SECURE BASE AND SAFE HAVEN WITHIN THE THERAPEUTIC RELATIONSHIP: AN ATTACHMENT THEORY-BASED ANALYSIS OF FOUR CASES

by

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ABSTRACT

Despite extensive literature documenting the importance of the client-therapist relationship in psychotherapy, the process of developing an effective therapeutic alliance is obscure and particularly daunting to novice therapists. Attachment theory, as proposed by Bowlby (1979, 1982, 1988) and expanded upon by Bartholomew (1991), offers promise in elucidating individual differences in attitudes, beliefs, and emotional regulation systems that clients, as well as therapists, bring into the therapy room. The purpose of this study was to illustrate the clinical usefulness of an attachment perspective in describing and understanding therapeutic alliance formation. In order to gain insight into how the quality of attachment proclivities colour clients' and therapists' approaches to the therapeutic relationship and impact on their experiences in therapy, four cases were selected for a systematic, theoretically-driven analysis that utilized both quantitative and qualitative data.

Participants were four adults seeking individual therapy at a university-affiliated outpatient clinic and their therapists who were graduate students in clinical psychology. Client and therapist attachment representations were assessed prior to therapy based on semi-structured clinical interviews using Bartholomew's two-dimensional, four-category model. Each client displayed a predominantly insecure attachment orientation (i.e., preoccupied, fearful, and dismissing). Therapist attachment profiles reflected secure as well as insecure representations. The overall quality of therapeutic relationships formed was assessed through independent client and therapist ratings of working alliance and session outcome following designated sessions, exit interview and questionnaire reports of the therapeutic relationship, and systematic observation of up to

16 videotaped sessions of psychotherapy per case. In addition, cases were analysed for the presence of two components of attachment relationships, Secure Base and Safe Haven, which were expected to vary systematically across relationships. The processes of secure base and safe haven were inferred from the unfolding of events in therapy as well as from specific episodes identified as meaningful by clients, therapists and/or observer. Results reflected important differences in both quality of relationship and the inferred extent of secure base and safe haven across dyads, although not always in ways that would be expected based solely on client attachment orientation. Therapist security was only partially associated with the successful provision of secure base and safe haven. Other factors attributed to be influential included client initiative and therapist sensitivity to client attachment issues as reflected in their case formulation. Implications for therapist training and avenues for future research are discussed.

DEDICATION

This work is dedicated to all the clients and therapists who completed this protocol and entrusted me in the role of bird on the wall during their therapy work, including some intimate and painful moments. Their sincerity, interest, and pluck were gifts that inspired me to remain curious, humble, and determined to see this study of relationships through to its completion.

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TABLE OF CONTENTS

Approval ii

Abstract iii

Dedication v

Acknowledgements vi

Table of Contents viii

List of Tables xi

List of Figures xii

INTRODUCTION 1

The Therapeutic Relationship as a Vehicle for Change 1
Attachment Theory and Psychotherapy: Theoretical Contributions 4
Basic Tenets of Bowlby's Attachment Theory 5
An Attachment Theory Perspective on Psychotherapy 7
Attachment Representations and Psychotherapy: Empirical Findings 9
Core Issues in the Measurement of Adult Attachment 10
Contribution of Client Attachment to Psychotherapy 12
Contribution of Therapist Attachment 15
The Interplay Between Client and Therapist Attachment 16
Summary of Findings 17
The Current Study: Examining the Development of Therapeutic Relationships from an Attachment Perspective 19
Bartholomew's Two-Dimensional Four-Category Model of Attachment 19
Integrating Quantitative and Qualitative Modes of Inquiry in the Study of Relationship 21
Exploring the Role of Secure Base and Safe Haven Within Therapeutic Relationships 23
Researcher's Expectations 24

METHOD 26

Participants 26
The Facility 26
Clients 27
Therapists 28
Procedures 28

Participant Recruitment 28
Study Protocol 30
Intake 30
Therapy 31
Debriefing 31
Measures 31
Outcome Measures 31
Client and Therapist Attachment Ratings 31
The Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) 33
Client Expectations of the Therapeutic Alliance (Bachelor, 1995) 34
Symptom Checklist - 90 - R (SCL-90-R; Derogatis, 1994) 34
Social Support Questionnaire – Short Form (SSQ-Short Form) 35
Relationship Measures 36
Working Alliance Inventory (WAI; Horvath and Greenberg, 1989) 36
Quality of Relationship Inventory (QRI; Pierce, Sarason, & Sarason, 1991) 37
Client and Therapist Exit Interviews 38
Session Impact Measure 39
Session Evaluation Questionnaire (SEQ; Stiles, 1980) 39
Therapy Analysis 40
Observation and Data Preparation 40
Attachment-based Analysis 42
Secure Base 43
Safe Haven 45

RESULTS 47

Characteristics of the Four Therapeutic Relationships 47
Case 1 47
Proposed Attachment Challenges to the Therapeutic Relationship 50
Therapy Parameters 51
Overview of the Relationship 52
Extent of Secure Base 54
Extent of Safe Haven 60
Case 2 64
Proposed Attachment Challenges to the Therapeutic Relationship 67
Therapy Parameters 68
Overview of the Relationship 68
Extent of Secure Base 71
Extent of Safe Haven 76
Case 3 79

Proposed Challenges to the Therapeutic Relationship 81
Therapy Parameters 82
Overview of the Relationship 83
Extent of Secure Base 86
Extent of Safe Haven 96
Case 4 103
Proposed Attachment Challenges to the Therapeutic Relationship 106
Therapy Parameters 107
Overview of the Relationship 107
Extent of Secure Base 110
Extent of Safe Haven 116

DISCUSSION 123

Case Outcome and Relationship Ratings 123
Extent of Secure Base 124
Extent of Safe Haven 131
Building Security within the Therapeutic Relationship 134
Influence of Client and Therapist Attachment Representations 138
Therapist as Attachment Figure 147
Limitations 149
Closing Remarks 152

REFERENCES 154

Appendix A: Expectations and Wishes for Therapy Questionnaire 162
Appendix B: Quality of Relationship Inventory Adapted for Therapeutic Relationships 163
Appendix C: Exit Interview with Clients 166
Appendix D: Exit Interview with Therapists 168

LIST OF TABLES

Table 1: Overview of When Measures Were Administered 32
Table 2: Average Scores For Each Case on the WAI and SEQ 48

LIST OF FIGURES

Figure 1: Bartholomew's Two-Dimensional Four-Category Model of Attachment 21

Figure 2: Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 1 52

Figure 3: Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 2 69

Figure 4: Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 3 84

Figure 5: Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 4 108

INTRODUCTION

Most aspiring clinicians approach their first therapy cases with a blend of enthusiasm and trepidation. After all, the litmus test of a therapist's potential, many supervisors will tell us, is our ability to forge a good therapeutic relationship with our clients. For example, Freud (1963), the founding father of current practices of psychotherapy, wrote:

> What turns the scale in [the patient's] struggle is not his intellectual insight...but simply and solely his relation to the doctor...In the absence of such a [positive] transference, or if it is a negative one, the patient would never give a hearing to the doctor and his arguments. (p.445, cited in Binder & Strupp, 1997)

Ironically, these observations, which are often intended as encouragement to novice therapists, point to arguably the most significant challenge of conducting psychotherapy. Indeed, even therapists with extensive experience and success will acknowledge that the negotiation of therapeutic relationships is an elusive process that does not necessarily come naturally, and for which there is no formula. It is in the spirit of respect for the therapeutic relationship and its complexities that this project was carried out, nonetheless with the hope that applying an attachment theory perspective on the study of its development would help shed light on areas of skill and knowledge that therapists can acquire.

The Therapeutic Relationship as a Vehicle for Change

The importance of the therapeutic relationship to the process and outcome of psychotherapy is acknowledged, although in varying degree, in virtually all theoretical schools and therapeutic modalities (Snyder & Ingram, 2000). It is also a robust finding in the empirical literature. Luborsky, Crits-Christoph, Mintz, & Auerbach (1988) reviewed 378 psychotherapy outcome studies published in the 20 years prior and reported that a

positive therapist-client relationship was significantly related to outcome in 88% of the studies reviewed, with a reported mean magnitude of r = .57. Similarly, Orlinsky & Howard (1986) found that the quality of the therapeutic relationship was significantly correlated with client outcome in 60% of studies examining the therapist's contribution and in 80% of studies evaluating the client's contribution to a positive therapeutic relationship. Lambert's (1989) review also led to the conclusion that the quality of the client-therapist relationship achieved is a major factor in discriminating helpful from less helpful therapists.

Researchers have long been interested in studying therapist and client characteristics in order to identify the elements of a positive and effective therapeutic relationship. Not surprisingly, however, the need to identify influential variables that are dynamic and interpersonal in nature has been explicitly recognized, since studies focusing on discrete variables such as age, gender, ethnicity, therapist training or client socioeconomic status have yielded largely equivocal findings (Petry, Tenne, & Affleck, 2000; Teyber & McClure, 2000). Even therapist empathy, for example, which has been repeatedly associated to varying degrees with client outcome and client endorsements of a good therapeutic relationship (e.g., Luborsky et al., 1988; Mohr, 1995), is increasingly acknowledged as contextually bound rather than as an enduring trait. That is, any given therapist may be found to be more or less empathically attuned depending on the client. Similarly, investigations of client attributes such as warmth or motivation have yielded few replicable main effects (Teyber & McClure, 2000).

A parallel line of research on a highly interactive variable, the working alliance component of the therapeutic relationship, has accumulated substantial empirical evidence that suggests it acts an agent of therapeutic change (Horvath & Luborsky,

1993; Weinberger, 1995). The term working alliance refers to the degree to which therapists and clients experience an emotional bond together as well as agreement on the goals and tasks of their work. For example, Horvath and Symonds (1991) conducted a meta-analysis of 24 studies and found a small (i.e., ES = .26) but reliable effect of the alliance on outcome across a range of varying treatments and diagnostic categories. Moreover, Kolden (1996) reported evidence for the working alliance's moderating role in the relationship between in-session progress and between-session change. Sexton, Hembre, & Kvarme (1996), conducted a sequential analysis of the interaction between working alliance and therapy micro-process in brief therapy and found that alliance was largely formed within the first session. They also reported that high versus low alliance therapies developed somewhat differently. As the authors themselves note, their findings suggest that pre-therapy patient and therapist characteristics may be significant contributors to the working alliance and client-therapist "fit," thus compelling us once again to turn to the study of interpersonally relevant individual difference variables that may help therapists tailor their interpersonal stance with different clients.

Although working alliance may be established early and quickly, it is important to note that it is conceived as only one component of therapeutic relationships, and that it is susceptible to disruption over the course of treatment (Gelso & Carter, 1994; Horvath & Marx, 1990). Alliance "ruptures" are described as episodes of covert or overt negative feelings that ensnare therapists and clients into conflict (Safran, Muran, & Samstang, 1994.) Thus, an effective therapeutic relationship is one that resolves or at the very least endures these expectable ruptures. Although a general assumption may be that therapists are well equipped to manage alliance ruptures, Binder and Strupp (1997) concluded based on their review of the empirical literature on negative process in

therapy that a common therapist shortfall is the failure to address and resolve these crises effectively. They reported evidence indicating that regardless of theoretical orientation, therapists are prone to respond to clients' negativity personally and with their own disapproving reactions including anger, emotional withdrawal, subtle rejection, and most frequently a pejorative attitude toward the client. They argued that despite advances in the study of psychotherapy process and outcome, clinical training fails to prepare therapists to cope with the inevitable negative processes that they will inevitably encounter at least occasionally with most clients.

In sum, these well-established findings on the importance of the therapeutic relationship to psychotherapy process and outcome unfortunately offer relatively little practical information to beginner therapists about its delicate negotiation. Although the reciprocal and interactive quality of the therapeutic relationship makes it difficult to capture, its potential as a vehicle of therapeutic effects underscores the need for research efforts aimed at differentiating successful from unsuccessful therapeutic relationships, as well as at identifying individual difference variables that directly influence therapeutic relationship development. Attachment theory, summarized in the next section, offers promise in elucidating the individual differences in attitudes, beliefs, and emotional regulation systems that clients and therapists bring into the therapy room and the ensuing challenges that they may face in working together.

Attachment Theory and Psychotherapy: Theoretical Contributions

Bowlby's (1969, 1973, 1980) ethological theory of attachment, which delineates the human inclination to form emotional bonds with particular others, is well recognized

as a conceptual template for understanding emotional and behavioural regulation within individuals across the lifespan.

Basic Tenets of Bowlby's Attachment Theory

Bowlby's attachment theory suggests that although people share a biologically determined goal to achieve and maintain a feeling of security, the specific strategies employed toward this end vary according to one's individual history of managing distress with attachment figures. Thus, the nature of caregiver attunement and responsiveness to a child's emotional signals is seen as providing a critical context for that child's organization of emotional experience. If the attachment figure is available and receptive to the child's distress signals, then distress will likely be regulated with coping strategies that involve active seeking of comfort from that attachment figure. The child will both go on to experience competence in his or her ability to initiate and maintain rewarding relationships and grow to expect security. In conditions where the caregiver tends to be unavailable, rejecting, or inept at comforting the child, however, expression of distress may come to be associated with negative outcomes. Alternative styles of coping will subsequently evolve that may include such strategies as downplaying suffering, withdrawal, or escalating one's dissent to mobilize the caregiver's response.

Another fundamental principle of Bowlby's theory (1979) is that attachment relationships remain significant throughout the lifespan. To explain the mechanism driving this, he put forward the notion of "internal working models" that are developed based on the internalization of relationships with primary caregivers. He identified two critical aspects of internal working models: perceptions of the self (i.e., whether the self is perceived as worthy of receiving comfort and support in times of stress) and of others (i.e., how willing and able others are of rendering such care). These largely unconscious

internal representations of attachment relationships provide the individual with guidelines for the assimilation and appraisal of experience and the regulation of emotions and behavior in a variety of social situations.

Bowlby (1969, 1988) described the attachment system as integral to personality development and highly influential on one's social functioning. Drawing on the principle of physiological homeostasis, he characterized attachment as a control system that serves to maintain a person's relation to his attachment figure within certain limits of distance and accessibility. The attachment system thus becomes triggered when the goal of felt security is disequilibrated. He distinguished attachment relationships by the presence of four related classes of behaviour: proximity-seeking, safe haven, secure base, and separation-protest. Proximity seeking, as the term implies, describes the natural inclination of the individual to generally remain in the vicinity of the attachment figure. This can be differentiated from safe haven behaviour, which involves an active retreat to an attachment figure to receive nurturance, soothing, and comfort in times of distress (e.g., feeling alarmed, anxious) or malaise (e.g., feeling tired or sick). In contrast, secure base behaviour involves exploration of one's environment away from the attachment figure, which gradually increases in both time and space as the individual comes to know the attachment figure as accessible and responsive. Finally, separation protest, involving efforts to prevent distance from the attachment figure, can also be expected upon the perceived threat of the attachment figure's imminent departure. Thus, although other social or non-attachment relationships may share one or more of these features, an attachment relationship is one that involves a sufficiently strong emotional bond or "psychological tether" that is comprised of all four components or functions (Hazen & Zeifman, 1994).

An Attachment Theory Perspective on Psychotherapy

Not surprisingly, Bowlby, who was a clinician and practising psychotherapist, saw therapy as a place to promote healthy personality functioning. In his writings on the topic, he clearly identified the therapeutic relationship as central to successful psychotherapy (Bowlby 1979, 1988). According to Bowlby, the essence of psychotherapy involves the therapist and client jointly uncovering the client's largely unconscious operating biases within intimate relationships. For most individuals, the initial novelty and stress of the therapy situation is likely sufficient to activate the attachment system and lead clients to repeat entrenched patterns of interacting with their therapist. The therapist is thus provided with first-hand information from which he or she can infer about the nature of the client's internal working models. He argued, however, that a truly therapeutic relationship not only facilitates the inspection of the client's existing relationship values and beliefs, but also provides a corrective emotional experience that enables the client to disconfirm and restructure his or her working models. Thus, through the therapeutic relationship, the client can become able to recognize the potential to establish security with appropriate others and enjoy mutual, intimate relationships.

Bowlby (1988) characterized the role of therapist as that of a reliably supportive, attentive, and sympathetically responsive companion who assists the client in exploring the ways in which he or she approaches relationships with significant others. As such, he likened the therapist to a sensitive caregiver who acts as a secure base from which a child explores both internal and external worlds. He identified the therapist's offering of a predictable, non-judgmental, and empathic environment for the client as a foremost yet likely boundless task in the psychotherapeutic journey. Indeed, he believed that, "unless

a therapist can enable his patient to feel some measure of security, therapy cannot even begin" (p. 140)

Also evident in Bowlby's writings is the acknowledgement of the therapist as a provider of safe haven. It is noteworthy that he did not embrace traditional psychoanalytic conceptions of therapist as neutral and expert and advocated instead for the importance of genuinely responding to client's unpleasant feelings of fear, sadness, and anger with concern and caring. He discussed the inevitability of the client's distress as he or she shares difficult memories or faces loss associated with the recognition of one's distortions and also addressed the need to provide effective soothing in such instances, thereby helping to restore the client's comfort within the therapy room, increase their confidence, and allow insight-oriented work to be resumed. Thus, his writings on secure base in psychotherapy evoke the concept of safe haven as a critical therapeutic aspect that facilitates security and, in turn, exploration. The journey of psychotherapy can therefore be seen as a balancing between the provision and acceptance of a safe, soothing haven that promotes successful emotional regulation and a solid yet flexible base that approves of and even encourages insight and interpersonal challenge, both within as well as outside of the therapeutic relationship.

Bowlby's blueprint of attachment-based psychotherapy raises a number of fundamental issues that merit research attention, such as, what constitutes security within the therapeutic relationship for a given individual? Should we assume that all clients can benefit from a particular type of therapeutic environment, not unlike Rogers' (1957) prescription of empathy and unconditional positive regard; or rather, does the notion of therapist as "authentic chameleon," as is advocated by Lazarus (1993), more

closely resemble the therapist's secure base behaviour? And how essential is the provision of safe haven within psychotherapy?

With advances in the conceptualization of attachment relationships across the lifespan and in the measurement of their associated internal representations, the time is ripe to examine the potential of client attachment representations as a critical "pre-therapy" factor in establishing solid therapeutic relationships. Interestingly, until relatively recently, studies designed to test the tenets of an attachment perspective as they relate to clinical work in general and to psychotherapy in particular were rare. In his last work, Bowlby (1988) expressed some disillusionment about this gap in the attachment literature stating,

> Whilst I welcome the findings of [developmental] research as enormously extending our understanding of personality development and psychopathology, and thus as of the greatest clinical relevance, it has none the less been disappointing that clinicians have been so slow to test the theory's uses. (p. ix)

Attachment Representations and Psychotherapy: Empirical Findings

Bowlby's famous plea to scientist-practitioners to test his theory's clinical applications has proved to be fruitful in stimulating a flurry of related research and discussion within the last decade. While many have concentrated their attention on the implications of attachment theory for the treatment of a myriad of client problems including postpartum depression (Whiffen & Johnson, 1998), HIV/AIDS (Purnell, 1996), bereavement (Field, Nichols, Holen, & Horowitz, 1999), borderline personality (Diamond, Clarkin, Levine, Levy, Foelsch, & Yeomans 1999), sexual abuse (Alexander & Anderson, 1994; Liem & Boudewyn, 2000; Marshall, Serran, & Cortoni, 2000), physical abuse (McCarthy & Taylor, 1999; Roche, Runtz, & Hunter, 1999), parenting difficulties (e.g.,

Erickson, Korfmacher, & Egeland, 1992), adult child-older parent relationships (Drause & Haverkamp, 1996), couple intimacy problems (Pistole, 1994; Johnson & Whiffen, 1999), divorce (Todorski, 1995), and family dysfunction (Byng-Hall, 1995), others have begun to investigate the role of attachment processes more generally within the realm of psychotherapy. The task of summarizing recently published findings on the influence of client and therapist attachment on the psychotherapeutic process is complicated by the diversity of measurement methods and nomenclature across studies, which are briefly reviewed below.

Core Issues in the Measurement of Adult Attachment

The range of available attachment measures reflect, in turn, important differences in the conceptualization of adult attachment as a categorical versus dimensional construct, and as one that is inaccessible to versus within conscious awareness (Griffin & Bartholomew, 1994a). For example, Main has coined the term attachment "states of mind" to represent conscious and unconscious rules that govern the processing of attachment-related information. Her classification system is based on discrete categories and emphasizes the unconscious nature of internal representations. Consequently, these are assessed through discourse analysis of a semi-structured interview, the Adult Attachment Interview (AAI; George, Kaplan, and Main, 1985). In contrast, attachment "style" reflects a prototype approach to measuring adult attachment that is based on a two-dimensional model (see *Bartholomew's Model* below for a more detailed description) and intended to capture observable patterns of behaviour (Fraley & Shaver, 1998). One's degree of fit to each of the resulting patterns can also be assessed through an interview in which participants describe significant relationships as well as their feelings and beliefs about the importance of close relationships (Bartholomew &

Horowitz, 1991; Griffin & Bartholomew, 1994a). However, the term attachment "style" is increasingly used more loosely to refer to self-perceptions within close relationships that are readily obtained from a variety of questionnaires now in circulation (Dozier & Tyrell, 1998; Crowell, Fraley, & Shaver, 1999). It is noteworthy that interview and questionnaire measures also vary with respect to the kind of attachment relationships queried including parental, romantic peers, and non-specific.

Perhaps one of the most clinically relevant discrepancies among available classification systems that also confounds comparison of research findings across studies is the inclusion of a fearfully avoidant prototype in Bartholomew's (1990; Bartholomew & Horowitz, 1991) classification system that is lacking within Main and Goldwyn's (in press) system. Although it has been suggested that the latter's fourth category of "unresolved with respect to mourning or trauma," which was included in part as a parallel of the infant categorization of "disorganized," may be similar to fearful attachment, the overlap between the two has not yet been investigated and should not be assumed. In contrast, in a sample of 30 interviews of bereaved women that were coded using both Main & Goldwyn's and Bartholomew's scoring systems, excellent concordance was found between respective judgments of preoccupied and dismissing attachment (Bartholomew & Shaver, 1998). Agreement between ratings of autonomous and secure attachment respectively was poorer and attributed to a tendency of AAI coders to more frequently employ the autonomous categorization relative to Bartholomew coders' use of secure. It is noteworthy that the proportion of the sample rated as fearful in Bartholomew's system (n = 7) was roughly evenly distributed among the three main categories of the AAI, which supports the distinction between the two models of attachment.

Nonetheless, in their review of adult attachment methodology, Bartholomew and Shaver (1998) proposed a continuum along which the multitude of measures can be systematically arranged according to domain, dimensionality, and method of assessment. The use of a continuum reflects the notion that diversity in measurement practice belies a common conceptual underpinning: that is, that a single representational system or set of core relational tendencies is involved in the measurement of adult attachment processes. Not surprisingly, higher convergence of results has been found between measures that share method variance (e.g., interview ratings, self-report questionnaires) or relational focus (Bartholomew & Shaver, 1998; Crowell, et. al., 1999; Griffin & Bartholomew, 1994b). The robust yet modest degree of convergence that exists even between measures that vary both in technique and domain of assessment suggests that a shared conceptual framework is present but should not be overemphasized (Bartholomew & Shaver, 1998, Crowell, et. al., 1999). It follows that the onus falls on researchers to carefully consider the theoretical assumptions underlying the various assessment procedures and use these to guide their selection of measures and interpretations. Similarly, we are cautioned against assuming that one measure is equivalent to the next. With these issues in mind, research on attachment processes in psychotherapy is presented.

Contribution of Client Attachment to Psychotherapy

To date, two studies have specifically examined the power of client attachment to predict client responsiveness to psychotherapy. Horowitz, Rosenberg, & Bartholomew (1993) found that client attachment style was related to the type of interpersonal problem presented in brief dynamic psychotherapy, which in turn correlated with degree of change. Specifically, individuals rated as predominantly dismissing were more likely to

express problems of hostile dominance and less likely to improve. This is consistent with clinical reports that dismissing individuals tend to reject help and thus pose particular therapeutic challenges (Slade, 1999). However, Fonagy and colleagues (1996), who used the AAI to assess attachment in psychiatric inpatients in long-term treatment, reported that dismissing was the most frequent status among individuals who showed improvement on their measure of overall adaptation. In contrast, they indicated that preoccupied individuals were the most difficult to treat and showed the least successful outcomes (Fonagy, Leigh, Steele, Steele, Kennedy, Mattoon, Target, & Gerber, 1996).

Other investigators have focused their efforts on investigating the relationship between client attachment and working alliance. Dolan, Arnkoff, & Glass (1993), for example, reported that although romantic attachment style did not predict quality of relationship alliance as perceived by clients after the third session, it did predict therapists' perceptions of alliance. The more secure the client, the better the therapist perspective with respect to agreement on tasks and goals, and the more avoidant the client, the weaker the therapist's endorsement of agreement on goals. Similarly, Satterfield and Lyddon (1998) offered partial support for the notion that clients' working models of attachment are meaningfully related to therapeutic rapport. They documented significant associations between two divergent self-identified patterns (i.e., secure and fearful) within Bartholomew's framework and aspects of working alliance evaluated in the early phase of therapy (i.e., after session 3 and before session 6) within a sample of students seeking counseling through a university-based clinic. Whereas positive correlations were reported between self-identified secure attachment and ratings of the bond and goal components of alliance, fearful attachment was negatively correlated with alliance bond. No significant results were found with dismissing and preoccupied

patterns, however. Eames and Roth (2000), who investigated changes in alliance over time within an out-patient sample of clients, also found that self-perceptions of secure attachment predicted relatively stronger ratings of alliance overall, whereas the fearful style was associated with client perceptions of weaker alliance. They also noted improved ratings of alliance over time among preoccupied and dismissing individuals. In contrast, another recent study on victims of political violence reported no differences in initial level of alliance across patients classified in Main's terms as autonomous, preoccupied, or dismissing (Kanninen, Salo, & Punamaeki, 2000). They did, however, note differential patterns of alliance fluctuation across groups, such that ratings by preoccupied and autonomous clients decreased mid-way more and less steeply, respectively. Ratings of dismissing individuals, however, remained approximately the same early and mid-way through the therapy, and decreased at the end. Taken together, these findings suggest a link between insecure client attachment and quality of working alliance. However, the nature of the link is unclear based on these studies.

Finally, a few studies have examined the impact of client attachment on the process of psychotherapy. For example, Dolan et al. (1993) reported that ambivalence and avoidance were both positively correlated with pre-therapy symptom levels, whereas degree of secure attachment was not. Hardy, Aldridge, Davidson, Rowe, Reilly & Shapiro (1999), coded client attachment states of mind and therapist responses in ten transcripts of psychotherapy sessions and reported that therapists responded differentially to preoccupied versus dismissing clients. Whereas therapists tended to intervene with preoccupied clients using emotion-based interventions (i.e., reflections), they responded to dismissing clients more frequently with cognitive-based (i.e., interpretations) interventions. Although serious methodological flaws limit the

conclusions that can be based from these studies, they suggest that client attachment styles influence client presentation and, in turn, therapist choice of intervention.

Contribution of Therapist Attachment

There is also some evidence that therapist attachment impacts on both working alliance and the quality of intervention delivered. For example, Dunkle (1996) surveyed clients and therapists who had completed three to five sessions and found that client reports of therapeutic bond were significantly positively associated to therapists' degree of endorsed security, even after controlling for therapist level of experience, perceived social support, and self-directed hostility. In a recent analogue study, Rubino, Barker, Roth, & Fearon (2000) investigated the relationship between therapist attachment style and resolution of a fictional therapeutic alliance rupture. Therapists' responses to videotaped expressions of discontent made by four role-played patients who each displayed one Bartholomew's four attachment patterns were coded. Overall, therapists tended to respond to patients portrayed as fearful and preoccupied with more empathy and deeper interventions than to clients displaying dismissing and secure attachment. In addition, they found that therapists who reported themselves to be high on the anxiety dimension of attachment tended to respond less empathically, especially in response to fearful and secure patients, than their less anxious counterparts although they saw no group differences in depth of intervention. It is important to note, however, that although the scripts representing each of the attachment styles employed in this study were prepared in consultation with attachment researchers, the writer knows of no published findings to date that illustrate how attachment representations influence clients' experience within the therapeutic relationship. Certainly, research within naturalistic settings that outlines the sorts of challenges associated with attachment insecurity and

that take into account the client experience is sorely needed before suggestions can be made about the suitability of interventions to people with differing forms of attachment insecurity.

The Interplay Between Client and Therapist Attachment

The interaction of client and therapist attachment has also been investigated through the study of various client-clinician matches (Dozier, Cue, & Barnett ,1994). In studying the impact of case manager attachment as assessed by the AAI on the intensity of interventions provided to clients with severe psychopathology, significant differences between secure and insecure case managers were found in their perceptions of client dependency needs and intensity of intervention delivered. Whereas secure case managers intervened more intensely with clients who were dismissing than they did with clients who were preoccupied, insecure case managers offered levels of intervention that were complementary to their own attachment strategies, with preoccupied case managers intervening more intensely overall and dismissing case managers intervening less intensely overall. The investigators also reported that secure case managers responded in a manner that balanced the perceived dependency needs of their clients, whereas insecure case managers tended to responded to the surface dependency needs of their clients, in ways that were consistent with clients' expectations of others. In a recent investigation on a similar sample of clients and clinical case managers, researchers replicated a significant interaction between client and case manager attachment states of mind that this time assisted the prediction of working alliance and client functioning (Tyrrell, Dozier, Teague and Fallot, 1999). By applying a dimensional analysis to the interview data, they showed that clients who were more deactivating (vs. hyperactivating) with respect to their emotional strategies formed

stronger alliances and reported higher life satisfaction when working with less deactivating case managers. In contrast, clients who were less deactivating tended to work better with case managers who were relatively more deactivating. Although the strength of the study's conclusions was limited by several factors including the absence of alliance evaluation early in relationship as well as the absence of observational measures of case managers' interactions with their clients, evidence was again provided for the benefit on both alliance and treatment outcome of matching clients to clinicians with dissimilar attachment, who may be more likely to balance their clients' emotional and interpersonal challenges and disconfirm their internal working models.

Summary of Findings

The budding research on the influence of client and therapist attachment in psychotherapy indicates that attachment is an individual difference variable that significantly impacts treatment processes, including the therapeutic relationship, for both clients and therapists. Specifically, security, whether it manifests in assessment as coherent internal representations of self and others in relationship or comfort with intimacy and care-seeking in times of distress, recurs within this literature as a good prognostic indicator of one's ability to form a satisfying working relationship and benefit from therapy. Although findings suggest that the reverse is true for insecurity, it remains unclear as to how the quality of insecurity undermines alliance formation and consequently and how it should be taken into account in the tailoring of interventions.

Despite the promise of attachment theory's potential to inform the therapeutic process, some researchers have argued that much more work needs to be done before the validity of attachment-based approach to therapy is established (Bartholomew & Thompson, 1995). The wisdom of applying the conceptual framework of attachment

theory and associated research findings to all therapeutic relationships, including those involved in brief therapy, has been justifiably challenged. Indeed, the clinical significance of current research findings and their potential to inform therapist training needs to be clarified. Much of the research to date has been limited to gross one-time assessments of alliance that provide an incomplete, overly simplistic picture of the working relationships involved. The few available studies that have measured the relationship between attachment and alliance development have neglected to evaluate the quality of interaction between clients and therapists, which could greatly inform our understanding of the interplay between the two.

Certainly, empirical findings based on the current trend of research that tests various attachment theory-based hypotheses need to be complemented by more focused, in-depth studies of developing therapeutic relationships within naturalistic settings. Small *n* methodologies that emphasize description of individual cases are well suited to investigations of the client-therapist relationship (Barkham, 1996). Although case studies have traditionally been considered an inadequate basis for drawing valid scientific conclusions, they have long been recognized within clinical and counselling psychology for their heuristic value in exploring unknown phenomena and stimulating, in turn, clinically relevant hypotheses for future research. Furthermore, the strength of inferences drawn from the case study approach can be improved through the use of continuous assessment procedures and multiple cases that are specifically selected for their heterogeneity with respect to a particular variable of interest (Kazdin, 1992). Thus, it is expected that case study findings that include quantitative and qualitative modes of inquiry will be invaluable in illustrating the unfolding of attachment issues within psychotherapy and informing clinical practice as well as future research.

The Current Study:

Examining the Development of Therapeutic Relationships from an Attachment Perspective

This project was designed with the training needs of clinicians in mind. It was inspired by Bowlby's basic postulate that clients are likely to behave with their therapist in accordance to their internal working models. Indeed, a primary goal of this research was to begin to document how attachment representations influence both clients' and therapists' respective experiences within therapy and the quality of relationships they form together. Like the pantheoretical notion of working alliance, the impact of attachment representations on client and therapist interactions was not expected to be associated with any particular school of psychotherapy. Stated another way, client and therapist attachment orientations were conceived as potential influences on therapeutic relationships regardless of the therapist's theoretical approach to intervention. Therefore, a series of cases involving clients presenting with interpersonal difficulties who displayed different predominant patterns of insecure attachment (i.e., preoccupied, dismissing, and fearful) were selected for systematic study over a period spanning up to 16 sessions. Therapists also varied in attachment orientation, as well as in regard to the theoretical framework they adopted with their clients. Client and therapist attachment representations were assessed according to Bartholomew's framework.

Bartholomew's Two-Dimensional Four-Category Model of Attachment

Bartholomew's model of individual differences in adult attachment representations (Bartholomew, 1990; Bartholomew & Horowitz, 1991) directly draws upon Bowlby's notion of internal working models that, as noted earlier, he conceptualised as comprised of two

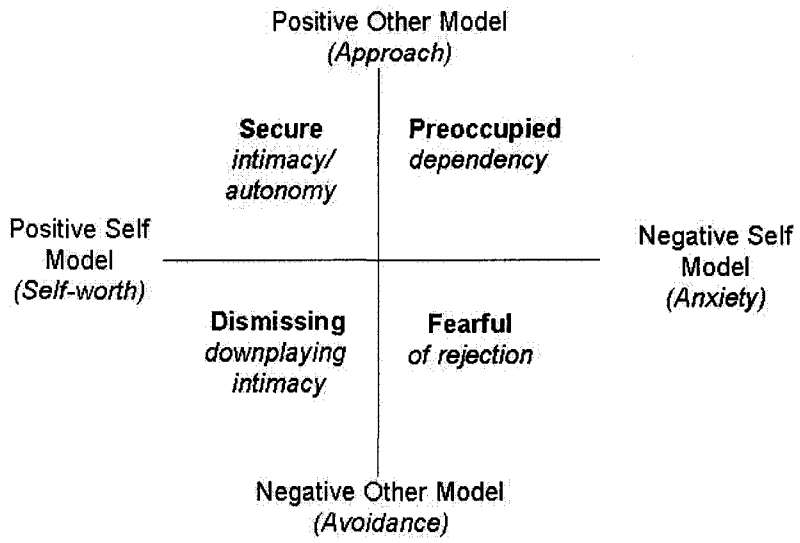
dimensions. These include positivity of Self (i.e., the degree of self-worth versus anxiety and dependency on other's approval) and positivity of Other (i.e., the degree to which one tends to seek out or avoid closeness in relationships). By intersecting these two hypothetical underlying dimensions, four prototypic patterns are yielded: secure, preoccupied, fearful and dismissing (see Figure 1). Based on interviews in which participants describe their experiences and feelings with respect to family, peer, and romantic relationships, individuals can be rated according to how closely they correspond to each of the theoretical attachment prototypes. A person who is coded high on the secure style, for example, is one who indicates a positive view of the self (i.e., worthy and loveable) and a positive expectation of others (i.e., trustworthy and accepting). The secure pattern is typified by a capacity for intimacy while maintaining personal autonomy. In contrast, the fearful pattern is characterised by low self-worth corresponding with anxiety concerning loss and rejection in close relationships and withdrawal from intimacy. The preoccupied pattern is also characterised by low self esteem and anxiety in close relationships; however, preoccupation is associated with the active pursuit of closeness and reassurance from others. Finally, the dismissing pattern is typified by high self-esteem and a defensive maintenance of autonomy and distance in relationships.

Research findings support the construct validity (Griffin & Bartholomew, 1994b) and reliability of these adult attachment patterns over a two-year period (Scharfe & Bartholomew, 1994). Bartholomew's model is advantageous in providing continuous ratings of theoretically discrete attachment prototypes that can be used in dimensional analyses as well as for categorical classification. In addition, her system allows both family and peer attachment representations to be evaluated based on semi-structured interviews that can be naturally integrated within one's clinical assessment practice.

Moreover, findings from parent and peer/romantic partner interviews can be combined to yield one parsimonious profile for each individual that encapsulates the complexity of organization of his or her attachment representations.

Figure 1:

Bartholomew's Two-Dimensional Four-Category Model of Attachment



Integrating Quantitative and Qualitative Modes of Inquiry in the Study of Relationship

In this study, quality of therapeutic relationship was initially assessed from the perspectives of client and therapist using objective (i.e., normed questionnaires) and subjective (e.g., interviews) measures. Whereas the former were selected for their promise in comparing client and therapist perceptions both within and across cases, the latter were employed to more clearly depict participants' individual experiences within each of the therapies and to highlight episodes that influenced alliance in each case. To maximize description and understanding of the influence of attachment representations

on therapeutic relationships, observation of client-therapist dynamics was also incorporated. The final analysis, which integrated the three perspectives of client, therapist, and observer, comprised interpretation rather than quantitative coding or statistical analyses, thus drawing on qualitative research approaches (McLeod, 1996). Indeed, consistent with the goal of qualitative research, which is to shed light on the *meaning* of social actions and situations, this study aimed to clarify the functional significance of client-therapist interactions using client and therapist accounts.

The field of qualitative research is diverse, reflecting different schools of methodology such as phenomenological (e.g., Bachelor, 1995), grounded theory (e.g., Rennie, 2000), narrative (e.g., Josselson & Lieblich, 1999) and discourse analysis (e.g., Madill & Barkham, 1997). Moreover, research approaches vary in their assumptions about how knowledge is developed, with some based on a stance of realism and positivism (e.g., Hill, Thompson, & Williams, 1997), others on a relativist, constructionistic epistemology (e.g., McLeod, 2001), and yet others on an intermediary position wherein realism and relativism are reconciled (e.g., Rennie, 2000). Nonetheless, the metaphor of qualitative researcher as *bricoleur*, "a kind of professional do-it-yourself person" who finds meaning in complexity has been coined to capture a commonality across paradigms (McLeod, 1996, p. 73). In contrast to the quantitative approach, which describes scientific inquiry as a value-free process (Barkham, 1996), the qualitative tradition identifies the researcher's values as inherently influential. It follows that the latter emphasizes the importance of articulating one's assumptions and considering their impact on findings. Thus, the *bricolage*, the product of the bricoleur's labour, is recognized as a patchwork-like illustration of the researcher's own images and understanding of the phenomenon in question (McLeod, 1996).

Whereas in typical qualitative studies the substrate of interpretation is comprised of participant stories obtained through a variety of procedures (e.g., interview, open-ended questionnaires, projective techniques, personal documents), the basis of interpretation in this project was the client-therapist relationship as represented by the three perspectives noted above. Attachment theory provided a guiding framework at the content level of investigation, and principles of qualitative research informed the general process involved in analysis and interpretation of each of the cases. Thus, although the foundation of the present design is a theoretical, hypothesis-driven (or quantitative) approach to investigation, it is also informed by discovery-oriented, qualitative paradigms of inquiry.

Exploring the Role of Secure Base and Safe Haven Within Therapeutic Relationships

In addition to obtaining quantitative evaluations of client and therapist attachment and therapeutic alliance, the degree of felt security in each therapeutic relationship was inferred based on a qualitative, attachment theory-based analysis of each psychotherapy case. Following systematic observation of therapy sessions, two elements were noted as capturing important differences in relationship quality and in the unfolding of events across cases and therefore selected as the basis of analysis. Secure Base referred to the degree of exploration accomplished within the period of study and Safe Haven represented the degree of soothing in response to client distress achieved. Derived from Bowlby's definitions of attachment relationship components, these were conceived as separate yet likely interrelated functions of each therapeutic relationship that contributed to client felt security. The dimension of Secure Base was operationalized as involving

the client's genuine engagement in core or difficult issues that was facilitated by the therapist's acceptance and challenge. Safe Haven, on the other hand, was defined as breaks from exploration due to distress that ideally would be met with therapist facilitation of emotional containment and soothing so that a reasonable degree of client comfort and associated exploration could be restored.

A primary purpose of the analysis was to document secure base and safe haven functions across cases and detect meaningful associations between these dimensions and individual differences in client and therapist attachment. Secure Base and Safe Haven therefore served as conceptual lenses from which to assess respective client and therapist contributions to relationship development and therapeutic outcome.

Researcher's Expectations

A fundamental assumption underlying this work was that despite attachment insecurity, each client was capable of developing a satisfying and effective therapeutic relationship. However, what might constitute or account for a good working rapport might differ systematically across cases in correspondence with client attachment needs and differential challenges to alliance formation. That is, it was anticipated that clients' emotional and relational vulnerabilities would surface within the early phase of the therapeutic relationship and be meaningfully related to their individual attachment orientations. Therapists' ability to recognize and appropriately respond to their clients' attachment needs was expected, in turn, to impact strength of working alliance and client degree of felt security. Thus, although each therapeutic relationship was expected to be unique, it was hoped that intensive analysis of events within each case would yield meaningful patterns of client-therapist interactions that would inform therapists'

understanding of key elements in the development of productive relationships with their clients.

METHOD

Participants

The Facility

Therapists and clients were recruited through the Clinical Psychology Centre (CPC) in Burnaby, British Columbia. The CPC serves as the primary clinical training facility for Simon Fraser University graduate students studying in Clinical Psychology. Masters and doctoral level students who are supervised by Registered Psychologists deliver assessment and therapy services to a broad clientele from the Greater Vancouver Regional District including adults, youth, and couples or families, for a nominal fee. Clients may be approved by clinic directors for a reduction in fees or *pro bono* services based on financial need. Presenting problems vary widely and are addressed from diverse theoretical perspectives including psychodynamic, interpersonal, cognitive-behavioural, humanistic, feminist, existential and systemic.

Service delivery occurs in a multi-phase process at the CPC Clients initially undergo a semi-structured telephone-screening interview with a student clinician that is assessed by clinic directors for suitability to the clinic's mandate. Case assignment, also the responsibility of clinic directors, involves matching client needs with therapist interest and experience as well supervisor competence and theoretical orientation. Clients deemed appropriate for potential service participate in an in-person intake with a student clinician, typically ranging from one to several sessions in duration. Following the completion of intake, further services may be contracted pending clinic directors' approval. When services cannot be provided, clients are referred elsewhere. Reasons

for declining services include client involvement in legal matters, high risk of violence and/or suicide, and lack of appropriate therapist and/or supervisor availability.

Clients

Four of six initial clients who completed the protocol were included in this study, primarily on the basis of their attachment profiles. Three clients, each with a different predominant attachment orientation (i.e., preoccupied, fearful and dismissing, respectively), were selected to allow representation of each of the insecure prototypes. None of the initial six clients were found to be predominantly secure, thus precluding representation of this prototype. A fourth predominantly fearful male was included to allow for comparison with the fearful woman and the dismissing male. Two other clients were not included in the final analysis to preserve the homogeneity of the sample and maintain the focus of analysis. One of these clients was rated predominantly fearful. However, the validity of his attachment profile was called into question even after coders reached agreement. In addition, his ethnic background added a potentially complicating variable that could not be compared across cases. Another client was highly insecure but displayed no predominant pattern of attachment. She also differed significantly from the remainder of the sample on several psychosocial variables including education, socioeconomic status, and psychiatric symptomatology.

The final sample consisted of two men and two women who ranged between 25 and 49 years of age (M = 42.0, $S.D.$ = 11.4 years), all of whom were Caucasian and employed in various blue-collar jobs. Each was approved for a fee reduction, suggesting limited financial resources. Their level of education ranged from high school equivalency to completion of an undergraduate university degree (M = 13.5, S.D. = 1.9 years education). Each had sought therapy in the past; one had extensive prior therapy

(approximately 6 years) and the remainder had some (approximately one to two years each). All four clients sought therapy for interpersonal problems and two identified a DSM-IV axis I disorder as an additional referral concern.

Therapists

Four of five initial therapists who completed the study protocol were included in this study. They were Caucasian females ranging between 25 and 28 years of age (M = 26.5, S.D. = 1.3). Three were doctoral level clinicians with approximately 3 years of therapy experience and one was completing her masters and in her second year of conducting therapy. Two therapists described their theoretical orientation as psychodynamic and two were undecided. The guiding theoretical framework varied across cases in part based on the orientation of the clinical supervisor, with one identified as cognitive-behavioural, one interpersonal, and two as a combination of psychodynamic/humanistic and cognitive-behavioural treatment approaches.

Procedures

Participant Recruitment

Clinical psychology students who were enrolled to see clients at the CPC between February 1997 and August 1998 were sent a letter inviting their participation in this study on several occasions during this period. They were explained that the purpose of the study was to get a better understanding of how clients' histories of relationships with caregivers and significant others influence progress in therapy in general and the relationships they form with therapists in particular. The letter detailed the protocol and stated that they would also be asked to provide information about their close

relationships in an interview with a research assistant. As the focus of the study was to observe the natural development of therapeutic relationships across various types of therapy and with minimal interference to training goals, no restrictions were placed on the nature or duration of therapy contracted with clients.

Three therapists with extensive training in Bartholomew's attachment coding system were disqualified, as their familiarity with the measure would have precluded valid assessment of their attachment representations (see *Client and Therapist Attachment Ratings* below). Therapists applying to work with their first client were also not approached, as it was felt that some degree of familiarity with the clinic's procedures would be required to facilitate data collection. All others who expressed interest to the clinic directors in conducting individual therapy with a new adult client during the study period were eligible (n = 13). Four therapists refused participation during the study period. Another declined upon the recommendation of the supervisor who felt it was important for the therapist to conduct his own intake with the client. Three others agreed to participate, however, in two instances their assigned clients declined, and in the third the client was deemed unsuitable for the CPC and referred elsewhere following intake.

With signed therapist consent, I contacted clients by telephone and invited them to participate in a study about new therapeutic relationships that would help inform therapist training in the future. I told them that I was interested in understanding what they would come to like and not like about their therapists, and how getting along with one's therapist influences one's goals and progress in therapy. I described the protocol including measures and procedures involved in data collection, analysis, and storage. I also explained that I would be their intake therapist if they decided to participate and that they would work with their assigned therapist following intake. They were assured that

participation was voluntary, that they could withdraw from the study at any time, and that their care as a CPC client would not be compromised if they chose to decline or withdraw. Those expressing interest were also mailed a written description of the study and their signed consent was obtained in person upon first contact.

Study Protocol

Information was collected from participants at three phases:

Intake

Each client participated in three intake sessions with me (an approximately 30-year-old Caucasian female) at the CPC prior to meeting and beginning therapy with his or her assigned clinician. Prior to the second interview, clients received a packet of questionnaires identified in the next section that they were asked to complete in private with the following set of instructions:

> Thank-you for taking the time to fill out these questionnaires. Please complete them in the order they appear. When you are finished, place them in the envelope provided and return them to me (Jocelyne) or the shiftworker at the front desk.

Therapists were asked to complete a brief questionnaire of demographic information as well as an attachment interview during this period (see *Outcome Measures* below). They were provided with a comprehensive report compiled by me prior to meeting their clients that summarized information gathered during intake. An atheoretical case conceptualization and general recommendations for treatment were included in this report. These were the same as impressions outlined in the *Proposed Attachment Challenges to the Therapeutic Relationship* section for each case, although attachment-specific terms were not employed.

Therapy

Due to end-of-semester clinic closures and to allow administrative review and approval of each case as is required by CPC procedure, there was a gap of several weeks between the completion of intake and the beginning of therapy. Such a lag between intake and therapy is common at the CPC. Therapy sessions were videotaped using a portable Panasonic 610-X VHS camera to allow full viewing of both client and therapist. Sessions were also audiotaped using portable recorders provided by the CPC or its central audiorecording system. Separate questionnaire packets were provided to therapists and clients to complete independently immediately following sessions 3, 5, 8, 12, and 16.

Debriefing

Following termination, or the 16th session of therapy, clients and therapists participated in separate final sessions with me. Clients were remunerated $50 for completing the study protocol in its entirety. Therapists were not financially compensated for their participation.

Measures

Table 1 provides a summary of which measures were administered at each of the phases of assessment.

Outcome Measures

Client and Therapist Attachment Ratings

As part of the intake procedure, clients participated in three semi-structured interviews of minimum one-hour duration conducted by me at the CPC. In the first

interview, clients provided background information relevant to treatment including referring concerns, medical and psychiatric history, educational and work history, activities of daily living, and goals for therapy. Bartholomew's Family and Peer Attachment Interviews were conducted in the second and third sessions, respectively. These interviews address various aspects of a person's past and current relationships with primary caregivers and peers, including friends and romantic partners.

Table 1:

Overview of When Measures Were Administered

Phase	Client Measures	Therapist Measures
Intake	RQ SCL-90-R Expectations of Therapy Family & Peer Attachment Interviews SSQ-Short Form	Demographic Questionnaire Family & Peer Attachment Interview
Therapy	SEQ WAI QRI	SEQ WAI
Debriefing	RQ SCL-90-R SSQ-Short Form Exit Interview	Exit Interview

Note. Therapy measures were administered following sessions 3, 5, 8, 12, and 16, with the exception of the QRI, which was administered once only following session 8.

A research assistant and clinician with no prior contact with therapists in this study (Mr. Doug Oram) conducted a two-hour long parallel version of Bartholomew's Family and Peer Attachment Interview with the therapists. These interviews occurred in Mr. Oram's home prior to therapists meeting their clients. Given that therapists were my colleagues, they provided consent for only the interviewer and a second coder to listen to their attachment interviews. That is, they were assured that I would access their

overall coding schemes for the purpose of my analysis and not the details of their attachment interviews.

Bartholomew's Combined Peer and Family Attachment framework was used to code each set of interviews. Each participant's degree of correspondence to four prototypic attachment patterns (secure, fearful, preoccupied, and dismissing) was rated on a 9-point scale ranging from 1 (*no correspondence with the prototype*) to 9 (*excellent fit with the prototype*) by two coders, the interviewer and a research assistant. The two independent sets of ratings were then averaged to yield an attachment profile for each client. In cases of disagreement of 2 or more points on any of the four patterns, another research assistant coded the interviews and provided a third rating, which sufficed to resolve discrepancies. The two most similar sets of ratings were averaged. Mr. Oram and Dr. Shanna Trinke served as second and third coders of client attachment and Ms. Mariana Brussoni and Dr. Antonia Henderson provided second and third ratings of therapist attachment, respectively. All research assistants had extensive experience in interviewing and coding using Bartholomew's framework and had established reliability on other clinical samples.

The Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991)

This measure, comprised of four short paragraphs describing each of the prototypical attachment patterns as they apply to close relationships in general, was used to obtain client self-perceptions of attachment at intake and again at debriefing. Participants are asked to circle the paragraph that best describes them and rate the extent to which each description suits them on a 7-point scale from 1 (*not at all like me*) to 7 (*very much like me*), thus providing both categorical and dimensional estimates of their self-perceptions. RQ ratings have established convergent validity with interview

ratings (Bartholomew & Horowitz, 1991; Griffin & Bartholomew, 1994a) and moderately high stability over an 8-month period (Scharfe & Bartholomew, 1994).

Client Expectations of the Therapeutic Alliance (Bachelor, 1995)

This measure, based on a standard, open-ended self-report inquiry format used in the phenomenological research literature, was administered to clients at intake. They were provided with an 8 ½ by 11 inch sheet and asked to describe a good client-therapist working relationship and the characteristics of an ideal therapist (see Appendix A).

Symptom Checklist - 90 - R (SCL-90-R; Derogatis, 1994)

This is a 90-item questionnaire that assesses severity and frequency of a wide range of psychological symptoms. Participants rate the extent to which they felt bothered by each symptom in the previous week on a 5-point scale from 0 (*not at all*) to 4 (*extremely*). Symptoms are averaged into nine clinical scales including Somatization (SOM), Obsessive-compulsive (OBSCON), Interpersonal Sensitivity (INSENS), Depression (DEP), Anxiety (ANX), Hostility (HOS), Phobic Anxiety (PHO), Paranoid Ideation (PAR), and Psychoticism (PSY). The composite of these scales, the Global Severity Index (GSI), provides a measure of general distress. This instrument has been widely used in medical and psychological research and norms are available for nonpatients, psychiatric outpatients, and psychiatric inpatients. Internal consistency estimates for each of the nine symptom scales based on the coefficient alpha have been reported to range between .79 for PAR and .90 for DEP. Test-retest reliability over a ten-week period has also been found to be good in untreated patients (between .68 for SOM to .83 for PAR; cited in Derogatis, 1994). Clients in this study completed the SCL-90-R at

both intake and debriefing. Raw scores were converted to standard T scores based on psychiatric outpatient norms, which were deemed the most appropriate basis for comparison for the clients in this study.

Social Support Questionnaire – Short Form (SSQ-Short Form)

The SSQ-Short Form is an established adaptation of Sarason and colleagues' measure of perceived close emotional support (Sarason, Sarason, Shearin, & Pierce, 1987). It queries both the number of supportive relationships available in several contexts as well as the associated degree of satisfaction experienced from this support on a scale of *1 (completely dissatisfied)* to *7 (completely satisfied)*. For example, participants are asked "Who can you really count on to distract you from your worries and help you feel more relaxed when you feel tense or under stress? You can list as many or as few people as you feel apply." Responses yield two subscale scores, SSQ-N (number) and SSQ-S (satisfaction), which represent mean scores across contexts. The SSQ-Short Form has been shown to have good internal consistency in university samples (coefficient alphas = .85 or higher; Trinke & Bartholomew, 1997) and its construct validity is well established in relation to other measures of perceived available social support (e.g., Sarason, et. al., 1987; Pierce, Sarason, & Sarson, 1991). An interview version of this measure was administered to clients at both intake and debriefing to obtain a clearer description of the client's social support network than could be obtained from attachment interviews alone.

Relationship Measures

Working Alliance Inventory (WAI; Horvath and Greenberg, 1989)

Clients and therapists independently completed respective versions of the WAI following designated therapy sessions to evaluate their views of the working alliance. Based on Bordin's (1976) transtheoretical model of the therapeutic alliance, the WAI is comprised of 36 items rated on a 7-point scale from 1 (*never*) to 7 (*always*). Twelve items are allotted to each of the three proposed dimensions of working alliance, Task Agreement (e.g. "I find what I am doing in therapy confusing" or "__ finds what we are doing in therapy confusing"), Goal Agreement (e.g. "I am clear on what my responsibilities are in therapy" or "I am clear and explicit about what ___'s responsibilities are in therapy"), and Bond Development (e.g., "I feel uncomfortable with ___" and "I believe ___ likes me"). Research on the measure's reliability indicates that its internal consistency is adequate for the total score within both client and counselor versions (estimated alpha = .93 and .87, respectively) as well as for the individual subscales (alpha ranging from .68 to .92; Horvath & Greenberg, 1989). In addition, the validity of the WAI has been established (Horvath & Greenberg, 1989; Tichener & Hill, 1989). For example, early ratings of the WAI have been reliably correlated with a variety of final counselor and client self-reported outcome measures (e.g. indicators of relationship satisfaction and change) across different therapy orientations. However, the discriminant validity of the Task, Goal, and Bond subscales is unclear given the high intercorrelations found between them (Horvath & Greenberg, 1989). Seeing as the subscales within this study were also found to be highly overlapping (i.e., Pearson correlation coefficients ranging from .70 to .97, $p < .01$), the sum of these three dimensions (WAI Total Score) was used as an overall measure of perceived therapeutic

rapport. The total score may range from 36 to 252, with higher scores indicating perceptions of stronger alliance.

Quality of Relationship Inventory (QRI; Pierce, Sarason, & Sarason, 1991)

This self-report was designed to measure the extent to which a specific current relationship is perceived to be positive. The original QRI consists of 29 items, each rated on a 4-point scale from 0 (*not at all*) to 4 (*very much*), which address three relationship components: (a) expectations for Social Support (e.g., "To what extent can you count on this person to listen to you when you are very angry at someone else?"), (b) Conflict (e.g., "How angry does this person make you feel?"), and (c) perceived Depth of the relationship, that is, the extent to which the person believes the relationship to be an important element in his or her network (e.g., "How much do you depend on this person?"). Research findings indicate that each of the scales has adequate internal consistency (Pierce, et. al., 1991). Evidence for the original measure's construct validity comes from the finding that expectations for a specific relationship (e.g., mother) reflected in the QRI are more strongly related to other measures of the quality of that relationship than to indicators of the quality of other relationships (e.g., father or friend; Pierce, et. al., 1991). QRI expectations for specific relationships also uniquely contribute to predictions of personal adjustment, over and above the variability accounted for by general expectations of social support. In consultation with Dr. Pierce, the format of the questionnaire and item content were modified to specifically assess the client's perception of the therapeutic relationship. Two items deemed inappropriate to therapeutic relationships ("If you wanted to go out and do something this evening, how confident are you that this person would be willing to do something with you" and "If you could have only a small number of social relationships, how much would you want your

contact with this person to be among them") were deleted, one was modified to be less general (i.e., from "To what extent could you count on this person for help with a problem" to "To what extent could you count on __ for help with a personal concern that you wouldn't normally share with other people"), and three new ones were included (items 28 through 30, Appendix B) that were expected to address Social Support and/or Depth of the relationship. The 30-item adapted version was administered to clients following the eighth therapy session and subscale means yielded indices of Social Support, Depth, and Conflict.

Client and Therapist Exit Interviews

I interviewed clients and therapists separately at the CPC two to three weeks following termination or the 16th therapy session if therapy was ongoing. I employed a semi-structured format inspired by Hill and her colleagues in their investigation of the phenomenon of transference (Hill, Gelso, Mohr, Rochlen, & Zack, 1997). Participants were asked to describe several aspects of the therapeutic relationship, including events enhancing or impeding their connection, positive and negative characteristics of their therapist or client, lessons learned and intentions for the future (see Appendix C, D). The interviews were administered to allow participants opportunity to share their perceptions of the therapeutic relationship formed during the protocol and to be debriefed on their study experiences. They were also used to focus session observation and inform interpretation of events identified as salient or meaningful by either or both client and therapist.

Session Impact Measure

Session Evaluation Questionnaire (SEQ; Stiles, 1980)

This 24-item measure assesses client and therapist immediate reactions to specific therapy sessions through two stimulus stems: "This session was" and "Right now I feel." Each stem is associated with 12 bi-polar adjective pairs separated by 7-point scales on which respondents are instructed to place an 'X'. Thus half the items assess characteristics of the session that are averaged across the two subscales of Depth (e.g. Valuable-Worthless, Special-Ordinary) and Smoothness (e.g., Easy-Difficult, Relaxed-Tense). The other half of the measure assesses two aspects of the respondent's mood at the time of administration, Arousal (e.g. Aroused-Quiet, Excited-Calm) and Positivity (e.g., Pleased-Angry, Confident-Afraid). Item directionality is approximately balanced such that higher scores, ranging from 1 to 7, reflect greater Depth, Smoothness, Positivity, or Arousal. Internal consistency of each subscale as estimated by coefficient alpha has been shown to be high for the perspectives of therapist, client, and external rater (Stiles & Snow, 1984). Research findings most strongly support the validity of the Depth and Smoothness subscales. For example, average ratings of Depth and Smoothness of session have been positively correlated with perceived degree of engagement in psychotherapy as well as with client reports of satisfaction and improvement (Tryon, 1990).

Therapy Analysis

Observation and Data Preparation

In a preliminary step similar to that of "bracketing biases," which involves articulating preconceptions about a phenomenon so that they can be suspended during the analysis stage in lieu of fresh ideas (Hill et. al., 1997), my expectations about the influence of attachment representations on therapy relationships were documented. I observed videotapes of all therapy sessions sequentially following the end of the study protocol. Spoken content, behavioural observations, and my impressions of the interpersonal process between the client and therapist (e.g., of emotional tone, degree of engagement, and collaboration versus dominance) were recorded. Attention was also paid to secondary, or unspoken messages relayed between participants (e.g., "I care about you" or "I am not listening").

Research assistants transcribed select sessions verbatim for supervision and illustrative purposes. Sessions transcribed from audiotape were checked against the videotape and important visual details were added where necessary (e.g, "client looking down"). In addition, identifying information (e.g., first names) was removed and minor grammatical changes or deletions (e.g., of excessive "umm") were made to enhance text fluency. To further preserve anonymity in case presentations, potentially identifying details such as age, occupation, diagnosis were omitted or modified according to recommended guidelines (Clifft, 1986; Gavey & Braun, 1997). Moreover, first names beginning with the letters A through F were arbitrarily assigned to each client who completed the protocol (i.e., not in chronological order of participation) and therapists were designated by titles of "Ms." with a first initial matching that of their clients. Using a

supervision technique suggested by Dr. Ofra Mayseless (personal communication, March 17, 24, and May 16, 23, 2000), I assigned a brief title intended to capture the perceived essence of client-therapist interaction in each session (e.g., "Client and therapist map out boundaries"). These titles were discussed in supervision (i.e., with Dr. Mayseless for one case and with Dr. Marlene Moretti in subsequent cases) and modified when necessary.

Upon review of assigned titles both within and across relationships, and in combination with exit interview data gathered from clients and therapists, finer variations in quality of relationship were noted than had been available based on client and therapist questionnaire ratings of relationship and sessions. Most notably, two concepts recurred within my observations and titles (based on Bowlby's attachment theory and explained more fully in the next section), although their frequency over time and across cases. These were therefore selected to draw out case distinctions and inform interpretation of episodes considered significant by either or both participants and myself: whether the episode reflected an attempt to use the therapeutic relationship as a base of client exploration or personal challenge (Secure Base), or whether the episode represented an attempt to use the therapeutic relationship as a source of comfort and protection in response to client distress (Safe Haven). Differences were also apparent across relationships with respect to how successful these various attempts, initiated by either client or therapist, had been. These two concepts of secure base and safe haven offered promise in elucidating the unfolding of events in therapy and their influence on case outcome. Moreover, they were expected to facilitate the distinction of depth and security among therapeutic relationships and add to our understanding of alliance.

Therefore, systematic application of these two concepts became the focus of a subsequent level of analysis.

Attachment-based Analysis

In a second level of analysis, I interpreted cases from an attachment theory perspective in close consultation with Dr. Moretti who observed a portion of videotapes from each therapy case and helped ensure consistency. The present interpretation strategy conceptually resembled discourse analysis, which reflects a functional approach to the analysis of language use rather than a particular set of procedures per se (Barkham & Madill, 1997). Each therapeutic relationship was evaluated for the degree to which it provided the client with two components of attachment relationships, namely secure base and safe haven, which were presumed to be reflective of relationship security and key in facilitating client change. Secure base and safe haven were conceptualized as separate potential functions of therapeutic relationships that would vary across relationships and enrich the distinction among them. The general extent of each of these components or functions was inferred based on the overall relationship tone as well as the unfolding of events within each therapy case. In addition, specific episodes designated as meaningful by participants in their exit interviews and/or me during videotape review were analysed for the extent to which they reflected the presence of either secure base or safe haven. My interpretations of specific events and secure base/safe haven determinations were reviewed in weekly supervision with Dr. Moretti and adjusted when necessary until agreement between us was reached (Hill et. al., 1997).

To systematize this level of analysis, secure base and safe haven functions were operationalized according to guidelines outlined below. These guidelines were inspired

by the writings of Bowlby and developed in consultation with Dr. Moretti and various research and clinical colleagues who were completing or had completed graduate training in Clinical Psychology at S.F.U. Another important source of inspiration for these guidelines were observations of two therapeutic relationships, each involving therapists with extensive experience in conducting and teaching psychotherapy. One therapist (Dr. James Marcia) was a Registered Clinical Psychologist and Professor in the Department of Clinical Psychology at Simon Fraser University whose therapeutic work is primarily influenced by psychodynamic and developmental theory. Over an approximate six-month period, several live psychotherapy sessions conducted by Dr. Marcia at the CPC with a female client suffering from major interpersonal and emotional difficulties were observed. The second therapist observed (Ms. Louise Alden) was a Registered Clinical Counselor with an extensive background in humanistic and experiential approaches to psychotherapy. She provided me with access to two consecutive videotaped sessions from a psychotherapy research project earlier on in her career. These recorded her work with a high-functioning male client seeking to resolve "unfinished business" and thus better himself.

Secure Base

This function involves the use of an attachment figure as a base from which to engage in exploratory or nonattachment behaviour (Bowlby 1988; Hazen & Zeifman, 1994), and thus implies movement away from an attachment figure. The parallel in psychotherapy was seen to be the degree to which the therapeutic alliance accommodates the client's movement or risk-taking within novel and/or challenging territory. Thus, the essence of this type of therapeutic interaction would be the client's and therapist's joint engagement in the exploration of the client's painful or difficult

issues. The therapist's provision of acceptance and emotional support was deemed to be critical in facilitating this function. Equally important, however, was the therapist's ability and willingness to appropriately challenge the client to overcome obstacles, facilitate increased insight, and encourage behavioural change.

It was expected that the successful provision of secure base would be reflected in the presence of interactions characterized by the following behavioural markers:

1. *Client or therapist raises a sensitive or difficult agenda for the client.* This may include past or current issues, as well as dissatisfaction within or concern about the therapeutic relationship.
2. The client is emotionally engaged in the discussion and deemed genuine in his or her preoccupation, interest, or curiosity in the subject matter, rather than actively defensive or distressed.
3. The therapist is also actively engaged and responds in a way to facilitate introspection, reflection, or perspective taking through direct or indirect questions, empathic reflections, or interpretations that help the client expand his or her views or beliefs.
4. The client appears receptive to therapist's perspective. He or she seeks input from the therapist and/or acknowledges the therapist's feedback. There is no evidence of a power struggle (e.g., "yes, but...")
5. The exploration is relatively mutual. Although one party may be talking more, the other is clearly engaged. One gets the sense that the client is talking "with" rather than "at" or "to" the therapist.
6. At the end of the interaction, which may vary in length from a few minutes to a full session, there may be a shift in the client suggesting insight or impact. For example,

the client might directly state greater or novel understanding, appear calmer or more animated than at the outset. There is no sense of inertia, futility, or "rehashing."

Safe Haven

This term refers to the cessation of exploratory behaviour and ensuing retreat to an attachment figure to obtain comfort and reassurance (Bowlby, 1969). Thus, the therapeutic equivalent to the provision of safe haven was understood as the act of soothing or de-escalating a distressed client and facilitating emotional containment so that exploration could eventually resume. Therapist sensitivity to and tolerance of negative emotion were deemed necessary to respond in a manner that effects emotional relief without punishing further expression of distress.

It was proposed that successful safe haven within the therapeutic context would be represented by episodes with the following characteristics:

1. Client distress becomes visible through a change in voice tone, facial flushing, appearance of tears, extended silence, etc. Client is judged to be genuine and emotionally vulnerable.
2. Therapist verbally or nonverbally acknowledges the client's distress and facilitates appropriate emotional expression through questioning or reflection.
3. The therapist continues to monitor the client's distress and responds in an effort to contain it or soothe the client. He or she may validate the client's emotional experience, offer verbal reassurance, or simply lend a calming, attentive presence.
4. The client's distress subsides, suggesting acceptance of comfort and protection from the therapist.

Conversely, two possible types of safe haven problems were conceived: the relationship does not support the client's expression of genuine distress (i.e., emotional

vulnerability is withheld), or in the presence of a safe haven opportunity, the therapeutic intervention does not succeed in alleviating or soothing acute distress. Whereas the former situation is best conceived as an absence of safe haven, the latter would represent a safe haven failure.

RESULTS

Characteristics of the Four Therapeutic Relationships

Two of the four relationships (Cases 1 and 2) remained in progress upon the study's completion and two were terminated (Cases 3 and 4). Average client and therapist ratings of the relationship, summarized in Table 2, indicated that clients in this study identified a range of therapeutic alliance comparable to that documented in other studies. In contrast, therapists in this study were notably more consistent and pessimistic in their evaluations of alliance in comparison to both clients and other samples of therapists. Similarly, clients evaluated sessions to be on average smoother and deeper than did therapists. Both clients and therapists reported higher ratings of smoothness relative to previous samples. Clients on average characterized their therapeutic relationships as moderately high in Social Support (M = 3.0, S.D. = 0.6) and Depth (M = 2.7, S.D. = 0.6) and low in Conflict (M = 1.4, S.D. = 0.3).

Case 1

Angela sought therapy to address her pervasive lack of motivation and sense of being "stuck in a rut" with respect to her career and relationships, especially her marital relationship of several years, which she described as at once comfortable and tumultuous. She noted longstanding difficulties with procrastination, poor self-concept, a proneness to worry about others' perceptions of her, depressed mood and irritability, and inability to express anger appropriately. She reported an infrequent history of panic symptoms triggered by feelings of mistrust toward her romantic partner as well as several somatic complaints.

Table 2:

Average Scores For Each Case on the WAI and SEQ

		WAI Total		SEQ Depth		SEQ Smoothness	
		M	SD	M	SD	M	SD
Case 1	Client	183.0	6.7	5.2	0.8	3.8	1.4
	Therapist	173.6	11.3	5.5	0.9	4.3	0.8
Case 2	Client	206.0	11.0	6.4	0.7	6.2	1.3
	Therapist	182.6	5.6	4.7	0.8	4.6	0.4
Case 3	Client	221.0	6.2	4.9	0.6	5.2	0.3
	Therapist	167.0	8.5	4.1	1.3	4.8	0.8
Case 4	Client	162.7	4.2	3.3	0.5	5.0	0.5
	Therapist	164.7	13.7	4.5	1.2	3.9	0.7
Means	Client	193.2	25.6	5.0	1.3	5.1	1.0
	Therapist	172.0	8.0	4.7	0.6	4.4	0.4
Norms	Client	195.1	33.1	5.1	1.0	4.2	1.4
	Therapist	192.5	25.3	4.6	1.1	4.0	1.1

Note. Norms for the WAI and SEQ are cited in Hill (1989, p.29) and based on transformed data from Horvath and Greenberg (1989) and Stiles and Snow (1984), respectively.

Angela's general level of distress was within the expected range in comparison to female psychiatric out-patients (GSI = 1.83, T = 57). Her score on the Hostility subscale was significantly elevated, however (HOS = 3.33, T = 70), suggesting particular difficulty with thoughts, feelings and actions associated with anger. On the SSQ, she identified several friends that constitute her social support network (SSQ-N = 3.8) and endorsed mild to moderate satisfaction with the level of support she receives from various individuals (SSQ-S = 5.5). She nonetheless expressed overall dissatisfaction in interview with her current level of contact and closeness with friends and noted particular discontent with her partner and family relationships.

Angela had sought psychiatric services for acute anxiety and insomnia related to her relationship breaking up several years prior. Upon the psychiatrist's recommendation, she began therapy with a psychologist at a university counselling centre whom she continued to see on a weekly basis for about ten months until her graduation. She described her previous therapist as very supportive and non-confrontational and noted having made good progress with respect to her body image and self-esteem. She reported feeling satisfied with the therapy but felt that she has lost some ground since termination.

Throughout intake, Angela presented as a highly expressive, introspective, and sociable person who took pride in her appearance and displayed more confidence and assertiveness than she reported feeling. Consistent with her self-description as emotionally intense, her disposition during sessions fluctuated quickly and at times unexpectedly from composed to tearful to bright. Despite a wish to be more independent, she described herself as crisis-oriented and acknowledged a tendency to rely heavily on others for support and self-worth. A striking theme that emerged was her long-standing, pervasive sense of disappointment toward important individuals including her parents, romantic partner, and friends, who she perceived as unable to tolerate her true self.

Angela was classified as predominantly preoccupied (6.5). In addition to the elevated proximity seeking and emotional expressiveness already noted, this attachment pattern was reflected in high ratings of emotional dependence, jealousy, and separation anxiety. Her fear of rebuff and associated inclination to avoid conflict revealed mild to moderate fearfulness (3). Her level of security, also low (3), reflected some level of insight and realistic relationship wishes. Her degree of fit with dismissing attachment was

slightest (1.5), manifest only in a judgmental disposition to other people. On the RQ, Angela also identified herself as primarily preoccupied, rating herself a good fit with this prototype. She perceived herself as having moderate fearful and dismissing tendencies, and being a poor fit with secure.

With respect to expectations, Angela articulated a keen interest in beginning therapy in interview. Her therapeutic goal was quite general, namely, improved well-being. When prompted for more specific information, she reported a desire to achieve a better sense of what she wants, a feeling of control over where her life is heading, and calmer relationships. In contrast, and in comparison to other clients in this study, her written descriptions of an ideal therapeutic relationship and therapist were elaborated. Her response to the first question is as follows:

> I am most comfortable with people who share my energy – they work with me and accept my personality – the more relaxed the better. I believe in being able to say absolutely everything I need to say without fear of judgment – an open mind and an open atmosphere. I need to know that I am in as much control as the therapist – good communication between two people not object and subject or boy and scientist etc. I want to feel I'm talking to a well informed friend – but I might not want to run into them in the grocery store... A safe place a safe person.

Thus, desire for acceptance and control within the therapeutic relationship was clearly indicated. Her preference for a therapist who displayed "frankness, sensitivity, an open mind, interest in my issues as more than just a topic, faults, a presence which takes care of you" reflected a wish for a nurturing therapist who would be willing to engage with her on a personal level.

Proposed Attachment Challenges to the Therapeutic Relationship

Angela displayed several characteristics expected to facilitate initial rapport including sociability, capacity for emotional expression, and expressed interest in introspection. Given her predominantly preoccupied attachment orientation, however, it

was projected that she would require explicit validation, direct feedback, and reassurance of caring from her therapist in order to remain engaged. By the same token, she would likely enjoy a collegial, non-demanding therapeutic style and have a low tolerance for emotional neutrality and confrontation. In light of her issues around acceptance and control, it seemed probable that she would engage in limit testing and resist direction from a therapist.

Nonetheless, therapist consistency and maintenance of expectations were anticipated to be necessary for the cultivation of safety and trust within the therapeutic relationship. Collaborative negotiation of clear and realistic goals was predicted to be a key task in this regard. Attunement to Angela's sensitivity to criticism was also expected to be an important therapist characteristic, as was tolerance for high emotional expression, particularly anger.

Given Angela's relatively specific expectations of a therapist and susceptibility to disappointment in significant others, it would be unsurprising to find fluctuations in her (and/or her therapist's) satisfaction in the therapeutic relationship over time. Conflict with her therapist was probable but, if resolved, might afford Angela the opportunity to alter her fundamental beliefs about herself and others.

Therapy Parameters

Angela was matched with Ms. A whose attachment style was rated as moderately secure (4.5) and fearful (4.5) and mildly preoccupied (2.5) and dismissing (2). Prior to the start of therapy, Ms. A identified the intent to apply a cognitive-behavioural treatment modality. However, she shifted her approach approximately mid-way through the study period. At the study's completion, she had recently arranged for a transfer to a new supervisor who worked from a psychodynamic perspective that she

deemed better suited to Angela. Termination had not been discussed. According to Ms. A, their work was expected to continue for several more months until she moved away.

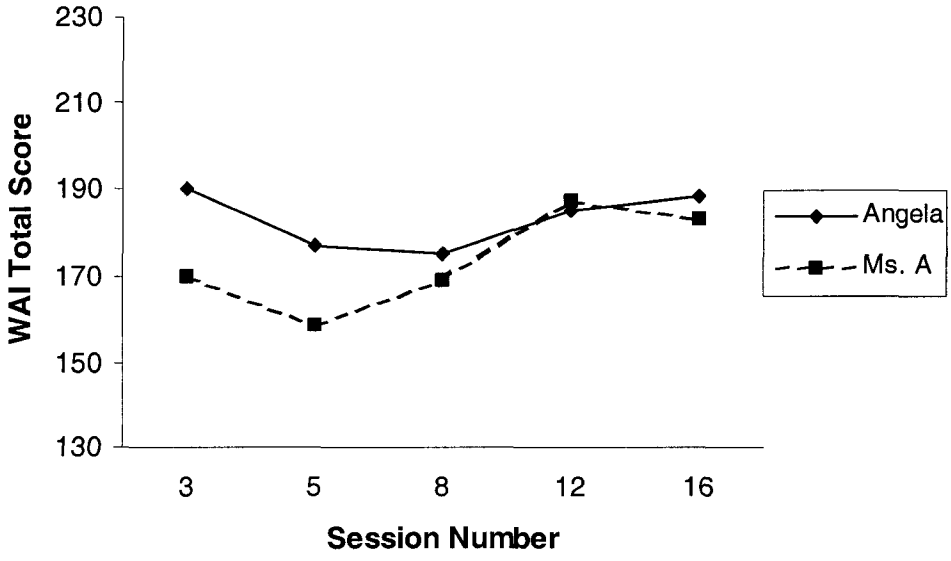
Angela and Ms. A completed the 16-session study protocol within a 23-week period. Angela cancelled one session after the eighth session to visit with her parents. Following the tenth session, and for reasons unknown to the writer, she cancelled two consecutive appointments prior to an end-of-semester clinic closure, which resulted in a six-week interruption in therapy.

Overview of the Relationship

Contrary to expectations, Angela and Ms. A's perceptions of the working alliance were stable, with only minor fluctuations in Angela's evaluation of the relationship and a slight increase in Ms. A's ratings observed over 16 sessions (see Figure 2):

Figure 2:

Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 1



In effect, Ms. A and Angela identified only one episode occurring toward the end of the study protocol (in session 15) that led Angela to later express dissatisfaction with one of Ms. A's interventions. Both rated the therapeutic relationship as moderately strong. Although goals were not specifically negotiated, their exit interview descriptions of the therapeutic focus corresponded fairly closely:

> ***Interviewer (Q)****: What do you see as being the main problem that you've been working on in therapy and if that's changed over time, you can let me know about that.*
>
> **Client (C):** I think there's a couple of things going on. One is my desire to get control over my life in any way. We talk about that a lot and all the different aspects of how its gets played out. Like a trust issue. So control, trust. ((pause)) Yeah, we spend a lot of time going through a lot of family stuff. I think it all comes down to similar issues about me just trying to become an adult, you know, emerging from the protective womb that I've had forever. ***Q:*** *Has that changed, has the focus changed at all since you started?* **C:** It has a bit. I can't even remember what we started. I think when we started we were trying to decide what it is I want to do with my life, you know, and try to get some focus and break out of the cloud of doom that I was in but ((laughs)) but as we touched on it we started getting down to what that doom was about. Working on anger, and my voice.
>
> **Therapist (T):** The main problem, I think, is sort of identity issues, individuation from her parents, yeah, developing her own sense of self. That's changed a little bit over time, because she's becoming increasingly depressed, clinically depressed. I think she meets criteria.

Reported satisfaction with their work notwithstanding, Angela and Ms. A were observed to interact in an unnaturally enthusiastic manner for the first half of the protocol, as though invested in making a positive impression on one another. It is notable that expectations for or impressions of the therapeutic relationship were not discussed. In addition, despite general agreement in perceptions of working alliance, interview descriptions of the relationship differed in important ways. Although Angela described Ms. A as "very reassuring and supportive", she cautiously characterized the relationship as a work in progress and noted continued difficulty in resisting censorship. She attributed this to a sense that Ms. A was unfamiliar with her experiences, based admittedly in part on her private pre-conceptions of Ms. A, as well as on Ms. A's "astonished" reactions. In contrast, Ms. A described their positive rapport as well

established. Interestingly, she emphasized how much she liked and identified with Angela as a person, as well as her own ability to empathize and sort out her client's issues because she herself had had similar experiences. In general, Ms. A gave the impression of being attuned to her client's personal and interpersonal challenges outside of the therapeutic relationship, but she appeared less aware of the client's experience of her.

Moreover, session observations revealed a potentially problematic difference in unspoken agendas. Throughout the study period, Ms. A regularly attempted to problem-solve and suggested homework in response to her client's expressions of distress, even after her shift away from a cognitive-behavioural framework. In turn, Angela quietly resisted an action-oriented approach, as manifested by her repeated failures to complete assignments and minimal responsiveness to suggestions. She seemed content instead to use the sessions to discuss ideas and vent feelings.

In sum, the apparent comfort within this therapeutic relationship was reflected in Angela's responses on the QRI, in which she characterized the relationship as very low in Conflict (1.5) and offering moderate levels of Social Support (2.7) and Depth (2.7). Nonetheless, Angela and Ms. A's expressed satisfaction and friendly interactions belied a certain lack of connection and superficiality that remained after 16 sessions.

Extent of Secure Base

The following excerpt from approximately mid-way through the first therapy session illustrates the nature of interaction between Angela and Ms. A observed throughout the study protocol:

> **C:** What am I going to say: "that I don't care what you think", but really ((laughs)). You know, like I see people, you know, people look at me and I'm obviously too big for them or I'm too dark for them, or I'm too dumb for them, you know ((laughs)). Or whatever it is that they

prefer and I just have this need to be accepted by people and, and I don't know, I guess it's never coming ((laughs)).
T: SO it sounds like if you don't care about what they think, then you won't do the right things to be accepted by them?
C: Probably, um...if I did what my impulses are to do I think I'd probably eliminate a few people ((laughs))
T: And what would be bad about that?
C: I don't know, I guess uh...I don't know what would be bad about that ((laughs)), I don't know. Yeah, if I want everyone to think, oh she's really nice. I don't think I'm that nice even. That is what I think my friends would say.
T: Why do you think that? Or what do you think they would say about you?
C: Um, I don't know, I have good friends. They wouldn't ((pause)), I think they'd probably say I worry too much about this.
T: So, you have good friends, but you have the feeling that they wouldn't say that you were the nicest person in the world.
C: Probably not, I'm sure they, you know, I'm sure they realize I'm human. But I'm sure all my friends would say something good, something bad. I don't know. Now, say if I thought they were bad ((soft laughter)).
T: If you thought they were what?
C: I don't know, just...If I thought people weren't fond of me, I don't think I'd hang around them. (**T:** Ok.) It just, if I think somebody doesn't like me I tend to just leave the situation. (**T:** Uhum) I guess I don't know ((pause)), it's a strange thing.
T: I think that that's a fairly common sort of reaction
C: ((laughs)) "Just go away now!" ((laughs))
T: ((laughs)) Nobody wants to be in a situation where it's uncomfortable, or if you know they think that you or the other person, you know, doesn't really care too much, or doesn't really like them (**C:** Umhmm, yeah...) No point in sticking around and wasting everybody's time (**C:** Yeah) I think that's a what a lot of people think, um, and I think that that's probably kind of adaptive, I mean, do you think it's possible for everybody to like everybody else? I mean, do you like everybody? (**C:** ((laughs)) No) No. And so, you don't like everybody, which is also very normal. I couldn't imagine liking everybody I met, people are different (**C:** Yeah.)

This demonstrates how Angela candidly disclosed her insecurities with Ms. A from the beginning, offering her therapist several avenues of exploration. She did so in an incongruent, over-bright manner consistent with her presentation during intake, likely in the service of masking or dampening the extent of her negative feelings and securing a positive impression from Ms. A. As shown above, Ms. A frequently made use of interventions closely matching the description of those Hill (1989) coined "approval," namely, offering emotional support in a manner that suggests sympathy or is intended to alleviate anxiety by minimizing the client's problem. In addition to paraphrasing and asking open-ended questions, she also occasionally offered limited self-disclosures and expressed open admiration of Angela. Angela expressed appreciation for Ms. A's style in

the exit interview, which generally matched her expectations of a therapist as a frank and friendly person, and acknowledged the ample support she received within this therapeutic relationship as a major benefit. Thus, the first condition for secure base was clearly met.

Although many topics were discussed in detail, the extent to which Angela was able to use her therapy time to adopt a novel perspective remained unclear by the end of the study protocol. Ms. A's therapeutic approach, which was relatively void of challenge and exploration, was deemed to be a contributing factor. She showed curiosity and interest in Angela's issues but seemed reluctant to push her very far beyond a perceived comfort zone, as indicated in the following segment from session 10:

> **T:** In an ideal world, with financial pressures aside, ((**C** laughs)) and say you could find any job that you wanted, what would it be?
> **C:** Uh, you see, I don't know if I'm prepared to answer that question ((laughs))
> **T:** Yeah? Okay ((in a soft voice))
> **C:** I'm not sure, um ((9 second silence)) Censored, censored, censored ((in a quiet voice)) (**T:** Umhmm) ((laughs)) Can't look at those files ((big laugh))
> **T:** Why is that? Why can't you look at those files?
> **C:** It's just ah... ((laugh))
> **T:** Sometimes when we get really stressed out it's just too hard to look at other stuff (**C:** Yeah) And that may be what's going on right now. Otherwise there might be other explanations for why you don't feel comfortable looking at those things, and those would be appropriate for us to look at here in therapy (**C:** Umhmm) So, I guess, I'll take your lead on that for now ((**C** laughs)) And see what, when you feel comfortable looking, or at least, um, talking about why you haven't been looking at things. But it may be that right now there's too much going on
> **C:** Umhmm. It's always going to on like this, isn't it? (**T:** Well,) I'm just gonna always be caught in that, you know, cycle
> **T:** Yeah, that's one possibility, and it may be that those files, that you don't feel like looking at, that may be contributing to the perseveration of everything happening, and hectic, and run down, so we'll keep an eye on that if, if you want, and we'll see how the pace of your life continues, and=
> **C:** =well I'm swimming three nights a week and I committed myself to that for a whole year

In the above, Ms. A perceived an opening to address Angela's reluctance to address an ongoing concern and inquired about the acknowledged obstacle to her "files." However, in reaction to her client's hesitation, she readily reverted to a reassuring stance. Ms. A's predilection to offer approval throughout the study protocol, together with her readiness

to amend stated agendas in any given session and absence of follow-through on assigned homework, suggests that Ms. A held expectations for her client similar to those of a permissive parent. She appeared relatively more concerned with ensuring respect for Angela's wishes and decisions than with maintaining consistency. Her apprehension around upsetting Angela is apparent in the following segment, also from session 10, wherein she addresses Angela's extended absence from therapy:

> **T:** Um okay, well, one other thing that I wanted to talk about was sometimes when, well, I'll step back a bit. Towards the end of the semester, I had to cancel a couple of appointments and then you cancelled a couple, and I was wondering about, um, I know that, that, sometimes things just come up and that schedules change, and that's okay. Other times, when people change their schedules, and things, appointments are missed, it's because there's something uncomfortable about coming to therapy (**C:** Mmmm) Or that, you know, I mean, it may not even be anything conscious, um (**C:** Umhmm) But, sometimes that's, that's what we realize is going on...
> **C:** Umhmm. Where were we?
> **T:** What were we talking about? (**C:** Yeah) I don't know, do you, do you remember, what do you remember about that?
> **C:** I remember discussing my family ((laughs))(**T:** Umhmm) And that's the last thing I remember ((laugh)) I was still trying to recover from them, I think ((laugh)) (**T:** Yeah) Um, now I did have a [work] schedule that they asked me to be around for, but I don't know how flexible that schedule would have been, I don't know if I was doing that or not (**T:** Yeah) That's interesting.
> **T:** Well, I mean that's just something to, to think about, I mean, I'm not, accusing you or anything
> **C:** No but, yeah! No, I find that very interesting.
> **T:** Umhmm. So, yeah, we were talking about your family, and there was some pretty painful sounding stuff coming up, I think (**C:** Umhmm) I think that we were going pretty, pretty deep at times (**C:** Yeah) ((soft laugh by C)) You were displaying a lot of emotion (**C:** Yeah) Obviously really important for you, uh, sometimes we see that clients are, you know, you end disclosing a bit more than you, you want to ((soft laugh by C)) Or you get into something and then you realize, "oh! My god! This is so awful I can't deal with it" (**C:** Umhmm) And sometimes that ends up changing the therapy relationship a bit and people withdraw a bit and that's something that's very NORMAL, (**C:** Yeah) But it's also something for us to LOOK at (**C:** Yeah) Because we don't want that to happen again. We don't want you to be uncomfortable. If in fact that's what happened, I, I'm not sure
> **C:** ((laugh)) I'm sorry! ((laughter))
> **T:** No, no, that's okay (**C:** yeah) I just want you to know that that's something that's been going through my mind, and so, one thing I'm wondering about doing is first of all, looking at your goals for therapy and what you want to accomplish (**C:** Umhmm) And definitely looking at the pace of how we do that, uh, where we go, things like that, so those are some things that I'll be wanting to talk about over the next couple of sessions (**C:** Okay) ((**C** laughs)) How does that feel for you?
> **C:** Yeah, I feel, that would be nice, yeah, just to get a frame.

The above illustrates that when Ms. A deemed it important to point out to a discrepancy or problematic behaviour to Angela, she avoided being direct and instead used general, distancing language (i.e., "people" or "clients" versus "you"), likely in an attempt to soften her feedback and her client's reaction. In addition, by presenting various possibilities that may have underpinned Angela's choice to cancel appointments, she in essence rescued Angela from voicing and openly addressing her potential discomfort within the therapeutic relationship. This was particularly striking given Angela's encouraging feedback. It may have been fruitful to pursue, for example, what Angela found "interesting" about Ms. A's reflections and verify whether Ms. A had had doubts about returning to therapy. Similarly, although Ms. A set the stage at the end of this interaction for her and Angela to negotiate goals, this discussion was quickly abandoned in response to Angela affirming an inability to do so. Again, it may have been useful for Ms. A to question Angela's inability versus her potential unwillingness, which was undoubtedly frustrating to both of them, and persist in such exploration by possibly referring to their own process.

As noted earlier, Ms. A emphasized in her exit interview her intent to be non-judgmental, as well as her fondness for and identification of Angela, which undoubtedly contributed to her gentle, overly accommodating approach and corresponding investment in maintaining a good working alliance. However, by inviting Angela to share any potential disappointment toward therapy or her in particular, Ms. A would have been conveying full acceptance of Angela. Moreover, by remaining patient and firm in discussing goals or lack thereof, her support for Angela's autonomy and ability to make choices may have been strengthened and their relationship deepened. One wonders to what extent Ms. A's own conflict avoidance tendencies, reflected in her moderate fit with

a fearful attachment orientation, influenced her lack of challenging and presumed hesitance to push her client.

Overall, viewed from an attachment perspective, this therapeutic relationship succeeded in providing Angela with a sufficiently comfortable and predictable forum in which to vocalize and reflect on her experiences, as she herself noted in the exit interview:

> **Q.** Anything you'd like to add about your therapy experience that we haven't talked about so far? About what's been useful, or any tidbits of training you'd like to pass on?
>
> **C:** ((laughs)) I've been up and down but I feel that as long as I can come here, I'm working through this stuff, that I have SOMETHING to get me through whenever. I'm trying SO hard to make these changes and [Ms. A] said that often [therapy]'s more than once a week. And that would be nice too, but that would be a little dependent, maybe. But it's nice to have, just that structure that we were talking about, to know that if there is no support anywhere else then I can come back and say, "You know, I'm REALLY trying, can you get me back on track, you know, help me think clearly about this."... So, I think this is just a very important thing for me.

Nonetheless, it is unclear whether this therapeutic relationship offered Angela a unique interpersonal experience. Her RQ responses at debriefing indicated no change from intake in her self-perception of attachment with the exception of her self-rating as a poor rather than moderate fit with the dismissing prototype. Her social support network also remained quite similar although her average degree of endorsed satisfaction was slightly higher (change in SSQ- S = 0.45) It is notable that her defensive style remained salient after 16 sessions and that she reported ongoing difficulty sharing her innermost thoughts and feelings with Ms. A despite a wish to be able to do so. It appears that there was a certain confidence lacking in Angela's ability to accept and tolerate Ms. A's confrontation which, in turn, may have prevented them from exploring Angela's experiences more fully and in a novel way. Stated differently, their mutual protection from conflict within the therapeutic relationship may have denied Angela opportunities to be exposed to modulated interpersonal challenges, the resolution of which would likely be beneficial to

Angela who struggled with anger and assertiveness. Thus, at the end of the study protocol, the establishment of the therapeutic relationship as a secure base for Angela's exploration was incomplete.

Extent of Safe Haven

Although Angela was highly expressive throughout the protocol, there were relatively few instances in which she presented as genuinely emotional and open to sharing her feelings of vulnerability. The first observed instance was in session 8, following a visit with her parents that triggered anger and hurt related to her perception of being treated like a child. As various disturbing interactions comprising the visit were discussed, Angela's coyness and incongruent laughter in the first forty-five minutes of the session finally gave way to a more thoughtful, sad presentation. As she disclosed how upset she had become with her father who she experienced as controlling, her emotional intensity increased:

> **C:** I shoved a HUGE piece of cake in my mouth because that's the only thing I could do ((pause)) is just EAT and I know that that's a problem (**T:** Mmhmm) I couldn't say anything to him, you know. I tried and I tried, I couldn't say anything. So finally I just shut myself up ((gets choked up)) I realized what I was doing, I can't stop it.
> **T:** Have you ever realized that before?
> **C:** Yeah, once. Um, I had a flash, you know. If there's anger in me, I often shove it back down (**T:** Yeah) and, so you know, it kind of gets stuck there (**T:** Mmhmm) It just gets really hard when I see it happening, I can't stop it. What is it, he's locking my door. Let it go. It's MY door, not his
> **T:** Your life, let you live it ((**C** nods)) but he's not
> **C:** ((nods)) Yeah. I was, it was REALLY frustrating. ((voice escalating)) I mean, of all the STUPID things to get me mad (**T:** Mmhmm) My mom's just looking at me, I know she'd figure it out too, right. She's just watching me, she wouldn't DO anything, she didn't say anything to me. She's just, "Feel better," you know, like= (**T:** =Mmhmm) Just, don't even GO there, cuz I would have been just SO mad
> **T:** A huge amount of anger in there
> **C:** ((nods)) Well, at that point, you know, I'd said it to him every night. I'd try to get my life. I said, "Don't worry about it, it's my lock, I WILL get it" (**T:** Mmhmm) He didn't understand. I couldn't elaborate on it, I didn't want to get into a huge, you know, big chat, you know, about the dynamics of a relationship, just to explain this to him (**T:** Yeah) But you know, like, it was either that, or start yelling (**T:** Mmm) you know, and I didn't want to do that
> **T:** Yeah. Yelling probably doesn't solve much either

> **C:** No, and, I mean for years, you know, I would yell and no one would listen (**T:** Mmhmm) you know. It didn't get me anywhere. (**T:** Mmhmm) You know, I got laughed at
> **T:** Yeah. But it sounds like you know that there is a discussion in there= (**C:** =Yeah) about dynamics
> **C:** Yeah. It's pretty gross, and then, I just can't deal with it
> **T:** Well, I think that you have, a huge amount of insight to know that this is what's going on and that really, it's ABOUT the dynamics. It's not just about locking doors. Did I talk to you about writing, writing a= (**C:** =Script=) =letter? Writing a script? Writing a, a discussion with your parents, or your mother or your father (**C:** Uh huh) Did you take a crack at that at all? (**C:** No) No? Do you think you might want to try that for next time? (**C:** I don't know) Nobody would have to see it. I wouldn't even have to see it. It would just be a hypothetical. ((pause)) I felt like there's a LOT of stuff in there that you need to get out. It's not going to happen yet, verbally. Doesn't necessarily ever have to happen, ACTUALLY, with them. But it's something that would help a bit. A lot.

Ms. A was well aware of Angela's distress and remained engaged. She initially responded by reflecting back Angela's position (i.e., "Your life, let you live it"), thus showing her understanding. This was successful in allowing Angela to further express her anger, which Ms. A then directly acknowledged. She subsequently responded to Angela's maintained emotional intensity with encouragement (e.g., "You have a huge amount of insight"), then a suggestion to vent feelings on paper. This seeming intent to soothe her client is arguably in line with the function of safe haven. However, Angela's silence and disinterest in the exercise suggests that Ms. A's response may have unwittingly replicated Angela's experience with caregivers, in which she perceived a lack of acceptance of her anger (e.g., messages of "Feel better", feeling ignored or laughed at when angry). In fact, she rated her subjective emotional experience immediately after the session as very low in positivity, and at its lowest in comparison to other evaluation time points in the study period, suggesting that Ms. A was not successful in alleviating Angela's immediate distress. It seems plausible that Angela was less concerned with finding a solution to her communication problem with her parents as she was in venting her frustration to a sympathetic and supportive ear. Stated in attachment terms, Angela appeared willing to take an emotional risk (i.e., engage in secure base) in experiencing

and expressing her deep-felt anger in Ms. A's presence. Ms. A's offer of comfort and protection (safe haven) appears mismatched. Timing was undoubtedly a factor in Ms. A's focus on de-escalating her client, whose emotional display remained intense as the session drew to a close. A concerning message that may have been conveyed by Ms. A's intervention, however, is that of discomfort with Angela's anger. It may have been useful to recommend exploring Angela's emotional reaction further at the next session to mitigate this possibility.

. Angela also presented as less defended and more genuine in session 15. Although Angela regularly cried in their sessions, Ms. A expressed concern for Angela in this particular interaction, which, in turn, elicited an intensification of Angela's sadness:

> **T:** Have you always been this sensitive? ((**C** is silent, softly crying)) Do you feel like you've let people down?
> **C:** ((crying)) I've always been an awkward person. It's always seemed like people had reason to push me off. I've always had this feeling of being someone's dirty lint that no one wants to have to deal with.
> **T:** You've always felt worthless
> **C:** That's not exactly true. I feel there's something in me that's good but I'm not allowed to show it. People don't know it's there. Maybe because it's slightly less than best.
> **T:** In their eyes or your eyes?
> **C:** I don't know that I know the difference between those two things

The focus of the session remained Angela's profound sense of disappointment in herself and others, notably facilitated by Ms. A's open-ended questions. Certainly, this session was deemed especially productive in comparison to others in bringing Angela's challenges to the forefront and in facilitating a more authentic presentation of the client. Ms. A, however, appeared to grow increasingly concerned about the depth of Angela's sadness and motivational difficulties and eventually proposed that Angela was suffering from depression:

> T: This might be kind of presumptuous of me, but have you ever considered medications? Anti-depressive medications?
> **C:** Umm...((sighs)) Yeah, kind of but, I'm anti drugs.

T: What about an herb? Have you ever heard of St. Johns Wart? (**C:** Yeah.) It's not really a "drug" drug, and it does have some documented effects. What you're describing to me sounds like a fairly long standing sort of, low to moderate grade depression. And, it's, you just don't have to suffer. ((long silence)) That's of course not the answer to everything, but it might increase your energy levels a bit so that you can feel like you can do some of the stuff and maybe get that spark back a bit.
C: ((crying softly, looking down; long silence)) I don't know how I feel about that. (**T**: Uhum) It's hard ((crying)). I feel so bloody stubborn. I don't know how I'm going to get through this horror.
T: You're gonna make yourself go through this because you deserve to do that?
C: To some degree, I dunno. I know I don't want to go through this, that's why I'm here.
T: Uhmm ((pause)). You know there is conflict in everybody= (**C:** =Yeah) There's probably part of you that says: "I don't really want to hurt this way anymore." There's probably another part of you that says: "You know, there's some good things about feeling that way".
C: ((crying softly, long silence)).
T: It does sound though that there are a lot of feelings in there...sounds like there's still quite a bit of stuff that you're not able to look fully at right now.
C: ((crying)) I can't see anything.
T: It's hard to see some of this stuff. It's hard to look at it. It's REALLY really tough.

Angela identified the above interaction in the exit interview as very upsetting, remarking that she "left mad as hell." Although this was not discussed until two sessions later, Ms. A also recalled in interview that her interpretation was "not well received", reflecting some attunement to her client's distress, although she did not perceive it to be directed toward her. However, her lack of acknowledgement of Angela's reaction during the session may have again reflected her own difficulty tolerating negative affect, particularly anger.

The common thread in these two episodes was Ms. A's choice to intervene out of concern for her client's well-being in a way that was intended to reduce negative emotion. Although this intent was appropriate, and in line with the provision of safe haven, Ms. A's failure to soothe her client on both counts may have been due, in part, to a discrepancy between her goal and the client's wish to share intensified emotion. It is important to note that Ms. A's concern for Angela's sadness, particularly in the latter instance, followed from her thinking, indicated at debriefing, that Angela's depressive tendencies had worsened to clinical levels. Nonetheless, at the same time, Angela

endorsed less overall distress (GSI = 1.34, down from 1.83), reduced hostility and anger problems (HOS = 1.33, down from 3.33), and fewer symptoms of depression (DEP = 1.92, down from 2.77) on the SCL-90-R in comparison to intake. Interestingly, Angela eventually addressed her dissatisfaction with being labeled and was pleased with Ms. A's response as well as with her own choice to be assertive. She indicated in interview that the repair helped her feel more positive about the relationship.

Of import for the purpose of this analysis, however, is that the therapist's efforts at providing safe haven had limited success. Together with incomplete secure base this corresponded to a lack of security within the therapeutic relationship manifest in conflict avoidance.

Case 2

Diane requested individual therapy to overcome various fears and address past experiences of physical, sexual, and emotional abuse by caregivers. She also reported mistreatment by a prior partner with whom she no longer had contact. Her fears had started about a decade earlier and reached their peak of intensity and debilitation several years prior to this referral. She reported having worked with several therapists, most of whom had little to no expertise in dealing with phobias. No longer house-bound, she attributed much of her progress to relatively recent participation in a specialized self-help program that recommended adjunct individual therapy. She had been obliged to discontinue her latest therapeutic relationship, described as the most helpful, for financial reasons but was determined to further her gains. Increasingly bothered of late by feelings of loss and abandonment related to her upbringing, she hoped that by exploring her past she might "unlock" something that would free her.

Diane reported general distress within the expected range in comparison to psychiatric outpatient women (GSI = 1.46, T = 52). Not surprisingly, her responses yielded a significant elevation on the Phobic Anxiety subscale (PHOB = 3.14, T =71), reflecting persistent fears leading to avoidance or escape behaviour. Although she described a social network of at least six friends, noting them to be "odd and reclusive" like herself, she reported minimal contact with them and little sharing of personal matters, particularly her fears. On the SSQ, she identified her husband as a sole source of emotional support (SSQ-N = 1, SSQ-S = 5.8). Although she endorsed high satisfaction with his support, she indicated a desire to be able to rely on friends as well.

With respect to prior therapy experiences, Diane had worked with four clinicians within a seven-year period. She reported having felt generally supported in each of these relationships and that all but the first one had helped her achieve some degree of symptom relief. Although she eventually ended the first therapeutic relationship, she stated that her two subsequent therapists initiated termination when they perceived a plateau in her progress. She acknowledged some disappointment and hurt associated with these experiences.

Diane presented as a poised, articulate, and private individual who held generally realistic perceptions of and expectations for herself and close others. Although her initial reserve and guardedness gave way to a warmer, generally relaxed demeanour during intake, she quietly struggled to remain composed at several points and indicated high emotional sensitivity. Despite currently healthy adult relationships, including those with her husband and children, she indicated at best precarious self-efficacy and worthiness, undoubtedly ensuing from considerable early hardship at the hands of multiple caregivers. She indicated a pattern of coping with problems largely independently and in

a self-protective manner, gravitating to few individuals perceived as safe and with great hesitancy. In effect, her success in establishing a few intimate and satisfying relationships seemed overshadowed by a deep-seated sense of vulnerability to losing the significant people in her life as she reported having so often experienced. A pattern of feeling alone, misunderstood, or judged and yet reticent to acknowledge this to others out of fear of alienating them further was also evident. Her phobia appeared to reflect the profound impact of her abuse and abandonment history on her ability to establish trust and feel secure. Just as importantly, her relatively new awareness of a population suffering from similar fears seemed to afford her an identity as well as renewed hope for a much longed-for sense of belonging.

Diane was rated as predominantly fearful (6.5). This was reflected in low levels of emotional expressiveness, confidence, and trust that appeared largely driven by a fear of rejection conflicting with a desire for closeness. Due to her ability to establish intimacy in her current marriage and terminate abusive relationships, she was afforded some security (3.5). Her fit with preoccupied attachment was low (2.5), typified in a series of romantic partners in early adulthood. She also received a negligible rating of dismissing attachment (1.5), manifest only in her style of discourse that included frequent use of verbal distancers and inappropriate laughter. Similarly, her responses on the RQ suggested that she perceived herself to be most like fearful and a good fit with this style, somewhat secure and preoccupied, and least like the dismissing prototype.

Diane described a good client-therapist relationship as one characterized by "continuity, commitment and respect." She highlighted the need for a trusting relationship and indicated discomfort with ambiguity. In addition to empathy, understanding, caring, and a good "bed side manner," she described her ideal therapist as imaginative, having

a good sense of humour, flexible, and open to sharing. Thus, getting to know her therapist as a person emerged as an important theme for Diane. She also specifically requested that her therapist be willing to listen to audiocassettes comprised in her self-help program in order to familiarize him or herself with the philosophy of the program and her progress to date.

Proposed Attachment Challenges to the Therapeutic Relationship

Diane's capacity for insight and intimacy, high motivation to work on confronting her problems, and generally positive experiences in therapy were considered to be good prognostic factors for further therapeutic contact. In contrast, her predominantly fearful attachment orientation and corresponding heightened propensity to feeling abandoned and rejected was seen as a potential barrier to the development of a strong working alliance. The process of developing a truly trusting therapeutic relationship was proposed to be slow and gradual and reflected in self-reports of working alliance. Her perceived sense of safety within the therapeutic relationship was proposed to remain a central determinant of her progress.

It was anticipated that Diane's comfort and safety would be facilitated by a warm, concerned, and non-judgmental therapeutic style. Given her expressed willingness to resolve her past and capacity for introspection, an unsuspecting therapist might underestimate the painful impact of exploring abuse-related issues and be deceived by her general poise. Thus, monitoring her potential to feel emotionally overwhelmed and assisting in containing her emotions at a tolerable level were considered critical therapist responsibilities. In this same vein, structure that would include judicious pacing of interventions centering on abuse issues, particularly at the outset, as well as regular, mutual evaluations of therapeutic goals and the process was expected to promote safety

and trust. Equally important would be the therapist's forthright interest in and attention to her fears and active efforts to help her overcome it. Diane's apriori request that her therapist become familiar with her specialized self-help program was essentially understood as a test of openness and commitment.

Therapy Parameters

Diane was matched with Ms. D who was rated as predominantly secure (6) with secondary preoccupied tendencies (3.5). Her degree of fit with avoidant orientations of attachment was lower (2.5 and 1.5 for fearful and dismissing, respectively). Ms. D indicated a plan to combine cognitive-behavioural treatment strategies with a psychodynamic approach. At the study's completion, their work was ongoing. They had negotiated from early on to continue together through to Ms. D's out-of-province move approximately six months later.

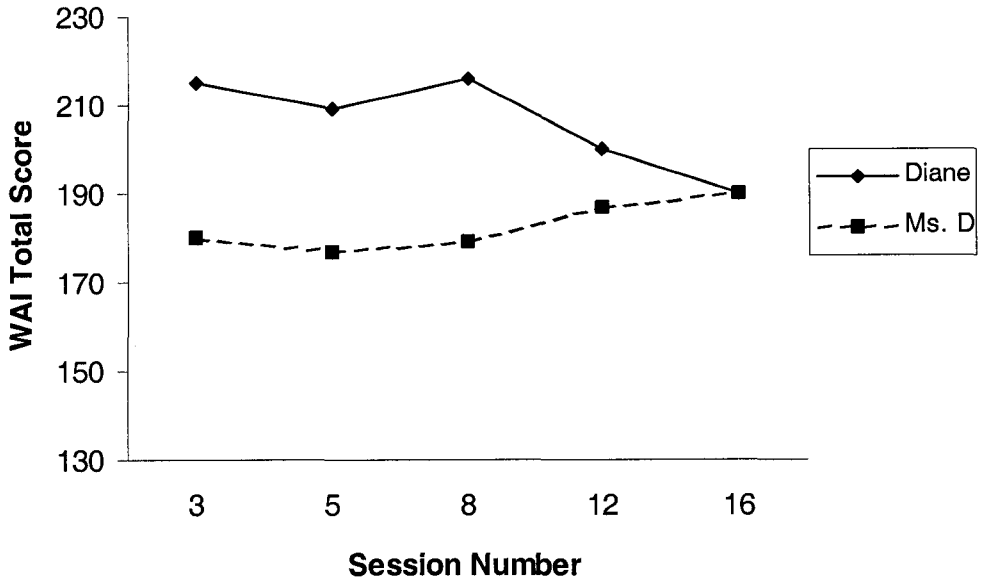
Diane and Ms. D completed the 16-session study protocol within a 25-week period. One appointment was cancelled due to poor weather after the ninth session. A holiday clinic closure resulted in a three-week break between sessions 12 and 13. Another three-week break occurred between sessions 14 and 15 due to the therapist's absence. Therapy was again interrupted for four consecutive weeks between sessions 15 and 16 due to Diane's illness. By their respective exit interviews, they were back to meeting weekly.

Overview of the Relationship

Both Diane and Ms. D affirmed a positive working relationship. As shown in figure 3, and somewhat contrary to prediction, Diane perceived her alliance with Ms. D to be very strong overall from early on:

Figure 3:

Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 2



Rather than increasing further, her ratings decreased to moderately strong in the latter quarter of the study protocol, coinciding with the inconsistency of their meetings at that time. In contrast, Ms. D's perception of their alliance, which was somewhat more modest than Diane's at the outset, improved slightly in the second half, thus converging with Diane's ratings by the end of study. Their respective exit interview reports highlighted warm feelings toward one another and a special connection that stood out for them in comparison to other therapeutic relationships. Diane, for example, noted that she felt more relaxed with Ms. D, whom she described as especially caring and interested, than with other therapists, and stated, "I feel comfortable saying pretty well anything I want to, I can express myself with her." She also indicated that this therapeutic relationship stood out from her relationships with family and friends in the degree to which she felt understood noting, "It's her job [to understand] and she does it well." In turn, Ms. D acknowledged thinking about Diane in between sessions more than she did other

clients. She characterized Diane as particularly interesting, articulate, and intellectually stimulating. She also reported optimism about the case largely due to Diane's apparent genuineness, creativity, and motivation to change.

Diane and Ms. D were also readily able to identify challenges to their work together:

> ***Q*** *What about __ makes it hard for you, or people like you, to work with her?*
>
> **C:** I guess I need some more structure...Sometimes I need to go into detail bit by bit and sometimes I do need to be pushed along. I realize I have responsibility [in therapy], but I would like a caretaker who would say, "now this, now that", like I do with my kids. They don't know how to specifically do things, so they need help. I sort of feel like a child with too much responsibility sometimes.
>
> **T:** She has a fundamental lack of trust in people, men and women alike. For her, the world is a dangerous place. Whereas I have the opposite orientation; the world is benevolent. It's sometimes hard because she doesn't always trust me.

In doing so, they provided a fuller, balanced perspective on their relationship and reflected openness to acknowledging room for improvement.

Session observations confirmed that Diane's desire for structure and direction, particularly with respect to symptom management, was recurrently at odds with Ms. D's interpersonally-based therapeutic approach. They nonetheless worked in a highly collaborative manner characterized by several episodes of goal negotiation wherein Diane's need for safety was explicitly recognized. Together they succeeded in elucidating roles and expectations for one another and addressed perceived deviations in their respective contributions. Although Ms. D maintained her therapeutic framework, believing it to be appropriate to the case, she occasionally incorporated cognitive-behavioural techniques to accommodate Diane's request for greater emphasis on her fears.

In sum, Diane's responses on the QRI indicated that she found her relationship with Ms. D to be quite supportive (3.2) and deep (3.0) and low in conflict (1.7). However,

their mutual recognition of and respect for trust as a maturing, delicate process, as well as their receptivity to addressing potential ruptures in alliance, lent strength to the relationship beyond that indicated by self-report indices.

Extent of Secure Base

The nature of interaction between Diane and Ms. D is captured in the following excerpt from session 5, in which Diane recalled a friend's suicide fifteen years earlier:

> **C:** Well, the cemetery, it turned out was close to this house, and, I hadn't realized it, I hadn't connected before, because I had never gone to the cemetery before. I am sure she, she got most of the flowers from the cemetery now, she was very poor ((laughs)) so I don't know how ((laughs)) and I just thought "Oh, my god, she!', you know. And she would do stuff like that, she was, she was very cheeky. Yeah.
> **T:** She was very cheeky. (**C:** Yeah.) She would steal flowers. (**C:** Oh yeah, I'm sure, yupp, I'm sure, yeah) And you and she only knew one another for a year and a half, but she's important.
> **C:** Yeah, I mean, I really liked her. Yeah, yeah, and, um ((pause)) I still feel very angry that she left her child. (**T:** The baby?) Mmhmm. I just, I just don't think that there is anything crueler. He's, um, 18 now and I saw pictures of him. And he looks great. He looks like her. And he's also, you know, very theatrical and ((mumbling)) very flamboyant.
> **T:** He is her son.
> **C:** Yeah, definitively, yeah. And when she used to stay at my place, which she often did ((clears throat)), her son would sleep with her, and um, you know, all that love she gave, you know, touching his hair, kissing it, very affectionate. It just, ah, I just couldn't understand how she could leave him.
> **T:** She left him young and she seemed to really love him (**C:** Oh, she ADORED him!=) =in your eyes. She adored him, she was kinda perfect, perfect mom. Very affectionate mom. And even she chose to leave him in order to get out of her own pain and her own life.
> **C:** Yeah, yeah. Well, I think she thought that everybody else would do a better job.
> **T:** Thought everyone else would do a better job? (**C:** Yeah, I think so.) And you are angry at her. You are angry at her. (**C:** Mmhmm.) What right do you have to be angry?
> **C:** ((laughs)) Well, that brings me to something that, last week, I've been reading a book about orphans.
> **T:** Orphans. Yes?
> **C:** And, I'm ((sigh)), I wanted to be angry at the world, you know and angry at parents that don't, aren't there for the children.

Diane disclosed sensitive and personally meaningful content, including early experiences of rejection and loss, with minimal guardedness or prompting from as early as the first session, reflecting readiness to address painful issues despite her predominantly fearful orientation. Also notable were her active efforts to clarify the

boundaries of their work by, for instance, directly inquiring at the outset about the projected frequency and duration of their contacts, and reiterating her wish that Ms. D listen to certain audiotapes. Like Ms. A, Ms. D's general stance was that of acceptance and approval. As shown above, she frequently intervened through paraphrase, thus communicating attentiveness and understanding (e.g., "He is her son"). However, in comparison to Ms. A, she was more inclined to encourage her client's exploration through the use of provocative questions (i.e., "What right do you have to be angry?"). As shown in the following excerpt later in session 5, she also regularly and persistently invited Diane to specify goals and targets of intervention, who, in turn, proved eager to do this:

T: And you said you still need to get past all this?
C: Well, so that when I can walk down a street I know that I'm not going to do anything. That, those scary thoughts won't be there. You know, I need scary thoughts to go away. It's time for them to go ((laughs)).
T: So that's what it would mean to you to be getting past this? To be getting past your friend's suicide or to be getting past your own orphanage, what is it that you want to get past?
C: The fear.
T: The fear. And so you think that getting past, working through what events, is necessary to get rid of the fear. What is your focus?
C: Well, it feels like I need to examine it all, really examine. I mean I want what happened to, to see why I am, ((pause)) why it became a fearful thing.
T: So you want to go back to the point in which you started to develop the thoughts, the scary thoughts, and you want to figure out why those developed. And it seems, to me, and tell me if I'm wrong, it seems to me like you have ideas already, you have some hypotheses, but you haven't actually had the opportunity ((pause)), you haven't gone there yet and really, really examined or talked about it, or turned over all the stones, but you know what the stones are. You could label them if I asked you to right now. (**C:** Yeah.) You are a very smart woman, you're insightful. You're ready to get down to doing the dirty work now...
C: Right, ((laughing)) that's why I'm here.
T: Yes, well you are doing a good job at it I think so far.
C: To just deal with it, I think it might be safe to do it.
T: To do it in the company of a professional?
C: Right. You'll see things that I don't see, you know.
T: Is that what you think that I will do, do you think that that's my role? To see some of the things that you don't see? (**C:** Part of it. Yeah, yeah.) I also think, I agree with you, that is my role. And I also think that I'm going to just go there with you. And probably you will see things as quickly as I do in some cases. But at least we'll be there together. (**C:** Right.) Looking at them together, instead of you having to do it on your own. (**C:** Yeah, yeah.)

Over the course of the study protocol, Diane achieved several new insights connecting her symptoms to efforts to cope with experiences of adversity, a process that appeared to deepen her understanding of her disorder and bring her corresponding relief. She realized, for example, that her friend's suicide corresponded with the development of bodily discomfort in automobiles that eventually led to her driving phobia and came to appreciate how this loss impacted on her developing sense of adult self. She remained invested in overcoming her fears, including interpersonal ones, and reported increased efforts to reach out and assert herself to significant people in her life. A noteworthy testimony to this progress was her decision to confront Ms. D early in session 8 about her insecurities within this relationship. She did so by sharing a recent journal entry abbreviated here:

> **C:** When we first started sessions, um,[Dr. X][previous therapist] asked me each session to bring in the [self-help] tapes and listened to it, and we discussed it each time. And at the end of it all, I felt she really understood more. What I was going through. Actually, today, I brought my journal with me because I've, in the last weeks since I've been here, I've been writing stuff about our sessions. And uh, some concerns I have about my sessions with you, and um, (**T:** Do you want to read it to me?) I do, but I'm definitely feeling a little bit apprehensive about this ((nervous laugh)) but at the same time, I feel that it's important. Yeah, and, I do, I do like you. I feel like you are a warm, compassionate person, and especially in the beginning of the writing here, you might feel it's a bit cheeky ((laugh)) but I guess that's the chance I have to take. (**T:** Okay.) "I had my appointment with [Ms. D]... She seemed quieter, tired, yawned a few times, discretely... I'd like to ask her a few questions about herself... I'd like to ask her about her workload, how stressed she is, is she truly in the room with me, how can I trust this person I barely know. Am I spilling my guts to this audience of one who is too stressed to be there for me... I feel my mistrust with the professionals surfacing. I was a ward of the court for fifteen years or so. I never felt they had my best interest at heart. I always felt like being quiet and good was safer. These social workers could get me in trouble with my foster parents. The social workers weren't with me at the end of the day to protect me. Does [Ms. D] have any life experiences that would lead her to being empathetic to what I've gone through? And I do not feel that [Ms. D] truly knows what it's like to be [like me]. And I feel that she will never truly know until she listens to the [audio]tapes... Pain and confusion and a sense of futility are some of the things that make me withdraw. I feel all this, hence, all this."

In light of her inability to acknowledge hurt to previous therapists, Diane's disclosure represented a tread into novel territory. Although she approached this task in a somewhat indirect (i.e., reading an entry aloud rather than posing concerns in the first

person) and placating manner (e.g., "I do like you"), her action appeared to represent a calculated risk based on a sense of security within the relationship. Diane's SEQ rating of this session as the least smooth in comparison to other assessment points lends support to the interpretation of this gesture as a significant personal challenge. However, it seems unlikely that she would have shared these reactions had she perceived Ms. D to be inclined to withdraw her acceptance and support. Further exploration and clarification of the psychological meaning of the audiotapes to which Diane recurrently alluded to in their sessions, as well as Ms. D's decision to not adhere to her requested protocol, may have been beneficial in explicating and perhaps expanding Diane's working models of self and other. As Ms. D's response was evaluated to be mainly reassuring in nature, it will be addressed more fully in the next section.

Suffice it to say here that Ms. D's initial response succeeded in allowing Diane to resume exploration of issues outside of the therapeutic relationship. Ms. D later revisited Diane's concern with a problem-solving focus aimed at clarifying expectations:

> **T:** You don't want to go back there. And right now you are evolving, you are changing, you are moving away from that. You are working on the fears on your own, which perhaps is not, the most ideal way for you. Is that correct?
> **C:** Yeah, yeah, it was, it was easier working on it with [Dr. X]. It's difficult to do on my own. You know, when I went through the [specialized self-help] program, they said that I could just do the program and then I could, that, I wouldn't really need to get professional, any professional help, but I'd found, when I went to see [Dr. X], I said, "I really like the program, but I do need one-on-one" (**T:** Yeah) to, you know, I need someone at each step along the way. All those baby steps.
> **T:** And do you feel like you've finished that journey with [Dr. X]? Or do you think that that's something you want to pick it up here?
> **C:** I need to pick it up here, yeah.
> **T:** So more sort of a, um, structured, or more focused approach, to dealing with your fears (**C:** Yeah) Well that sounds reasonable.
> **C:** I was wondering if, you know, cuz it's always been like this sort of, this, 'how do we fit in the past issues with the current, where I am now with [my fears].' If we could maybe, you know, like sort of have alternate sessions, where one session would be working with past issues, and then the next session would be just be looking at the fears. I guess that's a possibility.
> **T:** I think that that's totally a possibility. I think we can be flexible in that, so that if for example we're slated to really focus on what's happening with your walks and how you're feeling about being out here, how are you feeling about the ride up. If we are slated to talk

> about fears, but there are thoughts and feelings about things from the past, or other parts of your life that are really pressing, then certainly we can be flexible. And we can say, "Okay, today we'll be switching," um, but I'll leave that up to you. This is your time and I can support you in any which way that you want (**C:** okay).

Ms. D indicated a willingness to be flexible to Diane's request for change in structure, thus communicating trust in her client's decision-making ability. Even more importantly, she maintained her promise in subsequent sessions with respect to addressing Diane's symptomatic progress without forsaking her own consistent framework. For example, she assigned behavioural logs and reviewed them in subsequent sessions, an intervention which stood out to Diane in her exit interview as a particularly validating and successful in strengthening her sense of connection with Ms. D. Moreover, in response to Diane's evaluation that her progress had reached a plateau and that it was time to push herself, Ms. D supported her agenda by challenging her to set slightly more ambitious goals than she initially proposed. Thus, Ms. D responded in a manner, which Diane described in her exit interview as "very open-minded," that reinforced the likelihood of Diane taking subsequent risks within their relationship.

Overall, this therapeutic relationship, succinctly characterized by Diane in her exit interview as "intimate, with boundaries," was successful in establishing a secure base for Diane. Diane and Ms. D were equally active participants in this endeavour. In parallel, Diane exhibited more secure-like behaviours including appropriate proximity-seeking and assertiveness over the course of the protocol. This was reflected in a much wider social support network at debriefing (change in SSQ-N = 4.8, change in SSQ-S = -.8) She also more readily engaged in independent ventures such as driving herself to her therapy appointments rather than requiring the company of her husband. Her SCL-90-R report indicated somewhat less overall distress (change in GSI index = -.32)

Nevertheless, it is important to note that Diane's felt insecurity remained by the end of the study protocol, as suggested in her exit interview response:

> **C:** I know [Ms. D] knows I have a difficult time with trust due to abandonment and the relationships that I've had. I don't know if I'll ever lose that fear [of abandonment or rejection]. I feel I will always have it regardless of who it is. But every session I trust her more.

Interestingly, she now endorsed herself on the RQ to be a close fit with the preoccupied rather than fearful orientation, which may have paradoxically resulted from her growing efforts to establish closeness with important people in her life. That is, it is not surprising that her move toward an approach and away from an avoid orientation, which necessarily involves increased interpersonal risk-taking, would be initially accompanied by feelings of vulnerability and doubt regarding others' potential for reciprocity. Ms. D's own confidence and security, expressed in her respective exit interview, likely contributed to her ability to tolerate her client's confrontation and support her ongoing exploration:

> **T:** I'm her therapist. I'm safe, I've served the test of the last 16 weeks. I haven't responded with alarm, anger, etcetera. I'm a nice person and I have the basic characteristics that she needs. She's pretty invested as long as I'm available.

Extent of Safe Haven

As noted above, Diane was forthright and at ease with Ms. D. Although she regularly addressed difficult topics that she felt unable to discuss with others, her displays of emotion were subtle and contained. Her decision to voice distress arising from within the therapeutic relationship by reading her journal aloud, previously discussed as evidence of secure base, also serves as the clearest example of engagement in safe haven observed within this relationship. Ms. D's initial response was as follows:

T: How was that *like for you*?
C: Uncomfortable. (**T:** Yeah) Very. I wish I had some water before I came in here.
T: So, what does it mean. I listened, but I'd like to hear your impression of where that means that you are and where I am in terms of our work. Things that you'd like to see different, sounds like you'd like to see some things different.
C: Yeah, well, I would, um, like I expressed, I would like to know, I need to not have you as just a professional. I need to have you as um, a real person. So, if you're feeling stressed or tired, sad or happy, or anything, I would like some exchange.
T: You'd like to know how I feel. And you felt last week like I wasn't here. You were wondering if I was stressed or tired. Would you like me to answer that now?
C: Yes, please ((laugh))

Although Diane read her passage rather stoically, Ms. D showed sensitivity to Diane's feelings of disappointment and frustration. She acknowledged Diane's disclosure as one of discontent (i.e., "sounds like you'd like to see some things different") and encouraged elaboration of her wishes for the relationship. In effect, she accorded Diane permission to express criticism about the relationship and communicated tolerance of negative emotion directed toward her. Her subsequent decision to answer Diane's questions about her experiences in the previous session, as well as her general clinical experience and qualifications, appeared to serve as a conciliatory gesture that reassured Diane of her interest and competence. Diane, in turn, expressed appreciation for Ms. D's self-disclosure and accepted the focus of attention back onto her own issues. Thus, Ms. D's response successfully provided the function of safe haven.

Following this discrete and transparent episode in session 8, Ms. D's efforts to ensure safe haven were most evident in the session structure she adopted. In general, she assumed greater responsibility for the session agenda and appeared to increase her monitoring of Diane's level of exploration and associated emotional state. She continued to acknowledge, validate, and deepen her client's emotional experience through paraphrase, open-ended questions, and occasional interpretations. However, on several occasions she redirected them after a period of time from a relatively intense, emotional-laden focus on unresolved experiences to a more concrete assessment of the present

and future, thus ensuring greater and regular coverage of less painful and equally salient issues. Thus, implicit in Ms. D's approach was the goal of optimizing Diane's capacity to tolerate negative affect and conversely minimizing her likelihood of feeling overwhelmed (i.e., ensuring safe haven) in the service of assisting exploration (i.e., secure base) and resolution of past experiences of adversity. Ms. D's willingness to verify the extent of safety and explicitly acknowledge its importance to Diane is illustrated in the following excerpt from session 10:

> **T:** Now here inside these walls, does it feel chaotic? (**C:** No.) No. But it's something you have to go through in order to come to a different kind of safe place. (**C:** Umhmm, umhmm.) And is this a different kind of safe place? ((client nodding in approval)) And how safe is it? How safe does it feel here?
> **C:** Um, hard to say. Mostly safe, but, it's um, a bit intimidating being recorded ((laughs)).
> **T:** That would really irritate some people. (**C:** Yeah?) Yeah. It's interesting, I was looking over my notes, over three months of work now. It really interests me how each and every session, almost every session that you and I have had together, we have something of an agenda at the outset. For example, I had in my notes that I wanted to look at your log today. I was looking at previous entries, and I realized how, as much as we go in there intending to look at the log, we hit on some incredibly important, deep, past issue. Like for example, two weeks ago, the last time you and I met, we talked a little about your foster experiences= (**C:** =right) that I hadn't paid attention to yet... And I thought well, my god there's another very serious= (**C:** Umhmm) or quite a significant experience in Diane's life. And we were bound and determined to find something serious to talk about that last session. But it wasn't conscious, I certainly didn't go in there thinking we would talk about those times. What is it like for you, knowing that every time you come here, even if you are not planning on it, we're going to talk about something pretty personal? Something fairly deep.
> **C:** For it's me, it's, it's ((pause)) SPECIAL. It's important to me that I've finally found a place where I CAN talk about it. So, um, it's difficult, but it means a lot to me.
> **T:** You didn't have a place?
> **C:** No. Because it's, you just couldn't talk to everybody about it. ((softly)) They couldn't handle it.
> **T:** That makes you sad?
> **C:** It does, yeah. It's ((pause)) just thinking about it. Especially at that time. It was very difficult. So, just looking at it is difficult.
> **T:** You seemed emotional when you said that...it must be REALLY hard to have all this significant experiences and not be able to share them with people
> **C:** Umhmm. So I relish this time, I do. Even though it's difficult ((laughs)). But I mean, so much of my life is like this – agony and ecstasy, like it's, you know.

In discussions of past or current painful issues, Diane became increasingly expressive within the moment. Her presentation suggested increased tolerance for unpleasant emotions of grief and anger. She also seemed more efficient at managing

them on her own. For example, in the following interaction from session 16, Diane composed herself with little apparent effort following a clear expression of anger:

> **T:** So who are you angry at?
> **C:** I'm angry at the FATES more than anything. I'm angry because I'm HURT. ((pause)) It's part of the grieving process... For me it's scary because when things happen like that, they make me want to retreat in my sorrow and that's what happened in the first place, that's how the fears got STARTED. I recognize the pattern ((shakes head)).
> **T:** I was wondering about that. It makes so much SENSE
> **C:** In [the city where the disorder started] there was so much going on at once...After this complaint about my dog, I was really apprehensive about stepping out into the community with my dog
> **T:** Yet here you are, you did it. I'm impressed.
> **C:** Thanks! ((big smile)) I have a strong support system right now.
> **T:** Tell me about that.
> **C:** Coming here, friends, neighbours...When I delivered those letters, I thought, "this is something that is empowering, so you do it"
> **T:** Good for you—you are empowering yourself

Ms. D's level of intervention tended to be limited to attentive listening during these later displays of emotion, and she showed her interest and understanding through nods and reassuring facial gestures.

The successful provision of safe haven within this therapeutic relationship was confirmed by Diane's self-evaluation at the end of the study:

> ***Q:*** *What changes do you feel you've made so far?*
>
> **C:** I'm feeling lately like I can be a bit more emotional and not so careful and controlled. ((pause)) I'm softening up, not holding myself so tightly controlled.

Case 3

Eric sought individual therapy upon the recommendation of his couples' therapist to address personal issues that were posing challenges to intimacy with his wife. He identified his main concern as difficulty with anger and noted problems interacting with others, particularly authority figures, throughout his life. He indicated an upbringing characterized by significant neglect, emotional abuse, and familial violence and reported his own history of extensive alcohol abuse and violence until he stopped drinking about

twenty years prior. At intake, he reported lack of confidence in expressing himself in front of people, fear of rejection, feelings of inadequacy in his relationships, and substantial guilt following arguments with his wife and children.

Eric's responses on the SCL-90-R indicated general distress comparable to that in male psychiatric outpatients and no notable symptom cluster elevations (GSI = 1.06, T = 49). On the SSQ, he identified a range of people including an Alcoholics Anonymous support group, wife, children, several friends, and occasionally siblings as offering care, acceptance, and distraction from his worries (SSQ-N = 6), noting moderate to high satisfaction with their support (SSQ-S = 5.8). However, he indicated being able to go only to his AA group when sad or very upset and rated his satisfaction in this context as slightly lower. Although he indicated overall contentment with his sizeable social support network, he reported finding it difficult to confide in others. He nonetheless indicated recent efforts to talk with people when upset so as not to let feelings "bottle up."

Eric presented as a likable, self-reliant individual who on the one hand wished for greater closeness with significant others and on the other remained reluctant to open himself to the possibility of emotional hurt. In addition to struggling with self-disclosure, his reliance on others to lead interactions and make important relationship decisions emerged as an important theme. Although his emotional expression during intake was minimal and consistent with his self-description as stoic, he cried during a discussion of a parent's death, an admittedly rare occurrence, noting he had not previously been able to express grief. His anger was not observed but appeared to serve a protective if not altogether welcome function against recurring fears of inadequacy and rejection.

Eric's ambivalence to closeness with others (i.e., at once longing and fearing it), reflected a predominantly fearful attachment style (6). This was also manifest in low

ratings of confidence, self-disclosure, and trust. Despite a passive stance, he impressed as highly dependent on emotional relationships and disposed to relatively high separation anxiety. Nonetheless, his capacity for introspection and commitment to intimacy, as well as increased proximity-seeking and assertiveness, earned him some security (3.5). His history of successfully defending against sadness or hurt resulted in rating of mild fit with dismissing attachment (2.5). His rating on the preoccupied pattern was even slighter (2), reflected only in reports of role reversal in childhood. However, on the RQ he endorsed a primarily secure orientation to relationships, perhaps reflecting his general satisfaction with his current support network.

Eric showed difficulty elaborating on his expectations of therapy. He stated he hoped to achieve greater inner peace as a resulting of attending individual therapy but expressed hesitancy that this was possible. He described a good working relationship simply as one in which two parties understand each other. Similarly, he identified "a sense of caring, honest, understanding", and "willing to go the extra mile (making suggestions)" as ideal therapist traits. He requested to work with a female therapist.

Proposed Challenges to the Therapeutic Relationship

Eric's expressed motivation to achieve greater closeness with family members and learn ways of coping with overwhelming feelings, as well as his success at establishing warm relationships with women (i.e., his sisters and fellow female AA members), were deemed positive prognostic factors. In contrast, his predominantly fearful attachment orientation that encompassed expectations of rejection and discomfort with strong negative emotions was seen as a potential impediment to his capacity to benefit from a therapeutic relationship and work on his goal of emotional regulation. His history of passivity within close relationships and mixed feelings toward

the value of sharing private experience were also considered important challenges for his therapist to address and overcome.

Like Diane, the establishment of trust within the therapeutic relationship was expected to be slow and measured. The encouragement of Eric's perceived sense of safety, particularly with respect to expressing anger, was outlined as a central therapeutic goal. It was proposed that a non-authoritarian female therapist who would draw on his identity as an honest, giving person would be successful in establishing rapport. Validation of his struggle with self-disclosure, combined with encouragement of interpersonal risk-taking both within and outside the therapeutic relationship to provide relief from feelings of inadequacy and discontent, was recommended. It was also deemed important to keep the focus of responsibility for change on Eric and resist adopting an overly active or helpful therapist stance. The establishment of clear goals and a mutually agreeable time frame for the course of therapy were also suggested to facilitate a realistic commitment from Eric.

Therapy Parameters

Mr. E was matched with Ms. E who was rated as primarily secure (7) and mildly preoccupied (2.5). Her levels of dismissing and fearful attachment were low (2 and 1.5, respectively). She indicated that she would apply an eclectic framework to the case that would combine psychodynamic, humanistic, and cognitive-behavioural approaches.

Eric attended a total of eight sessions within a 3 ½ month period. Two extended breaks were noted in Ms. E's records. The first occurred between the first and second sessions, in part due to a two-week end-of-semester clinic closure. In addition, Eric cancelled his first appointment with Ms. E following the clinic's re-opening because of a work commitment, and missed the subsequent appointment without warning, thus

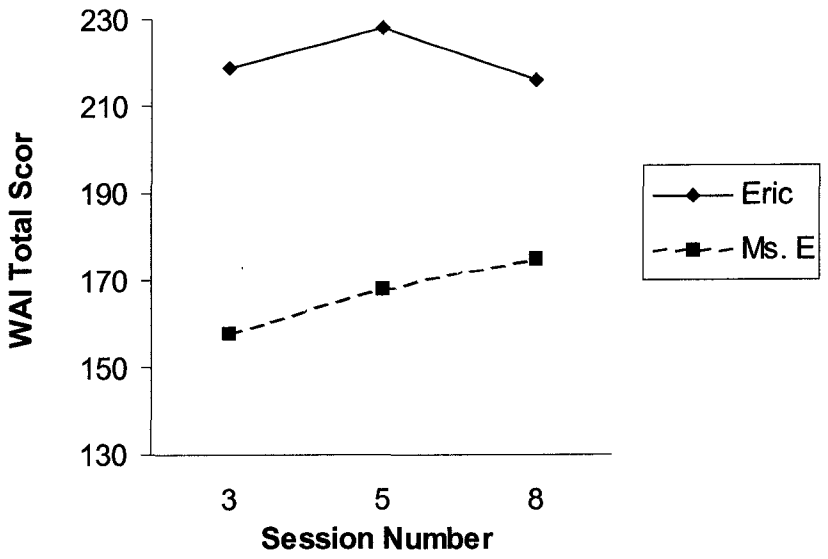
leading to a five-week interim period. He then attended five consecutive sessions. He cancelled another due to car problems. The seventh and eighth sessions were also four weeks apart due to his planned two-week holiday and to another work-related cancellation, respectively. According to Ms. E, Eric again failed to attend their next scheduled session. Although he left Ms. E a message in the following week and immediately prior to another end-of-semester clinic closure stating that he would like to resume meetings in the next semester, he did not call again to set an appointment. Ms. E sent him a letter in the third week following the clinic's re-opening indicating that the case file was closed.

Overview of the Relationship

Like Diane, Eric endorsed a stable and very positive alliance from early on. In contrast, Ms. E's ratings of their working relationship remained notably lower than her client's, despite improvement in her report from weak to moderately strong by the eighth session (see Figure 4). However, exit interview reports suggested that the discrepancy in their WAI ratings reflected a difference in their style of expression rather than in actual perceptions of their relationship. That is, whereas Eric's approach to the interview was economical and suggested a reluctance to be critical about the therapeutic process, Ms. E was more forthcoming about her pessimism during their work and subsequent feelings of disillusionment.

Figure 4:

Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 3



In his interview, Eric accepted responsibility for problems that arose with Ms. E, stating that he should have been more open and open-minded. He also acknowledged a tendency to compare her to other therapists that "didn't do anybody a whole lot of justice." He expressed appreciation for her efforts to ease him into sessions but had nonetheless sometimes hesitated to share salient thoughts and feelings, largely because these did not fit with "the direction that [they] were headed." He described Ms. E as "open, honest, and pushy." Although he did not offer the latter as a complaint, noting the latter as "probably one of the requirements of [working in] therapy with me," he suggested that he might have worked better with "somebody that's aggressive in a sort of a gentle way." With respect to termination, he indicated that he had intended to resume sessions with Ms. E but that her announcement that the file was closed allowed him to focus on other activities.

Although Ms. E described Eric as "on the whole likeable" and expressed admiration for his strong work ethic and commitment to providing a better life to his wife and children, she reported difficulty relating to him, especially at the outset. She attributed this in part to their vastly different upbringings, as well as to a view of him as fairly concrete, narrow-minded, and neither verbally nor emotionally expressive. She also reported a sense of apprehension from him about the nature and purpose of therapy and noted doubts of her own throughout their work regarding his motivation given his absenteeism and limited completion of homework. Despite these challenges to her connection with him, she indicated having grown fond of him and acknowledged feeling "a bit stung" by the way in which therapy ended.

A sense of insecurity in how each was perceived by the other emerged in both their interviews:

> ***Q:*** *How do you think she/he felt about you?*
>
> **C:** Uh, I don't know ((5 second pause)) I never did try to figure THAT one out ((4 second pause)) I think she thought of me as a person who needed a lot of HELP, I don't know ((soft laugh)) She figured that I was, I wasn't putting enough into this, and ((pause)) that I should be more committed to it. And I see that she was right because you have to really dig into it before you get something out of it.
>
> **T:** Hmm. That's a good question. I wasn't always very sure how he felt about me. I felt sometimes like he was testing me...For me it felt like, "Oh wow, I might actually be making him feel diminished at times, without even realizing it, but he has a hard time talking to me about it, so maybe I represent another authority figure who's sort of on his case at times and that's, that might not feel good for him." At other times I think he liked me, I think he appreciated that I understood his experiences and that I tried to sort of praise his efforts and his level of commitment and responsibility, especially in regard to his children.

Contrary to their common description of the relationship as neutral and too brief to be fully developed, session observations revealed a typically charged and steady evolution of interaction between Eric and Ms. E. Both appeared genuinely present and involved throughout most of the protocol. However, they shifted from a relatively equal, clearly collaborative dynamic at the outset to one wherein Ms. E primarily led the topic

and emotional tone of discussions. In the last third, sessions became exclusively geared toward teaching Eric perspective-taking to enhance his impulse control and conflict avoidance skills, which she saw as limited and interfering in his relationships. Although Eric generally complied with her direction during sessions, he repeatedly raised questions about their agenda and was more frequently the party who initiated discussion about their relationship.

Eric's ratings on the QRI summarized his view of this therapeutic relationship as high in Social Support (mean = 3.8) and Depth (mean = 3.5) and moderately high in Conflict (mean = 2.4). It is noteworthy that these average ratings were elevated in relation to those of other clients in this study, lending support to the interpretation that Eric was engaged in the therapeutic relationship despite his pattern of absences.

Extent of Secure Base

As noted in the previous section, observations of the first session showed ready engagement between Eric and Ms. E. Although relatively more subdued, Eric was receptive to Ms. E's cheerful efforts to set her new client at ease through the provision of structure and humour. Despite a somewhat hesitant tone and style of speech reminiscent of his fearfulness and a comment early in the session suggesting ambivalence toward attending therapy (i.e., "I feel pretty good today and was wondering whether I should come or not"), he showed initiative in disclosing core issues identified in intake and volunteered specific shortcomings in his marital relationship and parenting. He also instigated a discussion of his previous counseling experience and in doing so, essentially forewarned her about his expectations of and approach to therapy:

> **C:** I went to counseling for 2 years, when I got off the bottle, I don't know if you remember that in my report or not.
> **T:** Was that when you, was that before AA or at the same time?

> **C:** Uh, this was before I started AA, and then about 2 years into AA (**T:** Okay) I landed on a good counselor.
> **T:** Did that help, did that help make a difference for you?
> **C:** Yeah, uh, yeah, he helped me with the getting off the booze and he helped me uh, with separation between me and my wife. (**T:** Yeah, your first wife.) Yeah, and she wanted to get back together again, to do the same old trip again. And I previously had given up this other girl I was going out with to go back with her again. And then I said, "I don't want to do this again."(**T:** No.) So anyway, ((pause)) he helped me. Uh, are you familiar with AA? [ensuing discussion about Alcoholics Anonymous deleted]
> And you know, getting back to the counselor, he, he helped me with the 5th step, ..., and uh, I just, well, I just sorta touched the tip of the iceberg and told him things that were really bothering me at the time. And uh, I don't know if it, it didn't relieve me as such that I felt like a weight was lifted off my shoulders but I know, I look back now and that pre- that pressure is gone, so (**T:** Mmhmm), it has helped me with time.

Eric conveyed several important messages in the above passage. He indicated that in spite of a fearful orientation, he had managed to remain in a therapeutic relationship for a significant amount of time and benefited from the opportunity to share personal experience. In addition, his reference to the absence of immediate solace ("It didn't relieve me as such...") and to touching the "tip of the iceberg" suggested that the process was a burdensome one that required pacing. His broaching this topic implied a readiness to resume the challenge of personal exploration and potential associated discomfort. Ms. E, in turn, showed interest and openness through her warm tone of questions and frequent reflections that validated his experience (e.g., "It's hard for people to do things differently than their parents"). The following excerpt from the first session demonstrates the joint nature of their initial interactions:

> **T:** Now you said when you first came in that you've been feeling better and you were wondering why you should come. Why don't we just sorta go back to that for a second and figure out what it is that you hope to kinda get out of coming here on your own, and I know you're doing couple's therapy work with [couples' therapist] and your wife, and that at some point you may have thought that [individual therapy] would be useful to you, and certainly your mind can change over time, so, so what is it, do you think that you wanna get out of this?
> **C:** Well, I'd like to get a more positive attitude towards, towards life (**T:** Mmm.) And ah, for me, a lot of things are just like black and white, you know? I would sorta like to have an in-between. (**T:** See the gray?) Yeah, I'm getting that now, and ah, one of the, I wanna keep on, working on the, on my anger and uh, see that the cup is half full instead of half empty. And uh, maybe, I, I don't know, maybe to, to talk about my past and see if there's things that uh, are in my past that, that I haven't, haven't cleared up.

T: Mmhmm. Yeah, sounds like a reasonable plan. Certainly people sometimes have no idea, when they have problems in their adult lives that it has anything to do with way-back-when. (**C:** Yeah.) And you're already, like, miles ahead of those guys. Cause you, I guess, get the sense that sometimes things might be a problem now, cause they were a problem back then, and they never got sorted out. (**C:** Yeah.) Right? And I guess that for you, in couple's therapy is probably not a good place for you to have a chance to do all that stuff. (**C:** Yeah.)

We see how Ms. E guided them to a productive discussion of goals and, like the therapists in the two previous cases, offered ample support through attentive listening ("See the gray?") and praise ("You're way ahead of those guys"). It is noteworthy that both rated this session as the smoothest and as inducing the most positive emotion.

Despite their initial agreement, Ms. E began their next meeting with a specific agenda. As this was deemed to impact Eric emotionally, it will be dealt with in the safe haven section. Her shift to a rigorous interviewing style throughout most of that session resulted in a notably more detached stance in both her and her client. In a similar vein, she began the third meeting by raising the way he had approached her earlier in the week, which she had experienced as jarring and inappropriate.

T: I wanted to talk about what happened on Monday. When actually you came in for your couples' appointment I guess it was, and I happened to be working in the office and doing stuff and doing a, doing a shift.
C: Well, yeah, I didn't know that you were, I thought you were just sort of doing a, maybe an intake interview after that.
T: Mmhmm and you left a, you left a note for me. (**C:** Yeah, yeah.) Yeah, um, I guess what I wanted to talk to you about was that it seemed it was really important that we talked about it then and there, when you came out of your session, I still happened to be there, I'm still working sort of in a different capacity then as your therapist in that particular moment, and you really, really wanted to talk about this whole job opportunity that you'd heard about and how it might kinda conflict with our therapy. You didn't want to wait till today.
C: No, because they had, they had to go to print yesterday.
T: Their, the kinda curriculum? Or, or,
C: Yeah it was posted in a local newspaper, in a local uh, school district, a course catalog in the school district, for evening, for adult education.
T: Oh right, okay. So they wanted to have an answer from you. (**C:** Right, by Wednesday.) Well, I guess, what I wanted to talk about was, it was a little bit awkward in the sense that at that particular moment I wasn't really available to talk about any- about that sort of planning stuff. I was doing another job, I had a different hat on, I had my shift-worker hat on, I had to take the phone, take messages and so on. And it seemed really important for you to sort of get it cleared away and I guess, um, what I wanted to ask you was, does that happen a lot to you, where you really need to get something squared away and it sort of has to be deal with right away, right away, and it can't wait until later to talk about it. (**C:** Uh, no, no) Not usually? (**C:** No.) No? What would've happened had I not been there?

C: Well, actually what I was hope- what I was gonna do was leave a message for you here (**T:** Okay.). To get a hold of me.
T: To give you a call? (**C:** Yeah.) Okay.
C: Yeah, by, by like Wednesday. (**T:** Okay) I, was gonna phone over here and leave a message, but I thought,
T: You were coming here. Right.

Eric responded matter-of-factly and perhaps unexpectedly to Ms. E, who was prepared to discuss what she had perceived as impatience and pushiness (i.e., "Does it happen a lot to you?"). As illustrated in the following passage, and in line with her intent to foster open communication, she invited him to voice his ambivalence and modeled candor:

T: So, that kinda brings me the other question I sorta had about the whole note and that the course that you're describing is an awfully long time away. (**C:** Mmhmm) And I guess, partly what I was wondering was were you asking me kinda in a sort of way how long therapy would go for. (**C:** Mmhmm.) Is that kinda partly what you are interested to know, how long you figure you are gonna have to come? Before I say, "Okay, [Eric]. That's it, we're done, you got to go home, get out of here." What do you think?
C: Well, I was sort of wondering about yeah, I was wondering about,
T: Do you get the feeling a little bit like it's up to me?
C: Well, I don't know. I know you have a certain time limit that you uh, that you work here. Um, I don't how many semesters you're gonna be working, and uh, so.
T: Is that stuff that you are interested in finding about? Like how long I'm gonna be around and that sort of thing.
C: Well, I guess yeah, so I know just, down the road, how far we are gonna go with this.
T: Mmhmm. Well, that is a perfectly, you know, legitimate question and I can tell you that I am going to be around [for another year] so I'll probably be still seeing clients up to [then]. (**C:** Umhmm) So, I'll be around for a while and as far as, how that kinda, what difference that makes to you and I, well that remains to be seen. (**C:** Yeah.) You know, it depends on what you want to get out of this and whether you feel like you are getting something out of it. (**C:** Mmhmm.) I guess it sorta makes me think about who are you here for? Are you here for me, for [your couples' therapist] for your wife, for yourself. Who do you think, who do you think?
C: Well, I know who I'm here for. The person that I'm talking about. I'm here for myself. (**T:** Are you?) But ah, well, if somebody else than me, if they get some benefit out of it, it's fine by me, you know what I mean?
T: Yeah, I guess, sure, sure I, I guess what I'm asking about is did you get the feeling that your wife really wanted you to come and you're,
C: A little bit pushed into it?
T: I'm WONDERING! I, sometimes that happens, when people are in couples therapy together, somebody gets pushed by the other person, "You go and do something."
C: Well, I think that if, I sorta gave you that impression that I was sorta like uh, being pushed? (**T:** Mmhm.) And I was probably doing the pushing myself.
T: Mmm. So you are pushing yourself to come here?
C: Yeah, I would say it was myself.
T: Okay, okay. So more so, then say, your wife or [couples' therapist], or anybody else you could think of?
C: Yeah, yeah. Yeah, cause one sort of just compliments the other, hopefully. I had an understanding right when I had to go on for myself, that was 22 years ago, I made that

> decision and uh, I see that sometimes, I'm the only one that benefits from that. (**T:** The AA meetings?) Yeah, but then the people around me benefit also when, when I benefit.

In the above interaction, she made her arguably appropriate skepticism with respect to his commitment evident and used it to encourage discussion. This proved effective in alerting Eric to her concern (i.e., "A little bit pushed into it?"), who promptly offered reassurance that he was personally committed. Nonetheless, her continued delivery of pointed questions in subsequent sessions and repeated reference to his lack of intrinsic motivation during her exit interview suggests that he did not succeed in convincing her of his interest. In contrast to their first session, they both evaluated this session as relatively low in smoothness and as evoking little positive affect, confirming the observed sense of friction between them.

Ms. E increasingly took on an investigative role with Eric that corresponded to an agenda of clarifying current reality and correcting his perception of different interpersonal situations, as well as helping decrease his reactivity. Implicit in this therapeutic approach was an emphasis on challenging his views of the world in several domains of psychosocial functioning and building skills. He generally continued to answer her questions non-defensively but, consistent with his own therapy goal, found ways to interject family-of-origin related topics. His appeal for goal-setting at the end of the fourth session nonetheless suggested a wish for greater agreement:

> **C:** In those sheets, Jocelyne was mentioning goals?
> **T:** Yeah, I had to do those too, should we do that next week?
> **C:** ((nods)) Set goals.
> **T:** Let's do that, set some goals.
> **C:** It stood out in my mind.
> **T:** I'm glad you mentioned it.

Ms. E followed through in the next session by encouraging him to express his confusion and reiterate the type of change he hoped to accomplish. A renewed dynamic of collaboration ensued that was accompanied by a poignant discussion of his

relationship with his younger son. She herself offered moments within this session as examples of her feeling more strongly connected with him. Interestingly, she attributed this closeness to a sense of "usefulness" resulting from her role in that session as a genuinely sympathetic supporter, as well as to his interest in her ideas on ways to improve his situation.

Nevertheless, in remaining sessions Ms. E resumed a dominant, confrontational position that limited Eric's room for input. Her friendly tone belied a conceptualization of Eric as strongly self-oriented and needing to be in control at whatever cost:

T: Ok. Well, I'm going to show you a real simple drawing and see if this makes sense to you. Maybe I should even draw it on the same page as where we've been writing cuz this is going to fit it all together. Basically, we could look at the world in two ways, k? We could look at the world where people are up here, and people are down here. That's one way of viewing the world. And we could look at the world where people are like this, and like this. Now, this, my guess is, is how the world sometimes feels to you. You're either on top, if you're not on top, you're on the bottom. When you're on the bottom, you're wrong, people disrespect you, you have no power, you have no control. When you're up here, ahh, now this is the place to be! You're on top of the world, you're in control, you have the power, you're the top dog, right? (**C:** Mmhmm) You get to be right, you get the last word, that's it. The problem, with living in a world where people are either on the top or on the bottom, is that somebody's always got to be on the bottom. (**C:** Mmhmm) and how do you imagine it feels to be here?
C: I know how it feels to be there.
T: How does it feel? Can you give me some words to describe how it feels to be down there?
C: Well, it doesn't feel good at all
T: No. You feel rejected. You feel stupid. You feel lonely. And when you're up here, how do you feel?
C: Um, I try not to let myself get up there, though, either way.
T: Well, cuz the problem with getting up here is that you've always got to worry about slipping back down here (**C:** Yeah) Cuz it's kind of like this big nasty circle, right
C: I like to stay in between there somewhere.
T: WELL, that's what this picture is coming in to describe. See, when you're in relationships with people, right. Some people like to be in relationships this way. You're either top dog, or bottom dog. And you know, most of the time, that's hard because although it feels good when you're up here, it feels pretty crummy when you're down here. (**C:** Yeah) Right? So, you remember when you were talking about your goals? And one of them was to be respected, and a little bit, although you know that this gets you in trouble, you want to be right. You want to be in control, you want to be in charge, you want to have the power. That's kind of like being up here.
C: I don't know, I don't like that, I'm not that concerned about being in charge anymore.
T: You're more feeling like you want to try this, this= (**C:** =yeah, yeah) Yeah? Ok. I think you're absolutely right. I think, doing this thing, is hard and basically it always means that someone has to be down here= (**C:** =yeah=) =and that sucks
C: And your emotions are either up or down

> **T:** Yeah, and either you feel great about yourself one day, or, you know, you've just been spat out by the devil the next day= (**C:** =yeah=) =you know? It's just, It's hard to be like in this place (**C:** Mmhmm) The one thing that's good about being here is that when you're up here, boy, you feel, you feel like yeah you've got the world at your feet, right (**C:** Mmhmm) Ok. So that's, that's the advantage of, of operating in this way, right,
> **C:** When I was 35, I was "down- up" there
> **T:** Yeah, yeah. And more back and forth, I guess, huh? So sometimes being up here and sometimes being down here? (**C:** Mmhmm) Well, my guess is that, you're having some, you know, when you first came here, you wanted to know whether we should talk about your childhood (**C:** Mmhmm) and I said, "Yeah we could do that." Then I said, "Well, let's be a little more specific and talk about life right now, and how things are going" (**C:** Mmhmm) I think, you're trying to go from here, to over here. Like, I think you started out life in a family where it was all about who's on top and who's on bottom (**C:** Yeah) so you learn, "Gotta get on top, gotta get on top, gotta be better than that guy, I'm going to beat that guy up"= (**C:** =Stay on top=) ="I gotta stay on top. I don't care if it means being an asshole, I don't care if it means, I don't care if it means stealing, lying, cheating. I don't care, I want to be on top" (**C:** Mmhmm, mmhmm) M'kay. And that's cuz in your family, that's the way the world worked, right? (**C:** Yeah) and that's what your parents taught you, and all your brothers and sisters...

It is notable that Eric's main contributions revolved around either efforts to correct her projections of him (e.g., "I like to stay between there") or demonstrating his understanding of the concepts she was presenting (e.g., "And your emotions are either up or down"). Although he maintained a certain degree of acquiescence as Ms. E outlined her model, he eventually interrupted her with a likely unexpected request to share her direct experience of him:

> **T:** These are your choices. You can either be right, or you could be liked. You can't have it both ways. See what I mean? (**C:** Mmhmm) The problem with being liked, is that it might mean not saying what's on your mind, a lot the time. (**C:** Yeah) You sound like the kind of guy that, you know, when you get excited about stuff, when you feel strongly about something, it comes right out of your mouth. It comes right out of your mouth and the next thing you know, you're talking and people are like ((noise with mouth and arms extended in a pushing away motion))
> **C:** How did you feel when I asked you if, uh, about the money thing?

In the above, Eric was referring to an interaction that occurred immediately after the sixth session in which he confronted Ms. E about her tendency to remind him of fees following each session. Ms. E once again responded to Eric's direct question with candor:

> **T:** Oh, how did I feel when you asked me how, cuz you said to me, "You always ask me about money. Do you not trust me?"(**C:** Yeah) How did I feel? (**C:** Yeah) Well, I thought it was kind of funny that you, that you mentioned it. Because you're absolutely right, I do give you a hard time with the money every week. I felt a little bit embarrassed because I didn't want to make you feel that you were, that you're untrustworthy because I do trust you. I think

for me, I was sort of feeling like, "Oh gosh, he doesn't realize that we have to go through this with lots more people besides him who aren't anywhere near as reliable about paying." So as students we get told, you know, you gotta keep on top of things. Remind your clients that they owe a certain amount of money every week (**C:** Oh yeah), you know. So I felt kind of embarrassed because I didn't want to be nagging you, but at the same time, it's part of my job (**C:** Mmhmm). Did you think that maybe I was mad?
C: Well I couldn't, I didn't know actually what you thought (**T:** Oh) I didn't really, I was just trying to figure out what you were thinking
T: Yeah, were you wondering why I keep on asking you every week?
C: Yeah, because [couples' therapist], she doesn't ask us every week
T: So a little bit, it's like different people's styles, right. (**C:** Yeah) So [couples' therapist], doesn't mention it for months, and I like, every week, "[Eric], you owe me money"
C: Money money money.
T: Money money money. Yeah, I know, I guess it's a style thing. And yeah, I've fallen more into the habit of it, I guess, from my experience, people don't always remember until I remind them. So it's not a personal thing (**C:** No) it's not about you as a=
C: =Because I thought about it. And you know, I guess when it's in here, (**T:** Uh huh) you expect it to be part of the, the session, you know? When you mention it in here? I guess it sort of throws me (**T:** Okay). Once we're in here, we're going, we're doing the session thing, and even though we're in here, and you're mentioning money, it's still part of the session. You know what I mean?
T: Okay. You think that my reminding you about the money is supposed to happen in here? Or is NOT supposed to happen in here? I'm not sure what your point is= (**C:** =Oh=) Do you feel sometimes that we spend lots, like too much time talking about stuff like fees instead of talking about more important things to you?
C: No, that's all part of, like I was saying, that's what sort of threw, I was trying to think what it was that, ((pause)) why I had a reaction to this.
T: Yeah, well, I'm glad you were thinking about it. Why do you think you had that reaction? Did it make you feel like I don't trust you or that I think you're an unreliable person?
C: Well, I guess I must have felt that because uh, ((pause)) that's why I asked (**T:** Mmhmm, mmhmm) And it does throw me, because, I shouldn't be comparing people but, with [couples' therapist], you just go up front, you pay, (**T:** It's just done) And that's it.
T: It sounds like you prefer that (**C:** Yeah). Because you're someone who pays reliably (**C:** Yeah) It's kind of annoying for someone to always be on you about it.
C: Yeah, especially if that person has shown trust already, you know what I mean?
T: Okay, okay, I see what you mean ((pause)) so when I ask you about fees, it makes you kind of feel bad about yourself
C: I guess it did, yeah. I mean not, maybe not the first once or twice (**T:** Right) But when it goes on.
T: Okay. Well, I'm glad you told me because that's important. Because if I know that it kind of makes you feel like I don't trust you, or it makes you feel like I don't think you're good for it, then it's making you feel bad. I can sort of make a mental note. "Yeah, [Eric] and I had this conversation. He knows what the rules are." The rules are you pay each week. The rules are, we already know how much you pay, we agreed on that. The rules are, you come every week on time. The rules are, like, me too, I gotta come on time. You can yell at me when I'm not on time. And the rules are, if you can't make an appointment, if you schedule it, if you cancel it any less than 24 hours in advance, you have to pay for it anyway. You know. You're right, those are the rules, if we're clear on those, we don't have to talk about it every week. And I don't need to remind you about them. Because I can expect that you will remember...I noticed, though, instead of telling me that you were feeling kind of annoyed with me [after the session], you made a joke about it. You made kind of like a sarcastic joke...

Eric's comments suggest that he may have chosen to revisit this episode with Ms. E not only to verify how her reaction fit with her proposed schema of him, but also to provide her with feedback about his experience in their relationship. As shown above, Ms. E initially met his request for self-disclosure by frankly outlining her own position. Following his lead, she eventually sought out his perspective and helped him express it more clearly and fully. However, although she offered encouraging statements (i.e., "I'm glad you told me"), she also used his initiative as an opportunity to remind him of her expectations of him and to address her experience of his approach, which may have undermined her efforts to convey empathy. Seen from an attachment perspective, Eric's bid to make Ms. E aware of his growing resentment served as an attempt to address a problem that he perceived between them (i.e., her mistrust of him). As such, it was deemed to be a significant risk-taking behaviour coming from a conflict-avoidant person, much like Diane's sharing of her journal entry to Ms. D. However, in comparison to Diane's measured and articulate challenge, Eric's message was rather gruff, less effective in communicating his concern, and may have been experienced by Ms. E as out of context.

Both Eric and Ms. E referred to the above interaction in their exit interviews, thus confirming it as a salient interpersonal event. Eric described it as an illustration of their relationship and of Ms. E's openness to suggestions. He indicated that the issue had been satisfactorily resolved in that she had offered no further fee reminders. In contrast, Ms. E presented this incident in a more negative light as an example of Eric testing her throughout their work. She described him as indirect and underscored his difficulty in elaborating his feelings and intentions in raising the topic.

Overall, despite active efforts on behalf of both client and therapist to connect and collaborate, this therapeutic relationship was characterized by relatively minimal secure base. Ms. E expressed a sincere interest in offering non-judgmental support of Eric's self-evaluation and his adoption of new interpersonal practices, goals that are in line with the provision of secure base. He appreciated her honest stance, which fit with his image of an ideal therapist, and made efforts, in turn, to clarify his own position. However, he did not succeed in reassuring her, nor in clearly expressing his wishes for therapy. His approach efforts were experienced as off-putting and reinforced her uncertainty toward his level of motivation and capacity for change. The sense of insecurity within this relationship may well have mirrored that experienced by Eric's in other intimate relationships. By Ms. E's own account, his expressive style and absenteeism interfered with her capacity to engage with him in a truly receptive way, perhaps by triggering fears of inadequacy or feelings of futility. It appears that Ms. E's case formulation was geared toward helping Eric manage conflict in his close relationships, but without addressing the underlying motivation of conflict avoidance that, from an attachment perspective, was presumed to be driving much of his problematic behaviour.

Upon the study's end, Ms. E saw no identifiable change in Eric and attributed the absence of benefit from their work largely to his failure to practise her recommended exercises. For his part, Eric endorsed an important drop in his level of overall distress as reflected in his SCL-90-R ratings (GSI change score = -.63) at debriefing. Contrary to Ms. E's perception, he stated that he gained "food for thought" and reflected back the major point that Ms. E conveyed:

> **C:** Well, I learned that I'm not right all the time. ((starts to pound armchair)) I know I'm not right all the time but I always wanted to argue a point, and you know, (***Q:** With [Ms. E]?)* No,

> no, not with [Ms. E], just argue a point that I was right, sort of thing. And today it doesn't matter. Well, I shouldn't say that because I sometimes catch myself doing that. Like driving down the road, this person's getting into the lane in front of me and I won't let him in, sort of thing. Stupid stuff. But I got to learn when to back off sometimes. (***Q:*** *So that was something that you learned from your work with Ms. E?)* Yeah, yeah. Like she said, "You got a choice, whether to be right or be liked."

However, his fearful avoidance remained prominent. On the SSQ, for example, he described a similarly extensive social network at debriefing to that at intake (change in SSQ-N = 0, change in SSQ-S = .035), but then volunteered the caveat that he is "pretty independent, more than [he] should be," and that he has "a bad habit of not phoning people" when worried or upset. He reported an interest in the support of others, but stated that he hesitates and "[tries] to muddle [his] way through it." Interestingly, like Diane, he chose the preoccupied pattern on the RQ as his closest categorical match. In addition, he rated himself as very much like the fearful and preoccupied orientations (both 6 out of 7), and least similar to the secure (2 out of 7). This move away from identification with a secure prototype confirmed his desire for closeness and suggested greater anxiety concerning intimate relationships in comparison to intake. Thus, Eric showed greater insight into his difficulties at debriefing despite a limitation in secure base.

Extent of Safe Haven

As noted earlier, Eric identified Ms. E's tendency to begin sessions with brief, friendly conversation rather than "diving right into stuff" as a quality he valued, suggesting this helped create a sense of comfort. Nonetheless, problems in the establishment of safe haven were noted early on and fueled by clashing agendas. The following interaction at the outset of session two set the stage for a seeming

miscommunication between Ms. E and Eric that interfered with the development of safety within their therapeutic relationship:

> **T:** You mentioned two things last time that you want to go over because they're still causing you some problems in your relationships now... basically your growing up in your family, so for example your relationship with your dad... and your first marriage and how that all even came about... Of the two things, maybe we could start with your marriage because... to go back to your upbringing is a lot bigger and a lot harder emotionally is my guess, so I'm wondering to sort of test out what this is like for you, I thought we could start with something like that first relationship, to see how it goes. What to you think?
> **C:** Yeah, I need= (**T:** =Do you think that's a good place to start?) something pretty light right now. (**T:** What's that?). I said I need something pretty light right now (**T:** You do?) I'm getting a lot of this therapy stuff.
> **T:** Are ya? Is it a lot, do you think, to come twice a week, once with your wife and once by yourself? **C:** Well, and then I go to three AA meetings a week (**T:** That's right.) So that's a lot of head work=
> **T:** =A lot of head stuff, hun? Are you having second thoughts about coming here?
> **C:** I've had second thoughts, yeah.
> **T:** What are your thoughts on it?
> **C:** I'll just ride it through right now and if later on I figure it's too heavy, ((pause)) maybe I'm putting obstacles in my way here, I don't know,
> **T:** Okay. So it sounds like you want to give it a try but you think it might get a bit exhausting ((pause)). Do you find that couples' therapy helps?
> **C:** Well, it's helped me personally deal with things, yeah, and with my wife, I guess it helps my relationship too, yeah, I would say so. It's taken down some of the walls, and so there's better understanding and better communication too. (**T:** Between you and your wife, or your kids?) All the way around.
> **T:** So do you think, I mean I know that for you AA is a big commitment, and a life-long commitment, right, is that a fair estimate, that you'd be attending meetings till the day you die? (**C:** Yeah, good chance) And you've been attending couples therapy for a long time ((pause)) So of all the things you're doing, this [individual therapy] would be the first to get cut out because it's the newest—is that a fair assumption?
> **C:** Well, it's hard to say. It's not because it's the newest. (**T:** No?) No. Maybe because ((pause)) I really don't want to cut ANYTHING out, you know (**T:** Yeah) I want to do it all and get the benefit of all of it. (**T:** Yeah) If I have to cut something out, I'm not saying it would be this. (**T:** No?) No. If I get rid of some of my defects here, then the marriage would be alright, do you know what I mean?
> **T:** Yeah, I do. It sounds like you're not sure about what you want to do about this, that if it's too overwhelming then we might have to revisit this...because a lot of people in your position would be taxed out. That's a lot of work to be putting into making yourself a better person, getting to know yourself better. I can appreciate that this may feel like a lot...Take me back there and tell me about your first wife.

Eric replied to Ms. E's proposal with an assertion about his current state ("I need something light right now...") that implied an objection to delving into the topic of his first marriage at that time. Ms. E's response, which included a reflection of his expressed feeling of pressure (e.g., "A lot of head stuff"), suggests she heard the latter as a

message of ambivalence toward therapy (i.e., "Are you having second thoughts..."). Although her line of inquiry was fruitful in eliciting Eric's concern, it may have also been beneficial to further explore his emotional needs in that particular moment and include him in the choice of topic. In proceeding with a set agenda, which was likely determined in supervision, Ms. E did not follow her client's limit and thus increased the impetus for him to meet his own safety needs. He did so in the remainder of the session in a characteristically avoidant way, that is, by answering her questions about a painful period of his life with minimal eye contact and in a matter-of-fact manner punctuated by yawns and occasional pounding of his armchair. At the tail-end of the session, he raised the following question in an apparent effort at communicating feelings of discomfort during the session:

> **T:** I think we should stop here. I'm curious to hear how the story works out. I didn't figure we'd get through it all, it seems that there are lots of stories. I'm watching you and it seems as though while you're telling me, you're remembering lots more
> **C:** Yeah, but is it of any benefit for me?

Although it could not be determined from Ms. E's absence of remarks on Eric's body language whether or not she was aware of his uneasiness during the session, she spent some time explaining the purpose of her line of inquiry in a clear gesture of reassurance. She referred to the above in her exit interview as evidence of Eric's apprehension, which contributed to her reservation regarding the appropriateness of his requested focus of therapy:

> ***Q:*** *Where did you get the feeling of apprehension in [Eric] from, how did it show up?*
>
> **T:** He would ask questions at times about how long he would need to be in therapy and what the usefulness of us talking about his earlier issues would have anyways. So for example, his presenting problem was that he wanted to return to childhood issues because he thought they were creating ongoing problems for him and yet when I invited him to talk about specific experiences that he had, he then kind of concluded those sessions with, "I don't know if it helps to talk about these things, what is this going to do for me, how can this help me?" ***(Q:*** *So what did that leave you feeling?)* Well, a bit frustrated so as to how I could, how could I make the connection for him from talking about previous experiences and decisions he had

> made, paths he had chosen, how could we use these experiences to understand himself more fully and therefore understand his current state better. And I felt that that might be a bit of a leap for him? Which is why I ended up focusing on more current issues as opposed to trying to go backwards and say, "Well, look what happened here, doesn't that help you understand why you're doing what you're doing now." Because for him somehow the bridge was a very difficult one...

Her response suggests that she interpreted his question as stemming from inconsistency or confusion that reflected a limitation within the client. Certainly, the identification of a cognitive or emotional deficit would suggest a potential obstacle to certain types of psychotherapy and warrant a skill-building focus in intervention. What may have been missed, however, was consideration of the potency of the topic raised for the client and the accompanying emotional vulnerability it might have instilled.

Given Eric's discomfort with strong emotions, as well as Ms. E's case formulation and cognitively-oriented approach to treatment, it is not surprising that his displays of emotion were infrequent and understated. The next passage, taken from their discussion in session 5 of Eric's relationship with his younger son, nonetheless exemplifies one such incident:

> **T:** Do you think he's made the, the right decision, or? (**C:** ((softly)) N-no) Kinda touches and goes sometimes?
> **C:** He's very impulsive, so, it's hard to say. ((8 second pause)) Yeah ((6 second pause))
> **T:** What are you thinking about?
> **C:** What we are, what we're gonna talk about next.
> **T:** Now? How does it make you feel talking about your, your youngest having problems right now. Like, if you had to put a feeling to it, what would you say it was.
> **C:** It would be a little sad. Cause I can see myself, my, my past in him and. And it's, it's sad because, ((pause)) But the thing is you know, he's got a, he's got a safe home ((sneeze)). And uh, ev-even though he does get into trouble at school, you know, minor scraps here and there, we explain what's going on, how to get around things, you know, how to, what is expected of him, as a student. His teacher is a good teacher and uh, encourages a little bit of team work and uh. But sometimes it's been really a bit hard to show, to show him a good example. Do you know what I mean? When he figure's you are doing one thing and saying another.
> **T:** Mm-um. Kids are awfully good at picking up on that. (**C:** Yeah.) So what are the kinds of things that you have troubles showing by example?

In line with the function of safe haven, Ms. E appeared attuned to Eric's emotionality. She responded to his silence and palpable sadness by inviting him first to share his

reaction, and then to specifically express his feelings when he did not automatically do so. Although he acknowledged sorrow associated with his own past, his difficulty in managing hurt feelings manifested in a quick shift to a somewhat brighter, more personally objective topic of parenting, thus manifesting his difficulty tolerating hurt feelings. Ms. E followed his lead and thus respected his limit. Her labeling of this process may have been helpful in conveying her understanding and acceptance of his need to pace himself. By explicitly recognizing Eric's reluctance to such feelings and validating his choice, she may have made the most of this opportunity to build safety within their relationship and support his emotional coping.

A missed opportunity for the therapeutic relationship to fulfill the function of safe haven for Eric was noted in session six, in which Ms. E invited him to practice perspective-taking. He responded to her request to present a recent episode in which he had needed to consider another person's perspective by sharing frustration toward a friend who had recently left an abusive relationship. The friend was the parent of a teenager who was acting out and whom Eric felt was being emotionally neglected during this crisis. Despite Eric's staid disposition throughout the discussion and most of the following exchange, Ms. E maintained a bright, jovial tone:

T: Okay, so it sounds like it was a big MESS.
C: Yuck. Reminds me when I was a kid ((subtle laugh))
T: That must be part of why it's hard having them over there, huh?
C: Oh, I don't know.
T: It's like "Here we go again!"
C: Yeah, I know I was sitting there last night, and I couldn't get involved in the talking, you know.
T: No?
C: [Teenager]'s mother and father came over, [my wife] and all of them were sitting in, in the kitch-, in the living-room. I wouldn't even go into the living room to listen to them talking.
T: Why?
C: I don't know, I just, I just couldn't listen to it anymore.
T: It makes you mad.
C: No, I wasn't mad, I was sitting around reading the paper, I don't know. It was just, just garbage that's been hashed over so many times, you know?

> **T:** You're tired of the whole story.
> **C:** Oh, I'm ((pause)) Yeah, let's get on, you know. You know [my wife] talks about me, you know, getting on with life and my dumping all of this and that, and Jesus Christ, look at [friend].
> **T:** ((chuckle)) So it's like, "Enough already! Can we shut up and move on and solve some problems here!"

The mismatch in affect tone notwithstanding, Ms. E succeeded in reflecting the situation back to Eric ("Sounds like a big mess") accurately and elicited a major obstacle in the way of his offering support to his friend ("Reminds me when I was a kid"). However, Ms. E's exploration of her client's emotional reaction remained limited to surface feelings of frustration (i.e., "mad" or "tired") and omitted investigation into feelings of hurt, sadness, abandonment and rejection at the hands of his own parents that may have resurfaced. Had she shown curiosity in this potential aspect of Eric's experience, it is expected that she would have been in a better position to help him experience and articulate such feelings for a brief time and convey her empathy in a more powerful way. Such a provision of safe haven would have been consistent with her problem-solving approach that, as she explained in her exit interview, was structured to model "acceptance and openness to his feeling disappointed, hurt, resentful, or fed up."

Eric's sadness was poignantly displayed at the closing of this same session, when he made a final bid to redirect their work to more closely match his own agenda:

> **T:** So, we can practice thinking about what other people are feeling and thinking before we talk. Usually we can find a way of saying what we want to say, without ruffling too many feathers, right?
> **C:** Yeah, I came in here wondering about my, working on my, working on my past. (**T:** Mmhmm.) I mean that was one of my main reasons why I came in here originally.
> **T:** Yeah, that is why you came in here originally.
> **C:** I don't know if it's ah, what were you going to say?
> **T:** You finish, I've been cutting you off all, all hour. You finish what we were gonna say.
> **C:** I don't know if it's ah ((pause)) will be for my benefit?
> **T:** You know wh- I was thinking about that too. Because it's like what you were saying last week, we are kinda scattered, we talked about stuff in the past, we talked about stuff from the future, we talked about stuff from going on right now and I think that, as we talk about the perspective taking stuff and learning how to understand what people are thinking and feeling, that a little bit we will always go back to what it was like for you as a kid, right? But to just sort of focus on that, when it sounds like in your everyday experience things are going

> wrong with communicating with people, it feels a little bit like it might take a long time to kinda work out all these, this stuff from when you were a little kid to get to the real, like the day-to-day stuff that you are dealing with now. Do you know what I mean? Like, I'm not saying that it's not important to think about some of the terrible things that you suffered as, as a young boy. It's just that I'm not sure how immediate, like it's going to translate into you being happier with your wife and your kids and your family and the work stuff. Do you know what I mean? (**C:** Yeah.) I'm thinking that, it will come up as we talk, and as we get to know each other a bit better, you'll, you'll share with me more about stuff that happens. And we'll be able to understand maybe why it's so hard for you to take people's perspectives, because yeah, from, a kid coming from your background, no one was really there to teach how to do it, right? (**C:** Yeah.) But I'm thinking, we should practice together on how to do it. We can talk for hours about why you don't know how to do it, and how hard it would have been growing up in your family and trying to learn anything, besides learning how to be an alcoholic, right? I mean you've come such a far way from where you were at the beginning right? I mean you started over here and then you ended up over here, on your own, you know.
> **C:** Well, with a lot of help.
> **T:** Well, with a lot of help, right? And I guess what I wanna do is, I wanna give you some skills that will make a difference right away, as opposed to just focusing on stuff that happened a long time ago, that may help you understand things a little bit, but may not have any immediate, right now kinds of impact, do you know what I'm saying? (**C:** Mmhmm, yeah.) So, lets, you know, if there's stuff that you think about between one session to the other that you want to talk to me about, whether or not it has to do with this perspective taking stuff, write it down on a piece of paper, and bring your paper, okay? Because maybe there's something that we can do at the same time some other stuff, okay? But I think that as like, one of the goals is communicating better with people then we got to talk about how you're communicating today, not when you were five. Because, you know, you're not five anymore. (**C:** Yeah.) Right?
> **C:** ((soft voice)) Sometimes it feels like it.
> **T:** Of course, of course, everyone does, yeah, everyone does, you know, and so a little bit, yeah, it'll help us to kinda go, "How'd you get there"...

The driven nature of Ms. E's response, aimed to win him back on board, suggests that she heard an objection within Eric's question. However, it is not clear to what degree she considered that his opposition might be stemming from an attempt to assert his needs and wishes. Although she aimed to assuage Eric, she did not show openness to negotiating the agenda. This likely would have helped him to experience this relationship as a safe, comforting zone, as well as to develop the sense of trust that is fundamental to a secure base. In disregarding his unequivocal expression of sadness ("Sometimes it feels like it"), she may have inadvertently relayed the message that this therapeutic relationship was not an appropriate forum for him to share vulnerable feelings.

On the whole, this therapeutic relationship afforded Eric some safety and comfort. However, the relationship's potential to surpass his expectations and meet his safe haven needs was not deemed fulfilled. Ms. E's relatively limited attunement and responsiveness to Eric's distress may be understood as the natural consequence of her understanding of the case. It appears that this particular client was not conceived able to adequately access feelings of hurt or sadness to a degree that could be beneficial, which prohibited her from capitalizing on his few emotional displays. His readiness to change the topic when he was sad likely served to support a case formulation that did not expressly recognize his emotional vulnerability as an issue warranting clinical attention.

Case 4

Frank sought therapy due to a history of clinical depression. He recalled lethargy, despondency, and a poor self-image since his youth but stated he only became aware of the extent and impact of such feelings in recent years following diagnosis by his family physician. He also indicated difficulties with stress and anger management and a tendency to overreact to interpersonal conflict. He acknowledged heavy alcohol use on weekends to alleviate his mood and ruminative tendencies but did not consider this problematic. He was on antidepressant medication and hormone therapy monitored by his family physician.

Frank's level of distress was within the normative range for male psychiatric outpatients (GSI = 1.66, T = 58). Obsessive tendencies were moderately elevated (O-C subscale = 1.9, T = 65) reflecting frequent trouble remembering, feeling blocked in getting things done, difficulty making decisions, having to check and double-check actions, and poor concentration. Frank's social network was strikingly limited. On the SSQ, he identified his wife of many years as his sole source of support and indicated no

desire to receive more (SSQ-N = .8). Although he reported mild dissatisfaction with his wife's attempts to console or reassure him, he indicated feeling completely accepted and cared for by her (SSQ-S = 5.25). In addition to an absence of friendships, he had no contact with his parents, having abruptly terminated his relationship with them approximately a decade prior when he finally became "fed up" with their reported lack of appreciation of him. He indicated no desire to rekindle a relationship. Similarly, he maintained only minimal, superficial telephone contact with certain siblings.

In addition to various pharmacological prescriptions for depression, Frank described sporadic participation in psychological treatment and few positive experiences with mental health professionals. For example, he described repeated disputes over payment and paperwork that led him to terminate his work with a female psychiatrist after three months. He indicated that a male therapist, whom he consulted at one point through his Employee Assistance Program, had "done all the talking" and provided little assistance with the exception of helping him see how he used alcohol as "a bottle of numb." He noted one other brief and equally unsatisfying involvement with another therapist with whom he felt unable to connect. He had also completed a three-month day program sponsored by a local mental health centre from which he gained insight into his poor ability to recognize and express feelings. However, he stated he was mainly bored throughout the program, which he saw as suited to significantly lower functioning individuals than him. He also indicated feeling frustrated with the perceived contradiction between that particular therapist's encouragement to share more and other members' feedback that he monopolized class time.

Frank presented as a well-spoken, chatty individual whose initial affable disposition belied significant apathy and pessimism. Over the course of intake, his

passivity and paradoxical style of emotional expression became increasingly evident. Whereas he generally relayed information in a monotone, rationalizing voice, he became acutely and abruptly agitated while sharing annoyances and perceived injustice, doing so in a self-absorbed, driven manner. Although he noted several problem areas appropriate for therapy, he described himself as disinclined to approach people for help or support and reported distaste toward any sense of obligation. His general contentment with his lifestyle and relationship status was noteworthy, particularly in light of his few pastimes. He identified job security as his utmost priority and indicated he was seeking therapy to help maintain full-time employee status in the face of his proclivity to depression, which he conceptualized as "no different than a broken leg or other disease."

Due to Frank's high investment in self-sufficiency and significantly low levels of self-disclosure, proximity-seeking, need for closeness, and emotional involvement in his marriage as well as other relationships, he was rated as predominantly dismissing (6). Despite a vague recollection of early events and frequent use of verbal distancers in conversation, however, he showed a high sensitivity to feeling slighted, was frequently tangential, and easily lost his train of thought when agitated, thus displaying some characteristics of preoccupied attachment (3.5). In addition, his wariness to trusting others and fear of becoming too close, low confidence, and poor self-esteem, indicated a fearful component within his attachment orientation (3). His level of security was low (2), manifest slightly in some insight and sociability. On the RQ, he also endorsed the dismissing pattern as a perfect fit and rated the fearful pattern as moderately good fit. In contrast, he saw virtually no correspondence between himself and either the secure or

preoccupied descriptions, suggesting staunch identification with an avoidant interpersonal orientation.

Frank's therapy goals included gaining a better self-understanding and learning ways to manage his stress and anger, which he saw as exacerbating his depression. His expectations for a good therapeutic relationship emphasized the therapist as expert. In addition to patient and empathic, he described an ideal therapist as "able to understand the big picture and be able to explain it to me."

Proposed Attachment Challenges to the Therapeutic Relationship

Although Frank showed insight into his interpersonal style and expressed interest in learning strategies for emotional regulation, his steadfast investment in maintaining independence and distance from others (i.e., dismissing orientation) was expected to be a significant challenge to the establishment of a working alliance. Given his heightened sensitivity to criticism, discomfort with closeness, and active avoidance of obligation to others, he was predicted to resist therapeutic intimacy. Related threats included his history of disappointing therapeutic experiences, struggles with motivation, and proclivity to self-medicate through alcohol use. Furthermore, although he provided many recent and clear examples of daily hassles or ongoing concerns that were overwhelming to him, his expressed comfort and general satisfaction with his lifestyle and relationship status were salient obstacles to change.

Although prognosis for the unfolding of a therapeutic rapport was guarded, it was proposed that Frank would best respond to a non-judgmental, no-nonsense, and slightly detached approach that would liken his therapist to a supportive business consultant. Indeed, it seemed likely that Frank's evaluation of the therapeutic relationship would be closely tied to the degree to which he experienced symptom relief and perceived his

therapist to be a knowledgeable professional. Collaborative goal-setting was considered necessary to facilitate a realistic commitment from Frank. Drawing on his interest in maintaining good employee standing and his pride in work accomplishments were projected to be helpful in eliciting his participation. In addition, the establishment of concrete benchmarks of progress and use of tangible aides such as calendars and logs were recommended to mitigate potential confusion and discomfort in psychotherapy.

Therapy Parameters

Frank was paired with Ms. F who was assessed as moderately preoccupied (5.5) and fearful (4.5) and somewhat secure (3.5) in her attachment. Her degree of fit to the dismissing pattern (1) was rated as nil. She indicated she would employ an interpersonal therapeutic framework to this case.

Frank attended nine sessions and cancelled three, each a few sessions apart, within a thirteen-week period. Ms. F cancelled their last scheduled session, which immediately followed his latest cancellation and preceded a holiday clinic closure, due to illness. Frank terminated prematurely by leaving a message for Ms. F on the clinic answering machine at the end of the holiday in which he indicated he would no longer be requiring her service.

Overview of the Relationship

As expected, Frank proved to have difficulty establishing closeness with his therapist, Ms. F. As shown in figure 5, he endorsed a steadily mediocre therapeutic relationship across their period of study. Although Ms. F's WAI ratings were roughly similar to Frank's, exit interview responses indicated that the nature of their rapport had felt less satisfactory to him:

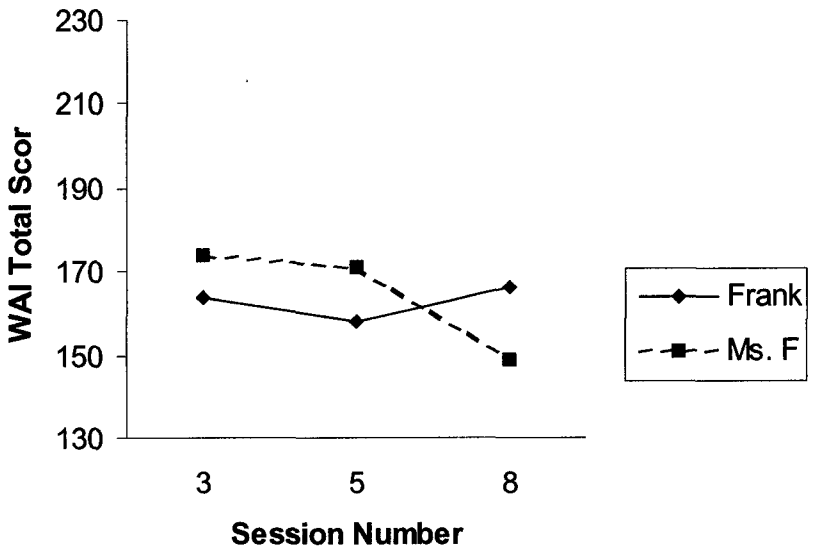
Q: How well would you say you worked together on a scale on one to ten?

C: I'd say maybe a three. ...I found that when I was talking to her, I thought, "How could she possibly understand?" She was so YOUNG...I didn't feel like she had much to offer or any credibility...I couldn't seem to warm up to her.

T: I'd say probably a seven or an eight. I felt like we actually worked very well together and that despite my initial first impression of "Oh, this guy is not gonna be that interesting to work with" or "I might not like him," I felt we established a fairly strong connection.

Figure 5:

Client and Therapist Total WAI Ratings of the Therapeutic Relationship in Case 4



In addition to feeling ill at ease with and disconnected from Ms. F due to a perceived difference in age and life experience, Frank described discomfort with their absence of agreement regarding goals, stating, "I really felt like I was sort of out floating in the middle of nowhere and really not knowing what direction to go in, you know, almost like you're in a huge white light and you have no idea where the door is to get out." He nonetheless acknowledged having gained some self-awareness and identified no regret with the experience. Rather, he stated that he terminated based on the conclusion that they "had accomplished as much as [he] thought [they] could and that

any further time together would be a waste." He acknowledged in hindsight an unwillingness to face change and psychological disruption that also influenced his decision to stop therapy.

Ms. F conceded that their lack of explicit agreement had been a weakness in their work, but she nonetheless emphasized the degree to which she had felt present, caring, and "in tune" with Frank during their sessions. She indicated awareness that Frank had lacked confidence in her and had actively resisted getting to know her as a person, perceiving her instead in a two-dimensional manner. Even so, she discerned that she had been able to offer him a sense that he was special and mattered. She admitted surprise and disappointment about their termination, recalling feeling very hopeful that he could "go from being mediocre, or just sort of getting through and not having any real joy to actually being quite a happy person." She reported having felt encouraged with the progression of their work that to her had felt increasingly emotionally involved, and she offered a perception that Frank was "capable of working at a much deeper level" than she had anticipated at the outset. However, following termination she speculated that their contact may have felt overly intense for him and that her expectations may have been too high.

Session observations confirmed the absence of explicit goal setting. In addition, an imbalance in their relative degree of involvement was noted. Whereas Ms. F was consistently attentive, engaged and goal-directed, Frank made minimal eye contact during the study protocol and often appeared to be talking aloud to either himself or a general audience rather than interacting with his therapist. Moreover, there was relatively little exchange about the therapeutic relationship or its impact on Frank despite

Ms. F's repeated efforts to involve him in such discussions. Overall, their interaction during the study remained formal and lacking in congeniality.

Consistent with other findings, Frank's responses on the QRI, which characterized his perception of the relationship as low in Conflict (1.5) as well as Depth (2.2) and moderate in Social Support (2.8), suggested a lack of personal investment on his part that precluded strengthening of the therapeutic alliance.

Extent of Secure Base

The following excerpt from session 2 illustrates a mode of interaction frequently observed between Frank and Ms. F throughout the study protocol:

> **C:** So what I did yesterday was I went to work and yesterday we were at the administration offices, it was recycling day. So I went to grab the two, grabbed the bags and went around the individual white boxes (**T:** Mmhmm) so we had this great big recycling program going on. I don't know if it does any good or not. Anyway, so I went around, have to go to the boxes and, and I did a couple of other things, thought I should do a couple of things. And then I went into the first aid room, a very complete room (**T:** Mmhmm) all bells, whistles. And then I fell asleep (**T:** Mmm) I slept for 2 hours I think. And um, I think I got up at about quarter to 5. I slept for about quarter to 3 (**T:** Mmhmm) to quarter to 5. And uh, I was just, I was just tired, and sometimes, well, I had things under control so
> **T:** And feeling a bit like you wanted to be alone in that room?
> **C:** Yeah, yeah
> **T:** How was it after you got up?
> **C:** It felt, I didn't feel, um, I looked at the clock and says, "Oh", I says, "It's too early to go home," I usually go home for dinner at 6 o'clock (**T:** Mmhmm) so it was too early to go home. So I walked around. I did a few odds and ends. I don't know, I emptied somebody's garbage, I filled a couple of paper towel dispensers, I was just killing time. And um, so I went home at about 6 o'clock and then went back at 7:30, and I hurried up and got things done. Some of it I let it slide, I knew I'd finish it up, I'd do it tomorrow (**T:** Mmhmm) and um, so I was supposed to work til 11 o'clock but I was out of there at about quarter to 10, I guess (**T:** Mmhmm) 10 to 10. I went home and just, I just sat in the chair. I was feeling really, as a matter of fact, I um, I watched the news, read a bit of the news. I really wasn't paying attention to the newspaper (**T:** Mmhmm) and then uh, I think I went to bed about midnight I guess. I usually take a sleeping pill
> **T:** Did you take one last night?
> **C:** Yeah. I took one the night before, I was about to do it again at noon. I got a prescription [one month ago], 60 of them (**T:** Mmhmm) so I use 1 or 2 a night. And uh, so I had 2, I had 10 left last night
> **T:** I just wanted to get back to talking about last week and what that was like for you. One of the things I had thought about over the week was that nothing really stood out for me. And when I thought about meeting you and what that had been like, it was sort of an effort to think back, what sort of things HAD we talked about, and I wonder if that was the sort of experience that, that you had before with people

> **C:** Mmhmm. Yeah, nothing really stood out for me either (**T:** Mmhmm) I came, I talked, but then it was um, I felt like last week it was only our first meeting (**T:** Mmhmm) it was almost like a rehash when I was with, um, I forgot her name (**T:** Jocelyne?) Jocelyne, yeah.
> **T:** It made me think about, um, some of the things you talked about in terms of connecting and making a connection and I wondered about how we'll do that. How we'll build a connection so that we can work together and how we'll know what it will look like (**C:** Mmhmm) when that's done. Like, when will you be able to say, "Yes I do feel connected with this person. This is how I know"?
> **C:** Mmhmm ((pause)) I don't know. Actually, I don't think I've ever connected with any people that I've talked to. I don't really connect with my wife. SHE knows me better than myself cuz she watches me (**T:** Mmhmm), she knows when I'm in a mood, but...

Frank's distancing style manifest itself through excessive and occasionally tangential (e.g., "I don't know if it does any good or not. Anyway...") detail, often in a monotone or rote manner, that limited dialogue. Ms. F demonstrated her attentiveness and interest through the occasional use of paraphrase and questions that directed her client to more personal and/or emotional experiences (e.g. "And feeling a bit like you wanted to be alone?"). More distinctive, however, was her forthright and abrupt sharing of observations or questions that challenged Frank to address relational topics he seemed disinclined to broach. Her perseverance in the face of her client's digressions was notable and succeeded in uncovering Frank's core beliefs and motivations. For example, with Ms. F's continued probing, he eventually came up with a metaphor later in this session that both identified in their exit interviews as a relative highlight in their work:

> **T:** So do you think that if I, if I understand you, if you had this sense that I understand you and are perceptive about how things are going for you and how you are feeling, will that be something that makes you feel connected with me?
> **C:** ((pause)) Mmm. I, I, I guess so. I'm [not sure=] (**T:**[=You're not sure]) I don't think I really felt, I don't think my whole life, I really felt, really connected to anybody. Um, I feel like I'm uh, sometimes I'm an island unto myself (**T:** Mmhmm) and occasionally I'll bump into other islands, but uh, some
> **T:** It would be nice to have a bridge,
> **C:** Sometimes it's uh, um, there's a bridge. No, no, I think that sometimes, I don't like to have a bridge. A drawbridge, that goes down maybe, that I could pull back up when I want to because it uh, so that nobody can um, come onto my island (**T:** Mmm) so that I have that distance
> **T:** Why don't you want them to come on the island? What would happen?
> **C:**((pause)) ((sighs)) I don't know, too close. I don't want to be that close, you know, I don't feel comfortable being that close, I don't. I find it scary. Um, because I don't know. I never did that before

> **T:** So there's this sense of on the one hand, wanting to feel connected to other people, but there's some fear about what that would that be like
> **C:** Uh, there's more fear than there is want. Wanting sometimes, and sometimes when I'm feeling really strong emotionally and feeling really together with myself, um, yeah I want that (**T:** Mmhmm) but uh, most of the time I don't

Frank's insight plainly summarized the challenge that would continue to face them, namely, his strong preference to keep others off his "island" in order to maintain control and familiarity and avert potential rejection.

In subsequent sessions, Frank's ambivalence toward being in therapy remained apparent. Not only did he repeatedly arrive late and cancel an appointment with little notice, he also directly expressed his wavering motivation, stating, for example, in session 3, "I was thinking today well maybe I don't need to come here anymore." Interestingly, he continued to vent his frustrations and to respond to Ms. F's self-reflective probes. She, in turn, persisted in her efforts to promote his increased self-awareness within a predictable environment, in line with the functions of secure base. For example, she encouraged him to voice and elaborate on his hesitance and shared her observations of his distancing behaviours (e.g., in session 4, "I've been thinking about [your lateness] and wondered if it's a way for you to avoid getting into things as intensely"). Similarly, she gently and non-punitively set limits with respect to attendance and promptly ended sessions at the expected time. She also repeatedly commended him for his metaphors, provided indications that she thought about him in between sessions, and raised their relationship in their discussions, thus demonstrating interest in connecting with him.

Despite her efforts, Ms. F's advances on Frank's "drawbridge" were deemed modest. In session 5, in response to her reminder regarding the cancellation policy, which she framed in the service of preserving his unique time, Frank showed recognition of his therapist's provision of a specific and beneficial role for the first time:

T: What are you thinking about?
C: ((11 second pause)) Umm., just the policy. Jocelyne explained it to me and I was aware of the policy ...yeah, it makes it different when you think about this is my hour or my time frame or my margin of space. Yeah, yeah.
T: How does that make it different?
C: Well, it makes it more special, I guess. Thinking that, "I'm not up to it today, I'm not going, I don't want to go today," but then when you think about other people putting themselves out for my benefit and reserving their time for me...

In another instance in session 6, identified by Ms. F in her exit interview as touching, Frank was initially moved by her offer to express what he would need from her in order not to feel "just like another number" as he had time and time again with others, stating, "Nobody's ever asked me that before." Nonetheless, in lieu of an answer to her question, he reported feeling awkward and less relaxed with her than he hoped. Moreover, in subsequent sessions he expressed a renewed resolution to maintain his interpersonal style, as illustrated in the following excerpt from session 7:

C: I was thinking about the session. And I thought, "Why do I have to have control?" Control was in my brain (**T:** Mmhmm) and then a little light went on, and the word rejection. If you have control, then you're in charge, you tell other people what to do, other people bend to your will. You're the man that's telling people what to do. People'd challenge you, but people can't reject you...And also if you're in control, and someone else doesn't like you, well, that's their problem because I'm in control and if they don't like that, that's too bad. I've got the authority, I've got the power and they don't. I do things where I'm in control so I feel safe and comfortable. Maybe everybody does that, I don't know, but it's really important to me (**T:** Mmhmm) I don't want to go anywhere where I don't feel safe or I feel uncomfortable.
T: So those are a couple of things we can keep in mind in terms of making you feel comfortable. Make sure you feel comfortable coming here and letting that lid off the box [of emotions] a little bit at a time (**C:** Mmhmm) in a way that you can handle it, a piece that you can handle. I'm going to have to rely on you to let me know that this piece is okay with you. You're going to have to be in charge of that. What is safe for you, what isn't, what's too much. (**C:** Mmhmm) Think about during the session, where are you in terms of the oven. You used that metaphor (**C:** Mmhmm) and be aware as we're drawing closer to the end of the session, that it might be time to turn the heat down.
C: Mmhmm. Also one other problem I have is um, I financially ran into a brick wall, I have enormous expenses this month and um, I didn't, I don't think I wrote you a check last week. (**T:** No.) I LITERALLY, literally cannot write you a check this week...

Although Ms. F's response to Frank's disclosure suggests that she may have seen in it an opportunity to align with him, his subsequent eschewing of her question and announcement that he would be unable to pay was interpreted as a rejection of any further closeness with her. Likewise, in the last two sessions he reiterated financial

difficulties that prevented him from paying for psychological services. Although he did not state an intention to withdraw from therapy, he expressed dissatisfaction with the process of therapy and lack of observable results:

> **C:** I go to a mechanic or to the laundromat and I know what to expect. When I come here, this is new for me and I don't like it. I find it difficult and I don't know what to expect. Like, am I getting good value for my money? Do I feel like I'm making good progress?
> **T:** There's no clean shirt that I hand you at the end of the session.
> **C:** No. In fact, there's nothing tangible. I don't walk away feeling like I've had a really nice dinner, like my needs were met. I leave feeling unsure, unsure of what I accomplished, if I accomplished anything. It's not easy to sit here and talk with you, so little seems to be accomplished.
> **T:** I think it's going to be important for us to talk about this, what is progress for you, what does a clean shirt look like.
> **C:** I guess when I was talking to Jocelyne earlier, I was looking for someone to talk me out of my past hurts and looking to understand what I'm feeling, but in the last few weeks, those things don't seem as important as they used to be. I've been thinking maybe I'm getting over it.
> **T:** Sounds like the goals you had at the beginning may have changed.
> **C:** I think so.
> **T:** We're just about out of time. I wanted to check whether you brought in your application for fee reduction.
> **C:** Yes, I don't know whether I filled it out correctly...

Like Diane in case 2, Frank was surprisingly candid about his doubts, and like Ms. D, Ms. F response (i.e., "There's no clean shirt...," and "Sounds like the goals you had...changed") reflected accurate understanding and encouraged him to further express his discontent, a clear interpersonal risk for a generally passive, avoidant person. However, it would likely have been useful to more powerfully reinforce his step toward assertiveness by offering him direct praise for this gesture, as well as a clearer commitment to problem-solve around his concern so that he might begin to feel and recognize his needs being met. As the above stands, it appears an opportunity may have been missed to help increase Frank's faith in the psychotherapeutic process.

Overall, this therapeutic relationship afforded Frank sufficient support and challenge to explore his interpersonal functioning and gain self-awareness. However, it appears that he was loath to stray beyond a familiar zone and unwilling to consider

whether the base offered might be trustworthy, let alone work on the development of security with his therapist. The absence of change in his extremely limited social network over the study period paralleled his lack of interpersonal risk-taking within the therapeutic relationship (change in SSQ-N = 0, and SSQ-S = .75). Interestingly, at debriefing he no longer rated himself to be predominantly dismissing, but rather endorsed a strong fit with the fearful pattern of attachment. Despite his fairly pessimistic view of the therapeutic relationship, Frank reported a drop in general distress (GSI change score = -.32) at the study's completion relative to intake that suggested he benefited from a comparable level of symptomatic relief to that of other clients in this study. In addition, although he remained angry toward his parents about his childhood, he showed greater acceptance of responsibility for his current level of functioning:

> ***Q:*** *If you were to go back into therapy, what would you like to work on next, in a few years from now or, what could you see as a useful focus? Sounds like you've made the decision that for now you can work things out on your own, that you've gained enough.*
>
> **C:** Yeah, I don't know if I'd go back to therapy. Because I'm not sure if I WANT to know. I'm actually afraid, maybe that's why I stopped with [Ms. F]...Sometimes you open doors. You don't want to confront what's on the other side of that door. And I'm not sure I want to ((pause)) it might cause such upheaval that I'd best leave the doors locked. And occasionally I hear rumbling behind the door, but my stress level is such that I can handle it, I can handle the devils I DO know ((pause)) I don't want my comfort zone removed...I'm gonna choose to leave that drawbridge up and some of my family members are withdrawing from me. I choose to leave it. On the one hand it makes me feel bad and on the other I feel better when that drawbridge is up.

It will unfortunately remain a mystery as to how the therapeutic relationship might have unfolded had Ms. F appreciated Frank's discomfort and dissatisfaction with their work more fully. Would she have offered Frank more reassurance that their work was valuable? Or challenged his unspoken view of her? Her optimism toward the case and sense of alliance with such a disconnected client were certainly remarkable and perplexing. It is possible that her own relatively high insecurity may have coloured her perception of their interactions and interfered with her ability to recognize undermining or

withdrawing gestures that forewarned a relinquishing of the relationship, such as Frank's refusal to pay or his various expressions of discontent. However, given his weak motivation to change his approach to relationships and admitted prejudice toward young women, it is unclear under what conditions forging a connection with Frank might have ever been a surmountable challenge for Ms. F.

Extent of Safe Haven

Although Frank presented as generally disengaged, there were several instances during the course of his work with Ms. F in which he displayed strong negative emotions. This excerpt from the last five minutes of session 2, for example, illustrates the degree to which he became riled up when talking about his family relationships:

> **C:** But um, when you trust people, they hurt you and even if I think of my own parents. Uh I trusted them all those years and all I got was hurt. And now I don't want to, I just want to be an island. I don't want to be that close anymore. I don't want to um, uh be that vulnerable
> **T:** You don't want trespassers?
> **C:** Nobody, nobody's coming that close to me anymore because it uh, um, the hurt was too deep (**T:** mmhmm) it was way too deep. I just can't do that, can't ((cries, grabs a tissue)). Sorry.
> **T:** So in the past when you let people come onto your island, like your parents, it, it was vandalism
> **C:** ((tone angry)) Oh, I says to them, "I don't want this kind of shit abuse." I says, "I can have people from my bus. I don't need to come here, honestly" (**T:** Mmhmm) ((voice raising)) "I don't need to take this from you." That's when we used to go over every Sunday night. And uh, the negativity, and the sarcasm, the remarks. And it was just, push all my buttons. And I'd come out of there and I'd just be FUMING, I'd be so angry and my wife would be angry too (**T:** Mmhmm) and the two of us would fight for two days, and um
> **T:** It must get lonely sometimes on an island alone
> **C:** Uh, yeah. And that's when I can reach out and uh, be friendly with somebody, uh, laugh with somebody, make a joke. But on a temporary basis, I can seek out, cuz I'm dealing with people all around me (**T:** Mmhmm) so I can seek somebody out and uh, make a bit of a conversation if I need somebody sort of to temporarily come on my island. And uh, I walk away and they're off. And they've I guess, I've fulfilled a need and they've fulfilled my need enough, and um
> **T:** And there's no danger of getting hurt
> **C:** No, it's just a very superficial thing, you know, just to uh, a human connection I guess and uh, yeah. So it uh, from people that you needed it from most, was SUPPOSED to give it to ya (**T:** Mmhmm) didn't. Not only they didn't give you that support, that love, all you ever got was sarcasm and abuse
> **T:** More than not getting something, it was something being taken away?

C: ((voice raising)) Oh there was, it was like a, it was like a 90/10 (**T:** Mmhmm) 90 percent of the, was uh, was uh the negativity the abuse and, and 10 percent, if you were lucky, probably 95/10. The only time you ever got any of it was when they were on my terms (**T:** Mmhmm) when I would invite THEM over for dinner, birthdays, anniversaries (**T:** and those times at, at YOUR house) ((voice raising again)) at my house, at MY expense. You know, I'd go my extra, new music to put on, buy a little liquor, you know, he liked to drink um, Spanish coffees. So, oh okay, so I went down and bought a whole order of brandy (**T:** Mmhmm) and coffee liqueurs and everything else, and orange liqueurs, special coffee cups, real whipped cream, sprinkles, cherries. ((speed of speech increasing)) I said to my wife, I says, "Make sure the cherries got the stem on top" (**T:** mmm) I says, "Don't buy one without the stem." You know, I says, EVERYTHING. Just so that it was just perfect= (**T:** =just perfect) and, and then, this and I says, "How did you like it?" "Oh yeah, it was good." "Would you like another?" "Okay, I'll make you another one." So he had about 3 of them
T: So every now and then there was that little tiny bit of approval that you got from him
C: A thank you, yeah (**T:** Mmhmm) and um, cakes, I'd get, order special cakes from [specialty restaurant] (**T:** Mmhmm) a deli-bakery, fresh fruit cake or whatever. ((tone angry)) And then when the evening was over, I give him the cake, "Here, take the cake home." You know, and uh, uh we'd go out of our way for uh things that we, we, ((voice raising)) wine and dinner and actually liquor and desserts and roast, prime rib roast or whatever, you know (**T:** Mmm) and uh, candles, fresh flowers. You know, the whole nine yards. We had the dishes, we had the cutlery, we bought a set of silverware. Um, so we had silver, we'd be polishing silverware (**T:** Mmhmm) polishing the glassware. We had, we had crystal glasses, Royal Daulton, we had old country roses. (**T:** Mmhmm) You had to have a certain correct dishes (**T:** Mmhmm) you know, you couldn't come over and eat off your, your everyday plates. You have to have special dishes you know. Gold rims, flowers. So you had to buy flowers to match the tableware
T: [Frank], I'm just aware of the time here. Just about out of time and I just wanted to check in with you before cutting you off, before we break and see how you're feeling
C: Upset (**T:** Yeah?) Upset, sad (**T:** Mmm) Yeah, it's something that brings up a lot of hurt
T: Mmhmm. I can see it
C: A lot of hurt. Actually, I uh, I'm not sure if I would have, if I'd known this would have happened, if I would have wanted to come. But uh, left me really, really upset
T: I'm sorry that we have to break here too

Ms. F's style of questioning and reflecting (e.g., "and those times at YOUR house") succeeded not only in stimulating insight as was noted in the previous section, but also in triggering and facilitating her client's genuine expression of feelings. In sharp contrast to Ms. A, Angela's therapist, whose primary agenda seemed to be to mitigate her client's embarrassment and discomfort, Ms. F made few efforts to interrupt Frank's emotional outbursts or diminish their potency, thus demonstrating high tolerance for negative emotion. In her exit interview, she identified this ability as a personal strength, noting that she was "comfortable just sitting with him, not patching it up, or taking a very problem-solving approach, but being able to sit with uncomfortable emotions." She showed a

good grasp of Frank's reactivity, stating that "his emotions were very close to the surface, so they would sort of bubble over very easily and he was not great at modulating them."

However, in order to facilitate Frank's emotional regulation, a goal that she herself acknowledged as foremost in this case, it may have been equally important to offer prompt recognition of his uneasiness in these times of vulnerability as well as extend some comfort. That is, through labeling and reflecting back to him in the moment how upset she sensed him to be, she may have increased the likelihood over time of his experiencing these emotional moments as shared and tolerable. It may have also been beneficial in this instance to acknowledge his apology in reaction to his tears and extend reassurance of the meaning and value of his crying in front of her. Moreover, an earlier indicator of session length remaining to allow him more time to compose himself by the end may have been warranted. Her arguably late check-in with Frank to see how he was doing suggests that she was not sufficiently monitoring the intensity of his emotion or its rate. His parting comment unequivocally indicates that he felt overwhelmed by his own reactions within the session and that the function of safe haven was not fulfilled in this instance. Ms. F's discussion of this event in her exit interview suggests that she may have overlooked the potential for his discomfort in the session to adversely influence his sense of safety and connection with her:

> ***Q:*** *So in the moment, when he said, "I wouldn't have come today if I knew I would feel this way," how did you feel at that time?*
>
> **T:** I was surprised ((pause)) because I'm an emotional person, like, even though I knew that he wasn't, I sort of thought he would know that yeah, there are going to be sessions that are a bit difficult. So, I was a bit surprised by it and I felt badly and I remember thinking, "Oh, this poor man, what have I done to him today?" you know, sort of put him through the ringer, but also a bit, uhm, satisfied makes me sound really mean, that's not quite the right word, but "Okay, we accomplished something today, you really felt something here, and that's good." I took it more as an indication, okay, we're going somewhere, we're making progress.

This is not to say that Ms. F ignored Frank's need for safety within their relationship. On the contrary, she repeatedly raised this issue and explicitly identified it as an important target in their work. She opened session 3, for example, with a statement of concern about the aftermath of their second session and a suggestion that they should work together on the pacing and timing of difficult material. Similarly, the following excerpt from session 6 in which Frank almost cried shows her expressing respect for his need for control and safety:

> **T:** So when I ask you what it's like to feel special, it doesn't feel like a positive thing
> **C:** No, when I'm here I don't feel positive, though I know I should. I feel like I might lose control
> **T:** Tell me about losing control
> **C:** Well, it's like the need to keep the lid on a box
> **T;** What happens when you loosen the lid from the box?
> **C:** Frustration. Disappointment. Hurt. Pain. Bad feelings.
> **T:** Mmhmm. Are those things IN that box or is that what happens when you open the box?
> **C:** I think it's what's in the box ((chokes up, suppressing a cry))
> **T:** So there's a feeling when you come here that you don't feel entirely safe. Like the lid will come off and that will be more than you can handle
> **C:** Yeah, it's too draining. I got to switch modes and carry on with the rest of my day. It's, it's difficult, and uncomfortable.
> **T:** I think it's really important for you to have a sense of safety here, that you don't feel like I might rip off the lid or expect you to rip it off at a pace faster than you can handle
> **C:** Yeah. Yesterday I was saying I wish I had two weeks vacation because it's getting very intense. (**T:** What is?) Life. With the things I should, could, need to be doing...

Nonetheless, although she used a gentle, caring tone, she did not respond directly to Frank's sadness, manifest in his restrained tears, perhaps because she viewed his feelings as appropriate reactions that did not necessitate special attention or that she did not want to obstruct. In not doing so, however, she may have missed an opportunity to express compassion and offer nurturance, which might have come as a powerful surprise to a client who did not expect it. In another instance in session 9, their final session, Frank became visibly sad as he described childhood experience of rejection within his family. Ms. F again did not acknowledge his sadness, but instead used it as an opportunity to offer feedback on his interpersonal style:

C: Then 5 kids came along, it got awful crowded. I don't know if I was aware of it at the time. Looking back, I kept silent because I noticed there was no use to complain to mommy
T: I'm aware as you're talking that quite often you don't make a lot of eye contact
C: ((pause)) I guess I'm visualizing, yeah, it helps me to see it as it was happening. Quite often when I'm working I make eye contact, it helps to show my presence. But,
T: I was wondering if I could use your eye contact as a way of knowing that about you?
C: Yeah, probably. I wasn't aware I was doing it here. That's probably an accurate assessment.

Although Frank accepted her observation, one wonders whether her abrupt comment reinforced his sense that she was unable to understand him. Eventually, he characteristically expressed struggle in therapy through a metaphor:

C: I always liked, when I was growing up James Bond was very popular. I remember watching his movies and I always watched him. He was always in control. He always knew what to do. He would walk in to a situation and he had it in hand. And I thought, "Oh, how do you do that? How does one become" ((pause)) because I always thought, I always felt that,
T: You've felt that in here, not sort of knowing what to do.
C: My neighbour came over and showed me how to trim a tree. There was a cedar tree and the branches were hanging down too low. I was down here, I was looking up there at all those branches and I thought, "Jesus," I was looking up thirty, forty feet at those branches. I didn't know how to do that. I just looked at it. So [John] came over, my neighbour. And he showed me how to do it. He showed me that the first thing you do is you tie yourself to the tree. You step beyond the ladder and you tie yourself to the tree. That gives you the margin of safety. So I says, "Oh!" So then after that, I had an idea of how to trim trees and I realized, you get a chain saw, power saw, whatever you use. So that, I did that. He showed me almost to my neighbour's place. So then I did his tree. Because I knew how, someone had showed me how to do it. So then my neighbour came over and I had to put a toilet in. So I joked with him, "This looks like a six-pack, a six-pack of beer." So he came over. And I wouldn't have tackled it myself because it's ((pause)) dangerous. What happens if you get it all apart and then you can't put it back together?
T: Is that your fear in here? We'll take everything apart and have to figure out how to put it back together?
C: Yeah, I think so. Because, you see, I don't know where I'm going. But I know where I am.
T: So there's some safety in that.
C: Yeah, yeah, and I don't seem to have much safety, I don't feel very safe a lot of times. I've never felt very confident. There are situations where I have this pit in my stomach, this uneasiness, and even if I just, um, fake my way through it, I never felt very uneasy or nervous. ANXIETY, I guess the word is. And I was surprised in '85, '86, when I was [working], my blood pressure was really really high. Even though I felt in control to a certain extent, but just in terms of inter-people things I felt really anxious
T: We're just coming to the end of our time here [Frank], so maybe we can continue with this and it's something that you can think about over the week. What your goals are and if there are any beyond the two that you've talked about today. (**C:** Mmhmm) So we can continue talking about that and you can tell me how you can gain a sense of safety, of your being in control of achieving those things.

Ms. F's closing comment indicates a move away from an earlier collaborative suggestion of assessing safety, to a stance in later sessions that placed the responsibility mainly on

Frank to proclaim his safety needs. This position is in keeping with her interpersonal conceptualization of Frank as a very passive person who needed to take steps for himself rather than to wait for others to initiate action. It is also possible that this shift was influenced by Frank's repeated diversions away from practical discussions on the importance of building safety. Regardless, Ms. F's inferred reliance on her client's self-monitoring abilities in the absence of progress with respect to emotional regulation appeared premature and not in keeping with the therapist's responsibility, from an attachment perspective, of granting a safe haven. It is unfortunate that little attention was attributed to addressing possible reasons behind Frank's persistence in claiming distance from Ms. F. Nor were his distancing efforts to ensure safety validated, which paradoxically may have lessened their usage. It is unlikely that Ms. F's lack of nurturance in critical moments of Frank's vulnerability, as well as her unresponsiveness to his transparent requests for direction, were calculated. Rather, it is proposed that her withholding of verbal encouragement and support reflected a lack of attunement to the extent of her client's discomfort within their sessions. At minimum, she may not have recognized her responsibility or potential as an active rather than passive soothing agent. Her exit interview responses lend support to these inferences:

> ***Q:*** *You said that you're an emotional person? (Umhmm). So how much do you think that that helped you in your work with him?*
>
> **T:** I think that it helped quite a bit because again, I was, I didn't feel uncomfortable if he cried, I didn't feel like I wanted to make him stop crying, that was fine, whatever he felt was fine. I was comfortable listening to it or seeing the impact on him.

In summary, despite Ms. F's stated empathy and intellectual understanding of Frank's need to establish a feeling of safety within their therapy, the provision of safe haven in times of distress during the study protocol was insufficient and precluded the growth of security. At best, a consequence of this safe haven failure is that this

therapeutic relationship did not succeed in inspiring in Frank motivation to change. At worst, it may have fueled his reluctance to trusting others to read and appropriately respond to his emotional needs.

DISCUSSION

The goal of this work was to study the development of therapeutic relationships through an attachment theory lens, thereby expanding our appreciation of the influence of attachment issues on alliance formation and the psychotherapeutic process. To this end, the relationships formed between four individuals and their therapists became the focus of investigation. Clients were selected to represent each of Bartholomew's insecure attachment prototypes and were reasonably typical of adult outpatient clients seeking individual therapy (Vessey & Howard, 1993). Therapists were intermediate level clinicians with similar training and experience. Combining traditional, quantitative ratings of therapy session and alliance with a systematic analysis of two components of attachment relationships, namely secure base and safe haven, proved useful in delineating observable, qualitative differences in relationship and case outcome. Indeed, therapeutic relationships varied not only in the degree to which alliance was evaluated as positive by clients, therapists, and/or observer, but also in the inferred extent of secure base and safe haven functions fulfilled for each client.

Case Outcome and Relationship Ratings

Each client in this study derived benefit from their sessions, be it reflected in symptom relief, greater insight, and/or improved social support networks. Moreover, ratings of alliance fell within the range of fair to strong, with no person having evaluated their therapeutic rapport as categorically poor. Similarly, sessions were rated on average as moderately deep and smooth, and quality of relationship according to clients was fairly high. Therapist alliance ratings on average were lower than those of their clients. Although this trend is consistent with previous research (Horvath & Luborsky, 1993), the

extent of the discrepancy is more extreme, likely reflecting a therapist response bias of caution, uncertainty, or of higher expectations in comparison to their clients that is not particularly surprising within a sample of student clinicians. Nevertheless, client and therapist self-reports provided an incomplete picture of quality of therapeutic relationship and case outcome. Despite reasonably positive overall evaluations on various questionnaires, two of the four relationships ended prematurely on disappointing, unsettled notes for the therapists involved. In both instances, exit interviews revealed client and/or therapist dissatisfaction with aspects of the therapeutic relationship that were inconspicuous within the self-report data. In the other two cases in which psychotherapy was ongoing, important nuances in what had so far been deemed constructive as well as problematic also emerged in exit interviews. Moreover, case comparisons of observations of videotaped sessions revealed unique client-therapist dynamics that suggested differing levels of client felt security within the different therapeutic relationships. The diversity in these findings underscores the complexity of therapeutic relationships and the importance of integrating multiple perspectives and sources of information when evaluating quality of relationship.

Extent of Secure Base

Therapeutic relationships were also found to differ in the extent to which they fostered the client's exploration, interpersonal risk-taking, and expansion of fundamental beliefs about self and others. Whereas a predominantly fearful client in case 2 (Diane) appeared to have established an optimal level of secure base with her therapist (Ms. D) that translated into notable gains, two of the four therapeutic relationships were found to be lacking in either the presence of appropriate challenge offered (case 1; Angela and Ms. A) or the extent to which therapist acceptance and support was extended (case 3;

Eric and Ms. E). In the fourth case, the therapist's (Ms. F) interventions were deemed well in line with the provision of secure base and successful in facilitating her dismissing client's (Frank) exploration to a certain degree. Despite her offer of secure base, however, his willingness to address his problems and challenge himself quickly reached a plateau and he showed little interpersonal risk-taking within or outside of the therapeutic relationship.

Results thus point to both client and therapist as significant players in the fulfillment of secure base. Indeed, these critical evaluations of secure base development are not intended to obscure or minimize the bi-directional, shared nature of interactions observed between clients and therapists. The latter was most clearly illustrated in Diane's and Ms. D's mutual efforts to address Diane's clinical problems as well as issues that arose in their relationship. Even in cases 2 and 3, however, where intervention limitations were identified as key to the level of secure base developed, each therapist's approach was shaped, at least in part, by their experience of the client. It is possible that Ms. A would have taken on a relatively less conciliatory, more challenging stance with Angela had the latter completed homework assignments or otherwise clearly indicated her readiness to try new interpersonal strategies. Or, Ms. E may have remained open to negotiating therapeutic tasks and goals had Eric's attendance been more consistent early on. In a similar vein, Frank's reticence in case 4 to address his personal challenges was likely fueled by several sources, only one of which included the discomfort he identified with Ms F. It is not possible to determine from these results whether his discomfort was a consequence of or a justification for his resolution to abandon further self-examination, or even whether he would have progressed further with any other therapist. Although this research design precludes causal conclusions, findings suggest

that assessing the extent to which a given therapeutic relationship affords appropriate support and challenge and attempting to tease out therapist and client roles would be useful supervision exercises.

The importance of balancing acceptance with appropriate challenge as suggested in the notion of secure base is consistent with previous research findings. For example, a qualitative investigation of clients' appraisals of therapists revealed four characteristic themes with respect to positively appraised therapists: (a) personal involvement, (b) technical restructuring, (c) authoritativeness, and (d) role modeling (Schneider, 1985, cited in Rennie, 2001). Thus, therapists who were well regarded by their clients conveyed a high level of personal involvement through genuineness, support, acceptance, and understanding. However, they were also perceived as skilled in shifting client viewpoints on matters of importance and in enhancing client awareness of their responses and impact on others. In addition, they demonstrated conviction and confidence and were accepted as role models personally, socially, and professionally. In contrast, negatively appraised therapists either conveyed too little or too much personal or technical involvement. While such findings offer therapists worthwhile aspirations of conduct, the concept of acting as a secure base may help to further clarify the therapist's role with any given client in that it offers a coherent, theoretically-based perspective in which to set realistic therapeutic goals and ground interventions.

Of special interest in making secure base determinations were episodes in which the client's core attachment issues as identified at intake (e.g., of self-esteem, trust, conflict management) were addressed. In three of the four cases, these included interactions in which problems in the therapeutic relationship were raised. Interestingly, these episodes were salient enough to both therapists and clients to be recalled upon

the study's completion. In line with suggestions from the empirical literature that negative client reactions or ruptures in alliance can provide opportunities for strengthening the therapeutic relationship (e.g., Horvath and Luborsky, 1993; Safran, et. al, 1994), having a conflict with one's therapist was not in itself deemed to be problematic. Rather, it was the resolution (or lack thereof) of such interactions that was considered indicative of the relative presence of secure base.

For example, Diane's readiness in case 2 to read aloud a journal entry and thus share her discontent and doubt about her therapist directly with her was interpreted as a paradoxical indication of her investment in the relationship. In addition, it suggested sufficient comfort with and confidence in the therapist's ability to hear her concerns and appropriately respond. As such, Diane's disclosure was seen as an approach (versus avoidant or withdrawing) behaviour, which was unusual for her in times of conflict. Ms. D's subsequent modification of her therapeutic approach proved effective in reassuring Diane that her view was valid and heard. Contrast this, however, to Frank's expressions of discontent with the therapeutic relationship in case 4, at times indirect and at other times blunt, and his therapist's generally empathic but minimal responses that did not address his hostility. Particularly by the end of the protocol, Frank's metaphors suggested he felt justified in engaging in familiar withdrawal. These disclosures did not result in a stronger alliance over time and instead were seen as markers of inadequate secure base. In case 3, Eric's queries regarding the therapeutic agenda were less transparent, in part because of his verbally economical style. These caught Ms. E off guard and appeared to be heard as therapeutic resistance or wavering motivation. Her explanations were considered counterproductive to the building of secure base in that they discouraged her client's collaboration and assertive expression of discontent,

arguably critical skills for a predominantly fearful client to develop. Thus, in applying an attachment framework to the interpretation of such events, the meaning and functional significance of expressions of discontent was attributed by considering of the context in which the behaviour was displayed and its impact on further therapeutic interactions.

An important implication stemming from the concept of secure base employed here, which regards interpersonal risk-taking within the therapeutic relationship as a valuable goal, is that it may provide therapists with a much needed conceptual framework for understanding and better managing clients' negative process. As noted earlier, there is substantial evidence that therapists of all ilks and caliber are prone to reacting to client expressions of hostility with negative complementary behaviour (Binder & Strupp, 1997). Just as a good therapeutic alliance is consistently associated with positive psychotherapy outcome (Luborsky, et. al., 1988), perceived lack of therapist empathy and negative countertransference are robust predictors of negative client outcome, namely, deterioration in functioning (Mohr, 1995). Although negative process or conflict is by definition interpersonal, and therapists' negative reactions are as unavoidable as their clients', the onus falls on therapists to maintain their composure and resist provocation to respond in kind (Binder & Strupp, 1997). This is particularly important when one considers the power differential inherent in the therapeutic relationship. In fact, qualitative investigations of client moment-to-moment experiences in psychotherapy suggest that it is common for clients to refrain from sharing their discomfort with the therapist's manner or approach and to respond with deference (Rennie, 2001). Thus, therapists need to be prepared to be proactive and initiate discussions about problems within the therapeutic relationship.

A therapist who aspires to act as a secure base offers interest in and openness to the client's perceptions as well as assurance that the client will not be rejected, ignored, or feared as a consequence of disclosing discontent. Within this framework, one recognizes the vulnerability associated with the expression of needs and therefore encourages the client's efforts to behave with him or her differently than with other significant people, even when this includes expressions of anger or disappointment aimed at the therapist. Moreover, one models negotiation and is prepared to engage the client in successful problem solving that in turn fosters hope for change. Thus, the reframe of client negativity as a client challenge and essentially a therapist test when appropriate may facilitate objectivity and help diffuse one's highly charged emotional reactions to a client. This was observed in case 2: although Ms. D acknowledged feeling "horrified" by Diane's claim of inattentiveness, noting this moment to be by far the most unpleasant for her, she succeeded in managing her own upset and recognizing an opportunity to reinforce her client's interpersonal risk-taking.

The value of a secure base-like approach to managing therapist-directed client negativity as described here receives some empirical support. Rhodes, Hill, Thompson, & Elliott (1994) provided evidence that therapists' active encouragement of discussions of clients' discontent within the relationship is influential in reaching a resolution. In contrasting the accounts of clients who reported resolution following an experience of feeling misunderstood by their therapist to clients who did not achieve resolution using grounded theory analysis, they noted several important group differences. All "resolvers" reported having raised their discomfort at some point (approximately half right away and half later on) with their therapists. Also, they reported that their therapists had responded to their criticisms by apologizing and discussing where to go from there. Moreover,

"resolvers" on the whole endorsed a positive rapport with their therapist. In contrast, most of the "non-resolvers" refrained from sharing their discontent. About half of this group endorsed a poor therapeutic alliance and most indicated that the event had contributed to their decision to terminate. Kivlighan & Schmitz (1992) compared client-therapist interactions in improving versus continued-poor alliance dyads and found that direct confrontation of problems arising within the therapeutic relationship was associated with better treatment outcome than in cases in which such problems were not addressed. Together these results suggest an association between collaborative efforts at working through alliance ruptures and strength of therapeutic relationship.

The existing literature suggests that therapist's initiation of meta-communication about the relationship, which involves offering observations and feedback about the nature of transactions within the therapeutic relationship, is useful in addressing client-therapist conflicts (Safran et. al., 1994; Safran & Muran, 1996). A question that has been raised in this field is how to train therapists effectively in meta-communication (Binder & Strupp, 1997). The latter is considered to be an interpersonal skill that necessarily combines the ability to observe process while one is engaged in it with the creative ability to improvise intervention strategies (Binder & Strupp, 1997). In addition to providing therapists-in-training with coaching on the systematic analysis of interpersonal process illustrated in videotaped therapy sessions as has been suggested (Binder & Strupp, 1997), education in attachment theory and the evolution of attachment processes over the course of development would be an asset. Moreover, videotaped observations of successful versus unsuccessful secure base interactions that specifically involve conflict in the therapeutic dyad could serve as a valuable experiential component to such teaching.

Although the power of an attachment theory framework in guiding therapists to be effective at promoting their clients' progress and better handling conflict within the therapeutic relationship was not investigated here, findings were promising. For example, observations of case 2 indicated that the therapist's sensitivity to her client attachment issues as reflected in her understanding of the case was associated with a good therapeutic relationship. Would further progress been achieved with Angela, Eric, and Frank had their therapists received supervision that explicitly addressed the client's attachment dynamics and their role as a provider of secure base (and safe haven for that matter)? To date, there is little research on this question. Interestingly, one analogue study comparing therapists who espoused an attachment theory framework versus those who did not found that an attachment-based orientation did not lead to narrower formulations of fictional cases, nor did it preclude a range of diagnostic possibilities from being considered (Waddington & Morley, 2000). Although it is encouraging that an attachment-based orientation did not appear to lead to an availability bias in therapists who participated in that study, such a finding does not in itself support the clinical value of an attachment perspective in psychotherapy. Clearly, more research is needed in this area.

Extent of Safe Haven

In contrast to Bowlby's concept of secure base, which has achieved popularity within psychotherapy circles (e.g., Brennan, 1999; Gooden, Leung, & Hindman, 2000; Slade, 1999), the safe haven component of attachment relationships has received little explicit attention.[1] Bowlby himself (1988) likened a primary function of the therapeutic

1 One exception is in Emotion Focused Therapy (EFT) for distressed couples, in which the creation of a safe haven *between partners* is identified as a central therapeutic goal (Johnson & Whiffen, 1999). The therapist's role within EFT includes facilitating the development of each partner's ability to comfort and reassure the other in times of emotional need, thereby building (or re-building) trust and fostering security within the marital relationship.

alliance to that described by Winnicott and Bion respectively as "holding" and "containing," but he encapsulated this within the realm of establishing a secure base. In this study, the function of managing client anguish through sensitivity and nurturance was treated as a separate, equally important function of the therapeutic relationship to that of promoting exploration through appropriate support and challenge. The successful provision of a safe haven in times of client acute emotional vulnerability was hypothesized to be a critical step to the client's development of felt security within the therapeutic relationship. Like its secure base counterpart, safe haven was expected to correspond to strength of alliance and positive therapeutic outcome. Cases were therefore analyzed for the degree to which the client's safety needs were acknowledged and met, as reflected in the relationship's ability to respond to the client's distress. Episodes involving a client's display of negative or painful emotion, be it relatively intense or restrained, were especially relevant to this analysis.

In each of the four therapeutic relationships, opportunities for providing safe haven arose, although in varying degrees. Whereas the client's genuine displays of painful or negative emotion occurred fairly regularly in cases 2 and 4, they were infrequent in cases 1 and 3. As well, different types of safe haven problems were identified. For instance, in case 1, although Ms A's initial responses to her client's acute distress on two different occasions included elements of safe haven, her ultimate efforts to alleviate Angela's anguish backfired, perhaps because they were too strong, premature, or too different from her client's expectations. These were understood as overreactions that signaled therapist intolerance or discomfort with strong negative emotion and paradoxically intensified the client's distress. In case 4, although the client's safety in case 4 was explicitly and repeatedly raised by the therapist as an issue

deserving their attention and collaboration, Ms. F appeared to insufficiently appreciate and attend to Frank's active distress, which he found overwhelming and highly unpleasant. In another vein, Eric's subtle signs of sadness upon reflection of his childhood were deemed not adequately acknowledged or pursued. In this case, the issue was not that the client remained distressed but rather that opportunities to help the client better manage his hurt were overlooked. The common element in these various therapist over- and under-reactions was a limitation in therapist attunement that helped maintain the client's status quo with respect to emotional reactivity and coping. In contrast, Ms. D's approach to Diane's negative emotions was better suited in both quality and timing to her client's safety needs and ultimately more successful at enhancing emotional regulation skills during the period of study.

Again, an attachment theory perspective to intervention that heightens awareness of client safe haven needs may be beneficial in that it promotes focus and persistence with respect to managing client emotionality or lack thereof. A therapist aspiring to offer a safe haven recognizes that the act of arousing or intensifying a client's emotional experience does not in itself fulfill safe haven needs and in some cases may even work against it. Rather, in granting safe haven, one is not only sensitive and responsive to signs of distress, but also aims to foster emotional expression to a degree that the client will be able to manage and build on. This view is consistent with a significant body of research that indicates that although enhancing client in-session emotional experience is generally associated with positive therapeutic outcome, dysregulated emotion is associated with several significant clinical problems including addiction and self-harm behaviours (Greenberg, Korman, & Paivio, 2001). An understanding of attachment issues including the concept of safe haven may be helpful

to therapists in differentiating under what circumstances and for whom interventions that heighten emotional arousal and awareness may be therapeutically indicated (Wiser & Arnow, 2001). The topic is addressed later in the discussion in the context of individual differences in safe haven.

Building Security within the Therapeutic Relationship

Although attachment-related themes were not formally quantified in this study, it was possible to make separate global evaluations of the extent of secure base and safe haven for each of the four therapeutic relationships. The fulfillment of secure base and safe haven via the therapeutic relationship were hypothesized to be critical ingredients to an insecure client's development of felt security with their therapist. Findings that secure base was more present or active than safe haven in case 1 and that safe haven was less problematic relative to secure base issues in case 3 support the distinctness of these two proposed functions of therapeutic relationships. It is nonetheless noteworthy that some episodes showed elements of both secure base and safe haven. For example, Diane's choice to share aloud a journal entry was interpreted as a risk-taking gesture and a reflection of secure base. However, Ms. D's initial response was seen as primarily serving the function of safe haven in that it served to help Diane regain her composure following an emotionally charged event. This suggests that that the processes of secure base and safe haven are not mutually exclusive or necessarily separated in time.

In addition, even episodes that were deemed to more clearly represent either phenomenon appeared to hold implications for the other. For instance, recall Ms. A's suggestion that Angela was clinically depressed, which was ultimately interpreted as a safe haven failure due to its threatening impact on Angela. Both client and therapist

reported in their exit interviews that they had reviewed this interaction together in a session subsequent to the end of the protocol and that, as a consequence, they had achieved a sort of rapprochement. Thus, in this case, a safe haven failure became an opportunity to further strengthen their alliance and develop secure base when it was later re-examined by the dyad. In the case of Frank, however, the therapist missed opportunities to adequately contain her client's emotional reactivity. This overall lack of a comforting function of the therapeutic relationship may have interfered with his willingness to continue accepting challenges or engaging in exploration and thus undermined the secure base that she was attempting to provide. Likewise, Ms. E's apprehension toward Eric's level of commitment, which was conceived as contributing to a secure base problem, was proposed to also have interfered with her ability to attend to his cues of emotional vulnerability and offer safe haven more fully. It is plausible that had she experienced more safe haven successes, she would have felt closer to her client, reassured of her role, and more open to collaborating with him in a way that would be consistent with the provision of secure base.

Given that the concepts of secure base and safe haven were useful in characterizing the interpersonal process between clients and therapists and in enriching the distinction between the therapeutic relationships, further systematic inquiry into the role of these attachment-related dimensions in psychotherapy is recommended. Whereas in this study judgments of the presence of secure base and safe haven were grounded in substantial data provided by clients and therapists, it would be worthwhile for both research and therapist training purposes to formalize a coding scheme for each proposed relationship function based on the guidelines presented here that could then be applied to recorded or live therapy episodes. Thus, raters blind to case status would

be asked to determine based on their observations of therapist and client interactions whether (or to what degree) individual episodes meet criteria for successful secure base and safe haven. One could then test the clarity of these respective descriptions by measuring the level of agreement reached between raters and refine secure base and safe haven prototypes as well as accompanying scales accordingly. It is likely that prior education in and familiarity with the process of psychotherapy would be an asset in making such determinations. With established reliability, one could proceed to more rigorous investigations pertaining to these proposed therapeutic relationship functions.

Certainly, several questions arise regarding the nature of the connection between secure base and safe haven components that warrant further inquiry, such as whether one serves as a necessary precondition for the other, or under what circumstances, if any, does one carry more influence on therapeutic relationship satisfaction and client security. Findings based on this close study of client-therapist interactions depict a complex, interdependent relationship between the two that is reminiscent of the dynamic interaction between thoughts, feelings, and behaviours comprising the cognitive-behavioural model of human psychology (Beck, 1976). Thus, although it was useful to evaluate these processes separately in each therapeutic relationship and to consider their individual impact on alliance and outcome, it is expected that in reality these processes occur in tandem rather than sequentially.

A clinical implication of the interconnectedness between secure base and safe haven functions is that either may serve as entrance points to the development of a satisfactory alliance and the client's security with his or her therapist. Thus, although a sensitive and responsive therapist should be well prepared to provide both aspects, a client's need or readiness in one area may serve as a natural starting place in

psychotherapy. As the therapeutic relationship progresses, both secure base and safe haven involvement can be expected to be necessary to foster, at least with an insecure client, in order to maintain or improve alliance. Either might wax or wane at any given point depending on a variety of factors such as the client's life circumstances, individual strengths, and agreed focus of therapy, yet their importance would likely balance out over time within an optimal therapeutic relationship.

Seeing as the fulfillment of secure base and safe haven functions have comprised the focus of this investigation, it is important to acknowledge the likely ceiling of the value of these concepts with respect to their impact on negotiating therapeutic relationships. Given that secure base and safe haven are conceived as interpersonal and requiring both therapist and client involvement, meeting a client's secure base and safe haven needs is unlikely to provide a guarantee of client progress. Conversely, faced with a highly motivated, resourceful client, a therapist's secure base and safe haven shortcomings may have a relatively minor impact on the course of psychotherapy. Nor is it suggested that therapists can or should be attuned and ideally responsive to every secure base or safe haven opportunity. Rather, the *general* fulfillment of these functions over time is expected to increase the likelihood of therapeutic success.

In short, the concepts of secure base and safe haven offer aspirations for clinical practise that may assist therapists in providing a "good-enough" therapeutic environment. Just as the assessment of client attachment representations may be helpful in identifying individual client needs and setting realistic therapeutic goals (Slade, 1999), the application of secure base and safe haven concepts in supervision and clinical practice may be beneficial in guiding the therapist's clinical decision-making with respect to the priority of intervention, particularly when both needs are present. For

example, at any given phase of therapy, faced with an imminent time constraint, does the therapist choose to support a client's exploration of a core issue, or is it wiser to respectfully bring closure on the discussion? Is it in the client's best interest to strictly adhere to the session's boundary, or to extend the length so that the client may leave in a tolerable emotional state? What, if anything, might be done today, or in the future, to ensure both needs for structure and safety are met? It is suggested that an understanding of secure base and safe haven notions may facilitate the therapist's choice and timing of techniques to help overcome the influence of client attachment insecurity on therapeutic process and outcome.

Influence of Client and Therapist Attachment Representations

In the present study, relative presence of secure base and safe haven in each therapeutic relationship was inferred based on the observed quality of client-therapist interaction and a variety of client and therapist self-report measures. A broad question that follows from this study is, what part do individual differences in client and therapist attachment representations play in the fulfillment of secure base and safe haven functions within psychotherapy? An assumption that I held stemming from the writings of Bowlby (1979, 1988) as well as from findings in the adult attachment literature (Crowell et. al., 1999) was that a client's attachment representations would colour his or her expectations of and approach to the psychotherapeutic relationship. As such, I expected that knowledge about a client's internal working models of self and other gleaned from intake would help predict an individual's fundamental challenges to forming a therapeutic alliance as well as his or her therapist's potential pitfalls. Thus, although a positive therapeutic rapport was considered possible for each client, I proposed systematic variation across cases in several important interpersonal client characteristics such as

level of expressed emotion, self-disclosure, and dominance. It seemed reasonable to explore whether these characteristics would impact the quality of one's connection with a therapist and correspond to differences in one's amenability to access a therapist as a provider of secure base and safe haven.

For example, I anticipated that a client with a predominantly preoccupied orientation (Angela) would engage very differently with a therapist than would a primarily dismissing client (Frank), particularly with respect to sharing feelings. The pull for safe haven would therefore be expected to be relatively more salient in the former case than in the latter, where avoidance or minimization of distress within sessions was anticipated. Based on the similarity of their attachment profiles, I supposed that Diane and Eric, who were both rated as predominantly fearful and somewhat secure, would initially present as similarly reticent but emotionally vulnerable and compliant. Correspondingly, engagement in safe haven would have been projected to fall in an intermediate range relative to preoccupied and dismissing cases. Hypotheses regarding relative levels of secure base were harder to derive solely from client attachment profiles. However, some resistance to exploration associated with issues of mistrust was anticipated for each insecure person and suggestions for addressing relational challenges were tailored to each individual's attachment histories. Needless to say, although clients' defensive styles surfaced during the course of the protocol in generally predictable ways, results derived from analysis of secure base and safe haven functions did not neatly match the above expectations. This is nonetheless not surprising given that the latter did not take into account the specific therapist involved.

As expected, therapists were key players in the development of rapport as well as in the presence of secure base and safe haven functions. Although there was some

variability in the profiles of the four therapists, it is important to note that the amount of available information on therapist attachment issues was substantially less than for clients, which restricted the depth of analysis with respect to the contribution of therapist attachment. Consistent with previous research that has pointed to clinician insecurity as a moderating variable on intensity of intervention delivered (Dozier et al., 1994), findings from this study provided only limited support for the notion that attachment representations influence therapist attunement and responsiveness. In the first case, Ms. A's reluctance to confront her client as well as her inclination to respond to her client's distress with unwelcome solutions appeared related to her moderate degree of insecurity, which manifest in conflict avoidance and discomfort with negative emotions. Likewise, I suggested in case 4 that Ms. F's predominant insecurity, which would have the potential to influence her perceptiveness and experience in relationship, might help account for her strong personal connection to a relatively disconnected client, Frank, and her associated difficulty in appreciating his withdrawing gestures as well as the impact of his distress. A common feature in these two cases is that the therapist's rather than the client's level of comfort with negative emotions appeared to dictate the delivery of interventions, particularly in response to client distress. This finding is in keeping with Dozier et. al.'s (1994) results that showed a tendency for insecure case managers to respond to their seriously disturbed clients in a complementary rather than a balanced fashion to their clients' interpersonal strategies, which led them to suggest that case manager insecurity "appears to be associated with countertransference reactions in which the clinicians' own issues predominate" (p. 799).

On the other hand, therapist security was not strictly related to better alliance ratings or greater inferred security within therapeutic relationships in this study. It is

indeed important to note the discrepancy between the two predominantly secure therapists in their demonstrated attunement to their clients. Although in the second case Ms. D was found to be appropriately sensitive to her client's needs, in the third case Ms. E's struggles with feeling empathy for her client were plain despite a predominantly secure attachment orientation and a record of other therapeutic successes. Her reactions of disconnection and increased directiveness to her client's avoidant tendencies are understandable when one considers that she interpreted the latter as resulting from disinterest and/or an inherent deficit. As previously noted, research findings suggest that her type of response is common among therapists. As a matter of fact, it has been shown that therapists who perceive compliant, avoidant clients as tacitly hostile tend to respond with overbearing or dominant contributions (Safran, et. al., 1994). Ms. E herself acknowledged that her unpleasant experience in certain interactions with him influenced her case conceptualization and resulted in a fairly dramatic shift in her treatment. Although her focus and style of intervention was suited to her impression of the client as a primarily self-interested individual with limited capacity for feeling emotions and perspective-taking, her approach was associated with limited provision of secure base and safe haven and was not deemed in sync with his predominantly fearful tendencies. Thus, in this case, the therapist's countertransference and case conceptualization appeared to be more salient influences on her degree of attunement to her client than did her generally secure interpersonal orientation. Similarly, although one could reasonably argue that Ms. D's attachment security may have placed her at an advantage with respect to managing her client's interpersonal and emotional challenges flexibly and sensitively (Slade, 1999), her success in fulfilling secure base and safe haven functions could equally plausibly be attributed to her case formulation. Although

Ms. D did not describe the case in explicit attachment terms, she provided an accurate account of her client's key issues of safety, mistrust, and sensitivity to rejection or abandonment, and acknowledged her potential role as a helpful or harmful agent. Moreover, she indicated that these issues were the focus of her supervision.

Thus, in contrasting these two dyads, which were similar with respect to individual attachment orientations yet different on various dimensions of relationship and case outcome, supervision emerged as influential on therapist degree of attunement. In case 2, it appeared helpful both in the therapist's management of negative personal reactions as well as in the identification of the client's attachment issues. While Slade (1999) suggests that a therapist's own security "is likely to be most predictive of a healthy and successful psychotherapy (p. 589)," these data indicate that even secure therapists may need support in manifesting their openness with certain clients. Similarly, it is possible that the efficacy of insecure therapists can be enhanced by educating and mentoring them in appropriately identifying and responding to their clients' attachment needs. Again, supervision that highlights the role of attachment dynamics in certain relationships may help foster in secure and insecure trainees alike the necessary therapist qualities of self-awareness, personal knowing, and compassion (Mahoney, 2000).

The question of whether individual differences in client and therapist attachment representations act as predisposing variables to one's readiness to effectively engage in psychotherapy raises several practical considerations that are worthy of further investigation. For example, is acquiring safe haven a more challenging and sensitive enterprise with avoidant versus approach-oriented clients? Data from this study offer some support for this. Of note is the finding that in two of the three cases in which the

fulfillment of safe haven was determined to be insufficient, the clients withdrew from therapy and were both avoidant. In the case of Frank, whose emotional displays in his sessions with Ms. F were raw and uncontained, it was suggested that more active efforts at labeling and de-escalating his distress may have been useful in increasing his overall comfort with or at least tolerance of the endeavour of self-exploration. On the flip side, an important strength of the therapeutic relationship in case 2 was the successful tailoring of the agenda in such a way so as to not emotionally overwhelm Diane who, like her avoidant counterparts, Eric and Frank, was prone to this.

Other research findings also converge in suggesting that intervening with avoidant individuals in the emotional realm poses special challenges. Studies on dismissing individuals found that during discussions of attachment-related topics, not only did they show discomfort despite efforts at nonchalance, but they also displayed levels of physiological arousal as measured by skin conductance ratings that were comparable to preoccupied and secure individuals (Dozier & Kobak, 1992; Fraley & Shaver, 1997). However, unlike preoccupied individuals, when instructed in an experimental task to suppress their thoughts and feelings, they were able to divert their attention from attachment issues and achieve a reduction in physiological arousal (Fraley & Shaver, 1997). Thus, the process of psychotherapy may be more inherently threatening to predominantly dismissing individuals whose primary coping strategies include minimizing or avoiding feelings of distress and the topics that trigger them (Slade, 1999).

Moreover, in a recent study of severely psychiatrically disturbed individuals and their clinical case managers, Dozier, Lomax, Tyrrell, and Lee (2001) reported that individuals with dismissing attachment spent less time on task during a ten-minute

interpersonal problem-solving interaction with their case managers than did preoccupied individuals and reported more confusion following these interactions. Interestingly, the researchers noted that case managers rather than clients frequently changed the topic during these interactions. Although case managers appeared to be responding to their clients' signs of discomfort, the researchers speculated that diverting attention away from attachment-relevant issues (i.e., going "off-task") may have left individuals feeling vulnerable and contributed to their confusion. Along with the finding of Hardy et. al. (1999) that therapists in their study tended to intervene with dismissing individuals using cognitive versus emotion-based interventions, these results suggests that clinicians tend to steer away from emotional exploration when working with avoidant clients. Slade (1999) describes the equanimity that dismissing individuals in particular display in her clinical practice and notes that sessions in which they disclose feelings of loss, sadness, rejection, and need are frequently followed by periods of denial. She also highlights the tendency for dismissing individuals to provoke in the therapist the same feelings of hopelessness of change and of establishing closeness that they were presumed to have encountered earlier in their development.

Indeed, one might expect that clients with avoidant strategies, especially that of dismissing, would find it more difficult to allow themselves to feel distress and thus initiate safe haven than would clients with approach-oriented attachment representations. Thus, the task of extending comfort and soothing may be wieldier with avoidant than with primarily secure or preoccupied clients who are more likely to expect their emotions to be recognized, discussed, and validated. The therapist who is unwittingly experienced by the client as intrusive or too apt at evoking strong emotion may become a threatening rather than benevolent figure. Conversely, it is plausible that

individuals who frequently initiate safe haven (e.g., individuals chronically in crisis) would pose a different type of therapeutic challenge. Rather than delicately fostering safe haven, the therapeutic task with such individuals might be to promote a decrease in this use of the therapeutic relationship. This too, could prove to be a highly demanding endeavour with respect to therapist patience, energy, and resilience. Is there an empirical basis for expecting differential progression in the expression of safe haven needs across clients of different attachment orientations? Is there a relationship between the progression of safe haven and therapeutic outcome? What would the course of safe haven look like with secure clients? These issues have yet to be addressed.

Similarly, questions can be raised with respect to the secure base component of the therapeutic relationship. For example, is direct collaboration of goal- and task-setting more necessary to facilitate secure base with some clients than others? To be sure, the degree and quality of discussion related to therapeutic tasks and goals varied meaningfully in the four relationships observed here. Or might interpersonal risk-taking in therapy be more difficult to generalize to outside relationships for avoidant versus approach-oriented clients? Benjamin (1996), for example, prescribes that therapists who work with highly avoidant clients provide ample, uncritical support so as to develop trusting alliances. However, she also forewarns about the risk that such therapists run in simply becoming one of the few people to whom their clients can relate, and thus inadvertently stunting their clients' affiliative attempts in other relationships.

Yet another set of questions arises with respect to the interaction of therapist and client attachment. Do dissimilar therapist-client attachment matches increase the likelihood of strong alliance formation and better client satisfaction as has been suggested by the work of Tyrell and colleagues (1999)? As noted earlier, results based

on these four dyads did not suggest a simple relationship between secure therapist-insecure client matches and good alliance. Instead, attunement to client attachment rather than therapist security per se was introduced as a potential moderator of therapist ability to fulfill attachment-related functions. Still, it would be worthwhile to investigate whether the trend that Tyrell et. al.'s uncovered in severe psychiatric patients and their case managers would be replicated in a larger sample of adult outpatients with interpersonal problems, as well as whether it would be upheld if the functions of safe haven and secure base were explicitly considered. Might certain therapist-client attachment combinations pose threats to the psychotherapy process that deserve special attention in supervision? Based on his study of therapist-trainees and university students who volunteered to discuss a personal issue in a therapy session, Mohr (2001) reported that therapist dismissing attachment was associated with hostile countertransference as judged by observing supervisors, and that this effect was strongest in sessions with preoccupied clients. Individual variation with respect to therapist pitfalls or pet peeves is to be expected. For example, as alluded to above, therapists likely will differ with respect to which type of safe haven extreme (i.e., reluctance to show vulnerability and accept therapist support versus explicit emotional fragility that summons active therapist care-taking) feels more comfortable and/or is more effectively managed. This individual variation may well be systematically related to therapist attachment histories.

In sum, results based on this series of theoretically driven case studies point to several clinically relevant issues that merit examination using larger scaled and more controlled paradigms that permit hypothesis-testing.

Therapist as Attachment Figure

A final question that merits discussion is whether the therapist can in actuality serve as an attachment figure for his or her client (Bartholomew & Thompson, 1995). The findings of Hazan and Zeifman (1994) on attachment formation and transfer in normative samples of youth and adults are pertinent to this question. Based on self-report data, they traced a trajectory of attachment transfer from parents to peers that begins with proximity seeking, followed by safe haven, then separation protest, and finally secure base. Moreover, "full-blown" attachments (that is, consisting of all four components) were almost exclusively limited to parents or romantic partners and were far more frequent in relationships of minimum two years duration. Therapists did appear as attachment figures but only rarely, and so were excluded from analyses along with other atypical responses, thus precluding the generalizability of results to therapeutic relationships. Nonetheless, these results highlight duration and strength of bond as necessary ingredients to attachment relationships. It is therefore reasonable to postulate that therapists are more likely to become attachment figures for clients in long-term rather than in short-term therapy.

However, there are several aspects of psychotherapy that may help forge a sufficiently deep and strong bond between clients and therapists within a shorter time than the two-year period that is typical for peer or romantic relationships. These include early establishment of a relational contract that usually outlines predictable, regular contact between therapist and client as well as respective roles and responsibilities, active encouragement of client self-disclosure (specifically with respect to one's difficulties) and emotional experience, and emphasis on the therapist's provision a supportive, receptive, and trusting environment that will facilitate the client's

improvement. Certainly, an ideal characteristic of the therapeutic relationship is that the therapist works in the service of the client's needs with no expectations for the reverse. The non-reciprocity of the therapeutic relationship in favour of the client may heighten the power of therapist as attachment figure.

Yet whether a therapist becomes an attachment figure for his or her client, and whether he or she helps fulfill attachment functions of secure base and safe haven are two separate questions, only the latter of which was encompassed in this investigation. In line with Bowlby (1988) who stated that establishing a secure base for the client's exploration is the therapist's first and foremost task (long before one can aspire to become an attachment figure), the current analysis led me to propose that working toward creating a secure base and safe haven can be seen as separate dimensions of a therapist's role that impact alliance and outcome even in short-term therapy. The notion of therapist as provider of secure base and safe haven functions is also supported by the findings of Knox and colleagues, who conducted a qualitative study of the internal representations that adults who had been in individual therapy for a minimum of six months (or 15 sessions) held of their therapists. Interestingly, they found an increased use by clients of therapist internal representations over the course of therapy that was generally not knowingly evoked by therapists (Knox, Goldberg, Woodhouse, & Hill, 1999). Even more pertinent to this study, however, the majority of clients reported deliberately employing internal representations of therapists to facilitate introspection and enhance the influence of their therapy work in between sessions (i.e., secure base). Also, a notable proportion of clients reported using therapist representations as sources of soothing, comfort and support outside of sessions (i.e., safe haven).

Thus, although it seems feasible that a therapist may become an attachment figure for a client given sufficient time and under certain conditions, this in and of itself is not identified as a central therapeutic objective. Rather, a valuable goal, at least when working with an insecure client, is to forge a relationship that affords two functions of secure base and safe haven that may be essential to client change.

Limitations

In addition to the caveats raised so far regarding the limits of the data, several methodological issues bear discussion. Of inevitable concern in research that includes qualitative analysis is the issue of interpretive bias. Although interpretations were guided by a well defined theoretical framework, it is important to acknowledge that findings reflect my own understanding of attachment theory and the cases. Efforts to remain objective and authentic to the therapeutic relationships included: following a systematic protocol of observation; developing descriptive guidelines of secure base and safe haven in consultation with peers and a supervisor; observing dyads outside the study protocol; incorporating multiple sources of data as well as several perspectives, including those of client and therapist reports; and obtaining regular feedback on interpretations from a supervisor who was very familiar with each therapy case. In addition, I monitored and voiced my personal expectations as well as countertransference reactions in supervision and made concerted attempts to distinguish statements, observations, and clinical impressions. Although the goal of these steps was to stay close to the data and render interpretations fairly transparent and open to challenge, judgments involved an essentially subjective weighting process that is prone to idiosyncrasy and bias (Haverkamp, 1994).

Researcher bias could be more rigorously addressed by adapting a formal, team-based approach to interpretation such as that used in the Consensual Qualitative Research (CQR; Hill et. al., 1997) method. As the name implies, the CQR, devised to analyze interview data, involves the arrival at consensus between three to five team members about the meaning, significance, and categorization of responses. Thus, although at least some initial disagreement is the norm, members come to agree on a final interpretation that is satisfactory to all through discussion of their individual viewpoints. A critical feature of this methodology is that members comprising the primary coding team are of equal status (e.g., all graduate students). In addition, one or two auditors, usually the primary investigators, work with the team to verify that consensus judgments do not overlook important data. Prior to coding, all members including auditors respond to interview questions as they would expect participants to and they record their biases pertaining to the research question. Although such resources were not available, the use of supervision in the current study to verify interpretations was modeled after this consensual approach. In future research, a parallel format to the CQR for analyzing client-therapist interactions could be achieved by recruiting graduate students with similar training in psychotherapy and Bartholomew's model of attachment to observe the research protocol and serve as primary judges of secure base and safe haven determinations. This would facilitate consistency of interpretations and help further attenuate the impact of attributional, evaluative, and confirmatory biases that can confound judgment (Haverkamp, 1994).

In addition, the generalizability of data is limited by several characteristics of the sample, the most obvious being its small size. This is, however, an inherent feature of the case study approach to scientific inquiry, which is recognized as a valuable

complement to experimental or quasi-experimental research in its power to uncover clinically meaningful patterns of data, generate hypotheses, and explore innovative ideas related to treatment (Kazdin, 1992). Within this paradigm, it is the systematic accumulation of a number of cases that is the ultimate goal, rather than a large sample size per se. Issues with respect to case selection thus become critical in evaluating the ecological and heuristic value of case study data. An important constraint of this study pertains to the sample from which participants were selected. As noted earlier, no secure clients completed the study protocol, thus necessarily confining the investigation of secure base and safe haven functions to clients with predominantly insecure attachment orientations. In addition, therapists were all in training and held a narrow range of experience. Kivlighan, Patton, & Foote (1998) found that the relationship between counselor experience and client endorsement of working alliance was moderated by client attachment. That is, whereas no relationship between counselor experience and alliance was found when clients were comfortable with intimacy, there was a significant positive relationship between counselor experience and alliance when clients were uncomfortable with intimacy, even after controlling for age. Given that the influence of client security and therapist experience on the fulfillment of secure base and safe haven functions was not addressed, future investigations of these attachment-related themes and their role in the formation of alliance and client felt security would benefit from the inclusion of secure clients and more extensively experienced clinicians.

In addition, although an effort was made to manage the complexity of the question under investigation by reducing the impact of potentially confounding variables such as ethnicity and psychosocial functioning, several variables related to participant self-selection could not be controlled. This rendered the ruling out of alternative

hypotheses less tenable and limited the strength of inferences. For example, variability in the quality of participant recollections at debriefing was noted across clients and therapists. In other words, it appeared difficult for some participants to generate specific events that had been experienced as helpful or harmful to their alliance. Although this may be associated to attachment style, it is also possible that the inadvertent variation in duration and/or phase of therapeutic relationships at time of debriefing influenced participant recall. For example, criticisms might have been more salient in cases of premature termination, in part to justify one's decision to end therapy. Alternatively, participants mid-stream into their therapy may be inclined to downplay negative reactions to certain events given an investment to continue their work with a particular client or therapist. Although good rapport helped detect such reporting biases in the exit interviews, the quality of interview data gathered may have been more consistent had all four cases completed an equal number of therapy sessions. Alternatively, it may have been helpful to employ a structured recall methodology immediately following designated therapy sessions that would enhance the reliability and specificity of participant reports. There was also uncontrolled variability corresponding to self-selection with respect to therapist attachment. Had it been possible to study one therapist's interactions with four clients (each representing an attachment prototype), for example, it would have further facilitated investigation of the interaction of therapist and client attachment. The restriction in range of possible phenomena observed associated with such a design would be balanced by the corresponding increase in strength of inferences drawn.

Closing Remarks

Despite the limitations noted above, this series of intensive case studies provided a vivid illustration of some of the ways in which attachment issues (particularly of the

client, but also the therapist) surface in psychotherapy and influence the negotiation of therapeutic relationships. As expected, clients with disparate predominant attachment styles differed in their approach to the relationship more so than did the two clients with similar profiles. Not surprisingly, therapists appeared as a strong influence on the manifestation of client attachment representations and the development of alliance. Therapist insecurity corresponded to shortcomings in the therapeutic approach in two of the four cases. Therapist security, on the other hand, was not neatly associated with stronger alliance or greater attunement to client core interpersonal and emotional challenges. Thus, the quality of alliance formed between two secure therapists and two fearful clients was distinctly different, as was the degree of security attributed to these two respective relationships based on evaluations of secure base and safe haven functions. The concepts of secure base and safe haven proved useful in interpreting the unfolding of events within these therapy cases and merit further empirical investigation. This work therefore adds to the growing literature that supports the clinical utility of Bowlby's attachment framework in the assessment and intervention of adults, particularly with those suffering from interpersonal difficulties. The addition of education on the evolution of attachment processes across the lifespan and their role in psychotherapy to the core curricula of graduate programs in clinical psychology is proposed be valuable in supporting the development of compassionate and effective therapists.

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Appendix A:

Expectations and Wishes for Therapy Questionnaire

Part 1.

Please describe below, in as much detail as possible, what is according to you a good client-therapist relationship (i.e., the working relationship that exists between client and therapist).

Part 2.

What characteristics would your ideal therapist have (i.e., what type of person would you like them to be)?

Appendix B:

Quality of Relationship Inventory Adapted for Therapeutic Relationships

Today's date: ____/____/____ I.D.: _____

Your answers are confidential and will not be shared with your therapist.

Directions: Please answer the following questions regarding your relationship with your ***therapist*** by mentally inserting his or her name in place of _____ in the text.

	Not at All	A little	Quite a bit	Very Much
1. To what extent could you turn to _____ for advice about personal problems?	1	2	3	4
2. How often do you need to work hard to avoid conflict with _____?	1	2	3	4
3. To what extent could you count on _____ for help with a personal concern that you wouldn't normally share with other people?	1	2	3	4
4. How upset does _____ sometimes make you feel?	1	2	3	4
5. To what extent can you count on _____ to give you honest feedback, even if you might not want to hear it?	1	2	3	4
6. How much does _____ make you feel guilty?	1	2	3	4
7. How much do you have to "give in" in this relationship?	1	2	3	4
8. To what extent can you count on _____ to support you if a family member very close to you died?	1	2	3	4
9. How much does _____ want you to change?	1	2	3	4
10. How positive a role does _____ play in your life?	1	2	3	4

	Not at All	A little	Quite a bit	Very Much
11. How significant is this relationship in your life?	1	2	3	4
12. Looking back on your therapy experience five years from now, how important will this relationship seem to you?	1	2	3	4
13. How much would you miss _____ if the two of you could not see or talk with each other for a month?	1	2	3	4
14. How critical of you is _____?	1	2	3	4
15. How responsible do you feel for _____'s well-being?	1	2	3	4
16. How much do you depend on _____?	1	2	3	4
17. To what extent can you count on _____ to listen to you when you are very angry at someone else?	1	2	3	4
18. How much would you like _____ to change?	1	2	3	4
19. How angry does _____ make you feel?	1	2	3	4
20. How much do you argue with _____?	1	2	3	4
21. To what extent can you really count on _____ to help you sort out your worries when you feel under stress?	1	2	3	4
22. How often does _____ make you feel angry?	1	2	3	4
23. How often does _____ try to control or influence your life?	1	2	3	4
24. How much more do you give than you get from this relationship?	1	2	3	4
25. To what extent can you trust _____ not to hurt your feelings?	1	2	3	4
26. How often do problems that occur in this relationship get resolved?	1	2	3	4
27. How considerate is _____ of your needs?	1	2	3	4

	Not at All	A little	Quite a bit	Very Much
28. How comfortable would you feel crying in front of _____?	1	2	3	4
29. To what extent do you think about _____ in between visits?	1	2	3	4
30. To what extent do you feel comfortable sharing your most private thoughts and feelings with _____?	1	2	3	4

Appendix C:

Exit Interview with Clients

I want to remind you that I am audiotaping this interview, but that all information will be coded to maintain confidentiality.

1. What was the main problem that you worked on in therapy with ____?
   How did that change over the course of therapy?

2. How would you describe the type of relationship that you formed with _____?
   Tell me how that changed over time.
   probe: How well did you work together?
   probe: What sort of an agreement did you have about where you were going and what you were doing?

3. Please describe ____ for me. What characteristics does (s)he have as a therapist?
   a) What is it about ____ that makes it EASY him/her to work with (people like) you?
   b) Tell me about a time when you felt understood by ___. What happened? How did he/she show you they understood? How is this different from what you've experienced with other people?
   c) What is it about ____ that makes it HARD him/her to work with (people like) you?
      probe: What didn't you like about how ____ was with you?
      probe: How would you have liked them to be different?
   d) Tell me about a time when you felt betrayed/let down/misunderstood by ___. What happened? What did they do? What did you do? Do you think they are/were aware of that?

4. a) At the beginning of therapy, what did you feel about ____ personally? How do you think he/she felt about you?
   b) What about by the end?

5. a) It's quite common for people's feelings and opinions about their therapists to change from time to time. What were some *specific* things (events) that happened in your therapy that made your connection with ____ feel stronger in some sessions?
      probe: What sorts of things did ____ do or say that really helped? What are some examples?

b) What were some specific things that happened in your therapy (events) that made your connection weaker? i.e., so that maybe you felt out of sync, or dissatisfied, confused, etc.

probe: What mistakes, if any, did ____ make?

6. What were some of the things that you COULDN'T tell your therapist about? What held you back?

7. What was the outcome of your therapy with ____? (OR, if not terminated) What was the outcome of these last 16 sessions? Where do you stand?

probe: How did it end?

probe: How do you think that you've changed?

8. (Optional) Looking back on your therapy experience, what kind of a therapist do you think you needed at the BEGINNING?

a) What kind of a therapist would you need NOW? (i.e., have there been any changes over time?

b) If you went back to therapy, what would you like to work on?

9. What would you like to add about your therapy experience that maybe we haven't talked about?

10. How was it for you to participate in this study? Do you have any questions for me before you go?

Appendix D:

Exit Interview with Therapists

I want to remind you that I am audiotaping this interview, but that all information will be coded to maintain confidentiality.

1. What was the main problem that you worked on in therapy with ____? How did that change over the course of therapy?

2. a) What was your initial impression of ____?

   probe: How did he/she present?

   probe: What was your reaction?

   b) (If only cognitive) What sorts of feelings did you have towards ____?

   probe: How did you feel about ___ personally (i.e., as a person that you might get to know or deal with OUTSIDE of therapy)?

   probe: How do you think ___ felt about you personally?

3. How would you describe the type of relationship that you formed with _____? Tell me how that changed over time.

   probe: How well did you work together?

   probe: What sort of an agreement did you have about where you were going and what you were doing?

   probe: How present/involved did you feel yourself being? How might this compare to some of the other clients you've worked with?

   probe: How present/involved was ___? Again, how might this compare to some of the other clients you've worked with?

4. I'm going to now ask you about client and therapist characteristics.

   a) What is it about ____ that makes it EASY for him/her to work with (people like) you?

   b) Now the reverse: What is it about YOU (or people like you) that makes it EASY for him/her to work with ___?

   c) What is it about ____ that makes it HARD for him/her to work with (people like) you?

   d) Now the reverse: What is it about (people like) YOU that makes it HARD for him/her to work with ___?

5. Tell me about some specific things (events) that happened in your therapy that made your connection with ___ feel STRONGER in some sessions?

   probe: Tell me about your role, and your client's role in this.

   probe: What sorts of things did you do, and that ___ did, that really helped?

6. What were some specific things (events) that happened in your therapy that made your connection weaker? i.e., so that maybe you felt out of sync, or dissatisfied, confused, etc.

   probe: Again, tell me about your role, and your client's role in this.

   probe: What sorts of things did you do, and that ___ did, that led to this (got in the way of your connection)?

   probe: What mistakes, if any, do you feel you('ve) made?

7. What was the outcome of your therapy with ____? (OR, if not terminated) What was the outcome of these last 16 sessions? Where do you stand?

   probe: How did it end?

   probe: How do you think that you've changed?

8. a) Looking back at this therapy experience, what, if anything, would you do differently? (OR, if not terminated) Looking toward the next little while, what, if anything, will you do differently?

   b) What do you think this client needs to work on next?

9. What would you like to add about your experience with ___ that maybe we haven't talked about?

10. Finally, how was it for you to participate in this study? Do you have any questions for me before you go?