THE DEVELOPMENT OF ATTACHMENT TO THE THERAPIST: A MIXED METHODS CASE STUDY

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by

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Attachment to the therapist is a relatively new area of psychotherapy research. While research has shown that clients can and do form attachments to their therapists (e.g., Mallinckrodt, Gantt, & Coble, 1995) it is unclear how and to what end these attachments develop. This study utilized a longitudinal mixed-methods case study design to examine how attachment to the therapist developed in brief (six-session) psychotherapy for a client with Major Depressive Disorder and Social Phobia. Multiple perspectives (client, therapist, observer) were considered. Associations between attachment to the therapist and client depressive and social anxiety symptoms were also explored. Task analysis was utilized to generate a model of the development of secure attachment to the therapist. Two phases of attachment development were identified in the rational-empirical model, including “pre-attachment” and “attachment-in-the-making.” Key behavioral, cognitive, and emotional tasks were identified for each phase. Quantitative findings showed a direct relationship between both secure and preoccupied-merger attachment to the therapist and depressive symptoms. An inverse relationship between both secure and preoccupied-merger attachment to the therapist and social anxiety symptoms was also found. Finally, fearful-avoidant attachment to the therapist was inversely related to depressive symptoms and not related to social anxiety symptoms. Qualitative and quantitative results indicated that secure attachment to the therapist developed rapidly in this case. Data suggested that the development of this attachment was aided by the therapist consistently serving as a safe haven and secure base for the client, and the client using the therapist as a safe haven and secure base. Implications for training, research, and practice are discussed.
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Chapter 1

Introduction

Bowlby’s (1982) attachment theory was originally developed to explain the nature of a child’s bond to his or her caretaker. This theory posits that when a caregiver consistently responds congruently to a child’s needs, the child develops a secure attachment to the caregiver. In contrast, when a caregiver is inconsistently responsive, or does not provide responses that are congruent with the child’s needs, the child develops an insecure attachment to the caregiver. Over time, based on interactions with caregivers, the child develops enduring expectations about the physical and emotional availability of his or her caregivers that are encoded as mental representations, or internal working models, of self and others (Bowlby, 1982). These internal working models are theorized to become resistant to change over time as they are reinforced by similar experiences and influence an individual’s expectations and beliefs about others in future relationships (Bowlby, 1982). Main, Kaplan, and Cassidy (1985) have provided empirical support for the existence of internal working models in children.

Internal working models are also theorized to influence the ways in which individuals interact in different types of adult relationships, including romantic relationships (e.g., Hazan & Shaver, 1987) and therapeutic relationships (e.g., Bowlby, 1988). Researchers have provided empirical support for the idea of working models in romantic relationships (Bartholomew & Horowitz, 1991; Collins & Read, 1990, 1994) and psychotherapy relationships (Mallinckrodt, Gantt, & Coble, 1995; Parish & Eagle, 2003a).

Conceptualizations of Adult Attachment

Attachment in adulthood has been conceptualized in both categorical and dimensional ways over time. Early approaches to conceptualizing adult attachment used categorical methods
(e.g., Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987). However, more recent research has demonstrated that attachment can be more accurately conceptualized in terms of two dimensions, attachment anxiety and attachment avoidance (Brennan, Clark, & Shaver, 1998; Fraley & Waller, 1998). Attachment anxiety refers to a desire to merge with another person, a fear of interpersonal rejection, and the stress an individual faces when his or her attachment figure is unavailable. In contrast, attachment avoidance refers to an individual’s fear of dependence, discomfort with relying on another person for emotional support, and excessive need for self-reliance. Fraley and Waller empirically demonstrated that this dimensional approach to adult attachment more accurately captures the natural structure of attachment security and allows for greater detection of individual differences in attachment than categorical conceptualizations of attachment. *Global attachment* can be understood as an individual’s general attachment orientation, in terms of attachment anxiety and attachment avoidance, without respect to a particular person.

Many foundational studies about attachment were conducted prior to the identification of attachment dimensions and thus, a substantial amount of theoretical and empirical work utilized categorical conceptualizations of attachment. It is important to understand how to translate categorical and dimensional conceptualizations of attachment. Mikulincer, Shaver, and Pereg (2003) provided a method of translating the categorical language of attachment into dimensional language. 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).
Attachment, Interpersonal Functioning, and Depression

Bowlby (1988) asserted that individuals’ attachment experiences and internal working models ultimately influence their ability to engage in effective, functional interpersonal relationships and maintain optimal psychological health. Empirical research has provided support for both of these assertions. With regard to interpersonal functioning, multiple studies have found links between individuals’ levels of global attachment anxiety and avoidance and their interpersonal functioning (e.g., Haggerty, Hilsenroth, & Vala-Stewart, 2009; Wei, Mallinckrodt, Larson, & Zakalik, 2005). Empirical findings suggest that when individuals have either high global attachment anxiety or high global attachment avoidance, their ability to function effectively in relationships is diminished and they report, for example, struggles with relationship satisfaction (e.g., Horowitz, Rosenberg, & Bartholomew, 1993) and loneliness (e.g., Wei, Russell, & Zakalik, 2005).

In addition to providing a framework for understand individuals’ behaviors in interpersonal relationships, Bowlby (1980, 1988) theorized that attachment security provides a strong foundation for future mental health functioning. He emphasized that attachment insecurity is associated with an increased risk for psychopathology, including depression. Multiple studies have found that individuals with low global attachment anxiety and avoidance (i.e., secure), as opposed to individuals with high global attachment anxiety and/or avoidance (i.e., insecure), demonstrate lower levels of depression (e.g., Dickstein, Seifer, Albus, & Magee, 2004; Treboux, Crowell, & Waters, 2004). More specifically, global attachment anxiety has been linked to interpersonal aspects of depression (e.g., neediness) whereas global attachment avoidance has been linked to achievement-related aspects of depression (e.g., perfectionism) (e.g., Davila, 2001; Murphy & Bates, 1997). In summary, extant research supports Bowlby’s theory that attachment insecurity increases an individual’s risk for depressive psychopathology and also suggests that
depression may be experienced and exhibited differently depending on an individual’s levels of global attachment anxiety and avoidance.

**Attachment in Psychotherapy**

Bowlby (1988) theorized that the therapeutic relationship is an attachment relationship in which the therapist has the potential to serve as an attachment figure for the client. For example, the therapist, like a caregiver, is viewed as stronger and wiser (Bowlby, 1977a, 1977b, 1988) and the relationship is characterized by care-seeking (client) and care-giving (therapist). Further, Bowlby believed that when clients develop a secure attachment to the therapist, the therapist is able to assist clients in the difficult work of altering their internal working models. Bowlby further suggested that when clients develop a secure attachment to the therapist, they use the therapist as a secure base from which to explore the difference between new models of attachment (based on the relationship with the therapist) and older, internalized models (based on relationships with early caregivers). These insights, theoretically, lead to client change. Research has supported the idea that clients use their therapists as attachment figures (Mallinckrodt et al., 1995; Mallinckrodt, Porter, & Kivlinghan, 2005; Parish & Eagle, 2003a). Obegi (2008) has proposed a three-stage model of development of attachment to the therapist; while based on empirical findings, the model has yet to be empirically examined. Thus, additional research is needed to examine how secure attachment to the therapist develops over time and explore the idea that secure attachment to the therapist leads to client change.

Bowlby (1988) also theorized that psychotherapy triggers clients’ internal working models, as clients typically enter therapy with some level of distress that activates their attachment systems. Therefore, Bowlby believed that a client enters the therapeutic relationship expecting the therapist to relate to him or her in a manner similar to his or her early caregivers. Whereas clients with low global attachment anxiety and avoidance (i.e., secure) are therefore primed to expect positive, consistent interactions with the therapist, clients with high global
attachment anxiety and/or avoidance (i.e., insecure), who do not have such positive internal working models, may be primed to expect negative or inconsistent interactions with the therapist. These clients may be unable to quickly develop a strong bond with the therapist. Multiple empirical studies have examined the impact of clients’ global attachment anxiety and avoidance on the general process and outcome of psychotherapy. A considerable number of studies have found important links between client global attachment anxiety and avoidance and working alliance (e.g., Eames & Roth, 2000; Kivlinghan, Patton, & Foote, 1998; Mallinckrodt et al., 1995; Mallinckrodt et al., 2005), such that low global attachment anxiety and avoidance (i.e., attachment security) are positively related to working alliance while high global attachment anxiety and/or avoidance (i.e., attachment insecurity) are negatively related to working alliance. These findings highlight the difficulty clients with high global attachment anxiety and/or avoidance seem to face in developing a strong working alliance with the therapist. Further, a recent meta-analysis highlight links between clients’ global attachment anxiety and avoidance and outcome. Levy, Ellison, Scott, and Bernecker (2011) found that high client global attachment anxiety (i.e., preoccupied attachment) was negatively associated with outcome, whereas low client global attachment and avoidance (i.e., attachment security) was positively related to outcome. These results draw attention to the potential continued influence of clients’ preexisting internal working models on treatment outcome and change via psychotherapy. However, research has also suggested that significant changes in global 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, Meehan, Kelly, Reynoso, Weber, Clarkin, & Kernberg, 2006).

Relatively few empirical studies have been devoted to exploring the role of the therapist’s attachment anxiety and avoidance on the therapeutic relationship and process of psychotherapy. Bowlby (1988) believed that the therapist’s own internal working models of attachment are
highly relevant to psychotherapy and countertransference in particular, as individuals’ abilities to serve as effective caregivers are based at least in part on their own early attachment experiences. Mikulincer and Shaver (2007) further theorized that therapists with low global attachment anxiety and avoidance (i.e., secure), compared to therapists with high global attachment anxiety and/or avoidance (i.e., insecure), are better able to focus on clients’ needs, provide compassion and empathy, serve as stronger and wiser security providers, and avoid automatically expressing potentially problematic countertransference reactions. George and Solomon (1999) theorized that therapists with high global attachment anxiety or avoidance (i.e., insecure) may be preoccupied by their own unfulfilled needs or distress and unable to respond appropriately, sensitively, and consistently to clients’ needs.

Research has provided support for these theoretical assertions about the benefits of low global attachment and avoidance in the therapist. Two studies found that therapists with low global attachment anxiety and avoidance (i.e., secure) had more positive working alliances with clients than therapists with high global attachment anxiety and/or avoidance (i.e., insecure; Black, Hardy, Turpin, & Parry, 2005; Sauer, Lopez, & Gormley, 2003). Additionally, studies have found links between therapist attachment and countertransference. Mohr, Gelso, and Hill (2005) found that therapists with low global attachment anxiety and high global attachment avoidance (i.e., dismissing) were more likely than therapists with both low global attachment anxiety and avoidance (i.e., secure) to demonstrate hostile countertransference behaviors. Again, these findings indicate that therapists with both low global attachment anxiety and avoidance (i.e., secure) may be best equipped to serve as positive, effective attachment figures for clients.

Only a few studies have examined the ways in which the interaction between client and therapist attachment is related to the process of psychotherapy. Attachment theorists (Bowlby, 1988; Dozier & Tyrell, 1998; Mallinckrodt, 2000; Mikulincer & Shaver, 2007) have argued that it is likely therapists with low global attachment anxiety and avoidance (i.e., secure) who most
successfully provide sensitive caregiving to clients as these therapists are able to utilize therapeutic strategies that best meet their clients’ needs. Research examining the interaction between client and therapist attachment dimensions has further supported this assertion by highlighting the problems that arise when there is a mismatch between client and therapist attachment. Mohr et al. (2005) found that when therapists elevated on one dimension of attachment (e.g., attachment anxiety) were matched with a client elevated on the opposite attachment dimension (e.g., attachment avoidance), therapists were more likely to exhibit hostile countertransference behavior. Romano, Fitzpatrick, and Janzen (2008) also found problematic interaction effects that occurred when there was a mismatch between client and therapist attachment. Specifically, Romano et al. found that clients with high global attachment anxiety, when paired with a therapist with moderate to high global attachment avoidance, experienced lower levels of session depth. These findings further support the idea that therapists with low global attachment anxiety and avoidance (i.e., secure) are likely best able to help clients effectively, regardless of the client’s particular attachment orientation. When clients are matched with a therapist with low global attachment anxiety and avoidance, issues surrounding a mismatch (e.g., hostile countertransference behavior, decreased session depth) are avoided.

An important line of psychotherapy research about attachment is beginning to explore how clients attach to their therapists. Although relatively few studies have examined the construct of attachment to the therapist, available findings are notable. In order to empirically examine clients’ attachments to their therapists, Mallinckrodt et al. (1995) created the Client Attachment to Therapist Scale (CATS), a measure that reflects multiple elements of an attachment relationship including proximity seeking, safe haven, secure base, separation anxiety, and stronger and wiser (Mallinckrodt, 2010). The CATS conceptualizes attachment to the therapist in terms of three dimensions: secure, fearful-avoidant, and preoccupied-merger. The secure dimension of the CATS is characterized by a perception of the therapist as consistently responsive and emotionally
available. Meanwhile, the fearful-avoidant dimension reflects a client’s distrust of the therapist, reluctance to engage in self-disclosure, and feeling unsafe with the therapist. Finally, the preoccupied-merger dimension is characterized by a desire to merge with the therapist, as well as worrying about obtaining the love and approval of the therapist.

Research using the CATS to conceptualize attachment to the therapist has drawn attention to the value of secure attachment to the therapist. Two studies have found that whereas secure attachment to the therapist was positively associated with working alliance, preoccupied-merger and fearful-avoidant attachment to the therapist was negatively related to working alliance (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005). These findings are in keeping with Mallinckrodt’s (2000) assertions that individuals who are able to quickly form a secure attachment to the therapist are likely able to function competently in interpersonal relationships and therefore form strong working alliances, whereas individuals who do not develop a secure attachment to the therapist may be less interpersonally competent.

Transference is also theorized to be related to secure attachment to the therapist, as the client’s ability to use the therapist as a secure base should permit the client to discuss and explore difficult issues, such as transference (Bowlby, 1988). Indeed, Woodhouse, Schlosser, Crook, Ligiéro, and Gelso (2003) found that secure attachment to the therapist was positively related to both negative transference and amount of transference. This finding provides empirical support to the idea that a secure attachment to the therapist enables clients to explore difficult material in therapy.

Research has also found important links between secure attachment to the therapist and in-session exploration (Janzen et al., 2008) and depth/smoothness of therapy sessions (Mallinckrodt et al., 2005). Bowlby (1988) argued that the client’s ability to securely attach to the therapist and use the therapist as a secure base will affect his or her ability to explore difficult issues in psychotherapy. Depth of session and in-session exploration have been used as indicators
of client exploration in two studies. As expected, client secure attachment to the therapist was positively related to both session depth and smoothness (Mallinckrodt et al., 2005), as well as level of in-session exploration (Janzen, Fitzpatrick, & Drapeau, 2008). In contrast, fearful-avoidant attachment to the therapist was negatively related to session depth and smoothness (Mallinckrodt et al., 2005). These findings again highlight the ways in which clients with secure attachment to the therapist are able to depend on the therapist to explore challenging material.

**The Present Study**

Attachment theory provides a highly useful theoretical framework through which to better understand the process of psychotherapy and the therapeutic relationship. A fundamental principle of the theory is that early attachment relationships with important significant others lead to the development of internal working models of self and others that influence subsequent relationships, including the psychotherapy relationship. Specifically, Bowlby (1988) theorized that when clients develop a secure attachment to their therapists, they are able to rely on the therapist for comfort and care, as well as use the therapist as a secure base from which to explore difficult material in therapy. Theoretically, then, secure attachment to the therapist allows for in-session exploration that ultimately leads to client change. Recent studies have provided support for the idea that secure attachment to the therapist is positively related to both duration and frequency of therapy (Parish & Eagle, 2003a), and is positively associated with in-session exploration (Janzen et al., 2008), as well as session depth (Mallinckrodt et al., 2005). However, no extant studies have explored, in-depth, the tasks associated with the development of a secure attachment to the therapist. In other words, how does a secure attachment to the therapist develop over time across sessions? Further, the theoretical link between secure attachment to the therapist and client outcome has yet to be empirically explored. The goal of the present study was to provide an in-depth examination of how secure attachment to therapist developed for a client
experiencing depression, as well as how this type of attachment to the therapist was related to client change in depressive symptomatology.

The present study utilized a longitudinal, mixed-method case study design to examine (1) the development of secure attachment to the therapist and (2) client-reported changes in depressive symptomology for a client with Major Depressive Disorder. This type of design permitted nuanced, session-by-session analysis of associations between these constructs. Task analysis (Greenberg, 2007; Pascual-Leone, Greenberg, Pascual-Leone, 2009) was used to examine the specific tasks that occurred as the client developed a secure attachment to the therapist. Further, correlational analysis was used to examine the associations between secure attachment to the therapist and client change in depressive symptomology. This study contributes to the existing knowledge about client secure attachment to the therapist and further elucidates links between secure attachment to the therapist and client change over the course of treatment.

Research questions and hypotheses.

Development of secure attachment to the therapist.

Prior research has suggested that secure attachment to the therapist may develop over time (Bachelor, Meunier, Laverdi’ere, & Gamache, 2010; Parish & Eagle, 2003a); however, the development of secure attachment to the therapist has never been qualitatively examined on a session by session basis with a single client. Thus, much remains unknown about the specific tasks that compose the development of secure attachment to the therapist. A primary research question for this study was: How does a client with Major Depressive Disorder (MDD) develop a secure attachment to the therapist during the course of brief psychotherapy?

Secure attachment to the therapist and client-reported depressive symptomology. Is secure attachment to the therapist linked with client symptomology? Specifically in the present case study, is secure attachment to the therapist related to client-reported depressive symptoms? Bowlby (1988) proposed that when clients are able to develop a secure attachment to the
therapist, they are able to use the therapist as a secure base from which to explore and modify
their negative internal working models; this exploration may, in turn, lead to a reduction in
symptomology. Prior research has found that symptom reduction is associated with change in
general attachment orientations over the course of psychotherapy (Levy et al., 2006). However,
the link between secure attachment to the therapist and symptom reduction had yet to be
explored. It was hypothesized that, for a client with Major Depressive Disorder, secure
attachment to the therapist would be negatively related to client-reported depressive
symptomatology over the course of brief psychotherapy.

Secure attachment to the therapist and client-reported increase in interpersonal
functioning. Do clinically significant changes in client-reported interpersonal functioning occur
over the course of treatment for a client who develops a secure attachment to the therapist?
Bowlby (1988) theorized that by developing a secure attachment to the therapist, clients may be
able to explore and change their internal working models which may lead to a change in the ways
individuals function interpersonally. Research suggests that changes in global attachment
dimensions over the course of therapy are related to positive shifts in interpersonal functioning
(Travis et al., 2001; Levy, et al., 2006). No specific hypotheses are advanced. Rather, pre-
treatment and post-treatment data regarding interpersonal functioning were examined to
determine if clinically significant change had occurred.

Planned post-hoc analyses. Specific research questions were developed regarding the
associations between secure attachment to the therapist and client-reported changes in depressive
symptomology. However, the CATS (Mallinckrodt et al., 1995) also identified two additional
dimensions of attachment to the therapist: preoccupied-merger and fearful-avoidant. Planned
post-hoc analyses addressed the following research questions:
1. What is the link between the development of fearful-avoidant attachment to the therapist and client-reported depressive symptomology for a client with MDD in brief psychotherapy?

2. What is the link between the development of preoccupied-merger attachment to the therapist and client-reported depressive symptomology for a client with MDD in brief psychotherapy?
Chapter 2

Literature Review

Attachment theory was originally formulated as a way to understand relational bonds between parents and children, but its applications are much broader in scope. Indeed, John Bowlby, himself a clinician, theorized about the ways in which attachment plays an important role in psychotherapy and the therapeutic relationship (Bowlby, 1977a, 1977b, 1978, 1988). Bowlby asserted that in order for a client to engage in the change-producing work of psychotherapy, he or she must develop a secure attachment to the therapist. This secure attachment will allow the client to rely on the therapist for comfort and support when distressed and use the therapist as a secure base for exploration of challenging material. Research has shown that attachment to the therapist is important, as it is linked to key aspects of the psychotherapy relationship, including the working alliance (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005), transference (Woodhouse et al., 2003), session depth (Mallinckrodt et al., 2005), and in-session exploration (Janzen, Fitzpatrick, & Drapeau, 2008; Mallinckrodt et al., 2005). As noted, however, by Mikulincer and Shaver (2007) in their review of the research on attachment and psychotherapy, empirical research in this area is relatively new, and a great deal is left to be discovered.

The purpose of the present study was to explore, in the context of a single case study of a client with Major Depressive Disorder, (a) how secure attachment to the therapist developed over the course of therapy, and (b) the link between secure attachment to the therapist and client-reported depressive symptomatology. Specifically, the present study employed a longitudinal, mixed-methods case study design using (a) task analysis to explore the tasks associated with the development of a secure attachment to the therapist and (b) correlational analysis to examine the links between secure attachment to the therapist and client-reported depressive symptoms.
Intriguing data suggests that symptom reduction is associated with change in general attachment orientations over the course of psychotherapy (Levy et al., 2006), consistent with Bowlby’s (1988) theory that psychotherapy allows clients to rework expectations about relationships that were based in earlier experiences with attachment figures. To date, however, no studies have longitudinally examined the development of attachment to the therapist, another key component of Bowlby’s theory. Further, no studies have examined the links between the development of attachment to the therapist and client symptomology and interpersonal functioning. Thus, although Bowlby (1977a, 1977b, 1978, 1988) theorized that secure attachment to the therapist is essential for clients to engage in the exploratory work of therapy and for change to occur, research is still needed to provide support for this assertion and elucidate how this process unfolds.

In this chapter, a review of the basic tenets of attachment theory, as well as its applications to psychopathology and psychotherapy, are presented. Additionally, relevant existing empirical research is reviewed. Finally, the rationale for the present study and specific research questions and hypotheses are presented.

**Introduction to Attachment Theory**

Attachment theory was originally developed to explain the nature of the child’s emotional bond to his or her parent (Bowlby, 1982). Bowlby proposed that infants are born with a collection of attachment-oriented behaviors designed to promote proximity to significant others, or attachment figures. Key features of attachment behavior include proximity maintenance, separation distress, and relying on the attachment figure as a safe haven and a secure base (Ainsworth, 1969, 1972; Bowlby, 1982). Children maintain close proximity to attachment figures to protect from threats to safety and ensure physical survival. Additionally, children rely on attachment figures to provide a *safe haven* to which they can retreat when distressed and in need of comfort, support, reassurance and protection. Similarly, children rely on attachment figures to
provide a secure base from which they can explore their environment and which is available to provide needed support during exploration.

Bowlby (1982) theorized that infants become more securely attached to their attachment figures when attachment figures are consistently responsive to infants’ distress and provide responses that specifically match the infants’ expressed needs. Ainsworth, Blehar, Waters, and Wall (1978) provided data supporting Bowlby’s theory. Ainsworth et al., following Bowlby, posited that over time, the infant develops a particular attachment style, or pattern of relating to important others, that derives from continued interactions with his or her attachment figures. Based on their observations of mother-infant interactions, Ainsworth et al. conceptualized distinct types of attachment, or attachment styles, that infants and children have to their attachment figures. Empirically, Ainsworth et al. found three unique categories of attachment security which they labeled secure attachment, insecure-avoidant attachment, and insecure-ambivalent attachment. During the Strange Situation (Ainsworth et al.), a procedure developed to assess child attachment style in which children undergo a series of separations from and reunions with their caregiver, children with a secure attachment to their attachment figure were more positive and had less conflicted affect toward the attachment figure upon reunion. Additionally, children with a secure attachment used their caregivers as secure bases to explore the environment and as safe havens to receive comfort and reassurance, were comfortable seeking proximity to the caregiver, and showed preferences for the caregiver. The attachment figures of children with secure attachments were consistently warm and responsive to their children’s needs.

In contrast, Ainsworth et al. (1978) found that children with insecure-avoidant attachments appeared detached from their caregivers and demonstrated avoidant behaviors, such as gaze aversion, lack of proximity seeking behavior, or behavioral avoidance of caregivers upon reunion. These children did not use their caregivers as a secure base or safe haven. Caregivers of these children encouraged independence and discouraged the expression of negative emotions
like crying. Ainsworth et al. further found that children who demonstrated an insecure-ambivalent attachment style were also unable to use their attachment figures as a secure base or a safe haven, but reacted differently to their caregiver than insecure-avoidant children. In fact, children with insecure-ambivalent attachment styles responded to their attachment figures with anger and ambivalence and were reluctant to engage with attachment figures when they returned from separation periods. These children were often difficult to soothe, as they sought proximity to their attachment figures but then resisted them angrily. Caregivers of children with insecure-ambivalent attachment styles were notably inconsistent in their responses to their children’s distress.

Several years after Ainsworth et al. (1978) initially described these three attachment styles, a fourth category of attachment style, insecure-disorganized, was identified (Main & Solomon, 1986; Main & Solomon, 1990). During the Strange Situation (Ainsworth et al., 1978), children with a disorganized attachment style demonstrated a lack of organized attachment strategies and their behavior was often disoriented, contradictory, or bizarre. Children categorized as insecure-disorganized, like the other children with insecure attachment styles, did not demonstrate use of the caregiver as a secure base and a safe haven. Caregivers of children with a disorganized attachment style were often frightened or frightening, maltreating, neglecting or intrusive (Main & Solomon, 1986).

Attachment in Adulthood

**Internal working models.** Bowlby (1979) theorized that infants and children form internal working models of attachment that continue to influence them over the lifespan, from the “cradle to the grave” (p. 129). He described internal working models as mental representations of the self and others that are formed based on early attachment relationships with caregivers (Bowlby, 1982). Bowlby asserted that interactions with attachment figures are internalized and stored as working models that allow individuals to create predictions about the outcomes of future
interactions with attachment figures. Over time, these working models are strengthened and reinforced, become resistant to change, and guide an individual’s thoughts, feelings, and expectations in future relationships (Bretherton & Munholland, 2008). Individuals create working models of both self and others. Working models of others are formed based on the type of responses provided by attachment figures, particularly during times of distress, when the attachment system is activated. An individual internalizes an attachment figure’s responses to his or her distress as models of the self (as worthy or not of care) and others (as trustworthy or not to provide needed care; Bowlby, 1973, 1980). Main, Kaplan, and Cassidy (1985) provided empirical support for the existence of working models in children.

Internal working models are theorized to influence the ways individuals interact in different types of adult relationships, including romantic relationships (e.g., Hazan & Shaver, 1987; Zeifman & Hazan, 2008) and therapeutic relationships (e.g., Bowlby, 1988; Cobb & Davila, 2009). Longitudinal studies have demonstrated empirically that patterns of attachment tend to persist over time from childhood into adulthood (Hamilton, 2000; Sroufe, Egeland, Carlson, & Collins, 2005; Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Two studies found a 70-75% correspondence rate between attachment security/insecurity in infancy and attachment security/insecurity in late adolescence and early adulthood (Hamilton, 2000; Waters et al., 2000). Additionally, Sroufe et al. (2005) followed participants from infancy into young adulthood and found a significant match between infants’ attachment security at 18 months and adults’ attachment security at age 26. Finally, a meta-analysis conducted by Fraley (2002) concluded that attachment security is moderately stable over the first 19 years of life and that the prototype perspective, which maintains that representations of early experiences are retained over time, was supported. Of note, studies found that lack of correspondence between infant and adult attachment styles was related to life stressors that affected the caregiving environment, such as divorce or death of a parent (Crowell, Fraley, & Shaver 2008). These studies support the theory
that attachment styles are formed at a young age and continue to influence the individual as he or she moves into adulthood.

Just as children form attachment relationships with caregivers responsible for providing them with comfort and security, adults form attachment relationships with others who provide these essential components of an attachment relationship. Theorists have postulated that adults can and do form attachment relationships with romantic partners (e.g., Ainsworth, 1989; Shaver & Hazan, 1987; Fraley & Shaver, 2000). Multiple studies have provided evidence to support this theory (e.g., Fraley & Davis, 1997; Hazan & Shaver, 1987, 1990). Additionally, Bowlby (1988) theorized that adults form attachment relationships with their therapists. Researchers have also demonstrated that the therapeutic relationship has the potential to become an attachment relationship (e.g., Mallinckrodt et al., 1995; Parish & Eagle, 2003a).

**Adult Attachment Interview.** Adult attachment has been conceptualized in a variety of ways over time. The Adult Attachment Interview (AAI; Main et al., 1985; Main & Goldwyn, 1984, 1998), the first tool created to assess adult attachment, was originally developed to evaluate a mother’s attachment style and predict her infant’s attachment style. The AAI, a semi-structured clinical interview, assesses adults’ general state of mind with regard to attachment (i.e., not with respect to any particular attachment figure). Three major patterns of adult state of mind with regard to attachment were originally identified and include secure/autonomous, dismissing, and enmeshed/preoccupied (George, Kaplan, & Main, 1985, 1996; Main et al., 1985). Individuals classified as secure/autonomous demonstrate an emotional openness, value attachment relationships, and are highly coherent in describing childhood experiences, indicating a coherent organization of attachment related information (Main, Goldwyn, & Hesse, 2003; Main et al., 1985). Meanwhile, individuals classified as dismissing demonstrate low levels of coherence in talking about attachment related experiences in that they relate general narratives about their childhood without supporting these histories with examples. In addition, they tend to idealize
their attachment figures, yet insist on a lack of memory for childhood experiences. They also actively dismiss the importance of attachment relationships or experiences (Main et al., 2003; Main et al., 1985). Finally, individuals classified as enmeshed/preoccupied with respect to attachment demonstrate low levels of coherence when talking about attachment related experiences in that their narrative is typically excessively long and focused on past attachment experiences. In addition, these individuals display anger toward past attachment figures and a passivity and/or vagueness in discourse (Main et al., 2003; Main et al., 1985).

Later, the additional categories of unresolved/disorganized and cannot classify were identified and added to the AAI classification procedure (Hesse & Main, 2000; Main et al., 2003). Individuals classified as unresolved/disorganized describe unresolved loss or abuse. When discussing the loss or abuse, such individuals demonstrate a lapse in the monitoring of reasoning and sometimes express thoughts that violate understanding of space or time (i.e., referring to a deceased person in the present tense; Hesse & Main, 2000; Main et al., 2003). Individuals identified as cannot classify display contradictory insecure classifications. For these adults, low coherence of speech is notable (Hesse & Main, 2000; Main et al., 2003).

**Attachment in romantic relationships.** Bowlby (1988) defined attachment as “any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is conceived of as better able to cope with the world. It is most obvious whenever the person is frightened, fatigued or sick, and is assuaged by comforting and caregiving” (p. 26-27). In keeping with the idea that attachment figures can be individuals other than parents or caregivers, attachment researchers have examined attachment in romantic relationships. Hazan and Shaver (1987) conceptualized romantic attachment as similar in many ways to child-parent attachment. Although a romantic relationship usually does not involve one partner being stronger and wiser all of the time, there are times, such as during illness, when partners serve in such a comforting and caregiving role for each other (Fraley & Shaver, 2000).
Additionally, theorists have asserted that the emotional and behavioral dynamics for both child-parent and romantic pair-bond relationships are directed by the same biological system that directs proximity seeking and use of other as a secure base for exploration (Fraley & Shaver, 2000; Hazan & Shaver, 1987). Zeifman and Hazan (2008) noted that both child-parent and romantic pair-bond relationships include similar reactions to separation and loss that includes a protest-despair-detachment sequence originally described by Bowlby (1973). Finally, distinct categories or types of attachment security or insecurity are observed in both child-parent and pair-bond relationships and are conceptually similar (Fraley & Shaver, 2000; Hazan & Shaver, 1987). Empirically, researchers have found that adults use their romantic partners both as a secure base (Feeney & Thrush, 2010) and a safe haven (Collins & Feeney, 2000).

It is important to note, of course, that differences also exist between child-parent and romantic pair-bond relationships. Romantic attachment is not often necessary for survival in the same way attachment is for infants and children in terms of physical protection (Zeifman & Hazan, 2008). Additionally, romantic partners provide reciprocal care-giving and care-seeking; the same is not true in healthy parent-child relationships, where the parent is the caregiver and the child is the careseeker (Zeifman & Hazan, 2008). Finally, romantic love differs from parent-child relationships because it involves the interaction of attachment, caregiving, and sex (Fraley & Shaver, 2000). Despite these differences, multiple similarities exist between romantic attachment and child-parent attachment, and theory regarding child-parent attachment has informed theory about romantic attachment. In fact, adult attachment was first conceptualized categorically based on patterns found in child-parent attachment (Hazan & Shaver, 1987).

**Categorical and dimensional approaches to adult attachment.** Adult attachment in romantic relationships has been conceptualized in multiple ways that have influenced the measurement of attachment. Initially, Hazan and Shaver (1987, 1990) used the typology of infant attachment identified by Ainsworth et al. (1978) to create a three-category model of adult
romantic attachment that matched the types (secure, insecure-avoidant, insecure-ambivalent) proposed by Ainsworth et al. Hazan and Shaver described adults classified as secure as comfortable being emotionally close to others, both in terms of relying on others and having others rely on them. In contrast, adults classified as insecure-avoidant were theorized to be uncomfortable with emotional closeness, both in terms relying on others and having others rely on them. For these individuals, it is difficult to develop trust in others and feels safest to remain distant. Finally, adults classified as insecure-ambivalent would like to be emotionally closer than others may like and this ultimately may push others away. These individuals are concerned about whether or not others want to be close to them.

Bartholomew and Horowitz (1991) later created a four-category model of adult attachment. These authors maintained the secure and preoccupied (insecure-ambivalent) categories described by Hazan and Shaver (1987), but split the avoidant category into two separate categories (dismissing-avoidant and fearful-avoidant). Bartholomew and Horowitz described individuals with a secure attachment as displaying high levels of warmth and intimacy in relationships, a balance of control in friendships, and high levels of involvement in romantic relationships. The authors indicated that individuals with a preoccupied attachment (formerly called insecure-ambivalent attachment) evidence high rates of self-disclosure and emotional expressiveness, including frequent crying, in their efforts to become close to others. Adults classified as preoccupied are described as highly reliant on others as they often attempt to use others as a secure base. However, these individuals demonstrate a low balance of control in friendships. Bartholomew and Horowitz theorized that adults with a dismissing-avoidant attachment style are in many ways opposite of preoccupied adults in that they display low levels of warmth, emotional expressiveness, self-disclosure, and intimacy in relationships. Individuals classified as dismissing-avoidant, who are often highly self-confident, have little ability to rely on others and do not often use others as a secure base. Finally, individuals with a fearful-avoidant
attachment style also demonstrate low levels of self-disclosure, intimacy, reliance on others, and use of others as a secure base. Unlike individuals with a dismissing-avoidant attachment style, however, individuals with a fearful-avoidant attachment style have low levels of self-confidence and desire close relationships, but are seemingly unable to have them.

Although the researchers mentioned above conceptualized attachment in terms of discrete categories, more recent research has demonstrated that attachment can be more accurately conceptualized in terms of two dimensions, attachment anxiety and attachment avoidance (Brennan et al., 1998; Fraley & Waller, 1998). Attachment anxiety refers to the fear of interpersonal rejection by others, a desire to merge with another person, and the stress one faces when one’s partner is unavailable (Brennan et al., 1998). Attachment avoidance refers to a discomfort in relying on others for emotional support, a fear of dependence, and an excessive need for self-reliance (Brennan et al., 1998). These two dimensions were initially identified by Brennan et al. during a factor analysis study of all extant self-report measures of adult attachment. Fraley and Waller later provided empirical support for the idea that adult attachment is best conceptualized as existing on a continuum from low to high attachment avoidance and low to high attachment anxiety. These authors demonstrated that a dimensional approach to attachment security more accurately captures the natural structure of attachment security. In addition to better matching reality, the dimensional approach to attachment allows for more accurate detection of individual differences in attachment (i.e., individuals who would have fallen on the borderlines of categorical styles; Fraley & Waller, 1998). Thus, this approach also allows more power to detect differences in attachment.

**Terminology.** Because previous conceptualizations of adult attachment examined attachment categorically rather than dimensionally, attachment-related terminology can become confusing without a method of translating the categorical findings into dimensional language to keep terminology consistent. It is important to understand how to translate the terminology, as
many foundational studies concerning attachment were conducted prior to the identification of dimensions and use of dimensional language. Mikulincer, Shaver, and Pereg (2003) provided a method of translating the categorical conceptualization of attachment into dimensional language. The attachment categories can be translated dimensionally as follows: secure (low attachment anxiety and low attachment avoidance), preoccupied (high attachment anxiety and low attachment avoidance), dismissing (low attachment anxiety and high attachment avoidance), and fearful (high attachment anxiety and high attachment avoidance). In the review of literature that follows, as well as in the present study, research findings are described using dimensional language. Previous research findings that utilized categorical conceptualizations of attachment are translated into the more current dimensional language for consistency.

**Attachment, Interpersonal Functioning, and Psychopathology**

Adult attachment has been linked to a variety of important variables including interpersonal functioning (e.g., Haggerty, Hilsenroth, & Vala-Stewart, 2009; Wei, Mallinckrodt, Larson, & Zakalik, 2005) and psychopathology (e.g., Mallinckrodt & Wei, 2005; Wearden, Cook, & Vaughan-Jones, 2002). These findings are consistent with the principles of attachment theory. Bowlby (1988) stated, “…the capacity to make intimate emotional bonds with other individuals, sometimes in the careseeking role and sometimes in the caregiving one, is regarded as a principle feature of effective personality functioning and mental health” (p. 121). In the following sections, important empirical associations between attachment and both interpersonal functioning and psychopathology are reviewed.

**Attachment and interpersonal functioning.** Associations between attachment and multiple facets of interpersonal functioning have been studied extensively. As previously mentioned, Bowlby (1973, 1982, 1988) theorized that individuals’ attachment orientations impact the ways in which they engage in important relationships. A large body of empirical research has supported Bowlby’s assertions by elucidating links between adult attachment anxiety and
avoidance and patterns of interpersonal problems or distress (e.g., Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Mallinckrodt & Wei, 2005; Wei et al., 2005). Importantly, research has highlighted the differences in interpersonal functioning and strategies of engagement for individuals with high attachment avoidance or high attachment anxiety.

Individuals with high attachment avoidance exhibit a discomfort in relying on others for emotional support, a fear of dependence, and an excessive need for self-reliance (Brennan et al., 1998). These individuals, who often seek to minimize their expression of attachment-related needs, favor self-reliance and are uncomfortable relying on others or being intimately close to others. Research has found links between attachment avoidance and the minimization of interpersonal closeness (Collins, Guichard, Ford & Feeney, 2004; Mikulincer & Selinger, 2001), as well as links between attachment avoidance and independence and social withdraw (Haggerty et al., 2009). Haggerty et al. also found that attachment avoidance is significantly related to interpersonal coldness and dominance. Individuals with attachment avoidance have a discomfort with and fear of the intimacy of close relationships (Greenfield & Thelen, 1997; Hudson & Ward, 1997). Likely in effort to avoid becoming close to others, whom they do not trust to be competent and reliable (Bartholomew, 1990; Bartholomew & Horowitz, 1991), such individuals tend to be restricted in their emotional expression (Bradford, Feeney, & Campbell, 2002; Haggerty et al., 2009; Wei, Russell, & Zahalik, 2005) and display heightened emotional control (Feeney, 1995, 1999; Kotler, Buzzwell, Romeo, & Bowland, 1994; Tacon, Caldera, & Bell, 2001). Notably, as individuals with high global attachment avoidance seek to distance themselves emotionally from others, they also report low relationship satisfaction (Horowitz, Rosenberg, & Bartholomew, 1993; Pietromonaco & Barrett, 1997). Indeed, several studies using a dimensional conceptualization of attachment have found links between attachment avoidance and loneliness (e.g., Wei, Russell, & Zakalik, 2005; Wei, Shaffer, Young, & Zakalik, 2005). Thus, individuals with high attachment avoidance do not appear to benefit from maintaining emotional distance.
from others and in fact report negative consequences from doing so; however, they persist in their efforts to remain emotional distant from others despite these negative consequences. This may be a strategy they learned early in life from interactions with caregivers, or attachment figures, that has persisted via internal working models of self and others.

In many ways, individuals with high attachment anxiety exhibit interpersonal strategies and behaviors that are opposite the strategies of individuals with high attachment avoidance described above. These individuals continuously look to others for care, and tend to maximize their attachment-related needs as they seek attention and care from others (Horowitz et al., 1993). Further, as these individuals are concerned with obtaining the love and support of others, they are also fearful of rejection and the loss of such support. Research has found links between attachment anxiety and increased sensitivity to the rejection of others (Downey & Feldman, 1996; Taubman-Ben-Ari, Findler, & Mikulincer, 2002) and efforts to avoid abandonment (Vorauer, Cameron, Holmes, & Pearce, 2003). Likely because of their preoccupation with avoiding abandonment, individuals with high attachment anxiety seek excessive reassurance from others (Davila, 2001; Shaver, Schachner, & Mikulincer, 2005). Despite the different ways in which individuals with attachment anxiety seek to meet their interpersonal needs, they too, like individuals with attachment avoidance, struggle with loneliness (e.g., Wei, Russell, & Zakalik, 2005; Wei, Shaffer, Young, & Zahalik, 2005) and report greater distress, lower self-esteem, and heightened emotional intensity as compared with individuals with low attachment anxiety (Horowitz, et al., 1993; Pietromonaco & Barrett, 1997). These individuals, like those with high attachment avoidance, may be repeating patterns of interpersonal engagement they learned in early relationships with attachment figures.

In summary, both theory and supporting research suggest that when individuals have either high attachment anxiety or high attachment avoidance, they struggle to function effectively in interpersonal relationships and report engaging in multiple unproductive and problematic
behaviors in such relationships. The behaviors and interpersonal strategies these individuals employ appear to differ according to which dimension of attachment (anxiety or avoidance) is predominant for that particular individual. Whereas individuals with high attachment avoidance remain distant from others and rely on themselves, individuals with high attachment anxiety depend excessively on others for love and care. These strategies are consistent with the theory of internal working models originally proposed by Bowlby (1979, 1982).

Attachment and psychopathology. In addition to providing a framework for understanding how individuals behave in important interpersonal relationships, attachment theory offers a framework for understanding the development and maintenance of psychopathology (Bowlby, 1973, 1982, 1988). Over the past several decades, since the conception of this theory, an extensive body of research has revealed empirically supported links between attachment insecurity and multiple forms and correlates of psychopathology. Theoretically, Bowlby (1980, 1988) stated that attachment security, which is formed via repeated positive interactions with a consistent, sensitive and caring attachment figure, lays a strong foundation for later mental health. In contrast, he stated that attachment insecurity, which is formed via repeated negative interactions with an inconsistent, insensitive, rejecting, or neglectful caregiver, is associated with an increased vulnerability to later psychopathology. Mikulincer and Shaver (2007) were careful to point out that there is not theory or evidence indicating that attachment insecurity causes psychopathology, but rather, theory and empirical evidence suggests that such insecurity increases an individual’s risk for mental health problems. These authors asserted that such risk and vulnerability occurs because individuals with insecure attachments, who have negative internal working models of self and others, are compromised in their ability to effectively regulate their emotions and maintain positive cognitive models of the world that help them cope in the face of adversity. With regard specifically to affective disorders, Bowlby (1980) also asserted that the repeated failure to form a secure attachment to a caregiver fosters the
development of negative representations of self and the world that are characteristic of depression.

Emotion regulation also plays a key role in the link between the attachment system and vulnerability to psychopathology. While low attachment anxiety and avoidance (i.e., attachment security) serves as an internal resource for coping with negative emotions and fostering resilience (e.g., Cassidy, 1994; Mikulincer & Shaver, 2005; Sroufe & Waters, 1977), high attachment anxiety or avoidance (i.e., attachment insecurity) serves as a risk factor for negative affectivity and persistent distress. Although individuals with high attachment anxiety and individuals with high attachment avoidance maintain distinct ways of coping with emotions, both groups of individuals may struggle to effectively regulate their emotions. Specifically, individuals with high attachment anxiety are theorized to frequently experience intense, prolonged distress in the form of negative thoughts and feelings that lead to cognitive disorganization, emotional instability, and ultimately psychopathology (Mikulincer & Shaver, 2007). Dozier and Kobak (1992) described individuals with high attachment anxiety as hyperactivating their attachment systems, or maximizing their distress, in order to increase the likelihood of having their needs met by an inconsistently available caregiver. Meanwhile, high attachment avoidance is theorized to interfere with individuals’ abilities to accept and tolerate normal emotional experiences; often, individuals with high attachment avoidance, especially when under stress, suppress their distress, limiting their ability to process and cope with adversity (Mikulincer & Shaver, 2007). Dozier and Kobak referred to this as a deactivating strategy that is focused on minimizing the experience and expression of distress, so as to decrease the likelihood of being rejected by an attachment figure who tends to dismiss distress. Mikulincer and Shaver (2007) noted that individuals with either attachment anxiety or attachment avoidance are made vulnerable to psychological disorders because of their susceptibility to “[a] self-exacerbating cycle of insecurity, pessimism, frustration, and life dissatisfaction” (p. 371). These authors further theorized that the cycle of insecurity is
exaggerated by interpersonal regulation difficulties; individuals with insecure attachment frequently struggle interpersonally (see previous section) and interpersonal theories of psychopathology (e.g., Hammen, 1991; Joiner & Coyne, 1999; Levenson, 1995; Strupp & Binder, 1984) suggest that negative relationship experiences may contribute to psychopathology. In summary, individuals with high attachment anxiety and/or high attachment avoidance are made vulnerable to psychopathology in part because of struggles to develop and maintain positive cognitive models, regulate their emotions, and regulate their interpersonal interactions.

Mikulincer and Shaver (2007) and Dozier, Stovall-McClough, and Albus (2008) provided extensive reviews of empirical associations between attachment insecurity, symptomatology, and various psychological disorders. For the purposes of the present study, which focused on an individual with depressive symptomatology, only empirical findings related to this type of distress are reviewed. As might be expected, a number of studies using categorical conceptualizations and measurements of attachment have found that low attachment anxiety and avoidance (i.e., secure attachment) is related to lower levels of negative affectivity and less severe psychological symptomatology (e.g., Moller, McCarthy & Fouladi, 2002; Davila & Cobb, 2003; Davila & Sargent, 2003; Zhang & Labouvie-Vief, 2004). Meanwhile, individuals with high attachment anxiety and/or high attachment avoidance (i.e., insecure attachment) reported greater negative affectivity and general distress than their peers with low attachment anxiety and avoidance (i.e., secure attachment; e.g., Adams, Gunnar, & Tanaka, 2004; Creasey, 2002; Kerr, Melley, Travea, & Pole, 2003; Roisman, Fortuna, & Holland, 2006; Roisman, Padron, Sroufe, & Egeland, 2002; Solomon, Ginzburg, Mikulincer, Neria & Ohry, 1998). Studies that utilized a dimensional approach to examining associations between attachment and affectivity have reported similar findings. Indeed, numerous studies found significant links between attachment anxiety and avoidance and self-reported negative affectivity and symptomatology (e.g., Lopez, Mitchell, & Gormley, 2002; Mallinckrodt & Wei, 2005; Vogel & Wei, 2005; Wearden et
al., 2002; Wei, Vogel, Ku, & Zakalik, 2005) such that both attachment anxiety and attachment avoidance were positively related to affective symptomatology and negative affectivity. Perhaps most importantly, this vein of research highlights the increased rates of self-reported distress and negative affectivity in individuals who have negative internal working models of self and other.

Substantial empirical evidence also supports the link between attachment insecurity and depression. Several studies found that individuals with low attachment anxiety and avoidance (i.e., secure), as opposed to individuals with high attachment anxiety and/or high attachment avoidance (i.e., insecure), demonstrated lower levels of depression (e.g., Dickstein, Seifer, Albus, & Magee, 2004; Kobak, Sudler, & Gamble, 1991; Pearson, Cowen, Cowen, & Cohn, 1993; Treboux, Crowell & Waters, 2004). Additional studies found that high attachment anxiety and/or high attachment avoidance (i.e., insecure attachment) was associated with depression (e.g., Lopez, Mauricio, Gormley, Simko, & Berger, 2001; Rholes, Simpson, & Friedman, 2006; Treboux et al., 2004; Wei, Heppner, & Mallinckrodt, 2003; Wei, Mallinckrodt, Russell, & Abraham, 2004; Wei, Mallinckrodt, Larson, & Zakalik, 2005; for a full review of all studies examining these associations, see Mikulincer & Shaver, 2007). Without exception, attachment anxiety was associated with depression. Attachment avoidance, on the other hand, was found to be associated with depression less consistently than attachment anxiety. In a review of all extant studies exploring such links, Mikulincer and Shaver (2007) concluded that in about half of these studies, attachment avoidance was associated with depression. Thus, the connection between attachment anxiety and depression appears to be quite strong, and stronger than the connection between attachment avoidance and depression; this connection highlights the particular vulnerability to depression that individuals with attachment anxiety face. Individuals with attachment avoidance are not immune, however, and appear to be at greater risk for developing depression than individuals with low attachment anxiety and avoidance (i.e., secure).
Other scholars have suggested that individuals with high attachment anxiety and high attachment avoidance may differ in how they experience depression. Dozier et al. (2008) suggested that individuals with high attachment anxiety (i.e., preoccupied) may be more likely to exhibit internalizing symptoms of depression (e.g., self-blame), whereas individuals with high attachment avoidance (i.e., dismissing) may be more likely to exhibit externalizing symptoms of depression (e.g., interpersonal hostility). In studies that have used the AAI to explore rates of depression for particular attachment styles, results may be interpreted to reflect Dozier et al.’s assertion. Although some studies found that depression is associated with a high attachment anxiety (i.e., preoccupied attachment style; Cole-Detke & Kobak, 1996; Fonagy, Leigh, Steele, Steele, Kennedy, & Mattoon, 1996; Rosenstein & Horowitz, 1996), others found that depression was associated with high attachment avoidance (i.e., dismissing attachment style; Patrick, Hobson, Castle, Howard & Maughan, 1994).

Findings from other studies (e.g., Davila, 2001; Murphy & Bates, 1997) have also suggested that individuals high in attachment anxiety and individuals high in attachment avoidance may experience distinct facets of depression from one another. In these studies, both attachment anxiety and attachment avoidance were associated with depression, but attachment anxiety was specifically related to interpersonal aspects of depression (e.g., neediness, dependence on others), whereas attachment avoidance was related to achievement-related aspects of depression (e.g., self-criticism, perfectionism). In conclusion, the preponderance of research evidence suggests that the presence of high attachment avoidance and/or high attachment anxiety may increase an individual’s vulnerability to depression.

**Attachment in Psychotherapy**

In addition to believing that attachment styles influence how adults interact in general interpersonal relationships, Bowlby (1988) also believed that attachment styles influence how individuals function in the therapeutic relationship. Bowlby theorized that individuals who have
developed negative internal working models based on relationships with early caregivers carry these models into the therapeutic relationship. He further asserted that psychotherapists may assist clients in modifying their working models through the process of therapy. Bowlby proposed that the therapeutic relationship is an attachment relationship in which the therapist serves as an attachment figure for the client; through this attachment relationship, the therapist is able to assist clients in the difficult work of changing their working models. He offered five main tasks for the therapist. First, the therapist should serve as a secure base for the client, so the client can explore difficult aspects of his or her life, both in the past and present. Second, the therapist should encourage the client to examine the ways in which he or she engages in relationships with important others. Third, the therapist should facilitate the client’s exploration of the ways in which he or she engages in the relationship with the therapist. Fourth, the therapist should encourage the client to reflect on how his or her current life situation, and related perceptions and expectations, are tied to the events and situations of childhood and relationships with past caregivers. Finally, the therapist should facilitate recognition by the client that his or her internal working models of self and others, which were created based on past experiences, may or may not be appropriate any longer.

**Psychotherapy relationship as an attachment relationship.** Bowlby (1988) proposed that the therapy relationship is an attachment relationship, as the structure of the therapeutic relationship parallels aspects of early caregiver relationships. The therapist, like the parent, is seen as stronger and wiser (Bowlby, 1977a, 1977b, 1988; Farber, Lippert, & Nevas, 1995; Obegi, 2008) and the therapeutic relationship, like the parent-child relationship, is characterized by care-seeking (client) and care-giving (therapist). Like a parent, the therapist ideally provides two key functions of an attachment figure by serving as a secure base and a safe haven.

Empirical findings support the theoretical assertion that clients use their therapists as attachment figures (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005; Parish & Eagle, 2003a).
Mallinckrodt et al. (1995) found that clients demonstrated distinct patterns of attachment to their therapists that closely corresponded to the categories of adult attachment identified by adult attachment theorists. Additionally, Parish and Eagle (2003a) assessed clients’ attachment to both self-identified “closest personal relationship” figures (usually romantic partners) and therapists and found that the extent to which clients used their personal relationship partners and their therapists as attachment figures was similar. These results suggest that clients do, indeed, use their therapists as attachment figures.

**Client global attachment.** As Bowlby (1988) theorized that the structure of the psychotherapy relationship parallels that of early relationships with caregivers, he further asserted that psychotherapy would trigger behavioral patterns in the client that are related to past attachment experiences. Bowlby stated that the working models of self and other developed by the client beginning in infancy would be applied in new relationships, including the therapeutic relationship. The client therefore enters therapy expecting the therapist to relate to him or her in a manner similar to important others in his or her life; thus, the client behaves and relates to the therapist accordingly. Whereas clients with low global attachment anxiety and avoidance (i.e., secure) have developed working models that allow them to rely on others, like therapists, for help and support, clients with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) do not have such positive working models and are unable to immediately develop strong working alliances. Global attachment can be understood as the client’s general attachment orientation, in terms of attachment avoidance and attachment anxiety, without respect to a particular person.

**Clinical examples of client global attachment.** Clinicians have provided qualitative and theoretical descriptions of how clients with different levels of global attachment anxiety and avoidance present in therapy and respond to therapeutic treatment; such illustrations may prove helpful in understanding the role of global attachment in psychotherapy. Slade (2004) offers an
excellent example of her work with a client she considered to have high global attachment avoidance and low global attachment anxiety (i.e., a dismissing attachment style). Slade indicated that throughout the course of treatment with this client, the client had “cool and unemotional” (p. 190) sessions, characterized by intellectualization and detachment. Slade noted that her efforts to provide “steadiness and availability” (p. 191), or a secure base, to this client resulted in small changes in the client. Dozier and Bates (2004) also commented on working with clients high in global attachment avoidance. These authors indicated that such clients have a tendency to devalue and dismiss attachment relationships; thus, developing a strong rapport may prove difficult for the clinician. Although these clients are often lonely (Dozier & Bates, 2004), Slade noted that “[they] maintain proximity to the caregiver (or to the therapist) by avoiding feelings, memories, or longings that might drive her away” (p. 199). Slade (1999) stated that the goal of treatment when working with clients high in global attachment avoidance is to help them access and understand their past experiences and how such experiences have affected them emotionally.

Slade (2004) also described a client she believed to have high global attachment anxiety and low global attachment avoidance (i.e., a preoccupied attachment style). Slade stated that throughout the course of therapy, this client was intensely needy and demanding of support. Additionally, the client presented with “unrelenting feelings of chaos and frenzy, and an overwhelming sense of badness” (p. 193) and lacked the capacity for reflection about her distress. Slade’s work with this client was focused on responding consistently and sensitively (i.e., as a safe haven), as well as examining the client’s transference material. Dozier and Bates (2004) indicated that although clients with high global attachment anxiety are open about their distress and problems, they are prone to unproductive rumination and anger. Slade (1999) stated that the goal of treatment for individuals high in attachment anxiety is to assist them in regulating their emotions, which are often overwhelming.
**Empirical findings.** Many empirical studies have also sought to further examine the impact of the client’s global attachment styles on the general process of psychotherapy. Bowlby (1988) theorized that global attachment security is related to individuals’ willingness to seek and accept care. It would follow, then, that clients with greater global attachment security may be more comfortable receiving care in psychotherapy. Research supports this idea. Clients low in both global attachment anxiety and global attachment avoidance (i.e., secure) were found to be more comfortable seeking therapy and better able to commit to the therapeutic process (Dozier, 1990; Dozier, Lomax, Tyrell, & Lee, 2001). Meanwhile, clients with low global attachment anxiety and high global attachment avoidance (i.e., dismissing) denied their need for therapeutic help, while clients with high global attachment anxiety and low global attachment avoidance (i.e., preoccupied) were needy and dependent on therapist, which made it difficult for them to use the therapist productively (Dozier, 1990; Dozier et al., 2001).

A considerable body of research has also examined how clients’ global attachment styles impact the working alliance (Dolan, Arnkoff, & Glass, 1993; Eames & Roth, 2000; Kanninen, Salo, & Punamaki, 2000; Kivlinghan, Patton, & Foote, 1998; Parish & Eagle, 2003a; Satterfield & Lyddon, 1995, 1998; Tyrell, Dozier, Teague, & Fallot, 1999). Psychotherapy researchers have long theorized that clients’ early emotional bonds with caregivers affect their ability to form a strong working alliance in psychotherapy (e.g., Gelso & Carter, 1985; Strupp, 1974), as clients’ previous experiences with attachment relationships are likely triggered in the psychotherapy relationship, causing clients to behave in the very ways they have previously (Bowlby, 1988). Indeed, attachment researchers have found that low global attachment anxiety and avoidance (i.e., attachment security) is positively related to working alliance, while both high global attachment avoidance and high global attachment anxiety are negatively related to working alliance (Eames & Roth, 2000; Kivlinghnan et al., 1998; Mallinckrodt et al., 1995; Mallinckrodt et al., 2005; Parish & Eagle, 2003a; Satterfield & Lyddon, 1995, 1998). When clients have both high global
attachment anxiety and high global attachment avoidance (i.e., are fearful-avoidant), they also have more negative working alliances (Eames & Roth, 2000). One study examined fluctuations in the working alliance over time as a function of clients’ global attachment. Kanninen et al. (2000) found a relatively stable trajectory in working alliance for clients low in both global attachment anxiety and avoidance (i.e., secure), while clients high in either global attachment anxiety (i.e., preoccupied) or global attachment avoidance (i.e., dismissing) demonstrated a much more jagged trajectory (i.e., steep rises and drops) of working alliance. Taken together, these findings indicate that when clients are high in global attachment anxiety and/or global attachment avoidance, they struggle to develop strong working alliances with their therapists. For such clients, who are likely struggling against their internal working models during the process of psychotherapy, the development of a positive working alliance likely takes longer and is a more complex process than it is for clients with low global attachment anxiety and avoidance (i.e., secure).

A recent meta-analysis by Levy, Ellison, Scott, and Bernecker (2011) has also demonstrated links between clients’ global attachment dimensions and outcome. Levy et al. (2011) conducted a meta-analysis of 14 studies (n = 1,467) and found significant links between client global attachment and outcome. More specifically, client global attachment anxiety was negatively related to client outcome. In contrast, low client global attachment anxiety and avoidance (i.e., secure) was positively related to outcome. Notably, client global attachment avoidance was not significantly related to outcome. These results highlight the continued influence of clients’ preexisting internal working models on the treatment outcome and change via psychotherapy. However, results do not shed light on the process of therapy. Much remains unknown about client change as it occurs, or does not occur, on a more nuanced, session by session level.

Therapist global attachment. Although early research examining attachment in psychotherapy focused on the role of clients’ global attachment dimensions on the process of
psychotherapy, researchers have more recently begun to examine the influence of therapists’ attachment dimensions on the therapeutic process. Bowlby (1988) stated that a therapist’s contribution to the therapeutic relationship is highly relevant and influenced by his or her own childhood experiences; he emphasized the importance of understanding countertransference as an inevitable part of the therapeutic relationship. Slade further (1999) theorized that therapists’ abilities to serve as effective caregivers will be based, at least in part, on their own early attachment experiences. Mikulincer and Shaver (2007) asserted that only when individuals experience safety and security can they effectively serve as caregivers and view others as in need of and deserving of comfort and support. Thus, when therapists feel secure, they are able to focus on caring for their clients and serve as a stronger and wiser security provider. Mikulincer and Shaver (2007) asserted, “…although the client’s working model is important to the formation of a good working alliance, the therapist’s effectiveness as a caregiver, which means sensitively providing a safe haven and secure base for the client, is equally important” (p. 421).

Mikulincer and Shaver (2007) theorized that therapists with low global attachment anxiety and avoidance (i.e., secure) are more easily able to create good working alliances, compared to therapists with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure), as they are better able to focus on clients’ problems and provide compassion and empathy rather than be preoccupied with their own distress. George and Solomon (1999) also theorized that therapists with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) will struggle to provide effective care to their clients. Mikulincer and Shaver asserted that such therapists are less likely to empathize accurately with clients and to keep their own personal distress from interfering with their ability to respond compassionately. Specifically, Mikulincer and Shaver theorized that therapists with high global attachment avoidance may lack the ability to form close emotional bonds with clients and provide sensitive, empathic care. These therapists may especially struggle with the intimacy of therapy.
Mikulincer and Shaver also asserted that therapists with high global attachment anxiety, on the other hand, might struggle to maintain appropriate boundaries with clients, as they may desire to merge with clients. These therapists also may experience intense distress and difficulty in regulating their own emotions, which interferes with their ability to respond appropriately and sensitively to clients’ needs.

A small number of studies have examined the influence of therapists’ global attachment styles on the psychotherapy relationship and process. For example, studies have examined links between therapists’ global attachment and working alliance (Black et al., 2005; Ligiero & Gelso, 2002; Rozov, 2002; Sauer et al., 2003). Mikulincer and Shaver (2007) theorized that a positive working alliance is dependent not only on the client’s contributions, but on the therapist’s ability to serve as an attachment figure, stating that the therapist’s own attachment insecurities can disrupt the formation of a positive working alliance. With the notable exception of a study by Ligiero and Gelso (2002), which did not find any significant associations between therapists’ global attachment dimensions and quality of working alliance, research has supported the idea that working alliance is related to therapists’ global attachment. Specifically, two studies found that therapists with low global attachment anxiety and low global attachment avoidance (i.e., secure) had more positive working alliances with clients than therapists with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure; Black et al., 2005; Sauer et al., 2003). Interestingly, both studies found that therapists with high global attachment anxiety had an especially difficult time forming a positive working alliance. Sauer et al. found that clients of therapists with high global attachment anxiety reported positive working alliances after the first therapy session, but this association disappeared by the fourth session. In fact, over time, these clients reported significantly negative working alliances. Black et al. also reported that therapists with high global attachment anxiety created particularly poor working alliances. Taken together, these findings highlight the particular difficulty therapists with high global attachment
anxiety may face in developing strong working alliances with their clients and promoting client secure attachment to the therapist.

Studies have also examined the association between therapists’ global attachment and their countertransference behavior (Ligiero & Gelso, 2002; Mohr et al., 2005; Rubino, Barker, Roth, & Fearon, 2000). Countertransference behavior, as defined by Gelso and Hayes (1998), can be understood as the therapist’s observable reactions to clients that stem from the therapist’s own personal issues and unresolved problems. Theoretically, individuals with low global attachment anxiety and avoidance (i.e., secure) are better able to recognize their own countertransference reactions, and avoid automatically expressing such reactions in the form of countertransference behaviors that could disrupt therapy (Mikulincer & Shaver, 2007). Additionally, Mallinckrodt (2000) theorized that the interpersonal sensitivity of these types of therapists may assist them in perceiving clients’ transference material and responding in a therapeutic manner, rather than adding to and reinforcing such transference. In contrast, therapists with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) are theorized to lack the ability to regulate their own distress and sense and manage their countertransference reactions, which may lead to problematic countertransference behaviors (Mikulincer & Shaver, 2007). Research supports the idea that therapists’ global attachment is related to their countertransference behavior. Mohr et al. (2005) found that therapists with low global attachment anxiety and high global attachment avoidance (i.e., dismissing) were more likely than therapists with low global attachment anxiety and avoidance (i.e., secure) or therapists with high global attachment anxiety and low global attachment avoidance (i.e., preoccupied) to demonstrate hostile countertransference behaviors. In summary, these findings draw attention to the ability of therapists with low global attachment anxiety and avoidance (i.e., secure) to create strong working alliance and avoid engaging in hostile countertransference behaviors. It may be that these therapists are best equipped to serve as positive, effective attachment figures for clients.
Interaction of client global attachment and therapist global attachment. As described above, a number of studies have examined the main effects of therapist and client global attachment dimensions on psychotherapy. In addition, some theoretical and empirical work has addressed the importance of examining the interaction between client and therapist global attachment in understanding how this interaction is related to the process of psychotherapy and therapeutic intervention. Theoretically, as discussed earlier, therapists who are low on both global attachment anxiety and global attachment avoidance (i.e., secure) are believed to be able to serve as an attachment figure for clients (e.g., Mikulincer & Shaver, 2007). Theoretically, Dozier and Tyrell (1998) and Mallinckrodt (2000) have argued that it is likely therapists with low global attachment anxiety and avoidance (i.e., secure) who are most successfully able provide sensitive caregiving and responses to clients. These therapists, who are able to be interpersonally flexible, are able to employ therapeutic strategies that best meet their clients’ needs, regardless of the clients’ attachment orientations.

Research that examines the interaction between client and therapist attachment provides further support for the idea that therapists with both low global attachment anxiety and avoidance (i.e., secure) are better able than therapists with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) to assist clients, regardless of client attachment style. Dozier, Cue, and Barnett (1994) found that case managers with both low global attachment anxiety and avoidance (i.e., secure), compared with case managers with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure), attended to clients’ underlying needs for connection or autonomy in a noncomplementary way. These case managers, regardless of their clients’ attachment styles, were able to provide appropriate interventions to clients that challenged their existing working models. Meanwhile, case managers with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) attended to clients’ most obviously presented needs, rather than their underlying needs for connection or autonomy,
and responded with superficial interventions that were complementary rather than noncomplementary.

Specific problems have been found to occur when therapists and clients with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure) are mismatched in terms of their elevation on the dimensions of attachment anxiety and attachment avoidance. That is, when therapists are elevated in one dimension of attachment (e.g., attachment avoidance) and clients are elevated in the other dimension of attachment (e.g., attachment anxiety), therapists are more likely to engage in hostile countertransference behavior (Mohr et al., 2005) and demonstrate low session depth (Romano et al., 2008). Specifically, Mohr et al., using a dimensional conceptualization of attachment, found that therapists’ countertransference behavior was related to the interaction between client global attachment and therapist global attachment. Therapists with high global attachment avoidance exhibited more hostile countertransference behaviors toward clients with high global attachment anxiety, while therapists with high global attachment anxiety exhibited more hostile countertransference behaviors toward clients with high global attachment avoidance. Thus, therapists exhibited more hostile countertransference behaviors towards clients who differed from themselves in terms of the dimensions of attachment. Mohr et al. stated that in both cases, the fact that clients’ global attachment strategies were different from their therapists’ global attachment strategies may have frustrated the therapists. For therapists with high global attachment avoidance, clients with high global attachment anxiety likely behave in a way that prevents these therapists from maintaining the interpersonal distance that they desire. For therapists with high global attachment anxiety, clients with high global attachment avoidance are likely preventing these therapists from obtaining the closeness they desire.

Romano et al. (2008) also examined the interaction between client and therapist global attachment, in an effort to explore links between this interaction and to session depth. Results indicated that therapist global attachment moderated the association between client global
attachment and session depth. Specifically, clients with high global attachment anxiety, when paired with a therapist with moderate to high global attachment avoidance, experienced lower levels of session depth. These results again highlight the importance in examining the match, or mismatch, between client and therapist attachment style. Here, a mismatch between client and therapist attachment proved problematic; these results are similar to the findings by Mohr et al. (2005).

Taken together, the above presented findings related to therapist attachment and the interaction between client and therapist attachment provide strong support for the theoretical assertion that therapists with both low global attachment anxiety and avoidance (i.e., with secure attachment styles) may be best able to serve as a secure base, or attachment figure, for their clients. These therapists appear to be best able to provide corrective, noncomplementary feedback to clients that help them change (Dozier et al., 1994). Further, when clients with high global attachment anxiety and/or high global attachment avoidance (i.e., insecure attachment styles) work with a therapist with low global attachment anxiety and avoidance (i.e., a secure attachment style), the issues surrounding a potential mismatch (e.g., hostile countertransference, decreased session depth) are avoided.

**Attachment to the therapist.** In addition to exploring the role of clients’ and therapists’ global attachment orientations, research has examined links between attachment to the therapist and the psychotherapy process. As previously mentioned, Bowlby (1988) asserted that clients are able to develop attachments specifically to their therapists and empirical findings have supported this idea (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005; Parish & Eagle, 2003a). More recently, others have added to the theoretical understanding of the therapist as an attachment figure for the client (e.g., Eagle & Wolitzky, 2009; Farber et al., 1995; Farber & Metzger, 2009; Obegi, 2008). Farber et al. elaborated on Bowlby’s (1988) theory about the therapist as a secure base by outlining the specific ways in which the therapist serves as a secure base. Clients use the
safety of their clinician’s office and their therapeutic alliance with the clinician to “discuss and attempt new ways of seeing and being in the world” (Farber et al., 1995, p. 207). As the client experiences and expresses distress, the therapist remains consistently available, sensitive, and responsive, thus facilitating a safe space and relationship for the client. Clients are able, then, to develop new ways of relating to others within the safe confines of the therapeutic relationship, try out these new ways of relating with others outside of the therapeutic relationship, and then return to therapy to process their experiences of relating to others in a different way. Farber et al. (1995) stated, “In general, then, the secure base provided by the therapist allows patients to explore the differences between new models of attachment (based on the relationship with the therapist) and older internalized models (based typically on relationships with parents) and, ultimately, to use these insights to effect change” (p. 207). This idea is consistent with Bowlby’s assertion that one of the goals of therapy is assisting the client in reflecting on their past relationships and internal working models in an effort to modify these models.

Obegi (2008) further theorized about specific tasks that occur as a client develops an attachment to the therapist. Specifically, Obegi proposed a three phase model of attachment to the therapist. Each phase he described consists of specific behavioral, cognitive, emotional, and physiological markers that occur as clients develop an attachment to the therapist. Obegi asserted that the first phase, pre-attachment, is characterized by the following markers: initial contact and surface-level problem disclosure; arousal and high levels of distress; client assessment of the therapist’s potential as an attachment figure; client reliance on extant internal working models to assess therapist and therapeutic relationship; agreement about therapeutic goals; and initial relief experienced by the client. The second phase, which Obegi termed attachment-in-the-making, is characterized by increasingly significant use of the therapist as a secure base and safe haven. Specifically, Obegi identified the following markers of the second phase: client provides increasingly detailed descriptions of feelings, thoughts and behaviors; client begins using
therapist as safe haven for comfort and secure base from which to explore; client is increasingly responsive to therapist’s encouragement of exploration; client shares joys and accomplishments with therapist; client exhibits less negative arousal as therapist has positive impact on emotion regulation; and client develops an increasingly complex internal working model of therapist and therapeutic relationship. Finally, Obegi named the third phase clear-cut attachment and theorized that this phase consists of the following markers: client consistently uses therapist as secure base and safe haven; client expresses figure preference for therapist; client demonstrates increased responsiveness to therapist’s interventions; client engages in separation protest; client is uninhibited in expression of affect in session and demonstrates high level of emotional comfort with therapist; and client evidences proximity seeking via access of new internal working model of therapist (e.g., thinks about therapist outside of session).

While the three-phase model of client development of attachment to the therapist is theoretical in nature and has not yet been empirically tested, Obegi utilized extant empirical findings, in conjunction with attachment theory literature, to develop the model. Obegi suggested that progression through the model will vary based on preexisting global attachment orientation. For example, clients high in attachment anxiety and/or attachment avoidance (i.e., clients with an insecure attachment) will undoubtedly move through the model at a different pace and in a different way than clients with low attachment anxiety and avoidance (i.e., clients with a secure attachment). Additionally, Obegi theorized that the three phases may overlap and vary according to treatment duration and session length. Nevertheless, the model Obegi proposed offers a remarkably concrete and useful way to explore the development of client attachment to the therapist. In the present study, the three-phase model proposed by Obegi was utilized extensively for the task analysis portion of the study.

A small but significant body of empirical research has examined client attachment to the therapist. Certainly, fewer studies have explored the construct of attachment to the therapist than
studies exploring client global attachment, but available findings are notable. In order to empirically assess clients’ attachment to their therapists, Mallinckrodt et al. (1995) created the Client Attachment to Therapist Scale (CATS). The CATS reflects the following elements of an attachment relationship: proximity seeking, safe haven, secure base, separation anxiety, and stronger and wiser (Mallinckrodt, 2010). The CATS conceptualizes attachment to the therapist in terms of three dimensions: secure, fearful-avoidant, and preoccupied-merger. The secure dimension of the CATS reflects a perception of the therapist as consistently responsive and emotionally available. Meanwhile, the fearful-avoidant dimension is characterized by a distrust of the therapist, reluctance to engage in self-disclosure and in the intimate process of psychotherapy, and feeling unsafe or patronized by the therapist. Finally, the preoccupied-merger dimension is characterized by a longing to merge with the therapist, as well as worrying about obtaining the love and approval of the therapist.

Although in their original article, Mallinckrodt et al. (1995) found that their model of client attachment to the therapist was conceptually similar to the four-category model of attachment developed by Bartholomew and Horowitz (1991), Mallinckrodt (2000) has since moved towards connecting the CATS with the hyperactivation-deactivation attachment and emotion regulation model originally explicated by Dozier and Kobak (1992) and Kobak, Cole, Ferenz-Gillies, Fleming, and Gamble (1993).

The hyperactivation-deactivation model (Dozier & Kobak, 1992; Kobak et al., 1993) describes strategies individuals employ to regulate their attachment systems. Individuals who rely on a hyperactivating strategy are thought to have had an inconsistently available caregiver in childhood. These individuals learned to engage in excessive or exaggerated emotional displays to obtain care from their attachment figures. Individuals with a hyperactivating strategy tended to observe the inconsistent caregiver carefully for any potential signs of abandonment in an effort to maximize the availability of the caregiver. In contrast, individuals who rely on a deactivating
strategy are thought to have had a caregiver in childhood who consistently dismissed or ignored attachment cues. In response, these individuals learned to deactivate their attachment behavior and conscious awareness of attachment-related emotions in an effort to prevent the caregiver from further rejecting or ignoring them (Dozier & Kobak, 1992; Kobak et al., 1993).

Mallinckrodt (2000) linked the two dimensional approach of attachment (Brennan et al., 1998; Fraley & Waller, 1998) to the hyperactivation-deactivation model (Dozier & Kobak, 1992; Kobak et al., 1993) by asserting that hyperactivation is indicative of attachment anxiety, while deactivation is indicative of attachment avoidance.

In addition to linking the CATS to the hyperactivation-deactivation model (Dozier & Kobak, 1992; Kobak et al., 1993), Mallinckrodt (2000) also drew parallels between the dimensions of the CATS and the two global dimensions of attachment, attachment avoidance and attachment anxiety, described by Fraley and Waller (1998). Specifically, the secure dimension of the CATS is theorized to reflect a lack of either hyperactivating or deactivating strategies in the attachment to the therapist and thus, low attachment anxiety and avoidance with the therapist. The preoccupied-merger dimension is believed to reflect a client’s use of hyperactivating strategies in his or her relationship with the therapist and therefore indicates high attachment anxiety and low attachment avoidance with the therapist. Theoretically, the fearful-avoidant dimension reflects a deactivating strategy (Mallinckrodt, 2000), although Woodhouse et al. (2003) asserted that it is likely that this dimension of attachment to the therapist reflects a mixture of both hyperactivating and deactivating strategies and therefore is indicative of high attachment anxiety and high attachment avoidance with the therapist. As Woodhouse et al. noted, if the CATS were to fully correspond to the two dimensional model of attachment, a fourth dimension reflecting only a deactivating strategy and indicative of low attachment anxiety and high attachment avoidance with the therapist might be expected. Mallinckrodt et al. (1995) believed that such a dimension
was not identified during the development of the CATS because these types of clients tend to minimize distress and therefore would not be likely to seek counseling.

Although dimensions of attachment to the therapist are conceptually related to global attachment dimensions, in the present study, the dimensions of attachment to the therapist identified by the CATS were not translated into the global dimensions of attachment anxiety and avoidance identified by Brennan et al., (1998) and Fraley and Waller (1998). The dimensions of the CATS (secure, preoccupied-merger, and fearful-avoidant) represent a relatively new, state-of-the-art way of conceptualizing attachment to the therapist and will benefit from further investigation. Greater clarity in the present study can be maintained through use of the names of the dimensions of the CATS. Empirical research has used these related conceptualizations of attachment and attachment-related strategies to examine the association between clients’ attachment to their therapists and a number of psychotherapy-related constructs (e.g., working alliance, transference, in-session exploration).

Research has found links between clients’ attachment to their therapists and the working alliance (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005). Working alliance is described as the therapist and client working together towards therapeutic goals and includes a relationship characterized by trust, respect, and mutual regard (Gelso & Carter, 1985). Mallinckrodt (2000) theorized that individuals who are better able to develop a secure attachment to the therapist are able to function competently in interpersonal relationships and therefore have the ability to develop a positive working alliance. Individuals who develop an insecure attachment to the therapist, in contrast, are less interpersonally competent and the process of forming a strong alliance with these clients may be complex and take longer. Indeed, in empirical studies, secure attachment to the therapist was positively related to working alliance while preoccupied-merger and fearful-avoidant attachment to the therapist was negatively related to working alliance (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005).
Research has also examined the association between clients’ attachment to their therapists and depth/smoothness of therapy sessions (Mallinckrodt et al., 2005), as well as in-session exploration (Janzen et al., 2008). Theoretically, these constructs are expected to be related to the client’s attachment to the therapist because, as Bowlby (1988) argued, the client’s ability to use the therapist as a secure base will affect his or her ability to explore issues in psychotherapy. Thus, depth of therapy sessions, as well as level of in-session exploration, can be used as indicators of exploration. Mallinckrodt (2000) theorized that clients’ exploration in therapy is a function of clients’ attachment to their therapists. Indeed, Mallinckrodt et al. (2005) found that clients’ secure attachment to their therapists was positively related to both session depth and smoothness. In contrast, clients’ fearful-avoidant attachment to their therapists was negatively correlated with session depth and smoothness. Also, clients’ secure attachment to their therapists was positively related to level of in-session exploration, despite the fact that client global adult attachment orientations were not (Janzen et al., 2008). Overall, these results indicate that clients who have a secure attachment to the therapist, as opposed to those with a fearful-avoidant attachment to the therapist, are more likely to explore issues deeply in-session, perhaps indicating their comfort with using the therapist as a secure base.

Although less research exists pertaining to transference and attachment to the therapist, one study revealed an interesting link (Woodhouse et al., 2003). Theoretically, transference is thought to be related to attachment to the therapist, as the client’s ability to use the therapist as a secure base will permit the client to discuss and explore difficult issues, such as transference in the relationship between the therapist and client (Bowlby, 1988). Eagle and Wolitzky (2009) theorized that the development of transference, both positive and negative, demonstrates that the therapist is serving as an attachment figure and therefore serving as a secure base for the client. In fact, Woodhouse et al. (2003) found secure attachment to the therapist was positively related to both negative transference and amount of transference. This finding highlights the benefit of
secure attachment to the therapist and provides empirical support for the idea that a secure
attachment to the therapist enables the client to explore difficult material, such as transference, in
therapy.

The Present Study

The purpose of the present study was to utilize a longitudinal, mixed-method case study
design to examine (a) how secure attachment to the therapist develops and (b) how the
development of secure attachment to therapist is related to client-reported depressive
symptomology for a client with Major Depressive Disorder.

Since the seminal works of John Bowlby (1982, 1988) and Mary Ainsworth (1967,
1972), hundreds of studies have utilized attachment theory to explore and explain how individuals
function in relationships with important others, including romantic partners and psychotherapists
(see Mikulincer and Shaver, 2007, for a review). More recently, several studies have
demonstrated links between attachment to the therapist and important psychotherapy constructs,
including the working alliance (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005), transference
(Woodhouse et al., 2003), session depth (Mallinckrodt et al., 2005), and in-session exploration
(Janzen et al., 2008; Mallinckrodt et al., 2005).

Bowlby (1988) believed that secure attachment to the therapist was essential, as it
allowed clients to rely on the therapist as a secure base from which to engage in exploration of
psychological material. Research supports Bowlby’s assertion that secure attachment to the
therapist allows for client exploration. Mallinckrodt et al. (2005) found that clients’ secure
attachment to their therapists was positively related to both session depth and smoothness.
Further, Janzen et al. (2008) demonstrated that clients’ secure attachment to their therapists was
positively related to level of in-session exploration. These two studies provide supporting
evidence for the idea that clients who have a secure attachment to the therapist are more likely to
explore issues deeply in-session. Bowlby also believed that when clients are able to develop an
attachment to their therapists and engage in exploration, they will also be able to participate in the
difficult work of reconstructing their negative internal working models of attachment. Bowlby
(1973, 1979, 1980, 1982) described internal working models as intricate models of self and others
that profoundly influence the ways in which individuals interact with the world. These models are
not simple templates, but rather complex models that that include cognitions, emotions,
expectations and reactions that inform how individuals are in relationships with important others.
It theoretically follows that a positive shift in these working models may improve interpersonal
functioning, decrease vulnerability to depression, and ultimately lead a change in depressive
symptomatology. However, to date, no studies have longitudinally examined how secure
attachment to the therapist develops, or how the development of this attachment is linked to
symptom change in the client.

The present study sought to contribute to existing research and knowledge in this area by
using a longitudinal mixed-methods case study design to examine how, session by session, a
client with Major Depressive Disorder developed a secure attachment to the therapist. This type
of design permitted a nuanced examination of associations between attachment to the therapist
and client-reported symptomatology for clients with depression. This type of study contributes to
the existing empirical research on attachment to the therapist and further elucidates potential
implications of secure attachment to the therapist.

Both theory (e.g., Dozier & Tyrell, 1998; George & Solomon, 1999; Mallinckrodt, 2000;
Mikulincer & Shaver, 2007) and empirical findings (e.g., Dozier et al., 1994; Mohr et al., 2005;
Romano et al., 2008) have drawn attention to the benefits of therapists who are low on both
attachment anxiety and low attachment avoidance (i.e., secure). Theoretically, these therapists are
better able to focus on the needs of their clients without becoming preoccupied with their own
distress (George & Solomon, 1999; Mikulincer & Shaver, 2007). Studies have found, for
example, that these therapists, when compared with therapists with high attachment anxiety
and/or high attachment anxiety (i.e., insecure) are best able to provide noncomplementary responses to clients (Dozier et al., 1994), create strong working alliances (Black et al., 2005; Sauer et al., 2003), and avoid demonstrating hostile countertransference behavior (Mohr et al., 2005). Thus, for the purposes of the present study, only therapists will low attachment anxiety and low attachment avoidance (i.e., secure) were included. By holding constant the attachment style of therapists, the potential confounding effects of therapist attachment were minimized, allowing the study to focus specifically on links between client attachment to the therapist and the outcomes of interest.

In conclusion, the present longitudinal, mixed-methods case-based study examined how a client with Major Depressive Disorder developed an attachment to the therapist over the course of brief psychotherapy. Task analysis was utilized to determine how, in this case, secure attachment to the therapist developed. Correlational analyses were utilized to determine the direction and strength of the association between secure attachment to the therapist and client-reported change in depressive symptomatology. This study contributes to extant research on attachment and the psychotherapy relationship by elucidating how the process of developing an attachment to the therapist is linked with client change.

**Research questions and hypotheses.**

**Development of secure attachment to the therapist.**

Mallinckrodt (2010) proposed that use of the therapist as an attachment figure may take time to develop and may not be present early in treatment. Research has supported this idea. Empirically, Parish and Eagle (2003a) found that secure attachment to the therapist is positively related to duration of therapy. However, this study only examined clients who had been in therapy for more than six months; many of the clients in this study had been in therapy with the same therapist for years. More recently, Bachelor, Meunier, Laverdi’ere, and Gamache (2010) found that clients seen for fewer than nine sessions reported lower levels of secure attachment to
the therapist than clients who were seen for more than 15 sessions. This finding supports the idea that secure attachment to the therapist grows over time and may be present in brief treatment. However, extant research as not explored how secure attachment to the therapist develops over the course of brief treatment. Thus, a research question for the present study was: How does a client with Major Depressive Disorder (MDD) develop a secure attachment to the therapist during the course of brief psychotherapy?

Client change in interpersonal functioning.

Bowlby (1973, 1982, 1988) theorized that individuals’ attachment orientations, which are representative of their internal working models of self and others, impact the ways in which they engage in important relationships. A large body of empirical research has found links between adult attachment styles and patterns of interpersonal problems or distress (e.g., Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; Mallinckrodt & Wei, 2000; Wei et al., 2005). Bowlby (1988) asserted that by developing a secure attachment to the therapist, a client may be able to explore and change their internal working models. A shift in these models of self and others would theoretically lead to a change in the way an individual engages interpersonally. Given the brief nature of the treatment in this particular study, however, no specific hypotheses were advanced. Rather, pre-treatment and post-treatment data regarding interpersonal functioning were examined to determine if clinically significant change had occurred.

Hypothesis regarding client-reported change in depressive symptomology.

1. Client secure attachment to the therapist will be negatively related to client-reported depressive symptomology for a client with Major Depressive Disorder.

Bowlby (1980) believed that the repeated failure to form a secure attachment to an early caregiver fosters the development of negative representations of self and the world that are characteristic of depression. These negative internal working models of self and other interfere with individuals’ abilities to effectively regulate their emotions and maintain positive cognitive
models of the world, placing them at risk for developing affective disorders (Mikulincer & Shaver, 2007). Multiple studies (e.g., Lopez, et al., 2001; Rholes, et al., 2006; Treboux et al., 2004; Wei, et al., 2003; Wei, et al., 2004; Wei, et al., 2005) have found links between depression and the insecure attachment styles that are characteristic of individuals with negative working models of self and other.

Bowlby (1988) proposed that when clients are able to develop a secure attachment to the therapist, they are able to use the therapist as a secure base from which they can explore and modify their negative internal working models; this in turn may lead to a reduction in symptomology. Thus, it was hypothesized that a secure attachment to the therapist would be negatively related to client-reported changes in depressive symptomatology.

**Planned post-hoc analyses.**

As previously stated, the Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995) contains three dimensions of attachment to the therapist. Hypotheses were advanced regarding links between the secure dimension of attachment to the therapist and client-reported change in depressive symptoms. No specific hypotheses were advanced with regard to the fearful-avoidant and preoccupied-merger dimensions of attachment to the therapist, as neither theory nor research has yet addressed links between these types of attachment to the therapist and client change. However, planned post-hoc analyses addressed the following research questions:

1. What is the link between the development of fearful-avoidant attachment to the therapist and client-reported depressive symptomology for a client with Major Depressive Disorder?

2. What is the link between the development of preoccupied-merger attachment to the therapist client-reported depressive symptomology for a client with Major Depressive Disorder?
Chapter 3

Methods

Participants and Recruitment

Therapist participant. Advanced mental health trainees practicing at the counseling center of a large, mid-Atlantic university were emailed a description of the study (Appendix N) and asked to consider participating in the study. Two therapists indicated an interest in participating. One therapist who met criteria for the study was able to successfully recruit a client and participated in the study. She had a score of 17 on attachment anxiety and a score of 14 on attachment avoidance. This therapist was compensated a total of $40 for her participation in the study.

The therapist who participated in the study was a 32-year-old woman of advanced standing in a psychology doctoral program. She had a master’s degree in counseling. She estimated that over the course of 9 years of clinical training and work experience, she had seen about 250 clients. The therapist was asked to rate how much she believed in and followed several theoretical frameworks (Appendix A). On a scale of 1 (do not believe in or follow) to 5 (believe in and follow), the therapist’s ratings were as follows: psychoanalytic/psychodynamic = 4, cognitive/behavioral = 2, humanistic/experiential = 2, and feminist/multicultural = 4.

Client participant. The selected therapist participant was asked to recruit one of her regularly assigned clients at the counseling center prior to seeing this client for a first session. The therapist was provided with a recruitment script (Appendix O) to email to clients who met study criteria (see below). The first client contacted by the therapist participant contacted the researcher and indicated interest in participating. The researcher described the study and the client agreed to participate.
The client participant was required to have a primary diagnosis of Major Depressive Disorder (MDD) according to criteria in *DSM-IV-TR* (American Psychiatric Association, 2000) and as assigned by the initial consultation clinician at the counseling center in order to be eligible for participation. The client was also required to have an elevated score (i.e., score of 1.73 or higher) on the Depression subscale of the Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62; Locke et al., 2011). McAleavey, Nordberg, Hayes, Castonguay, Locke, and Lockard (2012) suggest that this score can be utilized as a diagnostic cut score for the Depression subscale (see below). Finally, the client was required to be between 18 and 65 years of age.

Potential clients were excluded on the basis of the following exclusion criteria: (1) current substance abuse or dependence (also as defined by *DSM-IV-TR* criteria), (2) current diagnosis of borderline personality disorder (as defined by *DSM-IV-TR* criteria), (3) a history of psychotic symptoms, or (4) imminent risk of suicide. Individuals with borderline personality disorder (BPD) demonstrate unstable, intense interpersonal relationships, chronic fears of abandonment, and lack of a stable sense of self (American Psychiatric Association, 2000). Given the tendency for individuals with BPD to display erratic relationship engagement patterns, these individuals may demonstrate correspondingly irregular patterns in their development of attachment to the therapist. Thus, individuals diagnosed with BPD upon initial consultation were excluded from participation in this study. Additionally, the presence of substance abuse/dependence or psychosis may interfere in theoretically unpredictable ways with the client’s ability to form an attachment to the therapist and therefore, clients with these particular presenting concerns were excluded from participation.

The client participant was a 21-year-old, heterosexual White woman in her senior year of college. This was her first time attending counseling. She reported that she was seeking treatment to address a range of depressive symptoms, including passive suicidal ideation, social isolation,
hypersomnia, anhedonia, and low motivation. She did not take any medication during her treatment and did not report the occurrence of any significant life events during treatment. The initial consultation therapist diagnosed the client with Major Depressive Disorder, Recurrent, Moderate and gave a current Global Assessment of Functioning (GAF) score of 60. At termination, the therapist added a diagnosis of Social Phobia.

**Instruments**

**Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62) and Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34).** The Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62; Locke et al., 2011; Appendix D) was used to assess the client’s psychological symptoms at the time of initial consultation at the counseling center. A short form of the CCAPS-62, the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34; Locke et al., 2012; Appendix E) was used to assess the client’s psychological symptoms at each therapy session after the initial consultation.

**CCAPS-62 (Locke et al., 2011).** The CCAPS-62 was developed as a standardized, multidimensional instrument for use with clients at college counseling centers. The CCAPS-62 is comprised of eight factor-derived subscales including Depression, Eating Concerns, Substance Use, Generalized Anxiety, Hostility, Social Anxiety, Family Distress, and Academic Distress. Each subscale is composed of several questions. Students rate how closely each statement applies to them within the past two weeks, from 0 (*not at all like me*) to 4 (*extremely like me*). A total subscale score is then calculated by averaging responses across the subscale questions. Higher scores indicate more distress. Given that this study focused on individuals diagnosed with Major Depressive Disorder, the Depression subscale is of particular interest. The CCAPS-62 Depression subscale contains 13 items, including: “I feel isolated and alone,” and “I feel sad all the time.”

With regard to the CCAPS-62, Locke et al. (2011) provided evidence of good internal consistency of subscale scores (range: .78 – .92), as well as evidence of test-retest reliability with
one-week test–retest stability coefficients between .78 and .93 for each of the eight subscales. Additionally, scores for each subscale of the CCAPS-62 demonstrated convergent validity with scores from established measures administered concurrently. Specific to the Depression subscale, the internal consistency coefficient in the Locke et al. study was excellent (Cronbach’s \( \alpha = .913 \)). The Depression subscale was also highly correlated (Pearson product-moment correlation coefficient = .721) with the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) demonstrating convergent validity of this subscale.

**CCAPS-34 (Locke et al., 2012).** The CCAPS-34 (Locke et al., 2012) was developed in response to a need for a shorter version of the measure that would require only 2-3 minutes to complete. In addition to requiring less time to complete, the CCAPS-34 was designed to retain the multidimensional structure of the CCAPS-62 and make possible repeated measurement to monitor treatment progress and outcomes. The CCAPS-34 consists of 34 items and seven subscales. All items of the CCAPS-34 are present in the CCAPS-62 under the same subscales. Of note, the CCAPS-34 does not have a Family Distress subscale and the Substance Use subscale of the CCAPS-62 is the Alcohol Use subscale in the CCAPS-34 because all of the subscale items in the short version refer to alcohol use. The Depression subscale of the CCAPS-34 has 6 items including: “I feel isolated and alone,” and “I feel sad all the time.”

High correlations between the CCAPS-62 and the CCAPS-34 were found for all subscales (range: .92 -.98). Locke and colleagues (2012) reported internal consistency estimates range from 0.76 to 0.89. Tests of reliability demonstrated that the subscales were stable over 1- and 2-week time periods (\( r = .71–.86; \) Center for Collegiate Mental Health, 2010). Additionally, scores for each subscale of the CCAPS-34 demonstrated convergent validity with scores from established measures administered concurrently. Specific to the Depression subscale, the internal consistency coefficient was excellent (Cronbach’s \( \alpha = .876 \)). Additionally, the test-retest coefficients for this subscale are .87 for one week and .86 for two weeks (Locke et al., 2012).
The Depression subscale is also highly correlated with the BDI (Pearson’s $r = .698$) demonstrating convergent validity of this subscale.

**Cut scores:** McAleavey et al. (2012) conducted multiple studies examining the clinical validity of the CCAPS-62. One of these studies used therapist-rated diagnoses collected from 5 university counseling centers to examine the validity of specific CCAPS-62 subscale scores. Using receiver operating characteristic curves, these researchers identified cut points for diagnostic screening that can be used by counseling center clinicians. Specifically for the Depression subscale, which is of most interest in the current study, McAleavey et al. identified a diagnostic cut score of 1.73 (on a scale of 0 to 4). McAleavey et al. cautioned that because this cut point is likely to lead to many false positive diagnoses, it is important not to use this tool as a definitive diagnostic test. Rather, an elevated score on the Depression subscale of the CCAPS-62 that is at or above the diagnostic cut score serves to alert the intake clinician to explore this area further. Thus, in the current study, the client participant was required to have both a clinician-assigned diagnosis of MDD and a score on the Depression subscale of the CCAPS-62 that was at or above the diagnostic cut score. These two inclusion criterion increased confidence in selecting a client participant with MDD.

**Experiences in Close Relationships Scale- Short Form (ECR-S).** The Experiences in Close Relationships Scale-Short Form (ECR-S; Wei, Russell, Mallinckrodt, & Vogel, 2007; Appendix B) was used to measure global attachment dimensions of both therapists and clients. The full-length version of the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) was developed from the existing self-report measures of adult attachment. An initial pool of over 300 items was narrowed to a list of 36 items used to measure the two orthogonal factors of attachment avoidance and attachment anxiety. Each of the two subscales of the ECR is comprised of 18 items measured on a 7-point Likert scale ranging from 1 (*disagree strongly*) to 7 (*agree strongly*). In 2007, Wei et al. created short, 12-item version of the ECR.
using exploratory factor analysis. Six items from each of the two subscales were retained for the short form based on factor loadings and conceptual considerations. Each of the 12 questions is answered using the same 7-point Likert scale originally used in the ECR. The Avoidance subscale assesses the comfort a person feels in terms of emotional closeness to another person (e.g., “I try to avoid getting too close to my partner”). The Anxiety subscale measures the extent to which the respondent wishes to merge with the other person (e.g., “My desire to be very close sometimes scares people away”) and fears rejection and abandonment (e.g., “I get frustrated if romantic partners are not available when I need them”). Participants are asked to respond to items in terms of how they generally experience relationships instead of how they experience a specific relationship. Wei and colleagues reported good internal consistencies of 0.84 for the Avoidance subscale and 0.78 for the Anxiety subscale. High correlations between the original version and the short form were found for the Anxiety \((r = .95)\) and Avoidance \((r = .95)\) subscales.

Dimensions of attachment avoidance and attachment anxiety, as measured by the ECR-S, were related in theoretically expected ways to measures of excessive reassurance-seeking and depression (Wei, et al.), providing validity evidence.

In the present study, the ECR-S was used to assess global client attachment and global therapist attachment in terms of dimensions of avoidance and anxiety, as adult romantic attachment is conceptualized as a global component of personality that affects all close adult relationships that may activate the attachment system (Shaver & Mikulincer, 2005). As previously discussed in Chapter Two, therapists with low attachment anxiety and avoidance were sought for participation in this study. For the purposes of the present study, low attachment anxiety and avoidance was defined as scores on each dimension that are below the mean reported in prior research examining attachment anxiety and avoidance in therapists. Hardy (2010) utilized the ECR-S to assess dimensions of attachment anxiety and avoidance in a sample of therapists \((n = 53)\). She reported a mean of 19.58 \((SD 1.01)\) for therapist attachment anxiety and a mean of
14.89 (SD 1.0) for therapist attachment avoidance. Thus, for the present study, therapists with a score below 19.58 on attachment anxiety and a score below 14.89 on attachment avoidance on the ECR-S were invited to participate.

**Inventory of Interpersonal Problems (IIP-64).** The IIP-64 was administered to the client prior to the beginning of treatment, as well as at the conclusion of the present study, to assess her interpersonal functioning. The IIP-64 (Alden, Wiggins, & Pincus, 1990; Horowitz, Alden, Wiggins, & Pincus, 2000; Horowitz, Rosenberg, Baer, Ureno, & Villaseñor, 1988; Appendix C) is a 64-item self-report measure assessing interpersonal problems and distress. This instrument contains eight subscales that are correlated in the pattern of a circumplex. Each subscale consists of eight items that are scored on a 5-point Likert scale ranging from 0 (not at all) to 4 (extremely). The subscales include: (a) domineering/controlling, which indicates struggles to surrender control over others; (b) vindictive/self-centered, which describes difficulties with hostile dominance and the inclination to argue with others; (c) cold/distant, which refers to low levels of affection for and connection with others; (d) socially inhibited, which reflects the tendency to feel anxious and avoidant in the presence of others; (e) non-assertive, which assesses difficulties in taking initiative in relation to others and coping with social challenges; (f) overly accommodating, which reflects an excess of friendly submissiveness; (g) self-sacrificing, which demonstrates a tendency to affiliate excessively; and (h) intrusive/needy, which measures problems with friendly dominance (Horowitz, 2004; Horowitz et al., 2000). In addition to the dimensions assessed by these eight subscales, an overall level of distress is obtained by summing the scores of all items of the measure.

The IIP-64 has demonstrated high reliability and validity. Horowitz et al. (2000) provided evidence for the stability of the circumplex structure. Horowitz et al. (2000) and Tracey, Rounds, and Gurtman (1996) established validity for the measure by demonstrating that the IIP-64 was correlated in theoretically expected ways with convergent measures. Further, Horowitz et al.
(2000) found subscale coefficient alphas between .76 and .88. Finally, the IIP-64 demonstrated high test-retest reliability, producing correlation coefficient of .79 for the overall scale and between .58 and .84 for the subscales (Horowitz et al., 2000).

**Client Attachment to Therapist Scale (CATS).** The Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995; Appendix G) was administered to the client once per week starting at session two in order to assess the development of attachment to the therapist. The client participant completed the CATS immediately prior to each weekly therapy session. The CATS was designed to measure clients’ current perception of their relationship with their therapists from the perspective of attachment theory. The questionnaire consists of 36 self-report items on a six-point Likert scale ranging from 1 (**strongly agree**) to 6 (**strongly disagree**). The CATS contains three subscales: secure, preoccupied-merger, and avoidant-fearful.

The secure subscale, which consists of 14 items, assesses the degree to which a client views the therapist as emotionally available, accepting, understanding, and able to provide a secure base from which the client can explore difficult material (e.g., “When I show my feelings, my counselor responds in a helpful way”). Woodhouse, Schlosser, Crook, Ligiéro, and Gelso (2003) found an internal consistency coefficient alpha of .78 and Mallinckrodt et al. (1995) reported a test–retest reliability coefficient of .84 for the secure subscale (over a 2-4 week period). The preoccupied-merger subscale, which consists of 10 items, measures the client’s preoccupation with the therapist as well as the therapist’s other clients (e.g., “I think about being my counselor’s favorite client”). It also reflects the client’s desire for more contact and merger with the therapist, as well as their longing 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”). Mallinckrodt et al. (1995) reported an alpha of .81 and a test–retest reliability coefficient of .86 for the preoccupied-merger subscale (over a 2-4 week period). Finally, the avoidant-fearful subscale assesses the degree to which the client suspects the therapist as rejecting
and disapproving when displeased (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 shameful and humiliated in their interactions with the therapist (e.g., “Talking over my problems with my counselor makes me feel ashamed or foolish”). Woodhouse et al. reported an internal consistency coefficient alpha of .70 and Mallinckrodt et al. found a test-retest reliability coefficient of .72 for this subscale (over a 2-4 week period). Concurrent validity support has also been provided, as Mallinckrodt et al. found that the subscales of the CATS correlated in theoretically-expected directions with working alliance and object relations measures.

Helpful Aspects of Therapy (HAT). The Helpful Aspects of Therapy (HAT; Llewelyn, 1988; Appendix H) was completed by the client immediately following each weekly session, starting at session 1. The HAT is an open-ended, seven-item qualitative measure used to collect client perceptions of helpful and non-helpful events that occurred during psychotherapy sessions. Questions include: “Of the events that occurred in this session, which one do you feel was the most helpful for you personally? It might be something you said or did, or something your therapist said and did,” and “Did anything happen which might have been hindering? If yes, please describe it briefly and rate how hindering it was.” Clients use a scale ranging from 1 to 9 to rate the level of hindrance (1 = extremely hindering) or helpfulness (9 = extremely helpful). Elliott, Slatick, and Urman (2001) note that the descriptive data generated by the HAT typically fall into several general types of information, including: therapist actions, therapist as a person, client actions, and client reactions to within session processes.

The HAT data was used to identify significant therapeutic processes that may be associated with shifts in attachment to the therapist or other clinical changes. In addition to the Change Interview (see below), the HAT provided direct feedback from the client about her perceptions of what was helpful or hindering about psychotherapy.
The Change Interview. The Change Interview (Elliott, 1996) was administered to the client approximately two weeks after therapy ended (Appendix I). A modified version of the Change Interview designed for this study was administered to the participating therapist approximately three weeks after therapy ended (Appendix J).

The Change Interview was designed to assess three main types of information: (a) changes perceived by clients over the course of therapy; (b) clients’ understanding of the reasons for these changes, including helpful aspects of therapy; and (c) hindering or difficult aspects of therapy (Elliott et al., 2001). The Change Interview Outline consists of 9 content areas including: general experience of therapy, changes, attributions, helpful aspects, hindering aspects, difficult but OK aspects, missing aspects, research aspects, and suggestions. Questions include, for example: “What changes, if any, have you noticed in yourself since therapy started?” and “What has been the most helpful thing about your therapy?” The interview is semi-structured in that specific questions are provided, but additional questions may be asked as relevant. Elliott et al. (2001, p. 72) suggest that interviewers “are encouraged to adopt an attitude of curiosity, using both open-ended exploratory questions and empathic understanding responses to help the client elaborate his/her experiences.”

Given that the focus of this study was on the relational aspects of treatment (i.e., the attachment a client develops to his or her therapist), obtaining the therapist’s perceptions about treatment was important to have a more complete picture of what occurred during therapy. Thus, for this study, a modified version of the Change Interview was created. Questions were modified to be appropriate for the therapist. For example, the two questions provided as examples above were reworded as follows: “What changes, if any, have you noticed in your client since therapy started?” and “What do you believe has been the most helpful thing about therapy for this client?”

Standardized Data Set (SDS). The Standardized Data Set (SDS; Center for Collegiate Mental Health, 2011; Appendix F) is a standardized set of demographic and mental health
questions asked of clients at initial consultation who are seeking treatment at the counseling center. Demographic information of the participating client, including race/ethnicity, gender, and sexual orientation was collected using this form. Information about prior mental health treatment and other clinically relevant factors (e.g., trauma history, self-injurious behaviors, social support) was also collected in the SDS.

**Demographic questionnaire.** Potential therapist participants completed a demographic questionnaire prior to beginning the study (Appendix A). The demographic questionnaire for therapists asked for information regarding gender, age, race/ethnicity, years of clinical experience, approximate number of clients seen, level of highest degree, and type of graduate school program.

**Procedure**

Trainees serving as therapists at the college counseling center of a large, mid-Atlantic university were invited to complete the 12-item Experiences in Close Relationships Scale—Short Form (ECR-S; Wei, et al., 2007) and therapist demographic form to determine their eligibility to participate further in the present study. Two therapists completed informed consent forms (Appendix K), these measures, and were emailed a $5.00 gift card to Amazon.com. One therapist demonstrated low attachment anxiety and avoidance on this measure (as defined above) and participated in the study. This therapist was asked to successfully recruit one client for participation in the study.

As part of regular intake procedures at the counseling center, new clients attend an initial consultation session. During this time, they complete the CCAPS-62, SDS, and a clinical interview that is approximately one hour in length. The clinician conducting the initial consultation completes a multi-axial diagnosis for the client following this time. In the present study, the diagnoses assigned to the client following the initial consultation were later utilized to establish whether or not clients met inclusion and exclusion criteria for the study. Clients’ scores
on the Depression subscale of the CCAPS-62 that is completed during initial consultation was also a factor in assessing clients’ eligibility for the study.

Following the initial consultation, clients who remain at the counseling center for treatment are assigned to a therapist. The therapist who met criteria for this study and agreed to participate was asked to review the files (including diagnosis and CCAPS-62 scores) for all of her newly assigned clients to determine if those clients meet criteria for the study. When a client met criteria for the study, the therapist contacted the client via email prior to their first session. The therapist sent the client a recruitment script provided to her that describes the study. The client was interested in participating in the study and contacted the research via email. She was provided with further information about the study and agreed to participate.

The client next met with a research assistant of the study at the counseling center immediately prior to her first treatment session to complete the informed consent (Appendix L), HIPAA Authorization (Appendix M), and two initial measures. These measures included the 12-item Experiences in Close Relationships—Short Version (ECR-S; Wei et al., 2007) and the 64-item Inventory of Interpersonal Problems-64 (Alden et al., 1990; Horowitz et al., 2000; Horowitz et al., 1988). The client was emailed a $10 Amazon.com gift card after completing these measures.

Immediately before each therapy session (except session 1), the client completed a measure of attachment to the therapist, the 36-item Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995). The client also completed the 34-item Counseling Center Assessment of Psychological Symptoms (CCAPS-34; Locke et al., 2012) prior to all therapy sessions. This measure is frequently administered to clients at the counseling center in order to monitor symptoms over time. The therapist digitally video recorded all therapy sessions with the participating client and stored these recordings on a secure server for later review by the researcher and her assistant.
Immediately after each therapy session, the client completed two additional questionnaires. First, she completed the seven-item Helpful Aspects of Therapy (HAT; Llewelyn, 1988), asking about both helpful and hindering aspects of the therapy session. Second, she completed a questionnaire with only two questions, which are about (1) any significant life events that have occurred outside of therapy over the past week and (2) any changes in the type/dosage of psychotropic medications taken since the last session (Appendix P). The client was emailed a $5 gift card to Amazon.com after completion of all measures prior to and after session each week.

The client and therapist dyad engaged in therapy for a total of six sessions, which is the number of free therapy sessions provided to college students per academic year at the counseling center. Therapy proceeded in the way that was natural for the client and therapist without intrusion or instruction from the researcher. The therapist received supervision for the case as a part of her regular supervision provided by a licensed psychologist at CAPS. The supervision was not influenced in any way by the researcher and proceeded however the supervisor and supervisee wished.

Three weeks after the termination of therapy, the therapist participated in a modified version of the Change Interview (Elliott, 1996), an interview protocol that asked about her experiences providing therapy to the client participant. This interview was completed via telephone with the PI and lasted about 30 minutes. The therapist was compensated with a $35 Amazon.com gift card via email following the interview. Approximately two weeks after data collection ended, the client participated in the Change Interview (Elliott, 1996) via telephone with the PI. The client also completed two measures: the ECR-S (Wei et al., 2007) and the IIP-64 (Alden et al., 1990; Horowitz et al., 2000; Horowitz et al., 1988) electronically and emailed them to the PI two days after the final interview. The client was compensated with a $25 gift card to Amazon.com via email following the interview. The researcher transcribed the interviews with both the therapist and the client.
Data Analysis

Data analysis for this mixed-methods design consisted of both qualitative and quantitative analyses.

**Qualitative analyses.** Task analysis (e.g., Greenberg, 1976, 1984, 2007; Pascual-Leone, Greenberg, Pascual-Leone, 2009) was used in the present study to explore the key research question, “How did this client develop a secure attachment to the therapist over the course of therapy?” Pascual-Leone et al. (2009) stated that task analysis is a method of inquiry that asks the question, “How did the client do that?” During the initial discovery phase of task analysis, researchers engage in a qualitative study of the process of change as it unfolds in session and delineate the steps of the successful completion of a therapeutic task. This type of analysis is used to create descriptive models and infer causal models of change.

Task analysis (Greenberg, 2007; Pascual-Leone et al. 2009) is comprised of two phases: discovery and validation. Only the discovery phase was used during this study, as the validation phase involves the creation of a program of research conducted over multiple quantitatively-based studies. The first step of the discovery phase is to create a rational model that uses relevant theory to define the task of interest and create a map of theoretical task sequence. In the present study, the task of interest was the development of the client’s attachment to the therapist. The PI and her research assistant, both of whom are clinicians familiar with attachment theory and task analysis, together created this rational model prior to engaging in data analysis.

After the rational model was created, researchers engaged in an empirical analysis. As Pascual-Leone et al. (2009, p. 534) state, “The researcher’s struggle in this process, aided by the use of a theoretical lens, is to sort and to find invariant patterns…in the essential task performances that contribute to task completion. In the end, the qualitative approach that is necessary here is to identify and elaborate essential aspects of the phenomena’s teleological structure until such a model reaches stability.” Thus, analyzed data was constantly compared to
the rational model in order to create a rational-empirical model that is a true synthesis of rational and empirical modeling. Original components (tasks) of the rational model were modified or removed in accordance with empirical observations. Similarly, empirically observed tasks were added to the model when necessary. The resulting rational-empirical model represents a final model of client task completion (Pascual-Leone et al. 2009).

During the empirical modeling phase of data analysis, the PI and her research assistant immersed themselves in the data by (1) watching all video recorded psychotherapy sessions, (2) reviewing client feedback that was provided post-session via the HAT (3) reviewing client scores on the CATS, and (4) reviewing client and therapist Change Interviews. Multiple sources of data allowed the researchers to compare varying perspectives on the therapeutic relationship (observation, client perspective, and therapist perspective) and identify key patterns. They also added to the richness of the data, as well as the modeling of the task at hand.

Greenberg (2007) emphasized the importance of the explicating the clinician-investigators’ cognitive maps prior to creation of a rational model. Thus, prior to constructing the rational model or immersing themselves in the data to construct the rational-empirical model, the investigators engaged in bracketing by discussing salient assumptions and understandings relevant to the framework of the present study. Both investigators are strong proponents of attachment theory and have engaged in attachment research for several years. Further, both investigators are practicing clinicians who use attachment theory in their clinical work to conceptualize clients’ presenting concerns and the development of the therapeutic relationship. The assumptions the investigators explicated in this present study about the development of an attachment to the therapist were that attachment to the therapist will develop; that attachment to the therapist will grow stronger over time; and that the short-term nature of the therapeutic relationship in this study may prevent the client from developing a consistently secure attachment to the therapist. Further, both researchers discussed the potential influence of their personal
relationships with this therapist in order to bracket the following assumptions: this therapist is a skilled and relationally-savvy therapist and she tends to quickly develop positive working relationships with clients. Researchers were mindful of all bracketed assumptions as they analyzed the data.

**Quantitative analyses.**

Yin (2008) recommends that inferential statistics should not be used in case study research, as case studies are designed to permit generalizations about theory. However, unlike research with large sample sizes, case study research does not allow one to infer from a sample to a population. Thus, statistical generalization, which normally precedes theoretical generalization in research with large samples, is not appropriate for case study research. Rather, in case studies, generalizations are made directly from sample data to theory (Stiles, 2010; Yin, 2008). Cohen (1994) also argues that researchers should be more attentive to effect size than to probability-based significance testing. Therefore, in the current case study, effect sizes, rather than inferential statistics were used. Cohen and Cohen (1983) described correlations from .10 to .29 as representing small effects, from .30 to .49 as medium effects, and greater than .49 as large effects. These guidelines regarding effect sizes were utilized in interpreting quantitative data.

**Depressive symptoms.** Pearson correlation coefficients were computed to determine if there is a relationship between client secure attachment to the therapist (as measured by the Secure subscale of the CATS) and client depressive symptoms (as measured by the Depression subscale of the CCAPS-34). These analyses were used to evaluate the hypothesis that client-reported secure attachment to the therapist will be negatively related to client-reported depressive symptomatology.

Pearson correlation coefficients were also computed to explore the relationship between client preoccupied-merger attachment to the therapist (as measured by the Preoccupied-Merger subscale of the CATS) and client depressive symptoms (as measured by the Depression subscale...
of the CCAPS-34). Finally, Pearson correlation coefficients were computed to explore the relationship between client avoidant-fearful attachment to the therapist (as measured by the Avoidant-Fearful subscale of the CATS) and client depressive symptoms (as measured by the Depression subscale of the CCAPS-34). No specific hypotheses were advanced regarding these relationships, as neither theory nor research has yet to address links between these types of attachment to the therapist and symptomatology.

**Interpersonal functioning measure.** Differences between each client’s scores pre- and post-treatment were compared for the IIP-64 and tested for clinically significant change according to the criteria set forth by Jacobson and Truax (1991). These authors proposed two criteria for assessing clinical significance: first, the treated individual must move from a theoretically dysfunctional population to a theoretically functional one, and second, change must be reliable. To meet the first criterion, the individual client’s score on the IIP-64 at pre-treatment must be more than two standard deviations above the general (i.e., functional) population mean and must move, by post-treatment, to within two standard deviations of this mean. Muran, Safran, Samstang, and Winston (2005) established that the clinical cutoff for the IIP-64 is 1.13. Thus, the client participant’s scores pre-treatment and post-treatment was compared against this cutoff score to determine if she (a) was above the clinical cutoff pre-treatment and, if so, (b) demonstrated clinically significant change over the course of treatment. To determine if the client participant met the second criterion of clinically significant change proposed by Jacobson and Truax (1991), reliable change was calculated. Reliability was calculated using the Reliable Change Index (RCI): If the RCI for a client participant was greater than 1.96, then it can be concluded with at least 95% confidence that the change from pre-treatment to post-treatment is due to a true shift in functioning, rather than as a result in measurement error or random fluctuation in scores (Jacobson & Truax, 1991). Muran et al. (2005) established that the standard error for the IIP-64 is 0.34. Thus, a difference of 0.67 in scores pre- to post-treatment is required
for an RCI of 1.96. The client’s pre-treatment and post-treatment scores were assessed to
determine if she demonstrated reliable change as described above.

Global assessment measures. In the context of the present study, inclusion of
pretreatment assessment of client global attachment (as assessed by the ECR-S) allowed for
examination of whether the links between the development of attachment to the therapist and (a)
client changes in depressive symptomology and (b) interpersonal functioning appear to support
the predictions of theory for that client. For example, attachment theory (Bowlby, 1988) posits
that as clients grow more secure in their attachment to the therapist, they develop more positive
internal working models of self and other and ultimately, demonstrate less psychological distress
and greater interpersonal functionality. Thus, if the client participant demonstrated a secure
attachment to the therapist, as well as a reduction in symptoms and increase in interpersonal
functioning, we might expect to see changes in her ECR scores. If, however, a client participant
demonstrated positive changes in ECR scores (e.g., reduced attachment anxiety and/or avoidance)
but did not demonstrate secure attachment to the therapist, this would be inconsistent with
attachment theory and contrary to theoretical predictions.

Finally, obtaining additional information about each client’s global attachment style as
assessed by the ECR allowed for a more detailed, nuanced description of the specific client
included in the case study. This added to the richness of the case-study design and assisted with
interpretation of the data.
Chapter 4

Results

Qualitative Results

Rational analysis and model. Task analysis requires that a rational model be constructed prior to immersion in the data. The rational model uses theory to create a map of the task sequence (Pascual-Leone et al., 2009). Here, the task of interest was the development of a secure attachment to the therapist.

The rational model, as presented in Figure 1, was primarily composed based on the phase model of attachment to the therapist proposed by Obegi (2008), which is grounded in attachment theory (Ainsworth, 1967; Ainsworth et al., 1978; Bowlby, 1973, 1980, 1982). Three phases were identified, each consisting of several specific behavioral, cognitive, and emotional markers. The first phase was termed “pre-attachment” (Obegi, 2008). Several behavioral tasks comprised this phase, including: surface-level problem-related disclosures, the client’s assessment of the therapist as potential attachment figure, mutual agreement about therapeutic goals by the client and therapist, and the experience and/or report by the client that she has experienced some relief. Emotionally, the client was expected to demonstrate high levels of distress and physiological arousal. Cognitively, the client was anticipated to rely on her established internal working models (IWMs) to assess the therapist and the therapeutic relationship, as Bowlby (1988) asserted that clients’ prior attachment experiences influence the ways in which they approach the therapeutic work.

The second phase in the rational model was termed “attachment-in-the-making” (Obegi, 2008). During this phase, multiple behavioral tasks were predicted to occur, including: an increase in the detailed descriptions of events, thoughts, and feelings offered by the client, an increased responsiveness by the client to the therapist’s encouragement of exploration, the
client’s use of the therapist for comfort and reassurance (e.g., use of the therapist as a safe haven) and to explore intimate concerns (e.g., use of the therapist as a secure base), direct requests to the therapist for help or advice, and sharing by the client of joys and accomplishments. With regard to emotional tasks, the therapist was anticipated to have a positive impact on the client’s ability to regulate her emotions. Thus, the client was predicted to experience less negative emotional arousal. Finally, on a cognitive level, the client was anticipated to develop a unique IWM of the therapist and therapeutic relationship. That is, the client would no longer solely rely on her prior attachment experiences to assess the therapist and relationship but rather would integrate new information and experiences gained in therapy into her IWM.

The third and final phase in the rational model was termed “clear-cut attachment” (Obegi, 2008). Behavioral tasks in this phase include: consistent use by the client of the therapist as a safe haven and secure base, increased responsiveness to the interventions of the therapist, expressed figure preference for the therapist (i.e., prefers his or her specific therapist to another therapist), and separation protest. The client was anticipated to clearly display affect in session. Evidence of cognitive shifts in the client’s IWM were also expected. Specifically, it was proposed that the client would think about the therapist and the therapeutic relationship outside of session, especially during times of distress (i.e., the client is cognitively proximity-seeking).

In Figure 1 below, boxes with solid lines are tasks that were predicted to be observable to researchers. Boxes with dashed lines were tasks that may or may not be observable. Bidirectional arrows indicate that phases were not theorized to be linear, but rather flexible as the client may shift back and forth between phases of attachment to the therapist. Further, bidirectional arrows between behavioral, cognitive, and emotional tasks indicate that these tasks may occur in various sequences, and were not theorized to be linear.
Figure 1. The rational model.
Empirical analysis and rational-empirical model. The rational-empirical model was constructed via immersion of the two investigators in the data and constant comparison of the data to the rational model. Investigators reviewed all six session video recordings, client responses to the CATS, HAT, and Change Interview, and therapist responses to the Change Interview. The final rational-empirical model is presented in Figure 2. Consistent with Figure 1, boxes with solid lines were behavioral tasks observable by researchers, while boxes with dashed lines represent cognitive or emotional tasks that were not directly observable, but supported by other data sources (i.e., client or therapist report). Bidirectional arrows represent the bidirectional nature of both the phases of the model and the relationships between various behavioral, emotional, and cognitive tasks. Additionally, in order to facilitate comparison between tasks in the rational and rational-empirical models, tasks that were not present in the rational model or have been altered from the rational model appear as grey, shaded boxes in the rational-empirical model.
Figure 2. The rational-empirical model.
**Differences between rational model and rational-empirical model.** A key difference between the rational model and rational-empirical model is that the latter identifies three phases of attachment development, while the former identifies two distinct phases (pre-attachment and attachment-in-the-making). Evidence for the third phase of the rational model was not found in the data analysis for this case.

**Differences in the pre-attachment phase.** There are several differences between the rational model and rational-empirical model in the pre-attachment phase of attachment. Two behavioral tasks (client offers surface-level disclosures, and client experiences and reports some relief) remain the same in both models. However, the data did not provide support for two behavioral tasks present in the rational model, including client assesses the therapist’s potential as an attachment figure, and client and therapist agree on therapeutic goals. Instead, four new behavioral tasks were added to this phase in the rational-empirical model: client displays non-verbal signs of discomfort in session, client and therapist have brief moments of eye contact, therapist modulates therapeutic distance in response to client’s IWM, and therapist is interpersonally consistent. These new behavioral tasks will be explored in greater depth subsequently. The emotional and cognitive tasks proposed in the pre-attachment phase of the rational model were supported by the data and remain in the rational-empirical model.

**Differences in the attachment-in-the-making phase.** Substantial differences exist between the second phases of the rational model and the rational-empirical model. With regard to behavioral tasks, three tasks remain the same across the models. In both the rational model and rational-empirical model, the client offers increasingly detailed descriptions of events, thoughts, and feelings. The client also shares joys and accomplishments with the therapist. Additionally, the client demonstrates increased responsiveness to the therapist’s encouragement of exploration. One task, client directly requests advice from the therapist, was removed from the rational-
empirical model, as the data did not support the inclusion of this task. Two other behavioral tasks are similar across models, but have changed slightly. In the rational model, the client is thought to use the therapist as a safe haven for comfort and reassurance, and as a secure base from which to explore intimate concerns. In the rational-empirical model, the language used to describe similar tasks shifts in a slight, but important way. That is, in the rational-empirical model, the therapist serves as safe haven, offering comfort and reassurance to the client, and as a secure base from which the client explores intimate concerns. The important shift here revolves around the initiator in this interaction. Observational data indicated that it is initially the therapist who consistently offers and attempts to serve in these roles, rather than the client who seeks out the therapist for these reasons. See below for further explanation.

Another major difference between the two models is the addition of three behavioral tasks in the rational-empirical model that were not included in the rational model. These three tasks reciprocally influence several other behavioral tasks and are major additions to the rational-empirical model. They include (1) the therapist moderates, or titrates, the therapeutic distance to challenge the client’s IWM, (2) the therapist is interpersonally consistent, and (3) the therapist and client make eye contact during moments of connection.

With regard to cognitive tasks, there are also differences between the rational model and rational-empirical model. The rational-empirical model completely retains one cognitive task from the second phase of the rational model—the client develops a unique IWM of the therapist and the therapeutic relationship. Another cognitive task that was included in the third phase of attachment in the rational model shifts to the second phase of attachment in the rational-empirical model—the client seeks proximity to the therapist by thinking of her outside of session during times of stress.

Finally, a notable difference between the rational model and rational-empirical model was identified with regard to emotional tasks. In the rational model, separation protest was
included as a behavioral task in the third phase of attachment development. However, in the rational-empirical model, separation protest is included as an emotional task in the second phase of attachment development. One other emotional task remains the same in both models—the therapist has a positive impact on the client’s emotion regulation and the client displays less negative affect.

**Pre-attachment phase.** In order to best understand the rational-empirical model, each phase and task included in the phase is reviewed and supporting data are provided. Regarding the pre-attachment phase of attachment development, it is notable that all behavioral, cognitive, and emotional tasks were present beginning in the first session of psychotherapy.

**Behavioral tasks.** Early in the first therapy session, the client engaged in surface-level problem disclosure. The client was initially vague in her response and the therapist followed with more specific questions. The following dialogue occurred about four minutes into the first session.

Example: Surface-level problem disclosure

*Therapist:* Do you want to tell me a little bit about what’s bringing you in? I read your intake that I believe [intake therapist]—you met with [intake therapist]?

*Client:* [Nods]

*Therapist:* That [intake therapist] wrote up, so I have a little bit of a background but can you tell me what it is that you’d like to talk about or work on while you’re in therapy?

*Client:* [Smiles, plays with her hands, and looks down] Um, I just, I just like, I got really upset when I was talking to my friend and I just don’t want to ever do that again and like, freak her out. And um [pulls sleeves over hands, looking down] I just want to like be better, as, I don’t know, as a person I
The client’s surface-level problem disclosure continued through the first session and a large part of the second session of treatment. In her Change Interview, the therapist stated, “It felt a lot of times like I was pulling teeth in session. Um, like I would ask her a question and she would give me a one or two word answer or like a really short answer.” The client also commented on her reluctance to share many details early in treatment during her Change Interview. She indicated that this shifted for her over the course of therapy as she became more comfortable.

Client: I guess like at first just like I wasn’t really comfortable going into all of the personal things—I don’t know, I guess that was like kind of bad on my part because I was going to therapy to get better so I should have expected that, like the personal things. But like at first that was like kind of weird to me and I didn’t want to um, share anything so I guess that was negative at first but I don’t know, over the sessions I kind of felt more comfortable.

Another behavioral task that occurred beginning in the first session of treatment was the client’s display of overt, non-verbal signs of discomfort. During the surface-level disclosure previously referenced and throughout the remainder of the session, the client demonstrated several non-verbal signals of discomfort, including minimal and often avoided eye contact with the therapist, playing with her hands, and maintaining a stiff posture in her chair. The client continued to display these non-verbal signals of discomfort into the second session and beyond, although they decreased beginning in the third session. In the Change Interview, the client commented on this discomfort when asked by the interviewer how it felt to be in therapy.

Client: Um, it was a new thing. I’d never done it before um, so the first few sessions were kind of weird. Um, just like talking to her and getting to know somebody in that kind of setting for the first time was kinda weird
but um, after I got used to it, it was okay.

The therapist also commented indirectly on the client’s body language and discomfort in her Change Interview when asked about changes she noticed in the client over the course of treatment. The therapist stated, “…[A]t times I noticed her becoming more comfortable in session, so actual physical changes. Like she’d get more relaxed in her chair.”

The non-verbal discomfort expressed by the client is followed by two additional behavioral tasks early in the first session as the therapist and client engaged in brief moments of eye contact, and the therapist began to titrate the interpersonal distance between herself and the client. Specifically, the therapist sometimes responded to the client by attempting to join with her, or asking additional questions to elicit more sensitive information or emotional content. When the client began to express more discomfort (i.e., looking down or away from the therapist, offering brief or vague answers) the therapist sometimes used humor and laughter or shifted into asking more concrete, less emotionally-laden questions. This shift, or modulation of interpersonal distance, is illustrated with two examples that both occurred during the first session. Both examples also serve as illustrations of the brief periods of shared eye contact between the therapist and client. The following dialogue occurred about ten minutes into the first session.

Example: Therapist modulates interpersonal distance

Therapist: It seems like a big part of you maintaining this sense of privacy and being shy is around you not wanting to be a burden.

Client: [Nods, plays with hands, glances very briefly at the therapist and then down again]

Therapist: Did you ever feel like a burden with other friends?

Client: Um…I just don’t like, tell people more information than they ask for I guess because I don’t want to like, add…stuff. [Looks down, plays with hands]
Therapist: Yeah. Is there any part of you that wishes you could say more?

Client: Um. Yeah kinda. Like, I wish I wasn’t so reserved sometimes [moves around in chair, pulls on shirt hem, smiles] but, I don’t know, I wouldn’t want to add too much.

Therapist: [Nods] Yeah, yea. It’s interesting. I think these ways of being in the world, like ‘I’m not going to put too much on people’ or ‘I’m only going to provide the information they ask’, it comes from somewhere. You know what I mean? It’s not like you woke up one day [laughs brightly, gestures in the air with her hands, client makes eye contact and smiles with therapist] and decided, ‘I’m only going to tell people this much.’

[Client and therapist continue to look at each other] So I guess I’m just really curious. What were things like in your family growing up and how much did people want to know about you and how you are doing?

Client: [Smiles, plays with hands, looks down] Um…That, um, I don’t know. Like, I’m really close with my mom but um, not with my dad I guess but I don’t know. I think it was like we just like um, never had that much money so like I felt like I didn’t want to push it and um do things that cost money. Um, I guess like that just translated over to ‘I don’t want to be a problem at all.’

In the above example, the therapist was able to facilitate a moment of eye contact and connection with the client by using hyperbole and initiating laughter, even while discussing a serious topic. The client looked up and directly at the therapist, which she had rarely done so far in the session. The client and therapist laughed together and appeared joined in this moment. This same comment could have been interpreted as flippant, but the therapist’s tone was warm and engaging. Immediately following the moment of shared laughter, the therapist returned to her
question about the client’s upbringing and the client responded by disclosing a significant personal stressor (financial concerns) that becomes a theme throughout the rest of the treatment. She also mentioned her parents for the first time; the client’s family dynamics also became a central focus of treatment.

About ten minutes later, the following exchange occurs as the therapist and client are exploring the client’s role in her family of origin. The client has been crying for the past several minutes.

Example: Therapist modulates interpersonal distance

_Therapist:_ So in your family you had to be the strong one too. You’re the older sister, you’ve done well in school, you came to [college] first.

_Client:_ Mm hmm [Looks briefly at therapist]

_Therapist:_ So you did everything right or everything well growing up.

_Client:_ Mm hmm. [Nods, crying and wiping eyes]

_Therapist:_ And it sounds like you didn’t cause much of a problem at all. [Laughs gently]

_Client:_ [Laughs, smiles, looks at therapist]

_Therapist:_ If anything, you were like, ‘I want to spend less money because I want to be cautious or conscientious.’ So when you talk about missing your mom or feeling sad about your mom, it’s about not wanting to disappoint her?

_Client:_ [Nods, looks down]

_Therapist:_ And you feel like by getting help or talking to a counselor, it might be disappointing to her?

_Client:_ [Wipes eyes, no longer crying] Yeah, I’m just worried or… [shrugs]

_Therapist:_ Yeah, I can see that it’s really hard for you to talk about. What’s it like for you to cry here? I know this is your first time in therapy.
Client: [Laughs lightly]

Therapist: [Laughs lightly]

Client: Um, I don’t know.

Therapist: Do you wonder what I’m thinking or how I’m reacting?

Client: Um, yeah, I don’t know. I cried when I was with [intake therapist] too so… [Both therapist and client laugh more heartily]

Therapist: So it’s actually not your first time crying here? [Both therapist and client laugh]Well, if you ever want to know what I’m thinking or how I’m feeling, you know, or how I’m reacting to something you are saying or doing, you can ask. You know, right now I feel very honored that you would cry here [Client makes eye contact with therapist] because I know it’s not easy for you to come here and talk about stuff that you never really talk about with people. I know you are a private person. So I want you to know it’s ok to cry here, it’s okay to be sad or tearful. I’m not going to judge you or think that you are weak or be disappointed in you.

Client: [Watches therapist, makes good eye contact, nods]

Therapist: So, you’re pretty close with your mom. [Laughs lightly]

Client: [Laughs lightly, nods]

Therapist: Tell me a little bit about her.

In the dialogue above, the therapist initiated laughter with the client in what appears to be a way of gently teasing the client about her role in the family (e.g., “And it sounds like you didn’t cause much of a problem at all.”) The client’s response was to make eye contact with the therapist, smile, and laugh. Again, she seemed able to have a brief moment of connection with the therapist. The therapist responded immediately by asking the client about her desire to avoid disappointing her mother. The client quickly displayed strong affect (crying) and retreated into
avoiding eye contact with the therapist and staring at her hands. The client and therapist had
another moment of eye contact and laughter when the client commented, in response to the
therapist’s query, that she has cried at the counseling center before with the intake therapist. The
therapist’s subsequent acknowledgement and validation of the client’s tearfulness prolonged a
moment of connection and decreased the interpersonal distance between her and the client. The
therapist’s statement also served to communicate to the client that she will respond differently to
the client than how the client fears her mother will respond ( “I’m not going to judge you or think
that you are weak or be disappointed in you.”) The client continued to make eye contact with the
therapist while the therapist spoke. The therapist returned to asking about the client’s mother after
this moment of closeness and connection.

The dialogue provided above is illustrative of the first session and the pre-attachment
phase of attachment development. The therapist was able to use lightness and humor to connect
with the client, as the client struggled to connect with the therapist during discussions about
intense feelings and events. The therapist switched between this lightness and humor and more
intimate content in a gentle and connective manner that successfully engaged the client. The
therapist commented briefly on the ways she used humor during the Change Interview when
asked about potentially hindering events in treatment, although she stated that she was unsure
about the impact on the client.

*Therapist:* …I used humor when I could…She was kind of laughing at herself at
times. But other times I would use humor as an exaggeration and I
wasn’t always sure how she perceived that. I mean, my hope was that
she didn’t think I was making fun of her or taking things too lightly, but
she presented as so serious at times that [laughs] maybe this is my own
anxiety, but I felt the need to kind of lighten it a little bit. And I don’t
know, I guess model the fact that she didn’t always need to be so serious
about everything and that maybe taking herself so seriously was contributing to her symptoms.

The therapist also commented on interpersonal process and distance during the Change Interview. Her comments, which are in response to a question about what she believed was missing from the treatment she provided this client, highlight her observation that at times, she would pull back from the client.

*Therapist:* I think like, maybe attending to the interpersonal in our relationship a little bit more could have been helpful although at times I felt like that made her really uncomfortable so I think I would like back away from that really quickly if I did make an interpersonal comment.

Here, the therapist also questioned herself and her interventions in a manner similar to the way she was unsure about the impact of the use of humor and exaggeration on the client. Although the therapist does not conceptualize these interventions as necessarily useful—in fact, she questions her use of them—observers believe that they ultimately were helpful.

A related behavioral task is that the therapist is interpersonally consistent. Researchers observed that the therapist was dependably warm, engaging, and interested in the client during the pre-attachment phase of the model. Transcribed dialogues of sessions provided in this chapter serve as examples of the ways in which the therapist maintained a steady stance in relation to the client during this phase.

The final behavioral task in the pre-treatment phase of attachment development is that the client expresses and reports some relief. During the final moments of the first session, the client commented on relief she experienced, specifically related to the process of the therapy session.

Example: Client expresses and reports relief

*Therapist:* We have about one minute left for today. But I wanted to touch base with you and ask how this went. So what was this like for you, your first
counseling session?

Client: It was ok. I was worried because I thought you were just going to sit here and wait for me to talk. [Laughs lightly]

Therapist: Like the silent game? [Laughs lightly]

Client: [Smiles, brief eye contact with therapist] Yeah, I don’t know. Like I said I just don’t like readily offer information so I was scared about that but it was good.

Here, the client discloses a fear she had about the session and her relief that her fear was not confirmed. Also of note regarding the client’s expression of relief, immediately prior to the next session (session two), the client completed the CCAPS-34. Her score on the depression subscale at that administration of the CCAPS-34 was one of the two lowest scores she had during her course of treatment. Specifically, she scored a 1.67. (The client also had this same score on the final administration of the CCAPS-34 prior to her sixth and last session.)

Cognitive task. One cognitive task in the rational-empirical model occurred during the pre-attachment phase of attachment development. The client relied on her previous IWM of attachment to assess the therapist and therapeutic relationship. In Figure 2, this task is outlined by a dashed line, indicating that it may be unobservable. Indeed, it is challenging to assess this task based on observation alone. However, the therapist offered a conceptualization of the client’s relational experiences during the Change Interview that was consistent with the way we observed the client behave and relate to the therapist in the first session of treatment and during the pre-attachment phase of attachment development.

Therapist: I think [the client] doesn’t really have a voice anywhere in her life—like, she comes from a family where like her dad is a pretty dominant force and he, you know, can be kind of critical and very opinionated so he sort of like rules the house in that way and no one really stands
up to him, um, including the mom. And she sees the mom as this person who sacrifices everything for the family. Like the dad isn’t very consistent about work and so the mom works two jobs and kind of takes care of everything and is like, [the client’s] sort of emotional support even though she doesn’t rely on her as much as she could I think. So, she identifies more with her mom in terms of feeling a little bit like a victim of circumstances. But I think—so she really hasn’t had a voice. She has a really hard time standing up for herself, articulating, you know, what she wants or what she needs.

Indeed, in initial session and pre-attachment phase of attachment development, the client seemed to have difficulty verbalizing her wants and needs, as well as general background information about herself, to the therapist. She only spoke for brief periods of time, required encouragement and further questioning to reveal what brought her into treatment and what she was hoping to achieve in treatment, and struggled to make eye contact with the therapist most of the time. This presentation, along with the client’s particular family dynamics, supports the therapist’s conceptualization of the client has a person without her own voice and offers insight into the IWM of the client. The client’s comments in her Change Interview add support to the idea that the client relied on her prior IWM to assess the therapist and therapeutic relationship during the pre-attachment phase of treatment. When asked to what she attributes various changes, the client stated the following.

*Client:* Um I guess like, what we talked about a lot was, she would encourage me to like, say more things that I feel so I guess just like not being afraid to actually say what I’m feeling out loud and like, tell other people how I’m feeling instead of like, just keeping it to myself or being um, afraid of what people would think when I said it so, yeah, I guess just being more outspoken about
things…. For me personally I normally don’t like, um, say things about myself like, I just don’t openly tell people them so her asking me was definitely what made me say things.

In this statement, the client reflected on herself and her tendency to be private about herself and her experience. This statement infers that the client initially relied on her IWM in therapy, until the therapist pressed her to go beyond her comfort zone and reveal more information about herself.

*Emotional task.* The sole emotional task during the pre-attachment phase of attachment development is the client’s demonstration of high levels of distress and emotional arousal. As described in several transcript portions above, the client displayed non-verbal behaviors consistent with a high level of discomfort, including minimal eye contact, shifting around in the chair, playing with her hands, and pulling on the hem of her shirt. She also became very tearful and cried for several minutes during the middle of the session, when discussing her relationship with her mom (see above). Notably, this was the only time the client cried during the six sessions of treatment.

The client also reported a high level of distress on the CCAPS-34 she completed immediately before the first therapy session. In fact, the highest of the client’s CCAPS-34 scores occurs at this session. Specifically, she scored a 3.17 on the depression subscale of the measure. This score is indicative of a high level of emotional distress.

*Attachment-in-the-making phase.* During the second session of treatment, tasks from the second phase of attachment development, titled attachment-in-the-making, began to emerge. Tasks from this phase continued to emerge throughout the third session; by the end of the third session, all behavioral tasks in this phase had been demonstrated in session. The cognitive and emotional tasks of this phase also began to emerge during the third session in varying degrees, with the exception of separation protest. Separation protest appeared around the final session, or
end, of treatment. Each phase and task included in this phase is reviewed below and supporting
data are discussed.

*Behavioral tasks.* The first behavioral task that marked the beginning of the attachment-
in-the-making phase is that the client offered increasingly detailed descriptions of events,
thoughts, and feelings. This task first occurred in the third session, as the client started this
session with minimal prompting from the therapist. Upon entering the room for the third therapy
session, the following dialogue occurred.

Example: Client increases detailed description of events, thoughts, and feelings

_Therapist:_ How have you been doing?

_Client:_ Good.

_Therapist:_ What’s been going on for you?

_Client:_ Um, well, we had this whole big deal with one of our RAs and one of
them might be getting fired.

_Therapist:_ Oh no!

_Client:_ Yeah. It was like so these girls that were actually on my floor they…

[client continues to speak]

The client continued to talk for several moments about this incident. This represented a
significant increase in talkativeness for the client, as she typically offered brief answers to the
therapist’s questions during the first two sessions and did not spontaneously disclose information.
It also offered a departure from the client’s pre-attachment phase behavior of relying on the
therapist to ask many questions. During much of the third session, the client spoke at length
without the type of prompting she seemed to need in earlier sessions.

Following this task, another behavioral task occurred in the third session as the therapist
began to serve as a safe haven for the client by offering comfort and reassurance to the client. In
the following dialogue, the therapist offers support, compassion, and validation to the client, who
is experiencing sadness as they discuss a time when the client was worried her parents might lose
their house for financial reasons. As the dialogue below indicates, when the client talked with the
therapist about this painful material, she shifted back to speaking only briefly and the therapist
resumed her role of asking questions to engage the client. However, the client was increasingly
able to engage in the dialogue and share her feelings with the therapist over the course of these
few moments. She allowed the therapist to sit with her in the sadness and offer comfort to her.

Example: Therapist serves as a safe haven

*Therapist:* You sound so sad talking about this.

*Client:* Yeah [speaking very softly, looking down]

*Therapist:* I think I would be sad too.

*Client:* [Briefly looks at therapist, nods]

*Therapist:* This sounds normal.

*Client:* [Briefly looks at therapist, nods]

*Therapist:* [Speaking softly] I’m hearing you talk about how much you love your
mom and it’s really painful to watch her go through this and watch her
possibly lose her house, like something so meaningful. Your home.
When I hear you talk about your relationships with your family, it seems
complicated.

*Client:* Yeah, I guess. [Speaking very quietly, looking down]

*Therapist:* Is there a better word for it or does that one feel right?

*Client:* [ Shrugs] I don’t know, like I guess, because like I’ve never thought about
it like that because it’s just like…[shrugs shoulders]

*Therapist:* It just is what it is.

*Client:* Yeah.
Therapist: How are you feeling right now?

Client: Um, I don’t know, like I kind of forgot about the house thing until now.

Therapist: Yeah. How do you feel when you think about the house thing?

Client: Yeah, it just like sucks.

Therapist: Yeah, it really sucks. Can you put an emotion to that? Like how it makes you feel?

Client: I don’t know, sad.

Therapist: Yeah. Let’s stick with sad for a minute. You did a really nice job identifying an emotion. I know it’s easier for you to think about what’s going on and harder for you to feel and to acknowledge that it’s a strong feeling. When you sit with that feeling of sadness and let’s just sit with it for a moment—tell me what comes up for you?

Client: I don’t know, I guess just we’ve lived there all my life. They built the house whenever they found out they were going to have a kid. So they built it expecting me and my brother to happen and it just sucks.

Therapist: It feels unfair.

Client: [Nods]

Therapist: It’s your home. It’s where you grew up, where you have memories. Good memories of your mom.

Client: [Nods]

Therapist: That sounds really hard and scary.

Client: Yeah.

In the above example, the therapist actively offers herself as a safe haven as the client experiences negative affect. The therapist commented on this specific conversation during her Change Interview, although she did not reference her own role in the dialogue.
Interviewer: Were there things in the therapy that you believe were difficult or painful for the client but still OK or helpful?

Therapist: I remember one time she had—she didn’t always express much affect. It’s not like she came in and sobbed during sessions. But one time we were talking about family stuff and the financial strain on her family and she was saying that she um, was worried because her dad was not consistently employed and her mom had to work two jobs and they were worried that they might lose their house and she became really upset when talking about that—I don’t remember if she was really crying but I could tell that she was really upset about it. And so…um…I think that was one of the more painful things that we talked about for her. You know, she had grown up there and that was her home for her entire life so it would have meant quite a bit to lose that. Especially I think because the family itself was so unstable so her house being her house for her whole life probably meant quite a bit, you know? It was predictable. So I think that was really scary for her and just seemed to touch her in a way that—emotionally—that other stuff kind of didn’t.

The therapist’s comments above are reflective of her understanding of how painful this experience was for the client; the therapist’s compassion was also easily observed in session and seemed to be a key part of her offering herself as a safe haven for the client. She verbalized this compassion for the client by reflecting the client’s emotion, normalizing the client’s response, and stating that she, too, would be sad in such a situation. This moment illustrates the client’s use of the therapist as a safe haven when feeling sad.
Several comments from the client during her Change Interview also reflect the trust the client had developed in the therapist and the client’s increased comfort in leaning on the therapist for support. The following was the client’s response to the interviewer’s question about helpful events in therapy.

*Client:* Um, well, during the first session, like, she was asking me a lot of really personal things that I’d definitely not talked about before but like, she was always, like, saying ‘Thanks for sharing that with me’ and like, always being very understanding when I said things so like, as the sessions went on, it kind of like felt okay to bring things up ‘cause I know that she would like, take it well and not badly or anything.

Relatedly, when the interviewer asked the client about hindering events in therapy, the client responded, “I trusted [the therapist] and everything. I didn’t think that there was anything bad because I trusted her to help me, so.” These comments by the client suggest that the client felt she could share personal, intimate concerns with the therapist and the therapist would help her. Specifically, she described the therapist as understanding.

Several items on the CATS also support the idea that the therapist served as a safe haven for the client for sessions 3, 4, 5, and 6. The client’s responses to these questions are provided in Table 1.

Table 1

<table>
<thead>
<tr>
<th>CATS Questions</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>“When I show my feelings, my counselor responds in a helpful way.”</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>“I feel safe with my counselor.”</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>“My counselor is a comforting presence to me when I am upset.”</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
</tbody>
</table>

*Note:* Client responses to CATS questions related to use of the therapist as a safe haven. Client responses are on a scale of 1 (strongly disagree) to 6 (strongly agree).
The third behavioral task in the attachment-in-the-making phase also first occurred in the third session. The client’s use of the therapist as a safe haven allowed her to increase her responsiveness to the therapist’s encouragement of exploration. The therapist, in response, served as a secure base for the client. The following example illustrates both of these tasks (increased responsiveness and therapist serving as a secure base for the client). Here, the therapist and client continued to discuss the client’s family dynamics.

Example: Client demonstrates increased responsiveness and therapist serves as a secure base

Therapist: Can you tell me more about what it felt like in your family in terms of getting love and affection?

Client: It’s just weird because as you were saying that I was just thinking. Because my dad is always yelling and strongly expressing his opinions and that made me like, really turn against him. So I don’t know if that’s why.

Therapist: Wow. That seems like a really powerful realization you are having.

Client: Yeah. I never really thought about it.

Therapist: That’s pretty insightful, [client]. Because what you are saying is, ‘This thing about my dad, his tendency to be really opinionated and angry about it really turned me off to wanting to express my opinions or emotions.’ What was that like having a dad who was really opinionated and kind of got angry and sounds like had a short fuse?

Client: Yeah, I mean, it’s just like there was no point in ever fighting or saying anything back because he was never going to listen to what you were saying. As I got older and tried to say, ‘No, you’re wrong,’ my mom would just be like, ‘Let it go, let it go, let him have this, he’s old and he’s
not going to change his mind so just let him have this.’

Therapist: So, you felt stuck with him?

Client: [Nods, looks at therapist]

Therapist: And you kind of got the impression from your mom, too, that it wasn’t worth challenging him.

Client: Yeah, because he’s just like always going to think that.

In this example, the client appeared fully engaged in exploration with the therapist. She seemed to be actively thinking, reflecting, and talking to the therapist about her memories related to her family dynamics. The therapist joined the client in this exploration and served as a secure base that allowed the client to explore in this way. The client’s trust in the therapist and prior experiences of the therapist as a safe haven likely permitted this exploration to occur.

When the client was asked how the changes she has made and what enabled her to make changes, she cited ways in which the therapist helped her increase her level of responsiveness. The client specifically referenced an intervention made by the therapist early in the third session. The therapist, after receiving several minimal and vague answers from the client, gave the client a jar and several pieces of paper. When the client stated, “I don’t know,” she was asked to put a piece of paper in the jar. Below, the client refers to this as the “I don’t know jar.”

Client: Um, I think definitely like the way she would always ask me, like specifically how I was feeling or what I wanted to say about a situation and like during like the first few sessions, I would always say, ‘I don’t know’ or ‘I guess’ and like, she even like, made me do an I don’t know jar and every time I said it, I’d have to put a piece of paper in it to realize how many times I just like, don’t express my own opinion. So definitely that during the therapy—having her like, make me actually say things and say what I was feeling instead of giving the ‘I don’t know’ cop-out um, definitely
helped.

Several items on the CATS also support the idea that the therapist served as a secure base for the client for sessions 3, 4, 5, and 6. The client’s responses to these questions are provided in Table 2.

Table 2

<table>
<thead>
<tr>
<th>CATS Questions</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I feel sure that my counselor will be there if I really need him/her.”</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>“My counselor helps me look closely at the frightening or troubling things that have happened to me.”</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>“My counselor is dependable.”</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: Client responses to CATS questions related to use of the therapist as a secure base. Client responses are on a scale of 1 (strongly disagree) to 6 (strongly agree).

The three behavioral tasks that serve as linchpins for the four previously mentioned behavioral tasks in the attachment-in-the-making phase of the rational-empirical model are (1) the therapist is consistent, (2) the therapist modulates the therapeutic distance to challenge the client’s IWM, and (3) the client and the therapist make eye contact during moments of connection. With regard to the consistency of the therapist, the therapist continued to be warm, engaging, and attentive to the client. Notably, the therapist revealed in her Change Interview that she experienced anxiety about her competence at times during the treatment. Observers did not see evidence of any behavioral manifestations of this anxiety in the therapy sessions. Transcripts of dialogue included in this chapter provide multiple examples of the therapist’s interactions with the client over time and illustrate the consistency of the therapist. Transcripts of dialogue also provide multiple examples of eye contact between therapist and client during moments of connection. See specifically the examples included for therapist serves as a safe haven, client
demonstrates increased responsiveness to therapist’s encouragement of exploration and therapist serves as a secure base, and therapist modulates therapeutic distance to challenge client’s IWM.

Regarding the therapist’s modulation of therapeutic distance to challenge the client’s IWM, this task is similar to a behavioral task included in the pre-attachment phase of the model (entitled therapist modulates therapeutic distance in response to the client’s IWM), but distinct due to the emphasis on challenging, rather than simply responding to, the client’s IWM. As demonstrated in the rational-empirical model, this task is connected in a reciprocal fashion to the behavioral tasks already described and discussed, as we believe these tasks operate in part due to the therapist’s modulation of distance.

In the attachment-in-the-making phase, the therapist continued to use laughter and humor at times, but much less frequently than she did in the pre-attachment phase. These ways of engaging with the client previously helped the therapist facilitate moments of connection. During the attachment-in-the-making phase, the client has developed some trust in the therapist and feels the therapist understands her, so the therapist was able to facilitate moments of connection in a more direct way. Given that the client does not easily allow others to know about her internal experiences, this was a different experience for the client and served in contrast to the IWMs with which she entered treatment. In the example below, the therapist directly questioned some of the client’s responses to a question as they explored the client’s reactions to her father.

Example: Therapist modulates therapeutic distance to challenge client’s IWM

_Therapist:_ Sounds like in some ways you had to walk on eggshells around him a little bit.

_Client:_ Yeah, I guess.

_Therapist:_ Does that not feel true?

_Client:_ Yeah, I don’t know. Like, I don’t know…[Smiles, looks at therapist]

_Therapist:_ [Laughs]
Client: [Put paper in the I don’t know jar] We were used to it, so it didn’t really feel like something awful.

Therapist: It was the norm.

Client: Yeah.

Therapist: Yeah. Okay. And as you got older did you realize that like, maybe not everyone’s family is like this?

Client: I guess, but I don’t know, I figured like maybe everyone’s parents got mad at them when they didn’t do something. I don’t know. It wasn’t like…

Therapist: It felt more normal.

Client: [Puts paper in jar]

Therapist: I think. That makes a lot of sense. We grow up in our family so it’s like we know what we know based on our history with our mom or dad or whoever and I think it’s hard to imagine or even to know what it’s like in other families. So, being around this negative energy or being around your dad who would often get angry and escalate, it just felt normal. But it seems like it had a pretty strong effect on you over time.

Client: Yeah, I guess.

Therapist: Do you think so or are you just agreeing with me?

Client: I don’t know. [Puts paper in jar] It’s just kind of hard to think about because I never really assumed that it had an effect on me so I guess hearing it I’m like, ok whatever I guess it did but…

Therapist: But there’s a but.

Client: I don’t know, I guess it’s hard to believe that he did have that effect on me. Because I didn’t think anything of it when I was growing up.
In this dialogue, the therapist first questioned whether what the client was agreeing to actually felt true for her, directly asked the client if she truly believes something or was just agreeing with the therapist, and also drew attention to the client’s lingering “but...” The therapist also validated the client’s experience. The therapist might be thought of as coming closer to the client in order to encourage the client to explore and consider different viewpoints. Eventually, the client provided more of a complete response, extending the “Yeah, I guess,” she initially offered to allow the therapist access to more of her thought process. Elements of other tasks (client increases detailed description of events, thoughts, and feelings, and therapist serves as a secure base from which client can explore intimate concerns) are visible in this exchange and hang together as a result of the therapist’s continued challenge to the client’s typical way of interacting (not saying much or stating that she doesn’t know in response to questions). Indeed, even the exercise of the “I don’t know jar” that the therapist implemented created a different experience for the client. It is important to note that while this exercise could have been implemented in a negative or even punitive way, neither the therapist nor the client reported experiencing it in that way. The therapist stated in her Change Interview that she was hoping to make explicit to the client how frequently the client declined to share her opinion or experience. The client, in her Change Interview, reported that the exercise had just this effect and stated that it “helped.”

The final behavioral task in the attachment-in-the-making phase of the rational-empirical model is that the client shares joys and accomplishments with the therapist. The clearest example of this task occurred early in the fifth session. The therapist and client were discussing the client’s trip to another state over the weekend.

Example: Client shares joys and accomplishments with therapist

*Therapist:* One of your goals from last week was to try to give your opinion when you were doing something with a friend. Were you able to do that?
Client: Yeah. I really wanted to go to this one amusement park and I said that.

But we didn’t go.

Therapist: But you said it.

Client: [Laughs, moved around in her chair] It was weird.

Therapist: Tell me about it.

The therapist and client continued to process the client’s efforts to state her opinion when with friends. As previously discussed, the therapist often tried to help the client assert herself, so this represented a true accomplishment for the client that she was able to share with the therapist.

Cognitive Tasks. There are two cognitive tasks in the attachment-in-the-making phase of the rational-empirical model. One is that the client thinks about the therapist and therapeutic relationship outside of session. Another way to describe this task is that the client engages in proximity-seeking with the therapist via her IWM of the therapist. Observation of this task is, of course, not possible. However, there are two questions on the CATS that offer some insight into the client’s thoughts about the therapist outside of session. Table 3 summarizes the client’s responses to these questions by session.

Table 3

<table>
<thead>
<tr>
<th>CATS Questions</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
<th>Session 6</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I think about calling my counselor at home.”</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>“I wish there were a way I could spend more time with my counselor.”</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

Note: Client responses to CATS questions related to proximity keeping to therapist. Client responses are on a scale of 1 (strongly disagree) to 6 (strongly agree).

The client’s responses to these questions indicate that, on average, she tended to “slightly agree” with the statements about thinking about calling her therapist at home and wishing she
could spend more time with her therapist. These data supported the inclusion of this cognitive task in the rational-empirical model.

The second cognitive task is that the client develops a unique IWM of the therapist and therapeutic relationship. This task, like the other cognitive task, was challenging to observe as it references an internal process. However, the client offered several comments in her Change Interview that allowed a glimpse into her thoughts about the therapist and their relationship, as well as how those thoughts shifted over time.

*Interviewer:* What was helpful about therapy?

*Client:* Um, well, during the first session, like, she was asking me a lot of really personal things that I’d definitely not talked about before but like, she was always, like, saying “Thanks for sharing that with me” and like, always being very understanding when I said things so like, as the sessions went on, it kind of felt okay to bring things up ‘cause I know that she would like, take it well and not badly or anything.

*Interviewer:* Can you give me an example of a time that happened?

*Client:* Um, well, for me personally I normally don’t like, um, say things about myself like, I just don’t openly tell people them so her asking me was definitely what made me say things and that, like, I knew that um, that like, she made it seem like she actually cared about what I was going to say and everything so that really helped. Like, I trusted her by the second or third one, like to tell her things.

Here, the client revealed that her perception of the therapist changed over time and she grew more comfortable sharing issues with the therapist, as she trusted the therapist to respond positively to and care about the client’s disclosures. The client also drew a distinction between the therapist
and other people by noting that she doesn’t openly tell people about herself—but she was able to
tell the therapist because she trusts her. This comment highlights the idea that the client
experienced the therapist differently than other people—that is, she had a different IWM of the
therapist than of others.

_Emotional tasks._ The two emotional tasks in the attachment-in-the-making phase of the rational-empirical model are directly linked to the two cognitive tasks in this phase. First, the	herapist has a positive impact on the client’s emotion regulation and the client exhibits less
negative arousal. This task is directly linked to the client’s unique IWM of the therapist and her
proximity-seeking via this IWM of the therapist. Regarding specific observations, over the course
of treatment, the client decreased in her expression of negative arousal. She did not cry during
later sessions and no longer responded with any irritation when the therapist asked personal
questions (as she had in the first session). With regard to the client’s CCAPS scores, see Figure 6
for an overview of the depression subscale scores across treatment. One of the two lowest scores
(1.73) on this scale occurred at the sixth and final session.

The second emotional task is that of separation protest. This task was not observable via
the video recordings. That is, the client does not make any statements during any sessions—even
the final session—to indicate that she is unhappy about separating from the therapist. However,
she does comment about her wish to continue therapy briefly during her Change Interview.

_Interviewer:_ Was there anything missing from the therapy?

_Client:_ Um…I don’t think so. Obviously I wish there were more than just
six free sessions because it felt like I was just like getting into it
and like, getting comfortable with going there every week and
talking about that kind of stuff every week.
In this response, the client did not directly reference the therapist, but her statement implied that she wished to continue treatment, likely with the therapist whom she previously discussed trusting.

**Quantitative Results**

**Preliminary findings.** Means, standard deviations, ranges, and internal consistencies for variables pertaining to the case can be found in Table 4.
<table>
<thead>
<tr>
<th>Instrument Name</th>
<th>M</th>
<th>SD</th>
<th>Possible Range per Item</th>
<th>Possible Total Range</th>
<th>Total Range for Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECR-S anxiety (pre-treatment)</td>
<td>4.33</td>
<td>1.21</td>
<td>1-7</td>
<td>6-42</td>
<td>n/a</td>
</tr>
<tr>
<td>ECR-S anxiety (post-treatment)</td>
<td>4.83</td>
<td>1.17</td>
<td>1-7</td>
<td>6-42</td>
<td>n/a</td>
</tr>
<tr>
<td>ECR-S avoidance (pre-treatment)</td>
<td>3.17</td>
<td>1.47</td>
<td>1-7</td>
<td>6-42</td>
<td>n/a</td>
</tr>
<tr>
<td>ECR-S avoidance (post-treatment)</td>
<td>3.67</td>
<td>1.51</td>
<td>1-7</td>
<td>6-42</td>
<td>n/a</td>
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<tr>
<td>CCAPS-34 Depression (pre-treatment)</td>
<td>3.17</td>
<td>n/a</td>
<td>0-4</td>
<td>0-24</td>
<td>n/a</td>
</tr>
<tr>
<td>CCAPS-34 Depression (post-treatment)</td>
<td>1.67</td>
<td>n/a</td>
<td>0-4</td>
<td>0-24</td>
<td>n/a</td>
</tr>
<tr>
<td>CCAPS-34 Depression (across treatment)</td>
<td>2.47</td>
<td>.65</td>
<td>0-4</td>
<td>0-24</td>
<td>10-19</td>
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<td>CCAPS-34 Social Anxiety (pre-treatment)</td>
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<td>n/a</td>
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<td>CCAPS-34 Social Anxiety (across treatment)</td>
<td>2.83</td>
<td>.48</td>
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<td>IIP-64 (pre-treatment)</td>
<td>1.44</td>
<td>n/a</td>
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<td>92-106</td>
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<tr>
<td>IIP-64 (post-treatment)</td>
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<td>CATS Secure</td>
<td>4.84</td>
<td>.41</td>
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<td>14-84</td>
<td>62-74</td>
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<tr>
<td>CATS Preoccupied-Merger</td>
<td>3.72</td>
<td>.41</td>
<td>1-6</td>
<td>10-60</td>
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<tr>
<td>CATS Fearful-Avoidant</td>
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<td>.42</td>
<td>1-6</td>
<td>12-72</td>
<td>13-24</td>
</tr>
</tbody>
</table>

**Note.** ECR-S = Experiences in Close Relationships-Short Form, CATS = Client Attachment to Therapist Scale, CCAPS-34 = Counseling Center Assessment of Psychological Symptoms-34 item version, IIP-64 = Inventory of Interpersonal Problems-64 item version, and CATS = Client Attachment to Therapist Scale. N/A = not applicable, as value cannot be calculated.

*Global attachment.* Prior to the beginning of treatment, the client demonstrated a mean score of 4.33 on attachment anxiety and a mean score of 3.17 on attachment avoidance. Although the Experiences in Close Relationships—Short Form (ECR-S, Wei et al., 2007) offers a dimensional approach of assessing adult attachment and thus does not offer cut-scores to indicate high or low attachment anxiety and avoidance, scores can be graphed in the two dimensional space defined by attachment anxiety and avoidance. Figures 3 and 4 demonstrate that the client’s scores on the ECR-S place her in the quadrant representing high attachment anxiety and low attachment avoidance (e.g., a preoccupied attachment style) both at pre-treatment (Figure 3) and post-treatment (Figure 4).
Figure 3. Client global attachment, pre-treatment.
Attachment to the therapist. The client reported a high level of secure attachment to the therapist, with a case mean of 4.84, signifying that the client experienced the therapist as emotionally available, accepting, understanding, and able to provide a secure base from which the client can explore difficult material. The client reported a low level of fearful-avoidant attachment to therapist, with a case mean of 1.43, indicating the client did not feel shameful and humiliated in her interactions with the therapist, or experience the therapist as rejecting or disapproving. The client reported a moderate level of preoccupied-merger attachment to the therapist, with a case mean of 3.72. A moderate level of preoccupied-merger attachment to the therapist signifies the client experienced some preoccupation with the therapist.
Cronbach’s alphas for the subscales of the CATS were as follows: .68 for the Secure subscale (14 Items), .91 for the Preoccupied-Merger subscale (10 Items), and .94 for the Fearful-Avoidance subscale (12 Items).

**Symptomatology.** The Depression subscale of the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34; Locke et al., 2012) was found to be highly reliable in the present study (6 items; α = .93). The case mean for depressive symptoms, as assessed by this subscale, was 2.47. This score indicates that on average, the client experienced a clinically significant level of depression that surpassed the diagnostic cut-score of 1.73 identified by McAleavey and colleagues (2012).

Prior to conducting this study, hypotheses regarding other subscales on the CCAPS-34 were not advanced. However, as this client was diagnosed with Social Phobia by her therapist at termination, the decision was made post-hoc to explore this subscale. Thus, information about this subscale can be found in Table 4. The Social Anxiety subscale of the CCAPS-34 was found to be reliable in the study (5 items, α = .75). The case mean for social anxiety symptoms, as assessed by this subscale, was 2.83. This score indicates that on average across treatment, the client experienced a clinically significant level of social anxiety that surpassed the diagnostic cut-score of 2.5 (McAleavey et al., 2012).

With regard to interpersonal functioning, the client had a pre-treatment score of 1.44 on the Inventory of Interpersonal Problems-64 (IIP-64; Alden et al., 1990; Horowitz et al., 2000; Horowitz et al., 1988). She had a post-treatment score of 1.66 on this measure. The client’s pre-treatment and post-treatment IIP-64 scores were both above the established clinical cutoff point of 1.13 (Muran et al., 2005) indicating that the client experienced clinically significant interpersonal problems and distress.

Figures 5, 6, and 7 illustrate the total values for the variables that were assessed at each session.
Figure 5. Client ratings of type of attachment to the therapist over treatment.
Figure 6. Client ratings of depressive symptomatology over treatment.

Figure 7. Client ratings of social anxiety symptomatology over treatment.
Table 5

*Correlations Among Variables*

<table>
<thead>
<tr>
<th>CATS Secure</th>
<th>CATS Preoccupied-Merger</th>
<th>CATS Fearful-Avoidant</th>
<th>CCAPS-34 Depression</th>
<th>CCAPS-34 Social Anxiety</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATS Secure</td>
<td>Correlation</td>
<td>.58</td>
<td>-.86</td>
<td>.22</td>
</tr>
<tr>
<td>CATS Preoccupied-Merger Correlation</td>
<td>-.60</td>
<td>.27</td>
<td>-.40</td>
<td></td>
</tr>
<tr>
<td>CATS Fearful-Avoidant Correlation</td>
<td>-.54</td>
<td>.09</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CCAPS-34 Depression</td>
<td></td>
<td></td>
<td></td>
<td>.75</td>
</tr>
</tbody>
</table>

*Figure 8.* Client ratings of interpersonal functioning over treatment.
Primary and post-hoc findings.

Depressive symptomatology and attachment to the therapist. The first research hypothesis was that client-reported secure attachment to the therapist would be negatively related to client-reported depressive symptomatology. The correlation between secure attachment to the therapist and depressive symptomatology across treatment was .22, which is a small effect (Cohen & Cohen, 1983) in the opposite direction of what was hypothesized. This finding indicates that the more securely attached to the therapist the client perceived herself to be, the more depressive symptoms the client reported experiencing.

No specific hypotheses were advanced regarding the relationships between client-reported depressive symptomatology and (a) client-reported preoccupied-merger attachment to the therapist and (b) fearful-avoidant attachment to the therapist. However, planned post-hoc analyses were conducted to analyze these relationships.

As shown in Table 5, the correlation between client-reported preoccupied-merger attachment to the therapist and client-reported depressive symptomatology is .27, which is a small effect size indicating that as the client’s preoccupied-merger attachment to the therapist increased, her reported depressive symptoms increased. The correlation between client-reported fearful-avoidant attachment to the therapist and client-reported depressive symptomatology was -.54, which is a large effect indicating that as the client’s fearful-avoidant attachment to the therapist decreased, her depressive symptoms increased.

Social anxiety symptomatology and attachment to the therapist. The decision to examine the association between social anxiety symptomatology and attachment to the therapist was made post-hoc, as the therapist diagnosed the client with Social Phobia at termination. Thus, no specific hypotheses were advanced regarding these connections. As shown in Table 5, the correlation between secure attachment to the therapist and client-reported social anxiety symptomatology is -.49, which represents an inverse relationship and medium effect size. This
means that as the client’s secure attachment to the therapist increased, her reported social anxiety symptoms decreased, and as the client’s reported social anxiety symptoms increased, her secure attachment to the therapist decreased. A similar pattern was observed with regard to preoccupied-merger attachment to the therapist. The correlation between preoccupied-merger attachment to the therapist and client-reported social anxiety symptoms was -.40 (a medium effect size). Finally, the correlation between fearful-avoidant attachment to the therapist and client-reported social anxiety symptoms was .09.

**Interpersonal functioning.** No specific hypotheses were advanced regarding client change in interpersonal functioning. However, change in interpersonal functioning was examined to assess for clinically significant change. Specifically, differences between the client’s scores pre- and post-treatment on the Inventory of Interpersonal Problems (IIP-64; Alden et al., 1990; Horowitz et al., 2000; Horowitz et al., 1988) were compared and tested for clinically significant change according to the criteria set forth by Jacobson and Truax (1991). These authors proposed two criteria for assessing clinical significance: first, the treated individual must move from a theoretically dysfunctional population to a theoretically functional one, and second, change must be reliable. Muran et al. (2005) established that the clinical cutoff for the IIP-64 is 1.13. As shown in Figure 5, the client’s interpersonal functioning scores on the IIP-64 started above the clinical cut-off at the beginning of treatment and slightly increased over the course of treatment. Thus, the first criterion of clinically significant change was not met. Next, pre-to-post treatment change was assessed. Muran et al. (2005) established that the standard error for the IIP-64 is 0.34. Thus, a difference of 0.67 in scores pre- to post-treatment was required for a Reliable Change Index (RCI) of 1.96. Therefore, the client’s change of -.22 does not meet criteria for reliable change according to the second criterion of Jacobson and Truax. This means that with regard to interpersonal functioning, the client did not experience clinically significant change.
Chapter 5

Discussion

Since John Bowlby (1982) and Mary Ainsworth (1969) originally developed attachment theory, a multitude of studies have explored the central tenants of the theory in an effort to understand how, and to what end, individuals’ attachment styles develop. More recently, a body of research focused on the implications of attachment theory and psychotherapy has emerged, expanding upon many of the ideas Bowlby (1988) originally offered as a way to understand the psychotherapy relationship as an attachment relationship. The majority of this research, however, has been cross-sectional and quantitative in nature and has not explored the process of how, and with what outcome, attachment to the therapist develops over the course of treatment. The aim of this case study was to expand and deepen what is known about how secure attachment to the therapist develops and shifts from the beginning to end of treatment, as well as to explore how secure attachment to the therapist is related to change in relevant client symptoms for a client with Major Depressive Disorder (MDD). Perspectives of the therapist, client, and two observers were considered, and both quantitative and qualitative data were collected prior to treatment, at each session, and after treatment ended. Thus, this longitudinal, mixed-methods case study design offered the opportunity to examine the therapy from multiple angles.

The question of “how” was central to this investigation. For example, how did the client use the therapist as an attachment figure over time? How did the therapist promote the development of this type of relationship? Task analysis offered a way to explore the specific tasks associated with the main research question—how does a secure attachment to the therapist develop over time? Additionally, correlation analysis was used to examine the links between client-reported attachment to the therapist (secure, preoccupied-merger, and fearful-avoidant
types) and client-reported symptoms. Differences between the client’s pre-treatment and post-treatment global attachment orientation, as well as her interpersonal functioning, were also explored.

In the following sections, both quantitative and qualitative findings will be reviewed, discussed, and integrated to answer the research questions. Implications for theory, training, clinical practice, and future research will be presented and limitations will be reviewed.

Findings

Contextual factors. It is essential to place the results of this study into context in order to interpret the findings and discuss their implications. To review, this single-case study was composed of a 21-year-old college student engaged in brief psychotherapy at a college counseling center. The client was diagnosed with MDD following a one-session initial consultation and then received six 50-minute sessions of psychotherapy with an advanced doctoral student in counseling psychology. At the end of treatment, she was diagnosed with both MDD and Social Phobia by her therapist. She did not take any medication or report the occurrence of any significant life events during treatment. The therapist in this study was selected following the completion of an attachment measure that indicated she had low attachment anxiety and low attachment avoidance (i.e., a secure attachment style). The client demonstrated high attachment anxiety and low attachment avoidance (i.e., a preoccupied attachment style) at both pre-treatment and post-treatment.

The client. Both the client’s global attachment style and diagnoses are important to consider in interpreting the results of this study, as both may have influenced her behavior in treatment and development of attachment to the therapist, as well as her responses to items on the CATS. First, it is important to state that although the client’s results on the ECR-S indicate that she had high attachment anxiety and low attachment avoidance (i.e., a preoccupied attachment style), researchers observed that the client demonstrated a significant amount of avoidance
behavior throughout treatment. Multiple transcribed portions of sessions presented in Chapter 4 highlight these behaviors. Particularly early in treatment, the client frequently hesitated or avoided responding to the therapist when asked about her thoughts and feelings (e.g., she often said, “I don’t know” when asked questions), and avoided making eye contact with the therapist. Yet, the client also discussed a desire to connect with others and at times engaged in behaviors that allowed her to connect with her therapist (e.g., making direct, if brief, eye contact with the therapist, engaging in psychological exploration with the therapist). Observers believe that these behaviors may be indicative of both high attachment anxiety and high attachment avoidance (i.e., a fearful-avoidant attachment style). Individuals with this type of attachment organization typically demonstrate low levels of self-disclosure, intimacy, reliance on others, and use of others as a secure base. However, they also desire close relationships, even though they struggle to engage in intimate relationships (Bartholomew & Horowitz, 1991). Scholars theorize that a fear of rejection from others likely drives the behavior of individuals with a fearful-avoidant attachment style (Bartholomew & Horowitz, 1991). Also, as previously noted, the client’s scores on the ECR-S place her very close to the fearful-avoidant quadrant of global attachment. Taken together, these scores and researcher observations suggest that the client may have a fearful-avoidant attachment style rather than a preoccupied attachment style.

However, we must also consider the possible influence of the client’s social anxiety. Many of the avoidant behaviors cited above could stem instead from social anxiety, which is characterized by interpersonal avoidance (American Psychological Association, 2000). Or, perhaps both the client’s social anxiety and global attachment style contributed to her behavior and interpersonal presentation in therapy. Indeed, research has found positive relationships between fearful-avoidant attachment and social anxiety, as well as preoccupied attachment and social anxiety (Darcy, Davila, & Beck, 2005). Unfortunately, we cannot definitively ascertain which behaviors are due to social anxiety and which are due to the client’s particular attachment
style. However, the fear of interpersonal rejection is present for individuals with fearful-avoidant attachment, preoccupied attachment, or social anxiety. Thus, we must ask what role this desire to avoid interpersonal rejection played for this client.

One of the surprising findings in this case was that the client reported developing a secure attachment to the therapist rather rapidly. This was particularly surprising due the amount of avoidance behavior demonstrated by the client and observed by researchers. The scores on the CATS that the client completed prior to each session suggest that she experienced the therapist as a secure attachment figure prior to the second session. Specifically, the client scored a 4.43 on the Secure subscale of the CATS immediately prior to the second therapy session. (The CATS ranges from 1 to 6, and higher scores on CATS subscale indicate more endorsement of that dimension of attachment to the therapist.) It is possible that the client’s global attachment style and/or social anxiety influenced her completion of the CATS, however. During the Change Interview, the client specifically stated that she did not want to “mess up” the data in the study. It was unclear what this meant to her. One important possibility given the client’s presentation is that her desire to please others influenced the responses she provided on the CATS. The client, in a desire to avoid rejection from others, may have been motivated (perhaps unconsciously) to please the researchers by endorsing questions that indicated the therapist was serving as a secure attachment figure. Regardless of the client’s particular motivations, researchers noted a clear discrepancy between the client’s responses on the CATS and her behaviors in session.

Researchers engaged in task analysis found that the client completed the majority of the tasks (including all of the behavioral tasks) in the attachment-in-the-making phase of attachment during the third session. However, the client engaged in these tasks inconsistently over the course of treatment. Observers believe she was beginning to develop a secure attachment to the therapist, but did not see evidence of the high level of secure attachment reported by the client on the CATS.
Thus, the client’s responses on the CATS are discrepant from researcher observations and must be interpreted with caution. With these important caveats in mind, other interpretations are possible and must be considered. Obegi (2008), who proposed the phase model of development of attachment to the therapist relied upon to develop the rational model for this study, wrote about the ways in which a client’s global attachment orientation may influence the development of attachment to the therapist. Specifically, Obegi suggested that individuals with high attachment anxiety are motivated to accelerate attachment development, display exaggerated versions of attachment tasks, and even demonstrate markers of later phases prematurely. Meanwhile, individuals with high attachment avoidance are theorized to engage in distancing behaviors (i.e., suppressing thoughts and feelings related to intimacy) early in treatment that may lead therapists to believe attachment development is absent. Thus, Obegi believed that clients with high attachment avoidance may take a considerable amount of time to progress through the phases of attachment, and that expression of attachment markers may be subtle. Obegi did not specify how the presence of both high attachment anxiety and high attachment avoidance (i.e., a fearful-avoidant attachment style) may influence the development of attachment to the therapist.

Researchers believe that evidence of a variety of behaviors described by Obegi (2008) for both high attachment anxiety and high attachment avoidance were present in this case. Related to high attachment anxiety, this client demonstrated markers of later phases prematurely. In the rational model, proximity seeking and separation protest were not anticipated to occur until the third phase of attachment development (entitled clear-cut attachment), but both of these tasks appeared in the second phase (entitled attachment-in-the-making) of the rational-empirical model. That is, both proximity seeking to the therapist and separation protest from the therapist occurred much earlier than anticipated. Data provided support for inclusion of these tasks into the attachment-in-the-making phase of attachment development in the rational-empirical model.
Related to high attachment avoidance, researchers observed that early in treatment, the client engaged in what can be considered distancing strategies. Specifically, the client avoided revealing intimate thoughts and feelings to the therapist by repeatedly answering, “I don’t know” when asked questions by the therapist and avoiding eye contact with the therapist. Hyperactivation-deactivation model. Obégí’s theoretical assertions and the data in this case converge with attachment behavior described in the hyperactivation-deactivation model (Dozier & Kobak, 1992; Kobak et al., 1993). Briefly, this model states that individuals with high attachment anxiety and low attachment avoidance (i.e., a preoccupied attachment style) learned to engage in excessive or exaggerated emotional displays to obtain care from their attachment figures—that is, they engaged in a hyperactivating strategy in order to maximize the availability of the caregiver. Meanwhile, individuals with low attachment avoidance and high attachment anxiety (i.e., a dismissing attachment style) are theorized to rely on a deactivating strategy because they had a caregiver in childhood who consistently dismissed or ignored attachment cues. In response, these individuals learned to deactivate their attachment behavior and conscious awareness of attachment-related emotions in an effort to prevent the caregiver from further rejecting or ignoring them. Individuals with both high attachment anxiety and high attachment avoidance (i.e., a fearful-avoidant attachment style) are thought to vacillate between these deactivating and hyperactivating strategies. In this case, the client’s behaviors with regard to connection to the therapist appear to shift between hyperactivation and deactivation. Thus, this model offers an additional way to interpret the discrepancy between the client’s reported high secure attachment to the therapist and her avoidance behaviors in session.

The therapist. In addition to considering the specific contributions of the client’s diagnoses and global attachment orientations to the development of attachment to the therapist, we must consider the contributions of the therapist. A therapist with low attachment anxiety and avoidance (i.e., secure attachment) was purposely selected for this study because of both
theoretical (Bowbly, 1988; Mallinckrodt, 2010; Mikulincer & Shaver, 2007; Slade, 1999) and empirical (Black et al., 2005; Mohr et al., 2005; Rozov, 2002; Sauer et al., 2003) suggestions that this type of therapist is best able to assist a client in psychotherapy. Given the design of this study, it is impossible to know for certain what impact the therapist’s attachment style had on the therapeutic process and outcome. Certain characteristics of the therapist’s behavior that were observed during task analysis (e.g., consistency in interpersonal style, warmth, ability to engage with the client) are typical of individuals with low attachment anxiety and avoidance (i.e., secure attachment style; Mikulincer & Shaver, 2007). Also of note, this therapist also had nearly a decade of training and work experience as a clinician. Again, due to the design of this study, it is not possible to ascertain the specific influence of the therapist’s training. However, we wonder about the role of both the therapist’s attachment style and her training experiences in her ability to serve as a safe haven and secure base for this client.

Consistency and possible countertransference. In this study, the therapist was observed to be consistent in her interactions with the client throughout the treatment. Observers noticed that she maintained a warm, engaging, attentive demeanor across sessions; this is significant given that the presentation of the client sometimes varied markedly by session. Perhaps one of the reasons this is striking is that therapist revealed that she sometimes felt stuck with this client, noticed that her own anxiety increased at times, and sometimes questioned her own competence. During the Change Interview, the therapist spoke about her internal process when asked by the interviewer how it felt to be the therapist for this client.

Therapist: Um, well…conducting the therapy was challenging. Um, she was like a very agreeable client—like, I would suggest that she do something, like a homework assignment or you know, even like that jar example in therapy and she would do it and um, not really begrudgingly but you know, it looked like she wasn’t really thrilled about it but she
would do it, um, so it made me think she was fairly agreeable and like, I never knew if she was just trying to please me or if she had any hope that it would be helpful. But I think that it felt a lot of times like I was pulling teeth in session. Um, like I would ask her a question and she would give me a one or two word answer or like a really short answer. And I think, um, I think it caused me to feel kind of stuck a lot of the times. I think there was more silence in our sessions than there usually is with other clients, um, and for some reason like I would feel compelled sometimes to fill the silence and then other times I would just like, sit and let the silence be and then it kind of raised my anxiety and probably hers a little bit too… in some ways it made me question my competence a little bit.

Because the Change Interview does not ask questions specifically designed to assess for countertransference, it is impossible to know which, if any, of the therapist’s reactions could be considered countertransference (CT). Here, CT is defined as the therapist’s behavioral, cognitive, and affective reactions to clients that are based in the therapist’s unresolved intrapsychic conflicts (Gelso & Carter, 1985; Grotjahn, 1953; Hayes, 1995). The therapist was not asked questions to assess her own unresolved intrapsychic conflicts, nor did she spontaneously provide information that offered insight into these conflicts. However, the comments that she did make, as quoted above, indicated that she had cognitive and affective reactions to this client. While the origins of these reactions remain unknown, the therapist appeared to manage her reactions in such a way that they were not visible to observers, and did not appear noticeable to the client (as assessed via the HAT and Change Interview). It may be that many other therapists, regardless of their own history or unresolved personal issues, would react to this type of client in the same way. This client initially provided minimal answers to questions or deflected questions by stating, “I don’t
know.” Sustained effort to connect would be required by any therapist treating this client. Regardless of whether or not the therapist’s reactions to the client stemmed from her unresolved personal history, the model of CT management offered by Hayes may be helpful in conceptualizing therapist reactions and management of these reactions.

The model of CT management offered by Hayes (1995) specifies possible manifestations of CT, including internal reactions such as anxiety and feelings of liking or disliking for the client, and external, behavioral reactions that may include withdrawing from or avoiding the client or becoming overinvolved. In this study, the therapist did report feeling anxious and stuck with the client. She also reported questioning her own competence at times. She did not, however, evidence any behavioral reactions such as those listed above. The question that emerges, then, is if the therapist experienced CT or even non-CT based reactions, did she engage in management?

Gelso and Hayes (2007) theorized that five factors contribute to therapists’ ability to manage their own CT reactions, including: self-insight, anxiety management, self-integration, empathy, and conceptualization skills. Research has found that therapists demonstrated less CT behavior when they had an awareness of their CT reactions and were able to rely on theoretical framework to understand these reactions (Latts & Gelso, 1995; Robbins & Jolkovski, 1987). The information provided by the therapist in the Change Interview suggests that she was aware of her own reactions to the client, had a clear conceptualization of the client’s concerns, and considered the ways in which her reactions were related to her conceptualization. Less is known about the therapist’s self-integration and the specific ways the therapist managed her anxiety. However, the therapist reported that she engaged in supervision when feeling unsure about what to do with the client and she did not appear noticeably anxious in session. Future research about the development of attachment to the therapist that specifically explores the roles of therapist CT and CT management may offer further insight about how these variables are related to attachment development. Regardless of whether or not the therapist’s reactions are true CT, her ability to
remain steady and consistent in her relational approach across treatment appeared to serve the
client well. The client reported that she trusted the therapist and that this trust allowed her to open
up in a novel and corrective way when with the therapist.

The therapy

Depressive symptoms. The first and only hypothesis, which stated that client-reported
secure attachment to the therapist would be negatively related to client-reported depressive
symptomatology, was not supported. In fact, the correlation between secure attachment to the
therapist and depressive symptomatology across treatment was .22, which is a small effect
(Cohen & Cohen, 1983) in the opposite direction of what was hypothesized. This finding
indicated that the more securely attached to the therapist the client perceived herself to be, the
more depressive symptoms the client reported experiencing. Also, the less securely attached the
therapist the client perceived herself to be, the fewer depressive symptoms the client reported
experiencing. If the hyperactivation model is considered, this finding makes more sense. The
client, who had a preoccupied global attachment style, had to amplify her distress in order to
ensure continued connection with the therapist. It is possible, and perhaps even likely, that given
a significantly longer course of psychotherapy, the association originally hypothesized would be
found. That is, if the client had a more significant period of time in which to experience the
therapist as a consistently available secure attachment figure, she may have experienced reduction
in her depressive symptoms. However, in such a brief course of psychotherapy, during which
time the client’s global attachment orientation did not change (post-treatment assessment
indicated that the client continued to report high attachment anxiety and low attachment
avoidance), the client continued to rely on her well-established patterns of care-seeking.

The findings regarding client depressive symptomatology in this study converge with
those in the literature. A recent meta-analysis (Levy et al., 2011) found that client global
attachment anxiety negatively related to client outcome. Beutler, Blatt, Alimohamed, Levy, and
Angtuaco (2011, p. 34), in reviewing relevant studies of client attachment and outcome concluded, “...patients with pre-occupied or unresolved attachment status tend to respond more poorly than patients with other attachment patterns.”

*Social anxiety symptoms.* How, then, do we make sense of the associations between social anxiety symptomatology and attachment to the therapist? These associations were notably different than those between depressive symptomatology and attachment to the therapist. That is, as the client’s secure attachment (and preoccupied-merger attachment) to the therapist increased, her social anxiety symptoms decreased. The answer may lie in the focus of the psychotherapy, as well as its short duration. Observers noted that the therapist often directly explored with the client the ways in which the client’s shyness or discomfort having a voice or opinion impacted her relationships with others, including the therapist. For example, the therapist used the “jar exercise” (i.e., an exercise where the client placed a piece of paper into a jar each time she said, “I don’t know”) in order to encourage the client to share more of her thoughts and feelings in session. The therapist also assigned the client homework to challenge her ability to express her opinion with friends. For example, one week the client was asked to express an opinion to a friend and was able to tell a friend that she did not want to engage in a particular activity. In her Change Interview, the client reported that she found these kinds of activities helpful in encouraging her to tell other people how she was actually feeling, instead of remaining silent and afraid of what people would think about her. Additionally, the very act of coming to therapy and talking with the therapist was, in essence, a form of exposure therapy for this client. Her social anxiety and fear of others’ perceptions—including the therapist’s perception—was palpable. The therapist directly addressed this with the client by encouraging the client to ask the therapist what she was thinking about her, and openly sharing her care and empathy for the client. The combination of attending therapy, engaging in therapeutic activities (e.g., the jar exercise), successfully completing homework assignments given by the therapist, and direct encouragement
by the therapist for the client to use her own voice offered the client several opportunities to work directly and quickly on her social anxiety. In short, the client appeared to have a corrective experience with the therapist with regard to social anxiety.

In many ways, for this particular client, depression seemed to be a more deep-seated issue related to how she felt about herself and her worth as a person (i.e., her IWM of herself). Depression and social anxiety were certainly related in the present study (the correlation between these two subscales on the CCAPS-34 for this client was .75) and the therapist conceptualized these two issues as being linked for this client. During the Change Interview, the therapist commended on the connection between social anxiety and depression for this client when asked about her case conceptualization.

*Therapist:* It felt like she was not socially skilled and had a great deal of anxiety in social situations, which led her to feel more sad and depressed. I guess it’s the chicken or the egg—if she always feels depressed, it’s going to make her feel self-conscious and anxious with people. And if she has negative social experiences, she feels more depressed.

Based on observational data and interviews with the therapist and client, researchers believe depression may have been more difficult and time-intensive to successfully address for this client. Additionally, because the client’s social anxiety was glaringly present in the therapy, it seems likely that in order to even engage the client in the treatment, the therapist had to attend to the anxiety. If the therapist instead had attempted to only treat the depression the client was experiencing, or even first treat the depression, she likely would have hit a road block as the client would not have been able to get past her fear of sharing personal details with the therapist to sufficiently engage in exploration and allow for a unique relational experience.

*Interpersonal functioning.* The client did not demonstrate clinically significant change in interpersonal functioning from pre-treatment to post-treatment. Given the deep-seated nature of
the client’s presenting problems and the brief treatment she received, this is not surprising. Additionally, her global attachment style did not shift markedly over the course of treatment, indicating that her IWMs of herself and others have remained relatively stable. Again, it would be interesting to see if significant change occurs in longer-term treatment, or for clients with different incoming global attachment styles.

**Navigating interpersonal distance.** Observers, who engaged in task analysis, viewed the therapist’s ability to successfully navigate interpersonal distance with the client as a core task in the development of secure attachment to the therapist. The therapist’s modulation of therapeutic distance was a key component of both the pre-attachment and attachment-in-the-making phases of development of attachment to the therapist. In the pre-attachment phase, the therapist’s modulation of therapeutic distance appeared to be in response to the client’s pre-existing IWMs. However, in the attachment-in-the-making phase, the therapist appeared to titrate the therapeutic distance to challenge the client’s IWMs. That is, the therapist tailored her navigation of interpersonal distance to the client’s specific IWMs, or expectations of others based on prior attachment experiences. Specifically, he therapist had to find a way to help the client feel safe enough (e.g., not judged or negatively evaluated by the therapist) to verbally explore her distress and use the therapist as a safe haven and secure base. In the rational-empirical model, the therapist’s modulation of therapeutic distance was linked to all but one of the behavioral tasks in the attachment-in-the-making phase of attachment development, as it appeared to facilitate the client’s increased description of events, thoughts, and feelings, the client’s use of the therapist as a safe haven and secure base, and the client’s increased responsiveness to the therapist’s encouragement of exploration.

Daly and Mallinckrodt’s (2009) attachment-informed theoretical model of interpersonal distance is important to consider. These researchers suggested that the interpersonal distance necessary to engage clients in early stages of treatment is later adjusted to create a new, corrective
attachment experience with the therapist that facilitates client change. Daly and Mallinckrodt theorized that when working with clients with high attachment anxiety and low attachment avoidance (e.g., preoccupied attachment style), therapists may increase therapeutic distance over time in order to promote clients functioning more autonomously. In contrast, when working with clients with high attachment avoidance and low attachment anxiety (e.g., dismissing attachment style), therapists may decrease therapeutic distance in order to assist clients in feeling more comfortable with the intimacy of relationships. In essence, this theoretical model is about how much closeness and distance a client can tolerate given their global attachment orientation. Daly and Mallinckrodt do not offer a model of interpersonal distance for clients who have both high attachment anxiety and high attachment avoidance (i.e., a fearful-avoidant attachment style).

Given that observers believe this client demonstrated aspects of attachment anxiety and avoidance in her work with the therapist, Daly and Mallinckrodt’s model is challenging to apply directly. However, there are important ways in which the observations of this case challenge the model.

Over the course of treatment, the therapist in this case consistently worked to decrease the interpersonal distance between herself and the client. The therapist initially had to work with the client in a way that the client could tolerate, and she did so by first (in the pre-attachment phase) using more humor and hyperbole to relieve some of the anxiety in the room and then (in the attachment-in-the-making phase) shifting to using less humor and more empathy and validation. Later in treatment, the therapist did not allow the client to easily avoid exploration, as she discouraged the client’s habitual use of the phrase “I don’t know” and gently challenged the client to consider and share her thoughts and feelings. According to Daly and Mallinckrodt (2009), coming interpersonally closer, like the therapist did here, is the appropriate approach to take for a client with high attachment avoidance (i.e., a dismissing attachment style). The client in this case, though, also had high attachment anxiety; the recommendation from Daly and Mallinckrodt for a client with high attachment anxiety is to create more distance and autonomy
over time. The therapist in this case did not do this. Perhaps for clients with both high attachment anxiety and high attachment avoidance, it is preferable for therapists to come closer to clients rather than trying to move further away. Additional research with clients who demonstrate behaviors consistent with high attachment anxiety and high attachment avoidance is necessary to develop an appropriate model of interpersonal distance for these kinds of clients, as the extant model by Daly and Mallinckrodt (2009) is not inclusive of these individuals.

**A corrective emotional experience.** By modulating distance in the way that she did, the therapist offered the client a corrective emotional experience (Alexander & French, 1946). The therapist disconfirmed the client’s expectations, as she was not driven away by the client’s fear of sharing her thoughts and feelings. The therapist did not make the client sit in silence, as the client disclosed she feared the therapist might. The therapist was also not driven away when the client finally did reveal some of her most personal thoughts and feelings. By staying consistently physically and emotionally present with the client regardless of the client’s presentation in session, the therapist seemed to disconfirm the client’s expectations and challenge her IWMs. Additionally and importantly, the therapist also offered the client a new experience by providing something the client originally failed to receive from her caregivers. She offered the client a safe space in which to have a voice that was heard, encouraged, and respected. This type of experience offered a direct challenge to the IWMs constructed by the client’s early life experiences in her family.

Another potentially important component of this corrective emotional experience is the eye contact between the therapist and client. During moments of connection, the therapist and client made eye contact, while at other times, the client struggled to look at the therapist. Observers noted that this kind of eye contact increased during the attachment-in-the-making phase of attachment. Attachment theorists (e.g., Bowlby, 1958) and researchers (e.g., Beebe, Jaffe, Buck, Cohen, Feldstein, & Andrews, 2008; Beebe et al., 2010; Jaffe, Beebe, Feldstein,
Crown, & Jasnow, 2001) have attention to the importance of eye contact in forming secure attachments for infants and their caregivers. New research has suggested that three seconds of continuous eye contact between an infant and his or her mother predicts secure attachment (Woodhouse, Lauer-Larrimore, Hollander, Jog, & Billings, 2014). Future research could further explore the role of eye contact between the therapist and client in developing a relationship and facilitating a corrective emotional experience.

**Implications for Training and Clinical Practice**

*Personhood of the therapist.* Data in this study highlighted the importance of therapeutic consistency over the course of treatment. It is possible that the therapist’s own global attachment style (low attachment anxiety and avoidance) influenced her ability to provide consistently warm and engaging care to her client; due to the design of the current study, we cannot be sure that the therapist’s attachment style is directly connected to her behavior. What is notable is that the therapist was able to serve as a supportive caregiver to this client in spite of feeling frustrated and challenged at times. These data highlighted the importance of the therapist being able to serve as a safe haven and secure base for the client. It is unclear whether the secure attachment style of the therapist serves as a main effect or a moderator. For example, does having a secure attachment style allow the therapist to use certain interventions skillfully? Also, this therapist was an advanced trainee with multiple years of experience as a therapist. It is possible that her training and experience influenced her ability to serve as a caregiver for her client and manage her own reactions to the client.

Regardless of the specific causes of the therapist’s behavior, findings draw attention to the importance of attending to the personhood of the therapist during clinical training. Addis (2000) stated that graduate training for therapists typically includes developing conceptualization and critical thinking skills, skills training in implementing specific and generalized interventions aligned with particular theoretical orientations, as well as research training. Although the amount
of focus a graduate training program places on the therapist as a person likely varies depending on the specific program, overall, sometimes little emphasis is placed on the therapist as a person and personal characteristics that can help or hinder the therapist’s ability to engage in highly complex relationships with clients (Norcross, 2002). Therapists are instructed to be empathic, but vary in their empathic expression (Duan & Hill, 1996; Elliott, Bohart, Watson, & Greenberg, 2011; Peabody & Gelso, 1982; Watson, 2001). Attachment theory suggests that therapists’ abilities to be empathic and caring with clients is heavily influenced by therapists’ own experiences in relationships (Bowlby, 1988; Mikulincer & Shaver, 2007). However, the amount of attention paid to these factors in training is likely variable across training programs. Graduate training programs who are not doing so already could enhance their effectiveness by attending to the full person of the therapist, not just the mental capacity of the therapist. For example, training all therapists to systematically attend to their personal reactions to clients and countertransference, just as they would attend to the development of a case conceptualization, would be helpful in this regard. Safe supervisory relationships in training may be one space where therapists could engage in this type of systematic self-reflection (Bennett-Levy, 2006) and increase their self-awareness (Falender & Shafranske, 2004).

It is important for therapists to work through their own attachment insecurities. Therapists who experience and identify a degree of attachment insecurity in themselves should consider engaging in their own psychotherapy to explore and shift these deeply ingrained patterns and interpersonal expectancies. Countertransference researchers have suggested personal psychotherapy and clinical supervision are potentially valuable means to support self-integration, a key component of CT management (Hayes, Gelso, & Hummel, 2011). Actively vocalizing approval of and support for clinicians-in-training seeking personal therapy may also contribute to trainees attending to themselves and addressing any major internal conflicts. Studies of therapists in training have found that between 25% and 41% of trainees experience significant problems
with issues including depression, anxiety, and low self-esteem (Brooks, Holttum, & Lavender, 2002; Kuyken, Peters, & Lavender, 1998). However, perceived social stigma may prevent therapists in training from seeking psychotherapy (Digiuni, Jones, & Camic, 2013). Graduate training may provide an ideal time for therapists to engage in personal psychotherapy if they have not already. Clinical training alone—with its emphasis on conceptualization and intervention—is unlike to shift the global attachment styles with which clinicians enter their training programs. Additionally, training clinicians to manage their own reactions to clients—whether these reactions are grounded in countertransference or not—is essential to developing strong clinicians. In this study, the therapist had reactions to the client that she was able to manage so they did not appear to disrupt or otherwise negatively impact the therapy.

**Fostering attachment to the therapist.** Typically, attachment to therapist has not been measured before the fourth session because it was theorized that the attachment to the therapist would take more time to form based on experiences with the therapist (Mallinckrodt et al., 2005). However, the current study found that attachment to the therapist begins to develop earlier than the fourth session as observational data found that the client demonstrated all behavioral markers of attachment-in-the-making by the end of the third session. Thus, attachment to the therapist can and does develop more quickly than previously thought. Clinicians should be prepared for this to happen and also consider ways in which they can help foster this attachment from the beginning of treatment.

Fostering attachment to the therapist requires an understanding of and appreciation for the therapeutic relationship. Research has supported the idea that the therapeutic relationship accounts for a large percentage of the variation in client outcome (e.g., Imel & Wampold, 2008). This suggests that therapists should be highly attuned to the therapeutic relationship regardless of their specific theoretical orientation. The emphasis placed on the therapeutic relationship for therapist trainees, however, likely varies depending on the theoretical orientation of the graduate
training program and specific faculty members or supervisors in that program. For example, a graduate training program that heavily values manualized treatment may place more emphasis on learning and mastering specific techniques than on fostering a therapy relationship (e.g., Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010; Joyce, Woolfaardt, Sribney, & Alywin, 2006; Norcross, 2002). Data from the present study suggest that it is the development of a strong attachment-based relationship between the therapist and client that allowed the client to engage in the work of psychotherapy. Specifically, the tasks (i.e., therapist serves as a secure base and safe haven, therapist modulates therapeutic distance) that were observed and subsequently represented in the rational-empirical model suggested that the therapist’s consisting offering of herself as an attachment figure assisted the client in the exploration of painful emotions and past events. Both the client and therapist commented on the importance of their relationship in their Change Interviews, and both observers directly witnessed the influence of the positive quality of their relationship on the client’s engagement in in-session exploration, emotion regulation, and ability to develop a unique internal working model of the therapist.

Clinicians can be trained to recognize markers that indicate attachment to the therapist is developing. For example, in the present study, the client demonstrated a marked increase in detailed descriptions of events, thoughts, and feelings at the beginning of the attachment-in-the-making phase of attachment development. This particular marker indicated her movement from the pre-attachment phase (during which she engaged in surface-level disclosures) to the attachment-in-the-making phase of attachment development. The therapist then offered herself as a safe haven for the client, which led to the client engaging in increased exploration and using the therapist as a secure base. Another notable marker is related to the client’s emotional regulation. As the client shifted into the attachment-in-the-making phase, she demonstrated less negative arousal in session. These types of emotional and behavioral markers would be relatively easy for therapists to recognize and may assist them in thinking about how to respond to clients (e.g., if
client is engaging in increased exploration, the therapist could find opportunities to offer herself as a safe haven).

Part of fostering attachment to the therapist involves the therapist appropriately navigating interpersonal distance in the therapy in order to first engage the client, and then challenge the client’s problematic ways of relating with others. Attachment theory offers a useful lens through which to conceptualize therapeutic distance and may be helpful to consider across theoretical orientations. Considering the global attachment style of a client may offer clinicians additional information from which to gauge effective therapeutic distance. Regardless of which specific interventions the therapist chooses to use, the relationship is always present and needs to be managed. Therapeutic distance is part of this relationship management.

**Research Implications**

*Continued task analysis.* The present study represents a first step in the process of using task analysis to understand how attachment to the therapist develops. Task analysis (Greenberg, 2007; Pascual-Leone et al., 2009) has of two distinct phases: discovery and validation. Only the discovery phase occurred during this study. The discovery phase of task analysis consists of rational modeling and empirical modeling, as well as the quantification of qualitative categories. In the present study, only rational modeling and empirical modeling were completed for one specific case of a client with Major Depressive Disorder. Empirical modeling typically consists of analyzing and comparing multiple cases in order to create the most comprehensive rational-empirical model possible before shifting to the creation of quantitative categories. Thus, more cases should be obtained and analyzed to further develop the model of how attachment to the therapist develops.

The development of attachment to the therapist may look different depending on the global attachment of the client, as well as their diagnosis. The present study consisted of only one client with Major Depressive Disorder and Social Phobia who demonstrated high attachment.
anxiety and high attachment avoidance (e.g., a fearful global attachment style). Thus, future research should include additional case studies of clients with both similar and different global attachment styles, as well as clients with similar and different psychological disorders. This type of research would allow for the examination of case-specific factors as well as factors that hold true across cases.

A great deal of interesting information is likely to be gained by examining cases in which the therapist does not have a secure attachment style. Given that an estimated 30% of psychotherapists have an insecure attachment style (Leiper & Casares, 2000), it is essential to better understand the process of what happens when a therapist does not have a secure attachment orientation. For example, what happens with regard to development of attachment to the therapist when the therapist and client have similar attachment orientations? What happens when they have different attachment orientations? Does the specific diagnosis of the client influence attachment development? Additional information can also be gained by examining case in which the therapist is a novice. The therapist in this case, while still in training, has been practicing as a therapist for over nine years. Her training and clinical experiences may have played a role in her ability to serve as a safe haven and secure base for this client. Examining cases where therapists have a variety of experience levels will assist in the construction of a robust model that describes the development of attachment to the therapist.

**Influence of theoretical orientation.** The therapist in the present study reported that she primarily believed in and followed psychoanalytic/psychodynamic and feminist/multicultural theories. Attachment theory emerged from the psychoanalytic tradition and many of its key concepts are dynamic in nature. However, the therapist for the study was purposely not selected based on her theoretical orientation as the concepts of how attachment to the therapist develops are theorized to hold across theoretical models. That is, the present study was conceptualized out of a common factors approach rather than a specific factors approach. For example, one of the
tasks in the rational-empirical model is that the client demonstrated increased responsiveness to the therapist’s encouragement of exploration. While the therapist in this study tended to help the client explore past experiences in her family or origin, a therapist utilizing a cognitive-behavioral framework might help the client explore automatic thoughts and core beliefs. That is, the content of sessions may be different, but the process of the relationship development may look the same. Thus, future research might explore how and to what end attachment to the therapist develops across a variety of different theoretical models. Training programs that emphasize manualized treatment may, in fact, be a fertile ground for future research. By holding the constant the training experiences and theoretical orientation of therapists, the role of therapists’ specific attachment styles on development of attachment to the therapist could be better understood.

Theoretical Implications

Findings from this study offered support for many central constructs in attachment theory related to psychotherapy and the therapist as an attachment figure. The therapist was observed serving repeatedly as a safe haven and secure base for the client. The client reported experiencing separation protest and proximity-keeping to the therapist. Perhaps what was most remarkable, though, was how quickly a secure attachment to the therapist began to form. Given that studies have not typically explored attachment to the therapist prior to the fourth session of treatment, as attachment to the therapist was believed to take at least this long to develop (Mallinckrodt et al., 2005), this finding is significant and offers a unique contribution to the literature. Of course, this finding must be viewed in context of occurring with the particular global attachment styles of this therapist and client. However, this finding seems important in considering the role of attachment in very brief psychotherapy. If attachment to the therapist can begin to develop quickly, how might this inform the theoretical stance and actual work of psychotherapists who engage in brief psychotherapy? Further, even for therapists who engage in longer-term treatment, how might they foster attachment starting in the first session of treatment?
Relatedly, a multitude of factors may influence the development of attachment to the therapist including, among other variables, the therapist’s global attachment orientation, the client’s global attachment orientation, the client’s specific psychopathology, and the therapist’s ability to navigate the therapeutic relationship and interpersonal distance and manage her own reactions to the client. The interplay of these factors as observed in this case study is complex and nuanced, not straightforward or simple, and should serve as a reminder for attachment theorists to attend to all of these factors. It is tempting to focus solely on, for example, the role of clients’ global attachment styles to explain the ways they relate to the therapist, or on the importance of therapists’ own attachment styles in understanding their ability to serve as attachment figures. Attending to only one or two of these variables does not do justice to the complex nature of attachment and to the process of psychotherapy.

Although the hypothesized relationship between client-reported depressive symptoms and secure attachment to the therapist was not found, it is unclear whether this relationship would emerge if treatment had continued beyond six sessions. The ways in which Bowlby (1988) described attachment-based psychotherapy imply a significantly longer treatment than that conducted in the present study. Further, the association between client-reported social anxiety symptoms and secure attachment to the therapist provides some support for the theoretical idea that secure attachment to the therapist can lead to change in client symptomatology as a clear connection between increased secure attachment and decreased social anxiety was observed. Correlation, of course, does not equal causation and additional research would bolster support for the theorized link between attachment to the therapist and symptom change. Length of treatment and types of symptom change are additional factors to consider when exploring the role of attachment to the therapist in psychotherapy process and outcome.
Limitations

Measuring client attachment to the therapist is a relatively new concept and only two instruments assessing client attachment to the therapist currently exist. One is the CATS (Mallinckrodt et al., 1995), which was used in the current study. As described previously, the CATS assesses three dimensions to the therapist (secure, preoccupied-merger, and fearful-avoidant). In the present study, the client reported having a high level of secure attachment to the therapist, a moderate level of preoccupied-merger attachment to the therapist, and a low level of fearful-avoidant attachment to the therapist. It proved challenging to fully grasp the theoretical implications of a client demonstrating aspects of both secure and preoccupied-merger attachment to the therapist. Theoretically as the subscales have been constructed and defined (Mallinckrodt et al., 1995), the scores for these two constructs should not coexist in the way that they do in the present study. Yet, for this client, she reports experiencing aspects of both. To this author’s knowledge, the CATS has not been used in a case study like this one but instead has only been utilized in large n, cross-sectional studies. Perhaps this has limited the challenges other researchers have faced in interpreting findings using the CATS. Additionally, as mentioned earlier, the client’s specific global attachment style, as well as her social anxiety, may have influenced how she answered questions on this measure. What she reported and what researchers observed in her behavior did not align.

The CATS was chosen for the present study because more is known about this measure psychometrically than the only other published measure of attachment to the therapist, called the Client Attachment Questionnaire—Therapist (CAQ-T; Parish & Eagle, 2003a, 2003b). The CAQ-T is distinct from the CATS, as it only assesses secure attachment to the therapist. Future research would benefit from using both of these measures to understand the ways in which they uniquely assess attachment to the therapist. Observational data is irreplaceable, however, and future researchers are encouraged to consider how observational data matches up with self-report data.
It is possible that the Hawthorne effect influenced the client and therapist, and therefore the results of this study. The therapist commented during her Change Interview that she was hyperaware of the fact that she was participating in the current study and frequently wondered to herself how other therapists might work with this client. It is hard to know what impact this awareness had on the therapy. On one hand, it may have led the therapist to act differently than she might when conducting therapy that is not part of a research study. Acting differently could take multiple forms however (e.g., less attuned to the client due to a distraction about being filmed and later observed, more attuned to the client and psychotherapy process due to a desire to “look good” for others) and it is, of course, not possible to know. Similarly, the client commented during her Change Interview that when completing pre-session measures, she sometimes thought about her responses for the prior week and wondered about how her responses impacted the research.

Another potential limitation of this study is that the researchers knew the participating therapist. Before engaging in qualitative analysis, researchers bracketed their assumptions, which included their personal beliefs about the therapist and her abilities. However, it is possible that the personal relationships between the researchers and the therapist influenced their perceptions of her work with the client in this study.

Case study research inherently has low generalizability in terms of generalizing to a larger sample. However, the results of this study are first steps towards informing a theory of how attachment to the therapist develops over the course of treatment. As previously discussed, there are many case-specific variables that influence the development of this attachment. Task analyses conducted across many cases with different therapists, clients, and treatment-specific variables (e.g., length of treatment, client diagnosis) will help construct a more general model of how attachment to the therapist develops. The results of the present study are initial steps.
Limitations notwithstanding, this study offers a detailed examination of how, and to what end, secure attachment to the therapist develops over the course of psychotherapy. Perhaps most importantly, the study highlights the importance of considering a multitude of factors that contribute to the unique dance that is the relationship between the therapist and client, and the ways in which attachment theory provides a framework from which to understand this dance.
Appendix A

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__________________)

What is the highest degree you have achieved in a counseling-related field?
  ______ Masters in ______________________________
  ______ Ph.D. in ________________________________

Approximately how many clients have you counseled? ______ clients

If you are currently a student, approximately how many semesters of practicum experience have you had (prior to this semester)? ______ semesters

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

<table>
<thead>
<tr>
<th>Theory</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>psychoanalytic/psychodynamic</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>cognitive/behavioral</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>humanistic/experiential</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>feminist/multicultural</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
Appendix B

Experiences in Close Relationships-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:

<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>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Strongly</td>
<td>Neutral/</td>
<td>Mixed</td>
<td>Agree</td>
<td>Strongly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Inventory of Interpersonal Problems

This instrument was excluded due to copyright.
Appendix D

Counseling Center Assessment of Psychological Symptoms-62 (CCAPS-62)

This instrument was excluded due to copyright.
Appendix E

Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34)

This instrument was excluded due to copyright.
Appendix F

Standardized Data Set (SDS)

This instrument was excluded due to copyright.
Appendix G
Client Attachment to the 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.

1
Strongly Disagree
2
Somewhat Disagree
3
Slightly Disagree
4
Slightly Agree
5
Somewhat Agree
6
Strongly Agree

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 H

Helpful Aspects of Therapy

1. Of the events that occurred in this session, which one do you feel was the most helpful for you personally? It might have been something you said or did, or something your therapist said or did.

2. Can you say why it was helpful? Please describe what made it helpful and/or what you got out of it?

3. How helpful was this particular event? Rate it on this scale:

   HINDERING 1 2 3 4 5 6 7 8 9
   Neutral 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9
   HELPFUL

   E G M S G M S G E
   X R O L L O R X
   T E D I T D E T
   R A E G G E A R
   E T R H H R T E
   M L A T T A L M
   E Y T L L T Y E
   L E Y Y E L Y
   Y L Y L Y

4. About where in the session did this even occur?

5. About how long did the event last?

6. Did anything else particularly helpful (or important) happen during this session?
   YES  NO

   If yes, please describe it briefly and rate how helpful it was: __________

7. Did anything happen during the session which might have been hindering?
   YES  NO

   If yes, please describe it briefly and rate how hindering it was: __________
Appendix I

Client Change Interview

1. General experience of therapy. What was therapy like for you? How did it feel to be in therapy?

2. Changes? How are you doing now? What changes, if any, have you noticed in yourself since therapy started?

3. Attributions. In general, what do you attribute these various changes to? In other words, what do you think might have brought them about (Both outside & inside therapy)

4. Helpful aspects. What was the most helpful things about therapy so far? (general aspects, specific aspects) What made these things helpful to you?

5. Hindering aspects. What kind of things about the therapy were hindering, unhelpful, negative or disappointing for you?

6. Difficult but OK aspects. Were there things in the therapy that were difficult or painful but still OK or helpful?

7. Missing aspects. Was there anything missing from your therapy?

8. Research aspects. What has it been like for you to be involved in this research?

9. Suggestions. Do you have any suggestions for us, regarding the research or the therapy?
Appendix J

Therapist Change Interview

1. *General experience of therapy.* What has conducting this therapy been like for you? How has it felt to be the therapist for this client?

2. *Changes?* How do you think your client is doing now? What changes, if any, have you noticed in your client since therapy started?

3. *Attributions.* In general, what do you attribute these various changes to? In other words, what do you think might have brought them about (Both *outside & inside therapy*)

4. *Helpful aspects.* What do you believe been the most *helpful* things about that happened for this client in therapy so far? (*general aspects, specific aspects*) What made these things helpful for this client?

5. *Hindering aspects.* What kind of things about the therapy do you believe have been *hindering*, unhelpful, negative or disappointing for the client?

6. *Difficult but OK aspects.* Were there things in the therapy that you believe were *difficult* or *painful* for the client but still OK or helpful?

7. *Missing aspects.* Was there anything missing from the treatment you provided this client?

8. *Research aspects.* What has it been like for you to be involved in this *research*?

9. *Suggestions.* Do you have any suggestions for us, regarding the research?
Appendix K

Therapist Informed Consent

Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Psychotherapy Relationship Study

Principal Investigator: Jessica C. Effrig, MSW
327 Cedar Building
University Park, PA 16802-1003
814-308-5054; jcs307@psu.edu

Advisors: Dr. Jeffrey A. Hayes, Ph.D.
307 Cedar Building
University Park, PA 16802
814-863-3799; jxh34@psu.edu

1. Purpose of the Study:
The purpose of this research study is to investigate the relationship between the client and his or her therapist across the course of psychotherapy.

2. Procedures to be followed:
If you are interested in participating in this study, you will be asked to complete a brief, 12-item measure about relationships and a demographic form. You may be selected for further participation based on therapist characteristics.

If you are one of the therapists chosen to participate further in this study, you will be asked to see if your newly assigned clients meet criteria for participation in this study. A list of inclusion and exclusion criteria will be provided to you. If a newly assigned client does meet these criteria, you will be asked to email that client prior to beginning treatment and provide them with information regarding the study and the PI’s contact information.

Once you begin working with a participating client, you will meet with the client each week. Prior to each weekly session, the client will complete one brief additional measure. After each session, you will be asked to give the client one additional measure to complete. They will complete this measure and return it in an envelope to the front desk. You will not be responsible for collecting this measure and you will not have access to the measure once it is completed.

You will be expected to complete all standard paperwork associated with seeing clients at Counseling and Psychological Services (CAPS). You will also be asked to have clients complete the Counseling Center Assessment of Psychological Symptoms-34 (CCAPS-34) at each session.
After your client has stopped treatment (if a minimum of 6 sessions has been completed) or after your client has completed 12 sessions, you will be asked to participate in an interview about your experience working with this client. This interview will take approximately one hour.

After your client has stopped treatment (if a minimum of 6 sessions has been completed) or after your client has completed 12 sessions, the PI and an advanced Counseling Psychology doctoral student at Penn State University, Julie R. S. Beeney, will review videotapes of your counseling sessions with this client in order to conduct qualitative analysis.

3. **Discomforts and Risks:** There is no more than minimal risk involved in participating in this research beyond those experienced in everyday life. There is, however, the potential risk of loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed. In order to minimize the potential risk of loss of confidentiality, the questionnaires you complete will be stored without your name and only labeled with a code number. Additionally, these materials will be kept in a locked file in a locked office, only accessible to the PI and her advisor, and destroyed after 7 years.

You will also be asked to spend one hour completing an interview about your experiences in providing psychological treatment to a participating client. This could potentially cause you to experience minor inconvenience.

4. **Benefits:**
   **The benefits to you include:**
   As part of your participation in the research study, you will have the opportunity to participate in psychotherapy research that may contribute to your research training.

   **The benefits to society include:**
   In conducting this study, we hope to better understand how clients’ relationships with develop as therapy progresses. As we increase our understanding, we can provide psychotherapists with better information about the specific ingredients of therapeutic relationships that promote client change.

5. **Duration:** It will take about 5 minutes to complete the initial survey and demographic form. The final interview you will participate in will take between 30 minutes and 1 hour.

6. **Statement of Confidentiality:** Your participation in this research is confidential. The initial measure and the demographic form you complete will be stored in a locked file in a locked office and/or in a password protected computer file. All therapy sessions that have been videotaped will be stored on a secure electronic server at CAPS. Only Jessica Effrig, her advisor, Dr. Jeffrey Hayes, and her research assistant, Julie R.S. Beeney, 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.
The Pennsylvania State University’s Office for Research Protections and Institutional Review Board, and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this project.

7. **Right to Ask Questions:** Please contact Jessica Effrig at 814-308-5054 with questions, complaints or concerns about this research. You can also call this number if you feel this study has harmed you. If you have any questions, concerns, problems about your rights as a research participant or would like to offer input, please contact The Pennsylvania State University’s Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. Questions about research procedures can be answered by the research team.

8. **Compensation for participation:** If you complete the initial 12-item measure and demographic questionnaire, you will be given a $5 Amazon.com gift card. If you complete an interview at the end of your treatment with your client (if the client has completed a minimum of 6 sessions), you will receive a $35 Amazon.com gift card.

9. **Voluntary Participation:** Your decision to be in this research is voluntary and will not impact 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 contact if selected for further participation)

______________________________  ______________________
Person Obtaining Consent        Date
Appendix L

Client Informed Consent

Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Psychotherapy Relationship Study

Principal Investigator: Jessica C. Effrig, MSW
327 Cedar Building
University Park, PA 16802-1003
814-308-5054; jcs307@psu.edu

Co-Advisors: Dr. Jeffrey A. Hayes, Ph.D.
307 Cedar Building
University Park, PA 16802
814-863-3799; jxh34@psu.edu

1. Purpose of the Study:
The purpose of this research study is to investigate the relationship between the client and his or her therapist across the course of psychotherapy.

2. Procedures to be followed:
A total of four participants are sought for this research study. If you are eligible for participation, you will be invited to participate following your intake at Counseling and Psychological Services (CAPS). If you choose to participate, you will be asked to meet with a research assistant, Julie Beeney, to fill out two short questionnaires prior to starting psychotherapy at CAPS.

Immediately before your session, you will be asked to fill out one questionnaire asking about your feelings about and relationship with your therapist. Your therapist will not see your answers to this questionnaire.

Also immediately before each session, you will also be asked to complete another questionnaire about your psychological symptoms, called the CCAPS-34, as part of usual protocol at CAPS. Your answers to this questionnaire will be shared with the principal investigator of this study, as well as your therapist. Also, immediately after each session, you will be asked to complete a brief questionnaire about helpful and hindering events that may have happened during that therapy session and about any significant life events or changes in medication that happened during the week. The questionnaire you complete after each session will be shared with the principal investigator of this study and will not be shared with your therapist.
As part of this study and as is routine practice at CAPS, all of your sessions will be video recorded. These digital video recordings, which are kept on a secure computer server, will be reviewed to explore how the relationship between you and your therapist is developing over time.

At the end of your treatment at CAPS (if you complete at least 6 sessions), or after you complete 12 therapy sessions (whichever comes first), you will be asked to participate in an interview about your experiences in therapy. Finally, you will be asked to fill out two brief questionnaires similar to those you completed at the beginning of treatment. None of these assessments will be shared with your therapist.

In summary, all of the questionnaires that you complete as part of normal protocol at CAPS, (i.e., regarding your symptoms) will be shared with your therapist. The measures and the interview that you complete specifically about your relationship with your therapist and about helpful/hindering events that happened during each therapy session will NOT be shared with your therapist, but instead kept confidential by the principal investigator of this research project.

3. Discomforts and Risks:
There are no more than minimal risk involved in participation beyond those experienced in everyday life or in psychotherapy individuals would receive outside of the context of this study. There is, however, the potential risk of loss of confidentiality. Every effort will be made to keep participants' information confidential; however, this cannot be guaranteed. Efforts made to keep participants' information confidential include: labeling any questionnaires with a code number and never with other identifying information, storing confidential materials in a locked cabinet and locked office or on password protected computers and computer files, and destroying confidential information after the completion of the study. Digital video files will be stored on a secure server at CAPS. As in all psychotherapy, some things you discuss may cause you to feel strong emotions, including negative emotions. Likewise, some of the questions in the questionnaires you will be asked to complete are personal and could cause some discomfort. As previously mentioned, you will be asked to spend extra time filling out questionnaires that you would not normally have to fill out as part of treatment, and this could potentially cause you to experience minor inconvenience.

4. Benefits:

Benefits to you:
Your participation in the study has the potential to help you gain a better awareness and understanding of yourself, your relationship with your therapist, and your symptoms.

Benefits to society:
In conducting this study, we hope to better understand how clients’ relationships with their therapists develop. As we increase our understanding, we can provide psychotherapists with better information about the specific ingredients of therapeutic relationships that promote client change.

5. Duration/Time:
As part of pre-treatment participation, you will be asked to complete two short
questionnaires, which will take approximately 12 minutes.

Within the 24 hours prior to each therapy session, you will be asked to spend 5 minutes completing one brief measure online. Immediately prior to your session, you will be asked to spend 3-5 minutes filling out a brief measure about symptoms, as part of your normal treatment at CAPS.

After each therapy session, you will be asked to complete two brief questionnaires that will take about 7-8 minutes. Therefore, each week, you will need to plan to be at CAPS for about 65-67 minutes total.

Also, after you complete treatment, or at the conclusion of this study (whichever comes first), you will be asked to participate in a follow-up interview, conducted on the telephone. This interview will be about your experience in treatment and will take about 30 minutes. You will also be asked to complete two final questionnaires online, which will take an additional 12 minutes.

Although you are no longer eligible to complete in this research study after you have finished 12 sessions of psychotherapy, ending participating in this study does not impact your ability to continue treatment at CAPS. You can discuss your individual treatment needs and goals with your therapist and decide when it is appropriate for you to terminate therapy. Additionally, you do not need to commit to completing a total of 12 sessions to participate; again, you can discuss your particular treatment needs with your therapist in determining how many sessions you will attend.

6. Video and Audio Recording

As a part of usual clinical procedures at CAPS, therapy sessions may be video recorded (digitally) for supervision purposes.

Additionally, as part of this study, video recordings will be reviewed to explore how the relationship between you and your therapist is developing over time.

In these capacities, the recordings may be viewed/heard by the following individuals:
- Your therapist,
- The therapist’s clinical supervisor,
- The principal investigator, Jessica C. Effrig, MSW
- A research assistant of the project, advanced Counseling Psychology doctoral student, Julie R. S. Beeney, M.A.
- The project’s faculty advisor, Dr. Jeffrey Hayes

All of these individuals are required to keep information provided in these recordings confidential. Digital video recordings will be stored on a secure server (as is typical procedure at CAPS) and will only be accessible to your therapist, the therapist’s supervisor, a research assistant, and the principal investigator and her advisor. These digital recordings will only be accessible to the individuals listed above.

As part of this study, you will be asked to complete an additional interview about your
experiences in therapy that is not part of the usual protocol at CAPS. This interview will be audiotaped.

In these capacities, the audio recording of this interview may be viewed/heard by the following individuals:
- The principal investigator, Jessica C. Effrig, MSW
- A research assistant of the project, advanced Counseling Psychology doctoral student, Julie R. S. Beeney, M.A.
- The project’s faculty advisor, Dr. Jeffrey Hayes

All of these individuals are required to keep information provided in these recordings confidential. Audiotapes will also be stored in a locked room and will only be accessible to the principal investigator. Audiotapes will be labeled only with a code number and the date.

7. Statement of Confidentiality:
Your participation in this research is confidential. Only your therapist, the principal investigator, her faculty advisor, and her research assistant will know your identity. Data that is specific to the study will be stored in a locked office. (Information pertaining to your treatment that would be collected as part of normal clinical procedures will be stored and secured at CAPS in a locked electronic file, as it would regardless of your participation in this study). As part of the research project, your name will be matched with a code number. Once recorded, your name will then be removed from the copies of the measures provided for this research project. Your name will not be associated with the data you provide, and the list associating names with code numbers will be kept in a locked office. Access to these data identifying you will only be granted to the principal investigator and authorized research staff involved in collecting data. Data that are not associated with identifying information will also be kept in a separate file drawer in a locked office. Access to these data will be granted only to the principal investigator and the project’s faculty advisor. The Pennsylvania State University’s Office for Research Protections and Institutional Review Board, and the Office for Human Research Protections in the Department of Health and Human Services may review records related to this project. In the event of a publication or presentation of findings resulting from the research, no personally identifiable information will be shared.

8. Right to Ask Questions:
Please contact Jessica Effrig at (814) 308-5054 with questions, complaints, or concerns about this research. You can also call this number if you feel this study has harmed you. If you have any questions, concerns, problems about your rights as a research participant or would like to offer input, please contact The Pennsylvania State University’s Office for Research Protections (ORP) at (814) 865-1775. The ORP cannot answer questions about research procedures. Questions about research procedures can be answered by the research team.

9. Compensation:
If you choose to participate in this study, you will receive monetary compensation at multiple points throughout your participation. After completing two initial measures, you will be emailed a $10 Amazon.com gift certificate. Following each of your psychotherapy sessions, after the completion of the previously mentioned questionnaires prior to and after your session, you will be emailed a $5.00 gift card to Amazon.com. Finally, you will be emailed a $25 gift card to Amazon.com after completing the final interview and two brief measures.
10. Voluntary Participation:
Your decision to participate in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise. If you choose to withdraw from the study, you will be able to continue treatment at CAPS if you wish to do so. If at any time you wish to withdraw from the study, please send written notice to Jessica Effrig at the address on the front page of this document.

You must be 18 years of age or older to consent 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 signed and dated consent 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

_____________________________________________
Person Obtaining Consent                       Date
Authorization to Use & Disclose Protected Health Information for Research Purposes

IRB#: 43443

Project Title: Psychotherapy Relationship Study

Principal Investigator: Jessica C. Effrig, MSW

The privacy law, Health Insurance Portability & Accountability Act (HIPAA), protects my individually identifiable health information (protected health information). The privacy law requires me to sign an authorization (or agreement) in order for researchers to be able to use or disclose my protected health information (PHI) for research purposes in the above referenced study. I authorize Jessica Effrig and her research staff to use and disclose my protected health information for the purposes described below.

The following doctors and/or health care providers are authorized to disclose my protected health information for the purposes of this research study:

- Counseling and Psychological Services (CAPS), The Pennsylvania State University

My protected health information that may be used and disclosed includes:

- Information provided during intake assessment, including diagnosis and responses to Standardized Data Set (SDS)
- Responses to the Counseling Center Assessment of Psychological Symptoms-62 and -34 (CCAPS-62 and CCAPS-34)
- Name and contact information
- Videotapes of psychotherapy sessions

My protected health information will be used for:

- The purpose of this research study is to investigate the development of the relationship between the therapist and the client
• Access to protected health information is necessary to be able to conduct this research.
• Access to protected health information is necessary in order to ensure that the research meets legal, institutional, and accreditation requirements.

The Researchers may use and share my health information with:

• The Pennsylvania State University’s Institutional Review Board/Office for Research Protections
• Government representatives, when required by law

Your health information may be used or shared with other specific people or groups in connection with this research study. Research records that identify you will be kept confidential as required by law. You will not be identified by name, social security number, address, phone number or any other direct personal identifier in research records given to someone outside of The Pennsylvania State University (PSU), except when required by law. For records shared outside of PSU, you will be assigned a code number. The list that matches your name with the code number will be kept in a locked file in the principal investigator’s office.

The researchers agree to protect my health information by using and disclosing it only as permitted by me in this Authorization and as directed by state and federal law. Should the health information be disclosed by the researcher, to someone outside of this study, it may no longer be covered/protected by the federal regulation HIPAA.

I do not have to sign this Authorization. If I decide not to sign the Authorization:

• It will not affect my treatment, payment or enrollment in any health plans or affect my eligibility for benefits.
• I may not be allowed to participate in the research study.
• If applicable, I will not have access to this research-related therapy/treatment.

After signing the Authorization, I can change my mind and:

• Not let the researcher disclose or use my protected health information (revoke the Authorization).
• If I revoke the Authorization, I will send a written letter to: Jessica C. Effrig at 328 Cedar Building, University Park, PA 16802 to inform her of my decision.
• If I revoke this Authorization, researchers may only use and disclose the protected health information already collected for this research study.
• If I revoke this Authorization my protected health information may still be used and disclosed should I have an adverse event (a bad effect).
• If I change my mind and withdraw the authorization, I may not be allowed to continue to participate in the study.

I understand that I will not be allowed to review the information collected for the research until after the study is completed. When the study is over, I will have the right to access the information again.
This Authorization does not have an expiration date.

If I have any questions or concerns about my privacy rights, I should contact the Office for Research Protections at (814) 865-1775.

I am the participant or am authorized to act on the participant’s behalf. I have read this information, and I will receive a copy of this form after it is signed.

__________________________________________________________
Signature of research participant or *research participant’s legal representative

Date

__________________________________________________________
Printed name of research participant or *research participant’s legal representative

Representative’s relationship to research participant

*Please explain the Representative’s relationship to the participant. Include a description of the Representative’s authority to act on participant’s behalf:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

_________
Appendix N

Therapist Recruitment Email Script

Hello! My name is Jessica Effrig and I am a doctoral student in the Counseling Psychology program here at Penn State. You have the opportunity to participate in a study being conducted for research purposes at Penn State. This study, which is part of my doctoral dissertation, is about the development of the therapeutic relationship over the course of psychotherapy. Your participation is completely voluntary and confidential. Your decision to participate will not impact any of your evaluations in your role at CAPS.

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 and return it to me. Please indicate your interest by checking “yes” or “no.” If you are interested in participating in this study, please complete the brief, 12-item measure about relationships and the demographic form. Therapists may be selected for further participation based on the therapist characteristics.

If you are asked to participate further in the study and agree to do so, you will be asked to review all clients that are newly assigned to you to determine if they meet criteria for the study, which will be described to you if you participate further. If a client does meet these criteria, you will be asked to email client prior to your first session to tell them about this study and provide them with my contact information. A recruitment script will be provided to you that you can use to email the client.

After that client has terminated treatment (assuming a minimum of 6 sessions have been completed) or has completed 12 sessions (whichever comes first), you will be asked to meet with the principal investigator for an interview to discuss your experiences as the treating therapist of the participating client(s). This interview will last approximately one hour and may be completed on the phone.

For compensation, you will receive a $5 Amazon.com gift card if you complete the 12-item questionnaire and demographic form provided today. You will receive $35 if you complete the final interview.

Please do not hesitate to contact me with questions. You can contact me via email at jcs307@psu.edu or by phone at 814-308-5054.
Appendix O

Client Recruitment Email

You are eligible to participate in a research study being conducted at Penn State exploring how the relationship between you and your therapist develops. You will be compensated for your participation (see below).

If you are interested in participating, please contact the Principal Investigator, Jessica Effrig via email at jcs307@psu.edu or via phone at 814-308-5054.

Before your first therapy session, you’ll be asked to meet with a research assistant to give informed consent and complete two brief questionnaires (76 questions total).

After therapy starts, you will be asked to complete a brief, 36-item questionnaire about your relationship with your therapist immediately prior to each of your therapy sessions. As part of usual protocol at CAPS, you’ll also complete a 34-item measure about your symptoms. You will also be asked to complete two brief, paper surveys (9 questions total) immediately after each therapy session.

If you complete at least 6 therapy sessions, you will be asked to participate in a phone interview about your experiences in therapy and complete two questionnaires online (76 questions total).

You will receive a $10 Amazon.com gift card via email after completing the two initial measures prior to the start of therapy. You will receive a $5 Amazon.com gift certificate via email after you complete the required measures prior to and after each therapy session, up to 12 therapy sessions. You will receive a $25 Amazon.com gift card after completing the final interview and questionnaires. Thus, you can potentially be compensated up to $95 in Amazon.com gift cards.

Your participation in this research is voluntary and confidential. Your decision to participate or not participate in the study will not impact your treatment at the counseling center. Your therapist will know if you participate, but 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.

Jessica Effrig is the primary investigator for the research study. You can contact her at jcs307@psu.edu or 814-308-5054 with questions or concerns.

Thanks!
Appendix P

Changes Since Last Session

1. If you take psychiatric medication (e.g., anti-depressant, mood stabilizer), has the type or dosage of this medication changed since your last session? If so, what has changed?

2. Have you experienced any significant life events outside of therapy since your last session? That is, has anything very important changed in your daily life since your last session? If so, please describe briefly what has happened.
References


Main, M., & Solomon, J. (1986). Discovery of an insecure-disorganized attachment pattern. In T. B. Brazelton & M. W. Yogman (Eds.), Affective development in infancy, Norwood, NJ:


Tracey, T. J. G., Rounds, J., & Gurtman, M. (1996). Examination of the general factor with the interpersonal circumplex structure: Application to the Inventory of Interpersonal


VITA

Jessica C. Effrig, MSW

Education

The Pennsylvania State University, University Park, PA
Doctor of Philosophy in Counseling Psychology, August 2014
Dissertation Title: The Development of Attachment to the Therapist: A Mixed-Methods Case Study
Faculty Advisor: Jeffrey A. Hayes

University of Pennsylvania, Counseling and Psychological Services, Philadelphia, PA
APA-Accredited Internship in Professional Psychology

University of Maryland, Baltimore, MD

The Pennsylvania State University, University Park, PA
Bachelor of Arts in Psychology and Women’s Studies, December 2004

Publications

Effrig, J. C., Maloch, J. K., McAleavey, A. A., Locke, B. C., & Bieschke, K. J. Changes in depressive symptoms for treatment-seeking college student who are sexual minorities. Manuscript accepted for publication.


Selected Presentations


