

Clients' and Therapists' Attachment Styles: Do They Influence the Alliance?

By

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**Abstract**

This capstone answers two questions related to attachment styles and the working alliance: does the client's attachment style matter and does the therapist's attachment style matter? While the research is mixed regarding the ways that attachment styles interact within the alliance, the consensus is that secure attachment styles enable the strongest alliances. Clients and therapists with insecure attachment styles can nevertheless develop secure, relationship-specific attachments. Therapists with insecure attachment styles can learn to meet clients' needs for safety and security through the core caregiving behavioural system functions of attunement, responsiveness, and emotional regulation.

*Keywords:* client attachment style, therapist attachment style, alliance

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### **Dedication**

I dedicate this paper and all of my accomplishments to my dad who went to be with Jesus in March 2022. Dad, your life was full of hardship and suffering, but you lived it with dignity. You lived an inspiring life of humility, principles, hard work, service, sacrifice, and peace. May I live up to your legacy. I look forward to seeing you again in the next life where I know you have already been set free from the pain and restrictions of Parkinsons.

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## **Clients' and Therapists' Attachment Styles: Do They Influence the Alliance?**

### **Chapter One: Introduction**

#### **Overview**

The therapeutic alliance is a critical feature of psychotherapy. My City University professors informed us that approximately 30% of treatment outcome is attributable to the alliance (Cyrus-Blaise, personal communication, 2023). They also uniformly identified Roger's (1957) core conditions of congruence, empathy, and unconditional positive regard as necessary for the development of a strong, therapeutic client-therapist bond, which is at the heart of the alliance (Bordin, 1979). In a recent meta-analysis, Flückiger et al. (2020) reported that their findings provide, "empirical support for the robustness of the alliance–outcome correlation indicating that the alliance is a reliable process-based factor of therapy success independent of patients' characteristics and initial levels of distress, as well as therapists' adherence and competence ratings" (p. 710). An alliance is a specific helping relationship between two individuals who are essential to the healing dynamic and cannot be replaced without disrupting the relationship (Obegi, 2008). Bowlby (1988) recommended that the therapeutic alliance be understood as an attachment relationship with the therapist as the stronger and wiser attachment figure who acts as a secure base and safe haven for the client. The implication is that the person of the therapist is stronger and wiser, or at least more secure in their attachment style (Obegi, 2008). Being a therapist is a serious responsibility, sometimes with life and death consequences. Taking all of this into account, it is my duty as a counselling therapist/psychologist in training to investigate the influence and implications of attachment on the alliance.

#### **Reflectivity and Positionality**

Attachment theory is deeply meaningful to me. It is at the forefront of my mind as I engage with the world. I recognize the powerful effects of attachment in my life and in the lives of strangers, friends, family members, supervisors, and clients.

When I was around a year and a half, I was hospitalized for six weeks while my femoral heads were pulled apart from my acetabula in preparation for bilateral hip surgery. In the early 1970s, parents were only permitted to visit their children during visiting hours. My mom had to care for a four-year-old, an eight-year-old, a nine-year-old, a husband, and a house, so she would not have been able to stay even if it were permitted. According to the nurses who tended to me, I was a cheerful and pleasant toddler who passed the time twirling my hair between my fingers – a habitual behaviour I still perform today. While combing the Internet in my twenties, I read about James Robertson’s (1952) film *A Two-Year-Old Goes to Hospital* and I recognized myself in the story. So many things about myself and my relationships with my parents came into focus. This was the beginning of my fascination with attachment theory.

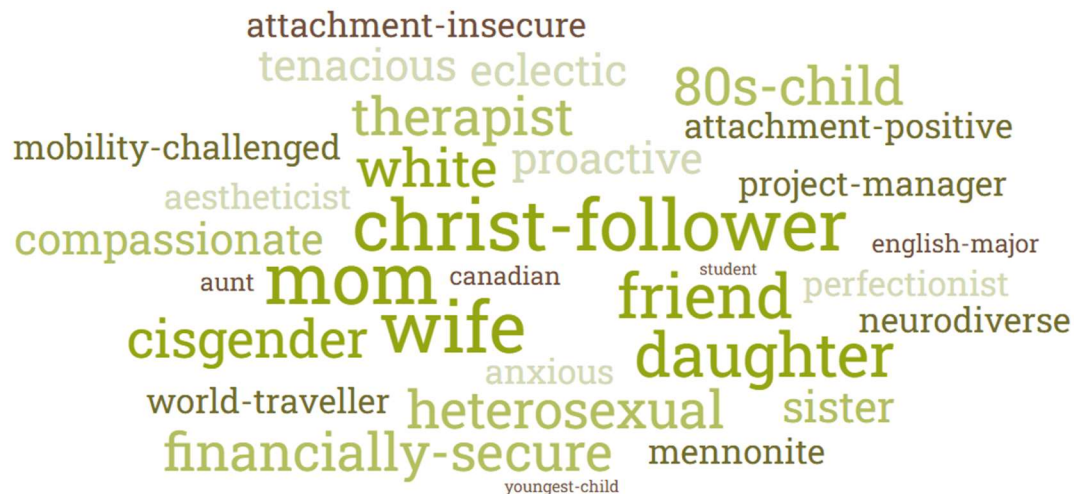
Much later, after my husband and I adopted two toddler boys, I worried about my ability to create the right conditions for my sons to develop secure attachments. I continued to learn. When I began taking undergraduate psychology courses, I read about Ainsworth’s strange situation and about adult attachment styles. While completing my coursework for my Master of Counselling with City University in Canada, nearly every class touched on the significance of attachment to psychological wellbeing, which reinforced my beliefs.

Figure one is a word cloud depicting my most salient identities at this time in my life. The largest words (i.e., Christ-follower, mom, wife, friend, and daughter) represent the identities that I associate myself with daily. As a Christ-follower, I believe in the innate, irrevocable worth of every human being as a person created in the image of God with a body, mind, and spirit. I believe that secure attachment is the pattern for the relationship that God wants to have with each of us. I believe that my purpose in life is to know, love, and serve God and that God has called me to serve Him as a therapist. I also believe that God works through me as a therapist to bring help, healing, and hope to my clients. My next most important roles are mom and attachment figure for my two sons and wife to my Filipino Canadian

husband. Identities such as White, financially secure, heterosexual, cisgender, Canadian, world-traveller, and English-major typify my significant privilege in the world. My identities of disadvantage include being Mennonite, mobility-challenged, neurodiverse, and anxious. My age, signified by my identity as an 80s-child, brings privilege in some settings and disadvantage in others. The fact that I am attachment-positive means that I am predisposed to filter information through the lens of attachment theory. My identity as a therapist is also particularly important to me, although it is not yet fully realized. As a therapist with an insecure attachment style who strongly believes in the influence of attachment style, I have an obvious bias toward this research and a substantial personal investment in the results.

**Figure 1**

***Identities Word Cloud***



**Purpose**

The purpose of this review is to understand (a) whether my clients' attachment styles will influence their therapeutic relationships with me. I expect to find a straightforward yes or no answer to this question, and my hypothesis is that, yes, the clients' attachment styles will influence their therapeutic alliances. Perhaps of greater significance to me as an up-and-coming therapist is (b) whether my personal attachment style, and that of other novice therapists such as myself, will influence our therapeutic relationships with our clients. I am hopeful that the answer is no, therapists' attachment

styles are superseded by their knowledge and skills and by embodying the core conditions of congruence, empathy, and unconditional positive regard (Rogers, 1957; Cyrus-Blaize, personal communication, 2023).

### **Theoretical Framework**

When deciding on a theoretical framework for this project, I asked myself how I wanted to approach the acquisition, review, analysis, and synthesis of literature. I also consulted the textbook entitled *Research Design* (Creswell & Creswell, 2022) that was used in my Research Methods and Statistics class. Creswell and Creswell (2022) advised that a well thought out research framework includes a worldview, a design, and a method. I have selected the pragmatic worldview, which has allowed me to use a mixed methods design, and a systematic review method (Creswell & Creswell, 2022; Snyder, 2019). My worldview, design, and method are described in more detail in the following sections.

#### ***Worldview***

Throughout this project, I kept in mind the necessity of contributing something to the field of counselling psychology. The pragmatic worldview paired well with this mandate in that the pragmatic worldview in research is solution-oriented, practical, flexible, adaptable, and action-oriented (Creswell & Creswell, 2022). In addition to seeking answers to my research questions, I have continually looked for opportunities to enhance current practices.

#### ***Design***

I employed a mixed methods systematic design in the process of this literature review (Snyder, 2019). As an outgrowth of the pragmatic worldview, I accepted qualitative, quantitative, and mixed methods research consisting of short-term studies, longitudinal studies, literature reviews, meta-analyses, case studies, theory-validating studies, and measurement-validating studies.

**Methodology**

My methodology was that of a systematic literature review (Snyder, 2019). I attempted to locate and review all recent and seminal research related to attachment and the therapeutic alliance.

**Questions.** The questions I have answered through this systematic literature review are:

1. Will my clients' attachment styles influence their therapeutic relationships with me?
2. Will my personal attachment style, and that of other novice therapists such as myself, influence our therapeutic relationships with our clients?

**Data Collection.** I searched both Google Scholar and the City University library for journal articles, books, book chapters, and dissertations, hereafter referred to as the literature. As a final measure, I searched the PSYCINFO database to ensure that my results were complete. To capture as much research evidence as possible, I favoured literature that had already summarized other literature, such as literature reviews and meta-analyses.

I used the search terms "attachment" AND ("working alliance" OR "therapeutic alliance" OR "alliance" OR "therapeutic relationship") with results sorted first by relevance and then by date. I selected literature that examined the following: the therapist attachment style and the alliance; the client attachment style and the alliance; and both the client and the therapist attachment style and the alliance. I excluded literature related to special populations such as adolescents, families, or groups, unless the literature was already included within a systematic review or a meta-analysis.

Most of the relevant research was available as a PDF file from Google Scholar or in a full text or PDF format through the City University. When the title suggested that the literature would be highly relevant to my research questions, I read the abstract. If the abstract also indicated that the literature was pertinent, I retrieved the literature for further review. I also retrieved and examined potentially interesting literature that was referenced within the literature I had already found. This was the most

fruitful source of seminal literature. If the literature was not directly accessible through Google Scholar or the City University's extensive library, I submitted a retrieval request to the City University library.

**Data Analysis.** As I read, I looked for the following themes related to the alliance: (a) client secure attachment; (b) client insecure attachment; (c) therapist secure attachment; (d) therapist insecure attachment; (e) and both client and therapist insecure attachment. I became familiar with the work of the leading researchers in the field such as Batholomew, Egozi, Fraley, Horvath, Mallinckrodt, Tishby, and Wiseman. I then searched for related literature written by these scholars. I located and reviewed approximately 120 sources. Although many were not ultimately referenced in this capstone dissertation, they nevertheless expanded and enhanced my knowledge and understanding. I printed the literature and added highlights and notes as I read. I then sorted the documents according to theme, summarized and synthesized their findings, and drew my conclusions. As I worked, I evaluated the relevance of each document to my capstone questions. I also kept in mind the need to contribute to the field.

**Review Process.** I completed chapter two first and sent it to my faculty advisor for review and feedback. I then sent to her chapter one and chapter two with her feedback incorporated. Next, I sent my faculty advisor the completed draft of my capstone. After she gave her approval, she forwarded my final document to the faculty second reader for review. I then incorporated feedback from the faculty second reader and from a human American Psychological Association (APA 7th edition) editor. Finally, I prepared slides and a presentation for the dissemination of my capstone project.

### **Contribution to the Field**

The City University's Master of Counselling program was conscientiously designed to satisfy the College of Alberta Psychologists' academic requirements for registration as a psychologist in the province of Alberta (H. Macdonald, personal communication, October 2022). The program covered all necessary elements, including classes in counselling skills, therapeutic modalities, ethics, psychological

theories, human development across the lifespan, psychopathology, etc. In every class, attachment theory was taught, and self-awareness was emphasized, and yet I was never prompted to consider how my own attachment style might affect my ability to form therapeutically beneficial relationships with my clients. It is my hope that because of my research both practicing and student therapists and psychologists will know what steps to take to know their own attachment style, and to use it effectively within their therapeutic alliances.

### **Definition of Terms**

#### ***Attachment***

An attachment is a specific, unidirectional bond between a person and an attachment figure whom the person perceives as stronger and wiser (Ainsworth, 1969). The attachment figure is usually the person's primary caregiver. An attachment to one's primary caregiver is enduring, although not always evident (Ainsworth, 1979). Instead, attachment behaviour emerges in response to novel and/or frightening environmental stimuli (Ainsworth, 1979). Attachment behaviour is directed toward the attachment figure and is intended to elicit an appropriate response of either a safe haven or a secure base from the attachment figure (Ainsworth, 1979). Once a person has received the needed comfort and/or support, attachment behaviours cease (Ainsworth, 1979).

#### ***Attachment Style***

Attachment style is a relatively stable individual characteristic that describes the type of attachments an individual typically forms with others (Egozi et al., 2023). Ainsworth et al. (1978) initially identified three types of attachments from her studies of infants and toddlers using the strange situation: secure, anxious, and dismissing. The latter two types of attachment are characterized as insecure. A third type of insecure attachment, disorganized, added following additional studies (Main et al., 1986). A person generally develops a secure attachment to their primary caregiver if the caregiver is generally responsive and comforting in times of distress and generally supportive and encouraging in

times of exploration (Ainsworth et al., 1978). An anxious attachment style develops if the primary caregiver either does not respond consistently or responds with increasing emotional activity, including anxiety, rather than soothing (Ainsworth et al., 1978). A dismissing attachment style develops if the primary caregiver typically either fails to respond to or actively deflects the person's bids for comfort and contact (Ainsworth et al., 1978). The disorganized or unresolved attachment style develops when the primary caregiver's responses are inconsistent and unpredictable; sometimes comforting, sometimes dismissing, and sometimes absent (Main et al., 1986).

### ***Alliance***

The alliance, also often called the working alliance, the therapeutic alliance, the therapeutic relationship, or the helping relationship, is a term originally used in psychoanalysis (Bordin, 1979). Bordin (1979) proposed that the alliance is a common factor in all individual psychological therapy and consists of three elements: the client and therapist bond, the client and therapist agreement on goals, and the client and therapist agreement on the tasks they will undertake to accomplish the goals. Although different therapeutic modalities place varying degrees of emphasis on defining goals and tasks, all individual therapy takes place within the context of the bond between client and therapist (Obegi, 2008).

### ***Therapeutic Distance***

Daly and Mallinckrodt (2009) defined *therapeutic distance* as "the level of transparency and disclosure in the psychotherapy relationship from both client and therapist, together with the immediacy, intimacy, and emotional intensity of a session" (p. 559).

### **Outline of Remaining Chapters**

In chapter two, I introduce the key tenets of attachment theory and the dominant definition of the therapeutic alliance within psychotherapy. Next, I synthesize and explain the results of the research on the influence of client and therapist attachment styles on the therapeutic alliance. Finally, I

synthesize and explain the research findings regarding the influence of the interaction of client and therapist attachment styles on the therapeutic alliance.

Chapter three revisits the purpose of the capstone and presents a discussion of the strengths and weaknesses of current knowledge on attachment styles and the alliance. Next, I share my thoughts on the alliance as an attachment relationship and introduce essential secure attachment caregiving behaviours that therapists can use to facilitate a more secure alliance. Then, I propose updates to the City University's Master of Counselling curriculum based on recommendations found in the literature. I also discuss ethical and cultural considerations in the context of the capstone questions and research. I conclude chapter three with a reflection on what I have learned over the course of completing this capstone project.

## **Chapter Two: Literature Review**

The focus of this chapter is on existing research and commentary on the influence of attachment within the alliance. I will begin with an overview of attachment theory and of the alliance. Next, I will highlight and synthesize the current collective understanding of how the client's attachment style comes to play within the alliance. I will then consider what is known to date about the role of the therapist's attachment style within the alliance. Not surprisingly, certain combinations of client and therapist attachment styles are also salient.

### **Attachment Theory**

#### ***Significance***

Attachment theory was first developed by John Bowlby and Mary Ainsworth and is widely accepted as one of the most influential theories in psychology (Fraley & Shaver, 2010; Shorey & Snyder, 2006; Strauss et al., 2022). According to a Google Scholar search run on November 4, 2024, over 377,000 scholarly books, chapters, and articles had been written about or included reference to "attachment theory" since its introduction in the 1950s. That amounts to an average of over 4,000 publications per year. Attachment theory has been researched and applied across the humanities and medicine. It informs our understanding of development across the lifespan, childcare, parenting best practices, personality, relationships, grief, psychopathology, and psychotherapy, to name a few (Bowlby, 1977; Bowlby, 1988; Peter & Böbel, 2020; Shorey & Snyder, 2006; Zilcha-Mano et al., 2021).

#### ***Selected History***

Attachment theory came about as the result of observation, curiosity, critical thinking, field studies, and synthesis (Ainsworth & Bowlby, 1991). John Bowlby was familiar with and incorporated ideas from Charles Darwin and from Konrad Lorenz (1935), who is best known for his experiments on the instinctual bonding of newly hatched precocial birds to the first larger animated object they see during their sensitivity period (Bowlby, 1977; Bowlby, 1982). Ainsworth based her graduate dissertation

on William E. Blatz's security theory and brought the concept of a secure base to the development of attachment theory (Ainsworth & Bowlby, 1991). Bowlby also exchanged insights, hypotheses, and experimentally derived discoveries with Harry Harlow (van der Horst et al., 2008). Harlow (1958) had noticed that solitary baby rhesus monkeys would cling to the soft sanitary cloths that lay on the floor of their cages. He became curious about this behaviour and experimented with offering the babies the choice of a wire milk-providing pseudo-mother or a soft but milk-less pseudo-mother (Harlow, 1958). Both object-relations theory and behaviourism, which were prevailing theories at the time (Ainsworth, 1969), asserted that babies bond to their mothers based solely on the survival value of milk (Harlow, 1958). The baby rhesus monkeys were therefore expected to prefer the wire mothers; however, the babies held tightly to the cloth mothers for up to twenty-two hours per day (Harlow, 1958). When frightened, the infants would run to their cloth mothers for contact comfort (Harlow, 1958). When introduced to novel stimuli in the presence of the cloth mothers, the infants were able to explore with confidence (Harlow, 1958). Bowlby's work was considerably shaped and energized by Harlow's findings (Bowlby, 1977; van der Horst et al., 2008).

### ***Behavioural Systems***

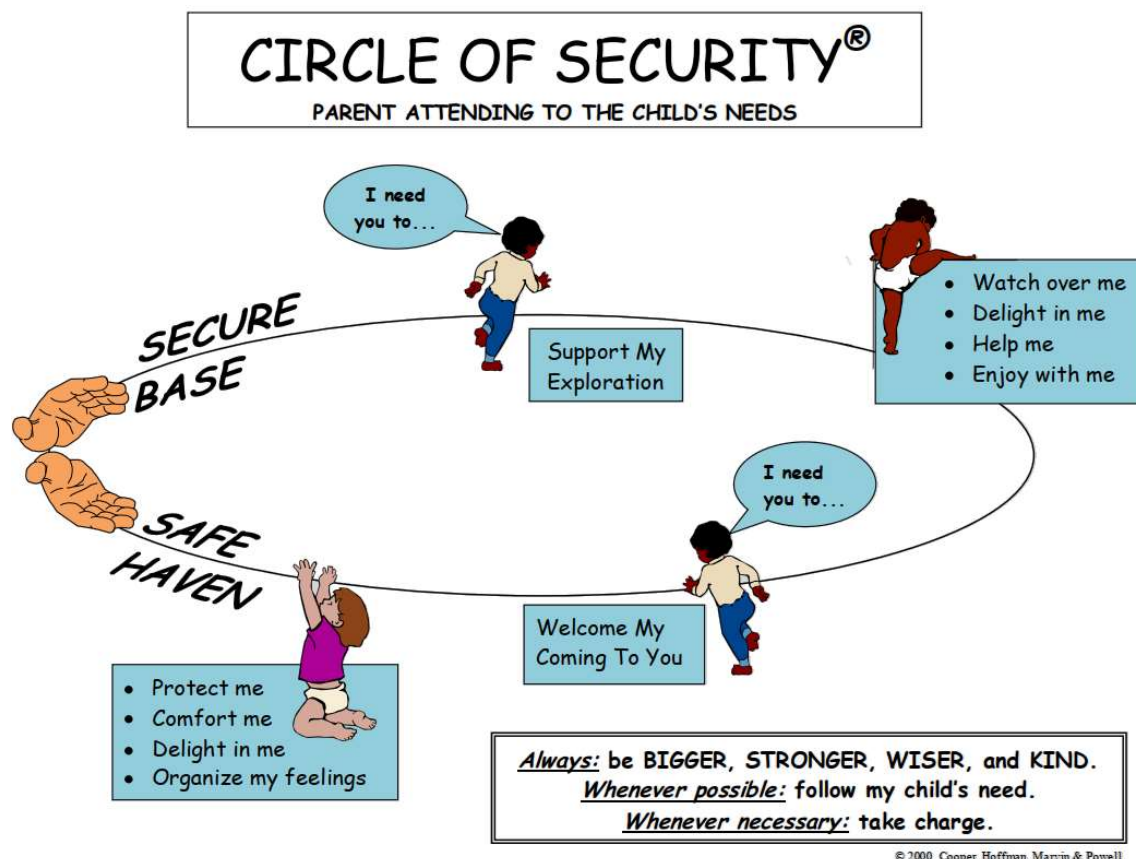
As Harlow (1958) saw with the baby monkeys and Bowlby (1977) experienced with his patients, attachment theory explains that connection is at the core of our beings, baked right into our DNA (Ainsworth & Bowlby, 1991). According to attachment theory, we are born with the instinct to seek close proximity to one or more primary caregivers who will meet our basic needs, not only for food, water, warmth, and cleanliness, but also for physical and emotional safety (Bowlby, 1977; Bowlby, 1982). Bowlby (1982) suggested that humans have several innate, symbiotic behavioural systems that are activated by our needs and deactivated when our needs are met. The attachment behavioural system activates when dependent humans feel hunger, thirst, fear, pain, loneliness, etc. and consists of safety-seeking behaviours such as crying, seeking, following, and clinging (Bowlby, 1982). The caregiving

system activates within caregivers in response to the dependents' attachment system behaviours (Bowlby, 1988). Ideally, the caregiver attempts to alleviate the dependents' distress through such behaviours as feeding, changing, holding, rocking, gazing, and soothing (Bowlby, 1982). As dependents grow, they develop enduring attachment bonds to the people who are primarily involved in their care (Bowlby 1977; Bowlby, 1982). If these caregivers, known as attachment figures, are attuned and responsive to the dependents' needs, dependents will feel protected, loved, and secure (Bowlby, 1982). Dependents typically develop the strongest attachment bond to their primary attachment figure who serves as a safe haven when the dependent is distressed and a secure base for exploration (Bowlby 1977).

**Figure 2**

*The Attachment, Exploration, and Caregiving Behavioural Systems Illustrated in the Circle of Security*

(Cooper et al., 2000)



The exploratory behavioural system activates in response to new stimuli and includes behaviours such as looking, touching, tasting, smelling, climbing, and questioning (Bowlby 1977). The exploratory behaviour system typically alternates with the attachment behavioural system and functions optimally when dependents are securely grounded by their attachment figure (Bowlby 1977). If attachment figures are mis-attuned or unresponsive; however, dependents feel unsafe, unloved, and insecure (Bowlby, 1977; Bowlby, 1982).

### ***Internal Working Models***

Over time, dependents catalogue their interactions with their attachment figure into beliefs about themselves and about others (Bartholomew, 1990). These core beliefs about self and others are called internal working models (Bowlby, 1977; Bowlby, 1982; Bowlby, 1988). When attachment figures are reasonably attuned to their dependents' bids for love, safety, and security, more often than not, then dependents will develop positive beliefs about themselves as lovable and valuable and about others as safe and trustworthy (Ainsworth et al., 1978). If, on the other hand, attachment figures are generally mis-attuned, unreliable, or even scary, then dependents come to see themselves as unlovable and unworthy and others as dangerous and untrustworthy (Ainsworth et al., 1978). Internal working models are always actively inferring other people's motives, predicting how others will behave, setting our expectations for how we deserve to be treated, and directing our behaviour toward others (Bowlby, 1977; Bowlby, 1982; Bowlby, 1988; Ainsworth et al., 1978).

### ***Infant Attachment Styles***

Taken together, our internal working models compose our attachment style or characteristic way of forming relationships (Bowlby, 1977; Bowlby, 1982; Bowlby, 1988; Ainsworth et al., 1978). After years of naturalistic, observational studies of infant and mother behaviours and responses in Uganda and the United States, Ainsworth et al. (1978) identified three categorical attachment styles. Infants who showed moderate distress upon separation from their mothers and were easily soothed upon

reunion were considered securely attached (Ainsworth et al., 1978). The attachment style of infants who showed escalating distress upon separation and were difficult to sooth upon reunion was known as anxious-ambivalent or preoccupied (Ainsworth et al., 1978). Finally, infants who did not appear distressed upon separation and who actively turned away from their mothers upon reunion were deemed to have an avoidant attachment style (Ainsworth et al., 1978). In 1986, Main and Solomon introduced the disorganized attachment style. Infants with this attachment style tend to behave inconsistently in response to inconsistent, unreliable, and frightening attachment figures. They may display the characteristics of the preoccupied attachment style, the avoidant attachment style, or both preoccupied and avoidant attachment styles simultaneously (Main & Solomon, 1986).

### ***Adult Attachment Styles***

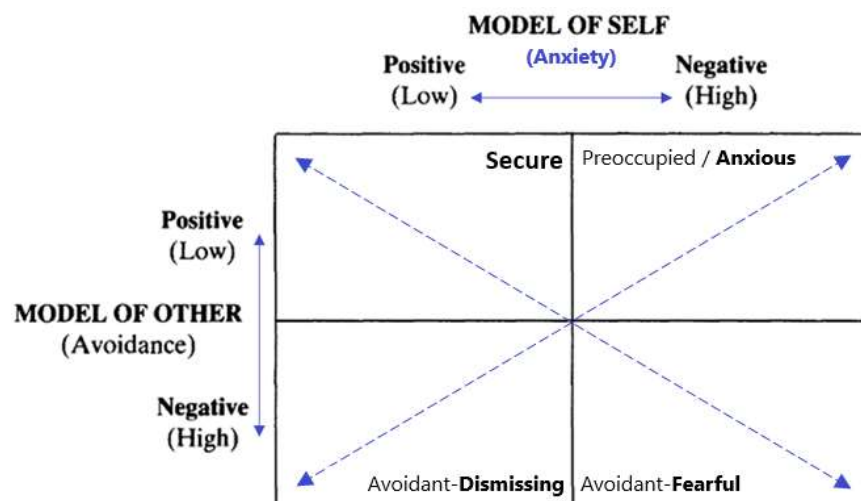
**Models of Self and Other.** As interest in attachment theory grew, researchers investigated the secure, preoccupied, and avoidant attachment styles during adulthood and specifically within romantic relationships (Hazan & Shaver, 1987). In 1990, Bartholomew proposed that attachment patterns could be conceptualized as combinations of positive or negative models of self and models of others and argued persuasively for separating the avoidant attachment style into two distinct motivational and behavioural patterns of avoidance: *avoidant-dismissing* and *avoidant-fearful*. People with a positive view of self and a positive view of others have a *secure* attachment style (Bartholomew, 1990). They believe that they are worthy of love and acceptance, and they expect others to be loving and accepting (Bartholomew & Shaver, 1998). People with a positive view of self but a negative view of others have an *avoidant-dismissing* or *dismissing* attachment style (Bartholomew, 1990). They rely on themselves and deny that they need close relationships (Bartholomew & Shaver, 1998). Those with a negative view of self and of others have an *avoidant-fearful* or *fearful* attachment style (Bartholomew, 1990). Those who are *avoidant-fearful* “are highly dependent on others’ acceptance and affirmation; however, because of their negative expectations, they avoid intimacy to avert the pain of loss or rejection” (Bartholomew &

Shaver, 1998, p. 31). It is important to note that the fearful attachment style is equivalent to the disorganized attachment style (Brown & Elliott, 2016). Finally, those with a negative view of self and a positive view of others have a *preoccupied* or *anxious* attachment (Bartholomew, 1990). People with a *preoccupied*, also known as *anxious*, attachment style “anxiously seek to gain acceptance and validation from others, seeming to persist in the belief that they could attain safety, or security, if they could get others to respond properly to them” (Bartholomew & Shaver, 1998, p. 31).

**Dimensions of Anxiety and Avoidance.** In 1998, Brennan et al. proposed that the two axes are more accurately conceptualized as degrees of anxiety and avoidance with individual patterns of attachment existing on a continuum. This dimensional understanding of attachment patterns has been widely accepted within the research community, although I do not recall it being identified in any of my graduate or undergraduate classes. Brennan et al. (1998) developed the Experiences in Close Relationships scale (ECR/ERCS) to measure adult attachment across the avoidance—anxiety continuum, and it appears to be the most used measure, perhaps because of the validity, reliability, and ease of administration.

**Figure 3**

*Bartholomew’s (1990) Attachment Styles with Brennan et al.’s (1998) Dimensions Overlaid in Blue*



Attachment style has the potential to influence all interpersonal interactions whether brief or ongoing (Wiseman & Egozi, 2021). Think, for example, about the driver who cut you off this morning, the barista at Starbucks, your co-worker, your romantic partner, your best friend, or even your therapist. Did the driver cut you off on purpose to spite you, were they being inconsiderate, or were they simply distracted? Did the barista mix up your order because they hate you? Would your therapist accept you if they knew the real you? A person's attachment style determines the motives that they infer from the actions of others, how they respond to threats, and how they behave toward others, including their typical response patterns to situations that activate the attachment, exploration, and caregiving behavioural systems (Wiseman & Egozi, 2021). Attachment styles can change over time and especially through therapy because clients and therapists are governed by their ability to form attachments to one another (Bowlby, 1988).

### **Alliance**

In fact, Bowlby (1988) suggested that the alliance between client and therapist should be seen as an attachment relationship with the therapist as the attachment figure. The therapist is ideally stronger, wiser, and more secure than the client and can therefore create an emotionally corrective experience for the client through the alliance (Bowlby, 1988; Mikulincer & Shaver, 2007).

Although the concept of the alliance originated in psychoanalytic theory (Bordin, 1979; Horvath & Luborsky, 1993), Bordin (1979) developed the most widely accepted pantheoretical definition of the alliance (Horvath & Luborsky, 1993). Bordin (1979) proposed that the alliance consists of three required components: the bond of trust and understanding between the client and the therapist, the desired outcomes of therapy collaboratively set out by the client and therapist (i.e., the goals), and the general approach to working together that the client and therapist agree upon (i.e., the tasks). While different therapeutic modalities place varying degrees of emphasis on the strength of the bond vs. the definition of goals and tasks, all three components are either explicitly or implicitly required for treatment to occur

(Bordin, 1979; Horvath & Luborsky, 1993). Bordin (1979) argued convincingly that the alliance is a core element of psychotherapy, regardless of the theoretical framework or therapeutic methodology (Horvath & Luborsky, 1993).

In addition to being essential and central to the work of therapy, there is considerable empirical evidence to demonstrate that the strength of the alliance is a significant factor in the outcome of therapy (Flückiger et al., 2018; Flückiger et al., 2020; Horvath & Luborsky, 1993). For example, Flückiger et al. (2018) reviewed previous meta-analyses of the correlation between alliance and outcome and concluded that the correlation is reasonably stable across time, measures, and statistical methods. Flückiger et al. (2018) then performed their own meta-analysis on 306 studies published in four languages between 1978 and 2017. The studies included approximately 30,000 adult clients who received individual therapy in a variety of theoretical models either in-person or online. Flückiger et al. (2018) validated previous findings that the alliance is significantly correlated with the outcome of treatment regardless of the treatment type, client diagnosis, country, measure of alliance, measure of outcome, time of measurements, or study design. It is especially noteworthy that Baier et al.'s (2020) meta-analysis found that the alliance mediated therapeutic outcomes in 70.3% of thirty-seven studies. Thus, the importance of the alliance cannot be overstated (Baier et al., 2020; Egozi et al., 2021b; Flückiger et al., 2018; Horvath & Luborsky, 1993).

The alliance is co-created between the client and the therapist and is influenced by numerous client and therapist factors, including their attachment styles, unconscious processes, and personalities, and by the clients' severity of symptoms (Bernecker et al., 2014; Horvath & Luborsky, 1993; Steel et al., 2018; Tschuschke et al., 2022). The therapist's inability to form the therapeutic bond has been shown to result in more ruptures and more frequent early therapy termination (Siefert & Hilsenroth, 2015; Tschuschke et al., 2022). Clients may be attending therapy because of intrapersonal or interpersonal conflicts rooted in their attachment styles and may be unaware of this (Mallinckrodt, 2010). Therapists,

on the other hand, will ideally set aside their personal relationship patterns when providing psychotherapeutic services and adapt to the clients' unconscious attachment needs to create a corrective emotional experience (Bowlby, 1988; Daly & Mallinckrodt, 2009; Mallinckrodt, 2010). These are logical conjectures, but are they true? Does the client's attachment style help or hinder their alliance? Will the therapist's insecure attachment style impede their alliances despite their knowledge, skills, and experience (Marmarosh et al., 2014)? The remainder of this literature review will attempt to answer these questions.

## **Measures**

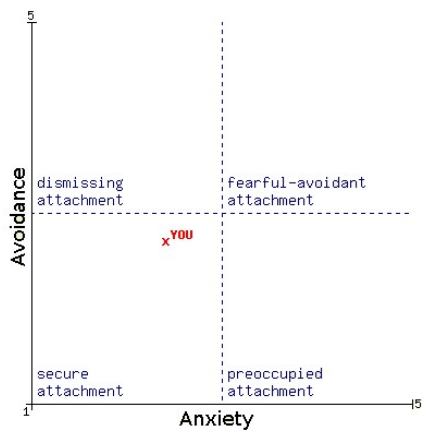
### ***Global Attachment Measures***

There are at least 29 measures of global adult attachment style (Ravitz et al., 2010) with some of the most common being the Experiences in Close Relationships scale (ERC/ERCS; Brennan et al., 1998), the Adult Attachment Interview (AAI; George et al., 1996), the Relationship Questionnaire (RQ, Bartholomew & Horowitz, 1991), and the Relationship Styles Questionnaire (RSQ; Griffin & Bartholomew, 1994). The AAI (George et al., 1996) is administered via a one-hour interview and requires specialized training for the administrator, which makes it an inaccessible tool for many researchers (Brennan et al., 1998). The AAI is intended to capture the subject's state of mind regarding attachment and pays particular attention to whether narratives of past attachment injuries are realistic, complete, and coherent (George et al., 1996). The ERC is a self-report measure that can be administered and scored with minimal effort from subjects and researchers (Brennan et al., 1998). Personally, I favour the Experiences in Close Relationships – Relationship Structures (ECR-RS; Fraley et al., 2011) scale, which is rooted in the perspective that attachment styles are relationship-specific. The ECR-RS asks nine questions four times: once for each parent, once for the romantic partner, and once for the best/closest friend (Fraley et al., 2011). The ERC-RS returns scores on the key relationships and a global attachment score. Figure four shows my score on the ECR and figure five shows my score on the ECR-RS. The ERC-RS

results resonate with me as a more accurate representation of my actual relationship-specific attachment dimensions.

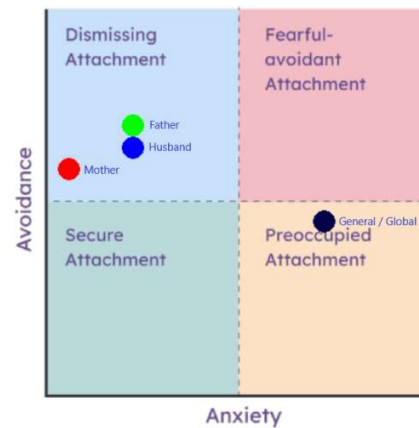
**Figure 4**

Personal ECR Result (Brennan et al., 1998)



**Figure 5**

Personal ECR-RS Result (Fraley et al, 2011)



Regardless of the measures used, most studies presented their findings as dimensions of anxiety and avoidance rather than as specific categories (Bernecker et al., 2014; Notsu et al., 2024; Smith et al., 2010). Some of the meta-analyses found common ground among the various measures by grouping results under the dimensions of secure, anxious, and avoidant (Smith et al., 2010). Other meta-analyses focused on self-report measures and excluded studies that used observational or interview measures on the grounds that the results would not be comparable (Bernecker et al., 2014).

### ***Specific Attachment to Therapist Measures***

In addition to measures of global attachment styles, some studies also captured a measure of the clients' specific attachment to their therapists (Smith et al., 2010). One common measure used for this purpose is the Client Attachment to Therapist Scale (CATS; Mallinckrodt et al., 1995). The CATS results in a rating of secure, preoccupied-merger or avoidant-fearful (Mallinckrodt et al., 1995).

### ***Alliance Measures***

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1986) was used by most of the studies to measure the three dimensions of the alliance as defined by Bordin (1979). Smith et al. (2010) explained that some studies in their meta-analysis reported values for the individual subscales and some only reported total scores; this made it difficult to detect which elements of the alliance are related to attachment style. Bernecker et al. (2014) reported that “the WAI was selected because it has been highly validated in terms of construct, convergent, and predictive validity ... and because the majority of studies showing a relation between alliance and outcome use the WAI” (p. 15).

### **Attachment Styles and the Alliance**

Historically, the influence of the clients’ global attachment styles on the alliance was investigated in isolation, followed by limited study of the effect of the therapists’ global attachment styles on the alliance. More recently, researchers are examining the cross-effects of client and therapist attachment styles.

### ***Client Attachment Styles***

The client’s style of relating to attachment figures may have significant bearing on their ability to develop a trust relationship with the therapist within which they can share themselves vulnerably (Smith et al, 2010; Bernecker et al., 2014; Wiseman & Tishby, 2014).

**Client Secure Attachment.** Research has shown that clients with a secure attachment style are generally able to create stronger alliances with their therapists and therefore get the most out of therapy (Bernecker et al., 2014; Egozi et al., 2021b; Egozi et al., 2023; Levy et al., 2011; Petrowski et al., 2021; Smith et al., 2010 ). In 2010, Smith et al. examined eighteen studies published between 1995 and 2008 and found evidence that clients with global secure attachment styles rate their alliances higher than clients with global insecure attachment styles. They also found that “the more secure the client is in relation to their attachment pattern, the greater their and their therapist’s ratings of the alliance”

(Smith et al., 2010, p. 334). After synthesizing the results of twenty-four studies on the relationship between the client's attachment style and the client's view of the alliance, Bernecker et al. (2014) likewise found that secure clients can form stronger alliances. Clients with secure attachment styles actively contribute to building the alliance, engage in secure attachment behaviours such as proximity seeking and exploring throughout therapy, and rate their alliances highly (Egozi et al., 2023). They also experience less distress during therapy (Wiseman and Tishby, 2014). Levy et al. (2011) noted a strong correlation between client global secure attachment style and better outcomes during a meta-analysis including nineteen therapy cohorts. Finally, clients with global secure attachment styles rated their specific attachment to their therapists favourably and the more favourable attachments to therapists led to greater increases in self-esteem (Petrowski et al., 2021). Taken together, these studies provide substantial evidence that clients with the global secure attachment style enjoy more secure alliances.

**Client Insecure Attachment.** While the correlation between secure client attachment style and a higher quality alliance has been firmly established, it is less clear whether an insecure attachment style adversely affects the alliance. Bernecker et al. (2014) found a small but significant mean weighted effect size for both avoidance and the alliance and anxiety and the alliance, indicating that attachment insecurity reduces the quality of the alliance. Researchers speculate that the effect size is most likely small in part because attachment is only one of many client and therapist factors influencing the alliance (Bernecker et al., 2014). Notsu et al. (2024) replicated Bernecker et al.'s (2014) meta-analysis using Bernecker et al.'s original twenty-four publications plus an additional nine studies that had been completed in the ten years between 2014 and 2024. Notsu et al. (2024) confirmed that there is a small but significant correlation between both attachment avoidance and the alliance and attachment anxiety and the alliance. Wiseman and Tishby (2014) similarly observed that clients with a global insecure attachment style formed less secure specific attachments to their therapists, which manifested as more distress, including ruptures, during the working phase of therapy. In addition, a global avoidant

attachment style predicted an avoidant specific attachment to the therapist (Wiseman & Tishby, 2014). Those clients had difficulty building the alliance and had greater difficulty relying on their therapists as a secure base during the engagement and working phases (Wiseman & Tishby, 2014). Clients with ECR-measured global attachment anxiety, on the other hand, were able to develop a positive alliance with their therapists during the engagement phase but struggled to maintain the alliance during the working phase (Wiseman & Tishby, 2014). Those clients became avoidant-fearful during the termination phase because of their anxious fear of abandonment (Wiseman & Tishby, 2014). Thus, Bernecker et al. (2014), Notsu et al. (2024), and Wiseman and Tishby (2014) confirmed that there is a correlation between the global insecure attachment styles and the alliance.

Not all studies agree, however. Smith et al. (2010) found that only the subscale avoidant-dismissing and not the dimension of avoidance was related to the alliance. In addition, they reported that “the majority of the evidence indicates that clients’ [global] attachment avoidance and anxiety are *not* [emphasis added] significantly related to alliance ratings” (Smith et al., 2010, p. 335). Instead, they noted that the clients’ specific attachment to the therapist was correlated with higher ratings on the WAI. Likewise, Levy et al. (2011) found that attachment anxiety, but not attachment avoidance, was slightly correlated with poorer therapeutic outcome.

In conclusion, the evidence is divided regarding client global insecure attachment styles and the formation of a strong alliance. Some studies reported that client global insecure attachment hindered the alliance and resulted in more distress, more ruptures, and more frequent premature termination (Siefert & Hilsenroth, 2015; Tschuschke et al., 2022). Other studies reported that a client global avoidant-dismissing attachment style is impactful, but not the avoidant-fearful or anxious attachment styles (Smith et al., 2010). Still others found that the quality of the client’s specific attachment to the therapist rather than the client’s global attachment style determines the quality of the alliance and the outcome (Bernecker et al., 2014). Additionally, some globally insecure clients develop secure specific

attachments to their therapists (Bernecker et al., 2014). Next, we will review some of the research on how the therapists' attachment style influences the alliance.

### ***Therapist Attachment Styles***

As with client attachment styles and the alliance, the results are mixed regarding the influence of the therapist's attachment style on the therapeutic alliance.

**Therapist Secure Attachment.** Bucci et al. (2016) found that both clients and therapists rate their alliances more positively when the therapists' global attachment style is secure, especially when the clients have more symptoms. In addition to better alliances, therapists with a secure attachment style also repair ruptures more easily and collaborate in better outcomes for clients (Egozi et al., 2021b). Most studies reviewed in Steel et al.'s (2018) systematic literature review also demonstrated a reliably positive correlation between therapists' global secure attachment style and a stronger alliance; although, in some cases, the alliance was only stronger from the therapists' perspective. Overall, therapists with secure attachment styles can create stronger alliances (Talia et al., 2020; Wiseman & Tishby, 2014; Wittenborn, 2012).

**Therapist Insecure Attachment.** Steel et al.'s (2018) systematic literature review showed that "insecure attachment negatively affects the therapeutic relationship" (p. 11). More specifically, Steel et al. (2018) noticed that therapists with an anxious global attachment style started out with stronger alliances as rated by their clients, but the quality of the alliance declined over time. One plausible reason is that the solicitous and accommodating behaviour of therapists with the anxious attachment style was initially flattering to clients but became tiresome as the clients sought deeper alliances. Therapists with global insecure attachment styles may also feel and therefore demonstrate less empathy than therapists with a global secure attachment style (Steel et al., 2018). Talia et al. (2020) found that therapists with an avoidant-dismissing global attachment style may show less empathy and therapists with an anxious attachment style may interfere with clients' autonomous problem-solving or become frustrated with

emotional distance in the relationship. Likewise, Wiseman and Tishby (2014) found that clients with a global anxious attachment style were unable to develop secure alliances with their clients during the initial, engagement phase of therapy. Wittenborn (2012) investigated the influence of global attachment style on the ability of novice therapists to engage directly with clients' attachment injuries and provide corrective emotional experiences through the delivery of Emotionally Focused Therapy (EFT).

Wittenborn (2012) discovered that novice therapists with the global secure attachment style or a predominantly anxious global attachment style were able to attune to their clients emotionally; however, novice therapists with a global avoidant-dismissing attachment style tended to avoid the clients' emotions and work cognitively, contrary to the EFT methodology. Interestingly, the clients who rated their alliances the highest had been matched with therapists with the same global attachment style as themselves (Wittenborn, 2012).

On the other hand, Degnan et al.'s (2016) systematic literature review found that despite positive correlations, most of the studies they analyzed found *no direct* relationship between the therapists' attachment style and the quality of the alliance as rated by both the client and the therapist. Bucci et al. (2016) also reported that therapists' global insecure attachment styles do not influence the alliance; however, they acknowledge that their study could be underpowered. In addition, Petrowski et al. (2021) found that therapists' attachment styles did not influence their client's specific attachment to them. Finally, Bucci et al. (2016) found that more symptomatic clients preferred working with avoidant-dismissing therapists (i.e., they rated these alliances higher than alliances with anxious or avoidant-fearful therapists), although avoidant-dismissing therapists did not reciprocate (i.e., avoidant-dismissing therapists rated their experience of the alliance lower when working with more symptomatic clients).

In conclusion, "although there was some evidence that therapist attachment style is important to alliance and outcomes, the findings are by no means consistent across the reviewed studies" (Wiseman & Tishby, 2014, p.60). Additionally, while it appears irrefutable that therapists with a more

secure attachment style create stronger alliances with their clients, the dismissing attachment style seems to be preferred by clients who are experiencing higher symptoms (Bucci et al., 2016). As we will see in the next section, therapists' insecure attachment styles are most influential in combination with clients' attachment styles.

### ***Interplay Between Client and Therapist Attachment Styles***

In general, while therapists' global attachment styles may not directly affect the therapeutic alliance, they do interact with client variables, including the client's attachment style, to influence the alliance (Marmarosh et al., 2014; Steel et al., 2018). Notably, client and therapist attachment style interactions contribute to the quality of the alliance and to the development of problems within the relationship over and above the clients' and therapists' personalities (Steel et al., 2018).

Most of the meta-analyses and systematic literature reviews I analyzed found that client and therapist complementary global attachment styles lead to better alliances (Degnan et al., 2016; Mallinckrodt, 2010; Mallinckrodt et al., 2015; Steel et al., 2018; Wiseman & Tishby, 2014). Marmarosh et al. (2014) found that high client anxiety paired with low therapist anxiety created a better alliance and low client anxiety paired with high therapist anxiety created a better alliance. Bucci et al. (2016) observed that when therapists with a global anxious attachment style collaborated with clients with a global avoidant-dismissing attachment style, the therapists but not the clients rated their alliances highly. The inverse was also true: clients with a global anxious attachment style rated their alliances with therapists with a global avoidant-dismissing attachment style highly, although the therapists did not (Bucci et al., 2016). Degnan et al. (2016) added the caveat that client and therapist global attachment styles interact to influence outcome with complementary attachment styles making the best match *if and only if* the therapist is more secure than the client. They also noted that clients with higher levels of disorganization work better with secure therapists or with slightly dismissing therapists who are less likely to intrude on the clients or push them to disclose until they are ready (Degnan et al., 2016).

Interestingly and seemingly in contrast to the other studies, Wiseman and Tishby (2014) reported that when both clients and therapists are low on the dimension of avoidance, clients experienced better outcomes. They suggest that the phase of therapy, the tasks of therapy, and the combined global attachment styles of the client and therapist influence the clients' specific attachment to the therapist from session to session, which then positively influences the outcomes (Wiseman & Tishby, 2014).

**Table 1***Client and Therapist Attachment Style Interactions*

Therapists	Clients				
	More Symptomatic	Secure	Anxious/ Preoccupied	Avoidant- Dismissing	Avoidant- Fearful
Secure	Negative influence on alliance <sup>4</sup>	Best outcomes <sup>2</sup>	Better outcomes <sup>2</sup>	Better outcomes <sup>2</sup>	Better outcomes <sup>2</sup>
Anxious/ Preoccupied	Client rated alliance lower <sup>1</sup>		High client and low therapist anxiety makes a better alliance <sup>3</sup>	Therapist rated alliance highly <sup>1</sup>	
Avoidant- Dismissing	Client rated alliance higher <sup>1</sup>		Client rated alliance highly <sup>1</sup>	Better outcomes <sup>5</sup>	Better outcomes <sup>2</sup>
Avoidant- Fearful	Client rated alliance lower <sup>1</sup>				

<sup>1</sup> Bucci et al., 2016; <sup>2</sup> Degnan et al., 2016; <sup>3</sup> Marmarosh et al., 2014; <sup>4</sup> Tschuschke et al., 2022;

<sup>5</sup> Wiseman & Tishby, 2014

Table one summarizes the interactions between clients' and therapists' global attachment styles. In general, if both clients and therapists have more secure attachment styles, they co-create stronger, more positive alliances. Alternatively, if clients' and therapists' attachment styles are generally opposite on the dimensions of anxiety and avoidance, they are considered complementary, which

enables clients and therapists to co-create stronger alliances, provided that the therapists are more secure than the clients.

While results are mixed regarding the effects of the clients' and especially the therapists' attachment styles on the alliance, most studies demonstrated that both the clients' and the therapists' attachment styles do influence the alliances they build. In fact, 7.5% of the variation in problems within the alliance were attributable to the therapist's attachment style alone over and above their personalities or any client factors (Steel et al., 2018). "Thus," as Egozi et al. (2021b) astutely observed, "a crucial challenge is to address the question of how to increase the likelihood that secure therapeutic relations will be achieved in cases of insecure clients, therapists, or both" (p. 964).

### **Conclusion**

My capstone questions were whether the alliance, which is correlated with outcome, is affected by client attachment styles, therapist attachment styles, or both. Through this literature review, I have shown that:

1. *Clients with a global secure attachment style* are generally able to create stronger alliances with their therapists and experience better outcomes (Bernecker et al., 2014; Egozi et al., 2021b; Egozi et al., 2023; Levy et al., 2011; Petrowski et al., 2021; Smith et al., 2010; Wiseman & Tishby, 2014).
2. *Therapists with a global secure attachment style* reliably and positively correlate with the alliance. These individuals create higher rated alliances, especially with more distressed clients; repair ruptures more easily; and collaborate in better outcomes for clients (Bucci et al., 2016; Egozi et al., 2021b; Steel et al., 2018; Talia et al., 2020; Wiseman & Tishby, 2014; Wittenborn, 2012).
3. The evidence is divided regarding *client global insecure attachment styles*. Some studies reported that client global insecure attachment hinders the alliance and results in more distress,

more ruptures, and more frequent premature termination. Other studies reported that only the client global avoidant-dismissing attachment style has a negative influence on the alliance. Still other studies asserted that the quality of the client's specific attachment to the therapist instead of the client's global attachment style determines the quality of the alliance and outcomes (Bernecker et al., 2014; Siefert & Hilsenroth, 2015; Smith et al., 2010; Tschuschke et al., 2022).

4. The evidence is divided regarding *therapist global insecure attachment styles* with some findings supporting the negative influence of the therapists' global insecure attachment style on both the alliance and outcomes (Steel et al., 2018; Talia et al., 2020; Wiseman & Tishby, 2014; Wittenborn, 2012). Others showed that there was no direct correlation between the therapists' insecure attachment style and the alliance (Bucci et al., 2016; Degnan et al., 2016; Lu et al., 2021; Petrowski et al., 2021).
5. Most studies demonstrated that *the interactions between the clients' and the therapists' global attachment styles* influence the alliances they build. Complementary global attachment styles generally lead to better alliances if the therapist is more secure than the client. As examples, anxious attachments relate better to avoidant attachments, avoidant attachments relate better to anxious attachments, and clients with higher levels of disorganization relate better with slightly dismissing therapists (Degnan et al., 2016; Mallinckrodt, 2010; Mallinckrodt et al., 2015; Marmarosh et al., 2014; Steel et al., 2018; Wiseman & Tishby, 2014).

Clients' and therapists' attachment styles are only two of many factors at work in the alliance (Hatcher, 2021) and within therapists guiding their behaviour within each session (Talia et al., 2019).

Hopeful research by Hatcher (2021), Talia et al. (2019), and others is introduced in chapter three.

### **Chapter Three: Discussion and Application**

#### **Discussion**

In chapter three, I comment on the limitations of the available research on attachment theory and the alliance. I then highlight a selection of the interesting concepts I encountered while following interconnected threads of knowledge, including therapeutic distance, attunement, mentalizing, responsiveness, and emotional regulation. Within the context of applying my research to current practice, I also describe the Therapist Attunement Scales (TASc, Talia et al., 2020) in some detail to accentuate its immediate usefulness. Chapter three continues with a discussion of the ethical and cultural issues related to client and therapist global attachment styles and the alliance, followed by my reflections on how this capstone project has led to my enlightenment in several ways. I conclude with the key takeaways that I entrust to you, my readers.

#### ***Limitations of Research***

In my estimation, there are no limitations to the research. Attachment theory and the working alliance have both been and continue to be thoroughly studied from every possible angle and in every imaginable domain, including how they each intersect with personality, culture, psychopathology, and emotion, to name a few. The client's global attachment style and the therapist's global attachment style have also been the subject of much inquiry. I think that the lack of unassailable evidence in support of the effects of attachment on the alliance is reasonable and accurate given the complexity of relationships in general and of the therapeutic alliance in particular. I would be unjustified in manufacturing a hole in the body of research simply to satisfy an expectation of this project.

#### ***Therapeutic Distance***

While researching my capstone questions, I was fascinated to discover for myself the emergence of innovative, pivotal, and ultimately seminal concepts: Bartholomew's (1990) attachment as models of self and other; Brennan et al.'s (1998) attachment as dimensions of anxiety and avoidance; and Daly and

Mallinckrodt's (2009) hyperactivating versus deactivating secondary attachment strategies. Of particular interest to the role of attachment in the alliance is Daly and Mallinckrodt's (2009) concept of therapeutic distance. Daly and Mallinckrodt (2009) proposed that effective attachment-based therapists transcend their own global attachment styles to create safety and invite clients to change by modulating the therapeutic distance within each session. Daly and Mallinckrodt (2009) defined *therapeutic distance* as "the level of transparency and disclosure in the psychotherapy relationship from both client and therapist, together with the immediacy, intimacy, and emotional intensity of a session" (p. 559). They went on to explain that in the early stage of therapy when the alliance was forming, these therapists granted more therapeutic distance to clients with a more dismissing attachment style and more therapeutic closeness to clients with a more anxious attachment style (Bernecker et al., 2014; Daly & Mallinckrodt, 2009). "Particularly in times of distress, the appropriate distance for one person is different from that of another and is influenced by each person's attachment history" (Wiseman & Egozi, 2021, p. 66). As the alliance developed and strengthened, the therapists they studied were "continuously assessing the client's threshold and 'moving in' very empathically" (Daly & Mallinckrodt, 2009, p. 558) toward a more adaptive level of therapeutic distance. As a result, more dismissing clients were able to take small emotional risks within their window of tolerance and more anxious clients were able to accept increased boundaries (Daly & Mallinckrodt, 2009).

To accomplish this effective modulation of therapeutic distance, therapists with global insecure attachment styles must learn to perform the functions of a secure attachment figure who provides safe haven and secure base (Ainsworth, 1979; Bowlby, 1988; Daly & Mallinckrodt, 2009). In fact, since the introduction of the Therapeutic Distance Scale (TDS) with its subscales of too close, too distant, growing autonomy, and growing engagement (Mallinckrodt et al., 2015), it appears that the alliance has become ipso facto an attachment relationship. Researchers have instead turned their attention to studying the factors that enable therapists with global insecure attachment styles to build secure alliances with their

clients (Egozi et al., 2021a; Egozi et al., 2021b; Egozi et al., 2023; Jacobsen et al., 2024; Sikand & Bhola, 2024; Wiseman & Atzil-Slonim, 2018).

### ***Secure Alliance Building Functions***

Although this is not an exhaustive list of the functions performed by therapists who succeed in building secure alliances, my journey through the research on attachment and the alliance exposed me to the secure base and safe haven functions of attunement, sensitive responsiveness, and emotional regulation (Bar-Sella et al., 2021; Hatcher, 2021; Sikand & Bhola, 2024; Talia et al., 2019; Talia et al., 2020; Wiseman & Egozi, 2021). It is important to note that these are the functions of the therapist's behaviour, as are empathy, congruence, and unconditional positive regard, rather than prescribed forms of behaviour (Mesman et al., 2016). The way each therapist attunes and responds to each client is dependent on the history and strength of the alliance, the immediate conditions in the session, and the life context of the session, among other factors (Wiseman & Egozi, 2021). Emotional regulation is also performed uniquely within broad guidelines that could stem from a person's culture, faith, ethnicity, gender, or other dimensions of identity. The understanding I have gained regarding attunement, sensitive responsiveness, and emotional regulation represents the *pièce de résistance* of my research; therefore, I will briefly describe each of these functions in the context of the work of the therapist.

**Attunement.** Attunement is a composite of the verbs *attune*, which means to "make harmonious" (Oxford Languages, n.d.) and *tune into*, which means to "become sensitive" toward (Oxford Languages, n.d.). Bringing these definitions together, attunement is the ongoing process whereby therapists become sensitive to and adjust themselves into harmony with their client's present experience. It is a vital characteristic of creating and holding safe space for the client. Attunement necessitates mindful awareness, observation, presence, equanimity (S. Parks, Personal Communication, December 6, 2024), emotional proximity, and mentalization (Talia et al., 2019). Attunement is especially

difficult for therapists with global insecure attachment styles, but it can be learned along with mentalizing, responsiveness, and emotional regulation.

**Mentalizing.** Mentalizing is an essential activity embedded within attunement that therapists must learn to perform continuously if they are to cultivate secure alliances with their clients. Fonagy and Target (2006) define mentalizing as “a form of mostly preconscious imaginative mental activity, namely, perceiving and interpreting human behaviour in terms of intentional states (e.g., needs desires, feelings, beliefs, goals, purposes, and reasons)” (p. 544). Mentalizing is also described as thinking about thinking and is typically turned both inward toward the self and outward toward others. “The core feature of a mentalizing stance is to operate from a position of curiosity which aids in flexible and detailed exploration of our client’s experiences and internal world” (Sikand & Bhola, 2024, p. 260).

**Responsiveness.** Responsiveness, also known as appropriate responsiveness, optimal responsiveness, or sensitive responsiveness, is a primary function of what Ainsworth (1979) called sensitivity and follows successful attunement. Once the therapist as the attachment figure attunes to the client’s implicit and explicit signals and interprets them correctly to know what the client needs in the moment (Messman et al., 2016, p. 102), the therapist then meets (responds to) the client’s needs with acceptance, validation, and caring (Wiseman & Egozi, 2021). Responsiveness can be thought of as doing the right thing at the right time in the right way so that the client feels seen, heard, and understood and is able to deactivate their attachment behavioural system (Hatcher, 2021; Wiseman & Egozi, 2021). Therapists respond to clients by attending to their “tone of voice, shift of subject, emergence of feeling, reference to the therapist, and new symptoms” (Hatcher, 2021, p. 39). They also consider “actions described by the client; the previous session’s content; racial, ethnic, gender, economic, cultural, and other differences” (Hatcher, 2021, p. 39).

Responsiveness is manifest through the reciprocal expressions, actions, and utterances of the client and therapist contingent on the other’s state of being (Hatcher, 2021; Wiseman & Egozi, 2021).

The Therapist Attunement Scales (TASc; Talia et al., 2020), which are described in the Applied Practices section, can be used to illuminate the types of responses that foster increased attunement and secure specific attachment to the therapist.

**Emotional Regulation.** Emotional regulation is a person's ability to monitor, alter, and control their emotions such that unpleasant emotions can be shifted through positive self-talk or temporarily waylaid until a more socially appropriate time and place (Bar-Sella et al., 2024). Emotional regulation is thought to develop when caregivers respond sensitively to signs of distress during infancy and childhood and is, therefore, a hallmark of a secure attachment style (Ruiz-Aranda et al., 2021). A client's ability to regulate their emotions can be nurtured through corrective emotional experiences with therapists who are attuned and responsive (Bar-Sella et al., 2024). As a result, clients with global avoidant attachment styles could shift from rigid self-reliance to adaptive coregulation with their therapist as a secure base (Bar-Sella et al., 2024). Likewise, clients with a global anxious attachment style could shift from maladaptive overdependence on others to a more balanced intrapersonal emotional regulation (Bar-Sella et al., 2024). Therapists can also improve their emotional regulation abilities even if they have a predominantly global insecure attachment style and "therapists who are able to understand and regulate their emotions are able to build a relationship of mutual trust and acceptance with clients regardless of their attachment security" (Ruiz-Aranda et al., 2021, p. 8).

The skills of attunement, responsiveness, and emotional regulation epitomize the caregiving behavioural system functions that come naturally to therapists with a global secure attachment style. Those therapists with a global insecure attachment style can nevertheless develop these skills through the following practices: attachment awareness; attachment self-knowledge; conscientious instruction; ongoing personal, attachment-healing therapy; and insightful supervision.

### Applied Practices

Nearly every study I reviewed recommended that attachment awareness and attachment self-knowledge be taught in counselling training programs (Berry & Danquah, 2016; Bernecker et al., 2014; Bucci et al., 2016; Degnan et al., 2016; Egozi et al., 2021a; Egozi et al., 2021b; Egozi et al., 2023; Levy et al., 2011; Mallinckrodt et al., 1995; Mallinckrodt et al., 2015; Marmarosh et al., 2014; Shir & Tishby, 2024; Shorey & Snyder, 2006; Siefert & Hilsenroth, 2015; Smith et al., 2010; Steel et al., 2018; Tschuschke et al., 2022; Zilcha-Mano et al. 2021). Some of the studies emphasized the importance of teaching therapists to understand and respond appropriately to the client's global attachment style, especially at the beginning of therapy (Degnan et al., 2016). Others advised that, "training programs should help trainees develop a curious stance and a developmental perspective when understanding their own attachment styles" (Lu et al., 2021, p. 7). Wiseman and Egozi (2021) asserted that therapists' awareness of their own global attachment style and related communication patterns is vital for the development of a secure alliance.

Throughout my coursework for my Master of Counselling degree, my instructors repeatedly taught that the "client and therapist relationship" is one of the most influential contributors to client outcome and is underpinned by Roger's (1957) core conditions: empathy, congruence, and unconditional positive regard. I was not taught the therapists' imperative attachment to develop self-understanding regarding their own global attachment styles or about the effects of the clients' and therapists' global attachment styles on the alliance. My contribution to the field, therefore, is to exhort university instructors and decision-makers to incorporate specific instruction and supervision on the multitude of factors that influence the working alliance, including and especially the client's and therapist's global attachment styles. Specifically, I endorse the Therapist Attunement Scales (TASc, Talia et al., 2020) as a powerful tool that could be employed immediately within the following City University in Canada courses: CPC501, Counselling Practice; CPC654, Practicum I; and CPC655, Practicum II.

### ***Therapist Attunement Scales***

The Therapist Attunement Scales measurement tool (TASc; Talia et al., 2020) was developed to evaluate therapists' verbal markers of attunement and is highly correlated with the AAI (George et al., 1996) indicating that it captures stable, trait-like, verbal attachment behaviour (Talia et al., 2019). The TASc is used to categorize therapists' in-session remarks into secure, dismissing, or preoccupied verbal behaviour related to the AAI (Talia et al., 2019; Talia et al., 2020). Note that while the authors acknowledged that attunement is also expressed non-verbally (Talia et al., 2019), their focus was on identifying and classifying verbal markers of attunement with the goal of describing therapists' attachment-related speech patterns and thereby "transform[ing] how we select, train, and supervise clinicians" (Talia et al., 2019; p. 2). Talia et al. (2019) recommended that the TASc be used for training and supervision to enhance the mentalizing abilities of counselling students so that they will recognize how their words influence their clients' responses.

**Scoring Procedure: Step One.** The TASc (Talia et al., 2020) is applied repeatedly to a verbatim session transcript. The first step is to assign a code to each complete speech turn or utterance (Talia et al., 2020). The codes are shown in table two.

**Table 2**

*Step One: TASc Utterance Codes (Talia et al., 2020, pp. 7, 8)*

Code	Description
Inquiry	Assigned to open questions or requests for disclosures.
Expression	Assigned to instances in which the therapist reveals his or her experience of the patient.
Action	Assigned when the therapist examines or proposes a possible course of action, such as when giving advice.
Education	Assigned when the therapist explains general theories or concepts.
Clarification	Assigned to statements that repeat or reformulate what the patient has already said ("so you are feeling___," "oh, in other words you are saying___").

Code	Description
Not-Knowing Statement	Assigned to closed questions or conjectures (e.g. “I wonder if you are . . .,” “it sounds like you are. . .,” “perhaps you are. . .,” or “are you . . .?”), which add to what previously said by the patient, but make it easy for the patient to elaborate or correct the therapist’s statement.
Objective Statement	Assigned to statements that add to what was previously said by the patient and present the therapists’ perspective in definitive, difficult to challenge terms (e.g. “obviously you are . . .,” “you look so. . .”).

**Scoring Procedure: Step Two.** According to Talia et al. (2020), “attunement is the process in which the therapist contributes to define and make sense of [the client’s] present internal states” (p. 8); therefore, in the second step, only utterances coded as expression, clarification, not-knowing statement, or objective statement are combined with “specific content (e.g., emotions, significant relationships, etc.)” (p. 8) to assign one of forty attunement markers. For those interested in additional depth, the attunement markers can be found in the TASC manual (Talia et al., 2020).

**Scoring Procedure: Step Three.** In the third step, the TASC rater assigns a score from one to seven to the five TASC scales (shown in table three) based on the frequency and intensity of each of the attunement markers (content plus form code) found within the therapist’s verbal participation in the session (Talia et al., 2020).

**Table 3**

*Step Three: TASC Scales (Talia et al., 2020, pp. 8, 9)*

Scale	Form Code	Attunement Behaviour
Self-State Conjecture	Not-Knowing Statement	Therapist’s tentative questions, conjectures, or proposals about the client’s internal states.
Empathic Validation	Objective Statement	Therapist’s perspective to validate the client’s experience (e.g., naming an emotion, acknowledging a need, supporting an interpersonal position).
Joining	Expression	Therapist’s feelings, conveyed either implicitly or explicitly, about the client’s progress, toward the client, or regarding something the client did or said.

Scale	Form Code	Attunement Behaviour
Detaching	Clarification or Objective Statement	Therapist's attempts to release themselves from attuning by minimizing or normalizing the client's experience (e.g., everyone feels that way).
Coercing	Clarification or Objective Statement	Therapist's statements that restrict the client's ability "to correct and elaborate upon the therapist's views."

**Scoring Procedure: Step Four.** In the last step, the rater determines the therapist's attunement style based on the therapist's constellation of TASC scales (Talia et al., 2020). The resulting attunement style is highly correlated with the therapist's AAI dominant classification (Talia et al., 2020). The TASC clusters and their correspondence to AAI categories are shown in table four.

**Table 4**

*Step Four: TASC Attunement Styles (Talia et al., 2020, p. 9)*

Attunement Style	AAI Classification	Attunement Scale Scores
Balanced/Secure	Autonomous/Secure	Self-state conjecture, empathetic validation or joining are higher than the other scales.
Balanced-Avoidant	F1	Detaching is moderate.
Balanced-Coercive	F2	Coercive is moderate.
Balanced-Autonomous	F3	
Avoidant	Dismissing	Detaching is higher than the other scales or all scales are low.
Avoidant-1	Ds1	Self-state conjecture, empathetic validation or joining are low.
Avoidant-2	Ds3	Self-state conjecture, empathetic validation or joining are moderate.
Coercive	Preoccupied	Coercive is higher than the other scales.
Coercive-1	E2	Self-state conjecture is moderate or high.
Coercive-2	E1	Self-state conjecture is low.

I anticipate that the greatest benefit of the TASC for would-be therapists occurs in the first three steps when utterances are coded according to their function within the session and then combined with the content of the utterances to identify attachment markers. Student and intern therapists could be

taught to mindfully notice their own utterances and gradually increase the quantity of self-state conjectures, empathic validations, and joining statements made during sessions. Students, instructors, interns, and supervisors could monitor “the subtle but distinct discursive acts associated with [their] untoward reactions ...: excessive quotation of discourse from past interactions, minimizing or down-playing remarks, or the insistence upon stating a thought in response to a probe about emotion,” etc. (Talia et al., 2019, p. 364). In this way, attunement could be taught along with other therapist skills such as active listening, reflection, open-ended questions, and self-disclosure. Additionally, Talia et al. (2019) explain that:

Knowledge of in-session attachment markers can help trainees and their supervisors: i) construct an attachment-based case formulation; ii) develop more process-oriented clinical listening; iii) identify triggers for negative countertransference; iv) assess therapeutic impasses; v) create deliberate practice exercises; vi) increase mindfulness of one’s own listening and reactivity patterns; and vii) provide new supervisory techniques and training objectives (p. 360).

If universities, including the City University in Canada, were to act on my recommendations, the calibre and effectiveness of their counselling program graduates would certainly garner the attention of the College of Alberta Psychologists (CAP).

### **Ethical Considerations**

Significantly, the CAP has adopted the Canadian Psychological Association’s (CPA, 2017) *Canadian Code of Ethics for Psychologists (Code)*, which sets out the aspirational values and ideals for psychologists in Alberta (CAP, 2019). Naturally, the entire *Code* must be held continually in the mind of all Alberta would-be, provisional, and registered Alberta psychologists, yet some parts of the *Code* are especially applicable to the themes of attachment and alliance. The following will touch on the prominent intersections of the four principles of the *Code* and attachment and/or the alliance.

***Principle I: Respect for the Dignity of Persons and Peoples***

This principle emphasizes “inherent worth, non-discrimination, moral rights” (CPA, 2017, p. 4) and ongoing, informed consent. Principle I rightly requires the demonstration of respect for the individuality and intersectionality of all persons and peoples, including “respect for the knowledge, insight, experience, areas of expertise, cultural perspectives, and values of others” (CPA, 2017, p. 12) regardless of their “culture, nationality, ethnicity, colour, race, religion, sex, gender, marital status, sexual orientation, physical or mental abilities, age, socio-economic status, or any other preference or personal characteristic, condition, or status” (CPA, 2017, p. 11). This principle reminds me that despite my confidence in attachment theory, clients know themselves in ways that I never could; therefore, I have an ethical responsibility to present my conjectures about who they are based on their attachment history and global attachment style with humility, curiosity, and caution. Therapists can also demonstrate respect for the dignity of others by following the client’s lead regarding the pace of therapy, the amount of therapeutic distance, the depth of exploration, the amount of self-disclosure, the goals and tasks of therapy, and the ongoing consent to participate in therapy.

See standards I.1, I.3, I.11, and I.17 of the *Code* (CPA, 2017) for more details.

***Principle II: Responsible Caring***

“Responsible caring requires competence, maximization of benefit, and minimization of harm, and should be carried out only in ways that respect the dignity of persons and peoples” (CPA, 2017, p. 4). It seems to me that the new discoveries in the fields of attachment and the alliance are outpacing academia; therefore, it is incumbent on me and other attachment-based therapists to read and integrate the latest research for the promotion of well-being and the avoidance of harm. In addition, therapists must be careful how they speak about clients’ imperfect attachment figures out of respect for those individuals and care for the enduring attachment bonds.

Principle II also reminds us that therapists cannot afford to neglect self-care or supervision lest they begin to satisfy their own attachment needs through the therapeutic alliance:

One characteristic that distinguishes the therapeutic relationship from healthy adult attachment relationships is that the therapeutic relationship is asymmetrical and non-reciprocal ... the therapists seek to serve as the secure base and safe haven for clients while monitoring and managing their own reactions so that they do not employ attachment strategies to meet their own attachment needs (Lu et al, 2021, p. 7).

The power differential between the therapist and the client is also evident here and must be recognized as a solemn trust-laden responsibility (Hatcher, 2021).

Self-knowledge and reflective practice are also essential to responsible caring. As Lu et al. (2022) stated, “we posit that a therapist’s awareness of [their] own attachment needs and vulnerabilities is central to their effectiveness” (p.2). Pell (2022) found that therapists with anxious attachment styles tend to experience countertransference in the form of feeling overwhelmed, inadequate, and criticized. Therapists with avoidant attachment styles also experience countertransference in the form of feeling disorganized and disengaged; however, therapists with secure attachment styles did not experience any attachment-related countertransference (Pell, 2022).

Finally, caring responsibly for clients’ attachment insecurities indicates that clients must be given plenty of lead time for absences and terminations, which can trigger fears of rejection and abandonment (Zilcha-Mano et al., 2021).

See standards II.1, II.2, II.9, II.10, I.11, I.12, II.13, II.14, II.28 and II.36 of the *Code* (CPA, 2017) for more details.

### ***Principle III: Integrity in Relationships***

According to principle III, “psychologists are expected to demonstrate the highest integrity in all their relationships (CPA, 2017, p. 4). This principle reinforces the needs expressed in principles I and II

for self-awareness, reflectivity, objectivity, and the mandate to clearly differentiate when explaining theories versus facts versus opinions.

See standards III.9 and III.10 of the *Code* (CPA, 2017) for more details.

#### ***Principle IV: Responsibility to Society***

Principle IV asserts that, “two of the legitimate expectations of psychology as a science and a profession are that it will increase knowledge and that it will conduct its affairs in such ways that it will promote the welfare of all human beings” (CPA, 2017, p. 31). This capstone demonstrates responsibility to society by disseminating current understanding from research about attachment and the alliance and offering recommendations that would strengthen the counselling program at the City University in Canada. My capstone also discourages misinterpretation by offering evidence to counter the mistaken view that attachment theory is a Western construct with no relevance to non-European cultures.

See standards IV.1, IV.15, and IV.24 of the *Code* (CPA, 2017) for more details.

#### **Cultural Considerations**

Although the cross-cultural relevance of attachment theory is not central to this capstone, I have too often heard the criticism that attachment theory is based in Western and European parenting practices and therefore lacks cross-cultural understanding. As mentioned in the *Ethical Considerations* section, I am obligated to do my part to correct this misunderstanding; therefore, it must be noted that:

Attachment theory derived originally from studies of animals, especially non-human primates.

Thus, beyond being a panhuman theory, it is even a cross-species theory. Moreover, the first empirical application of Bowlby’s theory was Ainsworth’s (1967) study in rural Uganda, about as far from Northern European culture as one could imagine. Most of the ideas about the link between parental sensitive responsiveness and quality of attachment derived from that study.

The next study by Ainsworth was with a largely Black sample in inner-city Baltimore (Ainsworth

et al., 1978). Only following this were studies done with middle-class North Americans and northern European samples. (Sroufe, 2017, p. 28)

As indicated in this quotation, the origins of attachment theory are rooted cross-culturally. In fact, Ainsworth discovered caregiver sensitivity while she was observing caregiver behaviour in Uganda. Her assessment of sensitivity looks for sensitive responses as a function of *how* the behaviour is performed rather than as prescribing specific behaviour (Mesman, 2021). Mesman (2021) gave two examples from two cultures to illustrate that teaching a child to herd sheep can be done sensitively and picking up a crying baby can be done insensitively, depending on the attunement, kindness, and appropriate responsiveness of the caregiver.

The main argument against attachment theory as cross-culturally germane is the prevalence of multiple caregivers in many cultures (Mesman, 2021). Unfortunately, the critics are ill-informed. From the beginning, attachment theory has accommodated and is in no way contrary to multiple caregiver models (Rudnytsky, 1997). Children develop relationship-specific attachments to each of their caregivers and each relationship contributes to the child's internal working models that develop (Mesman, 2021). Also, while it is true that in many cultures children have multiple caregivers (e.g., the Agta foragers in the Philippines; Mesman et al., 2016), it is also true that, "in all but modern industrial cultures, babies in the first months of life are cared for primarily by one person, usually a nursing mother" (Sroufe, 2017). Therefore, it seems likely that newborn infants spend some time being cared for by their mother specifically, in addition to their village of caregivers.

Sensitivity, attunement, and responsiveness as core features of secure attachments with multiple caregivers have been confirmed around the globe in places such as rural Kenya, rural Peru, urban and rural Iran, Yemen slums, Rio de Janeiro, urban Indonesian slums (Mesman, 2021), China, Mali, Mexico, the Philippines, and South Africa (Mesman et al., 2016). In my opinion, attachment theory is a beautiful, comprehensive, elegant, and timeless theory. To use an attachment lens with anyone,

anywhere, having any blend of individual characteristics, therapists must practice cultural curiosity and humility, as always.

### **Reflections on Personal Learning**

The process of completing this capstone project has come with several surprising lessons for me, some of which will quickly fade and others that will be with me for my lifetime.

First, I learned some interesting concepts and theories that have enriched my understanding of attachment and/or the alliance. For example, I learned that: attachment style is dimensional not categorical; attachment style is a global tendency; attachment is a relationship-specific bond; attachment style can be thought of as models of self and other; attachment style can be thought of as degrees of anxiety and avoidance; therapeutic distance is a variable of the alliance; emotional regulation is a product of attachment style; behavioural systems can be activated, deactivated, secondarily hyperactivated, or secondarily deactivated; the goals and tasks of therapy are essential; and mentalizing is a product of secure attachment (Strauss & Petrowski, 2017). I was especially surprised by the alliance as bond, goals, and tasks because I have been in therapy many times over the years and most of my therapists did not initiate a conversation about goals or tasks.

Second, I did find the answers to my capstone questions, and they have personal significance to me. As someone with a global insecure attachment style that leans toward dismissing in established relationships and toward preoccupied when relationships are new or affection is uncertain, I learned that my attachment style could indeed influence my therapeutic alliances. Reflecting on my internship, I recognize that God worked through me to provide a safe haven and a secure base for my clients that exceeded my ability as a novice therapist. As the years go by and I gain experience as a therapist, it will be vital for me to remember that God-with-me always gets better results than me-alone.

Third, I was relieved to learn that a somewhat insecure attachment style is sometimes the best match for a client (Degnan et al., 2016; Mallinckrodt, 2010; Mallinckrodt et al., 2015; Steel et al., 2018;

Wiseman & Tishby, 2014) and that therapists can learn to behave more securely (Daly & Mallinckrodt, 2009). I also have a solid foundation of knowledge about attunement, responsiveness, and emotional regulation from which to continue my lifelong journey of personal and professional growth and to select my supervisor when I become a provisional psychologist.

I also found the Therapist Attunement Scales (TASc; Talia et al. 2020) to be a valuable source of professional insight into my own verbal attachment patterns. In retrospect, I am certain that at least once during my internship I gave an overly long, convoluted explanation for something, referred to past sessions, and stated a conjecture about a client's feelings in an overly confident, irrefutable manner. I intend to use the TASc in my future practice to identify and eliminate more of these insecure, attunement-inhibiting verbal attachment patterns.

Finally, I now know with certainty that I will never attain a doctorate degree, unless it is bestowed honorarily, because the writing process is too onerous for me. It has been important to me to feel certain about the information I include, and this need has driven me to read literature far exceeding what I have been able to cite in this paper. While this has been a beneficial learning process for me, I will be thrilled to put this research project behind me and step into my new career!

## **Conclusion**

My objective in completing this capstone project was to learn about the influence of the client's and the therapist's attachment styles on the therapeutic alliance. I approached the project from a pragmatic worldview, making use of whatever legitimate qualitative and quantitative resources I could find that would support my effort. In that sense, this was a mixed methods systematic literature review. My approach to reviewing the research was the start with the newest articles and pay attention to the references within them that appeared to be the most influential. In this way, I encountered several seminal works that expanded on and enriched my understanding of attachment theory. As a byproduct, I learned more about the alliance and about attachment theory than I originally anticipated.

In chapter two, I summarized and highlighted the research on the client's attachment style and the alliance, the therapist's attachment style and the alliance, and the interplay of the client's and therapist's attachment styles on the alliance. In brief, having a secure attachment style allows both the client and therapist to contribute openness, trust, safety, and security to the relationships they build. Clients with a more anxious attachment style may initially push for too much closeness in the alliance and clients with a more avoidant attachment style may initially resist disclosure and emotion in the alliance. Therapists with a more anxious attachment style are often well liked by their clients during the engagement stage of therapy but their clients' alliance ratings tend to decline during the working stage. Therapists with a generally avoidant attachment style seem to be well suited for collaborating with clients who are experiencing higher levels of distressing symptoms. Although some of the studies found conflicting results, the consensus is that client attachment style definitely influences the alliance and therapist attachment style has the potential to influence the alliance.

In chapter three, I introduced recent research that has moved away from studying *whether* attachment style affects the alliance toward studying the ways in which some therapists are able to modulate the therapeutic distance within the alliance to increase client comfort, safety, and security. I briefly described attunement, responsiveness, and emotional regulation, which are functions of the caregiving behavioural system in response to the needs of the attachment behavioural system. I then recommended that university counselling programs, like the one at the City University in Canada, follow the advice of dozens of researchers who have strongly entreated educators to ensure that would-be therapists are aware of their own and their clients' attachment-related behaviours and discourse. The TASC has compelling potential as a training instrument to this crucial effort by identifying students' attachment-related speech patterns. Chapter three also identifies some of the ethical mandates that are especially relevant to attachment and the alliance. Finally, I offer a brief defence of attachment theory's cross-cultural utility before concluding with a few of my principal learnings from this project.

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