4

CLOSENESS AND DISTANCE DYNAMICS IN THE THERAPEUTIC RELATIONSHIP

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> ". . . unless a therapist can enable his patient to feel some measure of security, therapy cannot even begin."
>
> (Bowlby, 1988, p. 140)

> "To discover truth about the patient is always discovering it with him and for him as well for ourselves and about ourselves."
>
> (Loewald, 1980, pp. 297–298)

The major conceptualization of the development of the therapeutic relationship at the heart of our chapter relies on attachment theory and on contemporary relational thinking about the mutual impact client and therapist have on each other in the process of change.

ATTACHMENT-INFORMED CONCEPTUALIZATION

Bowlby's attachment theory provides a powerful lens to examine the therapeutic relationship in ways that are both empirically supported and clinically relevant (Eagle & Wolitzky, 2009; Farber & Metzger, 2009; Mallinckrodt, 2010). Bowlby (1962, 1982) posited that individuals form internal working models of the self and others in close relationships based on their early experiences with caregivers. The therapeutic relationship is likely

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to reactivate the client's long-standing expectations about the availability and responsiveness of others (Bowlby, 1988). Specifically in considering the application of attachment theory to the therapeutic process, Bowlby (1988) saw the therapist's role as providing "the conditions in which his patient can explore his representational models of himself and his attachment figures with a view to reappraising and restructuring them in light of the new understanding he acquires and the new experiences he has in the therapeutic relationship" (p. 138). Using the concept of *secure base* that Ainsworth introduced in her seminal work on infant–mother/caretaker attachment (Ainsworth, Blehar, Waters, & Wall, 1978), according to Bowlby, the therapist's first task is to provide the patient a secure base for exploration of his or her thoughts and feelings that is analogous to the mother providing her child a secure base from which to explore the world. As Bowlby noted, the concept of secure base is similar to Winnicott's (1971) "holding" and Bion's (1962) "containing." However, going beyond providing empathy and sensitivity (Rogerian-like conditions) and encouraging explorations, the therapist needs to respectfully challenge the client's internal working models of self and others (Dozier & Tyrrell, 1998; Farber & Metzger, 2009). This is where the therapist's own attachment history may also play in, contributing to the way he or she relates to the client and affecting the therapeutic relationship between them in the here and now (Bowlby, 1988).

Given that the client's working models dictate his or her expectations from the therapist, individual differences in attachment style will lead to different manifestations and dynamics in the relationship that will develop between the client and therapist. An individual's location in the two-dimensional space defined by attachment avoidance and attachment anxiety reflects both the person's sense of attachment security and the ways in which he or she deals with threats and distress. Individuals who score low on these dimensions are generally *secure* and tend to employ constructive and effective affect-regulation strategies. Those who score high on either the anxiety or the avoidant dimension (or both) suffer from attachment insecurities and tend to rely on *secondary attachment strategies*. To cope with threats when individuals feel their efforts to meet their emotional needs through a secure relationship have failed, they shift to one of two secondary attachment strategies (Mikulincer & Shaver, 2007). Individuals who rely on hyperactivating strategies intensify dependency needs and closeness in their relations with attachment figures, whereas those who rely on deactivating strategies increase distance so as not to get hurt. These diverse attachment strategies require therapists to conceive how clients with different secondary attachment strategies may work through their insecurities to establish a secure relationship with their therapist and build a working alliance that enables a collaboration on the goals and tasks in therapy (Mikulincer, Shaver, & Berant, 2013).

Daly and Mallinckrodt (2009) suggested that to foster a secure attachment in the psychotherapy relationship, it is important that the therapist regulate the *therapeutic distance* to enable clients to experience a corrective emotional experience. On the basis of qualitative interviews with experienced interpersonal therapists, they defined therapeutic distance as "the level of transparency and disclosure in the psychotherapy relationship from both client and therapist, together with the immediacy, intimacy, and emotional intensity of a session" (p. 559). Therapists distinguished between an initial *engagement phase* in which they largely acceded to a client's desired (but ultimately maladaptive) level of therapeutic distance, followed by a *working phase* in which therapists gradually attempted to steer the relationship toward a more optimal level of therapeutic distance. The therapeutic distance that is optimal for each phase is regulated by the therapist and depends on the client's hyperactivating versus deactivating strategies. With hyperactivating clients (high in anxiety), the therapist agrees to reduce levels of therapeutic distance in the engagement phase, and then after progress markers are reached, gradually increases distance as clients enter the working phase, thereby fostering autonomy. In contrast, with deactivating clients (high in avoidance), the therapist agrees to high levels of therapeutic distance in the engagement phase, and then after progress markers are reached, gradually lessens distance as clients enter the working phase, thereby fostering engagement. Thus, a corrective emotional experience is fostered not by one attachment relationship offered by the therapist, but rather by many relationships tailored to meet the client's needs through the changing phases of therapy (Mallinckrodt, 2010).

Attachment patterns in the therapeutic relationship are nearly always in a state of dynamic change rather than in static equilibrium. Either the client or the therapist, and more often both simultaneously, work actively to change the attachment dynamics (Mallinckrodt, 2010). In fact, the similarity or dissimilarity in attachment style of client and therapist will affect these dynamics (Wiseman & Tishby, 2014). In this sense, it has been suggested from both the perspective of interpersonal theory and attachment theory that "contrasting" (dissimilar) interpersonal orientations of the client and therapist are optimal for the process and outcome of psychotherapy (Bernier & Dozier, 2002).

CONTEMPORARY RELATIONAL PSYCHOTHERAPY CONCEPTS

These ideas fit with contemporary relational psychotherapy models that take a two-person psychology perspective assuming "that both therapist and client are always contributing to everything that takes place in the therapeutic relationship" (Safran, 2012, p. 196). From this perspective, theorists

such as Benjamin (2004) and Aron (2006) have contended that client and therapist may revive the wounds in the other related to the relational experiences that each internalized in interactions with early caregivers in a way that often leads to getting stuck in complementary relations. This complementarity is characterized by a split in which one side takes a position complementary to the other: If one person is experienced as "the doer," then the other becomes "the done to." The more each member of the dyad locks into a singular position, the more rigidly the other is locked into the opposing, complementary position. In the complementary structure, the dynamics are such that conflicts cannot be processed, observed, held, mediated, or played with. Instead, each partner feels that her perspective on how this is happening is the only right one, or at least that the two are irreconcilable. This structure may involve polarizations such as those between attachment and separation, autonomy and dependency, closeness and distance. Conceptualizing the dynamics of polarization in this way captures the mutual experience of the client and the therapist of deep, generally unconscious needs and vulnerabilities that are being revived in the therapeutic relationship. Thus, in this relational perspective (Mitchell, 1993), in order to facilitate the gradual transformation from relations of complementarity to relations of mutuality, it is important that therapists deeply accept their own contribution to enactments in the therapeutic relationship. This enables both the client and the therapist to open up the psychic space for self-reflection and mentalization.

In this chapter, we draw on attachment theory and contemporary relational psychoanalytic concepts in order to shed light on the dynamics of closeness versus distance in the development of the therapeutic relationship in psychodynamic psychotherapy. In the clinical case that we analyze, we focus on the encounter between a client and her therapist, in which at the beginning of treatment, when one party tended to use deactivating strategies, the other party tended to use hyperactivating strategies, without being aware of the opposite pole within herself. We examine the interplay between the relational processes of the client and the therapist and shifts in closeness and distance as key for the development of a therapeutic relationship.

ASSESSMENT

Assessment included two types of measures: (a) interpersonal patterns of clients and therapists in close relationships and in the therapeutic relationship were assessed with RAP interviews during the course of psychotherapy, and the CCRT method was applied to these interviews (Wiseman & Tishby,

2017); and (b) self-report measures of attachment, client attachment to the therapist, working alliance, and outcome were conducted.

RAP and CCRT

The Relationship Anecdote Paradigm interview (RAP; Luborsky & Crits-Christoph, 1998) was employed to obtain clients' and therapists' relationship narratives in close relationships and with each other (see Chapter 3, this volume, for the method). The underlying premise is that the client–therapist narratives serve as a window into clients' and therapists' unique relational experiences with each other during the sessions.

The Core Conflictual Relationship Theme (CCRT) method (Luborsky & Crits-Christoph, 1998) was applied to the relational narratives to assess client and therapist relational patterns (see Chapter 3 for a definition). Our CCRT approach to analyzing the narratives combines applying the standard categories (and clusters) and conducting in-depth qualitative analysis of the client-therapist narratives within dyads (Wiseman, 2017; see also Chapter 3, this volume).

Self-Report Questionnaires

The Experiences in Close Relationships Scale (ECRS; Brennan, Clark, & Shaver, 1998) was used to assess attachment of both client and therapist. The ERC is a widely used 36-item self-report measure of adult attachment that consists of two scales: Anxiety (18 items; e.g., "I worry about being abandoned") and Avoidance (18 items; e.g., "I prefer not to show a partner how I feel deep down").

The Client Attachment to Therapist (CATS; Mallinckrodt, Gantt, & Coble, 1995) measure was used to assess the therapeutic relationship within the perspective of attachment theory. The CATS is a 36-item measure that includes three subscales: Secure (14 items; e.g., "My counselor is sensitive to my needs"), Avoidant–Fearful (12 items; e.g., "Talking over my problems with my counselor makes me feel ashamed or foolish"), and Preoccupied–Merger (10 items; e.g., "I wish my counselor could be with me on a daily basis"). For a recent meta-analysis of the CATS, see Mallinckrodt & Jeong (2015).

The working alliance of client and therapist were measured using the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). Outcome was assessed using the Outcome Questionnaire–45 (OQ–45; Lambert et al., 1996) that yields a total distress score that has been found to be sensitive to change; and the Target Complaints Scale (TCS; Battle, Imber, Hoehn-Saric, Nash, & Frank, 1966), referring to three main problems for which

the client sought therapy, indicating severity of each complaint on a scale ranging from 1 (*not at all*) to 13 (*couldn't be worse*).

CLINICAL CASE STUDY

This case was chosen for intensive analysis from Wiseman and Tishby's research program on client–therapist relationship patterns in psychodynamic psychotherapy (see Chapter 3). We chose this case for four reasons (on the basis of the assessment on the above measures):

- Both partners of the dyad were characterized by having an insecure attachment style as measured on the ECRS.
- CCRT themes of closeness and distance were dominant in both the client's and the therapist's relational narratives and these themes evolved through the three measurement points of the study (after Sessions 5, 15, and 28).
- The client's attachment to the therapist on the CATS showed change from low CATS security and high avoidance in the early phase (Session 5), to an increase in CATS secure attachment to the therapist and decrease in avoidance by the later phase (Session 28).
- The client reported improvement on her main complaint (on Target Complaints) and some improvement in her overall symptom distress (on the OQ-45).

Client Description and Presenting Problems

N1 Hannah was a 25-year-old undergraduate student.[1] She was single and lived in a rented apartment off campus. She sought treatment because of feelings of depression and anxiety that had worsened recently when she had to take exams during her first undergraduate year in a prestigious program. Hannah said she continuously felt stressed and inferior compared with others and that it clearly affected her performance on all tasks and challenges in her life. She also described a pattern in which she usually avoided developing intimate relationships because she had difficulty trusting people and was afraid of being rejected or hurt. On the few occasions on which she actually began to date someone, she constantly felt anxious about being rejected, and this fear was usually confirmed in that the partner initiated a breakup at a relatively early stage of the relationship.

[1]Details of this case example have been altered to protect confidentiality.

Family Background

Hannah was the youngest of four children from an educated mid/upper class family. She described a general atmosphere of stress and extreme criticism in her childhood home. Her mother worked part-time and was described as intrusive and controlling; her father, who was busy with his career, was described as distant and rejecting. The parents' relationship was stormy and often included fights and outbursts of verbal violence. The sibling relationship was also a source of distress, as her older siblings were abusive toward her. When she turned to her mother for help, the mother dismissed her complaints. Hannah recalled that as a young child, she felt she had nowhere to escape the turmoil and shouting that were the norm at home; but as an adolescent, when the fighting started, she used to run outside and walk the streets until things calmed down a bit.

Diagnosis, Case Formulation, and Therapy Goals

Diagnosis. Based on the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013) and the *ICD–10 Classification of Mental and Behavioural Disorders* (World Health Organization, 1993), Hannah was diagnosed with generalized anxiety disorder. Her anxieties specifically concerned her academic performance and feeling alarmed upon hearing loud noises or in the dark, as well as continuously experiencing excessive worries about various life challenges. In addition, she described some avoidant traits manifested in unwillingness to get involved with people because of fear of disapproval or rejection.

Case Formulation. Hannah grew up in a family in which negative emotions were not managed or regulated. Her parents did not handle their own anxieties, feelings of anger and aggressiveness, nor did they acknowledge Hannah's difficult feelings or assist her in coping with them. Thus, Hannah did not internalize capacities to tolerate and regulate her negative emotions. She felt alone in the face of intense and overwhelming negative emotional experiences. Hannah's caregivers failed to protect her from her brothers' aggressiveness or meet her emotional needs through a secure, accepting, and responsive relationship. Throughout her childhood, Hannah experienced both her parents as critical toward her: Her mother was perceived mainly as controlling and intrusive, and her father as rejecting and distant. Therefore, both closeness and distance in relationships evoked fears of being hurt. She was left with an injured sense of self, and though she was yearning for comfort, support, and recognition, she felt she had to protect herself from being hurt again. On the basis of her early experiences she tended to minimize her expectations from close relationships, expected them to be either too invasive or disappointing and therefore tended to avoid them.

Goals. The main goals of therapy (a) to create a safe and supporting environment where Hannah could start exploring her actual and internalized relationships so as to open up new ways of experiencing self and others, (b) to help Hannah tolerate and regulate negative and stressful emotions, and (c) to help Hannah face developmental academic and interpersonal challenges with greater flexibility and freedom.

Client's Interpersonal Patterns

Hannah's CCRT patterns with her parents, as revealed by the first RAP interview (after the fifth session), were consistent with the above case formulation. The first narrative that she told about a meaningful interaction with her mother was the following:

> I talked with my mom about something, she wanted to know what was going on in my sessions. I told her that . . . I didn't want to tell her it's none of her business . . . I just said I don't want to talk about it. She started to get angry right away. She yelled and accused me of only wanting her money but not sharing my inner world with her. She said she would not pay for my treatment if she cannot know what is going on there. I tried to explain to her that this is private, this is my stuff, and I can't talk about it with her, I don't want to. We were both yelling at this point. She said I don't share anything with her and that I don't care about her. I just wanted her to go away and leave me alone. I also hated myself for being so unpleasant to her. All this just made me more distant than before. She cannot realize what is going on inside me and how stressed I am. I wish she could see what I really feel and take responsibility for her contribution to my state.

In this narrative Hannah described an encounter in which her mother tried to get close to her in a way that was experienced as inappropriate and intrusive. In response, Hannah pushed her mother away and distanced herself from her even more. At the same time, she expressed the wish that her mother could recognize how distressed she was and understand her situation. She felt bad because needing her mother evoked anxieties of being controlled by the mother, but she was also self-critical because she felt that her reaction toward her mother was offensive.

Hannah's first relationship narrative about a meaningful interaction with her father was from a memorable event from childhood:

> I think I was about 10; I needed help with my homework. I usually didn't turn to him for help, but this time I did. Then, after a very short while, he started to explain things beyond the task that was asked by the teacher.

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> He said he wanted to enrich my knowledge. I was afraid that this would confuse me. It was not what I needed. I said I don't want to learn new things at that time. I just needed him to help me with my homework. He insisted and he got angry and critical toward me. I just waited for him to stop shouting and I went away. He let me go. I regretted that I asked for his help to begin with.

A second relationship episode about a more current interaction with her father revealed a similar lack of responsiveness.

In the narratives, Hannah described situations in which she asked her father for help and support, but in his reactions he did not see her and the kind of age-appropriate help that she needed, or he failed to attend and respond appropriately to her seeking his help (proximity seeking). In both cases this made her regret turning to him for help to begin with.

Hannah's CCRT pattern with her parents consisted of two opposing wishes (Ws), the first one more apparent than the other. On the one hand, she expressed *a need to be distant so as not to feel intrusiveness and feel controlled or rejected by the other.* She repeatedly perceived the other (RO) as reacting in a way that was not congruent with her needs either by imposing his or her own needs and way of thinking or by rejecting her. On the other hand, a more hidden primary wish, was the wish *to get close to the other and be helped in a manner suited to her needs.* Her response of self (RS) in reaction to the other was to feel hurt, angry, and withdrawn. Thus, although she wished for help and closeness, through repeated frustration of this wish she had very low expectations that her wish to be helped and close could be fulfilled. In turn this contributed to her dominant tendency to avoid closeness and to keep her distance from the other so as not to be hurt.

A similar pattern was described in her relationship with her friends. All three narratives about friends described interactions in which Hannah had very low expectations that she could get help or sympathy from or establish closeness with her friends. These negative expectations were confirmed in her interactions with friends, as she experienced the other as rejecting, leading her to feel disappointed, hurt, and distant.

The Therapist

The therapist was a woman in her early 30s and married. She was clinical psychology intern with 3 years of post–master's degree clinical experience. She received ongoing individual and group supervision as part of her internship. She also reported that she had had previous personal therapy, as well as current personal therapy.

Therapist's Interpersonal Patterns

The therapist also participated in a RAP interview relating to interactions with her own parents (and spouse/romantic relationship). The narrative the therapist told about her mother was:

> I was about six years old. I really wanted to learn to play piano but I was terribly afraid to go to the first class on my own. I worried how it would be . . . on the one hand I guess I really wanted to please my mother and to behave in a mature way. On the other hand I was afraid I would not be able to please her. We got there . . . the teacher was scary: white hair tied back and a rigid look on her face. I was very scared to enter the class on my own and wanted my mother to go in with me. She didn't know what to do with me. She was very angry and impatient, and she said I was acting like a little girl. I was hurt, and I guess I was disappointed in myself.

The narrative the therapist told about her father was:

> I was 5 years old, and my parents dressed me up as Peter Pan for a costume party in kindergarten. I really didn't want to wear that costume. I objected and I cried. My father took me to preschool with the costume, and he sort of pushed me in forcefully . . . and I continued to object. He was probably stressed about getting to work on time. It was unpleasant. He wanted to get it over with, wanted me to stop crying and go inside. I felt angry and helpless. You can't really decide anything when you are 5 years old. (See also Tishby & Wiseman, 2014, p. 367.)

The therapist's CCRT with her parents showed that her primary wishes were *to be close and not to be abandoned.* She also wished to let her voice be heard, not to be forced, and at the same time to please the other. She perceived her parents as misunderstanding her, angry and controlling, and also helpless (RO). Her response of self (RS) with them was to feel helpless, angry, disappointed, and somewhat guilty.

Client and Therapist Matching in Attachment and CCRT

As is the case for any therapeutic dyad, Hannah's and her therapist's encounter was unique and included its baggage of hopes, fears, and internalized object representations that each brought to the relationship. Considering similarities and dissimilarities in relational patterns between Hannah and her therapist showed some prominent similarities in attachment style and interpersonal themes. The fearful attachment style that characterized Hannah—high on both avoidance (5.67, 98th percentile of clients in the larger sample) and anxiety subscales (4.22, 67th percentile)—also characterized her therapist, though to a lesser extent. The therapist's scores on the ECRS avoidance (3.89, 99th percentile of therapists in the larger sample) and anxiety (4.83,

77th percentile) subscales were high compared with the other therapists in the larger sample (Wiseman & Tishby, 2014). Thus, the therapist can also be classified as "fearful attachment" relative to the therapists in the study. However, the therapist's avoidance was considerably lower than Hannah's. In fact, while Hannah was higher on avoidance than anxiety, the opposite was true of her therapist, that is, she was higher in anxiety than in avoidance.

In examining the narratives that the therapist recounted regarding meaningful interactions with her parents, it can be seen that while there are differences between her and the client (as could be expected between different individuals, and given that one is the client and the other is the therapist), there are also significant similarities. It appears that both the client and the therapist tend to avoid closeness so as not to be hurt, as they experience the other as controlling and/or rejecting. It should be noted that in terms of form, the therapist's narratives about childhood experiences were relatively coherent and organized, possibly due to her working on these issues in her personal therapy.

Course of Treatment: Closeness and Distance in the Therapeutic Relationship

We describe the course of psychotherapy through the relational narratives the client and therapist told about meaningful interactions during psychotherapy at the three time points of assessment: early (fifth session), middle (15th session) late (28th session; Wiseman & Tishby, 2017). In addition, for this dyad we conducted a qualitative narrative analysis that was applied to the three narratives that each told about the other at the three assessment points (a total of 18 narratives). This analysis shed light on the pushes and pulls of the closeness versus distance "dance" in this dyad as therapist and client attempted to negotiate distance and closeness between them over the course of psychotherapy. In what follows, for each phase we provide excerpts from the narratives revealing their experiences with each other from the client's and therapist's perspectives followed by our CCRT and qualitative understanding, as well as quantitative data on self-report measures (WAI and CATS).

Early Phase of Therapy

The inner drama of each member of the dyad is clearly captured in their narratives, which show that both client and therapist did not have an easy start. Hannah recounted her difficulty opening up and trusting her therapist:

> She kept telling me that I should share things with her. She said I am always alone with what I feel and that I should give her access to what I feel. I wanted her to stop pushing me to open up to her. This is the

> way I am, I can't share, I don't trust people. She was making all kinds of gestures so I would trust her and she repeated the same mantra again and again telling me that I shouldn't stay alone with what I feel. I backed off. I felt very hesitant to share things with her. My instincts told me slow down, back off.

Hannah's CCRT toward her therapist at the beginning point of treatment conveyed the wish to be distant and to avoid close contact with the therapist. She perceived her therapist's repeated invitations to open up as invasive and as a rigid technique imposed on her. Her response of the self was to close up and feel even more distant.

The therapist's perspective is depicted by the following narrative:

> Throughout the session there was some sense that there is something we did not manage to touch. I tried to reach out to her and help her open up and share what was going on inside her, but she wouldn't let me. And then finally, just before the end of the hour, she became more in touch with her emotions and she looked sad and upset. I wanted to stay with her in that moment and I felt it was very hard for her that we had to stop. I felt helpless to have to send her away like that and that I couldn't stay with her. There was a very heavy atmosphere.

The therapist's CCRT toward her client included the wishes to get close, to help, and not to hurt Hannah. She perceived her as distant and unreachable as well as needy and vulnerable. Her responses of the self were to try hard to get close to Hannah but also to feel guilty, as though she were abandoning or rejecting her.

The client and the therapist appeared to be caught in complementary positions. Hannah mainly experienced closeness as a threat that included coercion and imposition of the will of the other; thus, she was mainly in touch with her wish *to avoid closeness with the therapist*. In contrast, the therapist mainly experienced distance as abandonment and was mainly in touch with her wish *to get close to Hannah and to help her open up*. It seems that the more the therapist tried to get close, the more Hannah pulled away and avoided the therapist. Both Hannah and the therapist described these contradictory positions without being in touch with the opposite experience within them. That is, Hannah did not identify with the therapist's wish to get close and the therapist seemed not to identify the parts in herself that are hesitant and anxious about getting close.

CATS and WAI Self-Report Measures. Hannah's scores on the CATS reflect her difficulty to feel secure with the therapist and to trust her. On the CATS secure subscale she is rather low in Secure (4.18) and high in Avoidant (3.08), and moderate on Preoccupied (2.30) (compared with the sample from Mallinckrodt, Choi, & Daly, 2015). Surprisingly, unlike the CATS,

her Alliance score on the WAI after Session 5 does not depict difficulty in building a strong alliance, with a score of 5.38. The therapist's WAI was 5.42, similar to Hannah's rating.

Middle Phase of Therapy

At midtherapy, the narratives that Hannah told about interaction with her therapist continue to show her struggles to open up and her difficulty feeling safe enough to explore. However, at the same time the narratives are more elaborate and she appears more aware of her approach–avoidance conflicts—not wanting to be left alone but also not being able to open up.

> She asked what goes on in my head. I told her I feel like everything is confused, and I didn't know how to find words to express it. She said it was okay, that we have time and that things will come out slowly. But it just made ??me more stressed and nervous and I just wanted her to leave me alone. I get into a kind of loop and inability to communicate. I tried to explain to her that on the one hand I don't want to be left alone, but on the other hand, this is the way I am. I am always suspicious about people's intention. I wish I could trust more.

Another narrative that she recounted at this time point was

> In the last meeting I was in a good mood after having made a successful presentation in class. She simply asked questions and she looked interested. We just sat and talked, you know, and I guess I was a bit less closed than usual. I was still excited because of the presentation I gave, and it was nice I could share it with her. But I also wondered whether her interest in me was genuine, or that she was putting on the face of the interested psychologist and that she was just doing her job. Anyway, I kept talking about myself and it felt OK.

Hannah's CCRT included her ongoing avoidance but also a wish to open up and to trust the therapist. In the first narrative, although indicating again her difficulty in accepting the therapist's invitation to disclose her thoughts, she appears more aware of her conflict between wanting not to "stay alone" and being able to trust. In the second narrative, while she begins to describe herself as a bit more open (sharing an experience of success), she still questions the possibility that the therapist was really interested in listening to her, but then ends by indicating feeling good about herself.

The therapist told again a narrative about the end of session:

> It was toward the end of a session and she only started talking about her difficulty to open up toward the end of the session. She said she felt as though she was in a closed room and could not find the key to get out. I could feel her pain and helplessness. I felt it was an important image and I wanted to explore it further with her, but it was the end of the

> session. I felt conflicted. On the one hand, I felt so desperate that these moments are so rare with her and always occur at the end of an hour. I felt exhausted and I wanted the hour to end. But on the other hand I felt I didn't want to give up trying and I could feel that she was trying, too.

In another narrative, the therapist refers to the time that Hannah came to the session in a good mood:

> She came in a good mood; it's not typical for her. She was happy about some presentation she did in class. On the one hand, I felt happy that I had the opportunity to be with her in a moment of contentment. She was also much less inhibited than usual. It made me feel close to her, but I also felt I had to be so cautious, because everything is so fraught and fragile with her. I wanted to get closer, but I felt too afraid to tread heavily. I felt I was being careful, approaching slowly.

The therapist's CCRT was similar to the earlier time point. She wished that Hannah would open up, to get close to her and not to hurt her, but here the opposite wish for distance is also present. She perceived Hannah as distant, avoiding contact, and vulnerable but also as struggling to get close and as slightly more open in sharing a positive experience. The therapist's RS was trying to get close, and at the same time being cautious and hesitating to get close.

At this time point, Hannah began to be able to speak of her relationship with the therapist in a more reflective and emotionally connected way. Although she still questioned her therapist's sincerity, she was able to reflect on her contribution to this experience and instead of warding the therapist off as she automatically tended to do, she was able to begin to try to disclose more to her therapist in the session. The therapist showed a greater awareness of the complexity of the emotions between them and the conflicted voices within herself. Although the therapist's main voice aimed to get close and Hannah's main voice was to fear closeness, these two voices were no longer isolated. Though still whispering, the opposite of the main voice was expressed by both parties. The therapist was more in touch with her own ambivalence regarding getting close to Hannah, and at the same time her caution seemed necessary, leading to more gentle steps toward Hannah instead of the direct invitation to get close that characterized their initial encounter. The therapist's awareness of her own ambivalence regarding getting close evolves at the same time as Hannah's increased awareness of her own yearning to get close. The therapist does not give up trying to find the right way to get close to Hannah, and this appears to enable Hannah to develop more trust in the therapist.

CATS and WAI Self-Report Measures. On the CATS, Hannah's scores showed somewhat higher secure attachment to the therapist (4.50 compared

with 4.18), and the Preoccupied score decreases somewhat (2.00). However, her avoidant attachment also increased (3.27). Consistent with this high avoidance, Hannah's WAI in midpoint was somewhat lower (from 5.38 to 4.89). The therapist's WAI was also lower at this point (from 5.42 to 4.64), perhaps related to the sense that progress was slow to develop given the time that had passed (about 4 months).

Late Phase of Therapy

In the RAP interview, Hannah and her therapist chose to recount the same moment in therapy. From the client's perspective:

> One time I came and I didn't want to sit in the chair, and I looked for a corner of the room where I could sit down. In the end I sat on the carpet. She asked: "Do you want me to sit with you on the carpet?" I answered, "No, I just feel comfortable sitting on the floor, it calms me down. I don't want you to sit on the floor, if it is not comfortable for you." I didn't want her to do something that she didn't want to do. And she sat with me and we sat together, and it calmed me down and also I guess it drew us closer. I felt I could trust her, that she was trying to get close to me. She was trying to adapt herself to me. It gave me a sense of security, it was like reaching out. I felt a bit uncomfortable that maybe I was making her do something she didn't really want to do, but then she probably wouldn't have done it. It gives me a good feeling when someone is really trying. It feels close when you sit with someone on the same eye level. I would like her to be the responsible one who I look up to (from the floor), but also want to talk on the same eye level.

From the therapist's perspective:

> I deliberated with myself as to where I should sit, so I asked her, "Where do you want me to sit?" She said: "It is up to you, I won't tell you where to sit." I felt uncomfortable, embarrassed, as it was not clear what was appropriate. So I decided I would sit with her on the floor, on the carpet. We sat on the carpet and it opened up a new kind of relationship between us. She told me more things, and talked about her problems in relationships and with men. We both sat on the carpet and there was feeling of closeness, pleasantness, it was a good session, where we could talk, and get connected, and look together, and ask questions and explore, something that isn't always possible with her . . . I wanted to be with her. . . . (See also Wiseman, 2017.)

In this interaction the possibility of being wrong while trying to get closer was taken into account by both parties. However, the risk of making a mistake while trying to get closer was less anxiety-evoking than it had been earlier in their relationship, and thus they both dared to cautiously take the step toward

one another. This led to a more mutual and collaborative encounter in which they felt safer to get close and to explore new experiences together.

Hannah began therapy with especially high attachment avoidance (and relatively high anxiety). When the therapist, with her high anxiety (and high avoidance relative to the therapist sample), insisted upon engaging, Hannah experienced it as a repetition of her object relations and resisted the therapist's attempts to get close. However, gradually, when the therapist became more attuned to Hannah's needs and accepted her request to get close at her own pace, a more secure attachment was developed. As the therapeutic relationship slowly developed to a point where both partners trusted each other, they were able to survive the other's feelings and tolerate their own and each other's "mistakes," because with a more secure attachment there is always another chance.

CATS and WAI Self-Report Measures. Hannah's scores on the CATS reflected the greater security (from 4.5 in Session 15 to 5.5 in Session 28) and the reduced avoidance with the therapist (from 3.27 to 1.70), while some moderate preoccupation remained (2.22). The drop in avoidance was especially impressive and was also reflected in the higher alliance scores of both Hannah and her therapist (5.81 and 5.44, respectively). It appeared that after 28 sessions, Hannah and her therapist had established a collaborative relationship.

Interpersonal Patterns in Close Relationships at the Late Phase. The narratives from the RAP interview with Hannah about her relationships with her parents and friends at this later phase of treatment show some positive change. Hannah recounted this narrative about an interaction with her mother:

> We talked on the phone. She asked how I am and I usually don't tell her too much, but this time I tried to talk with her. I tried to explain to her why I am not sharing things with her. I didn't want to throw the blame on her, just wanted to explain my point of view. I wanted her to understand that on the one hand I want to be close to her and share things with her, she is really important to me, but on the other hand, when she makes demands to know things and imposes her opinion on me I find myself distancing. It makes me sad that this is how things have been between us for so many years. I wish she could understand, but she didn't, she was very defensive and we both felt frustrated. I guess she was sad too because she is also trying to make things better between us and it's not easy.

Hannah also recounted a narrative about her father:

> He is constantly looking for someone to listen to him and I have no patience for that. He seems so helpless and needy. He called me a few days ago and he wanted to tell me something that had happened to him at work. I didn't have any patience to listen to him. I just wanted him to leave me alone. I told him "make it shorter." He got upset and offended. I just didn't have the energy to listen to him.

Hannah's CCRT with her parents at the later phase of treatment included the wish to be understood, to be close and to be distant; the RO was angry, not understanding, sad and needy; and the RS was frustrated, feeling not understood, sad and distant. Although the interaction with her mother included similar themes to those described in the initial interview, in the later narrative Hannah not only avoided her mother's intrusive attempts to get close to her but also experienced and reflected on the contradictory wishes of both parties. With the father, however, the split was reversed without significantly changing the structure of the complementarity—the needy one and the one who rejects were reversed, but the experience remained one-dimensional.

In her relationships with friends, Hannah also exhibited a greater repertoire of thoughts and feelings and a greater ability to reflect on her wish to get close, which still continued to be accompanied by the fear of getting hurt. The differences between the change processes in the relationship in different close relationships (mother, father, friend, and the therapist) demonstrate that emotional and cognitive changes do not necessarily occur in a symmetrical way within all relationships. In Hannah's case, there was more expansion and growth in the relationship with the therapist, her mother, and friends, but not much change with her father.

ASSESSMENT OF PROGRESS AND OUTCOME

The last research evaluation in the study was conducted after 32 sessions. Hannah's scores on the OQ–45 decreased by 16 points (from 101 to 85) and showed a clinically significant change, although she remained in the clinical range. On the Target Complaints, her three main complaints—anxiety, sadness and low self-esteem—decreased on a scale (from 13 to 1) from a mean of 12 to 5. Compared with published data (Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010) using an effect size analysis (d = the difference between scores of this case and the mean of published data divided by the standard deviation of the published data) showed that at pretreatment she was more distressed on the TCS (d = 1.05) than clients in published data, and after the 32nd session she was similar to clients in published data (d = .09), suggesting her distress alleviated more than clients in the published data. Hannah continued treatment for another 50 sessions for a total length of 2 years of treatment. Termination was set by mutual agreement at the therapist's completion of her internship. Overall, there was marked improvement in Hannah's ability to regulate her anxious and depressed emotions, as well as improvement in different domains in her life (academic functioning and being involved in a supportive romantic relationship).

RESEARCH TO PRACTICE AND BACK

Our analysis of Hannah's case echoes recent findings regarding the importance of therapists' attunement to their clients' changing experience as it fluctuates from session to session throughout therapy (e.g., Atzil-Slonim et al., 2015; Zilcha-Mano et al., 2015). Future studies may benefit from examining whether therapists who are more congruent with their clients' changing needs for closeness and distance gain better therapy outcome.

Recent findings on attachment style representations indicate that it is informative to be aware of clients' specific attachment styles as they relate to specific representational themes of their therapist and therapy (Geller & Farber, 2015). Many of the challenges that therapists face in treating insecurely attached individuals arise these clients'

> two-fold difficulties: on the one hand, they become painfully disappointed when their needs (whether unconscious or disavowed) for caring and affection are frustrated; on the other hand, they have great difficulty accepting the caring concern and affection of their therapists. (Geller & Farber, 2015, p. 466)

We contend that clients who oscillate between the two kinds of difficulties pose the most challenge for therapists, who need to be aware of their own attachment style and to monitor their own reactions to the conflicting representational patterns of the clients as well as to the conflicting patterns within themselves.

Alliance-focused training (AFT), designed to enhance therapists' ability to work constructively with negative therapeutic process or problematic transference–countertransference enactments (Muran, Safran, & Eubanks-Carter, 2010; Safran & Muran, 2000, see Chapter 2), can be especially beneficial to therapists in facing such challenges. Although Hannah's therapist did not receive formal AFT, it is possible that through the supervision she received, she was more able to recognize her own needs for reassurance that were frustrated by Hannah's difficulty in trusting her, and this enabled her to push Hannah less and later adjust herself to Hannah by providing a more optimal emotional distance that facilitated her engagement in therapy.

Mallinckrodt developed the Therapeutic Distance Scale (TDS) to assess the way clients perceive the therapist's responses to them in light of their attachment style in terms of distance and engagement. He showed that, as expected, client attachment avoidance (on the ECR) was significantly correlated with perception of therapists as *too close* (but not *too distant*). While, client attachment anxiety was significantly correlated with perception of therapists as *too distant* (but not *too close*) (Mallinckrodt et al., 2015). Egozi, Wiseman, Tishby, and Sharabany, (2016) adapted Mallinckrodt's TDS

self-report scale to an observer version (TDS–O) that includes client and therapist versions. This allows revelation of attachment dynamics that may not be evident from clients' self-reports and exploration of different trajectories of therapeutic distance in different styles of attachment insecurity in client–therapist dyads. Some preliminary findings suggest that clients' distance–closeness dynamics play out as a function of client attachment needs, therapist awareness of these needs, and the ability of therapists to monitor their own reactions and tailor their interventions accordingly.

Future research that includes more fine-grained analyses of these dynamics has the potential to inform clinicians and supervisors how to work with these dynamics in order to foster the needed corrective emotional experiences that will improve our clinical effectiveness.

IMPLICATIONS FOR CLINICAL PRACTICE AND SUPERVISION

A common dyadic pattern in psychotherapy is when client and therapist are locked in a complementary relation in which there appear to be only two choices: either submission or resistance to the other's demands. A common theme of this complementarity structure involves polarization between closeness and distance in the therapeutic relationship. Once therapists can deeply accept their own contribution to the impasse, and the fact of two-way participation becomes a vivid experience, it opens the space for negotiating differences, making it possible to connect. The experience of surviving breakdown into complementarity and subsequently of communicating and restoring dialogue is crucial to therapeutic action. From it emerges a more advanced form of relatedness. When clinicians are caught in complementary interactions, instead of having to choose between closeness and distance, they may try to open up the space to explore the internal battle that is taking place within themselves as well as within their clients. Exploring the longing and dread of closeness and distance may lead to a greater ability to bear conflict in these painful matters and to allow new ways of being together.

Facilitating corrective emotional experiences is a highly complex process in general, and with fearful clients in particular. When encouraging clients to share their inner feelings and inviting them to immerse themselves in the relationship, therapists need to be cautious not to get caught up by their own lenses without enough awareness of how these meet the client's lenses. Focusing on closeness–distance dynamics in attachment-informed training and supervision may be beneficial for reducing dropout and improving outcome.

SUMMARY AND MECHANISMS OF CHANGE

In this chapter we explored the interpersonal dynamics played out in a client–therapist dyad that began therapy with a disharmonious dance characterized by the pushes and pulls of closeness and distance. Client and therapist, who were both characterized by insecure attachment, each enacted in the therapeutic encounter their affect-regulation strategies that appeared to clash within the therapeutic context. The therapist's attempts to get close to the client were experienced as intrusive and controlling, and the client reacted with avoidance and distance. The more the therapist tried to get closer, the more rigidly the client was locked in the avoidant position. The therapist was caught in a relational dilemma in which trying to get close to the client was experienced as intrusiveness and distance was experienced as abandonment and rejection. As therapy progressed, instead of the direct invitation to get close that characterized the therapist's stance in the initial encounters, the therapist became more attuned to Hannah and made more gentle steps toward her. The therapist's awareness of her own ambivalence regarding getting close evolved at the same time as Hannah's increased awareness of her own yearning to get close. Moreover, the therapist did not give up trying to find the optimal way to get close to Hannah, and this appears to have enabled the client to develop more trust in the therapist and to use her as a secure base to engage in exploration.

The experience of surviving breakdown into complementarity, and subsequently of communicating and restoring dialogue, is crucial to therapeutic action (Benjamin, 2004). The centrality of the dialogue to the therapeutic relationship is key to working with ruptures in the therapeutic relationship. Recognizing ruptures provides a unique opportunity to explore and rework them in the therapeutic relationship in order to develop new avenues for experiencing the self and the other (Mitchell, 1993; Muran, 2002). As we have demonstrated, successful negotiation of the optimal distance in the therapeutic relationship is a central change mechanism that is crucial for promoting client change.

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