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Quality of Object Relations and Security of Attachment as Predictors of Early Therapeutic Alliance

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Security of attachment and quality of object relations were measured as predictors of initial impressions of the therapeutic alliance as well as dropout. Fifty-five individual psychotherapy clients were administered the Revised Adult Attachment Scale and the Bell Object Relations and Reality Testing Inventory prior to their initial therapy session. Thirty of these participants completed the Working Alliance Inventory following their 1st, 2nd, and 3rd sessions. Security of attachment and quality of object relations were strongly related. Security of attachment and quality of object relations showed relations to early alliance that decreased over time. Attachment and object relations were not related to dropout. Limitations include small sample size and low research compliance rate.

Keywords: attachment, object relations, alliance, psychotherapy, client characteristics

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Numerous studies have found a moderate relationship between the therapeutic alliance and the outcome of psychotherapy, regardless of therapeutic orientation, presenting problem, or problem severity (Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Although this consistent finding has been frequently cited as the highest of any process-to-outcome relationship (Norcross, 2002; Wampold, 2001), relatively little is known about pretreatment individual differences of the clients and therapists who participate in creating the alliance. In this study, we tested two client pretreatment interpersonal relationship trait variables (attachment style, quality of object relations) as predictors of early therapeutic alliance formation.

Object relations theory posits that early relationships are internalized or introjected, and these introjected relationships influence how the individual will experience subsequent similar relationships. Similarly, attachment theory posits that the infant learns what responses are likely to be obtained from the enactment of attachment behaviors, such as crying, and these expectations are generalized and become attachment patterns. In both theories, lifelong relational patterns are created in infancy and are apparent in how the individual engages and functions in close relationships, including the client–therapist alliance.

Security of Attachment

Prior research generally supports a link between attachment patterns and the alliance. For example, Satterfield and Lyddon (1995) administered the Adult Attachment Scale (AAS; Collins & Read, 1990) at intake and the Working Alliance Inventory (WAI; Horvath, 1981) at Session 3 to a sample of 60 first-time clients at a university-based counseling center in an effort to predict the quality of the alliance from underlying dimensions of adult attachment. Client-rated alliance was predicted by only one of the client AAS attachment dimensions, the Depend subscale. In other words, clients who felt able to depend on their therapists tended to form stronger alliances. Neither of the two remaining AAS attachment dimensions was significantly related to the alliance.

Kivlighan, Patton, and Foote (1998) investigated attachment and alliance in 40 counselor–client dyads at two university-based counseling centers. The AAS was administered to clients at intake, and the WAI was administered to clients after the third session. Correlations were calculated between the AAS subscales and the WAI total score, as was a hierarchical regression analysis predicting alliance from the AAS subscales and other measures. AAS Close and Depend subscale scores were positively correlated with the total WAI, whereas AAS Anxiety subscale scores were not related to the alliance. The AAS accounted for 33% of the variance in alliance, with the largest effect for the Close subscale. In both of these studies (Kivlighan et al., 1998; Satterfield & Lyddon, 1995), client attachment as measured by the AAS was associated with the alliance as measured by client-rated WAI.

Quality of Object Relations

Research has also found a link between clients' quality of object relations (QOR) and early alliance. Piper et al. (1991) measured QOR, interpersonal functioning, and therapeutic alliance in 64 outpatients in brief dynamic psychotherapy. Independent clinicians rated QOR in a 2-hr, unstructured interview prior to therapy, using the QOR Scale (Azim, Piper, Segal, Nixon, & Duncan, 1991). Raters using this system attend to patient data, such as behavioral manifestations, regulation of affect, regulation of self-esteem, and historical antecedents, to evaluate the patient's overall quality of object relations (i.e., strengths vs. deficits in object relational functioning). The therapeutic alliance was measured after every

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session with four 7-point Likert-type items (immediate impression rating), as well as with two additional, more general 7-point items after Sessions 7, 14, and 20 (reflective impression rating) by both therapists and clients. Significant correlations were found between QOR and patient immediate and reflective ratings of the alliance and between QOR and therapist reflective ratings of the alliance.

Mallinckrodt, Grantt, and Coble (1995) administered the Bell Object Relations and Reality Testing Inventory (BORRTI; Bell, 1991), as well as the AAS and the WAI, to 138 clients in individual therapy in four different treatment settings. The authors did not report correlations between these measures; however, in a recent reanalysis (Mallinckrodt, Porter, & Kivlighan, 2005), data from 44 of the participants were reexamined with closer attention to object relations deficits as predictors of the alliance and attachment to the therapist. The BORRTI Insecure Attachment and Social Incompetence subscales were negatively related to aspects of the alliance. Thus, it appears that some deficits in object relations (poorer QOR) may predict poorer alliances.

Although these researchers (Mallinckrodt et al., 1995) also administered the AAS, they did not investigate the relationship between the AAS and the WAI (Mallinckrodt et al., 1995, 2005). Thus, it is impossible to conclude from their data whether attachment or object relations was more strongly related to the alliance. Given the similarity of these two relational constructs (Greenberg & Mitchell, 1983), it is important to understand their comparative utility as predictors of the alliance. Satterfield and Lyddon (1995) and Kivlighan et al. (1998) have convincingly shown that adult attachment, as measured using the AAS, can be a valuable predictor of the alliance. Piper et al. (1991) and Mallinckrodt et al. (1995, 2005) have shown that QOR can similarly serve as a useful predictor of the alliance.

Another weakness of the studies by Mallinckrodt et al. (1995, 2005) is that their data from the WAI were inconsistent with regard to the session being rated: As long as participants had completed five sessions, their alliance ratings could be from any subsequent session (Mallinckrodt et al., 1995). This obscures the fluctuations in alliance that are typical across the course of treatment, especially in the middle phase of therapy (Horvath & Symonds, 1991). It might be more informative to focus on the earliest stages of the alliance, so as to better understand its formation at the outset of therapy.

The Present Study

The present study was undertaken as a partial replication and extension of studies by Mallinckrodt et al. (1995, 2005) but with particular focus on pretreatment security of attachment, QOR, and early alliance development. We furthermore sought to determine which of these two client individual difference variables was better able to predict the quality of the alliance at the earliest stages of therapy. Because both attachment and object relations theories emphasize lifelong relational patterns, we were interested in determining whether brief assessment of attachment patterns is more useful than brief assessment of QOR in predicting the establishment of an initial therapeutic alliance at the earliest points of contact with a new therapist or vice versa. If therapists can be made aware of potential issues in alliance formation, then perhaps they can be attentive to such issues. We make few distinctions between different components of the alliance (i.e., goals, tasks, bond) because we believe that at these earliest points of contact the alliance is still rather embryonic and undifferentiated for the client (cf. Bordin, 1980, as cited in Hatcher & Gillaspy, 2006).

One possible effect of problems in alliance formation may be premature dropout from therapy (Lingiardi, Filippucci, & Baiocco, 2005; Mohl, Martinez, Ticknor, Huang, & Cordell, 1991; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Indeed, premature dropout has long been known to be a significant problem in psychotherapy service delivery (Blackwell, Gutmann, & Gutmann, 1988; Pekarik, 1983). Identification of those at particular risk for premature termination could be helpful to therapists, who might then choose to give extra attention to alliance formation with these clients.

Given the theoretical parallels in attachment and object relations theories, in the present study we hypothesized a negative relation between security of attachment and deficits in QOR. It was also hypothesized that, on the basis of our above-mentioned arguments, both security of attachment and QOR would predict strength of the alliance at each of the first 3 sessions of treatment. Finally, we believe that when clients have had positive relational experiences in life, they are more likely to remain actively engaged in a therapeutic relationship despite any difficulties or disagreements. Therefore, it was hypothesized that those with greater security of attachment and fewer deficits in object relations would be less likely to drop out of treatment prematurely than would be those with less attachment security and greater object relations deficits.

Method

Participants

Clients. A total of 55 clients from two Midwestern university-based outpatient treatment centers agreed to participate in the present research. The main data collection site was a counseling center serving university students. During the data collection period, 50 clients at this site agreed to participate in the present study, with a participation rate of roughly 11% of all clients who began treatment at this site. The second data collection site was a training clinic housed within the Department of Psychology at the same university. During the data collection period, 5 clients from this second clinic chose to participate in the present study (14% participation rate).[1] Research participation was not required of clients at either center. This and other practical difficulties limited our efforts to obtain a high research compliance rate. Of the 55 clients who chose to participate, 25 failed to complete one or more of the three alliance assessments. Thus, all statistical analyses involving the WAI are based on a sample of 30 clients, whereas the analysis of dropout includes the full sample ($N = 55$).

The full sample of 55 clients in this study was predominantly female (89.1%), the mean age was 21.60 years ($SD = 6.36$ years), and it was predominantly White (85.5%). During the data

[1] Because this training clinic is staffed by student clinicians, whereas the counseling center employs both student clinicians as well as independently licensed clinicians, there was a concern that this mixture of training levels may have introduced a source of error variance. Therefore, we conducted parallel analyses removing the therapists from the training clinic (as well as those from the counseling center who were known to be trainees). A similar pattern of correlations emerged, only with reduced significance reflecting the limited sample size.

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collection period, the overall proportions of female and White clients seeking services at the counseling center were somewhat lower (54.15% and 61.56%, respectively) than in the present sample (these were the only ways in which the present sample appreciably differed from the counseling center population). The majority (96.4%) of the present sample reported having had at least a high school diploma, and the majority had some college (72.7%). Less than half of the participants (38.2%) had been in some form of previous therapy, with an average length of 15.4 months (SD = 21.66 months) and occurring an average of 2.8 years before their intake (SD = 3.87 years). The portion of the sample who completed all three alliance assessments (n = 30) did not appreciably differ from the full sample with regard to demographic characteristics.

Therapists. A total of 18 therapists treated the clients in the present study. The number of client participants seen by each therapist in the present study was variable: 2 therapists saw 1 client each, 7 therapists saw 2 clients each, 5 therapists saw 3 clients each, 2 therapists saw 4 clients each, 1 therapist saw 5 clients, and 1 therapist saw 11 clients. Demographic information is available for 11 of these 18 therapists, who treated 60% of the total sample. Eight of them were women, and 3 were men. Eight were White, 1 was Latina, and 2 were Asian American. Three (27.3%) held a doctorate, 7 (63.6%) held a master's degree, and 1 (9.1%) was working toward a master's degree. In terms of clinical experience, 1 therapist (9.1%) had less than a year, 6 therapists (54.5%) had between 1 and 5 years, 1 therapist (9.1%) had between 10 and 20 years, and 3 therapists (27.3%) had more than 20 years of clinical experience. Most of the therapists (54.5%) identified their therapeutic orientation as eclectic, but 2 (18.2%) were predominantly cognitive–behavioral and 3 (27.3%) were of some therapeutic orientation other than cognitive–behavioral, psychodynamic, humanistic, behavioral, or eclectic.

Measures

WAI. The WAI (Horvath, 1981; Horvath & Greenberg, 1989) consists of 36 self-report items based on Bordin's (1979) tripartite conception of the alliance. Three versions exist, allowing for patient, therapist, and observer ratings. In the present study, only patient ratings were used because they have been found to be the most predictive of outcome (Martin et al., 2000). There are three subscales: Agreement on Goals, Agreement on Tasks, and Bond. Each subscale contains 12 items and is scored on a 7-point Likert scale. Subscale scores range from 12 to 84, and total scores range from 36 to 252.

Tichenor and Hill (1989) reported high internal consistency for the total WAI-Client Version (α = .96), and alpha coefficients for the three subscales range from .85 to .88 (Horvath & Greenberg, 1989). In the present study, the Cronbach's alpha coefficients for total scores were .92 at Session 1, .92 at Session 2, and .93 at Session 3. High convergent and discriminant validity have been found with the Agreement on Goals and Agreement on Tasks scales of the WAI, though the convergent validity of the Bond subscale is often more tenuous (Greenberg & Pinsof, 1986; Horvath & Greenberg, 1989). The Agreement on Tasks and Agreement on Goals subscales of the WAI tend to be highly correlated, and confirmatory factor analysis yields a two-factor solution, with Agreement on Tasks–Agreement on Goals on one factor and Bond on another (Hatcher & Gillaspy, 2006). In the present study, pooled Agreement on Tasks and Agreement on Goals ratings from all three sessions were correlated (r = .94), and Agreement on Tasks–Agreement on Goals correlations at each session ranged between .80 and .90. Client ratings on the WAI have shown high predictive validity, correlating with multiple measures of outcome (Martin et al., 2000).

BORRTI. The BORRTI (Bell, 1991, 1995) is a 90-item, true–false, self-report questionnaire designed to assess QOR and ego functioning, though only the 45 object relations items were used in the present study. QOR is determined via four subscales that assess object relations deficits: Alienation, Insecure Attachment, Egocentricity, and Social Incompetence. Alienation refers to a basic lack of trust in relationships, inability to attain closeness, and hopelessness about achieving intimacy with others. Insecure Attachment refers to painful interpersonal relations, sensitivity to rejection, and overemphasis on acceptance by others. Egocentricity is composed of mistrust of others, regarding others only in relation to the self, and manipulation of others. Social Incompetence, as the name suggests, refers to shyness, uncertainty about interpersonal relations, and inability to form relationships. The four subscales can be summed to create a composite QOR score.

Lower scores on the BORRTI represent healthier responses, whereas higher scores are more pathological. The BORRTI has displayed adequate test–retest reliability as well as freedom from response bias due to age, sex, or social desirability (Bell, 1995). Cronbach's alphas range from .79 to .90 for object relations subscales, whereas Spearman split-half reliabilities range from .78 to .90 (Bell, 1995). In the present study, the Kuder–Richardson 20 coefficient (analogous to Cronbach's alpha but specific to true–false data) was .77. Subscale correlations tend to range between .21 and .50 (in the present study, subscale correlations ranged between .25 and .76). The BORRTI has discriminated between several criterion groups, including borderline pathology and other Axis II disorders; those with schizophrenia, affective disorders, and other Axis I pathology; and students and community samples (Bell, 1995). Engelman (1985) found correlations of BORRTI object relations subscale scores with other measures of therapeutic outcome. There are two possible methods for scoring the BORRTI: a computerized factor scoring procedure and a unit-weighting scoring method. These scoring methods have been shown to yield analogous results (rs range from .94 to .98; Bell, 1991). In the present study, we used the unit-weighting method.

AAS. The AAS (Collins & Read, 1990) consists of 18 items, derived from Hazan and Shaver's (1987) adult attachment descriptions, scored by the participant on a 5-point Likert scale ranging from 1 (*not at all characteristic of me*) to 5 (*very characteristic of me*). AAS scale development involved factor analytic work that produced three subscales: Depend, Close, and Anxiety. Depend refers to the extent one trusts and relies on others. Close refers to comfort with intimacy and emotional closeness. Anxiety refers to fears of rejection and abandonment.

Collins and Read (1990) found a test–retest reliability (2-month interval) using the original version of the AAS of .68 for Close, .71 for Depend, and .52 for Anxiety. Sperling, Foelsch, and Grace (1996) reported convergent validity of the AAS with other measures of attachment. In the present study, we used a revised version of the AAS (Collins, 1996), which correlates strongly with the original version (r = .98). Collins (1996) reported a fairly strong

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correlation (r = .53) between the Close and Depend subscales of the revised AAS (in the present study, this correlation was r = .52) and moderate negative correlations between the Anxiety and Close (r = –.34 and r = –.27 in the present study) and Depend (r = –.46 and r = –.33 in the present study) subscales. Collins (1996) reported Cronbach's alphas for the Close, Depend, and Anxiety subscales of .77, .78, and .85, respectively. In the present sample (n = 30), Cronbach's alphas for Close, Depend, and Anxiety were .81, .74, and .83, respectively. The revised AAS has shown an absence of sex differences in attachment dimensions (Collins, 1996). It is important to note that the AAS subscales are not considered categorical attachment styles but rather dimensions that are believed to underlie adult attachment.

Sperling et al. (1996) noted that a single continuous, bipolar measure of attachment security–insecurity would not only be consistent with Bowlby's (1973) theories but would also be particularly helpful in research efforts such as the present one. Allen, Huntoon, and Evans (1999) derived such a continuous measure of attachment security from the AAS by summing the Close and Depend subscales and subtracting the Anxiety subscale. Following Allen et al. (1999), in the present study we calculated a single bipolar dimension, which we call security of attachment, by summing the Close and Depend subscales and subtracting the Anxiety subscale. The resultant security of attachment dimension was correlated with the Close (r = .78), Depend (r = .79), and Anxiety (r = −.72) subscales in the present study. In an unpublished study in which 210 undergraduate students completed the AAS, we found a mean security of attachment score of 4.22 (SD = 2.30).

Dropout. Dropout and attrition are different in the present study. *Attrition* was defined as those who volunteered to participate but did not complete all of the requirements of the study (25 clients met this definition). This was differentiated from treatment *dropout*, which was defined in the present study as failure to attend a session, followed by failure to schedule any further sessions, regardless of whether the client completed all of the requirements of the study (24 clients met this definition). Thus, dropout status was not related to the completeness of the data that clients provided.

Out of the total sample (N = 55), 24 clients (43.6%) dropped out of treatment prematurely. Of the remaining clients (who are considered completers), 4 clients (7.3%) changed therapists, 23 clients (41.8%) had planned terminations, 2 clients (3.6%) remained in therapy at the study's completion, and 2 clients (3.6%) were given the designation of "other" with regard to dropout status because of lack of information. The mean length of treatment in the present study was 5.35 sessions (SD = 5.15).

Procedures

This study used a naturalistic design in which data were collected as part of treatment as usual. An invitation to participate in the present study was placed within the standard intake paperwork for new clients at each site, and it was attached to a sealed packet of initial measures, including the AAS and the BORRTI. Also included in the packet were consent forms, a demographic information form, and a copy of the WAI (which they were instructed to retain and complete after their first session). Participants returned all materials except the WAI to the receptionist with their intake paperwork (in the university counseling center, it is common for clients to complete their intake paperwork on a walk-in basis and then return at a different time for their initial session). The first WAI was returned to the receptionist after completion of the initial session. Session 2 and 3 WAI forms were placed in clients' therapy charts, and therapists were asked to hand these to the client after their second and third sessions to be completed immediately after the sessions in the waiting room and returned to the receptionist. Clients were reimbursed for their time with $5 after their first session and an additional $5 after their third session.

Results

Because the number of client participants seen by each therapist varies, it is reasonable to assume that the assumption of independence of data may be violated within the present study. Therefore, on the basis of recommendations by Kenny and Judd (1996), a W matrix was constructed to locate the pairs of observations that are linked (i.e., pairs of clients who were treated by the same therapist). We then separately calculated the average squared differences between pairs of WAI scores (averaged across the three sessions) that were specified as linked and unlinked in the W matrix. From these squared differences, the estimated variance of unlinked observations (σ^2) and estimated correlation between linked observations (ρ) were estimated. If nonindependence exists within the data, then we would expect the estimate of ρ, termed r_d, to differ from zero significantly. Using the random simulation method specified by Kenny and Judd to test the null hypothesis that r_d = 0, we found a nonsignificant negative correlation between linked observations (r_d = –.28, p = ns). In other words, pairs of same therapist dyads did not reliably produce similar WAI scores but, if anything, tended to produce dissimilar WAI scores. On the basis of these results, we feel it can be reasonably concluded that the assumption of independence is minimally violated in the present data.

Security of Attachment, QOR, and the Early Alliance

Means and standard deviations for the AAS, BORRTI, and WAI are included in Table 1. Ratings on the AAS clustered around the midpoint of the scale, whereas ratings on the BORRTI yielded T scores roughly half of a standard deviation above (more pathological than) normative nonpatient means (Bell, 1995). WAI ratings indicate that, in general, participants scored mean total scores in the "often" to "very often" range. A one-way repeated measures analysis of variance of total WAI across the three sessions indicated that, on average, total alliance significantly increased across the three sessions (Wilks's λ = .62), $F(2, 28) = 10.02$, $p < .001$, multivariate partial η^2 = .38.

To test our first hypothesis that security of attachment and deficits in QOR would be inversely related, we computed a bivariate correlation between AAS security of attachment (Close + Depend – Anxiety) and total deficits in QOR (sum of BORRTI subscales). This correlation was statistically significant (r = –.58, $p < .001$). To further elucidate this effect, correlations between AAS security of attachment and each BORRTI subscale are presented in the top row of Table 1. As the table shows, security of attachment was strongly and significantly related to three out of four areas of object relations deficits (Alienation, Insecure Attachment, and Egocentricity).

Table 1
Descriptive Statistics and Correlations Between Measures

Measure	AAS security (M = 3.35, SD = 1.93)	BORRTI ALN (M = 57.40, SD = 10.17)	BORRTI IA (M = 56.47, SD = 10.91)	BORRTI EC (M = 54.77, SD = 9.22)	BORRTI SI (M = 52.27, SD = 9.20)
AAS security	—	−.71**	−.53**	−.55**	−.15
Session 1 WAI (M = 213.14, SD = 23.94)	.39*	−.37*	−.28	−.13	−.03
Session 2 WAI (M = 221.17, SD = 20.55)	.30	−.27	−.16	−.02	−.03
Session 3 WAI (M = 222.47, SD = 22.23)	.16	−.16	−.11	−.03	−.09

Note: n = 30. AAS = Revised Adult Attachment Scale; BORRTI = Bell Object Relations and Reality Testing Inventory; ALN = Alienation; IA = Insecure Attachment; EC = Egocentricity; SI = Social Introversion; WAI = Working Alliance Inventory.
* $p < .05$. ** $p < .01$.

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Table 1 also presents exploratory correlations between the pretreatment predictors (AAS, BORRTI) and total WAI at Sessions 1, 2, and 3. As the table shows, security of attachment and aspects of QOR exhibited decreasing relationships with alliance over time.

To test the present study's second hypothesis (that security of attachment and QOR would predict strength of alliance at each of the three sessions) and to examine which of these variables provided more useful information in predicting the alliance, we conducted three hierarchical multiple regression analyses with total WAI scores at Sessions 1, 2, and 3 as the criterion variables, respectively. In the first versions of these analyses, for Step 1, AAS security of attachment (Close + Depend – Anxiety) was entered, followed by total deficits in QOR (sum of BORRTI subscales) in Step 2. Then, each regression analysis was repeated with the order of the steps reversed.

For the first hierarchical regression analysis (predicting alliance at Session 1), in the first version AAS security of attachment was entered first and accounted for a significant amount of variance in alliance (R^2 = .15, $p < .05$). QOR was entered second and did not produce a significant increment in R^2 (ΔR^2 = .00, p = *ns*). In the second version of this analysis, QOR was entered first and did not account for a significant amount of variance in alliance (R^2 = .06, p = *ns*). AAS security of attachment was entered second and did not produce a significant increment in R^2 (ΔR^2 = .09, p = *ns*).

For the second hierarchical regression analysis (predicting alliance at Session 2), in the first version AAS security of attachment was entered first and did not account for a significant amount of variance in alliance (R^2 = .09, p = *ns*). QOR was entered second and did not produce a significant increment in R^2 (ΔR^2 = .00, p = *ns*). In the second version, QOR did not account for a significant amount of variance in alliance (R^2 = .02, p = *ns*), and AAS security of attachment did not produce a significant increment in R^2 (ΔR^2 = .07, p = *ns*).

For the third hierarchical regression analysis (predicting alliance at Session 3), in the first version AAS security of attachment was entered first and did not account for a significant amount of variance in alliance (R^2 = .03, p = *ns*). QOR was entered second and did not produce a significant increment in R^2 (ΔR^2 = .00, p = *ns*). In the second version, QOR did not account for a significant amount of variance in alliance (R^2 = .01, p = *ns*), and AAS security of attachment did not produce a significant increment in R^2 (ΔR^2 = .02, p = *ns*).

Dropout

A binary logistic regression was used to determine whether those with less secure attachment and greater deficits in object relations were more likely to drop out of treatment prematurely. The entire sample of 55 participants who completed the revised AAS and BORRTI were included in this analysis. For this analysis, security of attachment was inverted by subtracting from a constant, so that higher scores represented less secure attachment. Dropout was calculated as a binary variable (dropout or completer). The results of this analysis indicated a poor fit for the overall model predicting dropout, $\chi^2(2, N = 55) = 2.53$, p = *ns*. Dropout status could not be reliably predicted from insecurity of attachment (odds ratio = .80, confidence interval = 0.56–1.15) nor from deficits in QOR (odds ratio = 1.02, confidence interval = 0.99–1.04). We also computed standardized mean differences comparing completers with dropouts on each of our predictor variables, along with effect sizes. For security of attachment, Cohen's d = –.086, $r_{Y\lambda}$ = –.043. For QOR, Cohen's d = –.271, $r_{Y\lambda}$ = –.134.

Discussion

Attachment, Object Relations, and Early Alliance

Our first hypothesis was that security of attachment would be correlated with elements of object relational functioning. This hypothesis was supported: AAS security of attachment was inversely correlated with three out of four areas of deficits in object relations. It is informative to consider what the subscales of the AAS and BORRTI are designed to measure: Themes such as trust, reliance, intimacy, and fear of rejection are evident in both measures. When one considers the theoretical backgrounds of attachment and object relations, such themes are indeed predominant in both theories (cf. Greenberg & Mitchell, 1983; Steele & Steele, 1998). Self-report instruments designed to measure these two constructs appear to assess some of the same subjective experiences.

The second hypothesis was that security of attachment and QOR would each predict strength of the alliance at each of the first 3 sessions. This hypothesis was only partially supported: Security of attachment accounted for significant variance in alliance at Session 1 but not when controlling for QOR (which did not display predictive ability on its own). Those who are comfortable with

intimacy and able to trust and rely on others without an overwhelming fear of rejection are apparently more able to form strong alliances in the first session of treatment, and this relationship decreases over time. Exploratory correlations also revealed negative relationships between some areas of deficits in object relations and alliance (*r*s of –.28 and –.37). One of these relationships reached statistical significance, and all of them decreased over time.

On the basis of the decrease in our obtained correlations over time, it would appear that relational patterns learned early in life come to bear in the first meeting with a new therapist but perhaps decreasingly so thereafter. It may be that these patterns of relating resurface as issues in the therapeutic relationship later in treatment, but it is impossible to know whether this is the case on the basis of the results of the present study (which are limited to the first 3 meetings only). Nevertheless, these results and those of prior studies (Kivlighan et al., 1998; Satterfield & Lyddon, 1995) offer useful information to therapists, who may be able to predict and address problems in alliance formation during the initial point of contact on the basis of knowledge gained from a brief attachment assessment instrument, such as the AAS.

Dropout

Our third hypothesis was that security of attachment and QOR would be related to dropout from treatment. No support was found for this hypothesis. Horowitz, Rosenberg, and Bartholomew (1993) suggested that attachment style may be an important predictor of how different clients will respond to treatment. However, research regarding the relationship between attachment style and dropout is simply absent from the literature. QOR has been found in prior research to be related to treatment retention (Piper & Duncan, 1999). However, the present study measured QOR with the BORRTI rather than with the interview measure that is used in Piper's research laboratory (Piper & Duncan, 1999). Also, dropout may have occurred for a number of reasons other than dissatisfaction with treatment or the therapist.

Wierzbicki and Pekarik (1993) noted that the "treatment-by-failure" method of dropout classification, which was used in the present study, may be overly conservative. This is partially because it classifies participants as treatment completers regardless of the number of sessions attended. Whereas Wierzbicki and Pekarik found an average outpatient psychotherapy dropout rate of 46.86% across 125 studies, we found a dropout rate in the present study of only 33.3%. Future research using more advanced methods of dropout measurement is needed to clarify the effect (if any) of attachment patterns and disturbed object relations on dropout.

Limitations

Arguably the most serious limitations of the present study stem from the relatively low client recruitment rates and high attrition rate. This resulted in a small, possibly nonrepresentative sample, and therefore the findings from the present study should be interpreted with caution. The fact that clients were self-selected volunteers may confound the findings because of a self-selection bias. It is unclear whether some client individual difference variable, perhaps even one of those measured in the present study, may have influenced the choice of whether to participate and/or to participate fully. Although clients rated their own level of distress prior to treatment, there is relatively little information regarding level or nature of client disturbance in this study. Therefore, it is unknown whether the findings of the present study reflect something about the nature of disturbance within the sample.

Moreover, those who chose to participate were largely Caucasian women and the population from which they were selected consists mostly of college students. As such, results of the present study may have limited application to numerous underrepresented groups (e.g., minorities, men). Findings from the present study should be considered exploratory until replicated within a more heterogeneous sample.

Conclusion

Therapists who are able to anticipate problems in the therapeutic alliance, through knowledge of relational, deficits such as insecure attachment, may stand a better chance of resolving them in a way that avoids reinforcement of the client's negative expectancies (Eames & Roth, 2000). The present study suggests that these kinds of relational issues bear on the alliance, particularly at the first point of contact. It is important, then, for therapists to understand clients' attachment histories prior to the initial interview, as this is a crucial time in alliance formation.

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