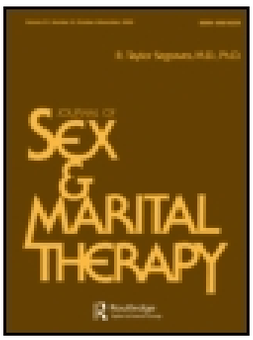

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Cumulative Childhood Trauma and Therapeutic Alliance: The Moderator Role of Attachment in Adult Patients Consulting in Sex Therapy

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ABSTRACT

While it is documented that clients consulting in sex therapy tend to report high rates of childhood interpersonal traumas (e.g., physical, psychological and sexual abuse), which are associated to insecure attachment and poorer therapeutic alliance, the interrelations of these variables have not yet been evaluated in this specific population. This study examined the associations between attachment, cumulative trauma and therapeutic alliance in 278 sex therapy patients who filled out self-report questionnaires. Results revealed that avoidant attachment acted as a moderator between cumulative trauma and the agreement on tasks dimension of therapeutic alliance. Results suggests the relevance for sex therapists to investigate past traumas and current attachment representations to guide interventions and optimize treatment benefits.

Adults seeking sex therapy (e.g., psychotherapy aimed at the treatment of sexual difficulties) tend to report higher rates of childhood interpersonal traumas (e.g., sexual, physical or psychological abuse and/or neglect) compared to individuals from community samples (Berthelot, Godbout, Hébert, Goulet, & Bergeron, 2014; Bigras, Godbout, Hébert, & Sabourin, 2017) and adults from other clinical populations (Brodsky et al., 2001). Indeed, nearly half (47%) of patients consulting a sex therapist reported a history of child sexual abuse (Berthelot, Godbout, et al., 2014) versus one third (38%) in depressive patients (Brodsky et al., 2001) and 13% in the general population (Stoltenborgh, Van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). Studies have shown that forms of maltreatment rarely occur in isolation and childhood cumulative trauma (CCT)—the accumulation of different forms of interpersonal traumas experienced before the age of 18—is associated with a more severe and complex symptomatology such as exacerbated psychological, sexual, and relational distress compared to a single traumatic experience (Berthelot, Godbout, et al., 2014; Berthelot, Hébert, et al., 2014; Bigras, Daspe, Godbout, Briere, & Sabourin, 2017; Hodges et al., 2013).

The importance of therapeutic alliance is increasingly discussed in the scientific literature on psychotherapy. This notion of alliance has repeatedly been highlighted as a key component to treatment efficacy (Baillargeon, Pinsof, & Leduc, 2005; Ferreira et al., 2013; Martin, Garkse, & Davis, 2000). The concept of therapeutic alliance was first developed and studied within the psychodynamic school of thought (e.g., Freudian theories; Bordin, 1979; Sandler, Holder, & Dare, 1975), and it is now recognized as a central variable to therapeutic success across the different approaches. More precisely, a strong alliance, established quickly in a therapeutic relationship, appears to be an efficient predictor of favorable therapy outcomes (Horvath, 2001). According to Bordin's theory (1979), therapeutic alliance includes three

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dimensions: (a) the bond between the therapist and the patient, as well as the agreement on (b) goals and (c) tasks. The bond between both parties involves all relational, affective, and emotional aspects of the therapeutic alliance (Baillargeon et al., 2005). This dimension refers to the affective facet of the alliance, while the two other dimensions—the agreement about goals and tasks—are more cognitive (Hietanen & Punamäki, 2006). Agreement on goals refers to the patient's impression that the therapist understands the reasons for consultation and suggests adequate objectives to achieve (Baillargeon et al., 2005). Agreement on tasks implies that the activities suggested by the therapist, such as open dialogues during sessions or "homework" (e.g., relaxation exercises or questionnaires to complete at home), are consistent with the patient's expectations and objectives (Baillargeon, Coté, & Douville, 2012; Baillargeon et al., 2005). Empirical data suggest that compared to the other two dimensions, the agreement on tasks shows the strongest association to therapy outcomes (Horvath, Del Re, Flückiger, & Symonds, 2011 cited in Hoffart, Øktedalen, Langkaas, & Wampold, 2013).

Past experiences of childhood interpersonal trauma may diminish the patient's capacity to establish a therapeutic alliance (Paivio & Cramer, 2004), yet key variables might inflect the link between CCT and alliance. The current study examined the potential role of attachment, since empirical data documented that greater exposure to interpersonal trauma is related to more insecure attachment (Godbout et al., 2017), and that an insecure attachment may be negatively associated to therapeutic alliance (Diener & Monroe, 2011; Smith, Msetfi, & Golding, 2010). Insecure attachment is also related to greater or higher levels of distress in general (Shallcross, Frazier, & Anders, 2014). Adult attachment comprises two related dimensions: *attachment avoidance*, referring to the tendency to escape from close relationships and from exposed vulnerability due to a negative representation of others as nonavailable, and *attachment anxiety*, referring to the negative internalized representation of the self as unworthy of love, demonstrating fears of rejection and abandonment, as well as presenting a tendency to validate oneself through others (Griffin & Bartholomew, 1994; Mikulincer, Shaver, & Pereg, 2003). Trauma survivors may present long-lasting intimate and avoidance issues in close relationships (Godbout et al., 2017; Godbout, Dutton, Lussier, & Sabourin, 2009), and it is recognized that attachment in adulthood is optimally understood through romantic relationships (Hazan & Shaver, 1987; Mikulincer & Goodman, 2006). These relationship avoidance schemas may also influence psychotherapy. Indeed, patients with avoidant attachment tend to consider that the development of interpersonal relationships is uncomfortable and scary, or that others are unreliable, which is related to reports of lower levels of therapeutic alliance (Tasca, Balfour, Ritchie, & Bissada, 2007), as if they are rejecting their need to form a relationship with their therapist (Smith et al., 2010). As such, insecure attachment, especially avoidant attachment, may act as a risk factor in the capacity of trauma survivors to establish a therapeutic alliance. Therefore, it appears relevant to study the link between trauma, alliance, and insecure attachment by evaluating if attachment avoidance and anxiety over abandonment act as risk factors in the relation between CCT and therapeutic alliance.

Although previous studies have revealed a negative association between attachment and therapeutic alliance (e.g., Diener & Monroe, 2011) and between trauma and therapeutic alliance (e.g., Paivio & Cramer, 2004), these interrelations have not been explored together nor specifically in a population of patients consulting in sex therapy. Yet, this clientele seems to differ from other adults seeking psychotherapy (e.g., higher level of interpersonal trauma). Moreover, the potential role of insecure attachment as a moderator of the link between trauma and alliance has not been examined. In summary, there is an apparent breach in scientific writings concerning the relationship between CCT, attachment representations in adulthood, and the ability to invest in a strong and satisfying therapeutic alliance in adults consulting in sex therapy. A study examining how attachment representations act on the building of a robust therapeutic alliance might provide guidance toward appropriate therapeutic tools and the design of tailored interventions for these patients.

As an additional gap in the literature, potential differences between genders need to be further explored, considering that women and men show differences in commitment to therapy (Symonds & Horvath, 2004) and in psychological distress after experiencing traumatic events (Olff, Langeland, Draijer, & Gersons, 2007; Ullman & Filipas, 2005), with women typically reporting a stronger alliance and more trauma-related repercussions. Furthermore, women tend be at higher risk than men of experiencing disempowering events (e.g., traumas or poorer socioeconomic status) and distress during their

life trajectory (Astbury, 2001; Caldwell, Swan, & Woodbrown, 2012). Therefore, invariance between women and men of the hypothesized moderation model needs to be examined.

Objectives and hypothesis

The current, one-wave cross-sectional correlational study aimed to examine the characteristics of adults seeking sex therapy, and the moderating role of attachment and gender in the link between CCT and therapeutic alliance in these patients. First, through a triple interaction, the moderating effect of (a) gender and attachment anxiety and of (b) gender and attachment avoidance on the association between CCT and therapeutic alliance was tested. It was hypothesized that insecure attachment, particularly attachment avoidance, would act as a moderator so that CCT would be related to lower alliance in patients with high attachment avoidance.

Differences between women and men concerning the impact of childhood traumas on therapeutic alliance, and factors explaining this impact (i.e., socioeconomic status) were also investigated. Then, the moderating effect of attachment was tested for gender specificities by testing the model independently in women and men. Considering the documented gender differences in therapeutic alliance and trauma sequelae, it was postulated that these associations will differ depending on the gender of the participants. Precisely, we expected the effect of attachment on the relationship between CCT and alliance to be greater among women.

Method

Participants and data collection

Patients consulting in sex therapy were recruited and invited to complete a set of self-reported questionnaires within the first weeks of treatment ($M = 5.4$ weeks; $SD = 5.1$) via their interns-therapists in clinical sexology. Interns were graduate students doing a master degree in clinical sexology, which leads to licensure in psychotherapy, seeing patients under supervision and practicing different therapeutic approaches (e.g., psychodynamic, humanistic, cognitive behavioral, and systemic). In terms of motive for consultation, patients reported consulting for lack of sexual desire (46.4%), lubrication (9.7%) or erection problems (24.5%), orgasm disorder (27.7%), premature (15.1%) or delayed (11.2%) ejaculation, sexual pain (24.8%), vaginismus (6.1%), sexual aversion (4.0%), or other motives (22.3%; paraphilic disorder, pornography dependence, excessive sexuality behavior, interrogation about their sexual orientation or gender identity, etc.). Half of the patients (50.4%) indicated at least two motives. Participants were patients seeking sex therapy through different facilities such as hospitals, family medicine units, community clinics, private clinics, and specialized clinics.

A total of 278 patients, 149 women (53.6%) and 129 men (46.4%), were included in this study. They were aged between 17 and 73 years old ($M = 38.9$; $SD = 12.9$). The majority, 240 (86.3%), defined their sexual orientation as heterosexual, 21 (7.6%) as homosexual, 12 (4.3%) as bisexual, and four (1.5%) identified with another sexual orientation. Regarding relational status, 100 patients (36.0%) were single, 40 (14.4%) were in a relationship with a partner (dating relationship), 89 (32.0%) were in a common-law relationship, 46 (16.5%) were married, and three participants (1.1%) preferred not to answer. The majority (65.9%) earned less than 40,000 CAN$ per year, had at least a college education degree (79.9%), were workers (60.4%), spoke French as their first language (88.7%), and were from Canada (88.1%).

Measures

Childhood cumulative trauma questionnaire

Childhood cumulative trauma (CCT) was assessed using the Childhood Cumulative Trauma Questionnaire (CCTQ; Godbout, Bigras, & Sabourin, 2017). This measure was adapted from existing maltreatment measures (e.g., Early Trauma Inventory–Self Report, Bremner, Bolus, & Mayer, 2007; Childhood Maltreatment Questionnaire, Godbout et al., 2009) and showed satisfactory psychometric

qualities (e.g., Bigras et al., 2017). Specifically, eight forms of traumas were evaluated: physical and psychological abuse by the parental figures; psychological and physical neglect; exposure to psychological and physical violence between the parents; peer bullying; and sexual abuse. The items of this questionnaire state a potentially traumatic event (e.g., "One of my parents, or both, ever slapped me in the face"; "One of my parents, or both, ever humiliated, denigrated or ridiculed me"), then inquire about its frequency, on a scale from 0 (*never*) to 6 (*every day, or almost every day*). Each form of trauma was divided as not experienced (0) or experienced (1). The CCT score therefore initially ranges from zero to eight, with higher scores revealing more trauma events. To optimally screen and define the prevalence of cumulative trauma, Finkelhor, Ormrod, and Turner (2007) recommend considering the report of at least four forms of trauma experiences. In our sample, participants presented a rounded average of four types of childhood interpersonal traumas ($SD = 2.1$). Consequently, this variable was dichotomized following these indications: the participants reporting four forms of interpersonal traumas or more are coded as having CCT (CCT = 1), in contrast to those relating three forms of interpersonal traumas or fewer (none to three forms of interpersonal traumas CCT = 0). Cronbach's alpha of the whole questionnaire indicates high internal consistency: .90.

Working alliance inventory-client short form (French version)

Therapeutic alliance was measured with the French version of the Working Alliance Inventory-Client Short Form (WAI; Tracey & Kokotovic, 1989), which includes three subscales assessing the three elements of Bordin's (1979) theory as well as a total score. Twelve questions (e.g., "My therapist and I are working towards mutually agreed upon goals", "I feel that my therapist appreciates me") are answered on a scale from 1 (*never*) to 7 (*always*). The total score varies between 12 and 84, and between 4 and 28 for the subscales. Higher scores imply stronger therapeutic alliance. Previous literature suggests the pertinence to assess alliance early in the therapeutic process. For example, studies documented that a patient's assessment of the therapeutic alliance within the first five weeks of treatment is a key clinical indicator of therapeutic outcomes (e.g., Horvath, 2001). Cronbach's alpha of the global score reflects a high internal consistency: .90 (agreement of task $\alpha = .70$; bond $\alpha = .81$; agreement on goals $\alpha = .75$).

Experiences in close relationships Scale-12 (French version)

Romantic attachment was assessed by the French and short version of the Experiences in Close Relationships Scale-12 (ECR-12; Lafontaine et al., 2016). This questionnaire includes two subscales measuring the two dimensions of attachment, anxiety over abandonment (e.g., negative perception of self and positive perception of others) and attachment avoidance (e.g., positive perception of self and negative perception of others). A Likert scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*) is used to answer questions such as "I'm afraid that I will lose my partner" or "I feel comfortable sharing my private thoughts and feelings with my partner." Higher scores on these subscales indicate a higher level of anxiety or avoidance, and clinical cutoff for both have been suggested (a score higher than 3.5 for anxiety, and 2.5 for avoidance) Brassard et al., 2012). The Cronbach's alpha of the anxiety over abandonment subscale is .87, and .84 for the attachment avoidance subscale.

Data analyses

First, descriptive analyses were conducted to portray the characteristics of the sample in terms of cumulated traumas, attachment style, and capacity to create therapeutic alliance. Second, regression analyses were performed to test the moderating role of avoidant and anxious attachment and gender in the association between CCT and therapeutic alliance. Correlational analyses were also performed to explore the relationship between the variables. Since the dependent variables (i.e., four scales measuring therapeutic alliance: agreement on tasks, agreement on goals, bond between the patient and the therapist, and total score) are continuous, a linear regression analysis was used (forced-entry method). The standardized subscales of attachment avoidance and anxiety over abandonment were considered in interaction with CCT to predict therapeutic alliance. Third, to interpret potential gender differences, *t* tests and

Table 1. Rates of interpersonal trauma reported.

	Full Sample %	Women %	Men %
Emotional abuse	63.3	69.2	56.6
Physical abuse	47.6	49.3	45.7
Psychological neglect	72.4	74.0	70.5
Physical neglect	23.6	21.8	25.6
Exposure to psychological violence	55.1	60.5	48.8
Exposure to physical violence	16.3	21.6	10.2
Bullying	66.2	64.4	68.2
Sexual abuse	41.4	53.5	27.1
Cumulative trauma (4 or more forms)	52.9	57.0	48.1

chi-square tests comparing women and men on various psychosocial factors were conducted. Finally, a model uniquely using attachment as a moderator was tested independently among women and men.

Results

Descriptive data

As indicated in Table 1, results revealed that interpersonal violence victimization during childhood is highly prevalent in the sample. Indeed, 83.8% of patients experienced more than one form of trauma, and more than half (52.9%) reported CCT, as defined previously (four to eight forms of interpersonal trauma). Indeed, clients presented on average four types of trauma. For both genders, the more frequent traumas were psychological neglect and bullying, and the less frequent were exposure to physical violence and physical neglect.

Patients also presented high rates of insecure attachment, with 60.1% of them reporting scores above the clinical cutoff score of attachment avoidance, 67.6% above threshold for anxiety over abandonment, and 46.8% above the clinical cutoff on both scales, which suggests a fearful attachment. Only 19.9% indicated a secure attachment. Analyses failed to reveal a significant difference in attachment style between women and men.

Regarding therapeutic alliance, total mean score was 70.1 ($SD = 10.06$), 23.0 for the agreement on tasks subscale ($SD = 3.6$), 23.4 for the agreements on goals subscale ($SD = 3.9$), and 23.7 for the bond between the therapist and the patient subscale ($SD = 3.5$). No significant difference between women and men was unveiled through t tests. Nevertheless, marginally significant differences were found between women and men for the settlement on tasks subscale ($p = .054$; $t = 1.93$; $df = 276$; CI = –.02 to 1.70), with women having higher scores ($M = 23.4$; $SD = 3.7$) than men ($M = 22.5$; $SD = 3.5$).

Moderation model in the full sample

A series of correlations (see Table 2) were computed to identify the links between the variables of interest of this study. Results indicated a significant relationship between attachment avoidance, the dichotomized CCT variable, and all the WAI subscales. Abandonment anxiety was also significantly correlated to CCT and all the therapeutic alliance dimensions, except for the agreement on tasks subscales. Correlations with anxiety over abandonment, however, appeared weaker than those with attachment avoidance. There was no significant link between CCT and the WAI scales. Differences between women and men were found and are also presented in Table 2.

Linear regressions were used to test two triple interactions. The first one tested the moderating effect of the interaction of gender and abandonment anxiety on the relationship between the CCT and each aspect of the therapeutic alliance. However, the results were not statistically significant. The second regression revealed a relation between the dependent variable (CCT), the interaction term (attachment avoidance and gender), and one dimension of the outcome variable (therapeutic alliance). Results highlighted a moderating effect of avoidant attachment and gender on the association between CCT and

Table 2. Correlation Matrix between WAI Subscales, Avoidant Attachment and Cumulative Trauma.

Complete sample	1	2	3	4	5	6	7
1. Agreement on tasks	—						
2.Agreement on goals	.81***	—					
3. Bond between the client and the therapist	.72***	.70***	—				
4. Total WAI score	.93***	.92***	.88***	—			
5. Cumulative trauma	− .02	− .05	.05	− .04	—		
6. Attachment avoidance	− .23***	− .26***	− .27***	− .28***	.23***	—	
7. Anxiety over abandonment	− .04	− .13*	− .17**	− .12*	.16**	.25***	

Women and Men	1	2	3	4	5	6	7
1. Agreement on tasks	—	.79***	.77***	.92***	.05	− .22*	− .14
2. Agreement on goals	.83***	—	.74***	.92***	− .01	− .27**	− .21**
3. Bond between the client and the therapist	.69***	.67***	—	.91***	− .05	− .27**	− .24**
4. Total WAI score	.93***	.92***	.86***	—	− .01	− .28**	− .21*
5. Cumulative trauma	− .10	− .09	− .06	− .09	—	.27**	.21*
6. Attachment avoidance	− .24**	− .24**	− .28***	− .28***	.21**	—	.30***
7. Anxiety over abandonment	− .03	− .06*	− .10	− .05	.11	.21**	

Note. Correlations for men are shown above the diagonal; correlations for women are shown below the diagonal.
*$p \leq .05$; **$p \leq .01$; ***$p \leq .001$.

common agreement on tasks, but not with the other subscales of the WAI. The interaction was, however, marginally statistically significant when the dependent variable was the WAI total score ($p = .075$; CI = −.44 to 9.23).

While attachment avoidance statistically correlated to common agreement on tasks ($p = .000$; $r = .234$; CI = −.34 to −.12), when integrated in interaction with gender and CCT, it acted as a moderator of the link between CCT and agreement on tasks (see Table 3). More precisely, in patients with high avoidance (scores > 4.5), CCT was associated with increased difficulties in settling on tasks with their therapist, while in patients presenting a lower score of avoidance, agreement on tasks does not statistically vary in function of the CCT.

Considering that sexual orientation could influence the results (e.g., experiences of traumas), regression analyses were retested excluding nonheterosexual participants. The results remained similar in terms of variance and moderation effect significance. In addition, age may be a factor, as older patients might have had more time to process the trauma experienced, which could impact their capacity to form a therapeutic alliance. Age was therefore tested as a control variable, and the same outcomes were observed. Therefore, all the participants were kept in the sample, regardless of their sexual orientation or age.

Table 3. Moderation Effects of Avoidant Attachment and Gender on the Relationship Between Cumulative Trauma and Common Agreement on Tasks in the Total Sample (linear regression: forced-entry method).

	p	Inf. CI (95%)	*b*	Sup. CI (95%)	SE	r^2	Δr^2
Gender	.010**	− 2.92	− 1.66	− .41	.64		
Cumulative trauma	.356	− 1.74	.56	0.63	.60		
Attachment avoidance	.881	− 1.03	.07	0.88	.48		
Gender × Attachment avoidance	.065	− 2.59	− 1.26	.08	.68		
Attachment avoidance × Cumulative trauma	.042*	− 2.46	− 1.25	− .05	.61		
Gender × Cumulative trauma	.136	− .42	1.32	3.05	.88		
Gender × Attachment avoidance × Cumulative trauma	.019*	.35	2.10	3.85	.89		
Bloc:						.092	
1. Gender							.013
2. Add: Trauma							.001
3. Add: Avoidance							.052
4. Add: Gender × Avoidance							.000
5. Add: Avoidance × Trauma							.001
6. Add: Gender × Trauma							.006
7. Add: Gender × Avoidance × Trauma							.019

Note. CI = Confidence Interval; SE = Standard Error. *$p \leq .05$; **$p \leq .01$; ***$p \leq .001$.

Table 4. Moderation effects of Avoidant Attachment on Cumulative Trauma and Common Agreement on Tasks in Women (linear regression: forced-entry method).

	p	Inf. CI (95%)	*b*	Sup. CI (95%)	SE	r^2	Δr^2
Cumulative trauma	.370	− 1.78	− .56	− .07	.62		
Attachment avoidance	.885	− 1.06	− .07	.91	.50		
Attachment avoidance × Cumulative trauma	.048*	− 2.50	− 1.25	− 0.01	.63		
Bloc:						.084	
1. Cumulative trauma							.009
2. Add: Attachment avoidance							.050
3. Add: Avoidance × Trauma							.025

Note. CI = Confidence Interval; SE = Standard Error. $^{*}p \leq .05$; $^{**}p \leq .01$; $^{***}p \leq .001$.

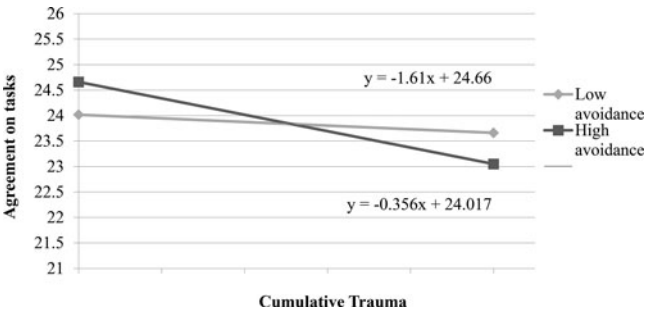

Figure 1. Moderation effects of avoidant attachment on cumulative trauma and common agreement on tasks in women.

Differences between women and men consulting in sex therapy

Using *t* tests, we were able to underline psychosocial differences between women and men. Compared to the men, women showed significant lower incomes ($p = .004$; $t = -2.89$; $df = 265$; CI = –.66 to –.13) and more accumulated traumas ($p = .041$; $t = 2.05$; $df = 276$; CI = .02 to 1.02). Using chi-square analyses, we found that women demonstrated less job stability and were overrepresented among students and stay-at-home parents of the sample, and underrepresented in full-time workers ($p = .020$; $df = 5$).

Moderation model: Gender specificities

As shown in Table 4 and Figure 1, in women, CCT is associated with an increase in difficulty in adhering to the tasks proposed by the therapist, but this relation is moderated by attachment avoidance. Using a macro process in SPSS as proposed by Hayes (2012), results revealed that, according to the ECR clinical cutoff, in women displaying very high avoidance (ECR-12 score $\geq$ 4.5) increased CCT leads to lower agreement on tasks, while lower attachment avoidance enables better agreement on tasks despite the cumulative trauma.

In men (see Table 5), agreement on tasks score did not significantly vary with CCT. The model of moderation therefore did not reach statistical significance. Results also revealed the agreement on tasks scores are generally lower than for women.

Discussion

This study aimed to explore the moderating role of attachment on the relationship between CCT and therapeutic alliance, and to compare these associations in women and men consulting in sex therapy. Our results showed not only that sex therapy patients report a high prevalence of both adverse events in childhood and insecure attachment, which is consistent with past studies (e.g., Berthelot, Godbout, et al., 2014; Berthelot, Hébert, et al., 2014; Bigras et al., 2017; Diener & Monroe, 2011), but also that the interaction between these trauma experiences and avoidant attachment impact on their ability to forge

Table 5. Moderation effects of Avoidant Attachment on Cumulative Trauma and Common Agreement on Tasks in Men (linear regression: forced-entry method).

	p	Inf. CI (95%)	*b*	Sup. CI (95%)	SE	r^2	Δr^2
Cumulative trauma	.223	− .47	.76	1.99	.62		
Attachment avoidance	.005	− 2.24	− 1.33	− .42	.46		
Attachment avoidance × Cumulative trauma	.175	− .38	.85	2.08	.62		
Bloc:						.074	
1. Cumulative trauma							.002
2. Add: Attachment avoidance							.058
3. Add: Avoidance × Trauma							.014

Note. CI = Confidence Interval; SE = Standard Error. $^{*}p \leq .05$; $^{**}p \leq .01$; $^{***}p \leq .001$.

a therapeutic alliance. Empirical data also highlight gender specificities in the degree of commitment to therapy (Symonds & Horvath, 2004), in trauma consequences (Olff et al., 2007; Ullman & Filipas, 2005), and regarding the interaction between CCT and attachment avoidance.

Descriptive analyses revealed that the majority (80%) of sex therapy patients in our sample reported insecure attachment and CCT with one out of two participants reporting four or more different forms of interpersonal trauma. In our sample, only one in every five patients reported a secure attachment, compared to about one out of two in the general population (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). Furthermore, sex therapy patients seemed to experience higher rates of childhood interpersonal traumas compared to individuals from the general population (Berthelot, Godbout, et al., 2014; Berthelot, Hébert, et al., 2014; Bigras et al., 2017) and from other clinical settings (Brodsky et al., 2001). This seems to imply that patients with sexual difficulties may be particularly vulnerable to traumas and their repercussions, suggesting that specialists working with sex therapy patients could benefit from specialized training in the effects of childhood trauma. Also, our data highlighted a tendency for women to be more likely to display a strong agreement on tasks with their therapist, this result being marginally significant. These results are similar to findings from other authors, reporting more trauma in sex therapy patients (Bigras et al., 2017) and showing that men demonstrate less commitment to therapy (e.g., Symonds & Horvath, 2004), in addition to showing new data on attachment in this clientele.

Attachment avoidance and gender as moderators between trauma and alliance

Our findings suggested a moderating effect of avoidant attachment and gender on the relation uniting CCT and common agreement on tasks, but there was no moderating effect of anxiety over abandonment with any of the WAI subscales. These results supported that attachment avoidance is of interest given that this dimension may inflect on the development of the therapeutic alliance. This interferes with the patients' capacity to acknowledge their suffering, their need for support, and the importance of their relationship with their therapist (Cassidy, Shaver, Mikulincer, & Lavy, 2009; Mikulincer & Shaver, 2007; Smith et al., 2010; Tasca et al., 2007). Indeed, avoidant individuals tend to deny their painful emotions and affective desires, since facing them is associated with discomfort and distress (Cassidy et al., 2009; Mikulincer & Shaver, 2007).

Results also underlined the central role played by the coherence between the activities proposed by the therapist, the patients' perception of these as appropriate, and, especially, compliance with those tasks. Indeed, patients agreeing to these tasks can demonstrate better compliance to prescribed "homework" (Bordin, 1979; Dunn, Morrison, & Bentall, 2002; Franco, 2012). It is also suggested that therapeutic tasks may be particularly hard to sustain for patients with high levels of attachment avoidance. For example, bringing "homework" could be synonymous with letting the therapy infiltrate their privacy, while it is documented that individuals with avoidant attachment may experience difficulties in recognizing their need to create a relationship with their therapist (Smith et al., 2010). Therapeutic tasks also carry a certain risk of bringing back memories of the traumas, from which patients typically prefer to refrain (Hoffart et al., 2013). Compliance to the tasks can also positively predict treatment success (Kazantzis, Deane, & Ronan, 2000). Likewise, it is documented that the agreement on tasks is the therapeutic alliance

dimension demonstrating the most powerful association to treatment outcomes (Horvath et al., 2011 cited in Hoffart et al., 2013). Yet, the other dimensions of the therapeutic alliance (the bond, agreement on goals, as well as the total score), were not influenced by the interaction between CCT and avoidant attachment. Considering the robust relationship between tasks, attachment avoidance, and therapeutic outcomes underlined in the scientific literature (Horvath et al., 2011 cited in Hoffart et al., 2013), we were especially interested in the agreement on tasks dimension, and these results were expected.

Gender specificities

Results highlighted that, among women, agreement on tasks was negatively influenced by the accumulation of traumas in participants with high avoidance. In other words, in women with high avoidance, CCT intensified the difficulty to agree on tasks with their therapist, thereby low avoidance acted as a protective factor which seems to neutralize the association between CCT and agreement on tasks. Women with low levels of avoidance were more prone to establish a satisfying common treatment plan, which in turn can lead to therapeutic efficiency (Baillargeon et al., 2005; Hoffart et al., 2013; Kazantzis et al., 2000). In men, no moderation effect was observed, suggesting that agreement on tasks is not necessarily affected by the accumulation of childhood traumas or by the attachment avoidance. This could be explained by social values influencing the general tendency of men to report fewer repercussions after traumatic events (Olff et al., 2007; Ullman & Filipas, 2005) and to potentially deny the interpersonal violence they experienced (Oransky & Marecek, 2009). Some authors also underline the social commandment of emotional continence imposed on men, for whom the mere recognition of emotion and vulnerability can be difficult (e.g., Chu, Porche, & Tolman, 2005; Kindlon & Thompson, 1999).

Additionally, women in the sample reported significantly lower job stability and annual incomes, and more childhood trauma than the men. This is consistent with authors stipulating that women present higher risk of enduring disempowering social situations (Astbury, 2001; Caldwell et al., 2012), such as negative trauma repercussions (Olff et al., 2007; Ullman & Filipas, 2005), lower incomes (Statistics Canada, 2013), greater job instability (Statistics Canada, 2013), and more sexual victimization (Pereda, Guilera, Forns, & Gómez-Benito, 2009). These results also appear consistent with data highlighting the association between lower socioeconomic status and more severe situations of childhood abuse (Kosidou et al., 2011; Zielinski, 2009), these risk factors being particularly present in the female population (Pereda et al., 2009; Statistics Canada, 2013).

Research limits and avenues for future studies

The conclusions of this study should be tempered by consideration of its limitations. First, self-report questionnaires are subject to recall bias. Secondly, some therapeutic approaches prescribe more tasks than others, which would be relevant to explore in future research. For example, directive approaches (e.g., cognitive-behavioral therapies) could foster stronger task agreement than less directive approaches (e.g., humanistic therapies), while these less directive approaches could facilitate other dimensions of the therapeutic alliance (the bond or the agreement on goals). Similarly, this study only examined the patients' characteristics (i.e., attachment and CCT) in relation with the alliance, although other patients' (e.g., motive of consultation, presence of current experiences of victimization) and therapists' attributes (e.g., the extent of clinical experience and training, personality factors) might influence the establishment of a strong alliance. Future studies are needed to evaluate these variables. Furthermore, the interaction model presented in this study could be used to explore therapy outcomes in further studies. For example, the improvement of sexual difficulties may be examined in a longitudinal study in an analogous sample, exploring the role and mechanisms of alliance in predicting successful treatment. Likewise, in future studies, multiple assessments should be used to evaluate the potentially evolving phenomenon of therapeutic alliance. The association between past childhood traumas and therapeutic alliance should also be further investigated in clinical samples of men, since avoidant attachment did not contribute to the prediction of agreement on tasks. As proposed, emotional continence level could be another research avenue to explore.

Clinical implications

The present study suggests that past traumatic experiences, their cumulation, and associated outcomes should be carefully assessed in sex therapy patients. While findings need to be replicated, they suggest the need for sex therapists to investigate both past traumas and current attachment representations to guide therapeutic interventions and optimize treatment benefits through therapeutic alliance. Taking into account our results and the work by Finkelhor, Ormrod, and Turner (2007) suggesting that efficient screening of cumulative trauma should consider the report of at least four forms of traumas, this accumulation appears to be essential to evaluate. Since the interaction between CCT and common agreement on tasks seems to fluctuate depending on the level of attachment avoidance, the interventions that are put in place should particularly be oriented toward improving task accordance and compliance. Indeed, few studies underlined that compliance to therapeutic tasks can efficiently predict treatment outcomes (e.g., Horvath et al., 2011 cited in Hoffart et al., 2013; Kazantzis et al., 2000). More specifically, according to the literature and to our findings, an effective strategy may be to tailor interventions that support the creation of the therapeutic alliance and the agreement on tasks in the early phases of sexual therapy, quick adherence being a great predictor of therapeutic success (Horvath, 2001). Since therapeutic alliance is a constantly evolving phenomenon, it is also suggested that its state be evaluated at various times during therapy, and that it be addressed with patients or supervisors as needed (e.g., Safran & Muran, 1996; 2000). Some authors recommend paying particular attention to the needs and capacity of patients in terms of tasks during the first therapy sessions to enhance therapeutic alliance (e.g., Horvath et al., 2011 cited in Hoffart et al., 2013). To do so, in highly avoidant patients, and especially in women, targeting avoidant attachment patterns in early phases of intervention may be crucial. For instance, emotionally focused therapy (EFT) offers techniques centered on attachment and is sensitive to trauma survivors (Johnson, 2002; MacIntosh & Johnson, 2008). Early evaluations and interventions based on attachment and trauma could allow for rapid detection of potential barriers to the quality of the therapeutic alliance, which may affect the efficacy of the therapy.

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