The Relationship between Client Attachment and Therapist Interventions in Client-Nominated Relationship-Building Incidents
La relation entre l'attachement du client et les interventions thérapeutiques dans les incidents critiques au développement du rapport thérapeutique selon le client

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ABSTRACT

Twenty-four clients were asked to nominate an incident that was critical to the development of their therapeutic relationship with a therapist trainee. Therapist interventions within each client relationship-building incident (RBI) were identified. Relationships between therapist interventions and the attachment dimensions of anxiety and avoidance were examined. The results of multiple regression indicated that attachment anxiety moderated the relationship between attachment avoidance and the type of therapist interventions present in the RBI. Findings offer support for Bowlby's secure base hypothesis. Secure clients (low anxiety, low avoidance) nominated incidents with higher levels of exploratory interventions. Dismissing clients (low anxiety, high avoidance) nominated incidents with higher levels of supportive interventions. Issues related to tailoring therapist behaviours to client attachment style to facilitate positive alliances are discussed.

RÉSUMÉ

Vingt-quatre clients ont été invités à identifier un incident qu'ils considéraient critique au développement de leur rapport thérapeutique avec un thérapeute stagiaire. L'étude identifie les interventions thérapeutiques particulières à chaque incident rapporté et examine la relation entre les interventions du thérapeute et les dimensions d'attachement—l'inquiétude et l'évitement chez les clients. Les résultats de la régression multiple ont indiqué que l'anxiété d'attachement modère le rapport entre l'évitement de l'attachement et le type d'intervention du thérapeute au moment de l'incident rapporté. Les constatations soutiennent l'hypothèse de Bowlby quant à la base de sécurité. Les clients sécures démontrant des niveaux faibles d'inquiétude et d'évitement ont rapporté des incidents caractérisés par des niveaux plus élevés d'interventions exploratoires. Les clients démissionnaires démontrant des niveaux faibles d'inquiétude et des niveaux élevés d'évitement ont rapporté des incidents caractérisés par des niveaux plus élevés d'interventions de soutien. On discute les questions reliées à l'adaptation des interventions du thérapeute au style d'attachement du client pour faciliter les alliances thérapeutiques positives.

Literature from the past two decades points to a consistent association between the strength of the early therapeutic relationship and positive therapeutic outcomes (see Horvath, 2001, for a review). The American Psychological Association Division 29 Task Force on psychotherapy relationships (Norcross, 2002) has underlined the need for theoretically based inquiries into the development of the therapeutic alliance that focus on client characteristics and include the client's perspective. The development of the alliance is likely not a simple linear process (Stiles, 2002) but may be punctuated by interpersonally important moments that signal to the client the presence of an important and meaningful therapeutic relationship. Client-nominated relationship-building incidents from early therapy sessions have been associated with sharp increases in alliance ratings (Fitzpatrick, Janzen, & Jaouich, 2003), in-session exploration, and attachment to the therapist (Janzen, Fitzpatrick, & Drapeau, 2008).

Security of attachment has emerged as a significant predictor of the therapeutic alliance (Eames & Roth, 2000), as well as of general therapy success (Fonagy et al., 1996; see Meyer & Pilkonis, 2001, for a review). Client attachment issues appear to play an important role in client-nominated positive events. Also, the types of interventions present in these events differ depending on the attachment style of the client (Hardy et al., 1999).

What is less well understood is how client attachment affects processes related to alliance development. In light of client attachment orientation, which interventions do clients nominate as important to the development of their relationship with their therapist? A promising research strategy for understanding the development of the therapeutic relationship is to examine client and therapist contributions to client-nominated therapy events in early therapy. This study investigated the therapist behaviours present in client-nominated relationship-building incidents across clients with differing attachment orientations.

First we will discuss attachment theory in regards to the development of adult attachment relationships in general and the therapeutic relationship in particular. We will then review research demonstrating associations between client adult attachment and the therapeutic alliance. Finally, we will review the research on therapist interventions and client adult attachment in light of conflicting evidence and methodological issues in the literature.

ATTACHMENT THEORY AND THE THERAPEUTIC ALLIANCE

According to attachment theory, individuals form an attachment bond based on the responsiveness of caregivers (Bowlby, 1973, 1988). These experiences translate into internal working models that guide perceptions of, and behaviours in, relationships. Current formulations of adult attachment dimensions (Brennan, Clark, & Shaver, 1998) describe an individual's level of comfort and confidence in close relationships on a continuum that assesses attachment *anxiety* and degree of yearning for intimacy, fear of rejection, and preference for interpersonal distance or self-sufficiency on a continuum that assesses attachment *avoidance*.

Brennan et al. (1998) and Mikulincer, Shaver, and Pereg (2003) have also proposed a system for discussing attachment categories in terms of underlying dimensions: *secure* (low anxiety, low avoidance), *preoccupied* (high anxiety, low avoidance), *dismissing* (low anxiety, high avoidance), and *avoidant-fearful* (high anxiety, high avoidance). Secure adult attachment is characterized by a combination of a positive self model (a sense of worthiness) and a positive model of others (an expectation that others are generally accepting and responsive). Preoccupied attachment is exemplified by a negative model of self and a positive model of others: striving for self-acceptance by gaining the acceptance of valued others. Fearful attachment includes negative models of self and others, and avoidance of close relationships for self-protection. Finally, dismissing attachment is characterized by a positive model of self and a negative model of others, with an avoidance of closeness and a defensive denial of the value of close relationships (Bartholomew & Horowitz, 1991).

As mentioned, the responsiveness of the caregiver in times of distress is a major contributor to individual differences in attachment-system functioning. Mikulincer and Shaver (2007) suggest that when the primary attachment strategy is working well, the individual organizes knowledge about distress management around a secure-base script that includes something like the following if-then proposition:

> If I encounter an obstacle and/or become distressed, I can approach a significant other for help; he or she is likely to be available and supportive; I will experience relief and comfort as a result of proximity to this person; I can then return to other activities. (p. 21)

However, when the attachment script is not working well and does not result in a sense of felt security, individuals develop secondary attachment strategies characterized by hyperactivation (anxiety) or deactivation (avoidance). Hyperactivation results from an intermittent schedule of responsiveness and is characteristic of individuals with high levels of attachment anxiety. In this state, the individual is unlikely to give up proximity seeking and may intensify demands for attention, support, and love to attain security.

The deactivating strategy, associated with high levels of attachment avoidance, is characterized by weakened proximity-seeking efforts likely developed in response to relationships where vulnerability has been disapproved of and punished. Fearing further rejection of proximity-seeking efforts, individuals attempt to deal with the threat or distress on their own. Adapting Mikulincer and Shaver's (2007) secure base script to the developing therapeutic relationship, early therapy may be characterized by the client's questioning of the following if-then proposition: *If I disclose distressing thoughts and feelings to my therapist, can he or she be trusted to be available and supportive; will I experience relief and comfort as a result of proximity to this person; then will I be able to continue working toward my therapeutic goals?*

If individuals with different attachment patterns approach interpersonal relationships differently, then their attachment patterns can be expected to influence

their relationship with their therapist. Clients with secure attachment orientations have been found to have stronger alliances with their counsellors (Kivlighan, Patton, & Foote, 1998; Satterfield & Lyddon, 1998), while clients with fearful attachment orientations have been found to form poorer alliances. For dismissing and preoccupied attachment styles, however, associations with alliance have been equivocal (Eames & Roth, 2000; Satterfield & Lyddon, 1998).

Specifically, Eames and Roth (2000) found that clients with preoccupied attachment styles reported more ruptures, whereas those with dismissing attachment styles reported fewer ruptures. The authors questioned the validity of client reports of the alliance. Specifically, it may be that in line with a protective tendency to downplay emotional involvement and their own vulnerabilities, dismissing clients may report a positive, though superficial, alliance.

In a recent study (Mallinckrodt, Porter, & Kivlighan, 2005), adult attachment anxiety was significantly negatively associated with the tasks and goals components of the alliance, but not the bond component. This pattern suggests that clients with high anxiety in adult attachment relationships have more difficulty agreeing with their therapist about the direction of therapy than they have difficulty forming an emotional bond.

If clients with different attachment patterns engage in therapy differently, it may be expected that client attachment patterns call forth different behaviours on the part of the therapist. Although attachment theory predicts that, in general, people elicit responses from others that confirm their working models of attachment, the theory also suggests that therapists should resist this natural pull with the goal of challenging relational strategies by responding with a contrasting approach (see Bernier & Dozier, 2002, for a review).

A confirmatory or complementary approach for avoidantly attached clients would involve cognitive or interpretive interventions, while a contrasting approach would involve a focus on affect, provision of support, and empathy. For anxiously attached clients, a complementary approach would entail a focus on affect, empathy, and support, while a contrasting approach would involve fewer affective interventions and a focus on cognitive or interpretive interventions. Research examining which approach best represents appropriate therapist responsiveness has been inconclusive.

Supporting a complementary approach, Rubino, Barker, Roth, and Fearon (2000) found that in the resolution of alliance ruptures, therapists tended to respond to videotaped statements made by actors role-playing fearful and preoccupied patients (high attachment anxiety) in a deeper and more empathic manner than they did with dismissing and secure patients (low attachment anxiety). Hardy, Stiles, Barkham, and Startup (1998) found that across therapy sessions, therapists tended to use more affective and relationship-oriented interventions with preoccupied clients and more cognitive interventions with dismissing clients. Similarly, Hardy et al. (1999) found that in mid-therapy client-nominated helpful events, therapists tended to respond to preoccupied attachment styles with reflection, and to dismissing styles with interpretation.

Examining the issue of therapist responsiveness from a different angle, focusing on the interaction between therapist and client attachment patterns, one study has reported support for a therapist approach that contrasts the client's attachment strategies. Tyrell, Dozier, Teague, and Fallot (1999) found that clients with the tendency to avoid discussion of emotional topics and reject help from treatment providers (strategies consistent with dismissing or avoidant attachment orientations) had better alliances and functioned better with case managers who used proximity-seeking strategies (strategies consistent with preoccupied attachment orientation) and vice versa, suggesting that interventions that break from the client's interpersonal pull are beneficial.

The cited studies differ with respect to how complimentarity was assessed, as well as in regards to whether the focus was on helpful mid-therapy events or therapy outcome, making integration of results difficult. Given the relationship between early alliance and outcome (Horvath, 2001), further investigations that focus on the early alliance are needed.

POSITIVE THERAPY EVENTS AND THE CLIENT'S EXPERIENCE OF THE THERAPIST AS A SECURE BASE

Creating good alliances with insecurely attached clients is an important training issue. While novice therapists appear to be equal to experienced therapists in their ability to foster good alliances in general, experienced therapists tend to have better alliances with clients who are not comfortable with intimacy (Kivlighan et al., 1998). Focusing on positive moments in early sessions can inform trainees about what they are doing well. Specifically, it would be informative to know how trainees respond to clients with different attachment patterns in moments deemed, by the clients themselves, important to developing a good therapy relationship.

Bowlby (1988) conceptualized the therapeutic relationship as an attachment relationship and speculated that existing attachment models would affect its development. In common with other attachment figures, therapists can be perceived as providing help and emotional regulation in times of distress, and as dependably available and responsive to needs, functioning as a secure base for exploration (Mallinckrodt et al., 2005; Romano, Fitzpatrick, & Janzen, 2008).

From an attachment perspective, positive relational events with partners signal availability, responsiveness, support, and caring, leading a person to feel protected, accepted, and valued (Shaver & Hazan, 1994). Adapting Mikulincer and Shaver's (2007) secure base script to the developing therapeutic relationship, early therapy can be understood as a time characterized by the client considering the question: *If I disclose distressing thoughts and feelings to my therapist, can he or she be trusted to be available and supportive; will I experience relief and comfort as a result of proximity to this person; then will I be able to continue working toward my therapeutic goals?*

Janzen et al. (2008) found that increases in attachment-related security with a therapist were associated with more positive appraisals of the therapist and the therapy, and higher levels of exploration following a self-nominated relationship-

building incident. Prior to the relationship-building incident, client attachment avoidance was related to lower levels of security with their therapist, and lower levels of security with their therapist were related to lower levels of perceived support and exploration; however, avoidant clients became significantly more secure with their therapist in the session following the relationship-building incident session.

Given positive therapy processes associated with client-nominated relationship-building incidents, it would be important to identify how novice therapists intervene during these incidents and if interventions vary with client attachment orientation. Relationship-building incidents nominated by the client may represent a snapshot of the types of interventions clients value when developing a relationship with their therapist, while other moments in the first three sessions of therapy may represent how therapists are likely to behave when working with individuals of differing attachment patterns.

To investigate the relationship between client attachment and trainee therapist interventions early in therapy, this study identifies the therapist behaviours present in client-nominated relationship-building incidents and in randomly chosen segments across clients with differing attachment orientations. Given the methodological differences between studies and inconsistent findings, the current study takes an exploratory approach. We examined if client attachment dimensions, uniquely or in interaction, predicted therapist behaviours in relationship-building incidents and in randomly chosen segments. Specifically, our research question was, "How are therapist interventions in relationship-building incidents related to client attachment dimensions?"

METHOD

Participants

CLIENTS

Client participants were students enrolled in a counselling course in an applied human sciences program at a Canadian university who chose a counselling experience as an optional, experiential component of their course. Their clients were 26 students completing a human science undergraduate program who chose to complete 12–15 sessions of personal counselling. Two clients, who saw the same therapist as other participants, were excluded to maintain independence of observations required by hierarchical regression. Exclusion was based on the number assigned to the participant upon entry to the study; the participant with the lower number was excluded. The remaining 24 clients were 17 women and 7 men, ranging in age from 21 to 54 years ($M = 28$, $Mdn = 23$, $SD = 10.28$). They identified their origins as Caucasian (9), European (6), Asian (2), Middle Eastern (1), and Latina (1); 5 participants did not identify an ethnic origin.

The Target Complaints Scale (Battle et al., 1966) was used as an indicator of client distress. This scale asks clients to name three problems they would like to address during treatment and to rate the amount of discomfort associated with

each problem on a 13-point scale ranging from 1 (*not at all*) to 13 (*couldn't be worse*). Complaints prior to the first session were categorized as follows: (a) relationship difficulties (54%), (b) problems with self-esteem (19%), (c) career and academic issues (8%), and (d) eating disorders (4%). Discomfort associated with identified problems ranged from 1 to 12 (M = 6.18, SD = 2.81), reflecting a mild degree of discomfort. On average, clients saw their therapist for 14 sessions (*Mdn* = 15, *Range* = 5, SD = 1.54).

THERAPISTS

Twenty-four master's-level trainee therapists saw clients in the counselling clinic housed within their department (22 women, 2 men; ages 21–44; M = 27, *Mdn* = 25, SD = 5.84). Therapists identified their ethnic origins as Caucasian (13), European (2), and Latina (1); 7 trainees did not report an ethnic origin. Trainees were enrolled in a practicum course at a different university from the university attended by clients. The course emphasized the importance of common factors and the building of a strong therapeutic relationship through the use of counselling microskills (Hill, 2004).

Clients and therapists were paired according to availability. Prior to meeting with their first practicum clients, trainee therapists had approximately 30 hours of training in helping skills. Doctoral supervisors closely monitored the work of trainees and met with a faculty instructor for 3 hours weekly to discuss issues related to the handling of the cases. The instructor met with trainee therapists to co-supervise cases identified as problematic.

RESEARCHERS

Six doctoral students with up to three years post-master's degree clinical experience conducted the relationship-building incident interviews. The four researchers who located relationship-building incidents within the videotaped therapy session included two counsellors with 1 to 2 years post-master's degree clinical experience, a second-year Master of Art student, and one of the interviewers. Finally, rating of therapist interventions was completed by two doctoral students with up to four years post-master's degree clinical experience.

Measures

EXPERIENCES IN CLOSE RELATIONSHIPS SCALE (ECRS; BRENNAN ET AL., 1998)

Client attachment was measured using the ECRS, a 36-item self-report measure of adult attachment. Items are rated on a 7-point Likert-type scale response format ranging from 1 (*disagree strongly*) to 4 *(neutral/mixed)* to 7 (*agree strongly*). The measure consists of two orthogonal dimensions: the anxiety subscale (18 items) taps fears of rejection and abandonment, and the avoidance subscale (18 items) assesses discomfort with dependence and intimate self-disclosure. The scale has been found to be highly reliable and to have high construct and predictive validity (Shaver & Mikulincer, 2002). In the current sample, internal reliabilities were

.86 for the avoidance and .96 for the anxiety subscales. The correlation between anxiety and avoidance was .18.

RELATIONSHIP-BUILDING INCIDENTS INTERVIEW

A semi-structured interview protocol was designed to examine clients' perspectives on the development of a relationship with their therapist (see Fitzpatrick, Janzen, Chamodraka, & Park, 2006, for details). The interview, administered one time immediately following session 3, began with an orienting section in which clients were asked questions about someone with whom they had developed an important relationship. The purpose of the orienting section was to ensure that participants share the interviewers' understanding of the type of event that will be discussed by making a link to an everyday life event (e.g., developing a relationship with a friend). In this orientation phase, we included questions that mirrored the questions that were asked about the event itself (e.g., influencing characteristics of the friend have aspects in common with influencing characteristics of a therapist) (Fitzpatrick & Chamodraka, 2007).

Clients were then asked about the importance they ascribe to a therapeutic relationship, the expectations they had prior to meeting their therapist, and how they would characterize their current therapeutic relationship. If the characterization was positive, the interviewer asked them to describe how they knew the relationship was "on the right track"; if the characterization was negative, they were asked to describe, "What got in the way of the relationship getting going?"

Clients were then asked to choose and describe in detail a therapy event that had been particularly poignant, important, or meaningful to them in the initiation of the relationship. Finally, clients were prompted to discuss both their own and their therapist's contributions to the incident. Interviews lasted on average 30 minutes (range 15–40 minutes). Of the 24 incidents nominated by the 24 participants, all were positive.

PARTICIPANT CRITICAL EVENTS METHOD (PCE; FITZPATRICK & CHAMODRAKA, 2007)

The PCE was used to identify the incidents within the client-designated therapy session. Researchers carefully read the interview and the relevant session transcript. Decision rules were used to demarcate exact beginning and ending dialogue lines of the incident based on the specificity of the quotation and the description of the interaction in the incident. Interrater reliability was calculated based on the ratio of agreed-upon versus disagreed-upon speaking turns.

Interrater reliability for identifying beginning and ending points of events was good (α = .82), in line with existing methods of locating in-session episodes (e.g., Luborsky & Crits-Christoph, 1998). To verify validity of segmentation, a subgroup of participants (n = 18) identified their relationship-building incidents on videotape upon completion of their 12–15 sessions of therapy (average 2 weeks following termination). The average level of agreement between the segmented incidents that researchers agreed on and incidents identified by the client in a follow-up interview was .81.

In order to examine instances of therapy prior to the relationship-building incident (RBI), random segments matched on average length to the RBIs were chosen from the same session in which the RBI occurred. As a number of RBIs occurred in session 1, random segments had to be chosen from the same session and, wherever possible, occurred before the RBI in the session. The relevant sessions were transcribed and therapist interventions were rated. Raters were unaware of segment type. To prevent rater drift and ensure reliability, after every fourth session rating, raters rated the same transcript, calculated reliabilities, and discussed disagreements.

PSYCHODYNAMIC INTERVENTION RATING SCALE (PIRS; COOPER & BOND, 2002)

Therapist interventions were described along an expressive-supportive continuum by first categorizing interventions with the PIRS and then rank-ordering interventions from most expressive to most supportive (Gabbard, 1994). The PIRS was used to identify the types of interventions delivered within the RBIs and randomly chosen segments.

The PIRS is a categorical rating scale suitable for macro- and micro-level analyses (Bond, Banon, & Grenier, 1998). Based on transcripts, therapist dialogue is divided into thematic units with each unit scored as an intervention. A thematic unit consists of a single idea as expressed by the therapist, usually one to a few sentences long. Thematic unit segmentation reliabilities tend to range from .77 to .87 (Stinson, Milbrath, Reidbord, & Bucci, 1994).

The PIRS identifies ten types of interventions broadly divided into two main categories: interpretation (defense and transference) and support (acknowledgements, clarification, questions, associations, reflections, work-enhancing strategies, support strategies, and contractual agreements). Milbrath et al. (1999) reported interrater reliabilities (Light's kappa) for each category (.83 to .99) and for the measure as a whole (.85). Hersoug, Bogwald, and Hoglend (2003) reported a range of intraclass coefficient reliabilities (ICC 2, 2) from .68 to .97 (M = 0.78).

Raters in the current study, trained by a developer of the scale (M. Bond), achieved acceptable agreement with expert ratings (ICC 2, 1) of .97 and intraclass coefficients among themselves (ICC 2, 1) ranging from .71 to .83. Construct validity of the PIRS was shown in a sequential analysis of therapist interventions and patient elaboration (Milbrath et al., 1999).

PIRS interventions are correlated in expected ways with the tasks involved in adequate dynamic interviews (Perry, Fowler, & Semeniuk, 2005). Also, therapists have been found to use significantly more supportive interventions in early than in mid-therapy (Hersoug et al., 2003), supporting the discriminant validity of the PIRS.

A summary score for the PIRS, the expressive-supportive intervention level (ESIL) (e.g., Despland, de Roten, Despars, Stigler, & Perry, 2001; Hersoug, Hoglend, & Bogwald, 2004; Perry et al., 2005), was derived from the PIRS by rank-ordering the interventions on a continuous, hierarchical scale from 1 (*most supportive*) to 7 (*most exploratory*) using the weighted average. PIRS categories

are weighted as follows: 1 (*association*), 2 (*support strategy, contractual agreement*), 3 (*reflection*), 4 (*question, clarification, work-enhancing strategy*), 5 (*defense interpretation at level 1*), 6 (*defense interpretation at levels 2-5*), and 7 (*transference interpretation*).

To produce a total ESIL score for each case, interventions at each level are summed and multiplied by their rank-ordered placement. The products are added for each case and divided by the total number of interventions to produce the weighted score. Higher ESIL scores indicate a higher frequency of exploratory interventions; lower scores indicate a higher frequency of supportive interventions.

Procedures

The study was approved by the ethical review boards of two participating universities. Prior to their first session, clients met with a researcher who invited them to participate in the research. Clients were informed that the purpose of the study was to examine how relationships between therapists and clients form and that participation in the study would involve videotaping of therapy sessions, interviews, and questionnaires. Clients who agreed to participate in the research completed a research package that included consent, demographics, ECRS, and TC forms. Consent included the videotaping of therapy sessions and audiotaping of an interview with a research assistant conducted immediately after the third session. Clients were assigned to a trainee therapist on the basis of scheduling availability and were seen in the counselling clinic of the training department.

RESULTS

To illustrate the content of RBIs efficiently, the authors used a consensus process to categorize the RBIs into six broad categories. Representative verbatim examples and number of clients nominating each type of RBI category are provided in Table 1.

Table 1
Relationship-Building Incident Categories and Representative Examples (N = 24)

Category 1: Therapist self-disclosure (*n* = 3)
I explained to him that I feel like literally—"do not operate heavy machinery" and he said, "Yeah, I know how that feels." He stressed that he's not diagnosing me with seasonal affective disorder, but he told me that he suffered from that and that a lot of the things that I was saying were similar. It's like when two people talk about a movie they saw and it's like, "Oh yeah! And that and that part!" I really felt like—we're meeting at some point.

Category 2: Therapist praised client (*n* = 2)
I made reference to something that I had noticed in my other relationships that I connect to the relationship with my father. She pointed out how insightful that was. A lot of what I told her wasn't very pretty, she sort of won my trust, when she wasn't sort of horrified or, or um she wasn't like "Oh, is that all?" She said, "This is very good, you're very aware of what's going on and you're beginning to piece it all together." I felt very relieved it was like, "Okay," you know like "I'm not an emotional basket-case."

Category 3: Therapist showed interest and acceptance (*n* = 4)
I was talking about shoplifting; it was—embarrassing I guess? Her response was straight-faced and non-judgmental and she was supportive. It was like I had—said it—and then waited for her reaction and she just waited for me to speak more. I would normally expect anybody else would be—like "Oh my god!"—with her it was just like "Yeah OK that's what you're talking about, keep going." It made me feel OK, I was glad that I had said it and it was there. I also knew from that point on like "Oh … I can really talk about anything."

Category 4: Therapist gave homework or advice (*n* = 4)
She gave me an assignment to do for the following week and explained why she wanted me to do it and what it would do to help. It would help me um not just with my relationship with my father, but just in general. Like it'll make me more aware, the whole purpose for why I'm doing this [counseling] is for me, not just for class. I left [the previous session] feeling a little lost, depressed, alone and a little frightened. And today I feel very alert and high and like I have a goal. I have an assignment to do.

Category 5: Therapist facilitated exploration and insight (*n* = 8)
I was explaining to her about—the reasons why I got very drunk. And as I was trying to explain to her what my choices were as opposed to staying home, she said, "Are those your only choices?" I felt like she knew that there was something else in my mind that I knew was a choice but I wasn't—making it a choice. Then I realized, "OK, she's right, I know there was another choice." With that question that I felt like OK, I'm on the spot so I'm forced to answer it. For me, for someone to ask just the right question to get me to ah—to be forced to answer that's—that's when I feel like, OK, now they're getting me, they are asking me the questions I know I want them to ask.

Category 6: Therapist helped client work through a difficulty in the therapy relationship (*n* = 3)
In the second session she said, "You know I reviewed the tape, from the first session. I may have done some things that weren't right, or maybe that you took the wrong way and I wanna—just to discuss that with you" and it made me feel so much better. You know I left the first session, I'm like "Oh my god, how old can she be! I just told her all this stuff and I was feeling like oh my god, maybe people can hear!" and like stressed, you know. When she addressed those issues it immediately made it better for me.

Attachment dimension scores and therapist intervention (ESIL) means and standard deviations in both RBIs and random segments are reported in Table 2. Eleven participants nominated an RBI in session 3, 11 nominated an RBI in session 2, and 2 nominated an incident in session 1. Data for the ESIL were normally distributed.

Table 2
Descriptive Statistics for Client Attachment Dimensions and Therapist Behaviours in Relationship-Building Incidents and Random Segments

	Relationship-Building Incident				Random Segment			
	M	*SD*	Min.	Max.	*M*	*SD*	Min.	Max.
Anxiety	3.85	1.38	1.50	5.79	-	-	-	-
Avoidance	2.62	1.39	1.06	6.22	-	-	-	-
ESIL	2.94	0.85	1.46	5.00	3.12	0.70	1.60	4.00

Note. *N* = 24. ESIL = Expressive-Supportive Intervention Level summary score.

Are Client Attachment Dimensions Related to Therapist Behaviours?

Two hierarchical regression analyses examined the relative contributions of anxiety, avoidance, and their interaction to therapist interventions in both the RBI and the random segment. To increase interpretability of interactions, the predictor variables (ECRS: avoidance, anxiety) were centred (put in deviation score form so that their means equal zero) by subtracting the mean from each data point. The interaction term (anxiety × avoidance) was formed by multiplying the two centred predictors (Aiken & West, 1991; Judd & McClelland, 1989). The overall F test gauges how well a single regression line (main effect) fits its underlying data; a significant interaction term indicates that two or more lines fit the data better. The omnibus F protects against inflated Type I error related to multiple comparisons; however, in a hierarchical model with predictor and moderator measured on a continuous scale, the single degree of freedom F test, representing stepwise change in variance explained as a result of the addition of the product term, provides the information needed to test significance (Frazier, Tix, & Barron, 2004).

For the RBI analysis, anxiety and avoidance were entered in Step 1 followed by the interaction term entered in Step 2. The omnibus F test was non-significant ($F(3,20) = 1.86$, $p > .10$); however, the incremental F-test for the interaction term ($F_{change}(1, 20) = 4.62$, $p < .05$) accounted for 22% of the variance in therapist expressive-supportive intervention level (ESIL) (see Table 3). In order to interpret the interaction, three simple regression lines of the regression of therapist intervention level (ESIL) on avoidance as a function of three levels of anxiety were plotted (Figure 1).

Table 3
Hierarchical Regression Analysis Predicting Expressive-Supportive Intervention Level from Client Attachment Dimensions

| Variable	B	$SE\ B$	t	p
Avoidance	-0.12	0.13	-0.92	0.36
Anxiety	0.06	0.15	0.41	0.68
Anxiety × Avoidance	0.27	0.13	2.15	0.04*

*p > .05

The three levels of anxiety (low, moderate, high) were calculated based on the mean and one standard deviation above and below the moderator mean (Aiken & West, 1991). A test of the significance of the simple slopes of the regression lines indicated a significant negative regression of therapist intervention level on avoidance for low anxiety, $t(20) = -2.08$, $p < .05$; however, no significant relationships between avoidance and therapist intervention level at either high or moderate levels of anxiety were found. When avoidance was entered as the moderator, the simple slopes of the regression lines were not significantly different from zero.

The results indicated that the relationship between ESIL and avoidance was conditional upon a low level of client anxiety. A low level of attachment anxiety and low avoidance predicted therapist use of more exploratory interventions, while a low level of anxiety and high avoidance predicted therapist use of supportive interventions. Observed power was .74 and effect size was medium to large (Cohen's f^2 = .28). By convention, f^2 effect sizes of 0.02, 0.15, and 0.35 are considered small, medium, and large, respectively (Cohen, 1988). When this analysis was repeated for the random segments, the incremental F was not significant at either Step 1 or Step 2, suggesting that attachment had no predictive power outside of the RBIs.

Figure 1

Interaction of Client Attachment Avoidance and Attachment Anxiety in Predicting Therapist Intervention Level Along the Expressive-Supportive Continuum in the Relationship-Building Incident
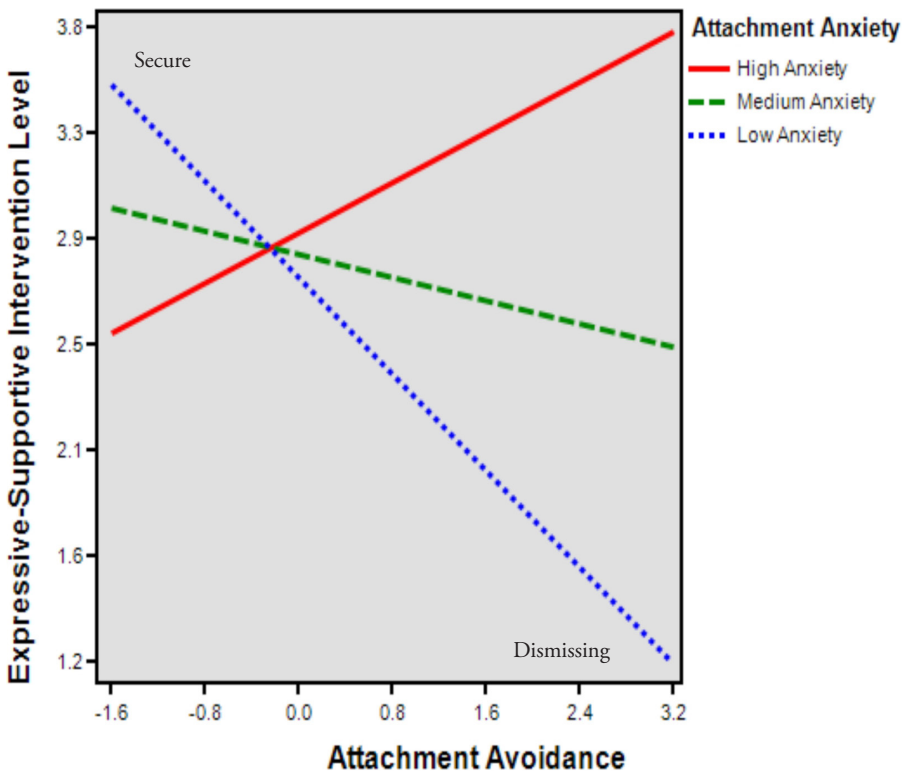
Note. Expressive-Supportive Intervention Levels (ESIL). 1 = Association/self-disclosure; 2 = Support strategy, contractual agreement; 3 = Reflection; 4 = Question, clarification, work-enhancing strategy; 5 = Defense interpretation (level 1), 6 = Defense interpretation (level 2-5); 7 = Transference interpretations. Secure = low anxiety, low avoidance; Dismissing = low anxiety, high avoidance.

<div align="center">DISCUSSION</div>

Therapist Interventions: The Moderating Role of Client Attachment Anxiety

This study provides support for the claim that therapist interventions are related to client attachment orientation. Following client-nominated relationship-building incidents, Janzen et al. (2008) found that clients felt more securely attached to their therapist, felt more positive about their therapist and their therapy, and explored more in session.

The results of the current study suggest that positive therapy processes are sparked by very different therapist interventions that depend upon the client's attachment orientation. Clients with secure and dismissing attachment styles nominate very different interventions when describing how they came to develop a relationship with their therapist. Specifically, results indicate that attachment anxiety moderated the relationship between therapist interventions and attachment avoidance in relationship-building incidents. This finding, which demonstrates an interaction between anxiety and avoidance, allows results to be interpreted in terms of attachment groups (Brennan et al., 1998). Discussion will focus on the two groups for which results were significant: the secure (low anxiety, low avoidance) and dismissing (low anxiety, high avoidance) client groups (see Figure 1).

SECURE ATTACHMENT AND EXPLORATORY INTERVENTIONS

Low levels of attachment anxiety and avoidance reflect a secure attachment style. Secure attachment has been associated with positive models of self and others, belief in the good intentions of others, positive response to feedback, and willingness to examine different perspectives (Brennan & Bosson, 1998; Mikulincer & Shaver, 2005). When working with secure clients, trainees used more exploratory interventions, including interpretations. Since clients who value themselves and others are not impeded in their ability to develop collaborative, reciprocal relationships, trainees may have felt confident enough in the therapeutic relationship to take an exploratory stance in early sessions. Such a stance asks the client to draw appropriate self-other boundaries and to take an autonomous position relative to ideas and avenues of inquiry (Gabbard, 1994).

The finding that clients with a secure attachment orientation responded positively to exploration as early as the first three sessions is in line with research that supports the use of exploratory interventions with secure clients (Gaston & Marmar, 1994). Further, this finding adds to the growing literature (e.g., Mallinckrodt et al., 2005; Romano et al., 2008) supporting Bowlby's hypothesis that securely attached individuals are better able to explore within therapy sessions.

DISMISSING ATTACHMENT AND SUPPORTIVE INTERVENTIONS

Low levels of anxiety and high levels of avoidance represent a dismissing attachment style. Dismissing individuals tend to defensively deny the importance of others in order to protect themselves from disappointment and to preserve their sense of self-worth (Mikulincer & Shaver, 2005). In their interpersonal worlds,

individuals who distance themselves from others tend to pull a complementary, distancing approach that keeps them from obtaining important social support (Kiesler, 1996).

The dismissing clients in this study, however, valued relational incidents in which therapists were more supportive, moments of therapist reflecting (on something that they had said at another point without making an interpretation), self-disclosing, and sharing a personal opinion, fact, advice, or praise. Although those who use deactivating strategies may be less likely to seek therapy as a viable option for relieving distress (Mikulincer & Shaver, 2005), these clients selected therapy as a component of a university program and perhaps found themselves in a novel situation of support-seeking. The relational events may have tapped their yearning for intimacy, providing an unaccustomed interpersonal moment—a focus on themselves and their issues within a containing framework. Results may be interpreted as representing a contrasting approach where the therapist is attempting to connect with the dismissing client in a personal way.

Although this study does not examine therapist attachment, findings relate to those of Dozier, Cue, and Barnett (1994), who found that dismissing clients tended to receive interventions aimed at underlying dependency needs from secure therapists. Future research should include an examination of the role of therapist attachment. Results contrast to those of Hardy et al. (1999), who found that dismissing clients tended to nominate helpful mid-therapy events characterized by interpretation, an exploratory intervention.

One explanation for this discrepancy may relate to the timing as well as the type of event. We speculate that, in early therapy, dismissing clients may feel more comfortable when they have explicit information about the therapist, direct support, and feedback. These types of interventions may help to disconfirm their negative expectation of rejection. As therapy progresses and issues are addressed, dismissing clients may come to prefer interpretations.

Another explanation may be related to the method used to assess attachment in the Hardy study. The Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) assesses *states of mind with respect to attachment* by examining the manner in which one speaks of her or his childhood rather than the content of what is said. The AAI may tap into the more unconscious aspects of attachment models, while self-report measures, such as the ECRS used in the current study, may reflect internal working models operating in current relationships that are more conscious and directly accessible to introspection (Simpson & Rholes, 1998). Although both measures are believed to tap into an underlying attachment construct, correlations between the two are relatively low (Bartholomew & Shaver, 1998), providing an additional explanation for the discrepant findings.

Limitations

Caution should be exercised in interpreting the findings, most importantly with respect to the generalizability of the sample. Although these volunteer clients discussed genuine personal concerns in sessions, they represent a high-functioning

client population and results must be interpreted within this context. Given the potentially important role of distress in activating the attachment system, the findings of the present study may have been different if clients had higher distress levels. Findings are restricted to early sessions; the type of anxiety evoked may differ from that evoked in later therapy.

Additionally, given that the sample consisted of trainee therapists, we cannot generalize the results to experienced therapists, who may respond to clients in different ways. Relative to the measurement of interventions, PIRS categories are based on a psychodynamic conceptualization of interventions. Although the PIRS was chosen because of the psychodynamic origins of attachment theory, the theoretical underpinnings of the measure may influence interpretation of the findings. For example, while questioning is used to promote client exploration of perceptions in cognitive-behavioural therapy (Beck, 1995), psychodynamic approaches categorize questions as supportive because they are geared toward obtaining information (Gabbard, 1994).

Finally, the sample size limits the generalizability of findings. Although tests of moderation with small samples (e.g., below 30) have been conducted in a number of published studies within the field of psychotherapy research (e.g., Romano, Janzen, & Fitzpatrick, 2009; Vogel, Hansen, Stiles, & Gotestam, 2005), it is important to acknowledge that low power due to small sample size may have obscured important associations and differences leading to Type II errors.

Directions for Future Research

Future research is needed to clarify if the same pattern of results would be seen with an experienced group of therapists and/or with a clinical population. Further, the therapeutic situation is a two-person endeavour. Examining the extent to which client and therapist perspectives of relationship-building incidents converge might be helpful in understanding the role of transference and countertransference in alliance development.

Recent evidence suggests that client and therapist attachment patterns interact to produce combined effects on the therapeutic relationship (e.g., Dozier et al., 1994; Mohr, Gelso, & Hill, 2005; Rubino et al., 2000; Tyrell et al., 1999). It may be that therapist attachment moderates the relationship between client attachment and interventions delivered. Studies investigating interactions in regards to other therapist behaviours as well as different types of therapeutic events at later stages in therapy would shed light on the important processes involved in the evolution of the therapeutic relationship.

CONCLUSION

This study contributes to the literature on client interpersonal characteristics and therapist training by suggesting some directions for tailoring therapist behaviours in the service of the development of the therapeutic relationship with a non-clinical population. Janzen et al. (2008) found that relationship-building

incidents are related to positive therapy processes. The current study adds to these findings by identifying the types of therapist interventions present within relationship-building incidents. Different interventions that address different attachment issues are required in order to produce an affirmative answer to the client's secure base script.

Securely attached clients feel they are building a relationship with their therapist when the therapist is helping them to explore the meaning of their thoughts, feelings, or behaviours through use of interpretive techniques. Dismissing clients reported feeling that they were building a relationship with their therapist when their therapist was not interpreting, but was offering support, advice, and self-disclosing. Dismissing individuals tend to fear that others will reject their proximity-seeking efforts and therefore attempt to deal with threats or distress on their own. The results of the current study suggest that dismissing clients feel they are building a relationship with their therapist when their therapist offers a different type of relational experience than that which they are accustomed to, one in which the client has access to a present and supportive therapist.

The findings in regards to securely attached clients have particular implications for those working with high-functioning clients. We tentatively suggest that securely attached clients may feel sufficiently safe and comfortable with the therapist quite early in therapy. These clients may be eager to begin exploring the meanings of their experiences with their therapist and may not require the same level of reassurance and support required by the client with a dismissing attachment orientation.

It may be useful for supervisors to be vigilant relative to helping trainees understand instances of unintentional complementarity. For example, attachment theory predicts that an everyday complementary response to a dismissing client's distancing would be a complementary distancing approach. When trainees broke from this pull, dismissing clients began to feel they were developing a relationship. Resisting a distancing pull or countertransference reaction may help to develop good relationships, particularly with dismissing clients. Trainees may benefit from being aware of the interpersonal pull and their own tendencies to reduce their own anxiety by giving into this pull. This awareness of their internal reactions may aid trainees in making mindful intervention decisions, helping them to develop positive relationships with their clients.

Research by Mohr et al. (2005) points to the need for therapists, particularly those high in anxiety whose relational and affect regulatory styles may be challenged by dismissing clients, to be aware of this type of countertransference. Finally, this work adds to the growing literature that supports the clinical utility of Bowlby's attachment framework, particularly in regards to the management of countertransference and development of the therapeutic relationship.

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