PSYCHOTHERAPY RELATIONSHIP AS A SECURE BASE: THE ROLE OF ATTACHMENT TO THERAPIST BEYOND ALLIANCE

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ABSTRACT

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Master's Program in Clinical Psychology

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The present study examines psychotherapy relationship within the scope of attachment theory. The secure base function of psychotherapy relationship is examined with the investigation of attachment to therapist, alliance, in-session exploration, rupture, and resolution in therapeutic alliance. Demographic Information Form, Client Attachment to Therapist Scale, Working Alliance Inventory, Session Evaluation-Adjective Form, and Post-Session Questionnaire were used to measure study variables. 81 participants who completed at least 5 sessions in their psychotherapy process participated in the current study. Results have shown that secure attachment to therapist was associated

with greater alliance, in-session exploration, and rupture resolution whereas avoidant attachment to therapist was associated with lower alliance, in-session exploration, and rupture resolution. There was no significant relationship between rupture intensity, neither secure attachment to therapist nor avoidant attachment to therapist. It may suggest that secure attachment to therapist can provide better repairing capacity regardless of intensity thus these individuals may conclude with greater outcome improvement in psychotherapy setting. Results have also shown that attachment to therapist predicts unique variance in in-session exploration beyond alliance. It may suggest that psychotherapy relationship includes more comprehensive relational dynamics beyond working collaboration in psychotherapy setting. Moreover, participants who were in cognitive behavior therapy group showed greater level of secure attachment to therapist and alliance comparing to psychodynamic oriented therapy group at the initial phase of psychotherapy process. Considering literature and current study findings, it is expected that examining attachment patterns in psychotherapy relationship provides a better understanding corrective emotional experience role of psychotherapy relationship.

Keywords: attachment theory, psychotherapy relationship, attachment to therapist, therapeutic alliance

ÖZET

PSİKOTERAPİ İLİŞKİSİNDE GÜVENLİ TEMEL: TERAPİSTE BAĞLANMANIN İTTİFAĞIN ÖTESİNDEKİ ROLÜ

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Klinik Psikoloji Yüksek Lisans Programı

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Bu çalışma psikoterapi ilişkisini bağlanma kuramı perspektifinde incelemektedir. Psikoterapi ilişkisinin güvenli temel işlevi, terapiste bağlanma, terapötik ittifak, seans içi keşif, ittifakta kırılma ve onarılma değişkenleri açısından incelenmiştir. Çalışma değişkenlerini ölçmek için Demografik Bilgi Formu, Danışanın Terapiste Bağlanma Ölçeği, Terapötik İttifak Ölçeği, Seans Değerlendirme Ölçeği-Sıfatlar Formu ve ittifakta kırılma-onarılma deneyimini ölçmek için Seans Sonrası Değerlendirme Ölçeği'nden seçilen sorular kullanılmıştır. Mevcut çalışmaya psikoterapi sürecinde en

az 5 seans tamamlayan 81 katılımcı katılmıştır. Sonuçlar terapiste güvenli bağlanmanın daha yüksek düzeyde ittifak, seans içi keşif ve ittifakta kırılmanın onarılması ile ilişkili olduğunu, terapiste kaçınmacı bağlanmanın ise daha düşük ittifak, seans içi keşif ve ittifakta kopmanın onarılması ile ilişkili olduğunu göstermiştir. Fakat ittifakta kırılmanın şiddeti ile terapiste güvenli bağlanma veya terapiste kaçınmacı bağlanma arasında anlamlı bir ilişki bulunmamıştır. Terapiste güvenli bağlanmanın, ittifakta kırılmanın yoğunluğundan bağımsız olarak daha iyi onarım kapasitesi sağlayabileceği ve dolayısıyla bu danışanların psikoterapiden daha fazla kazanım elde edebileceği düşünülmektedir. Sonuçlar terapiste bağlanma değişkeninin, terapötik ittifağın ötesinde seans içi keşfini bağımsız olarak yordadığını göstermektedir. Psikoterapi ilişkisinin, işbirlikçi çalışma tutumunun ötesinde daha kapsamlı ilişkisel dinamikleri içerdiği öne sürülebilir. Ayrıca psikoterapi sürecinin erken dönem aşamasında, bilişsel davranışçı terapi grubunda yer alan katılımcılar psikodinamik yönelimli terapi grubunda yer alanlara kıyasla daha yüksek terapötik ittifak ve terapiste güvenli bağlanma göstermişlerdir. Literatür ve mevcut çalışma bulguları göz önüne alındığında, psikoterapi ilişkisinde bağlanma örüntülerinin incelenmesinin psikoterapi ilişkisinin sağladığı düzeltici duygusal deneyimin öneminin anlaşılmasına katkı sağlayacağı düşünülmektedir.

Anahtar Sözcükler: bağlanma kuramı, psikoterapi ilişkisi, terapiste bağlanma, terapötik ittifak

Dedicated to my beloved grandfather who had been a secure base for me and bequeathed his providing secure base capacity to me. The internal representation of him will always enlighten me to provide a secure base for the clients in the psychotherapy setting...

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CHAPTER 1: INTRODUCTION

Since the initial years of psychotherapy research, mutual relational dynamics between client and therapist have been investigated as one of the essential components of an effective psychotherapy process and also one of the main predictors of therapeutic change. Although different schools of psychotherapy conceptualize psychotherapy relationship with different terms such as transference, working alliance, therapeutic bond, or limited re-parenting, all of them have agreed on the importance of psychotherapy relationship for a favorable outcome. In the current study, psychotherapy relationship will be examined beyond the psychotherapy approaches by focusing on common features of psychotherapy relationship within the scope of attachment theory.

Secure base provides encouragement for an infant to explore novel situations in the environment. If the infant internalizes his main caregiver as available and responsible towards his needs, he can demand for closeness from the caregiver when his distress is unmanageable due to uncertain environment. After he is soothed by his caregiver he can maintain exploration. Similar to infant-caregiver dyad, secure base stance of the therapist may present similar function for the client in psychotherapy relationship. It is expected that secure base function of psychotherapy relationship provides encouragement for the client to explore his emotions and thoughts during psychotherapy process.

In the present study, secure base function of psychotherapy relationship will be examined with the variables of attachment to therapist, alliance, in-session exploration, and rupture-resolution experiences in alliance. Firstly, attachment theory and the role of attachment theory in psychotherapy setting will be examined. Secondly, therapeutic alliance as one of the main components of a psychotherapy relationship will be mentioned. Lastly, in-session exploration and rupture-resolution experiences in alliance will be investigated in the terms of attachment to therapist and alliance variables.

1.1 Psychotherapy Relationship within Scope of Attachment Theory

1.1.1 Attachment Theory and Infant-Caregiver Relationship

Attachment theory proposes that relational experiences with the primary caregiver during early years of life lead construction of representations about self, others, and world which is named as the internal working model (Bowlby, 1973). The infant internalizes primary caregiver's attunement and responsiveness to his needs thus making inferences about the value of self, trustability of others, and safety in the world. These mental representations become a template to interact with others and the environment for infant and shape his emotional, cognitive, and behavioral development across the lifespan. Furthermore, these representations repetitively occur implicitly or explicitly in the close relationship from infancy to adulthood.

Bowlby (1973) conceptualizes attachment with four main manifestations: *proximity-seeking*, *separation protest*, *safe heaven,* and *secure base*. According to attachment theory, infants need physically closeness with their attachment figure to survive in the environment, which is named as proximity-seeking. Infants show discomfort such as restlessness and distress reactions when his attachment figure becomes distant. These reactions are conceptualized as separation protests. Safe heaven represents soothing and comforting stance of the attachment figure when infant is unable to relieve his distress by himself due to internal factors, such as anxiety, or external factors, such as existence of triggering stimulus in the environment. Internalization of safe heaven is going to form the capacity of self-regulation for infants in further years. Lastly, secure base represents a reliable, predictable stance, and responsiveness of attachment figure across infant's needs. Internalization of attachment figure as a secure base provides freely exploration of the environment without hesitation and turn back to attachment figure when it is needed.

Strange Situation experiments were conducted to examine the attachment patterns between infants and primary caregivers (Ainsworth et al., 1978). Infants are observed by an experimenter in eight different episodes, which include leaving and rejoining the primary caregiver and a stranger in each episode into a room. The experimenter observes infants' behaviors based on four attachment manifestations,

which were mentioned above: proximity-seeking, separation protest, safe heaven, and secure base. Infants identified as secure, insecure avoidant, and insecure ambivalent based on their reactions during the experiment. These attachment categorizations were given in Table 1.

In the terms of separation and reunion with primary caregiver during the experiment, securely attached infants show high separation anxiety but accept reunion and are easily soothed when the primary caregiver turns back. On the other hand, avoidant ones show almost no reaction to separation and ignore reunion with primary caregiver whereas ambivalent ones show the highest separation anxiety but also resistance towards reunion when the primary caregiver returns. When infants' exploration behaviors are observed, it is found that securely attached infants voluntarily explore the environment and show a highest level of exploration compared to avoidant and ambivalent infants. Therefore, Strange Situation experiments have shown that infants based on their internal working models show different behavioral reactions towards the same situation.

Table 1. Attachment Manifestations (Source: Ainsworth et al., 1978).

	Proximity Seeking	**Separation Protest**	**Secure Heaven**	**Secure Base**
Secure Attachment	When attachment figure is present, friendly towards stranger. Otherwise, avoids from stranger	Distress when attachment figure leaves	Easily be soothed when attachment figure returns	Use the attachment figure as a secure base and voluntarily explore the environment
Avoidant Attachment	No different reactions towards attachment figure or stranger	No signs of distress when attachment figure leaves	Shows little interest when attachment figure returns	No difference in exploring when attachment figure or stranger is in the room
Ambivalent Attachment	Avoids stranger and shows fear reactions regardless of the presence of attachment figure	Intense signs of distress when attachment figure leaves	Both approaches and resists when attachment figure returns	Restless and less explore the environment

In further years, physiological measurements were conducted in addition to observational behavioral evaluations during Strange Situation experiment. The aim was to clarify whether infants show also different psychobiological reactions beyond observable behavioral reactions based on their attachment patterns during the experiments. Results revealed that insecure infants show a higher level of physiological distress compared to the secure ones (Diamond and Fagundes, 2010; Donovan and Leavitt, 1985; Hill-Soderlund et al. 2008; Gunnar et al., 1996). These findings highlighted that although avoidantly attached infants show minimal behavioral reactions towards caregiver's separation or reunion, they show physiological distress as well as ambivalent ones. Both infant groups who have avoidant and ambivalent attachment patterns experience high level of distress, but they show different behavioral reactions to cope with their frustration as a consequence of failure to perceive primary caregiver as trustable, responsive, and be attuned to his needs. Therefore, these findings may clarify that examining attachment patterns contribute understanding of implicit reactions such as emotional and cognitive differences among individuals beyond their observable or explicit behaviors.

In the circumstances when infants fail to internalize their primary caregiver as trustable, responsible and be attuned to his needs, they perceive closeness with a significant other as a threatening experience rather than pleasurable or rewarding experience. Then, they develop secondary strategies, named *deactivating* or *hyperactivating* to cope with their frustration towards the unfulfillment of attachment needs (Shaver and Mikulincer, 2002). Avoidantly attached infants use deactivating strategy by downplaying the importance of intimacy. They have tendency to increase emotional distance due to their perception of emotional closeness is a non-rewarding and threatening interaction. Whereas anxiously attached infants show hyperactivating strategy by exaggerating need for closeness contrary to avoidantly attached ones. Due to the perception of their primary caregiver will not be available and responsive across their needs, they exaggerate their need for closeness (Mikulincer, Shaver and Pereg, 2003).

Although infants developed secondary attachment strategies to adapt to their environment due to unfulfilled attachment needs, these strategies become permanent

over time and transform into maladaptive function (Dozier, Stovall and Albus, 1999). Negative internal working models about self, others, and the world, which are rooted in in early experiences, predetermine how to relate with others in further years (Bowlby, 1979). In the following section, attachment and close relationship in adulthood will be examined.

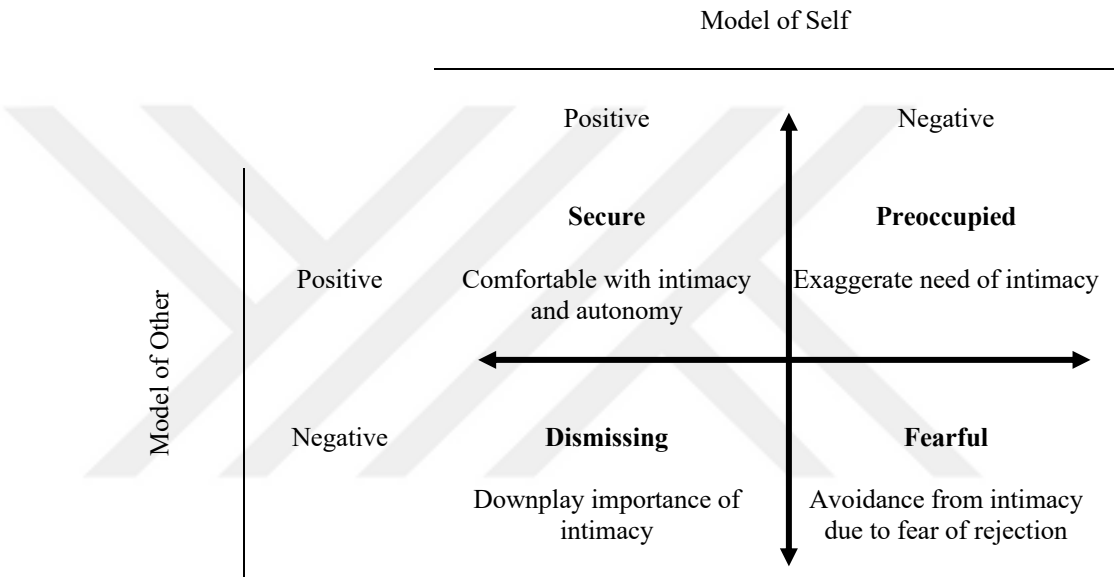
1.1.2 Attachment Theory and Lifelong Close Relationships

Hazan and Shaver (1987) and Bartholomew and Horowitz (1991) reconceptualize infant-caregiver attachment patterns and formulate adult attachment pattern in close relationships. Hazan and Shaver (1987) proposed three categorizations for adults similar to previous infant attachment literature: *secure, anxious-ambivalent,* and *anxious-avoidant*. Later on, Bartholomew and Horowitz (1991) suggested a two-dimensional attachment model for adults based on negative and positive assumptions about self and others. They define *secure* individuals as having a positive perception about both, self and others. They argue that secure individuals can ensure needs of intimacy and needs of autonomy with a balance in close relationships. Furthermore, they define *dismissing* individuals as having a positive perception about self but a negative perception about others. Therefore, these individuals are threatened in close relationships and show avoidance in the face of intimacy. On the contrary, they define *preoccupied* individuals as ones who have a negative perception about self but a positive perception about others. These individuals, contrary to dismissing ones, are highly anxious to maintain intimacy in close relationships and therefore, they may diminish their needs for autonomy to maintain intimacy. Lastly, they define *fearful* individuals as having both, negative perceptions about self and others. These individuals may also be detached from close relationships due to their negative model about both, self and others. Bartholomew and Horowitz (1991)'s adult attachment model is also represented in Table 2.

Individuals show differences in social information processing based on their working model (Bowlby, 1969; Bowlby, 1973). They selectively elicit responses from others which confirm their assumptions about self and others in close relationships. For example, an infant who experienced repeated rejection in his infanthood will be

more vulnerable to detecting rejection cues in other close relationships as an adult (Daniel, 2006). This selective information process causes more permanent negative assumptions about self and others over time. Therefore, hyperactivating and deactivating strategies can be more resistant. Insecure individuals' fear of intimacy or fear of abandonment can transform to self-fulfilling prophecy with reenactment in close relationships.

Table 2. Attachment Dimensions in Adulthood (Source: Bartholomew and Horowitz, 1991)



As a result of interpretative bias of relational interactions, insecure attachment pattern can increase vulnerability for psychopathology (Dozier, Stovall and Albus, 1999; Kobak and Bosmans, 2019). Meta-analyses have shown that insecurely attached individuals show lower relationship satisfaction (Candel and Turliuc, 2019), greater emotional distress (Hankin, Kassel and Abela, 2005), and poorer emotion regulation capacity (Mikulincer and Shaver, 2019) comparing to secure individuals.

Moreover, individuals who have insecure attachment show poorer treatment outcome in psychotherapy setting (Schauenburg et al., 2010) whereas individuals who have secure attachment style show greater improvement (Levy et al., 2011; Meyer et al., 2001; Travis et al., 2001). Although insecure attachment style can increase

vulnerability for psychopathology and decrease likelihood of greater improvement in psychotherapy setting, insecurely attached individuals can still get benefits from psychotherapy process as well securely attached ones. Tailoring psychotherapy process based on clients' attachment manifestations contribute to therapeutic change (Daly and Mallinckrodt, 2009; Mallinckrodt, 2010).

It is suggested that attachment pattern plays also an important role in psychotherapy relationship besides close relationships in adulthood. Examination of attachment manifestations in psychotherapy setting contributes to a deeper understanding of how insecurely attached individuals can get benefit from psychotherapy process as well as securely attached ones. Thus, the next section will focus on analogy between infant-caregiver and client-therapist relationship.

1.1.3 Attachment Theory and Psychotherapy Relationship

Object relations theorists, such as Winnicott and Bion, suggested a similar conceptualization of psychotherapy relationship to Bowlby. Winnicott used the infant-mother analogy while explaining the relationship between patient and therapist (Winnicott, 1960; Winnicott, 1965; Mitchell and Black, 1995). He suggested that the holding function of the therapist is essential in psychotherapy process. He proposed that the patient can express his feelings and thoughts without fear of rejection when the therapist provides a reliable and accepting stance with the attunement of patient's needs. The patient interacts with the therapist as a transition object and becomes able to internalize his true self during psychotherapy process. When the internalization of the true self occurs, patient achieves emotional integration and prefers to express himself rather than repress in his life.

Bion (1962) suggested that therapist's containment function is essential for psychotherapy process, similar to holding function as Winnicott suggested (Fraley, 2008). He proposed that the infant is not able to organize mental materials by himself yet, so projects them to the caregiver. These disorganized mental materials named as beta elements which represent actually raw emotional experiences. The caregiver provides a containment function, transforming beta elements to alpha elements for the

infant which convert raw emotional experiences for the infant into tolerable form. Moreover, he used infant-mother analogy while examining the relationship between patient and therapist. It is suggested that therapist should also provide a containment function for the patient as occur in infant-mother dyad. The patient comes to therapy with intolerable distress across their particular experiences and the therapist should provide a container stance for patient's intolerable or unmanageable mental contents. Intolerable or disorganized mental materials are transformed into tolerable material with the therapist's containment stance during psychotherapy process. Therefore, patient gains the capacity to relieve his distress via transforming intolerable experiences into tolerable ones gradually.

In addition to Winnicott and Bion, Bowlby (1988) also proposed that the relationship between patient and therapist presents similar characteristics to the infant-caregiver dyad. Moreover, attachment manifestations are inevitably enacted in psychotherapy relationship. Similar to infants that are seeking to be soothed by the caregiver in stressful circumstances because of lack in self-regulation capacity yet, patients also use psychotherapy as help-seeking when they cannot cope alone with particular situations. Therefore, the secure base function of psychotherapy relationship can be essential for psychotherapy process as similarly occur in infant-caregiver relationship. It provides a soothing function towards their unmanageable distress and supports the exploration of conflictual, repressed emotions and/or maladaptive cognitions freely during psychotherapy process.

Studies have shown that client's higher level of adult secure adult attachment pattern is related to a greater level of therapeutic alliance during psychotherapy process (Bernecker, Levy and Ellison, 2014; Diener and Monroe, 2011; Folke et al. 2016; Mallinckrodt and Jeong, 2015; Smith, Msetfi, and Golding, 2010). Individuals may have different assumptions about their therapist's responsiveness, and attunement to their needs based on their internal working model. In the following section, attachment manifestations in psychotherapy setting and how to tailor therapeutic distance based on attachment needs will be mentioned.

1.1.4 Tailoring Psychotherapy Process Based on Attachment Needs

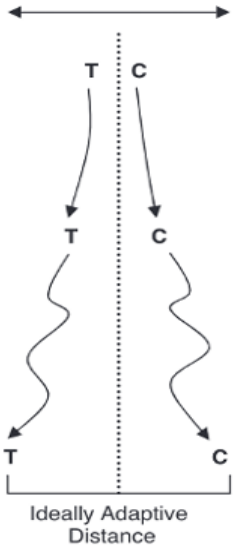
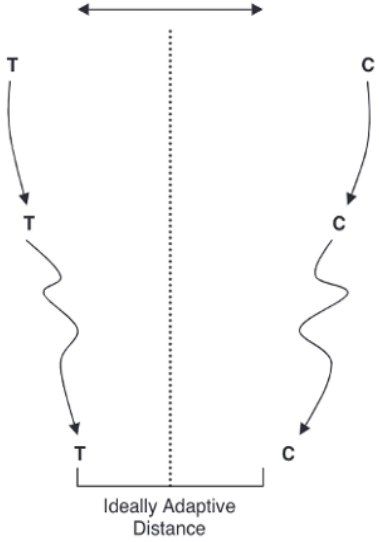
Individuals who have insecure adult attachment pattern may be less likely to build strong alliance in psychotherapy setting as a result of the emergence of deactivating and hyperactivating strategies (Mallinckrodt and Jeong, 2015). Individuals who have avoidant attachment may reject emotional closeness, refuse to make valid self-disclosure, repress their anxious feelings towards missing/termination sessions, or downplay bonding aspects of psychotherapy relationship. On the other hand, individuals who have anxious attachment may demand extreme closeness which can violate professional boundaries and show a high level of frustration towards unavailability of the therapist. They may also extremely idealize their therapist to maintain psychotherapy relationship. Consequently, neither of them can experience psychotherapy relationship as a secure base to explore their emotional and cognitive states during psychotherapy process.

Tailoring psychotherapy process based on client's attachment needs have a crucial role in increasing the efficiency of psychotherapy process (Daly and Mallinckrodt, 2009; Mallinckrodt, 2010). Highly anxious clients desire for extreme closeness with their therapist and they are more likely to perceive their therapist as too distant at initial phase of psychotherapy process. On the contrary, highly avoidant clients feel threatened across emotional closeness and they are more likely to perceive their therapist as too close at the beginning phase. It is suggested that integrating gradually contrary attachment manifestations provides greater alliance and outcome improvement in psychotherapy setting (Tyrell et al., 1999).

Daly and Mallinckrodt (2009) and Mallinckrodt, Choi and Daly (2015) proposed that during the relationship-building stage of the therapy, therapist should regulate therapeutic distance to comply with client's tendency of hyperactivating or deactivating manifestations. Subsequently, during the working phase of the therapy, therapist should gradually challenge these maladaptive strategies to reach a qualified therapeutic distance within psychotherapy relationship. They argued that it provides corrective relational experience in attachment patterns and client gradually gain self-regulation capacity across frustration in close relationships. It is expected that the

balance between autonomy and relatedness is experienced firstly in psychotherapy relationship and later in other close relationships. Consequently, as an outcome of psychotherapy process, clients' attachment patterns may transform from insecure to secure when their representation about self and other begin to change gradually.

Table 3. Therapeutic Distance to Facilitate Corrective Emotional Experience (Source: Mallinckrodt, Choi and Daly, 2015)

	Hyperactivating Clients	Deactivating Clients
	Therapeutic Distance	Therapeutic Distance
Engagement Working Phase Termination		

T: Therapist, C: Client

Egozi, Tishby and Wiseman (2020) conducted a study to examine fluctuations in therapeutic distance with 67 clients who were taking psychodynamic therapy. Clients' perception about the distance in psychotherapy relationship were measured at initial stage (*session 5*), middle stage (*session 15),* and late stage (*session 28*) during the psychotherapy process. Results revealed that clients' tendency to perceive their therapist as extremely distant decreased as psychotherapy proceeded. However, clients' perception of their therapist as extremely close did not significantly decrease during the process. Findings were attributed that highly avoidant clients may show also higher resistance against emotional closeness during psychotherapy process.

Thus, they may show slower changes about the biased perception of distance in psychotherapy relationship compared to highly anxious clients.

In the following section, alliance as a one of the main constructions of psychotherapy relationship will be examined.

1.2 Alliance

Alliance is one of the main components of psychotherapy relationship to examine efficacy of psychotherapy process. Although theoretical definition of what alliance is has changed over years, it is suggested that a greater level of alliance is essential for an efficient psychotherapy process. In this section, the change of alliance definition in psychotherapy literature and the relationship between alliance and attachment to therapist will be examined.

1.2.1 Conceptualization of Alliance: Transference to Alliance

Psychotherapy relationship has been conceptualized with different terms under different psychotherapy approaches. Firstly, Freud conceptualized psychotherapy relationship with the terms of *transference* and *countertransference* in psychoanalytic theory. In his first writings, Freud defined transference as a transformation of repressed libidinal or aggressive infantile desires to here and now relationship with the analyst (Freud, 1912; Crits-Christoph and Gibbons, 2003). Therefore, transference was evaluated as an unrealistic component of the patient-analyst relationship during the treatment process. The relational dynamic between patient and analyst attributed to only patient's projection of conflictual, unresolved desires and wishes to the therapist. Currently, this conceptualization may be evaluated as controversial and insufficient to examine psychotherapy relationship according to two-person model in contemporary psychodynamic theories. Nevertheless, Freud firstly highlighted the importance of positive attachment between patient and analyst as a vehicle of treatment success (Freud, 1912; Crits-Christoph and Gibbons, 2003). Moreover, in the following years, he started to elaborate that alliance is a part of transference which represent the conscious collaboration capacity of the patient during the treatment (Saketopoulou, 1999).

The term *therapeutic alliance* was firstly introduced by Zetzel referring to patient's capacity or functional ego parts for allying with the analyst **(**Zetzel 1956; Saketopoulou, 1999). Within the scope of object relation theory, she argued that early developmental experiences determine whether the person is able to engage in trusting and stable relationships. Thus, if the patient was not able to build a trusting alliance in psychotherapy relationship, therapist should prepare environmental conditions for building a trusting therapeutic alliance just like a mother who prepares the safe environment for the infant.

Later on, Greenson (1965) conceptualized the term *working alliance* refering to the patient's capacity to cooperate and maintain motivation to reach the goals of psychotherapy. The working alliance was differentiated from therapeutic alliance based on their main focus. While therapeutic alliance highlighted on bonding aspect of the relationship between patient and therapist, working alliance highlighted the purposeful working collaboration of the psychotherapy relationship. In addition to differentiation between these terms, Greenson and Wexler (1969) also contributed to differentiating transference and alliance from each other. They defined transference as unconscious projection of early relational experiences towards here and relationship with therapist and alliance as a real relationship component between therapist and patient. Therefore, the distinction between these two terms may provide the first examination of psychotherapy relationship beyond psychodynamic theory and its assumption of the unconscious, relational materials.

In the 1960s, Roger also introduced humanistic psychotherapy and emphasized empathic understanding, congruence, and unconditional positive regard as an essential focus of psychotherapy process and highlighted the importance of psychotherapy relationship (Rogers, 1957). Therefore, the importance of a mutual relationship between client and therapist has started to become theoretically more visible and started to evaluate as a main curative factor beyond specific techniques in psychotherapy process.

1.2.2 Transtheoretical Conceptualization of Alliance

In addition to theoreticians' different conceptualizations of the alliance, Bordin (1979) reconceptualized alliance in a transtheoretical way beyond psychotherapy approaches. Since Bordin's transtheoretical conceptualization, alliance has started to be examined as a common notion for psychotherapy process regardless of psychotherapy orientation. He proposed a tripartite framework while examining alliance including task, goal, and bond. According to Bordin's tripartite model of alliance, task refers to working collaboration in the attempts for achieving therapy goals, goal refers to client's and therapist's mutual agreement on the aim of the psychotherapy, and bond components refer to the affectionate attachment between client and therapists. He argues that all these three components are necessary for the establishment of an adequate level of alliance in psychotherapy setting. Although task and goal components may seem directly related with the outcome of the therapy, bond is the initial requirement to be able to maintain collaborative working during psychotherapy process. Therefore, these three concepts are also interrelated with each other and should co-occur for alliance. In the current study, alliance is conceptualized according to Bordin's tripartite model including task, goal, and bond aspects of psychotherapy relationship.

Mallinckrodt, Gantt, and Coble (1995) argued that although the conceptualization of alliance includes bonding aspect of psychotherapy relationship, it was not sufficient to examine relational aspects between client and therapist representing attachment needs and manifestations. They suggested that *attachment to therapist* is a distinct construct from *working alliance* and developed the Client Attachment to Therapist Scale to examine psychotherapy relationship beyond alliance according to the attachment theory perspective. In the following section the relationship between alliance and attachment to therapist, and findings in literature will be examined.

1.2.3 Alliance and Attachment to Therapist

In previous sections, it was emphasized how early relational dynamics may affect psychotherapy relationship according to attachment theory. Results have shown

that individuals' pretherapy global attachment style predicts quality of alliance, and a higher level of secure adult attachment is related with a greater level of alliance during psychotherapy process (Bernecker, Levy and Ellison, 2014; Diener and Monroe, 2011; Folke et al. 2016; Mallinckrodt and Jeong, 2015; Smith, Msetfi, and Golding, 2010). Moreover, alliance is one of the main predictors of therapeutic change (Martin, Garske and Davis, 2000; Smith, Msetfi and Golding, 2009).

Bernecker, Levy and Ellison (2014) conducted a meta-analysis to examine the association between client's adult attachment style and client-rated working alliance. Twenty-four studies which were conducted with outpatient clients who were taking individual psychotherapy were included in the meta-analysis. They found that both, higher level of avoidance and anxiety in adult attachment predicted lower level of perceived alliance in psychotherapy relationship. The results were consistent with a previous meta-analysis which was conducted by Diener and Monroe (2011). Results revealed that clients with a higher level of insecure adult attachment style, are more likely to have lower level of alliance.

Diener and Monroe (2011) also investigated whether there was a difference between therapist-rated alliance and client-rated alliance on the relationship between adult attachment style and alliance in psychotherapy relationship. They found that there was a stronger association between client's adult attachment style and client-rated alliance rather than therapist-rated alliance. Findings suggested that patients may perceive psychotherapy relationship in a biased manner based on their attachment representations. It can be one of the main reasons why there is an association between adult attachment style and client-rated alliance.

Furthermore, Smith, Msetfi and Golding (2010) conducted a meta-analysis to examine the association between client's adult attachment pattern and quality of alliance in psychotherapy relationship. Eighteen studies were included in the meta-analysis which were conducted with more heterogonous participants characteristics and with various instruments to measure adult attachment and alliance. Similar to previous results mentioned above, they concluded that secure adult attachment is associated with a greater level of alliance. However, neither avoidant adult attachment

nor anxious adult attachment patterns were significantly associated with alliance. They suggested that measuring specifically attachment to therapist rather than global adult attachment would be more informative to examine attachment manifestations in psychotherapy relationship.

Results of other studies which included attachment to therapist as a distinct variable have shown that adult attachment did not significantly predict alliance in psychotherapy relationship whereas attachment to therapist did (Mallinckrodt et al., 2005; Parish and Eagle, 2003; Taylor et al., 2015). In the study of Taylor et al. (2015)'s, they examined whether attachment to therapist remains significant to predict alliance after controlling the variance of adult attachment. Results have shown that attachment to therapist remained significantly associated with alliance after controlling the shared variance of adult attachment. Similarly, Sauer et al. (2010) have found that attachment to therapist was associated with greater symptom reduction comparing to adult attachment orientations.

In the light of these findings in the literature, it seems difficult to conclude that there is a direct relationship between adult attachment style and alliance in psychotherapy relationship. Recent studies in attachment literature have also suggested that each attachment pattern between two-person may be distinct from each other considering the dyadic factor of interpersonal relationships (Steele, Steele and Fonagy, 1996; Ravitz et al., 2010). Moreover, whether attachment pattern is a trait or relationship specific variable is still a heated debate in attachment literature (Daniel, 2006; Pinquart, Feußner and Ahnert, 2013; Opie et al., 2021). Considering these findings, specifically, attachment to therapist rather than adult attachment is included in the current study to investigate secure base function of psychotherapy relationship.

1.3 In-Session Exploration

In this section, clients' in-session exploration of their emotions and thoughts during psychotherapy process will be examined with the analogy of infants' exploration behaviors according to attachment theory. Firstly, the theoretical background of exploration and subsequently the role of secure base function on infants' exploration will be examined. Lastly, how secure base function of

psychotherapy relationship may emerge and affect clients' in-session exploration will be examined.

1.3.1 Infant-Caregiver Relationship and Exploration

Bowlby (1969) proposed two complementary behavioral systems under attachment theory. The first one is proximity seeking and the second one is exploration. According to the evolutionary perspective, he argued that proximity seeking has a survival function. Proximity is important for an infant to meet his physical needs to survive. In addition, proximity seeking has a survival function in the terms of also alleviating the anxious state of the infant. The experiments of surrogate mothers with infant monkeys enlighten that the important stance of the primary caregiver is not limited to satisfying physical needs such as providing breast milk (Harlow, 1958; Harlow 1961; Harlow and Harlow, 1965, Van Der Horst, LeRoy and Van Der Veer, 2008). Moreover, the soothing stance of primary caregiver is essential for relieving anxious state across novel objects or situations in the environment. It was observed monkey infants' choice of surrogates who provide food with artificial nipples or who provide comfort with fluffy material change under different situations. When there is a threatening situation in the environment such as loud noise or novel objects to explore, infants chose a fluffy surrogate mother to get relief and comfort.

Bowlby (1969) argued that exploration behaviors only emerged in terms of proximity needs being met. An infant's exploration can occur only with the existence of the primary caregiver as a secure base which provides a reliable, predictable, and comforting stance. If the caregiver presents a secure base for the infant, infant can regulate distress in the face of novel situations. In circumstances in which infant feel highly threatened, infant seeks proximity and demand soothing without inhibition then become able to continue to explore the environment.

Ainsworth et al. (1978) observed these two complementary behavior systems, proximity seeking and exploration behaviors with *Strange Situation* experiments. In these experiments infants who perceive their primary caregiver as a secure base, demand physical closeness and alleviation of distress in the face of triggering situations. After they get relief and regulate their anxious state, they are able to

maintain explorative behaviors in the environment. On the contrary, insecurely attached infants fail to perceive their caregivers as trustable and available to meet their needs. In other words, they cannot internalize their caregivers as a secure base who are responsive to their needs as securely attached ones. When they need proximity in the face of triggering situations their deactivating and hyperactivating strategies activate. While avoidantly attached ones show reluctant reactions for closeness as a part of deactivating strategy and anxiously attached ones show clingy reactions for closeness despite triggering situation has ended. Although they show different attachment manifestations, both of them cannot conclude alleviation of distress with intimacy of the caregiver. It hinders their exploration of the environment and they do not show exploratory behavior as much as secure infants during the experiment.

Therefore, attachment patterns may affect individuals' demanding support from others for the following years of life. Mikulincer and Nachson (1991) highlighted that secure individuals are more likely to turn to others to get support in face of stress and use self-disclosure. Because based on their internal working model, they perceive others as available and responsive towards their needs. Thus, they are able to disclosure and receive soothing from significant others in stressful situations. On the other hand, they argued that avoidant individuals are unwilling to make self-disclosure and demand support from others. Because based on their internal working model, they perceive others as non-trustable and downplay their intimacy needs. Therefore, they show a lack of motivation for disclosure in distress as a consequence of their dismissing attitudes towards close relationships. Contrary to avoidant individuals, ambivalent individuals show a willingness to make self-disclosure as secure individuals. However, self-disclosure aims to satisfy their merger tendencies and strive for closeness rather than relieving distress. Thus, in psychotherapy setting their self-disclosure may not be purposeful in terms of the goal of the psychotherapy process.

1.3.2 Psychotherapy Relationship and In-Session Exploration

In the psychotherapy setting, Saypol and Farber (2010) found that individuals who have a higher level secure attachment to therapist show a higher level of self-disclosure, and reported a higher level of pleasantness after making disclosure.

Whereas individuals who have a higher level of avoidant attachment to therapist show a lower level of self-disclosure. It was argued that individuals who have higher level of avoidant attachment to therapist may expect negative evaluation from their therapist based on their negative internal model about others. Therefore, they avoid closeness via decreasing meaningful self-disclosure about themselves.

Understanding differences in individuals' self-disclosure attitudes within the scope of attachment theory may also contribute to clinical practice based on client's needs. Similar to the infant-caregiver relationship, the client is asking for help in the psychotherapy relationship to regulate his distress which cannot manageable by himself. Bowlby (1988) argued that therapist's secure base function is important for exploration in psychotherapy setting. If therapist can provide a secure base, client can explore presenting problem and past experiences during psychotherapy process.

Mallinckrodt, Porter and Kivlighan (2005) conducted a study to examine Bowlby's secure base hypothesis on exploration. They examined whether secure attachment to therapist predicts greater exploration during psychotherapy process. Thirty-seven volunteer clients who were taking individual time-limited psychotherapy at a public university's counselling center participated in the experiment. Clients' adult attachment, attachment to therapist, client-rated alliance and session exploration were measured between 4th and 8th session. The time period was determined as middle phase of the time-limited therapy out of 12 sessions. Results showed that greater session exploration was positively associated with secure attachment to therapist and negatively associated with avoidant-fearful attachment to therapist. However, there was no significant relationship between session exploration and preoccupied-merger attachment to therapist. In addition, there was no significant relationship between session exploration, neither anxiety nor avoidance subscales of adult attachment. Moreover, results revealed that attachment to therapist predicted unique variance in session exploration which was not accounted by alliance. On the contrary, alliance did not predict unique variance in session exploration beyond the variance accounted by attachment to therapist.

Firstly, findings may suggest that attachment to therapist is a more relevant variable rather than adult attachment to examine relational dynamics in psychotherapy relationship as mentioned in previous chapters. Secondly, attachment to therapist is a distinct variable compared to alliance to explain various constructs in psychotherapy setting. Considering findings in line with theoretical expectations, secure attachment to therapist may have a crucial role in psychotherapy process beyond working collaboration which is represented with alliance.

Romano, Fitzpatrick, and Janzen (2008) have conducted another study to examine the role of secure base function on session exploration during psychotherapy process. Fifty-nine volunteer clients who were taking integrative short-termed psychotherapy with trainee counselors participated in the study. Participants adult attachment with attachment to therapist, alliance and session exploration was measured between 5th and 9th session. Similar to Mallinckrodt, Porter and Kivlighan (2005)'s study, the time period was determined as representing middle phase of the short-termed psychotherapy out of 15 sessions. In this study, session exploration conceptualized as perceived session depth by the researchers. Although session exploration was measured with different instrument compared to Mallinckrodt, Porter and Kivlighan (2005)'s study, results were consistent with previous findings. Greater level of session exploration was positively associated with secure attachment to therapist whereas negatively associated with avoidant attachment to therapist. However, there was no association between session exploration and preoccupied-merger attachment to therapist.

According to theoretical expectations and previous findings in the literature, in the current study it is expected that as secure attachment to therapist increases the level of in-session exploration also increases. On the contrary, as avoidant-fearful attachment to therapist increases the level of in-session exploration decreases whereas there was no association between preoccupied-merger attachment to therapist and session exploration. Similar to the infant-caregiver dyad, it is expected that clients who have a higher secure attachment to therapist can use psychotherapy relationship as a secure base to explore their psychological states.

1.4 Alliance Ruptures and Resolution

In previous sections, it is mentioned that individuals' attachment representations reenact in psychotherapy relationship. Reenactment of attachment manifestation in psychotherapy setting may not be limited to only exploration behaviors. Attachment to therapist can also provide information about rupture and resolution dynamics in psychotherapy relationship similar to separation and reunion reactions. In this section, separation and reunion reactions in the infant-caregiver dyad will be discussed with an analogy of alliance rupture and resolution dynamics in the client-therapist dyad.

Alliance ruptures are defined as strain in emotional bond, lack of collaboration on tasks, or disagreement on the goal of psychotherapy process (Safran and Muran, 2000). Disagreement, misattunement, or dissatisfaction are inevitable in an ongoing psychotherapy setting like other close relationship between two individuals. Ruptures may be interpreted as acting out of the client's working model in a therapeutic context (Eames and Roth, 2000). In the psychotherapy relationship, working on rupture experiences may make the client's permanent maladaptive assumptions about self and others more visible and open a door for change. Recent studies in literature highlighted that alliance rupture and resolution dynamics between client and therapist facilitate therapeutic change by itself (Coutinho, Ribeiro and Safran, 2009; Eubanks, Muran and Safran, 2018).

Strauss et al. (2006) conducted a study with 30 outpatients who were diagnosed with Cluster C personality disorders. Participants were taking personality disorder focused cognitive therapy for up to 52 session and their therapeutic change was measured at intake, 17th, 34th and last session. Therapeutic change investigated with both observer-rated and self-reported symptom reduction. Results revealed that therapeutic change over the sessions were associated with rupture repair. Although findings were promoting to highlight the importance of rupture resolution process in psychotherapy setting, the sample size was highly limited. Moreover, only clients diagnosed with personality disorder participated in the study. They may get greater benefit from experiencing the resolution of relational ruptures compared to others.

Thus, rupture resolution can be a more visible corrective emotional experience for them.

Findings of a meta-analysis by Eubanks, Muran and Safran (2018) were also consistent with previous findings in literature. Eleven studies were included in the meta-analysis which measured rupture-repair episodes in alliance and treatment outcomes. Results revealed that clients who were concluded with rupture resolution showed better treatment outcome compared to both, clients who did not conclude with resolution and surprisingly clients who did not experience any rupture in their process. They also found that results did not significantly differ between clients who were or not diagnosed with personality disorder.

Working on rupture experiences in psychotherapy relationship may provide firstly awareness about the client's similar rupture moments in other close relationship and underlying maladaptive assumptions about self and others. Secondly, it may contribute to gaining repairing capacity for these rupture moments in close relationship within accompaniment of psychotherapy relationship. Therefore, investigation of rupture and resolution dynamics in psychotherapy setting seems highly important to understand client's interpersonal dynamics and to facilitate therapeutic change during psychotherapy process.

Safran and Muran (2000) propose two categories of rupture markers in psychotherapy setting: *confrontation* and *withdrawal*. They argue that when a rupture occurs in the psychotherapy relationship, clients generally show confrontation or withdrawal manifestations rather than openly expressing their needs or emotions about the particular situation. In withdrawal marker, the client avoids expressing dissatisfaction and may give minimal response to the therapist's questions or investigation. On the other hand, in confrontation marker, the client may show hostile expression of dissatisfaction and may devaluate therapeutic tasks, therapist skills, or benefit of psychotherapy process. It is thought that confrontation or withdrawal manifestations can be strategies towards distress caused by conflict, disagreement, or misattunement in psychotherapy relationship which are similar to hyperactivating and deactivating strategies. Safran and Muran (2000) formulated confrontation and

withdrawal markers as maneuvering strategies in psychotherapy setting whereas Bowlby formulated hyperactivating and deactivating strategies as a kind of maneuvering strategies across unfulfilled attachment needs in close relationships.

When a rupture occurs in psychotherapy relationship, clients who have different attachment patterns may show different reactions like infants who show different reactions towards their caregiver's separation in Strange Situation experiments. As infants implicitly or explicitly show protestation against the separation of the caregiver with distress caused by loss of proximity with the attachment figure, similarly clients may show different protestation against rupture with distress caused by deterioration of alliance in psychotherapy relationship. Similar to secure infants who can easily be soothed during reunion, secure clients may easily be concluded rupture resolution during psychotherapy process. Thus, it is expected that clients may show different reactions against resolution of ruptures in psychotherapy relationship based on their attachment pattern.

In addition to the fact that secure attachment to therapist presents a more favorable therapeutic alliance, secure attachment to therapist may also contribute likelihood of working on rupture moments in psychotherapy. Previous studies have shown that secure attachment to therapist increases the likelihood of working on rough topics such as negative transference towards the therapist (Woodhouse et al., 2003) and alliance ruptures (Miller-Bottome et al., 2019).

According to the obtained literature review, the relationship between attachment and alliance rupture was firstly investigated by Eames and Roth (2000). They measured clients' adult attachment style, alliance, and self-report rupture experience by asking whether they experience any disruption after the initial five sessions. They also collect data from therapists whether they experience rupture during the therapy process. They found that clients' adult insecure attachment style was associated with ruptures reported by therapists but there was no significant relationship between clients' adult insecure attachment style and ruptures reported by clients. Moreover, they found that although therapists reported rupture in almost half of the sessions, clients only reported under one-fifth of sessions. Researchers argued that

clients may not report rupture experiences as a consequence of their hyperactivating or deactivating attachment strategies. Being able to make a clear interpretation of how attachment patterns may affect alliance ruptures in psychotherapy setting, they suggest further studies which examine the relationship between attachment and alliance ruptures more comprehensively.

However, except Miller-Bottome et al., 2019, studies investing the relationship between attachment, alliance ruptures, and resolution are limited. Differently from the previous study, they directly measured client attachment towards the therapist rather than adult attachment. Forty clients excluding substance use, psychosis or suicidality diagnosis participated in the study. Participants were taking brief relational therapy which was an integrative, time-limited, and relational oriented approach at a university's psychotherapy research center. Participants' attachment to therapist was measured via evaluation of session transcripts by trained raters. Rupture resolution experiences were measured by self-report instruments. Both, participants and their therapists reported the degree of rupture intensity and the level of rupture resolved or not over the course of sessions. Results revealed that a higher level of secure attachment to therapist was associated with a higher level of rupture resolution according to both, client-rated and therapist-rated evaluations. However, rupture intensity either reported by client or therapist was not associated with attachment to therapist.

Findings may highlight that secure attachment does not mean the absence of rupture experiences. Individuals who have secure attachment pattern can show greater resolution capacity against ruptures. Because they can communicate openly about their emotions and thoughts without deactivating or hyperactivating manifestations. It can be one of the reasons why securely attached individuals show greater change during course of psychotherapy process (Levy et al., 2018). Mallinckrodt, Porter and Kivlighan (2005) interpreted that *"the rich get richer",* meaning that individuals who have secure attachment may also get greater benefits from psychotherapy process. In the light of all these findings, it is hypothesized that attachment to therapist would be associated with rupture resolution but there would be no significant association with rupture intensity in the current study.

1.5 Aim of the Current Study

Attachment literature has emphasized that attachment representation of infants with the primary caregiver in early childhood plays a crucial role in the attachment pattern of close relationships established in later years (Bartholomew and Horowitz, 1991). When the psychotherapy relationship between client and therapist is examined, meta-analyses have shown that there is a relationship between individuals' attachment patterns and established therapeutic alliance with their therapist (Bernecker, Levy and Ellison, 2014; Diener and Monroe, 2011). Recent findings in attachment literature have also shown that individuals' attachment patterns may show different patterns with different figures (Ravitz et al., 2010; Daniel, 2006). Moreover, there are findings in the literature which show that attachment to therapist is associated with alliance whereas adult attachment did not (Mallinckrodt et al., 2005; Parish and Eagle, 2003; Taylor et al., 2015). Therefore, in the current study, only attachment to therapist variable was included while examining the secure base function of psychotherapy relationship.

As mentioned in previous chapters, Strange Situation experiments were conducted to examine the attachment patterns between infants and primary caregivers (Ainsworth et al., 1978). It has been observed that infants who are securely attached to their caregivers, can use the caregiver as a secure base to regulate their distress and then able to explore the environment in the face of novel situations. Therefore, it is expected that secure attachment to therapists would provide a secure base for clients for psychological exploration. Considering the previous findings of Mallinckrodt, Porter, and Kivlighan (2005)'s, and Romano, Fitzpatrick and Janzen (2008)'s studies, it is expected that secure attachment to therapist would be associated with a higher level of in-session exploration. Moreover, secure attachment to therapist would predict unique variance in in-session exploration beyond alliance.

The terms of alliance rupture and resolution have recently started to be examined in the literature. According to the obtained literature review, only a few studies have been conducted to examine the relationship between attachment to therapist, alliance rupture, and resolution (Eames and Roth, 2000; Miller-Bottome et

al., 2019; Miller-Bottome, 2020). It is also aimed to contribute to the literature by examining the relationship between these variables. Understanding of rupture-resolution dynamics in psychotherapy relationship at a micro level, may contribute to understanding of clients' rupture experiences in their close relationships at a macro level. Thus, the current study aims to improve theoretical knowledge and clinical implications about alliance rupture and resolution to improve the quality of psychotherapy relationships.

Considering different theoretical conceptualizations between psychotherapy orientations, psychodynamic oriented therapies may more emphasize on relational dynamics between client and therapist compared to cognitive behavioral oriented therapies. According to the obtained literature review, there is no study which investigate the difference between cognitive behavioral therapy and psychodynamic oriented therapy on attachment to therapist variable. Moreover, previous findings have shown that clients who undergoing cognitive behavioral therapy showed greater alliance compared to clients who undergoing psychodynamic oriented therapy (Raue, Castonguay and Goldfried, 1993; Raue, Goldfried and Barkham, 1997). Therefore, it is aimed to test whether cognitive behavioral therapy group and psychodynamic therapy group differ from each other on the scores of attachment to therapist, alliance and in-session exploration, and alliance rupture resolution.

Furthermore, Turkish validity and reliability study of the Client to Therapist Attachment Scale (Kahya et al., 2020) was recently conducted. According to the obtained literature review, there is no study in which the scale was used so far. Considering the limited number of research about psychotherapy process in Turkey, it is expected to contribute to the literature by using the scale in the current study.

Taking together, secure base function of psychotherapy relationship will be examined with investigation of associations between attachment to therapist, alliance, in-session exploration, and rupture-resolution. Based on theoretical explanation and findings in literature, the following research questions and hypothesis are stated below.

1.5.1 Research Questions and Hypotheses

Research Question-1: Is there a significant correlation between attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution?

H1.1: There would be a positive correlation between secure attachment to therapist, alliance, in-session exploration, and rupture resolution. However, there is no significant relationship expected between secure attachment to therapist and rupture intensity.

H1.2: There would be a negative correlation between avoidant-fearful attachment to therapist, alliance, in-session exploration, and rupture resolution. However, there is no significant relationship expected between avoidant-fearful attachment to therapist and rupture intensity.

H1.3: There would be no significant correlation between preoccupied-merger attachment to therapist, alliance, in-session exploration, rupture resolution, or rupture intensity.

Research Question-2: Is attachment to the therapist a unique variable to predict in-session exploration beyond alliance?

H2.1: Attachment to therapist would significantly predict unique variance in in-session exploration beyond the variance accounted for alliance.

H2.2: Alliance would not predict unique variance in in-session exploration beyond the variance accounted for attachment to therapist.

Research Question-3: Is there any difference between participants who were taking cognitive behavioral therapy and psychodynamic therapy on the scores of attachment to therapist, alliance, and in-session exploration?

H3*:* Cognitive behavioral therapy group would show a higher score on alliance compared to psychodynamic oriented therapy group. However, there is no significant differences expected between those two groups on the scores of attachment to therapist or in-session exploration.

Research Question-4: Is there any significant difference based on the length of the psychotherapy process on the scores of attachment to therapist, alliance, in-session exploration, and rupture intensity or resolution.

As an exploratory analysis, it was assumed that there might be possible differences in the scores of study variables considering the duration of the psychotherapy process.

Research Question-5: Is there any significant difference based on rupture presence on the scores of attachment to therapist, alliance, and in-session exploration?

As another exploratory analysis, only one-third of the participants in the current study reported their rupture experience within a psychotherapy relationship. Therefore, it was assumed that there might be possible differences between participants who reported rupture and who did not.

CHAPTER 2: METHOD

In this chapter descriptive sample characteristics, instruments which were used to measure study variables, procedure of the study, and statistical analyses used to test research hypotheses will be explained in following sequence.

2.1 Participants

The sample of this study consists of 81 volunteer participants who were taking psychotherapy and had completed at least 5 sessions in their process. Data collection was conducted in two phases. Firstly, volunteer clients who were taking psychotherapy at Izmir University of Economics Psychology Application and Research Center (PUAM) participated in the study. Due to the lack of sufficient numbers of participants to conduct meaningful statistical analysis, a second data collection phase was planned. The current study was announced via online professional platforms based on the convenience snowball sampling method. Twenty-one volunteer clients at PUAM and 60 volunteer individuals who were reached via the online announcement took part in the current study. Details about the data collection process will be explained in the procedure section.

Exclusion criteria were being younger than 18 years old and not having completed at least 5 sessions yet, based on Mallinckrodt, Gantt and Coble (1995)'s assumption that at least 5 sessions are required to measure attachment to the therapist properly. All participants provided those requirements, therefore none of them were excluded from the study. Seventy-three of the participants were women, 7 of them were men and 1 of them was non-binary. Participants' age was between 21 and 56 (M= 28.25, SD=7.18).

Referral reasons why those participants applied psychotherapy were as the followings, mood changes (N=30), acquiring self-awareness and introspection (N=26), family relationship issues (N=17), work/school adaptation issues (N=2), eating disorders (N=2), traumatic experience (N=3) and suicidal attempt (N=1). Participants reported their psychotherapy orientation as psychoanalytic/psychodynamic therapy (N=40), cognitive behavioral therapy (N=27), schema therapy (N=3), existential therapy (N=3), integrative therapy (N=4), and eye movement desensitization reprocessing therapy (EMDR) (N=4). Due to the pandemic conditions, participants

were pursuing their sessions face to face (*N*=29), online (*N*=25), and some sessions online some sessions face to face (*N*=27). The psychotherapy process was categorized by the researcher in three groups, namely up to 3 months (*N*=31) as initial stage, 3-12 months (*N*=24) as middle stage, and more than 12 months as late stage (*N*=26). Four participants reported that they were not currently satisfied with their process, the rest of the participants reported that they were satisfied with their process. Demographic characteristics of participant groups were shown below in Table 4.

Table 4. Descriptive Table

		Sample Groups (*N*)	
		Online Participants	PUAM Participants
Gender			
	Female	54	19
	Male	5	2
	Non-Binary	1	0
Age			
	Mean Score	*M*=28.22	*M*=28.36
Referral Reason			
	Self-Awareness-Introspection	18	8
	Mood Changes	21	9
	Family/Relationship issues	14	3
	Work/School Adaptation Problems	1	1
	Eating Disorders	2	0
	Traumatic Experience	3	0
	Suicidal Attempt	1	0
Therapy Orientation			
	Psychodynamic/ Psychoanalytic Therapy	29	11

Table 4. Descriptive Table (Continued)

	Cognitive Behavioral Therapy	17	10
	Schema Therapy	3	0
	Existential Therapy	3	0
	Integrative Therapy	4	0
	EMDR	4	0
Therapy Process			
	0-3 months (*0-12 sessions*)	10	21
	3-12 months (*12-50 sessions)*	26	0
	More than 12 months	24	0

2.2 Instruments

In the data collection, Demographic Information Form was used for gathering general information about participants' demographic features and psychotherapy process, Client Attachment to Therapist Scale was used for measuring participants' attachment to their therapist, Working Alliance Inventory-Short Form was used for measuring the client-rated quality of the alliance in psychotherapy relationship, Session Evaluation Questionnaire-Adjective Scale was used for measuring in-session exploration during the psychotherapy process. Lastly, 5 related questions from the Post Session Questionnaire were used for measuring participants' rupture and resolution experiences in alliance.

2.2.1 Demographic Information Form

The Demographic Information Form was developed by the researcher to gather information about the participant's gender, age, previous treatment history, and general information about the current psychotherapy process. Demographic Information Form is given in Appendix D.

2.2.2 Client Attachment to Therapist Scale

Participants' attachment to their therapist was measured with the Client Attachment to Therapist Scale **(**Mallinckrodt et al., 1995). Client Attachment to Therapist Scale (CATS) is a self-report measurement which was developed to measure participants' perception of the relationship between their therapist and themselves according to the attachment theory perspective. CATS includes 36 items loading on 3 subscales: secure, avoidant-fearful, and preoccupied-merger. Participants responded to each item on a 6-point Likert scale (1=Strongly Agree, 6=Strongly Disagree) with higher scores representing a higher tendency for each subscale.

Secure attachment to therapist subscale consists of 14 items *(ex. "My counselor is sensitive to my needs"*) and a higher score from this subscale shows that participants' perception of their therapist as emotionally available and responsive to their needs. Avoidant-Fearful subscale consists of 12 items *(ex. "I don't like to share my feelings with my counselor"*) and a higher score from this subscale shows that participants' resistance to disclosure and fear of rejection during psychotherapy process. Preoccupied-Merger subscale consists of 10 items *(ex. "I wish there were a way I could spend more time with my counselor")* and a higher score from this subscale shows participants' demand for intimacy beyond therapeutic relationship boundaries with their therapist. Internal consistency coefficient alpha levels for the subscale of secure, avoidant-fearful, and preoccupied-merger were .64, .63, and .81 respectively Mallinckrodt et al (1995). Internal consistency coefficient alpha levels were .78, .83, .82 respectively Mallinckrodt, Porter, and Kivlighan (2005), and .77, .75, and .83 respectively Romano, Fitzpatrick, and Janzen (2008).

The validity and reliability of the Turkish version of this scale, CATS-TR was conducted by Kahya et al. (2020). They found that the fifteenth item under Avoidant-Fearful subscale in the original scale *("I feel humiliated in my counseling session"; "Terapistimle görüşmelerimde aşağılanmış hissediyorum"*) did not fit well to psychometric features in Turkish adaptation. Therefore, this item was excluded from the Turkish adaptation of the scale. CATS-TR includes 35 items in total, secure subscale with 14 items, avoidant-fearful subscale with 11 items, and preoccupied-

merger subscale with 10 items. Internal consistency coefficient alpha levels range between 0.71 and 0.85 (Kahya et al., 2020). In the current study, the internal consistency coefficient alpha was found as .78 for secure subscale, .80 for avoidant-fearful subscale and .84 for preoccupied-merger subscale. The scale is given in Appendix E.

2.2.3 Working Alliance Inventory

Participants' perceived alliance during psychotherapy process was measured with the Working Alliance Inventory (WAI). WAI was developed by Horvath and Greenberg (1989) as a self-report measurement based on Bordin's (1979) conceptualization of alliance with the tripartite model of bond, task, and goal dimensions. WAI has different versions which are rated by the client, therapist, or observer. It is also appropriate to use for different psychotherapy approaches such as cognitive-behavioral or psychodynamic therapy (Tracey and Kokotovic, 1989). Only client rated alliance was used in the current study. The first version of WAI includes 36 items loaded on 3 subscales as *Task, Goal,* and *Bond*. Later on, Tracey and Kokotovic (1989) developed a 12-item Working Alliance Inventory Short Version (WAI-SF) to improve the applicability of the scale in clinical settings with the same 3 subscales. The internal consistency of the subscales for the client-rated version ranged between 0.90 and 0.92 (Tracey and Kokotovic, 1989). Participants responded to each item on a 7-point Likert (1=Never, 7=Always) scale with a higher score representing a greater level of perceived alliance in the psychotherapy process.

The validity and reliability of the Turkish version of this scale, WAI-SF were conducted by Gülüm et al. (2018). Bond subscale consists of 4 items *(ex. "My therapist and I trust one another*") and a higher score on this subscale shows a stronger emotional bond between client and therapist. Task subscale consists of 4 items *(ex. "What I am doing in therapy gives me new ways of looking at my problem"*) with higher scores showing greater agreement on therapeutic tasks. Goal subscale consists of 4 items *(ex. "My therapist and I are working towards mutually agreed upon goals"*) and a higher score on this subscale indicates greater mutual agreement on the goal of psychotherapy. Internal consistency coefficient alpha levels for the subscales of bond,

task, and goal were .67, .71, .65, and overall of the scale was .86 respectively (Gülüm et al., 2018). In the current study, internal consistency coefficient alpha values were .84 for task, .62 for goal, .76 for bond subscales, and .88 for total alliance score. The scale is given in Appendix F.

2.2.4 Session Evaluation Questionnaire-Adjective Scale

Participants' perceived in-session exploration during psychotherapy process was measured by Session Evaluation Questionnaire-Adjective Scale (SEQ-AS). The SEQ-AS was developed by Stiles (1980) as a self-report measure to examine clients' and therapists' perceived session impact. Only client rated session evaluation was used in the current study.

The original version of the scale consists of two units. The first one is the 12-item adjective part which evaluates the perceived level of the session depth and smoothness. The second one is the 10-item mood part which evaluates the clients' or therapists' mood after the session. Internal consistency coefficient alpha values were between .78 and .93 (Stiles and Snow, 1984). Although the original version of the scale includes these two units, only the 12-item adjective part which evaluates session depth-smoothness translated into Turkish considering the utilization of subscales in literature for session evaluation. The validity and reliability of the Turkish version of the SEQ-AS was conducted by Uluç et al. (2019). Therefore, only the 12-item adjective part was used in the current study.

The Turkish version of SEQ-AS consists of 12 items and participants responded to each item on a 7-point bi-dimensional scale. Depth subscale includes 5 items *(ex. shallow vs deep)* and a higher depth score represents the value and power of the session. Smoothness subscale includes 5 items *(ex. tense vs relaxed),* and a higher smoothness score represents more comfort and pleasantness in the session. The rest of 2 items (*bad/good and safe/dangerous)* were excluded from the categorization of neither depth nor smoothness subscales because of representing general information about session experience beyond depth or smoothness level (Stiles 1980; Uluç et al., 2019). Internal consistency coefficient alpha levels for depth and smoothness were .91 and 87 respectively Uluç et al. (2019). In the current study, only client rated depth and

smoothness subscales were used. Internal consistency coefficient alpha values were .88 for depth subscale and .78 for smoothness subscale. The scale was given in Appendix G.

Mallinckrodt, Porter, and Kivlighan (2005) argued that both depth and smoothness are required for greater exploration and expression of emotional struggles and/or maladaptive thoughts during the session. So, they calculated the in-session exploration score by adding standardized scores of session depth and smoothness subscales of SEQ-AS. In the current study, a composite score of in-session exploration score was calculated similarly as used in the study of Mallinckrodt, Porter, and Kivlighan (2005).

2.2.5 Post-Session Questionnaire

The original version of Post-Session Questionnaire (PSQ) was developed by Muran et al. (1992) and consists of several measurements including Working Alliance Inventory (WAI: Tracey and Kokotovic, 1989), Session Evaluation Questionnaire (SEQ; Stiles, 1980), and open-ended questions about rupture and resolution experiences in the alliance. According to the obtained literature review, to our knowledge, self-report Likert type measurement which evaluates rupture and resolution experiences in alliance has not been found yet. Therefore, 5 questions of the Post Session Questionnaire were used for measuring participants' self-reported alliance rupture and resolution experiences in the current study as used in the study which was conducted by Miller-Bottome et al. (2019).

The first question measures rupture presence, *"Did you experience any tension or problem, any misunderstanding, conflict, or disagreement in your relationship with your therapist during the session?"*. This question indicates whether the client experienced an alliance rupture. The second question measures rupture intensity with "*If yes, please rate how tense or upset you felt about the problem during the session?"* based on the 5-Likert scale (1=not at all; 5 =totally). The third question is *"Please describe the problem"*, an open-ended question which measures the reason for the alliance rupture during the session. The fourth question measures the level of rupture resolution "*To what degree do you feel this problem was resolved by the end of the*

session?" based on the 5-Likert scale (1=not at all; 5 =totally). Lastly, the fifth question *"What do you think contributed to the resolution of the problem?" is* also an open-ended question which measures facilitating factors for the resolution of the rupture. These five questions were translated into Turkish by two clinical psychology master's students with a translation-back translation method for the current study. A pilot study was conducted by the researcher to check the clarity of questions with 3 individuals who are taking psychotherapy and were not included in the study sample. English and Turkish versions of the questions also are presented in Appendix H.

Only rupture presence, rupture intensity, and rupture resolution were included in a statistical analysis similar to the study of Miller-Bottome et al. (2019). Rupture presence was used as a categorical variable to test differences on study variables between participants who report rupture and who did not. Rupture intensity and rupture resolution scores were used as continuous variables for statistical analysis.

2.3 Procedure

Izmir University of Economics Ethics Committee was applied to obtain necessary ethical approval to conduct this study and then the data collection process started. Firstly, it was planned to collect data from volunteer individuals who were taking psychotherapy at PUAM. Considering the working capacity in the 2021-2022 education term, it was aimed to collect data from approximately 50 participants. However, only 21 individuals participated in the study. The actual number of the participants was not sufficient to conduct statistical analysis adequately, therefore as a second step convenience-snowball sampling method was planned to collect data. The current study was announced via professional online platforms with the research poster (see Appendix I).

PUAM participants were given a form to be informed about the study before their first session. If they accepted to participate in the study, they were contacted after they had completed at least 5 sessions in their psychotherapy process. The information form was given in Appendix C. Both PUAM and online participants were asked for their consent at the beginning of the study. The consent form was given in in Appendix B.

In both sample groups, volunteer participants who completed at least 5 sessions in their psychotherapy process were included in the study. Participants used a survey link or QR code on the research poster to access online questionnaires via Google Forms. The data collection process from participants proceeded for 3 months. Before running statistical analysis to test research hypotheses, it was examined whether there is significant difference between sample groups on study variables. Results revealed that there were no significant differences between them. Thus, they were included together for further statistical analysis. Sequence of statistical analysis will be examined in statistical analysis section. Possible confounding factors or limitations because of the data collection process will be examined in the discussion chapter.

2.4 Statistical Analysis

The data analysis was examined through Statistical Package for Social Sciences (SPSS) version 21. Participants' demographic characteristics were used in the terms of defining sample characteristics and examining group differences in the length of psychotherapy process and psychotherapy orientation. Before statistical analysis of the research hypotheses, normality testing, and descriptive analysis were conducted to determine appropriate tests for further analysis. Normality assumptions were not met with current sample. Thus, non-parametric statistical analyses were used to examine research questions and hypotheses.

Mann-Whitney U test analysis was conducted to examine whether there was a significant difference between sample groups, participants who reached via the online announcement of the current study and participants who were taking psychotherapy at PUAM. Results revealed that there was no significant difference between these two sample groups based on all study variables. Therefore, further analyses were conducted including those two sample groups together.

Spearman's rho coefficient correlation analysis was conducted to examine whether there was significant relationship between attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution.

To examine whether attachment to therapist would predict unique variance in in-session exploration beyond the variance accounted for alliance alone, hierarchical regression analyses were conducted.

Mann-Whitney U test was used to examine whether there was a significant difference between cognitive behavior therapy group and psychodynamic therapy group on the scores of attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution. To minimize possible confounding variables about therapist's educational background and experience, variations within psychotherapy orientation, and completed session numbers, only participants who were taking psychotherapy at PUAM (*N*=21) were included in this analysis.

All of the PUAM participants were pursuing their sessions with master's degree students in clinical psychology under weekly supervision, following either cognitive behavioral or psychodynamic oriented psychotherapy approach. Moreover, completed session numbers were nearly similar for PUAM participants (*Min*= 5, *Max*= 15, *M*=8) whereas participant group who were reached out via online announcement (*Min*= 5, *Max*= 300, *M*=35.50) showed variation. Rupture intensity and resolution were not included in the analysis because only 4 participants out of 21 reported rupture experience.

Lastly, Kruskal-Wallis test was conducted to examine differences among three groups based on their duration of psychotherapy process (*initial, middle,* and *late* stages) and Mann-Whitney U test was conducted to examine differences between participants who reported alliance rupture and who did not on study variables.

CHAPTER 3: RESULTS

In this chapter, statistical analyses which were conducted to test research questions and exploratory analyses will be reported. The first section consists of preliminary analyses of normality assumptions and descriptive statistics of the variables used in the current study. The second section consists of the main analyses which were testing main research questions and hypotheses of the current study. The third section consists of exploratory analyses which was conducted to examine the differences between the length of psychotherapy process and rupture presence on study variables.

3.1 Preliminary Analyses

3.1.1 Normality Testing

The skewness, kurtosis, and the results of Shapiro-Wilk test obtained from the study sample which were testing normality assumption of the study variables of attachment to therapist, alliance, session-depth, session-smoothness, in-session exploration, rupture intensity, and rupture resolution were presented below in Table 5.

Skewness values of secure and avoidant-fearful subscales of Client Attachment to Therapist, task subscale of Working Alliance Inventory, depth subscale of Session Evaluation Questionnaire had a boundary value, according to critical values of normality +1.50 and -1.50, (Tabachnick and Fidell, 2007). In addition to that, Kurtosis values of secure and avoidant-fearful subscales of Client Attachment to Therapist, task subscale of Working Alliance Inventory, and depth subscale of Session Evaluation Questionnaire were above the critical values of +1.50 and -1.50, (Tabachnick and Fidell, 2007).

To determine the distribution of the study variables and choose appropriate statistical methods for further analysis, normality testing was also performed with the Shapiro-Wilk test. Results of Shapiro-Wilk tests were significant except for session smoothness (W=.98, p=.219). Indicating that normality assumption was violated for other study variables. Therefore, non-parametric tests were used for further statistical analysis to test research hypotheses. Skewness, Kurtosis and Shapiro-Wilk values of study variables were presented in Table 5.

Table 5. Skewness, Kurtosis and Shapiro-Wilk Values of Study Variables

				Shapiro-Wilk	
	N	Skewness	Kurtosis	W	*p*
CATS-Secure	81	-1.39	3.31	.90	< .001
CATS-Avoidant	81	1.28	2.11	.90	< .001
CATS-Preoccupied	81	.44	-.86	.95	.002
WAI-Task	81	-1.32	2.56	.90	< .001
WAI-Goal	81	-.66	-.25	.94	< .001
WAI-Bonding	81	-.64	-.46	.93	< .001
WAI-Total	81	-.72	.19	.96	.008
SEQ-Depth	81	-1.36	1.93	.87	< .001
SEQ-Smoothness	81	-.19	-.63	.98	.219
SEQ-Exploration	81	-.94	1.39	.95	.003
Rupture Intensity	27	.18	-.44	.92	.036
Rupture Resolution	27	-.61	-.71	.83	< .001

CATS: Client Attachment to Therapist Scale

WAI: Working Alliance Inventory

SEQ: Session Evaluation Questionnaire

SEQ-Exploration: standardized session-depth + standardized session-smoothness of SEQ

RI= Post Session Questionnaire-Rupture Intensity

RR= Post Session Questionnaire-Rupture Resolution

3.1.2 Descriptive Analysis

The mean, median, standard deviation, and minimum-maximum values of the scores obtained from the study sample which were measuring attachment to therapist, alliance, session-depth, session-smoothness, in-session exploration, rupture intensity and rupture resolution were shown in Table 6.

Table 6. Descriptive Scores of Study Variables

	N	Mean	Median	SD	Minimum	Maximum
CATS-Secure	81	4.83	4.92	0.58	2.31	5.62
CATS-Avoidant	81	1.76	1.58	0.63	1.00	4.08
CATS-Preoccupied	81	2.73	2.50	1.08	1.10	5.00
WAI-Task	81	22.56	24.00	4.27	5.00	28.00
WAI-Goal	81	23.48	24.00	3.01	16.00	28.00
WAI-Bonding	81	23.27	24.00	3.38	15.00	28.00
WAI-Total	81	69.31	70.00	9.29	42.00	84.00
SEQ-Depth	81	5.83	6.00	1.10	2.00	7.00
SEQ-Smoothness	81	5.02	5.00	0.99	2.50	7.00
SEQ-Exploration	81	0.00	0.21	1.66	-5.34	3.06
Rupture Intensity	27	3.00	3	1.11	1	5
Rupture Resolution	27	4.04	4	0.98	2	5

CATS: Client Attachment to Therapist Scale,
WAI: Working Alliance Inventory,
SEQ: Session Evaluation Questionnaire,
SEQ-Exploration: = standardized session-depth + standardized session-smoothness of SEQ,
RI= Post Session Questionnaire-Rupture Intensity,
RR= Post Session Questionnaire-Rupture Resolution

3.1.2 Mann-Whitney U Test Results of Sample Groups on Study Variables

An independent sample Mann-Whitney U test was conducted to examine whether participant groups who were clients at PUAM and who were reached via the online announcement of the study significantly differ from each other on the scores of attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution. All the results were given in Table 7.

There were no significant differences between two sample groups based on the scores of secure attachment to therapist (U=550.50, Z=-.86 p=.39), avoidant-fearful

attachment to therapist (*U*=548.50, *Z*=-.88, *p*=.38), preoccupied-merger attachment to therapist (*U*=591.50, *Z*=-.42, *p*=.68).

There were no significant differences between two sample groups on total alliance score (*U*=507.00, *Z*=-1.33, *p*=.18), in-session exploration (*U*=601.50, *Z*=-.31, *p*=.76), rupture intensity (*U*=34, *Z*= -.85, *p*=.39) or rupture resolution (*U*=41, *z*=-.36, *p*=.72). The Mann-Whitney U Test results with all subscales were shown in Table 7.

Although there were demographic differences between two sample groups which were mentioned in the method chapter (*Table-4*), Mann-Whitney U test results showed that these groups did not significantly differ from each other on the study variables. Therefore, participants were included together for further analysis.

Table 7. Differences Between Sample Groups

	Group	*Mdn*	*U*	*Z*	*p*	Effect size *r*
CATS-Secure			550.50	-.86	.39	.10
	PUAM participants	4.92				
	Online participants	5.00				
CATS-Avoidant			548.50	-.88	.38	.10
	PUAM participants	1.83				
	Online participants	1.58				
CATS-Preoccupied			591.50	-.42	.68	.05
	PUAM participants	2.60				
	Online participants	2.50				
WAI-Task			592.50	-.40	.68	.04
	PUAM participants	23.00				
	Online participants	24.00				
WAI-Goal			533.00	-1.05	.29	.11
	PUAM participants	24.00				
	Online participants	24.00				

Table 7. Differences Between Sample Groups (Continued)

WAI-Bond			473.50	-1.70	.09	.19
	PUAM participants	23.00				
	Online participants	24.00				
WAI-Total			507.00	-1.33	.18	.15
	PUAM participants	68.00				
	Online participants	72.00				
SEQ-Depth			574.50	-.60	.55	.07
	PUAM participants	6.00				
	Online participants	6.00				
SEQ-Smoothness			531.00	-1.07	.29	.12
	PUAM participants	5.00				
	Online participants	5.00				
SEQ-Exploration			601.50	-.31	.76	.04
	PUAM participants	.57				
	Online participants	.14				
Rupture Intensity			34.00	-.85	.39	.28
	PUAM participants	2.50				
	Online participants	3.00				
Rupture Resolution			41.00	-.36	.72	.12
	PUAM participants	4.00				
	Online participants	4.00				

Note. r effect size calculated with Z/(√N)

CATS: Client Attachment to Therapist Scale

WAI: Working Alliance Inventory

SEQ: Session Evaluation Questionnaire

SEQ-Exploration: Calculated as standardized session depth + standardized session smoothness

Rupture Intensity: Post Session Questionnaire-Rupture Intensity

Rupture Resolution: Post Session Questionnaire-Rupture Resolution

3.2 Main Analyses

3.2.1 Correlation Analyses

The Spearman's rho coefficient analysis was conducted to examine the first research question and hypothesis of *H1.1, H1.2,* and *H1.3.* The results of correlations between all study variables were presented in Table 8.

There was a significant positive correlation between secure attachment to therapist, alliance (r=.74, p<.001), in-session exploration (r=.62, p<.001), and rupture resolution (r=.49, p<.05). However, there was no significant correlation between secure attachment to therapist and rupture intensity (r=.04, p=.85). Results revealed that as secure attachment to therapist increased, perceived alliance and the level of exploring emotions and thoughts during psychotherapy process also increased. Moreover, as secure attachment to therapist increased the likelihood of alliance ruptures ended with resolution increased as well. But there was no significant relationship between secure attachment to therapist and perceived intensity of alliance rupture.

There was a significant negative correlation between avoidant-fearful attachment to therapist, alliance (r=-.63, p<.001), in-session exploration (r=-.53 p<.001) and rupture resolution (r=-.40, p<.05). However, there was no significant correlation between avoidant-fearful attachment to therapist and rupture intensity (r=.03, p=.87). Indicating that increased avoidant attachment to therapist was associated with decreased level of alliance, in-session exploration, and rupture resolution. But there was no significant relationship between avoidant attachment to therapist and perceived intensity of alliance rupture.

There was no significant correlation between preoccupied-merger attachment to therapist, alliance (r=.10, p=.38), in-session exploration (r=.07, p=.52), rupture intensity (r=-.81, p=.67), or rupture resolution (r=-.24, p=.22). Preoccupied-merger attachment to therapist was also not significantly correlated with other study variables as presented in Table 8 below.

Results showed that there was a negative correlation between secure attachment to therapist and avoidant attachment to therapist (r=-.66, p<.001). Lower avoidant attachment to therapist was associated with heightened secure attachment to therapist, whereas no significant relationship with preoccupied attachment to therapist was found.

Furthermore, there was a significant positive correlation between total alliance, secure attachment to therapist (r=.74, p<.001), in-session exploration (r=.57, p<.001), and rupture resolution (r=.41, p<.05). However, there was a negative correlation between total alliance and avoidant attachment to therapist (r=-.63, p<.001). These findings indicate that as the quality of alliance increased, the level of secure attachment to therapist, the level of exploring emotions and thoughts during psychotherapy process, and the likelihood of alliance ruptures ended with resolution also increased, whereas the level of avoidant attachment to therapist decreased.

Table 8. Correlation Table

	1	2	3	4	5	6	7	8	9	10	11	12
1. CATS-S	-											
2. CATS-A	-.66***	-										
3. CATS-P	.17	.18	-									
4. WAI-Total	.74***	-.63***	.10	-								
5. WAI-T	.63***	-.51***	-.02	.88***	-							
6. WAI-B	.71***	-.55***	.18	.89***	.70***	-						
7. WAI-G	.67***	-.58***	.12	.85***	.64***	.66***	-					
8. SEQ-D	.67***	-.56***	.01	.62***	.64***	.50***	.54***	-				
9. SEQ-S	.41***	-.33**	.14	.35**	.32**	.31**	.33**	.30**	-			
10.SEQ-E	.62***	-.53***	.07	.57***	.57***	.47***	.51***	.74***	.84***	-		
11. RI	.04	.03	-.08	.11	.15	.03	.09	.21	-.12	.06	-	
12. RR	.49*	-.40*	-.24	.41*	.50**	.38*	.03	.40*	.06	.24	.19	-

Note. * p< .05, ** p < .01, *** p < .001.

CATS-S: Client Attachment to Therapist- Secure Score, CATS-A: CATS-Avoidant, CATS-P: CATS-Preoccupied, WAI-Total: Working Alliance Inventory Total Score, WAI-T: WAI-Task, WAI-G: WAI-Goal, WAI-B: WAI-Bond, SEQ-D: Session Evaluation Questionnaire-Depth, SEQ-S: SEQ-Smoothness,, SEQ-E: In-Session Exploration, RI: Rupture Intensity, RR: Rupture Resolution

3.2.2 Hierarchical Regression Analyses

The Role of Attachment to Therapist Beyond Alliance in In-Session Exploration

Two-step two different hierarchical regression analyses were conducted to examine the second research question and hypothesis of *H2.1 and H2.2 to* test whether client attachment to the therapist predicts unique variance in-session exploration beyond the variance accounted for alliance alone. In the first analysis, the total alliance score was entered in the first step, and subscales of client attachment to therapist was entered in the second step. In the second analysis, in contrast to the first analysis, subscales of client attachment to therapist were entered in the first step and then total alliance score was entered in the second step.

The first hierarchical multiple regression analysis revealed that total alliance score (β=.58, 95% C.I (.07, .14) p<.001) significantly predicts in-session exploration at first step, F (1,79) = 39.24 p<.001, and accounted for 33% variance in-session exploration. In the second step secure, avoidant-fearful, and preoccupied-merger subscales of attachment to therapist entered the regression model. When alliance and subscales of attachment to therapist were added together, results revealed that the second step significantly predicts in-session exploration F (4,76) =15.49 p<.001 and accounted for 45% variance in-session exploration. Introducing attachment to therapist variables explained an additional 12% variation in-session exploration and this change in R^2 was significant, F (3,76) = 5.40 p<.01.

After entering attachment to therapist subscales into the model at the second step, alliance score did not predict in-session exploration anymore (β=.19, 95% C.I (-.02, .08) p=.17). For attachment to therapist subscales, only secure attachment to therapist significantly accounted for variance by itself, (β=.51, 95% C.I (.67, 2.25) p<.001). Neither avoidant-fearful attachment to therapist (β=.01, 95% C.I (-.63, .64) p=.98), nor preoccupied-merger attachment to therapist (β=.04, 95% C.I (-.23, .36) p=.66) significantly predicts variance in in-session exploration. Results were given in Table 9.

Table 9. Results of First Hierarchical Regression Analysis

	Standardized Coefficient			Overall Model Test				
	β	*t*	*p*	R	R^2	Adjusted R^2	*F*	*p*
First Step				.58	.33	.32	39.24	<.001
WAI-T	.58	6.26	<.001					
Second Step				.67	.45	.42	15.49	< .001
WAI-T	.19	1.38	.17					
CATS-S	.51	3.67	<.001					
CATS-A	.01	.02	.98					
CATS-P	.04	.44	.66					

WAI-T: Working Alliance Inventory Total Score,

CATS-S: Secure Subscale of Client Attachment to Therapist Scale,

CATS-A: Avoidant-Fearful Subscale of Client Attachment to Therapist Scale,

CATS-P: Preoccupied-Merger Subscale of Client Attachment to Therapist Scale

The Role of Alliance Beyond Attachment to Therapist in In-Session Exploration

In contrast to the first analysis, the second hierarchical multiple regression analysis was conducted via adding attachment to therapist scores at the first step and alliance at the second step. Results revealed that attachment to therapist scores significantly predicted in-session exploration at first step F (3,77) = 19.79 p<.001 and accounted for 44% variance in-session exploration. Only secure attachment to the therapist significantly accounted for variance in in-session exploration (β=.62, 95% C.I (1.13, 2.42) p<.001). Neither avoidant-fearful attachment to therapist (β=-.05, 95% C.I (-.73, .57) p=.67) nor preoccupied-merger attachment to therapist were significantly accounted for variance in in-session exploration (β=.05, 95% C.I (-.21, .37) p=.59).

In the second step, the total alliance score entered the regression model. When alliance and subscales of attachment to therapist added together results revealed that the second step still significantly predicted in-session exploration F (4,76) =15.49

p<.001 and accounted for 45% variance in-session exploration. However, the addition of the alliance score to the regression model explained only an additional 1% variation in in-session exploration and R^2 change was not significant F (1,76) = 1.90 p=.17. Moreover, results showed that alliance did not predict variance in session exploration after controlling the variance accounted for attachment to the therapist (β=.19, 95% C.I (-.02, .08) p=.17).

Table 10. Results of Second Hierarchical Regression Analysis

	Standardized Coefficients			Overall Model Test				
	β	*t*	*p*	R	R^2	Adjusted R^2	*F*	*p*
First Step				.66	.44	.41	19.79	<.001
CATS-S	.62	5.45	<.001					
CATS-A	-.05	-.43	.67					
CATS-P	.05	.54	.59					
Second Step				.67	.45	.42	15.49	< .001
CATS-S	.51	3.67	<.001					
CATS-A	.01	.02	.98					
CATS-P	.04	.44	.67					
WAI-T	.19	1.38	.17					

WAI-T: Working Alliance Inventory Total Score,

CATS-S: Secure Subscale of Client Attachment to Therapist Scale,

CATS-A: Avoidant-Fearful Subscale of Client Attachment to Therapist Scale,

CATS-P: Preoccupied-Merger Subscale of Client Attachment to Therapist Scale

As a conclusion, attachment to therapist subscales significantly accounted for a 12% unique proportion of variance in in-session exploration beyond the variance accounted for alliance alone. After attachment to the therapist entered the model, alliance did not significantly predict variance in in-session exploration. However, alliance did not significantly account for unique variance beyond the attachment to therapist in in-session exploration. The comparison of these two hierarchical analysis models was shown in Table 11.

Table 11. Attachment to Therapist Beyond Alliance in In-Session Exploration

Step / Variable	R^2	Adjusted R^2	ΔR^2	ΔF
First Analysis				
Step 1 (WAI)	.33**	.32**	-	-
Step 2 (WAI+ CATS subscales)	.45**	.42**	-	-
Unique variance of CATS beyond WAI			.12*	5.40
Second Analysis				
Step 1 (CATS subscales)	.44**	41**	-	-
Step 2 (CATS + WAI)	.45**	42**	-	-
Unique variance of WAI beyond CATS			.01	1.90

Note. *p<.01, **p<.001. Criterion variable was in-session exploration

WAI: Working Alliance Inventory

CATS: Client Attachment to Therapist Scale

3.2.3 Mann-Whitney U Test Results of Therapy Orientation on Attachment to Therapist, Alliance, In-Session Exploration

An independent sample Mann-Whitney U test was conducted to examine whether individuals who were taking cognitive behavioral therapy (CBT) or psychodynamic oriented psychotherapy (PDT) differ from each other on the scores of attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution. Only participants who were taking psychotherapy at PUAM (N=21) included this analysis to minimize possible confounding variables as mentioned in method chapter. Rupture intensity and resolution were not included in the analysis because only 4 participants out of 21 reported rupture experience.

There was a significant difference on secure attachment to therapist between participants who were taking cognitive-behavioral and psychodynamic oriented psychotherapy (U=26.00, Z=-2.05 p= .04) with a small effect size (r=.23). Individuals

who were taking cognitive behavioral therapy (*Mdn*=5.12*)* had higher scores on secure attachment to therapist compared to participants who were taking psychodynamic oriented psychotherapy (*Mdn*=4.62*)*.

Furthermore, there was a significant group difference between participants who were taking cognitive-behavioral and psychodynamic oriented psychotherapy on the score of total alliance (*U*=24.50 *Z*=-2.15 *p*= .03) with a small effect size (*r*=.24). Participants undergoing cognitive behavioral therapy (*Mdn*=71.00*)* had higher scores on total alliance comparing participants who were taking psychodynamic oriented psychotherapy (*Mdn*=66.00*)*.

There was no significant difference between participants who were taking cognitive-behavioral and psychodynamic oriented psychotherapy on the scores of avoidant-fearful attachment to therapist (*U*= 49.00, *Z*= -.43 *p*= .67), preoccupied-merger attachment to therapist (*U*= 47.00, *Z*= -.53 *p*= .60), and in-session exploration (*U*= 37.00 *Z*= -1.27 *p*= .21).

Table 12. Differences Between CBT and PDT Groups

	Group	Median	*U*	*p*	*Z*	Effect size *r*
CATS-Secure			26.00	.04*	-2.05	.23
	CBT	5.12				
	PDT	4.62				
CATS-Avoidant			49.00	.67	-.43	.05
	CBT	1.79				
	PDT	1.92				
CATS-Preoccupied			47.00	.60	-.53	.06
	CBT	2.35				
	PDT	2.60				
WAI-Total			24.50	.03*	-2.15	.24
	CBT	71.00				
	PDT	66.00				
SEQ-Exploration			37.00	.21	-1.27	.14
	CBT	1.17				
	PDT	.37				

Table 12. Differences Between CBT and PDT Groups (Continued)

SEQ-Depth			42.50	.38	-.89	.10
	CBT	6.00				
	PDT	5.75				
SEQ-Smoothness			34.50	.15	-1.45	.16
	CBT	5.75				
	PDT	4.83				

Note. *p values are significant. R effect size calculated with $Z/(\sqrt{N})$.

CBT: Cognitive-Behavioral Therapy Group, N=10.

PDT: Psychodynamic Therapy Group, N=11.

CATS: Client Attachment to Therapist Scale

WAI: Working Alliance Inventory

SEQ-Exploration: Composite score of session depth and smoothness of Session Evaluation Questionnaire

In sum, the CBT group showed higher scores on secure attachment to therapist and alliance compared to the PDT group. However, there were no significant differences between them on the scores of avoidant-fearful attachment to therapist, preoccupied-merger attachment to therapist, or in-session exploration.

3.3 Exploratory Analyses

3.3.1 Kruskal-Wallis Test Results of Length of Psychotherapy on Study Variables

A Kruskal-Wallis test was conducted to examine the effect of length of psychotherapy on the scores of attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution. Thirty-one of the participants were in the initial stage of psychotherapy (*less than 3 months*), 26 of them were in the middle stage (*more than 3 months and less than 1 year*) and 24 of them were in the later stage (*more than 1 year*).

Kruskal-Wallis test results showed that there was no significant effect of length of psychotherapy on the scores of secure attachment to therapist, $\chi2(2, N=81) = 1.99$, $p=.37$, preoccupied-merger attachment to therapist $\chi2(2, N=81) = 2.75$, $p=.25$, alliance $\chi2(2, N=81) = 3.22$, $p=.20$, in-session exploration $\chi2(2, N=81) = 2.38$, $p=.30$, rupture

intensity $\chi 2(2, N=27) = 1.78$, $p=.41$ and rupture resolution $\chi 2(2, N=27) = .15$, $p=.93$. Regardless of the duration of psychotherapy process, participants showed similar scores on these variables.

Moreover, Kruskal-Wallis test results showed that there was a significant difference on the scores of avoidant-fearful attachment to therapist $\chi 2(2, N=81) = 6.92$, $p=.03$ between initial, middle, and late stages of psychotherapy process. The Bonferroni adjusted Dunn's post hoc tests were conducted to examine pairwise differences among these three groups. The late stage group ($Mdn=1.37$) showed significantly lower score on avoidant-fearful attachment to therapist compared to the initial stage group ($Mdn=1.83$), $p=.04$. However, there were no significant differences between initial and middle stage groups ($p=.87$) or between middle and late stage groups ($p=.08$).

Another Kruskal-Wallis test result showed that there was a significant difference in score of session depth $\chi 2(2, N=81) = 7.89$, $p=.02$ between initial, middle, and late stage groups. The Bonferroni adjusted Dunn's post hoc tests were conducted to examine pairwise differences among those three groups. The later stage group ($Mdn=6.50$) showed significantly higher scores on session depth compared to the initial stage group ($Mdn=5.75$), $p=.02$. However, there were no significant differences between initial and middle stage groups ($p=.81$) or middle and later stage groups ($p=.66$).

In a conclusion, the length of psychotherapy significantly differs on avoidant attachment to therapist and session depth only between the initial and later stages. As the duration of the psychotherapy process increases, perceived session depth increases and avoidant attachment to therapist decreases. However, there were no significant differences in other study variables based on the length of the psychotherapy process.

3.3.2 Mann-Whitney U-Test Results of Rupture Presence on Attachment to Therapist, Alliance and In-Session Exploration

Regarding rupture experience, 27 participants out of 81 reported a rupture experience with their therapist. An independent sample Mann-Whitney U t-test was

conducted to examine whether participant groups who reported rupture and who did not, differ from each other on the scores of attachment to therapist, alliance, and in-session exploration.

There was a significant difference between participants who reported rupture and participants who did not based on secure attachment to therapist score (U=484.50, Z=-2.34 p= .02), with a small effect size (r=.26). Participants who did not report rupture experience (Mdn=5.08*)* had higher scores on secure attachment to therapist compared to participants who reported rupture (Mdn=4.85*)*.

There was a significant difference between participants who reported rupture and who did not on the avoidant attachment to therapist score (U=521.50, Z=-1.96 p= .50) with a small effect size (r=.22). However, the significance level is at the boundary level. Participants who did not report rupture experience (Mdn=1.58*)* had lower scores on avoidant attachment to therapist compared to participants who reported rupture (Mdn=1.88*)*.

Moreover, they were also significantly different from each other on alliance score (U=514.00, Z= -2.04, p= .04) with a small effect size (r=.23). Participants who did not report rupture experience (Mdn=72.00) had higher scores than participants who reported rupture (Mdn=67.50*)*. Lastly, there were no significant differences between participants who reported rupture and participants who did not report rupture on the scores of preoccupied attachment to therapist (U=703.50, Z= -.12 p= .91) or in-session exploration score (U=527.50, Z=-1.90 p= .06).

In conclusion, participants who reported rupture experience showed lower scores on secure attachment to therapist and alliance, whereas greater scores on avoidant-fearful attachment to therapist compared to participants who did not report any rupture experience. There were no significant differences between participants who report rupture and who did not on the scores of preoccupied-merger attachment to therapist and in-session exploration.

CHAPTER 4: DISCUSSION

In this section, results obtained from statistical analyses will be presented and discussed in the context of similarities and differences according to previous findings in the literature. The main aim of this study was to investigate the association between attachment to therapist, alliance, in-session exploration, rupture intensity, and rupture resolution.

The main results showed that attachment to therapist significantly predicted unique variance in in-session exploration beyond alliance. In addition, findings also showed that cognitive behavioral psychotherapy group had higher scores than psychodynamic therapy group on the scores of alliance and secure attachment to therapist. Lastly, results revealed that participants who were at the later stage in their psychotherapy process showed a higher level of perceived session depth and a lower level of avoidant attachment to therapist compared to participants who were at the initial stage.

The sequence of the result chapter will be followed while discussing the findings of the current study. Moreover, possible limitations and future suggestions will be discussed at the end of this chapter.

4.1. The Relationship Between Attachment to Therapist, Alliance, In-Session Exploration, and Rupture Resolution

A Spearman's correlation analysis was conducted to examine the first research question of whether there would be a significant relationship between attachment to therapist and the variables of alliance, in-session exploration, rupture intensity, and rupture resolution. Three hypotheses related to the first research question were listed below. Firstly, hypotheses and results will be briefly mentioned. Then results will be discussed with findings in the literature.

H1.1*: There would be a positive correlation between secure attachment to therapist, alliance, in-session exploration, and rupture resolution. However, there is no significant relationship expected between secure attachment to therapist and rupture intensity.*

Results revealed that the first hypothesis was supported. As expected, the tendency of secure attachment to therapist increased the client-rated quality of alliance with all the subscales of task, goal, and bond also increased. In addition, as secure attachment to therapist increased the level of exploring emotions and thoughts and the likelihood of ruptures ended with resolution during the psychotherapy process also increased. However, there was no significant association between secure attachment to therapist and perceived rupture intensity. The association between secure attachment to therapist, alliance, in-session exploration, rupture, and resolution will be discussed in the following sequence under sections separately.

Alliance

The construction of representations about self and others in early interpersonal relationships determine how to relate with others for further years (Bowlby, 1973). Similar to other close relationships, attachment needs may activate also in the psychotherapy relationship (Mallinckrodt and Jeong, 2015). Participants in the current study reporting a secure attachment to therapist showed also an increased alliance, which is in line with theoretical expectations.

Secure attachment to therapist provides the secure base function for clients to be able to negotiate with their therapist on collaborative working constructions during the psychotherapy process. Participants who have a higher score on secure attachment to therapist are more likely to perceive their therapist as responsive to their needs. Thus, they may easily negotiate on the therapeutic process compared to other clients. Results were also consistent with previous findings (Janzen, Fitzpatrick, and Drapeau, 2008; Mallinckrodt et al., 2005; Romano, Fitzpatrick, and Janzen, 2008; Sauer et al. 2010; Taylor et al., 2015).

Sauer et al. (2010) conducted a study with 95 clients who were taking psychotherapy at two university training clinics. Participants' adult attachment, attachment to therapist, and perceived alliance were measured immediately after the 3rd session was completed. Similar to the current study, they also used the Working Alliance Inventory to measure alliance, and the Client Attachment to Therapist Scale to measure attachment to therapist variables. Results revealed that clients with greater

secure attachment to therapist reported greater level of alliance. In addition, researchers also measured the outcome improvement at intake, third session, and termination session. Findings showed that greater secure attachment was associated with greater reduction in distress over time.

In another study, fifty-eight clients who were taking cognitive behavioural therapy at four different primary care therapy services participated in Taylor et al. (2015)'s study. Participant's adult attachment, attachment to therapist, perceived alliance, and therapeutic change were measured with the same questionnaires used in the current study. They also found that greater secure attachment to therapist was associated with greater alliance, and greater therapeutic change. Although they used a different instrument to measure therapeutic change compared to Sauer et al. (2010), the results were consistent.

In-Session Exploration

Similar to infants need a secure base to explore the environment, clients also need secure base stance from the therapist to be able to explore his emotional and cognitive states without any inhibition in the psychotherapy setting. As hypothesized, results revealed that as secure attachment to therapist increased the level of in-session exploration also increased. The secure base function of psychotherapy relationship may facilitate the disclosure of conflictual, repressed emotions and thoughts during the process. It provides a holding environment, as Winnicott argued, to express themselves openly. Thus, as secure attachment to therapist increased the level of in-session exploration increased. Results were consistent with previous findings which investigated the secure base function and session exploration (Mallinckrodt, Porter and Kivlighan, 2005; Romano, Fitzpatrick and Janzen, 2008).

Although results were in line with the literature, one of the main criticisms can be the method of measuring in-session exploration. In-session exploration score was calculated as a composite of session depth and smoothness scores of the Session Evaluation Scale as used in Mallinckrodt, Porter and Kivlighan (2005)'s study. They argued that both, depth and smoothness jointly are required to evaluate sessions as safe and meaningful to interpret valuable exploration or disclosure in psychotherapy

setting. Even so, it seems theoretically relevant, in-session exploration score was calculated artificially as a composite of two subscales. For further studies, using the exploring subscale of the Patient Attachment Coding System (Talia and Miller-Bottome, 2014) with a transcript-based research design might be more favorable to measure in-session exploration.

Alliance Ruptures and Resolution

Internalized working models rooted in early relational experiences form not only how to negotiate with others but also how to react when a conflict occurs in close relationships. In Strange Situation experiments, securely attached infants can be easily soothed after the caregiver's reunion. On the other hand, insecurely attached infants unable to relieve their distress. As ruptures occurred in other close relationships, alliance ruptures are also inevitable during the psychotherapy process. Similar to infant-caregiver-dyad, attachment to therapist may affect not only alliance quality but also how clients react when a rupture occurs in alliance.

Participants in the current study reported that as secure attachment to therapist increased the likelihood of rupture concluded with a resolution of increased, which is in line with theoretical expectation. However, there was no association between secure attachment to therapist and rupture intensity. Clients who have a higher level of secure attachment to their therapist may make open disclosure about feelings about the rupture and it may also increase the likelihood of concluding resolution when a conflict occurs. Regardless of rupture intensity, they may have a greater repair capacity compared to others.

Results were consistent with the findings of Miller-Bottome et al. (2019)'s study. They used Patient Attachment Coding System (Talia and Miller-Bottome, 2014) attachment to therapist based on observational method rather than self-report and found that attachment to therapist was associated with rupture resolution but not with rupture intensity. Although current findings were consistent, it should be still considered that rupture intensity and resolution were measured with only one item in the current study. Generatability of results can be skeptical and further studies are

required to examine alliance rupture and resolution dynamics within the scope of attachment theory.

Using of well-elaborated instruments to examine alliance ruptures and resolutions should be taken into account for further studies. For example, transcript-based instruments of the Collaborative Interaction Scale (Colli and Lingiardi, 2009; Colli et al., 2019) or the Rupture Resolution Rating System (Eubanks, Muran and Safran, 2015) may provide a better understanding of rupture experiences and resolution process in the psychotherapy setting. These two instruments provide the in-session examination of rupture experiences based on verbatim communication between client and therapist. Therefore, these instruments can evaluate reciprocal contributions or hinders from both client and therapist regarding rupture and resolution experiences.

Secondly, asking for rupture and resolution experiences on a self-report method can be also skeptical because some participants may ignore explicitly or implicitly repress reporting rupture experiences because of their hyperactivating or deactivating strategies. In the current study, only one-third of participants (*27 participants out of 81*) reported their rupture experience. Thus, using transcript-based instruments which are rated by the observer rather than self-report examination may provide a more objective understanding of the alliance ruptures and resolution process in the psychotherapy relationship.

H1.2*: There would be a negative correlation between avoidant-fearful attachment to therapist, alliance, in-session exploration, and rupture resolution. However, there is no significant relationship expected between avoidant-fearful attachment to therapist and rupture intensity.*

The second hypothesis was also supported. As expected, the tendency of avoidant-fearful attachment to therapist increased, the client-rated quality of alliance with all subscales of task, goal and bond decreased. In addition, as avoidant attachment to therapist increased the level of exploring emotions and thoughts and the likelihood of ruptures ended with a resolution during the psychotherapy process also decreased. However, there was no significant association between avoidant attachment to

therapist and perceived rupture intensity. The association between avoidant attachment to therapist, alliance, in-session exploration, and alliance ruptures will be discussed in the following paragraph separately.

Avoidant-fearful attachment to therapist represents an unwillingness to disclosure, feeling threatened in emotional closeness, and fear of rejection by therapist. Participants who have a higher score on avoidant-fearful attachment to therapist are more likely to show resistance to disclosing their emotions and thoughts because of their predetermined assumption that emotional closeness is threatening. Building and maintaining alliance can be difficult with these clients compared to clients who are securely attached to their therapist. Therefore, clients who have a higher level of avoidant attachment to therapist, may show a lower level of alliance during the psychotherapy process. The current finding was also consistent with previous findings in the literature (Janzen, Fitzpatrick, and Drapeau, 2008; Mallinckrodt et al., 2005; Romano, Fitzpatrick, and Janzen, 2008; Sauer et al. 2010; Taylor et al., 2015).

If the infants do not experience the primary caregiver being attuned to their needs, they fail to perceive others as reliable and secure to explore the environment. The frustration of unfulfilled attachment needs hinders their exploration behaviours. In psychotherapy setting, if clients do not perceive their therapist as a secure base it may also hinder their in-session exploration. In parallel with theoretical expectations, results showed that as avoidant-fearful attachment to therapist increases, the level of in-session exploration decreases. Clients who have a higher level of avoidant attachment to therapist may less likely to explore their emotions and thoughts compared to others because of their deactivating attachment manifestations during the psychotherapy process.

Negative internal working model about others forms not only how to negotiate with others but also how to react when a conflict occurs in close relationships. Participants in the current study reported that as avoidant attachment to therapist increases the likelihood of alliance ruptures concluded with a resolution decreases, which is in line with the literature. The result was consistent with Miller-Bottome et al. (2019)'s findings although the Patient Attachment Coding System was used to

measure attachment to therapist rather than Client Attachment to Therapist Scale. It is thought that participants who have a higher score on avoidant attachment to therapist are more likely to move away from directly expressing their emotions and thoughts about the rupture. When a rupture occurs in the psychotherapy relationship, their predetermined expectation of rejection may also be activated. These reasons can hinder to conclude a resolution regardless of the rupture intensity for participants who have a higher level of avoidant attachment to therapist.

H1.3*: There would be no significant correlation between preoccupied-merger attachment to therapist, alliance, in-session exploration, rupture resolution, or rupture intensity.*

The current findings supported the third hypothesis. Considering the theoretical definition of preoccupied attachment to therapist, significant associations can be expected between preoccupied attachment to therapist, alliance, in-session exploration, or rupture resolution. However, significant associations between preoccupied-merger attachment to therapist and other study variables were not found in the previous studies. In the light of previous findings in the literature, the significant associations were not hypothesized in the current study. Possible reasons why preoccupied-merger attachment to therapist were not significantly associated with study variables will be discussed below.

Preoccupied-merger attachment to therapist represents *"being one with therapist"* desire beyond professional relationship boundaries. In contrast to avoidant-fearful attachment pattern, it represents the desire to have extreme emotional closeness with therapist. The main reason why the association between preoccupied-merger attachment to therapist and study variables was not found can be explained that the subscale consists of questions about generally boundary violations rather than measuring anxious state or hyperactivation strategies (ex. "*I yearn to be at one with my counsellor; I wish my counselor could be with me on daily basis").* In addition, it may not be possible to report explicitly anxious dependence or clingy desires to therapist on a self-report measurement. These reasons may explain why there was no

statistically meaningful association between preoccupied-merger attachment and other study variables.

4.2 Attachment to Therapist Beyond Alliance on In-Session Exploration

H2.1: *Attachment to therapist would significantly predict unique variance in in-session exploration beyond the variance accounted for alliance.*

H2.2: *Alliance would not predict unique variance in in-session exploration beyond the variance accounted for attachment to therapist.*

The current study revealed a high level of positive correlation between secure attachment to therapist and alliance, similar to findings in previous literature. However, some researchers discussed that these two variables may not be distinct constructs considering especially bond subscale of alliance (Taylor et al., 2015; Meyer and Pilkonis, 2000). To examine whether secure attachment to therapist and alliance are different constructs or not, Mallinckrodt, Porter and Kivlighan (2005) conducted a study to investigate the role of secure attachment to therapist beyond alliance in object relation deficits and in-session exploration. Results showed that secure attachment to therapist significantly predicts unique variance by itself beyond alliance, when the variance of alliance was controlled in both, object relation deficits and in-session exploration. However, alliance did not predict unique variance when the variance of attachment to therapist was controlled.

Considering the association between attachment and exploration, which were discussed in previous sections, it was expected that attachment to therapist is a more relevant variable to predict in-session exploration during the psychotherapy process compared to alliance. In the current study, the role of secure attachment to therapist beyond alliance in in-session exploration was examined as a replication of Mallinckrodt, Porter and Kivlighan (2005)'s study. Hierarchical regression analysis was conducted to examine the roles of attachment to therapist and alliance in in-session exploration. Results revealed that attachment to therapist predicted unique variance in in-session exploration beyond alliance whereas alliance did not predict unique

variance beyond attachment to therapist. The results were consistent with the findings of Mallinckrodt Porter and Kivlighan (2005)'s study.

Alliance significantly predicted in-session exploration at the first step, however after adding secure attachment to therapist into the model alliance did not significantly predict in-session exploration anymore. On contrary, secure attachment to therapist remained significantly predicted in-session exploration although alliance was added into the model. Furthermore, in Romano, Fitzpatrick and Janzen (2008)'s study, although in-session exploration was measured via using only session depth rather than a composite score of smoothness and depth, they also concluded that secure attachment to therapist significantly predicted a greater level of in-session exploration beyond alliance. Findings indicated that psychotherapy relationship may consist of complex relational dynamics beyond working collaboration. Firstly, results showed that alliance and secure attachment to therapist were different constructs. Secondly, secure attachment to therapist by itself can be one of the main components of psychotherapy relationship to explain efficacy of the process.

Avoidant-fearful attachment to therapist did not significantly predict independently in-session exploration. Client attachment to therapist subscales added into regression block together. The main reason why avoidant-fearful attachment to therapist did not independently predict in-session exploration can be a high level of correlation between avoidant-fearful and secure attachment to therapist. Some researchers argued that the high level of negative correlation between them indicated a lack of independence of the particular subscales (Janzen, Fitzpatrick and Drapeau, 2008). Therefore, they calculated a composite of *secure/avoidant-fearful score* by subtracting avoidant-fearful attachment score from secure attachment to therapist in their study.

It was thought that the artificial calculation of a composite score can be controversial. Although there was a low level of variance between subscales, subtracting scores would ignore any variance between them. Collecting observer-rated data with Patient Attachment Coding System-PACS (Talia and Miller-Bottome, 2014) in addition to Client Attachment to Therapist Scale, can provide information about

content validity between these subscales. Moreover, PACS also consists of the examination of clients' exploration manifestations during the psychotherapy process. Therefore, using PACS can be a more favorable instrument for further studies to investigate relationship between attachment to therapist and in-session exploration.

4.3 Comparison of CBT and PDT Groups on Study Variables

H3: *The cognitive behavior therapy group would show higher scores on alliance compared to the psychodynamic therapy group. However, there is no significant differences expected between these two groups on the scores of attachment to therapist and in-session exploration.*

Results revealed that participants who were taking cognitive behavioral therapy showed significantly higher scores on alliance and secure attachment to therapist comparing participants who were taking psychodynamic therapy. However, there were no differences between these two groups on the scores of in-session exploration avoidant-fearful attachment to therapist or preoccupied-merger attachment to therapist at the initial phase of the psychotherapy process. The hypothesis is partially supported. As expected, the alliance score was higher but surprisingly secure attachment to therapist score was also higher in the CBT group comparing the PDT group.

The results revelated that the CBT group reported a greater alliance compared to the PDT group. Results were consistent with the previous findings even though alliance is rated by the observer rather than the client's self-report (Raue, Castonguay and Goldfried, 1993; Raue, Goldfried and Barkham, 1997). Cognitive behavioral therapies are criticized for not focusing on relational components of psychotherapy relationship in general. However, on contrary, the therapist presents a more active role during sessions in comparison to psychodynamic therapy. In cognitive behavioral therapy, the therapist actively contributes to building working collaboration via asking for feedback, determining the agenda, and evaluating homework together. Determining tasks during the process and goal of the therapy is much more concrete and observable in cognitive behavioral approach compared to psychodynamic therapy. It is the one of the main reasons why alliance score was higher in the CBT group than in the PDT group.

Results have shown that the CBT group showed a higher score on secure attachment to therapist, which is contrary to the research hypothesis. Cognitive behavioral therapy approach presents a more solution-oriented, time-limited treatment plan compared to psychodynamic therapy. The active and collaborative role of the therapist may contribute construction of secure attachment since early sessions. On the other hand, the therapist's neutral stance is essential in psychodynamic oriented therapy to observe how clients relate to significant others in early encounters. It can be one of the main reasons why CBT group shows a higher score on secure attachment to therapist at the initial phase of the psychotherapy process. However, the current study has a cross-sectional design, so perceived secure attachment to therapist was collected only for the initial phase of therapy process with the current sample. Process research design evaluating perceived alliance through a long-term psychotherapy process would provide a deeper understanding of whether there is a clinically significant difference between these groups.

4.4 Differences Among Length of Psychotherapy Process on Study Variables

The differences among participants who were in the initial (*less than 3 months)*, middle (*between 3 months and 1 year),* and late stage (*more than 1 year)* of the psychotherapy process regarding study variables were examined. Results showed that there were significant differences between initial and late stage groups on the scores of session depth and avoidant-fearful attachment to therapist.

Results may suggest that there should be an essential amount of time for measurable or visible differences to occur in the psychotherapy process. Participants who were in the late stage of the psychotherapy process reported a higher level of session depth comparing the ones who were in their initial stage. Obviously, it can be expected that the length of psychotherapy is associated with greater session depth. Previous findings in the literature also have shown that as the length of psychotherapy process increases, the level of disclosure also increases (Farber and Hall, 2002; Pattee and Farber, 2008). As the duration of psychotherapy process increases clients may make valuable disclosure and also therapist may provide meaningful interpretations of

these materials with the accumulation of knowledge about clients' self-organization. It may increase the depth of psychotherapy process reciprocally.

Participants who were in the late stage in their psychotherapy process reported a lower level of avoidant-fearful attachment to therapist comparing the ones who were in their initial stage. It can be also expectable that as the duration of psychotherapy process increases, the tendency to feel threatened by emotional closeness decreases. Another possible reason can be also that clients with a higher level of avoidant attachment to therapist may have already dropped out before reaching the late stage in the psychotherapy process. Therefore, participants who are in the late stage group may show a lower level of attachment to therapist comparing other ones.

One of the main limitations of these results can be that initial (*N*=31), middle (*N*=24), and late stage (*N*=26) groups were created artificially by the researcher based on the number of the sample distribution. Considering the different structures of psychotherapy orientations, these classifications may not represent the proper phases of psychotherapy process. For example, cognitive-behavioural psychotherapy suggests a solution-oriented and short-term process whereas psychoanalytic and psychodynamic oriented psychotherapy suggests a long-term psychotherapy process. Therefore, time-based categorization may not represent an equal amount of progress in different psychotherapy approaches. It should be considered that 6 different therapy approaches (*psychodynamic, cognitive-behavioral, schema, existential, integrative, and EMDR)* were reported by participants in the current study. It might be one of the limitations that the comparison of different approaches on the equal categorization of the psychotherapy phases. Further studies which will be conducted with a homogenous psychotherapy sample would provide a better understanding to interpret the role of length of psychotherapy on study variables.

4.5 Differences Between Rupture Presence in Study Variables

Participants who reported rupture alliance and who did not were compared on the scores of attachment to therapist, alliance, and in-session exploration. Although it was not one of the main research questions, it may be interesting that only one-third of the participants (*N*=27) reported rupture experience. Results have shown that

participants who reported rupture showed a lower level of secure attachment to therapist and alliance, whereas a higher level of avoidant attachment to therapist compared to participants who did not report rupture. There was no significant relationship between preoccupied attachment to therapist or in-session exploration.

Alliance ruptures are defined as a strain of emotional bond, lack of working collaboration, and disagreement on the goals of psychotherapy process (Safran and Muran, 2000). Thus, it can be expected that individuals who reported rupture would show a lower level of alliance compared to participants who did not. The reason why these participants showed a higher level of avoidant attachment to therapist can be related to questions under Client Attachment to Therapist. Avoidant-fearful attachment to therapist subscale includes questions that may reflect dissatisfaction about the process (ex. *''I'm not certain that my therapist is all concerned about me'').* Therefore, it is possible that participants who reported rupture also reported a higher level of avoidant attachment to therapist. Moreover, they also showed a lower level of secure attachment to therapist compared to participants who did not have rupture experience. Clients who have a higher level of secure attachment to therapist may be less likely to show confrontation or withdrawal markers across conflicts in the psychotherapy relationship. They can express their emotions and thoughts across conflicts and do not need to use maneuvering strategies such as confrontation or withdrawal. Minor conflicts or disagreements can be repaired without concluding as alliance ruptures. Therefore, participants who report rupture may show lower scores on secure attachment to therapist compared to others.

However, it should be considered that the analysis was conducted with a small sample size. The variables of rupture presence, intensity, and resolution were measured with only one item within a cross-sectional study design. It is a highly limited structure to examine rupture experiences in the psychotherapy relationship. Longitudinal research design with a transcript-based method, which provides evaluations of reciprocal communication between therapist and client can be a more proper method to examine rupture and resolution dynamics during the psychotherapy process. Coutinho et al. (2014) conducted a study to examine whether self-report or observer-rated methods are better to detect rupture experiences. They compared fluctuations in

scores of Working Alliance Inventory as a self-report instrument and Rupture Resolution Rating System (Eubanks, Muran and Safran, 2015) as an observer-rated instrument to investigate rupture. They concluded that Rupture Resolution Rating System provided better detection of ruptures in the psychotherapy relationship. Therefore, using of Collaborative Interaction Scale (Colli et al., 2019) or Rupture Resolution Rating System (Eubanks, Muran and Safran, 2015) would be comprehensive instruments to examine rupture experiences in psychotherapy relationship for further studies.

4.6. Limitations and Future Suggestions

Besides important research findings and strengths, the current study has some limitations. The sample of the study consists of 81 participants who were mainly reached with the convenience snowball sampling method via the online announcement of the study. Although it was planned to collect data from volunteer clients at Izmir University of Economics Psychology Application and Research Center (PUAM), the number of participants (N=21) was limited at the end of the planned data collection process. To be able to collect more data from an equivalent sample, psychology applications and research centers of other universities where master's degree students see clients under supervision were contacted to ask whether it would be possible to collect data for the current study. Presumably due to the high workload or possible confounding factor for other ongoing studies, none of them accepted collaboration for collecting data.

Therefore, the second data collection phase proceeds with the online announcement of the present study. These two sample groups did not significantly differ from each other on study variables, but they have some differences in demographic characteristics. Moreover, the PUAM participants who were pursuing their sessions with master's degree students in clinical psychology under weekly supervision, following either cognitive behavioral or psychodynamic oriented psychotherapy approach but there was no acknowledgment of other participants' therapists' educational background, professional experience, or possible variations in their clinical practice. Participants who were reached out via online announcement of

the study may not reflect homogeneous sample characteristics as PUAM participants. Although the results were coherent with previous findings in general, the number of participants and sample characteristics should be considered in the terms of generalizability of the results.

Another limitation was that the present study investigated psychotherapy relationship based on self-report evaluation from clients only. Although research has shown that client-rated alliance is a better predictor comparing therapist-rated alliance for therapeutic change (Horvath and Bedi, 2002), psychotherapy relationship is also a mutual dyad like every relationship. Considering the two-person stance of psychotherapy relationship, the therapist has an active role in building a strong relationship (Gelso and Hayes, 1998). Moreover, the study conducted by Mohr, Gelso, and Hill (2005) has shown that the therapist's adult attachment pattern may moderate the relationship between the client's adult attachment and negative countertransference in psychotherapy relationship. Therefore, the therapist's individual characteristics or attachment orientations may have a moderating role in providing secure base for clients in psychotherapy setting.

Taber, Leibert and Agaskar (2011) conducted a study to examine how personality congruence between client and therapist affects alliance and they concluded that higher congruence between client and therapist is associated with greater bond but not related with task or goal subscales of alliance. However, in the terms of attachment style, studies speculated that the contrast in attachment style between therapists and clients may provide a more favorable process (Bernier and Dozier, 2002; Bucci et al., 2016; Wiseman and Tishby, 2004; Romano, Fitzpatrick and Janzen, 2008).

Bucci et al. (2016) found that neither client nor therapist adult attachment is associated with alliance directly however therapists' adult insecure attachment is associated with alliance only with clients who have severe symptoms. Moreover, in the meta-analysis of Levy et al. (2011), they concluded that the effect of match or mismatch between clients' and therapists' attachment styles on the therapeutic process

is still controversial and more studies are required to investigate the interaction between these variables.

Therefore, it does not seem possible to conclude a straightforward conclusion about the interaction effect between therapists' and clients' adult attachment patterns on alliance in psychotherapy process yet. Considering these findings, collecting data from both clients and therapists while examining psychotherapy relationship will be a more proper research design for further studies. Therapists' individual characteristics, adult attachment patterns, and interpersonal schemas may affect inevitably psychotherapy relationship. For further studies, the examination of attachment, alliance, rupture experiences, and in-session exploration variables by collecting data from both clients and therapists is suggested.

Besides, it should be also considered that the current study includes only self-report measurements. Self-report measurements are still in doubt to objectively investigate or reflect psychotherapy relationship. Interpretation of numerical data and investigation of statistical significance may not be in the same manner as clinical significance (Knox and Lutz, 2014). Therefore, qualitative analysis such as conversation analysis may reflect the natural process of psychotherapy relationship including intersubjectivity (Dilekler, 2021).

In literature, it is still controversial which measurement method, whether self-report or observer-based measurements, give more proper information about the attachment patterns of individuals (Daniel, 2006). Ravitz et al. (2010) conducted a review study to compare self-report or observer-based attachment instruments and they concluded that self-report measurement of attachment can be misleading. They argued that attachment manifestations are beyond conscious awareness and activation of attachment needs is required to measure attachment-related behaviors and manifestations such as observed in Strange Situation experiments. In addition to that, insecure individuals' tendency of deactivating and hyperactivating strategies can also mislead self-report measurement of attachment. In psychotherapy setting, when attachment to therapist is measured with self-report preoccupied individuals may report as fake secure individuals with reporting good evaluations about therapist or

process. However, it is rooted in the excessive idealization of their therapist as a consequence of their exaggerating need to maintain close relationships (Mallinckrodt et al. 2017). On the other hand, avoidant individuals may not report emotional closeness or distress across frustration as a consequence of the tendency to downplay bonding needs on self-report questionaries.

Therefore, using Patient Attachment Coding System (Talia and Miller-Bottome, 2014) is suggested to measure attachment to therapist during the psychotherapy process for further studies. It provides both examinations of the reciprocal dynamic between client and therapist and also gives detailed information about changing attachment dynamics in psychotherapy relationship. Because attachment manifestations can be dynamic rather than static in psychotherapy relationship (Mallinckrodt, 2010). In addition to that, Patient Attachment Coding System also examines exploration during psychotherapy process. It investigates attachment to therapist based on proximity seeking, contact maintaining, avoidance, resistance, and also exploring subdimensions. In the current study, in-session exploration was measured via a composite of the session depth and session smoothness scores. The utilization of this instrument for further studies can also provide more proper measurements to investigate in-session exploration rather than using an artificial composite of scores.

Lastly, alliance ruptures and resolution experiences can be also measured with the observational method which examines the reciprocal dynamic between client and therapist in psychotherapy setting for further studies. In the current study rupture intensity and resolution were measured with only one item. It is highly limited to understanding rupture resolution dynamics and the effect of hinder or contributor factors during these experiences. Therefore, utilization of the Rupture Resolution Rating System (Eubanks et. al., 2009; Eubanks, Muran and Safran, 2015) or Collaborative Interaction Scale (Colli and Lingiardi, 2009; Colli et al., 2019) is suggested for further studies.

Although there are several limitations, the results of the current study were in congruence with previous findings in literature. It is suggested that study variables

should be examined with a greater number of participants with more homogenous characteristics. Investigation of the current study variables with a transcript-based analysis rather than self-report method can reflect naturalistic features of psychotherapy relationship more properly. In addition, transcript-based analysis also provides examination of therapist's mutual contribution or hinder on building alliance, secure attachment or rupture resolution. It is expected that the findings of the current study contribute to the literature and evidence-based clinical implications. Examining psychotherapy relationship in the scope of attachment theory beyond specific psychotherapy techniques or orientations, will contribute to the understanding of common curative factors in the dyadic relationship between client and therapist in psychotherapy setting.

CHAPTER 5: CONCLUSION

5.1 Clinical Implications

Although attachment literature has shown that early attachment dynamics with the primary caregiver are mainly stable lifelong in other close relationships, there is also the contemporary argument that attachment patterns can be re-organized based on life experiences (Fraley, 2002; Simpson et al., 2003; Waters, Weinfield and Hamilton, 2000). Bowlby (1998) argues that the secure stance of the therapist provides corrective relational experience for the client to explore and reframe relational assumptions rooted in adverse early experiences. Providing an appropriate level of responsiveness and attunement across clients' needs may change their internalized negative representations about self, others, and the world (Daniel, 2006; Taylor et al., 2015). Therefore, how to provide corrective emotional experience based on an individual's need in psychotherapy setting can be one of the main questions to improve the efficiency psychotherapy process.

It should be beneficial to observe clients' insecure attachment manifestations during psychotherapy process. For example, while avoidantly attached individuals need greater distance, anxiously attached ones need closer distance at the initial or relationship-building phase of therapy (Daly and Mallinckrodt, 2009; Mallinckrodt, 2010). Hence, tailoring clinical practice based on clients' attachment orientation to reach gradually adaptive distance level throughout the working phase can provide corrective relational experience for insecurely attached individuals. It may also provide a change in relational dynamics for other significant relationships in their life.

Considering these findings, attachment-informed psychotherapy focuses on relational dynamics between client and therapist beyond psychotherapy approaches and suggests 3 main essential components for psychotherapy process (Slade and Holmes, 2018). Firstly, attachment between therapist and client has a fundamental role in therapeutic change and the therapist should provide a secure stance for the client to explore his repressed emotional experiences or thoughts. Secondly, recognition of the client's attachment manifestations in the relationship with therapist provides information about his predetermined representations about self, others, and the world,

self-regulation capacity, and defense mechanism across his unfilled needs. Lastly, ongoing corrective relational experience during psychotherapy process can change client's maladaptive attachment manifestations and negative internal working models. Clients would start to internalize therapist's secure base stance over to process which provides an emotionally safe, trustful interaction to explore their repressed emotional experiences or thoughts. They can gain the capacity to relate with others in balance with autonomy and relatedness without deactivating or hyperactivating strategies. Thus, rather than showing avoidant or preoccupied manifestations, they may conclude as secure individuals. Earned attachment security may provide long-lasting improvements for psychological complains by contributing to reframing maladaptive interpersonal interactions with significant others.

Examining and interpreting attachment patterns in psychotherapy relationship may provide a better understanding of common curative and therapeutic factors in the psychotherapy setting beyond different psychotherapy theories and approaches. Although there is a high number of studies about alliance in literature, psychotherapy relationship cannot be limited to working collaboration. Reenactment of attachment tendencies, deactivating or hyperactivating strategies for self-regulation can occur in client-therapist dyad similar to other close relationships. However, the psychotherapy relationship may provide a chance to change these insecure dynamics to secure ones with being a corrective emotional experience. As ruptures occurred in every close relationship, alliance ruptures in psychotherapy relationship is also inevitable. Alliance ruptures can be turning points to reverse maladaptive mental representations to adaptive ones via repairing these ruptures. Open a space to express alliance ruptures rather than repress or ignore them during psychotherapy process may provide a greater examination of clients' unfulfilled attachment needs and frustration towards conflicts in other close relationships. Ruptures repaired session may turn into ruptures repaired in life. Therefore, being aware of attachment dynamics in the clinical setting can contribute efficacy of the psychotherapy process.

In conclusion, results of the current study have shown that secure attachment to therapist is associated with a greater in-session exploration and rupture resolution. Current findings are consistent with previous findings in literature (Mallinckrodt,

Porter and Kivlighan, 2005; Miller-Bottome et al., 2019). It is expected to contribute evidence-based clinical practice with replication of previous findings with different samples. Thus, current study may contribute to enlighten that psychotherapy relationship consists of more complex relational dynamics beyond working collaboration. Integrating attachment theory into the psychotherapy relationship can increase the effectiveness of the process. It may contribute to restructure clients' maladaptive attachment representations. Thus, earned secure attachment to therapist can be therapeutic change in itself.

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APPENDICES

Appendix A: Ethics Committee Approval

SAYI : B.30.2.İEÜ.0.05.05-**020**-*174* 23.12.2021

KONU : Etik Kurul Kararı hk.

Sayın Dr. Öğr. Üyesi Yasemin Meral Öğütçü,

"Psychotherapy Relationship as a Secure Base: The Role of attachment to Therapist, Rupture Resolution in Alliance and Session Depth-Smoothness" başlıklı projenizin etik uygunluğu konusundaki başvurunuz sonuçlanmıştır.

Etik Kurulumuz 23.12.2021 tarihinde sizin başvurunuzun da içinde bulunduğu bir gündemle toplanmış ve Etik Kurul üyeleri projeleri incelemiştir. Başvurunuza ilişkin yapılan değerlendirmede, ilgili uzmanlardan/psikologlardan izin alınması koşulunun eklenmesi gerektiği belirtilmiştir.

Sonuçta 23.12.2021 tarihinde **"Psychotherapy Relationship as a Secure Base: The Role of attachment to Therapist, Rupture Resolution in Alliance and Session Depth-Smoothness"** konulu projenizin etik açıdan uygun olduğuna oy birliğiyle karar verilmiştir.

Gereği için bilgilerinize sunarım.

Saygılarımla,

Prof. Dr. Murat Bengisu

Etik Kurul Başkanı

Appendix B: Consent Form

Onam Formu

Sayın Katılımcı,

Bu çalışma, İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı kapsamında, Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında, psikolog Buse Bey tarafından yürütülen bir tez çalışmasıdır. Çalışmanın yaklaşık olarak 10 dakika sürmesi beklenmektedir. Araştırmanın amacı; danışan-terapist arasındaki psikoterapi ilişkisini incelemektir.

Bu çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Çalışmaya katılmama veya katıldıktan sonra herhangi bir anda çalışmadan çıkma hakkında sahipsiniz. Sizden hiçbir kimlik bilgisi talep edilmeyecek, cevaplarınız gizli tutulacak, terapistiniz ile paylaşılmayacak ve yalnızca araştırma yürütücüsü tarafından değerlendirilecektir.

Araştırmadan edilen sonuçlar genel olarak değerlendirilecek ve yalnızca bilimsel amaçlar doğrultusunda kullanılacaktır. Ölçeklerde bulunan sorulara vereceğiniz yanıtların doğruluğu, araştırmanın niteliği açısından oldukça önemlidir. Lütfen sorulara sizi en iyi ifade eden cevabı vermeye çalışınız. Herhangi bir sorunuz olması durumunda adresi üzerinden araştırma yürütücüsü ile iletişime geçebilirsiniz.

Katılımınız için teşekkürler.

☐ Bu çalışmaya gönüllü olarak katılmayı ve verdiğim bilgilerin bilimsel amaçlarla kullanılmasını kabul ediyorum.

Appendix C: Information Form for PUAM participants

Bilgilendirme Formu

İzmir Ekonomi Üniversitesi Klinik Psikoloji Yüksek Lisans programı kapsamında, Dr. Öğretim Üyesi Yasemin Meral Öğütçü danışmanlığında psikolog Buse Bey tarafından yürütülen danışan-terapist ilişkisini inceleyen bilimsel bir araştırma yürütülmektedir. Çalışmaya katılmak tamamen gönüllülük esasına dayanmaktadır. Araştırmaya dahil olmayı kabul ediyorsanız, 5. seansınızı tamamladıktan sonra sizinle iletişime geçilecektir.

☐ Evet; telefon ile iletişime geçilsin.

☐ Evet; mail ile iletişime geçilsin.

☐ Hayır.

Appendix D: Demographic Information Form

Demografik Bilgi Formu

1) Cinsiyetiniz: _____

2) Yaşınız: _____

3) Şu an devam etmekte olduğunuz psikoterapi süreci haricinde, daha önce psikoterapi ya da psikiyatrik tedavi almış mıydınız?

☐ Evet; ilaç tedavisi aldım
☐ Evet; psikoterapi aldım
☐ Evet; ilaç tedavisi ve psikoterapi aldım
☐ Hayır

4) Daha önce psikoterapi ya da psikiyatrik tedavi aldıysanız, bu süreç nasıl/neden sonlanmıştı?

5) Şu an devam etmekte olduğunuz psikoterapi sürecine başvurma nedeniniz:

☐ İlişki sorunları

☐ İş/okul uyum zorlukları

☐ Kendini tanıma/iç görü kazanma

☐ Duygu-durum değişiklikleri

☐ Yeme davranışlarındaki zorluklar

☐ Alkol/madde kullanımı

☐ Diğer: _____

6) Şu an devam etmekte olduğunuz psikoterapi sürecinde, bugüne kadar tamamlamış olduğunuz seans sayısı:

7) Devam etmekte olduğunuz terapi ekolü:

☐ Bilişsel-Davranışçı Terapi

☐ Psikodinamik Terapi

☐ Diğer: _____

8) Terapistim ile...

☐ Online olarak görüşüyorum

☐ Yüz yüze görüşüyorum

☐ Bazı seanslar online, bazı seanslar yüz yüze görüşüyorum

9) Genel olarak, şu an almakta olduğunuz psikoterapi desteğinden fayda sağladığınızı düşünüyor musunuz?

☐ Evet

☐ Hayır

Appendix E: Client Attachment to Therapist Scale

Aşağıda yer alan ifadelere ne düzeyde katılıp katılmadığınızı belirtiniz.

1= Kesinlikle katılmıyorum 2= Çoğunlukla katılmıyorum 3= Biraz katılmıyorum 4= Biraz katılıyorum 5= Çoğunlukla katılıyorum 6= Kesinlikle katılıyorum	**1**	**2**	**3**	**4**	**5**	**6**
1. Terapistimden yeterince duygusal destek almıyorum.						
2. Terapistim ihtiyaçlarıma duyarlıdır.						
3. Terapistimin beni onaylamadığını düşünüyorum.						
4. Terapistimle "bir bütün" olmayı çok isterim.						
5. Terapistim güvenilirdir.						
6. Terapistimle sorunlarım hakkında konuşmak, beni utandırır veya aptal gibi hissettirir.						
7. Terapistimin her gün benimle birlikte olmasını dilerdim.						
8. Terapistimle birlikteyken işlerin bir şekilde yoluna gireceğini hissederim.						
9. Terapistime her şeyi söyleyebileceğimi ve beni reddetmeyeceğini biliyorum.						
10. Terapistimin bana daha yakın hissetmesini isterdim.						
11. Terapistim bana yeterli dikkati vermiyor.						
12. Hislerimi terapistimle paylaşmaktan hoşlanmıyorum.						

13. Terapistimi bir insan olarak daha fazla tanımak isterdim.						
14. Hislerimi gösterdiğimde terapistim yardımcı olacak şekilde karşılık verir.						
15. Evdeyken terapistimi aramayı düşünürüm.						
16. Terapistimin görüşmeden görüşmeye nasıl tepki vereceğini kestiremiyorum.						
17. Bazen, terapistimi memnun etmezsem beni reddedeceğinden korkuyorum.						
18. Terapistimin en sevdiği danışanı olmayı aklımdan geçiririm.						
19. Terapistimin benimle çalışmaktan keyif aldığını söyleyebilirim.						
20. Terapistimin bana karşı dürüstlüğü konusunda şüpheliyim.						
21. Terapistimle daha çok zaman geçirebilmenin bir yolu olmasını dilerdim.						
22. Terapistim daha fazla yardımcı olabilecekken sorunları kendi başıma halletmek zorunda kaldığım için kızgınım.						
23. Terapistim kendimle ilgili rahatça anlatabileceğimden daha fazlasını bilmek istiyor.						
24. Ben de terapistim için bir şeyler yapabilmeyi dilerdim.						
25. Terapistim, başıma gelen korkutucu veya rahatsız edici şeylere yakından bakmama yardımcı olur.						
26. Terapistimle güvende hissediyorum.						
27. Terapistimin, terapistim/danışmanım olmamasını dilerdim; böylelikle arkadaş olabilirdik.						

28. Üzgün olduğumda terapistimin varlığı benim için rahatlatıcıdır.						
29. Terapistim bana bir yetişkinden çok bir çocukmuşum gibi davranıyor.						
30. Genellikle, terapistimin diğer danışanlarını merak ederim.						
31. Terapistimin beni rahatsız eden şeyleri anlayacağını bilirim.						
32. Terapistime güvenmek benim için zordur.						
33. Terapistime gerçekten ihtiyaç duyarsam orada olacağından eminim.						
34. Terapistimin beni o kadar da umursadığından emin değilim.						
35. Terapistimle birlikteyken onun ilk önceliği olduğumu hissediyorum.						

Appendix F: Working Alliance Inventory Short Form

Aşağıdaki herbir cümleyi okuduktan sonra, ifadelerle ilgili değerlendirmenizi belirtiniz

1= Hiçbir Zaman 2= Çok Seyrek 3= Seyrek 4=Bazen 5= Sık Sık 6=Çok Sık 7= Her Zaman	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. Terapistim ve ben sorunlarımın düzelmesi için terapide neler yapmam gerektiği konusunda aynı şekilde düşünüyoruz.							
2. Terapide yaptıklarım, bana sorunumla ilgili yeni bir bakış açısı kazandırıyor.							
3. Terapistimin bana yakın hissettiğine inanıyorum.							
4. Terapistim terapide neye ulaşmak istediğimi anlamıyor.							
5. Terapistimin bana yardım edebileceğine inanıyorum.							
6. Terapistim ve ben, ortak hedeflerimize doğru ilerliyoruz.							
7. Terapistimin beni takdir ettiğini hissediyorum.							
8. Ne tür değişikliklerin benim yararıma olacağı konusunda anlaşmaya vardık.							
9. Terapistim ve ben birbirimize güveniyoruz.							
10. Terapistim ve ben sorunlarımın neler olduğu konusunda farklı düşünüyoruz.							
11. Benim için neyin üzerinde durmamızın daha önemli olacağı konusunda hemfikiriz.							
12. Sorunumu ele alma yollarımızın doğru olduğuna inanıyorum.							

Appendix G: Session Evaluation Questionnaire-Adjective Scale

Terapistiniz ile şu ana kadar yapmış olduğunuz görüşmeler hakkında nasıl hissettiğinizi uygun sayıyı işaretleyerek belirtiniz.

Kötüydü	1	2	3	4	5	6	7	İyiydi
Güvenliydi	1	2	3	4	5	6	7	Tehlikeliydi
Zordu	1	2	3	4	5	6	7	Kolaydı
Anlamlıydı	1	2	3	4	5	6	7	Anlamsızdı
Yüzeyseldi	1	2	3	4	5	6	7	Derindi
Dingindi	1	2	3	4	5	6	7	Gergindi
Nahoştu	1	2	3	4	5	6	7	Hoştu
Doluydu	1	2	3	4	5	6	7	Boştu
Etkisizdi	1	2	3	4	5	6	7	Etkiliydi
Özeldi	1	2	3	4	5	6	7	Sıradandı
Acıtıcıydı	1	2	3	4	5	6	7	Yumuşaktı
Rahattı	1	2	3	4	5	6	7	Rahatsızdı

Appendix H: Post-Session Questionnaire

English Version:

1. Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your therapist during the session?

☐ Yes

☐ No

2. If yes, please rate how tense or upset you felt about the problem during the session?

Not at all		**Moderately**		**Completely**
1	2	3	4	5

3. Please describe the problem.

4. To what degree do you feel this problem was resolved by the end of the session?

Not at all		**Moderately**		**Completely**
1	2	3	4	5

5.What do you think contributed to the resolution of the problem?

Turkish Translation:

1. Seanslar süresince terapistiniz ile olan ilişkinizde, herhangi bir gerginlik ya da sorun, yanlış anlaşılma, çatışma ya da aynı fikirde olmadığınız bir durum yaşadığınız oldu mu?

☐ Evet

☐ Hayır

2. Bir önceki soruya evet cevabı verdiyseniz; lütfen bu sorun hakkında ne kadar gergin ve üzgün hissettiğinizi değerlendirin

Neredeyse Hiç		**Orta Derecede**		**Tamamen**
1	2	3	4	5

3. Lütfen bu sorunun ne olduğunu kısaca yazınız.

4. Bu problem seanslar süresince sizce ne kadar çözüme ulaştı?

Neredeyse Hiç		**Orta Derecede**		**Tamamen**
1	2	3	4	5

5.Sizce bu problemin çözüme ulaşmasını kolaylaştıran/çözüme ulaşmamasına neden olan faktörler nelerdi?

Appendix I: Research Poster for Online Announcement