

# THE DEVELOPMENT OF THE CLIENT–THERAPIST BOND THROUGH THE LENS OF ATTACHMENT THEORY

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*The bond between client and therapist, a component of the global alliance, is widely believed to play a crucial role in supporting the work of therapy. However, we know little about how the client–therapist bond becomes established and have few theoretical tools to conceptualize its development. Attachment theory, with its focus on the development and dynamics of intimate relationships, is a lens through which we can expand our understanding of the client–therapist bond. I argue that the therapeutic bond may be usefully viewed as an in-progress attachment to therapists. Using Bowlby (1969/1982) and Ainsworth's (Ainsworth et al., 1978) ideas about normative attachment development, I present a phase model of attachment to the therapist and include behavioral, cognitive, emotional, and physiological markers of each phase. I draw empirical support from the psychotherapy process and alliance literatures and discuss research considerations and clinical implications of the model.*

**Keywords:** attachment behavior, client attachment to therapist, therapists, therapeutic alliance, therapeutic bond

It is a well-accepted idea that the emotional bond between client and therapist is the bedrock of therapeutic alliances. A strong bond facilitates smooth collaboration, buffers the relationship from the strain of therapeutic work, and is considered a healing element of psychotherapy. Despite its central importance, we know very little about how the client–therapist bond develops (Castonguay, Constantino, & Holtforth Grosse, 2006). This poses a problem for experienced clinicians and trainees alike: Being unable to easily ascertain the maturity of the bond compromises the ability to gauge whether rapport building skills have been effective or to comprehend the changes in how clients behave with us over time. An additional challenge for clinicians is to predict how personality differences impinge on the initiation and maintenance of the therapeutic relationship. Attachment theory, with its focus on the nature and unfolding of relationships across the life span, may be able to redress these issues.

Bowlby and Ainsworth, the originators of attachment theory, argued that all people, be they infants or elders, seek to establish an affective tie, or attachment, with a specific other to meet needs for physical and psychological security (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1988). Attachment and the therapeutic bond are analogous constructs: both describe social-emotional connections. However, the characteristics, motivational basis, and development of attachment offer several theoretical advantages over existing theories of the therapeutic bond. I propose that it is advantageous to view the therapeutic bond as an in-progress attachment to the therapist. To make this case, I first clarify the differences between bond and attachment in terms of their definition and theoretical ideas about development and draw attention to the strengths of an attachment-based view. Next, I

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propose, using Bowlby and Ainsworth's developmental framework, a phase-based model of attachment to the therapist. I also consider how a sense of security, or lack thereof, might color the development of attachment to the therapist. Finally, I discuss research and clinical implications of viewing the client-therapist bond as an in-progress attachment.

### A Comparison of the Client-Therapist Bond and Attachment

Bordin's (1979) pan-theoretical formulation of the alliance is the most widely held view of the therapeutic relationship. In it, the client-therapist bond is considered a component of the alliance. According to Bordin, the alliance refers to the "here and now" relationship between client and therapist (in psychoanalytic terms, the "real" relationship) and consists of goals, tasks, and bonds. *Goals* referred to the extent to which the client and therapist agreed on aims of treatment, whereas *tasks* refer to how relevant and potent the client and therapist perceive the means of change to be. However, to enable and maintain the work of treatment, a high-quality bond between client and therapist is essential. *Bond* refers to the socioemotional aspects of the alliance, namely, the degree of trust and liking between client and therapist:

Partner compatibility (bonding) is likely to be expressed and felt in terms of liking, trusting, respect for each other, and a sense of common commitment and shared understanding in the activity. (Bordin, 1994, p. 16)

Descriptors such as caring, acceptance, confidence, mutual understanding, and mutual respect are also used to describe the bond component. Some alliance models define the bond component in comparable ways (e.g., Gaston, 1990; Gelso & Carter, 1985) whereas others distinguish between aspects of the bond that refer to personal rapport and those that refer to collaborative effort (Hatcher & Barends, 2006; Orlinsky, Rønnestad, & Willutzki, 2004). Regardless of these variations in definition, there is a consensus that bonds play a central role in treatment: Without strong bonds little collaborative work can be sustained and therapeutic progress will be stalled.

Among attachment-informed clinicians and researchers there is a long history of viewing the relationship clients have with their therapist as an attachment. Bowlby (1975, 1988), a psychoanalyst and researcher, believed that therapists should assume the role of temporary attachment figure and act as a secure base from which clients could confidently explore painful issues. More forcefully, some, like Ainsworth (1989), have argued that clients can and do form an attachment to their therapist (e.g., Amini, Lewis, Lannon, & Louie, 1996; Farber, Lippert, & Nevas, 1995; Mallinckrodt, Gantt, & Coble, 1995) or that alliances are, in fact, attachments (Holmes, 1996, 2001).

One appeal of attachment theory is that it accounts for behaviors indicative of affectional ties but that are omitted from Bordin's (1979) view of bonds. Anecdotally speaking, clients' behavior

TABLE 1. Similarities Between Attachment and the Therapeutic Relationship

Attachment	Therapeutic relationship
Persists over time and space	Clients continue to value the relationship beyond termination and may turn to representations of the therapist for comfort and support
A tie with specific and noninterchangeable person	Clients prefer ongoing consultation with a single therapist and become reluctant to depend on substitute therapists
Desire to maintain contact with attachment figure as evidenced by proximity seeking	Clients attend sessions regularly, disclose problems, seek advice
Distress felt on separation; grief follows loss	Increased anxiety when therapist is out of reach; sense of sadness, loss upon termination; sense of loss, grief when therapist dies
Joy upon reunion	Clients feel pleasure and relief on seeing the therapist either from week to week or after a short break
Turning to attachment figures for relief from distress (safe haven)	Clients seek out and consult with therapist about distressing problems in hope of relief
Sense of security achieved with contact and exploration ensues (secure base)	Clients feel more confident when therapists are perceived as available, helpful, and empathic; clients use safety of sessions to explore painful feelings, events, and alternative ways of feeling and acting

*Note.* Some of the similarities between attachments and the therapeutic relationship that appear in this Table were drawn from Farber, Lippert, & Nevas (1995).

closely parallels characteristics of attachment described by Ainsworth (1989; see Table 1 for a summary). First, many clients appear to form an enduring tie to their therapist, that is, they continue to value the relationship well after termination. In contrast to the long-standing nature of attachment, the definition of bond implies that ties last only as long as treatment does. Second, clients tend to perceive their therapist as unique and noninterchangeable persons (i.e., attachment figures). This figure preference signifies the affinity for and emotional significance of the therapist. Although definitions of bonds make it clear that a sense of liking occurs, figure preference is not specified. Figure preference is evident in the desire to maintain contact with the therapist and in the distress, even grief, felt on separation, the third and fourth attributes of attachment. Separation distress is omitted from definitions of the alliance's bond component. Finally, like attached persons, clients purposefully seek comfort and security from their preferred figure (therapists) that, once gained, reduces stress and engenders the confidence to engage in challenging pursuits. Again, bond definitions imply but make no mention of this attribute. Although there is face validity to these comparisons, clinical researchers have only just begun to investigate the possibility that clients can become attached to therapists. In two questionnaire-based studies that directly examined this possibility, some clients did identify their therapists as attachment figures (Allen et al., 2001; Parish & Eagle, 2003).

Another appeal of attachment theory is that it sheds light on why clients are motivated to seek out and maintain contact with therapists and describes the psychological systems that could support these efforts. The theory was designed to explain the universal disposition of human beings to form especially close relationships with a select few persons (Bowlby, 1975). According to Bowlby (1969/1982) and Ainsworth (1972; Ainsworth et al., 1978), an attachment enhances the chances of survival because it keeps the organism in close proximity to a “stronger and/or wiser” figure (Bowlby, 1975; p. 292). An organized system (the attachment behavioral system) evolved for the purpose of regulating proximity to a caregiver in response to internal (psychological) or external (environmental) threats to safety. In times of threat, attachment behaviors are deployed to increase proximity to a specific figure (an *attachment figure*), thereby, promoting phys-

ical and psychological safety (Sroufe & Waters, 1977; for a recent elaboration of the attachment system, see Mikulincer & Shaver, 2007). Over the course of many interactions, mental representations, called internal working models, of the self and the attachment figure are constructed and used to inform encounters with relational partners.

The implication of the above ideas is that clients seek therapists because doing so is expected to alleviate distress. Clients rely on the same psychological apparatus to initiate and maintain proximity as they do in other attachments (e.g., to romantic partners, parents), and they reuse previously constructed mental models as a guide. Bordin (1980) also believed that clients sought therapists when in “a state of personal crisis” (p. 63) but had little to say about why clients might do so and what psychological systems mediated in-session behavior.

A third potential benefit of applying attachment theory to the therapeutic bond is that the theory distinguishes between affectional ties (attachment) and a sense of safety in them (attachment security). Unlike client–therapist bonds, attachments are not conceived as differing in strength (i.e., a strong vs. weak attachment). Attachment theorists have argued that understanding attachment in a quantitative fashion has little use at best and is misleading at worst<sup>1</sup> (e.g., Ainsworth, 1972; Sroufe & Waters, 1977). Rather, the quality and patterning of attachment behavior is more informative than the presence, intensity, or frequency of any one behavior. Individuals are held to differ in attachment security, that is, “a sense that one can rely on close relationship partners for protection and support, can safely and effectively explore the environment, and can engage effectively with other people” (Mikulincer & Shaver, 2004, p. 159). In both infancy and adulthood, researchers have amply demonstrated that attachment security predicts individual dif-

<sup>1</sup> For example, it is an error to infer a “strong” attachment from the intensity or frequency of any one attachment behavior. The extent and kind of attachment behavior depends on the level of threat to felt security. Serious threats will strongly activate the attachment system and, consequently, the most potent attachment behaviors will be deployed (e.g., panic-stricken cries, desperate clinging). Mild threats will weakly activate the attachment system and so evoke less potent behaviors (e.g., calling, increasing proximity). In either case, the attachment is unchanged.

ferences in relationship functioning, affect regulation, and psychopathology (Cassidy & Shaver, 1999).

Attachment, once formed, is a stable feature of a relationship, but the sense of security in that relationship is susceptible to shifts in response to changing interpersonal circumstances or life stressors (for a review of attachment and change, see Davila & Cobb, 2004). Optimally, over the course of repeated interactions with an attachment figure, an inner sense of confidence in the protective abilities of the attachment figure is encoded and enables exploration, a dynamic commonly referred to as using the attachment figure as a secure base (Ainsworth, 1967). The emotional quality and history of interactions with the specific figure around whom the system has become organized lends a distinctive quality to attachments and their corresponding mental representations. Attachments that balance closeness and autonomy and include positive expectations about availability and sensitive responding are labeled *secure*. Attachments in which people chronically lack confidence in the responsiveness of attachment figures and constantly pursue closeness and reassurance are called *anxious*, whereas attachments characterized by an overemphasis on self-reliance and discomfort with emotional or physical closeness are called *avoidant*. Anxious and avoidant attachments are called collectively *insecure*.

There is an important benefit of viewing the emotional connection between clients and therapists as attachments that vary in attachment security rather than as bonds that vary in strength. First, an attachment-based view of the therapeutic relationship posits that attachment, once achieved by clients, is a stable feature, whereas the degree of attachment security clients feel will fluctuate because it is a function of their attachment history, the actual behavior of the therapist, and current interpersonally relevant events outside of treatment. Therefore, attachment to the therapist is durable, even if it is, overall, secure or insecure, and the level of security felt can fluctuate over the course of a single session or multiple ones. In contrast, the client–therapist bond described by Bordin (1979) is unidimensional. For example, if trust diminishes after a particularly difficult exchange or session, the bond is considered to have weakened, if not jeopardized (e.g., Horvath & Luborsky, 1993).

In summary, it seems reasonable to suspect

that clients can form an attachment to therapists. As well, the perspective of attachment theory offers several theoretical and practical benefits. Explicit in attachment theory are concepts such as psychological safety, behavioral systems, mental representations, and individual differences in security that go beyond the definition of the client–therapist bond in alliance theorizing.

### Contrasting Views of Development

Despite several decades of research on the therapeutic relationship, precisely how the client–therapist bond develops remains obscure. (For a profession predicated on relationships, this is a conspicuous problem.) By *bond development* I mean the processes or stages through which the acquaintance between client and therapist becomes increasingly complex and mature over time such that an affective tie (a bond) is established. Although Bordin (1979) believed that “deeper bonds of trust and attachment are required and developed” (p. 254) in advanced stages of therapy, to my knowledge there are no theories that specifically address how bonds unfold. In addition, because few studies have focused on the bond component current ideas about bond development must be inferred from approaches to the development of the global alliance. I briefly discuss some of these approaches and contrast them with attachment theory’s model of attachment development.

There are four sources of knowledge regarding alliance development. The first is Luborsky’s (1976) theoretical distinction between a Type I alliance (experiencing the therapist as supportive) and a Type II alliance (feelings of joint investment in and responsibility for treatment). Unfortunately, the model has been seldom researched, underspecifies how one type evolves into the other, and does not clearly integrate Bordin’s (1979) bond component. A second source of data is investigations into the proposition that alliance strength fluctuates according to the phase of treatment (e.g., reaching its nadir in the working phase) or with the working through of inevitable strains and interruptions (e.g., Bordin, 1994; Horvath & Luborsky, 1993). The early findings are somewhat contradictory (cf., Kivlighan & Shaughnessy, 2000; Stiles et al., 2004), though it can be safely said that alliance strength rarely remains unchanged as therapy proceeds (Bache-



lor & Salamé, 2000). The third source of data is only peripherally about developmental processes; numerous studies have documented factors that are associated with alliance strength or weakness (e.g., client characteristics, therapist contributions; for a review, see Horvath & Bedi, 2002). The final source of knowledge is the robust finding that early measurements of alliance strength, say between the third and fifth session, are better predictors of therapeutic outcome than later measurements (e.g., Martin, Garske, & Davis, 2000). Some have taken this to mean that the alliance, including the bond component, is more-or-less formed in three to five sessions. However, a correlation between alliance strength and outcome is insufficient to draw firm conclusions about the developmental course of alliances.

Taken together, these approaches and findings suggest that the client–therapist bond forms early, its strength is crucial to positive therapeutic outcome, and the bond may or may not remain uniformly positive or stable over time. However, questions remain: How does the first meeting between client and therapist mature into an intimate and valued relationship? What behavioral indicators suggest a bond is forming or has formed? As Horvath (2005) noted: “Progressive enrichment and complexity is a characteristic of all intimate relationships over time, so why should we assume that this is not the case in therapy?” (p. 5). Theories of bonds and alliances are relatively mute on these questions. They also do not deal with the thorny problem of explaining how a bond forms in 3 to 5 nonconsecutive hours of face-to-face contact or, by one account (Sexton, Littauer, Sexton, & Tommeras, 2005), a single hour. I am hard pressed to find evidence of any human relationship that develops this way.

The assumptions of bond and attachment are different. First, compared to the client–therapist bond, which is believed to take root in several weeks, an attachment forms over months and years. Both Bowlby (1969/1982) and Ainsworth (Ainsworth et al., 1978) posited that a clear-cut attachment in infancy appears no earlier than 6 months of age. Among adults, research findings suggest that the majority of romantic relationships are likely to have all characteristics of attachment when relationships endure 2 or more years (Fraley & Davis, 1997; Hazan & Zeifman, 1994).

Second, whereas bond development is often

treated as a sense of personal rapport and collaboration that increases over time, the development of attachment is conceived as progressing through overlapping but qualitatively distinct phases, both in infancy and adulthood (Hazan, Gur-Yaish, & Campa, 2004). Bowlby (1969/1982) and Ainsworth (Ainsworth et al., 1978) stated that attachment unfolds gradually in a series of phases. In the first phase, or preattachment (0 to 2 months), infants do not discriminate between one caregiver and another; while their distress provokes attachment behavior, the behavior is not focused on any one person and infants readily accept comfort from whoever offers it. Given the consistent availability of one or a small number of caregivers, infants are able to move into the attachment-in-the-making phase (2 to 6 months). Attachment behaviors, primarily signaling behaviors such as crying, are directed to a preferred figure and this figure is able to soothe the infant more easily than can other adults. The phase of clear-cut attachment (beginning at 6 to 7 months) marks a new level of behavioral organization. The infant takes a more independent role in achieving proximity (via locomotion) and uses the attachment figure as both a haven of safety in times of danger and as a secure base from which to confidently explore the immediate environment. Stranger wariness and separation protest become prominent. As well, the infant increasingly develops a sense of how his attachment figure typically responds to his attachment needs. In the final phase of the goal-corrected partnership (around 36 months), the child becomes less egocentric and more able to take into account the feelings and motives of his attachment figure in negotiating his attachment needs. Bowlby suspected these same phases described attachment to figures later in life (Ainsworth et al., 1978). Indeed, Hazan et al. (2004) successfully applied this normative model to adult romantic relationships. In addition, they specified behavioral, cognitive, physiological, and emotional “attachment markers” for each phase.

Thus, a potential advantage of attachment theory is that it can fill a conspicuous gap in theorizing about the bond; attachment theory proposes a developmental template for understanding how durable, intimate, and enduring affectional ties come into being and suggests that a set of behavioral signposts mark its developmental progress. Assuming that clients can form an attachment to therapists and that the attachment unfolds accord-

ing to Bowlby and Ainsworth's stages, what might this look like in behavioral terms? In the next section, I offer some speculative answers.

### **The Development of Attachment to the Therapist**

Using the framework specified by Bowlby, Ainsworth, and Hazan and colleagues, I outline phases of attachment to the therapist. I focus on normative development, that is, phases and phase markers that are relatively independent of individual differences in attachment security.<sup>2</sup> Because investigations of attachment to the therapist is scarce, I draw on the broader literature of psychotherapy to support my inferences. Following the presentation, I discuss how attachment insecurity may alter the model.

#### *Phase 1: Preattachment*

The agenda of clients in this phase is twofold: to seek proximity to a stronger, wiser figure in the hopes of relieving distress caused by current problems and, unlike in infancy, to assess whether the therapist is a viable attachment figure. Behaviorally, accomplishing this agenda includes searching for a therapist, making initial contact, and surface problem disclosure. Clients may ask direct questions about the therapist's competence, approach, and personal values in order to judge the therapist's potential as an attachment figure. With interns or in clinics with high therapist turnover, clients may inquire about the therapist's longevity. In the course of these early exchanges, mutual agreement on the goals and methods of treatment occurs. The achievement of consensus indicates clients' willingness to further consider the therapist's potential as an attachment figure.

Cognitively, clients are primarily relying on established internal working models to understand and assess the therapist's behavior; perceptions and expectations of the therapist are strongly influenced by experiences with previous attachment figures. Nevertheless, early client-therapist interactions are a kind of "groundbreaking" for the construction of a specific internal working model of the therapist, a key process of which is covert assessments of interpersonal safety. Essentially, clients are "asking": Is this a safe person to disclose my private concerns to?

Can this person help me lower my distress? Will I be able to work well with this person? Do we share similar ideas about what is wrong and what will help? How available and dependable might this person be? Searching for answers, clients scrutinize their therapist's tone of voice, comments, questions, and appearance (Rappoport, 1997). Unless clients collect at least tentatively affirmative answers, the development of attachment will be delayed if not aborted. Qualities of the therapist such as warmth, an attitude of non-judgment, an air of competence, and a willingness to (initially) accommodate clients' interpersonal style are critically important.

Physiologically and emotionally, arousal and relatively high levels of distress mark the beginning of most therapy sessions in this phase. Intimate disclosure to a stranger results in some autonomic arousal (increased heart rate, perspiration), emotions associated with the presenting problems are dominant, and some anxiety about rejection or shame is present. At this point, the presence and ministrations of the therapist have only a modest effect on their client's emotional and physiological regulation. Ideally, however, clients should experience some relief at the end of early sessions, an indication to him or her of the therapist's viability as an attachment figure.

*Evidence.* Turning toward figures believed to be capable of providing support in times of distress, be they family members, friends, or professionals, appears to be a normative phenomenon. Although few people who experience psychological problems seek help from a mental health professional (Howard, Cornille, Lyons, & Vessey, 1996), they are most inclined to do so when their psychological distress is severe (Oliver, Pearson, Coe, & Gunnell, 2005) and alternative coping strategies have proven inadequate (Saunders, 1993). More important, the first contact with a therapist does not automatically make him or

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<sup>2</sup> To some readers, the model I describe is more a model of secure attachment. There are two reasons why I believe "normative" is the more appropriate label. First, I am not aware of any research, in either infant or adult attachment literatures, that suggests insecure attachment does not conform to the phases Bowlby (1969/1982) and Ainsworth (Ainsworth et al., 1978) proposed. Second, I suspect that insecure attachment to the therapist does follow the model but that it may exhibit a different timing (e.g., some phases may take more or less time to complete) or distorted versions of phase markers. I address this issue later in the paper.

her an attachment figure; clients are no more likely to engage in treatment when assigned to an intake therapist than to a subsequently assigned therapist (Noel & Howard, 1989).

Research suggests that clients evaluate, early on, the ability of therapists to act as an attachment figure (i.e., as a person who regulates rather than contributes to their distress). In a large sample of undergraduates, Vogel, Wade, and Haake (2006) found that students do not seek psychotherapy for fear that therapists might make them feel inadequate or incompetent (i.e., increase their distress). Clients also enter treatment with various expectations, including the expectation that the therapist will be of assistance and that interactions will be at least somewhat comfortable (Joyce & Piper, 1998). Some express skepticism in the therapy process or inquire about the therapist's qualifications whereas others monitor the therapist's behavior for signs of safety (Clarke, Rees, & Hardy, 2004). The latter has been long observed by psychoanalysts when clients first attempt free association (Greenson, 1967). When clients perceive therapists as trustworthy and as having expertise during an initial intake, they are less likely to prematurely terminate treatment (Kokotovic & Tracey, 1987; Tryon, 1989). Relatedly, Saunders (1999) found that clients, as of the third session, reported more hope and relief when they perceived their therapists as self-assured and easy to be close to, whereas they reported more distress when their therapists appeared emotionally unavailable. In a qualitative review of the engagement literature, Tryon and Winograd (2002) concluded that therapists who are better able to respond to clients' concerns, relay meaningful diagnostic information, and create a collaborative atmosphere were more likely to retain clients beyond the first session.

### *Phase 2: Attachment-in-the-Making*

At the end of the first phase, clients have identified the therapist as a potential attachment figure. By deciding to regularly attend sessions (i.e., maintain proximity), clients have opened the door to developing an attachment to the therapist. Markers of this phase are characterized by tentative but increasingly bold experiments in using the therapist as a safe haven for comfort and reassurance and, given positive results, as a secure base for exploring intimate issues.

Regarding behavior, clients carefully gauge

how safe it is to explore their frailties and failings by monitoring the extent to which the therapist is accepting, encouraging, and supportive in response to their disclosures. In other words, clients engage in more overt actions (e.g., more detailed disclosures) than in the previous phase in an effort to assess the therapist's ability to provide comfort, regulate affect, and facilitate exploration. Assuming positive assessments of the therapist's behavior, clients give fuller descriptions and divulge details or issues previously felt to be too shameful or painful to verbalize. Clients also become more responsive to their therapist's encouragement to explore prompting events, origins of presenting problems, or uncomfortable feelings. Similarly, clients turn to their therapist for reassurance that their psychological state or situation is manageable and "normal." They appeal to the therapist's expertise with direct or indirect requests for assistance (e.g., advice, information) or comfort (e.g., empathic understanding, normalizing, reframing), although they are unlikely to readily accept either. Clients in this phase are increasingly likely to share accomplishments or experiences of joy with the expectation that the therapist will receive them with delight and provide affirmation.

With each interpersonal cycle of exploration and comfort seeking, clients build a more complex internal working model of their therapist and the therapeutic relationship. They develop certain beliefs and expectations about this particular therapist's emotional availability and behavioral responsiveness. As well, they come to know which of their strategies optimally engages the therapist and how they typically feel during interactions with him or her. Their database of experience with the therapist allows them to predict, with increasing accuracy, the therapist's behavior toward them and their resulting feelings. Moreover, the accessibility of the model strengthens as treatment continues and begins to have a small but reliable impact on clients' subjective well-being and self-worth. For instance, clients occasionally evoke the model of their therapist outside of session in response to conflict or negative emotional states in hopes of reinstituting the comfort previously felt in the therapist's presence. The model also begins to compete with the chronic accessibility of clients' more solidified models of themselves in relation to previous attachment figures.

Physiologically, the presence of the therapist evokes negative arousal less often than in the previous phase. Instead, arousal is triggered primarily by struggles with ongoing life problems. Contact with the therapist often leads to soothing and is regularly pleasurable; the therapist frequently has a positive effect on the clients' emotional regulation. As this phase draws to a close, clients are inclined to feel trusting, accepted, understood, and comfortable rely on the therapist.

*Evidence.* What clients say and do not say in treatment supports the current characterization of a client's behavior in the attachment-in-the-making phase. Using qualitatively coded interviews conducted well after the beginning of treatment, Hill, Thompson, Cogar, and Denman (1993) found that clients in long-term therapy continue to monitor when it is sufficiently safe or comfortable to share certain types of information (e.g., personal secrets, negative reactions to interventions). However, over time, clients appear to disclose more as they feel more confident in the security of the therapeutic relationship. For example, Farber and Hall (2002; Hall & Farber, 2001) found that the duration of therapy and alliance strength both positively predicted disclosures.

Several studies suggested that clients gradually build and rely on an internal working model of their therapist. Early in treatment clients appeared to have limited access to the model, invoke them less often, and report only modest levels of comfort after doing so (Knox, Goldberg, Woodhouse, & Hill, 1999; Rosenzweig, Farber, & Geller, 1996). Nevertheless, early models can exert some effect on clients' self-perceptions. Shortly after treatment begins (approximately eight or nine sessions) clients become more self-accepting and self-loving when they have internalized their therapists as understanding and nurturing (e.g., Quintana & Meara, 1990).

Research also suggests that the emotional climate of the therapeutic relationship becomes more positive overall as treatment progresses. Clients report more trust, reliance, and "joyful connection" as treatment progresses (Quintana & Meara, 1990) as well as feelings of safety, comfort, and acceptance (Rosenzweig et al., 1996; Stiles et al., 1994). Based on these findings, it is tempting to speculate that anxiety-based physiological arousal caused by the presence of the therapist diminishes toward the end of this phase.

### *Phase 3: Clear-Cut Attachment*

Near the end of Phase 2, clients have a good sense of the therapist's responsiveness, availability, and sensitivity during times of distress. They perceive benefits to seeking support and have a subjective perception of being supported. More and more they view the therapist as their unique and irreplaceable consultant. In infancy, the markers of clear-cut attachment include figure preference, separation protest, stranger wariness, and attachment behavior that are organized around a preferred figure (safe haven, secure base behavior). Though less obvious, clients may exhibit similar markers.

Behaviorally, clients in this phase are more likely to have perceptible reactions to separations initiated by their therapist (e.g., vacations, therapist illness). They may protest (e.g., express anger or dread), disclose that the separation was stressful, or express relief when sessions resume. Moreover, they may report considerable reluctance relying on the "on-call" therapist during the intervening separation. In general, clients' attachment behavior becomes organized around the person of the therapist and clients' are more responsive to the therapist's interventions. Clients explicitly turn to the therapist in between sessions during times of crisis, report a desire for consultation between sessions, actively participate in making the session agenda (e.g., bringing questions), or recall previous conversations they found particularly influential ("I remember you said . . ."). Other less certain indications of figure preference are inquires about the therapist's personal interests and well-being or expressions of gratitude either verbally or through gift giving.

By this phase, clients have a reasonably complete internal working model of the therapist that they turn to during times of emotional or interpersonal strain. By "complete" I mean that the model has the all components of internal working models, namely, a rich network of memories of experiences with the therapist, beliefs and expectations about the self and the therapist, and strategies for fulfilling attachment needs (e.g., for comfort, security; Collins, Guichard, Ford, & Feeney, 2004). Evoking this model during times of need is a cognitive form of proximity seeking that may manifest itself in various ways (e.g., recollection of in-session conversations or sensations, evoking the memories or psychological presence of the therapist) and, more often than not, provides either some measure of relief (i.e.,



security) or facilitates independent exploration of and coping with the issue at hand. Given the therapist's status as an attachment figure, a severe therapeutic rupture during this phase is likely to be perceived by clients as an "attachment injury" (Johnson, Makinen, & Millikin, 2001), that is, a sense of abandonment or betrayal that occurs when an attachment figure is unavailable during a time of intense need or responds in a grossly invalidating manner. This injury can radically undermine confidence in the availability and sensitivity of the attachment figure (i.e., substantially "rewrites" the mental model of the other in negative terms) and, left unaddressed, may cause irreparable damage to the attachment and result in premature termination.

The primary physiological and emotional markers in this phase are characterized by regulation that is a result of contact with the therapist. The presence of the therapist, rather than provoking arousal as in the first phase of attachment, regularly leads to soothing. Clients find contact in this phase pleasurable and feel trusting, accepted, and understood. Comfort with the intimacy of the sessions is higher than in previous phases and uninhibited, genuine displays of affect, like crying, warm greetings, or mutual laughter, are more the norm.

*Evidence.* Although there is a dearth of empirical research on therapist-initiated separations, considerable anecdotal evidence documents that clients' reactions to breaks in treatment are similar to, though perhaps less intense than, the reactions of children to separations. For example, in a small survey conducted by Webb (1983) clinicians reported that clients reacted most commonly with anger and anxiety, feelings often associated with fears of abandonment, and some reported that clients looked forward to resuming sessions (i.e., reunion). In residential settings, patients may respond to separations with violence (Adshead, 1998) or their symptoms may destabilize (Persaud & Meux, 1994). When a therapist dies unexpectedly, clients in long-term therapy may experience loss and mourning (Rendely, 1999; Schwartz & Silver, 1990) not unlike that of bereaved spouses. More generally, clients report that the relationship with their therapists contains many components of attachment (Parish & Eagle, 2003), including proximity seeking, feeling comforted and supported, perceiving the attachment figure as wiser, viewing the therapist as irreplaceable, and having strong feelings for the therapist.

Not only were levels of these components positively correlated with both the duration and frequency of therapy, they were generally comparable to the levels clients reported regarding their primary attachment figure.

With continued treatment, clients appear to have greater access to the internal working model of their therapist and this access impacts both their behavior under stressful circumstances and the extent to which self-representations are revised. Clients deliberately invoke the model of their therapist during challenging situations or experiences of painful affect (e.g., Geller & Farber, 1993; Knox et al., 1999). As treatment lengthens, clients' self-representation becomes more accepting and less critical, apparently reflecting the internalization of a positive therapeutic relationship (Arnold, Farber, & Geller, 2000). Thus, the cognitive impact of the therapeutic relationship is consistent with predictions of attachment theory: Persons seek proximity when threatened in order to achieve a sense of security and progressively internalize the quality of relationships.

Several findings suggest that the emotional impact and intensity of the bond between client and therapist deepens over time. For some clients, internalization of interactions with their therapist appears to promote symptom reduction and improvement in overall functioning (Harrist, Quintana, Strupp, & Henry, 1994). Invoking memories of therapeutic interactions is also linked to improvements in clients' subjective rating of progress and gaining a sense of relief or comfort (Geller & Farber, 1993; Rosenzweig et al., 1996). Clients are more likely to report missing their therapist between sessions during the second year of treatment (Rosenzweig et al., 1996) and not uncommonly desire to continue the therapeutic dialogue beyond the consulting room (Geller & Farber, 1993). These findings also support the view that the therapeutic relationship functions in the service of emotional regulation. Accordingly, a similar degree of physiological regulation would also be expected but I am not aware of data that bear on this issue. Finally, Woodhouse, Schlosser, Crook, Ligiero and Gelso (2003) found a positive association between clients' sense of security with their therapist and treatment duration. They also found that security and negative transference were positively correlated leading them to speculate that clients delved into

more difficult issues when they felt a sense of security.

#### *Phase 4: Goal-Corrected Partnership*

Once a base of security is firmly established, clients and therapists are free to begin a more egalitarian partnership. In this phase, there is considerably less focus on issues of security between client and therapist and less overt proximity seeking by the client. Instead, attention is directed almost exclusively toward presenting problems. Clients are able to imagine that outside influences and events may realistically impinge on their therapist's availability, and they either make the necessary accommodations in their behavior or negotiate these obstacles with the therapist to achieve mutually agreeable solutions.

The behavior of clients in this phase is characterized by genuine consultation. Although the therapist is still seen as someone with special expertise, clients confidently contribute their perspective on current problems as well as ideas about treatment strategies. There is mutual curiosity about present struggles and equal investment in addressing them. Both client and therapist flexibly adapt to changes in schedules or interruptions of treatment. Not only is there less proximity seeking (other than attending sessions), but therapy-interfering transferences are rare.

The internal working model of the therapist becomes further elaborated during this phase and continues to influence clients' habitual ways of thinking, feeling, and behaving both toward themselves and toward other important individuals on whom they rely. The person of the therapist is a source of soothing and grounding rather than arousal, and interactions between client and therapist take on a "business as usual" flavor. Clients' attachment to their therapist still supports emotional regulation but this pattern is increasingly internalized.

*Evidence.* The empirical literature is strangely silent on the characteristics of the client-therapist relationship in long-term therapies. Characteristics of Luborsky's (1976) Type II alliance, discussed earlier, overlap with those in this phase, namely, a sense of teamwork and the client's ability to contribute his or her own ideas and reflections. Luborsky found that clients who developed Type II alliances were more likely to have improved over the course of treat-

ment and had therapies that were relatively long in duration (over 70 sessions).

The durability inherent in the partnership phase is most akin to the state of the alliance in the working phase of therapy as described by Greenson (1967). Greenson's definition of the alliance highlights the ability of the client to do the work of therapy, that is, to move easily between regression in service of the ego and jointly analyzing the content that arises. The prerequisite for this flexibility is a therapeutic relationship that is sufficiently reliable to encourage the client's exploration of problematic experiences and to buffer the client from the emotional strain of analytic work. Psychoanalytic writers agree that a firmly established working alliance is necessary to support the repetitive working through of resistances and transference issues (e.g., Fialkow & Muslin, 1987).

#### **The Role of Individual Differences in Attachment Security**

Many clients will not conform closely to the normative model I have proposed. As Bowlby (1984) noted (and as Bordin, 1979, recognized), people differ in their ability to "collaborate with that person [who provides a secure base] in such a way that a mutually rewarding relationship is initiated and maintained" (p. 104). Some clients, due to psychopathology or insecurity, may never reach the final phase of attachment, may move through the phases at different speeds, or may exhibit distorted versions of attachment markers in each phase. A benefit of applying attachment theory to the therapeutic relationship is that, unlike Bordin's formulation, the theory integrates normative processes and personality differences (i.e., attachment security); it gives a frame of reference to judge deviations from "normal" or "optimal" developmental processes. Because clients enter treatment with polished attachment strategies that are the outcome of their own interpersonal history with attachment figures, insecurity should manifest itself in differences in in-session behavior and in the growth of attachment to the therapist. I discuss this implication in terms of two broad types of insecurity: avoidant and anxious attachment.

The deactivating strategies of avoidant attached clients may retard the development of attachment. Because of their intense discomfort with dependence and intimacy, avoidant clients

will be prone to distancing and distrust in early therapeutic encounters and their typical defensive maneuvers (e.g., suppressing thoughts and feelings related to intimacy, self-inflation, devaluation; Mikulincer, Shaver, Cassidy, & Berant, 2008) will give therapists the impression that attachment development is absent. Thus, avoidant clients may take longer to move through each phase of attachment and the expression of attachment markers may be subtle or subdued (e.g., they may appear less distressed than others in Phase 1, make fewer, less overt, or abortive bids for reassurance, or their disclosures may involve less feeling in Phase 2). Research findings point in this direction. In a study of undergraduates, avoidance seemed to impede the development of attachment to peers (Fraley & Davis, 1997). Using the Adult Attachment Interview (AAI, George, Kaplan, & Main, 1996), Dozier (1990) found that, among patients who had been in short-term residential treatment for psychiatric problems, more avoidant patients tended to reject or avoid help, be less disclosing, and underutilize treatment. In a psychiatric case management program, more avoidant patients tended to underreport symptoms (Dozier & Lee, 1995). Avoidant mothers receiving a home visiting intervention were less likely to be invested in treatment and were unlikely to use crisis intervention or supportive therapy services (Korfmacher, Adam, Ogawa, & Egeland, 1997). In studies using self-report measures of adult attachment, more avoidant clients were unlikely to view their therapists as attachment figures (Parish & Eagle, 2003) and had difficulty forming strong alliances (e.g., Kivlighan, Patton, & Foote, 1998; Satterfield & Lyddon, 1995, 1998). Being more avoidant was associated with a precipitous decline in alliance strength at termination (Kanninen, Salo, & Punamaki, 2000) and prematurely dropping out of a treatment for eating disorders (Tasca et al., 2006). A similar picture appears when attachment security is measured with respect to the therapist using the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, & Coble, 1995). Mallinckrodt and colleagues found that avoidance was associated with weaker alliances (Mallinckrodt, Coble, & Gantt, 1995) and less in-session exploration (Mallinckrodt, Porter, & Kivlighan, 2005).

Anxiously attached clients will exhibit a different developmental pattern. Because they are inclined to feel helpless and lack the confi-

dence to cope independently, they amplify their distress, engage in self-deprecation, and convince themselves that they are closer or more similar to others than is true, all in an effort to elicit compassion, support, and avoid the threat of isolation (Mikulincer et al., 2008). Thus, anxiously attached clients are motivated to accelerate attachment development, display amplified versions of attachment markers, and possibly exhibit markers of later phases prematurely. Several research findings point to these possibilities. Using the AAI, Dozier and Lee (1995) found that attachment-related anxiety was associated with more self-reported symptomatology. Dozier (1990) found that highly anxious patients sought more help, were more disclosing, and utilized treatment more than highly avoidant patients. Yet, more anxious clients, as assessed by self-report scales, have difficulty forming strong alliances (Mallinckrodt, Coble, & Gantt, 1995; Satterfield & Lyddon, 1995), the strength of their alliances vacillate dramatically across treatment (Kanninen et al., 2000), and they experience more therapeutic ruptures (Eames & Roth, 2000) that are likely due to unrealistic expectations of care. When attachment security is assessed with the CATS, the subscale indicative of attachment-related anxiety (Preoccupied-Merger) is positively associated with negative transference (Woodhouse et al., 2003).

## **Discussion**

I have asserted that the emotional connection between client and therapist can be fruitfully viewed through the lens of attachment theory. In doing so, I have proposed the following: (a) the client–therapist bond is better conceived as an in-progress attachment to a therapist; (b) attachment to the therapist evolves in a series of sequential but overlapping phases; (c) each phase contains unique markers that fall across psychological domains; (d) over time, therapists progressively meet the criteria of an attachment figure; (e) clients' development of attachment to the therapist is influenced by attachment insecurity; (f) clients build an internal working model of their therapist; and, finally, (g) the ability of clients to evoke this model during times of stress is related to therapeutic change. Below, I discuss research issues involved in investigating attachment to therapists and clinical implications.

### Research Considerations

Verifying a normative model of attachment development in therapy dyads necessarily involves four challenges: documenting the existence, sequencing, and patterning of phases (i.e., to what extent phases overlap); empirically identifying phase markers; determining the time frame for each phase; and reliably measuring developmental progress. Regarding the task of documenting the phases, the literature on the therapeutic relationship is only partially helpful because studies in this area frequently target phases of treatment, which may or may not correspond to the developmental status of the therapeutic relationship, and no consensus exists on either the phases themselves or how they should be identified. In addition, attachment markers, especially the emotional and physiological ones, have not been studied in all time frames. Certainly, qualitative and longitudinal studies of attachment development will be essential. Once the normative attachment process is better described, variations that insecurity may impose should be aggressively researched since most clients presenting for psychotherapy exhibit insecurity.

Regarding the issue of time, variability in treatments, in addition to differences in attachment security, prevent generalizable estimates for each phase. Treatments vary in their session frequency, session duration, and length. Because interpersonal contact is necessary for an attachment to form, therapeutic dyads that have lengthier or more frequent contact are expected to steadily advance through the phases, whereas shorter therapies may cap the growth of attachment. An open question is whether brief therapies that mobilize strong affects accelerate attachment development.

There are good reasons to suspect that attachment to therapists may not take as long to develop as romantic attachments. First, the client is usually in intense distress, which mobilizes the attachment system. Second, the weekly format of most psychotherapies guarantees regular and sustained contact; absent is the haphazard contact characteristic of the early phase of an adult romantic relationship. Third, the social expectation of disclosure of private and emotionally sensitive issues, a fertile test bed of trust and intimacy, exists from the first session. Finally, because therapists are trained to alleviate distress and establish relationships, they are near tailor-made attachment figures.

A major challenge is how to empirically identify when a phase of attachment has been reached. One approach is to measure components of attachment and the time frame in which each component is transferred to a potential attachment figure. The approach has proven successful in the area of romantic relationships using the WHOTO scale (Hazan & Zeifman, 1994). An analogous measure, the Components of Attachment Questionnaire (CAQ; Parish & Eagle, 2003), shows promise as a scale for rating the extent to which a therapist fulfills the functions of an attachment figure. Care must be taken in using current attachment assessments (e.g., the AAI or self-report scales) to measure attachment development. These tools specifically assess the degree of attachment security and not the extent to which one person is attached to another. They are best used to track changes in the security of clients and client-therapist dyads over time or to examine how insecurity impedes attachment to the therapist.

### Clinical Implications

For clinicians, there are several advantages of recasting the bond component of the alliance in attachment terms. The first is the addition of a motivational framework to alliance theorizing. Attachment theory provides a rationale for why clients pursue treatment, why the person of the therapist is such an integral part of successful treatment, why the quality of the relationship is important, and how therapeutic relationships might evolve normatively as well as idiosyncratically. Second, the proposed framework offers a heuristic guide to clinicians. It includes a number of observable behavioral markers that can be used to monitor the unfolding of the therapeutic relationship. Deviations from the phases can be useful adjuncts to the assessment of attachment insecurity beyond self-report or interview measures. Third, identifying the current phase of attachment might also inform judgments about the timing and choice of therapeutic interventions, for example, abstaining from interventions in Phases 1 or 2 that require the emotional durability of a clear-cut attachment.

Although I have not discussed the therapist's role in the client's attachment process due to space limitations, Bowlby (1988) certainly believed that the behavior of the therapist was a critical ingredient to the therapeutic relationship:



Even so, a patient's way of construing his relationship with his therapist is not determined solely by the patient's history: it is determined no less by the way the therapist treats him. Thus the therapist must strive always to be aware of the nature of his own contribution to the relationship which, among other influences, is likely to reflect in one way or another what he experienced himself during his own childhood. (p. 141)

Indeed, there is ample evidence that therapists' behavior is an important variable in alliance strength (e.g., Ackerman & Hilsenroth, 2003). Behaviors that positively correlate with higher alliance scores (e.g., warmth, trustworthiness) are consistent with characteristics of a security-enhancing attachment figure. Research also suggests that the therapist's own security impacts the therapeutic process, as does the match in security between therapist and client (for a review, see Berant & Obegi, 2008). Thus, it seems likely that the length of phases will turn on, in part, the ability of therapists to provide a security-enhancing climate that is adapted to individual differences in attachment security.

#### *Attachment, Alliance, and Therapeutic Change*

Because I have focused on the bond component of the alliance, I have not addressed how attachment theory can also be applied to the other aspects of alliance, namely, collaboration on tasks and goals. In brief, an attachment-based view suggests that collaboration is a function of the client's sense of security in the therapeutic relationship or, if a clear-cut attachment to the therapist has formed, how securely attached the client is. Security should enable clients to explore difficult issues, recruit necessary resources, and problem-solve effectively. In the nonclinical literature, several studies have found that security is related to effective conflict management with partners (for a review see Mikulincer & Shaver, 2007). Thus, in attachment terms the alliance, that is, the degree of collaboration on tasks and goals in the context of a mutual bond, is simply the degree of attachment security a client feels within an in-progress attachment. Future theorizing should elaborate this distinction.

Although strong alliances are related to therapeutic change, alliance theory has little to say about how and why this occurs (Castonguay et al., 2006). By necessity, I have given limited attention to how an attachment-based view conceptualizes therapeutic change. I suggested that opportunities to revise long-standing internal working models are embedded in the process of

becoming attached and that this may contribute to therapeutic change. Of course, this idea is not original—it is present in many conceptualizations of change, including Bowlby's (1988). If attachment theory is to be applied more fully to adult psychotherapy, the process of therapeutic change will need more attention from theorists. The ideas of Mikulincer and Shaver (2004), among others (Fonagy, Gergely, Jurist, & Target, 2002; Wallin, 2007), offer fertile ground for this work.

In summary, I have proposed a framework of attachment to the therapist that offers an alternative and expanded view of the emotional connection or bond between clients and therapists. I argued that it is advantageous and possibly more accurate to view the therapeutic bond as an unfolding attachment, that the development of attachment to the therapist conforms to Bowlby and Ainsworth's phases of attachment, and that each phase should evince certain attachment markers across a range of behavioral domains. Although I reviewed evidence for the framework, considerable work will be necessary to establish its validity and to document the variations that individual differences in attachment security may impose. Nevertheless, an attachment perspective on the therapeutic bond shows promise as a rich source of testable hypotheses.

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