

## ABSTRACT

Title of Dissertation: TRANSFERENCE AND CLIENT  
ATTACHMENT TO THERAPIST:  
CHANGES ACROSS THE COURSE OF  
PSYCHODYNAMIC PSYCHOTHERAPY

Kathryn V. Kline, Doctor of Philosophy, 2020

Dissertation directed by: Professor Clara E. Hill, Department of  
Psychology

Although there are important clinical connections between transference and client attachment (Bowlby, 1983), limited empirical research exists examining their relationship across psychotherapy. This study examined the association between positive and negative transference and Client Attachment to Therapist (CAT; Mallinckrodt et al., 1995) across the course of 51 cases of open-ended psychodynamic psychotherapy. Using multilevel growth modeling, results indicated that Client Secure CAT increased and Avoidant-Fearful CAT decreased across the course of psychotherapy. In addition, higher initial Avoidant CAT was associated with higher initial negative transference, and a decrease in negative transference across psychotherapy. Finally, psychological distress moderated the relationship between CAT and transference, such that only clients reporting high psychological distress showed significant associations between insecure attachment and transference at the beginning of psychotherapy. Implications for research, practice, and therapist training are offered.

TRANSFERENCE AND CLIENT ATTACHMENT TO THERAPIST: CHANGES  
ACROSS THE COURSE OF PSYCHODYNAMIC PSYCHOTHERAPY

by

Kathryn Victoria Kline

Dissertation submitted to the Faculty of the Graduate School of the  
University of Maryland, College Park, in partial fulfillment  
of the requirements for the degree of  
Doctor of Philosophy  
2020

Advisory Committee:

Professor Clara E. Hill, Chair  
Professor Dennis M. Kivlighan  
Professor Mary Ann Hoffman  
Professor Hedwig Teglasi  
Assistant Professor Pepper Phillips

© Copyright by  
Kathryn Victoria Kline  
2020

## Dedication

This dissertation is dedicated to psychotherapist trainees of the past, present, and future. May we continue to do the difficult work of examining the dark and unknown parts of our minds in order to better understand those parts of our patients.

## Acknowledgements

I would like to acknowledge my steadfast support system during the three years of this study. To my advisor—Clara—thank you for being an inspiration. You have taught me vital lessons about psychotherapy research and training, finding meaning in work, and most importantly the power of persistence. To Jen Brady and Yun Lu—my best cohort mates and fellow lovers of psychoanalytic theory—it has been invigorating to learn and grow alongside one another. Finally, to my husband—Abe Massad—you supported me in my darkest moments of this process. Thank you for being my light and for seeing the light in me.

# Table of Contents

Dedication .....	ii
Acknowledgements .....	iii
Table of Contents .....	iv
List of Tables .....	v
List of Figures .....	vi
Chapter 1: Introduction .....	1
Chapter 2: Method .....	11
Participants .....	11
Measures .....	12
Procedures .....	16
Data Analyses .....	17
Chapter 3: Results .....	22
Chapter 4: Discussion .....	28
Appendices .....	41
References .....	74

## List of Tables

Table 1: Means, Standard Deviations, and Intercorrelations among All Variables.....	68
Table 2: HLM Fixed Effects for Models of CATS Predicting Negative Transference.....	69
Table 3: HLM Fixed Effects for Models of CATS Predicting Positive Transference.....	70

## List of Figures

Figure 1: Client OQ as moderator of initial Avoidant-Fearful CATS and Negative Transference.....	71
Figure 2: Client OQ as a moderator of initial Avoidant-Fearful CATS and Positive Transference .....	72
Figure 3: Client OQ as a moderator of initial Secure CATS and Negative Transference .....	73



## Chapter 1: Introduction

Transference can be defined as the “client’s experience and perceptions of the therapist that are shaped by the client’s psychological structures and past, involving carryover from earlier significant relationships and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully to those earlier relationships” (Gelso, Palma, & Bhatia, 2013, p. 1161). Understanding this phenomenon is important because it can provide insight into clients’ dynamics and problematic interpersonal patterns. Furthermore, given that transference is tied to a client’s earlier relationships, how the client attaches to the therapist is likely associated with it. Hence, the overall goal of the present study was to investigate transference and its relation to client attachment to therapist across the course of open-ended psychodynamic psychotherapy.

### **Transference and Attachment: A Theoretical Background**

Transference has been viewed as one of Freud’s greatest discoveries, although it has sparked much controversy even among psychoanalytic thinkers (Gelso et al., 2013). Freud (1888) initially described transference using the term “displaceable energies” to signify the transfer of strong feelings from one relationship to another person who was not associated with the origin of those feelings. Freud highlighted how clients attributed characteristics to the therapist that were not fitting of the therapist but rather of earlier caregiving figures (e.g., parents). He, among other theorists such as Piaget, explained how a client assimilates the therapist into their established schemas of caregivers, which leads to distorted beliefs, expectations, and

feelings toward the therapist (Wachtel, 1981). At the end of his life, Freud (1937) concluded that the client's ability to explore, understand, and ultimately resolve transference is indeed a reflection of client change in psychotherapy.

Bowlby (1982), whose attachment theory contributed significantly to the object-relations school of psychoanalysis, provided a rich understanding of why and how transference occurs. According to Bowlby, internal working models (defined as a person's experience-based mental models of how they view caregivers and themselves), are the link between the quality of attachment from childhood with caregivers and how people expect relationships to unfold later in life. Bowlby (1973) suggested that a client's internal working models lead the client to make "forecasts" (predictions) of how the therapist might act toward the client. For example, if insecurely attached clients have internal working models of being unworthy of care, they might expect that therapists will not want to help them, thereby expressing a negative transference toward the therapist.

Like Freud, Bowlby believed there was value in exploring the origins of these distorted forecasts. The ultimate goal is to show that these forecasts are not only incorrect but also damaging to the client's current relationships. Put another way, the goal is to show clients that they are living their present lives through a past lens. In the present study, we examined client attachment to therapist because we believed it would have an association with how clients transferentially perceive their therapists.

### **Empirical Studies of Transference in Psychotherapy**

The main methods that have been used to investigate transference in psychotherapy are semi-structured interviews with former clients (e.g., Ryan &

Gizynski, 1971), observers' ratings (e.g., Fried, Crits-Christoph, & Luborsky, 1992; Barber, Foltz, DeRubeis, & Landis, 2002), and therapists' ratings (e.g., Gelso et al., 1991, Woodhouse et al., 2003). Client interviews allow for rich detail about the transference phenomenon but are limited to clients' awareness and what they can describe. Observer-rating methods such as the Core Conflictual Relationship Theme (CCRT; Luborsky, 1977; Luborsky & Crits-Christoph, 1990) and Quantitative Assessment of Interpersonal Themes (QUAINT; Crits-Christoph, Demorest, & Connolly, 1990) provide standardized data across clients, but are limited in that judges are not directly involved in the therapeutic relationship and may not know how it feels to be in the room with the client. A strength of therapists' ratings is that they have first-hand knowledge of the phenomenon because they are participants in the event, but the limitation is that therapists' countertransference undoubtedly influences their ratings. Because we were interested in therapists' experiences of transference and wanted to examine multiple cases of open-ended psychotherapy, we chose therapist ratings to measure transference. Therapists were able to complete a brief measure about transference after each session, whereas observer ratings for the same number of sessions would have taken significant time and resources, and interviews would have intruded in the therapy process.

The most frequently used therapist-rated measure of transference is the Therapy Session Checklist-Transference Items (TSC-TI; Graff & Luborsky, 1977), which assesses overall amount of transference, positive transference, and negative transference post-session. The TSC-TI defines transference as the degree to which the client is dealing with material that is overtly or covertly related to the therapist; this

material may be a manifestation of or a displacement of earlier important relationships, and may be inferred due to the presence of distortion, strong affect, or inappropriate affect. Positive and negative transference are defined as client feelings toward the therapist or projections onto the therapist that are positively or negatively valenced, respectively. An advantage of the TSC-TI is that it includes only three items and can be assessed quickly after sessions. Limitations include the bias inherent in self-report and the use of only one item for each construct.

Transference, using the TSC-TI, was assessed longitudinally across psychotherapy in relation to outcome in three studies. Examining the course of transference, Graff and Luborsky (1977) and Patton et al. (1997) found that clients with better outcomes showed a linear increase in transference (assessed by a combination of all three items) across time. In contrast, Gelso et al. (1997) found that clients with better outcomes exhibited an increase in overall amount of transference and negative transference, assessed separately, in the first three quarters of therapy followed by a decrease of both in the fourth quarter. One explanation for this difference in findings is that the therapists in Graff and Luborsky and Patton et al. were specifically trained in and used psychoanalytic techniques, whereas the therapists in Gelso et al. were primarily psychodynamic but also reported some adherence to humanistic and cognitive-behavioral theories in their counseling. In addition, Graff and Luborsky's study comprised experienced psychotherapists, Gelso et al. comprised a combination of doctoral trainees and psychologists, and Patton et al. comprised practicum trainees. Also, different outcome measures were used (the TSC-Resistance Scale and a 1-item outcome measure in Graff and Luborsky, the

Counseling Outcome Measure in Gelso et al., and the Brief Symptom Inventory, Inventory of Interpersonal Problems, Goal Instability Scale, and Superiority Scale in Patton et al.), which limits the ability to compare results across studies. Overall, then, there is limited empirical evidence about how transference unfolds across psychotherapy and how patterns are related to other variables such as client attachment to therapist.

### **Empirical Studies of Client Attachment to Therapist in Psychotherapy**

The Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, and Coble, 1995) measures clients' perceptions of their relationship with the therapist from an attachment theory perspective. In the CATS, clients are conceptualized in terms of the hyperactivating or deactivating interpersonal strategies they use with the therapist. The Secure subscale reflects the degree to which a client perceives the therapist as emotionally responsive, available, and able to provide a secure base from which to explore the client's issues. The Preoccupied-Merger subscale assesses the degree to which a client is preoccupied with the therapist, longs for more contact with the therapist, and wishes to expand the boundaries of the therapeutic relationship (thus capturing hyperactivating strategies seen in an anxious attachment style). The Avoidant-Fearful subscale measures the degree to which a client suspects that the therapist is disapproving and rejecting, and the degree to which a client is reluctant to talk about issues for fear of feeling ashamed (thus capturing both hyperactivating seen in an anxious attachment style and deactivating strategies seen in an avoidant attachment style).

The CATS does not map onto other conceptualizations and measures of attachment styles. For example, Bartholomew and Horowitz's (1991) model includes a dismissive attachment category that reflects use of only deactivating strategies (i.e., individuals who are avoidantly attached). Mallinckrodt et al. (1995) argued that they did not find a purely avoidant factor in a client population because it is unlikely that individuals who use only deactivating interpersonal strategies would seek psychotherapy. Hence, the CATS does not measure a client's pure avoidance with respect to a therapist.

The CATS has been associated with important psychotherapy process and outcome variables including session depth and smoothness (Mallinckrodt, Porter, Kivlighan, 2005), client resistance (Yotsidi, Stalikas, Pezirkianidis & Pouloudi, 2018), and symptom change (Wiseman & Tishby, 2014). Only one study (Janzen, Fitzpatrick, & Drapeau, 2008) longitudinally examined the CATS, and they assessed it only in the first four sessions of psychotherapy. Because of the high negative correlations between the Avoidant-Fearful and Secure subscales, they created a composite subscale of Secure/Avoidant-Fearful attachment (i.e., Avoidant-Fearful scores were subtracted from Secure scores), which they reported as a Secure subscale. Thus, they conceptualized the Avoidant-Fearful subscale as a measure of attachment insecurity and did not examine results for the Avoidant-Fearful subscale alone. Janzen et al. found a significant increase in the CATS Secure subscale after a relationship building incident, but no changes in the CATS Preoccupied-Merger subscale.

### **Empirical Studies about the Association Between Transference and CATS**

Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) investigated the link between the CATS and transference (using a combined measure of the TSC-TI and Missouri Inventory of Transference Items, a 37-item measure with two subscales of positive and negative transference) for 51 client-therapist dyads after one psychotherapy session. They found that the CATS Preoccupied-Merger subscale was positively related to overall amount of transference and negative transference, which was consistent with evidence that individuals high in preoccupation, or anxious attachment, do not tend to have a positive view of others (Fraley & Shaver, 2000). Clinical evidence suggests that anxiously attached clients can feel rage toward therapists because they do not perceive the therapist as helpful or available enough (Slade, 1999). In addition, the CATS Secure subscale was also positively associated with overall amount of transference and negative transference, a finding that was contrary to the researchers' hypothesis but may suggest that a secure attachment to the therapist allows negative transference to emerge. That is, clients could be using their therapist as a secure base from which to explore challenging internal working models of self and other, as suggested by Bowlby (1988).

Woodhouse et al. (2003) was limited in that they only examined one middle session of psychotherapy. We suggest that it is important to examine these variables over time, especially because theoretically there should be changes in these variables across the course of psychotherapy. Given that the hope is for clients to develop more secure attachment styles, especially with their therapist as Bowlby (1988) proposed, it would be interesting to see if this is indeed the case, and how this relates to transference. We believe it is also important to examine how different attachment

styles to therapist are related to type of transference (i.e., positive or negative) because the interpersonal strategies used to maintain connection and resolve conflicts with the therapist are likely different for secure, preoccupied-merger, and avoidant-fearful clients.

### **Purposes of the Present Study**

The overarching purpose of this study was to explore the association between type of transference and client attachment to therapist across the course of open-ended psychodynamic psychotherapy. Given that it has been theorized that internal working models of others are akin to transference and influence how individuals think, feel, and behave in therapeutic relationships (Bowlby, 1973; Gelso et al., 2013), it seems likely that transference will relate to client attachment to therapist. Hence, the purposes were to examine the relationships among types of transference (positive and negative) and client attachment to therapist (secure, preoccupied-merger, and avoidant-fearful) across the course of psychotherapy.

Mallinckrodt et al. (1995) suggested that the CATS Preoccupied-Merger subscale involves hyperactivating strategies seen in individuals with an anxious attachment style. Clients with preoccupied-merger attachment yearn for more from their therapist and wish to expand boundaries with their therapist. Considering how these feelings seem similar to positive transference, it is possible that preoccupied-merger clients might display positive transference (i.e., idealize their therapist in hopes of building a positive, special bond), but it is also possible that they might display negative transference (i.e., have feelings of anger and disappointment that their therapist is not available or giving enough). Because there is not a clear



expectation for how this relationship will unfold, and because there is a lack of research providing support for specific hypotheses, we pose the following research questions:

**Research Question 1a:** What is the relationship between preoccupied-merger attachment to therapist and positive transference across therapy?

**Research Question 1b:** What is the relationship between preoccupied-merger attachment to therapist and negative transference across therapy?

Mallinckrodt et al. suggested that the CATS Avoidant-Fearful subscale involves both hyperactivating and deactivating attachment strategies seen in individuals with an anxious or avoidant attachment style, respectively. Clients with avoidant-fearful attachment to therapist have difficulty opening up to their therapist and fear rejection from their therapist. It seems possible that clients might exhibit a negative transference because of their difficulty being emotionally vulnerable, but they might exhibit a positive transference to try and prevent the rejection they fear. Because there is not a clear expectation for how this relationship will unfold, and because there is a lack of research providing support for specific hypotheses, we ask the following research questions:

**Research Question 1c:** What is the relationship between avoidant-fearful attachment to therapist and positive transference across therapy?

**Research Question 1d:** What is the relationship between avoidant-fearful attachment to therapist and negative transference across therapy?

Mallinckrodt et al. suggested that the CATS Secure subscale reflects a general secure attachment style. Although individuals with secure attachment tend to have

positive views of others in relationships (Bartholomew & Horowitz, 1991), Bowlby's (1988) clinical theory and one empirical study (Woodhouse et al., 2003) suggest that secure attachment to therapist allows negative transference to emerge during therapy, thereby allowing negative internal working models to be worked through in therapy. However, because of the lack of empirical evidence for this hypothesis, we ask the following research questions:

**Research Question 1e:** What is the relationship between secure attachment to therapist and positive transference across therapy?

**Research Question 1f:** What is the relationship between secure attachment to therapist and negative transference across therapy?

A second purpose of the present study was to examine the strength of the association between transference and client attachment to therapist as moderated by client psychological distress. It is possible that there is a stronger association between client attachment to therapist and transference for clients with higher psychological distress in contrast to clients with lower psychological distress. Thus, we asked:

**Research Question 2:** Is the strength of the relationship between transference and client attachment to therapist moderated by psychological distress?

## Chapter 2: Method

We used data from a university research clinic where low-cost, open-ended individual psychodynamic psychotherapy is provided by doctoral student therapists to adult community clients. Because we were interested in longer-term psychotherapy, only cases that had at least 32 sessions were included. Thus, the data comprised 3,051 sessions, 51 clients, and 24 therapists; cases ranged from 32 to 165 sessions ( $M = 68.04$ ,  $SD = 35.61$ ).

### Participants

**Therapists.** Therapists [16 female, 8 male; Age  $M = 31.04$  years  $SD = 8.54$  years; 11 White (1 international), 8 Asian (7 international), 3 Hispanic/Latinx (1 international), 2 Black] were counseling psychology doctoral students. Throughout their doctoral program, therapists trained in a variety of therapy modalities including psychodynamic, humanistic, and multicultural theories; had completed at least three practica prior to their work in the clinic; and agreed to work within a psychodynamic framework in the clinic. Theoretical orientation, assessed using the Therapist Orientation Profile Scale—Revised (TOPS, Worthington & Dillon, 2003), which had a 10-point scale (1 = *not at all*, 10 = *completely*), were as follows: Psychodynamic  $M = 7.53$   $SD = 0.92$ ; Humanistic  $M = 6.11$   $SD = 1.59$ ; and Cognitive-Behavioral  $M = 4.51$   $SD = 1.55$ .

**Clients.** Clients (26 male, 25 female;  $M = 34.65$ ,  $SD = 10.92$  years of age; 25 White (1 international), 15 Black, 4 Asian, 3 Multiracial, 2 Hispanic/Latinx, 2 Middle Eastern) were adult individuals from the community who sought low-fee open-ended psychotherapy. Presenting problems as reported in the screening interview were as

follows (more than one problem could be reported): Relationships (N = 40), depression (N = 24), anxiety (N = 21), career (N = 15), meaning in life (N = 14), and grief and loss (N = 8).

## **Measures**

The **Therapy Session Checklist-Transference Items** (TSC-TI; Graff & Luborsky, 1977) assesses post-session therapist-perceived client transference. There are three items, all rated on a 5-point scale (1 = *None or Slight*, 3 = *Moderate*, 5 = *Very Much*). The first item (overall transference, defined as, “The degree to which the client is dealing with material that is overtly or covertly related to the therapist. This material may be a manifestation of or displacement from an early important relationship(s). The previous person, or transference source, however, need not be mentioned; he or she may be inferred, and thus transference is inferred because of the presence of distortion, strong affect, inappropriate affect, etc.”) is, “How much transference did the client have in this session?” The second item (positive transference, defined as, “client feelings toward the therapist and projections onto the therapist that are positively valenced”) is, “How much positive transference did the client have in this session?” The third item (negative transference, defined as “client feelings toward the therapist and projections onto the therapist that are negatively valenced”) is, “How much negative transference did the client have in this session?” The TSC-TI has been used in 8 studies thus far, making it the most frequently used measure of therapist-rated transference. Some studies (i.e., Luborsky, Crabtree, Curtis, Ruff, & Mintz, 1975; Luborsky, Graff, Pulver, & Curtis, 1973; Woodhouse et al., 2003; Marmarosh et al., 2009) have treated the three items (amount, positive,

negative) as distinct constructs. In contrast, Gelso et al. (1991) combined the positive and negative transference items. And, Graff and Luborsky, 1977, Gelso et al. (1997), and Patton et al. (1997) combined all three transference items, reporting internal consistency alphas ranging from .81 to .84. Furthermore, even when some of these authors combined items, they did post-hoc analyses of the positive and negative items (Gelso et al., 1991; 1997).

Studies using the TSC-TI, either as single-item measures or as a combined measure, found results that fit theoretically. Specifically, Graff and Luborsky (1977) and Patton et al. (1997) found that the TSC-TI (combined three items) was stable in unsuccessful cases but increased in successful cases. Gelso et al. (1991) found that session evaluation was related to the interaction of transference and insight in a single session, found for both positive and negative transference items which were assessed separately, suggesting that both positive and negative transference are equally defensive processes. Similarly, Gelso et al. (1997) found that both client- and therapist-rated outcome were related to amount and negative transference (assessed separately) and the interaction of transference (combined three items) and insight. Marmarosh et al. (2009) found that negative transference (single item) was negatively correlated with therapist-rated real relationship, and that client romantic attachment anxiety was positively correlated with positive transference and negatively correlated with negative transference (both assessed as single items). Thus, there is some support for construct validity.

In terms of reliability, Luborsky and colleagues (Graff and Luborsky, 1977; Luborsky, Crabtree, Curtis, Ruff, & Mintz, 1975; Luborsky, Graff, Pulver, & Curtis,

1973) found a moderate level of interrater reliability (significant positive correlations ranging from .40 to .60) between therapists and observers on each of the three items. Kivlighan (1995) found a high correlation ( $r = .67$ ) between therapist and supervisor ratings of transference when the three items were combined for each rater. Gelso et al. (1997), who calculated alpha coefficients for the first four sessions of therapy, which they considered a measure of stability equivalent to test-retest reliability), found coefficients of .69 for overall transference, .66 for positive transference, and .86 for negative transference.

In the present study, we used the negative and positive transference items separately in the analyses because of the clinical distinction between internal working models of secure, preoccupied-merger, and avoidant-fearful attachment styles to therapist. That is, we believed that internal working models manifested as transference of these different client attachment styles to therapist would have different valences. Hence, we were interested in the association between attachment to therapist and the valence (positive, negative) of transference rather than overall transference. Correlations among the three items at the client-level (Level-2), which is the level at which analyses were examined, were: positive and negative transference  $r = .43, p = .002$ , positive and overall  $r = .84, p < .000$ , and negative and overall  $r = .69, p < .000$ .

The **Client Attachment to Therapist Scale** (CATS; Mallinckrodt, Gantt, & Coble, 1995) is a 36-item self-report measure of clients' perceptions of their relationship with their therapist from an attachment theory perspective. Items are rated on a 6-point scale with 1 = *strongly disagree* and 6 = *strongly agree*. The Secure

subscale (14 items) assesses the degree to which a client perceives the therapist as emotionally available and responsive, understanding, and able to provide a secure base from which to explore the client's issues (e.g., "My counselor is dependable"). The Preoccupied-Merger subscale (10 items) assesses the degree to which a client is preoccupied with the therapist and the therapist's other clients, wishes to expand the boundaries with the therapist, and longs for more from the therapist or to merge with the therapist (e.g., "I would like my counselor to feel closer to me."). The Avoidant-Fearful subscale (12 items) assesses the degree to which a client suspects the therapist is rejecting, disapproving, or dishonest, as well as the degree to which a client is reluctant to discuss difficult topics because they feel threatened or shamed when speaking with the therapist (e.g., "I feel humiliated in my counseling sessions."). Woodhouse et al. (2003) found adequate internal consistency coefficient alphas for the Secure, Preoccupied-Merger, and Avoidant-Fearful Subscales (.78, .84, .70, respectively). Mallinckrodt et al. reported adequate test-retest reliability for the Secure, Preoccupied-Merger, and Avoidant-Fearful Subscales (.84, .86, and .72, respectively). In addition, Mallinckrodt et al. 1995 and Mallinckrodt et al. 1998 found significant moderate correlations between the CATS subscales and object-relations deficits, working alliance, difficulty identifying and describing feelings, and aspects of dysfunctional family structures in theoretically predicted directions providing evidence of concurrent validity. For the multiple administrations of the CATS in the present study, internal consistency alphas for Secure ranged from .79 to .97, for Preoccupied-Merger from .75 to .96, and for Avoidant-Fearful from .81 to .99. Correlations among the three subscales at the client-level (Level-2, the level at which

analyses were conducted) were: Secure and Preoccupied-Merger  $r = -.03, p = 0.82$ , Secure and Avoidant-Fearful  $r = -.80, p < .000$ , Preoccupied-Merger and Avoidant-Fearful  $r = .13, p = .37$ .

The **Outcome Questionnaire 45.2** (OQ; Lambert et al., 1996) is a 45-item self-report instrument designed for repeated measurement of client psychological distress and progress. The OQ focuses specifically on symptomatology (e.g. “I have thoughts of ending my life”), interpersonal functioning (e.g. “I feel unhappy in my marriage/significant relationship”), and social role performance (e.g. “I find my work/school satisfying”). Each item is rated using a 5-point Likert scale from 0 (*never*) to 4 (*always*), with the total score being a sum of all the items. Higher scores reflect higher levels of symptomatology, poor interpersonal functioning, and poor social role performance. Evidence of adequate validity and reliability has been consistently reported for this widely-used measure. For the present study, internal consistency alphas ranged from .93 to .98 (based on multiple administrations).

## **Procedures**

Clients were recruited through various means (e.g., a website and Psychology Today). Clients first called or emailed the clinic for a screening by a clinic therapist. If considered appropriate during screening (i.e., 18 years or older, not receiving other individual therapy, interested in open-ended insight-oriented work, not needing substance abuse treatment, and if on medication then stabilized for at least two months) and agreed to be videotaped and pay the session fee, a therapist with matching availability scheduled an intake with the client. At the intake session, clients first signed informed consent and then completed pre-therapy measures including



demographics questionnaires. They next had an intake session where the therapist asked about presenting problems, childhood and family background, past and present relationships, and expectations for therapy. If clients continued at the clinic after intake, they stayed with the intake therapist for future sessions. Treatment was open-ended, ending when the client and therapist mutually decided on termination, client decided on termination unilaterally, or the therapist left the clinic. Therapists met weekly in individual supervision and biweekly in group supervision with experienced licensed psychodynamic psychologists. For the present study, clients completed the CATS after intake, session 3, and every 8<sup>th</sup> subsequent session (e.g., 8, 16, 24...), and the OQ after intake and every 8<sup>th</sup> session. Therapists completed the TSC-TI after intake and every session.

### **Data Analyses**

**Changes in CATS and transference across psychotherapy.** We used HLM 6.0 (Raudenbush, Bryk & Congdon, 2010) to create multilevel models controlling for the nested and interdependent nature of the data (i.e., sessions were nested within clients, which were nested within therapists). In separate analyses, we examined the change in CATS Secure, CATS Preoccupied-Merger, CATS Avoidant-Fearful, positive transference, and negative transference over time with a three-level model where scales were regressed onto time (i.e., session 0, session 3, session 8, session 16, and so on). Random effects at Levels 1 and 2 were included for each parameter in this model because we wanted to examine the variability in scales at these levels (i.e., how much variance in attachment and transference was at the session versus client levels).

**Multilevel growth modeling: CATS predicting transference.** We

constructed, as a second step, a 3-level model to examine growth in transference (positive or negative) with the retained CATS (Secure, Preoccupied-Merger, Avoidant-Fearful) intercept and slope coefficients as Level 2 predictors of initial transference (intercept), as well as growth of transference (slope).

The Level 1 model, using the example of positive transference and secure attachment, was:

$$Y (\text{Transference\_Pos}_{ijk}) = \pi_{0jk} + \pi_{1jk} * (\text{Session})_{ijk} + e_{ijk}$$

where Y represents positive transference outcome and Session represents the slope of positive transference.

The Level 2 model was:

$$\pi_{0jk} = \beta_{00k} + \beta_{01k} * (\text{Secure Attachment Intercept}_{jk}) + \beta_{02k} * (\text{Secure Attachment Slope}_{jk}) + \beta_{03k} * (\text{Length}) + r_{0jk}$$

$$\pi_{1jk} = \beta_{10k} + \beta_{11k} * (\text{Secure Attachment Intercept}_{jk}) + \beta_{12k} * (\text{Secure Attachment Slope}_{jk}) + \beta_{13k} * (\text{Length}) + r_{1jk}$$

The Level 2 model shows that there were two client-level predictors of a client's initial level of transference (intercept) and change in transference (slope). The first predictor variable, Secure Attachment Intercept, represents a client's initial (after intake) Secure CATS rating, and the second predictor variable, Secure Attachment Slope, represents the average change in client Secure CATS between observations. Both models controlled for length of treatment on Level 2.

The Level 3 model was:

$$\beta_{00k} = \gamma_{000} + \mu_{00k}$$

$$\beta_{01k} = \gamma_{010}$$

$$\beta_{02k} = \gamma_{020}$$

$$\beta_{03k} = \gamma_{030} + \mu_{03k}$$

$$\beta_{10k} = \gamma_{100} + \mu_{10k}$$

$$\beta_{11k} = \gamma_{110}$$

$$\beta_{12k} = \gamma_{120}$$

$$\beta_{13k} = \gamma_{130} + \mu_{13k}$$

The Level 3 Model shows that all random slopes at Level 3 were included and that there were no Level 3 predictors. Six models were run to examine the association between clients' intercept (initial) and slope (growth) of Transference and CATS subscales, such that the 3 CATS subscales each predicted positive or negative transference.

**Multilevel growth modeling: OQ as moderator of CATS and transference.** To examine the OQ as a moderator for the association between CATS subscales and Positive or Negative transference, we ran the following Level 1 model:

$$Y(Transference\_Pos_{ijk}) = \pi_{0jk} + \pi_{1jk}*(Session)_{ijk} + e_{ijk}$$

where Y represents positive transference outcome and Session represents the slope of positive transference.

The Level 2 model was:

$$\begin{aligned} \pi_{0jk} &= \beta_{00k} + \beta_{01k}*(WT\ OQ) + \beta_{02k}*(Secure\ Intercept_{jk}) + \beta_{03k}*(Secure\ Slope_{jk}) + \\ &\beta_{04k}*(Length_{jk}) + \beta_{05k}*(OQSecureIntercept_{jk}) + \beta_{06k}*(OQSecureSlope_{jk}) + r_{0jk} \\ \pi_{1jk} &= \beta_{10k} + \beta_{11k}*(WT\ OQ) + \beta_{12k}*(Secure\ Intercept_{jk}) + \beta_{13k}*(Secure\ Slope_{jk}) + \\ &\beta_{14k}*(Length_{jk}) + \beta_{15k}*(OQSecureIntercept_{jk}) + \beta_{16k}*(OQSecureSlope_{jk}) + r_{1jk} \end{aligned}$$

The Level 2 model shows that there were 6 client-level predictors of a client's initial level of transference (intercept) and change in transference (slope). The first predictor variable, WT OQ (within-therapist OQ), represents a client's average OQ score; the second predictor variable, Secure Intercept, represents a client's initial (after intake) Secure CATS rating; the third predictor variable, Secure Slope, represents the average change (slope) in client Secure CATS between observations; the fourth predictor variable, Length, controlled for treatment on Level 2; the fifth predictor variable, OQ Secure Intercept, represents the interaction of a client's average OQ rating and initial (after intake) Secure CATS rating; and the sixth predictor variable, OQ Secure Slope, represents the interaction of a client's average OQ rating and the average rate of change (slope) in Secure CATS between observations. The fifth and sixth predictors tested the moderation effects of the OQ on attachment and transference.

The Level 3 model was:

$$\beta_{00k} = \gamma_{000} + \mu_{00k}$$

$$\beta_{01k} = \gamma_{010}$$

$$\beta_{02k} = \gamma_{020}$$

$$\beta_{03k} = \gamma_{030}$$

$$\beta_{04k} = \gamma_{040} + \mu_{04k}$$

$$\beta_{05k} = \gamma_{050}$$

$$\beta_{06k} = \gamma_{060}$$

$$\beta_{10k} = \gamma_{100} + \mu_{10k}$$

$$\beta_{11k} = \gamma_{110}$$

$$\beta_{12k} = \gamma_{120}$$

$$\beta_{13k} = \gamma_{130}$$

$$\beta_{14k} = \gamma_{140} + \mu_{14k}$$

$$\beta_{15k} = \gamma_{150}$$

$$\beta_{16k} = \gamma_{160}$$

The Level 3 Model shows that all random slopes at Level 3 were included and that there were no Level 3 predictors. The 3 CATS subscales were run separately, each predicting positive or negative transference. Hence, 6 models were run to examine OQ as a moderator of the association between clients' intercept (initial) and slope (growth) of transference and CATS.

## Chapter 3: Results

### **Descriptive Analyses**

Means and correlations for all variables are shown in Table 1. For all variables, means were first calculated across each client's sessions and then across clients, so these represent Level 2 (client-level) scores. Table 1 shows significant positive correlations between negative and positive transference, positive transference and Preoccupied-Merger, negative transference and Preoccupied-Merger, positive transference and OQ, Avoidant-Fearful and OQ, and a significant negative correlation between Secure and Avoidant-Fearful, and Secure and OQ. Using Cohen's (1988) criteria that correlations  $> .10$  are small,  $> .20$  are moderate, and  $> .50$  are large, the correlations were generally weak to moderate, except the correlation between Secure and Avoidant-Fearful was large.

**Amount of variance for CATS.** We first ran an empty model with no predictor variables to determine the amount of variance in attachment subscales for each level. The intraclass correlation coefficient (ICC) for Secure was  $.67, p = .000$ , at Level 2 and  $.07, p = .035$ , at Level 3, indicating that 67% of variance was at the client level, 7% was at the therapist level, and 26% was at the session level. Variance significance could only be tested for the client and therapist levels, which indicated that there were significant client effects and therapist effects for the Secure subscale.

The ICC's for Preoccupied-Merger were  $.63, p = .000$ , at Level 2 and  $.11, p = .113$ , at Level 3, indicating 63% of variance was at the client level, 11% of variance was at the therapist level, and 26% was at the session level. Hence, there were significant client effects but not significant therapist effects.

Finally, ICC's for Avoidant-Fearful were  $.50, p = .000$ , at Level 2 and  $.21, p = .002$ , at Level 3, indicating that 50% of variance was at the client level, 21% of variance was at the therapist level, and 29% was at the session level. Hence, both client and therapist effects were significant.

In summary, most of the variance was at the client level for the three attachment subscales (67%, 63%, 50%). More of the variance was at the therapist level for Avoidant-Fearful than for the other two subscales (21% vs. 7% and 11%). About the same amount of variance was at the session levels for the 3 subscales (26%, 26%, 29%).

**Amount of variance for transference.** The ICC for negative transference was  $.08, p < .001$  at Level 2, and  $.20, p < .001$  at Level 3, indicating that 8% of variance was at the client level, 20% was at the therapist level, and 71% was at the session level. Hence, there were both significant client and therapist effects.

The ICC for Positive Transference was  $.09, p < .001$  at Level 2, and  $.38, p < .001$  at Level 3, indicating that 9% of the variance was at the client level, 38% was at the therapist level, and 53% was at the session level. Hence, there were both client and therapist effects.

In summary, most of the variance for transference was at the session level (71%, 53%), with less at the client (8%, 9%) and therapist level (20%, 38%). Sessions, however, accounted for more variance in negative than positive transference, and therapists accounted for more variance in positive than negative transference.

### **Changes in CATS and Transference across Psychotherapy**

To examine the linear growth in attachment subscales, we modeled time as a predictor of client attachment. Results indicated that Secure significantly increased over time,  $\gamma_{100} = .0061, p = .001$ , Avoidant-Fearful significantly decreased over time,  $\gamma_{100} = -.0031, p = .008$ , but there were no significant changes in Preoccupied-Merger over time,  $\gamma_{100} = .0005, p = .76$ . Thus, clients became more securely and less avoidant-fearfully attached to their therapists over time but did not change in preoccupied-merger attachment to their therapists.

To examine the linear and quadratic growth in negative and positive transference, we modeled time as a predictor of transference. Results indicated no significant linear,  $\gamma_{100} = -.001, p = .67$ , or quadratic,  $\gamma_{200} = .000, p = .77$ , changes in negative transference, and no significant linear,  $\gamma_{100} = -.000, p = .97$ , or quadratic,  $\gamma_{200} = -.000, p = .45$ , changes in positive transference.

### **Multilevel Growth Modeling: CATS Predicting Transference**

Next, we examined if initial levels and growth in client attachment styles were related to initial levels and growth in positive or negative transference. We ran the CATS subscales separately, each predicting positive or negative transference. We first tested models in which all random effects at Level 3 were estimated to account for variability in attachment to therapist at the client and session level. Many of these models failed to converge, probably because the models were overparameterized. Hence, we examined the random effects for attachment slope and intercept predictors by estimating and testing their significance one at a time. Most of these random effects were not significant, indicating that there was minimal variance between



therapists. Hence, we dropped the random effects for the attachment predictors on Level 3.

In the fixed effects model, the avoidant-fearful intercept (beginning of therapy) predicted both intercept,  $\gamma_{010} = 0.212$ , S.E. = 0.091663,  $p = 0.025$ , and slope of negative transference,  $\gamma_{110} = -0.005$ , S.E. = 0.001674,  $p = 0.006$ . That is, clients with higher initial avoidant-fearful attachment to their therapist had higher initial negative transference, but decreased in negative transference over time. There were no significant fixed effects for secure or preoccupied-merger attachment, nor for the association between attachment growth and transference growth.

### **Multilevel Growth Modeling: OQ as Moderator of CATS and Transference**

Next, we examined OQ as a client-level moderator for the association between the three CATS subscales (intercept and slope) and transference (intercept and slope). We ran the CATS subscales separately, each predicting positive and negative transference. Because most of the random effects were not significant in the previous models, we ran a fixed effects model.

In the fixed effect models, 3 of the 6 models predicting positive or negative transference intercept (initial positive or negative transference) showed significant interactions between client-level OQ and CATS intercept (initial CATS scores). There were no significant interactions between OQ and CATS slope predicting transference slope. That is, there were no significant moderation effects for the association between CATS and transference across time. Thus, all of the significant moderation effects were at the beginning of therapy. Specifically, initial negative transference and initial Avoidant-Fearful was moderated by client-level OQ,  $\gamma_{05} =$

0.701, S.E. = .218674,  $p = 0.003$ . Simple slope tests indicated that the relationship between negative transference and Avoidant-Fearful was only significant for clients with high levels of psychological distress ( $\gamma_{05} = .317, p = .000$ ). Thus, for clients who generally had high psychological distress, higher initial avoidant-fearful attachment predicted higher initial negative transference at the beginning of therapy, whereas for clients who generally had low psychological distress, the relationship between avoidant-fearful attachment and negative transference was not significant at the beginning of therapy.

In addition, initial positive transference and initial Avoidant-Fearful was moderated by client-level OQ,  $\gamma_{05} = 0.961, S.E. = 0.340760, p = 0.008$ . Simple slope tests indicated that the relationship between positive transference and Avoidant-Fearful was only significant for clients with high levels of psychological distress ( $\gamma_{05} = .268, p = .053$ ). Thus, for clients who generally had high psychological distress, higher avoidant-fearful attachment predicted higher positive transference at the beginning of therapy, whereas for clients who generally had low psychological distress, the relationship between avoidant-fearful attachment and positive transference was not significant at the beginning of therapy.

Finally, initial negative transference and initial Secure was moderated by client-level OQ,  $\gamma_{05} = -0.777, S.E. = 0.339169, p = .027$ . Simple slope tests indicated that the relationship between negative transference and Secure was only significant for clients with high levels of psychological distress ( $\gamma_{05} = -.322, p = .018$ ). Thus, for clients who generally had high psychological distress, lower secure attachment

predicted higher negative transference at the beginning of therapy, whereas for clients who generally had low psychological distress, the relationship between secure attachment and negative transference was not significant at the beginning of therapy.

### **Summary of Findings**

Secure CATS increased and Avoidant-Fearful CATS decreased across time in psychotherapy, although there was no change in Preoccupied-Merger CATS. There were no significant linear or quadratic changes in positive or negative transference across time in psychotherapy. In addition, clients who were initially higher in avoidant-fearful attachment to their therapists initially had higher negative transference and this decreased across time. There were no significant results for the association between transference growth and client attachment growth across the course of psychotherapy. Finally, clients with higher psychological distress and higher initial avoidant-fearful attachment to their therapists had higher initial negative and positive transference at the beginning of therapy, whereas clients with higher psychological distress and lower initial secure attachment to their therapists had higher negative transference at the beginning of therapy.

## Chapter 4: Discussion

In this study of 24 doctoral student therapists providing open-ended, individual psychodynamic psychotherapy to 51 adult clients for at least 32 sessions, we found some associations among secure and avoidant-fearful attachment to therapist, positive and negative transference, and psychological distress. These results suggest that client attachment to therapist and transference are indeed related.

Before interpreting our findings, however, we need to think about the CATS more deeply. In this study and in previous studies (Mallinckrodt et al., 1995; Woodhouse et al., 2003; Janzen et al. 2008), the Secure and Avoidant-Fearful subscales have been highly inversely related, with correlations ranging from  $-.64$  to  $-.80$ , suggesting a lack of independence between these subscales. Given that previous researchers have found that the CATS Avoidant-Fearful Subscale was positively related to both ECR Anxiety and Avoidance subscales (Mallinckrodt, Porter, & Kivlighan, 2005; Janzen et al., 2008; Wiseman & Tishby, 2014) and that this subscale reflects hyperactivating and deactivating strategies seen in anxious and avoidant attachment, respectively, researchers have suggested that the Avoidant-Fearful subscale assesses general insecure attachment to therapist. Hence, the Avoidant-Fearful subscale seems to reflect insecure attachment (i.e., a combination of anxious and avoidant attachment) or the opposite of the Secure subscale, and we interpret our findings through this lens.

In contrast, previous researchers have found no associations between Preoccupied-Merger and attachment insecurity as rated by the ECR, although theoretically they should be associated (Janzen et al., 2008; Wiseman & Tishby,

2014). An examination of the Preoccupied-Merger items indicates that they seem to tap into client boundary crossing (e.g., “I wish my counselor could be with me on a daily basis.”) and feeling special to the therapist (e.g., “I think about being my counselor’s favorite client”) rather than fearing rejection and abandonment. Boundary crossing and feeling special reflect a more positive preoccupation with the therapist, whereas fearing rejection and abandonment have a negative valence. Hence, it seems that this subscale is capturing a different construct than anxious insecure attachment to the therapist.

### **Changes in Client Attachment to Therapist Across Psychotherapy**

We found an overall increase in secure attachment to therapist across psychotherapy (i.e., Secure increased and Avoidant-Fearful decreased), which provides support for Bowlby’s (1982) clinical theory that clients begin to view their therapists as a secure base over time. We also extend Janzen et al.’s findings about increases in attachment security (a composite of Secure and Avoidant-Fearful) to therapists in the first four sessions to longer-term psychotherapy (our cases ranged from 32 to 165 sessions).

In contrast, scores on Preoccupied-Merger did not change across psychotherapy, which is similar to Janzen et al.’s (2008) findings. As noted above, it is not surprising that results for Preoccupied-Merger did not follow the same course across psychotherapy as the other two subscales since it seems to measure something different than client insecure attachment. These results suggest that whatever it is that is measured by this scale does not change as a result of therapy. Perhaps the subscale reflects more of a personality trait.

## **Changes in Transference Across Psychotherapy**

Examining empty growth models of transference, we found no significant linear or quadratic trends in positive or negative transference across the course of psychotherapy. This suggests that transference does not follow a specific trajectory across cases, but rather varied across sessions. Hence, transference may be situation-specific and perhaps triggered at any time. Furthermore, there were also client effects, indicating that clients significantly differed from one another in terms of positive and negative transference, which is interesting because it suggests that clients have very different styles in terms of transference. In addition, there were also therapist effects, indicating that therapists significantly differed from one another in their ratings of transference, especially for positive transference. Some therapists were more attuned to transference, perhaps because it fit more into their theoretical orientation or because their supervisors focused on it more. Given the vagueness and lack of operationalization of the construct, we also suspect that therapists were not completely sure about how to rate transference, which we will discuss in implications.

## **Client Attachment to Therapist in Relation to Transference**

In this section, we discuss the results for the three attachment subscales in relation to the two transference items.

### **Avoidant-Fearful CATS in relation to negative and positive transference.**

Clients who reported feeling insecurely attached to their therapists in the beginning of therapy were perceived by their therapists as exhibiting higher negative transference in the beginning of therapy. According to attachment theory, individuals with insecure attachment styles tend to have negative perceptions of others, such that they

misperceive and treat others as negative figures (Dykas & Cassidy, 2011). Hence, our results suggest that as clients were feeling insecurely attached to the therapist, they were perceiving or treating the therapist as a negative figure, to which therapists were attuned and labeling as negative transference. Interestingly, these insecurely attached clients decreased in therapist-rated negative transference, such that therapists perceived these clients as having a less negatively distorted relationship with them across time. Thus, it is possible that these clients altered their internal working model of the therapist as being less of a negative relational figure, although therapists could have rated transference lower based on other factors (e.g., a stronger working alliance or real relationship developing). These results do not align with Woodhouse et al. who found no significant associations between avoidant-fearful attachment to therapist and negative transference. A potential explanation for this divergence is that our sample had slightly higher avoidant-fearful attachment to therapist than Woodhouse et al.'s sample (Cohen's  $d = .19$ ).

The lack of a significant relationship between Avoidant-Fearful and positive transference aligns with previous studies. For example, Gelso et al. (1991, 1997), Multon et al. (1996), and Woodhouse et al. (2003) all found that correlations between therapist-rated positive transference and other variables were consistently lower and less often statistically significant than correlations between therapist-rated negative transference and those same variables.

Overall, these results suggest that clients with high initial insecure attachment to therapist engage in more negative than positive transference. Alternatively, therapists may be less attentive to positive than negative transference.

**Secure CATS in relation to negative and positive transference.** Although the Secure and Avoidant-Fearful subscales were highly inversely related, results diverged in that the significant associations found for Avoidant-Fearful and negative transference were not inversely found for Secure. In addition, our results do not align with Woodhouse et al.'s (2003) findings that Secure attachment to therapist was positively associated with negative transference, although the different results may be because Woodhouse et al. examined only one middle session of therapy, whereas we conducted a longitudinal study. Also, Secure scores were higher in Woodhouse et al.'s study than in our sample (Cohen's  $d = .31$ ). Hence, our study does not provide support for Bowlby's (1988) theory that a secure attachment to therapist allows negative transference to emerge and be processed in the therapeutic relationship.

**Preoccupied-Merger CATS in relation to negative and positive transference.** There were no significant results between Preoccupied-Merger and negative or positive transference. Hence, our findings do not align with Woodhouse et al.'s (2003) finding that Preoccupied-Merger was positively associated with negative transference, although as noted above Woodhouse et al. studied only one middle session of therapy, and Preoccupied-Merger scores were higher in Woodhouse et al. than in the present study (Cohen's  $d = .39$ ). As noted above, it is not clear that Preoccupied-Merger is assessing insecure attachment given that this construct has not been correlated with general anxious attachment (Wiseman & Tishby, 2014), so it is difficult to interpret the results in terms of attachment theory.

**Growth associations of attachment and transference.** Because we found no significant associations between client attachment to therapist growth and



transference growth, our findings suggest that these two variables are not related across the course of psychotherapy. However, we believe the lack of significant findings is due to limitations in the HLM growth model approach examining client-level variables. Specifically, only 8% of the variance in negative transference and 9% of the variance in positive transference was accounted for at the client level. Thus, using the two-step growth model analyzing how client-level attachment was related to client-level transference was not a good way to analyze this data set.

### **OQ as a Moderator of Transference and CATS**

Psychological distress helped to explain the relationship between CATS and transference at the beginning of therapy. Specifically, both positive and negative transference emerged at the beginning of therapy only for insecurely attached clients who were in high psychological distress. This finding can be explained by the fact that individuals' attachment systems are activated when they feel distressed (Bowlby, 1982). Hence, when insecurely attached individuals are experiencing psychological turmoil, they may rely on their coping mechanisms of shutting down emotionally (i.e., an avoidant attachment behavior) or increased bids for help (i.e., an anxious attachment behavior) with the therapist. We suspect that the former may manifest as negative transference, and the latter may manifest as positive transference. It makes sense that insecurely attached clients who enter therapy as highly symptomatic, versus insecurely attached clients who are less symptomatic, would have activated insecure attachment systems, thereby engaging in more insecure attachment behaviors that are perceived as transference. Consequently, therapists may perceive more

transference for clients whose insecure attachment behaviors are activated by the psychological distress they are experiencing.

It is interesting that the moderation analyses were the only analyses that showed significant results for positive transference. This suggests that psychological distress is an important variable in understanding positive transference. We believe that positive transference is harder for therapists to estimate than negative transference, and suggest that therapists attune to positively distorted versus realistic aspects of the relationship, especially because positive transference was associated with higher psychological distress among insecure clients.

### **Strengths and Limitations**

This study is one of the few studies to examine client attachment to therapist and transference across psychotherapy. Another strength is the use of multilevel growth modeling which allowed us to examine variables at the client level while controlling for session and therapist levels. Although we were unable to see how client-level attachment and transference were related across the course of psychotherapy, the multilevel variance partitioning indicated significant client- and therapist-level effects for these variables. A final strength is that we included another client-level variable, psychological distress, as a moderator between client attachment and transference.

Several limitations must also be noted in considering the results of this study. First, this study was conducted on therapist trainees in at least their third year of doctoral training, and therefore the results may not generalize to other populations such as experienced therapists. This limitation is important given that the transference

measure relied on therapist self-report. It is possible that experienced psychodynamic therapists would be more attuned to transference and more aware of how it manifests across a wide range of clients. It is likely that theoretical orientation plays a role in therapist ratings as well. Although the present study's therapist sample was generally psychodynamic, it is probable that experienced therapists with more psychoanalytic training, such as psychoanalysts, would more readily recognize fluctuations in transference. Relatedly, therapist trainees' attunement to transference and how much their supervisors helped them conceptualize the transference aspects of the therapeutic relationship may have played a significant role in their transference ratings for this study. Some supervisors of this clinic were more psychoanalytically-oriented than others and worked more with their supervisees to conceptualize and work with concepts like transference. Thus, it is possible that such differences in supervision influenced differences in therapists' transference ratings.

Another limitation lies in the measure of transference. Although the TSC-TI is a brief measure and permits transference to be assessed quickly after sessions, positive and negative transference are each assessed by only one item, which compromises construct validity. In addition, we assessed only the therapist perspective, which limits us to what the therapist was aware of immediately following a session; clients, supervisors, and external judges would undoubtedly have provided different perspectives.

A final limitation relates to the measure of client attachment. Because the CATS does not provide a measure of avoidant attachment to therapist, and the Preoccupied-Merger subscale seems to reflect client boundary issues and feeling

special rather than fear of abandonment and rejection, it limits the ability to highlight how client insecure attachment styles toward the therapist are related to other variables. Furthermore, the use of a self-report measure limits us to what the client was aware of immediately after sessions. Finally, we may have missed some vital information given that we only administered the CATS every eight sessions.

### **Implications for Practice**

Our findings suggest that clients were increasingly able to use their therapist as a secure base over time, as proposed by Bowlby (1982). Thus, over time in psychotherapy, clients felt their therapists were increasingly dependable, attuned, and safe individuals with whom they could explore their problems. Our findings also indicate that when clients were feeling more insecurely attached to their therapist at the beginning of therapy, therapists were also perceiving negative transference. We thus first suggest the importance for therapists to be trained in both theories about attachment and transference so that they can recognize manifestations of both in therapy sessions. Then, when therapists think negative transference is present, they can conceptualize the dynamics and work to explore what attachment-based internal working models are getting activated and what material is activating them, with the goal of helping clients gain awareness about negative internal working models and provide opportunities to explore their origins. It is important to assess if other aspects of the therapeutic relationship, such as the working alliance, are strong enough to withstand the exploration of negative internal working models as they arise with the therapist. Because transference is at the heart of clients' interpersonal concerns, we suggest that therapists attune to ruptures that may occur in different components of

the therapeutic relationship when transference material is explored (Gelso & Kline, 2019).

In addition, our findings also indicated that clients with higher insecure attachments in the beginning of therapy decreased in negative transference across time, suggesting that these insecurely attached clients began to see their therapists as less negative attachment figures over time. Thus, therapists can work to alter internal working models of those clients who are initially insecurely attached to their therapists. We suggest that therapists take time to assess and conceptualize the transference before addressing it in session. By conceptualizing the transference, we believe therapists will be less likely to engage in countertherapeutic countertransference behaviors in response to the transference.

In addition, our moderation findings suggest that insecurely attached clients exhibit more transference when they are in high psychological distress. Thus, we suggest that therapists be attuned to how transference may emerge more strongly for insecurely attached clients during distressing times, and that a more compassionate stance may be warranted then.

The finding about therapist effects suggested that some therapists perceive more transference, especially positive transference, than do other therapists. Based on conversations with the trainees about the results of this study, we speculate that some trainees may have viewed positive transference as purely beneficial to the therapeutic work rather than seeing it as a distortion or defensive function. For example, some therapists might have rated positive transference low when the client was expressing feeling safe and understood by the therapist and wishing for similar relational

experiences outside of therapy. On the surface, this may seem like the client and therapist had a strong connection and that the therapist was attuned to the client. However, these positive feelings may have prevented the client and therapist from examining problematic patterns in the therapeutic relationship. Indeed, clinicians have highlighted how a positive transference often masks a negative transference (Greenson, 1967; Gelso & Bhatia, 2012). Thus, we suggest it is important for therapists to reflect about the positive aspects of the therapeutic relationship to identify which parts are distortions, defensive, and inhibitory, versus which parts are genuine and facilitative to the therapeutic work. We also suggest that training about the construct of transference, especially positive transference given that it can be misleading, is critical.

### **Implications for Research**

It would be interesting to see if increases in secure attachment and decreases in avoidant-fearful attachment to therapist translate to changes in clients' general attachment style (in other words, are they able to generalize attachment to therapists to other relationships). Collins and Read's (1994) theory of a hierarchical network of interconnected attachment models suggests that various attachment relationships (e.g., with therapists, with romantic partners) influence a person's general attachment style. Accordingly, a person with an anxious general attachment style can become more secure over time if this person has secure attachment experiences with significant others, like a therapist. Indeed, as Bowlby and other object-relations clinicians have theorized, one goal of psychodynamic psychotherapy is for clients' positive relational experiences with therapists to translate to clients' other

relationships (e.g., increased ability to trust others, or work through conflict). Hence, a next research step is to empirically test if changes in client attachment to therapist translate to client changes in general attachment.

Another future research direction is to use other methods (e.g., the CCRT) for assessing transference for clients with different attachment styles. For example, researchers could more closely examine how transference unfolds for secure, anxious, and avoidant clients by observing cases and using the CCRT method to examine if there are prototype transference patterns for these different attachment groups. This could provide important information about clinical distinctions of transference (e.g., positively versus negatively valenced) among securely and insecurely attached clients.

Another implication for research is to use other statistical strategies to analyze the data given that lack of significant associations between transference and attachment growth. Future studies could examine this question using a method that capitalizes on explaining the transference variance at the session level. For example, a cross-lagged multilevel model could examine if client attachment to therapist during one time period predicts transference in the following time period and vice versa.

Another need is for better measures of transference and client attachment to therapist. It is problematic that positive and negative transference is only captured using two items in the TSC-TI. It could be useful to create items that more specifically reflect the different manifestations of negative transference (e.g., client intense negative reactions toward the therapist, client unfounded beliefs that the therapist thinks poorly of the client, client expectations that the therapist will shame

or criticize the client) and positive transference (e.g., client idealization of the therapist, client beliefs that the therapist is perfect, client expectations that therapist could never hurt the client) in place of broad questions about how much negative and positive transference occurred. Such specificity may help therapists, especially trainees, be more clear about what constitutes transference. Furthermore, given that fewer significant results have been found in this study and previous ones for positive transference in comparison to negative transference, more focus is needed on defining and examining positive transference. Case studies of extreme positive transference could be helpful to alert therapists to what positive transference looks like. It could also be helpful to interview therapists to more thoroughly understand what they are attuning to and understanding as positive transference versus other positively valenced elements of the therapeutic relationship (e.g., a strong real relationship). In addition to therapist observations about what positive transference is, it could be useful to see if other perspectives, such as observers or supervisors, agree about times in which clients are exhibiting positive transference.

Finally, a better measure of client attachment to therapist seems warranted given the high correlation between Secure and Avoidant-Fearful subscales, the lack of relationship between Preoccupied-Merger and general anxious attachment, and conflation of the Avoidant-Fearful subscale with both anxious and avoidant attachment styles. Thus, a measure that captures pure avoidant and anxious attachment toward the therapist is needed.



# Appendix A

## Measures

### Theoretical Orientation Inventory—Therapist (TOPS)

The phrases below describe how a therapist might follow different theoretical orientations. There are no right or wrong answers to these items. Please read each statement carefully and then fill in bubble that corresponds to where you place yourself on the scale.

1. I identify myself as Psychoanalytic or Psychodynamic in orientation.

Not at all Completely

2. I conceptualize my clients from a Psychoanalytic or Psychodynamic perspective.

Never Always

3. I utilize Psychoanalytic or Psychodynamic methods,

Never Always

4. I identify myself as Humanistic or Existential in orientation.

Not at all Completely

5. I conceptualize my clients from a Humanistic or Existential perspective.

Never Always

6. I utilize Humanistic or Existential methods.

Never Always

7. I identify myself as Cognitive or Behavioral in orientation.

Not at all Completely

8. I conceptualize my clients from a Cognitive or Behavioral perspective.

Never Always

9. I utilize Cognitive or Behavioral methods.

Never Always

## Therapy Session Checklist—Transference Items (TSC-TI)

**Amount of transference:** The degree to which the client is dealing with material that is overtly or covertly related to the therapist. This material may be a manifestation of or a displacement from an early important relationship(s). The previous person (or transference source), however, need not be mentioned; he or she may be inferred, and thus transference from him/her to the therapist inferred, because of, for example, the presence of distortion, strong affect, inappropriate affects, etc.

**Positive transference** is when client feelings toward the therapist and projections onto the therapist are positively valenced.

**Negative transference** is when client feelings toward the therapist and projections onto the therapist are negatively valenced.

1. How much transference did the client have in this session?

1	2	3	4	5
None or slight	Some	Moderate	Much	Very much

2. How much positive transference did the client have in this session?

1	2	3	4	5
None or slight	Some	Moderate	Much	Very much

3. How much negative transference did the client have in this session?

1	2	3	4	5
None or slight	Some	Moderate	Much	Very much

## Outcome Questionnaire (OQ) 45.2

Looking back over the last week, including today, help us understand how you have been feeling. Read each item below and mark the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth.

Items rated:   Never       Rarely       Sometimes       Frequently       Almost Always

1. I get along well with others.
2. I tired quickly.
3. I feel no interest in things.
4. I feel stressed at work/school.
5. I blame myself for things.
6. I feel irritated.
7. I feel unhappy in my marriage/significant relationship.
8. I have thoughts of ending my life.
9. I feel weak.
10. I feel fearful.
11. After heavy drinking, I need a drink the next morning to get going. (If you do not drink, choose "never.")
12. I find my work/school satisfying.
13. I am a happy person.
14. I work/study too much.
15. I feel worthless.
16. I am concerned about family troubles.
17. I have an unfulfilling sex life.
18. I feel lonely.
19. I have frequent arguments.
20. I feel loved and wanted.
21. I enjoy my spare time.
22. I have difficulty concentrating.
23. I feel hopeless about the future.
24. I like myself.

25. Disturbing thoughts come to my mind that I cannot get rid of.
26. I feel annoyed by people who criticize my drinking (or drug use). (If not applicable, choose “never.”)
27. I have an upset stomach.
28. I am not working/studying as well as I used to.
29. My heart pounds too much.
30. I have trouble getting along with friends and close acquaintances.
31. I am satisfied with my life.
32. I have trouble at work/school because of drinking/drug use. (If not applicable, choose “never.”)
33. I feel that something bad is going to happen.
34. I have sore muscles.
35. I feel afraid of open spaces, of driving, or being on buses, subways, and so forth.
36. I feel nervous.
37. I feel my love relationships are full and complete.
38. I feel that I am not doing well at school/work.
39. I have too many disagreements at work/school.
40. I feel something is wrong with my mind.
41. I have trouble falling asleep or staying asleep.
42. I feel blue.
43. I feel satisfied with my relationships with others.
44. I feel angry enough at work/school to do something I might regret.
45. I have headaches.

## Client Attachment to Therapist Scale (CATS)

These statements refer to how you currently feel about your counselor. Please try to respond to every item using the scale to indicate how much you agree or disagree with each statement.

Items rated: Strongly Disagree, Somewhat Disagree, Slightly Disagree, Slightly Agree, Somewhat Agree, Strongly Agree

### **Secure Subscale**

1. I don't get enough emotional support from my counselor.
2. My counselor is sensitive to my needs.
3. My counselor is dependable.
4. I feel that somehow things will workout ok for me when I am with my counselor.
5. My counselor isn't giving me enough attention.
6. When I show my feelings, my counselor responds in a helpful way.
7. I don't know how to expect my counselor to react from session to session.
8. I can tell that my counselor enjoys working with me.
9. I resent having to handle problems on my own when my counselor could be more helpful.
10. My counselor helps me to look closer at the frightening or troubling things that have happened to me.
11. My counselor is a comforting presence to me when I am upset.
12. I know my counselor will understand the things that bother me.
13. I feel sure that my counselor will be there if I really need her/him.
14. When I'm with my counselor, I feel I am his/her highest priority.

### **Avoidant-Fearful Subscale**

1. I think my counselor disapproves of me.
2. Talking over my problems with my counselor makes me feel ashamed or foolish.
3. I know I could tell my counselor anything and s/he would not reject me.
4. I don't like to share my feelings with my counselor.
5. I feel humiliated in my counseling sessions.
6. Sometimes I'm afraid that if I don't please my counselor, s/he will reject me.
7. I suspect my counselor probably isn't honest with me.
8. My counselor wants to know more about me than I feel comfortable talking about.
9. I feel safe with my counselor.
10. My counselor treats me more like a child than an adult.
11. It's hard for me to trust my counselor.
12. I'm not certain that my counselor is all that concerned about me.

**Preoccupied-Merger Subscale**

1. I yearn to be "at one" with my counselor.
2. I wish my counselor could be with me on a daily basis.
3. I would like my counselor to feel closer to me.
4. I'd like to know more about my counselor as a person.
5. I think about calling my counselor at home.
6. I think about being my counselor's favorite client.
7. I wish there were a way I could spend more time with my counselor.
8. I wish I could do something for my counselor too.

9. I wish my counselor were not my counselor so we could be friends.
10. I often wonder about my counselor's other clients.



# Appendix B

## Literature Review

In this section, I will expand on relevant theory and studies to provide a greater context for the present study. I will review theories of transference, measurement of transference in psychotherapy, empirical investigations of transference in psychotherapy, measurement of client attachment in psychotherapy, and empirical studies examining associations between transference and client attachment.

### **Transference: A Theoretical Background**

Transference has been viewed as one of Freud's greatest discoveries, although it has sparked much controversy even among psychoanalytic thinkers (Gelso et al., 2013). The concept has also developed considerably since Freud's writings through theoretical and empirical investigation spanning multiple disciplines. Freud (1888) initially described transference using the term "displaceable energies" to signify the transfer of strong feelings within a certain relationship to another person who was not associated with the origin of those feelings. Freud highlighted how clients attributed characteristics to the therapist that were untrue of the therapist but true of earlier caregiving figures (e.g., parents). He, among other theorists such as Piaget, explained how a client assimilates the therapist into their established schemas of caregivers, which leads to distorted beliefs, expectations, and feelings toward the therapist (Wachtel, 1981). Freud believed that transference was primarily rooted in a client's Oedipal situation. That is, the feelings that are transferred to a therapist primarily relate to the client's unresolved conflicts with mother and/or father that developed

during the Oedipal period (Singer, 1970). In his later writings, Freud wrote about many more conceptions of transference that were not necessarily linked with Oedipal dynamics, but he remained firm in that the Oedipus complex is the primary birthplace for transference (Luborsky & Crits-Christoph, 1990). Unsurprisingly, many theorists do not believe transference is mainly related to Oedipal dynamics. However, a tenet of transference that most theoreticians have agreed with since Freud is that transference involves carryover from past to present and that transference reactions are distorted (Gelso & Bhatia, 2012). In addition, since Freud, transference has been viewed as a key phenomenon to explore, understand, and resolve in dynamic therapies.

Bowlby was another chief psychoanalyst who viewed transference as an important source of information. His concept of internal working models from attachment theory provides a richer understanding of why and how transference occurs. Internal working models are defined as a person's experience-based mental models of how they view caregivers and themselves (Main, Kaplan, & Cassidy, 1985). Internal working models are the link between the quality of attachment children had with their caregiver, and how they expect to be treated in relationships later in life. Bowlby (1973) described how a client's internal working models lead the client to make "forecasts," or predictions, of how the therapist might act toward the client. For example, if insecurely attached clients have internal working models of being unworthy of care, they might expect that the therapist will not want to help them. This prediction typically comes out in some way during therapy (e.g., by the client's statements to the therapist or intense feelings toward the therapist). Like

Freud, Bowlby believed there was much value in exploring the origins of these distorted forecasts. The ultimate goal was to show that these forecasts are not only incorrect but also self-defeating to the client's current relationships. Put another way, the goal is to show clients how they are living their present lives through a past lens. In sum, transference provides important data about clients' earliest caregiving relationships, as well as a means of evaluating the validity of their internal working models in new relationships.

Other psychoanalytic theorists from relational/intersubjective camps challenge classical psychoanalytic theories of transference, mainly about the extent to which transference is a distortion. They contend that transference is a co-construction by both client and therapist, paying more attention to how the client may be reacting to realistic parts of the therapist and how the therapist also pulls for certain reactions from the client. These intersubjective/relational psychoanalysts believe it is necessary for the therapist to facilitate exploration around what client and therapist both have created in the therapeutic relationship. Although most theorists believe that transference reactions can be realistic, or deserved to some extent, it is mainly held that transference always involves some distortion that is carried over from earlier figures. A final conception of transference is that it is totalistic, meaning it includes any and all reactions to the therapist. However, as Gelso and Hayes' (1998) highlight, when defining a construct it is important to be clear about what it is and what it is not. Hence, they arrived at the following definition that attempts to integrate classical and intersubjective/relational schools of thought: transference represents the patient's experience and perceptions of the therapist that are shaped by the patient's own

psychological structures and past, involving carryover from and displacement onto the therapist of feelings, attitudes, and behaviors belonging rightfully in earlier significant relationships. Although the therapist contributes to transference in some way, the element that distinguishes it from other aspects of the therapeutic relationship like the working alliance or real relationship, is that distortion is involved (Gelso et al., 2013).

### **Measurement of Transference in Psychotherapy**

Three methods have been used to investigate transference in psychotherapy. The first involves open-ended client interviews, the second involves observers' rating similarities between clients' narratives of significant others and of therapists, and the third involves therapists' ratings of transference in sessions.

**Client Interviews.** One study illuminated more descriptive details of transference through open-ended client interviews. Ryan and Gizinski (1971) interviewed 14 clients of six therapists about their experiences in behavior therapy to see if the phenomenon experienced in such therapy were similar to psychodynamic therapy. The clients (3 male, 11 female; age range 16-46) were seen in an outpatient setting for behavior therapy to work on relationship difficulties and anxiety. The median session number was 20 (minimum 3, maximum 50).

Interview data showed that clients talked considerably about interpersonal dynamics between them and their therapists, although they said these dynamics were infrequently paid attention to by their therapists in the therapy. Clients talked about both negative and positive transference reactions. For example, one client talked about her frequent spiteful arguments with her therapist, who often responded

similarly. These were never worked through, and the treatment failed in the client's eyes. Conversely, clients also talked about positive transference reactions. For example, one client regarded her therapist as warm and sensitive underneath, despite coming off as cold and intellectual on the outside, which was "similar to her brother" (p.7). She said she overcame her phobia to "show him she was a really brave person" (p.7). Another client regarded her therapist as the "kind of mother for whom it could be worth being good (p. 7)," and discussed envy toward her therapist's children. One client even discussed how she believed her treatment lasted longer than it should have, but she was "willing to stay because . . . I would hurt her if I quit" (p.7). The authors pointed out that despite the clear evidence in some cases suggesting dependent and sexual feelings, these therapists rarely discussed such reactions, even when they threatened the treatment's success. Hence, the authors concluded that that interpersonal elements were crucial to the success or failure of the treatment, but oftentimes were ignored.

One major limitation of client reports of transference is that clients are limited to discussing conscious elements of transference reactions. Thus, unconscious transference reactions and how they influence treatment are missed. It is possible that clients may be able to talk about transference after they develop an awareness and understanding of these reactions, but they are limited in reflecting on transference while it is occurring in the treatment.

**Observer Ratings.** The Core-Conflictual Relationship Theme method (CCRT; Luborsky, 1977; Luborsky & Crits-Christoph, 1990) was developed to assess similarities between narratives of significant others and therapists. The CCRT

examines a client's wishes and needs in relationships, perceived responses of other toward the client, and the subsequent responses of the client. Judges typically rate the presence of these wishes (W), responses of others (RO), and responses of self (RS) in clients' narratives of significant others and of their therapists in psychotherapy transcripts. Three studies (Luborsky et al. 1985; Crits-Christoph & Luborsky, 1990; Fried, Crits-Christoph, & Luborsky, 1992) used the CCRT method to examine narrative similarity between significant others and therapists. To provide more detail about the CCRT method I will review Fried et al. (1992). They analyzed the psychotherapy transcripts of 35 clients in psychodynamic therapy. Judges first derived each client's primary CCRT by selecting the most frequent wishes and responses from narratives told about significant others in psychotherapy. Next, judges rated the similarity of this primary CCRT with the client's narratives about his or her therapist. To control for chance similarity, narratives that focused on the therapist were also compared with other clients' CCRTs. They found that a clients' own CCRTs were more similar to the narratives about their therapist than were the CCRTs of other clients. Taken together, the three studies using the CCRT method indicated that most clients experience a single pervasive relationship theme that occurred with clients' significant others and their therapists, suggesting that similar relational patterns occur inside and outside of therapy.

One limitation of the CCRT method is that judges rate narratives consecutively as they occur for each client, which could increase the chance that judges see greater similarity in relationship narratives than actually exists. In addition,

the CCRT method extracts the most common relationship themes, which excludes exploring the prevalence of other themes.

To improve on limitations of the CCRT, researchers developed the Quantitative Assessment of Interpersonal Themes (QUAINT; Crits-Christoph, Demorest, & Connolly, 1990). The QUAINT method eliminates potential rater bias by assessing narratives in a randomized order. Judges rate the presence of W, RO, and RS in each psychotherapy narrative presented in a randomized order so that the client or session from which the narrative was derived cannot be identified. For example, Connolly, Crits-Christoph, Barber, and Luborsky (2000) examined the similarity between a client's interpersonal themes, derived from pre-treatment interviews, and the evident interpersonal themes with the therapist during short-term psychotherapy for major depression. They found that one-third of clients showed a significant association between the most pervasive interpersonal theme from pre-treatment narratives and the narratives about their therapist during treatment. Although transference occurred for a significant portion of these clients, it did not occur for the majority. This could be explained by short-term treatment (i.e., there was not enough time for major interpersonal themes to emerge) or client characteristics (e.g., clients talked less about interpersonal themes because they did not believe they were related to their depression). A number of studies (e.g., Crits-Christoph, Demorest, Muenz, & Baranackie, 1994; Connolly, Crits-Christoph, Barber, & Luborsky, 2000; Barber, Foltz, DeRubeis, & Landis, 2002; Waldinger et al., 2002; Tellides et al., 2008) using the QUAINT method have found significant

similarities in clients' narratives between significant others and therapists and that this association becomes stronger over time in therapy.

The observer-rating methods involving the CCRT and QUAIN T have certain strengths, particularly in terms of providing standardized data across clients. These measures are limited, however, in that judges are not directly involved in the therapeutic relationship so they may not actually know how it feels to be in the room with the client. Furthermore, these measures only assess a particular framework in terms of thinking about transference (i.e., similarity in narratives about significant others and the therapist in W, RO, and RS) that does not completely map onto earlier theories of transference. Finally, observer ratings of the CCRT and QUAIN T assess the form of transference but not the amount.

**Therapist Ratings.** Given that therapists are the individuals interacting with clients, they offer a valuable source of information about client transference. Two primary measures have been used to assess therapist-rated transference: the Missouri Identifying Transference Scale (MITS; Multon, Patton, & Kivlighan, 1996) and the Therapy Session Checklist-Transference Items (TSC-TI; Graff & Luborsky, 1977). The MITS was developed to reflect Greenson's (1967) clinical criteria for identifying transference reactions as opposed to realistic reactions to the therapist, and consists of 37 words or phrases reflecting potential transference reactions rated on a 5-point Likert-type scale ranging from 1 (*not evident*) to 5 (*very evident*). The MITS has two subscales: negative transference (25 items) and positive transference (12 items). Initial evidence for validity and reliability has been gathered from two studies (Patton et al., 1997; Woodhouse et al., 2003), which will be reviewed in sections below. One



of the limitations of the MITS is that it has many items, and perhaps is one reason why only two studies have used it.

The other primary measure used to assess therapist ratings of transference is the Therapy Session Checklist-Transference Items (TSC-TI; Graff & Luborsky, 1977). The TSC-TI asks therapists for their assessments on amount, positive, and negative transference, with all three subscales rated on a 5-point Likert scale (from 1 = *none or slight* to 5 = *very much*). Amount of transference is defined as the degree to which the client is dealing with material that is overtly or covertly related to the therapist that is a manifestation of or displacement from early important relationships and may be inferred by the presence of distortion, strong affect, or inappropriate affect from the client. Positive transference is defined as positive distorted reactions to or perceptions of the therapist that are transference based, whereas negative transference is defined as negative distorted reactions to or perceptions of the therapist that are transference based.

Researchers have demonstrated reliability and validity of the TSC-TI in several ways, which will also be reviewed thoroughly in sections below. An advantage of the TSC-TI is that it readily allows assessment of both the amount and valence of transference. Furthermore, the TSC-TI offers economic value because it includes only three items, as opposed to the 37 items for the MITS, and can be assessed immediately after sessions without training raters. Limitations include the bias inherent in self-report and the use of only three items. A comparison to observer-rated methods, however, suggests that the TSC-TI is optimal for assessing transference in cases with many sessions given the cost of observers rating many sessions.

## **Transference Patterns over the Course of Psychotherapy**

Graff and Luborsky (1977) examined long-term trends in transference as measured by the TSC-TI in four cases of psychoanalysis conducted by two experienced psychoanalysts. Treatment ranged from 508 to 1200 sessions and means for the TSC-TI were computed for units of 25 sessions and then graphed across time. In the two more successful cases transference increased throughout the therapy, whereas in the two less successful cases transference remained stable. In addition, in the two more successful cases, as transference increased resistance decreased. Graff and Luborsky proposed that the successful outcome in these two cases could be attributed to this simultaneous increase in transference and decrease in resistance, which they interpreted as the clients developing awareness and insight about the transference.

Extending upon this investigation, Gelso, Kivlighan, Wine, Jones, and Friedman (1997) examined transference (as reported by therapists using the TSC-TI after every session) over the course of quarters of treatment and its relation to psychotherapy outcome (as assessed by the Counseling Outcome Measure (COM), which assesses client improvement in terms of feelings, behavior, self-understanding, and overall) in 33 cases of time-limited therapy with a 12-session limit. They also split the cases by more and less successful outcome, which was determined by a median split on the combined client- and therapist-rated COM scores. They found that in more successful cases, amount of transference and negative transference increased during the first three quarters of therapy and then declined, whereas in less successful cases transference amount and negative transference continued to increase

throughout therapy. These findings suggest that in successful cases of short-term psychotherapy, clients experience an increase in amount and negative transference and then work through it during the last quarter of therapy, resulting in its decline. In addition, the increase in transference across the first three quarters suggests that the building of the therapeutic relationship may allow client transference to emerge, which is similar to Bowlby's theory (1988) that the client's using the therapist as a secure base allows problematic internal working models of caregivers to emerge.

Finally, Patton, Kivlighan, and Multon (1997) examined a short-term psychoanalytic counseling model to identify process dimensions and client outcome (a combination of the Brief Symptom Inventory, Inventory of Interpersonal Problems, Goal Instability Scale, and Superiority Scale) in 16 cases of short-term psychotherapy (up to 20 sessions). From a combination of several therapist (MITS, TSC-TI, Collaboration Scale, and Working Alliance Inventory) and observer measures (Vanderbilt Therapeutic Strategies Scale, Missouri Addressing Resistance Scale, and Resistance Scale) rated for each session, they identified four factors that accounted for 68.5% of the total variance: Psychoanalytic Technique, Working Alliance, Client Resistance, and Client Transference. They investigated how these variables related to one another and client outcome across treatment. The transference factor was a combination of the TSC-TI and the Missouri Identifying Transference Scale (MITS), which were both rated by therapists after each session like the TSC-TI. In general, transference increased during the middle phase of treatment and then decreased during the late phase, but those clients who had a linearly increasing pattern of transference had better outcomes. They also found that transference led to higher

levels of psychoanalytic technique, which in turn led to lower levels of transference. Furthermore, transference led to higher resistance in subsequent sessions. Finally, and perhaps most interestingly, higher levels of working alliance were followed by increases in transference and decreases in resistance in subsequent sessions. Again, it seems that a strong therapeutic relationship may help transference to emerge, as suggested by Bowlby (1988).

In sum, we found only three studies assessing transference across time in psychotherapy, all using the TSC-TI. Two of these studies involved short-term or time-limited therapy, whereas one involved very long term psychoanalysis. Graff and Luborsky (1977) and Patton et al. (1997) similarly found that clients with better outcomes showed an increase in transference across time. However, this finding contradicts Gelso et al. (1997) who found that clients with better outcome exhibited an increase in transference in the first three quarters of therapy followed by a decrease in the fourth quarter. One explanation for this is that the therapists in Graff and Luborsky and Patton et al. were specifically taught and used psychoanalytic technique, whereas this was not the case for therapists in Gelso et al. who were primarily psychodynamic, but also reported some adherence to humanistic and cognitive-behavioral theories in their counseling. It is also important to note that different outcome measures were used in each study, which limits the ability to draw firm conclusions about transference patterns and how they relate to outcome. Furthermore, no studies have yet been conducted of open-ended psychodynamic psychotherapy, which is important since transference patterns and relationships with outcome may vary from short-term/time-limited psychotherapy and psychoanalysis.

In addition, no studies have examined how transference patterns across psychotherapy may differ for clients with different attachment styles.

### **Transference and Client Insight**

Given that it is theorized that clients can only resolve their transference if they come to understand it, researchers have begun to empirically investigate the interaction between transference and insight. Gelso, Hill, and Kivlighan (1991) investigated transference, client insight, intentions of interventions, and session quality in a middle counseling session for 38 experienced therapists. After reviewing an audio recording of their session, therapists rated transference (positive and negative, using the TSC-TI) and insight (intellectual and emotional) on a 5-point Likert scale (from 1 = *none or slight* to 5 = *very much*), as well as session quality on a 5-point Likert scale (from 1 = *very poor* to 5 = *very good*). Gelso et al. found an interaction effect such that when transference (a combination of positive and negative ratings) was high, client insight (a combination of intellectual and emotional) was positively related to session quality. These findings suggest that when transference is high, accompanying insight is beneficial to session quality. However, when transference was high and there was low accompanying insight, session quality was low. When transference was low, session quality remained the same whether there was high or low insight. Overall, the highest session quality was related to high transference and high insight whereas the lowest session quality was related high transference and low insight. Gelso et al. also examined if there were any differences between the four insight-by-transference combinations (intellectual by positive or negative transference, emotional by positive or negative transference). Interestingly,

the same transference-insight interactions occurred whether the transference was positive or negative and whether the insight was intellectual or emotional. Hence, although there are theoretical speculations that negative transference can harm the therapeutic relationship (Gelso & Carter, 1985), it seems that an understanding of the negative transference can be helpful. Furthermore, both positive and negative transference are conceived as defensive, so insight on either theoretically could be important. In addition, the type of insight did not make a difference in session outcome. In sum, transference seems to be positively related to positive aspects of treatment if the client gains understanding of their dynamics and defenses regarding the transference.

Gelso, Kivlighan, Wine, Jones, and Friedman (1997) similarly examined the interactive role of transference (using the TSC-TI) and client insight (using the two-item measure used in Gelso et al., 1991) from the first session and first quarter of treatment in predicting the outcome of 33 cases of time-limited psychotherapy (12-session limit). They measured client- and therapist-rated outcome using the COM one month after termination. For both first session and first quarter predictions, results indicated that neither overall transference (combined measures of amount, positive, and negative) nor insight (intellectual or emotional) alone predicted outcome, but the interaction of overall transference and emotional insight was significantly related to therapist- and client-rated outcome, suggesting that emotional insight could be the influential variable in treatment. They also analyzed positive and negative transference separately, but no differences emerged with either intellectual or emotional insight. Hence, both positive and negative transference displayed the same

pattern of interaction with insight, and in no case were the interactions significant with either intellectual or emotional insight.

In sum, both of these studies found that the interaction of transference and insight is important for session and client outcome, and that positive and negative transference in conjunction with insight had the same effects on outcome. However, Gelso et al. (1991) found no differences between intellectual and emotional insight, whereas Gelso et al. (1997) found that only the interaction between transference and emotional insight was related to better outcome. This could be explained by the different outcome measures used in each study. That is, perhaps emotional insight is more important for client outcome, which was assessed in Gelso et al. (1991), whereas intellectual insight is sufficient for better session outcome, which was assessed in Gelso et al. (1997). Both studies suggest that the interaction between transference and insight variables are important for outcome, and offer a starting point on understanding this interaction. However, given there are only two studies investigating this hypothesis, both of which examined short-term treatment, it is important to replicate this investigation and extend it to longer-term treatment. Furthermore, it is possible that different interactions of insight and transference as they relate to outcome differ depending on client attachment style. Another concern is that these studies were conducted with a limited sample that prevented examination of session, client, and therapist-level effects. Hence, it is important to examine this question using a larger sample that permits such an investigation.

### **Measurement of Client Attachment in Psychotherapy**

Two main measures have been used to measure client attachment in psychotherapy: the Experiences in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) and the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, and Coble, 1995). The ECR was developed on the basis of a factor analysis of 14 self-report attachment measures and consists of an Anxiety and Avoidance subscale. The Anxiety subscale measures the degree to which respondents fear being rejected, abandoned, or neglected by others and the degree to which respondents desire more closeness to their partners than that desired by their partners. The avoidance subscale measures the degree to which respondents feel comfortable with interdependence and emotional closeness in close relationships. Reliability and validity evidence has been gathered in many studies (see review by Mikulincer and Shaver, 2007).

In contrast to the ECR, which measures an individual's general or romantic attachment (two separate forms), the CATS measures clients' perceptions of their relationship with the therapist from an attachment theory perspective. The CATS conceptualizes clients in terms of the hyperactivating or deactivating strategies they use with the therapist, and places clients into one of three categories. The Secure category represents the degree to which a client perceives the therapist as emotionally responsive, available, and able to provide a secure base from which to explore the client's issues. The Preoccupied-Merger category represents the degree to which a client is preoccupied with the therapist, longs for more contact with the therapist, and wishes to expand the boundaries of the therapeutic relationship—reflecting hyperactivating strategies seen in anxious attachment. The Avoidant-Fearful subscale



measures the degree to which a client suspects that the therapist is disapproving and rejecting, and the degree to which a client is reluctant to talk about issues for fear of feeling ashamed. This last subscale captures both hyperactivating and deactivating strategies. It is important to note that the CATS does not exactly map onto other conceptualizations of attachment. For example, Bartholomew and Horowitz's model includes a dismissive attachment category that reflects use of only deactivating strategies (i.e., individuals who are avoidantly attached). Mallinckrodt et al. (1995) argue that they did not find a purely avoidant factor in a client population because it is unlikely that individuals who use only deactivating strategies would seek psychotherapy. Hence, the CATS is not apt to measure a client's pure avoidance with respect to their therapist.

### **Transference and Client Attachment**

Although there are clear theoretical links between transference and client attachment, we found only two empirical studies examining this association. Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003) investigated the association between client attachment to therapist using the Client Attachment to Therapist Scale (CATS; Mallinckrodt, Gantt, & Coble, 1995) and transference using the TSC-TI and MITS. Examining 51 client-therapist dyads in single middle sessions of ongoing psychotherapy (i.e., had completed at least 5 but no more than 50 sessions), Woodhouse et al. found that preoccupied-merger attachment to therapist and secure attachment to therapist was positively associated with amount of transference and negative transference perceived by therapists, as assessed a combination of the TSC-TI and MITS. Avoidant-fearful attachment to therapist was not significantly

associated with amount or type of transference. Finally, no attachment style to therapist was associated with positive transference. Results for preoccupied-merger clients are consistent with other evidence that individuals high in preoccupation do not tend to have a positive view of others (Fraley & Shaver, 2000). In fact, clinical evidence suggests that clients with preoccupied attachments can feel rage toward therapists because they do not perceive the therapist as helpful or available enough (Slade, 1999). Results for secure attachment, contrary to the researchers' hypothesis, suggest that secure attachment to the therapist allows negative transference to emerge. That is, clients could be using their therapist as a secure base from which to explore challenging internal working models of self and other, as suggested by Bowlby's (1988) clinical theory. The Woodhouse et al. study was limited in that it was a cross-sectional design in which data were collected for only single therapy sessions for 51 unique dyads. Thus, this study cannot draw conclusions about the development of clients' attachment to therapist or transference overtime, nor can it reveal any multi-level effects of sessions, clients, or therapists.

Marmarosh et al. (2009) also examined the association between client attachment style (using the Experiences in Close Relationships Scale) and transference (using the TSC-TI) for 31 client-therapist dyads from a counseling center at the third therapy session and at termination. The Experiences in Close Relationships (with subscales of attachment anxiety defined as the extent to which a person fears being rejected, abandoned, or neglected by others, and attachment avoidance defined as the extent to which a person feels uncomfortable with emotional closeness and interdependence in relationships) is different from the CATS in that it

assesses trait-level attachment patterns with romantic partners rather than state-level attachment with the therapist. Marmarosh et al. found that client attachment anxiety was positively associated with positive transference and negatively associated with negative transference at the third psychotherapy session. Thus, clients with higher attachment anxiety expressed greater positive transference and lower negative transference at the third session. These findings conflict with Woodhouse et al.'s (2003) findings that preoccupied-merger attachment (similar to anxious attachment) was positively related to negative transference and had no association with positive transference. Different attachment measures, client samples, and time points in therapy could explain these different findings. In addition, Marmarosh et al. (2009) only examined two time points in therapy and therefore could not assess changes in transference or client attachment over time. We suggest that it is important to examine these variables over time, especially because three studies suggest that transference patterns change across the course of therapy (Graff & Luborsky, 1977, Gelso et al., 1997, & Patton et al., 1997). Furthermore, given that the hope is for clients to develop more secure attachment styles, it would be interesting to see if this is indeed the case, and how this relates to transference.

Table 1. Means, Standard Deviations, and Intercorrelations among All Variables.

Variable	1	2	3	4	5	6	M	SD
Pos Transference	--						1.87	.62
Neg Transference	.43**	--					1.79	.50
Secure CATS	-.13	-.14	--				5.28	.51
Preoccupied CATS	.35*	.29*	-.03	--			2.41	.69
Avoidant CATS	.11	.22	-.80**	.13	--		1.60	.58
OQ	.30*	.22	-.35*	.13	.40**	--	1.49	.45

*Note.* N = 51. \* p < .05, \*\* p < .01

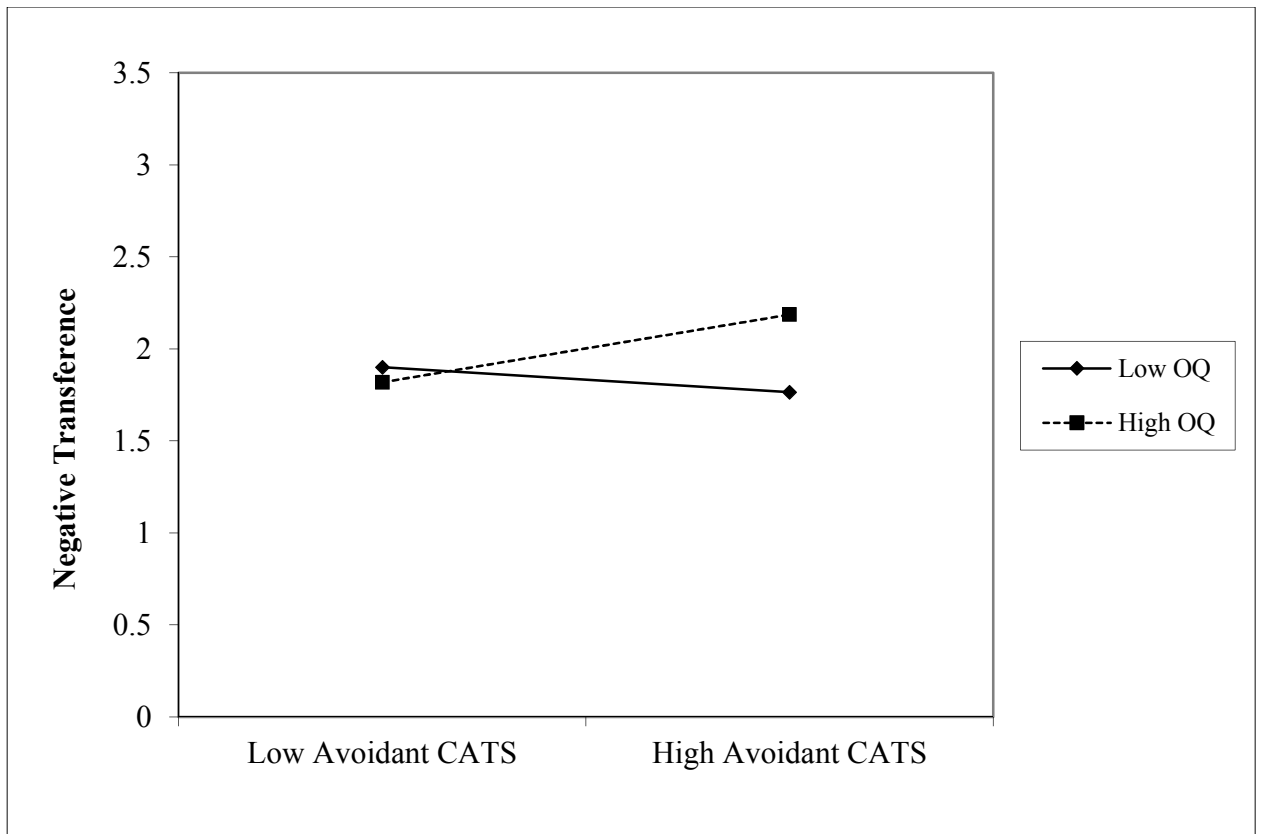
Table 2. HLM Fixed Effects for Models of CATS Predicting Negative Transference

Fixed Effect	Coefficient	Standard error	t-ratio	p-value
<b>Prediction of Negative Transference</b>				
Intercept	1.777	0.105	16.977	0.000
Avoidant CATS Intercept	0.212	0.092	2.316	0.025*
Avoidant CATS Slope	6.644	4.810	1.381	0.174
Slope	-0.001	0.002	-0.279	0.783
Avoidant CATS Intercept	-0.005	0.002	-2.915	0.006*
Avoidant CATS Slope	0.036	0.128	0.282	0.779
Intercept	1.741	0.105	16.529	0.000
Preoccupied CATS Intercept	0.124	0.079	1.565	0.124
Preoccupied CATS Slope	-3.069	3.327	-0.923	0.361
Slope	-0.000	0.002	-0.434	0.668
Preoccupied CATS Intercept	0.000	0.002	0.407	0.685
Preoccupied CATS Slope	0.018	0.094	0.196	0.846
Intercept	1.767	0.108	16.338	0.000
Secure CATS Intercept	-0.104	0.116	-0.899	0.374
Secure CATS Slope	-3.34	4.226	0.789	0.434
Slope	-0.001	0.002	-0.505	0.618
Secure CATS Intercept	-0.003	0.002	1.467	0.149
Secure CATS Slope	-0.052	0.106	-0.492	0.624

Table 3. HLM Fixed Effects for Models of CATS Predicting Positive Transference

Fixed Effect	Coefficient	Standard error	t-ratio	p-value
<b>Prediction of Positive Transference</b>				
Intercept	1.885	0.107	17.644	0.000
Avoidant CATS Intercept	-0.014	0.139	-0.101	0.920
Avoidant CATS Slope	-2.193	6.654	-0.330	0.743
Slope	0.000	0.002	0.153	0.880
Avoidant CATS Intercept	-0.000	0.002	-0.612	0.543
Avoidant CATS Slope	0.068	0.099	0.681	0.499
Intercept	1.875	0.101	18.557	0.000
Preoccupied CATS Intercept	0.177	0.107	1.659	0.103
Preoccupied CATS Slope	-0.211	4.501	-0.047	0.963
Slope	0.000	0.002	0.209	0.836
Preoccupied CATS Intercept	-0.000	0.001	-0.813	0.420
Preoccupied CATS Slope	0.041	0.071	0.580	0.564
Intercept	1.879	0.107	17.560	0.000
Secure CATS Intercept	0.247	0.147	1.685	0.098
Secure CATS Slope	2.163	5.456	0.396	0.693
Slope	0.000	0.002	0.184	0.856
Secure CATS Intercept	-0.002	0.002	-0.960	0.342
Secure CATS Slope	0.021	0.076	0.279	0.781

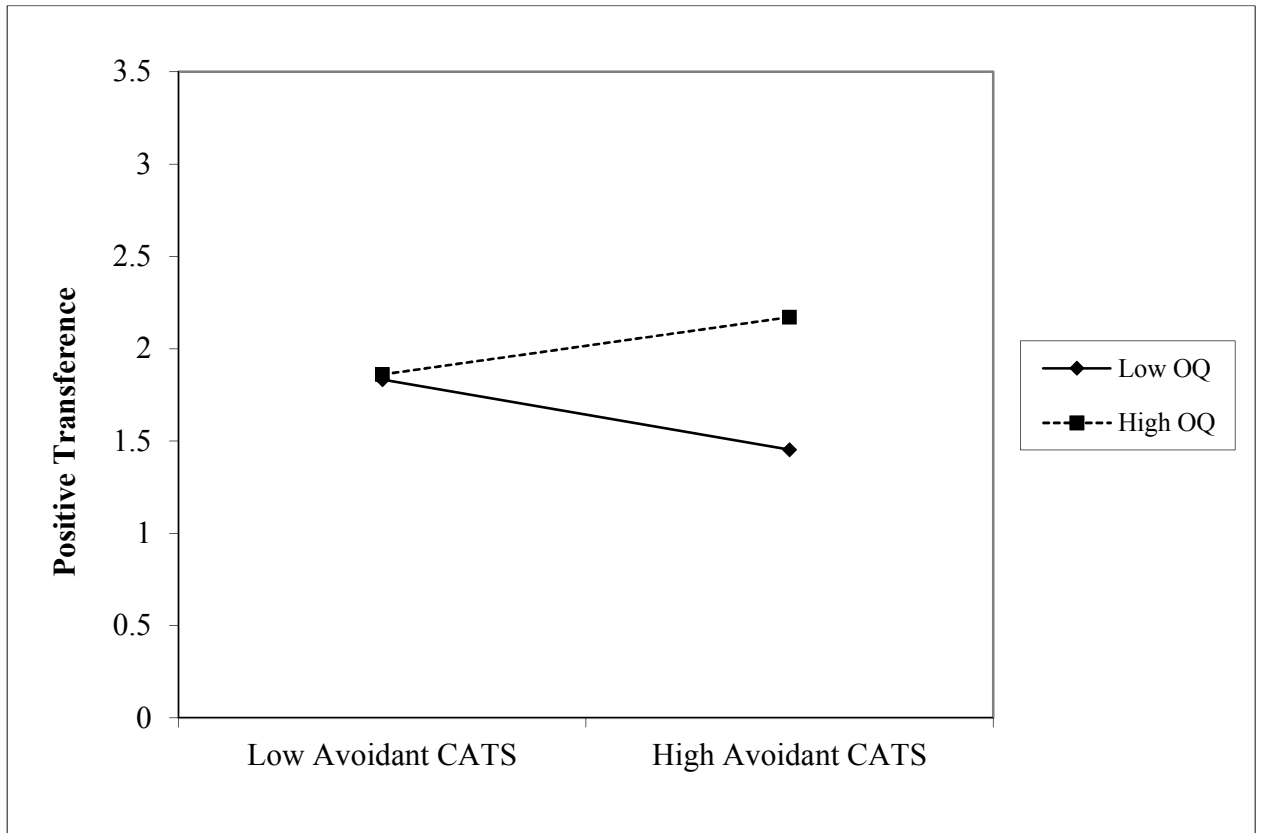
Figure 1. Client OQ as moderator of initial Avoidant-Fearful CATS and Negative Transference.



Note: These findings were for client-level OQ, initial Avoidant-Fearful CATS, and initial negative transference. Slope for Low OQ = -0.117, t-value = -1.019,  $p = .31$ .

Slope for High OQ = 0.317, t-value = 7.062,  $p = 0.000$ .

Figure 2. Client OQ as a moderator of initial Avoidant-Fearful CATS and Positive Transference.

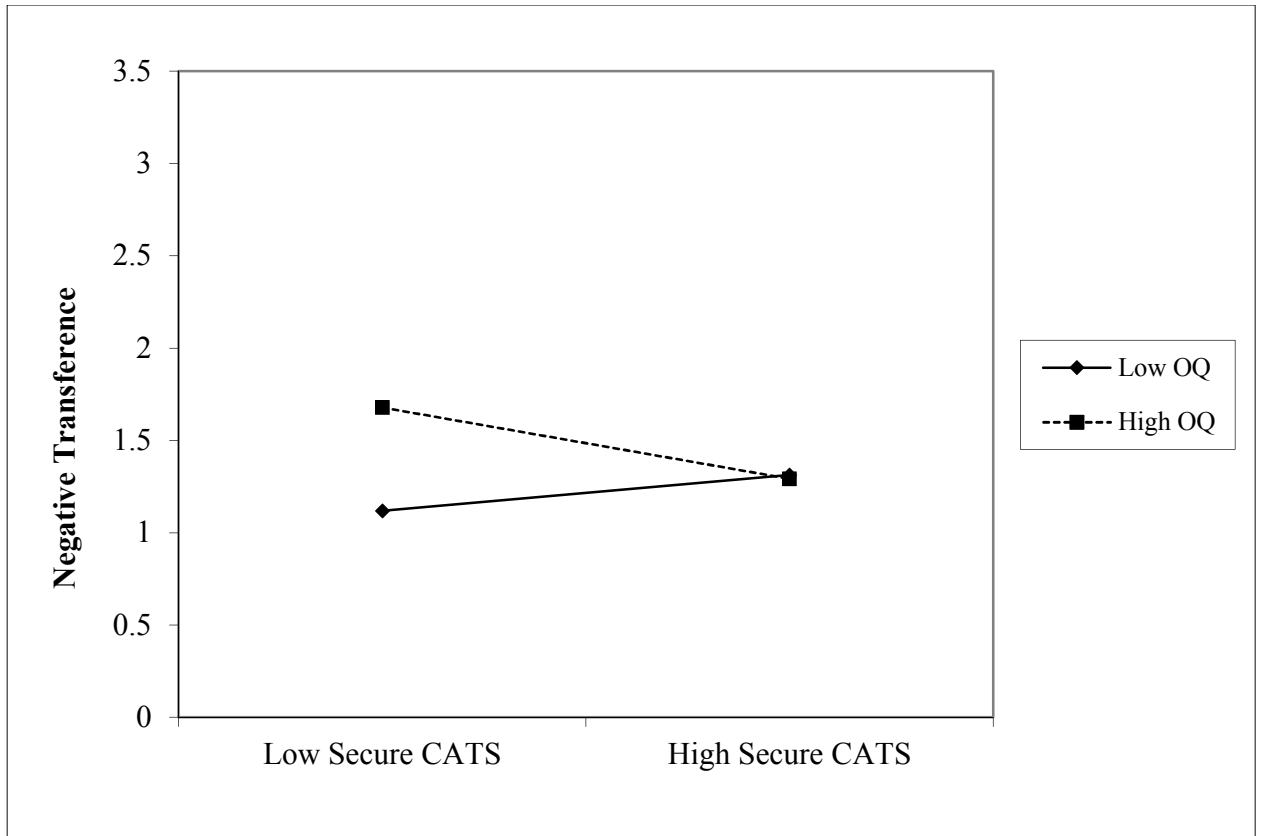


Note: These findings were for client-level OQ, initial Avoidant-Fearful CATS, and initial positive transference. Slope for Low OQ = -0.328, t-value = -1.771,  $p = .08$ .

Slope for High OQ = 0.268, t-value = 1.990,  $p = 0.05$ .



Figure 3. Client OQ as a moderator of initial Secure CATS and Negative Transference.



Note: These findings were for client-level OQ, initial Secure CATS, and initial negative transference. Slope for Low OQ = 0.162,  $t$ -value = 0.984,  $p = .33$ . Slope for High OQ = -0.322,  $t$ -value = -2.461,  $p = 0.01$ .

## References

- Barber, J. P., Foltz, C., DeRubeis, R. J., & Landis, J. R. (2002). Consistency of interpersonal themes in narratives about relationships. *Psychotherapy Research, 12*, 139–158. doi:10.1093/ptr/12.2.139
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.
- Bowlby, J. (1973). *Attachment and loss: Vol. 2. Separation: anxiety and anger*. New York: Basic Books.
- Bowlby, J. (1982). *Attachment and loss: Vol. 1. Attachment (2<sup>nd</sup> ed.)*. New York: Basic Books. (Original work published 1969)
- Bowlby, J. (1988). *A secure base: Parent– child attachment and healthy human development*. New York: Basic Books
- Collins, N.L., & Read, S.J. (1994). Cognitive representations of attachment: The structure and function of working models. In K. Bartholomew & D. Perlman (Eds.), *Advances in personal relationships* (Vol. 5, pp. 53–90). London: Jessica Kingsley.
- Connolly, M. B., Crits-Christoph, P., Barber, J. P., & Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive-expressive psychotherapy for depression. *Psychotherapy Research, 10*(3), 356-372.
- Crits-Christoph, P., Demorest, A., & Connolly, M. B. (1990). Quantitative assessment of interpersonal themes over the course of a psychotherapy. *Psychotherapy, 27*, 513-521.

- Dykas, M. J., & Cassidy, J. (2011). Attachment and the processing of social information across the life span: theory and evidence. *Psychological bulletin*, *137*(1), 19.
- Fraley, R. C., & Shaver, P. R. (2000). Adult romantic attachment: Theoretical developments, emerging controversies, and unanswered questions. *Review of General Psychology*, *4*, 132–154.
- Freud, S. (1888). Hysteria. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (pp. 41–57). London, England: Hogarth Press, Inc.
- Freud, S. (1937). Analysis terminable and interminable. *The International Journal of Psychoanalysis*, *18*, 373–405.
- Fried, D., Crits-Christoph, P., & Luborsky, L. (1992). The first empirical demonstration of transference in psychotherapy. *The Journal of Nervous and Mental Disease*, *180*, 326–331.
- Gelso, C. J., & Bhatia, A. (2012). Crossing theoretical lines: The role and effect of transference in nonanalytic psychotherapies. *Psychotherapy*, *49*(3), 384-390. doi:10.1037/a0028802
- Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship: Theory, research, and practice*. John Wiley & Sons Inc.
- Gelso, C. J., Hill, C. E., & Kivlighan, D. M. (1991). Transference, insight, and the counselor's intentions during a counseling hour. *Journal of Counseling & Development*, *69*, 428 – 433. doi:10.1002/j.1556-6676.1991.tb01539.x

- Gelso, C. J., Kivlighan, D. M., Wine, B., Jones, A., & Friedman, S. C. (1997). Transference, insight, and the course of time-limited therapy. *Journal of Counseling Psychology, 44*, 209–217. doi:10.1037/0022-0167.44.2.209
- Gelso, C.J., & Kline, K.V. (2019). The sister concepts of the real relationship and the working alliance: On their development, rupture, and repair. *Research in Psychotherapy: Psychopathology, Process, and Outcome, 22*(2), 141-148. doi: 10.4081/ripppo.2019.373
- Gelso, C.J., Palma, B., & Bhatia A. (2013). Attachment theory as a guide to understanding and working with transference and the real relationship in psychotherapy. *Journal of Clinical Psychology, 69*(11), 1160-1171.
- Graff, H., & Luborsky, L. L. (1977). Long-term trends in transference and resistance: A report on a quantitative-analytic method applied to four psychoanalyses. *Journal of the American Psychoanalytic Association, 25*, 471-490.
- Greenson, R. R. (1967). *The technique and practice of psychoanalysis* (Vol. 1). New York: International Universities Press.
- Janzen, J., Fitzpatrick, M., & Drapeau, M. (2008). Processes involved in client-nominated relationship building incidents: Client attachment, attachment to therapist, and session impact. *Psychotherapy: Theory, Research, Practice, and Training, 45*, 377–390. doi:10.1037/a0013310
- Kivlighan, D. M., Jr. (1995). *Similarities and differences among counselor, supervisor and observer ratings of individual counseling process*. Unpublished manuscript, University of

Missouri—Columbia.

- Lambert, M. J., Burlingame, G. M., Umphress, V., Hansen, N. B., Vermeersch, D. A., Clouse, G. C., & Yanchar, S. C. (1996). The reliability and validity of the Outcome Questionnaire. *Clinical Psychology and Psychotherapy, 3*, 249–258. doi:10.1002/(SICI)1099-0879(199612)
- Luborsky, L., Crabtree, L., Curtis, H., Ruff, G., & Mintz, J. (1975). The concept of “space” of transference for eight psychoanalysts. *British Journal of Medical Psychology, 48*, 65–70.
- Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference*. New York, NY: Basic Books.
- Luborsky, L., Graff, H., Pulver, S., & Curtis, H. (1973). A clinical–quantitative examination of consensus on the concept of transference. *Archives of General Psychiatry, 29*, 69–75.
- Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the society for research in child development, 66-104*.
- Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology, 42*, 307-307.
- Mallinckrodt, B., King, J. L., & Coble, H. M. (1998). Family dysfunction, alexithymia, and client attachment to therapist. *Journal of Counseling Psychology, 45*, 497–504.

- Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M., Jr. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 42, 85–100. doi:10.1037/0033-3204.42.1.85
- Marmarosh, C. L., Gelso, C. J., Markin, R. D., Majors, R., Mallery, C., & Choi, J. (2009). The real relationship in psychotherapy: Relationships to adult attachments, working alliance, transference, and therapy outcome. *Journal of Counseling Psychology*, 56(3), 337-350.
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York, NY: Guilford Press.
- Multon, K. D., Patton, M. J., & Kivlighan, D. M. (1996). Development of the Missouri Identifying Transference Scale. *Journal of Counseling Psychology*, 43, 243-252.
- Patton, M. J., Kivlighan, D. M., Jr., & Multon, K. D. (1997). The Missouri psychoanalytic counseling research project: Relation of changes in counseling process to client outcomes. *Journal of Counseling Psychology*, 44, 189–208.
- Raudenbush, S. W., Bryk, A. S., Cheong, Y. F., Congdon, R. T., & du Toit, M. (2011). *HLM7: Hierarchical Linear and Nonlinear Modeling*. Chicago, IL: Scientific Software Intern'l.
- Ryan, V. L., & Gizinski, M. N. (1971). Behavior therapy in retrospect: Patients' feelings about their behavior therapy. *Journal of Consulting and Clinical Psychology*, 37, 1–9. doi:10.1037/h0031293

- Singer, E. (1970). *Key concepts in psychotherapy* (2nd ed.). New York, NY: Basic Books.
- Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical implications* (pp. 575–594). New York: Guilford Press.
- Tellides, C., Fitzpatrick, M., Drapeau, M., Bracewell, R., Janzen, J., & Jaouich, A. (2008). The manifestation of transference during early psychotherapy sessions. *Counseling and Psychotherapy Research, 8*, 85–92.  
doi:10.1080/14733140802014331
- Wachtel, P. L. (1981). Transference, schema, and assimilation. The relevance of Piaget to psychoanalysis. *The Annual Review of Psychoanalysis, 8*, 59–76.
- Waldinger, R. J., Diguier, L., Guastella, F., Lefebvre, R., Allen, J. P., Luborksy, L., & Hauser, S. T. (2002). The same old song? Stability and change in relationship schemas from adolescent to young adulthood. *Journal of Youth and Adolescence, 31*, 17–29. doi:10.1023/A:1014080915602
- Wiseman, H., & Tishby, O. (2014). Client attachment, attachment to the therapist and client-therapist attachment match: How do they relate to change in psychodynamic psychotherapy?. *Psychotherapy Research, 24*(3), 392-406.
- Woodhouse, S. S., Schlosser, L. Z., Crook, R. E., Ligiéro, D. P., & Gelso, C. J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counseling Psychology, 50*(4), 395-408.

Worthington, R.L. & Dillion, F.R. (2003). The theoretical orientation profile scale-revised: A validation study. *Measurement and Evaluation in Counseling and Development, 36*(2), 95-113.

Yotsidi, V., Stalikas, A., Pezirkianidis, C., & Pouloudi, M. (2019). The Relationships Between Client Resistance and Attachment to Therapist in Psychotherapy. *Journal of Contemporary Psychotherapy, 49*(2), 99-109.