



The Relationships Between Client Resistance and Attachment to Therapist in Psychotherapy

Vasiliki Yotsidi^{1,2} · Anastassios Stalikas¹ · Christos Pezirkianidis¹ · Maria Pouloudi¹

Published online: 21 September 2018
© Springer Science+Business Media, LLC, part of Springer Nature 2018

Abstract

Through the lens of contemporary views on client resistance and attachment theory, which underpins the role of security in psychotherapy, the present study examines the relation between client resistance and client attachment to therapist. Forty-six clients and 19 therapists in long-term psychotherapy completed the Client Attachment to Therapist Scale and a therapist-reported questionnaire for client resistance, respectively, in three different times including the therapist's summer holidays, so as to take into consideration the role of the therapist's temporary absence as a real relationship component. Results indicate that resistance is negatively associated with clients' secure attachment to their therapists, while it is positively associated with insecure attachment patterns. Also, holidays in psychotherapy were found to intervene in the interrelation between client's resistive behaviors and attachment security. These preliminary findings indicate the interpersonal and state-like character of client resistance, a conceptual shift that augments clinical work as clients and their resistances are seen in more benevolent terms.

Keywords Client resistance · Client attachment to therapist · Therapeutic relationship · Vacations · Security

It is well-established that client resistance is an integral part of therapeutic work, a clinically important variable that accompanies treatment step-by-step (Beutler et al. 2011). Yet, resistance was also discussed as if it was some disruptive, negative, anti-therapy behavior or attitude that relates negatively with several treatment process- and outcome-related variables. In particular, resistance has been associated with low working alliance levels (Callahan 2000; Watson and McMullen 2005), therapeutic setting violations (Choi-Kain and Gunderson 2009), low client perceptions of therapist's empathy (Hara et al. 2016), low early engagement (Yasky et al. 2016), homework noncompliance, in-session avoidance and debating with the therapist (Aviram and Westra 2011; Newman 2002), as well as an overall reduced engagement with the treatment process (Beutler

et al. 2011). Furthermore, lack of improvement, drop-outs and premature termination of therapy have been consistently associated with client resistance (Beutler et al. 2002; Button et al. 2015). While the unfavorable role of client resistance on treatment is clear, little is known about how resistance unfolds in the here-and-now of the therapeutic relationship, and especially in relation to the client attachment to the therapist.

Contemporary views of client resistance focus on its co-construction in the therapeutic interplay (e.g., Tuckett 2003; Van Denburg and Kiesler 2002) as well as on its protective and affirmative role, as a safeguard of psychological security (e.g., Frankel and Levitt 2006; Miller 2003; Mouque 2005). Respectively, rather than being a necessary evil or even an anathema for the clinicians, resistance can also be framed in terms of the ways the client protects himself against a perceived threat that sometimes can even be, at least in part, real. Along these lines, when dealing with resistance clinicians may also take into account its latent "threatening affirmation", as Schafer (1973) called it. That is, either resting on client's attempt to avoid painful affects, such as sadness, guilt, anger and shame (Greenson 1967), or driven by the so-called "safety principle" (Sandler et al. 1970), resistance may also defend client's psychological security and

✉ Vasiliki Yotsidi
vickyotsidi@netscape.net

¹ Department of Psychology, Panteion University of Social and Political Sciences, Athens, Greece

² 2nd Psychiatric Clinic of the Medical School, National and Kapodistrian University of Athens, University General Hospital "Attikon", 1 Rimini str., Chaidari, 124 62 Athens, Greece

regulate feelings of loss and grief that arise in therapy. Thus, the extent in which security is cultivated in the therapeutic relationship is critical in either exacerbating or diminishing client resistance (Horner 2005).

In support of the inter-connectedness of resistance and security in the therapist-client bond, studies have demonstrated that a supportive therapeutic approach tends to elicit less resistance than directive styles (e.g., Miller and Rollnick 2012; Moyers and Martin 2006). Furthermore, Levitt and Williams (2010) demonstrated that security in the therapeutic relationship is identified by clients as a key mediator for therapeutic change. Similarly, Westra et al. (2012) showed that the greater the therapists' early positive reactions to their clients, especially liking, enjoyment, and attachment, the lower the levels of client resistance in mid-treatment and the greater the reductions in client resistance from early to mid-treatment. On the contrary, when the therapists in the same study reported feelings of helplessness, guilt and frustration and early power struggles with their clients, the levels of client resistance were higher. Even though resistance may be primarily born intrapsychically, interpersonal factors associated to security, like the attachment style, seem to play a significant role on the therapeutic interchange. However, there is a paucity of research on how client resistance may be associated with attachment issues. For this reason, studying resistance from a client-therapist attachment perspective has been outlined as a research priority (Eagle 2006; Parish and Eagle 2003).

Through the lens of attachment theory, the therapists constitute important attachment figures for their clients and they function as a "secure base" for psychic change (Bowlby 1988; Mallinckrodt 2010; Skourteli and Lennie 2011). Research demonstrates that, when clients are securely attached to their therapists, they display stronger working alliance (Diener and Monroe 2011; Taylor et al. 2015), and higher levels of self-disclosure (Saypol and Farber 2010), report more relief and perceived support (Janzen et al. 2008), and perceive therapists as emotionally responsive, accepting, and promoting exploration of threatening aspects of their emotional experience (Mallinckrodt and Jeong 2015; Mallinckrodt et al. 1995; Parish and Eagle 2003). On the other hand, an insecure attachment bond with the therapist, depending on the specific attachment style, can be associated with clients' mistrust, fear of rejection (Mallinckrodt et al. 1995), low levels of working alliance (Taylor et al. 2015) or unwillingness to self-exploration and self-disclosure (Saypol and Farber 2010). However, to our best knowledge no previous study has examined the relationship between client resistance and attachment with the therapist in terms of real aspects of the therapeutic relationship (Gullo et al. 2012), especially from the viewpoint of the therapist (Mallinckrodt and Jeong 2015). This existing gap in the literature is

even more profound, given that resistance in psychotherapy is not a static condition, but rather a dynamic process (Schlesinger 2003).

Recent research has stressed this conceptual and methodological shortcoming by shedding light on the importance of examining both client's and therapist's perspectives as well as the role of therapy-context variables (e.g., treatment orientation, treatment length) on how trait-like versus state-like components of the therapeutic relationship (i.e. working alliance and alliance ruptures) unfold over the course of treatment (Zilcha-Mano 2017). Following this line of argumentation, the present study explored the relations between client resistance and attachment at different stages of treatment by also taking into account state-like clinical variables, working alliance and transference. Transference, defined either as the most powerful resistance (Freud 1912) or as a co-constructed aspect of the patient-therapist encounter (Handley 1995), is also a part of Gelso's tripartite model of therapeutic relationship that includes transference-countertransference, working alliance and the real relationship (Gelso 2014).

A major challenge for the here and now therapeutic process is frequently the period around therapist's summer vacations. Various forms of resistance have been reported during the vacations period in treatment, such as lack of cooperation, acting outs, tardiness and cancellations of sessions (Goin 2002; Shengold 2006; Stein et al. 1996). All in all, it seems that therapist's absence for holidays, though temporary, interrupts treatment continuity and in a way threatens the status quo of treatment (Handley and Swenson 1989; Rhoads and Rhoads 1995). Even though the separation from the therapist challenges client's security and incites resistive behaviors, examining client's attitudes and behavior before and after therapist's vacation has received little empirical evidence, so far.

The present study sought to redress some of the gaps in the literature by investigating the relationship between client resistance and attachment to therapist, while also taking into examination therapist's temporary absence (i.e. summer holidays). Particularly, our research questions pertained to: (i) which is the relationship between client attachment to therapist and resistance at different time points of treatment, (ii) are there significant differences in client attachment and resistance levels among clients with different treatment orientation, setting and length?, (iii) do summer vacations play a significant role on predicting client resistance considering attachment to therapist and therapy-context variables?, and (iv) which are the specific forms of resistance prior and after the holidays, depending on the client attachment to the therapist?

Method

Participants

Participants completing the whole study period were 46 adult clients in ongoing psychotherapy and their 19 therapists, from a total initial sample of 52 clients and 21 therapists. Due to premature treatment termination, four clients in the second phase and two clients in the third phase dropped out from the study, thus excluding two therapists as well. All drop-outs were women and half of them were 31–35 years old, while most of them ($n=4$) were described as presenting personality disorder issues, along with primarily mood or anxiety disorders.

Clients were recruited indirectly through their therapists in the period between October and May, so as the forthcoming summer vacations to be the first in the course of treatment. An attempt was made to include clients across a variety of treatment settings and modalities through opportunity sampling of mental health facilities or private practices located in the same rural area. Therapists who agreed to participate were asked to randomly select clients over 18 years old by soliciting participation from the next eligible client who had been in therapy for 10–12 sessions, thus assuring that all participants had the same treatment length distribution at the start of the study. Clients with major psychopathology, or in an acute phase, were not included in the study.

Clients

The 46 clients (34 women and 12 men) ranged in age from 19 to 55 ($M=35.3$, $SD=8.7$). Most of them (41.3%) had primarily sought psychotherapy for life problems, 30.4% for mood disorders, while 19.6% and 13.6% for anxiety and phobic disorders, respectively. As the therapists indicated, 27 clients were in psychoanalytic/psychodynamic psychotherapy, while 19 clients received systemic, cognitive, or humanistic/person-centered therapy at either public mental health centers ($n=17$), a private community psychotherapy centre ($n=11$), or in private practice ($n=18$). Prior to summer vacations, the participants had been in treatment from 3 to 10 months ($M=4.54$ months, $SD=1.82$ months). Eleven clients joined the study between October and February and the majority ($n=35$) between March and May. Most of them held an undergraduate or postgraduate degree (60.9%), high school graduates were 32.6% and merely 6.5% had a primary education level. The majority of them (76.1%) were occupied in the public and the private sector, or as entrepreneurs, while 10.9% were students.

Therapists

The 19 therapists (13 women and 6 men) ranged in age from 30 to 55 ($M=39.6$, $SD=7.1$). The therapists included 15 psychologists, 3 psychiatrists and 1 social worker. The majority of them (73.7%) were each treating more than 11 clients in total at the time of the study, while the mean overall clinical experience was 11 years ranging from 2 to 20 years.

Measures

Client Attachment to Therapist (CATS, Mallinckrodt et al. 1995)

This self-report 36-item scale depicts the client perceptions of their relationship with the therapist, from the attachment theory perspective. It consists of three subscales corresponding to different attachment patterns: (a) Secure (14 items), (b) Avoidant/Fearful (12 items), and (c) Preoccupied/Merger (10 items). CATS is a 6-point Likert scale (1 = “strongly disagree”, 6 = “strongly agree”) and can be administered at any time in the therapeutic process. Means and standard deviations were $M=72.86$ ($SD=10.11$) for the Secure, $M=21.44$ ($SD=9.26$) for the Avoidant/Fearful, and $M=26.43$ ($SD=8.72$) for the Preoccupied/Merger original subscales, respectively. Internal consistency and test–retest reliability were found to be strong for all subscales in several studies (Mallinckrodt et al. 1995, 2005; Woodhouse et al. 2003; Yotsidi et al. 2018).

Therapist Questionnaire of Client Behaviors (TQCB, Siebel 1994; Siebel and Dowd 1999)

The Therapist Questionnaire of Client Behaviors is the only available and most comprehensive therapist-rated measure to evaluate client resistance, and cooperation, in a substantial number of sessions (i.e. 4–5 sessions). TQCB consists of 61 client-in-therapy behaviors, and it measures frequency of occurrence on a 5-point Likert scale, from 1 (*never or hardly ever*) to 5 (*always or almost always*). Items were drawn primarily from Otani’s (1989) pantheoretical taxonomy of client resistance. The questionnaire measures four factors: (a) boundary augmentation, (b) boundary reduction, (c) collaborative relationship, and (d) behavioral disengagement (Siebel and Dowd 1999). The first factor represents client’s attempts to control treatment by exhibiting distancing and competing behaviors (e.g. argumentativeness, defensiveness, sarcasm). The second factor refers to rather latent types of resistance indicating client’s efforts to react passive-aggressively (e.g. “Consents to do then “forgets”), or to affiliate with the therapist (e.g. “Tries to learn personal information”). The third factor represents client’s willingness to be involved in

the therapeutic endeavor and to collaborate towards change (e.g. “Attempts to use interventions to change”). Finally, the fourth factor involves resistance behaviors that challenge the therapeutic setting and rules (e.g. “Cancels sessions”, “Tardy to sessions”). The means and standard deviations in the original study were $M = 1.73$ ($SD = .80$), $M = 1.83$ ($SD = .95$), $M = 2.96$ ($SD = .88$), and $M = 1.39$ ($SD = .65$) for the four factors, respectively. The validity of the TQCB factors has been established by many studies (Dowd 1999a, b; Dowd et al. 2001; Siebel and Dowd 1999).

Working Alliance Inventory (WAI, Horvath and Greenberg 1987)

The 36-item client self-report WAI uses a 7-point Likert scale (1 = *never* to 7 = *always*) to measure working alliance and consists of three subscales that assess (a) the agreed goals of treatment, (b) the agreed tasks relevant for achieving these goals, and (c) the emotional bond between therapist and client. The mean and standard deviation of the total WAI score were $M = 4.35$ and $SD = 0.18$. The WAI has shown satisfactory validity and reliability scores in several studies (Hersoug et al. 2002; Martin et al. 2000).

Therapy Session Checklist-Transference Items (TSC-TI, Graff and Luborsky 1977)

Therapists rated client transference on a 5-point Likert scale (1 = *none or slight* to 5 = *very much*) by scoring the three single-item measures of positive, negative and total transference in the last month. According to the results of previous studies, the TSC-TI has a moderate level of interrater reliability between therapists and other raters (Kivlighan 1995), as well as an adequate internal consistency and construct validity (Gelso et al. 1997; Woodhouse et al. 2003).

Procedure

The therapists were recruited by inviting to participate private practice clinicians or the entire therapeutic personnel of clinical settings after institutional permission. Prior to their participation, both therapists and clients signed informed consent forms emphasizing that the study was not related to the treatment services, that participation was voluntary, and that the therapist would never have access to the client's responses. The completed questionnaires were labeled with anonymous identifiers, so as to ensure anonymity and to enable matching data from different measurements. The CATS and the TQCB were completed in three different times: (a) a baseline assessment after the initial 10–12 sessions of treatment, (b) a pre-vacation follow-up after therapist announced summer break (at the end of the session), and (c) a post-vacation follow-up upon his/her return (at the end of the first

session). The WAI was completed at the baseline and post-vacation, while the TSC-TI at the baseline. The interval time between the first and the second follow-up was 1 month (4–5 sessions) in line with the TQCB instructions, so as to allow enough time for resistance to unfold and become manifest (Strean 1990). Therapists' vacations took place between July and August and they lasted for 3–4 weeks, as it is usually the case of summer holidays in Greece. The role of time in the development of resistance was examined in the study analyses.

Statistical Analysis

The Statistical Package for Social Sciences (version 25) was used to analyze the data collected. First of all, preliminary analyses focused on providing descriptive statistics for all variables, Cronbach's alphas for the scales used, information on clients who dropped out, and Pearson's correlation coefficients to explore the associations of client attachment to therapist and resistance with working alliance and transference. Only significant results at $\alpha = .05$ level are discussed.

In order to answer the first research question regarding the association of therapist-rated resistance with client's attachment to therapist, correlations between CATS subscales and TQCB factors at baseline, before and after therapists' summer vacations were presented. Also, changes of the two measures during the follow up period were examined using repeated measurements analysis of variance (RM ANOVA). Furthermore, in order to examine whether treatment orientation (i.e. psychoanalytic vs. other approach), type of treatment service (public vs. private) and treatment length up to the vacations (short vs. long duration) played a significant role in client attachment to therapist and resistance levels, the sample was divided into groups and independent samples *t* tests were employed.

The effect of time on resistance was examined and the impact of other important influential factors was investigated to answer the third research question. The three TQCB resistance factors (i.e. boundary augmentation, boundary reduction and behavioral disengagement) were the dependent variables in the three models presented. The basic data analytic model was the unbalanced design Repeated Measures General Linear Model (GLM-RM) using Type III Sums of Squares in a forward stepwise method (*p* for entry was set at .05). Type of orientation, type of service, treatment length prior to vacations and negative transference were considered as the predictors, with attachment as covariate. Mauchly's test was used to check for violations of the sphericity assumption. Confidence intervals for the parameter estimates were reported at 95% confidence level. In pairwise comparisons Bonferroni correction was applied. Residual scatterplots were used to confirm the absence of outliers and whether the model residuals were normally distributed.

Since this was the first study that examined client resistance with client attachment in psychotherapy, it was considered to be of added clinical value to examine the correlations between the TQCB single items and the CATS subscales pre- and post-therapist's vacations to answer the fourth research question of the present study.

Results

Preliminary Analyses

Means and Standard Deviations

The values of means and standard deviations of the constructs measured in this study were comparable to those found in the studies reported in the [Method](#) section (Table 1).

Internal Consistency Reliability

All the measures demonstrated acceptable reliability scores ($\alpha > .70$), except for the TQCB behavioral disengagement subscale, whose internal consistency ranged from .56 to .60 in the three time-points.

Drop-outs

The six clients who prematurely terminated treatment had higher scores than the rest of the sample in avoidant/fearful attachment ($M = 22.17$, $SD = 7.25$), boundary augmentation ($M = 2.07$, $SD = .61$) and reduction ($M = 2.00$, $SD = .49$), negative ($M = 2.17$, $SD = 1.47$) and positive transference

($M = 3.17$, $SD = .75$). On the contrary, they had lower mean scores in secure ($M = 68.17$, $SD = 13.00$) and preoccupied/merger attachment ($M = 24.83$, $SD = 8.80$), collaborative relationship ($M = 3.10$, $SD = .87$), behavioral disengagement ($M = 1.07$, $SD = .10$) and working alliance ($M = 4.09$, $SD = .75$).

Correlations of Client Attachment to Therapist and Resistance with Working Alliance and Transference

Working alliance was negatively correlated to boundary augmentation ($r = -.48$, $p < .01$) and fearful-avoidant attachment to therapist ($r = -.76$, $p < .001$), and strongly positively correlated with client's secure attachment ($r = .81$, $p < .001$). Positive transference was positively correlated only to collaborative relationship ($r = .43$, $p < .01$), while negative transference was positively correlated with boundary augmentation ($r = .48$, $p < .01$) and reduction ($r = .33$, $p < .05$).

Which is the Relationship Between Client Attachment to Therapist and Client Resistance in Baseline, Before, and After Therapist's Summer Vacations?

Repeated measurements analysis of variance (RM ANOVA) indicated that there was no significant change in attachment and the three TQCB factors (i.e. boundary augmentation, boundary reduction, and collaborative relationship) over time. In contrast, significant increase was found in the behavioral disengagement mean scores ($F(2, 90) = 3.34$, $p < .05$).

The examination of the correlation matrix between client attachment styles and resistance factors at baseline, before

Table 1 Means, standard deviations and alpha levels for client attachment to therapist, client resistance, working alliance and transference variables (N = 46)

Scale	Measurement						
	Baseline			Pre-vacation		Post-vacation	
	α	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>
CATS							
Secure	.76	73.13	7.50	72.61	8.64	73.91	6.70
Fearful-avoidant	.78	20.24	7.56	20.11	7.41	18.67	7.32
Preoccupied-merger	.85	27.63	11.60	27.35	12.89	27.07	12.62
TQCB							
Boundary augmentation	.89	1.81	.46	1.79	.49	1.80	.50
Boundary Reduction	.83	1.85	.44	1.91	.45	1.86	.48
Collaborative relationship	.80	3.35	.59	3.30	.59	3.21	.54
Behavior. disengagement	.58	1.33	.45	1.46	.48	1.50	.50
WAI	.94	4.56	.51	–	–	4.63	.39
TSC—TI							
Negative transference	–	1.49	.84	–	–	–	–
Positive transference	–	3.07	.94	–	–	–	–

CATS client attachment to therapist, TQCB Therapist Questionnaire of Client Behaviors, WAI Working Alliance Inventory; TSC—TI Therapy Session Checklist-Transference Items

and after therapists' summer vacations showed that secure attachment to therapist was correlated negatively to boundary augmentation ($r = -.43$ to $-.45$, $p < .01$) and boundary reduction ($r = -.24$ to $-.25$, $p < .10$) in all three time points. However, secure attachment was positively correlated to collaborative relationship only at baseline measurement ($r = .33$, $p < .05$). Furthermore, avoidant/fearful attachment to therapist was found to be positively correlated with boundary augmentation in all three time points ($r = .40$, $.28$, and $.30$, respectively, $p < .05$), while preoccupied/merger attachment was correlated to the collaborative therapeutic relationship only prior to therapists' holidays ($r = .24$, $p < .05$).

Are There Significant Differences in Client Attachment to Therapist and Resistance Levels Among Clients with Different Treatment Orientation, Type of Setting and Treatment Length?

Independent samples t tests showed that at baseline clients in psychoanalytic psychotherapy scored lower on the secure ($t(37.48) = -3.81$, $p < .01$) and preoccupied/merger subscales ($t(37.48) = -3.81$, $p < .01$), but higher on the avoidant/fearful subscale ($t(40.45) = 2.86$, $p < .01$). Also, they had higher levels of boundary augmentation ($t(42.46) = 4.18$, $p < .01$) and lower levels of behavioral disengagement

($t(39.30) = -3.22$, $p < .01$) compared to clients in other modalities. Regarding the type of service, the results indicated that the preoccupied/merger scores were higher among clients in public treatment settings ($t(43) = 3.16$, $p < .01$). Moreover, clients who were in therapy for a shorter period of time prior to the therapist vacations, reported higher scores in preoccupied/merger attachment ($t(43) = 2.36$, $p < .05$) and lower scores in boundary augmentation ($t(43) = -2.34$, $p < .05$).

Do Therapist Summer Vacations Play a Significant Role on Predicting Client Resistance Considering Attachment to Therapist and Therapy-Context Variables?

GLM repeated measures models with forward selection were used to study important influential factors on resistance. Parameter estimates for the final models are presented in Table 2. Of the three CATS subscales, only the secure attachment entered the boundary reduction model.

Boundary Augmentation

The final model for boundary augmentation did not reveal a time effect ($F(2, 82) = .02$, $p = .98$, $\eta_p^2 = .001$), but the predicted main effect of negative transference ($F(1, 41) = 27.07$,

Table 2 Parameter estimates for between-subject factors of therapist-rated resistance models

Variable	Measurement					
	Baseline		Pre-vacation		Post-vacation	
	<i>B</i>	95% CI	<i>B</i>	95% CI	<i>B</i>	95% CI
TQCB—boundary augmentation						
Constant	1.78**	[1.53, 2.04]	1.93**	[1.66, 2.19]	1.86**	[1.61, 2.11]
Negative transference ^a	-.37**	[-.61, -.14]	-.53**	[-.78, -.28]	-.52**	[-.76, -.29]
Type of therapy ^b	.44**	[.21, .67]	.33**	[.09, .57]	.44**	[.21, .67]
TQCB—boundary reduction						
Constant	2.32**	[.78, 3.86]	2.43**	[.93, 3.92]	3.05**	[1.47, 4.62]
Negative transference ^a	-.34*	[-.62, -.06]	-.48**	[-.76, -.21]	-.45**	[-.73, -.16]
Time in therapy ^c	2.25	[-.68, 5.18]	.28	[-2.57, 3.14]	-1.78	[-4.78, 1.22]
CATS-secure	-.003	[-.02, .02]	-.003	[-.02, .02]	-.01	[-.03, .01]
Time in therapy ^c × CATS-secure	-.03	[-.07, .01]	-.004	[-.04, .04]	.02	[-.02, .07]
TQCB—behavioral disengagement						
Constant	1.26**	[1.09, 1.42]	1.34**	[1.17, 1.51]	1.43**	[1.24, 1.62]
Type of service ^d	.22	[-.06, .50]	.31*	[.02, .60]	.22	[-.09, .54]

CI confidence interval, TQCB Therapist Questionnaire of Client Behaviors

* $p < .05$; ** $p < .01$

^a1 = "None/some negative transference"

^b1 = "Psychoanalytic orientation"

^c1 = "Long time in therapy"

^d1 = "Public centers"

$p < .001$, $\eta_p^2 = .40$) and treatment orientation ($F(1, 41) = 20.70$, $p < .001$, $\eta_p^2 = .34$) were significant. Pairwise comparisons with Bonferroni adjustment yielded that clients with “none or slight” negative transference were estimated to have lower boundary augmentation levels than clients with “some-up-to-very much” negative transference ($M_{diff} = -.47$, $SE = .09$, $p < .001$). Also, clients in psychoanalytic psychotherapy had increased boundary augmentation scores compared to other clients ($M_{diff} = .40$, $SE = .09$, $p < .001$).

Boundary Reduction

In the final GLM-RM model for boundary reduction Mauchly’s test indicated that the assumption of sphericity had been violated ($X^2(2) = 9.91$, $p < .01$). Therefore, degrees of freedom were corrected using the Greenhouse-Geisser estimates of sphericity ($\epsilon = 0.81$). The main effects of time as within-subjects factor ($F(1.63, 63.4) = 4.07$, $p < .05$, $\eta_p^2 = .10$) and negative transference ($F(1, 39) = 10.91$, $p < .01$, $\eta_p^2 = .22$) were significant, indicating that clients with “none or slight” negative transference had lower boundary resistance than clients with “some-up-to-very much” negative transference ($M_{diff} = -.42$, $SE = .13$, $p < .01$). The two-order interaction terms of treatment length prior to vacations with time ($F(1.63, 63.4) = 8.36$, $p < .01$, $\eta_p^2 = .18$), secure attachment with time ($F(1.63, 63.4) = 4.54$, $p < .05$, $\eta_p^2 = .10$), and the three-order interaction of treatment length by secure

attachment by time ($F(1.63, 63.4) = 8.21$, $p < .01$, $\eta_p^2 = .17$) were all significant.

Visual representation of the data (Fig. 1) showed that the negative slope of the linear association between boundary reduction and secure attachment remained the same across time for clients with short time in therapy. On the other hand, the steep negative slope in the relationship between the two variables gradually became positive after the vacations, for clients with long time in therapy.

Behavioral Disengagement

The type of treatment service was the only factor that met the inclusion criterion in the GLM model regarding behavioral disengagement ($F(1, 43) = 4.62$, $p < .05$, $\eta_p^2 = .10$). More specifically, the results indicated that clients in public settings had significantly higher mean scores than clients in private settings ($M_{diff} = .25$, $SE = .12$, $p < .05$). The linear effect of time was not significant.

Which are the Specific Forms of Resistance Prior and After the Summer Holidays, Depending on the Client Insecure Attachment to the Therapist?

In anticipation for the summer break, clients with a predominant avoidant/fearful attachment to the therapist were likely to exhibit rather overt forms of resistance [e.g., “expresses impatience with pace of therapy” ($r = .31$, $p < .05$), “expresses skepticism about therapy” ($r = .30$, $p < .05$),

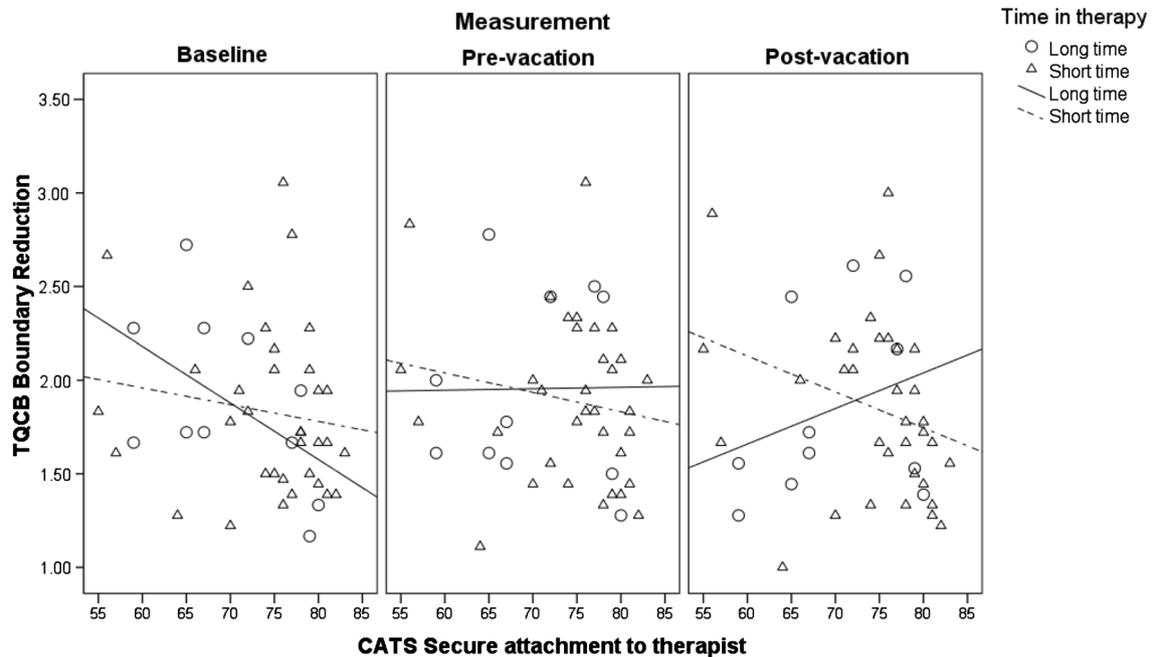


Fig. 1 Scatterplot of TQCB boundary reduction factor by CATS secure subscale in the three time-points depending on time in therapy

“appears to feel criticized” ($r = .39, p < .01$), “appears suspicious” ($r = .41, p < .01$)]. In contrast, upon therapist’s return avoidant/fearful attached clients turned to more subtle resistances [e.g., “delays bill-payment” ($r = .39, p < .05$)]. On the other hand, prior to the summer break, clients with a more preoccupied/merger attachment to the therapist were likely to start being “tardy to sessions” ($r = .38, p < .01$), “extend sessions” ($r = .46, p < .01$), or “delay bill-paying” ($r = .40, p < .05$), the last two being also present after therapist’s return ($r = .44, p < .01$ and $r = .41, p < .05$ respectively). Additionally, after vacations clients with a preoccupied/merger attachment were prone to avoid to “solicit therapist’s advice” ($r = -.39, p < .01$) or “attempt to use interventions to change” ($r = -.32, p < .05$).

Discussion

The purpose of the present study was to shed light on the relationship between client resistance and attachment to the therapist by taking into account therapist’s temporary absence (i.e. summer holidays). Overall, the findings from this study suggested that client resistance, a core element in clinical work, was significantly associated with the clients’ attachment relationship to their therapists. Further, results of this study indicated that the intercorrelation between client resistance and attachment security to therapist was a dynamic one, since it was differentiated when real aspects of the therapeutic relationship (i.e. vacations as a reality factor or therapy-context elements) emerged. To our best knowledge, this is the first time that client resistance was examined in relation to the interpersonal elements of security, attachment and loss in the therapeutic relationship.

The first research question concerned the relationship between resistance levels and attachment style to the therapist at different stages of treatment. We hypothesized that higher levels of resistance would be associated with insecure attachment to the therapist. The findings demonstrated that clients who felt more securely attached to their therapists exhibited less resistance across treatment, especially boundary augmentation or reduction, and more collaborative behaviors at the start of treatment. On the contrary, clients who reported an avoidant/fearful attachment to their therapists exhibited higher boundary augmentation during therapy. The findings of the present study lend support to previous results, which maintained that clients who are securely attached to their therapists demonstrated higher levels of working alliance (Diener and Monroe 2011; Taylor et al. 2015) and self-disclosure (Saypol and Farber 2010), while clients who developed an insecure attachment with their therapist displayed mistrust, fear of rejection, avoidance of self-disclosure (Mallinckrodt et al. 1995; Saypol and Farber 2010), and low levels of working alliance (Taylor et al. 2015).

Notwithstanding the correlational nature of these findings, the negative relations found between the client resistance and the secure attachment bond with the therapist provide some preliminary evidence on Bowlby’s (1988) tenets regarding the role of the therapeutic relationship as a “secure base”. Additionally, these findings are in keeping with the contemporary theoretical views about the development of client resistance in the therapeutic interaction around the feeling of security (Mallinckrodt 2010; Skourteli and Lennie 2011). The present study expands further the existing knowledge by shedding light on the relationship between attachment and resistance to therapy in terms of real aspects of the therapeutic interaction (Gullo et al. 2012), especially from the therapist viewpoint (Mallinckrodt and Jeong 2015).

Another telling finding was that clients who received psychoanalytic psychotherapy presented lower levels of secure attachment and behavioral disengagement, and on the other hand, higher avoidant/fearful attachment and boundary augmentation. Similarly, the clients in public clinical services reported higher levels of preoccupied/merger attachment, while they exhibited higher behavioral disengagement compared to those treated in private settings. The role of state-like elements of the therapeutic relationship has been already identified regarding working alliance (Zilcha-Mano 2017). Yet, further research is needed on their role on the broader therapist-client interactions. For example, therapist’s neutrality and limits are in the crux of the psychoanalytic approach (Schlesinger 2003), which may explain somehow our results. However, trait-like predispositions that urge someone to receive psychoanalytic therapy as a treatment of choice may be another plausible explanation that warrants empirical evidence.

Our third research question examined how the effect of therapist absence during summer holidays was associated with client resistance and attachment. The findings showed that the more secure the attachment relationship with the therapist, the lower the client’s resistance of boundary reduction early in treatment, whilst the higher prior, and especially, upon therapist’s return. Furthermore, the longer treatment duration the more a client tended to reduce the therapeutic boundaries, compared to those with a shorter time in therapy prior to the summer. These findings are in keeping with previous research that found secure attachment to therapist to be associated with time in treatment (Parish and Eagle 2003; Woodhouse et al. 2003). They also provide some preliminary evidence of the state-like and potentially affirmative role of resistance since they may indicate client’s earned security to pursue a less distant and more satisfying relationship with the therapist. Consistent with such a positive interpretation are the findings regarding the relation between lower amount of clients’ negative transference and lower levels of resistance.

As the aforementioned findings depict, resistance in the psychotherapeutic process is a dynamic process (Schlesinger

2003). The results of the present study consort with the literature which supports that many resistance manifestations make their appearance around the vacations period in psychotherapy, e.g. lack of cooperation, acting outs, tardiness and cancellations of sessions (Goin 2002; Shengold 2006; Stein et al. 1996). The absence of the therapist, even though it is temporary, interrupts treatment continuity and in a way threatens therapy's status quo (Handley and Swenson 1989; Rhoads and Rhoads 1995). These findings also indicate the need for further examination of the role of the various disruptions in the treatment process and they alert therapists in paying attention to the possible impact of temporary absences (i.e. holidays, sick-leaves, cancellations) on the therapeutic process.

The last research question concerned the determination of specific resistance forms prior and after therapist's holidays depending on the client attachment bond to the therapist. The findings of the present study showed that clients with an avoidant/fearful attachment before the summer vacations were likely to be defensive and express skepticism and impatience about therapy. In contrast, upon therapist's return avoidant/fearful attached clients resisted in rather passive ways (e.g., delay fees). On the other hand, clients with a pre-occupied/merger attachment both prior and after the summer break were likely to be tardy to sessions, or extend them, whilst after holidays they were also prone to avoid therapist's interventions. These preliminary findings contribute to inform clinical practitioners that resistance may differ not only in degree but also in valence (Horner 2005), depending on the level of security in the therapeutic relationship.

The study's main weakness is the small size of sample which may have resulted in loss of power and increased likelihood of Type II error. The next step will be to test the effect of therapist's vacations on the levels of client resistance and security in larger samples that would enable to have comparative data of both clients' and therapists' perceptions on different clinical variables conjointly. The conduct of such empirical work from the perspective of the attachment theory would help to support claims of causality and it will foster the positive re-conceptualization of client resistance, as a potential indicator of lack of security in the therapeutic relationship. Based on our preliminary findings, a fruitful avenue for future research would be to study the role of the therapist in providing a "secure-enough" relationship with their clients, following the Winnicottian "good-enough" notion. Investigating resistance in relation to diverse components of the wide array of the therapeutic relationship may shed light on the obscure phenomenon of resistance and thus deepen therapist's potential for adequate interventions and psychotherapy integration. In our study, the relationships between resistance, attachment to therapist, working alliance and transference were consistent with previous results (Mallinckrodt and Jeong 2015; Woodhouse et al. 2003).

Yet, longitudinal studies that would investigate the various aspects of the therapeutic relationship together, also in relation to outcome and drop-outs, are still scarce. Another limitation of our study was the use of self-reported measures. Although, on one hand, our data derived from different sources (i.e. both therapists and clients), and on the other hand, the client-therapist attachment bond is highly subjective, future research could also include data from external observers, to increase interrater reliability.

Whatsoever, this study provides some primary empirical evidence on the relations between client resistance and the client attachment to the therapist in view of real aspects of the therapeutic relationship, such as the therapist's absence for vacations. In closing, it is possible to understand the results of this study as a preliminary empirical endeavor to perceiving resistance in more affirmative and interactive terms with regard to its vital force of safeguarding security through the lens of attachment theory.

Compliance with Ethical Standards

Conflict of interest The authors declares that they have no conflict of interest.

References

- Aviram, A., & Westra, H. A. (2011). The impact of motivational interviewing on resistance in cognitive behavioural therapy for generalized anxiety disorder. *Psychotherapy Research, 21*(6), 698–708.
- Beutler, L. E., Harwood, T. M., Michelson, A., Song, X., & Holman, J. (2011). Resistance/reactance level. *Journal of Clinical Psychology, 67*(2), 133–142.
- Beutler, L. E., Moleiro, C. M., & Talebi, H. (2002). Resistance in psychotherapy: What conclusions are supported by research? *Journal of Clinical Psychology, 58*(2), 207–217.
- Bowlby, J. (1988). *A secure base*. New York: Basic Books.
- Button, M. L., Westra, H. A., Hara, K. M., & Aviram, A. (2015). Disentangling the impact of resistance and ambivalence on therapy outcomes in cognitive behavioural therapy for generalized anxiety disorder. *Cognitive Behaviour Therapy, 44*(1), 44–53.
- Callahan, P. E. (2000). Indexing resistance in short-term dynamic psychotherapy (STDP): Change in breaks in eye contact during anxiety (BECAS). *Psychotherapy Research, 10*(1), 87–99.
- Choi-Kain, L. W., & Gunderson, J. G. (2009). Borderline personality disorder and resistance to treatment. *Psychiatric Times, 26*(8), 35–38.
- Diener, M. J., & Monroe, J. M. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy, 48*(3), 237–248.
- Dowd, E. T. (1999a). Why don't people change? What stops them from changing? An integrative commentary on the special issue on resistance. *Journal of Psychotherapy Integration, 9*(1), 119–131.
- Dowd, E. T. (1999b). Toward a briefer therapy: Resistance and reactance in the therapeutic process. In W. Mathews & J. W. Edgette (Eds.), *Current thinking and research in brief therapy* (pp. 263–286). New York: Brunner/Mazel.
- Dowd, E. T., Pepper, H. F., & Siebel, C. (2001). Developmental correlates of psychological reactance. *Journal of Cognitive Psychotherapy: An International Quarterly, 15*(3), 239–252.

- Eagle, M. N. (2006). Attachment, psychotherapy, and assessment: A commentary. *Journal of Consulting and Clinical Psychology, 74*(6), 1086–1097.
- Frankel, Z., & Levitt, H. M. (2006). Postmodern strategies for working with resistance: Problem resolution or self-revolution? *Journal of Constructivist Psychology, 19*, 219–250.
- Freud, S. (1912). *The dynamics of transference. Standard edition 12*. London: Hogarth Press.
- Gelso, C. (2014). A tripartite model of the therapeutic relationship: Theory, research, and practice. *Psychotherapy Research, 24*, 117–131. <https://doi.org/10.1080/10503307.2013.845920>.
- Gelso, C. J., Kivlighan, D. M., Wine, B., Jones, A., & Friedman, S. C. (1997). Transference, insight, and the course of time-limited therapy. *Journal of Counseling Psychology, 44*, 209–217.
- Goin, M. K. (2002). Practical psychotherapy: What is it about the holidays? *Psychiatric Services, 53*, 1369–1375.
- Graff, H., & Luborsky, L. (1977). Long-term trends in transference and resistance: A report on a quantitative analytic method applied to four psychoanalyses. *Journal of the American Psychoanalytic Association, 25*, 471–490.
- Greenson, R. (1967). *The technique and practice of psychoanalysis*. New York: International Universities Press.
- Gullo, S., Coco, G. L., & Gelso, C. (2012). Early and later predictors of outcome in brief therapy: The role of real relationship. *Journal of Clinical Psychology, 68*(6), 614–619.
- Handley, N. (1995). The concept of transference: a critique. *British Journal of Psychotherapy, 12*(1), 49–59.
- Handley, R. B., & Swenson, C. R. (1989). Acting out of separation conflicts in borderline pathology: An empirical case study. *Bulletin of the Menninger Clinic, 53*, 18–30.
- Hara, K. M., Westra, H. A., Constantino, M. J., & Antony, M. M. (2016). The impact of resistance on empathy in CBT for generalized anxiety disorder. *Psychotherapy Research. https://doi.org/10.1080/10503307.2016.1244616*.
- Hersoug, A. G., Monsen, G. T., Havik, O. E., & Hoglend, P. (2002). Quality of early working alliance in psychotherapy: Diagnoses, relationship and intrapsychic variables as predictors. *Psychotherapy and Psychosomatics, 71*, 18–27.
- Horner, A. J. (2005). *Dealing with Resistance in Psychotherapy*. New York: Jason Aronson.
- Horvath, A. O., & Greenberg, L. S. (1987). Development of the working alliance inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook*. New York: Guilford Press.
- Janzen, J., Fitzpatrick, M., & Drapeau, M. (2008). Processes involved in client-nominated relationship building incidents: Client attachment, attachment to therapist, and session impact. *Psychotherapy Theory, Research, Practice, Training, 45*(3), 377–390.
- Kivlighan, D. M. (1995). *Similarities and differences among counselor, supervisor and observer ratings of individual counseling process*. Unpublished manuscript, University of Missouri-Columbia.
- Levitt, H. M., & Williams, D. C. (2010). Facilitating client change: Principles for fostering awareness while maintaining the therapeutic relationship. *Psychotherapy Research, 20*, 337–352.
- Mallinckrodt, B. (2010). The psychotherapy relationship as attachment: Evidence and implications. *Journal of Social and Personal Relationships, 27*(2), 262–270.
- Mallinckrodt, B., Gantt, D. L., & Goble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology, 42*, 307–317.
- Mallinckrodt, B., & Jeong, J. (2015). Meta-analysis of client attachment to therapist: Associations with working alliance and client pretherapy attachment. *Psychotherapy, 52*(1), 134–139.
- Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M. (2005). Client attachment to therapist, depth of in-session exploration and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42*(1), 85–100.
- Martin, D. J., Garske, G. P., & Davis, K. M. (2000). Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Clinical and Consulting Psychology, 68*, 438–450.
- Miller, S. J. (2003). Analytic gains and anxiety tolerance: Punishment fantasies and the analysis of superego resistance revisited. *Psychoanalytic Psychology, 20*(1), 4–17.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. New York: Guilford Press.
- Mouque, T. (2005). What is the meaning of my resistance to psychotherapy? *Psychodynamic Practice, 11*(2), 153–164.
- Moyers, T. B., & Martin, T. (2006). Therapist influence on client language during motivational interviewing sessions. *Journal of Substance Abuse Treatment, 30*(3), 245–251.
- Newman, C. F. (2002). A cognitive perspective on resistance in psychotherapy. *Journal of Clinical Psychology, 58*(2), 165–174.
- Otani, A. (1989). Client resistance in counseling: Its theoretical rationale and taxonomic classification. *Journal of Counseling and Development, 76*(8), 458–461.
- Parish, M., & Eagle, M. N. (2003). Attachment to the therapist. *Psychoanalytic Psychology, 20*(2), 271–286.
- Rhoads, E. J., & Rhoads, J. M. (1995). The benefits of vacations/interruptions in psychoanalysis. *Journal of Clinical Psychoanalysis, 4*(2), 209–222.
- Sandler, J., Holder, A., & Dare, C. (1970). Basic psychoanalytic concepts: V. Resistance. *British Journal of Psychiatry, 117*, 215–221.
- Saypol, E., & Farber, B. A. (2010). Attachment style and patient disclosure in psychotherapy. *Psychotherapy Research, 20*(4), 462–471.
- Schafer, R. (1973). The idea of resistance. *International Journal of Psychoanalysis, 54*, 259–285.
- Schlesinger, H. J. (2003). *The texture of treatment. On the matter of psychoanalytic technique*. New York: Taylor & Francis Group.
- Shengold, L. (2006). As August approaches. *Psychoanalytic Quarterly, 111*(5), 879–886.
- Siebel, C. (1994). *Reactance, noncompliance, and the identity process*. (Unpublished doctoral dissertation). Kent State University, Kent, Ohio.
- Siebel, C. A., & Dowd, E. T. (1999). Reactance and therapeutic noncompliance. *Cognitive Therapy and Research, 23*(4), 373–379.
- Skourtelis, M. C., & Lennie, C. (2011). The therapeutic relationship from an attachment theory perspective. *Counselling Psychology Review, 26*(1), 20–33.
- Stein, H., Corter, J. E., & Hull, J. (1996). Impact of therapist vacations on inpatients with borderline personality disorder. *Psychoanalytic Psychology, 13*(4), 513–530.
- Strean, H. S. (1990). *Resolving resistances in psychotherapy*. New York: Brunner/Mazel.
- Taylor, P. J., Rietzschel, J., Danquah, A., & Berry, K. (2015). The role of attachment style, attachment to therapist, and working alliance in response to psychological therapy. *Psychology and Psychotherapy: Theory, Research and Practice, 88*(3), 240–253.
- Tuckett, D. (2003). Resistance: How do we think of it in the twenty-first century? *Panel held at the winter meeting of the American psychoanalytic association, 24 January 2003*, New York.
- Van Denburg, T. F., & Kiesler, D. J. (2002). An interpersonal communication perspective on resistance in psychotherapy. *Journal of Clinical Psychology, 58*, 195–205.
- Watson, J. C., & McMullen, E. J. (2005). An examination of therapist and client behavior in high- and low-alliance sessions in cognitive-behavioral therapy and process experiential therapy. *Psychotherapy: Theory, Research, Practice, Training, 42*(3), 297–310.
- Westra, H. A., Aviram, A., Connors, L., Kertes, A., & Ahmed, M. (2012). Therapist emotional reactions and client resistance in cognitive behavioral therapy. *Psychotherapy, 49*(2), 163–172.

- Woodhouse, S. S., Schlosser, L. Z., Crook, R.E., Ligiero, D.P., Gelso, C.J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counseling Psychology, 50*(4), 395–408.
- Yasky, J., King, R., & O'Brien, T. (2016). Resistance, early engagement and outcome in psychoanalytic psychotherapy of patients with psychosomatic disorders. *Counselling and Psychotherapy Research, 16*(4), 266–276.
- Yotsidi, V., Pezirkianidis, C., Karakasidou, E., & Stalikas, A. (2018). The Client Attachment to Therapist Scale (CATS) in a Greek clinical population: A validation study. *Open Journal of Medical Psychology, 7*, 59–81. <https://doi.org/10.4236/ojmp.2018.74006>.
- Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist, 72*(4), 311–325.