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ATTACHMENT TO THE THERAPIST

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This study examines the ways in which therapists function as attachment figures for patients. Patients in long-term psychoanalytic therapy answered questionnaires about their feelings about their therapists and their closest personal relationships. Components of attachment prominent in the therapeutic relationships were looking up to the therapist and feeling the therapist was responsive to emotional needs. Stronger attachment to therapists was associated with greater frequency and duration of therapy, a stronger working alliance, and greater security of the patients' attachment style, as well as with the gender of the patient and therapist. Using attachment theory to understand psychoanalytic relationships emphasizes the unique importance of a therapist to a patient and can offer new perspectives on both therapeutic and attachment processes.

There seems to be an increasing consensus that therapeutic change is based not only on cognitive factors such as awareness and insight, but also on the nature of the relationship between patient and therapist. And at least since Freud's (1912/1963a, 1905/1963b, 1915/1963c) writings on the concept of transference, there has been wide recognition that patients in psychotherapy often experience strong feelings toward their therapists. One useful way of understanding the therapeutic relationship when it works well is that the therapist, at least in certain respects, serves as an attachment figure, as a "secure base" from which the patient can explore his or her inner world (Bowlby, 1988). Although understanding the therapeutic relationship in this way makes a good deal of intuitive sense, there has been little empirical research on the therapist as an attachment figure.

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Originally used to examine the emotional bond of infants to their mothers (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969/1982), the ideas of attachment theory, in recent years, have also been applied to adult relationships. Not only do the qualities of early attachments affect later adult relationships, but also some adult relationships themselves function as attachments. For example, adults also have feelings of security associated with attachment figures, show increased attachment behaviors in situations of perceived danger, and protest separation from attachment figures (Weiss, 1982). Most researchers have studied adult attachment in romantic relationships, but some have noted that other kinds of relationships, including therapy relationships, may also have features of attachment (Ainsworth, 1991; Weiss, 1991). Not all close relationships are attachment relationships; attachment relationships are understood to be those that have particular characteristics and fulfill particular functions.

If attachments develop in psychotherapy relationships, then attachment theory can contribute to our understanding of what happens in therapy, particularly of the relationship aspects of therapeutic change. In fact, there are notable similarities between the attachment concept and the psychoanalytic idea of transference: both refer to a strong emotional connection to another person, in which one repeats patterns of relating that are rooted in early childhood relational experiences. There is a growing literature on the interface between attachment theory and psychoanalysis (e.g., Eagle, 1997; Fonagy, 2001; Mitchell, 1999; Silverman, 1998; Steele & Steele, 1998), and on the relevance of attachment concepts to clinical work (e.g., Bowlby, 1977, 1988; Dozier & Tyrell, 1998; Eagle, 1995, 1996; Eames & Roth, 2000; Holmes, 1993, 1996, 1998; Liotti, 1995; Lyons & Sperling, 1996; Osofsky, 1988, 1995; Rutter, 1995; Sable, 1997; Slade, 1999; Szajnberg & Crittenden, 1997; West & Sheldon-Keller, 1994). A number of these authors have noted that certain aspects of the therapy situation cater to attachment needs; for example, the therapist provides a secure base from which to explore past and present experiences, and the therapist is a person to whom one can turn in times of distress. Early attachment patterns may influence the therapy relationship, however, without therapy actually being an attachment relationship (Schuengel & van IJzendoorn, 2001). Several authors have more directly considered attachments to therapists (Farber, Lippert, & Nevas, 1995; Holmes, 1996, 1998; Lyons & Sperling, 1996; Mackie, 1981; Mallinckrodt, 2000; Mallinckrodt, Gantt, & Coble, 1995; Mitchell, 1999). Amini et al. (1996) went so far as to propose that psychotherapy works precisely because it functions as an attachment relationship.

There have not, however, been prior studies that investigate empirically how the properties of attachment are manifest in therapy relationships. Using a new measure, the Components of Attachment Questionnaire (CAQ; Parish, 2000), we examined the extent to which defining components of attachment are active in therapy relationships. We compared the intensity of these components in relation to the therapist and in relation to the person's primary attachment figure. We also examined how the components of attachment to the therapist vary with duration and frequency of therapy, use of an analytic couch, the strength of the working alliance, the gender of the patient and therapist, and the patient's attachment style.

Method

Participants

Participants were 105 adults currently in psychoanalysis or psychodynamic psychotherapy, working with the same analyst or therapist for at least 6 months. They were

recruited from several sources. Questionnaire packets were distributed to current and recent doctoral-level students at several training programs in psychodynamic therapy, most of whom were in psychoanalysis or psychodynamic therapy. These students distributed packets informally to other people they knew who were also in psychoanalytic treatment. Finally, packets were given to current patients in a university counseling center staffed by doctoral candidates conducting psychodynamic psychotherapy. Of 362 packets distributed, 107 were completed and returned, a response rate of 30%. Two of these could not be included in the study: one was not in current treatment and the other was in a treatment that was not psychodynamic in nature.

The age of the participants in the study ranged from 19 to 65 years ($x = 34.5$, $SD = 8.4$). Seventy nine (75.2%) participants were women, and 26 (24.8%) were men. Ninety-seven (92.4%) were Caucasian. Thirty-six (34%) were married, 60 (57.1%) single, 1 (1%) separated, and 8 (7.6%) divorced. Seventy-two (68.6%) reported that they were currently in a romantic relationship, and 33 (31.4%) reported that they were not. Twenty-six (23.3%) had one or more children, and 79 (76.7%) had no children. The sample was highly educated: 83 (79.1%) had engaged in some graduate-level studies, and 10 (9.5%) had a doctoral-level degree, while only 6 (5.7%) did not have a college degree.

Measures

CAQ. The CAQ (Parish, 2000) is a 45-item self-report measure based on the essential characteristics of attachment relationships identified in the theoretical literature. It is designed to assess which aspects of attachment are prominent in a particular relationship. There are 5 items pertaining to each of nine components of attachment. Respondents rate each item on a Likert scale ranging from 1 (*not at all true*) to 5 (*very true*). The mean score on the 5 items tapping each component yields a measure of the intensity of that component in that relationship. The mean of all 45 items in the scale is understood as a measure of the intensity of overall attachment to that particular person. Two forms of the CAQ were used in this study, one pertaining to the therapist (CAQ-T) and the other pertaining to the primary attachment figure (CAQ-AF). Each respondent began this second version by identifying the person to whom he or she felt the closest, who was considered the primary attachment figure.

The CAQ was developed as part of this study. Preliminary evidence for its validity comes from several sources. First, items were written based on the defining characteristics of attachment identified in the theoretical literature. They were then presented to a study group of advanced doctoral candidates conducting research in the area of adult attachment. Members of the group came to agreement about which items were most relevant to each component of attachment. Further evidence of construct validity comes from the fact that the CAQ responses were affirmative in relation to the people identified by the participants, at the outset, as their primary attachment figures. The following is a brief description of the nine central components of attachment.

Proximity Seeking: To say that someone is attached "means that he is strongly disposed to seek proximity to and contact with a specific figure" (Bowlby, 1969/1982, p. 371).

Separation Protest: One feels distress upon separation from an attachment figure, and may protest the separation (Bowlby, 1969/1982; Weiss, 1991).

Secure Base: The attachment figure is used as a secure base, from which to explore the world and to which to return; this provides a person with a sense of felt security (Bowlby, 1977; Hazan and Shaver, 1990; Weiss, 1991).

Safe Haven: An attachment figure is also used as a safe haven, or someone to turn to for comfort in times of distress (Bowlby, 1969/1982, 1977).

Stronger/Wiser: Bowlby stated that the attachment figure "is usually conceived of as stronger or wiser" (Bowlby, 1977, p. 203). There has been debate about the extent to which this particular aspect of attachment is relevant to adult relationships. One would expect that therapeutic relationships would be more likely to manifest this aspect of childhood attachment than would other adult relationships, since one generally looks to a therapist for expertise in certain areas.

Availability: The attachment figure's availability and sensitive responsiveness to emotional needs facilitates the development of an attachment bond (Bowlby, 1969/1982).

Strong Feelings: An attachment figure is associated with especially strong feelings (Bowlby, 1969/1982, 1977).

Particularity: The attachment figure is a particular, unique other person, who cannot be easily replaced by another (Bowlby, 1977, p. 203).

Mental Representation: A feature that is especially characteristic of *adult* attachment is the reliance on evoking a mental representation, or summoning an internal sense of the attachment figure for comfort or guidance (West & Sheldon-Keller, 1994, p. 100).

Relationship Questionnaire. The attachment style measure used in this study is the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991). The RQ, which has been used in numerous previous studies of attachment style, is a direct self-report measure which asks respondents to rate how closely each of four paragraphs describes their feelings about relationships. The paragraphs describe the typical features of each of the four attachment styles, as follows:

Secure: "It is easy for me to become emotionally close to others. I am comfortable depending on them and having them depend on me. I don't worry about being alone or having others not accept me."

Fearful: "I am uncomfortable getting close to others. I want emotionally close relationships, but I find it difficult to trust others completely, or to depend on them. I worry that I will be hurt if I allow myself to become too close to others."

Preoccupied: "I want to be completely emotionally intimate with others, but I often find that others are reluctant to get as close as I would like. I am uncomfortable being without close relationships, but I sometimes worry that others don't value me as much as I value them."

Dismissing: "I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient, and I prefer not to depend on others or have others depend on me" (Bartholomew & Horowitz, 1991).

Studies of attachment style often regard style as a category, with individuals falling into one of three or four mutually exclusive categories. The RQ can be used either as a categorical or as a continuous (dimensional) measure, allowing for conceptualization of the styles as dimensional as well as categorical, with each individual exhibiting elements of each dimension. When responding to the RQ paragraphs listed above, respondents not only check the *one* paragraph that is most characteristic of them, they also indicate how much *each* paragraph describes them on a scale of 1 to 5. This allows for a more complex picture of attachment style in each individual.

Working Alliance Inventory. The concept of the working alliance was initially developed by Greenson (1965; Greenson & Wexler, 1969) to highlight that aspect of the relationship between the therapist and the patient that enables the two to work collaboratively to aid the patient, despite the emotional storms of the transference. Later research

has demonstrated a connection between a strong working alliance and positive therapy outcome (Horvath & Symonds, 1991).

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), based on an elaboration of Greenson's ideas, is a 36-item self-report questionnaire designed to measure the therapeutic alliance along three dimensions: "task," the extent to which therapist and patient agree about what to do in sessions; "goal," the extent of agreement about the desired outcome of therapy; and "bond," the extent of positive personal feeling between the two. The present study uses a short form of the WAI, consisting of 12 items which have been shown to have the same factor structure as the original questionnaire, thereby accomplishing the same purpose more efficiently (Tracey & Kokotovic, 1989).

Procedures

Participants were asked to complete the packet of self-report questionnaires, described above, and to provide demographic and treatment history information. The order of the questionnaires in the packet was randomly varied: half the subjects answered questions about their therapist first, while the other half answered questions about their closest relationship first. All participants indicated informed consent and returned the questionnaires anonymously in the business-reply envelope included in each packet.

Results

Characteristics of the Treatments

Duration of therapy ranged from 6 months to more than 10 years, and frequency of the sessions ranged from less than once a week to 4 times a week. A third of the participants lay on a couch in therapy.

Thirty-eight (36.2%) of the therapists were male and 66 (62.9%) female. The therapists were predominantly Caucasian. Sixty-one (57.3%) of the therapists were psychologists, 12 (11.4%) were psychiatrists, 8 (7.6%) were social workers, and the others were of another discipline, still in training, or their profession was not revealed by the respondent. Participants who listed the institutional affiliation of their therapists (71 responded to this question) listed a wide range of psychoanalytic training institutes (15 different institutes), primarily in the New York and Boston areas. Thirty (28.6%) of the therapists were still in training, over half of these at the postdoctoral level.

The 13 patients who were in treatment with graduate students did not differ significantly on any demographic variable, or in their level of attachment to their attachment figure, from the other respondents in the study. They did, however, show a lower level of overall attachment to their therapists than did the people in the other groups, $F(3, 101) = 6.64$, $p < .001$. There was no difference in level of attachment either to the therapist or to the attachment figure based on the order of the questionnaires in the packet.

Attachment to the Therapist and to the Primary Attachment Figure

Participants in the study identified the person to whom they felt the closest and used this person as the primary attachment figure, about whom they responded to the CAQ-AF. The attachment figure was most often a spouse or romantic partner, but friends and other

relatives were also represented, as well as a few professionals. For the following analyses, in which attachment to the primary attachment figure is compared with attachment to the therapist, 5 participants were omitted for whom this comparison could not be made, because they had indicated that their therapist *was* their primary attachment figure. The CAQ scores for both the therapist and the primary attachment figure were above the scale's midpoint (with the exception of Separation Protest for the therapist, which was only slightly below), suggesting that both served as attachment figures, in almost all respects.

To determine whether levels of attachment to the primary attachment figure and the therapist were significantly different, *t* tests for paired samples were conducted (see Table 1). The overall level of attachment, and of most of the individual components, was higher for the person identified as the primary attachment figure. However, the therapist was rated more highly on two components, Wiser/Stronger and Availability. Secure Base was the only component for which there was not a significant difference between the two.

The same comparisons were then made separately for two groups of respondents, those who had identified a spouse or romantic partner as their primary attachment figure, and those who had identified a friend or other relative as their primary attachment figure. People who felt closest to a romantic partner had significantly higher levels of attachment to the romantic partner than to the therapist, both overall, $t = 5.58$, $p < .001$, and on most components. People whose primary attachment was not a romantic one, on the other hand, viewed that person and their therapist more similarly with respect to attachment: they did not have different levels of overall attachment with respect to the two figures. In addition, these people manifested stronger attachment to the therapist than to the primary attachment figure in the domains of Separation Protest, $t = -2.51$, $p < .05$, Secure Base, $t = -2.22$, $p < .05$, and Wiser/Stronger, $t = -2.76$, $p < .01$.

A related question is whether there were differences in attachment to the same person (the attachment figure or the therapist), depending on the nature of the primary attachment relationship. As one would expect, people who listed a romantic partner as their primary attachment figure had substantially higher levels of overall attachment to that person than people who listed a friend or other relative did to their attachment figure, $F(1, 99) = 14.39$, $p < .001$. In addition, the respondents who were attached to a romantic partner

Table 1
Comparing Mean Components of Attachment Questionnaire (Parish, 2000) Scores for Primary Attachment Figure (AF) and Therapist (TH)

Attachment component	AF *M*	TH *M*	*t*
Overall Attachment	3.87	3.63	3.59**
Proximity Seeking	4.30	3.65	7.10***
Separation Protest	3.14	2.77	2.94**
Secure Base	3.84	3.91	–.88
Safe Haven	4.20	4.01	2.79**
Wiser/Stronger	3.35	3.73	–4.49**
Availability	4.11	4.29	–2.30*
Strong Feelings	4.16	3.16	8.37***
Particularity	4.25	3.76	4.99***
Mental Representation	3.83	3.49	3.08**

*$p < .05$. **$p < .01$. ***$p < .001$.

showed higher levels of Proximity Seeking, $F(1, 98) = 5.14$, $p < .01$, Separation Protest, $F(1, 98) = 32.40$, $p < .001$, Secure Base, $F(1, 98) = 8.07$, $p < .01$, Strong Feelings, $F(1, 98) = 70.91$, $p < .001$, and Mental Representation, $F(1, 98) = 18.39$, $p < .001$, toward their attachment figures than did the other respondents. There were fewer differences in attachment to the therapist based on the identity of the primary attachment figure. There was more intense Proximity Seeking in relation to the therapist for those whose primary attachment figure was not a romantic partner, $F(1, 98) = 6.75$, $p < .05$.

Duration and Frequency of Therapy

The overall attachment to the therapist was positively correlated with both duration of the therapy and frequency of sessions. The longer the respondent had been in therapy, and the more frequent the sessions, the stronger was the attachment to the therapist (see Table 2). Frequency of therapy sessions was unrelated to attachment to the primary attachment figure in all respects. Duration of therapy was also unrelated to overall attachment to the attachment figure. However, duration was related to several components of attachment to the primary attachment figure, specifically, Secure Base, $r = .24$, $p < .05$, Safe Haven, $r = .22$, $p < .05$, and Availability, $r = .20$, $p < .05$.

Use of an Analytic Couch

As noted earlier, a third of the participants in the study lay on a couch during their therapy sessions. People using the couch tended to be in more frequent treatment (3–4 times per week), but this was not exclusively so. The relationship between the use of the couch and attachment to the therapist was investigated using a one-way analysis of variance to compare the attachment of people who lay on a couch with that of people who sat in a chair during therapy sessions. The use of the couch was unrelated to overall attachment to the therapist, and to all but one of the components of attachment to the therapist, Particularity, $F(1, 103) = 4.61$, $p < .05$. Use of the couch was also unrelated to attachment to the primary attachment figure in all respects.

Table 2
Correlations of Attachment to Therapist (CAQ-T) With Duration and Frequency of Therapy

Attachment component	Duration	Frequency
Overall Attachment	.29**	.28**
Proximity Seeking	.18	.06
Separation Protest	.03	.32***
Secure Base	.31**	.15
Safe Haven	.30**	.16
Wiser/Stronger	.16	.17
Availability	.12	−.05
Strong Feelings	.37***	.41***
Particularity	.28**	.20*
Mental Representation	.24**	.29**

Note. CAQ-T = Components of Attachment Questionnaire pertaining to the therapist (Parish, 2000).
*$p < .05$. **$p < .01$. ***$p < .001$.

The Working Alliance

The overall attachment to the therapist was highly correlated with the working alliance (see Table 3), and the overall attachment to the primary attachment figure was unrelated to the working alliance. This pattern held for the individual components of attachment: most components of attachment to the therapist were highly correlated with the working alliance. There were a few exceptions to this pattern, however. Separation Protest with respect to the therapist was unrelated to the working alliance, and Strong Feelings had a much lower correlation with the working alliance than the other components. On the other hand, Availability and Secure Base with respect to the attachment figure showed a low but significant correlation with the WAI.

Since there was such a strong correlation between the WAI and the CAQ-T, a multiple regression analysis was performed to determine whether certain components of attachment to the therapist were uniquely related to the working alliance (see Table 3). Both Secure Base and Availability were uniquely related to the working alliance.

Gender Match

There were no significant differences in overall attachment to the therapist or to the attachment figure based on gender of either the respondent or the therapist. Female respondents did have higher levels of one component of attachment to the therapist: Safe Haven, $F(1, 103) = 5.95$, $p < .05$. In addition, people in therapy with male therapists had significantly higher levels of Strong Feelings, $F(1, 103) = 17.10$, $p < .001$, and Separation Protest, $F(1, 103) = 4.32$, $p < .05$.

When respondents were divided into four categories based on the gender of each person in the therapy dyad, there were differences in levels of attachment to the therapist (see Table 4). The female patients who were in therapy with male therapists showed higher levels of overall attachment to the therapists than did the other groups. This difference was most marked with the Strong Feelings component and was also significant

Table 3
Multiple Regression Analysis: Components of Attachment to the Therapist (CAQ-T) Uniquely Related to Working Alliance (WAI)

Variable	*r*	β	*t*
Secure Base	.65***	.43	5.43***
Availability	.65***	.42	5.37***
Overall Attachment	.56***	.02	.16
Proximity Seeking	.48***	.08	.91
Separation Protest	.13	−.03	−.36
Safe Haven	.54***	−.07	−.71
Wiser/Stronger	.32***	.10	−1.25
Strong Feelings	.19*	−.00	−.02
Particularity	.50***	.11	1.36
Mental Representation	.47***	.12	1.56

Note. CAQ-T = Components of Attachment Questionnaire pertaining to the therapist (Parish, 2000); WAI = Working Alliance Inventory (Horvath & Greenberg, 1989).
*$p < .05$. ***$p < .001$.

Table 4
Components of Attachment to Therapist (CAQ-T) in Different Sex Dyads

Attachment component	FT, MP (n = 12)	FT, FP (n = 54)	MT, MP (n = 14)	MT, FP (n = 24)	F
Overall Attachment	3.38_{a}	3.61_{a}	3.53	3.93_{b}	3.70*
Proximity Seeking	3.55	3.62	3.76	3.83	0.78
Separation Protest	2.38_{a}	2.72_{a}	2.67	3.23_{b}	3.35*
Secure Base	3.50	3.96	3.84	4.11	1.99
Safe Haven	3.58_{a}	4.05_{b}	3.91	4.21_{b}	3.19*
Wiser/Stronger	3.75	3.74	3.64	3.90	0.40
Availability	4.33	4.35_{a}	3.93_{b}	4.38	2.56
Strong Feelings	2.81_{a}	2.95_{a}	3.04_{a}	4.13_{b}	10.76***
Fury	2.58_{a}	3.28_{c}	$3.93_{b,d}$	4.38_{b}	
Sexual attraction	$2.75_{a,c}$	$1.54_{a,d}$	1.93_{a}	6.67_{b}	
Particularity	3.60	3.73	3.83	3.95	0.68
Mental Representation	3.25_{a}	3.44_{a}	3.21_{a}	4.03_{b}	3.52*

Note. For each row, means with different subscripts are different from one another at the .05 level of significance using Neuman–Keuls post hoc tests. CAQ-T = Components of Attachment Questionnaire pertaining to the therapist (Parish, 2000); FT = female therapist; MP = male patient; FP = female patient; MT = male therapist.
*$p < .05$. ***$p < .001$.

with Separation Protest, Safe Haven, and Mental Representation. These four groups showed no differences in levels of attachment to the attachment figure.

Because the Strong Feelings component yielded such a striking gender difference, this component was examined more closely. The CAQ subscale consists of items representing strong feelings in general (e.g., "I have especially strong feelings about my therapist") as well as particular strong feelings (e.g., "At times I have felt furious at my therapist"). The feelings accounting for the strength of this difference were fury and sexual attraction. Patients in therapy with male therapists were much more likely to report fury. Patients in treatment with someone of the other gender were more likely to report sexual attraction to their therapists, and this was particularly true in the female patient–male therapist dyads.

The Patient's Attachment Style

To investigate the relationship between attachment style and components of attachment, correlations were calculated between the RQ and the CAQ-T and the RQ and the CAQ-AF (see Table 5). Dismissing attachment was negatively correlated with overall attachment to the therapist and with many components of attachment to the therapist, while secure attachment was positively correlated with the overall attachment to the therapist and with many components.

Attachment style was unrelated to the other variables in the study with two exceptions. Increased duration of therapy was positively correlated with secure attachment, $r = .31$, $p < .01$, and negatively correlated with both fearful, $r = -.40$, $p < .001$, and dismissing, $r = -.29$, $p < .01$, attachment. In addition, the working alliance was positively correlated with secure attachment, $r = .25$, $p < .05$, and negatively correlated with fearful, $r = -.20$, $p < .05$, and dismissing, $r = -.22$, $p < .05$, attachment.

Table 5
Correlations of Attachment Styles (RQ) and Attachment Components

Attachment component	Secure	Fearful	Preoccupied	Dismissing
		Therapist (CAQ-T)		
Overall Attachment	.24*	−.11	.08	−.31***
Proximity Seeking	.17*	−.02	−.03	−.20*
Separation Protest	−.03	.03	.06	−.16
Secure Base	.22*	−.13	−.02	−.25**
Safe Haven	.38***	−.29**	−.02	−.32***
Wiser/Stronger	.18	−.14	.09	−.17
Availability	.25**	−.15	.10	−.18
Strong Feelings	.16	−.12	.05	−.33***
Particularity	.15	−.03	.15	−.31***
Mental Representation	.17	−.06	.10	−.18
		Primary Attachment Figure (CAQ-AF)		
Overall Attachment	−.00	−.11	−.01	−.25**
Proximity Seeking	−.05	−.08	.09	−.20*
Separation Protest	−.03	−.01	−.01	.00
Secure Base	−.07	−.05	.04	−.34***
Safe Haven	.02	−.14	.03	−.20*
Wiser/Stronger	.01	−.13	.05	−.21*
Availability	.09	−.15	−.00	−.18
Strong Feelings	.07	−.04	−.19	−.14
Particularity	−.07	−.01	−.05	−.26**
Mental Representation	.06	−.11	.07	−.08

Note. RQ = Relationship Questionnaire (Bartholomew & Horowitz, 1991); CAQ-T = Components of Attachment Questionnaire pertaining to the therapist (Parish, 2000); CAQ-AF = Components of Attachment Questionnaire pertaining to the primary attachment figure.
*$p < .05$. **$p < .01$. ***$p < .001$.

Discussion

The relationship that forms in long-term psychoanalytic psychotherapy clearly has many qualities of an attachment relationship. The people in this study looked up to their therapists and found them emotionally responsive. They sought proximity to their therapists, turned to them in times of distress, evoked a mental representation of them in their absence, and relied on them as a secure base, helping them to feel confident in their work and exploration outside of therapy. They regarded their therapists as unique and irreplaceable, and experienced particularly strong feelings about them. Thus, these therapy relationships had every feature of attachment identified in the theoretical literature with the sole exception that the respondents did not generally report protesting separation from the therapists. In addition, the features characterizing the therapy relationships were in many respects the same features that characterized the respondents' relationships with their primary attachment figures. It is notable that Separation Protest was the component that was stressed least for the primary attachment figures as well as for the therapists. Adults' greater reliance on an internal sense of the presence and availability of the attachment figure may incline them to protest actual physical separation less strongly than do children.

Nearly all the people in this study had developed some level of attachment to their therapists, and certain circumstances of the treatment, most notably the frequency of sessions and the duration of the therapy, were associated with stronger attachment. Only longitudinal research could reliably determine that time spent with the therapist caused the strength of attachment, rather than the other way around. However, these results do suggest that long-term psychodynamic psychotherapy might, by its nature, result in the attachment of almost any patient to the treating therapist, and that the more time the patient spends with the therapist, the more attached he or she is likely to become. This is consistent with Bowlby's (1969/1982) statement that time spent together is the factor most likely to foster an attachment relationship. Several components of attachment to the therapist were individually associated with duration and frequency; the strongest of these was experiencing strong feelings about the therapist. More contact fosters more intense emotional involvement.

In many respects, the bond patients form with their therapists resembles the bond adults form with anyone they feel close to. In general, the attachment to the primary attachment figure was similar to, but stronger than, the attachment to the therapist. There were two exceptions to this. Not surprisingly, respondents were more likely to look up to their therapists than to their primary attachment figures. Therapeutic relationships are asymmetrical in nature, with the therapist sought out explicitly for help because of his or her presumed expertise. Respondents were also more likely to feel their therapists were sensitively responsive to their emotional needs, perhaps because a therapeutic relationship, unlike other relationships, is designed to focus exclusively on the patient's needs. One might expect the therapist to be regarded more often as a safe haven, the person to turn to in times of distress, but this was not the case. In times of distress these adults were somewhat more likely to turn to their primary attachment figures, although therapists, too, were used for this function.

Most people in this study listed a spouse or other romantic partner as the person to whom they felt closest, and the romantic relationships manifested the strongest attachments. This was true across components but was strongest in the case of Separation Protest, Strong Feelings, and Mental Representation. Attachments to close friends and relatives, and to therapists, were similarly less intense than the romantic attachments.

Some aspects of the primary attachment relationship also varied with duration of therapy: longer duration was associated with the sense that the primary attachment figure was available and responsive and with using that person as a safe haven and a secure base. Longer duration of therapy was also strongly positively correlated with secure attachment style and negatively correlated with both fearful and dismissing attachment styles. These findings suggest that therapy may facilitate security of attachment and a patient's ability to rely on others, not just on the therapist. Long-term psychotherapy influences a person's way of relating to others, expressed, in part, in his or her attachment style. As the patient's confidence in the reliability of the therapist increases over time, his or her confidence in the reliability of others also increases. On the other hand, it is also likely that people who are more secure and better able to rely on others to begin with find the task of being a therapy patient easier, and they may remain in therapy longer as a result.

Consistent with this, security of attachment style was associated with longer duration of therapy and with a stronger attachment to the therapist (although not to the primary attachment figure), with particular emphasis on Availability, Safe Haven, and Secure Base. Turning to a responsive other in distress and using that person as a base from which to explore is arguably the foundation of a therapy relationship. In fact, the inclination to turn to the therapist in distress (Safe Haven) had a particularly strong and unique rela-

tionship with three of the attachment styles: secure attachment was associated with higher scores on Safe Haven (and a stronger working alliance), while both types of avoidant attachment, the fearful and the dismissing, were associated with lower scores on Safe Haven (and a weaker working alliance). People with more secure attachment styles evidently enter into a therapy relationship much more easily than do those who are insecurely attached. Different strategies might be needed to engage more insecure patients in therapy.

Dismissing attachment style was associated with weaker attachments to both the therapist and the primary attachment figure. It is not clear whether this is because the more dismissing people are inclined to report lower levels of attachment than are actually present, (i.e., to deny attachments that do exist), or whether they actually place less importance on close relationships and do not feel as close to other people. This association was stronger in relation to the therapist: people who endorsed a dismissing style were especially dismissing in the therapy relationship.

We found an unexpected difference in levels of attachment to the therapist depending on the gender of the patient and therapist. Female patients in therapy with male therapists had higher levels of overall attachment to the therapist, and in particular, higher levels of Safe Haven, Separation Protest, and Mental Representation, and substantially higher levels of Strong Feelings. The latter three components are also those more intensely present in the romantic attachments. Assuming a predominantly heterosexual population, a cross-gender therapeutic match might more closely resemble a romantic relationship and tend to evoke feelings often found in romantic relationships. This is an observation, after all, that Freud (1915/1963c) originally made in his discussion of transference love. But the same was not true of the male patients paired with female therapists; these dyads, in fact, had the lowest levels of attachment of the four. (They did, however, endorse sexual feelings more frequently than did patients in same-gender dyads.) One possible explanation is that, despite recent changes in the nature of relationships between men and women, it is still more common in romantic partnerships for the man to be in a position of greater status relative to the woman (Steil, 1997). A therapeutic relationship in which the greater status partner (the therapist) is male and the lesser status partner (the patient) is female might more readily be experienced as a romantic attachment. This could lead to heightened Separation Protest and Strong Feelings, and particularly strong sexual and aggressive feelings, which were those most frequently endorsed by the female patients. This is consistent with the findings of other studies that erotized transferences are more common in male therapist–female patient dyads (Gabbard & Lester, 1995).

We found a very close connection between the working alliance and attachment to the therapist. In particular, the Secure Base and Availability components were closely linked to a strong working alliance. On the other hand, Strong Feelings was only weakly related, and Separation Protest was not related, to the working alliance. These latter two components are relatively pronounced, in contrast, in romantic attachments, providing evidence that the components of attachment that are prominent in romantic attachments differ from those that facilitate a working alliance. The working alliance may not be enhanced by attachments that resemble the romantic, another way of saying that a sexualized transference can function as an impediment to the work.

Early discussions of the working alliance distinguished it sharply from the transference, and this distinction has been preserved in some discussions of the relevance of attachment to the therapy relationship. Mackie (1981), for example, equated attachment with the alliance as distinct from the transference, because attachment and the alliance share an emphasis on the "real" aspects of the relationship. Other authors (e.g., Slade,

1999), however, have linked the idea of transference, as a distorted view of present relationships based on past experiences, to the internal working models that form the cognitive and emotional foundation of attachment styles. The distinction between transference and the alliance is itself difficult to maintain; as Gill (1982) noted, "the idea of an attitude determined solely either by the past or by the present is an abstraction" (p. 85). We are not suggesting here that attachment to the therapist is either identical to, or entirely distinct from, either the working alliance or the transference, but rather that it bears a close relation to certain aspects of both.

One advantage of thinking about therapy in terms of attachment is that attachment theory emphasizes the emotional intensity and importance of the relationship, which may contribute to the efficacy of therapeutic treatment. For example, Amini et al. (1996) propose that psychotherapy works precisely because it is "an attachment relationship capable of regulating neurophysiology and altering underlying neural structure" (p. 232). Their model resembles other recent models of therapeutic change, which have in common the observation that therapy alters implicit or procedural memories of attachment, the nonverbal knowledge of how to have a close relationship (Fonagy, 1999; Lyons-Ruth, 1999; Stern et al., 1998). Problems that began in very early relational experiences are addressed in a new, therapeutic relationship that, in some respects, replicates the central emotional bonds of childhood, and that is experienced as vitally important to the patient. In the language of attachment theory, the "internal working models" of attachment change through their activation and transformation in the therapy relationship. This can happen with or without accompanying insight on the part of the patient. Such changes in turn contribute to changes not only in a person's way of relating to others, but also in psychological functions that develop in the context of attachment relationships, for example, the regulation of affect and the capacity to reflect on the mental states of oneself and others.

Recognizing therapy relationships as attachments will also influence how we view termination, again because attachment theory emphasizes the real emotional importance of the therapist to the patient. Even if the transference is resolved (old expectations of relationships revised) to a great extent at the time of termination, this is not necessarily accompanied by a dissolution of the emotional bond of the patient to the therapist. The therapist as an attachment figure is not likely ever to be relinquished entirely. Loss is therefore an inevitable part of termination, and attention to mourning in the process is essential.

While this is true of any termination, it is particularly so of those that are premature, such as occur upon the death of a therapist. Unexpected loss of a therapist is the loss of an attachment figure, which can have a profound impact on a patient. While separation may be less problematic to an adult because of the development of an internalized sense of the presence of the other person, loss of an attachment figure can be devastating. If therapists are attachment figures, they are not interchangeable; one cannot replace another any more than one parent, or one spouse, can replace another. Humans do form new emotional bonds, and similar transference paradigms may recur in new therapeutic relationships; however, to the extent that the therapy relationship is an attachment relationship, the therapist can never be replaced. Complicating this is the fact that the opportunities for socially recognized mourning of a lost therapist are limited. With a few exceptions (Barbanel et al., 1989; Rendely, 1999; Schwartz & Silver, 1990), there is a dearth of literature about death or serious illness in the therapist, attesting to a peculiar lack of theoretical attention paid to an issue which inevitably, and not so infrequently, arises in clinical practice.

A final implication of recognizing attachment processes occurring in psychotherapeutic relationships is that the therapy situation then becomes a laboratory in which to study adult attachment. Because a therapy relationship often has identifiable beginnings and endings, it might lend itself to longitudinal investigation more readily than informal adult attachments. Thus understanding attachment can help us to understand and refine therapeutic technique, while therapy can also provide a unique perspective on a certain sort of attachment in adults.

A limitation of this study is that the respondents were highly educated people, and many were in the mental health field, which might alter the relationship with the therapist. For example, such patients might be more likely to identify with the therapist, or to look to the therapist as a professional role model. This study also has the limitations of any self-report study: respondents may not be fully conscious of their own attachment behavioral styles and attitudes, or of the importance of the therapist and the primary attachment figure to them.

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