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### Therapist Self-Reported Attachment Organization and Countertransference Responses to Psychotherapy Clients

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THERAPIST SELF-REPORTED ATTACHMENT ORGANIZATION AND  
COUNTERTRANSFERENCE RESPONSES TO PSYCHOTHERAPY CLIENTS

A Dissertation

Presented to the Faculty of  
Antioch University New England

In partial fulfillment for the degree of

DOCTOR OF PSYCHOLOGY

by

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April 2022

THERAPIST SELF-REPORTED ATTACHMENT ORGANIZATION AND  
COUNTERTRANSFERENCE RESPONSES TO PSYCHOTHERAPY CLIENTS

This dissertation, by Morgan Janay Pell, has  
been approved by the committee members signed below  
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Antioch University New England  
in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

### THERAPIST SELF-REPORTED ATTACHMENT ORGANIZATION AND COUNTERTRANSFERENCE RESPONSES TO PSYCHOTHERAPY CLIENTS

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Therapists experience thoughts, feelings, and behaviors in response to their clients, which are sometimes referred to as countertransference. Such responses may be influenced by the therapist's personal history, including the quality of their attachment experiences. Research has demonstrated that adult attachment organizations influence a person's cognitive, behavioral, and affective responses toward close others, thus providing a useful framework for understanding some countertransference experiences of therapists. This quantitative study sought to add to the existing literature by examining the relationship between therapist self-reported attachment organization and countertransference responses to clients. Seventy-three therapists participated in this study, including licensed psychologists, doctorate-level psychologists, and psychologists-in-training. Results of this study found that therapist self-reported attachment anxiety and avoidance are associated with a range of countertransference responses to clients. Specifically, attachment-related anxiety was positively correlated with overwhelmed/disorganized countertransference and was a significant predictor of helpless/inadequate, disengaged, and criticized/mistreated countertransference responses. Attachment-related avoidance was positively correlated with overwhelmed/disorganized and disengaged countertransference responses, but was not a significant predictor of any countertransference response types. Additionally, attachment-related security was not associated with any countertransference response types. This study expands existing literature for understanding the relationship between therapist attachment and countertransference, and

provides a novel use for the Therapist Response Questionnaire, as this measure has not yet been utilized when examining therapist attachment and countertransference. The general direction of the findings have clinical implications for psychotherapy practitioners, suggesting that therapists may benefit from developing and maintaining an awareness of the potential influence of their attachment history. This dissertation is available in open access at AURA (<https://aura.antioch.edu>) and OhioLINK ETD Center (<https://etd.ohiolink.edu>).

*Keywords:* countertransference, attachment, psychotherapy, psychologists, psychologists-in-training, adult attachment, attachment-related anxiety, attachment-related avoidance, attachment security.

## **Dedication**

This dissertation is dedicated to my parents, Joy and Michael Pell. There are no words that can adequately express my gratitude for you and all you have done for me. Your unconditional love, unwavering support, and continuous sacrifices have molded me into the person and psychologist I am today. I could not have done this without you, and I am so proud to be your daughter.

Forever your Tarzan girl, ti voglio tanto bene.

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## Table of Contents

Abstract.....	iv
Dedication.....	vi
Acknowledgements.....	vii
List of Tables.....	x
List of Figures.....	xi
CHAPTER I: INTRODUCTION.....	1
CHAPTER II: LITERATURE REVIEW.....	2
Attachment Theory.....	2
Measuring Adult Attachment.....	4
Attachment and Interpersonal Relationships.....	6
Therapist Attachment Organization.....	8
Therapist Countertransference.....	9
Therapist Attachment and Countertransference.....	10
The Present Study.....	11
Research Questions.....	12
Hypotheses.....	12
CHAPTER III: METHOD.....	13
Participants.....	13
Materials.....	15
Experiences in Close Relationships Scale.....	15
Therapist Response Questionnaire.....	16
Procedure.....	18

CHAPTER IV: RESULTS .....	20
Multiple Regression Analyses.....	20
Bootstrap Results.....	21
Multicollinearity .....	22
Pearson’s Correlation .....	22
CHAPTER V: DISCUSSION .....	24
Attachment-Related Anxiety and Avoidance Correlation .....	24
Attachment-Related Anxiety and Countertransference.....	25
Attachment-Related Avoidance and Countertransference.....	29
Additional Results: Overwhelmed/Disorganized and Disengaged Countertransference....	31
Secure Attachment Organization and Countertransference .....	33
Implications.....	35
Limitations .....	36
Future Directions.....	38
Conclusion .....	39
References.....	41
APPENDIX A: RECRUITMENT LETTER.....	55
APPENDIX B: INFORMED CONSENT FORM .....	56
APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE .....	57
APPENDIX D: EXPERIENCES IN CLOSE RELATIONSHIPS SCALE .....	59
APPENDIX E: PERMISSIONS .....	60

List of Tables

Table 3.1 Demographic Characteristics ..... 61

Table 4.1 Bootstrapped Multiple Linear Regression Analyses ..... 63

Table 4.2 Tests for Multicollinearity in Bootstrapped Multiple Linear Regressions ..... 64

Table 4.3 Correlation Matrix for Attachment-Related Anxiety and Avoidance and  
Countertransference Factors ..... 65

Table 4.4 Totals, Means, and Standard Deviations of Attachment and Countertransference ..... 66

List of Figures

Figure 4.1: Multiple Regression for Overwhelmed/Disorganized Countertransference: Demonstration of Heteroscedasticity of Residuals ..... 67

Figure 4.2: Multiple Regression for Helpless/Inadequate Countertransference: Demonstration of Heteroscedasticity of Residuals..... 68

Figure 4.3: Multiple Regression for Helpless/Inadequate Countertransference: Demonstration of Heteroscedasticity of Residuals..... 69

Figure 4.4: Multiple Regression for Special/Overinvolved Countertransference: Demonstration of Heteroscedasticity of Residuals..... 70

Figure 4.5: Multiple Regression for Sexualized Countertransference: Demonstration of Heteroscedasticity of Residuals ..... 71

Figure 4.6: Multiple Regression for Disengaged Countertransference: Demonstration of Heteroscedasticity of Residuals ..... 72

Figure 4.7: Multiple Regression for Parental Countertransference: Demonstration of Heteroscedasticity of Residuals ..... 73

Figure 4.8: Multiple Regression for Criticized/Mistreated Countertransference: Demonstration of Heteroscedasticity of Residuals..... 74

## CHAPTER I: INTRODUCTION

Therapists experience a range of thoughts, feelings, and behaviors toward their clients. Within psychoanalytic, psychodynamic, and relational theories, the conscious and unconscious experiences of the therapist are thought to provide critical information about the client, therapist, and the therapeutic relationship (Ogden, 2018; Parth et al., 2017). The therapist's responses to their client may be influenced by their unique personal qualities and history, such as race and ethnicity, socioeconomic status, and religion, as well as unconscious conflicts and defenses, unresolved emotional needs, and the quality of their attachment experiences. Research indicates that adult attachment organization may contribute to the way in which humans experience and respond cognitively, behaviorally, and affectively to close others, thus providing a useful framework for understanding therapists' countertransference responses to their clients (Gillath et al., 2016; Mikulincer & Shaver, 2016). Few studies have examined the relationship between therapist attachment organization and countertransference, but have yielded inconsistent results (Mohr et al., 2005; Steel et al., 2018). Thus, the purpose of the present study is to add to the existing literature on therapist attachment by quantitatively examining the relationship between therapist self-reported attachment organization and their countertransference responses to clients. To fully understand the complexity of this potential relationship, the present study first offers a detailed review of attachment theory, therapist countertransference, and the existing literature on the relationship between therapist attachment organization and countertransference responses to clients.

## CHAPTER II: LITERATURE REVIEW

### Attachment Theory

Attachment theory posits that infants are biologically predisposed to form strong affectional bonds, or attachments, to their primary caregivers (Bowlby, 1988; Cassidy, 2016; Fraley, 2019; Simpson et al., 2021). The attachment system assists the infant in obtaining physical and emotional safety, thereby fulfilling the need for security which is essential for survival. The caregiver, referred to here as the attachment figure, acts as a secure base from which the child can explore their environment, as well as a safe haven to return to in times of distress (Bowlby, 1988; Cassidy, 2016; Fraley, 2019; Simpson et al., 2021).

To attain felt security from an attachment figure, individuals utilize the primary strategy of proximity seeking (Bowlby, 1988; B. C. Feeney & Woodhouse, 2016; Mikulincer & Shaver, 2016; Simpson et al., 2021). In young children, proximity seeking manifests in an attempt to gain close physical proximity to an attachment figure (Simpson et al., 2021), while adults seek proximity in forms of verbal communication in which their needs, concerns, and desires are expressed to their attachment figure (B. C. Feeney & Woodhouse, 2016; Simpson et al., 2021). When proximity seeking is unsuccessful, secondary strategies are employed, including hyper-activation and deactivation (Arriaga et al., 2018; Main, 1981, 1990; Mikulincer & Shaver, 2016; Overall et al., 2014). Hyper-activating strategies refer to the protest of the attachment figure's inconsistency and the subsequent demand for their attention, while deactivating strategies refer to the minimization of distress and the shifting of attention away from the source of threat (Arriaga et al., 2018; Main, 1981, 1990; Mikulincer & Shaver, 2016).

Bowlby (1982) theorized that, from the quality of the attachment figure's responsiveness and sensitivity in times of distress, individuals develop internal working models (IWM), or

mental representations, of self, others, and relationships (Simpson et al., 2021; Verhage et al., 2016). The precise structure of IWM have not been directly measured, and several questions need to be investigated, such as how they differ from general schemas, and how they tend to transform from early infancy and childhood into adulthood (Simpson et al., 2021; Thompson, 2017). However, current attachment theory maintains that these structures organize one's thoughts, feelings, goals, expectations, and behaviors within close relationships, and underlie attachment organizations (Bowlby, 1982, 1988; Cassidy, 2016; Fraley & Shaver, 2021; Gillath et al., 2016; Girme & Overall, 2021; Mikulincer & Shaver, 2016; Simpson et al., 2021).

Attachment organizations are relatively stable patterns of thoughts, feelings, and behaviors exhibited in the context of relationships (Ainsworth et al., 1978; Simpson et al., 2021; Slade, 2016). These patterns represent a range of dynamic processes that serve distinct interpersonal and defensive functions (Ainsworth et al., 1978; Slade, 2016). The categorization of attachment was initially developed through observational studies of infant–caregiver dyads through the Strange Situation Procedure (SSP). The SSP has been considered a gold standard for examining infant attachment organization (Ainsworth et al., 1978; Solomon & George, 2016; Spies & Duschinsky, 2021) and has been utilized in meta-analyses examining a range of consequences of early attachments (Groh et al., 2014; Groh et al., 2017; Sroufe et al., 2005). This procedure also served as a blueprint for the development of adult attachment measures in the 1980s (Hazan & Shaver, 1987; Main et al., 1985; Raby et al., 2021).

Within the SSP, infants are identified as either secure, anxious, or avoidant, classifications which are based on the infant's organization of behaviors before, during, and after separation from their mother (Ainsworth, 1978). Secure infants tend to use their attachment figures as a base from which to explore their environment and as a source of security they return

to when distressed. Due to consistent rejection by the attachment figure, avoidant infants explore their environment, but, when distressed, tend to ignore their attachment figure and cope on their own. Anxious infants, resulting from inconsistent caregiving, appear to rarely use their attachment figure as a secure base and are not easily comforted by them (Ainsworth et al., 1978; Simpson et al., 2021).

While secure, anxious, and avoidant infants appear to demonstrate organized patterns of attachment behaviors, Main and Solomon (1990) discovered a fourth category of infants who do not use organized behaviors. These infants engage in fearful, conflicted, apprehensive, or disoriented behaviors upon reunion with their attachment figure (Lyons-Ruth & Jacobvitz, 2016; Main & Solomon, 1990; Paetzold et al., 2015; Simpson et al., 2021). Disorganized attachment has been shown to develop when children are exposed to frightening, strange, or unusual parenting that is often associated with abuse or their caregiver's clinical disorders (Lyons-Ruth & Jacobvitz, 2016; Paetzold et al., 2015). This disorganized pattern of attachment is believed to coexist with organized strategies, and is not a complete replacement for them. For example, an infant might engage in avoidant behavior but may be interrupted briefly by the intrusion of disorganized behavior (Paetzold et al., 2015).

### **Measuring Adult Attachment**

Adult attachment has been studied, defined, and measured in different ways across psychological disciplines. In developmental psychology, adult attachment is often measured through narrative-based assessments, such as the Adult Attachment Interview (Hesse, 2016; Main et al., 1985) and the interpretation of Secure Base Scripts (Steele et al., 2014; Waters & Waters, 2006). Conversely, in social and personality psychology, adult attachment is often examined through self-report measures (Crowell, 2021); the Experiences in Close Relationships



Scale (ECR) and its revised versions are the most commonly used and recommended questionnaires for measuring self-reported adult attachment (Brennan et al., 1998; Crowell, 2021; Fraley et al., 2000; Lafontaine et al., 2016; Wei et al., 2007).

Within self-report measures, adult attachment is typically examined on a two-dimensional plane of anxiety and avoidance, factors which have been proposed to underly all attachment organizations (Bartholomew & Horowitz, 1991; Brennan et al., 1998; Fraley, 2019; Fraley & Waller, 1998; Simpson et al., 1992; Simpson et al., 2021; Steele et al., 2014). Higher scores on the anxiety dimension are defined as having an intense desire for closeness, jealousy, and a fear of rejection and abandonment (Brennan et al., 1998; Fraley et al., 2000; Lafontaine et al., 2016; Wei et al., 2007). These individuals tend to utilize hyper-activating strategies to attain attachment-related needs (Arriaga et al., 2018; Main, 1981, 1990; McClure et al., 2013; Mikulincer & Shaver, 2016). Higher scores on the avoidant dimensions are defined by an avoidance of intimacy, discomfort with closeness, and increased self-reliance (Brennan et al., 1998; Fraley et al., 2000; Lafontaine et al., 2016; Wei et al., 2007). These individuals tend to utilize deactivating strategies to attain attachment-related needs (Arriaga et al., 2018; Farrell et al., 2016; Main, 1981, 1990; Mikulincer & Shaver, 2016; Overall et al., 2013). Low scores on each of these dimensions are indicated to reflect a secure attachment organization, where individuals can attain attachment-related goals through proximity seeking, are comfortable with closeness and independence, and can comfortably rely on others (Brennan et al., 1998; Fraley et al., 2000; Lafontaine et al., 2016; Mikulincer & Shaver, 2016; Wei et al., 2007).

Importantly, meta-analytic research indicates that attachment anxiety and avoidance dimensions, as measured by ECR and its revised version, have an average correlation of .20 (Cameron et al., 2012). These results suggest that attachment-related anxiety and avoidance may

not be as orthogonal as has been consistently proposed, although this discussion is beyond the scope of this study. To further understand the shared variance of anxiety and avoidance, Cameron and colleagues (2012) suggest the use of multiple linear regression analyses.

### **Attachment and Interpersonal Relationships**

Research examining adult attachment, typically conducted on romantic and peer relationships (Mikulincer & Shaver, 2016), has yielded associations between attachment organization and emotional, behavioral, and cognitive outcomes within the context of interpersonal relationships. Secure individuals appear to be comfortable with intimacy, autonomy, and interdependence, and can more readily accept other people's needs for closeness, sympathy, and support (Slade, 2016). Securely attached individuals also tend to have relationships that are characterized by less conflict (Campbell et al., 2005; J. Feeney & Fitzgerald, 2019; Mikulincer & Shaver, 2016; Simpson et al., 1996), are more likely to report higher levels of self-esteem (Bartholomew & Horowitz, 1991; Kawamoto, 2020; Mattingly & Clark, 2012; Towler & Stuhlmacher, 2013), and have the potential to cope effectively in response to stressful events (Berant et al., 2008; Karreman & Vingerhoets, 2012). The experiences of securely attached individuals are thought to subsequently enhance their capacity to tolerate and manage affect (Deklyen & Greenberg, 2016).

Attachment-related avoidance has been associated with less reactivity and awareness for their emotional states (Stevens, 2014), as well as a preference to avoid, rather than pursue, close relationships (Jiang & Tiliopoulos, 2014; Lemay & Spongberg, 2015; Mattingly & Clark, 2012; Meyer et al., 2015). Avoidantly attached individuals may also demonstrate a decreased willingness to share personal thoughts and feelings with a partner and ask for support in times of need (Garrison et al., 2012; Lynch, 2013). The tendency to minimize interdependence makes it

unlikely that avoidantly attached individuals will attend carefully to a partner's disclosures, thereby reducing the accuracy of decoding nonverbal messages (Mikulincer & Shaver, 2016; Schachner et al., 2005). Additionally, these individuals tend to view others as untrustworthy, distant, rejecting, and hurtful (Cyranski et al., 2002; Hofstra et al., 2005; Jiang & Tiliopoulos, 2014; Lemay & Spongberg, 2015; Strauss et al., 2012).

Attachment-related anxiety is associated with a fear of being alone as well as excessive reassurance-seeking to mitigate fears of separation and abandonment (Arriaga et al., 2018; Beckes et al., 2017; Cozolino, 2014; Downey & Feldman, 1996; Shaver et al., 2005; Spielmann et al., 2013). These individuals have been shown to score high on scales measuring rejection sensitivity and tend to anticipate and overreact to rejection (Arseth et al., 2009; Downey & Feldman, 1996; Sato et al., 2020; Scharf et al., 2014; Taubman-Ben-Ari et al., 2002). Similarly, anxiously attached individuals are quicker to recognize rejection-related words in lexical decision tasks (Baldwin & Kay, 2003; Baldwin & Meunier, 1999), as well as to divert their attention away from closed-mouth rejecting faces (Westphal et al., 2014). Furthermore, anxious attachment has been negatively associated with self-esteem and self-efficacy (Gentzler & Kerns, 2004; Lemay & Spongberg, 2015; Liu et al., 2018; Lockhart et al., 2017; Strodl & Noller, 2003).

While IWMs and organized attachment behaviors have been associated with specific emotional, behavioral, cognitive, and interpersonal outcomes, what is important to understand is the dynamic and evolving nature of these structures and behaviors; they are not simply static and absolute (Jacobvitz & Hazen, 2021). The phenomenon of earned security is described in the literature, which is defined as the ability to have a secure state of mind with respect to attachment, despite recounting unloving relationships with both parents (Jacobvitz & Hazen, 2021; Saunders et al., 2011). Security may be earned through experiencing emotional support

through an alternative attachment figure during childhood, which is associated with adults' abilities to coherently describe early negative experiences as well as to develop a secure attachment with their own infant (Jacobvitz & Hazen, 2021; Saunders et al., 2011). Additionally, later life experiences and therapy may be effective in earning security (Arriaga et al., 2018; Burgess Moser et al., 2015; Jacobvitz & Hazen, 2021).

As demonstrated, the literature indicates that attachment organizations and IWM shape, and are shaped by, an individual's interpersonal experiences within close relationships.

Therapists are no exception to this process. Therefore, examining therapist attachment histories in the context of the therapeutic relationship is imperative. Attachment theory and research provides a foundation for understanding the potential relationship between the therapist's attachment organization and their responses toward their clients.

### ***Therapist Attachment Organization***

Due to their consistent and close relational involvement with clients, the therapist's attachment organization is an important area of study. Research has demonstrated that the therapist's attachment organization may impact the development and maintenance of the working alliance (Berry et al., 2008; Black et al., 2005; Degnan et al., 2016; Dinger et al., 2009; Schauenburg, 2010; Steel et al., 2018). Specifically, securely attached therapists have been found to report stronger and higher quality alliances (Berry et al., 2008; Black et al., 2005; Degnan et al., 2016; Fuertes et al., 2019; Mallinckrodt & Jeong, 2015; Schauenburg, 2009). Conversely, anxiously attached therapists are more likely to report poorer alliances as well as a decline of alliance quality over time (Degnan et al., 2016; Dinger et al., 2009), while avoidant therapists have been associated with a decreased ability to reflect on one's own and others' mental states, resulting in a weaker alliance (Berry et al., 2008; Degnan et al., 2016). Because of the influence

of the therapist's attachment organization on their ability to develop and sustain a working alliance with clients, it is plausible that therapist attachment organization may influence other relational therapeutic processes including the responses they may have toward their clients.

### **Therapist Countertransference**

Historically, therapists' responses to their clients have sometimes been referred to as countertransference. Research indicates that countertransference reactions may impact the working alliance (Dahl et al., 2012) as well as overall treatment outcome (Colli & Ferri, 2015; Gelso et al., 2002; Hayes et al., 2011; Hayes et al., 2018). The conceptualization of countertransference is theoretically laden, which results in definitional inconsistencies (Parth et al., 2017). However, these definitions all refer to the therapist's feelings and reactions to clients, including cognitive, behavioral, and affective domains (Hayes & Gelso, 2001; Kiesler, 2001; Westerling et al., 2019).

Despite entailing a range of thoughts, behaviors, and feelings, many of the current measures of countertransference do not offer an investigation into all three response domains (Betan & Westen, 2009; Colli & Ferri, 2015). However, one measure of countertransference, the Therapist Response Questionnaire (TRQ), has been developed to examine therapists' cognitive, behavioral, and affective responses to clients (Betan et al., 2005; Tanzilli et al., 2016). The TRQ revealed eight factors of countertransference: (a) overwhelmed/disorganized, (b) helpless/inadequate, (c) positive, (d) special/overinvolved, (e) sexualized, (f) disengaged, (g) parental/protective, and (h) criticized/mistreated. The TRQ has been used to examine the association between patterns of therapists' responses and clients' personality disorders (Betan et al., 2005; Betan & Westen, 2009; Colli et al., 2014; Gazzillo et al., 2015; Tanzilli et al., 2018); to study countertransference of therapists treating individuals with eating disorders (Colli et al.,

2015; Satir et al., 2009); and to investigate the mediated effect of severe symptomatology on the relationship between clients' personality pathology and therapists' responses (Lingiardi et al., 2015). Overall, the TRQ is a promising measure that provides a self-report method for assessing and understanding the pattern of therapists' thoughts, feelings, and behaviors in response to their clients.

### **Therapist Attachment and Countertransference**

Few studies have examined the relationship between therapist attachment organization and their countertransference responses toward their clients. For example, Steel and colleagues (2018) conducted a systematic review of the effect of therapist internalized relational models on direct and indirect measures of the therapeutic relationship, including countertransference. The researchers selected 13 out of 134 studies to review based on their eligibility criteria (i.e., studies had to be in English, be published in a peer-reviewed journal, clinicians sampled had to be primarily involved in the delivery of psychological therapy, and sampled clients had to be over 18). Of the selected studies, three examined therapist attachment and countertransference, with only one finding an effect (Steel et al., 2018). Specifically, Mohr and colleagues (2005) found that therapists with an avoidant attachment organization were more likely to be rated by supervisors as displaying hostile countertransference. However, these results should be utilized with caution due to particular limitations including the use of a supervisor-rated measure of countertransference behavior as well as data collection within a single, first session. Additionally, the TRQ has been utilized to assess attachment organization and countertransference; however, only the client's attachment in relation to therapists' responses has been examined (Westerling et al., 2019). Thus, further research is needed to gather a deeper understanding of the relationship between therapist attachment organization and their countertransference responses to clients.

Filling this research gap has important ethical and clinical implications for psychologists. As indicated in General Principle A of the *Ethical Principles of Psychologists and Code of Conduct* (Ethics Code; American Psychological Association, 2017), it is the ethical duty of the psychologist to strive to benefit those with whom they work while ensuring that no harm is inflicted. Further, psychologists are called to “be aware of the possible effect of their own physical and mental health on their ability to help those with whom they work” (American Psychological Association, 2017, p. 3). Additionally, research has demonstrated that unmanaged countertransference can negatively impact therapy outcomes, and that self-awareness is important in understanding and mitigating harmful manifestations of countertransference (Hayes et al., 2018). Thus, it behooves every psychologist to maintain self-awareness of their thoughts, feelings, and behaviors toward clients, including the potential influence of their attachment histories.

### **The Present Study**

The purpose of the present study was to quantitatively examine the relationship between therapist attachment organization and their countertransference (i.e., cognitive, affective, and behavioral) responses to their clients. This study utilized the ECR, an empirically valid, reliable, and widely used self-report measure of adult attachment (Brennan et al., 1998), as well as the TRQ, a validated self-report measure of the therapist’s cognitive, behavioral, and affective responses to their client (Betan et al., 2005; Tanzilli et al., 2016). The TRQ has not yet been utilized to assess the relationship between therapist attachment organization and their responses to their clients. Thus, the present study attempted to fill this gap in the literature, as well as to provide further understanding of the relationship between therapist attachment organization and their countertransference responses to clients. This information is critical for licensed psychology

professionals and psychologists-in-training, highlighting the importance of maintaining self-awareness in providing ethical and effective psychotherapy treatment.

### **Research Questions**

The present study sought to explore the following questions:

1. Is there a relationship between therapist attachment organizations and their cognitive, behavioral, and affective responses to their clients?
  - a. If there is an existing relationship, what does this relationship look like?

### **Hypotheses**

1. Therapists with secure attachment organizations (as indicated by low scores on the anxiety and avoidance domains of the ECR) will emerge with elevations in the positive and/or parental/protective countertransference subscales of the TRQ.
2. Therapists with anxious attachment organizations (as indicated by high scores on the anxiety domain and low scores on the avoidance domain of the ECR) will emerge with elevations in the helpless/inadequate, special/overinvolved, and/or sexualized countertransference subscales of the TRQ.
3. Therapists with avoidant attachment organizations (as indicated by high scores on the avoidance domain and low scores on the anxiety domain) will emerge with elevations in the overwhelmed/disorganized, disengaged, and criticized/mistreated countertransference subscales of the TRQ.



### CHAPTER III: METHOD

The present study utilized quantitative methods to examine the relationship between therapist attachment organization and countertransference responses to clients. Two self-report questionnaires were used to measure therapist attachment organization and their countertransference responses to one identified client. Attachment organizations are defined by patterns of thoughts, feelings, and behaviors exhibited in the context of relationships that serve distinct interpersonal and defensive functions (Fraley, 2019; Slade, 2016). Consistent with the literature, attachment organizations were measured in a two-dimensional space characterized by anxiety and avoidance (Brennan et al., 1998; Fraley, 2019). Therapist countertransference responses are defined pan-theoretically as cognitive, behavioral, and affective responses that the therapist has toward the client (Betan et al., 2005). Additionally, demographic information was collected regarding the participant and one specific client (see Appendix A).

#### Participants

The participants of this study included doctorate-level and licensed psychologists, as well as psychologists-in-training who were enrolled in a doctorate-level clinical psychology program (see Table 3.1). Participants were eligible to participate if they were providing individual psychotherapy to a client 18 years or older, for a minimum of eight sessions. This criterion was specified based on the development and administration procedure of the Therapist Response Questionnaire (TRQ), the questionnaire utilized in this study to measure therapists' cognitive, behavioral, and affective responses (Betan et al., 2005).

A total of 84 individuals participated in this study. After checking for missing, duplicate, and outlying data, 73 participants were included in the data analysis (see Table 3.1). Participants represented a range of practicing psychologists and psychologists-in-training. This included

licensed psychologists (48%), ranging from fewer than three years (11%) to greater than 20 years (13.7%). Participants were also psychologists-in-training (45.1%), ranging from third-year doctoral students (8.2%), to sixth year and above students (1.4%), and to those completing post-doctoral training (6.8%). Additionally, 6.8% of participants had completed their doctoral training but were not licensed.

A range of theoretical orientations were represented including, psychodynamic (37.2%), cognitive-behavioral (8.2%), integrative (27.4%), relational (15.1%), and eclectic (1.4%). Other theoretical orientations (9.6%) were represented, as well, such as multicultural, reconstructive narrative, acceptance and commitment, and existential/gestalt theories. Regarding client information, a range of diagnoses were represented, including trauma and stressor related disorders (31.5%), anxiety disorders (21.9%), depressive disorders (9.6%), bipolar disorder (4.1%), unspecified personality disorders (2.7%), eating disorders (1.4%), obsessive compulsive disorders (1.4), and gender dysphoria (1.4%). Many participants also reported multiple diagnoses for their specified client (26%), which included presenting problems such as autism spectrum disorder, attention-deficit/hyperactivity disorder, and a combination of anxiety, depressive, trauma, and personality disorders. The number of sessions conducted with the specific client ranged considerably, from 8–2,000.

Participants were between the ages of 18–24 (2.7%), 25–34 (41.1%), 35–44 (23.3%), 45–54 (9.6%), 55–64 (12.3%), and 65 or older (11%). Participants also identified as White/Caucasian (83.6%), Middle Eastern/West Asian (2.7%), Asian American (1.4%), Black (2.7%), and Latina (1.4%). Participants were also Biracial (5.5%), self-identifying as White and Indigenous/Alaska Native, White and Indian, and White and Asian. Some participants did not identify with any race/ethnicity (1.4%) and some did not provide an answer (1.4%). Additionally,

the sample identified as female (68.5%), male (15.1%), gender queer (2.7%), gender fluid (2.7%), non-binary (2.7%), as well as female and gender fluid (1.4%). Some participants did not identify with any gender (1.4%) and some did not provide an answer (5.5%).

## **Materials**

### **Experiences in Close Relationships Scale**

The Experiences in Close Relationships scale (ECR) is a 36-item self-report measure that assesses attachment organization within two relatively orthogonal, continuous attachment dimensions of anxiety and avoidance (see Appendix D and Appendix E; Brennan et al., 1998). The items measuring attachment anxiety are conceptually similar to Ainsworth and colleague's (1978) coding scales of anxiously attached infants, emphasizing both fear of abandonment and anger regarding separation. Conversely, the items on the avoidant scale are reminiscent of Ainsworth and colleagues' coding scale of avoidant infants, emphasizing a lack of closeness and emotional suppression.

Additionally, Brennan and colleagues (1998) conducted hierarchical and nonhierarchical cluster analyses to determine whether the dimensions of the ECR resemble the categories of Bartholomew and Horowitz's (1991) Relationship Questionnaire, including secure, preoccupied, dismissing, and fearful. Results revealed four distinct groups whose patterns of scores on the anxiety and avoidance dimensions clearly resembled Bartholomew and Horowitz's (1991) categories. Specifically, participants in the secure cluster scored low on both avoidance and anxiety; those in the preoccupied cluster scored low on avoidance and high on anxiety; those in the dismissing cluster scored high on avoidance and low in anxiety; and those in the fearful cluster scored high on both anxiety and avoidance (Brennan et al., 1998). However, cut-offs indicating high or low scores for each dimension were not provided by the authors.

Participants use a 7-point Likert scale ranging from 1 (disagree strongly) to 7 (agree strongly). Point 4 on the scale is anchored by a neutral/mixed option. Of the 36 items, 10 are reverse keyed (nine items from the avoidance subscale and one item from the anxiety subscale). Participants rate how well each statement describes their typical feelings in romantic relationships. Higher scores on the anxiety and avoidant dimensions indicate higher levels of attachment-related anxiety and avoidance, respectively, although cut-off scores were not provided by the authors (Brennan et al., 1998). Additionally, Brennan and colleagues (1998) reported that the ECR has a high level of internal consistency in a sample of undergraduates, with coefficient alphas of .91 and .94 for the anxiety and avoidance domains, respectively.

Since its development, the ECR has been utilized in hundreds of studies and is the currently most used and recommended self-report measure of adult attachment (Crowell, 2021). A recent meta-analysis of 503 published studies utilizing the ECR reported high average Cronbach alpha coefficients for the two ECR subscales: .89 for anxiety and .90 for avoidance (Graham & Unterschute, 2015). Additionally, the ECR has been translated into 17 languages (Graham & Unterschute, 2015; Mikulincer & Shaver, 2016) and has been utilized across several populations including psychiatric clients with severe psychopathology (Cierpiałkowska et al., 2021; Picardi et al., 2011), adolescents (Brenning et al., 2011; Jones et al., 2018), older adults (Kho et al., 2015; Van Assche et al., 2013), and individuals in same-sex relationships (Bouaziz et al., 2013; Gabbay & Lafontaine, 2017).

### **Therapist Response Questionnaire**

The Therapist Response Questionnaire (TRQ), formerly known as the Countertransference Questionnaire, is a 79-item clinical-report instrument that has been normed and validated to measure therapist countertransference responses. The TRQ assesses cognitive,

behavioral, and affective countertransference responses in psychotherapy for both clinical and research purposes (Betan et al., 2005). Participants use a 5-point Likert-type scale ranging from 1 (not true) to 5 (very true), indicating the extent to which each item is true of the participant and their work with a specific client.

Items were reportedly generated based on a review of the clinical, theoretical, and empirical literature on countertransference and related variables. To ensure that clinicians of any theoretical orientation could use the instrument, Betan and colleagues (2005) wrote the items in everyday language, without jargon. Items assess a range of responses, from relatively specific feelings (e.g., “I feel bored in sessions with him/her”) to complex constructs such as “projective identification” (e.g., “More than with most patients, I feel like I’ve been pulled into things that I didn’t realize until after the session was over”).

The thoughts, feelings, and behaviors measured within the TRQ are grouped into eight factors. These include: (a) overwhelmed/disorganized (coefficient alpha = .90) which indicates a desire to avoid or flee the session and strong negative feelings, including dread, repulsion, and resentment; (b) helpless/inadequate (coefficient alpha = .88) which describes feelings of inadequacy, incompetence, hopelessness, and anxiety; (c) positive (coefficient alpha = .86) which indicates the experience of a positive working alliance and close connection with the client; (d) special/overinvolved (coefficient alpha = .75) which describes a sense of the client as special, relative to other clients, and includes ‘soft signs’ of problems in maintaining boundaries, including self-disclosure, ending sessions on time, and feeling guilty about, responsible for, or overly concerned about the client; (e) sexualized (coefficient alpha = .77) which describes sexual feelings toward the client or experiences of sexual tension; (f) disengaged (coefficient alpha = .83) which describes feeling distracted, withdrawn, annoyed, or bored in sessions; (g)

parental/protective (coefficient alpha = .80) which is marked by a wish to protect and nurture the client in a parental way, above and beyond normal positive feelings toward the client; and (h) criticized/mistreated (coefficient alpha = .83) which describes feelings of being unappreciated, dismissed, or devalued by the client (Betan et al., 2005; Betan & Westen, 2009). Analysis of the TRQ confirms that the measure is robust, containing good construct validity and high reliability with Cronbach's alpha values for the factors equaling .80 or above (Tanzilli et al., 2016). The scales' scores are obtained by calculating the average score of the items that make up each factor. Permission to reproduce the TRQ in this dissertation was requested of the authors; however, permission was not obtained.

### **Procedure**

Following Antioch University New England Institutional Review Board approval, participants were recruited via the academic listservs, consisting of licensed psychologists and psychologists-in-training (see Appendix A). Specifically, an email was sent via academic listservs which provided a description of the study and inclusion criteria, as well as a link to the brief online survey (see Appendix B). The link included the informed consent document which, once electronically signed, directed the participant to a basic demographic survey and two questionnaires: Experiences in Close Relationships scale (ECR) and the Therapist Response Questionnaire (TRQ; see Appendix A, C, and D, respectively). The ECR assessed adult attachment organization in terms of anxiety and avoidance, while the TRQ assessed therapists' cognitive, behavioral, and affective responses to one specific client. To minimize selection biases on the TRQ, participants were directed to consult their calendar and to select the last client they saw during the prior week who met the study criteria (i.e., enrolled in individual psychotherapy, 18 years or older, a minimum of eight sessions). Following the completion of data collection,

quantitative statistical analyses were conducted to examine the relationship between therapist attachment organization and their cognitive, behavioral, and affective responses to their clients. It should also be noted that data was collected during the COVID-19 pandemic.

## CHAPTER IV: RESULTS

A total of 73 participants were included in data analysis after checking for duplicate, missing, and incomplete responses, and participant data points were removed if their scores fell beyond the 3<sup>rd</sup> Quartile Range. Participants were given one average score for attachment-related anxiety and one average score for attachment-related avoidance. Additionally, participants were given an average score for each of the eight countertransference factors. To determine the relationship between therapist attachment organization and their responses to clients, multiple linear regression analyses and Pearson's correlations were computed utilizing SPSS.

### Multiple Regression Analyses

Multiple linear regression analyses were utilized to investigate whether therapist attachment organization could significantly predict countertransference responses. Specifically, attachment-related anxiety and avoidance scores were analyzed, simultaneously, in a regression framework to predict countertransference responses. Attachment organizations that are reported to be conceptually aligned with Bartholomew and Horowitz's (1991) typology of adult attachment (e.g., secure, preoccupied, fearful, dismissing categories) can be identified based on the pattern of regression coefficients (Brennan et al., 1998; Fraley, 2012).

Eight multiple regressions were computed, and all main assumptions were first assessed. Each multiple regression analysis violated the assumption of homoscedasticity of residuals, thus yielding heteroscedasticity (see Figures 4.1–4.8). Heteroscedasticity occurs when the residuals at each level of the predictor variables have unequal variances (Field, 2018). Within a multiple linear regression model, the variance of residual terms should be constant, or homoscedastic. Violating this assumption invalidates confidence intervals and significance tests (Field, 2018). Despite this violation, estimates of the model parameters are considered valid, but not optimal.



This problem can be overcome with the use of statistical methods that are robust to violations of model-specific assumptions (Field, 2018). To account for the violation of homoscedasticity within this study, the robust method of bootstrapping was utilized. This method estimates the properties of the sampling distribution from the data and yields a percentile bootstrap confidence interval known as a bias corrected accelerated confidence interval (BCa CI; Field, 2018).

### **Bootstrap Results**

Three of eight bootstrapped multiple linear regression analyses yielded statistically significant predictions (see Table 4.1). Regarding helpless/inadequate countertransference, attachment organization accounted for 26.3% of the variance, with an adjusted  $R^2$  of 24.1%, a medium effect size according to Cohen's (1988) classification,  $F(2, 66) = 11.786, p < .001$ . Attachment-related anxiety ( $B = .330, p < .001, \text{BCa CI } [.177, .474]$ ) significantly contributed to the model, while attachment-related avoidance ( $B = .066, p = .515, \text{BCa CI } [-.097, .296]$ ) did not. The final predictive model was: Helpless/Inadequate Countertransference =  $.613 + (.330 * \text{Anxiety}) + (.066 * \text{Avoidance})$ . These results support hypothesis two.

Regarding disengaged countertransference, attachment organization accounted for 20.9% of the variance, with an adjusted  $R^2$  of 18.5%, a medium effect size according to Cohen's (1988) classification,  $F(2, 66) = 8.701, p < .001$ . Results indicated that attachment-related anxiety ( $B = .224, p = .002, \text{BCa CI } [.104, .371]$ ) significantly predicted disengaged countertransference, while attachment-related avoidance ( $B = .102, p = .252, \text{BCa CI } [-.073, .323]$ ) did not. The final predictive model was: Disengaged Countertransference =  $.705 + (.224 * \text{Anxiety}) + (.102 * \text{Avoidance})$ . These results reject hypothesis three.

Additionally, attachment organization predicted 16% of the variance for criticized/mistreated countertransference, with an adjusted  $R^2$  of 13.4%, a small effect size per

Cohen's (1988) classification,  $F(2, 66) = 6.280$ ,  $p < .01$ . Attachment-related anxiety ( $B = .173$ ,  $p = .019$ , BCa CI [.051, .297]) significantly predicted criticized mistreated countertransference, while attachment-related avoidance ( $B = .030$ ,  $p = .657$ , BCa CI [-.102, .157]) did not. The final predictive model was: Criticized/Mistreated Countertransference =  $.768 + (.173 * \text{Anxiety}) + (.030 * \text{Avoidance})$ . These results reject hypothesis three.

### ***Multicollinearity***

Data analyses revealed a low, significant correlation between attachment-related anxiety and avoidance ( $r = .275$ ,  $n = 70$ ,  $p = .21$ ; see Table 4.3). This is consistent with the literature (Cameron et al., 2012). However, further investigation of the bootstrapped multiple linear regressions indicated that this correlation did not significantly impact the analysis, as the models passed all tests regarding multicollinearity (see Table 4.2; Field, 2018). Bootstrapped multiple linear regression analyses yield a variance inflation factor (VIF), which indicates whether a predictor variable has a strong linear relationship with other predictors. Values that are cause for concern are substantially greater than 1 and greater than 10 (Field, 2018). Within the present sample, VIF values remained close to 1 (see Table 4.2). Additionally, this analysis yields a Durbin-Watson value, which tests for serial correlations between errors. Values that are less than 1 and greater than 3 are cause for concern (Field, 2018). The Durbin-Watson values in the present sample remained close to 2 (see Table 4.2).

### **Pearson's Correlation**

Bivariate Pearson's correlations were conducted to further examine the relationship between attachment organization and countertransference responses. These analyses allowed for the independent examination of attachment-related anxiety and avoidance dimensions in relation to countertransference responses (see Tables 4.3 and 4.4). Regarding attachment-related anxiety,

results revealed five low, yet significant, positive correlations. Specifically, attachment-related anxiety was significantly correlated with overwhelmed/disorganized ( $r = .280, n = 73, p \leq .05$ ), special/overinvolved ( $r = .247, n = 71, p \leq .05$ ), helpless/inadequate ( $r = .247, n = 72, p < .001$ ), disengaged ( $r = .247, n = 72, p < .001$ ), and criticized/mistreated ( $r = .379, n = 72, p \leq .001$ ) countertransference responses. Regarding attachment-related avoidance, results revealed two low, yet significant, positive correlations. Specifically, attachment-related avoidance was significantly correlated with overwhelmed/disorganized ( $r = .302, n = 70, p \leq .05$ ) and disengaged ( $r = .241, n = 69, p \leq .05$ ) countertransference responses. Additionally, there was a low, yet significant correlation between attachment-related anxiety and avoidance ( $r = .275, n = 70, p = .21$ ).

Regarding attachment-related security, Brennan and colleagues (1998) indicated that security is reflected by low scores on both anxiety and avoidant dimensions, although cutoff scores were not provided by the authors. Thus, it was expected that anxiety and avoidance scores on the ECR would yield negative correlations with the countertransference responses of the TRQ. However, results did not achieve significant negative correlations between attachment-related anxiety and avoidant scores, and countertransference responses (see Tables 4.3 and 4.4).

## CHAPTER V: DISCUSSION

The purpose of this study was to examine the relationship between therapist attachment organization and countertransference (i.e., cognitive, affective, and behavioral) responses to clients. Two questionnaires were administered to participants which assessed the level of therapists' self-reported attachment-related anxiety and avoidance, as well as their self-reported thoughts, feelings, and behaviors in response to one specific client. Data analysis revealed that hypothesis one was not supported: low scores on attachment-related avoidance and anxiety dimensions were not significantly associated with countertransference responses. However, hypotheses two and three were supported: scores on attachment-related anxiety were significant predictors of countertransference responses, and both attachment-related anxiety and avoidance scores yielded significant positive, yet low, Pearson's correlations with specific countertransference responses. Additional significant, yet low, Pearson's correlations emerged from the data as well, providing further information regarding the relationship between therapist attachment organization and countertransference responses.

### **Attachment-Related Anxiety and Avoidance Correlation**

Prior to discussing the results of this study, important to note is the significant positive, yet low, correlation between attachment-related anxiety and avoidance within the present study. This significant, yet low, correlation is consistent with previous research. Specifically, a meta-analysis of 204 studies utilizing the ECR and its revised version found that anxiety and avoidance dimensions are correlated (Cameron et al., 2012). Analyses further revealed that anxiety-avoidance dimensions have an average correlation of .20, and that the revised version of the ECR has significantly higher correlations between dimensions than the original ECR measure, the latter which was used within the present study (Cameron et al., 2012). These

correlations are said to suggest that attachment-related anxiety and avoidance may not be as orthogonal as has been consistently proposed, a discussion which is beyond the scope of this study. Cameron and colleagues (2012) suggested the use of multiple linear regression analyses to further understand the shared variance of anxiety and avoidance dimensions. Within the present study, bootstrapped multiple regression analyses were utilized, which yielded significant predictions and provided further information regarding the covariance of attachment-related anxiety and avoidance in predicting countertransference.

### **Attachment-Related Anxiety and Countertransference**

One of the aims of this study was to examine the relationship between therapist anxious attachment organization, as defined by high scores on the anxiety domain and low scores on the avoidance domain of the ECR, and their countertransference responses toward one identified client. Results supported hypothesis two: higher scores on attachment-related anxiety yielded a significant, yet low, Pearson's correlation with helpless/inadequate countertransference responses. Further, multiple linear regression analyses indicated that attachment-related anxiety was a significant predictor of helpless/inadequate countertransference, yielding a medium effect size (Cohen, 1988). As conceptually aligned with Bartholomew and Horowitz's (1991) typology of adult attachment, these results suggest that preoccupied and fearfully attached therapists (i.e., people on the high end of the anxiety dimension) may be more likely to experience helpless/inadequate countertransference than therapists who are secure or dismissing (i.e., people on the low end of the anxiety dimension). This particular type of countertransference indicates feelings of inadequacy, incompetence, hopelessness, and anxiety in response to clients (Betan et al., 2005). Thus, therapists with higher scores on attachment-related anxiety may experience increased feelings of inadequacy and incompetency regarding their ability to successfully help

their clients. These results are consistent with the literature which has shown a negative association between anxious attachment, self-esteem, and self-efficacy (Gentzler & Kerns, 2004; Lemay & Spongberg, 2015; Liu et al., 2018; Lockhart et al., 2017; Strodl & Noller, 2003).

Results also revealed that higher scores on attachment-related anxiety yielded a significant positive, yet low, Pearson's correlation with special/overinvolved countertransference responses. However, multiple linear regression analyses indicated that attachment-related anxiety was not a significant predictor of special/overinvolved countertransference responses. This type of countertransference includes a sense of the client as special, relative to other clients, and difficulty maintaining boundaries, such as self-disclosure, ending sessions on time, and feeling guilty, responsible, or overly concerned about the client (Betan et al., 2005). The yielded correlation is consistent with the literature, as those with higher levels of attachment-related anxiety may intensify psychological distress, intensely monitor others, and do what is necessary to maintain proximity (Arriaga et al., 2018; Main, 1981, 1990; Mikulincer & Shaver, 2016). However, because attachment-related anxiety was not a significant predictor of special/overinvolved countertransference, it is plausible that additional factors contribute to therapists' experience of this countertransference response. These factors may include professional status, theoretical orientation, number of sessions, and client diagnoses. While the present study obtained this information, the sample limited further analysis of these variables. Additionally, the client's self-reported attachment scores may contribute to special/over involved countertransference (Westerling et al., 2019), as well as interact with the therapist's attachment scores to predict this specific countertransference response.

Although hypothesis two was partially supported, attachment-related anxiety failed to achieve a significant correlation with sexualized countertransference. Feelings of sexual

attraction toward clients has been described as taboo (Celenza, 2010; Pope et al., 2006; Vesentini et al., 2022). This attitude may be influenced by the ethical standards that psychologists are meant to uphold (American Psychological Association, 2017), along with cultural beliefs surrounding sexuality, in general and within the context of the therapeutic relationship (Vesentini et al., 2022). There is limited current recent research regarding intimacy and sexuality within the therapeutic relationship, as well as how therapists evaluate the occurrence of such intimate feelings and behaviors (Vesentini et al., 2022). Additionally, most research examining sexualized feelings towards clients was conducted in the late 1980s and 1990s (Borys & Pope, 1989; Garrett & Davis, 1998; Giovazolias & Davis, 2001; Jackson & Nuttall, 2001; Lamb & Catanzaro, 1998; Pope & Tabachnick, 1993; Pope et al., 1986; Rodolfa et al., 1994; Stake & Oliver, 1991).

However, a recent study of 758 therapists in Belgium examined intimate feelings and behaviors on behalf of the therapist, along with engagement in sexual relationships between therapists and clients (Vesentini et al., 2022). Based on a self-report measure, results indicated that the majority of respondents (70.6%) found a client sexually attractive, sometimes or regularly, and that therapists (26.8%) fantasized about sexual contact with a client. Within the current study, it is important to note the lack of variability in participant responses regarding sexualized countertransference. Discussing sexualized thoughts, feelings, and behaviors, in general and in the context of the therapeutic relationship, is an incredibly vulnerable endeavor, even with the anonymity of the data collection process (Celenza, 2010; Krumpal, 2013; Perinelli & Gremigni, 2016; Pope et al., 2006; Vesentini et al., 2022). Thus, participants within the current study may have responded to the questionnaire in a biased manner that felt socially, and ethically, acceptable, and that reflected cultural attitudes toward sexuality, both generally and within the context of the therapeutic relationship.

Beyond hypothesis two, higher attachment-related anxiety scores yielded a significant positive, yet low, Pearson's correlation with criticized/mistreated countertransference responses. Additionally, multiple linear regression analyses indicated that attachment-related anxiety was a significant predictor of criticized/mistreated countertransference responses, with a small effect size (Cohen, 1988). As conceptually aligned with Bartholomew and Horowitz's (1991) typology of adult attachment, these results suggest that preoccupied and fearfully attached therapists (i.e., people on the high end of the anxiety dimension) may be more likely to experience criticized/mistreated countertransference than therapists who are secure or dismissing (i.e., people on the low end of the anxiety dimension). This particular type of countertransference is characterized by feeling unappreciated, dismissed, or devalued by the client (Betan et al., 2005). While attachment-related avoidance has been associated with perceiving others as more distant, rejecting, and hurtful (Cyranowski et al., 2002; Hofstra et al., 2005; Jiang & Tiliopoulos, 2014; Lemay & Spongberg, 2015; Strauss et al., 2012), it is also understandable that attachment-related anxiety is associated with criticized/mistreated countertransference. Specifically, attachment-related anxiety has been associated with a fear of, sensitivity to, and overreaction to rejection (Arseth et al., 2009; Baldwin & Kay, 2003; Baldwin & Meunier, 1999; Brennan et al., 1998; Downey & Feldman, 1996; Sato et al., 2020; Scharf et al., 2014; Taubman-Ben-Ari et al., 2002; Westphal et al., 2014). Thus, therapists with high scores on attachment-related anxiety may be increasingly attentive to signs of criticism and rejection on behalf of the client, which could include the client's facial expressions, language, and behaviors. As such, the rejection sensitivity associated with higher scores on attachment-related anxiety may contribute to the therapist feeling criticized and mistreatment by their client.



### **Attachment-Related Avoidance and Countertransference**

Another aim of this study was to examine the relationship between therapist avoidant attachment organization, as defined by high scores on the avoidance domain and low scores on the anxiety domain of the ECR, and countertransference responses to one identified client. Higher scores on the attachment-related avoidance dimension yielded significant positive, yet low, Pearson's correlations with multiple countertransference responses. However, multiple linear regression analyses indicated that attachment-related avoidance was not a significant predictor for any countertransference response type within the present study. This may be due to the low, yet significant, correlation between attachment-related anxiety and avoidance; a higher average score of attachment-related anxiety within the sample; and other variables that were unable to be analyzed within this study (i.e., professional status, theoretical orientation, number of sessions, and client diagnosis). Thus, it is important to consider these limitations and extraneous variables when interpreting the results.

Higher scores on attachment-related avoidance yielded a significant positive, yet low, correlation with overwhelmed/disorganized countertransference. Such responses are characterized by a desire to avoid or flee the client as well as strong negative feelings, including dread, repulsion, and resentment (Betan et al., 2005). While attachment-related avoidance is associated with attempts to sustain psychological distance, these individuals simultaneously experience and attempt to suppress anger and resentment (Mikulincer & Shaver, 2016). Thus, the results may suggest that, while therapists with high attachment-related avoidance feel strongly overwhelmed by and resentful of their clients at times, they may continue to evidence thoughts, feelings, and behaviors that distance themselves from the client, and perhaps their own psychological distress.

Additionally, analyses revealed that hypothesis three was partially supported: higher scores on attachment-related avoidance yielded a significant positive, yet low, correlation with increased disengaged countertransference responses. Such countertransference is characterized by the therapist feeling distracted, withdrawn, annoyed, or bored in sessions (Betan et al., 2005). These responses appear to align with deactivating strategies, as were previously described. Consistent with attachment theory in adulthood, disengaged countertransference could be a manifestation of regulating emotions through deactivating strategies by maximizing psychological distance from the client. Additionally, because attachment-related avoidance was not a significant predictor of disengaged countertransference, there may be other factors that mediate the relationship between these variables, such as the client's attachment-related avoidance (Bistricky et al., 2017; Stevens, 2014; Webster et al., 2016).

Hypothesis three was partially rejected, as attachment-related avoidance failed to significantly correlate with criticized/mistreated countertransference responses. Participants may have been influenced by a response bias, including answering items in a manner that felt socially acceptable or due to limited insight (Heppner et al., 2016). Similarly, participant responses may reflect associations between attachment-related avoidance and a decreased awareness of emotional states (Stevens, 2014), as well as attempts to maximize psychological distance from others (Jiang & Tiliopoulos, 2014; Lemay & Spongberg, 2015; Mattingly & Clark, 2012; Meyer et al., 2015) and inhibit, suppress, or exclude from awareness thoughts or feelings related to rejection or that imply vulnerability (Mikulincer & Shaver, 2016). When attention is diverted away from these experiences, information may not be properly encoded into memory (Mikulincer & Shaver, 2016). The response patterns of participants may reflect this phenomenon, such that therapists with higher scores on attachment-related avoidance may disavow, or

misremember, the experience of feeling criticized, mistreated, or rejected by their clients. However, further examination is needed.

### **Additional Results: Overwhelmed/Disorganized and Disengaged Countertransference**

In addition to avoidance, higher scores on attachment-related anxiety yielded a significant positive, yet low, Pearson's correlation with overwhelmed/disorganized countertransference responses. However, multiple linear regression analyses indicated that attachment-related anxiety was not a significant predictor of overwhelmed/disorganized countertransference. The literature indicates that anxiously attached individuals are more likely to be hypervigilant toward, and intensify, their emotional and physiological experiences (Arriaga et al., 2018; Main, 1981, 1990; Mikulincer & Shaver, 2016), as well to ruminate on actual and potential threat, even after the threat subsides (Mikulincer & Shaver, 2016). Therefore, the correlation between attachment anxiety and the intense emotion related to overwhelmed countertransference is understandable. Additionally, multiple linear regression analyses revealed that attachment-related anxiety was a significant predictor of disengaged countertransference, yielding a medium effect size (Cohen, 1988). These results suggest that preoccupied and fearfully attached therapists (i.e., people on the high end of the anxiety dimension) may be more likely to experience disengaged countertransference than therapists who are secure or dismissing (i.e., people on the low end of the anxiety dimension; Bartholomew & Horowitz, 1991).

The relationship between attachment-related anxiety, disengaged, and overwhelmed/disorganized countertransference is somewhat surprising. Again, attachment-related anxiety is often associated with the intense monitoring of others and maintaining proximity through any means necessary (Arriaga et al., 2018; Main, 1981, 1990; Mikulincer & Shaver, 2016), rather than avoiding, fleeing, or disengaging from others. Although

attachment-related avoidance was not a significant predictor of countertransference responses, the yielded Pearson's correlations between attachment-related avoidance and disengaged and overwhelmed/disorganized countertransference may assist in understanding the results. Specifically, fearfully attached individuals, or those on the high end of both the anxiety and avoidance dimensions (Bartholomew & Horowitz, 1991), may cycle between strategies of closeness seeking and emotional distancing (Marks et al., 2014). Because closeness may feel rewarding, fearfully attached individuals may exhibit ambivalence toward maintaining relationships (Park et al., 2019). Thus, it is possible that fearfully attached therapists experience intense emotional responses toward their client, while simultaneously retreating from psychological closeness, perhaps as a manifestation of a conflicted motivation or as a method for decreasing distress. Importantly, the relationship between attachment-related anxiety and disengaged and overwhelmed/disorganized countertransference responses may be considerably different, and even non-linear, when attachment scores are on the higher end of the anxiety dimension. Future research should continue to explore the unique qualities of this relationship, as the results of this study challenge existing literature on attachment-related anxiety and interpersonal outcomes. Similar to Cameron and colleagues (2012), it is recommended that these variables be reevaluated within a multiple linear regression framework to account for covariance, as well as within a larger sample to yield more reliable, and thorough, conclusions.

Additionally, it might be tempting to conceptualize higher scores on both anxiety and avoidance as a disorganized attachment. These individuals seek to approach a partner in times of distress, but these approaches may be interrupted or incomplete, appearing chaotic or incoherent; fear of a relationship partner may simultaneously cause apprehension and a desire to distance themselves (Mikulincer & Shaver, 2016; Paetzold et al., 2015). However, it has been argued that

disorganization is not necessarily a combination of organized strategies, but an experience that coexists with them. Specifically, disorganized adults may be high in anxiety and/or avoidance in addition to exhibiting disorganization (Paetzold et al., 2015). Furthermore, whether attachment-related avoidance and anxiety on the ECR represents disorganization has not yet been established (Paetzold et al., 2015). Therefore, the results of the present study may not accurately reflect disorganized attachment organizations and inferences must not be made without further examination.

### **Secure Attachment Organization and Countertransference**

The final aim of this study was to examine the relationship between secure attachment organizations and countertransference responses. As defined by the ECR, the higher-order concept of secure attachment is indicated by low scores on the anxiety and avoidance dimensions, although cut off scores were not provided by the authors (Brennan et al., 1998). Within the present study, results indicated that low scores on attachment-related anxiety and avoidance domains failed to significantly correlate with parental/protective and positive countertransference responses.

Parental/protective countertransference describes a wish to protect and nurture the client in a parental way, above and beyond normal positive feelings toward the client, while positive countertransference describes the experience of a positive working alliance and close connection with the client (Betan et al., 2005). Although low scores on anxiety and avoidance dimensions were not significantly associated with these countertransference responses, readers should not interpret these findings to say that therapists with secure attachment organizations do not experience such thoughts and feelings. As parental/protective and positive countertransference responses were not significantly associated with, or predicted by, attachment-related anxiety or

avoidance in any direction, results may indicate that these particular thoughts and feelings toward clients do not emerge with specific placements on either plane of avoidance or anxiety. Rather, such responses may be indiscriminately experienced by therapists across the spectrums of attachment-related anxiety and avoidance.

Additionally, the literature indicates that securely attached individuals have the potential to cope effectively in response to stressful events (Berant et al., 2008; Karreman & Vingerhoets, 2012), as their experiences subsequently enhance their capacity to tolerate and manage affect (Deklyen & Greenberg, 2016). Further, these individuals may have less conflictual relationships (Campbell et al., 2005; J. Feeney & Fitzgerald, 2019; Mikulincer & Shaver, 2016; Simpson et al., 1996), are more likely to report higher levels of self-esteem (Bartholomew & Horowitz, 1991; Kawamoto, 2020; Mattingly & Clark, 2012; Towler & Stuhlmacher, 2013), and tend to be more comfortable with intimacy, autonomy, and interdependence (Slade, 2016). Thus, securely attached therapists may experience a range of countertransference responses, but to a degree that does not reach significance, perhaps due to a potential to manage interpersonal boundaries and affect in effective ways.

Research also suggests that the ECR does not appear to tap into the full range of attachment security (Brennan et al., 1998; Cameron et al., 2012; Fraley et al., 2000). Brennan and colleagues (1998) stated that, when utilizing the ECR, participants were more likely to be measured as insecure and less likely to be measured as secure when compared to Bartholomew and Horowitz's (1991) measure. Though the ECR may be less sensitive to attachment security, the measure benefits from more statistically distinct anxiety and avoidance dimensions than the revised version (Brennan et al., 1998; Cameron et al., 2012; Fraley et al., 2000; Mikulincer & Shaver, 2016). This measurement limitation is important when interpreting the results of the

current study, as they may reflect the measure's insensitivity to security, rather than a true absence of a relationship between the studied variables.

Furthermore, the thoughts, feelings, and behaviors of securely attached therapists in response to their clients may be explained by confounding variables, as well. These may include characteristics individually pertaining to the therapist and the client, or an interaction between the two. For example, the relationship between therapist attachment and countertransference may be mediated by the quality of the working alliance, which has already been associated with therapist and client attachment (Berry et al., 2008; Black et al., 2005; Degnan et al., 2016; Dinger et al., 2009; Fuertes et al., 2019; Mallinckrodt & Jeong, 2015; Schauenburg et al., 2010). Additionally, therapist attachment and countertransference responses may be mediated by characteristics of the client, including their attachment organization, an association which has been demonstrated, as well (Westerling et al., 2019). Other variables such as professional status, theoretical orientation, number of sessions, and client diagnosis may contribute to countertransference responses, as well. Due to the present study's limitation of a small sample size, the ability to compute these additional analyses to further understand the complexity of the data was diminished.

### **Implications**

The general direction of this study's findings indicate that the level of therapist attachment-related anxiety and avoidance may be associated with countertransference responses to an identified client. Few studies have examined this relationship, with only one yielding an effect; however, the study was subjected to limitations in regard to methodology, including supervisor-rated countertransference behavior within a single, first session (Mohr et al., 2005). Additionally, at the time of this document, research has not yet examined the relationship

between therapist attachment and countertransference while utilizing the TRQ. Therefore, not only does this study provide expanded knowledge on the relationship between therapist attachment and countertransference, but it also provides novel research for the TRQ.

As the purpose of this study was to explore the relationship between therapist attachment and countertransference, results suggest that therapists may benefit from developing and maintaining an awareness of their thoughts, feelings, and behaviors in response to clients, including considering the potential influence of their attachment history. Research indicates that unmanaged countertransference can negatively impact therapeutic outcomes and that self-awareness is important in understanding and mitigating harmful manifestations of countertransference (Hayes et al., 2018). Importantly, many of the participants were psychologists-in-training (45.1%). Therefore, it is recommended that clinical psychology students assess and consider their attachment organizations throughout their training sequence, particularly as it pertains to their countertransference experiences. Similarly, graduate psychology programs should provide their students with ample opportunity and support for discussing their countertransference experiences and to intentionally consider the potential influence of their attachment histories.

### **Limitations**

This study was subjected to a number of limiting factors. The small sample size limited the statistical analyses that could be computed, which included the mediating effects of confounding variables on the relationship between level of therapist attachment-related anxiety and avoidance and countertransference (i.e., professional status, theoretical orientation, number of sessions, and client diagnosis). This study also relied on self-report measures which have inherent limitations. While convenient for data collection, self-report measures are subject to



response bias and rely on participants' self-insight and reflective capabilities (Heppner et al., 2016). Because attachment and countertransference experiences require a level of vulnerability to reflect on and express, participants within this study may have responded to the questionnaires in a manner that reflected limited insight, or in a way that felt socially, and ethically, acceptable.

There are also methodological limitations of the self-report measures utilized within this study. The TRQ measured therapists' countertransference responses toward one identified client. However, therapists may have varying countertransference experiences with different clients. The results of the present study may, therefore, reflect the qualities of the specific relationship that therapists reported on, rather than a more general account of their countertransference experiences. Additionally, the ECR evidences a lack of sensitivity to attachment-related security (Cameron et al., 2012) and yielded a weak correlation between anxiety and avoidance domains within the present study. An argument has also been made that self-report measures of attachment only characterize attachment-relevant behaviors, emotions, and cognitions in close adult relationships, rather than directly assessing IWM (Steele et al., 2014). A similar argument can be made for countertransference responses in that self-report measures may assess and categorize the manifestation of countertransference through thoughts, feelings, and behaviors, rather than the unconscious content or structures themselves. While the results of this study suggest that attachment-related anxiety and avoidance are correlated with, and can predict, countertransference responses, the analyses may have yielded stronger effect sizes with the use of interview methods, such as the Adult Attachment Interview (Hesse, 2016; Main et al., 1985). This interview assesses the participant's ability to provide a coherent narrative about their early caregiving experiences, rather than relying solely on the participant's ability to agree or disagree

to specific items proposing to represent attachment-related thoughts, feelings, and behaviors with a current close relationship.

Furthermore, the current study was conducted during the COVID-19 pandemic, and many practitioners began providing psychotherapy services via telehealth. As such, participants in this study may have developed a therapeutic relationship with their client via telehealth, or transitioned to telehealth after having an already established therapeutic relationship. While yielding important benefits such as increased access to mental health services, telehealth platforms may also pose their own challenges for the therapist. Specifically, recent research revealed that, due to the transition to remote therapy, the strongest negative change for therapists were their countertransference responses (Jesser et al., 2021). Additionally, research has demonstrated that, throughout the pandemic, attachment anxiety emerged with an increased risk of relationship problems, a more chaotic and less cohesive family environment, and lower relationship quality (Overall et al., 2022), while attachment avoidance predicted lower problem-solving efficacy and family cohesion (Overall et al., 2022). Consequently, the results of this study may, to some degree, reflect the complex impact of the COVID-19 pandemic and the transition to telehealth services on the therapist's attachment organization and their countertransference responses to a specific client.

### **Future Directions**

Future directions include continuing to explore the relationship between therapist attachment and countertransference responses toward clients. It is important that future studies yield a larger sample size to be able to further understand the predictive nature of therapist attachment on countertransference, as well as the contributing effects of other demographic or confounding variables. Similarly, with understanding the limits of self-report measures, utilizing

qualitative research methods might provide greater breadth and understanding of the relationships between these variables. Specifically, utilizing interview-based assessments of attachment organization, such as the Adult Attachment Interview (Hesse, 2016; Main et al., 1985), might provide a more nuanced account of the influence of attachment on countertransference.

The present study offers some evidence for the association between attachment organization on countertransference responses. As the literature has demonstrated the negative impact of unmanaged countertransference (Hayes et al., 2018), future research should explore the relationship between unmanaged countertransference, therapist attachment, the therapeutic relationship, and treatment outcomes. Research should also examine the role that psychology graduate programs play in assisting trainees in maintaining an awareness of, and discussing, their countertransference responses and related attachment histories. Furthermore, as telehealth platforms become routine and continue to flourish in the mental health field, future research should examine the effects of telehealth treatment on therapists' countertransference experiences as well as their attachment-related thoughts, feelings, and behaviors.

### **Conclusion**

The present study examined the relationship between therapist attachment organization and countertransference responses. Quantitative data analyses revealed that therapist attachment organization can be associated with countertransference responses toward clients. While most of the findings were consistent with existing research on adult attachment and interpersonal outcomes, some results were surprising, including attachment-related anxiety as a significant predictor of disengaged countertransference. This relationship is contrary to adult attachment research that indicates an association between attachment-related anxiety and a desire for

closeness. Further research is needed to examine the covariance of attachment-related avoidance and anxiety in predicting countertransference. Due to limited existing research on therapist attachment and countertransference, the results of this study provide an expanded understanding of the relationship between these variables. This study also provides novel research for the TRQ, as this measure has not yet been utilized when examining therapist attachment organization and countertransference.

Overall, the present research has important implications for psychotherapy practitioners across theoretical orientations. The psychotherapy process includes the development of a close relationship built upon a series of interactions and therapeutic tasks, explicit and implicit. Regardless of the specific treatment utilized, the therapist brings to the relationship a set of thoughts, feelings, behaviors, expectations, and previous experiences that have the potential to influence the manner in which they respond to, and interact with, their clients. Maintaining an awareness of one's countertransference and attachment history underscores the ethical duty of psychotherapists in prioritizing the well-being of those they commit to serve and empower.

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## APPENDIX A: RECRUITMENT LETTER

Hello,

My name is Morgan Pell, and I am a doctoral candidate in the Clinical Psychology Department at Antioch University New England. I am seeking your participation in my dissertation survey which will explore therapist characteristics and their experiences of patients in psychotherapy. Participant responses will be anonymous; no identifying information beyond basic demographics will be requested. This research is being supervised by Theodore Ellenhorn, Ph.D. ABPP.

You are eligible to participate in this study if you are providing individual psychotherapy to patients 18-years or older, and if you meet any of the following criteria:

- Are at least a second-year student within a doctorate-level clinical psychology program;
- Are enrolled in a pre- or post-doctoral internship;
- Have received your doctorate-level clinical psychology degree;
- Are a licensed psychologist, with a doctorate-level degree.

Your participation in this study is completely voluntary and you can withdraw at any point without consequence. If you decide to participate, you will be asked to complete an electronic questionnaire including an informed consent form and a questionnaire. Completion of the questionnaire should take 20-30 minutes. If you'd like to participate, please click the following link to access the consent form and questionnaires: *[insert link here]*.

Should you have any questions or concerns regarding the study or your participation, please feel free to email me at [redacted], or my dissertation chairperson at [redacted].

Thank you very much for your consideration and participation!

Sincerely,  
Morgan Pell, M.S.  
Clinical Psychology  
Psy.D. Doctoral Candidate  
Antioch University New England  
Keene, NH  
(she/her/hers)

## APPENDIX B: INFORMED CONSENT FORM

**Principal Investigator:** Morgan Pell, M.S.

**Sponsor:** Antioch University New England

Dear participant,

This survey is part of my dissertation research at Antioch University New England, within the Clinical Psychology Psy.D. Program. This survey explores therapist characteristics and their experiences of patients in psychotherapy. Your responses will assist current and future psychologists, as well as other mental health providers, in understanding their responses to patients and how their personal histories contribute. The survey will take approximately 20-30 minutes to complete.

There are minimal, if any, risks from participating. You will not be asked to provide identifying information about yourself or your patient. Additionally, your anonymous responses will be stored within a password-protected document, on a password-protected computer, that will only be accessed by me and my dissertation chairperson, Theodore Ellenhorn, Ph.D., ABPP.

Your participation is completed voluntary, and you may elect to discontinue your participation at any time. If you have any questions about this study or your participation, please contact me, **Morgan Pell**, at [redacted], or my dissertation chairperson, **Theodore Ellenhorn** at [redacted].

Should you have any questions about your rights as a research participant, please contact [redacted], **Chair of Antioch University New England IRB**, at [redacted] or [redacted]. You may also contact [redacted], **Antioch University New England Provost**, at [redacted] or [redacted].

### **Documentation of Consent:**

I have read and understood the above information. By clicking "agree" below, I am indicating that I have read and understood this consent form **and** agree to participate in this research study.

## APPENDIX C: DEMOGRAPHIC QUESTIONNAIRE

### Biological Sex:

Female  
 Male  
 Conditions of Sex Development/Intersex  
 Prefer not to say

### Gender Identity:

Female  
 Male  
 Trans  
 Nonbinary  
 Genderqueer  
 Genderfluid  
 Agender  
 Two-spirit  
 Pangender  
 Queer  
 Other: \_\_\_\_\_  
 Prefer not to say

### Age:

18-24  
 25-34  
 35-44  
 45-54  
 55-64  
 65+  
 Prefer not to say

### Race/Ethnicity (Select all that apply):

Indigenous American or American Indian or Alaska Native  
 Aboriginal or Indigenous Canadian  
 Native Hawaiian or Pacific Islander  
 East Asian  
 South Asian  
 Southeast Asian  
 Middle Eastern/West Asia  
 North Africa  
 South Africa  
 Black or African American  
 Hispanic or Latinx  
 Australian/New Zealander  
 White or European Descent  
 Jamaican

Caribbean  
Other: \_\_\_\_\_  
Prefer not to say

**Professional Status:**

Second Year Student  
Third Year Student  
Fourth Year Student  
Fifth Year Student  
Sixth Year or above Student  
Completing Pre-Doctoral Internship  
Completing Post-Doctoral Training  
Have completed training and not licensed  
Licensed fewer than 3 years  
Licensed 4-7 years  
Licensed 8-11 years  
Licensed 12-15 years  
Licensed 16-19 years  
Licensed 20+ years  
Prefer not to say

**Theoretical Orientation:**

Cognitive-Behavioral  
Psychodynamic  
Humanistic  
Interpersonal  
Relational  
Cognitive  
Behavioral  
Systems  
Eclectic  
Integrative  
Other: \_\_\_\_\_  
Prefer not to say

## APPENDIX D: EXPERIENCES IN CLOSE RELATIONSHIPS SCALE

Directions: The following statements concern how you feel in romantic relationships. We are interested in how you generally experience relationships, not just in what is happening in a current relationship. Respond to each statement by indicating how much you agree or disagree with it. Write the number in the space provided, using the following rating scale:

- | Disagree Strongly | Neutral/Mixed |   |   |   |   | Agree Strongly |  |   |
|-------------------|---------------|---|---|---|---|----------------|--|---|
| 1                 | 2             | 3 | 4 | 5 | 6 | 7              |  |   |
| 1.                |               |   |   |   |   |                |  | I prefer not to show a partner how I feel deep down.  |
| 2.                |               |   |   |   |   |                |  | I worry about being abandoned.  |
| 3.                |               |   |   |   |   |                |  | I am very comfortable being close to romantic partners.                                       |
| 4.                |               |   |   |   |   |                |  | I worry a lot about my relationships.   |
| 5.                |               |   |   |   |   |                |  | Just when my partner starts to get close to me I find myself pulling away.                    |
| 6.                |               |   |   |   |   |                |  | I worry that romantic partners won't care about me as much as I care about them.              |
| 7.                |               |   |   |   |   |                |  | I get uncomfortable when a romantic partner wants to be very close.                           |
| 8.                |               |   |   |   |   |                |  | I worry a fair amount about losing my partner.  |
| 9.                |               |   |   |   |   |                |  | I don't feel comfortable opening up to romantic partners.                                     |
| 10.               |               |   |   |   |   |                |  | I often wish that my partner's feelings for me were as strong as my feelings for him/her.     |
| 11.               |               |   |   |   |   |                |  | I want to get close to my partner, but I keep pulling back.                                   |
| 12.               |               |   |   |   |   |                |  | I often want to merge completely with romantic partners, and this sometimes scares them away. |
| 13.               |               |   |   |   |   |                |  | I am nervous when partners get too close to me.   |
| 14.               |               |   |   |   |   |                |  | I worry about being alone.  |
| 15.               |               |   |   |   |   |                |  | I feel comfortable sharing my private thoughts and feelings with my partner.                  |
| 16.               |               |   |   |   |   |                |  | My desire to be very close sometimes scares people away.                                      |
| 17.               |               |   |   |   |   |                |  | I try to avoid getting too close to my partner.   |
| 18.               |               |   |   |   |   |                |  | I need a lot of reassurance that I am loved by my partner.                                    |
| 19.               |               |   |   |   |   |                |  | I find it relatively easy to get close to my partner.   |
| 20.               |               |   |   |   |   |                |  | Sometimes I feel that I force my partners to show more feeling, more commitment.              |
| 21.               |               |   |   |   |   |                |  | I find it difficult to allow myself to depend on romantic partners.                           |
| 22.               |               |   |   |   |   |                |  | I do not often worry about being abandoned.   |
| 23.               |               |   |   |   |   |                |  | I prefer not to be too close to romantic partners.  |
| 24.               |               |   |   |   |   |                |  | If I can't get my partner to show interest in me, I get upset or angry.                       |
| 25.               |               |   |   |   |   |                |  | I tell my partner just about everything.  |
| 26.               |               |   |   |   |   |                |  | I find that my partner(s) don't want to get as close as I would like.                         |
| 27.               |               |   |   |   |   |                |  | I usually discuss my problems and concerns with my partner.                                   |
| 28.               |               |   |   |   |   |                |  | When I'm not involved in a relationship, I feel somewhat anxious and insecure.                |
| 29.               |               |   |   |   |   |                |  | I feel comfortable depending on romantic partners.  |
| 30.               |               |   |   |   |   |                |  | I get frustrated when my partner is not around as much as I would like.                       |
| 31.               |               |   |   |   |   |                |  | I don't mind asking romantic partners for comfort, advice, or help.                           |
| 32.               |               |   |   |   |   |                |  | I get frustrated if romantic partners are not available when I need them.                     |
| 33.               |               |   |   |   |   |                |  | It helps to turn to my romantic partner in times of need.                                     |
| 34.               |               |   |   |   |   |                |  | When romantic partners disapprove of me, I feel really bad about myself.                      |
| 35.               |               |   |   |   |   |                |  | I turn to my partner for many things, including comfort and reassurance.                      |
| 36.               |               |   |   |   |   |                |  | I resent it when my partner spends time away from me.   |

## APPENDIX E: PERMISSIONS

### Experiences in Close Relationships Scale (ECR)

Experiences in Close Relationships - Permission to Reproduce

External Inbox x



**Morgan Pell**

to kbrennan

Tue, Mar 29, 9:20 AM (5 days ago)



Dear Dr. Brennan-Jones,

My name is Morgan Pell and I am a doctoral candidate in the Clinical Psychology PsyD program at Antioch University New England. I am currently in the process of defending my dissertation, chaired by Dr. Theodore Ellenhor, Ph.D., ABPP.

My IRB-approved research examined the relationship between therapist self-reported attachment organization and countertransference responses toward psychotherapy clients. Within this study, I utilized your measure, the Experiences in Close Relationships scale, which was taken from J. A. Simpson and W. S. Rholes' (Eds.) Attachment Theory and Close Relationships (1998).

I am writing to ask permission to reproduce this questionnaire in my dissertation which will be published in two open access databases (OhioLINK and Antioch University Repository and Archive) and a commercial database (ProQuest). If not, I will immediately remove it from the final product.

Please let me know if you need further information, or if you have any questions or concerns. Thank you so much for your time and I look forward to your response.

Sincerely,  
Morgan Pell

--

Morgan Pell, M.S.  
Clinical Psychology  
Psy.D. Doctoral Candidate  
Antioch University New England  
Keene, NH  
(she/her/hers)



**Brennan-Jones, Kelly (kbrennan)**

to me

Mar 29, 2022, 9:25 AM (5 days ago)



No problem, Morgan, permission granted. Permission not needed, though. (I wonder what will happen after I die? People will no longer be able to write me for permission!)

Anyway, the measure is difficult to obtain, as it's in a book chapter from 1998. I've attached it (along with a related chapter from the same book) and the measure itself, in case that's useful.



## Tables

Table 3.1

*Demographic Characteristics*

<b>Gender</b>	<b>Percent (%)</b>	<b>Count</b>
Female	68.5	61
Male	15.1	2
Genderqueer	2.7	1
Gender fluid	2.7	2
Non-binary	2.7	1
Female and Gender Fluid	1.4	4
Don't identify with any	1.4	1
Did not answer	5.5	1
<b>Age</b>		
18–24	2.7	2.7
25–34	41.1	41.1
35–44	23.3	23.3
45–54	9.6	9.6
55–64	12.3	12.3
65+	11	11
<b>Race/Ethnicity</b>		
White	83.6	61
Middle Eastern/West Asian	2.7	2
Asian American	1.4	1
Black	2.7	2
Latina	1.4	1
Biracial	5.5	4
Did not answer	1.4	1
Don't identify	1.4	1
<b>Professional Status</b>		
Third Year Student	8.2	6
Fourth Year Student	12.3	9
Fifth Year Student	6.8	5
Sixth Year or above Student	1.4	1
Completing Post-Doctoral Training	6.8	5
Completing Pre-Doctoral Internship	9.6	7
Have completed training and not licensed	6.8	5
Licensed fewer than 3 years	11	8
Licensed 4-7 years	9.6	7
Licensed 8-11 years	5.5	4

Licensed 12-15 years	4.1	3
Licensed 16-19 years	4.1	3
Licensed 20+ years	13.7	10

<b>Theory</b>	<b>Percent (%)</b>	<b>Count</b>
Cognitive-Behavioral	8.2	6
Psychodynamic	37	27
Humanistic	1.4	1
Relational	15.1	11
Eclectic	1.4	1
Integrative	27.4	20
Other	9.6	7

### **Patient Diagnosis**

Anxiety Disorders	21.9	16
Trauma and Stressor-Related Disorder	31.5	23
Depressive Disorders	9.6	7
Bipolar Disorder	4.1	3
Multiple Diagnoses	26	19
Eating Disorders	1.4	1
Obsessive Compulsive Disorders	1.4	1
Personality Disorders	2.7	2
Gender Dysphoria	1.4	1

### **Number of Sessions**

8-49	61.6	45
50-99	6.8	5
100-149	11	8
150-199	2.7	2
200-249	5.5	4
250-299	2.7	2
300-349	1.4	1
350+	8.2	6
<b>Total</b>	<b>100%</b>	<b>73</b>

**Table 4.1***Bootstrapped Multiple Linear Regression Analyses*

Variable	R <sup>2</sup>	Anxiety				Avoidance			
		<i>b</i>	<i>SE B</i>	$\beta$	<i>p</i>	<i>b</i>	<i>SE B</i>	$\beta$	<i>p</i>
Overwhelmed	.143	.087 (-.003, .185)	.057	.238	.150	.106 (-.006, .251)	.075	.236	.175
Helpless	.263	.330 (.177, .474)	.080	.487	<.001	.066 (-.097, .296)	.103	.078	.515
Positive	.037	-.045 (-.195, .109)	.066	-.089	.469	-.094 (-.253, .052)	.073	-.149	.208
Special	.058	.151 (-.033, .328)	.092	.234	.114	.016 (-.149, .207)	.094	.021	.873
Sexualized	.005	.008 (-.061, .08)	.034	.025	.816	.024 (-.092, .149)	.064	.058	.711
Disengaged	.209	.224 (.104, .371)	.060	.399	.002	.102 (-.073, .323)	.091	.147	.252
Parental	.071	.193 (-.023, .418)	.112	.223	.088	-.239 (-.496, .007)	.120	-.222	.050
Criticized	.160	.173 (.051, .297)	.067	.382	.019	.030 (-.102, .157)	.068	.057	.657

Multiple linear regression models of attachment-related anxiety and avoidance and countertransference. 95% bias corrected and accelerated confidence intervals reported in parentheses. Confidence intervals and standard errors based on 1000 bootstrap samples.

**Table 4.2***Tests for Multicollinearity in Bootstrapped Multiple Linear Regressions*

	<i>VIF Anxiety</i>	<i>VIF Avoidance</i>	<i>Durbin-Watson</i>
Overwhelmed	1.082	1.082	1.959
Helpless	1.073	1.073	1.864
Positive	1.081	1.081	1.971
Special	1.077	1.077	1.487
Sexualized	1.082	1.082	2.040
Disengaged	1.059	1.059	1.632
Parental	1.082	1.082	2.171
Criticized	1.067	1.067	2.021

*Note:* VIF = Variance Inflation Factor. VIF indicates whether a predictor variable has a strong linear relationship with other predictors. Values that are cause for concern include VIF values substantially greater than 1 and greater than 10 (Field, 2018). Durbin-Watson tests for serial correlations between errors. Values that are less than 1 and greater than 3 are cause for concern (Field, 2018).

**Table 4.3**

*Correlation Matrix for Attachment-Related Anxiety and Avoidance and Countertransference Factors*

Variable	1	2	3	4	5	6	7	8	9	10
Anxiety	-									
Avoidance	.275*	-								
Overwhelmed	.280*	.302*	-							
Helpless	.450**	.206	.674**	-						
Positive	-.122	-.174	-.196	-.183	-					
Special	.247*	.083	.258*	.247*	.404**	-				
Sexualized	.047	.065	.032	.035	.095	.023	-			
Disengaged	.389**	.241*	.480**	.570**	.420**	.087	-.025	-		
Parental	.143	-.162	-.027	.197	.445**	.343**	.107	-.03	-	
Criticized	.379**	.152	.650**	.619**	-.022	.343**	.144	.292*	.083	-

*Note:* \* significant at the 0.05 level, \*\* significant at the 0.01 level.

**Table 4.4***Totals, Means, and Standard Deviations of Attachment and Countertransference*

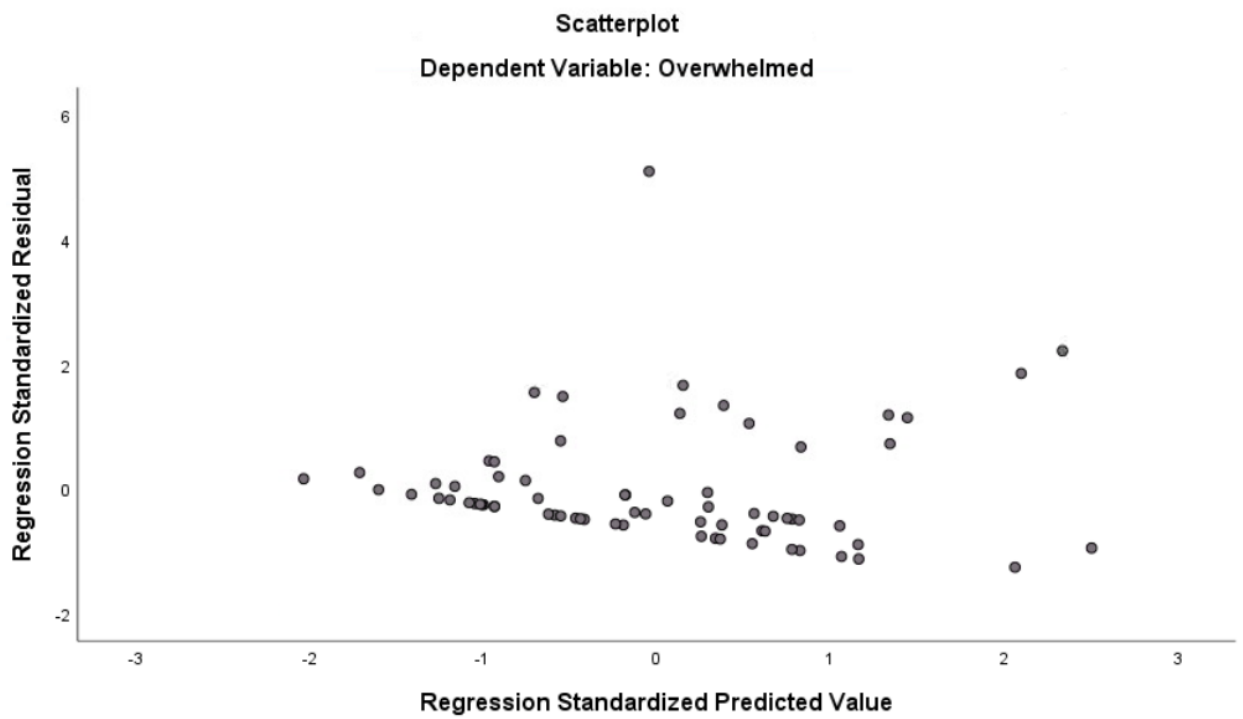
Variable	<i>n</i>	<i>M</i>	<i>SD</i>
Anxiety	73	2.96	1.0
Avoidance	70	2.41	.83
Overwhelmed	73	1.23	.37
Helpless	72	1.76	.70
Positive	72	3.26	.52
Special	71	1.62	.65
Sexualized	73	1.15	.34
Disengaged	72	1.63	.59
Parental	73	3.03	.90
Criticized	72	1.34	.44

*Note:* *n* = number of participants, *M* = mean, *SD* = standard deviation.

### Figures

**Figure 4.1**

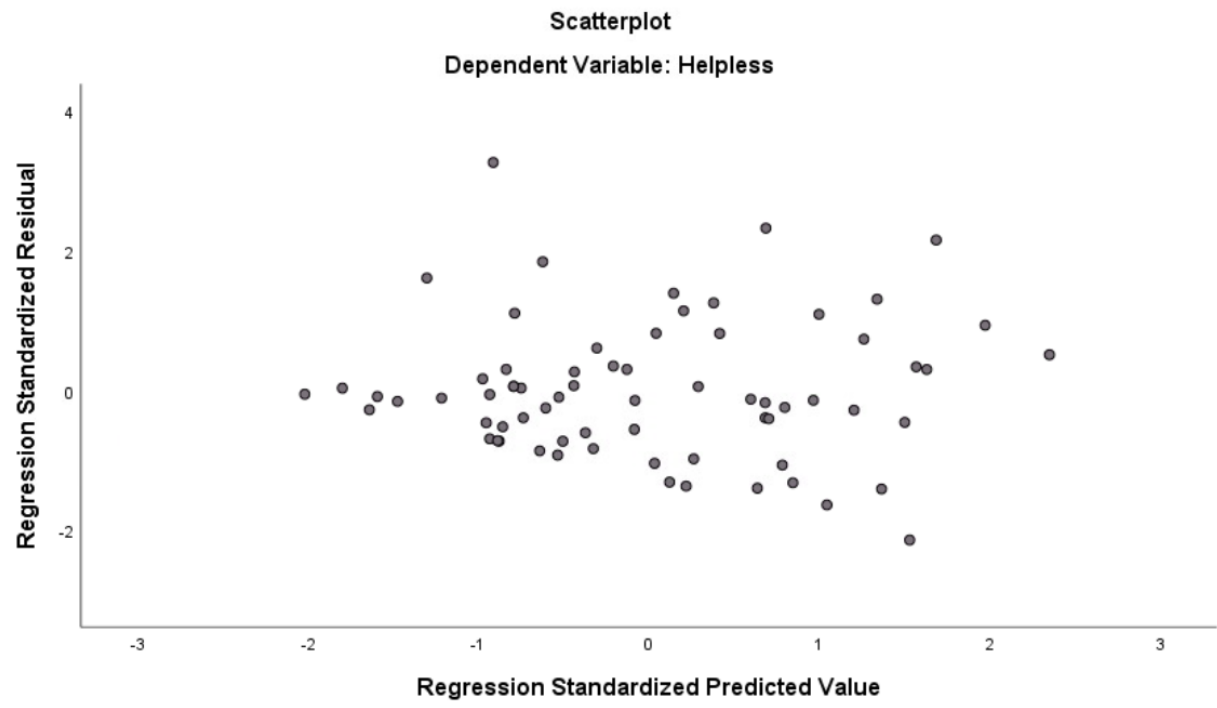
*Multiple Regression for Overwhelmed/Disorganized Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.2**

*Multiple Regression for Helpless/Inadequate Countertransference: Demonstration of Heteroscedasticity of Residuals*

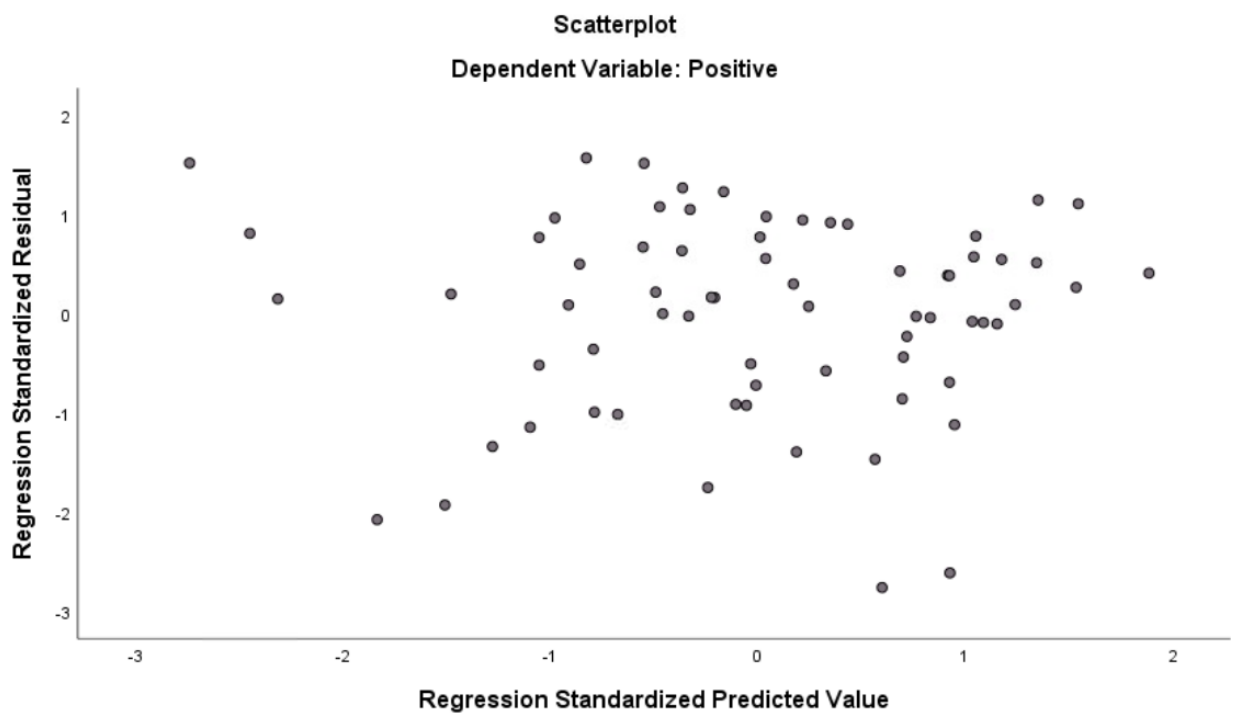


*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.



**Figure 4.3**

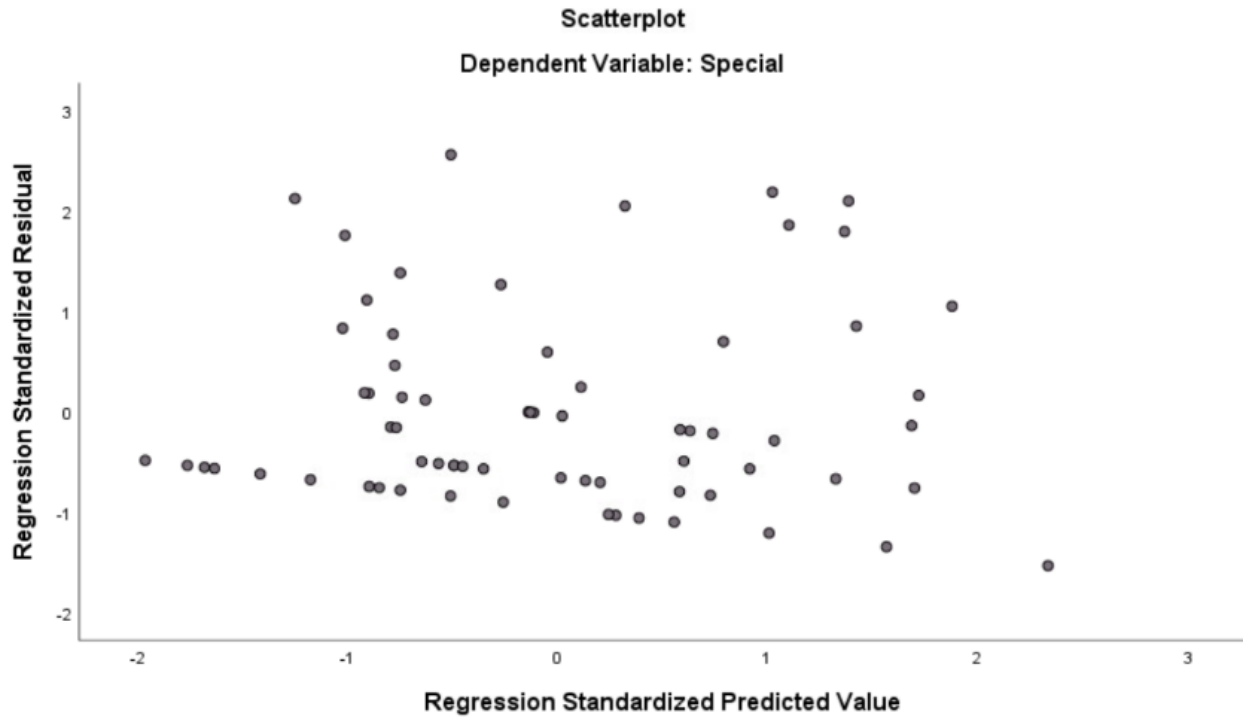
*Multiple Regression for Helpless/Inadequate Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.4**

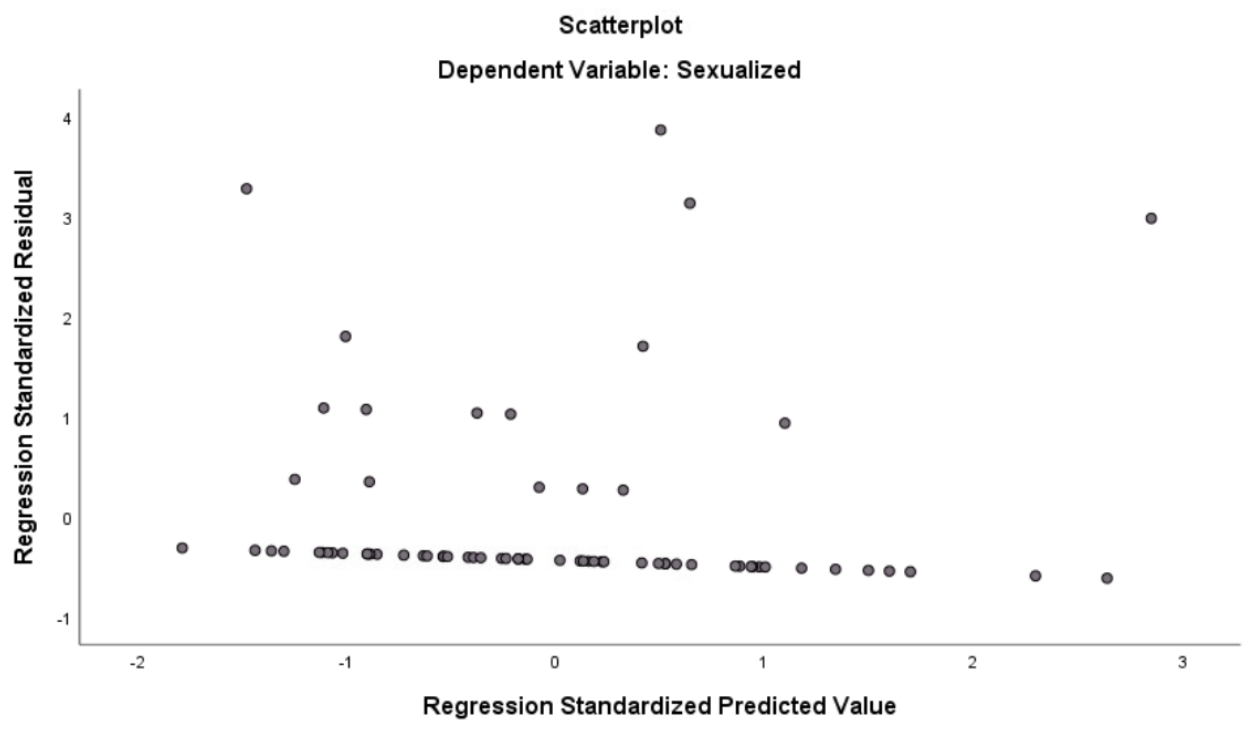
*Multiple Regression for Special/Overinvolved Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.5**

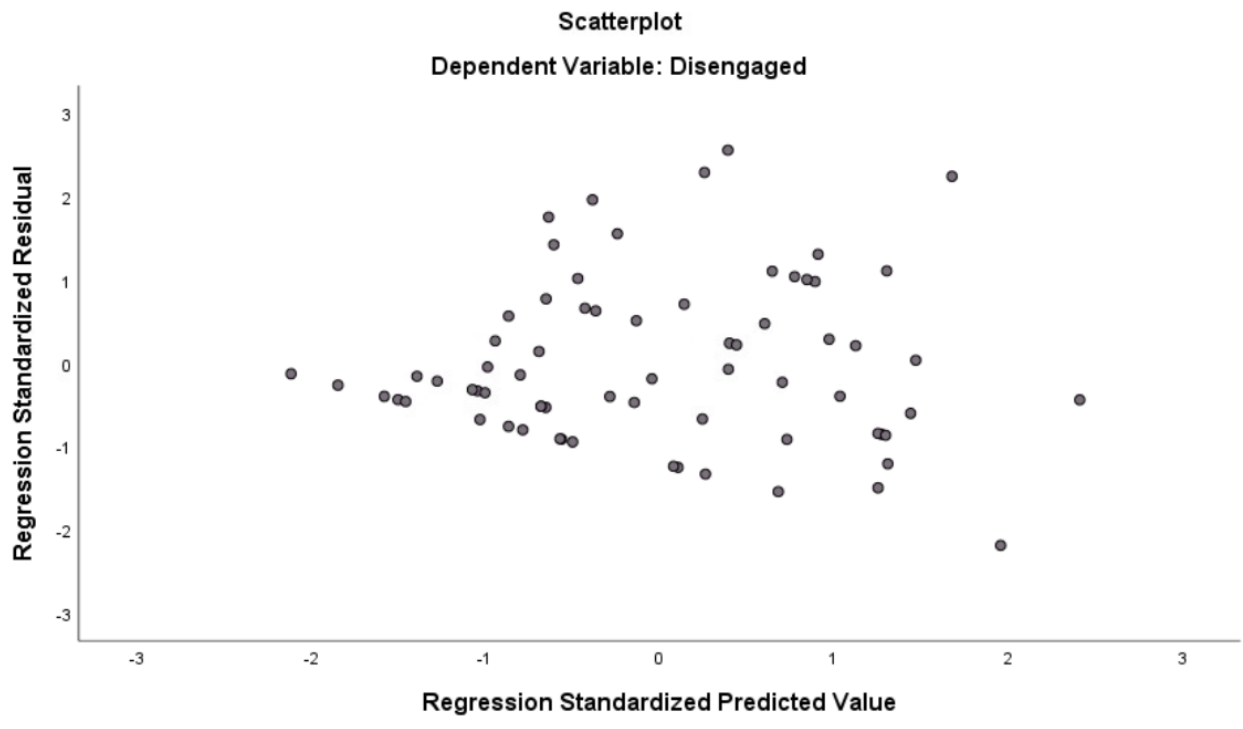
*Multiple Regression for Sexualized Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.6**

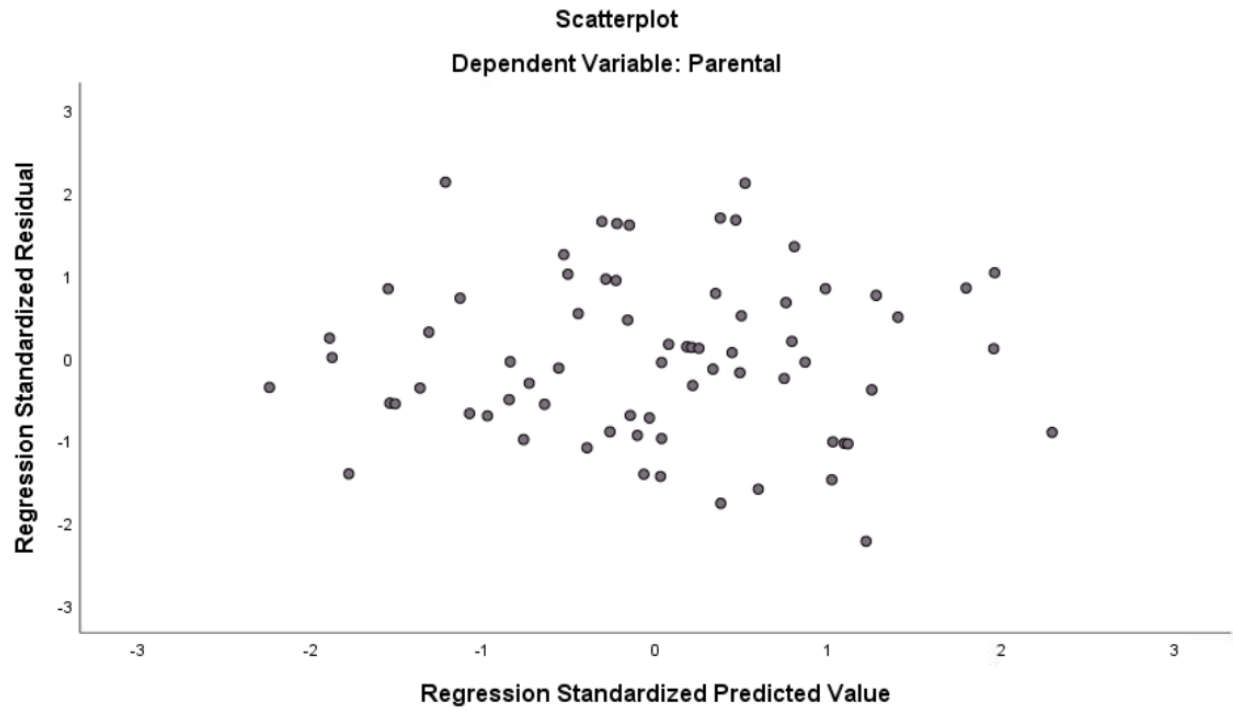
*Multiple Regression for Disengaged Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.7**

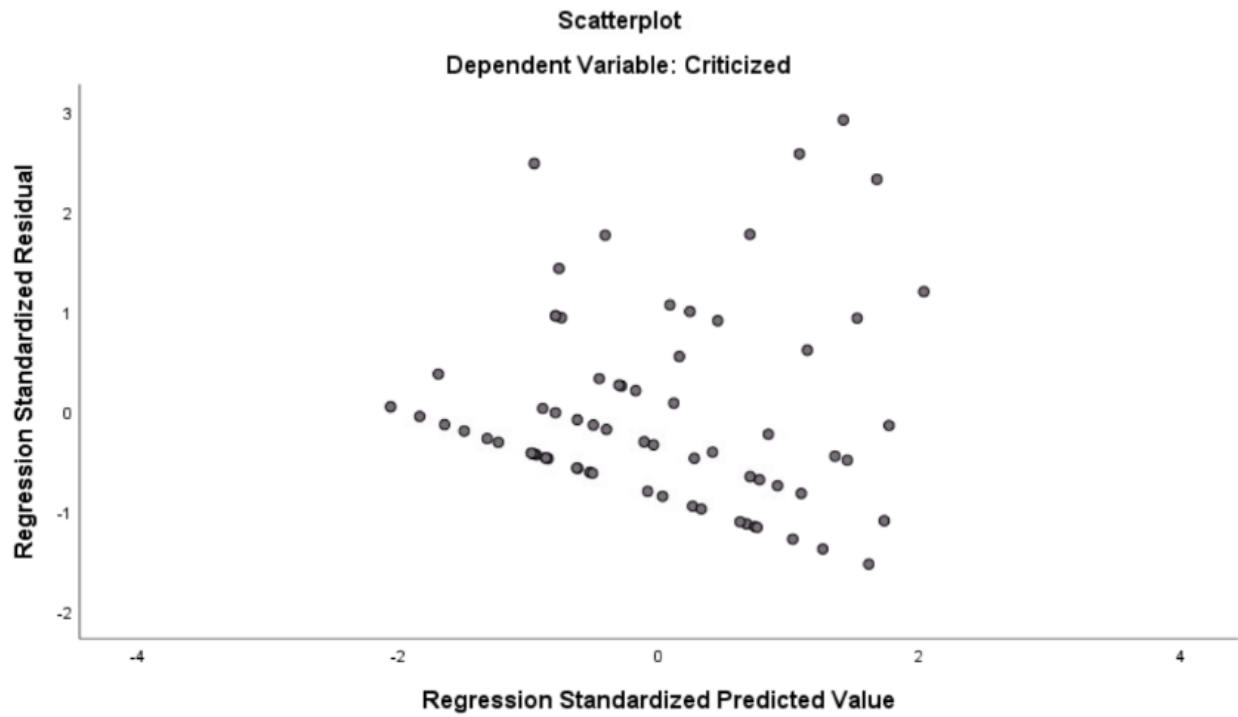
*Multiple Regression for Parental Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.

**Figure 4.8**

*Multiple Regression for Criticized/Mistreated Countertransference: Demonstration of Heteroscedasticity of Residuals*



*Note:* This figure demonstrates heteroscedasticity of residuals, which violates the assumptions of multiple regression analyses.