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The Effect of Attachment on the Therapeutic
Alliance in Couples Therapy

Shawn A. Bills

A thesis submitted to the faculty of
Brigham Young University
in partial fulfillment of the requirements for the degree of
Master of Science

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ABSTRACT

The Effect of Attachment on the Therapeutic Alliance in Couples Therapy

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There is substantial evidence that the strength of the therapeutic alliance in couples therapy is predictive of successful treatment outcome. However, little research has examined the factors that predict a strong therapeutic alliance in couples therapy. With evidence indicating that attachment styles play an important role in the development of healthy adult relationships, it was hypothesized that the attachment styles of partners in couples therapy would predict the development of a strong therapeutic alliance. Data from 115 heterosexual couples seen at a university-based MFT clinic in the southeastern region of the U.S. were used to test this hypothesis. Using multiple regression, results generally found that attachment styles generally predicted the therapeutic alliance among women, but there was only limited support among men. The results of the study suggest the importance of couples therapists being aware of attachment issues, especially among women, as they relate to the establishment of a strong therapeutic alliance.

Keywords: avoidant attachment, anxious attachment, therapeutic alliance, couples therapy

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Introduction

Marital therapy is successful in treating relationship dysfunction (Sprenkle, 2012; Lebow, Chambers, Christensen & Johnson, 2012). For example, in a review on the effectiveness of couple therapy, Snyder, Castellani and Whisman (2006) reported that multiple models of couple therapy generate statistically and clinically significant results when treating couple dysfunction. Also, Barbato and D'Avanzo (2008) reviewed eight studies in a meta-analysis that used couple therapy to treat depression and found that couple therapy was generally successful in reducing relational distress. In addition, Atkins, Marin, Lo, Klann, and Hahlweg (2010) found that when utilizing marital therapy to treat infidelity, couples' were less depressed and were more satisfied with their marriage.

However, not all couples benefit from marital therapy. For example, Whisman and Snyder (1997) found that nearly one third of the couples in their study did not improve in the course of therapy. In addition, Snyder and Castellani (2006) found that both partners made substantial gains in relationship quality in only about half of the treated couples. Furthermore, Snyder, Wills, and Grady-Fletcher (1991) studied the effect of marital therapy among 59 couples and found that over one-third of the couples were divorced four years after the completion of therapy.

Because not everyone benefits from couples therapy, it is important to understand what predicts therapy success. For example, Johnson and Talitman (1997) found that couples were more likely to benefit from therapy when partners were willing to engage with each other emotionally in order to establish a secure connection with one another. Also, Baucom, Atkins, Simpson, and Christensen (2009) found that couples who are more similar in the way they exert power (i.e., determining how they interact, changing the topic of conversation, starting the

conversation) were more likely to benefit from marital therapy. Further, Atkins, Berns, George, Doss, Gattis, and Christensen (2005) found a positive relationship between number of years married and treatment success; the longer a couple had been married at the outset of therapy, the more successful the outcome of therapy would be.

In addition to client factors that influence the outcome of therapy, there is also evidence that the relationship between the therapist and the couple, referred to as the therapeutic alliance, has a positive effect on couples therapy outcome. For example, one study (Darwiche et al., 2008) found that when the therapeutic triad (both partners and the therapist) was highly aligned, there was more positivity during therapy, which positively influenced the outcome of therapy. Also, Johnson and Talitman (1997) found that there was a positive correlation between the therapeutic alliance and marital satisfaction at termination. Further, Knobloch-Fedders, Pinsof, and Mann (2007) found that the therapeutic alliance strongly predicted couple progress and outcome in therapy, as measured by a positive shift in the alliance score when measured during the middle of treatment.

Recognizing the importance of the therapeutic alliance on the outcome of therapy, it is important to understand what predicts the development of a strong therapeutic alliance. Research suggests that there are several client factors that can contribute to the development of the alliance. For example, the amount of trust that the couple has in their relationship, the level of marital distress, and client gender all play a significant role in the formation of the alliance (Johnson & Talitman, 1997; Knobloch-Fedders, Pinsof & Mann, 2004; Thomas, Werner-Wilson & Murphy, 2005)

Another possible predictor, attachment, has not been researched as a predictor of the therapeutic alliance in couples therapy. Attachment theory posits that individuals are born with

behaviors that function to maintain proximity to attachment figures for protection against psychological or physical threats when they are in distress (Mikulincer & Shaver, 2005). Based on their experiences when young, children develop styles of attachment, or ways of relating to others. These attachment styles become templates for relating in close relationships and carry over through adulthood (Bischof, 1975; Collins & Read, 1990). Because adults in therapy develop close relationships with their therapist, which are based on trust and safety, the concept of attachment has been applied to the client-therapist relationship (Bowlby, 1988). Although research has found that attachment is an important predictor of the therapeutic alliance in individual therapy (Meier, Donmall, Barrowclough, McElduff & Heller, 2005; Mallinckrodt, Gantt & Coble, 1995), no research has examined the effect of spouses' attachment styles on the development of the therapeutic alliance in couples therapy. One study (Johnson, Ketring, Rohacs, & Brewer, 2006) found that attachment was predictive of the therapeutic alliance in family therapy, but the research hasn't been extended into couples therapy. Therefore, the current study sought to understand the effect that partner attachment has on the therapeutic alliance in couples therapy.

Review of Literature

Therapeutic Alliance in Individual Psychotherapy

The therapeutic alliance has been defined as “the collaborative and affective bond between therapist and patient” (Martin, Garske and Davis, 2000, p. 438). An early scholar (Stone, 1961) suggested that establishing the alliance has two important elements: the first pertains to the client trusting that the therapist will provide appropriate support, help, and care. The second deals with the client's ability to believe in and rely on the process of therapy and their commitment in being responsible for their own work. Also, Bordin (1979) hypothesized

that a strong alliance was the result of three major tasks in therapy: first, the therapist's and the client's ability to agree upon the goals of therapy; second, the individual tasks that constitute therapy; and third, the bond between the therapist and the client. Further, in more recent research, Horvath, Del Re, Flukiger, and Symonds (2011) stated that the alliance consisted of the attainment of more collaborative aspects of the relationship.

Research has found that the therapeutic alliance plays an important role in the outcome of individual therapy (Martin, Garske & Davis, 2000). Horvath and colleagues (2011) conducted a meta-analysis and found a significant effect size of .27, indicating that there is a modest relationship between alliance and outcome. Also, the relationship was reported to be strong regardless of point of view (therapist or client), how it is measured, or mode of therapy. Additionally, Lambert and Barley (2001) reported that, among factors that influence the outcome of therapy, the alliance is "more significant in contributing to client improvement (as opposed to therapeutic techniques) and accounts for 30% of the variance in client outcome" (p. 358). Further, Ilgen, McKellar, Moos and Finney (2006) found that, when working with clients who were being treated for alcohol abuse, a strong therapeutic relationship was important in predicting reductions in alcohol consumption among patients with low motivation. Finally, Cloitre, Stovall-McClough, Miranda, and Chemtob (2004), when working with women who suffered from post-traumatic stress disorder (PTSD) as a result of being abused as children, found that the therapeutic alliance in the initial phase of treatment effectively predicted a reduction in PTSD symptoms at the end of treatment.

Conversely, a poorly developed, or weak, therapeutic alliance can have an inverse effect on the outcome of therapy. Research has found that initial alliance formation is critical, that if the alliance is not formed and established in the first few sessions of therapy, the outcome of

therapy is more likely to be negative (Frieswyk et al., 1986). Horvath (2000) stressed that within the first few sessions of therapy, the therapist needs to develop a collaborative relationship with the client or the likelihood of a poor treatment outcome is high.

Predictors of the Alliance in Individual Therapy

Recognizing the importance of the therapeutic alliance in individual therapy, a substantial amount of research has examined predictors of a strong therapeutic alliance. Meier, Donmall, Barrowclough, McElduff, and Heller (2005) looked at 187 individuals who were in residential treatment for drug use. They found that attachment style and pre-admission support from friends and family predicted stronger alliances. In addition, Diamond, Liddle, Hogue, and Dakof (1999) reported that the therapeutic alliance was predicted by the quality of interpersonal relationships when working with adolescents. In the same study, they found that the alliance would be stronger if the therapist presented themselves as the adolescents' ally, listened and warmly responded to their experience, and aided them in establishing meaningful goals. Further, Coleman, Wampold and Casali (1995) found that ethnicity was an important predictor of the therapeutic alliance for clients that were ethnically diverse. Clients reported that there was a closer bond to the therapist if they shared the same ethnic background. Additionally, Wintersteen, Mensinger, and Diamond (2005), found that when a client was matched with a therapist of the same gender, the client and the therapist reported higher alliance scores.

Therapeutic Alliance in Couples Therapy

The concept of the therapeutic alliance, which was developed within the context of individual therapy, has been applied to couples therapy. The therapeutic alliance in couples therapy differs from that in individual therapy because the therapist is responsible for more than just a single alliance between himself or herself and a single client. Quinn, Dotson, and Jordan

(1997) stated that “with two or more clients, couple and family therapy creates a social field that presents unique challenges, demands, and processes not found in individual psychotherapy” (p. 430). For example, instead of viewing the alliance individualistically, the therapeutic alliance must be considered in terms of the couple relationship (Rait, 2000), meaning that the therapist’s actions in joining with one member of the couple subsystem could have an effect on the other member simultaneously (Pinsof, Zinbarg & Knobloch-Fedders, 2008). Thus, the therapist must also focus on the relationship between himself and each client and between the clients, which makes establishing an effective therapeutic alliance more difficult and complex.

There is substantial evidence that the therapeutic alliance is a significant predictor of successful outcome in couples therapy (Anker, Owen, Duncan & Sparks, 2010). Friedlander, Heatherington, Escudero and Diamond (2011) reviewed 7 studies on the relationship between the therapeutic alliance and outcome in a meta-analysis and found a significant positive relationship, with the average effect size being $r = .37$. Also, Symonds and Horvath (2004) studied 47 couples and found that there was a significant relationship between the therapeutic alliance and the outcome of therapy. Additionally, Anderson and Johnson (2010) studied 173 couples to understand the effect that the alliance had on marital therapy outcome. They discovered that, although the therapeutic alliance between the therapist and couples positively influenced relationship therapy outcome, it was not as important as the alliance between members of the couple. Further, Brown and O’Leary (2000) researched 70 husband-to-wife violent couples and found a positive correlation between alliance and outcome, as evidenced by decreased levels of physical and psychological aggression.

Predictors of the Alliance in Couples Therapy

Because of the influence of alliance on outcome when working with couples, it is salient to know what factors predict a strong therapeutic alliance. In the context of Emotionally Focused Therapy (EFT), Johnson and Talitman (1997) examined 36 couples to determine what predicts a successful outcome in couples therapy. As part of their study, they also examined predictors of a strong therapeutic alliance. They found that the initial level of trust in one's partner was predictive of the therapeutic alliance, while the level of relationship distress was not a significant predictor.

Also, Knobloch-Fedders and colleagues, (2004) studied 35 couples to determine the effect of individual symptomology, family-of-origin experiences, and marital distress on alliance formation. They found that the level of marital distress had a negative influence on couples' ability to form an alliance with each other. However, individual symptomatology was not a significant predictor of the therapeutic alliance. Further, the family-of-origin experience variable affected males and females differently. The researchers found that men's experience with their families-of-origin was related to their ability to create an alliance with their wife and therapist. For women, however, family-of-origin experiences predicted their tendency to form a split alliance, wherein the couple would perceive the alliance differently.

Additionally, Thomas, Werner-Wilson and Murphy (2005) found a difference in the formation of the alliance based on gender; for males, negative statements made by their partner toward them was predictive of a poorer alliance, whereas females were not affected by them. On the other hand, challenging statements made by the therapist were predictive of stronger alliances with females, while challenging statements made by their partner predicted a weaker alliance.

Attachment

As a lifespan developmental theory (Crowell, Fraley, & Shaver, 1999), attachment theory predicts the quality of future relationships that people have with attachment providers based on the relationship they had with their caregiver as an infant (Stakert & Bursik, 2003). The theory explains the nature of a child's bond to his or her caregivers and the impact it has on their development over the life course. It also emphasizes the role of early experiences in shaping the beliefs a person develops concerning the responsiveness and trustworthiness of significant others (Fraley & Vicary, Brumbaugh & Roisman, 2011).

Research suggests that there are three styles of attachment: anxious/ambivalent, avoidant, and secure (Simpson, 1990; Feeney & Noller, 1990). Secure attachment is characterized by the expectation that one's needs for comfort, protection from danger, and their needs for soothing will be met (Svanberg, Mennet & Spieker, 2010). Those classified as securely attached will readily welcome their caregiver's return after a period of separation, will seek closeness, and will easily receive comfort (Bartholomew and Horowitz, 1991). It has been associated with improved self-reflective capacities and emotional self-regulation (Fonagy, 2001).

Scholars describe avoidant attachment as the attachment style in which one tends to be uncomfortable with close relationships, therefore distancing oneself from attachment providers as a means of coping (Fraley & Shaver, 2000; Mikulincer & Shaver, 2003). Children who have an avoidant attachment style feel more comfortable in dissipating negative affect on their own, instead of seeking comfort from an attachment provider (Simpson, Rholes & Phillips, 1996). In romantic relationships, this attachment style is characterized by jealousy, fear of intimacy, and emotional highs and lows (Stakert, 2003). Recent research suggests that there is a positive relationship between the avoidant attachment style and infidelity, that a partner will be more

likely to seek safety from a different companion than from their own spouse (DeWall et al., 2011; Treger & Sprecher, 2011).

Lastly, anxious/ambivalent attachment is characterized by one's uncertainty regarding the availability of attachment providers (Cassidy & Berlin, 1994). This attachment orientation develops when one receives inconsistent care from their attachment provider, resulting in uncertainty concerning the availability of the caregiver, especially when one is in need (Campbell & Marshall, 2011). For example, children will tend to make inconsistent and conflicted attempts to obtain emotional support from their attachment providers, characterizing their uncertainty about the availability of their caregivers (Simpson, Rholes & Phillips, 1996). In adult relationships, anxious/ambivalent individuals have a strong desire to connect to others but have an accompanying fear of rejection and abandonment (Stakert, 2003).

Research suggests that as one ages, these attachment styles continue into adulthood and eventually play a role in how one interacts in romantic relationships. Avoidant individuals, or those with an avoidant-attachment style, have a tendency to avoid being committed in their relationships and tend to keep their distance, emotionally and psychologically (Campbell & Marshall, 2011). Anxious individuals are concerned that others will not love them; as a result, they tend to wish that they could completely merge with someone so that the likelihood of separation anxiety is diminished (Roisman et al., 2007). In addition, securely-attached individuals do not spend time worrying about being abandoned or having someone get too emotionally attached to them; rather, they find it easy to get close to and to depend on others, as well as be depended on (Simpson, 1990).

Research has shown that attachment styles are predictive of the quality of adult romantic relationships. For example, Saavedra, Chapman and Rogge (2010) and Mikulincer, Shaver, Bar-

On, and Ein-Dor (2010), in separate studies, found that anxious/ambivalent and avoidant attachment styles were indicative of lower levels of current relationship quality, and the avoidant attachment style was also predictive of lower relationship satisfaction over time. Further, Sumer and Cozzarelli (2004) studied 352 individuals in relationships and found that a secure attachment style was related to higher relationship quality.

Attachment and Alliance

Recently, the concept of attachment has been applied to the therapeutic relationship. Bowlby (1988) contended that the therapeutic alliance may be a representation of attachment that embodies the same elements that trigger attachment-related behaviors. Smith et al. (2011) pointed out similarities between attachment and the alliance, such as deciding whether or not social support will be available from the therapist and figuring out how to elicit the required support. Because of these similarities, they hypothesized that the attachment style that was formed in childhood would predict the extent to which clients would benefit from therapy.

Research suggests that attachment styles play a role in the ability to form an effective alliance in individual therapy. Diener and Monroe (2011) found that clients who were insecurely attached had a difficult time trusting, creating an emotional bond with, and agreeing on therapeutic goals and tasks with their therapist. In their research, Mallinckrodt, Gant, and Coble (1995) found a strong relationship between attachment style and in-session behavior; clients that were securely attached tended to trust the therapist and assisted in facilitating a deeper relationship, wherein they were more agreeable on therapeutic tasks. Anxiously-attached clients sought to quickly bond with the therapist and were found to be overly concerned with the therapist. Avoidantly-attached clients detached themselves from therapy by distrusting the therapist and failing to cooperate with therapeutic tasks. Moreover, Bachelor, Meunier,

Laverdiere, and Gamache (2010) found that these attachment-based responses became more pronounced in the presence of stress or pain. In addition, Goldman and Anderson (2007) found that clients who were comfortable with intimacy and were able to rely on and trust others without fearing rejection were more able to form stronger alliances during the first session.

Although there is a robust literature demonstrating the significance of client attachment on the development of the therapeutic alliance in individual therapy, only one study has examined the effect of attachment on outcome in relational therapy. In their study, Johnson and associates (2006) examined the development of the therapeutic alliance among 32 families that included 27 mothers, 15 fathers, and 23 adolescents. They found that only mothers' level of attachment with their child was significantly predictive of the alliance with the therapist. Fathers' and adolescents' levels of attachment did not predict the therapeutic alliance. However, the study did not include a measure of attachment between the parents; consequently, the association between couple attachment and therapeutic alliance remains untested.

Research Question

Based on a foundation of research from individual therapy that the client's attachment style is an important predictor of the therapeutic alliance, and extending the study by Johnson and associates (2006) on attachment and the development of the therapeutic alliance in family therapy, this study determined the effect of partners' attachment style on the strength of the therapeutic alliance in couples therapy.

Methods

Sample

The data came from a larger clinical study that was conducted at a university-based MFT clinic in the Southeastern part of the U.S. (see Anderson & Johnson, 2010), which was associated with an accredited masters MFT program. One hundred seventy-three heterosexual couples were seen at the clinic. Every couple completed a battery of assessment measures before the first session, but only 115 couples completed the assessment at session four. Because therapeutic alliance was measured at the fourth session, the sample for this study was 115 couples.

Of the 115 couples in the study, 72% were in a married relationship, while 28% were in a cohabiting relationship. The average income per couple was between \$21,000 and \$40,000. The most common racial demographic was Caucasian (78.8%), with approximately 15% of both males and females reporting that they were African American. All but one of the males had graduated from high school, and 40.0% had graduated from college. All of the females had graduated from high school, and 54.6% of them had graduated from college. The average age was 31.25 years for men and 29.40 years for women ($SD= 8.11$ and 7.91 years, respectively). The average reported time that each couple had been together was 5.53 years ($SD = 4.53$ years).

Measures

Experiences in Close Relationships-ECR (see Parker, Johnson & Ketring, 2011)

Adult attachment style was measured using the Experiences in Close Relationships questionnaire (ECR; Brennan, Clark & Shaver, 1998). It is a 36-item self-report measure that contains two scales with 18 items each: Avoidance and Anxiety. Responses ranged from “Disagree strongly” to “Agree Strongly” on a 7-point Likert Scale. There is minimal correlation

between the two scales ($r=.11$), indicating that the measure includes two separate, underlying dimensions of adult attachment. High reliability was concluded due to the alphas of the avoidance (.94) and anxiety (.91) subscales.

Although Brennan and colleagues (1998) found high internal reliability and robust validity in the ECR, Parker, Johnson and Ketring (2011) examined the factor structure of the ECR to determine if it was a valid measure among clinical populations. They confirmed the factor structure using a clinical sample, and they reported Cronbach's alphas among the men of .91 for the anxiety subscale and .90 for the avoidance subscale. The reliability coefficient for the women was .90 for both subscales.

Couples Therapy Alliance Scale-Revised (CTAS-R; Pinsof, 1994)

The CTAS-R is a revised version of the original 29-item scale developed by Pinsof and Catherall (1986). It contains 40 items and measures three different areas of the couples' alliance: goals, tasks, and bonds. It measures the four interpersonal subsystems in couples therapy; (a) self-therapist (self-subscale), (b) partner-therapist (other subscale), (c) the alliance between the therapist and the couple (group subscale), and (d) the alliance between partners (within subscale). Pinsof, Zinbarg and Knobloch-Fedders (2008) conducted a factor analysis that demonstrated a lack of support for the factor structure of the CTAS-R. They recommended that the scale be revised to reflect three subscales: other, within, and self/group. Consequently, this study used those items that measure the self-group alliance (the alliance between the therapist and each partner) score by adding 6 scale items that measure bonds, goals, and tasks. The within-system alliance (the alliance between partners) was also included in the analysis. It was determined by adding together three items that also measure goals, tasks, and bonds. The items were measured using a 7-point Likert-type scale, creating a self-group score range from 6 to 42.

The within-system alliance ranged from 3 to 21 for the same reason. Lower scores indicate weaker alliance. The Cronbach's alpha for the within and the self-group subscales sample were .89 and .83, respectively.

Control Variables

The education level and race of each spouse in the relationship, as well as the number of years that they have been together, were included as control variables in the analyses. They were measured using standard demographic questions. The race variable was recoded so that 0 represented European American and 1 represented other racial groups.

Analysis

Multiple regression was used to analyze the data. The therapeutic alliance was regressed on the independent variable, the level of attachment. Educational level and race of each partner, as well as the number of years that the couple has been together, were included in the regression models as control variables. Because of potential gender differences in the relationship between attachment and the therapeutic alliance, regression models were run separately for males and females. In addition, regression models were run separately for the two main independent variables (anxious and avoidant attachment) and the two dimensions of the therapeutic alliance (between and within). Consequently, there were four separate regression models run for each gender (anxious attachment and between therapeutic alliance, avoidant attachment and between therapeutic alliance, anxious attachment and within therapeutic alliance, and avoidant attachment and within therapeutic alliance).

Results

Preliminary Analysis

The mean score for females on the avoidant subscale was 52.08 ($SD = 19.41$), and it was 73.37 ($SD = 19.64$) on the anxiety subscale. For males, the mean score on the avoidant subscale was 47.02 ($SD = 15.83$), and 60.65 ($SD = 20.27$) on the anxiety subscale. The mean female score for the self/group alliance subscale was 33.48 ($SD = 4.89$), and 16.61 ($SD = 2.93$) for the within alliance subscale. The mean male score for the self/group alliance was 3.26 ($SD = 5.56$) and 16.69 ($SD = 3.07$) for the within alliance subscale.

Pearson correlations were conducted to examine zero order correlations among the variables in the study. As indicated in Table 1, among the females, there was a significant association between self/group alliance and within alliance ($r = .62, p < .01$), as well as between anxious and avoidant attachment ($r = .37, p < .01$). There was also a significant association between avoidant attachment and self/group alliance ($r = -.31, p < .01$), but not between anxious attachment and self/group alliance. There was a significant association between anxious attachment and within alliance ($r = -.27, p < .05$), and between avoidant attachment and within alliance ($r = -.29, p < .01$).

For males, as indicated in Table 2, there was a significant association between self/group alliance and within alliance ($r = .73, p < .001$), but not between anxious attachment and avoidant attachment. None of the relationships between attachment and alliance were significant.

Results of the multiple regression analysis indicated that attachment was generally predictive of the therapeutic alliance among the females. As indicated in Table 3, which reports unstandardized regression coefficients, avoidant attachment ($b = -.034, p < .05$) and anxious attachment ($b = -.038, p < .01$) were predictive of the within alliance. Avoidant attachment was

also predictive of self/group alliance ($b = -.069$, $p < .01$), but the relationship between anxious attachment and self/group alliance was not significant. The percentage of variance that the models explained ranged from 7.1% to 16.4%.

Among the males, however, there was only limited evidence that attachment was predictive of the therapeutic alliance. As indicated in Table 4, of the four models that tested the relationship between attachment and the therapeutic alliance, only the relationship between anxious attachment and within alliance was significant ($b = -.032$, $p < .05$). The amount of variance that the models explained ranged from 1.7% to 6.4%, which is substantially less than the females' models.

The results from the multiple regression analysis indicated that the control variables were largely not associated with the therapeutic alliance. Among the control variables of race, education, and the number of years in the relationship, only education was significant in any of the models. Education significantly positively predicted self/group alliance among the females ($b = .616$, $p < .05$), and education negatively predicted self/group alliance among the males ($b = -.184$, $p < .05$).

Discussion

In summary, these results suggest that there is some evidence that attachment is associated with the development of the therapeutic alliance by the fourth session. This is especially true among the females in the study. For females, both attachment styles play a role in alliance formation. Being avoidantly attached explains 16.4% of the variance in the strength of the alliance she forms with the therapist, indicating that higher levels of avoidant attachment predicts lower levels of alliance. This is perhaps because of the nature of being avoidantly attached: one generally detaches him- or herself because of a learned lack of trust in an

attachment provider, which is, in this case, the therapist (Mallinckrodt, Gant, & Coble, 1995). Also, the nature of therapy may not suit those that are avoidantly attached because it is transitive. A female client may shy away from engaging with the therapist because she knows it will end and that the therapist will no longer be there. Further, because the therapist is likely to ask probing questions, it may cause the female client to disengage due to the amount of trust that is required to answer those types of questions.

Being avoidantly attached also explains 11.1% of the variance in the alliance between herself and her partner. As earlier research suggests (Mallinckrodt, Gant & Coble, 1995), those who are avoidantly attached have a difficult time trusting those that are close to them because of previous experiences in which the attachment providers gave inconsistent care to them as children, therefore, learning a style of interaction in which they distance themselves from their attachment providers as a means to cope (Fraley & Shaver, 2000).

Further, the anxious-attachment style was found to be significant only in the alliance with her partner, which style explained 9% of the variance in the strength of the within alliance. Research suggests that the need to quickly bond with the therapist is buffered by the presence of her partner, which would fulfill the attachment need for the female partner (Mallinckrodt, Gant, & Coble, 1995). Also, because the nature of anxious attachment is such that people tend to emotionally cling to their attachment providers due to the uncertainty of a provider's availability (Cassidy & Berlin, 1994), it makes sense to assume that the strength of the alliance is explained by actions that involve increasing the probability of availability and reducing the probability of pain and separation.

For males, the analysis yielded only one significant result: 6.4% of the variance in the strength of the within alliance was explained by the anxious attachment style. When one is

anxiously attached, they feel the need to emotionally cling to their partner because of the accompanying fear of abandonment (Stakert, 2003). In therapy, this could look like the male partner agreeing with everything his partner says so that she does not leave him. Or, he might feel that he has to be totally honest in therapy in order to keep his partner or she will leave him, thereby receiving pain via separation anxiety.

This study revealed that attachment, in contrast to females, does not generally explain the strength of the therapeutic alliance for males as it does for females.

One possible explanation is offered by research that has found gender differences in alliance scores in marital therapy. When studying the influence that therapist and client behaviors had on the alliance, Thomas et al. (2005) found that women had higher alliance scores than men in marital therapy because they often had more success at introducing topics than did men. One of the basic tenets in attachment theory is that, beginning in infancy, people tend to attach themselves to those who are responsive and sensitive. If males do not speak up and introduce topics in marital therapy very often, the therapist will not spend as much time validating him as the therapist would his partner, thereby making attachment less of a predictor for the strength of the therapeutic alliance for males.

Moynehan and Adams (2007) offer another possible explanation. They explained that because men are culturally conditioned to keep personal matters private, they are prone to solving problems on their own and without the aid of a therapist. Therefore, when they are made to discuss marital issues in a therapeutic setting, they will do so reluctantly, possibly minimizing the opportunity to create an attachment relationship with anyone other than his partner.

Limitations and Future Research

The majority of the limitations in this study stem from the dataset. It did not provide information concerning whether or not the sample of interest had any children. This is salient because of the influence of children on the relationship between partners. Perhaps, then, attachment scores might have been different among partners, altering the results of the study. For example, one of several studies indicates that children have a negative effect on marital quality (Waite and Lillard, 1991). Assuming that children also affect the attachment quality of marital relationships, this might have altered the attachment scores of this study.

In addition, the sample of interest was young. If, on average, the participants in the sample were older, the results of the study may vary because anxious or avoidant attachment may not explain the variance in the strength of the alliance because a couple's attachment might become more secure over time. Another limitation of this study is that the most common racial group was Caucasian. Because there were too few Hispanics and Asian Americans in the sample, this limits the results from being entirely generalizable across race.

Future research might address the following: What, if any, are the individual behavioral attachment differences among gender? Which alliance is the most important in couples therapy? How strong does the alliance between either each partner or the alliance between the therapist and each partner need to be in order to achieve a positive outcome in therapy? Why does attachment style more accurately predict the strength in the alliance for females as opposed to males? How does attachment change over the life course and how would that affect the alliance in therapy for older couples? How would children affect the relationship between attachment and the alliance? If there were more ethnic minorities in the sample, how would the results vary

and would they be generalizable? And finally, how could one make these results generalizable for homosexual couples?

Clinical Implications

Clinicians may want to explore the relationship between the female partner and those with whom she was attached if there seems to be an issue either in connecting with her or in getting her to buy into the process of therapy, as nearly 20% of the alliance between the clinician and the female client is explained by an avoidant attachment style. Recent research coincides with this finding. In their study, Fraley and Shaver (2000) examined current research to understand the trends in romantic attachment. They concluded that individuals who were avoidantly attached were more likely to employ different strategies to defend themselves by inhibiting attachment formation in new relationships. However, one must be careful not to assume that emotional distance in therapy is, solely, the result of an avoidant attachment orientation.

This study also found that attachment style also affected the alliance the female had with her partner. This finding is also consistent with research that studied Emotionally Focused Therapy (EFT). Johnson, Makinen & Millikin (2001) reported a link between insecure attachment and couple behaviors, such as withdrawal, defensiveness and criticism. Because of this link, clinicians may want to focus their efforts in training the couple how to effectively communicate so that the couple alliance becomes stronger, alleviates distress and, therefore, improves relationship satisfaction (Anderson & Johnson, 2010).

Conclusion

Understanding the effect of the therapeutic alliance in couples therapy is important for therapeutic success, which makes it important to understand what factors predict a strong

therapeutic alliance. As this study has outlined, attachment style, namely anxious and avoidant, play a role in explaining the possible causes of the strength of the therapeutic alliance in couples therapy, particularly among females.

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Appendix

Table 1-Correlation Matrix for Females

	<i>Education Level</i>	<i>Length of Current Relationship</i>	<i>RDAS</i>	<i>Race</i>	<i>Self/Group</i>	<i>Anxiety Subscale</i>	<i>Avoidant Subscale</i>
<i>Length of Current Relationship</i>	.066						
<i>RDAS</i>	.227*	-.168					
<i>Race</i>	-.057	.044	-.071				
<i>Self/Group</i>	.162	-.188	.178	.161			
<i>Anxiety Subscale</i>	-.144	.224*	-.401**	-.088	-.198		
<i>Avoidant Subscale</i>	-.147	.067	-.273**	-.096	-.307**	.369**	
<i>Within</i>	.038	-.119	.187	.049	.620**	-.270*	-.291**

NOTE: *p< .05. **p< .01.

Table 2-Correlation Matrix for Males

	<i>Education Level</i>	<i>Length of Current Relationship</i>	<i>RDAS</i>	<i>Race</i>	<i>Self/Group</i>	<i>Anxiety Subscale</i>	<i>Avoidant Subscale</i>
<i>Length of Current Relationship</i>	.205*						
<i>RDAS</i>	.241*	-.057					
<i>Race</i>	-.169	.007	-.167				
<i>Self/Group</i>	.054	-.07	.065	-.04			
<i>Anxiety Subscale</i>	-.261*	-.009	-.253	.111	-.067		
<i>Avoidant Subscale</i>	-.257**	.095	-.241*	.033	-.15	.12	
<i>Within</i>	-.01	-.117	.173	-.082	.733**	-.194	-.165

NOTE: *P< .05. **P< .01.

Table 3-Results of the Female Self/Group and Within Alliance Regression Analysis

	Female Self/Group Alliance		Female Within Alliance	
	Avoidant	Anxious	Avoidant	Anxious
Self/Group Alliance	-.069(.024)**	-.034(.024)	NA	NA
Within Alliance	NA	NA	-.034(.015)*	-.038(.014)**
Race	1.98(1.20)	2.24(1.23)	.132(.725)	.175(.714)
Education	.536(.289)	.616(.296)*	-.034(.174)	-.013(.014)
Years Married	-.015(.009)	-.015(.010)	-.006(.005)	-.004(.006)
R ²	.164	.111	.071	.090
F value of model	4.65**	2.97*	1.80	2.34

Note: * p < .05; ** p < .01; regression coefficients are unstandardized, with standard errors in parenthesis

Table 4-Results of the Male Self/Group and Within Alliance Regression Analysis

	Male Self/Group Alliance		Male Within Alliance	
	Avoidant	Anxious	Avoidant	Anxious
Self/Group Alliance	-.050(.036)	-.019(.028)	NA	NA
Within Alliance	NA	NA	-.028(.020)	-.032(.015)*
Race	-.184(1.32)*	-.110(1.34)	-.516(.732)	-.405(.725)
Education	.161(.287)	.224(.287)	.012(.158)	-.011(.155)
Years Married	-.003(.010)	-.005(.010)	-.005(.006)	-.006(.006)
R ²	.032	.017	.040	.064
F value of model	.782	.408	1.01	1.64

Note: * $p < .05$; ** $p < .01$; regression coefficients are unstandardized, with standard errors in parenthesis.