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The Effects of Therapist Attachment on the Process and Outcome of Psychotherapy

Kristin Elizabeth Roberts
Western Michigan University, kristinroberts77@gmail.com

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THE EFFECTS OF THERAPIST ATTACHMENT ON THE PROCESS AND OUTCOME OF
PSYCHOTHERAPY

Kristin Elizabeth Roberts, Ph.D.

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Researchers have demonstrated that therapist attachment is associated with therapeutic relationships and client outcomes (Steel et al., 2018). Yet, results have varied and, at times, seemed contradictory. This study explores how therapist attachment might influence the working alliance and symptom change throughout psychotherapy and uses the recently validated, transcript-based Therapist Attunement Scales (TASc; Talia & Muzi, 2017). The TASc was developed to measure in-session attachment-related verbal behavior. The third session from each pair of 23 therapists-in-training and their clients was transcribed and coded. Clients completed the OQ-45.2 and the Working Alliance Inventory prior to each session.

Growth curve modeling was used to examine changes over time. Overall, client distress levels reduced over time and the quality of the working alliance improved as therapy progressed. Therapist avoidant attachment was significantly associated with change in OQ scores. Therapists high in avoidance were associated with clients who increased in distress over time; whereas therapists low in avoidance had clients who decreased in distress over time. There were no significant effects of therapist attachment on working alliance ratings.

THE EFFECTS OF THERAPIST ATTACHMENT ON THE PROCESS AND OUTCOME OF
PSYCHOTHERAPY

by

Kristin Elizabeth Roberts

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Doctoral Committee:

Eric M. Sauer, Ph.D., Chair
Mary Z. Anderson, Ph.D.
Kathryn Lewis-Ginebaugh, Ph.D.

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Kristin Roberts

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CHAPTER I

LITERATURE REVIEW

In this chapter, I will begin with an overview of attachment theory and an exploration of how our current understanding of attachment has evolved. Next, I will explore the literature on attachment theory relevant to the psychotherapy relationship, as this is the focus of my study. Finally, I will discuss the proposed study and the contributions to the literature that I hope to provide.

Attachment Theory

Attachment theory was initially developed by John Bowlby (1973) as a way of explaining the behavioral and emotional responses children exhibit to maintain proximity to their caregivers. For secure attachment to develop, caregivers act as a *secure base* from which children can freely explore the world. Ideally, caregivers are a *safe haven*, in which children can seek support, protection, and comfort in times of distress. Central to attachment theory, the attachment system would become activated during times when the child was in need (e.g., hungry or afraid). It was postulated that attachment behaviors were adaptive, meaning a child will alter attachment-related behaviors in whatever way necessary to ensure safety and maintain critical relationships with caregivers. These attachment behaviors later develop into characteristic ways of seeking care and closeness from significant others (Bowlby, 1982).

Bowlby's theory sparked new research interests in attachment, particularly child-caregiver relationships. The Strange Situation study was a critical development in the assessment of attachment security (Ainsworth et al., 1978). In this experiment, researchers observed young children in a play environment with several separation episodes from their mothers. First, the mother and child were introduced to an experimental room in which the child was free to

explore. Then, a stranger entered the room and the mother left conspicuously. The stranger stayed in the room with the child for several minutes until the mother re-entered. The mother greeted and comforted the child and then left again for a second separation episode. Finally, the mother re-entered the room, greeted the child, and the stranger left conspicuously.

The behavior of the children during each phase of the experiment was analyzed. The researchers identified three patterns of attachment: secure, anxious-ambivalent, and anxious-avoidant. Securely attached children explored the research playroom in their mother's presence, were somewhat anxious during separation from their mother, and were easily comforted upon their mother's return. Children with anxious-ambivalent attachment patterns were anxious, angry, and clung to their mother when introduced to the research playroom. These children also expressed distress upon separation from their mother and were difficult to comfort when their mother returned. Children with anxious-avoidant attachment avoided or ignored their mother upon re-contact and displayed minimal emotion when their mothers departed and returned. These children also did not explore the experimental room. It was hypothesized that although anxious-avoidant children appeared undisturbed throughout the experiment, they were in fact masking their distress.

Ainsworth et al. (1978) posited that the attachment styles identified in the experiment mentioned above were directly related to the consistency in which caregivers responded to the child's emotional and physical needs. The researchers proposed that secure attachment developed as caregivers consistently responded to a child's request for closeness and soothing. Ambivalent attachments were thought to form when caregivers inconsistently responded to the child. This type of caregiver may sometimes respond to the bids for soothing from the child, but at other times, be emotionally or physically unavailable. Avoidant attachments were thought to

develop when caregivers were unresponsive to the child's needs and emotionally unavailable.

Main and Solomon (1986) expanded on Ainsworth's model and added a fourth attachment category they named disorganized. Children with this style of insecure attachment had the typical responses of insecure attachment; however, they also displayed lapses that involved intense fear, freezing, and disorientation. The researchers discovered that children with disorganized attachment had a history of trauma or had mothers with a history of trauma. These mothers also exhibited disorganized attachment strategies. Main and Solomon posited that these mothers were often perceived as unpredictable and frightening to their children.

Internal Working Models

Bowlby (1982) postulated that attachment security develops from repeated interactions with primary caregivers, from which internal working models of the self and others form. Internal working models include a model of others as being trustworthy, a model of the self as valuable, and a model of the self as effective in interactions with others. Internal working models organize personality and shape thoughts, feelings, and behaviors in future relationships (Feeney, 2016). Internal working models may be likened to other unconscious cognitive constructs, such as schemas, scripts, and prototypes. However, internal working models are distinct in that they are not only cognitive, but also represent motivational and behavioral tendencies (Shaver et al., 1996).

To illustrate, individuals who had available, sensitive, and responsive attachment figures develop an internal working model in which they expect others to be available to meet their emotional needs during times of distress (Cobb & Davila, 2008). These individuals will also develop a generally positive view of themselves as deserving of affection, support, and love (Bowlby, 1982, 1988), as well as feel effective in interpersonal relationships (Feeney, 2016). In

general, positive models of self and others reflect attachment security. On the other hand, negative models of self-and/or others generally reflect attachment insecurity (Cobb & Davila, 2008). Secure internal working models are associated with social confidence, self-worth, assertiveness (Collins & Read, 1990), and integrated knowledge of self (Mikulincer, 1995).

Collins and Read (1994) postulated that internal working models contain four related components. The first is autobiographical memories of attachment experiences, which include specific memories as well as individuals' interpretations of the content of those experiences. Securely attached individuals are more likely to recall positive experiences with attachment figures, including specific memories such as a parent providing comfort when upset. Secure individuals are also able to recall and logically process negative memories. In contrast, avoidantly attached individuals may describe relationships with caregivers as mostly positive but are unable to provide specific examples of positive memories. These individuals may also struggle to access negative emotional memories and minimize the intensity of these memories. Anxiously attached individuals may describe memories of their caregivers as inconsistently available. They may find it difficult to remain emotionally regulated when describing negative memories (Cobb & Davila, 2008).

The second component contains beliefs and attitudes that are attachment related. These beliefs and attitudes form through real-world experiences with others (Collins & Read, 1994). Attachment-related beliefs are foundational to how individuals interpret and respond to their attachment figures. Securely attached individuals are likely to believe that others can be relied upon to provide support when needed. Whereas avoidantly attached individuals may believe others will reject or disapprove of their bids for support, and anxiously attached individuals may only feel supported when others provide excessive amounts of attention (Cobb & Davila, 2008).

The third component is attachment-related goals or desires. These goals form through individuals' histories of attachment experiences that result in distinctive defenses, needs, and motives that are activated when relating to others (Collins & Read, 1994). For instance, secure individuals are typically able to balance desires for closeness and autonomy, but while anxiously attached individuals desire intimacy, worry about rejection often results in expecting unrealistic amounts of closeness from others. On the other hand, avoidantly attached individuals desire emotional distance from others to maintain self-reliance (Cobb & Davila, 2008).

Finally, internal working models contain a set of behavioral plans and strategies that individuals utilize to obtain attachment-related goals (Collins & Read, 1994). These strategies include ways of coping with difficult experiences, seeking others when in need of support, and regulating emotions related to attachment (e.g., anxiety or fear). Securely attached individuals are typically flexible in their coping strategies. These individuals may use self-reliance or ask for help from others as needed. Anxiously attached individuals may over-rely on others and feel angry when their attachment needs go unmet. The strategies of avoidantly attached individuals may include shutting down emotionally to distance themselves from feelings and relationships to avoid attachment-related anxiety (Cobb & Davila, 2008).

Stability over the lifespan. Internal working models are thought to be relatively stable throughout the lifetime. Bowlby (1979) postulated that internal working models of attachment built in childhood stay constant from the "cradle to the grave" (p. 129). Researchers have sought to examine this assertion, and several longitudinal studies have followed cohorts of participants from childhood through adulthood. For example, the Minnesota study, a 30-year study by Sroufe and colleagues (2005), examined how variations in attachment style in infancy could predict later variations in personality. They found significant positive associations between secure attachment

in infancy to corresponding qualities in adolescence, such as appropriate self-reliance, positive affect, resilience, and social competence. Main et al. (2005) conducted the Berkeley longitudinal study, which also found, as expected, that one's attachment security/insecurity remained relatively stable from childhood through adulthood. Changes in attachment security or insecurity appeared to happen as a result of intervening trauma during childhood or adolescence. Specifically, attachment related stressful life events were most often associated with changes from secure to insecure attachment. (Main et al., 2005).

To further examine the stability of attachment representations throughout time, Fraley (2002) conducted a meta-analysis of longitudinal attachment studies reporting data from participants at one year of age up to 19 years of age. Fraley (2002) found that a moderate level of stability in attachment existed from infancy to adulthood ($\rho = 0.39$). The patterns reported in the meta-analysis supported the prototype perspective, which posits that internal working models of attachment developed in childhood continue to influence attachment behavior in adulthood. The prototype perspective "implies that there is room for both stability and change in attachment patterns" (Fraley, 2002, p. 126). Early representations can motivate individuals to seek out environments that are consistent with their internal working models, thus promoting stability in attachment patterns. Yet, as individuals encounter situations that are inconsistent with their expectations, a shift in attachment security can occur (Fraley, 2002). Researchers have found that adult romantic relationships, as well as involvement in psychotherapy, can lead to a change in attachment security (Crowell & Waters, 2005). Involvement in a stable and satisfying relationship may serve to disconfirm negative expectations based on prior experiences (Booth-LaForce et al., 2014; Feeney, 2016).

Attachment theory has become one of the most widely researched theories in psychology

(Feeney, Noller & Hanrahan, 1994; Hazan & Shaver, 1987). Beyond caregiver and child

relationships, attachment theory has been used to predict behaviors and styles of interacting in

adult functioning and adult romantic relationships. In the section that follows, I will summarize

the research on adult attachment.

Attachment in Adulthood

One of attachment theory's basic tenets is that the quality of an individual's early

emotional bonds with a primary caregiver becomes the model for attachment bonds in adult

relationships (Bowlby, 1988). Hazan and Shaver (1987), in their seminal work, were among the

first to apply attachment theory to close adult relationships. They emphasized that the

relationship between infants and their caregivers and the relationship between adult romantic

partners shared many of the same features. These features included feeling safe when the other is

near and responsive, engaging in close bodily contact, insecurity when the other is not

accessible, sharing discoveries, and exhibiting a mutual fascination and preoccupation with one

another. Their research was based on a sample of over 1200 participants. The participants

responded to advertisements in newspapers asking people to answer a questionnaire related to

their relationship partner. The results of their research highlighted three essential concepts

related to adult attachment (Hazan & Shaver, 1987).

First, they found that the relative prevalence of three attachment styles is approximately

the same in adulthood as is found in infancy (56% self-identified as secure, 25% self-identified

as avoidant, and 19% self-identified as anxious/ambivalent). Second, the adult styles of

attachment differ in predictable ways regarding the experience of romantic love. Secure

attachment was associated with closeness, trust, and a general lack of fear of intimacy and

jealousy. Avoidant attachment was characterized by self-reliance, emotional distance, and a fear

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of intimacy. In contrast, anxious/ambivalent attachment was associated with emotional highs and lows, preoccupation with partners, and high levels of jealousy. Third, attachment style is related in theoretically meaningful ways to internal working models of self and others, and relational experiences with caregivers (Hazan & Shaver, 1987). The researchers posited that the relationship between childhood attachment and adult attachment orientations becomes less stable as an individual gets further into adulthood. They theorized that environmental factors, friendships, and romantic relationships could change one's internal working models of self and others, and thereby influence adult attachment (Hazan & Shaver, 1987).

Building on this foundational work, Bartholomew and Horowitz (1991) developed a four-category model to describe these distinct adult attachment styles. The researchers hypothesized that the avoidant pattern of attachment enveloped two distinct forms of avoidance: fearful and dismissing. They argued that fearfully avoidant individuals adopt an avoidant style toward attachment figures to prevent being hurt or rejected by partners. The researchers suggested that dismissing individuals adopt an avoidant orientation as a way to defend themselves through self-reliance and independence (Fraley & Shaver, 2000).

The foundation of each style are the two underlying dimensions of adult attachment: the internal working model of self (positive or negative) and the internal working model of others (positive or negative). The researchers tested their categorical model by conducting semi-structured interviews in which participants described close friendships and romantic partnerships, and their connections to personality and interpersonal functioning. They described four distinct working models of attachment. Securely attached individuals have a favorable view of themselves, believe in the responsiveness of others, and feel comfortable with intimacy in relationships. Preoccupied individuals have negative views of themselves but look at others

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positively. These individuals gain self-worth by feeling accepted by others. Fearful individuals feel they are unworthy of acceptance and expect that others will reject or harm them. These adults tend to seek less intimacy from partners to avoid rejection. Dismissive individuals have a positive view of self but see others in a negative manner. These individuals may not seek out intimate relationships and deny or minimize a need for emotional closeness (Bartholomew & Horowitz, 1991).

Figure 1. Bartholomew & Horowitz (1991) Model of Adult Attachment.
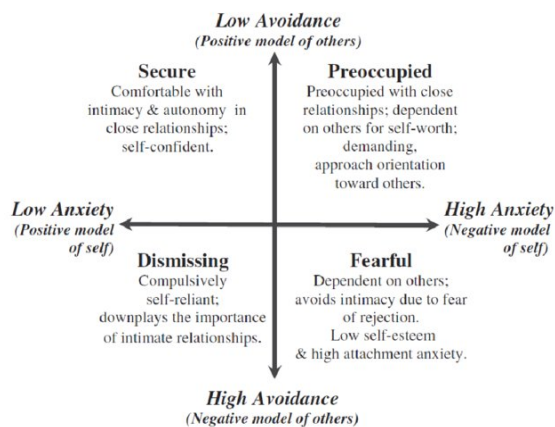
Since this initial work, researchers have sought to replicate and extend the literature on adult attachment (Fraley & Shaver, 2000; Shaver & Hazan, 1993). Although the four-category model was helpful for scholars to understand the distinct styles of attachment-related behavior, the updated conceptualization of attachment dynamics is based on dimensional models. Due to increased interest in attachment research, a wide array of self-report attachment scales were created. Brennan et al. (1998) sought to reduce confusion by combining a majority of the existing self-report attachment measures and creating a pool of 323 items that assess 60 attachment-related constructs. They then conducted a factor-analysis and found two independent factors of avoidance and anxiety, indicating that the majority of self-report attachment measures tap into these same two underlying dimensions.

The first dimension is attachment-related anxiety. Attachment-related anxiety is based on the worry that partners in close relationships will not be accessible or responsive. The second dimension is attachment-related avoidance. Attachment-related avoidance is based on the distrust of others in close relationships. The two dimensions also describe the regulation of attachment behavior (Fraley & Shaver, 2000). These strategies are described as secondary attachment responses and develop as a result of attachment insecurity in the relationship (Mikulincer & Shaver, 2007). To regulate attachment-related anxiety, individuals either seek contact with an attachment figure (move closer) or they withdraw from the attachment figure (distancing the self). These decisions are often unconscious and are responsible for individual differences in attachment-related anxiety and attachment-related avoidance (Fraley & Shaver, 2000). Adults that are low on both dimensions are thought to have secure attachment. A prototypical secure adult is thought to be sure of the perceived responsiveness of their partners. They also are more open to intimacy and are comfortable depending upon and having others depend upon them (Fraley & Shaver, 2000).

Measurement-related issues are essential to understand, as measurement is closely linked to how researchers have conceptualized adult attachment. Next, I will review the measurement of adult attachment.

Measurement of Adult Attachment

The measurement of adult attachment has evolved along with researchers' conceptualizations of adult attachment. In this section, I will review changes in the measurement of attachment over time, as well as a critique of current measures of adult attachment. Finally, I will explore newer measurements of adult attachment that specifically measure therapist and client attachment based on discourse in the psychotherapy session.

Narrative-based assessments were among the first instruments developed to measure adult attachment. The most robust assessment, the Adult Attachment Interview (AAI; George et al., 1996; Main et al., 2003), is based on the premise that working models operate somewhat outside of awareness, and that adult-level thinking can provide the ability to assess early relationship experiences (Crowell et al., 2016). The AAI is a one-hour semi-structured interview with 18 questions and follow-up probes designed to measure the current representation of attachment experiences based on participant narratives. A trained interviewer prompts descriptions of childhood memories representing the relationship between caregiver and participant. The assessment explores experiential and representational attachment domains. Subsequent analysis of verbatim transcripts leads to one of the four following states of mind concerning attachment: secure/autonomous, insecure/dismissing, insecure/preoccupied, and disorganized/unresolved trauma. According to theory, securely attached adults will maintain a coherent discourse regarding their childhood experiences, no matter what type of memories they recall. Incoherent narratives in which the person's assessment of experiences does not match their description of parental behavior is indicative of insecure attachment (Main et al., 2003). The intensive training of raters ensures high reliability. Both inter-rater and test-retest reliabilities are excellent (Bakermans-Kranenburg & van Ijzendoorn, 1993; Hesse, 2008).

Although the AAI is considered the gold standard for measuring adult attachment, it is time-intensive to conduct interviews and analyze transcripts. It takes approximately 18 months to become certified and the training process is costly, making this instrument impractical for many researchers to use (Brennan et al., 1998). Thus, researchers began to rely on self-report measures to assess adult attachment. Early self-report instruments consisted of brief paragraphs describing attachment behaviors in relationships and yielded categorical attachment classifications.

(Bartholomew, 1990; Griffin & Bartholomew, 1994; Hazan & Shaver, 1987). This type of self-report measure relied on individuals to identify their feelings and perceptions of attachment relationships. These measures are therefore conscious descriptions of individuals' experiences in close relationships (Bartholomew & Shaver, 1998).

The Experiences in Close Relationships scale (ECR, Brennan et al., 1998), a 36-item scale, became the most widely used assessment of adult attachment. In creating this scale, Brennan and colleagues (1998) compiled the non-redundant items from a majority of the self-report attachment measures in use and used factor-analysis to determine what constructs were assessed. Factor analysis revealed two major factors (anxiety and avoidance). These results indicated that most of the self-report measures were tapping into underlying dimensions of anxiety and avoidance. Scoring low on both avoidance and anxiety indicates attachment security. High scores on either dimension or both dimensions are reflective of attachment insecurity. Most researchers currently conceptualize and measure individual differences in attachment along these two dimensions (Fraley & Waller, 1998; Obegi & Berant, 2009). The dimensional approach is thought to allow for a more nuanced perspective of individual differences by measuring attachment security along a continuum rather than a fixed point (Fraley & Phillips, 2009).

Dimensional self-report measures of attachment are relatively easy to administer and cost-effective for research, with many having strong reliability and validity. However, self-report measures also introduce response bias and rely on individuals to record their perceptions of close relationships accurately and honestly (Brennan et al., 1998). It is also important to consider that many of these self-report measures only moderately correlate with the AAI (Bartholomew & Shaver, 1998). The AAI assesses early child and parent relationships and focuses on the more unconscious internal working models present within the narrative. Alternately, self-report

measures focus on conscious and current feelings and perceptions of close relationships (Brennan et al., 1998).

Responding to the need to combine in-depth observer-based measures with the practical demands of researchers (Marmarosh, 2015), several researchers recently developed a method of assessing in-session attachment, which is defined as the regulation of attunement between client and therapist through their discourse. Attunement is described as the process in which therapists contribute through their verbal responses to define and make sense of clients' current internal states (Talia et al., 2017; Talia & Muzi, 2018). These assessment tools move beyond self-report and interviews to an observational method of measurement. Through the analyzing of session transcripts, reliable classifications of attachment status are obtained by tracking patterns of attunement behavior as it occurs in psychotherapy sessions. For the Therapist Attunement Scales (TASc; Talia & Muzi, 2017) the resulting attachment classifications had high convergent validity with the AAI (K = .81). Other attachment measures currently used in psychotherapy research rely on the client to retrospectively reflect on the therapeutic relationship. Conversely, the transcript-based assessments allow for analyzing the actual client-therapist interaction to obtain attachment status (Talia et al., 2017). These assessments have been described as leading the way toward a paradigm shift in attachment-informed research and clinical practice because they examine both dynamic patterns of attachment activation and their relational functions within a treatment context (Slade, 2016). As these transcripts-based assessments are based on the in-session relational dynamics between client and therapist, I will describe them in more detail after reviewing clinical applications of attachment theory, which are foundational in understanding the new measures.

Attachment in the Psychotherapy Relationship

Bowlby (1988) argued that the therapeutic relationship is influenced by the client's and therapist's working models of self and others. He postulated that the psychotherapy relationship involves care-seeking and caregiving behaviors, thus likely activating behavioral patterns related to past attachment experiences. Bowlby (1988) believed that a primary task of the therapist was to provide the client with a temporary attachment figure, or secure base. From a secure base, the client is allowed to find the courage to explore and reflect on potentially difficult and painful memories, strong emotions, and expand into new areas of self-understanding. He posited that through this process, the client could uncover and understand deep-seated fears, defenses, and distorted perceptions that create the conditions for revising maladaptive working models of self and others (Mikulincer & Shaver, 2016).

Farber et al. (1995) expanded upon these ideas and described how the therapist could serve as a secure base. They noted that clients often feel safe in the therapy relationship to discuss and try out new ways of being. If clients can use the relative safety of the therapeutic environment to manage anxiety and distress, they may be better able to explore new thoughts, feelings, and behaviors. When ineffective ways of interacting with others are met with the therapist's acceptance and care, clients can explore alternative ways of viewing themselves and others.

Typically, clients enter therapy experiencing anxiety, frustration, or depression, which may activate their attachment system. These attachment needs may be easily directed towards the therapist because the therapist is likely to be viewed as "stronger and wiser" (Bowlby, 1977, 1988; Farber et al., 1995; Obegi, 2008). In this way, the psychotherapy relationship can resemble a traditional attachment relationship, with the therapist functioning as a secure base. Mikulincer

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and Shaver (2016) describe three ways in which the therapist may become a secure base for the client: (a) the client seeks proximity to the therapist, (b) the client experiences anxiety when the therapist is temporarily unreachable or as therapy terminates, and (c) the client perceives the therapist as stronger and wiser. Mallinckrodt (2010) points out that all these elements may not be evident in the early stages of therapy but may develop as the therapeutic relationship progresses.

Empirical findings. Preliminary empirical findings confirm the theoretical assertions that the therapeutic relationship can function as an attachment relationship (Mallinckrodt et al., 1995; Mallinckrodt et al., 2005; Parish & Eagle, 2003). Mallinckrodt and colleagues (1995) found that clients exhibited distinct patterns of attachment to their therapists that corresponded with their adult attachment styles. Another empirical study by Parish and Eagle (2003) included a sample of 105 adults, all of whom had been in therapy for at least six months. The researchers attempted to determine differences between the client-therapist attachment and attachment to a primary figure (i.e., friend, spouse, relative). They found that clients perceived the therapeutic relationship as having many qualities of an attachment relationship. For instance, clients looked up to their therapists, found them emotionally responsive, sought proximity to their therapists, and evoked a mental representation of them in their absence. Clients also perceived their therapists as stronger and wiser and more available and sensitive than their primary attachment figure. Moreover, the perception of the therapist as a secure base was positively associated with the quality of the therapeutic relationship. Additionally, clients high in attachment avoidance were found to have lower ratings of the therapist as a secure base. This finding implies that avoidant attachment may interfere with the forming of a secure therapeutic relationship, just as it does in other close relationships (Parish & Eagle, 2003).

Just as Bowlby (1988) posited that the therapist could function as a secure base for the

client, he also believed that attachment security and insecurity would influence the therapeutic relationship. Mikulincer and Shaver (2016) argue that, in the same manner that attachment orientations affect close interpersonal relationships, the attachment orientations of both clients and therapists may "affect the quality of the client-therapist relationship, determine clients' reactions to therapists' interventions and therapists' reactions to clients' disclosures, and thereby bias the therapeutic process" (p. 454). Accordingly, in the next section, I will review how client and therapist attachment orientations may influence the process and outcome of psychotherapy, as this is the central component of this study.

Client Attachment Orientation

Bowlby (1988) theorized that if the psychotherapy relationship could function as an attachment relationship, then entering therapy would activate clients' behavioral patterns related to past attachment experiences and internal working models. As a result, clients enter therapy with expectations of how the therapist will relate to them. Specifically, he thought that clients would expect the therapist to react similarly as other close relational figures have. That is, clients who are low in attachment anxiety and avoidance (i.e., secure) have internal working models that allow them to trust others and reach out for help and support when distressed. They are also likely able to rely on the therapist and quickly develop a strong working alliance. Clients who have either high attachment anxiety or high attachment avoidance (i.e., insecure), have less positive internal working models. These clients may have difficulty immediately establishing a strong therapeutic relationship. For instance, clients with insecure attachment may doubt their therapist's regard for them and their worries and defenses against dependency may impede the forming of a working alliance (Mikulincer & Shaver, 2016). Therapy outcomes for these clients is less predictable and will be reviewed in further detail later.

Client characteristics in therapy. Researchers have theorized that clients' presentation in therapy and responses to therapeutic interventions will vary based on their different levels of attachment anxiety and avoidance (Farber & Metzger, 2009; Fonagy et al., 1996; Slade, 1999). Based on preliminary findings, researchers found that clients low in attachment anxiety and avoidance (i.e., secure) are more comfortable seeking therapy (Dozier et al., 2001) and generally collaborative within the therapy relationship (Levy et al., 2011). These clients tend to be likely to self-disclose (Grabill & Kerns, 2000; Mikulincer & Nachshon, 1991) and have an ability to integrate and interpret past experiences that are related to their presenting problems (Buchheim & Mergenthaler, 2000). They also tend to perceive their therapists as emotionally responsive and accepting (Mallinckrodt et al., 1995). Secure clients, whose basic orientation is toward trusting others, are likely to be able to use the therapist as a secure base, generally disclose thoughts and feelings, acknowledge relational patterns that affect their experiences with others, and use this information to move toward growth (Farber & Metzger, 2009).

Farber and Metzger (2009) suggest that clients who are high in attachment anxiety and low in attachment avoidance (i.e., preoccupied) are likely able to derive some sense of felt security in the relationship with the therapist, but may have more difficulty using the therapist as a secure base for exploration. Researchers have highlighted several characteristic ways that these clients might show up in therapy. They found that individuals high in attachment anxiety and low in avoidance scored high on measures of self-disclosure, emotional expressiveness, crying frequency, and reliance on others. These individuals scored low on measures of self-confidence and coherence regarding relationships and had difficulty responding to the disclosure of their partners (Bartholomew & Horowitz, 1991; Mikulincer & Nachson, 1991; Mikulincer & Shaver, 2003). These clients were found to be highly dependent on the therapist, which made it hard for

them to use the therapist productively (Dozier et al., 2001). These clients may find the therapeutic relationship safe enough to disclose at a deep level, but may have difficulty accepting reassurance, support, or invitations to explore new ways of being that the therapist offers (Farber & Metzger, 2009).

Finally, researchers have hypothesized that clients with low attachment anxiety and high attachment avoidance (i.e., dismissing) may deny their need for help and have difficulty accepting help when it is offered. These clients may want to maintain emotional distance (Levy et al., 2011) and perceive the therapist in the same manner as other attachment figures in their lives, as consistently unresponsive (Farber & Metzger, 2009). Research supports these impressions. Bartholomew and Horowitz (1991) found that these individuals scored low on measures of emotional expressiveness and warmth, as well as measures reflecting closeness in personal relationships. Moreover, Mikulincer and Nachshon (1991) reported that due to their goal of maintaining distance from others, these individuals are unwilling to self-disclose and reciprocate others' disclosures. They tend to be more focused on the situation at hand and may intellectualize their experiences rather than express their feelings about them, thus maintaining the distance they desire in the therapeutic relationship (Farber & Metzger, 2009).

Client attachment and the working alliance. A substantial body of research has explored how clients' attachment orientations impact the working alliance (e.g., Eames & Roth, 2000; Kanninen et al., 2000; Kivlighan et al., 1998; Parish & Eagle, 2003; Satterfield & Lyddon, 1995, 1998; Tyrell et al., 1999). An attachment perspective on the working alliance suggests that attachment orientations that clients bring to therapy are likely to impact the formation and stability of the client-therapist alliance (Mikulincer & Shaver, 2016). The working alliance construct, initially proposed by Bordin (1979), focuses on three main components: agreement on

the goals of therapy, collaboration on the tasks of therapy, and a bond between client and therapist (Fluckiger et al., 2018). Researchers have asserted that a strong alliance is a prerequisite for change in all forms of psychotherapy (Safran et al., 2006). Moreover, the quality of the early working alliance between client and therapist has been repeatedly found to be an important predictor in the outcome of therapy (Fluckiger et al., 2018; Horvath & Bedi, 2002; Horvath et al., 2011; Martin et al., 2000). Indeed, these findings are robust in that in over 7,000 studies of adult psychotherapy, an effect size of .275 was found (Horvath et al., 2011). Successful therapy also depends on clients' and therapists' abilities to maintain a strong working relationship throughout therapy and effectively manage potential ruptures in the alliance as they occur (Safran et al., 2006), all of which may be influenced by clients' attachment orientation.

Indeed, researchers have found that clients low in attachment anxiety and avoidance (i.e., secure) have higher ratings of the working alliance. However, high attachment anxiety or high attachment avoidance has been found to be negatively related to the working alliance (Eames & Roth, 2000; Kivlingham et al., 1998; Mallinckrodt et al., 1995; Mallinckrodt et al., 2005; Parish & Eagle, 2003; Satterfield & Lyddon, 1995). Three meta-analyses of studies that examined clients' attachment orientations and client-reported working alliance ratings (Bernecker et al., 2014; Diener et al., 2009; Diener & Monroe, 2011) found significant, but small correlations (ranging between .12 and .17). These findings indicate that other factors contribute to the formation and quality of the working alliance, in combination with clients' attachment orientations. The inclusion of therapist-related factors, such as therapist attachment orientation, may be key to further understanding the dynamics of the therapeutic relationship.

Researchers have also examined how the working alliance fluctuates over time as a function of clients' attachment orientation (Eames & Roth, 2000; Kanninen et al., 2000).

Kanninen et al. (2000) found a relatively stable alliance throughout therapy for clients that were low in both attachment anxiety and avoidance (i.e., secure), whereas clients high in attachment anxiety (i.e., preoccupied) had a poor alliance in the middle of therapy, but a strong alliance in the later stages of therapy. In contrast, clients high in attachment avoidance (i.e., dismissing) reported a drop in ratings of the alliance toward the end of therapy. In a similar study, Eames and Roth (2000) also found a strong initial working alliance and positive alliance across five sessions of therapy for clients low in both attachment avoidance and anxiety (i.e., secure). They reported that clients high in either attachment anxiety or attachment avoidance had weaker alliances during beginning sessions but showed significant improvement in the alliance strength over time. They hypothesized that the therapists in this study were able to instill a sense of attachment security in their clients, thus reducing clients' attachment-related worries and defenses as therapy progressed (Eames & Roth, 2000).

In summary, these findings indicate that clients high in attachment anxiety or attachment avoidance may struggle to develop strong working alliances with their therapists. For these clients, the development of a positive working alliance may take longer and may not be as stable as it is for clients with low attachment anxiety and avoidance (i.e., secure).

Client attachment and psychotherapy outcome. Many empirical studies have sought to further examine the influence of clients' attachment orientations on the outcome of psychotherapy (Byrd et al., 2010; Cyranowski et al., 2002; Fonagy et al., 1996; Hardy et al., 2001; Horowitz et al., 1993; Wiseman & Tishby, 2014). A qualitative review of this literature (Berant & Obegi, 2009) indicated that clients low in both attachment anxiety and avoidance (i.e., secure) tended to benefit more from psychotherapy than clients high in either attachment anxiety or attachment avoidance. However, the results across these studies were variable, with some

researchers finding that low attachment anxiety and avoidance did not necessarily result in significant improvements compared with other attachment variations (Cyranowski et al., 2002; Fonagy et al., 1996). In response, Levy et al. (2018) conducted a meta-analysis of 36 studies ($n =$ 3,158) examining client attachment style and psychotherapy outcome. They found that clients who scored high in attachment anxiety (i.e., preoccupied) or high in attachment avoidance (i.e., dismissing) showed the least improvement in symptoms, whereas clients who scored low in attachment anxiety and avoidance (i.e., secure) had more favorable outcomes.

Joint contribution of client attachment orientation and working alliance on psychotherapy outcome. Recently, studies have begun to focus on the joint contribution of clients' attachment orientation and working alliance on therapy outcomes. For instance, Sauer et al. (2010) found that a stronger working alliance was associated with greater reductions in client distress over time. They also found that clients high in attachment anxiety entered therapy in more psychological distress as compared to their peers, while there was no relationship between client attachment avoidance and initial distress levels or change in distress levels over time. A similar study by Zack et al. (2015) reported that a strong working alliance with the therapist was significantly related to reducing clinical symptoms among young adult clients that were either high in attachment anxiety or attachment avoidance. For clients low in both attachment anxiety and avoidance (i.e., secure) the working alliance was not a significant predictor of symptom reduction.

These results indicate the ongoing influence of clients' internal working models on the process and outcome of psychotherapy. Overall, while hardly conclusive, current research findings point to clients high in attachment anxiety (i.e., preoccupied) having poorer symptom reduction throughout therapy, whereas the picture is more mixed and ambiguous for clients high

in attachment avoidance (i.e., dismissing). Generally, it seems that clients high in attachment avoidance have a less stable course in psychotherapy, with shifting alliances and poorer outcomes than clients low in attachment anxiety and avoidance (i.e., secure; Slade, 2016).

Therapist Attachment Orientation

The majority of research on the effects of attachment orientation in psychotherapy have focused on the role of clients' attachment dimensions. However, a growing body of research has begun to explore the influence of therapist attachment dimensions on therapy processes and outcomes. In line with the tenets of attachment theory, the therapist's attachment security will promote the provision of a secure base for the client, and lead to more positive therapeutic processes and outcomes (Mikulincer et al., 2013; Slade, 2016). Mikulincer and Shaver (2007) theorized that it is only when individuals experience safety and security, are they then able to effectively serve as caregivers and view others as in need of and deserving support. Thus, from a theoretical standpoint, therapists with secure attachment (i.e., low attachment anxiety and avoidance) should be better able to focus on caring for their clients and able to serve as a safe base (George & Solomon, 1999; Mikulincer & Shaver, 2007). Mikulincer and Shaver further theorized that therapists with low attachment anxiety and avoidance (i.e., secure) are likely to easily create a strong working alliance with their clients. These therapists should be better able to focus on the client's problems and provide empathy, rather than becoming distracted by their own distress. Further, they should be able to follow a client's narrative and handle alliance ruptures more effectively due to their own reliance on constructive conflict resolution strategies (George & Solomon, 1999).

In contrast, Mikulincer and Shaver (2007) theorized that therapists high in attachment anxiety and/or attachment avoidance (i.e., insecure) are less likely to accurately empathize and

keep personal problems and defenses from interfering with compassion towards clients. They posited that therapists high in attachment avoidance (i.e., dismissing) might not have the emotional availability necessary to develop emotional bonds with clients and provide sensitive care. Thus, these therapists might not be comfortable with the intimacy of therapy due to their preference for distance in relationships. On the other hand, Mikulincer and Shaver theorized that therapists high in attachment anxiety (i.e., preoccupied) may struggle with regulating emotions and maintaining boundaries with clients, thus interfering with their ability to respond appropriately and sensitively in therapy. Researchers have sought to empirically examine these theoretical hypotheses and found mixed results, which I will review in the following sections.

Therapist attachment style and the working alliance. Researchers have determined that relevant traits associated with attachment security, such as therapist warmth, trustworthiness, and openness, promote an effective therapeutic alliance (Ackerman & Hilsenroth, 2003). In support of this connection, researchers have begun to explicitly examine the relationship between therapist attachment security and the working alliance in psychotherapy. For example, Black et al. (2005) found that therapists low in attachment anxiety and avoidance (i.e., secure) reported a higher level of therapeutic alliance with their clients overall. Conversely, therapists that reported being high in either attachment anxiety or avoidance reported a poor level of global therapeutic alliance with their clients. These therapists also perceived more problems in therapy sessions overall. Similarly, a study conducted by Sauer et al. (2003) found that therapists' self-reported attachment anxiety was associated with clients' initially reporting a stronger working alliance, but the ratings fell as therapy progressed. Dunkle and Friedlander (1996) also found positive associations between a therapist's secure attachment and working alliance as rated by the client.

Dinger et al. (2009) used the Adult Attachment Interview (AAI) to assess therapists'

attachment orientations and had clients rate the quality of the working alliance over time. The researchers found that higher therapist attachment anxiety was significantly associated with a lower overall quality of the working alliance. Additionally, clients of therapists high in attachment anxiety (i.e., preoccupied) reported a decrease in alliance quality over the course of therapy. Another study by Schauenburg et al. (2010) also used the AAI and found that higher attachment security of therapists was associated with higher quality working alliances as rated by clients, but only for clients that started therapy with high levels of interpersonal problems and high overall symptomatology. Although many studies point towards an association between therapist attachment orientation and the working alliance, a recent meta-analysis conducted by Degnan et al. (2016) reported several studies found no direct relationship between the attachment orientation of the therapist and the quality of the working alliance (e.g., Bucci et al., 2016; Ligiero & Gelso, 2002; Petrowski et al., 2011). Thus, further exploration into the role of therapist attachment orientation in the establishment of an effective therapeutic relationship is warranted.

      Therapist attachment style and psychotherapy outcome. Mikulincer and Shaver (2007) theorized that therapists' attachment security would contribute to better outcomes, whereas therapists' attachment insecurities may impair the building of a therapeutic relationship and provision of security. Researchers have begun to explore this idea by examining the effect of therapists' attachment orientation on client outcomes in psychotherapy. As of yet, only one study by Bruck et al. (2006) found a direct relationship between therapists' attachment orientations and therapy outcomes. The sample consisted of 52 client-therapist dyads in a mix of psychiatric medical care and outpatient clinics. The researchers found that higher therapist attachment security was moderately correlated with improvement in clients' interpersonal problems ($r = -0.54$), global functioning ($r = -0.35$), and symptomatic distress ($r = -0.30$) following therapy.

Additionally, they discovered that higher therapist attachment anxiety was related to poorer client-reported symptom change, whereas higher therapist avoidant attachment was related to the worsening of clients' symptoms during therapy. Clients of therapists high in attachment avoidance also reported greater interpersonal problems following therapy. This study was limited in that outcome measures were only administered twice, at intake and upon termination of therapy. Therefore, change trajectories throughout the process of psychotherapy could not be examined. The study was also limited by using a self-report attachment measure for both therapists and clients. Further, their measure assigned attachment classifications, rather than measuring attachment dimensionally which would have allowed for more nuance in the interpretation of scores.

Three other studies examined the relationship between therapist attachment security and therapy outcomes and did not find direct relationships (Schauenburg et al., 2010; Tyrrell et al., 1999; Wiseman & Tishby, 2014). One explanation for the lack of direct effects of therapist attachment security on therapeutic processes and outcomes in these studies is the finding of significant interactions between therapist attachment orientation and client attachment orientation. Accordingly, I will examine these interaction effects in the following section.

The interaction of client and therapist attachment on alliance and outcome. Tyrrell et al. (1999) examined case managers and their clients and found that attachment orientations of both members of the dyad (measured by the AAI) had an interaction effect on both alliance and outcome. Results suggested that matching case managers and clients with dissimilar attachment dimensions (i.e., preoccupied versus dismissing) led to more positive outcomes in therapy and more positive interpersonal relationships for the client. Specifically, case managers who were less deactivating regarding attachment were able to form stronger alliances with clients who

were more deactivating (i.e., dismissing). Better therapeutic outcomes, defined as higher general life satisfaction, were also reported when clients were matched with case managers that had dissimilar deactivating attachment dimensions. The authors argued that the mismatch of the client and clinician might serve to disconfirm the client's usual interpersonal and emotional strategies and lead to more flexible behaviors and better outcomes. However, these results have limited generalizability to psychotherapy relationships due to the sample consisting of case managers and their clients. Moreover, alliance and outcome measures were administered at only one point during treatment. The average treatment length in this study was 31 months, so more frequent measurement of alliance and outcome could have picked up potential fluctuations in change throughout long-term therapy.

Another study by Bruck et al. (2006) conducted at an outpatient psychiatric center also reported that greater dissimilarity between therapist and client attachment orientations produced better working alliance and outcomes. Specifically, they found that greater differences in the avoidant attachment dimension were associated with improvements in therapist-reported global functioning, client-rated psychiatric symptoms and target complaints by both clients and therapists. Additionally, greater dissimilarity in attachment anxiety was associated with improvements in therapist-reported global functioning. The researchers measured the working alliance weekly for the first nine sessions, but therapy outcome was only measured pre-treatment and at the end of therapy. More frequent assessments of outcome over time would allow for more powerful growth curve modeling analysis to examine the nuances in change throughout therapy.

In a similar study, Petrowski et al. (2011) used the AAI to measure attachment in outpatient therapy dyads. They found that the client-rated working alliance was higher when the

client was high in attachment anxiety, and the therapist was high in attachment avoidance. However, this interaction effect did not hold for therapists low in both attachment anxiety and avoidance (i.e., secure) when they were matched with clients high in either attachment anxiety or attachment avoidance (i.e., insecure). The researchers posited that clients with high attachment anxiety might benefit from a dismissing therapist who may be less intrusive and demanding. These results support the notion that it may be therapeutically beneficial for the client and therapist to have dissimilar attachment orientations. However, this study's limitations include that it measured alliance once at the end of treatment, and thus, is not as informative as measuring alliance session-by-session throughout the course of therapy.

Supporting these findings, Bucci et al. (2016) reported that client attachment orientation and therapist attachment orientation interacted to affect the working alliance. They found that the greater the distance between client and therapist insecure attachment dimensions, the more highly clients rated the working alliance. Thus, dissimilar attachment orientations may support the building of stronger therapeutic alliances. This study was limited by the use of a single-item attachment measure, rather than measuring attachment dimensionally, which does not capture the full range of attachment patterns client and therapist may present with.

Wiseman and Tishby (2014) conducted a longitudinal examination of the interactions between therapist and client attachment orientations on therapy outcomes in a university counseling center. They found that regardless of the therapist's attachment orientation, clients high in attachment avoidance demonstrated the least amount of symptom change from the intake session to the 32nd session. Interestingly, they found that client attachment avoidance predicted higher distress in the early and last measurement points of the study (5th and 32nd sessions), while attachment anxiety predicted higher distress in the mid and late points of therapy (15th and

28th sessions). The researchers posited that clients with high avoidance strategies might have experienced more symptom distress during the initial working phase and at termination due to having to manage difficult interpersonal feelings. Clients with high attachment anxiety may have felt more distress during the working phase of therapy. The researchers reported that therapist avoidant attachment was found to moderate the relationship between client avoidant attachment and outcome. That is, when low-avoidant therapists treated clients with low-avoidant attachment styles, these clients were more likely to show a decrease in symptom severity than high-avoidant clients treated by low-avoidant therapists. The authors argued that there may be benefits to a similar attachment style between clients and therapists, but only when the therapists and clients were both low in avoidance. These findings are contradictory to other studies described above, in which opposite attachment orientations between therapist and client were found to be most beneficial.

Two additional studies examined the interaction of client and therapist attachment orientations but did not find interaction effects (Romano et al., 2008; Sauer et al., 2003). Although Romano et al. (2008) found interactions between client and therapist attachment orientations in regard to session depth, they did not find a significant interaction in terms of the quality of the working alliance. This study was limited in that they used volunteer clients from a university course, so it is unknown if the working relationship was typical of that formed in psychotherapy relationships. As described earlier, Sauer et al. (2003) found main effects for therapist attachment orientation and the working alliance but did not find interaction effects. The authors described several limitations, including the use of a self-report attachment inventory with marginal reliability and small sample size ($n = 28$).

Due to the limited number of studies and conflicting findings, it is difficult to draw

conclusions regarding the interaction between therapist and client attachment orientations and their effects on therapeutic processes and outcomes. Degnan et al. (2016) suggest more longitudinal studies with multiple alliance and outcome ratings throughout the course of therapy as important steps in better understanding the effects of therapist attachment orientation.

Transcript-Based Attachment Measures

Having reviewed the clinical applications of attachment theory and how client and therapist attachment style might influence the therapeutic process, I will now review the transcript-based assessments that will be used in this study. The Patient Attachment Coding System (PACS; Talia et al., 2014) was developed as the researchers sought to find observable processes in psychotherapy that were specific to the different AAI classifications (Talia et al., 2017). The authors initially grouped two sessions each from eight clients that were engaged in psychotherapy. The groupings were based on the clients' independently obtained AAI classifications. Three of the clients were classified as secure, two were classified as dismissing, and three as preoccupied. The authors examined the transcripts for indications of clients' anxious or avoidant behavior towards the therapist that fit characterizations described in the literature. Clients' in-session discourse was also assessed for the same linguistic features assessed by the AAI coding system. Through this analysis, the authors realized that clients of differing attachment classifications could be identified according to how they used language at an interpersonal level (Talia, et al., 2019).

The authors found that clients with a secure classification easily engaged in a free and collaborative dialogue with the therapist. Conversely, clients with a dismissing classification often appeared to be engaged in a one-way conversation, not providing bids for support to the therapist. The clients with a preoccupied classification appeared to need the therapist to validate

their perspective and did not allow much separateness in the relationship. Talia et al. (2014) described this new method as a "move to the level of relation" (p. 151) and proposed that attachment differences are seen in session in the way that clients attune with the therapist through discourse. Therefore, attachment is revealed through the way clients speak about their experiences, and not the content or quality of their experiences (Talia et al., 2014).

From the first sample of sessions, the PACS authors put together three lists of markers specific to the main AAI classifications. Next, the markers were grouped according to their possible function in regulating attunement under four scales accordant with the Strange Situation coding scales. The resulting scales were labeled Proximity Seeking (rating the extent to which the client openly expresses vulnerability), Contact Maintaining (rating the extent to which the client communicates about the therapy relationship), Avoidance (rating the clients' reluctance to describe detailed examples, attitudes, and internal experiences), and Resistance (rating the patients' lack of clarity and orderliness in the exposition of their narrative). The researchers applied the scales to a new sample of 20 clients and found that the PACS ratings could be predicted based on independently obtained AAI classifications, as well as scale ratings being able to predict AAI classification accurately. Upon review of the initial sample again, it was observed that secure clients elicited attunement even without disclosing negative emotion or distress. These clients were able to reflect in the present on their own and others' internal experience, as well as discuss positive experiences. Thus, the researchers added a fifth scale called Exploring that encompassed discourse that allowed for independent exploration while still maintaining a connection with the therapist. The Exploring scale rates the extent to which the client demonstrates openness with regards to their positive experience. The scales were then verified on a larger combined sample of 160 clients treated in five different treatment modalities

from three different countries (Talia et al., 2017).

Building upon their innovative research, Talia and Muzi (2017) developed a measurement specific to assessing therapist attachment. Similar to the PACS, this assessment was developed to analyze therapist attunement with clients in session and thereby predict their attachment classification. The Therapist Attunement Scales (TASc; Talia & Muzi, 2017) measure attunement, described as the process in which therapists help their clients symbolize their internal states and understand them (Talia et al., 2018). It is important to note, that attunement is considered to be an activity that is highly regarded by most therapists, regardless of their abilities or skill sets. So even trainees learning basic core skills are thought to be engaged in attunement with their clients.

To develop the TASc, Tali and Muzi (2017) began with a qualitative analysis of 14 verbatim psychotherapy transcripts, two for each of seven Italian therapists who were also independently assessed with the AAI (three secure, two dismissing, and two preoccupied). They noted that secure therapists used three characteristic types of expressions. They offer their perceptions of clients' internal states that are open to correction and elaboration from the client. For example, they would make a tentative statement about the client's current needs. Secure therapists also validated clients' previously expressed experience by adding their perspective in support. Lastly, they would convey how they experienced the client. Three scales were created to rate the frequency and intensity of three types of secure communication markers: Self-state conjecture, Empathic validation, and Joining. Self-state conjecture includes interventions that are focused on the client's present state and are made in a tentative manner. Empathic validation includes interventions that offer an additional perspective to reinforce the client's disclosure or implicit experience. Joining includes interventions that highlight the relationship between the

client and therapist (Talia et al., 2018).

Therapists classified as dismissing use the markers described above, but sparingly. The therapists classified as preoccupied used markers from the Empathic validation and Joining scales, but not from Self-state conjecture. These therapists seemed not to use tentativeness in their communication with clients. Therapists with dismissing and preoccupied AAI classifications also used two other types of communication with clients. Therapists classified as dismissing seemed to downplay clients' disclosures (i.e., "so you are feeling a bit sad"). Therapists with a preoccupied classification spoke in a way that did not appear to allow for the client to correct them. The authors then coded these markers on two new scales, Detaching and Coercing, which described the attunement styles of these therapists. Detaching includes interventions in which the therapist implicitly disengages from offering a contribution to understanding the client's present state. Coercing includes interventions in which the therapist presents reflections as certain without leaving room for the client to disagree. The entire instrument was then validated on a separate sample of 50 Italian therapists (Talia et al., 2018).

The verification study by Talia et al. (2018) reported that the scales accurately predicted AAI attachment classifications conducted independently. Due to the TASc's ability to predict therapists' AAI administered independently, the authors deduced that therapists' attunement patterns seem to be relatively independent of the influence of clients' individual characteristics. The verification study revealed the TASc has excellent inter-rater reliability, stability, and high agreement with the AAI.

The TASc are a promising development in the assessment of therapist attachment style because the training is of short duration compared to the lengthy training required for the AAI and coding takes approximately 45 minutes to 1 hour based on the number of speech turns. The

TASc are also based on observation, rather than self-report, eliminating the response bias that may be present in therapists asked to participate in research. Slade (2016) notes that while self-report instruments allow for the evaluation of dynamic change, they lack the potential for more in-depth examination of attachment-related processes that are provided by the AAI and the newly created attunement assessments. The PACS and the TASc are both instruments specific to the therapeutic relationship and measure in-session attunement behavior of both client and therapist. The use of these instruments moves the study of attachment and psychotherapy research to "the level of relation" and provide the ability to demonstrate meaningful differences in the patterns of relating and regulating affect within the therapeutic process (Slade, 2016).

Purpose of the Study

Although there is preliminary evidence that therapist attachment orientation is important to the working alliance and psychotherapy outcomes, inconsistent results limit conclusions. Several concerns may contribute to mixed findings in the literature. First, a wide range of instruments have been used to measure the attachment of the client and therapist. Most studies used various self-report instruments, and those using the AAI implemented different scoring methods (Degnan et al., 2016). Self-report measures and interview methods (i.e., the AAI) are likely assessing separate constructs of the attachment system, and each may relate to alliance and outcome in differing ways. Second, the alliance was measured at different time points across many of the studies. Two studies reviewed above reported that the alliance was initially high and then declined throughout psychotherapy (Dinger et al., 2009; Sauer et al., 2003). Thus, the influence of therapist attachment on alliance is likely to differ depending on the phase of therapy in which alliance is measured. Several studies were not able to report the exact time that surveys were administered due to participants being sent the surveys through the mail (Dunkle &

Friedlander, 1996; Ligiero & Gelso, 2002). The influence of time is also not able to be assessed when participants make one-off retrospective ratings (Petrowski et al., 2011; Schauenburg et al., 2010) or are asked to think generally about their alliances with clients across cases (Black et al., 2005). Multiple weekly ratings are a more sensitive way to measure alliance dynamics rather than single time-point or retrospective ratings (Degnan et al., 2016).

Finally, the assessment of psychotherapy outcome has also been measured in inconsistent ways. Most of the studies involving therapist attachment orientation reviewed above assessed outcome by use of a global distress measure (i.e., OQ-45, SCL-90-R). However, therapy outcome was typically assessed at two points in time, at the outset of therapy and again at termination (Bruck et al., 2006; Schauenburg et al., 2010). One study assessed outcome in six-month intervals (Tyrell et al., 1999) and one study assessed outcome at five points throughout long-term psychotherapy (Wiseman & Tishby, 2014). As of yet, no study has examined the effects of therapist attachment orientation on treatment outcome by assessing client overall distress levels every week. Weekly outcome evaluation would allow for a more nuanced perspective of the patterns and possible fluctuations of distress levels over time.

In the current study, I will extend the existing literature in several key ways. First, I will use instruments specifically designed to measure in-session attunement behaviors, from which the attachment orientation of client and therapist can be derived. As Slade (2016) notes, this recent work (Daniel, 2006, 2009, 2011, 2014; Talia et al., 2014) moves the study of attachment and psychotherapy research to "the level of relation." This in-session examination is a nuanced way to understand the influence of attachment orientation on the dynamic relationship between the client and therapist. In particular, it explores the ways that the client's discourse elicits, maintains, or disrupts emotional proximity with the therapist. These instruments can

meaningfully make clear the differences in the patterns of relating and regulating affect within the context of psychotherapy (Slade, 2016). To my knowledge, this is the first study that will assess client and therapist attachment security using the TASc and the PACS together.

Second, I will longitudinally examine alliance and outcome throughout treatment with the weekly administration of both measures. The assessment of change in alliance and distress levels over time allows for the exploration of the dynamic nature of these processes in psychotherapy. It allows for examination of what happens as the attachment system is activated throughout the course of therapy (Slade, 2016), as one-time assessments may not capture these patterns. Third, I will examine the interaction between client and therapist attachment orientation to determine if secure therapists are indeed more therapeutic and if certain combinations of attachment orientations lead to better therapeutic alliances and outcomes.

In order to better understand the influence of therapist attachment orientation on client-rated alliance ratings and the outcome of psychotherapy, I will examine the following research questions. First, what is the relationship between therapist attachment orientation and client symptom change in therapy? Second, what is the relationship between therapist attachment orientation and client ratings of the working alliance? Third, what is the interaction between therapist attachment orientation and client attachment orientation on the client-rated working alliance? In particular, (a) What effect does the relationship between therapist Balance scores and client Balance scores have on the client-rated working alliance? (b) What effect does the relationship between therapist Balance scores and client Resistance scores have on the client-rated working alliance? (c) What effect does the relationship between therapist Coercive scores and client Balance scores have on the client-rated working alliance? (d) What effect does the relationship between therapist Coercive scores and client Resistance scores have on the client-

rated working alliance? (e) What effect does the relationship between therapist Detaching scores and client Balance scores have on the client-rated working alliance? and (f) What effect does the relationship between therapist Detaching scores and client Resistance scores have on the client-rated working alliance?

Finally, I will examine the interaction between therapist attachment orientation and client attachment orientation on client symptom change. In particular, (a) What effect does the relationship between therapist Balance scores and client Balance scores have on client symptom change in therapy? (b) What effect does the relationship between therapist Balance scores and client Resistance scores have on client symptom change in therapy? (c) What effect does the relationship between therapist Coercive scores and client Balance scores have on client symptom change in therapy? (d) What effect does the relationship between therapist Coercive scores and client Resistance scores have on client symptom change in therapy? (e) What effect does the relationship between therapist Detaching scores and client Balance scores have on client symptom change in therapy? and (f) What effect does the relationship between therapist Detaching scores and client Resistance scores have on client symptom change in therapy?

Research Hypotheses

Hypothesis 1: There is a significant positive relationship between therapist attachment security and client symptom change on the OQ.

Hypothesis 2: There is a significant positive relationship between therapist attachment security and client ratings of the working alliance on the WAI-SR.

Hypothesis 3: Therapist attachment security will influence the relationship between client attachment security and client ratings of the working alliance on the WAI-SR. Given prior contradictory findings, I did not hypothesize the specific configuration of

client-therapist attachment that would be most beneficial to the working alliance.

Hypothesis 4: Therapist attachment security will influence the relationship between client attachment security and symptom change on the OQ. Given prior contradictory findings, I did not hypothesize the specific configuration of client-therapist attachment that would be most beneficial to therapy outcome.

CHAPTER II

METHOD

Participants

A nonrandom sample of therapist-trainee participants were recruited from a psychology training clinic at a large Midwestern university over two consecutive semesters. Across the two semesters, 29 therapist-trainees participated in the study. Two therapist-trainees were not included in the study due to not having clients that fit criteria (i.e., child clients). One therapist-trainee was removed because their therapy session could not be coded due to poor audio quality. Clients with multiple therapists posed conceptual and practical problems for the analyses and therefore the first therapist for each client was selected for inclusion in the study. Due to trimming the data in this way, three therapists-in-training were not included as they were seeing clients who had already been included in the study with a previous therapist.

Of the 23 therapists-in-training in the study, 23% identified as men, 76% identified as women, and 2 identified as non-binary. Therapist-trainee participants ranged in age from 23 to 50 (M = 34, SD = 7.8). Approximately 83% identified as White and the other 17% identified as African American or Black. Regarding gender, race, and age, the trainee participant sample was similar to other studies examining graduate trainees' attachment orientation (Sauer et al., 2003).

When asked to report theoretical orientation, 13% reported cognitive-behavioral, approximately 34% person-centered, about 17% humanistic, 4% psychodynamic, and the rest identified as integrative. Twenty-one percent of therapists-in-training had prior counseling work experience and 75% of those participants had less than 15 months of experience. Trainees were mostly from Clinical Mental Health (30%) and Counseling Psychology (44%) programs. Most trainees were in their third, fourth, or fifth year of their programs (96%). Approximately 78% of

therapist-trainees endorsed having been in their own personal counseling at a prior time or currently.

Twenty-three clients were in therapy with the participating therapists. Clients attended an intake session and up to 11 therapy sessions. Sessions attended, not including intake appointment, ranged from two sessions to 11 sessions. The average number of sessions attended was 6.5. Approximately 39% of clients identified as men, 57% as women, and 4% chose to self-identify. Clients ranged in age from 20 to 62 with a mean age of 36 (SD = 11.8). The majority of client participants identified as White (78%) with smaller percentages identifying as American Indian or Alaskan Native (4%), Hispanic or Latino (9%) and Multiracial (9%). As a measure of socioeconomic status, client participants were asked to report their approximate level of household income. Approximately 48% reported a household income of less than $19,000, 26% reported a household income between $19,001 and $25,000, 13% reported a household income between $25,001 and $32,000, 9% reported a household income between $38,001 and $45,000 and 4% reported a household income between $45,001 and $52,000. Regarding highest education level completed, one participant reported not finishing high school (4%), 30% earned a high school diploma, 22% earned an associate degree, 39% earned an undergraduate degree, and 4% (n = 1) earned a master's degree. Only three client participants (13%) reported being currently enrolled in college. Eighty-two percent of client participants indicated they had previously attended therapy at some time in their lives. When asked to report the severity levels of their current distress, about 17% endorsed 'mildly upsetting,' 26% endorsed 'moderately upsetting,' 35% endorsed 'severely upsetting,' and 22% endorsed 'very severe.' Client then rated how many sessions they estimated they would need. Thirteen percent of client participants estimated 2 to 4 sessions, 17% estimated 5 to 8 sessions, 35% estimated 9 to 12 sessions, 22%

estimated more than 12 sessions, and 3 clients did not fill out this item. All clients were seen by master's level therapist-trainees and only one client (4%) was mandated to treatment. The demographics of the initial sample were similar to the demographics of clients from studies using therapist training clinics (Richardson et al., 2017; Sauer et al., 2017).

Measures

Demographic Questionnaires

The therapist demographic questionnaire contained items about gender, age, race, and theoretical orientation. The client demographic questionnaire contained items about gender, age, race, as well as presenting problem, relationship status, and prior history of counseling.

Therapist Attunement Scales

The Therapist Attunement Scales (TASC; Talia & Muzi, 2017) are a set of scales used in analyzing therapists' attunement and attachment status in a psychotherapy session. In using the scales, a single session from the therapist is transcribed verbatim. Raters follow four consecutive steps in coding one therapy session and the entire process takes approximately one hour depending on how many times the therapist speaks. In the first step, each complete speech turn of the therapist is examined on its own and the raters must assign one of seven mutually exclusive form codes. More than one form code can be assigned to the same speech turn if applicable. The form codes include: 1) Inquiry (open questions or requests for disclosure), 2) Expression (therapist reveals how they experience the client), 3) Action (therapist proposes possible courses of action), 4) Education (therapist explains general concepts), 5) Clarification (repeating or reformulating what client has already said), 6) Not-knowing stance (closed questions or conjectures), and 7) Objective stance (repeats what client has already said and adds therapists' perspective in definitive terms). Secondly, the rater examines the content of the

interventions to determine if utterances that received a code in the first step can be coded with one of 40 attunement markers described in the manual. Each marker is defined by specific content (i.e., emotions, relationships, etc.) and by their form (e.g., Expression, Objective stance, etc.). Every speech turn coded in step one as either Expression, Clarification, Not-knowing statement, or Objective statement can be coded with an attunement marker according to the specific criteria in the manual. Each of these four forms has distinctive markers. Speech turns that are coded as Inquiry, Action, or Education are not assigned an attunement marker, as attunement is a process where the therapist contributes to defining and making sense of clients' internal states. Specifically, speech turns that are coded as Inquiry (i.e., an open question) prompt clients to share their experience without actively contributing to understanding it. Utterances coded as Action focus on behavior and not on internal states, and Education provides general theories that do not address any current experiences of clients.

In the third step, five 7-point scales are scored based on the frequency and intensity of the attunement markers assigned in step two associated with each scale. Then, a global scale of security, called Intersubjective engagement, is obtained using a simple algorithm. The five scales include the Self-state conjecture scale which rates the frequency and intensity of Not-knowing statements that focus on internal states. For example, these markers may include the therapist asking if the client feels a certain way (e.g., *are you feeling sad?*), make a qualified guess about a client's intention (*it feels like you want to meet new friends*), or tentatively propose how the client may be evaluating another person (i.e., *it sounds like your father was quite rejecting*). The Empathic validation scale rates the frequency and intensity of Objective statements in which the therapist validates clients' experiences. For example, the therapist might agree the client is experiencing a certain emotion based on interpersonal cues (i.e., *yeah, I've never seen you this*

angry before!), or the therapist might provide reasons for why clients feel a certain way based on their underlying needs (i.e., *of course you're frustrated, you really needed a different kind of support*), or on the therapist's view of the client's interpersonal situation (i.e., *yeah he was trying to impede your progress*).

The Joining scale rates the frequency and intensity of Expression statements that implicitly or explicitly convey the therapist's feelings about the client. For example, the therapist might share their current feelings (i.e., *I'm so proud of you*), their appreciation for progress made (i.e., *I'm not sure you would have been able to be this open with me only a few weeks ago*), or for what the client said or did (i.e., *this is really interesting*). The Detaching scale rates interventions that discharge the therapist from attuning to the client. For example, the therapist might use a Clarification statement that downplays the client's experience (i.e., *oh so you are a little disappointed*) or an Objective statement to normalize what a client is experiencing (i.e., *it's certainly not rare to break up at your age*).

The Coercing scale rates interventions in which the therapist reflects the client's experience in a way that restricts the client from correcting or elaborating the therapist's views. For example, the therapist might state overly certain statements about a significant other's intention (i.e., *your father is just trying to pretend he isn't angry*) or repeat what was already said by the client in a way that is vague, overly long, or otherwise confusing.

In the fourth step, the rater assigns a classification to the therapist's attunement that is based on the ratings of the five scales. The therapist can be classified as Balanced, Avoidant, or Coercive. The therapist is classified as Balanced if Self-state conjecture, Empathic validation or Joining are higher than the other scales. Raters assign an Avoidant classification if Detaching is higher than the other scales, or if all scales are low. A Coercive classification is assigned if the

Coercing scale is higher than the other scales.

Each classification has sub-classifications. Therapists that are classified as Balanced can receive a balanced-avoidant or balanced-coercive sub-classification if the ratings of the Detaching and the Coercing scales are in the moderate range, respectively. If the Detaching and Coercing scales are low, then a balanced-autonomous classification is assigned. Therapists classified as Avoidant receive an Avoidant-1 sub-classification if Self-state conjecture, Empathic validation, or Joining are low. They are classified as Avoidant-2 if any of these three scales are rated moderate. Lastly, therapists given a Coercive classification are sub-classified as Coercive-1 if the Self-state conjecture rating is moderate or high, and Coercive-2 if the rating is low.

After consultation with the scale author, Alessandro Talia, I decided to use the global scores on the Balance scale, Detaching scale, and the Coercing scale as measures of attachment security and insecurity, respectively (personal communication, June 17, 2021). Due to the small sample size and potential complications from using multiple categorical predictors, the attachment classification categories were not able to be used in the growth modeling analyses. The classifications are reported in terms of frequency and percentages found in the sample.

The validation sample included 50 psychodynamic therapists located in various regions of Italy. Therapists predominately identified as female (79%) and their age ranged between 27 and 52, with a mean age of 32.4 ($SD = 4.8$). Reporting of identified genders within the remaining 21% of the sample was not available. Fifty-eight percent of therapists worked in the public sector and the others were in private practice. Therapists' years of clinical experience ranged between two and 10 years, with a mean of four years ($SD = 2.1$).

Talia et al. (2018) reported excellent internal consistency of the scales (.88). In a study validating the TASc, interrater reliability was strong at .92 (Talia et al., 2018). Reliability for the

main scale Intersubjective Engagement/Balance was excellent at .86. Reliability for the Detaching and Coercing scales were good at .72 and .76, respectively. Convergent validity was examined by comparing the results of the TASc with independently obtained AAI classifications. The TASc is highly correlated with the AAI for three-way classifications (.90) and two-way classifications (.92). Correspondence between the TASc and the AAI sub classifications was moderate at .64. Divergent validity was demonstrated by low and insignificant association between the TASc global scale and the Working Alliance Inventory Therapist-rated version (WAI-T; Horvath & Greenberg, 1989).

Patient Attachment Coding System

The Patient Attachment Coding System (PACS; Talia & Miller-Bottome, 2014) is a transcript-based instrument that assesses clients' in-session attachment based on any session of psychotherapy. A single therapy session is transcribed verbatim, and all the client's verbal utterings are rated. The coder identifies 59 markers detailed in the manual, as they occur in clients' speech turns. The coder gives a rating from 1 to 7 in .5 increments on nine subscales based on both the frequency and intensity of the markers. The PACS contains five main scales, which are scored based on the ratings of their respective subscales. Lastly, a global score on a sixth scale, Security, is obtained using an algorithm outlined in the manual.

A given marker can be assigned to any of the client's passages in the text if the criteria is met throughout the utterance. If the passage is interrupted by the therapist speaking, another marker, or non-coded text, it is then possible to code the given marker again. The manual provides examples from client transcripts for each marker, along with several criteria that help rule out passages that would not qualify. Once markers for Proximity Seeking, Contact Maintaining or Exploring scales are assigned, they are given a score for their intensity, according

to criteria outlined in the manual. Markers for the Avoidance and Resistance scales do not receive a rating and are only counted for frequency of use throughout the transcript.

The five main scales are Proximity Seeking, Contact Maintaining, Exploring, Avoidance, and Resistance. Proximity Seeking and Contact Maintaining comprise markers that actively elicit or encourage attunement and do not have subscales. An example of proximity seeking is, "I'm just angry at him." Contact Maintaining is assigned for speech turns such as, "Talking to you about these things has been so helpful."

Exploring captures the capacity to remain open to different therapeutic interventions and elicit attunement by conveying one's present experience. A client expression that would fit in this category would be "I don't want these problems to get in the way of our relationship." Exploring includes three subscales, Self-asserting, Affective Sharing, and Autonomous Reflection. Avoidance comprises markers that shift the attention away from clients' ongoing experience and avoid the direct elicitation of attunement. This scale is assigned for expressions such as, "I think it's normal. I'm just stressed, probably." Avoidance includes three subscales, Direct Avoidance, Downplaying, and Releasing. Resistance comprises markers that prevent the therapist from expressing a different point of view, thereby impeding any less than perfect attunement. This scale is assigned for speech turns such as, "I mean, I'm sure you agree with me, so…"

A client is classified as *secure* if Proximity Seeking, Contact Maintaining or Exploring are higher than the other scales. A rater classifies the client as *avoidant* or *preoccupied* if Avoidance or Resistance are higher, respectively. Clients that are classified as secure can receive sub-classifications based on their ratings on the Avoidance and Resistance scales (e.g., *secure-avoidant, secure-autonomous,* or *secure-preoccupied*). Clients that are classified as avoidant can

be subclassified as *avoidant-1* if Proximity Seeking is low, and *avoidant-2* if Proximity Seeking is moderate. Clients classified as preoccupied can receive sub-classifications of *preoccupied-1* if Proximity Seeking is moderate or high, and *preoccupied-2* if it is low.

After consultation with the scale author, Alessandro Talia, I decided to use the global scores on the Balance scale and the Resistance scale as a measure of attachment security and insecurity, respectively (personal communication, June 17, 2021). Due to the small sample size and potential complications from using multiple categorical predictors, the attachment classification categories were not able to be used in the growth modeling analyses. However, the classifications are reported in terms of frequency and percentages found in the sample.

In validating the measure, the authors used a sample of 160 clients treated in five different treatment modalities across three countries. A clinic in Denmark enrolled 68 clients who were being treated for bulimia and received either psychoanalytic psychotherapy or cognitive behavioral therapy enhanced. A treatment facility in New York enrolled 72 clients who received brief relational therapy. Finally, a counseling facility in Italy enrolled 20 clients who received supportive psychotherapy. Approximately 90% of clients were White, 7.6% were African American or Black, and 2% were of another ethnic origin. Clients ranged from 19 to 65 years of age, with a mean age of 32 years. Approximately 72% of the clients identified themselves as women and information was not available regarding other identified genders in the study. Additionally, 87% of clients were being treated for an Axis I disorder, while 46.7% were treated for an Axis II diagnosis (Talia et al., 2017).

Talia et al. (2017) reported that internal consistency was fair for the Avoidance scale (.73) and Resistance scale (.81). Internal consistency was marginal for Exploring at .67. The Proximity Seeking scale had low internal consistency at .21. All the scales significantly predicted

the global score on the Security scale, and all the subscales significantly predicted the score on the related main scale. Talia et al. (2017) reported inter-rater reliability as excellent at .91. A principal-component analysis with varimax rotation was conducted by Talia and colleagues (2017) on the nine PACS subscales and the two primary scales with no subscales (Proximity Seeking and Contact Maintaining). Results indicated three factors underlie the scales. Factor 1 represents resistance, Factor 2 represents security or autonomy (combining both Proximity Seeking and the Exploring subscales), and Factor 3 represents avoidance (and is inversely related to Contact Maintaining).

Outcome Questionnaire

The Outcome Questionnaire (OQ-45; Lambert et al., 1996) is a 45-item self-report measure of client change during mental health treatment. The OQ-45 contains three subscales, Symptom Distress (25 items), Interpersonal Relations (11 items), and Social Role Performance (9), which are added together to obtain a total score. Items are rated using a 5-point Likert scale (0 = *never*, 1 = *rarely*, 2 = *sometimes*, 3 = *frequently*, 4 = *always*), yielding a range of possible scores from 0 to 180. In clinical use of the OQ-45, participants' answers to four critical items (indicating suicidality, substance abuse, and workplace conflict) and the total score are considered. High total scores indicate the client has endorsed a large number of distress symptoms (anxiety, depression, somatic problems, and stress), as well as interpersonal difficulties. A cutoff score of 63 was established indicating clients above this threshold are experiencing more severe symptoms of distress.

Test-retest reliability coefficients in a university sample were .78 for Symptom Distress, .80 for Interpersonal Relations, .82 for Social Role Performance, and .84 for Total score. Internal consistency reliabilities were .92, .74, .70, and .93, respectively, in a university sample; and in a

clinical sample, they were .91, .74, .71, and .93, respectively (Lambert et al., 1996). These findings indicate good reliability for the Total score and Symptom Distress subscale, while the reliability of the Interpersonal Relations and Social Role subscales are only sufficient. A confirmatory factor analysis (CFA) was conducted by Mueller et al. (1998) using a sample of university students, finding that a one-factor solution fit equally well as either of the two or three-factor solutions. Shaffer (2010) conducted confirmatory factor analyses of three competing models and supported a unidimensional factor structure. Consequently, researchers typically recommend reporting only the Total score.

The OQ yields scores that are sensitive to change in clients yet remains stable in non-treated individuals. Convergent validity was demonstrated between the total scale and subscale scores and multiple measures of psychological functioning (e.g., Beck Depression Inventory, State-Trait Anxiety Inventory). The OQ total score correlated positively with the Symptom Checklist-90-Revised (SCL-90-R; Derogatis et al., 1976) General Severity Index (.84) with a community clinic sample (Umphress et al., 1997).

Working Alliance Inventory-Short Form Revised

The Working Alliance Inventory-Short Form Revised (*WAI-SR; Hatcher & Gillaspy, 2006*) is a 12-item instrument used to assess the therapeutic alliance construct proposed by Bordin (1979). The WAI-SR measures three domains of the therapeutic alliance: (a) agreement between client and therapist on the goals of the treatment (Goal); (b) agreement between client and therapist about the tasks necessary to achieve those goals (Task): and (c) the quality of the bond between client and therapist (Bond). Participants are asked to rate items on a 5-point Likert scale with answers ranging from 0 (*rarely or never*) to 5 (*always*). The Goal, Task, and Bond domains each have scores ranging from 5 to 20, with higher scores indicative of a better

therapeutic alliance. The shortened version requires less time to complete, making it less burdensome on clients when administered repeatedly over the course of psychotherapy.

The WAI-SR was developed as a shortened version of the original scale, the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Hatcher and Gillaspy (2006) performed a confirmatory factor analysis of the WAI and the Working Alliance Inventory-Short Form (WAI-S; Tracey & Kokotovic, 1989) on two large samples ($N = 231$ and 235) and found that one-, two-, and three-factor structures did not show an acceptable model fit (Falkenström et al., 2015). Due to the problematic model fits for the WAI-S, the authors developed the alternative short form that would more clearly differentiate Bordin's Task, Goal, and Bonds dimensions. The WAI-SR was validated with two separate samples. Total scores of the original WAI and the WAI-SR were highly correlated in both samples (.94 & .95). The WAI-SR subscales correlated strongly with the corresponding subscales of the WAI. As the authors expected, the respective Bond scales correlated highest (.94, .91); the Goal scales (.91, .86) and the Task scales (.83, .87) demonstrated substantial but weaker correlations. CFA demonstrated that a three-correlated factor model best fit the WAI-SR (Hatcher & Gillaspy, 2006).

The WAI-SR has high internal consistency, with Cronbach's α of the subdomains ranging from .81 to .90, and Cronbach's α of the total score at .91. High reliability has been reported, with test-retest reliability of .93 (Falkenström et al., 2015). Construct validity has been demonstrated with the WAI-SR correlating well with other therapeutic alliance measures: the California Psychotherapy Alliance Scale ($r = .80$) and the Helping Alliance Questionnaire ($r = .74$; Hatcher & Gillaspy, 2006). The Goal and Task domains have failed to be differentiated in subsequent more stringent confirmatory factor analyses, suggesting that the two domains are measuring similar constructs. For this reason, many researchers recommend using the overall

mean of the WAI-SR rather than its subscales (Falkenström et al., 2015). Accordingly, in this study, I used the overall mean of the WAI-SR.

Procedures

In this study, I used a naturalistic, longitudinal design in which data were collected as part of treatment-as-usual. Therapists were recruited from a psychology training clinic housed at a large Midwestern university. The therapists-in-training at the clinic consisted of supervised masters and doctoral level students. A broad description of the study was given verbally to all students who provide counseling at the clinic at the beginning of the semester during which data were collected. Therapists-in-training were invited to participate in a study that aims to "learn more about attunement characteristics that contribute to the therapy relationship and outcome of psychotherapy." The purpose and nature of the study was outlined in the consent form that therapist-in-training participants were asked to sign. The consent form also asked permission to access clients' recorded counseling sessions. Participating therapists-in-training were informed that their transcripts would be kept confidential and more specifically that their supervisors at the clinic would not have access to their transcripts. Sessions were transcribed by the primary researcher and other trained research assistants. Data from this study were confidential but not anonymous. Coded transcripts were coded using an identification number associated with participant names and client numbers. Identification numbers were used to link data from client files with client and therapist transcripts during the research. A master list of ID numbers and names were stored in a locked file in the clinic office separate from participants' research data and client records. Transcribed sessions were also kept separate from regular client files, and only the primary researcher and research assistants had access to the information collected in this study. Transcriptions were stored on a private network at the clinic and were password-protected.

As an incentive, therapists-in-training had the option to receive a $5 Amazon gift card or a parking pass for completing the study.

All client data existed in archival form as part of the research database for the clinic. As part of the standard procedure, clients at the clinic sign an informed consent allowing clinic staff to access recordings of their sessions throughout treatment. On the informed consent, clients are given the option to withdraw their session data from research without impacting access to clinical services. The session transcripts were coded by the author of the TASc and PACS, Alessandro Talia, so the primary researcher and research assistants could remain blind to the participants' attachment classifications.

Therapists participating in the study completed a demographic questionnaire in conjunction with signing the study consent form. At the intake session, the client completed the OQ-45 and the demographic questionnaire, administered by front desk staff as part of the standard clinic procedure. As part of the routine procedure, clients completed the WAI-SR and the OQ-45 before every session. The surveys were presented in a random sequence to avoid confounds from an ordering effect. The surveys took approximately 15 minutes to complete, and all surveys were collected and stored electronically by front desk staff not involved in the study to preserve confidentiality. The clinic front desk staff were asked to record any deviation from the protocol.

Research Design and Analyses

Research questions were analyzed through multilevel modeling. Data were nested within two levels: Time level and person level. A within-person model was examined, in which changes across time were assessed. Additionally, a between-person model was examined, in which effects of attachment predictors were examined.

CHAPTER III

RESULTS

In this chapter, I will review the results of the study. First, I will describe the data screening process, including managing missing data. Next, I will report the descriptive statistics. Finally, I will describe and summarize the statistical analyses used to evaluate the research questions and hypotheses.

The data were screened for any visually inconsistent or improbable scores. There were no data points outside of the range of respective Likert scales for the OQ and WAI-SR. Any scores above 100 on the OQ were double checked for accuracy. There was one intake OQ score missing and 9 WAI-SR scores missing, including WAI-SR scores missing for one client entirely. Regarding the missing OQ score and WAI-SR scores, it is likely that clinic procedures may have contributed to the client not filling out the measure before session (i.e., iPad not working, error with administration). According to McNeish et al. (2017), multilevel modeling manages missing data in longitudinal designs well when using the maximum likelihood estimation model, which was used in this study. Multilevel modeling also does not require balanced data across different time points; thus, these missing scores were coded as -99 to indicate they were missing when running the analyses.

Preliminary Analyses

To determine if there were differences in scores on the OQ due to client gender, I conducted a one-way ANOVA using the Intake OQ data. No significant differences were found between gender and scores on the Intake OQ. To determine if there were differences in scores on the WAI-SR due to client gender, I conducted a one-way ANOVA using the session two WAI-SR data. No significant differences were found between client gender and WAI-SR session two

scores. To determine whether age of the client participants influenced the results, I conducted

Pearson product-moment correlations between age and the outcome variables (i.e., Intake OQ &

WAI-SR session 2). There were no significant correlations between age and client symptoms or

between age and working alliance rating. To determine if there were differences in scores on the

dependent variables and race, I conducted a series of one-way ANOVAs using the Intake OQ

scores and WAI-SR session two scores. There were no significant differences found between

clients' race and scores on the Intake OQ and WAI-SR session two rating.

I explored the relationship between the dependent variables at session three OQ and time

three of the WAI by using Pearson Product-moment Correlations. The relationships are

displayed in Table 1. Table 1 shows a statistically significant, moderate positive correlation

between client Balance scores and therapist Balance scores. This result indicates the Balance

scale is measuring the same construct of attachment security in clients and therapists.

There was a statistically significant, moderate negative correlation between therapist

Balance and therapist Coercing scores. This result differs from the non-statistically significant,

small negative correlation (r =-.16) reported by Talia et al. (2018) in the TASc validation study.

There was a statistically significant, moderate negative correlation between client Balance and

client Resistance scores. This result is comparable to the moderate negative correlation (r = -.34)

found by Talia et al. (2017) in the PACS scale development study.

Table 1

Pearson Product-moment Correlations among Measures

Measures	1	2	3	4	5	6	7
1. OQ-45	--						
2. WAI-SR	.13	--					
3. TASc Bal	-.09	-.01	--				
4. TASc Coer	.12	-.02	-.43*	--			
5. TASc Det	-.28	.08	-.03	-.35	--		
6. PACS Bal	-.16	.41	.49*	-.40	-.03	--	
7. PACS Res	.08	-.41	-.02	.12	-.14	-.48*	--

Note. N = 23, OQ-45 = Outcome Questionnaire 45; WAI-SR = Working Alliance Inventory – Short Version; TASc Bal = TASc Balance; TASc Coer = TASc Coercing; TASc Det = TASc Detaching; PACS Bal = PACS Balance; PACS Res = PACS Resistance; $* p < .05$

I checked scores on the study measures for multicollinearity by examining the tolerance and VIF values for the variables. Tolerance scores above 1 and VIF scores above 5 indicate a potential problem with multicollinearity (Heppner & Heppner, 2004). All variables in the present study had tolerance scores below 1 and VIF scores below 5, suggesting no issues with multicollinearity.

I conducted assumption testing to assess for normality and outliers. Testing normality included evaluating the significance of the Komogorov-Smirnoff test and examining histograms and scatterplots for each outcome variable. The Komogorov-Smirnoff tests indicated the data were normally distributed. Multilevel modeling does not necessitate testing for homogeneity of variance-covariance, as it allows modeling of the variance-covariance matrix from the data (Cohen et al., 2003). I assessed for univariate outliers by examining plots of the data and one OQ score of 122 was identified as an outlier. Removing the client with the outlier did not impact the

results of the analyses, so the client's scores were left in. To increase ease of interpretation, I centered the predictor variables.

Descriptive Statistics

The mean scores, standard deviations, and N for the outcome variables at each session are presented in Table 2. Twenty-three clients started at intake with 11 being the maximum number of sessions attended. The average number of sessions attended was 6.5. The mean score for the OQ at Intake was 72.9, which is close to the mean from intake sessions reported by Richardson et al. (2017) in a study using a training clinic (M = 77.45, SD = 27.40). The mean for the WAI-SR at the second therapy session was 3.82. This result is comparable to means reported by Volz et al. (2021) using a clinical sample of 650 clients receiving 50 weekly sessions of individual outpatient psychotherapy. Volz et al. reported the mean of the first session WAI-SR as 3.74 and the fifth session as 3.78.

Table 2
Descriptive Statistics for Outcome Measures at Each Session

Scale	Intake	Session 1	Session 2	Session 3	Session 4	Session 5
	n M SD	n M SD	n M SD	n M SD	n M SD	n M SD
OQ	22 72.9 20.4	23 65.4 20.1	23 64.9 24	22 64.3 22.5	20 66.2 26.2	16 60.4 22.1
WAI	--	--	21 3.82 0.83	22 3.98 0.74	19 4.14 0.67	16 4.17 0.60

Scale	Session 6	Session 7	Session 8	Session 9	Session 10	Session 11
	n M SD	n M SD	n M SD	n M SD	n M SD	n M SD
OQ	14 60.9 23.9	12 56.4 20.7	8 54 18.8	6 48.2 23.2	4 48.5 10.8	3 48 10.4
WAI	12 4.07 0.54	8 4.38 0.47	6 4.47 044	4 4.69 0.38	4 4.6 0.47	3 4.78 0.39

The mean scores and standard deviations for the TASc and the PACS are presented in Table 3. The mean score for the TASc Balance scale was 3.80, the mean for the TASc Detaching scale was 1.57, and the mean for the TASc Coercing scale was 2.74. Currently, the validation study of the TASc is the only published study that I could find using the TASc measure. Talia et al. (2018) reported a mean for the Balance score as 4.5, the mean for the Detaching scale as 2.2, and the mean for the Coercing scale as 2.3. The current sample appears to be lower in attachment security ratings (Balance scale) than the validation study.

For the PACS scales, the mean for the Balance scale was 3.26 and the mean for the Resistance scale was 4.20. The mean for Balance was somewhat lower than the mean of 3.82 reported by Miller-Bottome et al. (2019) using an outpatient clinical sample of 40 patients receiving 30 sessions of brief relational therapy. Talia et al. (2018) also reported a mean for Resistance of 3.67, which is lower than the mean for the current sample. In comparison to Talia et al.'s study using the PACS, the current sample of clients seem to have lower attachment security and higher attachment resistance.

Table 3

Descriptive Statistics for TASc and PACS Scales

Scale	Mean	SD
TASc		
Balance	3.80	1.03
Detaching	1.57	.92
Coercing	2.74	1.95
PACS		
Balance	3.26	1.62
Resistance	4.20	2.19

Although the attachment classifications were not able to be used in the analyses, I am reporting the percentage of classifications for the TASc and the PACS for comparison to other studies. Table 4 displays the classification frequencies and percentages for the TASc and the PACS. There were 8 (34.8%) therapist trainees classified as Avoidant, 7 (30.4%) classified as Balanced, and 8 (34.8%) classified as Coercing. The results vary significantly from the TASc validation study. Out of a sample of 50 therapists, Talia et al. (2018) reported 13 (26%) were classified as Avoidant, 32 (64%) were classified as Balanced, and 5 (10%) were classified as Coercive. In comparison, the sample used in my study was more insecurely attached with a similar percentage of Avoidant-classified therapists and a much larger percentage of Coercing-classified therapists.

For the PACS, Table 4 shows that 5 clients were classified as Avoidant (21.7%), 6 clients were classified as Balanced (26.1%), and 12 clients were classified as Coercing (52.2%). There is currently one study utilizing the PACS with a clinical sample. Using a sample of 40 clients from an outpatient medical center receiving brief relational therapy, Miller-Bottome et al. (2019) reported that 32.5% (N = 13) were classified as Secure, 25% (N = 10) were classified as Avoidant, and 42.5% (N = 17) were classified as Coercing. The current sample had a higher percentage of coercing-classified clients, a similar percentage of avoidant-classified clients, and a slightly lower percentage of clients classified as secure.

Table 4

Percentages of Classifications for TASc and PACS Scales

Classification	Frequency	Percent
TASc		
Avoidant	8	34.8
Balanced (Secure)	7	30.4
Coercing	8	34.8
PACS		
Avoidant	5	21.7
Balanced (Secure)	6	26.1
Coercing	12	52.2

Main Analyses

Hypothesis Testing

Growth curve modeling was used to answer all four of my research questions. The statistical approach used to analyze data from this study was modeled after recommendations from sources examining change models in psychotherapy (Kahn, 2011; Kahn & Schneider, 2013). The data was analyzed using a mixed effect model with maximum likelihood estimation and follows a procedure outlined by Shek and Ma (2011).

First, an unconditional means model is performed to examine the individual variation in the outcome variable without regard to time. This model examines the mean of the outcome variable and the amount of outcome variation present in intra- and interindividual levels. This information helps determine which predictors to add when fitting the subsequent models. If this model is not significant, then it indicates there is no change over time and further modeling is not warranted.

The unconditional means model also examines the intraclass correlation coefficient (ICC). ICC describes the amount of variance within the outcome that can be attributed to

differences between individuals. Shek and Ma (2011) state that the ICC value needs to be 0.25 or higher for growth curve modeling to be appropriate, otherwise traditional methods (i.e., ANOVA) of estimating fixed effects should be used. If this criterion is met, then the next step is to conduct an unconditional growth model using the outcome variable. This model adds in examination of individual changes over time. If there are no interindividual difference in changes over time, no further model testing is performed. If there are significant interindividual differences in change over time, then further model testing can be performed by adding in predictors to investigate whether the predictor is related to the growth parameters (i.e., initial status, linear growth, quadratic growth, and cubic growth). Shek and Ma (2011) also indicate that examination of -2 log likelihood (-2LL; a likelihood ratio test/deviance test), Akaike Information Criterion (AIC), and Bayesian Information Criterion (BIC) help to select the best model fit. Typically, the smaller the values for these tests, the better the model fit.

Research question 1. What is the relationship between therapist attachment security and client symptom change in therapy? The associated null hypothesis is that there is no relationship between therapist attachment security/insecurity and client symptom change.

Change in OQ: Unconditional mean model (UMM). To examine changes in OQ scores, I conducted an initial unconditional means model (UMM) test. Results from the UMM indicate that the grand mean of the OQ scores was 65.14 ($SE = 4.42$). The UMM revealed significant within- and between- individual variability for OQ scores (B = 68.50; see Table 1). The Intraclass Correlation (ICC) was 437.93/(437.93 + 68.50) = 0.86, indicating that 86% of the total variance in OQ scores was attributable to between-client differences. Because this score is well above 0.25, further growth curve modeling is warranted.

Change in OQ: Unconditional growth model (UGM). Next, I ran the unconditional

growth model adding in time as an effect. The linear slope for time was statistically significant

(B = -0.97, SE = 0.38, $p < .05$), indicating a decline in OQ scores over time (see Table 1). The

change in residuals from the UMM (68.50) to the UGM (49.04) indicated that the addition of

time reduced variance in OQ by 28.44%. Fit statistics for this model (-2LL = 1283.78, AIC =

1295.78, BIC = 1314.73) were smaller than the UMM, indicating it is a better fit (see Table 1).

Although the UGM was improved over the UMM, it still has statistically significant unexplained

residual variation in OQ (49.04). Significant variation indicates that other predictors should be

added to the model.

Change in OQ: Conditional growth model (CGM). Before adding in attachment-related

predictors, I examined the potential effects that ongoing counseling might have had on client

symptom change. Twelve clients were ongoing clients at the training clinic prior to the start of

the current study. I wanted to explore whether these clients had different change trajectories than

clients who started counseling at the training clinic during the data collection period. If they did,

they may have needed to be examined separately from new clients. Analysis through UGM

indicated that ongoing client status did not have a significant effect on symptom change over

time (B = .11, SE = 8.36, p = .99).

I then added the TASc variables (i.e., TASc Balance, TASc Coercing, TASc Detaching)

to the model as level two, time-variant predictors to explore whether therapist attachment

security and insecurity and change over time predict the growth trajectory of client OQ scores.

The slope of -0.87 (SE = 0.25, $p < .001$) was statistically significant indicating that severity of

symptoms decreased over time.

For level-two predictors, the literature recommends centering predictors around the grand mean to ease interpretation of the results (Khan, 2011; Singer & Willet, 2004). When the centered Balance, Coercive, and Detaching variables are added as predictors, the unconditional growth model becomes a conditional growth model. None of the TASc scale scores had statistically significant effects on change in OQ on their own without time as an interaction. However, a significant effect for the TASc Detaching predictor was found ($B = 0.78$, $SE = 0.37$, $p < .05$) on the interaction of time. This result indicates that therapists with higher ratings on the TASc Detaching scale (i.e., higher attachment avoidance) were associated with client increase in OQ over time. Similarly, therapists with lower ratings on the TASc Detaching scale (i.e., lower attachment avoidance) were associated with client decrease in OQ over time (see Figure 1). There were no significant effects for TASc Balance ($B = 0.26$, $SE = 0.33$, $p = .43$) or TASc Coercive ($B = .03$, $SE = 0.18$, $p = .87$) over time. The results indicate that therapist Balance scores and therapist Coercive scores did not predict change in OQ in initial status or over time.

The CGM model still has statistically significant unexplained residual variation in OQ (59.98), which is higher than the UGM model (49.04). Finally, the fit statistics for this model (-2LL = 1256.59, AIC = 1278.59, BIC = 1313.02) were smaller than the fit for the prior UGM, indicating the addition of the TASc predictors improved the fit of the model (see Table 5).

Table 5

*Multilevel Model Tests for Change in Client Psychological Distress (Outcome Questionnaire)*

		Unconditional Means Model	Unconditional Growth Model	Conditional Growth Model
Fixed Effects				
Initial status	Intercept	65.14 (4.42)***	68.38 (4.17)***	66.37 (6.46)***
Rate of change	Linear Slope		-0.97 (0.07)*	-0.87 (0.25)***
	Balance-Therapist			-2.34 (4.67)
	Coercive-Therapist			-1.83 (2.93)
	Detaching-Therapist			-5.77 (5.43)
	Time x Balance-Therapist			0.26 (0.33)
	Time x Coercive-Therapist			0.30 (.18)
	Time x Detaching-Therapist			0.78 (0.37)*
	Continuing			1.03 (8.79)
Random Effects				
Level 1	Residual	68.50 (7.89)***	49.01 (6.10)***	59.98 (7.00)***
Level 2	Intercept	437.93 (132.05)***	379.95 (118.24)***	396.53 (122.21)***
	Linear Slope		3.90 (7.7)	
	Covariance		1.74 (1.00)	
Fit statistics				
-2LL		1317.13	1283.78	1256.59
AIC		1323.13	1295.78	1278.59
BIC		1332.61	1314.73	1313.02

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$.

Singer and Willett (2004) suggest that using plots to examine the effect and interaction of predictors can aid in interpretation of conditional growth models. Prototypical plots graph the trajectory of a dependent variable for selected values of the predictors. To create the plots, the full equation of the estimated model is written out and then values of the predictor are substituted to calculate predicted scores. Figure 1 is the plot for the linear model for OQ scores with the centered TASc Detaching variable as a predictor. The plot illustrates the negative trend in OQ scores over time for clients seen by low Detaching therapists, as well as the positive trend in OQ scores over time for clients seen by high Detaching therapists.

Figure 2

Cross-level trend interaction effect of TASc Detaching moderating linear change in OQ over Intake and 11 sessions.
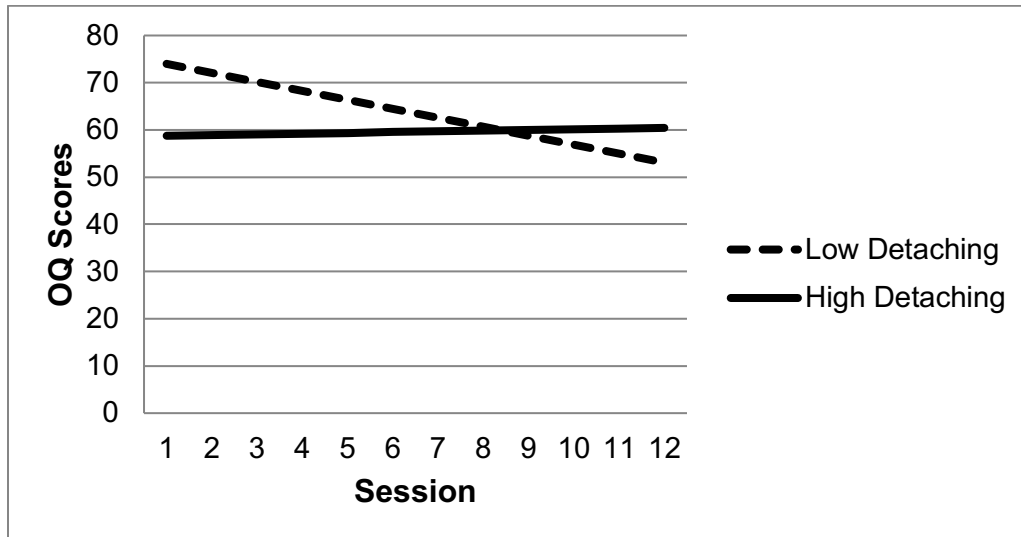
Research question 2. What is the relationship between therapist attachment security and client ratings of the working alliance? The associated null hypothesis is there is no relationship between therapist attachment orientation and client ratings of the working alliance.

Change in WAI-SR ratings: Unconditional mean model (UMM). To examine changes in WAI-SR scores, I conducted an initial unconditional means model (UMM) test. Results from the UMM indicate that the grand mean of the WAI-SR ratings was 4.1 (*SE* = 0.12). The UMM revealed significant within- and between- individual variability for WAI-SR scores (*B* = 0.15, *SE* = 0.02, *p* < .001) (see Table 6). The Intraclass Correlation (ICC) was 0.294/(0.294 + 0.15) = .66, indicating that 66% of the total variance in WAI-SR scores was attributable to between-client differences. Because this score is well above 0.25, further growth curve modeling is appropriate.

Change in WAI-SR ratings: Unconditional growth model (UGM). Next, I ran the unconditional growth model adding in time as an effect. The linear slope for time was

statistically significant (B = 3.68, SE = 0.20, p < .001), indicating an increase in WAI-SR scores over time (see Table 6). The change in residuals from the UMM (0.15) to the UGM (0.08) indicated that the addition of time reduced variance in OQ by 7%. Fit statistics for this model (-2LL = 119.11, AIC = 131.11, BIC = 147.58) were smaller than the UMM, indicating it is a better fit (see Table 6). Although the UGM was improved over the UMM, it still has statistically significant unexplained residual variation in OQ (0.08). Significant variation indicates that other predictors should be added to the model.

Change in WAI-SR ratings: Conditional growth model (CGM). Before adding in attachment-related predictors, I again examined the potential effects that ongoing counseling might have had on change in client ratings of the WAI-SR. Analysis through UGM indicated that ongoing client status did not have a significant effect on client ratings of the WAI-SR over time (B = -0.24, SE = 0.22, p = .29).

I then added the TASc variables (i.e., TASc Balance, TASc Coercing, TASc Detaching) to the model as level two, time-variant predictors to explore whether therapist attachment security/insecurity and change over time predict the growth trajectory of client WAI-SR ratings. The slope of 0.09 (SE = 0.02, p < .001) was statistically significant indicating that client ratings of the WAI-SR increased over time. When the centered Balance, Coercive, and Detaching variables are added as predictors, the unconditional growth model becomes a conditional growth model. None of the TASc scale scores had statistically significant effects on change in client WAI-SR ratings on their own without time as an interaction (see Table 6). There were also no significant effects for TASc Balance (B = 0.001., SE = 0.03, p = 0.96), TASc Coercive (B = -0.005, SE = 0.01, p = 0.69) and TASc Detaching (B = 0.02, SE = 0.03, p = 0.52) over time.

The results indicate that therapist Balance, Coercive, and Detaching scores did not predict change in client WAI-SR ratings in initial status or over time.

The CGM model still has statistically significant unexplained residual variation in WAI-SR ratings (0.11), which is higher than the UGM model (0.08). Finally, the fit statistics for this model (-2LL = 128.32, AIC = 150.32, BIC = 180.32) were larger than the fit for the prior UGM, indicating the addition of the TASc predictors did not improve the fit of the model (see Table 6).

Table 6

Multilevel Model Tests for Working Alliance Ratings (WAI-SR)

		Unconditional Means Model	Unconditional Growth Model	Conditional Growth Model
Fixed Effects				
Initial status	Intercept	4.11 (0.12)***	3.68 (0.20)***	3.96 (0.19)***
Rate of change	Linear Slope		0.10 (0.03)**	0.87 (0.09)***
	Balance-Therapist			-0.05 (0.16)
	Coercive-Therapist			-0.04 (0.09)
	Detaching-Therapist			-0.06 (0.20)
	Time x Balance-Therapist			0.001 (0.03)
	Time x Coercive-Therapist			-0.01 (0.01)
	Time x Detaching-Therapist			0.02 (0.03)
	Continuing			-0.38 (0.24)
Random Effects				
Level 1	Residual	0.15 (0.02)***	0.08 (0.01)***	0.11 (0.02)***
Level 2	Intercept	0.29 (0.10)**	0.75 (0.27)**	0.27 (0.09)**
	Linear Slope		-0.07 (0.03)*	
	Covariance		0.01 (0.01)	
Fit statistics				
-2LL		159.39	119.11	128.32
AIC		165.39	131.11	150.32
BIC		173.63	147.58	180.32

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$.

Research question 3. What effect does the relationship between therapist attachment orientation and client attachment orientation have on the client-rated working alliance? In particular, (a)

What effect does the relationship between therapist Balance scores and client Balance scores have on the client-rated working alliance? (b) What effect does the relationship between therapist Balance scores and client Resistance scores have on the client-rated working alliance? (c) What effect does the relationship between therapist Coercive scores and client Balance scores have on the client-rated working alliance? (d) What effect does the relationship between therapist Coercive scores and client Resistance scores have on the client-rated working alliance? (e) What effect does the relationship between therapist Detaching scores and client Balance scores have on the client-rated working alliance? and (f) What effect does the relationship between therapist Detaching scores and client Resistance scores have on the client-rated working alliance?

The associated null hypotheses are (a) There is no relationship between therapist Balance scores and client Balance scores on the client-rated working alliance, (b) There is no relationship between therapist Balance scores and client Resistance scores on the client-rated working alliance, (c) There is no relationship between therapist Coercive scores and client Balance scores on the client-rated working alliance, (d) There is no relationship between therapist Coercive scores and client Resistance scores on the client-rated working alliance, (e) There is no relationship between therapist Detaching scores and client Balance scores on the client-rated working alliance, and (f) There is no relationship between therapist Detaching scores and client Resistance scores on the client-rated working alliance.

Interactions effects and change in WAI-SR ratings: Conditional growth model (CGM). To examine this research question, I built on the previous conditional growth model (CGM) for the WAI-SR ratings and TASc predictors. To examine effects between therapist TASc variables and client PACS variables, I added in the mean centered PACS Balance and PACS Resistance scale scores as level two predictors.

3a. My first analysis examined the interaction between TASc Balance scores and PACS Balance scores. There was a significant effect for time ($B = 0.08.$, $SE = 0.03$, $p = 0.001$), as previously found in research question 2. There was a significant effect for PACS Balance on initial status ($B = 0.32.$, $SE = 0.11$, $p = 0.004$) indicating there was statistically significant variability in client WAI-SR scores based on PACS Balance scores. However, the interaction between TASc Balance scores and PACS Balance scores over time was not significant (see Table 7). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 7

Multilevel Model Tests for Interactions of TASc Balance and PACS Balance on Working Alliance (WAI-SR)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	3.79 (0.13)***
Rate of change	Time	0.08 (0.03)***
	Balance-Therapist	-0.22 (0.15)
	Balance-Client	0.32 (0.11)**
	Time*Balance-Therapist	0.01 (0.03)
	Time*Balance-Client	-0.01 (0.02)
	Time*Balance-Therapist*Balance-Client	-0.01 (0.02)
Covariance		
Level 1	Residual	0.11 (0.02)***
Level 2	Intercept	0.16 (0.06)**
Fit statistics		
-2LL		121.47
AIC		139.47
BIC		164.17

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

3b. My second analysis examined the interaction between TASc Balance scores and PACS Resistance scores. There was a significant effect for time ($B = 0.06.$, $SE = 0.02$, $p = 0.003$), as previously found in research question 2. There was a significant effect for PACS

Resistance on initial status (B = -0.15., SE = 0.07, p = 0.032) indicating there was statistically significant variability in client WAI-SR scores based on PACS Resistance scores. However, the interaction between TASc Balance scores and PACS Resistance scores over time was not significant (see Table 8). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 8

Multilevel Model Tests for Interactions of TASc Balance and PACS Resistance on Working Alliance (WAI-SR)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	3.81 (0.14)***
Rate of change	Time	0.06 (0.02)***
	Balance-Therapist	-0.06 (0.14)
	Resistance-Client	-0.15 (0.07)*
	Time*Balance-Therapist	0.01 (0.02)
	Time*Resistance-Client	0.02 (0.01)
	Time*Balance-Therapist*Resistance-Client	-0.002 (0.01)
Covariance		
Level 1	Residual	0.11 (0.02)***
Level 2	Intercept	0.26 (0.09)***
Fit statistics		
-2LL		129.32
AIC		147.32
BIC		172.03

Note. Table displays estimates with standard errors in parentheses. *** p < .001; ** p < .01; * p < .05; + p < .10

    3c. My third analysis examined the interaction between TASc Coercive scores and PACS Balance scores. There was a significant effect for time (B = 0.09., SE = 0.02, p = 0.000), as previously found in research question 2. There was again a significant effect for PACS Balance on initial status (B = 0.28., SE = 0.10, p = 0.006) indicating there was statistically significant variability in client WAI-SR scores based on PACS Balance scores. However, the interaction between TASc Coercive scores and PACS Balance scores over time was not significant (see

Table 9). The between-individual variability is statistically significant, indicating there remains a

large degree of unexplained variance in the scores.

Table 9

Multilevel Model Tests for Interactions of TASc Coercive and PACS Balance on Working Alliance (WAI-SR)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	$3.78 (0.12)^{***}$
Rate of change	Time	$0.09 (0.02)^{***}$
	Coercive-Therapist	$0.06 (0.07)$
	Balance-Client	$0.28 (0.10)^{***}$
	Time*Coercive-Therapist	$-0.01 (0.01)$
	Time*Balance-Client	$-0.01 (0.02)$
	Time*Coercive-Therapist*Balance-Client	$0.01 (0.01)$
Covariance		
Level 1	Residual	$0.11 (0.02)^{***}$
Level 2	Intercept	$0.18 (0.06)^{***}$
Fit statistics		
-2LL		122.60
AIC		140.60
BIC		165.30

Note. Table displays estimates with standard errors in parentheses. $^{***} p < .001; ^{**} p < .01; ^{*} p < .05; + p < .10$

3d. My fourth analysis examined the interaction between TASc Coercive scores and

PACS Resistance scores. There was a significant effect for time ($B = 0.07.$, $SE = 0.02$, $p =$

0.001), as previously found in research question 2. There was again a significant effect for PACS

Resistance on initial status ($B = -0.14.$, $SE = 0.07$, $p = 0.04$) indicating there was statistically

significant variability in client WAI-SR scores based on PACS Resistance scores. However, the

interaction between TASc Coercive scores and PACS Resistance scores over time was not

significant (see Table 10). The between-individual variability is statistically significant,

indicating there remains a large degree of unexplained variance in the scores.

Table 10

Multilevel Model Tests for Interactions of TASc Coercive and PACS Resistance on Working Alliance (WAI-SR)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	3.80 (0.14)***
Rate of change	Time	0.07 (0.02)***
	Coercive-Therapist	0.01 (0.07)
	Resistance-Client	-0.14 (0.07)*
	Time*Coercive-Therapist	-0.01 (0.01)
	Time*Resistance-Client	0.01 (0.01)
	Time*Coercive-Therapist*Resistance-Client	0.002 (0.01)
Covariance		
Level 1	Residual	0.11 (0.02)***
Level 2	Intercept	0.26 (0.09)***
Fit statistics		
-2LL		128.57
AIC		146.57
BIC		171.28

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

3e. My fifth analysis examined the interaction between TASc Detaching scores and PACS Resistance scores. There was a significant effect for time ($B = 0.08.$, $SE = 0.02$, $p = 0.001$), as previously found in research question 2. There was again a significant effect for PACS Resistance on initial status ($B = -0.14.$, $SE = 0.07$, $p = 0.05$) indicating there was statistically significant variability in client WAI-SR scores based on PACS Resistance scores. However, the interaction between TASc Detaching scores and PACS Resistance scores over time was not significant (see Table 11). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 11

Multilevel Model Tests for Interactions of TASc Detaching and PACS Resistance on Working Alliance (WAI-SR)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	$3.75 (0.14)^{***}$
Rate of change	Time	$0.08 (0.02)^{***}$
	Detaching-Therapist	-0.09 (0.19)
	Resistance-Client	$-0.14 (0.07)^{*}$
	Time*Detaching-Therapist	0.02 (0.03)
	Time*Resistance-Client	0.01 (0.01)
	Time*Detaching-Therapist*Resistance-Client	-0.003 (0.01)
Covariance		
Level 1	Residual	$0.11 (0.02)^{***}$
Level 2	Intercept	$0.28 (0.10)^{**}$
Fit statistics		
-2LL		127.18
AIC		145.18
BIC		169.73

Note. Table displays estimates with standard errors in parentheses. $^{***} p < .001;$ $^{**} p < .01;$ $^{*} p < .05;$ $+ p < .10$

3f. My final analysis examined the interaction between TASc Detaching scores and PACS Balance scores. There was a significant effect for time ($B = 0.09.$, $SE = 0.02$, $p = 0.001$), as previously found in research question 2. There was again a significant effect for PACS Balance on initial status ($B = 0.26.$, $SE = 0.09$, $p = 0.006$) indicating there was statistically significant variability in client WAI-SR scores based on PACS Balance scores. However, the interaction between TASc Detaching scores and PACS Balance scores over time was not significant (see Table 12). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 12

Multilevel Model Tests for Interactions of TASc Detaching and PACS Balance on Working Alliance (WAI-SR)

	Conditional Growth Model
Fixed Effects	
Initial status Intercept	3.75 (0.13)***
Rate of change Time	0.09 (0.02)***
Detaching-Therapist	-0.01 (0.16)
Balance-Client	0.26 (0.09)**
Time*Detaching-Therapist	0.02 (0.03)
Time*Balance-Client	-0.08 (0.01)
Time*Detaching-Therapist*Balance-Client	-0.01 (0.02)
Covariance	
Level 1 Residual	0.11 (0.02)***
Level 2 Intercept	0.20 (0.07)**
Fit statistics	
-2LL	122.21
AIC	140.21
BIC	164.76

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

Research question 4. What effect will the interaction between therapist attachment orientation and client attachment orientation have on client symptom change in therapy? In particular, (a) What effect does the relationship between therapist Balance scores and client Balance scores have on client symptom change in therapy? (b) What effect does the relationship between therapist Balance scores and client Resistance scores have on client symptom change in therapy? (c) What effect does the relationship between therapist Coercive scores and client Balance scores have on client symptom change in therapy? (d) What effect does the relationship between therapist Coercive scores and client Resistance scores have on client symptom change in therapy? (e) What effect does the relationship between therapist Detaching scores and client Balance scores have on client symptom change in therapy? and (f) What effect does the relationship between therapist Detaching scores and client Resistance scores have on client

symptom change in therapy?

The associated null hypotheses are (a) There is no relationship between therapist Balance scores and client Balance scores on client symptom change in therapy, (b) There is no relationship between therapist Balance scores and client Resistance scores on client symptom change in therapy, (c) There is no relationship between therapist Coercive scores and client Balance scores on client symptom change in therapy, (d) There is no relationship between therapist Coercive scores and client Resistance scores on client symptom change in therapy, (e) There is no relationship between therapist Detaching scores and client Balance scores on client symptom change in therapy, and (f) There is no relationship between therapist Detaching scores and client Resistance scores on client symptom change in therapy.

Interactions effects and change in OQ: Conditional growth model (CGM). To examine this research question, I built on the previous conditional growth model (CGM) for the OQ scores and TASc predictors. I added in the mean centered PACS Balance and PACS Resistance scale scores as level two predictors.

4a. My first analysis examined the interaction between TASc Balance scores and PACS Balance scores. There was a significant effect for time ($B = -1.01.$, $SE = 0.32$, $p = 0.002$), as previously found in research question 1. There were no significant effects on initial status or over linear time for any of the TASc or PACS variables (see Table 13). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 13

Multilevel Model Tests for Interactions of TASc Balance and PACS Balance on Change in Client Psychological Distress (Outcome Questionnaire)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	68.55 (4.36)***
Rate of change	Time	-1.01 (0.32)**
	Balance-Therapist	0.08 (4.82)
	Balance-Client	-2.37 (3.43)
	Time*Balance-Therapist	0.20 (0.33)
	Time*Balance-Client	0.01 (0.24)
	Time*Balance-Therapist*Balance-Client	-0.05 (0.25)
Covariance		
Level 1	Residual	61.01 (7.02)***
Level 2	Intercept	413.65 (124.76)**
Fit statistics		
-2LL		1298.31
AIC		1316.31
BIC		1344.74

Note. Table displays estimates with standard errors in parentheses. $^{***}p < .001;^{**}p < .01;^{*}p < .05;+p < .10$

4b. My second analysis examined the interaction between TASc Coercive scores and PACS Balance scores. There was a significant effect for time ($B = -1.05., SE = 0.29, p = 0.000$), as previously found in research question 1. There were no significant effects on initial status or over linear time for any of the TASc or PACS variables (see Table 14). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 14

Multilevel Model Tests for Interactions of TASc Coercive and PACS Balance on Change in Client Psychological Distress (Outcome Questionnaire)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	68.51 (4.35)***
Rate of change	Time	-1.05 (0.29)***
	Coercive-Therapist	0.01 (2.54)
	Balance-Client	-2.23 (3.27)
	Time*Coercive-Therapist	-0.19 (0.17)
	Time*Balance-Client	-0.06 (0.22)
	Time*Coercive-Therapist*Balance-Client	-0.03 (0.11)
Covariance		
Level 1	Residual	60.69 (6.98)***
Level 2	Intercept	411.70 (124.16)***
Fit statistics		
-2LL		1297.41
AIC		1315.41
BIC		1343.85

Note. Table displays estimates with standard errors in parentheses. *** $p < .001;$ ** $p < .01;$ * $p < .05;$ + $p < .10$

    4c. My third analysis examined the interaction between TASc Coercive scores and PACS Resistance scores. There was a significant effect for time ($B = -0.90.$, $SE = 0.25$, $p = 0.000$), as previously found in research question 1. There were no significant effects on initial status or over linear time for any of the TASc or PACS variables (see Table 15). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 15

Multilevel Model Tests for Interactions of TASc Coercive and PACS Resistance on Change in Client Psychological Distress (Outcome Questionnaire)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	68.37 (4.42)***
Rate of change	Time	-0.90 (0.25)***
	Coercive-Therapist	0.60 (2.37)
	Resistance-Client	0.003 (2.13)
	Time*Coercive-Therapist	-0.03 (0.15)
	Time*Resistance-Client	-0.08 (0.12)
	Time*Coercive-Therapist*Resistance-Client	-0.12 (0.07)
Covariance		
Level 1	Residual	59.64 (6.86)***
Level 2	Intercept	426.02 (128.35)***
Fit statistics		
-2LL		1295.53
AIC		1313.53
BIC		1341.97

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

4d. My fourth analysis examined the interaction between TASc Detaching scores and PACS Balance scores. There was a significant effect for time ($B = -0.81.$, $SE = 0.25$, $p = 0.001$), as previously found in research question 1. There was again a significant effect for therapist Detaching (TASc) scores and linear time ($B = 0.75$, $SE = 0.34$, $p = 0.03$), as already previously explained in research question 1. There were no other significant effects on initial status or over linear time for any of the TASc or PACS variables (see Table 16). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 16

Multilevel Model Tests for Interactions of TASc Detaching and PACS Balance on Change in Client Psychological Distress (Outcome Questionnaire)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	67.11 (4.38)***
Rate of change	Time	-0.81 (0.25)***
	Detaching-Therapist	-4.18 (4.97)
	Balance-Client	-1.37 (3.02)
	Time*Detaching-Therapist	0.75 (0.34)*
	Time*Balance-Client	-0.005 (0.19)
	Time*Detaching-Therapist*Balance-Client	-0.05 (0.25)
Covariance		
Level 1	Residual	60.34 (7.04)***
Level 2	Intercept	398.32 (122.79)***
Fit statistics		
-2LL		1257.57
AIC		1275.57
BIC		1303.73

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

4e. My final analysis examined the interaction between TASc Detaching scores and PACS Resistance scores. There was a significant effect for time ($B = -0.81.$, $SE = 0.25$, $p = 0.001$), as previously found in research question 1. There was again a significant effect for therapist Detaching (TASc) scores and linear time ($B = 0.73$, $SE = 0.34$, $p = 0.03$), as already previously explained in research question 1. There were no other significant effects on initial status or over linear time for any of the TASc or PACS variables (see Table 17). The between-individual variability is statistically significant, indicating there remains a large degree of unexplained variance in the scores.

Table 17

Multilevel Model Tests for Interactions of TASc Detaching and PACS Resistance on Change in Client Psychological Distress (Outcome Questionnaire)

		Conditional Growth Model
Fixed Effects		
Initial status	Intercept	66.86 (4.38)***
Rate of change	Time	-0.79 (0.27)**
	Detaching-Therapist	-4.79 (4.96)
	Resistance-Client	-1.00 (2.14)
	Time*Detaching-Therapist	0.73 (0.34)*
	Time*Resistance-Client	-0.02 (0.12)
	Time*Detaching-Therapist*Resistance-Client	0.03 (0.17)
Covariance		
Level 1	Residual	60.37 (7.05)***
Level 2	Intercept	395.60 (122.73)***
Fit statistics		
-2LL		1257.51
AIC		1275.51
BIC		1303.67

Note. Table displays estimates with standard errors in parentheses. *** $p < .001$; ** $p < .01$; * $p < .05$; + $p < .10$

Summary of Findings

Overall, there were several statistically significant results. The results related to client symptom change indicated that OQ scores did significantly decrease across sessions. There were no differences in symptom change for new clients when compared to clients who participated in ongoing counseling at the training clinic. With respect to therapist attachment effects, only therapist Detaching scores were statistically significant regarding change in OQ scores. Therapists with high Detaching scale scores were associated with clients who increased in symptom distress throughout therapy. Therapists with low Detaching scale scores were associated with clients who decreased in symptom distress over time. When interactions between therapist attachment variables and client attachment variables were examined, there were no

significant interactions.

Regarding the working alliance, results indicated a statistically significant overall increase in client WAI-SR ratings over time. Ongoing counseling did not make a statistically significant difference in client ratings of the working alliance over time. When therapist attachment variables were added to the models, there were no significant effects on how clients perceive the working alliance. Client attachment variables did have significant effects on initial status only, indicating that PACS Balance and PACS Resistance scores did significantly affect variability in WAI-SR ratings overall, but did not significantly affect the time trajectory of WAI-SR ratings. When interactions between therapist attachment variables and client attachment variables were examined, there were no statistically significant effects on client ratings of the working alliance.

CHAPTER IV

DISCUSSION

This chapter will discuss the implications of the results presented in Chapter 3. First, I will review the main findings associated with each research question and reference possible explanations of the findings and how they relate to the current literature. Next, I will discuss the theoretical and research implications of the study. Finally, I will address limitations of the study. Throughout the chapter, I discuss suggestions for future research.

Research Findings

The primary purpose of this study was to examine the influence of therapist attachment security and insecurity levels on the process and outcome of psychotherapy. Attachment theory provides a relevant framework for understanding the contributions of client and therapist on therapy process and outcome. There is a growing body of literature that supports the significant influence of client attachment on the working alliance and symptom change in psychotherapy. In their meta-analysis, Diener and Monroe (2011) reported that more securely attached clients had stronger working alliances, whereas more insecurely attached clients had weaker alliances. Findings regarding the various insecure styles (i.e., avoidant, anxious, fearful) have been diverse. Regarding client outcomes, clients high in attachment anxiety or attachment avoidance have been shown to have the least improvement in symptoms, whereas clients high in attachment security have demonstrated the best outcomes (Levy et al., 2018).

The literature is less conclusive about the role of therapist attachment. There is initial support that suggests therapists' secure attachment predicts stronger alliances and better treatment outcomes (Dunkle & Friedlander, 1996; Schauenburg et al., 2010). However, studies on the interaction of client and therapist attachment styles have mixed findings. Several

researchers found support for dissimilar attachment styles having effective outcomes (Bruck et al., 2006; Bucci et al., 2016; Petrowski et al., 2011; Tyrell et al., 1999). The authors of one study found support for similar attachment styles having the best outcomes (Wiseman & Tishby, 2014). Thus, my primary goal in this study was to add to the recent psychotherapy literature to explore if and how therapist attachment security influenced client-therapist working alliances and client symptom change throughout the course of psychotherapy. I also wanted to explore how therapist attachment and client attachment might interact and influence client symptom change and clients' perception of the working alliance.

Therapist Attachment and Client Symptom Change

My first hypothesis was that there is a significant relationship between therapist attachment security and client symptom change on the OQ. This hypothesis was partially supported as I found a statistically significant difference between therapist Detaching scores and client change in OQ scores. Clients that were seen by therapists that scored low on the Detaching scale showed improvement in symptoms over time. Similarly, clients seen by therapists that scored high on the Detaching scale seemed to slightly worsen throughout therapy. The results suggest that although therapist Balance scores (a measure of security) did not influence client symptom change, therapists that were rated as low Detaching (avoidant attachment) had more success in seeing clients improve as sessions went on. Interestingly, although therapist avoidance was significant, therapist anxious attachment, as measured by the TASc Coercing scale, was not significantly associated with change in OQ in any direction.

The results share some similar and dissimilar results to the only other study in which direct relationships between therapist attachment and client symptom change was found (Bruck et al., 2006). First, the researchers found that therapists high in attachment avoidance were also

associated with worsening client symptoms over time. In contrast, Bruck et al. found that therapists higher in attachment security were moderately correlated with improvement in symptom distress following therapy. They also reported that higher therapist attachment anxiety was related to less client symptom change. However, it may be difficult to compare results from this study to the current one, as Bruck et al. used a categorical measure of attachment and only measured symptom distress at intake and at termination of therapy. Thus, their analyses did not use growth curve modeling to explore change, which helps in more fully describing changes occurring between and within subjects. It may also be difficult to compare therapist attachment in these studies, because self-report measures and in-session observational methods vary in how they assess the attachment construct.

In the current study, I also assessed client symptom change over time before adding therapist attachment variables to the model. The results suggest that when assessing from the intake session through every session attended, clients improved overall. This result is similar to other findings from training clinics using therapist-trainees and outpatient community client samples (Richardson et al., 2017; Sauer et al., 2020). It is important to note that at the training clinic used in the current study, intakes are completed by doctoral assistants and the client does not meet their primary therapist until the first session. Therefore, statistically significant change in OQ scores may have also been influenced by the intake therapist.

Although linear time in the growth curve model accounts for a significant proportion of variability, it should be noted that there remained significant residual variability in inter-individual scores at initial status and over time, which indicates there may be other factors not assessed in this study that contribute to client symptom change throughout therapy.

Therapist Attachment and the Working Alliance

My second hypothesis was that there is a significant relationship between therapist attachment security and client ratings of the working alliance on the WAI-SR. The hypothesis was not supported by the results. Neither therapist Balance scores, Detaching scores, nor Coercing scores were significantly associated with change in client-rated working alliance. The results are similar to multiple other studies reporting no direct relationship between therapist attachment and the quality of the working alliance (Bucci et al., 2016; Ligiero & Gelso, 2002; Petrowski et al., 2011). However, the results stand in contrast to several studies that found support for a relationship between therapist attachment and the working alliance. Specifically, Sauer et al. (2003) found that therapists' self-reported attachment anxiety was associated with a worsening working alliance as therapy progressed. Similarly, Dinger et al. (2009) found that higher therapist attachment anxiety was associated with a poor overall working alliance, as well as a decrease in alliance quality over time.

Other researchers found connections between secure therapist attachment and the working alliance. Dunkle and Friedlander (1996) found positive associations between therapist secure attachment and client-rated working alliance. Schauenburg et al. (2010) also found a significant relationship between higher therapist attachment security and higher quality client-rated working alliances. However, the researchers found this relationship was only true for clients that started therapy with high levels of interpersonal problems and high overall psychological distress. In both studies by Dinger et al. (2009) and Schauenburg et al. (2010), the AAI was used to measure attachment, which has high agreement and predictive validity with the TASc. Thus, it is not likely a measurement difference that contributed to mixed findings but may rather be related to sample differences between these studies and the current one. For example,

the samples used by Dinger et al. and Schauenburg et al. were inpatient clients diagnosed with severe psychiatric disorders, while the current sample consisted of outpatient clients. Perhaps, client symptom severity may influence a change in the working alliance over time.

Although therapist effects were not statistically significant predictors of working alliance, I found that client ratings of the working alliance did increase over time when examined independent of client and therapist attachment effects. As well, there was significant unexplained between-individual variability left in the models. A result such as this indicates there were likely other factors than therapist or client attachment that contributed to client perceptions of the working alliance.

Interaction of Therapist Attachment and Client Attachment

Interaction and the Working Alliance

My third hypothesis was that therapist attachment security will influence the relationship between client attachment security and client ratings of the working alliance on the WAI-SR. Given prior contradictory findings, I did not specify a certain configuration of therapist-client attachment that would be most beneficial to the working alliance. This hypothesis was not supported by the results. I examined each configuration of therapist-client attachment specifically and no combination proved to be statistically significant. The results are similar to two other studies that did not find interaction effects on the client-rated working alliance (Romano et al., 2008; Sauer et al., 2003).

The results differ from several other studies with statistically significant interaction effects on the working alliance. Bucci et al. (2016) found that dissimilar attachment orientations of client and therapist resulted in stronger therapeutic alliances. However, a single-item attachment measure was used, which does not allow for the full range of attachment patterns to

be examined. Similarly, Petrowski et al. (2011) found that therapists with high attachment avoidance and clients with high attachment anxiety had the best client-rated working alliance. It may be difficult to compare results from this study with the current study, as the researchers only measured alliance at the end of treatment instead of session-by-session.

Bruck et al. (2006) also found support for dissimilar therapist and client attachment orientations interacting for better working alliances. The researchers measured the alliance weekly over nine sessions and was like the current study in that way. However, a categorical attachment measure was used which assesses the attachment construct in a different way than the transcript based TASc. Similar results were also reported by Tyrell et al. (1999) in a study with case managers and their clients. The researchers found that dissimilar attachment dimensions led to stronger client-rated working alliances. The AAI was used to assess attachment in this study, however; the results may not apply to psychotherapy relationships as the focus of case management relationships may differ from relationships in psychotherapy.

Interaction and Client Symptom Change

Finally, I hypothesized that therapist attachment security would influence the relationship between client attachment security and symptom change on the OQ. Again, given prior contradictory findings, I did not hypothesize a specific configuration of therapist-client attachment that would be most beneficial to therapy outcome. This hypothesis was not supported by the results. I examined each configuration of therapist-client attachment specifically and no combination proved to be statistically significant. Only three studies examined interaction effects and client symptom change. Wiseman and Tishby (2014) found significant decrease in symptom severity for low-avoidant clients treated by low-avoidant therapists. Bruck et al. (2006) also reported significant interactions on outcome. The researchers found that greater differences in

the avoidant attachment dimension for therapist and client were related to improvements in therapist-rated and client-rated psychological distress. However, outcome was only measured pre-treatment and at the end of treatment, not allowing for more powerful growth modeling analyses to be used to examine change over time. Similarly, Tyrell et al. (1999) found that dissimilar attachment dimensions led to more positive therapeutic outcomes. Again, this study utilized case managers and their clients, and the results may not generalize to psychotherapy relationships.

Implications

The results of this study have implications for future research on psychotherapy process and outcome, as well as therapist training and supervision. The primary significant finding from the current study was that therapist attachment avoidance influenced client symptom change. Therapists that were low in avoidance saw a significant reduction in symptoms for their clients. Therapists high in avoidance had clients that worsened over therapy. Perhaps therapists that are low in attachment avoidance can attune and respond to their clients in a way that facilitates symptom reduction. It appears that the in-session attunement style of therapists high in attachment avoidance was not facilitative for symptom change. To be rated highly on the Detaching scale of the TASc, therapist participants had utterances that minimized their contribution to the internal experience of their clients. Perhaps this communication style characterized by minimization, externalizing, and providing superficial reassurance contributed to clients feeling worse or intensifying their distress.

Interestingly, therapist attachment avoidance did not influence the working alliance. There was a significant relationship with symptom change but not with how the client perceived the relationship with the therapist. This is important to note considering a meta-analysis by Degnan et

al. (2016) concluded there was preliminary evidence that therapist attachment impacts the therapeutic alliance, and that therapist attachment anxiety may be more important as a predictor than avoidance. The conflicting results may be due to the small sample size of the current study, or other limitations discussed in the following section.

The findings of the current study have implications for therapists, as well as supervisors and training programs. Given the association between therapist attachment avoidance and therapy outcome, therapists should be sensitive to their own attachment experiences and how their attachment characteristics might show up as they respond to clients and deliver interventions in therapy. Therapists can become more aware of their attachment style through training classes and supervision to better understand attachment-related behaviors and communication in therapy, guide interventions, pace sessions, and manage ruptures in the therapeutic relationship (Wallin, 2009).

The TASc and PACS instruments also have implications for therapists-in-training. Talia et al. (2019) suggests various ways in which the TASc can be used as a training tool, including focusing on empathic interventions through deliberate practice with trainees. Awareness-focused role-plays and exercises can help trainees become more aware of their own attachment-related communication styles, as well as those of their clients. Learning to be mindful of one's own communication style allows for choosing remarks more carefully and tailoring responses in a way that is informed by research on in-session attachment-related processes. Talia et al. states that trainees can learn to "listen to how they listen," which will enhance awareness and acceptance of their own characteristics, as well as develop a greater understanding for how the client also impacts them.

The results of the current study point to the need for further research on the relationship of therapist attachment with the process and outcome of therapy. Results continue to be varied and, at times, contradictory, and methodologically robust studies are needed to reconcile these differences. Other attachment studies assessing symptom change and the working alliance session-by-session with a larger sample than the current study, would allow for statistically powerful growth curve modeling to assess linear changes over time and capture the nuances of this change throughout psychotherapy. Further psychotherapy research is also needed utilizing the TASc and PACS, which Slade (2016) states takes our understanding of attachment in therapy to the 'level of relation.' These instruments have the potential to deepen our understanding of attachment-related processes of therapy, as well as contribute meaningfully to the training of future psychotherapists.

Finally, the results of this study also point to the need for examining other potential predictors of therapy process and outcome. Unexplained inter-individual residual variation was consistently statistically significant across the models analyzed in this study, which indicate other therapist related variables may have explained some of the changes demonstrated in OQ and WAI-SR scores. A systematic literature review of therapist variables that influenced psychodynamic psychotherapy by Lingiardi et al. (2018) reported that therapists' characteristic interpersonal patterns had the strongest evidence of direct effects on therapy outcome. For instance, Reading (2013) found that therapist reflective functioning abilities contribute to depth of sessions and was moderately related to therapy outcome. Moreover, therapist mindfulness and self-awareness were also linked to more positive client ratings of the therapeutic relationship (Ryan et al., 2012; Williams & Fauth, 2005). Examining these factors and other interpersonal variables may be informative in understanding how therapists may influence client symptom change and perceptions of the working alliance.

Limitations

There are several limitations to the current study. First, as mentioned previously, the sample size was relatively small. Due to the small size, I was not able to examine multiple clients per therapist and explore how attachment may have varied with differing configurations per therapist. Further research could examine whether therapist attachment variables change depending on the attachment of the client. Daly and Mallinckrodt (2009) posit that therapists can adapt to their clients' attachment styles and monitor the degree of therapeutic distance they use in-session to best 'fit' their client. However, it is unlikely that therapists in training would be experienced enough to be mindful of this strategy in sessions, as they are more apt to pay attention to their own internal experience rather than the experience of the client. Thus, future research should be conducted on a larger sample and could potentially include exploration of dynamic therapeutic adjustments based on client attachment.

Therapy length was also a limitation to consider. Not all clients completed the 11 sessions, which also limited examination of change trajectories over time. In fact, the average number of sessions attended was approximately six. Thus, implications from this study may not be applicable to longer-term therapies. Replications of this study with longer-term treatment would be helpful, as it may be possible that therapist attachment takes a longer time to influence outcome and alliance than briefer models allow space for.

Another limitation to the study was the use of therapists-in-training as participants. Most of the therapists-in-training in the study were providing therapy to clients for the first time during the practicums in which I collected data. It seems reasonable that trainees would feel nervous or experience performance anxiety, which may contribute to less attunement with their clients in sessions. It is common for novice therapists to worry about where to take the session, how to

phrase what they want to say next, be preparing advice, or worrying about their supervisor's evaluation of them (Teyber, 2000). Such worries may make it harder to empathically enter the client's subjective worldview and be emotionally present and attuned. This is one potential explanation for the therapist-in-training participants in the current study being less securely attached and higher in attachment anxiety than the more experienced therapists used in the published TASc study (Talia et al., 2018). Replicating the current study with a more experienced therapist sample may produce differing results.

Finally, the sample demographics may also limit generalizability of the findings, as therapist trainees and clients predominately identified as White and female. The study was also conducted in a training clinic in the Midwest which may limit generalizability to other therapy settings (i.e., inpatient program, university counseling centers, private practice) and geographic regions of the United States. Due to the COVID-19 pandemic limiting the length of data collection for my study, I was unable to complete additional purposive sampling. It would have been helpful to track demographics of the participating therapists-in-training to recruit a more diverse sample, particularly in terms of racial identity and gender identity. Future research efforts could include therapy settings with more diverse populations of therapists and clients.

Conclusion

Overall, I found that while, in general, clients improved over time and reported a higher working alliance as therapy progressed, therapist attachment did not influence these relationships as expected. Therapist attachment avoidance significantly influenced change in client symptoms over time, but other dimensions of therapist attachment did not have effects. The findings of the current study suggest that perhaps the relationship between therapist attachment, working alliance, and outcome of therapy is not as straightforward or as simple as we may like to believe.

More research is, therefore, necessary to further our understanding of how therapist attachment

impacts psychotherapy.

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Appendix A

Therapist Demographic Form

Participant
Demographic
Questionnaire

Name: _____

Gender: _____   Age: _____

Your Racial/Ethnic Group:

☐ Caucasian   Hispanic/Latino(a)
☐ Asian/Pacific Islander   Multiracial
☐ African American   Other (please specify): _____
☐ American Indian/Alaska Native

Your Current Relationship Status:

☐ Single, never married   Widowed
☐ Remarried   Divorced
☐ Separated   Partnered
☐ Married   Other (please specify): _____

Year in Program: Program Type:

☐ 1st   ☐ Clinical Mental Health Counseling
☐ 2nd   ☐ Counseling Psychology M.A.
☐ 3rd   ☐ Counseling Psychology Ph.D.
☐ 4th   ☐ Marriage, Couple & Family Counseling
☐ 5th or higher   ☐ School Counseling
                                                ☐ Rehabilitation Counseling
                                                ☐ College Counseling

Previous Personal Counseling:

☐ Yes   Theoretical Orientation:
☐ No
                                                ☐ Humanistic
                                                ☐ Person-Centered
Prior Counseling Work Experience?   ☐ Cognitive-Behavioral
☐ Yes, # of months _____   ☐ Psychodynamic
☐ No   ☐ Integrative

Hours of Supervision Received:

_____

Appendix B

Therapist Consent Form

Western Michigan University
Department of Counselor Education and Counseling Psychology

Principle Investigator: Eric Sauer, Ph.D.
Co-Investigators: Kenneth Rice, Ph.D., Alessandro Talia, Ph.D., Kristin Roberts, M.A., Char Houben, M.A., Jon Hook, B.S.
Title: Therapist Attunement and Their Effects on Psychotherapy Process and Outcome

STUDY SUMMARY: This consent form is part of an informed consent process for a research study and it will provide information that will help you decide whether you want to take part in this study. Participation in this study is completely voluntary. The purpose of the research is to learn more about how therapist attunement is associated with the therapeutic relationship and treatment outcome. If you take part in the research, you will be asked to allow the researchers to access one of your therapy sessions per each client you see. Your time in the study will not take any additional time beyond your regular clinical responsibilities. Possible risk and costs to you for taking part in the study are expected to be minimal to none, and potential benefits of taking part may be advancing the scientific knowledge base. Your alternative to taking part in the research study is not to take part in it.

You are invited to participate in this research project titled "Therapist Attunement and Their Effects on Psychotherapy Process and Outcome" and the following information in this consent form will provide more detail about the research study. Please ask any questions if you need more clarification and to assist you in deciding if you wish to participate in the research study. You are not giving up any of your legal rights by agreeing to take part in this research or by signing this consent form. After all of your questions have been answered and the consent document reviewed, if you decide to participate in this study, you will be asked to sign this consent form.

What are we trying to find out in this study?
Thank you for your interest in this study of how therapist attunement impacts the therapy relationship and treatment outcome. We will use recently validated, transcript-based scales to examine how therapist attunement is associated with the working alliance and client outcome. *Please read this all the way through before agreeing to participate.* You are being invited to participate in this study because you are a therapist trainee at the Center for Counseling and Psychological Services. Participation will not require any time commitment from you.

Who can participate in this study?
Students completing clinical training at the CCPS-GR are eligible to participate in this study.

Where will this study take place?
The study will take place in the Center for Counseling and Psychological Services Grand Rapids.

What is the time commitment for participating in this study?
Participation will not require any time commitment from you.

What will you be asked to do if you choose to participate in this study?
If you decide to participate, you will be granting the study investigators permission to access one of your therapy session recordings for each client you see in order to transcribe and code the session. You will also be asked to fill out a demographic form.

What information is being measured during the study?
Therapist attunement, the working alliance, and client distress levels will be measured.

What are the risks of participating in this study and how will these risks be minimized?
There are no known risks beyond what you standardly encounter as a counselor-in-training. Your transcript will not be shared with anyone beyond the principal investigator and co-investigators of this study. Your transcript will be de-identified and assigned an ID number so that it cannot be linked to you in any way.

What are the benefits of participating in this study?
You may or may not benefit from participation in this study. The primary benefit of your participation is to help us add to the counseling literature and may serve to benefit future clients, students, and counselors by advancing clinical training, research, and practice. If you would like to learn about the results of this study once it is completed, please email Dr. Eric Sauer at eric.sauer@wmich.edu.

Are there any costs associated with participating in this study?
There are no costs associated with participation in this study.

Is there any compensation for participating in this study?
You may choose to receive a $5 Amazon gift card or a 1-hour parking validation card for your participation in this study. You will be contacted by the primary investigator via email to indicate your compensation preference.

Who will have access to the information collected during this study?
Your transcript is completely confidential. Your transcript will not be shared with anyone else in the clinic under any circumstances. At no time will any identifying information that may point to you be released in association with this study. An ID number will be assigned to your transcript and will not be associated with your name in any way. Any personal information or personal health information will not be included in the transcript. Findings will be summarized and reported in group form. Your privacy will be protected to the maximum extent allowable by law. All data associated with this project will be accessible only to the principal investigator and co-investigators and will be password protected in an electronic format. After information that could identify you has been removed, de-identified information collected for this research may be used by or distributed to investigators for other research without obtaining additional informed consent from you.

What will happen to my information or biospecimens collected for this research after the study is over?
After information that could identify you has been removed, de-identified information collected for this research may be used by or distributed to investigators for other research without obtaining additional informed consent from you. Recordings are erased after completion of research purposes.

What if you want to stop participating in this study?
Your participation in this research project is completely voluntary. Should you choose not to participate, it will not impact your training experience in any way. Your participation in this project is separate from your clinic duties and no information will be shared with your supervisor. You have the right to drop out at any time without penalty.

Should you have any questions prior to or during the study, you can contact the primary investigator, Dr. Eric Sauer, at (616) 771-4171or eric.sauer@wmich.edu. You may also contact the Chair, Institutional Review Board at 269-387-8293 or the Vice President for Research at 269-387-8298 if questions arise during the course of the study.

This consent document has been approved for use for one year by the Western Michigan University Institutional Review Board (WMU IRB) as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is older than one year.

I have read this informed consent document. The risks and benefits have been explained to me. I agree to take part in this study.

_____

Please Print Your Name

_____   _____

Participant's signature   Date

Appendix C

Working Alliance Inventory – Short Revised

Working Alliance Inventory – Short Revised (Hatcher & Gillaspy, 2005)

For Adult Clients Only: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of _____ in the text. Think about your experience in therapy, and decide which category best describes your own experience. IMPORTANT!! Please take your time to consider each question carefully.

SELDOM 1	*SOMETIMES* 2	*FAIRLY OFTEN* 3	*VERY OFTEN* 4	*ALWAYS* 5

_____ 1. As a result of these sessions I am clearer as to how I might be able to change.

_____ 2. What I am doing I therapy gives me new ways of looking at my problem.

_____ 3. I believe _____ likes me.

_____ 4. _____ and I collaborate on setting goals for my therapy.

_____ 5. _____ and I respect each other.

_____ 6. _____ and I are working towards mutually agreed upon goals.

_____ 7. I feel that _____ appreciates me.

_____ 8. _____ and I agree on what is important for me to work on.

_____ 9. I feel _____ cares about me even when I do things that he/she does not approve of.

_____ 10. I feel that the things I do in therapy will help me to accomplish the changes I want to make.

_____ 11. _____ and I have established a good understanding of the kind of changes that would be good for me.

_____ 12. I believe the way we are working with my problem is correct.

Appendix D

Outcome Questionnaire – 45.2

Outcome Questionnaire – 45.2 (Lambert & Burlingame, 1996)

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.					
1. I get along well with others	Never	Rarely	Sometimes	Frequently	Almost Always
2. I tire quickly	Never	Rarely	Sometimes	Frequently	Almost Always
3. I feel no interest in things	Never	Rarely	Sometimes	Frequently	Almost Always
4. I feel stressed at work/school	Never	Rarely	Sometimes	Frequently	Almost Always
5. I blame myself for things	Never	Rarely	Sometimes	Frequently	Almost Always
6. I feel irritated	Never	Rarely	Sometimes	Frequently	Almost Always
7. I feel unhappy in my marriage/significant relationship	Never	Rarely	Sometimes	Frequently	Almost Always
8. I have thoughts of ending my life	Never	Rarely	Sometimes	Frequently	Almost Always
9. I feel weak	Never	Rarely	Sometimes	Frequently	Almost Always
10. I feel fearful	Never	Rarely	Sometimes	Frequently	Almost Always
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, mark "never")	Never	Rarely	Sometimes	Frequently	Almost Always
12. I find my work/school satisfying	Never	Rarely	Sometimes	Frequently	Almost Always
13. I am a happy person	Never	Rarely	Sometimes	Frequently	Almost Always
14. I work/study too much	Never	Rarely	Sometimes	Frequently	Almost Always
15. I feel worthless	Never	Rarely	Sometimes	Frequently	Almost Always
16. I am concerned about family troubles	Never	Rarely	Sometimes	Frequently	Almost Always
17. I have an unfulfilling sex life	Never	Rarely	Sometimes	Frequently	Almost Always
18. I feel lonely	Never	Rarely	Sometimes	Frequently	Almost Always
19. I have frequent arguments	Never	Rarely	Sometimes	Frequently	Almost Always
20. I feel loved and wanted	Never	Rarely	Sometimes	Frequently	Almost Always
21. I enjoy my spare time	Never	Rarely	Sometimes	Frequently	Almost Always
22. I have difficulty concentrating	Never	Rarely	Sometimes	Frequently	Almost Always
23. I feel hopeless about the future	Never	Rarely	Sometimes	Frequently	Almost Always
24. I like myself	Never	Rarely	Sometimes	Frequently	Almost Always
25. Disturbing thoughts come into my mind that I cannot get rid of	Never	Rarely	Sometimes	Frequently	Almost Always
26. I feel annoyed by people who criticize my drinking (or drug use) (If not applicable, mark "never")	Never	Rarely	Sometimes	Frequently	Almost Always
27. I have an upset stomach	Never	Rarely	Sometimes	Frequently	Almost Always
28. I am not working/studying as well as I used to	Never	Rarely	Sometimes	Frequently	Almost Always
29. My heart pounds too much	Never	Rarely	Sometimes	Frequently	Almost Always
30. I have trouble getting along with friends and close acquaintances	Never	Rarely	Sometimes	Frequently	Almost Always
31. I am satisfied with my life	Never	Rarely	Sometimes	Frequently	Almost Always
32. I have trouble at work/school because of drinking or drug use (If not applicable, mark "never")	Never	Rarely	Sometimes	Frequently	Almost Always
33. I feel that something bad is going to happen	Never	Rarely	Sometimes	Frequently	Almost Always
34. I have sore muscles	Never	Rarely	Sometimes	Frequently	Almost Always
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth	Never	Rarely	Sometimes	Frequently	Almost Always
36. I feel nervous	Never	Rarely	Sometimes	Frequently	Almost Always
37. I feel my love relationships are full and complete	Never	Rarely	Sometimes	Frequently	Almost Always
38. I feel that I am not doing well at work/school	Never	Rarely	Sometimes	Frequently	Almost Always
39. I have too many disagreements at work/school	Never	Rarely	Sometimes	Frequently	Almost Always

40. I feel something is wrong with my mind	Never	Rarely	Sometimes	Frequently	Almost Always
41. I have trouble falling asleep or staying asleep	Never	Rarely	Sometimes	Frequently	Almost Always
42. I feel blue	Never	Rarely	Sometimes	Frequently	Almost Always
43. I am satisfied with my relationships with others	Never	Rarely	Sometimes	Frequently	Almost Always

Appendix E

Statement of Professional Intent

DEPARTMENT OF COUNSELOR EDUCATION AND COUNSELING PSYCHOLOGY
THE CENTER FOR COUNSELING AND PSYCHOLOGICAL SERVICES
Western Michigan University
Statement of Professional Intent
(Please read and take to your first session. Do not sign if you have questions.)
Welcome to the Center for Counseling and Psychological Services (CCPS). As a possible client, it is important that you know about the CCPS practices and procedures.

First, whatever you share with the CCPS counseling staff is considered confidential but is shared with others for research. The CCPS staff will break confidentiality only when we have a duty to warn. Duty to warn means that potential harm to self or others seems likely to occur. In such an instance, we are obliged to act. In most cases, you as a client will be the first to know. Duty-to-warn situations occur very rarely.

Most individuals experience counseling as positive and find their sessions to be helpful in resolving problems. Occasionally, however, discussions about problems may cause negative feelings. If this occurs, please tell your counselor as soon as you can. Discussion of negative feelings is important in evaluating our work with you.

The CCPS counselors are advanced master's and doctoral degree students studying to be professional counselors and psychologists. They work under the direct supervision of a faculty member who is responsible for their training. Supervising faculty are professional counselors and/or licensed psychologists. For the purpose of being supervised, the students will have to digitally record some or all of their counseling sessions. Therefore, the CCPS can accept you for its services only if you sign a release that permits the recording of your sessions.

To insure proper service, the first visit here is considered to be an intake interview. During this interview, you are expected to tell why you came to the CCPS and what you would like to gain. Based on your needs, a student counselor will be assigned to you and a second appointment made. If we cannot respond to your needs, we refer you to another community provider.

The CCPS also serves as a site for developing a better understanding of counseling through research. Research in the CCPS is designed so that information is treated confidentially. Code numbers rather than names are used confidentially, and reports offer information only in the form of group data. Your signature on the specific release indicates your willingness to allow staff members to obtain information on file, including demographic information, survey responses, and video recordings, for the purpose of research.

In order to gain a better understanding of the long-term impact of counseling, we would like to email surveys to you at various times after you have completed your services here.
Finally, to maintain a high level of service to clients, the CCPS must charge fees. The intake counselor will discuss the amount of your fee with you during the first interview. Thereafter, your counselor will collect the fee at the end of each session. You may pay with cash or a check made out to WMU.

We encourage discussion and questions about any aspect of your service at the CCPS. If you have problems with the service you receive that you do not want to discuss with your counselor, please contact the CCPS director at 616-771-4171.
I have read and understand this statement and have had the chance to discuss it before sharing personal information.

_____
Signature and Date

Appendix F

Client Informed Consent

DEPARTMENT OF COUNSELOR EDUCATION AND COUNSELING PSYCHOLOGY

THE CENTER FOR COUNSELING AND PSYCHOLOGICAL SERVICES (CCPS)

Western Michigan University

Informed Consent Form
(Recording, Observation and Training – CECP 6120, 6930, 6950 in Grand Rapids)

I hereby give my permission to have digital recordings made of our counseling sessions.

I hereby give my permission to have our counseling sessions observed by my counselor's supervisors and colleagues.

Due to the nature of this training environment, counseling sessions will be video recorded. I understand, and permit, that the recordings, observations, and/or information pertaining to my counseling sessions may be shared with my counselor's supervisors and colleagues for the purpose of counselor training. Transcripts of sessions may be created and analyzed for counseling process research. Research in the CCPS is designed so information is treated confidentially. Code numbers rather than names are used confidentially, and any identifying information in the transcript will be omitted. Recordings will be digitally stored on a secure WMU online program. Recordings are erased after they are used for supervision and/or research purposes. While we require videotaping for the purposes of supervision and training, you may opt out of having your recordings used for research and still receive clinical services. If you decide to opt out for research purposes, do not sign this form and return the unsigned form to the front desk staff. If you have concerns about the use of recordings, please contact the Clinic Director to discuss alternative options (616-771-4171).

The use of information obtained in the above activities will be consistent with ethical and professional standards of the counseling profession safeguarding the confidentiality of such information.

_____

Please Print Your Name Legibly

_____   _____

Client Signature   *Date*

_____   _____

Parent or Guardian Signature (if client is under 18)   Date

_____   _____

Counselor Signature   *Date*

_____   _____

Supervisor Signature   *Date*

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Appendix G

Human Institutional Review Board Approval Letter

WESTERN MICHIGAN UNIVERSITY

Date: September 12, 2019

To: Eric Sauer, Principal Investigator
      Kristin Roberts, Student Investigator for dissertation
      Char Houben-Hop, Student Investigator

From: Amy Naugle, Ph.D., Chair

Re: IRB Project Number 19-08-20

This letter will serve as confirmation that your research project titled "The Effects of Therapist Attachment on the Process and Outcome of Psychotherapy" has been **approved** under the **expedited** category of review by the Western Michigan University Institutional Review Board (IRB). The conditions and duration of this approval are specified in the policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes to this project (e.g., *add an investigator, increase number of subjects beyond the number stated in your application, etc.*). Failure to obtain approval for changes will result in a protocol deviation.

In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the IRB for consultation.

The Board wishes you success in the pursuit of your research goals.

A status report is required on or prior to (no more than 30 days) September 11, 2020 and each year thereafter until closing of the study.

When this study closes, submit the required Final Report found at https://wmich.edu/research/forms.

Note: All research data must be kept in a secure location on the WMU campus for at least three (3) years after the study closes.