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EMPIRICAL PAPER

Client attachment, attachment to the therapist and client-therapist attachment match: How do they relate to change in psychodynamic psychotherapy?

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Abstract

Objective: We examined the associations between client attachment, client attachment to the therapist, and symptom change, as well as the effects of client-therapist attachment match on outcome. Clients ($n = 67$) and their therapists ($n = 27$) completed the ECR to assess attachment. **Method:** Clients completed also the Client Attachment to Therapist scale three times (early, middle, and late sessions) and the OQ-45 at intake and four times over the course of a year of psychodynamic psychotherapy. **Results:** Clients characterized by avoidant attachment and by avoidant attachment to their therapist showed the least improvement. A low-avoidant client-therapist attachment match led to a greater decrease in symptom distress than when a low-avoidant therapist treated a high-avoidant client. **Conclusions:** These findings suggest the importance of considering client-therapist attachment matching and the need to pay attention to the special challenges involved in treating avoidant clients in order to facilitate progress in psychotherapy.

Keywords: client attachment; therapist attachment; client attachment to therapist; therapeutic relationship; outcome; client-therapist matching; psychodynamic psychotherapy

Attachment theory constitutes a promising framework for studying the contributions of the client, the therapist, and the relationship bond to psychotherapy process and outcome. Bowlby (1962/1982) posited that individuals form internal working models of the self and others in close relationships based on their experiences with childhood caregivers. The therapeutic relationship is likely to reactivate the client's long-standing expectations about the availability and responsiveness of others (Bowlby, 1988; Farber & Metzger, 2009). Of the vast number of client variables that have been studied in relation to the process and outcome of psychotherapy (Bohart & Wade, 2013; Clarkin & Levy, 2004), a growing body of research suggests that clients' attachment styles may have an important influence on the relationship clients develop with their therapist (e.g., Diener & Monroe, 2011; Eames & Roth, 2000;

Mallinckrodt, 2000, 2010) and on the final outcome (Fonagy et al., 1996; Levy, Ellison, Scott, & Bernecker, 2011; Meyer & Pilkonis, 2002).

Attachment styles in adulthood have been depicted as reflecting the intersection of two dimensions: A positive versus negative model of self and a positive versus negative model of other (Bartholomew & Horowitz, 1991). These dimensions yield a four-style typology: Securely attached individuals have positive models of the self and others; preoccupied individuals have a positive model of others but a negative model of the self; dismissing types have a negative model of others, but a positive self-model; and the fearful have negative models of the self and others.

Studies on attachment and the therapeutic alliance suggest that securely attached clients obtain higher alliance scores (Satterfield & Lyddon, 1998).

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A recent meta-analysis of 17 studies linking client attachment style and alliance found a significant overall effect size ($r = .17$) indicating that more securely attached clients have stronger alliances, whereas more insecurely attached clients have weaker alliances (Diener & Monroe, 2011).

The findings regarding the various insecure styles have been diverse, probably due to the reliance on different attachment assessment methods such as the interview-based AAI (Dozier, Cue, & Barnett, 1994; Fonagy et al., 1996) and self-report typological or dimensional attachment measures (Eames & Roth, 2000; Mallinckrodt, Porter, & Kivlighan, 2005), as well as due to the different time points of alliance assessment over the course of therapy. Client fearful attachment was found to be related to lower client-rated early working alliance (Eames & Roth, 2000). Findings on the preoccupied and dismissing attachment styles are less clear and may partly depend on the interaction between client and therapist attachment styles (Roth & Fonagy, 2005; Rubino Barker, Roth, & Fearson, 2000) and on early versus late assessments of the alliance.

Client Attachment and Psychotherapy Outcome

The association between adult attachment and psychotherapy outcome was examined in a recent meta-analytic review (Levy et al., 2011). This meta-analysis included 14 studies (containing 19 separate samples) that measured client attachment style and treatment outcome, with a combined N of 1467 patients. To overcome the problem of the use of 11 different attachment measures in these studies (e.g., Adult Attachment Prototype Rating, Adult Attachment Interview, and Adult Attachment Scale), Levy et al. focused the analysis on the two attachment dimensions: Anxiety and avoidance. These two dimensions have been found to underlie most measures of adult attachment style (Brennan, Clark, & Shaver, 1998; Mikulincer & Shaver, 2007), with attachment security conceptualized as a blend of anxiety and avoidance dimensions (individuals low on both are securely attached whereas individuals high on both or only on one dimension are insecurely attached). The meta-analytic findings showed that higher attachment anxiety predicted worse outcomes after therapy, whereas higher attachment security predicted more favorable outcomes. Attachment avoidance had a negligible overall effect on outcomes in psychotherapy. The authors concluded that the effect sizes of the associations of both attachment anxiety ($r = -.22$) and attachment security ($r = .18$) with treatment outcomes were “in the small but moderate range, but just below those

found for the association of therapeutic alliance with outcomes” (Levy et al., 2011, p. 201).

One of the limitations of this recent meta-analytic review is the absence of baseline levels which would make it possible to assess actual change in symptoms. Post-treatment symptoms were considered to be the outcome; hence, the associations may to some extent reflect the relation between attachment and psychopathology (Levy et al., 2011). Taking this point into consideration, the present study includes a baseline assessment of symptoms at intake and at different time points throughout psychotherapy. Client attachment to the therapist and symptom change over the course of psychotherapy were also assessed at several points in time.

Client Attachment to the Therapist

Conceptualizing the therapeutic relationship from an attachment perspective, Mallinckrodt, Gantt, and Coble (1995) developed the Client Attachment to Therapist Scale (CATS). This led to the identification of three patterns of client attachment to the therapist that reflect patterns of adult attachment. Secure clients perceive their therapist as emotionally responsive, accepting, and promoting a “secure base” (Bowlby, 1988) for the exploration of threatening emotional experiences. Avoidant-Fearful clients tend to distrust their therapists and fear rejection, and are reluctant to cooperate in the self-disclosure tasks of therapy and feel threatened or humiliated during sessions. Preoccupied-Merger clients desire more intense contact and to be “at one” with their therapists. They aim for a dissolution of boundaries because they are preoccupied with the therapist and want to be their therapist’s “favorite” client (Mallinckrodt et al., 1995, 2005). Mallinckrodt (2010) suggests that although not specifically intended to assess the essential elements of attachment bonds, the CATS items appear to tap the five essential elements identified by Mikulincer and Shaver (2007): (1) therapist as stronger and wiser, (2) proximity seeking, (3) safe haven, (4) secure base, and (5) separation anxiety in anticipation of loss of the therapist. He argued that this correspondence “provides some evidence that the psychotherapy relationship can serve the functions of an attachment bond” (Mallinckrodt, 2010; p. 263).

The secure base element of the psychotherapy relationship was supported in two studies that employed the CATS to test the hypothesis that secure client attachment to the therapist would be associated with deeper exploration (Mallinckrodt et al., 2005; Romano, Fitzpatrick, & Janzen, 2008). Clients who reported a secure attachment in their relationship with their therapist described their

sessions on the Session Evaluation Questionnaire (SEQ; Stiles & Snow, 1984) as characterized by greater depth.

Considering the conceptual triangle of adult attachment, client attachment to the therapist, and alliance suggests that these constructs, although related, do not overlap (Mallinckrodt et al., 2005). Diener and Monroe's (2011) meta-analytic review showed that client attachment style was linked to alliance in individual therapy. However, they noted that "much of the variance in alliance remains to be accounted for even after taking into consideration patients' attachment styles" (p. 244). In Mallinckrodt et al.'s (2005) study, the association between clients' attachment to significant others and the CATS showed that avoidant adult attachment (assessed on the Experiences in Close Relationships Scale; Brennan et al., 1998) was positively correlated with avoidant-fearful attachment to the therapist. Regarding the association between the CATS and the alliance, as assessed on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), it was found that secure attachment to the therapist was strongly associated with positive alliance, whereas avoidant-fearful CATS was strongly associated with a negative alliance. No associations were found between preoccupied-merger CATS and WAI. Addressing a concern regarding the discriminant validity of the CATS (Meyer & Pilkonis, 2002), Mallinckrodt et al. (2005) showed that the CATS scales account for unique variance over and above the WAI in session depth and smoothness, as well as in object relations deficits.

Studies utilizing the CATS have mostly measured client attachment to the therapist in the early sessions of therapy (e.g., Janzen, Fitzpatrick, & Drapeau, 2008), middle sessions (e.g., sessions 5 to 9 in Romano et al., 2008), or administered it only once in later sessions (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). The present study was designed to examine the association between ECR attachment avoidance and attachment anxiety and the client's attachment to the therapist over the course of psychotherapy at three time points: Early, middle, and late sessions.

Previous research has examined the link between client attachment to the therapist and psychotherapy process variables such as the working alliance and session depth and smoothness (Mallinckrodt et al., 2005; Romano et al., 2008). Researchers have only recently begun to test the relationship between the CATS and psychotherapy outcome (Mallinckrodt, 2011). Sauer, Anderson, Gormley, Richmond, and Preacco (2010) examined the association between client attachment to the therapist on the CATS (assessed in the third session) and progress in

therapy on the Outcome Questionnaire (OQ-45) and found that secure attachment to the therapist was associated with greater reduction in client distress over time.

Client-Therapist Match versus Mismatch in Attachment

The client-therapist match has long been suggested as accounting for outcome beyond any single client or therapist variable (Bernier & Dozier, 2002; Berzins, 1977; Beutler, et al., 2004; Taber, Leibert, & Agaskar, 2011; Talley, Strupp, & Morey, 1990). Research on matching involves studies on similarities and dissimilarities between client and therapist on demographic variables (e.g., gender, ethnicity), attitudes, beliefs and values, and personality variables (e.g., self-concept, personality types) and interpersonal styles. Attachment theory and research on individual differences in attachment (Mikulincer & Shaver, 2007) provide a solid framework to examine the benefit of client-therapist match versus mismatch in attachment styles.

In a study of case managers working with severely impaired psychiatric patients, therapists were most effective with patients showing attachment states of mind (on the AAI) different from their own (i.e., dissimilar attachment tendencies on the dismissing-preoccupied dimension). Case managers in dissimilar dyads rated the patients as higher in global functioning and the patients reported better life satisfaction and stronger working alliances than dyads with similar attachment states of mind (Tyrrell, Dozier, Teague, & Fallot, 1999). This finding on the benefits of dissimilar attachment was attributed to the case managers' ability to challenge the clients' rigid and maladaptive interpersonal strategies and refrain from colluding with them (see Eagle & Wolitzky, 2009).

In a study with college students and volunteer professors providing academic counseling, the students' attachment was measured on the AAI and the professors' relational style was measured on a self-report questionnaire (Bernier, Larose, & Soucy, 2001; reported in Bernier & Dozier, 2002). It was found that students with dismissing attachment tendencies worked better with counselors who reported valuing interdependence and relationships, whereas students with preoccupied attachment tendencies had better relationships with professors valuing independence and achievement. Thus, based on these two studies, Bernier and Dozier (2002) suggested that contrasting (mismatch) relational styles are optimal for treatment, though they caution that these results need to be replicated with trained therapists in psychotherapy dyads.

The combination of client attachment and therapist attachment (interaction effects) was studied using the ECR in two studies with volunteer clients and counselor trainees. Mohr, Gelso and Hill (2005) found that counselor attachment moderated the association between client attachment and negative counselor countertransference reactions. In dyads composed of a high attachment anxiety (preoccupied) client and a high attachment avoidance (fearful or dismissing) counselor, the supervisor rated the counselors as higher in distancing and hostile countertransference behavior. In Romano et al.'s (2008) study, this combination of client high attachment anxiety with counselor high to moderate attachment avoidance predicted lower levels of client perceived session depth.

Thus although in some studies dissimilarity in reliance on attachment strategies, hyperactivation or deactivation was advantageous, in other studies this dissimilarity was related to negative aspects of the counseling process. In their meta-analytic review on attachment style and outcome, Levy et al. (2011) indicated that there were not enough studies to address the issue of matching patients to treatment or therapists based on attachment patterns. In the present study we examine the effects of match and mismatch in client-therapist attachment in predicting client progress from intake to outcome.

The Present Study

The aims of the present study were to test the associations between client attachment characteristics, client attachment to the therapist, and symptoms over the course of psychodynamic psychotherapy, and between therapist attachment characteristics and client attachment to the therapist. We also examined the effects of client attachment to the therapist on change in symptoms. Finally, we explored the effects of the configuration of client-therapist attachment match versus mismatch on change in symptoms. The following hypotheses were tested:

1. Clients' insecure attachment (attachment avoidance and attachment anxiety) will be associated with higher symptom distress at each time point (intake, early, middle, and later stages of therapy).
2. Client global attachment will be associated with client attachment to the therapist at the beginning, middle, and later stages of therapy. Specifically, secure attachment (low on both avoidance and anxiety) will be associated with client secure attachment to therapist, avoidant attachment with avoidant-fearful attachment to therapist, and anxious attachment with

preoccupied-merger attachment to therapist. In addition, therapist global attachment will be associated with client attachment to the therapist at the different stages of therapy.

3. CATS scores will be associated with OQ at each time point over the course of psychotherapy, and client's early CATS scores will predict changes in OQ from intake to the last OQ assessment point (session 32).
4. Therapist attachment will moderate the relationship between client attachment and change in OQ (i.e., therapist attachment by client attachment interaction). Given previous contradictory findings, we did not hypothesize the specific configuration of client-therapist attachment that would be most beneficial to outcome.

Method

Participants

Clients. At the outset, the sample of the study consisted of 67 clients at a university counseling center. Two-thirds were female (46 females and 21 males), which is a common ratio in university psychological services. They were mostly young adults with a mean age of 24.89 (range 20 to 32) and the majority were undergraduate students (76.6%). These students are somewhat older than the usual sample in the USA as in Israel most students begin university after their compulsory army service (3 years for men and 2 for women and many only begin university after another year of travel abroad). They were single (95.5%), the majority were Israeli-born (82.4%), and 78.5% came from intact families. Most of the clients were diagnosed either with mild depression and/or anxiety, presenting with difficulties in relationships, in their academic studies, or issues pertaining to identity formation. Of these 67 clients, 54 remained in psychotherapy and 13 dropped out. No significant differences were found on the variables of the study at the fifth session between clients who remained in therapy and those who dropout out.

Therapists. The therapists were 22 females and five males, with a mean age of 36 (range 23–57), 63% were married, and 59% had at least one child. The therapists were mostly Israeli-born (85%) and came from intact families (81.5%). The majority held MA degrees (70.4%) in clinical psychology (63%) or social work (26%). In terms of their experience level, 63% were interns and 18.5% were licensed therapists (with 5 to 15 years of experience). Due to the training program structure

in Israel, the number of years of experience of the interns ranged from 3 to 5 years. All therapists (except one) were receiving supervision at the time of the study. The number of clients per therapist ranged from 1 to 6 clients, with a mean of 2.41, $SD = 1.18$.

Therapy. The therapy was conducted at a large university counseling center. Clients were seen once a week for 50 minutes in a year-long psychodynamic psychotherapy. The model of psychotherapy in our naturalistic study can be described as based mainly on principles of contemporary psychodynamic psychotherapy (e.g., Summers & Barber, 2010) and on object relations (Winnicott, 1971) and relational psychotherapy (Aron, 1996; Mitchell, 1993).

Measures

Outcome Questionnaire (OQ-45; Lambert et al., 1996). This a 45-item self-report instrument designed for repeated measurement of client changes throughout the course of mental health treatments. Clients are asked to rate their functioning in the past week on a 5-point Likert scale from 0 (*never*) to 4 (*almost always*). The OQ-45 is composed of three subscales, Symptom Distress, Interpersonal Problems, and Social Role, which are summed to provide a total score. The total score ranges from 0 to 180, with high scores indicating greater overall levels of symptom severity. Research has shown that the OQ-45 has adequate test-retest reliability (.84) and high internal consistency (.93). Concurrent validity has been demonstrated with a wide variety of self-report scales (e.g., Beck Depression Inventory, State-Trait Anxiety Inventory) (Lambert et al., 1996). The OQ-45 is widely used in university counseling centers and mental health centers. The total distress score has been found to be sensitive to change in counseling center clients (Vermeersch et al., 2004). The OQ-45 has been translated into several languages, including Hebrew (Gross et al., *in press*). In the present study, the alpha coefficient of the total Hebrew version was .91. Using formulas developed by Jacobson and Truax (1991), the reliable change index of the OQ was estimated to be 14 points and the clinical range cutoff was 63 (Lambert et al., 1996, 2001).

Experiences in Close Relationships Scale (ERC; Brennan et al., 1998). The ERC is a widely used 36-item self-report measure of adult attachment. The ERC employs a 7-point Likert-type response scale ranging from 1 (*not at all*) to 7 (*very much*). Eighteen items assess attachment anxiety (e.g., "I worry about being abandoned") and 18 assess

avoidance (e.g., "I prefer not to show a partner how I feel deep down"). These yield two highly consistent dimensions: Anxiety and Avoidance (alpha coefficients of .91 and .94, respectively). The Hebrew version of the ERC has also demonstrated high internal reliabilities (Mikulincer & Florian, 2000). Evidence of validity has been widely established (see Mikulincer & Shaver, 2007, for a review). In the present study, Cronbach's alpha was .92 and .91 for the anxiety scale and .92 and .82 for the avoidance scale, for clients and therapists, respectively.

Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995). The CATS was developed to measure the psychotherapy relationship from the perspective of attachment theory. This 36-item self-report questionnaire consists of three subscales: Secure, Avoidant-Fearful, and Preoccupied-Merger. Clients respond using a 6-point scale ranging from strongly agree (1) to strongly disagree (6). In the study that reported the construction and psychometric properties of the scale (Mallinckrodt et al., 1995), clients had to complete at least five sessions with a median of 10 sessions (range 5–62). Test-retest reliability, which was obtained on average after a 3-week interval, was moderate to high for the three dimensions (.84, .86, and .72). In a study on brief psychotherapy, clients completed the CATS once after the fourth or eighth sessions (Mallinckrodt et al., 2005). With permission received from the author of the CATS, the scale was translated into Hebrew. In the present study, Cronbach's alphas (fifth session) were .84 for secure, .77 for avoidant, and .68 for preoccupied.

Procedure

Therapists at a large university counseling center were asked to give their initial consent to participate in the study and to indicate that they agreed in principle that their clients could be invited to participate in the study. Clients were recruited through the reception office upon seeking counseling and a research assistant contacted only those clients whose therapists agreed to participate. Clients received information about the study and were assured that their participation was voluntary, and that they could choose to terminate their participation in the study at any time. Clients signed a consent form in which it was stated that the data would not be transferred to their therapist, and that their anonymity would be preserved. The clients and therapists in this study took part in a research project that included also undergoing RAP (Relationship Anecdote Paradigm; Luborsky & Crits-Christoph, 1998) interviews three times during psychotherapy

and completing post-session questionnaires (Wiseman & Tishby, 2011; Wiseman, Tishby, & Barber, 2012). Clients were paid 50 NIS (\$12) after completing the questionnaires and taking part in the RAP interviews at the three time points.

Clients completed the OQ-45 at five time points: At intake, after session 5, session 15, session 28, and session 32. They completed the CATS at three time points: after sessions 5, 15, and 28. Due to technical problems, some clients completed the ECR at intake and also after session 28 and most clients completed the ECR only at session 28. No differences were found in the ECR scores of these two groups, and no differences in the ECR scores at intake and session 28 for those clients who completed the ECR at both times. Hence, we only used the ECR scores for session 28. Therapists completed the ECR when their first client joined the study. The study was approved by the Helsinki Ethics Committee.

Data Analysis

Due to the assumed dependency of the scores on each variable per therapist, and the fact that the variables were measured at both the client and the therapist levels, the data were analyzed in a hierarchical three-level model (mixed models): Time (within the individual), client level, and therapist level. Individual level variables included: Client attachment, Client CATS, and Client OQ, and therapist level variables included Therapist attachment. OQ was measured five times, and CATS was measured three times. All temporal differences and predictions were analyzed via mixed hierarchical models. Post hoc tests that were used were paired comparisons. In cases in which the independent variables did not temporally precede the dependent variables the results are described in terms of relationships rather than predictions. In the mixed models analysis that tested the client-therapist attachment match, significant interactions were plotted according to the simple slopes procedure (Aiken & West, 1991; Preacher, Curran, & Bauer, 2006) and the significance of the slopes was assessed.

Results

Descriptive Statistics

The means and standard deviations of all the study variables are presented in Table I. For the OQ there were five time points (from intake through sessions 5, 15, 28, and 32) and for the CATS there were three time points (sessions 5, 15, and 28). The ECR of the clients and of the therapists were measured once.

The OQ and CATS scores of clients who dropped out after the fifth session were compared to those who completed session 28. No significant differences were found on the fifth session between completers and dropouts on the OQ [$F(1,63.76) = 2.50, p = .119, \eta^2 = .029$] (completers $M = 67.29, SD = 19.61, n = 54$; dropouts $M = 77.50; SD = 18.14, n = 13$). Similarly, there were no differences on the CATS between the two groups for the three scales: CATS secure $F(1,61.31) = 1.83, p = .181, \eta^2 = .050$ (completers $M = 4.65, SD = .74$; dropouts $M = 4.14, SD = .78$); CATS avoidance $F(1,62.14) = .05, p = .828, \eta^2 = .005$ (completers $M = 1.93, SD = .64$; dropouts $M = 2.06, SD = .57$); and CATS preoccupied $F(1,62.15) = 2.68, p = .107, \eta^2 = .031$ (completers $M = 2.33, SD = .79$; dropouts $M = 2.75, SD = .81$).

Change over Time in Outcome (OQ). The results of a repeated measures ANOVA that tested client change on OQ over the five time points showed that the total difference was significant, $F(4,209.63) = 12.79, p < .001, \eta^2 = .206$. Post hoc paired comparisons of the time differences indicated that compared to OQ at intake ($M = 75.57, SD = 22.76$), OQ decreased significantly ($p = .003, \eta^2 = .027$) on the fifth session ($M = 68.51, SD = 19.60$) and was significantly lower on the 15th ($M = 64.41, SD = 22.00, p < .001, \eta^2 = .059$), 28th ($M = 60.54, SD = 25.52, p < .001, \eta^2 = .090$), and 32nd sessions ($M = 55.69, SD = 23.41, p < .001, \eta^2 = .155$). Compared to the OQ at session 5, OQ was significantly lower on the 28th session ($p = .004, \eta^2 = .031$) and significantly lower on the 32nd session ($p < .001, \eta^2 = .081$). Compared to the 15th session OQ was significantly lower on the 32nd session ($p = .011, \eta^2 = .035$). However, no significant change was found between sessions 28 and 32 ($p = .221, \eta^2 = .010$, see Table I). In terms of the reliable change index of the OQ, which is estimated to be 14 points (Lambert et al., 2001), on average, clients made reliable change on the OQ from the assessment at intake to session 28. In terms of the OQ clinical range cutoff of 63 (Lambert et al., 2001), 63% of the clients had OQ scores in the nonclinical range on session 28, and 70% of the clients were in the nonclinical range on the last assessment point (session 32), thus demonstrating clinically reliable improvement.

Client Global Attachment and OQ

The findings on global attachment and OQ at each of the five time points indicated that higher client avoidant attachment was related to higher OQ at the 5th [$B = 8.69, Se = 3.59; t(29.41) = 2.42, p < .05$]

Table I. Means and standard deviations for the OQ-45, CATS and client and therapist ECR

	Intake	5th session	15th session	28th session	32nd session
OQ-45	75.57 (22.76) (<i>n</i> = 58) Range 23–138	68.51 (19.60) (<i>n</i> = 67) Range 25–118	64.41 (22.00) (<i>n</i> = 61) Range 18–102	60.54 (25.52) (<i>n</i> = 54) Range 15–120	55.69 (23.41) (<i>n</i> = 39) Range 15–98
CATS - Secure		4.59 (.76) (<i>n</i> = 66)	4.79 (.79) (<i>n</i> = 61)	4.98 (.66) (<i>n</i> = 54)	
CATS - Avoidance		1.94 (.63) (<i>n</i> = 66)	1.86 (.70) (<i>n</i> = 61)	1.84 (.72) (<i>n</i> = 54)	
CATS - Preoccupied		2.38 (.80) (<i>n</i> = 66)	2.34 (.85) (<i>n</i> = 61)	2.35 (.96) (<i>n</i> = 54)	
		Clients (<i>n</i> = 55)		Therapists (<i>n</i> = 27)	
ECR - Avoidance		3.63 (1.16)		2.31 (.58)	
ECR - Anxiety		3.88 (1.19)		3.53 (1.03)	

and 32nd [$B = 10.53$, $Se = 3.90$; $t(15.90) = 2.70$, $p < .05$] sessions. Interestingly, in the middle phase of therapy it was found that higher client anxious attachment was related to higher OQ at 15th [$B = 7.34$, $Se = 3.53$; $t(26.10) = 2.08$, $p < .05$] and 28th sessions [$B = 9.80$, $Se = 3.85$; $t(25.95) = 2.54$, $p < .05$].

Client and Therapist Global Attachment and Client Attachment to the Therapist

Client ECR and CATS. The results of the mixed models for the relationship between clients' global attachment on ECR and their attachment to their therapist on the CATS at the three time points showed that client ECR avoidance was significantly and positively associated with CATS avoidant attachment to therapist at both the 5th [$B = .23$, $Se = .11$; $t(23.79) = 2.09$, $p = .047$] and the 15th [$B = .31$, $Se = .11$; $t(21.24) = 2.82$, $p = .01$] sessions. By contrast, client ECR avoidance was associated negatively with CATS secure attachment to therapist [$B = -.30$, $Se = .14$; $t(33.44) = -2.07$, $p = .046$] at the 15th session. Client ECR anxiety was associated positively with CATS avoidant attachment to therapist [$B = .32$, $Se = .13$; $t(13.21) = 2.44$, $p = .029$] on the 28th session. Finally, client ECR on both avoidance and anxiety was unrelated to CATS preoccupied attachment to therapist.

Therapist ECR and CATS. An analysis (mixed models) of the relationship between therapists' global attachment on the ECR and the client attachment to the therapist on the CATS at each of the

three time points revealed only one significant association. Namely, therapist ECR anxious attachment was significantly related to lower client secure attachment to therapist on the CATS on the 5th session [$B = -.23$, $Se = .11$; $t(23.09) = -2.06$, $p = .050$]. No other relationships were found between therapist ECR and client attachment to therapist.

Client Attachment to Therapist, OQ and Change in OQ

The findings on CATS and OQ-45 at the same time points (see Table II) indicated that higher OQ on the 5th session was significantly related to higher client preoccupied attachment to therapist [$B = 7.72$, $Se = 2.76$; $t(35.22) = 2.80$, $p = .008$]. Higher OQ at the 15th session was significantly related to both higher client avoidant [$B = 7.96$, $Se = 3.58$; $t(32.36) = 2.22$, $p = .033$], as well as higher client preoccupied attachment to therapist [$B = 7.66$, $Se = 3.39$; $t(31.90) = 2.26$, $p = .031$].

We also examined the prediction of change in OQ from intake to session 32 by the client's CATS on the fifth session. The mixed models analysis showed no significant relationships of CATS secure and of CATS preoccupied with the change in OQ; however, higher CATS avoidance was significantly related to an increase in symptoms from intake to the 32nd session [$B = .45$, $SE = .19$; $t(20.48) = 2.36$, $p = .028$]. That is, lower CATS avoidance was associated with a decrease in OQ from intake to the 32nd session; i.e., greater improvement. In line with the literature on the alliance-outcome correlation that tests whether change in symptoms before the

Table II. Mixed models for the relationship between client attachment to therapist and OQ-45

CATS - Secure	OQ - 5th session			OQ - 15th session			OQ - 28th session		
	CATS - Avoidance	CATS - Preoccupied	CATS - Secure	CATS - Avoidance	CATS - Preoccupied	CATS - Secure	CATS - Avoidance	CATS - Preoccupied	
$B = -2.11$ $SE = 2.85$ $t(34.24) = -.74$	$B = 4.30$ $SE = 2.82$ $t(34.08) = 1.52$	$B = 7.72$ $SE = 2.76$ $t(35.22) = 2.80^{**}$	$B = -2.30$ $SE = 3.76$ $t(31.22) = -.61$	$B = 7.96$ $SE = 3.58$ $t(32.36) = 2.22^*$	$B = 7.66$ $SE = 3.39$ $t(31.90) = 2.26^*$	$B = 4.21$ $SE = 5.51$ $t(25.61) = .76$	$B = 4.59$ $SE = 4.95$ $t(25.61) = .93$	$B = -3.56$ $SE = 4.58$ $t(25.61) = -.78$	

* $p < .05$, ** $p < .01$, *** $p < .001$; ($N = 54-66$).

measurement of the alliance causes subsequent change in symptoms or is it the alliance (Barber, Muran, McCarthy, & Keefe, 2013; Crits-Christoph, Connolly Gibson, & Mukherjee, 2013), we also examined the prediction of subsequent change in OQ (from session 5 to 32) by the client's CATS on session 5, while controlling for prior change from intake to session 5. The results of this mixed models analysis for subsequent change in OQ showed no significant effects for either client CATS avoidance in session 5 [$B = .36$, $SE = .23$; $t(20.89) = 1.49$, $p = .151$] or early change in OQ from intake to session 5 [$B = -.33$, $SE = .19$; $t(25.22) = -1.70$, $p = .101$].

Predicting Symptom Change from Client and Therapist Global Attachment: Client-Therapist Attachment Match

To test the prediction of change in OQ from clients' and therapists' global attachment since several clients were treated by each therapist, a hierarchical linear method was used (Mixed Models) to predict change in OQ from client attachment and therapist attachment. In these models change in OQ was defined as residual gains from intake to session 32, while controlling for the OQ intake score. Global attachment of the client and of the therapist consisted of the ECR avoidance and anxiety scores. To examine the extent to which therapist attachment moderated the relationship between client attachment and change in OQ, the independent and moderator variables were standardized. The model tested the prediction of change in OQ in terms of client attachment, therapist attachment, and their two-way interactions (four combinations of client attachment by therapist attachment).

The findings of the mixed models analysis showed a significant main effect for client attachment on the avoidance scale, $t(13.98) = 2.20$, $p = .045$. This suggests that regardless of the therapist's attachment, higher-avoidant clients had a greater increase in symptoms from intake to the 32nd session. Moreover, consistent with the hypothesis that change in OQ would be predicted by the configuration of client-therapist attachment, the interactions of therapist avoidance by client avoidance was found to be statistically significant, $t(13.02) = -3.09$, $p = .009$ (See Table III). This interaction was plotted according to the simple slopes procedure (Aiken & West, 1991; Preacher, Curran, & Bauer, 2006). An examination of the significance of the slopes showed that when treated by low-avoidant therapists, low-avoidant clients were likely to decrease to a greater extent in OQ than high avoidant clients ($B = 1.80$, $t = 3.33$, $p = .003$). However, when treated by high-

Table III. Mixed models predicting change in OQ-45 from intake to session 32 with client and therapist global attachment

	<i>B</i>	<i>SE</i>	<i>t</i>
Client - Anxiety	.22	.20	<i>t</i> (10.01) = 1.13
Client - Avoidance	.56	.26	<i>t</i> (13.98) = 2.20*
Therapist - Anxiety	.12	.22	<i>t</i> (18.14) = .53
Therapist - Avoidance	-.07	.31	<i>t</i> (17.31) = -.24
Anxiety - Therapist * Anxiety - Client	.35	.65	<i>t</i> (20.79) = .54
Anxiety - Therapist * Avoidance - Client	-.40	.52	<i>t</i> (20.34) = -.76
Avoidance - Therapist * Anxiety - Client	-.31	.46	<i>t</i> (13.87) = -.68
Avoidance - Therapist * Avoidance - Client	-1.24	.40	<i>t</i> (13.02) = -3.09**

N = 31. **p* < .05, ***p* < .01.

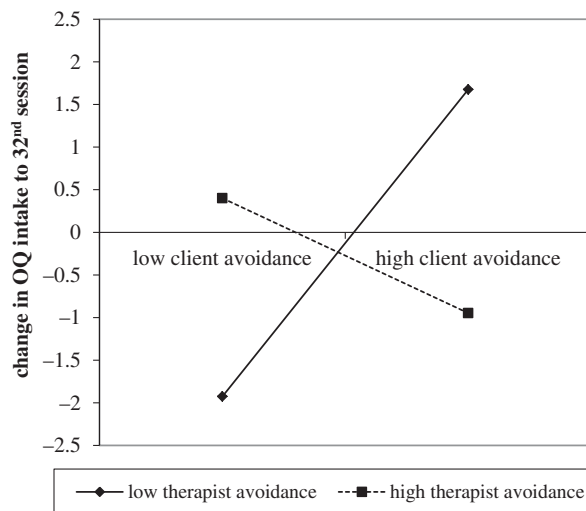


Figure 1. Interaction of client avoidant attachment by therapist avoidant attachment in predicting change in OQ-45 from intake to session 32.

avoidant therapists, the change in OQ of low-avoidant clients in comparison to high-avoidant clients did not differ significantly ($B = -.67$, $t = -1.69$, $p = .104$) (see Figure 1).

In summary, the results of the model examining change in OQ from intake to session 32 as a function of client attachment, therapist attachment, and their combination indicated: (1) Overall, regardless of therapist attachment, avoidant clients showed the least change from intake to the 32nd session; and (2) when treated by low-avoidant therapists, low-avoidant clients were likely to decrease to a greater extent in OQ than high-avoidant clients treated by low-avoidant therapists.

Discussion

In the last decade, Bowlby's attachment theory has received growing attention as a theoretical framework for studying psychotherapy process and outcome (Mikuklincer & Shaver, 2007; Obegi & Berant,

2009). Through the lenses of attachment theory and research, in this study we examined client attachment characteristics as a personality factor that the client brings to psychotherapy and the specific attachment the client forms with the therapist as an element of the therapy relationship. The association between client attachment and client attachment to the therapist was tested, as well as the association of each to symptom distress over the course of psychodynamic psychotherapy. Furthermore, we extend previous research on the effects of client attachment on post-treatment symptoms by exploring the moderating effect of therapist attachment on the relationship between client attachment and change in symptom distress.

Overall, the symptom distress of the clients in the study, as measured on the OQ-45 at five time points, decreased throughout psychotherapy. On average, in terms of the reliable change index (Lambert et al., 2001), clients made reliable change (14 points) from the intake to session 28. In terms of the clinical range cutoff (OQ below 63), 63% of the clients (on session 28) and 70% (on session 32) showed clinically reliable improvement. Our sample presented initially with higher distress levels ($M = 75.57$, $SD = 22.76$) than that reported (OQ intake: $M = 66.43$, $SD = 28.69$) in a recent study that used the OQ in a sample of clients from two psychology Midwestern US university-based training clinics (Sauer et al., 2010, p. 706). Hence, the distress levels of the clients in our sample are more similar to those reported in community outpatient clinics. Our major focus in this paper was on client attachment characteristics, the relationship between these characteristics and the attachment bond that develops with the therapist during psychotherapy, and the relationship of each to symptom distress; as well as on how client-therapist attachment match versus mismatch relate to client change in symptom distress over the course of psychodynamic psychotherapy.

Client Attachment and Symptom Distress

The hypothesized relationship between client attachment and symptom distress was supported for the different time points (early, middle, and later) during psychotherapy. Although none of the client attachment dimensions significantly related to distress at intake, attachment avoidance predicted distress in the early (session 5) and last (session 32) measurement points, whereas attachment anxiety predicted distress in mid (session 15) and late (session 28) psychotherapy. In a meta-analytic review, Levy et al. (2011) reported that higher attachment anxiety predicted the worst outcome, but that attachment avoidance did not have an overall effect on outcome after therapy. Our findings suggest that the effects of the avoidance and anxiety dimensions may differ at different stages of therapy. This may depend on the way clients begin and end psychotherapy and on the way they experience the working phase of psychotherapy. Specifically, clients' strategies of deactivating (high avoidance) or hyperactivating (high anxiety) the attachment system (Mikulincer & Shaver, 2007) may impact their symptom distress differently at different stages of psychotherapy. Deactivating clients may experience more symptom distress during the engagement phase and termination phase, whereas hyperactivating clients may feel intensified distress during the working phase of psychotherapy. Overall, regardless of phase of psychotherapy, secure clients (low on both avoidance and anxiety) reported lower distress. This is in keeping with the meta-analytic findings that showed that higher attachment security predicted more favorable outcomes (Levy et al., 2011).

Client Attachment to Therapist, Symptom Distress and Change

The associations between client global attachment and client attachment to the therapist at the different time points confirmed the hypothesis that clients who are high on avoidance in their close relationships (global attachment) form avoidant attachment to their therapist in the early- and mid-points of psychotherapy. This finding replicates earlier findings with the CATS in American university counseling samples (Mallinckrodt et al., 2005). Studies that employed the CATS with volunteer clients (Romano et al., 2008) or assessed the CATS on the third counseling session (Sauer et al., 2010) did not find such a relationship. In addition, we found that greater client global avoidance was associated with less security with the therapist in mid-therapy (session 15). This may suggest that avoidant clients are less able to use the therapist as a secure base

(Mallinckrodt, 2010) during the working phase of therapy. Contrary to our hypothesis, clients high in global attachment anxiety, rather than being preoccupied about their attachment to the therapist, report higher avoidant-fearful attachment to the therapist at the later stage of therapy (session 28). Thus, as termination approaches, the fear of rejection and abandonment (anxiety) is associated with resentment and the feeling that the therapist is rejecting (avoidant-fearful attachment to the therapist) to a greater extent than the fear of intimacy (avoidance), which is less at the forefront toward the end of therapy (Joyce, Piper, Ogradniczuk, & Klein, 2007). The variability that we found in the associations between clients' global attachment and the attachment that clients developed with their therapist over time may be understood as due to differences in the therapeutic tasks that require different levels of closeness in the relationship at different phases in psychodynamic psychotherapy.

Regarding the impact of the therapist's global attachment on the client's attachment to his or her therapist, higher therapist anxiety attachment was related to lower client secure attachment to the therapist on the fifth session. Hence, the therapist's anxious attachment may interfere with helping the client to feel that the therapist is a comforting presence. The therapist may be too caught up in his or her own insecurity and consequently the client may perceive the therapist as less responsive, sensitive, or emotionally available. The therapist's anxiety attachment may be particularly detrimental given that this occurs during the alliance-building stage of the therapy relationship (Horvath, 2006).

The relationship between client attachment to the therapist and symptom distress at each time point showed that avoidant CATS was related to greater distress in mid-therapy (session 15). This is unlike avoidance ECR attachment, which was not related to distress in mid-therapy, but rather at the early (session 5) and late (session 32) time points. Preoccupied attachment to the therapist was associated with greater distress in early and mid-therapy. Although no significant associations were found between distress and secure attachment to the therapist, the findings clearly show that insecure attachment to the therapist characterized by greater avoidance and preoccupation in the therapy relationship is associated with higher distress levels in mid-therapy. During this working stage of therapy, the relationship tends to be vulnerable to cycles of rupture and repair (Eubanks-Carter, Muran, & Safran, 2010; Horvath, 2006; Safran & Muran, 2000; Safran, Muran, & Eubanks-Carter, 2011).

Finally, we also tested the prediction of change in symptoms from intake to session 32 by the three

CATS scales. The results showed that the lower the avoidant attachment to the therapist during early therapy, the greater the improvement was (decrease in OQ from intake to late therapy). It should be noted that our exploratory examination of the issue of the temporal sequence of attachment to the therapist and symptom distress, which has received much attention in alliance-outcome research (see Barber et al., 2013; Crits-Christoph et al., 2013), did not show that avoidant attachment to the therapist predicted subsequent change in OQ; nor did it show that in our sample initial symptom reduction predicted subsequent change. The only study that we are aware of that examined the CATS and change in OQ over time (Sauer et al., 2010) found that secure attachment to the therapist was related to reduction in client distress over time, paralleling that of the working alliance that was tested separately, whereas we found that avoidant-fearful attachment to therapist, rather than security in clients' attachment to the therapist, was predictive of change. It is possible that, the time at which the CATS was collected (third session) and the length of therapy (four to 11 sessions for clients contributing a termination OQ) may partially account for the differences between Sauer et al.'s study and our findings.

Client-Therapist Attachment Match

The findings on the contribution to symptom change of client attachment, therapist attachment, and their combination showed a significant main effect for client avoidant attachment. These findings on change in OQ from intake to session 32, while taking into account the client's baseline at intake, suggest that clients characterized by higher attachment avoidance not only may not improve, but their OQ may increase after 32 sessions of psychodynamic psychotherapy. In a study of a 16-session supportive-expressive (S-E) dynamic psychotherapy for depression with an outpatient Australian university sample, Reis and Grenyer (2004) found that clients reporting high levels of fearful attachment (as assessed using the Relationship Questionnaire, RQ; Bartholomew & Horowitz, 1991) showed significantly less improvement (as assessed on the Hamilton Rating Scale for Depression, HRSD).

Going beyond previous studies on client attachment and outcome, our study suggests that therapist avoidant attachment moderates the association between client avoidant attachment and outcome. This moderating therapist effect on change in symptom distress is germane to the issue of client-therapist matching in attachment (Eagle & Wolitzky, 2009), addressing the question of whether similarity or dissimilarity in client-therapist attachment results

in better outcome. It has been suggested from the perspective of both interpersonal theory and attachment theory that "contrasting" (dissimilar) interpersonal orientations of the client and therapist are optimal for the process and outcome of psychotherapy (Bernier & Dozier, 2002). Our findings on the impact of client-therapist attachment match and mismatch suggest the benefits of similarity in attachment, but only in the case when therapists and their clients are both low in avoidance. This was not the case when therapists low in avoidance treated clients high in avoidance or when both therapist and client were high in avoidance. Hence, therapist attachment moderates the impact of client attachment on client change, such that low-avoidant clients improve significantly more than high-avoidant clients only when treated by a low-avoidant therapist. That is, although overall low-avoidant clients improved more than high-avoidant clients, when the therapist of low-avoidant clients himself or herself was high in avoidance the difference in the change in symptoms between low- and high-avoidant clients was not apparent. Moreover, the findings suggest that high-avoidant therapists do not fare significantly better either with low-avoidant clients or with high-avoidant clients who are similar to them.

Taken together, our findings on change in symptom distress suggest that avoidant clients not only appear to improve the least, but they also do not enjoy the benefits that low-avoidant clients experience when treated by a low-avoidant therapist. Mallinckrodt (2010) emphasized the need to consider the fluid nature of the attachment relationship. As he put it: "A corrective emotional experience is fostered *not* by one attachment relationship offered by the therapist, but rather by many relationships tailored to meet the client's needs through the changing phases of therapy" (p. 266, authors' emphasis). Based on interviews with experienced therapists who were given vignettes of hypothetical clients described as having high attachment avoidance or anxiety, Daly and Mallinckrodt (2009) suggested that these therapists sought to establish the optimal therapeutic distance from each client as a function of the client's attachment style as well as the phase of treatment. They distinguished between clients that hyperactivate (anxious) and those that deactivate (avoidant) the attachment system in terms of the optimal therapeutic distance in each of three phases of therapy: Engagement, working, and termination. Our findings on client-therapist attachment matching suggest that therapists face the challenge of finding the optimal therapeutic distance, especially with avoidant clients. Even therapists who are themselves characterized by low avoidant attachment tendencies need training and supervision

(e.g., alliance-focused training, Muran, Safran, & Eubanks-Carter, 2010; alliance-fostering techniques, Crits-Christoph, Crits-Christoph, & Gibbons, 2010) on how to face these challenges in treating avoidant clients at the different phases of therapy.

Limitations and Future Directions

Our study contributes to the growing interest in client-therapist match versus mismatch in attachment style (Eagle & Wolitzky, 2009). However, the client-therapist match in attachment may depend on the specific outcome under study (Bernier & Dozier, 2002). Previous studies on the effects of client-therapist attachment matching on the session level, such as client depth ratings on the SEQ (Romano et al., 2008) and supervisor's ratings of countertransference behavior in first sessions (Mohr et al., 2005), have reported significant findings for the combination of high-anxiety clients and high-avoidance therapists. We obtained significant findings that included the combination of therapist avoidance and client avoidance, but not the combination of client anxiety and therapist avoidance. Our focus on change in symptom distress on the OQ-45 from intake to a later stage in psychodynamic therapy may have highlighted the difference in avoidance but was less sensitive to the combination of client anxiety and therapist avoidance.

It should be noted that overall the therapists in this study had much lower anxiety and avoidance scores than their clients. Thus, higher-avoidant therapists in our study were still not as high in avoidance as their clients. This contrasts with previous research on therapist attachment that employed the ECR with trainee counselors (Mohr et al., 2005; Romano et al., 2008) who appeared to be less secure (higher scores on both avoidance and attachment) than the relatively more experienced therapists in our study (3 years and up). In conducting our study in a naturalistic manner, we faced difficulties in administering the ECR at intake for all clients. The associations we found between the ECR and the CATS and between the CATS and the OQ strengthen our claim that the ECR indeed captured attachment as a personality characteristic. However, there is a need to replicate our findings with the client ECR taken at intake and also at later phases of therapy, possibly also as an outcome (Levy et al., 2011).

Another limitation is that due to the sample size we were unable to test the effects on symptom change of attachment characteristics and attachment to the therapist in the same model. We showed that client attachment characteristics impact the attachment to the therapist developed by the client at different stages. Our findings suggest that avoidant

clients appear to develop an avoidant attachment to the therapist and this difficulty in the attachment bond with their therapist at the engagement stage (session 5) was found to be related to significantly less improvement from intake to session 32. Nevertheless, client avoidant attachment to the therapist did not predict subsequent change when controlling for early symptom change, but neither did early symptom change predict subsequent change. Future research with larger numbers of clients and therapists is needed to further explore the interplay of attachment characteristics of the partners and the therapeutic relationship that evolves over time and client change and to address the temporal sequence of client attachment to therapist and symptom change. Overall, in our study the level of probability was controlled for in each set of analyses (HLM, MANOVAs); however, the overall probability of getting a significant result by chance alone experiment-wise may be elevated. The results of this study should thus be interpreted with caution, and further study with larger samples is required which will also address various client diagnostic categories and client problems.

In addition, given that the meeting of the client and therapist interpersonal patterns is dynamic rather than static (Mallinkrodt, 2010), more sensitive measures of attachment are needed to capture these dynamics, such as the AAI (e.g., Levy et al., 2006) or the Adult Attachment Prototype Rating (e.g., Strauss et al., 2006). Using the AAI and the CATS in a large sample of inpatients, Petrowski, Pokorny, Nowacki, and Buchheim (2013) recently found that rather than the general security/insecurity of the therapist's attachment representation the type of insecurity (preoccupied or dismissing) was associated with the patient's attachment to the therapist.

The conceptualization and measurement of client attachment to the therapist requires further development and empirical evidence taking the issue of sensitivity to change over time into account as well as the temporal sequence of the association between CATS and outcome (i.e., prior symptom change). In our naturalistic study there were three assessment points for the CATS throughout treatment (sessions 5, 15, and 28) and the OQ was also assessed at session 32. While session 32 was the most advanced assessment point of the OQ in our design, it was not the post-treatment point for all patients. Future research on attachment and outcome is needed that will take into account the setting (e.g., inpatient, university clinic), the timing of measurements during psychotherapy, and length of treatment.

Bowlby (1988) posited that the therapist's role is to provide patients with the conditions in which they can explore their representational models of self and

of attachment figures with a view to reappraising and restructuring them in light of new understanding and new experiences in the therapeutic relationship. Our findings on the associations with the attachment elements need to be understood in the specific context of psychodynamic therapy in which the hallmark of this type of treatment is that it focuses on the therapist-patient relationship over time to achieve therapeutic goals (Messer & Wolitzky, 2010). In fact, Barber (2009) asserted that the prediction of outcome by alliance beyond initial symptom improvement is more evident in psychodynamic models that focus on interpersonal patterns. Nevertheless our findings may be applicable to CBT approaches that include relational features (Castonguy, 2011; Muran et al., 2009). Future research would need to explore the generalizability of our findings to other psychotherapy orientations.

In his call for pathways of connections and integration, Castonguy (2011) suggests connecting between research domains, such as developmental studies on attachment, as a promising direction that can “provide us with rich conceptual heuristics in our exploration of individual differences” (p. 133). In pursuing the research recommendations of the second Task Force on Evidence-Based Therapy Relationships to disentangle the patient’s contributions and the therapist’s contributions to relationship elements and ultimately to outcome (Norcross & Wampold, 2011, p. 425), we explored the usefulness of the attachment framework. However, it should be acknowledged that although promising, attachment elements are only part of the complex picture of the interplay between the client’s and the therapist’s contributions to the therapeutic relationship and to client change.

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