Hardy et al., 1999; Rubino, Barker, Roth, & Fearon, 2000). Additionally, clinicians high in attachment anxiety generally intervened more deeply than clinicians high in attachment avoidance (Dozier et al.) but were found to be less empathetic (Rubino et al.). It appears as though clinicians low in attachment anxiety and avoidance are more flexible than insecure clinicians in their manner of interacting with clients, resulting in interventions focused on dependency needs much more often with clients high in attachment avoidance than those high in attachment anxiety (Dozier et al.; Rubino et al.).

These results suggest that when attachment styles are incongruent the therapist with high attachment anxiety or avoidance struggles not only to maintain a healthy relationship but also to ensure that his or her own personal experiences do not interfere with the process of therapy. As Dozier and colleagues suggest, “these clinicians who are insecure appear to feel the pull of the client’s attachment strategies and to react accordingly” (Dozier et al., 1994, p.798). In contrast they found that clinicians who did not have significant attachment anxiety and avoidance (i.e., secure therapists) were able to provide their clients with a corrective emotional experience. These clinicians “tended to respond more to the dependency needs of clients who were dismissing [i.e., high in avoidance] than they did to clients who were preoccupied [i.e., high in attachment
anxiety], thus providing interpersonal experiences that challenge existing models of the world” (Dozier et al., p. 798). Mallinckrodt termed these approaches “counter-complimentary attachment proximity strategies (CCAPS)” and considered these interventions to be opportunities for the client to experience different, more adaptive patterns of relating to significant others (2000, p. 256). The most beneficial CCAPS typically occur when a client who is high in either attachment anxiety or avoidance is in a relationship with a secure therapist (i.e., low on both attachment anxiety and avoidance).

*Client attachment to therapist.* In order to assess the attachment patterns that emerge in the relationship between the client and therapist, Mallinckrodt, Gantt, and Coble developed a scale that would assess the nature of the client’s attachment to their therapist (1995). The Client Attachment to Therapist Scale (CATS) was designed to assess the four characteristics of an attachment bond: secure base, safe haven, proximity seeking, and emotion regulation (Mallinckrodt et al.). The CATS consists of three subscales that measure the degree to which a Secure, Preoccupied-Merger, and Avoidant-Fearful attachment has formed between the therapist and client. Thus, this scale has yet to be updated to reflect a dimensional approach to client attachment to therapist, using categorical descriptions instead. Nevertheless, Mallinckrodt (2000) explicated the ways in which the three dimensions measured by the CATS can be understood using the more current two-dimensional approach. The Secure subscale reflects the degree to which clients possess neither attachment anxiety nor avoidance in their relationship with their therapist (Mallinckrodt). The Preoccupied-Merger subscale is comparable to the level of attachment anxiety that clients experience in their relationship with their therapist (Mallinckrodt). The third subscale, Avoidant-Fearful, assesses the degree to which clients
experience both attachment avoidance and anxiety with their therapist (Mallinckrodt). Of note is the lack of a CATS subscale reflecting elevated attachment avoidance and minimal attachment anxiety. Mallinckrodt et al. (1995) suggested that this factor was not identified during scale development because individuals with high attachment avoidance are unlikely to seek treatment. Additionally, the CATS can assist the clinician in understanding some transference and countertransference reactions based upon the reactions common to therapists working with clients of different degrees of attachment insecurity.

Mallinckrodt et al. (1995) found evidence for construct validity of the CATS: attachment to therapist was related in theoretically expected ways to working alliance, object relations deficits, adult attachment style, and self-efficacy. Subsequent research found that a preoccupied-merger attachment to therapist (high attachment anxiety, low attachment avoidance) was negatively related to session exploration and working alliance reports, whereas a secure attachment to therapist (low anxiety and avoidance) was positively related to session exploration (Mallinckrodt, Porter, & Kivlighan, 2005). The authors theorized that session exploration may tap into the client’s interpretation of the therapist as a secure base. Mallinckrodt, King, and Coble (1998) found that a secure attachment to therapist is negatively related to childhood fears of separation from parents (a measure that may tap attachment anxiety) and alexithymia (a construct that may indirectly measure attachment avoidance). Finally though attachment to therapist did not predict the presence and level of positive transference, both secure and preoccupied-merger attachment to therapist were significantly related to amount of transference and level of negative transference (Woodhouse, Schlosser, Crook, Ligiéro, & Gelso, 2003).
Conclusion

Both research and theory suggest that attachment significantly influences interpersonal behavior not only in general but also more specifically in the psychotherapy relationship. Given this impact, it is important to understand how attachment-based interpersonal behavior is specifically enacted in therapy. The Structural Analysis of Social Behavior (SASB) provides a conceptual framework for understanding interpersonal and intrapsychic interactions. Through SASB, relational patterns specific to attachment anxiety and avoidance can be identified. Also, SASB provides an opportunity to examine the interaction between therapist and client attachment as well as the subsequent impact of that interaction on the psychotherapy relationship.

Structural Analysis of Social Behavior

Structural Analysis of Social Behavior (SASB) was developed as a means to visually describe interpersonal and intrapersonal interactions (Benjamin, 1974). SASB was intended to provide a common metric in both empirical and clinical work by operationalizing interpersonal and intrapsychic behaviors (Benjamin). Rooted in interpersonal theory, Benjamin based the structure of her model on the work of Sullivan (1953), Leary (1957), and Schaefer (1965).

Inherent in the model is the assumption that individuals develop interpersonal patterns based on early experiences with caregivers (Benjamin, 1974). These processes become unconscious and relatively stable over time regardless of their adaptiveness (Benjamin, 1993). Also, these patterns tend to be exhibited throughout the lifespan within other important relationships (Benjamin, 1993). In fact, Benjamin proposed that mental disorders are actually adaptations to the environment and one’s own genetic
vulnerabilities, conceptualizing psychopathology as a “gift of love” bestowed by early caregivers (Benjamin, 1993). Interpersonal patterns are transmitted generation by generation, and it is from problematic patterns that psychopathology develops (Benjamin, 1993). Thus, different symptoms emerge from different environments (Benjamin, 1993). “For every interpersonal and intrapsychic pattern, there are specific antecedent or concurrent social inputs that relate in meaningful ways to the symptom, given the requisite temperament” (Benjamin, 1993, p. 7). Benjamin also proposed that the psychotherapist can understand the adaptiveness of an interpersonal pattern by understanding the client from the client’s perspective rather than as an outside observer (Benjamin, 1993).

Finally, Benjamin proposed that attachment is an essential human need that is necessary for survival (1993). Adopting the ideas of the attachment theorist John Bowlby, an underlying assumption of the SASB model is that early experiences related to attachment behaviors such as exploration and careseeking form the foundation of personality as well as working models of self and others (Benjamin, 1993; Henry, 1996). Thus, individuals learn both about themselves and others from early experiences with their caregivers. This social learning is proposed to occur through “copy processes,” hypothetical constructs that describe how early experiences are integrated into interpersonal patterns (Benjamin, 1996). First, identification involves acting in ways similar to one’s caregiver such as mimicking a mother’s tendency to sulk (Benjamin, 1996). Next, recapitulation is the process of acting with others as you do with your caregiver (Benjamin, 1996). For example, recapitulation occurs when someone approaches authority figures with trust because of their tendency to trust their caregivers.
A final copy process is *introjection* which occurs when an individual treats themselves as caregivers have treated them (Benjamin, 1996). Thus, an individual who was affirmed by caregivers during early years will grow to be self-affirming. In contrast, a person who was ignored by early caregivers will likely be self-neglecting.

*Description of SASB*

*Surfaces.* Generally speaking, SASB follows a circumplex structure and is a model of social behavior that can be depicted visually along a couple of dimensions (see Figure 1). Three different surfaces comprise SASB and are designed to conceptually overlap one another (Benjamin, 1974). The first surface is the transitive surface. This surface contains behaviors that are directed toward something or someone (Benjamin). Benjamin proposed that these transitive behaviors such as *affirming, protecting,* and *ignoring* are prototypical of parental behaviors. The second surface, the intransitive surface, includes behaviors that are interpersonal reactions to others (Benjamin). Intransitive behaviors are prototypically child-like in that they are conceptualized to encompass the behaviors that a child may have in response to their caregiver’s behaviors (Benjamin). For example, *disclosing, trusting,* and *walling-off* are intransitive responses. Finally, the third surface is the introject. These behaviors are actions directed toward the self and are developed from the copy processes previously discussed (Benjamin). Examples of introject behaviors include: *self-affirmation, self-protection,* and *self-neglect.* Thus, interpersonal interactions occur across the transitive and intransitive surfaces which may overtime influence the individual’s intrapsychic behavior (i.e., self-treatment).
Additionally, individuals may spend more of their time on one surface in comparison to another. For example, the transitive surface is conceptualized to contain parent-like behaviors. Therefore, it is logical to assume that parents are more likely to display behaviors primarily on the transitive surface when interacting with their children but balance their interpersonal behaviors between the transitive and intransitive surfaces during interactions with their partner. Furthermore, parents ideally provide protection (transitive surface) to their child, resulting in trust (intransitive surface) from their child in response. It would be considered unhealthy for this relationship to be reversed, with the child providing protection for their parents. Similarly, the relationship between a therapist and client will likely have the therapist’s behaviors disproportionately on the transitive surface with the client primarily responding on the intransitive surface (Critchfield, Henry, Castonguay, & Borkovec, 2007; Henry, Schacht, & Strupp, 1990).

In order to better understand how these surfaces interact, consider the following two examples. First, a mother who blames her child (surface 1 behavior, transitive) will have a child who reacts with sulking (surface 2 behavior, intransitive). If this interpersonal pattern continues, the child will eventually come to treat himself in a similar, self-blaming manner (surface 3 behavior, introject). In contrast, a father who protects his child (surface 1 behavior, transitive) will have a child who responds with trust (surface 2 behavior, intransitive). As this interaction pattern continues, the child will learn to treat herself in a self-protecting manner (surface 3 behavior, introject).

Dimensions. Within each of the three surfaces, behaviors are plotted along the two dimensions of affiliation and interdependence. Affiliation is the horizontal axis that runs from love to hate. Benjamin (1974) applied Leary’s (1957) horizontal axis of love-hate to
her axes of affiliation. The vertical dimension, interdependence, involves how behaviors vary in terms of differentiation and enmeshment (Henry, 1996). More specifically, this dimension runs from emancipate to control on the transitive and introject surfaces, with the intransitive (reaction) surface spanning from separate to submit. Just as the horizontal dimension of affiliation was based upon Leary’s interpersonal circumplex, this vertical dimension is attributed to Schaefer’s (1965) system of classifying parent-child interactions.

Two final notes with regard to the layout of the SASB surfaces are needed. First, the more common Interpersonal Circumplex (Kiesler, 1983; Leary, 1957) requires that some element of dominance and submission are present in any interpersonal interaction (Benjamin, 1996). This assumption is not made with SASB. Instead, SASB accounts for power in relationships by observing both degree of differentiation (vertical dimension) and the “focus” of the interaction via the different surfaces (e.g., transitive surface as prototypically parent-like; Benjamin). Also, autonomy and control are considered to be distinctly measurable constructs within SASB in contrast to other interpersonal circumplexes (Kiesler; Leary; Schaefer, 1965; Wiggins & Trapnell, 1996) that consider them together (Benjamin). Second, as mentioned previously, the three SASB surfaces overlap one another. This implies that a behavior that occurs on the transitive surface will be related to behaviors on the other surfaces that have similar amounts of both affiliation and interdependence. For example, acting with empathetic understanding (transitive behavior) contains relatively the same amount of affiliation as does clearly expressing oneself (intransitive behavior) and possessing a solid and integrated core (introject). Furthermore, each of these three behaviors contains similar degrees of interdependence.
Thus, the only distinction between acting with empathetic understanding, clearly expressing oneself, and possessing a solid and integrated core is who the behavior is focused on. For example, acting with empathetic understanding is a behavior that is focused on another individual whereas clearly expressing oneself is the reaction of the other individual to the empathy of the first. In sum, though the focus of behavior is different across the surfaces, the components of any behavior (affiliation and interdependence) are consistent throughout.

**Principles of interpersonal behaviors.** Benjamin, Rothweiler, and Critchfield (2006) described several interpersonal behaviors that occur between dyads that facilitate not only increased understanding about relationship dynamics but also how these patterns relate to early relationships and self-concept. These include: complementarity, introjection, similarity, opposition, and antithesis.

Complementarity occurs between individuals when their interactions are plotted in similar locations on the SASB surfaces (similar both in terms of affiliation and interdependence), but the individuals’ behaviors differ in focus (Benjamin et al., 2006). In other words, one individual is described on the transitive surface whereas the other’s interaction is best described on the intransitive surface. Outside of the surface on which the behaviors are coded, complementary behaviors are conceptually the same in terms of the dimensions of affiliation and interdependence. Complementary interactions generally appear congruent with one another such that kind words elicit kind reactions, not hostile ones. As a result, these interactions are relatively stable in that complementarity is more likely to continue once established than cease (Benjamin et al.).
Introjection is a principle that has already been described briefly. In general, introjection “captures the way people tend to treat themselves as they have been treated by important people” (Constantino, 2000, p. 159). The concept of introjection, or self-concept, is a theoretical personality construct that stems from early relationships with caregivers (Sullivan, 1953). It is relatively stable and resistant to change. As a result, knowledge of a client’s introject provides clinically useful information to the psychotherapist because it provides insight into how early relationships are influencing current interpersonal functioning (Constantino).

Similarity occurs when two important people in an individual’s life act in similar ways (Benjamin et al., 2006). For example, a person may describe the relationship with his or her mother and partner in the same fashion. This implies that the interpersonal pattern established with the mother is replicated in the relationship with the partner, regardless of its health and adaptability. In this case, the partner may have been selected in part because of the familiarity of this interaction style.

Opposition involves points on the interpersonal surfaces that are 180 degrees apart from one another (Benjamin et al., 2006). This may be present in complex communications such as saying something affirming in a blaming tone (Constantino, 2000). Alternately, opposition occurs when an individual is treated in significantly different ways by important figures (Benjamin et al.). For example, a child will experience opposition when treated in a nurturing manner by her mother and in a blaming way by her father. When the child is working to develop her introject, these opposing perspectives must be resolved in some manner.
Finally, an antithesis is a complement of opposite behaviors (Benjamin et al., 2006). Not only are these behaviors 180 degrees apart, but they also occur on different surfaces. For example, a therapist can ‘move’ a client who is sulking to disclosing about difficulties by acting in a consistently affirming manner. In a way, the client is interpersonally ‘pulled’ to respond in a complementary manner to the therapist. Interactions that involve antitheses are difficult to maintain because of their incongruence, resulting in the dyad shifting to a more stable and complementary manner of interacting. Whether this shift will be in the direction of the client or therapist’s interaction style will likely depend on the therapist’s skill in developing a positive working alliance (Constantino, 2000).

Clearly SASB is a complex means of describing interactions. Perhaps it also suggests the complexity of interpersonal and intrapsychic interactions. In either case, the SASB surfaces have been shown to represent patterns that exist between a dyad as well as across important figures in an individual’s life (Benjamin, 1974, 1993; Humphrey & Benjamin, 1986). The model is described in a manner that emphasizes the importance of early figures on the development of personality and interpersonal patterns. Benjamin has also elaborated more specifically on the nature of attachment and how different attachment relationships would be conceptualized with SASB (1994; Henry, 1996).

Understanding Attachment with SASB

Though not as complex as attachment theory in describing the different patterns of attachment relationships, Benjamin described two groupings of interpersonal patterns based on early experiences with attachment figures: the attachment group (AG) and the disrupted attachment group (DAG; Henry, 1996). Essentially these groups are
distinguished by differences along the affiliation dimension in that the *disrupted attachment group* contains all interactions on the disaffiliative side of the surfaces. In contrast, the *attachment group* represents all interactions on the affiliative side of the surfaces.

The *attachment group* is conceptualized to represent “normal” development because “it corresponds to the successful satisfaction of basic drives or needs as proposed by attachment theory” (Henry, 1996, p. 264). Additionally, a balance between enmeshment and differentiation is obtained so that the individual is best able to bond with attachment figures as well as explore the external world (Henry). Thus while individuals will likely display a wide array of interpersonal behaviors across the SASB surfaces, individuals with this attachment grouping will be more likely to participate in affiliative interactions than disaffiliative (Henry).

In contrast to the *attachment group*, the *disrupted attachment group* is characterized by excesses of submission, distance, and hostility (Henry, 1996). Individuals who experience disaffiliative early relationships will typically enact behaviors from the disaffiliative sides of the SASB surfaces (e.g., *attacking, protesting, self-rejecting*; Henry). Whereas the *attachment group* is theorized to be “normal personality,” the *disrupted attachment group* is considered to be associated with abnormal personality and psychological disorders (Henry). Despite the universal wishes for affirmation, love, and safety, individuals with disrupted attachment are thought to not experience satisfaction of these drives and may fixate on a specific unmet wish (Henry). “Because these central organizing wishes and fears are so rigidly fixed, and because interpersonal perception is skewed by toxic internalized representations, the resulting
attachment-seeking behaviors are maladaptive” (Henry, p. 1265). Additionally, these interactions are believed to be the early social learning experiences that shape interpersonal patterns that continue throughout the lifespan (Benjamin, 1993).

The Psychotherapy Relationship and SASB

Though SASB is rooted in interpersonal theory, it was intended to be used by clinicians as a way to shape treatment planning regardless of theoretical orientation (Benjamin, 1974; Henry, 1996). Ideally, Benjamin sought to create a common language for discussing relationships, particularly within the context of therapy (Henry). Virtually any relationship interaction can be conceptualized using SASB. Data about relationship patterns are generated by either outside observers trained in SASB coding procedures or by self-report. Though use of self-report could be criticized due to perception bias, Benjamin suggested that this perceptual bias is a necessary and critical element because “one is moved by how one sees the world more than by how the world really is” (Benjamin, p. 399).

SASB was also created in part to provide a common metric for evaluating the efficacy of psychotherapy and for examining what elements of the psychotherapeutic process are most conducive to client change (Benjamin, 1974). A growing body of literature has developed that has examined the roles of complementarity, disaffiliation, and affiliation in the psychotherapy relationship.

At the beginning of therapy, both therapist and client are rated as affiliative, though therapists are generally rated as more affiliative than their clients (Bruck, Winston, Aderholt, & Muran, 2006; Harrist, Quintana, Strupp, & Henry, 1994). Affiliative behavior has been positively related to working alliance contributions (Bruck
et al.; Coady & Marziali, 1994). Furthermore, when the complementarity between therapist and client is rated as affiliative, both the therapist and client describe the therapy as effective, smooth, and deep in content (Bruck et al.; Henry, Schacht, & Strupp, 1986; Rudy, McLemore, & Gorsuch, 1985). For example, affirming comments by therapists are significantly related to the client continuing with the same content (Karpiak & Benjamin, 2004). The relationship between affiliation in therapy and symptom change is less understood. Halvorsen and Monsen found that clients with disaffiliative introjects were significantly more affiliative and reported significantly lower symptoms post-treatment when compared to pre-treatment ratings (2007). Affiliative complementarity has been found to explain patient symptom change over and above therapist competence (Harrist et al.; Svartberg & Stiles, 1992). Also, positive changes in client introject (self-directed behaviors becoming increasingly affiliative) have been negatively related to relapse (Vittengl, Clark, & Jarrett, 2004). However, other researchers have failed to find a significant relationship between affiliation and symptom change (Critchfield, Henry, Castonguay, & Borkovec, 2007; Rudy et al.).

While interactions during psychotherapy are typically affiliative, disaffiliation, when present, is negatively related to outcome. In fact, when complementarity is rated as disaffiliative, symptoms either did not improve or increased (Henry et al., 1986; Henry, Schacht, Strupp, Butler, & Binder, 1993; Rudy et al., 1985; Schut et al., 2005). Disaffiliation is negatively related to ratings of working alliance contributions for both therapist and client (Coady & Marziali, 1994). Henry and colleagues examined whether psychotherapy training could reduce therapist disaffiliation in session (1993). Contrary to hypotheses, disaffiliation increased after training. These findings suggest that
interpersonal patterns are deep-rooted, resistant to change, and perhaps unconscious. Therapists with disaffiliative introjects were significantly more likely to interact with clients in disaffiliative ways (Henry et al. 1990). In fact, disaffiliative introjects (self-treatment) by either therapist or client is negatively related to client working alliance ratings (Dunkle & Friedlander, 1996; Paivio & Bahr, 1998). In contrast, when clients rate their therapist as affiliative, they also reported increased affiliation and decreased disaffiliation toward significant others at the end of treatment (Bedics, Henry, & Atkins, 2005).

Research suggests that complementarity between client and therapist is established early in treatment, even within the first session (Quintana & Meara, 1990; Svartberg & Stiles, 1992). Complementarity between the client’s behaviors early in therapy and their introject may not be significantly related initially (Harrist et al., 1994; Quintana & Meara). However, complementarity between the client’s interpersonal style and intrapsychic processes tends to increase over the course of therapy until they are significantly related (Quintana & Meara). It appears as though “clients begin to see themselves through their counselor’s therapeutic eyes” (Quintana & Meara, p. 130). Thus, therapists who establish affiliative working relationships with their client appear to provide a context to explore different means of interacting with others that ultimately affects the clients’ relationships with significant others as well as their own self-concepts and treatment of self.

Attachment Theory and SASB

Although attachment theory and SASB have developed from different historical roots and have stimulated unique lines of research, their points of overlap are substantial.
Both SASB and attachment theory emphasize the importance of early relationships on later interpersonal functioning and personality. Furthermore, both have theorized about the influence of early important figures on the expectancies that an individual forms about the world and the self. Despite the conceptual overlap, little empirical research has been conducted to date that specifically tests how these models relate to one another. However, such research is clinically useful. First, attachment theory provides a conceptual grounding for both interpersonal theory and SASB. Second, SASB helps to operationalize how attachment dimensions present themselves in relationships not only through the constructs of attachment group and disrupted attachment group but also through the structure of SASB, which can be used to describe the interpersonal interactions that would reflect varying attachment styles within dyads. Also, SASB provides an opportunity to observe patterns of behavior that stem from early relationships.

**Research Using Both Attachment and SASB**

Some researchers have already begun to examine the relations between attachment constructs and SASB. Affiliation has been more often related empirically to attachment security (minimal levels of attachment anxiety and avoidance) than the autonomy dimension (Gallo, Smith, & Ruiz, 2003; Pincus, Dickinson, Schut, Castonguay, & Bedics, 1999). Also, attachment security is significantly related to reports of affiliation in early experiences with caregivers (Pincus et al.). In contrast, both attachment anxiety and avoidance are associated with low nurturance as well as interactions with others characterized as controlling (Gallo et al.; Morrison, Goodlin-Jones, & Urquiza, 1997; Morrison, Urquiza, & Goodlin-Jones, 1997; Pincus et al.). As a
result, these interactions are inversely related to autonomy and affiliation (Gallo et al.). Attempting to understand how attachment avoidance may independently relate to the SASB dimensions, Gallo et al. proposed that individuals high in attachment avoidance may actually interact predominantly within the disaffiliative/autonomous sector of SASB. Given the withdrawing nature of attachment avoidance, it is reasonable to propose that individuals high in attachment avoidance would prefer to maintain interpersonal distance, mapped as highly autonomous within SASB surfaces (Gallo et al.).

Finally, researchers have also examined the relations between attachment dimensions and introject. Attachment anxiety is associated with disaffiliative, specifically self-attacking introject behaviors (Morrison, Goodlin-Jones, & Urquiza, 1997; Pincus et al., 1999). To a lesser extent, attachment avoidance is related to self-attacking behaviors (Morrison et al.). Thus, the research, though limited, suggests that links are empirically observable between attachment and SASB dimensions, warranting future research.

**Psychotherapy Research Using Attachment and SASB**

Three studies were identified that examined both attachment styles and SASB constructs within psychotherapy (Bruck et al., 2006; Dunkle & Friedlander, 1996; Hilliard, Henry, & Strupp, 2000). Of these studies, one measured attachment via the SASB ratings of early relationships. As a result, attachment in this particular study is conceptualized in terms of the *attachment group* and the *disrupted attachment group*, with affiliative ratings considered healthy attachment.

Psychotherapists generally have more affiliative introjects than their clients (Bruck et al., 2006). When psychotherapist and client introjects are both affiliative, working alliance ratings and evaluations of sessions (i.e., depth and smoothness) are
positively impacted (Bruck et al.; Dunkle & Friedlander, 1996). Also, clients’ early
relationships with caregivers (measured either through an attachment measure or through
SASB) directly impact both the process and outcome of therapy (Hilliard et al., 2000).
For example, using Core Conflictual Relationship Theme (Luborsky & Crits-Christoph,
1997), Beretta and colleagues found that 60% of clients reenacted interpersonal patterns
with their parents in session (2007). Interestingly, client early relationships were related
to the client ratings of the psychotherapy relationship but not related to the
psychotherapist or outside observer relationship ratings (Hilliard et al.). This pattern was
also evident for psychotherapist ratings of the psychotherapy relationship (Hilliard et al.).
Psychotherapist early parental relationships were found to directly impact the process of
psychotherapy only when measured by the psychotherapist (Hilliard et al.). Thus, it
appears that unconscious processes greatly influence how both the psychotherapist and
the client perceive the psychotherapy relationship. In a sense, reality is filtered through
the lens of past experiences and relationships.

Client report of emotional bond was positively associated with psychotherapist
comfort with closeness (a measure of attachment security; Dunkle & Friedlander, 1996).
This result suggests that a psychotherapist with minimal attachment anxiety and
avoidance (i.e., secure) is able to establish positive working relationships that contribute
to the client’s ability to develop an emotional bond with the psychotherapist. In contrast,
client report of the emotional bond was negatively related to psychotherapist self-directed
hostility (disrupted attachment group; Dunkle & Friedlander). Thus, psychotherapists
who treat themselves in disaffiliative ways were less likely to develop a psychotherapy
relationship characterized by trust and closeness.
Bruck et al. (2006) found that larger personality style differences (SASB ratings and attachment) between psychotherapist and client were related to more favorable client outcome, as long as the therapist had minimal attachment anxiety and avoidance. Also, these psychotherapists were most likely to see significant positive changes in their clients over the course of psychotherapy as compared to psychotherapists with higher levels of attachment anxiety and/or avoidance. Also, psychotherapist personality and attachment style significantly impacted client outcome, with psychotherapist introjected affiliation and attachment security positively affecting client outcome. In contrast, client introject and attachment style in part predicted variance in the interpersonal process within psychotherapy but did not significantly relate to psychotherapy outcome. This suggests that the relationship developed with the psychotherapist (and the interpersonal interaction between psychotherapist and client attachment) overrides the interpersonal pattern typical of the client and that the psychotherapist’s relational style (both in terms of attachment and SASB ratings) more strongly contributed to the client’s psychotherapeutic outcome.

Though the research examining client and therapist attachment as well as specific assessments of the interpersonal process in psychotherapy is limited, the results to date lend weight to the proposition that these constructs independently and conjointly impact client outcome.

Unanswered Questions

Given the literature to date, it is apparent that client and therapist attachment independently, and in interaction, impact the psychotherapy relationship. To date, no studies have been conducted that have specifically assessed the dyad considering the most current dimensional conceptualization of attachment as well as the interpersonal
process in the psychotherapy relationship. Additionally, researchers typically examined either client or therapist attachment style rather than assessing both psychotherapist and client attachment in interaction. Finally, the focus of the present study involved client perceptions of the therapy relationship as measured through SASB in addition to the influence of attachment.

Measurement issues also leave unanswered questions. The research that has examined the relationship between SASB constructs and attachment has not utilized the most up-to-date attachment measure which assesses the dimensions of attachment anxiety and avoidance. Given the increased statistical power of the two-dimensional approach, it is greatly preferred over the previous categorical approach. While the CATS relies on a dimensional approach to attachment, it utilizes an earlier three-dimensional approach (i.e., Secure, Preoccupied-Merger, and Avoidant-Fearful) rather than the current two-dimensional conceptualization (i.e., attachment anxiety and avoidance). It is important to note, however, that the three dimensions of the CATS can be conceptualized in terms of attachment anxiety and avoidance (Mallinckrodt, 2000). Similarly, measurement limitations are evident within the use of SASB. The psychotherapy research conducted thus far has generally utilized only the introject surface of SASB, relying on inference to examine the interpersonal process in psychotherapy. While the introject is easier to analyze statistically and provides an opportunity to make inferences as to how interactions are occurring in session, it would be more beneficial to have therapists and clients actually rate the relational dynamics.

Finally, relatively little is empirically known about the mechanisms that influence the type of attachment that clients develop toward their therapist. Although it could be
thought that clients develop similar relationships with their therapist as with other key attachment figures, the research to date suggests that these statistical relations are relatively small (Mallinckrodt, Gantt, & Coble, 1995). As a result, questions remain regarding what other constructs may independently and in interaction with client attachment impact type of attachment relationship that develops in the psychotherapy dyad.

**Conclusion**

Both research and theory suggest that SASB has the capability to measure the interpersonal process of psychotherapy with enough precision to detect differences that may be present in part because of one’s attachment style. In doing so, greater clarity can be developed regarding the independent contributions of therapist and client attachment. Furthermore, the unique contributions of the attachment dimensions and the interpersonal process of psychotherapy can be ascertained. Specifically, it will be beneficial to assess how these constructs independently contribute to the type of attachment that a client forms toward their psychotherapist as well as how these constructs interact to significantly impact client attachment to therapist.

**The Present Study**

The present study utilized three hierarchical multiple regressions to examine the relations between the three types of attachment styles that clients may develop toward their therapists and several possible contributing factors including: therapist general attachment anxiety and avoidance, client general attachment anxiety and avoidance, affiliation within the psychotherapy relationship as rated by clients, and autonomy within the psychotherapy relationship as rated by clients. While client and therapist general
attachment will be measured using a two-dimensional approach to attachment (i.e., attachment anxiety and avoidance), the only available instruments to measure client attachment to therapist adopted a three-dimensional approach (i.e., secure, preoccupied-merger, avoidant-fearful). As a result, the subsequent hypotheses utilize terminology from both of these approaches, depending on the construct referred to. Because of limited statistical power, only client perceptions of the psychotherapy process were included in the subsequent hypotheses. Client perceptions were prioritized because they were thought to more significantly influence client attachment to therapist than the perceptions of the therapist. Relations between therapist perceptions of the psychotherapy relationship and attachment were considered in planned post-hoc analyses. Prior to discussing the specific hypotheses of the study, the research related to clinical experience will be reviewed.

*Therapist Experience*

The present study included clinicians with a wide range of clinical experience from master’s students in their first practicum experiences to senior staff therapists at a university counseling center. However, the majority of clinicians were either master’s or doctoral students. It could be that clinical experience confounded the relations examined in the study. On the other hand, the concepts under examination were relatively stable relational patterns (e.g., attachment anxiety and avoidance) that developed during early childhood experiences with caregivers. One could question whether graduate training significantly modifies these relational patterns. In fact, Henry, Schacht, et al. (1993) found that attempts to train disaffiliative therapists to relate to their clients in a more affiliative manner had the opposite effect such that disaffiliation increased after training. Further, a direct relation between therapist early parental relations and therapy process.
has been evident in several studies (Henry, Schacht et al.; Henry, Strupp, et al., 1993; Strupp, 1993; Hilliard, Henry, & Strupp, 2000).

So, what contribution does therapist experience make? At least two studies have failed to find a relationship between therapist experience and working alliance (Dunkle and Friedlander, 1996; Kivlighan, Patton, & Foote, 1998). Also, Mallinckrodt and Nelson (1991) found that experienced therapists were rated more highly than inexperienced therapists by clients on the goal and task components of the working alliance. However, no significant difference existed between training level and the bond component, the component that most directly assesses the therapeutic relationship.

Positive relational dynamics between therapist and client explained client change over and above therapist competence (Svartberg & Stiles, 1992). In addition, Vasco and Dryden found that theoretical orientation explained more variance in therapeutic style than experience (1997). Therapist experience was significantly related to client symptom change over the course of therapy, but this relationship was no longer significant when considered in terms of “clinically significant change” (Burlingame, Fuhriman, Paul, & Ogles, 1989). Thus, it appears as though experience aids the clinician in terms of clinical expertise and symptom reduction. These benefits do not seem to extend to the actual relationship developed between client and therapist. In conclusion, the research did not suggest that master’s and doctoral-level trainees would differ in terms of their relational style due to experience.

Secure Attachment to Therapist Hypotheses

Client general attachment anxiety and client general attachment avoidance will be negatively related to level of secure attachment to therapist. Conceptually, both
general attachment anxiety and avoidance are characteristic of an “insecure attachment,” thereby suggesting an inverse relationship to level of secure attachment to therapist. Both client attachment anxiety and avoidance have been negatively related to working alliance (Bruck et al., 2006; Dolan, Arnkoff, & Glass, 1993; Dozier, 1990; Eames & Roth, 2000; Kivlighan, Jr., Parish & Eagle, 2003; Mallinckrodt, Coble, & Gantt, 1995; Patton, & Foote, 1998; Satterfield & Lyddon, 1995, 1998). In contrast, attachment security (low levels of both attachment dimensions) has been positively related to working alliance ratings (Dozier; Eames & Roth; Korfmacher et al., 1997; Reis & Grenyer, 2004) as well as to level of secure attachment to therapist (Mallinckrodt, Porter, & Kivlighan, 2005). Also, level of secure attachment to therapist has been negatively related to childhood fears of separation, a construct believed to tap an aspect of attachment anxiety (Mallinckrodt, King, & Coble, 1998). Finally, level of secure attachment to therapist has been negatively related to alexithymia (Mallinckrodt, King, & Coble, 1998).

*Therapist general attachment anxiety and therapist general attachment avoidance will be negatively related to level of secure attachment to therapist.* Although less research has been conducted on therapist attachment styles, the relationship directions are expected to be the same as the client attachment dimensions. As attachment avoidance and/or anxiety increase, the therapist is less likely to be comfortable both with closeness and client exploration. Therapist attachment anxiety and attachment avoidance have been negatively related to working alliance (Black et al., 2005; Sauer et al., 2003).

*Client and therapist affiliation, each rated by the client, will be positively related to level of secure attachment to therapist.* Affiliation has been positively related to working alliance (Bruck et al., 2006; Coady & Marziali, 1994). Furthermore, affiliation
has been related to both the therapist and client describing therapy as effective, smooth, and deep in content (Bruck et al.; Henry, Schacht, & Strupp, 1986; Rudy, McLemore, & Gorsuch, 1985). As reviewed previously, working alliance and a secure attachment to therapist have also been empirically related (Mallinckrodt, Gantt, & Coble, 1995).

*Therapist affiliation, as rated by the client, will moderate the relation between client general attachment anxiety and level of secure attachment to therapist.* A negative relationship has been expected between client attachment anxiety and level of secure attachment to therapist. However, therapist affiliation is hypothesized to moderate that relationship such that increasing degrees of therapist affiliation will increase the likelihood that a client with high attachment anxiety will develop a secure attachment to their therapist. Although this has not been directly tested previously, researchers have identified discrepancies between client introject (self-treatment) and their behaviors early in the psychotherapy relationship that decrease over time so that the client begins to treat themselves as their therapist treats them (Harrist et al., 1994; Quintana & Meara, 1990). This finding suggests that clients can experience a different relationship when guided by an affiliative therapist.

*Therapist affiliation, as rated by the client, will moderate the relation between client general attachment avoidance and level of secure attachment to therapist.* Similar to the preceding hypothesis, the negative relationship expected between client attachment avoidance and level of secure attachment to therapist is theorized to be moderated by therapist affiliation. In essence, affiliative therapists may be better able to establish a collaborative and safe environment that will enable otherwise distant clients to develop a higher degree of secure attachment to their therapist.
Preoccupied-Merger Attachment to Therapist Hypotheses

Client general attachment anxiety and therapist general attachment anxiety will be positively related to level of preoccupied-merger attachment to therapist. Attachment anxiety and level of preoccupied-merger attachment to therapist have been conceptually linked. Both suggest a desire to dissolve boundaries and merge with another. Although the relationship between client attachment anxiety and a preoccupied-merger attachment to therapist failed to reach significance in a study by Mallinckrodt, Porter, and Kivlighan, the authors attributed this to insufficient power due to a small sample size ($N = 38$) rather than a null relationship (2005). Thus, the current study was designed to obtain a sample large enough to detect these effects.

Therapist and client autonomy, as rated by the client, will both be negatively related to level of preoccupied-merger attachment to therapist. Because preoccupied-merger attachment to therapist suggests enmeshment and closeness, the client with this attachment to therapist will likely describe their relationship as one of merger rather than autonomy and distance.

Therapist general attachment anxiety will moderate the relationship between client general attachment anxiety and level of preoccupied-merger attachment to therapist. Although client general attachment anxiety has been positively related to level of preoccupied-merger attachment to therapist, this relation was hypothesized to be stronger when the therapist is also high in general attachment anxiety. In essence, both therapist and client would be working toward merger. On the other hand, a client high in attachment anxiety will be less likely to develop higher levels of preoccupied-merger attachment when their therapist is low in attachment anxiety. In this event, the therapist
with low attachment anxiety will be less likely to be drawn toward merger and extreme
closeness. Instead, it is predicted that therapists low in attachment anxiety will assist the
client with high attachment anxiety in developing a working relationship that contains
some degree of autonomy.

*Therapist autonomy, as rated by the client, will moderate the relationship
between client general attachment anxiety and level of preoccupied-merger attachment to
therapist.* Attachment anxiety was hypothesized to be positively related to level of
preoccupied-merger attachment to therapist. However, this relation was predicted to vary
in terms of the therapist’s degree of autonomy. A client who views his or her therapist as
highly autonomous will be less likely to report higher levels preoccupied-merger
attachment than the client who views the therapist as low in autonomy.

**Avoidant-Fearful Attachment to Therapist Hypotheses**

*Client general attachment anxiety will be negatively related to level of avoidant-
fearful attachment to therapist.* Mallinckrodt, Porter and Kivlighan found a negative,
though not significant, relation between client general attachment anxiety and level of
avoidant-fearful attachment to therapist (2005). The authors speculated that the non-
significant results were due in part to insufficient power to detect the relationship because
of a small sample size ($N = 38$). The current study was designed with sufficient power to
detect these effects.

*Client general attachment avoidance and therapist general attachment avoidance
will be positively related to level of avoidant-fearful attachment to therapist.* An
avoidant-fearful attachment to therapist is characterized by distrust of the therapist and
reluctance to disclose within therapy, components similar to attachment avoidance
(Mallinckrodt, Gantt, & Coble, 1995). Client attachment avoidance has also been positively related to level of avoidant-fearful attachment to therapist (Mallinckrodt, Porter, and Kivlighan, 2005).

Client and therapist affiliation, as rated by the client, will be negatively related to level of avoidant-fearful attachment to therapist. Because an avoidant-fearful attachment to therapist is characterized by feelings of distrust and rejection by the therapist, client and therapist affiliation are expected to be negatively related to this attachment style to therapist.

Therapist affiliation, as rated by the client, will moderate the relation between client general attachment avoidance and level of avoidant-fearful attachment to therapist. A positive relation has been hypothesized between client attachment avoidance and level of avoidant-fearful attachment to therapist. However, therapist affiliation was expected to moderate that relation such that increasing degrees of therapist affiliation would make it less likely that a client with high attachment avoidance would develop higher levels of avoidant-fearful attachment to their therapist. As mentioned previously, therapist affiliation can create a safe environment in which the client high in attachment avoidance can feel comfortable enough to share emotional experiences and develop a strong therapeutic relationship.

Client general attachment anxiety will moderate the relation between client general attachment avoidance and level of avoidant-fearful attachment to therapist. Mallinckrodt, Gantt, and Coble (1995) based their attachment to therapist patterns on the work of Bartholomew (1990; Bartholomew & Horowitz, 1991) with avoidant-fearful attachment to therapist similar to fearful-avoidant attachment. Fearful-avoidant
attachment is characterized by high attachment anxiety and high attachment avoidance. Thus, it was hypothesized that client attachment anxiety would moderate the positive relationship between client attachment avoidance and level of avoidant-fearful attachment to therapist. As client attachment anxiety increases, a client high in attachment avoidance would be significantly more likely to report higher levels of avoidant-fearful attachment to therapist than a client without high attachment anxiety.

*Planned Post-Hoc Analyses*

Because only minimal research has been conducted to examine the relationship between attachment dimensions and SASB constructs of affiliation and autonomy, a series of planned post-hoc analyses were also conducted. Each SASB construct (clients’ ratings of therapist affiliation and autonomy, clients’ rating of their own affiliation and autonomy, therapists’ rating of client affiliation and autonomy, therapists' rating of their own affiliation and autonomy) were considered independently in terms of variance explained by the seven attachment constructs (client general attachment anxiety and avoidance, therapist general attachment anxiety and avoidance, secure attachment to therapist, preoccupied-merger attachment to therapist, and avoidant-fearful attachment to therapist). Due to the exploratory nature of these post-hoc analyses, no hypotheses were specified.
Chapter 3

Method

Participants

A sample of 53 therapists and therapists in training (77 % female, 23 % male) participated in the study. Therapists and therapists in training were recruited from a variety of sources at a mid-Atlantic university in the United States including practicum courses in two doctoral programs, counselor education and counseling psychology, as well as two masters programs, secondary school counseling and rehabilitation counseling. In addition, recruitment occurred at the university counseling center amongst staff therapists, pre-doctoral interns, and advanced psychology graduate students providing supervised therapy as graduate assistants. The age of therapists ranged from 21 to 57 ($M = 29.85, SD = 7.19$). The final sample consisted of 11 master’s students, 37 doctoral students (e.g., doctoral practicum students, graduate assistants, pre-doctoral interns), and 5 staff therapists with either terminal master’s or doctoral degrees in a mental health profession. As expected, the sample was predominantly Caucasian (64%), followed by Asian/Asian American/Pacific Islander (13%), Bi/Multiracial (4%), Black/African American (8%), Hispanic/Latino (4%), and Middle Eastern (4%). Approximate number of clients previously seen ranged widely from none to 1500 ($M = 103.92, SD = 224.12$), and previously completed practicum semesters also varied substantially from zero to ten ($M = 3.33, SD = 3.01$). Finally, therapist participants were asked to rate the degree to which they currently believe in and follow each of four different theoretical approaches on a scale ranging from 1 ("Do not believe in or follow") to 5 ("Believe in and follow"). The means and standard deviations for each are: Psychoanalytic/Psychodynamic ($M =$
3.24, \(SD = 1.01\), Cognitive/Behavioral \((M = 3.57, SD = 1.14)\), Humanistic/Experiential \((M = 4.06, SD = .91)\), and Feminist/Multicultural \((M = 3.79, SD = .93)\).

Because the therapist sample included individuals completing their first master’s practicum course, doctoral students, as well as doctoral-level psychologists with multiple years of experience (and because clients were assigned to therapists with different levels of experience based on clinical impression), ANOVAs were conducted on all of the variables under consideration in the main and post hoc analyses to assess whether master’s student therapists and non-master’s student therapists (i.e., doctoral students, staff therapists) differed significantly on any of these variables (see Table 1). No significant differences between these two groups were found in any of the measures. Staff therapist participants (2 pairs in the data for the main analyses and less than 10% of the total therapist sample) were grouped with doctoral students because they represented the two most experienced groups and had seen clients in the same setting. Because staff therapists had more experience and may have been more skilled and because more challenging clients may have been assigned to the staff therapists than to the doctoral students, analyses shown in Table 1 were run with and without staff therapists included. Results were parallel in each case; thus, staff therapist data were retained. The lack of difference between the two groups on the client-reported variables (ECR-S general attachment, SASB Intrex ratings, CATS attachment to therapist) suggest that although it could be expected that clients referred to staff therapists and advanced doctoral students may have presented with more intense symptomatology, the clients who were treated by staff therapists and doctoral level therapists were still similar enough to the master’s students’ clients to be considered together in subsequent analyses. Further, the therapists
in the sample, regardless of training, do not significantly differ in terms of their attachment anxiety and avoidance. Note however that master’s level therapists were represented in only 5 pairs of data, so the ability to detect differences between the master’s students and non-master’s student samples is limited.
Table 1

*Differences between Master’s Student Therapists and Non-Master’s-Student Therapists.*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Master’s Students</th>
<th>Non-Master’s Students</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n )</td>
<td>Mean ( SD )</td>
<td>( n )</td>
<td>Mean ( SD )</td>
<td>( F )</td>
</tr>
<tr>
<td>CLANX</td>
<td>11</td>
<td>.49</td>
<td>1.11</td>
<td>66</td>
<td>-.08</td>
</tr>
<tr>
<td>CLAVO</td>
<td>11</td>
<td>-.27</td>
<td>.78</td>
<td>66</td>
<td>.05</td>
</tr>
<tr>
<td>THANX</td>
<td>13</td>
<td>-.01</td>
<td>.89</td>
<td>40</td>
<td>.00</td>
</tr>
<tr>
<td>THAVO</td>
<td>13</td>
<td>-.05</td>
<td>.77</td>
<td>40</td>
<td>.02</td>
</tr>
<tr>
<td>SECURE</td>
<td>5</td>
<td>-.33</td>
<td>.94</td>
<td>48</td>
<td>.03</td>
</tr>
<tr>
<td>PMCATS</td>
<td>5</td>
<td>-.25</td>
<td>1.08</td>
<td>48</td>
<td>.03</td>
</tr>
<tr>
<td>AFCATS</td>
<td>5</td>
<td>.15</td>
<td>1.15</td>
<td>48</td>
<td>-.02</td>
</tr>
<tr>
<td>CL-CLAFF</td>
<td>5</td>
<td>.37</td>
<td>.68</td>
<td>48</td>
<td>-.04</td>
</tr>
<tr>
<td>CL-CLAU</td>
<td>5</td>
<td>-.40</td>
<td>1.17</td>
<td>48</td>
<td>.04</td>
</tr>
<tr>
<td>CL-THAFF</td>
<td>5</td>
<td>.41</td>
<td>.45</td>
<td>48</td>
<td>-.04</td>
</tr>
<tr>
<td>CL-THAU</td>
<td>5</td>
<td>.34</td>
<td>.62</td>
<td>48</td>
<td>-.04</td>
</tr>
<tr>
<td>TH-CLAFF</td>
<td>10</td>
<td>-.25</td>
<td>1.10</td>
<td>115</td>
<td>.02</td>
</tr>
<tr>
<td>TH-CLAU</td>
<td>10</td>
<td>.16</td>
<td>.75</td>
<td>115</td>
<td>.01</td>
</tr>
<tr>
<td>TH-THAFF</td>
<td>10</td>
<td>.02</td>
<td>.98</td>
<td>115</td>
<td>.01</td>
</tr>
<tr>
<td>TH-THAU</td>
<td>10</td>
<td>.08</td>
<td>1.28</td>
<td>115</td>
<td>-.01</td>
</tr>
</tbody>
</table>

*Note:* CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist; CL-CLAFF = Client ratings of client affiliation; CL-CLAU = Client ratings of client autonomy; CL-THAFF = Client ratings of therapist affiliation; CL-THAU = Client ratings of therapist autonomy; TH-CLAFF = Therapist ratings of client affiliation; TH-CLAU = Therapist ratings of client autonomy; TH-THAFF = Therapist ratings of therapist affiliation; TH-THAU = Therapist ratings of therapist autonomy.

* *p < .05*
Participants also included 79 clients recruited from 2 sources: a university counseling center and a university training clinic. Of these 79 client participants, 54 (68%) completed questionnaires following their fourth session, with the remainder either not continuing with therapy through four sessions (20%) or not completing questionnaires after their fourth session (11%). No client participants provided information regarding the reason for not completing the second half of the survey or for terminating therapy prior to session four. No significant group differences were found on client attachment anxiety or avoidance between clients who completed both portions of the study and clients who continued with therapy but did not complete the second half of the study (attachment anxiety: \( F = .01, p = .93\); attachment avoidance: \( F = 1.82, p = .18 \)). No significant group differences were detected in client attachment avoidance between clients who completed both portions of the study and clients who terminated prior to session four (\( F = .17, p = .68\)). One significant group difference approached but did not attain conventional levels of significance: clients who completed both portions of the study had higher general attachment anxiety than clients who terminated therapy prior to session four (\( F = 3.46, p = .07\)). Two group differences were detected in therapist interpersonal process ratings done after the fourth session, one that was significant and one that approached but did not attain conventional levels of significance. First, therapists rated clients who completed the second half of the survey significantly higher in in-session affiliation (\( F = 5.99, p = .018\)) than those clients who initially signed up to participate but did not end up completing the second portion of the study. Second, therapists rated their own autonomy in-session somewhat higher (\( F = 3.52, p = .066\)) in
dyads in which client participants completed the second half of the survey compared to dyads in which clients dropped out of the study. Finally, no differences were detected regarding therapist ratings of client autonomy ($F = .27, p = .61$) and therapist affiliation ($F = 2.67, p = .11$) for client participants who completed and who did not finish the survey.

For two clients who completed the study, their therapists did not complete a SASB questionnaire, leaving 52 complete dyads. Client participants initially presented for services to the university counseling center and were either assigned to a therapist on-site (42%) or referred to the university training clinic (58%). Clients were referred to the university training clinic if they met the following criteria: suicidal and homicidal ideation were absent at intake; the client was currently enrolled at the university and was willing to have sessions videotaped; and the intake counselor had a clinical impression that the client is an “appropriate” referral to a training clinic. Clients assigned to counseling trainees at the university counseling center were also full-time students agreeable to videotaping. However, their presenting issues and distress may have been more severe than the clients referred to the training clinic. In terms of therapist training, 19% were assigned to a master’s student, 65% to a doctoral student, 14% to a predoctoral intern, and 3% to a staff therapist. Client participants ranged in age from 18-33 ($M = 20.97, SD = 2.80$), and most were female (73%). Most clients reported their race/ethnicity as Caucasian (80%) followed by Asian/Asian American/Pacific Islander (8%), Black/African American (8%), and Hispanic/Latino (5%). In terms of year in school, 11% were freshman, 20% were sophomores, 27% were juniors, 32% were seniors, and 10% were graduate students. Of client participants, 48% had previously attended
counseling, all of whom indicated previous individual counseling. Eight percent of the total client sample reported previous group experience, 6% had participated in family therapy, and 4% had prior couples counseling.

The sample size for this study was determined through a power analysis that considered the number of independent variables, the requirements for hierarchical multiple regression, and the practical limitations of the population under examination. Initially a sample size of 70 therapist-client pairs was decided upon because this number would detect medium effects (Soper, n.d.). After nine months of data collection, only 33 pairs had completed the study despite procedural changes made to increase client interest in participation (e.g., shortened email script, reminder emails, and advertisement changes to highlight incentive). As a result, the decision was made in consultation with the dissertation committee to reduce the minimum sample size to 50 pairs, a number that would be obtainable with 7 additional months of data collection and that would detect medium-to-large effects.

**Instruments**

*Demographic questionnaire.* The demographic questionnaire for therapists was created for the current study and asked for information regarding age, gender, race-ethnicity, semesters of practicum experience, approximate number of clients seen, theoretical preferences, educational background, and type of graduate school program. The demographic questionnaire for clients asked questions regarding their age, gender, race-ethnicity, year in school, and previous experience in counseling.

*Experiences in Close Relationship Scale- Short Form* (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007). In the current study, the ECR-S was used to assess both
therapist and client attachment style. Also, clients completed the ECR-S prior to session one with their therapists as well as following session four in order to assess the stability of these ratings. The full length version of the ECR (Brennan, Clark, & Shaver, 1998) was developed from the all of the extant adult attachment self-report measures. From an initial 300 items, 36 items were retained as measures of two orthogonal factors: attachment anxiety and attachment avoidance. Each subscale consists of 18 items measured on a 7-point scale ranging from disagree strongly to agree strongly. In 2007, Wei and her colleagues developed a short-form of the ECR using exploratory factor analysis. Six items from each subscale were retained for the short form based on factor loadings as well as conceptual considerations, providing a mix of positively and negatively worded items and ensuring that each aspect of the attachment dimensions were represented within the subscales. The Anxiety subscale measures the preoccupation the respondent experiences in close relationships with regard to abandonment and rejection (e.g., “I worry that romantic partners won’t care about me as much as I care about them”) as well as the extent to which participants desire more closeness than their partners [e.g., “I find that my partner(s) don’t want to get as close as I would like”]. The Avoidance subscale assesses the comfort the participant feels in terms of emotional closeness and interdependence (e.g., “I want to get close to my partner, but I keep pulling back”). Participants are instructed to respond to items in terms of how they experience relationships in general rather than in terms of a specific relationship. Wei et al. reported good internal consistency: .84 for the Avoidance subscale and .78 for the Anxiety subscale. Correlations between the original version and the short form were also calculated for the Anxiety ($r = .95$) and Avoidance ($r = .95$) subscales. In the current
study, reliability estimates were adequate: for Therapist Avoidance $\alpha = .78$, for Therapist Anxiety $\alpha = .76$, for Client Anxiety pre-therapy $\alpha = .73$, for Client Avoidance pre-therapy $\alpha = .77$, for Client Anxiety after session four $\alpha = .71$, and for Client Avoidance after session four $\alpha = .85$. Further, correlations between the client subscales before therapy and after four sessions were high for both Anxiety ($r = .71, p < .01$) and Avoidance ($r = .81, p < .01$; See Table 3). Evidence for validity was provided by theoretically expected relationships with measures of excessive reassurance seeking and depression (Wei et al.).

It is important to note that adult romantic attachment is now conceptualized as a global aspect of one’s personality that extends to all close adult relationships that may activate an attachment system (Shaver & Mikulincer, 2005). Data have shown that attachment anxiety and avoidance (as measured by the original ECR) are related as expected with a variety of constructs in contexts other than romantic relationships (e.g., self-other perceptions in group psychotherapy, Chen & Mallinckrodt, 2002; general loneliness, see Mikulincer & Shaver, 2007, for a review).

*SASB Intrex Questionnaire* (Benjamin, 2000). The Intrex form was designed as a series of self-report measures of the three SASB surfaces previously described: the transitive, intransitive, and introject surfaces. These Intrex measures are intended to assess the individual’s perception of interpersonal and intrapsychic relationships at a given time or across time (Benjamin). Also, Benjamin provides SASB models of varying specificity, ranging from a very simple model that is divided into eight sections, or clusters (four poles and four areas between these poles), per surface to a full model that is split into 36 sections (four poles and eight areas between these poles) on each surface. Benjamin also developed corresponding instruments that measure behavior with these
varying degrees of specificity and complexity. These range from one descriptor per SASB cluster (Short-Form) to four or five items per cluster (Long-Form). The most commonly utilized and least specific model is associated with the Short-Form questionnaire (Figure 1).

Questions directly correspond to a specific cluster on a specific SASB surface. Questions were also developed to measure the same degree of affiliation and interdependence but on different surfaces. For example, the item “He lets me speak freely, and warmly tries to understand me even if we disagree” represents an affiliative and autonomous space on the transitive surface. In comparison, the item “I let him speak freely, and warmly try to understand him even if we disagree” represents the corresponding intransitive space (similar amount of affiliation and interdependence). Another pair of items represents disaffiliation and enmeshment. “With much sulking and fuming, I scurry to do what s/he wants” is an item on the intransitive surface. “With much sulking and fuming, s/he scurries to do what I want” represents the corresponding behavior on the transitive surface.

In the current study, Intrex forms were administered to therapists and clients as a means of examining the interpersonal dynamics of the psychotherapeutic relationship. Specifically, participants completed scales which measure their transitive and intransitive experiences over the first four psychotherapy sessions. Thus therapists rated both their own behaviors and their client’s behaviors during session. Similarly, clients reported on their own behaviors as well as their therapist’s actions. The short form contains one item per cluster per surface. Thus, the participants completed 16 items, 8 per surface. Items were rated on 10-point intervals ranging from 0 (never/not at all) to 100 (always/perfect).
Measures were scored using SASB software (Benjamin, 2000). Overall scores of affiliation and autonomy (vectors) were obtained by linearly transforming raw cluster scores with the assistance of the Intrex questionnaire software (Benjamin). Test-retest reliabilities over a four-week period averaged .79 (Benjamin). Internal consistencies cannot be calculated for the short-form because there is only one item per cluster (Benjamin). However, the medium-form, which correlates highly with the short-form and is the source of the short-form items, has been shown to have good internal consistency (α = .90). Convergent, construct, predictive and concurrent validity have been demonstrated for the Intrex (Benjamin). Benjamin reported excellent convergent validity between the short and long forms of the Intrex. Construct validity has also been supported. Dimensional ratings (i.e., affiliation, interdependence) on each surface consistently generated appropriate spacing of model points as well as correctly order the points on the circumplex (Benjamin). In other words, the items accurately represented the different degrees of affiliation and interdependence as intended. Also, predictive validity has been established with SASB ratings predicting psychotherapy outcome and symptom change (Benjamin). Concurrent validity has been demonstrated. SASB and the Interpersonal Circumplex (IPC) were compared to the Five Factor Model, relating in theoretically consistent ways (Benjamin). Finally, no specific norms have been specified based on cultural factors such as race/ethnicity and gender, although Benjamin noted that the normative sample generally included Caucasian undergraduate and graduate students. Although the sample described by Benjamin was limited, it was consistent with the sample presented in the current study.
Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, & Coble, 1995). The CATS was designed to measure the clients’ current perceptions of their therapeutic relationships from the perspective of attachment theory. The questionnaire consists of 36 self-report items rated from 1 (strongly agree) to 6 (strongly disagree) that form three subscales. First, the Secure subscale (14 items) assesses the level to which a client views the therapist as emotionally available, accepting, and understanding (e.g., “My counselor is a comforting presence to me when I am upset”). Second, the Preoccupied-Merger subscale (10 items) measures the client’s preoccupation with the therapist as well as the therapist’s other clients (e.g., “I often wonder about my counselor’s other clients”). It reflects the client’s desire to change the boundaries of the relationship so that more contact can be achieved (e.g., “I wish there were a way I could spend more time with my counselor”). Third, the Avoidant-Fearful subscale assesses the degree to which the client perceives the therapist as rejecting and disapproving (e.g., “I think my counselor disapproves of me”). Also, the Avoidant-Fearful subscale measures the degree to which the client is reluctant to self-disclose and feels threatened and humiliated in interactions with the therapist (e.g., “My counselor wants to know more about me than I am comfortable talking about”). Mallinckrodt et al. (1995) found internal consistency alphas of .63 for the Avoidant-Fearful subscale, .64 for the Secure subscale, and .81 for the Preoccupied-Merger subscale as well as test-retest reliability coefficients of .72 for the Avoidant-Fearful subscale, .86 for the Preoccupied-Merger subscale, and .84 for the Secure subscale (Mallinckrodt et al., 1995). Woodhouse, Schlosser, Crook, Ligiéro, and Gelso (2003) found slightly higher internal consistency alphas of .70 (Avoidant-Fearful), .78 (Secure), and .84 (Preoccupied-Merger). Reliability estimates for
the current study were good: Avoidant-Fearful CATS: $\alpha = .84$, Secure CATS: $\alpha = .83$, Preoccupied-Merger CATS: $\alpha = .78$. Concurrent validity support has also been provided. Mallinckrodt et al. found that the subscales of the CATS correlated in theoretically-expected directions with working alliance and object relations measures.

**Procedure**

Master’s and doctoral student therapists were recruited at the beginning of each semester and asked to participate in a study regarding the impact of general interpersonal styles on the psychotherapy relationship. Staff therapists and pre-doctoral interns were recruited mid-semester. Therapists could participate for up to two semesters. After completing the informed consent, therapist participants completed a short demographic questionnaire as well as the ECR-S. They were also reminded that they would be completing a single measure about their psychotherapy relationship immediately following the fourth session for each client in their caseload during the semester. Therapist participants did not know which of their clients participated and did not have access to client responses. The number of clients on each participating therapist caseload could vary widely (e.g., full-time staff therapist caseload of 15 in comparison to master’s student caseload of 5). However, since full-time therapists were recruited mid-semester, they were instructed to only complete forms on clients added to their caseload from that point on because the study focused on the first four sessions. Because therapists completed surveys regardless of client participation, the number of questionnaires that therapists completed regarding their relationships with clients greatly exceeded the number of dyads in the final sample. Immediately following the fourth session, therapists were given the Intrex questionnaire and asked to rate their counseling relationship with
that particular client. They were instructed to complete a survey immediately after the fourth session for each client on their caseload. The purpose of this administration timeframe was to minimize memory biases so that a more “accurate” measure of the relational dynamics could be obtained. It was particularly important to minimize memory biases because such biases have previously been associated with attachment avoidance (Fraley & Shaver, 1997; Fraley, Garner, & Shaver, 2000; Fraley & Brumbaugh, 2007) and anxiety (Woodhouse & Gelso, 2008).

Prior to their first session with their therapist, client participants recruited at the university counseling center as well as from the university training clinic during the 2008-2009 academic year received an email asking them to participate in a study regarding the impact of general interpersonal styles on their relationship with their counselor. In the informed consent, they were told that their consent was voluntary and that there would be no negative consequences for refusing to participate. Clients were assured that their therapists would not know whether they decided to participate and would not have access to any of their responses. All participants were notified that data would remain confidential. In order to increase response rate, clients at the university training clinic during the 2009-2010 academic year received a paper copy of the consent form prior to their first session with their therapist. After obtaining informed consent, clients completed a short demographic questionnaire as well as the ECR-S online. Clients were notified that they would receive an email asking them to complete additional measures online after the fourth session. Following the fourth session, client participants completed the Intrex questionnaire, the CATS, and the ECR-S online, entering the survey via an email link. Thus, they rated the interpersonal dynamic with their therapist across
four therapy sessions, their attachment to their therapist, and their general attachment style. Because attachment has been shown to be associated with differences in memory (Fraley & Shaver, 1997; Fraley et al., 2000; Fraley & Brumbaugh, 2007; Woodhouse & Gelso, 2008), clients were asked to complete the questionnaires within 24 hours of their session. The Intrex questionnaire, the CATS, and the ECR-S were counterbalanced in the online survey. Following completion of the survey, clients were emailed a ten dollar gift certificate to Amazon.com. Therapists received ten dollars at the end of each semester of participation. In order to maximize response rates, all participants received reminder emails prior to their fourth sessions.
CHAPTER 4

Results

Preliminary Analyses

Prior to testing the hypotheses, the dataset was examined for missing values. The SASB Intrex software manages missing data in its calculations, so no adjustments were made to these data. For missing data in the CATS and ECR-S forms, the average score within the subscale was entered for each missing value. In each case of missing data, no more than one missing value was present for each subscale.

Next, preliminary analyses were conducted to ensure that the assumptions of regression were met. First, data were examined for univariate outliers. A value that is 3.29 standard deviations or more from the mean was considered an outlier (Tabachnick & Fidell, 2007). No univariate outliers were found for therapist ECR-S general attachment scales, client ECR-S general attachment scales (either prior to session one or after session four), or for client CATS attachment to therapist scales. Five univariate outliers were found for the therapist SASB Intrex ratings, and one univariate outlier was detected for the client SASB Intrex ratings. Because four of the cases that had univariate outliers on therapist SASB Intrex ratings did not have associated client data and therefore would not be included on tests of the main hypotheses or post-hoc analyses, they were removed from the dataset. The remaining case involved a therapist who was part of a complete therapist-client pair. This therapist had a univariate outlier ($z = -3.80$) on a variable that would be examined during post-hoc analyses: the therapist rating of the therapist’s affiliation in relation to the client. In addition, one client had a univariate outlier ($z = -3.44$) on a variable considered during the main analyses: client ratings of therapist
affiliation. The extreme values for the measures in these two cases were changed to be within one unit of the next most extreme value (Tabachnick & Fidell). The data contained no additional univariate outliers following this modification. Second, the score distributions within each subscale were found to be normally distributed, with acceptable levels of skewness and kurtosis according to guidelines by Chou and Bentler (1995) and Curran, West, and Finch (1996), who recommended a skew of less than 2 and kurtosis less than 7.

Means, standard deviations, skew, and kurtosis for each of the subscales in the study are presented in Table 2. Next, the data were examined for multivariate outliers using procedures outlined by Tabachnick and Fidell (2007). No multivariate outliers were discovered.
Table 2
Descriptive statistics for Experiences in Close Relationships-Short Form, Client Attachment to Therapist Scale, and Structural Analysis of Social Behavior Intrex Questionnaire

<table>
<thead>
<tr>
<th>Variables</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>ICC</th>
<th>Skew</th>
<th>Kurtosis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client Attachment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td>77</td>
<td>23.56</td>
<td>6.67</td>
<td>.03</td>
<td>.48</td>
<td>-.23</td>
</tr>
<tr>
<td>CLAVO</td>
<td>77</td>
<td>21</td>
<td>7.27</td>
<td>.08</td>
<td>-.02</td>
<td>-1.06</td>
</tr>
<tr>
<td>CLANX4</td>
<td>53</td>
<td>28.28</td>
<td>6.91</td>
<td>.11</td>
<td>-.36</td>
<td></td>
</tr>
<tr>
<td>CLAVO4</td>
<td>53</td>
<td>21.22</td>
<td>8.28</td>
<td>-.06</td>
<td>-1.01</td>
<td></td>
</tr>
<tr>
<td><strong>Therapist Attachment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>THANX</td>
<td>53</td>
<td>19.58</td>
<td>1.01</td>
<td>.01</td>
<td>-.95</td>
<td></td>
</tr>
<tr>
<td>THAVO</td>
<td>53</td>
<td>14.89</td>
<td>1.00</td>
<td>.51</td>
<td>-.90</td>
<td></td>
</tr>
<tr>
<td><strong>Attachment to Therapist</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SECURE</td>
<td>53</td>
<td>69.03</td>
<td>8.00</td>
<td>.20</td>
<td>-.45</td>
<td>.33</td>
</tr>
<tr>
<td>PMCATS</td>
<td>53</td>
<td>25.44</td>
<td>7.37</td>
<td>-.03</td>
<td>-.47</td>
<td>.33</td>
</tr>
<tr>
<td>AFCATS</td>
<td>53</td>
<td>20.08</td>
<td>7.03</td>
<td>.28</td>
<td>1.24</td>
<td>.33</td>
</tr>
<tr>
<td><strong>Client SASB</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL-CLAFF</td>
<td>53</td>
<td>130.27</td>
<td>44.40</td>
<td>.26</td>
<td>-.86</td>
<td>.33</td>
</tr>
<tr>
<td>CL-CLAU</td>
<td>53</td>
<td>38.52</td>
<td>45.32</td>
<td>.14</td>
<td>-.14</td>
<td>.33</td>
</tr>
<tr>
<td>CL-THAFF</td>
<td>53</td>
<td>160.22</td>
<td>30.23</td>
<td>-.03</td>
<td>-.56</td>
<td>.33</td>
</tr>
<tr>
<td>CL-THAU</td>
<td>53</td>
<td>47.98</td>
<td>44.09</td>
<td>.10</td>
<td>-.94</td>
<td>.33</td>
</tr>
<tr>
<td><strong>Therapist SASB</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TH-CLAFF</td>
<td>125</td>
<td>89.61</td>
<td>58.89</td>
<td>.13</td>
<td>-.61</td>
<td>.22</td>
</tr>
<tr>
<td>TH-CLAU</td>
<td>125</td>
<td>43.10</td>
<td>45.01</td>
<td>.53*</td>
<td>.01</td>
<td>.22</td>
</tr>
<tr>
<td>TH-THAFF</td>
<td>125</td>
<td>154.99</td>
<td>36.28</td>
<td>.71*</td>
<td>-1.32</td>
<td>.22</td>
</tr>
<tr>
<td>TH-THAU</td>
<td>125</td>
<td>39.38</td>
<td>40.32</td>
<td>.27</td>
<td>.17</td>
<td>.22</td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; CLANX4 = Client attachment anxiety after session 4; CLAVO4 = Client attachment avoidance after session 4; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist; CL-CLAFF = Client ratings of client affiliation; CL-CLAU = Client ratings of client autonomy; CL-THAFF = Client ratings of therapist affiliation; CL-THAU = Client ratings of therapist autonomy; TH-CLAFF = Therapist ratings of client affiliation; TH-CLAU = Therapist ratings of client autonomy; TH-THAFF = Therapist ratings of therapist affiliation; TH-THAU = Therapist ratings of therapist autonomy.

* * p < .05
Correlations of all of the measured variables were calculated to assess for multicollinearity. Table 3 displays all zero-order correlations between variables under study for the main analyses. Tabachnick and Fidell (2007) suggested that correlations above .95 are especially problematic and warned also that correlations above .70 may pose issues for data analysis. In this study, no correlations exceeded the lower .70 threshold.

As expected, Secure CATS attachment to therapist was positively related to client SASB Intrex ratings of client affiliation and therapist affiliation (see Table 3). Clients’ SASB Intrex ratings of their own affiliation in session were positively related to their ratings of therapist affiliation and therapist autonomy. Contrary to hypotheses, none of the general therapist or client general attachment variables were significantly correlated with Secure CATS attachment to therapist with the exception of client general attachment anxiety which, consistent with expectation, was negatively related to Secure CATS attachment to therapist.

As hypothesized, therapist general attachment anxiety was positively related to Preoccupied-Merger CATS attachment to therapist, and client SASB Intrex ratings of therapist autonomy were negatively correlated to Preoccupied-Merger attachment to therapist (see Table 3). Also, therapist general attachment anxiety was negatively related to client SASB Intrex ratings of therapist autonomy. Of note, therapist general attachment anxiety was positively related to therapist general attachment avoidance. Contrary to expectations, client general attachment anxiety and client SASB Intrex ratings of client autonomy were not significantly related to Preoccupied-Merger CATS attachment to therapist.
As expected, client general attachment avoidance was positively related to Avoidant-Fearful CATS attachment to therapist. Also as hypothesized, Avoidant-Fearful CATS attachment to therapist was negatively related to client SASB Intrex ratings of client affiliation and therapist affiliation. Contrary to expectations, client general attachment anxiety and therapist general attachment avoidance were not significantly correlated with Avoidant-Fearful CATS attachment to therapist. Finally, Secure CATS attachment to therapist was negatively related to Avoidant-Fearful CATS attachment to therapist.

In order to test the stability of the general attachment constructs, clients completed the ECR-S prior to their first session as well as following their fourth session (see Table 3). Correlations were high even after four sessions of therapy, suggesting that the ECR-S measured relatively stable constructs.

An additional set of correlations were conducted to examine the degree of similarity in SASB Intrex ratings within each dyad (see Tables 4 and 5). Significant agreement was found within the dyad on client affiliation and therapist autonomy. Interestingly, however, there was no significant correlation between therapist and client ratings of therapist affiliation or client autonomy. These results suggest that while client and therapist are rating the same relationship, their perspectives may not always agree. The dyads tended to agree on SASB Intrex ratings of client affiliation but not therapist affiliation. Further, the SASB Intrex ratings of therapist autonomy were significantly correlated, whereas no significant relation was detected for ratings of client autonomy.
Table 3: Intercorrelations among predictor and outcome variables among therapy dyads (n = 52)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CLANX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CLAVO</td>
<td>-.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. CLANX4</td>
<td>.70**</td>
<td>-.03</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. CLAVO4</td>
<td>.06</td>
<td>.82**</td>
<td>.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. THANX</td>
<td>.02</td>
<td>-.21</td>
<td>.20</td>
<td>.07</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. THAVO</td>
<td>-.02</td>
<td>-.02</td>
<td>.04</td>
<td>.10</td>
<td>.23**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. SECURE</td>
<td>-.27*</td>
<td>-.08</td>
<td>-.26</td>
<td>-.12</td>
<td>-.25</td>
<td>-.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. PMCATS</td>
<td>-.17</td>
<td>-.05</td>
<td>-.04</td>
<td>.12</td>
<td>.31*</td>
<td>.07</td>
<td>-.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. AFCATS</td>
<td>.16</td>
<td>.35*</td>
<td>.17</td>
<td>.28*</td>
<td>.14</td>
<td>.11</td>
<td>-.69**</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. CL-CLAFF</td>
<td>-.09</td>
<td>-.05</td>
<td>-.25</td>
<td>.02</td>
<td>-.14</td>
<td>-.21</td>
<td>.40**</td>
<td>.11</td>
<td>-.42**</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. CL-CLAU</td>
<td>-.10</td>
<td>-.02</td>
<td>-.03</td>
<td>.06</td>
<td>-.07</td>
<td>.07</td>
<td>-.05</td>
<td>-.06</td>
<td>-.04</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. CL-THAFF</td>
<td>-.27</td>
<td>-.08</td>
<td>-.32*</td>
<td>-.21</td>
<td>.04</td>
<td>-.10</td>
<td>.39**</td>
<td>.14</td>
<td>-.32*</td>
<td>.47**</td>
<td>-.06</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. CL-THAU</td>
<td>.10</td>
<td>-.02</td>
<td>-.14</td>
<td>-.04</td>
<td>-.32*</td>
<td>-.17</td>
<td>.13</td>
<td>-.31*</td>
<td>-.13</td>
<td>.53**</td>
<td>.08</td>
<td>.19</td>
<td></td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1, CLAVO = Client attachment avoidance prior to session 1, CLANX4 = Client attachment anxiety after session 4, CLAVO4 = Client attachment avoidance after session 4, THANX = Therapist attachment anxiety, THAVO = Therapist attachment avoidance, SECURE = Secure attachment to therapist, PMCATS = Preoccupied-merger attachment to therapist, AFCATS = Avoidant-fearful attachment to therapist, CL-CLAFF = Client ratings of client affiliation, CL-CLAU = Client ratings of client autonomy, CL-THAFF = Client ratings of therapist affiliation, CL-THAU = Client ratings of therapist autonomy.  **p < 0.01 level (2-tailed).  *p < 0.05 level (2-tailed).
Table 4: Intercorrelations among SASB affiliation ratings within therapy dyads \((n = 52)\)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CL-CLAFF</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CL-THAFF</td>
<td>.47**</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. TH-CLAFF</td>
<td>.34*</td>
<td>.31*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. TH-THAFF</td>
<td>-.01</td>
<td>.14</td>
<td>.45**</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* CL-CLAFF = Client ratings of client affiliation, CL-THAFF = Client ratings of therapist affiliation, TH-CLAFF = Therapist ratings of client affiliation, TH-THAFF = Therapist ratings of therapist affiliation.

**\(p < 0.01\) level (2-tailed).**

*\(p < 0.05\) level (2-tailed).*

Table 5: Intercorrelations among SASB autonomy ratings within therapy dyads \((n = 52)\)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. CL-CLAU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. CL-THAU</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. TH-CLAU</td>
<td>.10</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. TH-THAU</td>
<td>.02</td>
<td>.29*</td>
<td>.23*</td>
<td></td>
</tr>
</tbody>
</table>


* \(p < 0.05\) level (2-tailed).
Examsing Data for Therapist Effects

Because twelve therapists were members of more than one therapy dyad, therapist effects were a potential confound in the current study. Intraclass correlations (Kenny, Mannetti, Pierro, Livi, & Kashy, 2002), which represent the degree that clients of the same therapist are more similar than they are to clients of different therapists, are displayed in Table 2 for each of the variables under examination both for the main hypotheses and post-hoc analyses. Of note, the means, standard deviations, observed range, and possible range represent the entire sample whereas the ICC’s were calculated only for those cases that had a duplicate therapist. Deviance testing (Snijders & Bosker, 1999) was implemented to test the statistical significance of the intraclass correlations. No significant therapist effects were discovered for the client and therapist ECR-S general attachment constructs, the CATS attachment to therapist, or the client SASB Intrex ratings. Thus, there were no significant therapist effects for the variables involved in the central analyses. Significant therapist effects were found, however, for two of the therapist SASB Intrex ratings under examination in the post hoc analyses: therapist affiliation, $\chi^2(1, n = 32) = 16.022, p < .001$; and client autonomy, $\chi^2(1, n = 32) = 7.485, p < .01$. Of note, as described above, it was these therapist SASB Intrex ratings that were not significantly correlated with the associated client ratings (i.e., client SASB Intrex ratings of therapist affiliation and client autonomy, respectively). After further examination of the data for therapist affiliation, it appeared that one therapist consistently self-rated as very disaffiliative in relation to each of his/her clients (ranging from -2.86 to -3.28 standard deviations below the mean) which in turn contributed to therapist effects for this variable. In contrast, client ratings of this therapist’s affiliation, though
disaffiliative, were within 1 standard deviation of the mean (ranging from -.25 to -.52). When the analyses testing for therapist effects were run without this particular therapist’s data, no significant therapist effects remained for therapist SASB Intrex ratings of therapist affiliation. In terms of therapist SASB ratings of client autonomy, visual inspection of the data suggested that therapists as a whole tended to create a type of response set for themselves, rating each of their clients with similar degrees of autonomy in session. In this case, the therapist effect did not appear to be due to the influence of one particular therapist.

Hypotheses Regarding Prediction of Secure Client Attachment to the Therapist

A hierarchical multiple regression was conducted to test the first five hypotheses related to prediction of secure CATS attachment to the therapist. Prior to running this regression analysis and all others in the study, all variables were standardized. The following predictors were entered in the first block of the regression: client ECR-S general attachment anxiety, client ECR-S general attachment avoidance, therapist ECR-S general attachment anxiety, therapist ECR-S general attachment avoidance, as well as client SASB Intrex ratings of client affiliation and therapist affiliation. In the second block, two interaction terms were entered: client SASB Intrex ratings of therapist affiliation X client ECR-S general attachment anxiety and client SASB Intrex ratings of therapist affiliation X client ECR-S general attachment avoidance. The model in the first block was significant (see Table 6), explaining 31% of the variance in Secure CATS attachment to therapist. In Block 1 none of the individual terms was significant, although therapist ECR-S attachment anxiety approached, but did not attain, conventional levels of significance. The model in the second block was also significant, explaining an additional
9% of the variance in Secure CATS attachment to therapist above and beyond the variance explained by the first model. As discussed below, one of the interaction terms was interpreted. Because the interaction term was interpreted, it was crucial to examine model 2. For this reason, all main effects and interaction effects described were interpreted from the second model.

Support was not found for the first hypothesis that predicted negative relations between client ECR-S general attachment variables (attachment anxiety and avoidance) and Secure CATS attachment to therapist. Although the associations were in the expected direction, results showed no significant relations between either clients’ general attachment anxiety or avoidance and Secure CATS attachment to the therapist.

The second hypothesis predicted negative relations between therapist ECR-S general attachment variables (attachment anxiety and avoidance) and Secure CATS attachment to therapist. The negative relation between therapist ECR-S general attachment anxiety Secure CATS attachment to therapist, however, approached but did not attain conventional levels of significance. This non-significant effect is mentioned because this term explained 8% of the variance in Secure CATS attachment to therapist. Also, because this is a new area of research concerns about Type 2 error must be considered along with Type 1 error concerns. Further, though no benchmarks are in place for evaluating $\eta^2$, an effect size of .08 is comparable to a small to medium effect size based on standards for $R^2$ (Cohen & Cohen, 1983). In fact, interpreting $\eta^2$ in terms of the Cohen and Cohen benchmarks is likely overly conservative because variance due to other variables is partialled out in $\eta^2$. Contrary to expectation, there was no significant relation between therapist ECR-S general attachment avoidance and Secure CATS client
attachment to the therapist.

Table 6

Summary of Hierarchical Regression Analysis Predicting Secure CATS (n = 52)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>B</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Block 1</td>
<td>.31</td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td></td>
<td></td>
<td>-.18</td>
<td>-.19</td>
<td>-1.48</td>
<td>.15</td>
<td>.05</td>
</tr>
<tr>
<td>CLAVO</td>
<td></td>
<td></td>
<td>-.10</td>
<td>-.10</td>
<td>-.76</td>
<td>.45</td>
<td>.02</td>
</tr>
<tr>
<td>THANX</td>
<td></td>
<td></td>
<td>-.23</td>
<td>-.24</td>
<td>-1.80</td>
<td>.08</td>
<td>.07</td>
</tr>
<tr>
<td>THAVO</td>
<td></td>
<td></td>
<td>-.04</td>
<td>-.04</td>
<td>-.33</td>
<td>.75</td>
<td>.00</td>
</tr>
<tr>
<td>CL-CLAFF</td>
<td></td>
<td></td>
<td>.23</td>
<td>.23</td>
<td>1.57</td>
<td>.12</td>
<td>.05</td>
</tr>
<tr>
<td>CL-THAFF</td>
<td></td>
<td></td>
<td>.23</td>
<td>.23</td>
<td>1.59</td>
<td>.12</td>
<td>.05</td>
</tr>
<tr>
<td>Block 2</td>
<td>.39</td>
<td>.09</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td></td>
<td></td>
<td>-.18</td>
<td>-.18</td>
<td>-1.44</td>
<td>.16</td>
<td>.04</td>
</tr>
<tr>
<td>CLAVO</td>
<td></td>
<td></td>
<td>-.14</td>
<td>-.14</td>
<td>-1.17</td>
<td>.25</td>
<td>.03</td>
</tr>
<tr>
<td>THANX</td>
<td></td>
<td></td>
<td>-.25</td>
<td>-.26</td>
<td>-2.00</td>
<td>.05</td>
<td>.08</td>
</tr>
<tr>
<td>THAVO</td>
<td></td>
<td></td>
<td>-.04</td>
<td>-.04</td>
<td>-.32</td>
<td>.75</td>
<td>.00</td>
</tr>
<tr>
<td>CL-CLAFF</td>
<td></td>
<td></td>
<td>.18</td>
<td>.18</td>
<td>1.27</td>
<td>.21</td>
<td>.04</td>
</tr>
<tr>
<td>CL-THAFF</td>
<td></td>
<td></td>
<td>.32</td>
<td>.32</td>
<td>2.21</td>
<td>.03</td>
<td>.10</td>
</tr>
<tr>
<td>CLANX X THAFF</td>
<td></td>
<td></td>
<td>-.23</td>
<td>-.23</td>
<td>-1.64</td>
<td>.11</td>
<td>.06</td>
</tr>
<tr>
<td>CLAVO X THAFF</td>
<td></td>
<td></td>
<td>-.12</td>
<td>-.13</td>
<td>-.93</td>
<td>.36</td>
<td>.02</td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; CL-CLAFF = Client ratings of client affiliation; CL-THAFF = Client ratings of therapist affiliation; CLAVO X THAFF = Interaction effect between client attachment avoidance and client ratings of therapist affiliation; CLANX X THAFF = Interaction effect between client attachment anxiety and client ratings of therapist affiliation.
Partial support was found for the third hypothesis, as there was a significant relation between client SASB Intrex ratings of therapist affiliation and Secure CATS attachment to therapist. There was however, no significant association between client SASB Intrex ratings of client affiliation and Secure CATS attachment to the therapist. Of note however, there were significant positive correlations between Secure CATS attachment to therapist and client SASB Intrex ratings of both therapist and client affiliation in the initial correlation tables. Thus, although client SASB Intrex ratings of both therapist and client affiliation were correlated with Secure CATS attachment to therapist, only client ratings of therapist affiliation uniquely predicted Secure CATS attachment to therapist.

The final two hypotheses involved proposed interaction effects. The first hypothesis, that client SASB Intrex ratings of therapist affiliation would moderate the relation between client ECR-S general attachment anxiety and Secure CATS attachment to the therapist, approached but did not attain conventional levels of significance. Nevertheless, the interaction effect was probed because moderator effects are difficult to detect with relatively small sample sizes (see Aiken & West, 1991), because this is a relatively new area of research in which concerns about Type II error must be balanced with concerns about Type I error, and because at 6% the effect size was small to moderate if compared to benchmarks that exist for $R^2$ (Cohen & Cohen, 1983). Moreover, the effect size estimate is likely a conservative one because 31% of the variance has been partialled out in Step 1. Following the procedures identified by Aiken and West (1991), simple regression lines were plotted to represent the relations between client ECR-S attachment anxiety and secure CATS attachment to therapist at high (1 $SD$ above the
mean) and low (1 SD below the mean) levels of client-rated SASB therapist affiliation (while keeping secure attachment to therapist constant at the mean). The significance of the simple slopes were tested using procedures identified by Preacher, Curran, and Bauer (2006). The interaction is displayed in Figure 2. The slope for low client SASB Intrex ratings of therapist affiliation was not significant, $t(43) = .27, ns$, but the slope for high client-rated therapist affiliation was significant, $t(43) = -2.52, p = .02$. Thus, clients low on attachment anxiety appear to benefit from an affiliative therapist, in that such clients reported higher levels of secure attachment to therapist if their therapists were high in affiliation than if therapists were low in affiliation. In contrast, clients who were high on attachment anxiety did not appear to benefit from having a highly affiliative therapist: For clients high in attachment anxiety there were no significant differences in security in attachment to therapist whether therapist affiliation was high or low. The hypothesis that the client SASB Intrex ratings of therapist affiliation would moderate the relation between client ECR-S general attachment avoidance and Secure CATS attachment to therapist was not supported. The interaction effect was not significant.
Hypotheses Regarding Prediction of Preoccupied-Merger Client Attachment to the Therapist

A second hierarchical multiple regression equation tested the four hypotheses concerning Preoccupied-Merger CATS attachment to therapist. Client ECR-S general attachment anxiety, Therapist ECR-S general attachment anxiety, client SASB Intrex ratings of therapist autonomy, and client SASB Intrex ratings of client autonomy were entered into Block 1. Also, the following interaction terms were entered in Block 2:
therapist ECR-S general attachment anxiety X client ECR-S general attachment anxiety and client SASB Intrex ratings of therapist autonomy X client ECR-S general attachment anxiety. Table 7 summarizes the findings. Block 2 did not explain significant additional variance, thus the interaction terms were not interpreted. For this reason, only the first block of the model will be considered further.

Therapist and client ECR-S general attachment anxiety had been hypothesized to be positively related to client Preoccupied-Merger CATS attachment to the therapist. Contrary to expectation, client ECR-S general attachment anxiety was not related to Preoccupied-Merger CATS attachment to the therapist. Therapist general attachment anxiety, however, approached, but did not attain conventional levels of significance ($p = .08$). Because this is a new area of investigation in which concerns about Type 1 error must be balanced with concerns about Type II error, this non-significant result was reported.

There was no support for the hypotheses that client SASB Intrex ratings of client and therapist autonomy would be negatively related to Preoccupied-Merger CATS attachment to therapist. Neither relations between either client SASB Intrex ratings of client autonomy of therapist autonomy and Preoccupied-Merger attachment to therapist were significant.
Table 7

Summary of Hierarchical Regression Analysis Predicting Preoccupied-Merger CATS (n = 52)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>B</th>
<th>$\beta$</th>
<th>t</th>
<th>p</th>
<th>sr$^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td>.17</td>
<td>-.15</td>
<td>-1.13</td>
<td>.26</td>
<td>.02</td>
<td></td>
<td></td>
</tr>
<tr>
<td>THANX</td>
<td></td>
<td>.24</td>
<td>.25</td>
<td>1.76</td>
<td>.08</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>CL-CLAU</td>
<td></td>
<td>-.04</td>
<td>-.04</td>
<td>-.29</td>
<td>.78</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>CL-THAU</td>
<td></td>
<td>-.21</td>
<td>-.21</td>
<td>-1.51</td>
<td>.14</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>Step 2</td>
<td></td>
<td>.18</td>
<td>.01</td>
<td></td>
<td>.82</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CL-THAU X</td>
<td></td>
<td>-.02</td>
<td>-.02</td>
<td>.14</td>
<td>.89</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX X THANX</td>
<td>.08</td>
<td>-.077</td>
<td>-.50</td>
<td>.62</td>
<td>.01</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; THANX = Therapist attachment anxiety; CL-CLAU = Client ratings of client autonomy; CL-THAU = Client ratings of therapist autonomy; CL-THAU X CLANX = Interaction effect between client ratings of therapist autonomy; CLANX X THANX = Interaction effect between client attachment anxiety and therapist attachment anxiety.

Because Block 2 of the regression model was not significant, the hypothesized interaction effects were not supported. First, it had been hypothesized that therapist ECR-S general attachment anxiety would moderate the relation between client ECR-S general attachment anxiety and Preoccupied-Merger CATS attachment to therapist. A second
interaction effect, that client SASB Intrex ratings of therapist autonomy would moderate the relation between client ECR-S general attachment anxiety and Preoccupied-Merger attachment to therapist, was also not supported.

*Hypotheses Regarding Prediction of Avoidant-Fearful Client Attachment to the Therapist*

A third hierarchical multiple regression equation tested the five hypotheses concerning Avoidant-Fearful CATS attachment to therapist. Client ECR-S general attachment anxiety and attachment avoidance, Therapist ECR-S general attachment avoidance, client SASB Intrex ratings of client and therapist affiliation were entered into the first block. Also, two interaction terms were examined in the second block: client SASB Intrex ratings of therapist affiliation X client ECR-S general attachment avoidance and client ECR-S general attachment anxiety X client ECR-S general attachment avoidance. Although the model as a whole in Block 2 was significant, neither interaction term was significant on its own. Thus, only the first block in the model was interpreted further.

The model in Block 1 as a whole was significant, explaining 31% of the variance in Avoidant-Fearful CATS attachment to therapist ratings (see Table 8). It was predicted that client ECR-S general attachment anxiety would be negatively related to Avoidant-Fearful CATS attachment to therapist, but the data did not support this proposed relation.

Partial support was found for the second hypothesis which predicted positive relations between client and therapist ECR-S general attachment avoidance and Avoidant-Fearful CATS attachment to therapist. Specifically, client ECR-S general attachment avoidance, but not therapist ECR-S general attachment avoidance, was significantly related to Avoidant-Fearful attachment to therapist.
Table 8

*Summary of Hierarchical Regression Analysis Predicting Avoidant-Fearful CATS* *(n = 52)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$\Delta R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td>.10</td>
<td>.10</td>
<td>.80</td>
<td>.10</td>
<td>.43</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>CLAVO</td>
<td>.32</td>
<td>.37</td>
<td>2.67</td>
<td>.37</td>
<td>.01</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>THAVO</td>
<td>.01</td>
<td>.01</td>
<td>.04</td>
<td>.01</td>
<td>.97</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>CL-CLAFF</td>
<td>-.35</td>
<td>-.35</td>
<td>-2.48</td>
<td>-.35</td>
<td>.02</td>
<td>.12</td>
<td></td>
</tr>
<tr>
<td>CL-THAFF</td>
<td>-.10</td>
<td>-.10</td>
<td>-.70</td>
<td>-.10</td>
<td>.49</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td><strong>Step 2</strong></td>
<td></td>
<td>.01</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.71</td>
</tr>
<tr>
<td>CLANX X CLAVO</td>
<td>-.08</td>
<td>-.08</td>
<td>-.53</td>
<td>-.08</td>
<td>.60</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>CLAVO X THAFF</td>
<td>-.10</td>
<td>-.11</td>
<td>-.78</td>
<td>-.11</td>
<td>.44</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

*Note:* CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THAVO = Therapist attachment avoidance; CL-CLAFF = Client ratings of client affiliation; CL-THAFF = Client ratings of therapist affiliation; CLANX X CLAVO = Interaction effect between client attachment anxiety and client attachment avoidance; CLAVO X THAFF = Interaction effect between client attachment avoidance and client ratings of therapist affiliation.

Next, it was predicted that client SASB Intrex affiliation ratings would be inversely related to Avoidant-Fearful CATS attachment to the therapist. Consistent with prediction, client SASB Intrex ratings of their own affiliation was significantly negatively
related to Avoidant-Fearful attachment to therapist. Although client SASB Intrex ratings of therapist affiliation was significantly negatively correlated to Avoidant-Fearful CATS attachment to therapist, as stated above (also see Table 2), these client ratings of therapist affiliation did not significantly predict unique variance in Avoidant-Fearful attachment to therapist in the present regression model.

As mentioned earlier, though Block 2 in the regression model was significant, neither interaction effect was independently significant. As a result, neither interaction effect was interpreted. Thus, no support was found for the hypothesis that client SASB Intrex ratings of therapist affiliation would moderate the relation between client ECR-S general attachment avoidance and Avoidant-Fearful attachment to therapist. Likewise, no support was found for the hypothesis that client ECR-S general attachment anxiety would moderate the relation between client ECR-S general attachment avoidance and Avoidant-Fearful attachment to therapist.

Planned Post-hoc Analyses

In addition to analyses used to test the main research questions, eight post hoc regression analyses were planned in advance to further examine the relations between client ECR-S general attachment, therapist ECR-S general attachment, CATS attachment to therapist and SASB Intrex ratings. Specifically, the post hoc analyses were designed to better understand how the various attachment constructs explained variance in SASB Intrex ratings of the psychotherapy relationship. Due to the exploratory nature of these analyses no specific hypotheses were proposed. Because two of the variables had significant therapist effects (i.e., therapist ratings of client autonomy and therapist affiliation), they were omitted from analyses. As a result six regressions were conducted,
one for each of the SASB Intrex ratings that were calculated from the therapist and client ratings forms including the following ratings by clients: client affiliation, client autonomy, therapist affiliation, and therapist autonomy. In addition, the two therapist SASB Intrex ratings of client affiliation and therapist autonomy were examined. For each regression, the following predictors were entered: client general attachment anxiety and avoidance, therapist general attachment anxiety and avoidance, and the 3 CATS attachment to therapist subscales (i.e., Secure, Preoccupied-Merger, and Avoidant-Fearful attachment to therapist).

Three of the six regressions showed statistically significant results (see Tables 9, 10, 11, 12, 13, and 14). First, 29% of the variance in therapist SASB Intrex ratings of therapist autonomy was explained by the attachment variables (see Table 9). Only client general attachment anxiety uniquely predicted therapist SASB Intrex ratings of therapist autonomy, showing a negative relation to this SASB Intrex rating (with 12% of the variance explained). In other words, if client general attachment anxiety was high, then therapists tended to rate their own autonomy as low. Therapist SASB Intrex ratings of therapist autonomy were not significantly related to therapist general attachment anxiety or avoidance, client general attachment avoidance, or any of the client attachment to therapist variables.
Table 9

Summary of Regression Analysis Predicting Therapist Ratings of Therapist Autonomy (n = 50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.29</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>.03</td>
</tr>
<tr>
<td>CLANX</td>
<td>- .32</td>
<td>- .33</td>
<td>-2.38</td>
<td>.02</td>
<td>.12</td>
<td></td>
</tr>
<tr>
<td>CLAVO</td>
<td>.14</td>
<td>.14</td>
<td>.99</td>
<td>.33</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>THANX</td>
<td>-.18</td>
<td>-.18</td>
<td>-1.25</td>
<td>.22</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>THAVO</td>
<td>-.18</td>
<td>-.18</td>
<td>-1.33</td>
<td>.19</td>
<td>.04</td>
<td></td>
</tr>
<tr>
<td>SECURE</td>
<td>.06</td>
<td>.05</td>
<td>.30</td>
<td>.77</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>PMCATS</td>
<td>-.16</td>
<td>-.16</td>
<td>-1.17</td>
<td>.25</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>AFCATS</td>
<td>-.07</td>
<td>-.06</td>
<td>-.35</td>
<td>.73</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist.

Second, 32% of the variance in therapist SASB Intrex ratings of client affiliation was explained by the attachment variables (see Table 10). Both therapist general attachment avoidance and Avoidant-Fearful CATS attachment to therapist were negatively related to and explained significant unique variance in therapist SASB Intrex ratings of client affiliation. Also, the positive relation between client general attachment...
avoidance and therapist ratings of client affiliation approached, but did not attain, conventional levels of significance. As mentioned above with regard to interpretation of other non-significant results, this non-significant result was interpreted because this is a new area of research so concerns about Type 1 error should be balanced with concerns about Type II error and because at 6% the effect size was small to moderate if compared to benchmarks that exist for $R^2$ (Cohen & Cohen, 1983). Therapist general attachment anxiety, client general attachment anxiety, and the other two CATS attachment to therapist variables were not significantly related to therapist SASB Intrex ratings of client affiliation.

Table 10

Summary of Regression Analysis Predicting Therapist Ratings of Client Affiliation (n = 50)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.32</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td>.10</td>
<td>.10</td>
<td>.77</td>
<td>.45</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>CLAVO</td>
<td>.24</td>
<td>.23</td>
<td>1.62</td>
<td>.11</td>
<td>.06</td>
<td></td>
</tr>
<tr>
<td>TH ANX</td>
<td>-.04</td>
<td>-.04</td>
<td>-.30</td>
<td>.77</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>THAVO</td>
<td>-.35</td>
<td>-.34</td>
<td>-2.53</td>
<td>.02</td>
<td>.13</td>
<td></td>
</tr>
<tr>
<td>SECURE</td>
<td>-.01</td>
<td>-.01</td>
<td>-.03</td>
<td>.98</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>PMCATS</td>
<td>.21</td>
<td>.20</td>
<td>1.48</td>
<td>.15</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>AFCATS</td>
<td>-.50</td>
<td>-.43</td>
<td>-2.41</td>
<td>.02</td>
<td>.12</td>
<td></td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist.
Third, 28% of the variance in client SASB Intrex ratings of client affiliation was explained by the attachment variables (see Table 11). None of the client or therapist general attachment variables were significantly related to client SASB Intrex ratings of client affiliation, nor was Secure CATS attachment to therapist. Avoidant-fearful CATS attachment to therapist did explain significant unique variance and was negatively linked to this SASB rating. In other words, if Avoidant-Fearful CATS attachment to therapist was high, then client SASB Intrex ratings of client affiliation was low. Further, Preoccupied-Merger CATS attachment to therapist approached, but did not attain conventional levels of significance ($p = .07$) and was positively related to client SASB ratings of their own affiliation. Although this relation was not significant, the result was interpreted because Preoccupied-Merger CATS attachment to therapist explained 7% unique variance in client SASB Intrex ratings of client affiliation and because of the exploratory nature of these analyses.
Table 11

Summary of Regression Analysis Predicting Client Ratings of Client Affiliation (n = 52)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.28</td>
<td>.05</td>
<td>.05</td>
<td>.38</td>
<td>.71</td>
<td>.00</td>
</tr>
<tr>
<td>CLANX</td>
<td>.05</td>
<td>.05</td>
<td>.05</td>
<td>.38</td>
<td>.71</td>
<td>.00</td>
</tr>
<tr>
<td>CLAVO</td>
<td>.11</td>
<td>.12</td>
<td>.12</td>
<td>.80</td>
<td>.43</td>
<td>.01</td>
</tr>
<tr>
<td>THANX</td>
<td>-.08</td>
<td>-.08</td>
<td>-.08</td>
<td>-.56</td>
<td>.58</td>
<td>.01</td>
</tr>
<tr>
<td>THAVO</td>
<td>-.15</td>
<td>-.15</td>
<td>-.15</td>
<td>-1.13</td>
<td>.26</td>
<td>.03</td>
</tr>
<tr>
<td>SECURE</td>
<td>.15</td>
<td>.15</td>
<td>.15</td>
<td>.78</td>
<td>.43</td>
<td>.01</td>
</tr>
<tr>
<td>PMCATS</td>
<td>.26</td>
<td>.26</td>
<td>.26</td>
<td>1.88</td>
<td>.07</td>
<td>.07</td>
</tr>
<tr>
<td>AFCATS</td>
<td>-.39</td>
<td>-.39</td>
<td>-.39</td>
<td>-2.01</td>
<td>.05</td>
<td>.08</td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist.

Of note, the model that examined client-rated therapist affiliation approached but did not attain conventional levels of significance (see Table 12) explaining 23% of the variance in this SASB rating. None of the attachment variables, however, uniquely contributed to the overall model. The two final post-hoc regressions failed to explain significant variance in client SASB Intrex ratings of client (see Table 13) and therapist autonomy (see Table 14) via the attachment variables. Though no hypotheses had been
identified prior to data analysis, the results suggest that client perceptions of autonomous behaviors in the psychotherapy relationship function independently of attachment-related constructs.

Table 12

Summary of Regression Analysis Predicting Client Ratings of Therapist Affiliation (n = 52)

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$β$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.23</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLANX</td>
<td>-.13</td>
<td>-.14</td>
<td>-.99</td>
<td>.33</td>
<td>.02</td>
<td></td>
</tr>
<tr>
<td>CLAVO</td>
<td>.03</td>
<td>.03</td>
<td>.20</td>
<td>.84</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>THANX</td>
<td>.11</td>
<td>.11</td>
<td>.75</td>
<td>.46</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>THAVO</td>
<td>-.08</td>
<td>-.08</td>
<td>-.57</td>
<td>.57</td>
<td>.01</td>
<td></td>
</tr>
<tr>
<td>SECURE</td>
<td>.30</td>
<td>.30</td>
<td>1.54</td>
<td>.13</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>PMCATS</td>
<td>.16</td>
<td>.16</td>
<td>1.15</td>
<td>.26</td>
<td>.03</td>
<td></td>
</tr>
<tr>
<td>AFCATS</td>
<td>-.14</td>
<td>-.14</td>
<td>-.70</td>
<td>.49</td>
<td>.01</td>
<td></td>
</tr>
</tbody>
</table>

Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure attachment to therapist; PMCATS = Preoccupied-Merger attachment to therapist; AFCATS = Avoidant-Fearful attachment to therapist.
Table 13

**Summary of Regression Analysis Predicting Client Ratings of Client Autonomy (n = 52)**

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.05</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.94</td>
</tr>
<tr>
<td>CLANX</td>
<td></td>
<td>-.14</td>
<td>-.15</td>
<td>-.95</td>
<td>.35</td>
<td>.02</td>
</tr>
<tr>
<td>CLAVO</td>
<td></td>
<td>-.04</td>
<td>-.04</td>
<td>-.22</td>
<td>.82</td>
<td>.00</td>
</tr>
<tr>
<td>THANX</td>
<td></td>
<td>-.11</td>
<td>-.11</td>
<td>-.67</td>
<td>.51</td>
<td>.01</td>
</tr>
<tr>
<td>THAVO</td>
<td></td>
<td>.08</td>
<td>.08</td>
<td>.51</td>
<td>.62</td>
<td>.01</td>
</tr>
<tr>
<td>SECURE</td>
<td></td>
<td>-.20</td>
<td>-.20</td>
<td>-.93</td>
<td>.36</td>
<td>.02</td>
</tr>
<tr>
<td>PMCATS</td>
<td></td>
<td>-.06</td>
<td>-.06</td>
<td>-.38</td>
<td>.71</td>
<td>.00</td>
</tr>
<tr>
<td>AFCATS</td>
<td></td>
<td>-.12</td>
<td>-.12</td>
<td>-.53</td>
<td>.60</td>
<td>.01</td>
</tr>
</tbody>
</table>

*Note: CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure client attachment to therapist; PMCATS = Preoccupied-Merger client attachment to therapist; AFCATS = Avoidant-Fearful client attachment to therapist.*
Table 14

*Summary of Regression Analysis Predicting Client Ratings of Therapist Autonomy (n = 52)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.17</td>
<td>.26</td>
<td></td>
<td>.26</td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>CLANX</td>
<td>.08</td>
<td>.08</td>
<td>.54</td>
<td>.59</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>CLAVO</td>
<td>-.05</td>
<td>-.05</td>
<td>-.33</td>
<td>.75</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>TH ANX</td>
<td>-.23</td>
<td>-.24</td>
<td>-1.55</td>
<td>.13</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>THAVO</td>
<td>-.10</td>
<td>-.10</td>
<td>-1.66</td>
<td>.51</td>
<td>.01</td>
<td>.01</td>
</tr>
<tr>
<td>SECURE</td>
<td>.02</td>
<td>.02</td>
<td>.10</td>
<td>.92</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>PMCATS</td>
<td>-.21</td>
<td>-.21</td>
<td>-1.41</td>
<td>.17</td>
<td>.04</td>
<td>.04</td>
</tr>
<tr>
<td>AFCATS</td>
<td>-.02</td>
<td>-.02</td>
<td>-.11</td>
<td>.91</td>
<td>.00</td>
<td>.00</td>
</tr>
</tbody>
</table>

*Note:* CLANX = Client attachment anxiety prior to session 1; CLAVO = Client attachment avoidance prior to session 1; THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance; SECURE = Secure client attachment to therapist; PMCATS = Preoccupied-Merger client attachment to therapist; AFCATS = Avoidant-Fearful client attachment to therapist.

Because many therapists completed forms on clients who did not participate in the study, a significant number of therapy dyads had partial data (i.e., therapist general attachment and therapist SASB Intrex ratings only). As a result, two final simultaneous regressions were conducted, entering therapist general attachment anxiety and avoidance to predict variance in therapist SASB Intrex ratings of client affiliation and therapist
autonomy. The other two therapist SASB Intrex ratings of therapist affiliation and client autonomy were not examined because of previously detected therapist effects. Tables 15 and 16 summarize these results. For the first model, 8% of the variance in therapist SASB Intrex ratings of client affiliation was explained by therapist general attachment. Therapist general attachment avoidance explained significant unique variance, relating in a negative direction to therapist SASB Intrex ratings of client affiliation. In other words, if therapist general attachment avoidance was high, then therapist SASB Intrex ratings of client affiliation were low. No significant relation was detected between therapist general attachment anxiety and therapist SASB Intrex ratings of client affiliation.

As in the previous model, the therapist general attachment variables were entered in a simultaneous regression to explore their relations with therapist SASB Intrex ratings of therapist autonomy (see Table 16). The overall model was also significant, explaining 10% of the variance in therapist ratings of their own autonomy. Only therapist general attachment anxiety explained significant unique variance in therapist ratings of their own autonomy, with higher scores on therapist attachment anxiety linked to lower therapist ratings of their own autonomy.
Table 15

*Summary of Exploratory Post Hoc Analysis Predicting Therapist Ratings of Client Affiliation (n = 124)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.08</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.01</td>
</tr>
<tr>
<td>TH ANX</td>
<td></td>
<td>-.07</td>
<td>-.07</td>
<td>-.82</td>
<td>.41</td>
<td>.01</td>
</tr>
<tr>
<td>THAVO</td>
<td></td>
<td>-.25</td>
<td>-.25</td>
<td>-2.81</td>
<td>.01</td>
<td>.06</td>
</tr>
</tbody>
</table>

*Note:* THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance.

Table 16

*Summary of Exploratory Post Hoc Analysis Predicting Therapist Ratings of Therapist Autonomy (n = 124)*

<table>
<thead>
<tr>
<th>Variable</th>
<th>$R^2$</th>
<th>$B$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>$p$</th>
<th>$sr^2$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model</td>
<td>.10</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>.00</td>
</tr>
<tr>
<td>TH ANX</td>
<td></td>
<td>-.26</td>
<td>-.26</td>
<td>-.30</td>
<td>.00</td>
<td>.07</td>
</tr>
<tr>
<td>THAVO</td>
<td></td>
<td>-.14</td>
<td>-.14</td>
<td>-1.54</td>
<td>.13</td>
<td>.02</td>
</tr>
</tbody>
</table>

*Note:* THANX = Therapist attachment anxiety; THAVO = Therapist attachment avoidance.
Chapter 5

Discussion

The central goal of the present study was to examine factors that may contribute to the client’s attachment to the therapist in psychotherapy. Factors considered included therapist and client general attachment orientations, as well as the interpersonal process in early sessions as rated by the client. Planned post hoc analyses were also conducted to further understand how client general attachment orientation, therapist general attachment orientation, and client attachment to the therapist were linked to interpersonal process ratings by both clients and therapists in early therapy sessions. This chapter will: (a) review the major findings of the current investigation, (b) discuss limitations of the present study, (c) offer suggestions for future research, and (d) summarize the research and practice implications of the findings.

Secure Client Attachment to Therapist

Contrary to expectation, clients’ ratings of secure attachment to the therapist were not linked to either client general attachment anxiety or avoidance. Inverse relations between secure attachment to the therapist and both attachment anxiety and avoidance had been hypothesized because it could be expected that clients with generally insecure working models of attachment may have difficulties in therapy, at least initially, establishing a secure attachment relationship with their therapist. Three other studies have failed to find a significant link between client general attachment and attachment to therapist. First, Mallinckrodt et al. (1995) similarly found that client general attachment orientations were not linked to client security of attachment to the therapist in a sample of 138 clients who had attended at least five sessions and a median of ten sessions,
suggesting that this lack of relations would hold for a larger sample and across longer treatment lengths. Also, Romano, Fitzpatrick, and Janzen (2008) found no significant relation between volunteer client attachment and composites of attachment to therapist ratings between sessions five and nine. Finally, Mallinckrodt et al. (2005) also failed to find a significant relation between client general attachment and attachment to therapist in a smaller sample (n = 47) of clients who rated their attachment to therapist between the fourth and eighth therapy session. Though this lack of association may seem promising and suggest that attachment security with one’s therapist develops independently of one’s internal working models, it is difficult to know with certainty how a client’s attachment to therapist may change over the course of treatment without further research that examines the development of client attachment to therapist longitudinally beginning in the initial sessions. Typically, attachment to therapist has not been measured before the fourth session because it was theorized that the attachment to the therapist would take time to form based on experiences with the therapist (Mallinckrodt et al., 2005).

Also, contrary to expectation, there was no link between therapist general attachment avoidance and client secure attachment to the therapist. An inverse relation between these two variables had been expected in the present study and was found in a previous study of trainee counselors and volunteer clients (Romano et al., 2008). It is important to note that the mean value of therapist general attachment avoidance, as well as the mean of therapist general attachment anxiety, was relatively low with a small standard deviation. The restricted variability of these constructs may have reduced the ability of the therapist attachment variables to predict attachment to therapist. At the same time, these low mean values for therapist attachment anxiety and avoidance are likely to
be replicated in future studies as these values are at least partially a function of the type of people who choose to become therapists, a career that requires comfort with others’ distress as well as the ability to focus one’s attention on caring for others. Also, the findings suggest that therapists generally endorse relatively low degrees of attachment insecurity in their own close relationships which is promising because therapists low on attachment anxiety and avoidance may be better able to provide a secure base for their clients than therapists who are more insecure. In contrast to results for therapist avoidance, a negative relation that approached but did not attain conventional levels of significance (with 8% of the variance explained) was detected between therapist general attachment anxiety and secure attachment to therapist; such a relation was not observed in previous research by Romano et al. As described earlier, this potential effect was interpreted because the effect, at 8%, represents a small to medium effect if compared to standards set for $R^2$ (Cohen & Cohen, 1983) and because it is important to balance concerns about Type II error and Type I error given that this study represents a relatively new area of research. It is striking that therapist attachment anxiety was able to explain 8% of the variance in secure attachment to therapist given the restricted range for the variable and that it explained more variance than any of the other predictors. This finding suggested that clients may perceive therapists high in attachment anxiety as slightly less able to provide a secure base than their counterparts who are lower on attachment anxiety. Bowlby (1988) theorized that the therapist’s ability to function as a secure base is critical for progress in therapy. Mikulincer and Shaver (2007) suggested that therapists high in attachment anxiety may struggle to develop appropriate therapeutic boundaries out of their desire for closeness and may be motivated more by unmet personal needs.
than the altruistic desire to help others. As a result, these therapists may struggle to manage their own countertransference in a way that permits them to respond empathically and genuinely, factors found to be associated with client outcomes (Norcross, 2002). Also, the finding suggests that clients may perceive therapists’ relational dynamics, particularly when their therapists are high in general attachment anxiety, i.e., therapists desire closeness while being sensitive for signs of rejection. Finally, the result demonstrates the importance of therapist attachment anxiety on client perceptions of the therapist as a secure base, even more so than the client’s own attachment style. One of the most important findings of the present study is that therapist attachment anxiety appears to be linked to client perceptions of attachment security in the psychotherapy relationship and that therapist attachment anxiety should be considered in future studies examining client attachment to therapist. Moreover, as discussed below, therapist attachment anxiety may be clinically important to consider in supervision and consultation.

Next, although the expected significant bivariate correlation between client self-rated affiliation and security of attachment to therapist was found, regression analyses provided no support for the hypothesis that there would be a positive relation between secure attachment to therapist and clients’ ratings of their own in-session affiliation; client ratings of their own in-session affiliation did not uniquely explain secure attachment to therapist ratings. This finding suggested that clients’ attachment to the therapist is not particularly linked to clients’ perceptions of their own friendly behaviors in session when considered in the context of other the constructs examined. Taken with previous findings, the results suggest that client attachment to the therapist is more
closely tied to therapists’ general attachment anxiety rather than to clients’ own attachment or clients’ perceptions of their own friendly actions in session. Thus, clients may look to their therapists to determine the degree of attachment security clients feel in the therapy relationship and that clients may tend to respond to the attachment anxiety that their therapists endorse experiencing in interpersonal relationships.

Interestingly, it was clients’ perception of their therapists’ in-session affiliation rather than their own affiliation that explained significant variance in secure attachment to the therapist. In other words, this finding suggests that clients are better able to use their therapists as a secure base when they perceive their therapists’ actions as affiliative and warm than when they consider their therapist to be uncaring and negative and that client attachment to therapist was dependent on how clients viewed their therapists and not on how affiliative they viewed themselves in session. These findings are consistent with Bowlby’s conceptualization of the therapist as an attachment figure for the client (1988), mainly that therapists are viewed as caregivers and that their emotional availability is a critical element in developing a safe and trusting attachment bond. This finding is also consistent with a pattern that emerged in the present study suggesting that therapist factors (e.g., therapist attachment anxiety) were predictive of client secure attachment to the therapist whereas client factors (e.g., client general attachment, degree of warmth in session by clients) were not. Research on common factors empirically shown to be efficacious in psychotherapy treatment has shown that positive regard, genuineness, and empathy are all important common factors related to positive treatment outcomes (Norcross, 2002). Therapist affiliation is very similar to these constructs because it is characterized by acts of affirmation, understanding, nurturance, and warm
protection. In sum, it appears that the factors that may most influence clients’ ratings of security in the therapy relationship are therapist-related (i.e., client-rated therapist affiliation, therapist attachment anxiety) and not client-related (i.e., client general attachment, client-rated client affiliation).

Next, an interaction effect that approached but did not attain conventional levels of significance was detected between client ratings of therapist affiliation and client attachment anxiety. As explained earlier, this interaction effect was interpreted because moderator effects are difficult to detect within relatively small sample sizes (see Aiken & West, 1991) and because this study is a relatively new area of exploration in which concerns regarding Type I and II error must be balanced. Further, the effect size is small to medium in size (Cohen & Cohen, 1983) which is likely an underestimate since 31% of the variance had previously been explained. This interaction suggests that therapist affiliation relates to security of attachment to the therapist differently depending on the degree of client attachment anxiety present. In other words, there may be a benefit in terms of client security of attachment to the therapist if therapists are perceived by their clients as affiliative and if the clients are low on attachment anxiety. This benefit, however, is lost if clients do not perceive their therapists to be affiliative or if clients are high in attachment anxiety.

In sum, results suggested that the client sample as a whole endorsed a relatively high degree of attachment security with their therapist and that these ratings were independent of clients’ general attachment and clients’ perceptions of their own affiliation in session. In contrast, therapist attachment anxiety and client perceptions of therapist affiliation significantly predicted client attachment to the therapist. Specifically,
clients indicating a high degree of attachment security in their therapy relationship tended to have therapists who were less sensitive to rejection and who were not pulled to seek excessive closeness in their own attachment relationships (i.e., low on attachment anxiety). Moreover, clients who experienced their therapists as nurturing and warm tended to be more securely attached to their therapists, but this benefit in terms of secure attachment to the therapist may only accrue to clients who are themselves low in general attachment anxiety. More research will be needed to examine the potential moderating effect of client attachment on the link between client perceptions of therapist affiliation and client security of attachment to the therapist.

*Preoccupied-Merger Client Attachment to Therapist*

Contrary to expectations, clients’ ratings of preoccupied-merger attachment to therapist were not linked to client general attachment anxiety. Inverse relations between preoccupied-merger attachment to therapist and client general attachment anxiety had been hypothesized because it was expected that clients with internal working models of attachment that involve seeking reassurance and merger from relational partners would also imply that clients would seek out these characteristics in their therapy relationships. Nevertheless, findings did not support this notion. Other researchers have also found no significant relation in larger samples and at later points in treatment (Mallinckrodt et al., 1995, 2005; Romano et al., 2008), which would suggest that this is a robust finding. This lack of significant relation appears to suggest that therapists tend to find a way to connect with clients high in attachment anxiety such that these clients are able to develop therapy relationships distinctively different from the relationships with other attachment figures in their lives. Nevertheless, it is impossible to determine how clients’ attachment to
therapist changes over the course of therapy and whether this lack of effect for clients high in general attachment anxiety would remain over time without further longitudinal research that tracks the therapist relationship over time. Because the work of therapy is in developing new patterns of interacting with and relating to others (Bowlby, 1988), the lack of a significant association between client general attachment anxiety and preoccupied merger attachment to therapist suggests that meaningful changes in patterns of relating may be detectable early in treatment.

A link between therapist attachment anxiety and preoccupied-merger attachment to therapist had been hypothesized. The association between these two variables approached, but did not attain conventional levels of significance. This relation was interpreted because it is important to balance concerns regarding Type I and II error in new areas of research. Moreover, there was a significant bivariate correlation between therapist general attachment anxiety and preoccupied-merger attachment to therapist. The only other study identified that explored client and therapist attachment and attachment to therapist did not find this relation (Romano et al., 2008). It is striking that therapist attachment anxiety and not client attachment anxiety was related to preoccupied-merger attachment to therapist, suggesting that therapists who described themselves as desiring very close relationships and reassurance ended up having clients who tended to describe similar qualities in the therapy relationship. Taken with previous findings regarding therapist attachment anxiety and secure attachment to therapist, it appears that therapists’ own attachment security in the context of their own attachment relationships may be linked to their behavior with their clients in ways that are related to how much clients are able to perceive them to be a secure base for the client to explore in therapy. These results
are consistent with Bowlby’s (1988) theory that the therapist must serve as a secure base for the client. In fact, previous research has found links between general attachment and caregiving in the context of romantic relationships (see Mikulincer & Shaver, 2007, for a review) and parenting (see Mikulincer & Shaver, for a review). The same may be true in the psychotherapy relationship and future research may help to explain how this may occur.

Next, regression analyses did not provide support for the hypothesis that there would be negative relations between preoccupied-merger attachment to therapist and client ratings of their own autonomy and of therapist autonomy. It is important to note, however, that bivariate correlations indicated that client ratings of therapist autonomy were significantly negatively correlated to preoccupied-merger attachment to therapist, suggesting that clients who perceived their therapists’ behaviors as enmeshed (the low autonomy pole of SASB) also tended to describe their relationship as lacking appropriate interpersonal boundaries. Descriptors of these qualities (with varying degrees of affiliation) include: nurturing, controlling, and blaming (Benjamin, 2000). Interestingly, it was client ratings of their therapists’ behaviors and not their own that were significantly correlated with client preoccupied-merger attachment. Once again, findings suggested that therapist behaviors tend to be associated with the degree to which clients can perceive their therapists as serving as a secure base, and thus, may be linked to client attachment to the therapist.

Finally, no support was found for the two hypothesized interaction effects, specifically that therapist attachment anxiety would moderate the relation between client attachment anxiety and preoccupied-merger attachment to therapist and that client-rated
therapist autonomy would moderate the relation between client attachment anxiety and preoccupied-merger attachment to therapist. No such moderation effects emerged. Given that only therapist attachment anxiety approached but did not attain significance, it is difficult to make meaning from the lack of significance of these interaction effects.

To summarize the findings from this section, clients endorsing a high degree of preoccupied-merger attachment in their therapy relationship tended to have therapists who were sensitive to rejection and who tended to be pulled to seek closeness in their own attachment relationships. Perhaps therapists high in attachment anxiety struggle to place their own relational concerns and needs aside in order to manage their own countertransference and truly empathize with their clients. Also, client ratings of preoccupied-merger attachment to therapist were independent of their own relational tendencies toward excessive closeness and merger. Further, clients indicating a high degree of preoccupied-merger attachment to their therapist also tended to describe their therapist’s behaviors in therapy as excessively close and enmeshed. It is possible that some tension in the therapeutic alliance may emerge as a result of these in-session interactions. As found previously with secure attachment to therapist, it is striking that the variables that emerged as unique predictors of preoccupied-merger attachment to therapist were therapist-related, highlighting the importance of considering therapist factors when conducting research to understand client attachment to therapist. Again, these findings suggest that clients’ security depends upon therapists’ ability to provide appropriate interpersonal experiences in session. Therapists who are high in attachment anxiety may not be able to manage interpersonal boundaries well enough, and clients may
perceive them as controlling, smothering, and/or wishing that the boundaries of the relationship could be crossed.

Avoidant-Fearful Client Attachment to Therapist

Contrary to expectation, avoidant-fearful attachment to therapist was not linked to client general attachment anxiety. Conceptually avoidant-fearful attachment involves high degrees of both attachment anxiety and avoidance because individuals with high degrees of this attachment desire intimacy but avoid close relationships out of distrust and fear of rejection (Bartholomew, 1990). Despite this conceptualization, others have also failed to find a significant link between client attachment anxiety and avoidant-fearful attachment to therapist (Mallinckrodt et al., 2005; Romano et al., 2008).

As expected, client general attachment avoidance was significantly, positively related to avoidant-fearful attachment to therapist. This finding was consistent with a study by Mallinckrodt et al. (2005) but not consistent with findings by Romano et al. (2008), who did not find a significant correlation between volunteer client general attachment avoidance and avoidant-fearful attachment to therapist. However, because the study by Romano et al. used volunteer clients, it could be less relevant to the present study and the study by Mallinckrodt et al. which both contained samples of self-referred clients. The findings suggest that at least some clients high in general attachment avoidance struggle with developing a trusting, safe therapy relationship. Previous research has also found negative relations between working alliance and avoidant-fearful attachment to therapist such that higher endorsement of an avoidant-fearful attachment to therapist is associated with lower working alliance ratings (Mallinckrodt et al., 1995b). Given the importance of a strong working alliance for positive client outcomes, these
findings could suggest that clients high in attachment avoidance may struggle to attain positive outcomes in therapy, particularly as they endorse higher degrees of avoidant-fearful attachment to therapist.

Also, contrary to expectation, there was no link between therapist general attachment avoidance and avoidant-fearful attachment to therapist. Romano and colleagues (2008) also failed to find a significant relation between these constructs. In comparison to both secure and preoccupied-merger attachment to therapist, which were each significantly associated with therapist general attachment anxiety, it is interesting to note that avoidant-fearful attachment to therapist was not related to therapist general attachment avoidance. Taken with the significant relation between client general attachment avoidance and avoidant-fearful attachment to therapist, clients high in attachment avoidance may not be connecting with their therapists enough to even follow the interpersonal cues and influences to which other clients have responded.

Partial support was obtained for the hypotheses that client ratings of both client and therapist affiliation would be inversely related to avoidant-fearful attachment to therapist. Client ratings of client affiliation were linked inversely to avoidant-fearful attachment to therapist. Thus, when clients saw themselves in session as highly disaffiliative (e.g., withdrawing, defending, fearful), they also indicated high levels of avoidant-fearful attachment to therapist. Clients perceived themselves as protesting and recoiling from the therapist when attached in an avoidant-fearful manner. In contrast, client ratings of therapist affiliation did not uniquely explain avoidant-fearful attachment to therapist ratings but were correlated in a negative direction with this type of attachment to therapist. Thus, clients indicating high degrees of avoidant-fearful attachment to
therapist not only tended to view themselves as disaffiliative in therapy but there was also at least some evidence that they also may see their therapists in this light (e.g., attacking, neglecting, and belittling the client). In sum, clients endorsing high levels of avoidant-fearful attachment to therapist tend to view the psychotherapy relationship as a somewhat hostile environment, lacking in empathy and positive regard. Disaffiliation has been found to be quite problematic, negatively impacting psychotherapy outcome (Henry et al., 1986, 1993; Rudy et al., 1985; Schut et al., 2005).

Finally, no support was found for the two proposed interaction effects. Two moderators, client general attachment anxiety and client ratings of therapist affiliation, were examined for their impact on the relation between client general attachment avoidance and ratings of avoidant-fearful attachment to therapist. Thus these results suggest that the positive relation found between client attachment avoidance and avoidant-fearful attachment to therapist is unaffected by both client general attachment anxiety and client ratings of therapist affiliation. In other words, clients who prefer to maintain interpersonal distance in relationships likely experience their therapy relationship in a similar fashion regardless of how warm they consider their therapists to be or their degree of ambivalence about this interpersonal distance.

In summary, clients endorsing high degrees of avoidant-fearful attachment to therapist were characterized by excessive self-reliance and the desire for interpersonal distance. The results perhaps demonstrate the difficulty that therapists face in attempting to connect to clients high in attachment avoidance. Unlike client ratings of secure and preoccupied-merger attachment to therapist, client ratings of avoidant-fearful attachment to therapist were independent of therapist attachment, specifically therapist general
attachment avoidance. Further, it is interesting to note that client ratings of their own in-session affiliation uniquely predicted avoidant-fearful attachment to therapist ratings rather than client ratings of therapist in-session affiliation as found with secure and preoccupied-merger attachment to therapist. It appears that clients who have a more fearful-avoidant attachment to their therapist may not be connecting enough with their therapists to respond to therapists’ relational cues and dynamics. These clients also tended to see themselves and their therapists interacting in predominantly disaffiliative ways within their therapy relationships. More research needs to be conducted to explore how these dynamics unfold over the course of therapy, as the present study only measured through session four, as well as their impact on client outcome. Finally, future research is needed to better understand how to best help and connect to clients high in general attachment avoidance.

Planned SASB Post-Hoc Analyses

Several post-hoc analyses were planned prior to data analysis to further explore the interpersonal process ratings provided by both therapists and clients. Specifically, these post hoc analyses were intended to shed light on the relations between the various attachment constructs (i.e., therapist general attachment, client general attachment, attachment to therapist) and the interpersonal process ratings of affiliation and autonomy provided by therapists and clients. No specific hypotheses were identified. Rather, these analyses were exploratory in nature.

Because two of the therapist interpersonal process ratings had significant therapist effects (i.e., therapist ratings of client autonomy and therapist affiliation), the links between these ratings and the attachment constructs were not examined in the post hoc
analyses. No links were found between the attachment constructs and two interpersonal ratings (i.e., client ratings of client autonomy, client ratings of therapist autonomy).

Avoidant-fearful attachment to therapist was negatively linked to both client and therapist ratings of client affiliation. In other words, each member of the dyad reported significant disaffiliative behavior by the client in session when the client also indicated a highly avoidant-fearful attachment to therapist. As previously discussed, an avoidant-fearful attachment relationship seems especially problematic because clients are not developing a sense of trust in their therapy relationship. Rather, they are likely to be concerned that their therapists see them in a non-empathic, negative light and that they maintain interpersonal distance with their therapist. Such client perceptions could be important because they may be indicative of problematic patterns in the therapy relationship, particularly since therapist empathy has been found to be an effective element of positive psychotherapy outcomes (Norcross, 2002). It is interesting that both clients and therapist noted the disaffiliative behavior of clients high in fearful-avoidant attachment to the therapist because it suggests that both parties are aware of distancing, recoiling, and sulking behaviors on the part of the client that end up being related to the client perceiving the therapy relationship as a threatening environment.

Therapist general attachment avoidance was negatively linked to therapist ratings of client affiliation. It appears that the more general attachment avoidance therapists report, the more likely they are to believe the client as being hostile towards them in the psychotherapy relationship. These therapists may feel rejected by their clients or frustrated by events in therapy. They appear to struggle to develop a collaborative, empathetic stance toward their client. Previous research has found an association between
attachment and biased social information processing, whereby insecure attachment is associated with more negative social expectations (Vogel & Wei, 2005) and interpretations of social experiences (Guterman, 2006). The present results are consistent with these findings. Taken with previously discussed findings regarding the relations between fearful-avoidant attachment to therapist and ratings of affiliation, it seems as though attachment avoidance, whether the therapist’s general avoidance or the client’s fearful-avoidant attachment to the therapist, is associated with the perception of dismissing and/or attacking behaviors by at least one member of the psychotherapy relationship. In contrast to results indicating a link between therapist attachment avoidance and therapist rating of client affiliation, there was no significant association between therapists’ ratings of their own attachment anxiety and of client affiliation.

A positive link between therapist ratings of client affiliation and client general attachment avoidance approached, but did not attain conventional levels of significance. Although this relation did not reach conventional standards of significance, it was interpreted because this is a new area of investigation in which concerns about Type I error must be balanced with concerns about Type II error. This finding runs in contrast to the finding of a negative relation between client fearful-avoidant attachment to the therapist and client in-session affiliation. It may be that if the therapist is sufficiently available as a secure base, that clients high in general attachment avoidance blossom and show high levels of affiliation towards the therapist because, perhaps for the first time, they experience a relationship in which they feel safe to express themselves freely. In contrast, if the attachment to the therapist is high in fearful-avoidance, clients do not feel safe and thus are disaffiliative (or they may be disaffiliative and push the therapist away,
and consequently are not able to attach securely to the therapist because the therapist is not available as a secure base). It is also notable that even though therapist ratings of client affiliation were negatively linked to therapist attachment avoidance, therapist ratings of client affiliation were positively related to client general attachment avoidance. Perhaps therapist and client general attachment orientations affect the psychotherapy relationship differently because of the different roles clients and therapists play. Because the therapist is responsible for providing care in the relationship, unchecked general attachment avoidance may bias how the therapist views the client because the client role is not one in which the client would be expected to provide supportive behavior that would counter such a bias. Thus, the therapist’s attachment avoidance may incline the therapist to see the client as disaffiliative in accordance with a social information processing bias to view interpersonal interactions as more negative. Interestingly, therapists high in general attachment avoidance do not tend to be perceived by clients as being more disaffiliative, so it could not be argued that therapists high in general attachment avoidance are behaving in ways that would create an interpersonal pull for client to respond more disaffiliatively (at least not as far as clients are able to perceive). On the other hand, the clients high in general attachment avoidance may be influenced by receiving the caring, supportive behavior typically provided by therapists and thus tend to respond in an affiliative way to that support. Thus, as recipients of care, clients’ tendency toward biased interpersonal information processing may be overcome by therapist behavior that is unambiguously supportive, although it is nevertheless important to recall that higher levels of client general attachment avoidance are associated with higher levels of fearful-avoidant attachment to the therapist.
The positive link between preoccupied-merger attachment to therapist and client ratings of their own affiliation approached, but did not attain conventional levels of significance. As mentioned previously, this non-significant relation was explored because it is important to balance concerns regarding Type I and II error within relatively small sample sizes and because the effect size was a respectable 7% of the variance explained. Thus, clients who seek extreme closeness and reassurance in their therapy relationship may also view themselves as warm and friendly with their therapists.

Next, therapist ratings of their own autonomy in-session were negatively linked to client general attachment anxiety. In other words, as clients indicated higher needs for reassurance and interpersonal closeness, their therapists also endorsed a more enmeshed, interpersonally close psychotherapy relationship. It appears that these therapists were responding to the interpersonal pull of clients high in attachment anxiety by maintaining less interpersonal distance from these clients.

Because interpersonal rating sheets were completed by therapists for about 75 non-participating clients, two additional post hoc analyses were conducted to explore the relations between therapist general attachment and the therapist interpersonal process ratings that did not have significant, confounding therapist effects. First, therapist general attachment avoidance was inversely linked to therapist ratings of client affiliation. This inverse relation was also detected in a previous post hoc analysis (described above) that explored the links between various attachment constructs (i.e., therapist general attachment, client general attachment, and attachment to therapist) and therapist ratings of client affiliation in participating client-therapist dyads. Second, therapist general attachment anxiety was inversely linked to therapist ratings of therapist autonomy. This
relation was not detected when explored in the context of other attachment constructs (i.e., client general attachment, therapist general attachment avoidance, and attachment to therapist). This finding suggests that therapists who indicate higher dependency needs also indicate less interpersonal distance in their interactions with clients.

It is also important to note that the bivariate correlations between therapist and client SASB ratings were relatively low when they were rating the same person (e.g., client and therapist ratings of therapist’s affiliation toward the client) as well as when they were rating the same quality (e.g., therapist affiliation and client affiliation in-session). In other words, therapists and clients had markedly different perspectives on the interactions occurring within their therapy sessions. Benjamin has suggested that complementary interactions are generally congruent (e.g., kind words tend to be responded to with kindness rather than hostility), so these low correlations seem to run in contradiction to her theory (Benjamin et al., 2006). It is difficult to know if correlations would increase over the course of therapy or the degree to which these low correlations are influenced by perspective bias, a phenomena that has been thoroughly documented in the working alliance literature (e.g., Horvath & Symonds, 1991).

**Limitations**

Three major limitations are of note and bear further discussion as to how they may have influenced the findings. These weaknesses include: (1) restricted range of clinical severity in the client sample, (2) limited statistical power to detect small effect sizes, and (3) lack of outcome measures in the model tested. The subsequent section will discuss each of these factors in greater detail.
Restricted Clinical Severity. One limitation of the current study is the restricted clinical severity of the client participants. The client sample was drawn from a population of university students at an academically rigorous institution. While many students present to university counseling centers with significant distress and impairment, it is reasonable to assume that this clientele is also relatively high functioning in comparison to the clients seen in other settings. Further, the great majority of therapist participants were master’s or doctoral students whose clients had been screened by a clinical services director as appropriate for a therapist-in-training. Additionally, when possible, the most severely impaired clients are referred from their initial consultation session to private practitioners with the idea that these clients had issues more appropriate for long-term therapy. Another sampling consideration is client self-selection. Though it is difficult to derive the consent rate of clients for the study, it is estimated that only about 30-35% of eligible clients joined the study. The current client sample likely represents clients who are more open to new experiences or feel more comfortable with the counseling process. Further, of the clients who consented, several did not attend four therapy sessions to be eligible to complete measures of the interpersonal process and therapy relationship. It could be that these clients who terminated therapy prior to the fourth session were not having their needs met in some way, resulting in early termination. Alternatively, these clients may have had their needs met prior to session four. Also, nine clients did complete four therapy sessions but did not complete the second portion of the survey. It is not clear how the results may have been different if these clients had continued in the study.

As noted earlier, there were no differences in general attachment anxiety and avoidance between client participants who completed the second half of the study and
those clients who remained in therapy but did not completed the second half of the study. No group differences were present in client general attachment avoidance between clients who completed both portions of the study and clients who terminated therapy prior to session four. Clients who completed the survey in its entirety indicated higher general attachment anxiety than those clients who terminated therapist prior to the fourth session, though this relation approached but did not attain conventional levels of significance. With regard to therapist interpersonal process ratings, there was one significant difference and one difference that approached, but did not attain, conventional levels of significance. First, therapists rated clients who completed the study as significantly more affiliative than those clients who did not. Second, therapists rated their own autonomy higher in dyads where clients completed the study in comparison to dyads in which clients initially agreed to participate but then did not complete the second half of the survey, though this relation did not reach a conventional level of significance. Thus, clients who completed both sections of the survey were seen as warmer by their therapist and had therapists who offered less enmeshed therapy relationships than clients who initially consented to participate but then did not finish the second set of questionnaires following session four.

Even though the sample was somewhat restricted in terms of range of client attachment insecurity, it is important to note that means and standard deviations on the types of attachment to therapist were comparable to other studies (e.g., Mallinckrodt et al., 1995, 2005; Romano et al., 2008). Although no previous psychotherapy studies have been published using the ECR-Short Form to measure attachment anxiety and avoidance, comparisons can be made to the long form because each short form subscale is highly
correlated \( (r = .95) \) with the original subscale. The means and standard deviations for therapist attachment anxiety and avoidance were comparable with the findings of Romano et al. For client attachment anxiety and avoidance, the current study found slightly higher attachment insecurity than two studies that sampled volunteer clients (Woodhouse & Gelso, 2008; Romano et al., 2008). Although restriction of range in client attachment insecurity may have a factor in generalizing the research to community settings, the current study is comparable to other psychotherapy research in university counseling centers and training clinics.

Limited Statistical Power. Statistical power was limited and likely contributed to lack of findings. Based on the results of a power analysis (Soper, n.d.) prior to data collection, 73 pairs were needed to observe medium effects. Although several modifications were made to study procedures in order to increase client participation, the sample remained limited and only 52 pairs of therapists and clients participated. With this sample size, moderately large effect sizes were detectable, but it is possible that small and medium effects were present but undetected. For example, therapist general attachment anxiety explained 8\% of the variance in secure attachment to therapist ratings but this effect did not attain conventional levels of significance. Further, because of limited statistical power, it was very difficult to detect interaction effects with small effect sizes. For example, it was hypothesized that the interaction between client general attachment avoidance and client ratings of therapist affiliation would significantly predict ratings of attachment security in therapy. Although the effect size was respectable \( (sr^2 = .06) \), the finding did not attain conventional levels of significance \( (p = .109) \).
Lack of Indicators of Outcome. The final major weakness of the current study is the lack of outcome measures in the general design. Though significant relations were detected between therapist and client general attachment, interpersonal process ratings, and client attachment to therapist, it is impossible to assess the impact of these relations on the client’s treatment outcome because session outcomes and treatment outcomes were not assessed. Further, because the current study only tracks clients early in therapy and at only two time points, there is no way to examine change trajectories.

Research Implications

Several implications of the study for future research will be discussed in this section. First, future research should be conducted to explore the impact of therapist and client attachment as well as the nature of the attachment relationship in therapy on client outcome. Although it could be assumed that client general attachment would have the highest association to client ratings of attachment to therapist, results of the current study suggest that therapist attachment and not client attachment is predictive of attachment to therapist. Thus, future studies perhaps could include measures of therapist attachment in order to better understand the dynamics that contribute to the various types of client attachment to therapist. Several studies (Rudy et al., 1985; Henry et al., 1986; Henry et al., 1993; Schut et al., 2005) have found that disaffiliation in therapy, even in very small amounts, is negatively related to outcome and is associated with increased symptomatology. Given the connections made in the current study between attachment constructs and interpersonal process ratings, future research might address which aspects of attachment are directly related to outcome. Because the current study identified significant relations between affiliative behaviors and secure client attachment to
therapist as well as significant negative relations between affiliation and avoidant-fearful client attachment to therapist, next research steps could include examining the differential outcomes of clients with the three types of attachment to therapists. Also, with the inclusion of an outcome measure such as a symptom rating or measure of well-being, these attachment constructs will be better connected to the broader psychotherapy process-outcome research already conducted. In addition, because therapist general attachment was significantly related to interpersonal process ratings of affiliation and autonomy as well as the nature of client attachment to therapist, future research could further consider therapist contributions to the nature and quality of the therapeutic relationship.

Although some greater understanding of secure and avoidant-fearful attachment to therapist was developed through the current study, much is yet to be learned about preoccupied-merger client attachment to therapist. None of the variables examined including client and therapist general attachment anxiety or client ratings of autonomous behaviors uniquely predicted variance in preoccupied-merger attachment to the therapist, although Preoccupied-Merger attachment to the therapist was negatively correlated to client ratings of therapist autonomy. Also, the positive link between Preoccupied-Merger attachment to the therapist and therapist general attachment anxiety approached but did not attain conventional levels of significance. These results were suggestive and it may be that clients in therapy relationships with therapists who are high in attachment anxiety perceive their therapists’ needs for closeness and reassurance, responding with dependency needs of their own. The alternative explanation that therapists grow in attachment anxiety in the presence of clients high on Preoccupied-Merger attachment to
the therapist is unlikely given that general attachment was measured prior to the first session. Thus, one is left to wonder if clients in psychotherapy relationships with therapists high in attachment anxiety feel that their needs are being met given their pull to respond to their therapists’ interpersonal style. Clearly future research is needed to better understand the preoccupied-merger therapy relationship.

Third because this study had therapy dyads rate their relationships after four sessions, future researchers could consider including additional assessment points to see whether these relations hold and if these constructs are related to measures of client outcomes. An additional benefit of additional time points is the possibility of examining meaningful change in client general attachment anxiety and avoidance over the course of therapy. Further, future studies could examine critical events in therapy that contribute to changes in client attachment. It would also be interesting to see if interpersonal process ratings shifted over time as the psychotherapy dyad ideally develops a healthier, corrective therapy relationship than other core attachment relationships in the client’s life.

Finally, the models under examination in the current study could have been conceptualized as a series of mediation models with interpersonal process ratings mediating the relations between general attachment dimensions and client attachment to therapist. With a larger sample, the influence of individual differences such as age and gender could have also been accounted for in the proposed models.

Practice Implications

The findings provide several implications for clinical practice, particularly the key attachment and interpersonal process factors that relate to the attachment relationships that develop in therapy. First, this study sheds light on the components that contribute to
the development of a secure attachment to therapist, a relationship in which the client feels safe and trusts the therapist with difficult experiences and hurts. This type of attachment relationship is one in which the client views the therapist as empathic, genuine, and offering positive regard. Two important factors that contributed to attachment security in the therapy relationship were therapist characteristics. First, client ratings of therapist affiliative behaviors in session were significantly related to secure attachment to therapist. Also, there may be an inverse relation between therapist general attachment anxiety and secure attachment to therapist (although the result only approached conventional levels of significance in the present study). Thus, it would appear that clients were attending to the relational patterns of their therapists, either consciously or unconsciously.

Links between the interpersonal process ratings of affiliation and secure client attachment to therapist point to the importance of developing a positive, warm, and supportive environment and working relationship. This finding is very consistent with research showing that therapist empathy and positive regard appear to be important in the effectiveness of psychotherapy relationships (Norcross, 2002). Clients, in turn, may respond to therapist-offered affiliation by relaxing themselves, expressing themselves clearly, trusting, and learning from their therapist, qualities present on the affiliative sides of the SASB surfaces (Benjamin, 2000).

It is important to note, however, that client characteristics may interact with therapist characteristics, such as therapist affiliation, in determining client attachment to the therapist. Specifically, it appeared that client attachment anxiety may interact with therapist affiliation such that only those who are low in attachment anxiety, and not those
who are high in attachment anxiety, show greater security of attachment to the therapist when the therapist is high on affiliation. Because the benefit of a highly affiliative therapist in developing a secure attachment to therapist did not translate to clients who had higher levels of attachment anxiety, there may be other factors that are important for clients who are high on general attachment anxiety. For example, it may be that therapist affiliation is important in establishing a safe, trusting therapeutic alliance but it may not be enough to counteract the relational expectancies of the client high in attachment anxiety. It may be that other relational qualities, such as therapists’ capacity for autonomy, are be more influential for clients high in attachment anxiety in developing a secure attachment to their therapists. For example, Dozier et al. (1994) found that insecure case managers tended to respond to the dependency needs of clients high in attachment anxiety, intervening more deeply than secure case managers who provided non-complementary responses that promoted client autonomy. The presence of interactions between therapist and client characteristics may lead some clinicians to suggest that therapy dyads should be paired based on these qualities. Although the results certainly display the importance of therapist characteristics on the therapy relationship, it is difficult to determine if these interactions remain after the fourth session and if they eventually impact client outcome. Thus, the present study does not suggest that therapists and clients should be matched, rather that both members bring important characteristics to the relationship.

Findings also suggest that it may be important for clinicians to have worked through their own attachment insecurity. Specifically, therapist may need to work through their fears of abandonment and desires for closeness, as these dynamics appear to
contribute to the type of therapy relationship that develops with clients because clients with therapists high in general attachment anxiety may tend to have a less secure attachment to their therapists. In a similar vein, supervisors should attend to their supervisees’ pulls toward excessive closeness and sensitivity to rejection as these characteristics may be related to attachment anxiety and may influence the degree of attachment security and preoccupied-merger attachment that the client experiences toward the supervisee. When supervisors observe such indicators either in the supervisees’ therapy work or in their own supervisory sessions, the supervisors can help their supervisees to explore these dynamics.

Next, much work remains to be done to better understand the factors that contribute to a preoccupied-merger attachment to therapist, although the current study did provide some tentative indicators. First, a relation was suggested between therapist general attachment anxiety and preoccupied-merger attachment to therapist (though this relation approached but did not attain conventional levels of significance). Thus, therapists who have the desire for extreme closeness as well as fears of rejection in their own attachment relationships may have therapy relationships in which their clients tend to endorse these same qualities. As mentioned previously, such findings suggest that therapists who recognize a degree of attachment insecurity in themselves should consider participating in their own psychotherapy to work through these deep-seated patterns and expectancies as typical clinical training alone is unlikely to shift one’s own attachment style.

Finally, the study provides insights into the features that may play a role in avoidant-fearful attachment to therapist. Client general attachment avoidance was
positively related to avoidant-fearful attachment to therapist. Given that avoidant-fearful attachment to therapist also was related to lower levels of client ratings of their own affiliation in session, therapists may want to be mindful that clients high in general attachment avoidance perhaps perceive the therapy relationship as a somewhat hostile environment and may experience a degree of mistrust in comparison to clients with low attachment avoidance. These clients may be particularly sensitive to therapist behaviors that could be perceived as judging or critical. As a result, therapists may want to make concerted efforts to develop an affiliative, trusting, secure environment for clients who present with even moderate degrees of general attachment avoidance.
Appendix A

Client Demographic Form

Age  _____ Years

Sex  _____ Female
      _____ Male
      _____ Transgender

Year in School
      _____ Freshman
      _____ Sophomore
      _____ Junior
      _____ Senior
      _____ Other

Race (check all that apply)
      _____ Black/African American
      _____ Asian/Asian American/Pacific Islander
      _____ White/European American
      _____ Hispanic/Latino/a
      _____ Native American
      _____ Middle Eastern
      _____ Other (please specify__________________)

Prior Experience in Counseling?
      _____ No
      _____ Yes

If yes, what kind (check all that apply):
      _____ Individual
      _____ Group
      _____ Family
      _____ Couple
Appendix B

Therapist Demographic Form

Age _______ Years

Sex _______ Female
_____ Male
_____ Transgender

Race (check all that apply)
_____ Black/African American
_____ Asian/Asian American/Pacific Islander
_____ White/European American
_____ Hispanic/Latino/a
_____ Native American
_____ Middle Eastern
_____ Other (please specify__________________)

Degree Program
_____ Masters
_____ Doctoral

Approximately how many clients have you counseled? ______ clients

Approximately how many semesters of practicum experience have you had (prior to this semester)? _____ semesters

What is the highest degree you have achieved?
_____ Bachelor's
_____ Master's
_____ Doctorate

How much do you currently believe in and follow each of the following theoretical frameworks?

<table>
<thead>
<tr>
<th>Framework</th>
<th>do not believe in or follow</th>
<th>believe in and follow</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychoanalytic/psychodynamic</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>cognitive/behavioral</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>humanistic/experiential</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>feminist/multicultural</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Appendix C

Experiences in Close Relationship
Scale-Short Form (ECR-S)

The following statements concern how you feel in close relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Select the appropriate number, using the following rating scale:

1  2  3  4  5  6  7
Disagree Neutral/ Agree
Strongly Mixed Strongly

1. It helps to turn to my romantic partner in times of need.
2. I need a lot of reassurance that I am loved by my partner.
3. I want to get close to my partner, but I keep pulling back.
4. I find that my partner(s) don't want to get as close as I would like.
5. I turn to my partner for many things, including comfort and reassurance.
6. My desire to be very close sometimes scares people away.
7. I try to avoid getting too close to my partner.
8. I do not often worry about being abandoned.
9. I usually discuss my problems and concerns with my partner.
10. I get frustrated if romantic partners are not available when I need them.
11. I am nervous when partners get too close to me.
12. I worry that romantic partners won't care about me as much as I care about them.
Appendix D

SASB Intrex Questionnaire-Short Form

This instrument was excluded due to copyright.
Appendix E

Client Attachment to Therapist Scale (CATS)

These statements relate to how you CURRENTLY feel about your counselor. Please try to respond to every item using the scale below to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Disagree</td>
<td>Somewhat Disagree</td>
<td>Slightly Disagree</td>
<td>Slightly Agree</td>
<td>Somewhat Agree</td>
<td>Strongly Agree</td>
</tr>
</tbody>
</table>

1. I don’t get enough emotional support from my counselor.
2. My counselor is sensitive to my needs.
3. I think my counselor disapproves of me.
4. I yearn to be “at one” with my counselor.
5. My counselor is dependable.
6. Talking over my problems with my counselor makes me feel ashamed or foolish.
7. I wish my counselor could be with me on a daily basis.
8. I feel that somehow things will work out OK for me when I am with my counselor.
9. I know I could tell my counselor anything and s/he would not reject me.
10. I would like my counselor to feel closer to me.
11. My counselor isn’t giving me enough attention.
12. I don’t like to share my feelings with my counselor.
13. I’d like to know more about my counselor as a person.
14. When I show my feelings, my counselor responds in a helpful way.
15. I feel humiliated in my counseling sessions.
16. I think about calling my counselor at home.
17. I don’t know how to expect my counselor to react from session to session.
18. Sometimes I’m afraid that if I don’t please my counselor, s/he will reject me.
19. I think about being my counselor’s favorite client.
20. I can tell that my counselor enjoys working with me.
21. I suspect my counselor probably isn’t honest with me.
22. I wish there were a way I could spend more time with my counselor.
23. I resent having to handle problems on my own when my counselor could be more helpful.
24. My counselor wants to know more about me than I am comfortable talking about.
25. I wish I could do something for my counselor too.
26. My counselor helps me to look closely at the frightening or troubling things that have happened to me.
27. I feel safe with my counselor.
28. I wish my counselor were not my counselor so that we could be friends.
29. My counselor is a comforting presence to me when I am upset.
30. My counselor treats me more like a child than an adult.
31. I often wonder about my counselor’s other clients.
32. I know my counselor will understand the things that bother me.
33. It’s hard for me to trust my counselor.
34. I feel sure that my counselor will be there if I really need her/him.
35. I’m not certain that my counselor is all that concerned about me.
36. When I’m with my counselor, I feel I am his/her highest priority.
Appendix F

Cedar Clinic Client Consent Form

Informed Consent Form for Social Science Research—CEDAR Client Form The Pennsylvania State University

Title of Project: An Examination of the Interpersonal Process of Psychotherapy

Principal Investigator: Jennifer Hardy, Graduate Student
132 Career Services Center
University Park, PA 16802
(814) 933-6520; jah1066@sa.psu.edu

Advisor: Dr. Susan Woodhouse
313 Cedar Building
University Park, PA 16802
(814) 863-5726; ssw10@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to explore how relational styles impact the therapy relationship that develops.

2. **Procedures to be followed:** Prior to your first appointment with your therapist, you will be asked to answer 19 questions on a survey. You will receive a reminder email as you approach your fourth session with your therapist. Following your 4th session, you will receive an email linking you to an online survey that asks questions regarding your relationship with your therapist (totaling 81 questions). Please try to complete the survey by the end of the same day.

3. **Duration:** It will take about 5 minutes to complete the initial survey. It will take approximately 10-15 minutes to complete the second survey at the end of your fourth session.

4. **Statement of Confidentiality:** Your participation in this research is confidential. The data will be stored in a locked file in a locked office and/or in a password protected computer file. Only Jennifer Hardy will have access to identifying information and this information will be stored separately from your survey answers. Your confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties. Your therapist will not have access to any of your responses. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

5. **Right to Ask Questions:** Please contact Jennifer Hardy at (814) 933-6520 or jah1066@sa.psu.edu with questions or concerns about this study.
6. **Payment for participation:** You will receive a $10 Amazon.com gift certificate after completing surveys at the end of the 4th session with your therapist. These gift certificates will be distributed via email (to the email address provided below) within 72 hours of survey completion.

7. **Voluntary Participation:** Your decision to be in this research is voluntary and will not impact the services you receive at the Cedar Clinic. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this form for your records.

Please check one of the boxes:

- [ ] Yes, I am interested in participating.
- [ ] No, I am not interested in participating.

______________________________________________  __________________
Participant Signature                              Date

______________________________________________
Participant Printed Name

______________________________________________
Participant Email Address (in order to send out reminder emails)

______________________________________________  __________________
Person Obtaining Consent                           Date
Appendix G

CAPS/Cedar Client Implied Consent Form

Informed Consent Form for Social Science Research—Client Form The Pennsylvania State University

Title of Project: An Examination of the Interpersonal Process of Psychotherapy

Principal Investigator: Jennifer Hardy, Graduate Student
132 Career Services Center
University Park, PA 16802
(814) 865-4654; jah1066@psu.edu

Advisor: Dr. Susan Woodhouse
313 Cedar Building
University Park, PA 16802
(814) 863-5726; ssw10@psu.edu

1. Purpose of the Study: The purpose of this research study is to explore how relational styles impact the therapy relationship that develops.

2. Procedures to be followed: Prior to your first appointment with your therapist, you will be asked to answer 19 questions on an online survey. You will receive a reminder email as you approach your fourth session with your therapist. During your 4th session, your therapist will give you a second packet of questionnaires regarding your relationship with your therapist (totaling 81 questions). Please complete and return these by the end of the day to the Cedar Clinic receptionist (who will place it in a locked box).

3. Duration: It will take about 5 minutes to complete the initial survey. It will take approximately 10-15 minutes to complete the second survey at the end of your fourth session.

4. Statement of Confidentiality: Your participation in this research is confidential. The data will be stored in a locked file in a locked office (132 Career Services) and/or in a password protected computer file. Only Jennifer Hardy will have access to identifying information and this information will be stored separately from your survey answers. Your confidentiality will be kept to the degree permitted by the technology used. No guarantees can be made regarding the interception of data sent via the Internet by any third parties. Your therapist will not have access to any of your responses. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.
5. **Right to Ask Questions:** Please contact Jennifer Hardy at (814) 865-4654 with questions or concerns about this study.

6. **Payment for participation:** You will receive a $10 Amazon.com gift certificate after completing surveys at the end of the 4th session with your therapist. These gift certificates will be distributed via email (to the email address provided below) within 72 hours of survey completion.

7. **Voluntary Participation:** Your decision to be in this research is voluntary and will not impact the services you receive at the Cedar Clinic. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. Completion and return of the survey implies that you have read the information in this form and consent to take part in the research. Please keep this form for your records or future reference.
Appendix H

Cedar Clinic Therapist Consent Form

Informed Consent Form for Social Science Research-Cedar Therapist Form- The Pennsylvania State University

Title of Project: An Examination of the Interpersonal Process of Psychotherapy

Principal Investigator: Jennifer Hardy, Graduate Student
132 Career Services Center
University Park, PA 16802
(814) 865-4654; jah1066@sa.psu.edu

Advisor: Dr. Susan Woodhouse
313 Cedar Building
University Park, PA 16802
(814) 863-5726; ssw10@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to explore how relational styles impact the therapy relationship that develops.

2. **Procedures to be followed:** You will be asked to answer 23 questions on an initial survey. Following the fourth session with each of your clients on your caseload, you will be asked to answer an additional 32 questions regarding your relationship with that client. You will receive a reminder email for each of these surveys (to the address provided below). You will receive and return these questionnaires in a sealed envelope to 106 Cedar (Marie Land’s office) by the end of the same day as your session.

Some of your clients will also be completing surveys as a part of the study. If you receive a client packet with your questionnaire, please give it to them at the beginning of the session. In either case, please complete and return your questionnaire by the end of the same day as your session in a sealed envelope to Jennifer Hardy’s mailbox in 106 Cedar.

In summary, you will complete an initial survey. Then, you will complete a survey immediately following the fourth session with each of your clients on your caseload. You will return all survey materials to Jennifer Hardy’s mailbox in 106 Cedar.

3. **Duration:** It will take about 5 minutes to complete the initial survey. It will take approximately 5 minutes to complete each survey at the end of your fourth session with each client. For example, if you have five clients who reach their fourth session, you will spend approximately 30 minutes completing surveys.
4. **Statement of Confidentiality:** Your participation in this research is confidential. The data will be stored in a locked file in a locked office (132 Career Services) and/or in a password protected computer file. Only Jennifer Hardy and Marie Land will have access to identifying information and this information will be stored separately from your survey answers. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

5. **Right to Ask Questions:** Please contact Jennifer Hardy at (814) 865-4654 with questions or concerns about this study.

6. **Payment for participation:** You will receive $10 at the end of each semester of participation (up to 2 semesters).

7. **Voluntary Participation:** Your decision to be in this research is voluntary and will not impact practicum evaluations. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this form for your records.

Please check one of the boxes:

- [ ] Yes, I am interested in participating.
- [ ] No, I am not interested in participating.

______________________________________________ ________________
Participant Signature Date

______________________________________________
Participant Printed Name

______________________________________________
Participant Email Address (in order to send out reminder emails)

______________________________________________ ________________
Person Obtaining Consent Date
Appendix I

CAPS Therapist Consent Form

Title of Project: An Examination of the Interpersonal Process of Psychotherapy

Principal Investigator: Jennifer Hardy, Graduate Student
132 Career Services Center
University Park, PA 16802
(814) 865-4654; jah1066@sa.psu.edu

Advisor: Dr. Susan Woodhouse
313 Cedar Building
University Park, PA 16802
(814) 863-5726; ssw10@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to explore how relational styles impact the therapy relationship that develops.

2. **Procedures to be followed:** You will be asked to answer 23 questions on an initial survey. Following the fourth session with each of your clients on your caseload, you will be asked to answer an additional 32 questions regarding your relationship with that client. You will receive a reminder email for each of these surveys (to the address provided below). You will receive these questionnaires in your CAPS mailbox.

   Some of your clients will also be completing surveys as a part of the study. If you receive a client packet with your questionnaire, please give it to them at the beginning of the session. In either case, please complete and return your questionnaire by the end of the same day as your session in a sealed envelope to Jennifer Hardy’s mailbox at CAPS.

   In summary, you will complete an initial survey. Then, you will complete a survey immediately following the fourth session with each of your clients on your caseload. You will return all survey materials to Jennifer Hardy’s mailbox.

3. **Duration:** It will take about 5 minutes to complete the initial survey. It will take approximately 5 minutes to complete each survey at the end of your fourth session with each client. For example, if you have five clients who reach their fourth session, you will spend approximately 30 minutes completing surveys.
4. **Statement of Confidentiality:** Your participation in this research is confidential. The data will be stored in a locked file in a locked office (132 Career Services) and/or in a password protected computer file. Only Jennifer Hardy will have access to identifying information and this information will be stored separately from your survey answers. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

5. **Right to Ask Questions:** Please contact Jennifer Hardy at (814) 865-4654 with questions or concerns about this study.

6. **Payment for participation:** You will receive $10 at the end of each semester of participation (up to 2 semesters).

7. **Voluntary Participation:** Your decision to be in this research is voluntary and will not impact any CAPS evaluations. You can stop at any time. You do not have to answer any questions you do not want to answer.

You must be 18 years of age or older to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below.

You will be given a copy of this form for your records.

Please check one of the boxes:

- [ ] Yes, I am interested in participating.
- [ ] No, I am not interested in participating.

______________________________________________  ____________________
Participant Signature                                      Date

_____________________________________________________
Participant Printed Name

_____________________________________________________
Participant Email Address (in order to send out reminder emails)

______________________________________________  ____________________
Person Obtaining Consent                                     Date
Appendix J

Initial Client Recruitment Email Script

You are eligible to participate in a research study being conducted at Penn State exploring how relational styles impact the therapy relationship that develops. You can click on the link below to view the consent form and complete the initial questionnaire (19 items).

https://www.psychdata.com/s.asp?SID=125499
Or, go to www.psychdata.com and enter 125499 where it says “Go to Survey #”

Your ID when completing the survey is [insert ID number].

In addition to this initial questionnaire, you will be asked to complete a second online questionnaire immediately following your 4th session with your therapist (81 questions). It will take about 5 minutes to complete the initial survey and 10-15 minutes to complete the second survey at the end of your fourth session.

Your participation in this research is voluntary and confidential. Your therapist will not know whether you decide to participate and will not have access to any of your responses. You can stop at any time. You do not have to answer any questions you do not want to answer.

You will receive a $10 Amazon.com gift certificate via email after completing surveys at the end of the 4th session with your therapist. Jennifer Hardy is the primary investigator for the research study. You can contact her at jah1066@sa.psu.edu with questions or concerns.

Thanks!
Appendix K

Final Client Recruitment Email Script

Finally, you qualify for a Penn State research study being conducted at our clinic. To find out more about the research study and see if you would like to participate, click on this link to view the consent form:

https://www.psychdata.com/s.asp?SID=125430. Your ID when completing the survey is [Insert ID].

This research study is completely voluntary and confidential. As a thank you for completing the research study, you will receive a $10 Amazon.com gift certificate. If you have questions, you can contact Jennifer Hardy at (814) 933-6520.

Thanks!
Appendix L

Therapist Recruitment Script

You have the opportunity to participate in a research study being conducted at Penn State regarding the interpersonal process of psychotherapy. Your participation is completely voluntary and confidential. Your decision to participate will not impact any practicum evaluations. All of your surveys will be coded with a unique ID number in order to ensure your confidentiality.

You can review the informed consent form now and return it to me. Please indicate your interest by checking “yes” or “no.” If you are interested in participating, please complete and return the 2 surveys attached within the next couple of days. You can return them to my mailbox in the Cedar Clinic Office in a sealed envelope.

Also, you will receive an additional instrument to complete after the fourth session with each of your clients on your caseload. In the questionnaires, you will be asked rate your relationship with that particular client. Please complete this by the end of the same day of the session. I will send you a reminder email prior to each of these sessions to help you remember to complete the questionnaire.

For compensation, you will receive $10 at the end of each semester of participation, up to 2 semesters. Please do not hesitate to contact me with questions. Are there any questions now?
Appendix M:

Therapist Initial Paperwork Reminder Email Script

This is a reminder that you agreed to participate in a research study being conducted at Penn State regarding therapy relationships. On your consent form you indicated interest in participating, but I have not received your initial questionnaires. Please complete and submit these materials to Jennifer Hardy’s mailbox at [insert location as either locked mailbox in CAPS mailroom or mailbox in Cedar Clinic Office]. If you need additional forms, please let me know via email. If you have decided not to participate, please indicate that via email as well.

Thanks!

Jennifer Hardy
Appendix N

Client Recruitment Reminder Script

I just wanted to let you know that you still have time to participate in this Penn State research study. Click on this link to find out more about the research study and see if you would like to participate:

https://www.psychdata.com/s.asp?SID=125430  Your ID when completing the survey is 349.

As noted before, this research study is completely voluntary and confidential. As a thank you for completing the research study, you will receive a $10 Amazon.com gift certificate. If you have questions, you can contact Jennifer Hardy at (814) 933-6520.

Thanks!
Appendix O:

Client Upcoming Fourth Session Email Script

This is a reminder that you agreed to participate in a research study being conducted at Penn State regarding therapy relationships. You are scheduled for your fourth session with your therapist this week. You will receive an email containing a link to a set of online questionnaires to complete following your next session. Please try to complete the survey the same day as your session. The research survey should take approximately 10-15 minutes and you will receive a $10 online gift certificate to Amazon.com after completing the survey.

Please contact me with any questions regarding this process (jah1066@sa.psu.edu).

Thanks!

Jennifer Hardy
Appendix P

Therapist Upcoming Fourth Session Email Script

This is a reminder that you agreed to participate in a research study being conducted at Penn State regarding therapy relationships. You will be receiving a questionnaire to complete following your session scheduled for ____ [insert day and date] at ________ [insert time]. You will find this questionnaire in [insert location].

Please contact me with any questions regarding this process (jah1066@sa.psu.edu).

Thanks!

Jennifer Hardy
Appendix Q

Client Fourth Session Survey Link Email Script

This is a reminder that you agreed to participate in a research study being conducted at Penn State regarding therapy relationships. Here is the link to complete the second set of surveys regarding your relationship with your therapist. You can complete the surveys online using this link:

https://www.psychdata.com/s.asp?SID=125906

Or, go to www.psychdata.com and enter 125906 where it says “Go to Survey #”

Your ID when completing the survey is [insert ID number].

The research survey should take approximately 10-15 minutes and you will receive a $10 online gift certificate to Amazon.com after completing the survey.

If you have questions, please contact me at jah1066@sa.psu.edu.

Thank you!

Jennifer Hardy
Appendix R

Client Reminder to Complete Second Survey Email Script

I did not yet receive your completed research surveys. If you are still interested in participating, you can complete the surveys online using this link:

https://www.psychdata.com/s.asp?SID=125500

Or, go to www.psychdata.com and enter 125500 where it says “Go to Survey #”

Your ID when completing the survey is 349.

If you have completed and returned the survey, please disregard this email. If you have questions, please contact me at jah1066@sa.psu.edu or 814.865.4654.

Thank you!

Jennifer Hardy
Figure Captions


Copyright: The Guilford Press.
Figure 1

INTERPERSONAL
TRANSITIVE-FOCUS ON OTHER

1-7 ATTACKING AND REJECTING

1-6 BELITTLING AND BLAMING

1-5 WATCHING AND CONTROLLING

1-4 NURTURING AND PROTECTING

1-3 LOVING AND APPROACHING

1-2 AFFIRMING AND UNDERSTANDING

1-1 FREEING AND FORGETTING

1-8 IGNORING AND NEGLECTING

INTERPERSONAL
INTRANSITIVE-FOCUS ON SELF

2-8 WALLING OFF AND DISTANCING

2-7 PROTESTING AND RECOLING

2-6 SULKING AND SCURRYING

2-5 DEFERRING AND SUBMITTING

2-4 TRUSTING AND RELYING

2-3 JOYFULLY CONNECTING

2-2 DISCLOSING AND EXPRESSING

2-1 ASSERTING AND SEPARATING

INTRAPSYCHIC
INTRODUCTION

3-7 SELF-REJECTING AND DESTROYING

3-6 SELF-INDICTING AND OPPRESSING

3-5 SELF-MONITORING AND RESTRAINING

3-4 SELF-NOURISHING AND ENHANCING

3-3 SELF-LOVING AND CHERISHING

3-2 SELF-ACCEPTING AND EXPLORING

3-1 SPONTANEOUS SELF

3-0 DAYDREAMING AND NEGLECTING OF SELF

3-0 SELF-REJECTING AND DESTROYING
References


predictor of change in patients’ important relationships during time-limited
dynamic psychotherapy. *Psychotherapy: Theory, Research, Practice, and
Training, 42*, 279-284.

392-425.

Research, 3*, 1-24.

psychology. *Psychological Inquiry, 5*, 273-316.

Structural analysis of social behavior (SASB). *Journal of Personality, 66*, 248-266.

Benjamin, L. S. (2000). *The Intrex users’ manual*. Salt Lake City: University of Utah,
Department of Psychology.

analysis of social behavior (SASB) as an assessment tool. *Annual Review of
Clinical Psychology, 2*, 83-109.

Beretta, V., Despland, J., Drapeau, M., Michel, L., Kramer, U., Stigler, M., & de Roten,
Y. (2007). Are relationship patterns with significant others reenacted with the
therapist? *Journal of Nervous and Mental Disease, 195*, 443-450.

Black, S., Hardy, G., Turpin, G., & Parry, G. (2005). Self-reported attachment styles and


attachment style: Circumplex descriptions, recalled developmental experiences, self-representations, and interpersonal functioning in adulthood. *Journal of Personality, 7*, 141-182.


Levy, K. N., Kelly, K. M., Meehan, K. B., Reynoso, J. S., Clarkin, J. F., Kernberg, O F.,


Mallinckrodt, B. (2000). Attachment, social competencies, social support, and
interpersonal process in psychotherapy. *Psychotherapy Research, 10,* 239-266.


mediating roles of psychological distress and perceived social support. *Journal of Counseling Psychology, 52*, 347-357.


VITA

Jennifer A Hardy, M.A.
jenenniferhardy@gmail.com

Education
Ph.D. Counseling Psychology, The Pennsylvania State University, University Park, PA
August 2010
Dissertation Defended: May 2010

M.A. Community Counseling, Ball State University, Muncie, IN
August 2004

B.S. Psychology, Indiana Wesleyan University, Marion, Indiana
May 2002

Work Experience
Pre-doctoral Intern in Professional Psychology, August 2009-August 2010
Counseling and Psychological Services, The Pennsylvania State University

Career Counseling Graduate Assistant, August 2007-August 2009
Career Services, The Pennsylvania State University

Senior Research Assistant, September 2004-July 2006
Rehabilitation Institute of Michigan, Detroit, MI

Publications


Selected Presentations


Grants
Alumni Society Graduate Student Research Initiation Grant Award Winner, 2008
Penn State University, College of Education