PLURALISTIC PRACTICE

RESEARCH ARTICLE

The Relationship Between Secure Therapeutic Attachment Alliance and Psychotherapy Satisfaction

MARWAH BAHLOUL & ALAN PRIEST

ABSTRACT

This study examines the relationship between secure attachment, therapeutic alliance, and psychotherapy satisfaction within the context of pluralistic psychotherapy. To capture clients' subjective experiences beyond symptom reduction, this research introduced a brief psychotherapy satisfaction measure designed specifically for the study.
Using a quantitative, non-experimental cross-sectional design, data were collected from 206 participants who had completed a course of psychotherapy. Participants completed an attachment style inventory, a therapeutic alliance measure, and a bespoke satisfaction questionnaire. The study aimed to determine whether therapeutic alliance moderated and/or mediated the relationship between secure attachment and satisfaction.
Moderation analysis showed that therapeutic alliance significantly moderated this relationship: secure attachment predicted higher satisfaction at lower levels of alliance, suggesting that a strong alliance can offset less secure attachment. Mediation analysis indicated that therapeutic alliance fully mediated the link between secure attachment and satisfaction, highlighting the therapeutic relationship as the key mechanism through which attachment influences client experience.
These findings underscore the central role of alliance within pluralistic psychotherapy and that, while secure attachment supports engagement and satisfaction, a strong alliance can buffer the effects of insecure attachment. Implications include the potential value of considering attachment styles in clinical formulation and the importance of collaborative, flexible, and meta-therapeutic processes.
Limitations include reliance on self-report measures and the need for further validation of the satisfaction scale. Future research could examine therapist attachment styles and investigate pluralistic processes, such as client preference and shared decision-making, in greater depth.

CORRESPONDING AUTHOR:

Marwah Bahloul
City St. George's, University of London

Marwah.bahloul@nelft.nhs.uk

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INTRODUCTION

BACKGROUND

Pluralistic psychotherapy is a collaborative approach, which emphasises tailoring therapy to the unique needs, preferences and client objectives, integrating a range of approaches. Historically, it emerged in response to single modality therapy driven by a desire to introduce flexibility, recognising that different people have different needs at different times. The approach emphasises a dialogical approach and the client-centeredness on which many humanistic approaches are based, emphasising integration according to clinical need. (Cooper & McLeod, 2012). Pluralistic therapy is characterised by how the therapist seeks to engage the client in the process of change, arguably facilitating them to take responsibility for their own outcomes. The therapist aims for transparency, involving the client, discussing the therapy process non-defensively (Cooper & McLeod, 2012, p. 7).

A crucial factor in pluralistic practice is an equalisation of power between therapist and client, to create client agency, discouraging client deference (Rennie, 1994) and helping clients achieve their therapeutic goals in ways that feel comfortable, the argument being that this is more likely to facilitate efficacy (Swift et al. cited on p. 4 in Cooper & Dryden, 2015; McLeod, 2017; Murphie & Smith, 2025). This equalisation is exemplified by the way in which the meaning of events for the client is co-constructed, rather than provided by the therapist as “expert,” such a relationship being described as the “bedrock of the pluralistic encounter” (Gabriel, 2016, p. 302).

FACTORS AND OUTCOMES

The goal of all psychotherapy is, of course, the benefit of the client, although how this is evaluated tends to focus on symptom reduction as measured using scales such as CORE-OM (Evans et al., 2000), PHQ-9 (Kroenke et al., 2011) or GAD-7 (Spitzer et al., 2006). Whilst these instruments have been found to demonstrate high levels of validity and reliability, they are not designed to illuminate how or why therapy works, nor what factors are instrumental in producing benefit for the client. In the same way, in which “only the client knows what hurts” (Kirschenbaum & Land Henderson, 1996) it is perhaps arguable that only the client knows what helps, or as Rogers put it, “rely upon the client for the direction of movement in the process” (*ibid.,* p. 13).

Norcross and Lambert (2019) undertook extensive research investigating a range of factors that were implicated in therapy outcomes. In an explained variance model, they reported that the most common and significant factors were modality, common factors (for example, client-therapist relationship and goal consensus) and extra therapeutic change. Therapeutic modality contributed, they reported, to the same extent as the placebo effect (15%) (Figure 1). The extra therapeutic change to which the authors refer is described as “self-change, spontaneous remission, social support [and] fortuitous events” and may also include individual differences (Norcross & Lambert, 2019, p. 13).

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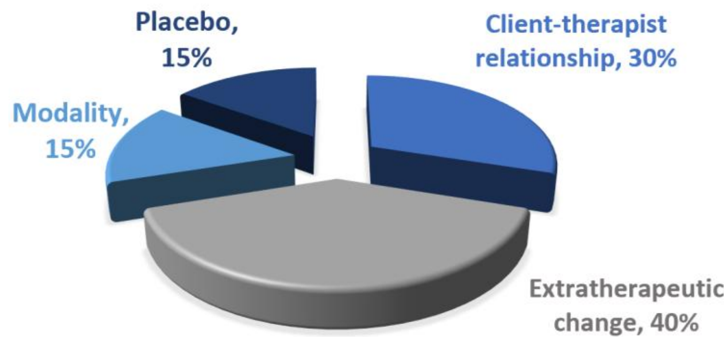
Figure 1

Psychotherapy Outcomes (Norcross & Lambert, 2019)



Consistent with pluralistic practice, this research emphasises the importance of working with clients according to their individual needs, recognising and honouring differences to achieve positive therapy outcomes. Moreover, the factors cited as having an impact on therapy outcome contributed significantly, irrespective of diagnosis. In other words, the nature of the presentation seems not to mediate outcomes, which further emphasises the importance of the relationship in determining outcomes.

Notably, the authors reported that there were a number of activities therapists could avoid that were found to be unhelpful and even counter-productive to the purpose of therapy; such things include the therapist adopting a rigid approach and being unable to tailor treatment according to client needs, therapist assumptions and misconceptions about the client, and "therapist-centricity". This would suggest that both positive and negative therapy outcomes can be attributed to how the therapist works with and according to the client's unique differences (Norcross & Lambert, 2019).

THE THERAPEUTIC RELATIONSHIP AND INDIVIDUAL DIFFERENCES

Norcross and Lambert (2019) described the therapeutic relationship as "the feelings and attitudes" between the therapist and client and how they are communicated and experienced (p. 3). It is a collection of behaviours and traits that the therapist imparts in the therapeutic space with the client that fosters a trusting relationship between the two. The therapeutic relationship could also be defined as collaboration, a personal bond, an agreement on goals and tasks, and empathy between therapist and client (Bordin, 1979; Elliott et al., 2018; Horvath et al., 2011; Martin et al., 2000). All of these factors are entirely consistent with pluralistic practice, which emphasises collaboration, flexibility and client empowerment in the therapeutic relationship.

Other studies confirm the pantheoretical importance of the therapeutic relationship and its importance across therapies (Falkenström et al., 2013; Flückiger et al., 2018). Indeed, it has been suggested that the psychotherapeutic process of change occurs mainly as a result of the therapeutic alliance and its strength; the stronger the therapeutic alliance, the more likely there will be positive

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changes and positive therapeutic outcomes (Stefana et al., 2024; Vaz et al., 2024). According to Bordin (1979), the strength of the therapeutic relationship is "a function of the goodness of fit of the respective personalities of patient and therapist" (p. 252).

TRUST IN THE PROCESS

Pluralistic psychotherapy is frequently a deeply personal and relational experience for both the client and their therapist. This is built on a foundation of trust, a core component of alliance and an important factor in helping the client to manage their anxiety or distress when the work is experienced as challenging. Trust is essential in building empathy. (Greenberg et al., 2001), collaboration, and goal consensus (Tryon & Winograd, 2011). Fonagy and Allison (2014) discussed mentalising as it relates to epistemic trust in the therapeutic relationship. Epistemic trust refers to the "social experience" of being understood and validated in therapy. Once this is experienced and internalised in therapy, it can then be assimilated into social experiences outside of therapy, whereby positive feedback can be received and reinforced, leading to therapeutic change in different areas of life. It is arguable, therefore, that positive change and progress are facilitated by what happens between therapist and client, rather than therapist skills or techniques "taught" to the client.

ATTACHMENT THEORY

Given that a large volume of existing research emphasises the importance of relationships and alliances in mediating therapeutic outcomes, it is perhaps helpful to consider the role of attachment styles in the therapeutic encounter. The theory of attachment is one way to understand and explain the complexities of interpersonal interactions, relationships and relational processes (Cassidy & Shaver, 2002).

John Bowlby established the theory of early attachment as an important psychological construct that has been shown to shape future relationships, influence various aspects of mental health and have an impact on overall well-being (Bifulco, 2015). Bowlby believed that infants have an evolutionary instinct that drives them to seek proximity, a secure base and a safe haven with the main caregiver (traditionally the mother) (Bowlby, 1973). When this experience is adequate, it leads to secure attachment, and when it is inadequate, it can lead to insecure attachment. Attachment theory was further developed by Mary Ainsworth (1979), whose infant-caregiver observations identified three distinct attachment styles: insecure-avoidant, insecure-resistant and secure attachment. Later research added disorganised-disoriented attachment style (Main & Solomon, 1990).

Secure attachment is linked to better quality relationships, healthy levels of self-esteem, and resilience when faced with challenges (Fonagy et al., 2017). Insecure attachment is usually linked to childhood trauma and is often one of the underlying causes of emotional dysfunction and psychological disturbance in adults (Bifulco, 2015).

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It is thought that attachment styles are not only pertinent to overall well-being and functioning, but there is a strong association between attachment styles and therapy processes and outcomes (Obegi & Berant, 2010). Obegi and Berant (2010) discussed how the therapist can serve as a secure base and safe haven; specifically, in attachment-informed psychotherapy, the client-therapist relationship is at the centre of the therapeutic process. Daniel (2006) pointed out that when therapists are aware of and attend to their clients' historical relational difficulties, attachment patterns will naturally emerge and become evident in the therapy room. Irrespective of therapy goals, these patterns will likely influence help-seeking behaviours and hence require some degree of therapeutic attentiveness in order to support the client's progression (Daniel, 2006).

Indeed, there is also evidence to suggest that there is a relationship between attachment styles and therapeutic alliance, which can impact the therapy process (Mikulincer et al., 2013). Mikulincer et al. (2013) reported that attachment style influences self-disclosure, where insecurely attached clients were found to be less inclined to self-disclose. Self-disclosure is something that is necessary to develop intimacy and closeness within relationships. Without it, relationships cannot progress beyond the formal; they remain distant and lack emotional depth or closeness.

For an in-depth review of the role of attachment in psychotherapy, see (Cassidy & Shaver 2016; Slade & Holmes, 2019).

THERAPY OUTCOME

There exists significant research supporting the use of empirically validated standardised Routine Outcome Measures (ROMs) (Barkham et al., 2023; Jong et al., 2023; Reese et al., 2024) focussed on implementing or employing ROMs in quantifying therapeutic outcomes. However, although widely used, ROMs are context dependent, often employing patient reports, and are not applied in controlled conditions, unlike randomised controlled trials. This arguably limits the confidence with which firm conclusions may be drawn (Roe et al., 2022).

Other studies focus on standardised inventory outcome scores of specific pathologies or conditions, such as depression or anxiety. Improvement or deterioration in symptoms might be determined by analysing changes in scores based on a standardised depression or anxiety inventory and then comparing differences among and between control/experimental groups. For example, Cuijpers et al. (2011) identified at least 250 studies examining the efficacy of psychotherapy for depression that evidenced a significant reduction in depressive symptoms and improvement in quality of life. Interestingly, if not surprisingly, differences in effect sizes between different types of psychotherapy were small.

Alternatively, some research approaches focus on overall well-being using the corresponding inventories, such as WHO-5. (Topp et al., 2015) or Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al., 2007) measured periodically throughout treatment.

This emphasis on modification of symptoms or comparisons against standard lifestyle measures means that the client's subjective experience is often neglected, thus missing an opportunity to delve into detailed aspects of the

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psychotherapy process and develop service provision that is, as emphasised in pluralistic practice, more relevant and meaningful to, and aligned with, the individual service user.

The client's input is not only important for research and therapy outcome purposes; without it, the therapeutic experience is one-sided and potentially meaningless (Macran et al., 1999). Macran et al. (1999) also posited that, taken into consideration from a social constructivist view, it is not reasonable for a therapist or third party to assume a therapeutic intervention has been successful if we are under the assumption that there is no "empirically observable objective truth" (p. 330). This means that only the client can truly ascertain and confirm if they benefited from therapy or not.

Although there has been some increase in research on client satisfaction, such research has not reached the same level of abundance as research using more common nomothetic outcome measures. This is not to dismiss standard nomothetic measures of well-being and/or functioning as arbitrary or of little use. However, assessing client satisfaction would provide more context for how mental health practitioners assess progress and might help guide the treatment approach. Indeed, the outcome and satisfaction with treatment have been found to correlate with positive changes on standardised nomothetic routine outcome measures (Miglietta et al., 2018). This would suggest that assessing for client satisfaction is a valid and informative indicator of outcome. Studies show that therapy clients who report satisfaction with their mental health services are more engaged with treatment, other ROMs are more positive, and there are lower dropout rates (Fortin et al., 2018; Miglietta et al., 2018).

As early as 1964, Strupp et al. carried out an investigation on former clients' psychotherapy experiences in retrospect and found a strong positive correlation between feeling dissatisfied with psychotherapy and feeling uncertain with regard to how the therapist felt towards the client (as cited in Timulak & Keogh, 2017, p. 1557). This points to the potential relational link between satisfaction with psychotherapy and therapeutic alliance.

RESEARCH AIM

The evidence would suggest that, among the many possible individual differences, the attachment style of both client and therapist will influence the therapeutic relationship, for example, mediating what may or can occur in the therapy space and the client's capacity and willingness to engage with both the intervention and the clinician. Indeed, there might exist a relationship between secure attachment and therapeutic alliance. At the time of this study, there were no studies, to the knowledge of the researchers, that investigated the level of *satisfaction* and its relationship to the therapeutic alliance and individual differences, a potentially important gap in the literature. Therefore, the purpose of this research was to quantitatively investigate the relationship between therapeutic alliance, secure attachment and psychotherapy satisfaction.

Hypotheses

Two complex hypotheses were proposed:

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Hypothesis 1

H_1: The relationship between Secure Attachment and Satisfaction will be moderated by Therapeutic Alliance.

H_0: The relationship between Secure Attachment and Satisfaction will not be moderated by Therapeutic Alliance.

Hypothesis 2

H_1: Therapeutic Alliance will mediate the relationship between Secure Attachment and Satisfaction.

H_0: Therapeutic Alliance will not mediate the relationship between Secure and Satisfaction.

METHODOLOGY

RESEARCH DESIGN AND METHODS

This was a quantitative, non-experimental, cross-sectional research design (Lewis-Beck et al., 2004). The study was carried out between 2023-2024, and data were collected at one point in time, post-therapy. There was no control group, nor was there any manipulation of the independent variables. Consistent with the cross-sectional design criteria (Lewis-Beck et al., 2004), it was delivered in survey/questionnaire format, using standardised inventories. The data collected were then subjected to statistical moderation and mediation analyses to investigate the relationships between variables.

The current research could be categorised as process-outcome research (POR). Process-outcome research is best investigated quantitatively and “mostly follows a non-experimental approach” (Gelo & Manzo, 2014, p. 263). This type of research differs from change-process research in that, with the latter, the effect of therapeutic events occurring in therapy is evaluated in terms of how they are experienced and the impact they have on the client. In the case of POR, the focus of research is on relevant therapy factors that can be interpreted in a therapeutically meaningful outcome.

ANALYTIC STRATEGY

Moderation and mediation analyses of the data were determined to be the most appropriate method to assess the relationship between the variables in question, across a representative sample of the population. Regression models, such as moderation and mediation analyses, are considered suitable for cross-sectional studies that are designed to investigate relationships that may or may not exist between variables (Gelo & Manzo, 2015). Additionally, regression models can provide important information about the strength and direction of a relationship between variables.

The analysis for the current study, based on previous studies, identified specific variables implicated in client satisfaction, arguably a key component in therapy outcomes, and investigated the relationships between the hypothesised predictor

variables and the moderators and mediators (Edwards & Lambert, 2007). The predictor (independent) variables under investigation were therapeutic alliance and secure attachment. The dependent variable was psychotherapy satisfaction. This was established by means of a brief retrospective self-report questionnaire, using three questions, each measured on a five-point Likert scale:

How satisfied are you with the therapy you received?

Did the therapy you received meet your expectations

To what extent did therapy help you with your problem(s)?

The quality index of the psychotherapy satisfaction scale was assessed through various approaches, including reliability and validity measures; by examining descriptive statistics, internal consistency, inter-item correlations, and correlations with the overall satisfaction composite score. Descriptive statistics showed that all items had acceptable variability, with means ranging from 1 to 5, which is expected as subjective experiences with satisfaction will normally vary. Mean values and standard deviation (SD) revealed further useful information; Item 1 (Met Expectations) M = 3.73, SD = 1.05; Item 2 (How Helpful) M = 3.69, SD = 1.13; Item 3 (How Satisfied) M = 3.95, SD = 1.16. These values would suggest that participants expressed moderate to high levels of satisfaction with their psychotherapy experience, with some variability in responses across the items as indicated by the SD. Indeed, the SDs suggest that the scale is sensitive enough to capture a range of responses, which is important for understanding the wide range of satisfaction levels among participants.

Internal reliability, measured by Cronbach's alpha, was .86, indicating strong internal consistency. This value is well above the widely accepted threshold of 0.70, suggesting that the items were reliably measuring the construct of psychotherapy satisfaction as a whole. Furthermore, the mean inter-item correlation was 0.67, above the recommended range of 0.15–0.50 (Briggs & Cheek, 1986). Each satisfaction scale item also positively correlated with the composite score for satisfaction: 0.87 (Met Expectations), 0.87 (How Helpful) and 0.89 (How Satisfied). Overall, this evaluation indicated that the three items measured the same construct: satisfaction with psychotherapy. These findings suggested that the scale was reliable and appropriate for assessing satisfaction with psychotherapy, with potential for refinement in future research.

For the analysis, a composite score of the three items was used to create an overall satisfaction variable by calculating their mean. The statistical analysis for both moderation and mediation analyses was carried out using the software PROCESS Macro created by Andrew Hayes (2022), for IBM's SPSS Statistics for Windows, Version 29.0 (IBM Corps, 2023). Hayes PROCESS Macro (2022) is a statistical extension that was designed for SPSS and SAS. It simplifies the analysis of mediation, moderation, and conditional process modelling.

PROCEDURE

Data collection took place online between October 2023 – January 2024, hosted on the platform Qualtrics. Eligible participants, who were former therapy clients, were asked to answer an information-gathering questionnaire online. The first section

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collected details about their demographic characteristics and their experiences with psychotherapy. Following this, they were asked to complete an attachment inventory and a therapeutic alliance scale regarding their completed course of psychotherapy. Shortened and brief versions of inventories were selected to avoid "survey fatigue" (Porter et al., 2004). Participants went on to complete a brief outcome survey to assess satisfaction with psychotherapy. The average time it took to complete the entire questionnaire was approximately 15 minutes.

RECRUITMENT

Participants were recruited through purposive sampling and were from the general public located in any country as long as there was access to the internet. Out of the total number of participants recruited (*N* = 206), approximately 15% were undergraduate students recruited through City, University of London (renamed City St. George's, University of London in 2025) in exchange for credit (*n* = 30), approximately 8% were recruited through flyers distributed on social media platforms (X/Twitter, Facebook, and LinkedIn) or personal contacts who passed the link along to their own acquaintances (*n* = 16). The rest were paid participants recruited through the platform Testable (*n* = 160).

According to the World Health Organisation (WHO, 2022), globally, it was estimated that women made up over 50% of the population that sought out therapy. The UK also reported a similar distribution, with women making up over 50% of those in therapy (Lubian et al., 2016). Although this disparity was reported not to exist in 2023-24 according to Clery et al. (2025) in the current study, sample representativeness of the therapy-seeking population was consistent with the previous reports, with 59.2% of the participants being female (Table 1).

Table 1

Participants' Demographic Details

Variable		**Frequency (n)**	**Percentage (%)**
Gender	Female	122	59.2%
	Male	82	39.8%
	Other	2	1.0%
Age Group	18 – 29	114	55.3%
	30 – 39	53	25.7%
	40 – 49	27	13.1%
	50 – 59	10	4.9%
	60 – 69	2	1.0%
	70 or above	0	0%
Race	White	94	45.6%
	Black	56	27.2%
	Asian	40	19.4%
	Mixed Race	9	4.4%
	Arab/Middle Eastern	4	1.9%
	Other	2	1.1%
	Hispanic	1	0.5%

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Education Level Completed	Did not finish high school/secondary	0	0%
	Completed high school/secondary	64	31.1%
	Bachelor's degree		
	Master's degree	99	48.1%
	Doctorate/PhD	35	17%
		8	3.9%
Are you/Have you ever been a mental healthcare practitioner?	No	189	91.7%
	Yes	17	8.3%

INCLUSION CRITERIA

Participants were required to have commenced psychotherapy within the past year at the time of participation and must have completed it before they participated in the study (to reflect on the outcome and respond accordingly). They were required to have had a minimum of five sessions with the same practitioner, and none of the sessions could have been computerised. Participants must have been 18 at the time of their participation in the study as well as at the time that they were in therapy. They were required to have access to the internet and an adequate level of digital literacy to participate. They needed to be sufficiently fluent in English to ensure they could understand the questions and answer them accordingly.

RESEARCH MATERIAL

Information Gathering Questionnaire

After participants consented to take part in the research and confirmed that they met the inclusion criteria, participants were asked to answer a multiple-choice questionnaire to gather demographic information and details about their therapy experiences. Participants were also asked about why they had sought treatment and could select several reasons. Following this, they were asked to select the *main* reason they sought therapy (Table 2).

Table 2

Participants' Main Reason for Seeking Therapy

Reason	***n***	**%**
Depression	63	30.6
Anxiety	61	29.6
Romantic Relationship Issues	14	6.8
Family Issues	15	7.3
Work Issues	12	5.8
Other	12	5.8
Someone Told Me To (had to go for a relationship, work, legal mandate, etc.)	11	5.3
Complex/Long-term Mental Health Condition	10	4.9
Bereavement	8	3.9
Total	206	100

Following the information gathering section of the questionnaire, participants went on to complete standardised inventories for attachment and therapeutic alliance. Inventories were scored according to the developer's guidance, and reliability scores were calculated.

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Attachment Inventory

The Revised Adult Attachment Scale (RAAS; Collins, 1996) was used to determine attachment style. The RAAS is a self-report measure that evaluates how individuals experience close relationships along three dimensions: secure, avoidant, and anxious. This scale consists of 18 items measured on a five-point Likert scale (1 = not at all characteristic of me to 5 = very characteristic of me). The RAAS demonstrates good convergent validity, correlating with other similar measures such as the Adult Attachment Interview (AAI) and the Experiences in Close Relationships scale (ECR) (Collins, 1996; Ravitz et al., 2010). It has also demonstrated good factor structure through confirmatory factor analysis and is highly correlated with other similar measures (Collins, 1996; Ravitz et al., 2010). Internal reliability of the RAAS has good support, as Collins and Read (1990) previously reported alpha coefficients of 0.83 for secure, 0.85 for avoidant, and 0.72 for anxiety. In the current study, subscales were also assessed for internal consistency, and Cronbach's alpha coefficient was 0.77 for secure, 0.74 for avoidant, and 0.87 for anxious, indicating similarly good levels of internal reliability across the subscales (Taber, 2018).

Therapeutic Alliance

The Working Alliance Inventory-Short Revised (WAI-SR; Hatcher & Gillaspy, 2006) was used to assess the therapeutic alliance. The WAI-SR is the shortened version of the original 36-item Working Alliance Inventory (WAI) developed by Horvath and Greenberg in 1989. The WAI-SR effectively captures the original WAI's conceptual framework in a format that allows users to complete it in significantly less time. This 12-item scale measures attachment across three subscales: goals, tasks, and bond. For the current study, the three subscales were assessed altogether on a five-point Likert scale (*seldom, sometimes, fairly often, often, always*). The WAI-SR has good construct validity demonstrated through confirmatory factor analysis and convergent validity as it correlates highly with other similar measures (Falkenström et al, 2014; Hatcher & Gillaspy, 2006; Munder et al., 2010). Reliability testing also shows good internal consistency with Cronbach's alpha coefficients for its subscales usually in the range of .85 to .92 (Falkenström et al, 2014; Hatcher & Gillaspy, 2006; Munder et al., 2010). In the current study, consistent with previous research, Cronbach's alpha revealed high internal consistency for the WAI-SR (alpha coefficient = .94).

Outcome Measure

Satisfaction with psychotherapy was determined using a set of three questions, each measured on a five-point Likert scale. The questions asked about satisfaction, the meeting of expectations, and the helpfulness of psychotherapy. Altogether, these three questions regarding psychotherapy satisfaction showed

positive intercorrelations. Reliability testing indicated good reliability (Cronbach's alpha = .86). A composite score for the variable, Satisfaction, was created by calculating the mean of all three factors.

RESULTS

HYPOTHESIS TESTING

Moderation Analysis

The moderation analysis was carried out in Hayes Process MACRO in SPSS with "Model 1" selected from the dropdown menu for simple moderation. Model 1 produces the interaction effect of a moderating variable (W) on the relationship between an independent variable (X) and a continuous dependent variable (Y). Figure 2 illustrates the theoretical concept of moderation analysis, and Figure 3 illustrates the statistical concept of moderation analysis, which includes the interaction term X*W.

Figure 2

Illustration of Model *1: Simple Moderation Analysis (Hayes & Rockwood, 2017), a Theoretical Representation*

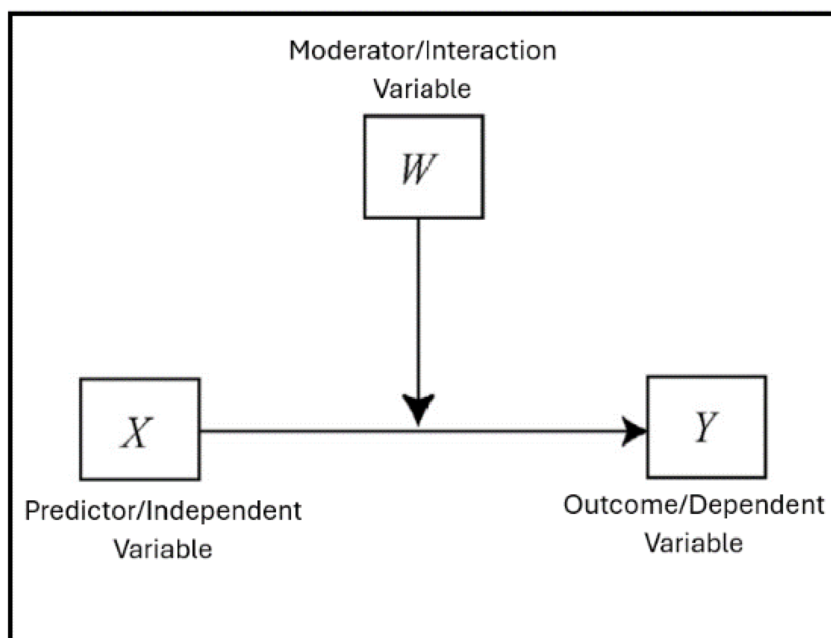

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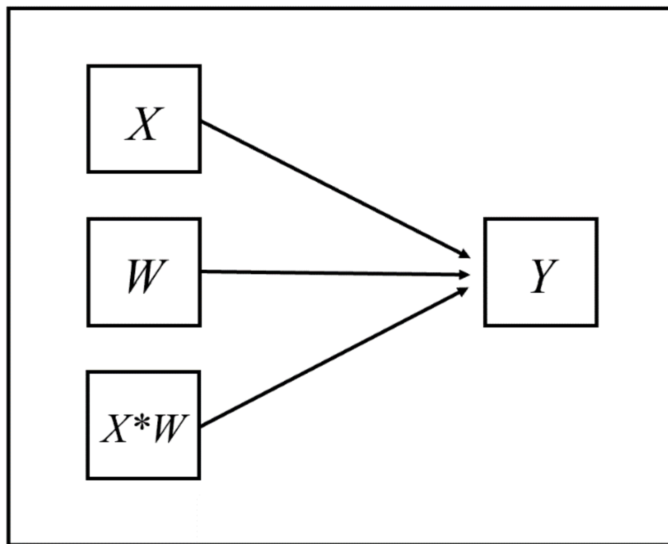
Figure 3

Illustration of Model 1: Conceptual Statistical Representation



Hypothesis 1

The relationship between attachment styles and Satisfaction will be moderated by Therapeutic Alliance. Null hypothesis: The relationship between attachment styles and Satisfaction will not be moderated by Therapeutic Alliance.

The first moderation analysis model using Hayes PROCESS Macro in SPSS examined three models for each of the three attachment styles. The first model consisted of the predictor variables Secure, Therapeutic Alliance and their interaction term with the dependent variable being Satisfaction. Results of the analysis were statistically significant and showed that the relationship between Secure and the outcome variable Satisfaction was moderated by Therapeutic Alliance (Figure 4). The overall model $R^2 = .56$, $F(3, 202) = 93.05$, $p < 0.001$, indicated the interaction explained 56% of the variance. The coefficient for the moderator was found to be statistically significant, $b = -.13$, bootstrap SE = .06, bootstrap 95% CI [-0.24, -0.01], $p < .05$, indicating a moderation effect (Table 4). Regarding conditional effects of the focal predictor Secure at different levels of the moderator Therapeutic Alliance, at the lower level, when Therapeutic Alliance was -0.86, Secure was 0.18, SE(HC4) = .095, 95% CI [-0.01, 0.36], $p = .06$ (marginally significant). When Therapeutic Alliance was at the middle range 0, Secure was 0.07, *SE*(HC4) = 0.06, 95% CI [-0.04, 0.18], $p = .22$. At the higher level when Therapeutic Alliance was 0.86 Secure was -0.04, SE(HC4) = .05, 95% CI [-0.14, 0.06], $p = .45$) (Table 3).

In testing for moderation, that is, how Therapeutic Alliance affects the relationship between Secure Attachment and Satisfaction, the focus is on interaction effects. The Johnson-Neyman (J-N) technique identifies the range of values of the moderator (Therapeutic Alliance) where the relationship between the independent variable (Secure Attachment) and the dependent variable (Satisfaction) is statistically significant. The J-N output identifies a precise threshold or region of significance, obviating the need for testing the effect at arbitrary points (e.g. low, medium, high). In this case, Secure Attachment significantly predicted

Satisfaction when Therapeutic Alliance was > -1.43 (6.31% of cases below, 93.69% of cases above), indicating Secure Attachment positively impacts Satisfaction at lower levels of Therapeutic Alliance.

Figure 4

Graph of the Moderation Effect between Secure Attachment and Therapeutic Alliance on Outcome Satisfaction

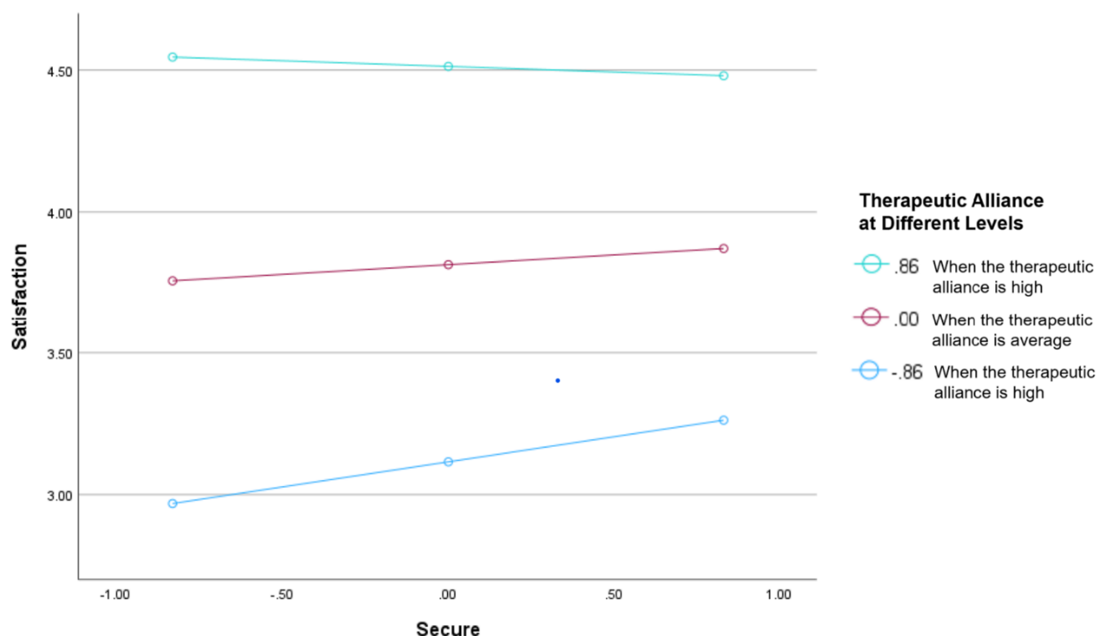


Table 3

Conditional Effect *of Focal Predictor Secure; Moderator Therapeutic Alliance; Outcome Variable Satisfaction*

Therapeutic Alliance	Effect	SE (SE-HC4)	t-value	Bootstrapped CI 95% LL	Bootstrapped CI 95% UL	p-value
-.8592	.1771	.0951	1.8631	-.0103	.3645	.0639
.0000	.0687	.0563	12.1719	-.0423	.1797	.2236
.8592	-.0396	.0528	-.7503	-.1438	.0645	.4540

Note. CI = confidence interval; LL = lower limit; UL = upper limit.

In summary, these results suggested that the hypothesis was supported as the relationship between Secure Attachment and Satisfaction was moderated by the Therapeutic Alliance.

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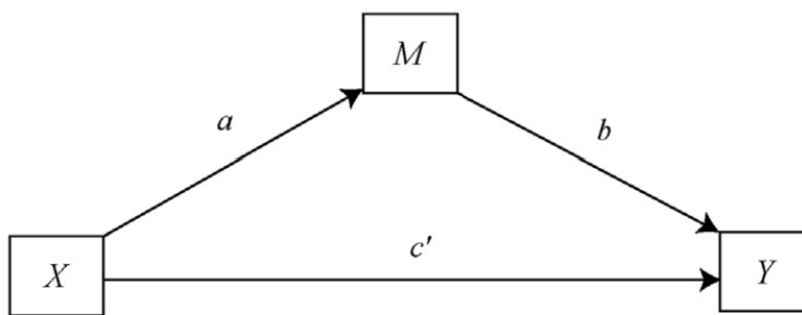
MEDIATION ANALYSIS

In Hayes PROCESS Macro, the selection "Model 4" from within the programme allows the processing of a simple mediation analysis. This produces statistical information explaining if there is a causal effect of a mediating variable (M) on the relationship between an independent variable (X) and a continuous dependent variable (Y) (Figure 5). In mediation analysis, *path a* is the path between the predictor (X) to the mediator (M), *path b* is from the mediator (M) to the outcome (Y) while controlling for the predictor (X), and *path c'* is the direct effect path from the predictor (X) to the outcome (Y).

Figure 5

Illustration of Mediation Analysis; Model 4 from Hayes & Rockwood (2017)



Hypothesis 2

Therapeutic Alliance will mediate the relationship between Secure and Satisfaction. Null hypothesis: Therapeutic Alliance will not mediate the relationship between Secure and Satisfaction.

A mediation analysis was conducted to examine whether the Therapeutic Alliance mediated the relationship between Secure and Satisfaction (Figure 6). The results showed that Secure significantly predicted Therapeutic Alliance (b = .25, p = .002) (Table 4). Therapeutic Alliance significantly predicted Satisfaction (b = .83, p < .001). The total effect of Secure on Satisfaction was significant (b = .27, p = .005). The direct effect of Secure on Satisfaction was not significant when controlling for Therapeutic Alliance (b = .06, p = .28). The indirect effect of Secure on Satisfaction through Therapeutic Alliance was significant (b = .21), bootstrap 95% CI [0.08, 0.35]. These findings suggested that Therapeutic Alliance fully mediated the relationship between Secure attachment and Satisfaction.

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Figure 6

Illustration of Variables Under Investigation in the Mediation *Analysis*

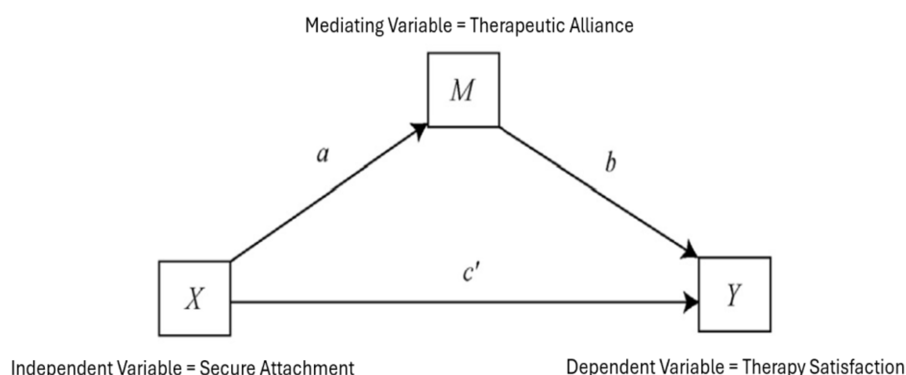

Table 4

Mediation Analysis Summary for Secure Attachment as Predictor; Therapeutic Alliance as Mediator; and Satisfaction as Outcome

Effect	Path	b	SE	CI 95%	p-value	
				LL	UL	
Total	Secure → Satisfaction (with direct/indirect effect)	.2670	.0929 (HC4)	.0838	.4502	p = .0045
Indirect	Secure → Therapeutic Alliance → Satisfaction	.0612	.2058 (Bootstrapped)	.0729	.3452	-
Direct	Secure → Satisfaction	.2058	.0559 (HC4)	.0802	.3476	p = .2752

Note. CI = confidence interval; LL = lower limit; UL = upper limit.

DISCUSSION

The analysis revealed important relationships among the variables. Below is a summary of relevant findings with recommendations.

ATTACHMENT STYLES AND THE THERAPEUTIC ALLIANCE

The analysis indicated that secure attachment and therapeutic alliance were consistently significant factors that influence client satisfaction. Secure attachment positively predicted satisfaction, which is consistent with many previous studies (Horvath et al., 2011; Norcross & Lambert, 2019; Sharf et al., 2010). Moderation analysis showed that the relationship between secure

attachment and psychotherapy satisfaction was moderated by levels of therapeutic alliance. This outcome meant that secure attachment positively predicted therapy satisfaction at lower levels of therapeutic alliance. Or, conversely, secure attachment had a less significant impact on therapy satisfaction at higher levels of therapeutic alliance. This might be interpreted to mean that the therapeutic alliance supersedes a secure attachment or that a secure attachment becomes less important as long as there is a satisfactory therapeutic alliance to compensate. Mediation analysis supported the moderation analysis and provided further context that the therapeutic alliance might be the path through which different levels of secure attachment could predict satisfaction.

These results, consistent with previous research, point to the importance of the therapeutic alliance and indicate that attachment styles play a significant role in the therapeutic process. For example, secure attachment supports mentalisation, enabling clients to understand their own and others' mental states. (Fonagy & Target, 1997); it arguably facilitates epistemic trust in the secure base of the therapist (Talia, 2024), enabling the client to explore unsettling aspects of their presentation (Lilliengren et al., 2015). Higher levels of client attachment to the therapist are associated with deeper sessions of brief psychotherapy. (Mallinckrodt et al., 2005).

Attachment styles are factors that both the client and therapist bring to therapy that arguably impact the therapeutic alliance. The present study suggests there should be an intentional emphasis by the practitioner, irrespective of the client's presentation or "diagnosis".

Pluralistic practice eschews formulaic approaches and emphasises the individuality of the client, shared goals and the uniqueness of each relationship (Cooper, 2015). Therapists endeavour to facilitate an approach tailored to each client relationship. Within the client, their attachment style arguably impacts their meaning making, the way they might interpret not only life events but also what happens – and perhaps *can* happen – in the therapeutic relationship. This is very likely the case also for the therapist, and whilst trained to monitor the impact of their "own stuff" on the process, usually helped by personal therapy, at least during training, it is possible that a more attentive focus on attachment style and the possible interactions with that of the client could be facilitative.

RECOMMENDATIONS

PRE-SCREENING

An awareness of the client's attachment can inform how the therapist responds to the client and determine what adjustments should be made in therapy. An initial brief screening of clients' attachment styles, with their consent, could help guide the work and provide the practitioner with important and relevant context that is connected to the client's attachment style. Indeed, this is already standard practice within some therapeutic modalities; however, it may be of benefit if it were more widely adopted and applied, irrespective of the type of intervention that is offered. Practitioners can provide brief psychoeducation to clients about

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attachment styles and have discussions with clients if relevant to them and if the scope of therapy permits it.

Introducing pre-screening and requiring extra time with the client for this purpose would, notably, be one of the main challenges in implementing such an approach. There may be service limitations due to various factors that make it difficult to implement such pre-screening. For example, a publicly funded NHS setting, third sector organisation, or mental health charity provision may be restricted due to the limited number of sessions provided or limited resources, whereas in private practice, therapists may have more liberty and flexibility in how they work.

As the therapeutic alliance seems to offset the need for secure attachment, it emphasises the importance of practitioners focusing their attention on ways they can foster the therapeutic relationship. Much has been written about how to develop the therapeutic alliance, including empathy, active listening, and validation (Bodin, 1979; Elliott et al., 2018; Sharf et al., 2010). Many strategies that are effective in fostering the therapeutic alliance, such as responsiveness and attunement, can be adapted to fit within any intervention, and practitioners can adapt the intervention accordingly (Baldwin et al., 2007). This links to the importance of recognising the role of attachment style in the development of the therapeutic alliance; practitioners can ensure that they are well-trained and well-equipped to identify attachment styles and be prepared to address any challenges that may arise accordingly.

PLURALISTIC INTERVENTION

Epistemic humility, or the therapist's ability to recognise the limits of their own knowledge and perspective (Potter, 2022), is at the heart of pluralistic practice while creating a more collaborative and respectful relationship between therapist and client. Pluralistic interventions arguably facilitate therapeutic benefits by empowering the client, tailoring therapy to the individual and adapting to changes arising from evolving client circumstances. These qualities of pluralistic therapy communicate validation of and responsiveness to the client, which can serve to strengthen the relationship between client and therapist (Boswell et al., 2021; Norcross & Lambert, 2018).

Norcross and Wampold (2011) discussed the way in which, consistent with pluralistic practice, most psychotherapists seemingly recognise there is no "one size fits all" approach to the way they work with their clients. However, the authors point out that there is a tendency for psychotherapists to follow the research regarding how a particular modality would be most effective in treating a particular presentation, despite the relative unimportance of modality relative to outcome (Norcross & Lambert, 2019). The risk here is overlooking how it is more "effective to tailor psychotherapy to the entire person" (cited in Norcross, 2011b, p. 128). Indeed, we should be thinking not only of tailoring therapy to the client, but also of tailoring therapy to the particular *relationship* in each case, including the interaction of attachment styles between therapist and client.

The American Psychological Association (APA) states in their Policy Statement on Evidence-Based Practice in Psychology that best practice involves "the integration of the best available research with clinical expertise in the context of patient

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characteristics, culture, and preferences'' (APA, 2006, p. 273). This statement demonstrates that best practice involves understanding what the client is communicating, accommodating their needs within the therapeutic context, and implementing strategies informed by evidence-based theory. This may involve additional training in various therapeutic approaches to ensure therapists have a breadth of knowledge and can tailor therapy based on their expertise and competent clinical judgment.

Some therapists have specialised training or have a particular preference for working within a particular framework or modality; they may be resistant to a pluralistic approach and perhaps, in particular, one in which they are required to deeply explore their own responses and the influences of their own attachment style in relating to an individual client. In traditional psychoanalytic approaches, for example, there is potential for the client to experience the psychoanalyst as the "expert" rather than as a collaborator, leading the client to feel disempowered and detached (Ardito & Rabellino, 2011).

Arguably, it is possible to empower clients within the framework of any therapeutic modality, as long as the therapist has the willingness to do so (McLeod, 2022).

Particularly interesting findings in the present study suggest that where clients are insecurely or avoidantly attached, therapeutic alliance can ameliorate the central challenges this might pose in terms of achieving successful outcomes. This might suggest that focusing on developing a working relationship should be a primary focus for the work, perhaps initially even at the expense of "addressing the problem," on the basis that the "real work" cannot happen in the absence of an alliance. Levitt et al. (2016) highlighted the importance of "involvement" with the client, which refers to empathic attunement to the client. One of the authors of this paper (AP) recalls vividly the experience of working with a young male client who seemed determined not to engage. At the point of thinking that all efforts might be in vain, he realised he shared with the client a passion for all things "Star Trek." Lively discussions around which of the various incarnations was best led to new energy and conversation, which ultimately facilitated a therapeutic relationship that the client found extremely useful; certainly "off topic" and seemingly irrelevant, but ultimately essential.

Another key finding relates to the relative unimportance of alliance in client satisfaction where there exists secure attachment. Nevertheless, it is arguable that this does not mean alliance is unnecessary; rather, we suggest an interpretation in which alliance in such cases might perhaps be inherent, even taken for granted, certainly implicit. Lack of alliance could cause a securely attached and trusting yet discerning client to fail to engage or withdraw in its absence.

An essential element of any therapeutic intervention is the initial stages, during assessment and formulation. Within pluralism, a key feature is that both assessment and formulation are ideally co-produced with the client (Cooper & Dryden, 2015). This is one example of how pluralistic practice empowers clients, creating the ideal environment for therapists to foster trust and a sense of security, thereby strengthening and deepening the therapeutic relationship. However, the findings suggest that pluralistic therapists should be mindful of the extent to which the client's attachment style enables them to truly participate or contribute to formulation and planning. Pluralistic formulation is designed to remain open-ended, flexible, modifiable and allow for new information as therapy progresses,

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accommodating changing client circumstances (Cooper & Dryden, 2015). This should include attention to the changing dynamics of attachment, perhaps as the client settles into the relationship.

MANAGING RUPTURES

Ruptures are associated with both attachment styles and therapeutic alliance. Proper management of insecure attachment styles and the therapeutic alliance is likely to help prevent disengagement, premature termination, and ultimately poorer therapy outcomes (Slade & Holmes, 2019). They reported that the over-arousal of feelings towards the therapist in anxiously attached clients and the under-arousal of feelings towards the therapist in avoidantly attached clients can lead to ruptures. It is therefore important for practitioners to be prepared to manage ruptures if and when they occur as a result of insecure attachment. The ability to address ruptures effectively is associated with the development of a good therapeutic alliance between therapist and client, which leads to positive outcomes (Meyer & Pilkonis, 2001; Slade & Holmes, 2019). Likewise, an already good therapeutic alliance can help facilitate the management of ruptures that are due to insecure attachment.

There are many approaches to managing ruptures; one way is through prevention, by fostering the therapeutic alliance and identifying any potential attachment issues early on. Another approach is through the therapist's self-awareness of training needs and pursuing further professional development to address gaps in skills and knowledge. This ensures that therapists are prepared to identify and manage ruptures when they emerge. One strategy to consider when a rupture has occurred in the therapeutic relationship is to seek feedback from the client around the issue that caused the rupture, which is known to improve client engagement and lead to better outcomes (Lappan et al., 2018). Indeed, Bárez et al. (2025), whilst highlighting the importance of feedback in creating and maintaining therapeutic alliance, also identified a need for improved training, greater awareness of feedback benefits, and strategies to address therapists' emotional and logistical concerns about requesting feedback. As Irvin Yalom said, "I urge you to let your patients matter to you, to let them enter your mind, influence you, change you – and not to conceal this from them" (2011, p. 52).

Finally, attention to the therapist's own processes as they relate to the client, their own attachment styles and/or relational issues are important ways ruptures can be indirectly managed. Various ways therapists might increase attention to their own processes include regular supervision, attending their own personal therapy, continued professional development and independent self-directed learning.

PLURALISTICALLY INFORMED COMMUNICATION

Following on from the recommended management of ruptures, it is arguable that acknowledging, understanding, and discussing experiences of rupture in the therapy setting is an important part of the pluralistic approach (McLeod & Sundet, 2016). Pluralistic practice places an emphasis on the use of meta-therapeutic communication (MTC) as a strategy to repair ruptures (Cooper & Dryden, 2015). Pluralism is based on humanistic philosophical underpinnings, meaning it is

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deeply relational, and so dialogue serves as the pathway and conduit for the therapeutic relationship. Within pluralistic therapy, MTC might involve discussions about what was communicated, what was understood, and what was experienced, etc. Essentially, MTC creates space for clients to develop important interpersonal skills, which helps them engage relationally both inside the therapy space and outside. In the case of ruptures, MTC can create clarity for both the therapist and client in terms of expectations, boundaries, conflict, misunderstandings and the co-construction of meaning within therapy. It can also be used to repair ruptures by communicating the need for a break or therapy review (Cooper & Dryden, 2015).

Crucially, the use of MTC creates the conditions needed for the client to feel that their views are valued and respected. These various ways of interacting with the client support and encourage their self-expression as well as feeling more connected both to themselves and to the therapist. The client benefits even more by experiencing a sense of safety and security with the therapist and seeing the therapist as a trusted ally.

CLIENT PREFERENCE

Attention to client preferences is another way to work flexibly and achieve client empowerment (Cooper et al., 2018). Positive outcomes have indeed been reported when clients received their preferred intervention; it seems this higher success rate can be attributed to clients being able to collaborate with their therapist and take an active role in their treatment (Cooper et al., 2018; Kazantzis & Kellis, 2012; Tryon et al., 2018; Windle et al., 2020). This kind of collaboration between therapist and client has been referred to as shared decision making (SDM; Joosten et al., 2008).

Shared decision making is the involvement of the client in all stages of the treatment process, from beginning to end, after being provided all information relevant to the intervention (Coulter & Collins, 2011). Within pluralistic practice, this can be in the form of therapeutic goals, tasks and methods that are discussed and mutually agreed upon between client and therapist (Cooper & Dryden, 2015). Again, attachment style may influence the extent to which the client feels able to engage with and participate in this process. The overall flexible approach to therapy, the collaborative planning, and the way the process is open to being revisited create trust in the therapist, which in turn should facilitate the therapeutic relationship.

CONCLUSION

The current study demonstrated that there exists an important moderating and mediating effect between secure attachment and the therapeutic relationship on therapy outcome (client satisfaction). A pluralistic approach, working dialogically, involving the client in the process and engaging them in a discussion about the progress of therapy and responding to client preferences, is likely to lead to the kind of therapeutic alliance which can offset the negative impacts of insecure or avoidant attachment in the client. At the same time, the results highlight the importance of being mindful and responsive to the interface of client and therapist attachment styles and the likely impact on the process. The research suggests that

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such an approach is likely to lead to higher levels of satisfaction and, therefore, better outcomes. Accordingly, recommendations were made regarding therapist attention to attachment styles in the relationship, pre-screening to identify client attachment style, attention to and resolution of ruptures. These recommendations could facilitate the development of a stronger therapeutic alliance, likely to enhance client satisfaction to result in improved outcomes.

LIMITATIONS

It is important to note that, although attachment styles are relatively stable and unchanging, it is difficult to know for certain if any of the participants in the current study experienced significant changes in their personalities or attachment styles due to therapy or other factors co-occurring outside of therapy. Due to the nature of the research design, it was not possible for the researchers to clearly identify specific pluralistic processes that may have occurred between client and therapist. In future, a similar study might query pluralistic processes, such as the client's preferences and shared decision-making were implemented in therapy or various aspects of meta-communication.

Whilst mindful of the importance of building on previous studies on this topic, this is challenging due to the complexity of the therapeutic process (a multitude of interventions, differences in healthcare settings, client population, other individual differences, therapist traits, etc.). Unless under strict experimental conditions - inconsistent with pluralistic practice - it is difficult to know how closely therapists adhere to the prescribed intervention and are working towards fostering the therapeutic alliance. Hence, a novel and inevitably untried research approach was deemed necessary.

Future studies might investigate the pluralistic therapist's own attachment style and how this impacts the therapeutic process. Such research might evaluate how the therapist's attachment style influences their therapeutic decisions, their responsiveness to the client, their ability to self-regulate during ruptures, and what strategies and skills they draw upon to manage challenges that might arise in therapy.

The study focused on client satisfaction as the outcome variable, rather than measures of effectiveness assessed indirectly, using changes in symptoms, for example. This decision relies on the assumption that clients are more likely to feel satisfied with their therapy when they believe it has been effective. Whilst a reasonable assumption, this approach could nonetheless be critiqued. There has been little attention paid explicitly to client satisfaction in previous research. A decision was made to use a three-item client satisfaction measure partly to reduce "questionnaire fatigue." Whilst this appears to have had utility, future studies might look to evaluate and perhaps further develop this simple scale.

Finally, whilst a pluralistic approach has been shown to be effective in primary care for a range of presentations (Murphie & Smith, 2025), certain types of client presentation, for example, but not limited to, substance abuse or anorexia nervosa, may require highly specific or manualised therapeutic approaches, including presentation-specific interventions and outcome assessments. This warrants further investigation. A further potential area for research that would extend the

scope of the current study might be to include pluralistic processes regarding how preferences or shared decision-making were facilitated within the therapeutic dyad.

COMPETING INTERESTS

The authors declare there are no conflicts of interest.

ETHICAL APPROVAL

This research received ethical approval from the City, University of London's Research Ethics Committee (ethics reference: ETH2223-0862).

INFORMED CONSENT OF PARTICIPANTS

Participants' informed written consent to participate, including use of findings in publication, was provided after they had read all of the information about the purposes and uses of the study, including publication.

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AUTHOR CONTRIBUTIONS

MB initiated the research aim and study design. MB implemented the study, analysed the data and drafted the manuscript; AP supervised the research, offering guidance and input. The writing and editing of the manuscript were undertaken jointly.

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