

Rewriting History: Attachment Theory in the Practice of Adult Psychotherapy

Jillian D. Farrell, B.A.
Department of Counseling and Clinical Psychology
Teachers College, Columbia University

Jacqueline A. Carleton, PhD
National Institute for the Psychotherapies

Attachment theory can enhance both the therapist's and patient's awareness of their roles in the psychotherapeutic process, their effect on the therapeutic alliance, and their understanding of themselves and one another. John Bowlby (1980) proposed that the innate developmental task of infants is to seek and grow a relationship with their primary caregiver, offering the child protection and security (Dolan et al., 1993; Farber et al., 1995; Levy, 2005; Sable, 2007). As an adult, the acquired pattern of attachment behavior guides how an individual relates to others, functions in interpersonal situations and relationships, regulates emotions, and reflects on past or present attachments (Atkinson et al., 2004; Mikulincer et al., 2007; Sable, 2007; Zilcha et al., 2011). By reviewing the selected literature in the field, the present article strives to help clinicians deepen their understanding of the role of attachment theory with adult patients, in the psychotherapeutic process, as it has been elaborated in the recent literature. It is hoped that clinicians will be inspired to follow up with some of the multitudinous references we have provided to this fascinating literature. We would also hope that they realize that a great deal of evidence has accrued of the effectiveness of attachment based psychotherapy.

Introduction

Background

John Bowlby (1980), the father of attachment theory, established a conceptual framework that continues to inspire attention and research. The principles of the theory address the innate developmental task of infants to seek and grow a relationship with their primary caregiver, offering the child protection and security (Sable, 2007; Levy, 2005; Dolan et al., 1993; Farber et al., 1995). This is congruent with the ethological principle that all mammals require the presence of a caregiving figure as the protector of the fragile infant striving for survival (Bernier et al., 2002; Bowlby, 1980; Diener et al., 2011; Muller, 2009). Using Bowlby's theory as a foundation, Mary Ainsworth went on to systematically assess attachment needs and behaviors of toddlers in her well-known experiment, The Strange Situation (Ainsworth, 1985; Ainsworth et al., 1978). From there, Mary Main and colleagues developed the Adult Attachment Interview (AAI), enabling researchers and clinicians to explore attachment related phenomena in late adolescence and adulthood (Wallin, 2007). An enormous amount of attachment research continues to flourish and there is now substantial empirical support for Bowlby's (1980)

conviction that early family experience is related to later personality functioning (Harris, 2004; Sable, 2007).

The present paper strives to help clinicians deepen their understanding of the role of attachment theory in the psychotherapeutic process with adult patients, as it has been elaborated in the plethora of recent literature. By reviewing selected literature in the field, knowledge and perspectives of attachment concepts are examined and integrated to form a comprehensive overview. The various elements of attachment theory are discussed in the context of psychotherapy, including suggestions for the application of theory to practice and possible directions for future research.

Significance of Attachment Theory in Clinical Practice

The phrase "attachment state of mind" denotes the way an individual in adulthood processes attachment-related cognitions, feelings, and memories (Atkinson et al., 2004). Attachment systems impact people's trust in close relationships, their fears of rejection, their weak or intense yearning for intimacy, and their tendency to favor dependency or autonomy (Meyer et al., 2001). The acquired pattern of attachment behavior guides how he or she relates to others, functions in interpersonal situations and relationships, regulates emotions, and reflects on past or present attachments (Atkinson et al., 2004; Mi-

Keywords: attachment, psychotherapy, working alliance, AAI

kulincer et al., 2007; Sable, 2007; Zilcha et al., 2011). Indeed, attachment theory offers a foundation from which a clinician can better understand the limitations and capacities of an adult patient through the consideration of childhood and current relationships that have brought about the person's representations of the self and others (Sable, 2007; Smith et al., 2009).

Utilizing attachment theory, an adult patient's capacity to form positive relationships can be examined (Smith et al., 2009). In adults, psychopathology may arise from or result in the inability to form and maintain close relationships (Sable, 2007). Additionally, attachment theory can be understood as a theory of trauma in which the lack of and/or disruption in secure connections to others generates traumatic stress and modified styles of attachment (Levy, 2005). An individual's attachment system is associated with the capacity for intersubjectivity, affect-regulation, mentalization, and other developmental processes; thus, the disruption or weakness of these processes due to a maladaptive attachment system can weigh heavily on one's functioning and be manifested in symptoms (Bowlby, 1980; Sable, 2007). Lamagna (in press) states, "This 'internal attachment system', comprising states representing our subjective experience and states reflecting on and appraising that experience coordinates its activity in ways that best regulate the individual's affects, thoughts, perceptions, and behavior." Research shows a convincing connection between attachment deficits and Axis I and Axis II diagnoses (Shorey et al., 2006). Bowlby (1980) pointed out long ago that separations, losses, and other disturbances in attachment are the foundations from which emotional distress and personality disorders arise.

How Attachment Theory Is Related to Psychopathology in Adulthood

Wallin (2007) proposes that the guiding rules of a person's life are those evolved from the "rules of attachment" that were internalized and embedded in infancy through interactions with caregivers. These "rules", in time, define the means by which one accesses attachment-related cognitions, emotions, and recollections. The attachment they had as infants has been found to be strongly linked to their psychological health as adults (Atkinson et al., 2004; Shorey et al., 2006).

The individuals typically exhibiting psychopathology are unable to protect themselves against and/or cope with threats, stresses of human interaction, and the hassles of everyday life due to the absence of the flexible psychological processes developed through early attachment experiences (Bateman et al., 2003; Bowlby, 1980; Levy, 2005; Sable, 2007; Zilcha et al., 2011). Losses and unresolved experiences in a person's attachment system can be kept hidden in a dissociated state that only releases these overwhelming experiences when provoked with cues relating to them (Wallin, 2007).

The Modification of Attachment Systems in Psychotherapy

Fortunately, attachment systems can be modified by subsequent relationships, one of which is psychotherapy (Mikulincer et al., 2007; Wallin, 2007; Zilcha et al., 2011). The experience of psychotherapy, first described by Freud as "the talking cure", generally involves self-disclosure of concerns by the client and facilitation of change by the therapist (Leger, 1998). Vaughn and Burgoon (1976) noted, "Parsons (1951) maintains that therapy becomes necessary when the control mechanisms inherent in the reciprocities of ordinary human relationships break down" (p.256, quoted from Leger, 1998). Thus, psychotherapy, particularly attachment-focused psychotherapy, has the potential to transform the rigid processes of one's attachment system to become more robust, as well as re-write the way a person views him or her self and others (Harris, 2004).

The growing research in attachment is beginning to facilitate greater application of the theory to the practice of psychotherapy (Mikulincer et al., 2007; Wallin, 2007). Findings have supported the notion that clinicians' knowledge of attachment theory enhances the efficacy of the therapeutic relationship (Farber et al., 1995). Psychotherapeutic treatment utilizing attachment theory provides an opportunity for a patient to delve into both early and current attachment experiences while in a safe setting and with a safe person: the therapist (Bowlby, 1980; Sable, 2007). Attachment theory can "enrich (rather than dictate) the therapist's understanding of his or her patient" (Steele et al., 2008), allowing the therapeutic alliance

and intervention techniques to be designed to match a patient's specific needs (Mallinckrodt et al., 2005).

Developmental Processes Starting In Early Attachment Experiences

Internal Working Models of Attachment

Internal working models are the foundations of adaptive or maladaptive thoughts and behaviors (Zilcha et al., 2011). An individual's unique internal representations strongly influence his or her behaviors and security later on in life (Bowlby, 1980; Cortina et al., 2003; Harris, 2004; Lamagna, in press; Levy, 2005; Smith et al., 2009; Zilcha et al., 2011). These internal working models are organized behavioral systems and cognitive structures developed through the internalization of early interactions with caregivers and the environment (Bowlby, 1980; Cortina et al., 2003; Diener et al., 2011; Harris, 2004; Levy, 2005; Meyer et al., 2001; Mikulincer et al., 2007; Sable, 2007; Zilcha et al., 2011). Once these representations of self and others are formed, one's expectations and style of thinking are virtually automatically implemented in subsequent relationships (Diener et al., 2011; Muller, 2009). The meaning of events is constructed to be congruent with the inner working models, whether accurate or inaccurate. Negative internal working models lead to the misinterpretation of social cues, like attributing hostility to others' benign intentions (Muller, 2009). In other words, as a child matures through life his or her internal expectations, established from early experiences, govern the experience and navigation of the external world (Harris, 2004; Leger, 1998).

The propositions of both Bowlby (1980) and interpersonal theorists suggest that an essential goal of therapy is the restructuring of representations of early attachment interactions and the transformation of insecure internal working models and destructive relational behaviors (Diener et al., 2011). These changes are thought to occur as a result of the new relationship experiences with the therapist (Diener et al., 2011). Although initially clients' negative working models influence his/her attachment and perceptions of the therapist, they become more secure during the course of therapy as the client is subjected to the consistency and responsiveness of the therapist (Bowlby, 1980;

Mallinckrodt et al., 2005; Smith et al., 2009). For example, clients with a dismissing attachment style may be cold and unwelcoming towards the therapist at the onset of therapy, making it difficult to have a conversation. After they experience the warmth and helpfulness of the therapist at a carefully titrated pace, these clients begin to feel more motivated and comfortable sharing with the therapist and interacting in sessions.

Through the internalization of the therapist as a nurturing and reliable figure, a client gradually builds an internal working model of the therapist and comes to see the therapist as an attachment figure that he or she can resort to during distress, at first through direct contact and eventually by internalization (Bowlby, 1980; Farber et al., 1995). The evocation of the therapist by the client during emotional and/or interpersonal difficulty allows for the employment of affect regulation strategies and the revision of maladaptive expectations and behaviors (Obegi, 2008). The changes in reaction to stressful circumstances and the experience of a positive attachment relationship contribute to an increased confidence in the self and/or others (Obegi, 2008).

The internalization of the benevolent role of the therapist and the formation of a positive internal working model of the therapist is critical to therapeutic change (Zilcha et al., 2011). Clients can reveal their internal working models through attachment behaviors, transference, narratives, and self-reports (Harris, 2004). In the case of transference, the patient actually projects his or her internal working models onto the therapist (Smith et al., 2009). Transference can include positive manifestations that progress treatment forward, or negative manifestations that may be seen as resistance (Cortina et al., 2003).

Dozier and Tyrell (1998) stressed the need for the therapist to gently challenge the client's attachment patterns, assumptions about relationships, and coping strategies in order to encourage the steady exploration of emotional and interpersonal issues. The goal is to restructure the models to be more congruent with accurate and current knowledge and experiences (Sable, 2007). Dozier and Tyrell (1998) termed this process a "correctional experience". In adult patients, there is an unconscious, active adherence to the preexisting "rules of attachment". Therefore, disconfirming the

client's internal working models propels the client to investigate, reevaluate, and understand past experiences that have shaped his/her problematic models and representations (Eagle et al., 2006; Shorey et al., 2006). Some label this type of intervention involving a push for change as "purposeful misattunement" (Shapiro et al., 1999). From this exploration, expectations and perceptions of the self and/or relationships can be revised and internal working models can be reconfigured (Zilcha et al., 2011). As Holmes (2000) describes, this restructuring of working models is like "story-making" and "story-breaking". The internal world of the adult patient is reassembled in a way that allows a more coherent narrative of the self to be formed, as well as the events of one's life to "fall into place" (Sable, 2007). With regard to attachment, it is the discovery of meaning in our personal history that influences the security of our state of mind, rather than the actual content of this history.

Attachment and interpersonal theorists agree that a therapist's noncomplementary response to a client's attachment tendencies promotes an opportunity for a client's internal working models (also called "interpersonal complementary hypothesis") to be challenged and revised (Bernier et al., 2002; Goodman, 2010). By flexibly taking on a contrasting stance to the client's rigid assumptions, no reinforcement is given to the client's inflexible interpersonal orientation and there is an opportunity for the client to explore alternative expectations of the self and/or relationships. For example, a therapist treating a dismissing patient needs to slowly encourage reflection on the patient's emotional issues he/she is trying to ignore, rather than allowing these issues to be overlooked (Bernier et al., 2002). On the other hand, a therapist working with a preoccupied patient, who is pouring out his/her emotional issues and is clinging to the therapist, must gradually encourage autonomy (Bernier et al., 2002). If the therapist gives in to every demand and need of the preoccupied patient, the individual's internal working model of the self will only become more enmeshed with his/her relationships and the negative attachment behaviors will be reinforced.

The security of the therapist's own attachment system, which will be discussed below, contributes to his or her capacity to adapt to the needs of the

client. In some cases, it is extremely challenging or impossible for a therapist to provide the patient with the sense of security needed to establish the restorative positive relationship with the therapist (Mallinckrodt et al., 1995; Zilcha et al., 2011). If this is the case, the patient may be able, guided by the therapist, to use a current intimate relationship.

Mentalization and Attachment Style

Mentalization is the ability to understand human action in the context of one's underlying mental representations (Bateman et al., 2003). The capacity for mentalization is the foundation of a stable structure of the self and is developed through early attachment and subsequent social experiences (Gergely et al., 1996). Disorganized and/or weak early attachments can become incorporated into the self-structure resulting in the experience of oneself and others in this maladaptive, disoriented mode. In adults, there is an unconscious, active adherence to the preexisting "rules of attachment" based on these assumptions. With an unstable sense of self, the individual inherently strives to defend their distorted and schematic perceptions of self, others, and relationships against threats that may conflict with these perceptions, perhaps through aggressive impulses or mental isolation (Bateman et al., 2003). This reduced capacity to mentalize can be reflected in poor interpersonal relations, maladaptive and insecure assumptions about oneself, and emotional volatility.

In psychotherapy, the issues of mentalization can be addressed and improved (Bonovitz, 2010). The therapist can help cultivate a patient's capacity for mentalization by consistently questioning and reflecting on the internal states within the patient (and within the therapist) characterizing the current moment (Bateman et al., 2003). The mutual exploration allows the therapist to discover links between external and internal experiences that seem incomprehensible for the patient (Bateman et al., 2003). This clarification allows the patient to become aware and make sense of previously ambiguous feelings about oneself, others, and relationships (Bateman et al., 2003). The argument is that feelings are re-experienced and released during the psychotherapeutic process as one reprocesses past experiences. This allows for the patient

to organize a more accurate construction of experience and restructure the self (Leger, 1998). Consequently, this new understanding and sense of control over one's internal states facilitates mentalization.

Internal Working Models of Patients Based On Attachment Style

It is critical for the therapist to understand the nature of the internal working models each patient brings into treatment. Individuals with a secure attachment style hold assumptions that are both practical and beneficial for their internal wellbeing and social experiences. Their internal working models sustain a trust in the goodness and competence of the self and others, as well as a desire for and a confidence in relationships (Bordin, 1979; Diener et al., 2011; Levy, 2005). Individuals with a secure attachment are less restricted by internal rule-based patterning, enabling them to be flexible in their interpersonal communications (Wallin, 2007). This internalized positive inner working model facilitates a higher tolerance for anxiety, especially in novel experiences, resulting in a greater freedom to explore the world and a more coherent integration of experiences (Mallinckrodt et al., 2005). They have overall better functioning in areas such as impulse control, empathy, and marital relations (Levy, 2005; Main et al., 1986). A more secure attachment is beneficial for the type of mentalization that permits the efficacy of introspection that can disclose and evaluate attachment influences on one's relationship functioning and affect regulation (Obegi, 2008).

In contrast, an insecure attachment style consists of internal working models that have a negative, ambiguous, and mistrusting view of the self and others (Diener, et al., 2011). Inadequate early caregiving experiences encode in the memory attachment interactions that are inconsistent (Sable, 2007). The dissociated representations of attachment, hypothesized by Main as "multiple models" of attachment, are similar to Freud's ideas regarding the dynamic unconscious. Instead of the unlimited access to attachment-related information present within secure individuals, those with "multiple models" are governed by rigidity in what they are supposed to know and feel rather than being able to use the entirety of their experiences (particularly those that are threatening). Therefore,

an insecurely attached individual may feel discomfort with closeness in relationships and/or anxiety in times of separation (Wallin, 2007). The negative internal working models of the self and/or other fuel distress due to the insufficient development of appropriate physiologic and affect regulation as a result of poor early caregiving experiences. In these cases, attachment repair must precede introspective exploration.

Categorization of Attachment Patterns

In regards to childhood attachment, several different categorization schemes have been proposed consisting of different labels and numbers of categories. For the sake of simplicity, in this piece, I will focus on the categories proposed by Ainsworth (1978) and Main et al (1986). Their work yielded four patterns of attachment: secure, insecure-ambivalent, insecure-avoidant, and disorganized (Dolan et al., 1993; Hietanen et al., 2006). Children's attachment styles are highly correlated with similar attachment patterns in adulthood. There are also children with attachment styles deemed "cannot classify" since a clear pattern of attachment does not present itself in the assessment. But, for most, placement into one of the four styles of attachments is possible. A caretaker may be nurturing and responsive, promoting the child's development of a sense of security and secure attachment (Levy, 2005; Pally, 2001). On the contrary, inadequate early caregiving experiences could hinder processes like attaining the ability to self-regulate, as well as result in unstable attachment thoughts and insecure attachment (Sable, 2007). For adults, the attachment styles are conceptualized as: secure-autonomous, preoccupied, dismissing, or unresolved/disorganized (Hietanen et al., 2006).

Assessing Attachment Style & The Adult Attachment Interview (AAI)

As previously described, an infant's early attachments to caregivers are internalized forming cognitive-affective structures (Bowlby, 1980) that evolve into similar models in adulthood and are active in one's current emotional and relational involvements. The concept of adult attachment styles refers to individuals' comfort and position in close relationships,

their tendency to favor autonomy or dependency, as well as their anxiety regarding rejection and inaccessibility in relationships (Ainsworth et al., 1978; Meyer et al., 2001). For an attachment-informed psychotherapist, the initial assessment focuses on the quality of the potential client's relationships (Cortina et al., 2003). A central part of the assessment will be the history of primary caregivers' responsiveness or inattentiveness, especially noting whether the client experienced a loss of or abandonment by a caregiver, and the subsequent attachment style the client developed (Cortina et al., 2003). Attachment style can usually be adequately assessed without the complete implementation of a validated instrument; however, a tool like the Adult Attachment Interview (AAI) is very useful (Cortina et al., 2003).

The Adult Attachment interview (AAI) is the most accepted interview method of assessing adult attachment measures; however, self-report questionnaires can also be used to measure attachment patterns (Eagle, 2006). The AAI, formulated by Mary Main and her colleagues, involves an hour-long interview in which an adult self-reports behaviors in intimate relationships and narrates experiences in childhood concerning early relationships with his or her parents (Bernier et al., 2002). This process unveils the person's "states of mind regarding attachment" (Harris, 2004) and "autobiographical competence" (Holmes, 1995). Of primary importance, is the coherency of the narrative one relates about childhood experiences and relations. The clinician's task is to listen to the patient's story, try to find meaning within it, and uncover the clues in the story that underlie the attachment pattern (Holmes, 1995). With treatment, the therapist and client can work jointly in re-writing the client's narrative (Holmes, 1995). As the psychotherapeutic process unfolds, change and improvement can be assessed by the cultivation of a more flowing, comprehensible, and expressive story (Holmes, 1995).

It is important to note the AAI's focus on childhood omits insight from some relevant relationships, such as those with siblings, marital partners, and co-workers (Cortina et al., 2003). The optimal means of assessment may be for the clinician to use the AAI with other measures or questions (Cortina et al., 2003). A measure like the Attachment Style Inter-

view (ASI) may be a valuable supplement given that it concentrates on the aspects and coherence of one's narrative, but also addresses the entire range of adult relationships (Cortina et al., 2003). There are also some measures that use a multi-item continuous scale (Smith et al., 2009), such as the Experiences in Close Relationship Scale (ECRS; Brennan et al., 1998) and the Adult Attachment Inventory (AAI; Simpson et al., 1992). These measures evaluate anxiety and avoidance, with lower scores on both dimensions indicating a more secure attachment pattern (Smith et al., 2009).

The three insecure attachment styles discussed above are the result of poor and/or inadequate early attachment relationships. Individuals possessing these attachment styles often suffer problems in emotional control and serious psychological distress that contribute to their anxiety, depression, hostility, and maladaptive patterns in interpersonal relations (Bachelor et al., 2010). Anderson and Perris (2000) performed two studies to assess the relationship between adult attachment styles and dysfunctional working models using the AAI, the Attachment Styles Questionnaire (ASQ), and the Dysfunctional Working Models Scale (DWM-S). They found statistically significant correlations supporting their hypotheses that secure attachment is negatively associated with dysfunctional assumption scores and insecure attachment is positively associated with dysfunctional assumptions. Consequently, individuals with insecure attachments have a greater need to piece together experiences that have caused the dysfunctional working models increasing distress and symptomology (Sable, 2007).

Cortina and Marrone (2003) present a chart matching attachment style and type of prior caregiver with the related issues involving the creation of a supportive therapeutic alliance and potential solutions. For example, a client who is fearful of rejection is paired with a previous caregiving figure that is consistently rejecting and/or unresponsive to needs (Cortina et al., 2003). An issue in therapy may be the client's avoidance of talking about his or her actual concerns and needs since there is a fear that doing so will lead to rejection (Cortina et al., 2003). To address this issue, the therapist must focus on conveying the non-judgmental context of therapy and the therapeutic relationship (Cortina et al., 2003).

The table provided by Cortina & Marrone (2003) incorporates the augmented classification of attachment styles used by Bifulco and colleagues (2002) as a guide to help the development of the alliance. However, a plausible concern for using attachment measures in a clinical setting is: if the patient is classified as having a certain attachment style, is there a greater likelihood therapists will misinterpret experiences with a patient and establish their views based on the patient's initial attachment classification?

Daly and Mallinckrodt (2009) interviewed experienced therapists about approaches they found effective for clients with particular attachment styles. Therapists reported the importance of gradually increasing the therapeutic distance with anxiously attached clients (Daly et al., 2009). Conversely, the therapists suggested a gradual decrease in therapeutic distance for avoidant patients (Daly et al., 2009). In addition to guiding the therapist's approach for the patient, awareness of the patient's attachment history prepares the therapist for the types of transference experiences that may occur, as well as improves the therapist's understanding of his or her own possible countertransference reactions (Shilkret, 2005). There are different manifestations of transference that patients can display, which may vary throughout treatment (Goodman, 2010). Interestingly, Freud (1912, 1913) discussed the dynamic of transference involved in psychotherapy: the unconscious negative component, the unconscious positive component, and the conscious "unobjectionable" component (Goodman, 2010). The first two serve as oppositions to treatment, while the latter represents feelings of value towards treatment and facilitates success in treatment (Goodman, 2010). Moreover, he identified the patient's attachment to the therapist as a requirement for the occurrence of unobjectionable transference, which facilitates the development of the working alliance (Goodman, 2010).

The "Working Alliance" in Attachment-Focused Therapy with Adults

Attachment theory and research shed enormous light on both the client's and therapist's internal working models influencing the progression of ther-

apeutic process, especially with regard to the creation of the working alliance (or client-therapist alliance) (Hietanen et al., 2006; Smith et al., 2009). Greenson (1967) was the first to use the term "working alliance" (Diener et al., 2011; Horvath et al., 1991), which he defined as a "rational relationship between patient and analyst" (p. 46). Considering the heavy influence of the attachment styles of both the therapist and of the patient on the formation of the alliance, Bordin (1979) views the alliance as "dyadic and mutual with the therapist and client as active co-constructors, constantly negotiating and renegotiating the alliance in order for successful work to take place" (Bordin, 1979; Smith et al., 2009). When it comes to the actual "alliance", Bordin (1979) hypothesized the alliance to consist of three facets: the goal, the task, and the bond (Diener et al., 2011; Hietanen et al., 2006; Smith et al., 2009). The goal and the task involve the cognitive elements of the alliance, specifically the agreement on the general objectives of treatment and the particular actions that will be employed to achieve the set goals (Bordin, 1979; Hietanen et al., 2006). The bond, the emotional and relational component, involves all the affective experiences that enables client to develop an attachment to the therapist, such as the client's feelings of trust and empathy (Bordin, 1979; Hietanen et al., 2006). It is the attachment to the therapist that allows the client to participate in the tasks and achieve the goals (Smith et al., 2009). The opportunity for therapeutic change occurs with the therapist and client attending to and repairing obstacles resulting from a disagreement about one or more of the three components (Smith et al., 2009). Since times of danger or distress both activate attachment systems and often bring clients to therapy, researchers have come to link the concept of the therapeutic alliance with attachment theory (Farber et al., 1995; Harris, 2004; Sable, 2007; Smith et al., 2009).

Research has found that a stronger alliance is associated with less distress in psychotherapy as treatment progresses (Sauer, 2010; Smith et al., 2009). In contrast, the failure to develop an alliance can bring about a premature termination of therapy (Harris, 2004). Horvath and Greenberg (1986) developed the Working Alliance Inventory (WAI) to measure this working alliance, which includes the three subscales (task,

goal, and bond) (Goodman, 2010; Smith et al., 2009).

The Therapist As A Secure Base

The therapeutic relationship is more than a bond; it is also an attachment (Obegi, 2008; Zilcha et al., 2011). The relationship incorporates characteristics of child-caregiver relationships, such as the reassuring presence of the therapist and the possibility for emotion regulation (Goodman, 2010; Meyer et al., 2001). First, the child must come to see the caregiver as a reliable attachment figure that he or she can turn to if threatened or distressed, making them a safe haven (Eagle, 2006). Through experiences of an encouraging and available attachment figure, the child then can use the caregiver as a secure base that provides the comfort and confidence a child needs to be motivated to explore the world (Ainsworth et al., 1978; ,1980; Eagle, 2006; Farber et al., 1995; Lamagna, in press; Levy, 2005; Lipton & Fosha, 2011; Mikulincer et al., 2007).

Similar to the caregiver-infant relationship, Bowlby (1980) proposes the therapist serve as a secure base from which the patient can safely explore difficult psychological matters relating to both internal and external factors (Dozier et al., 2004; Eagle et al., 2009; Farber et al., 1995; Goodman, 2010; Holmes, 1995; Meyer et al., 2001; Schauenburg et al., 2010; Zilcha et al., 2011). As a receptive figure, the therapist accepts the client's feelings, offers emotional availability, and provides regulated affect, which allows for the development of attachment (Malinckrodt et al., 1995; Mikulincer et al., 2007; Sable, 2007). The positive attachment relationship with the therapist facilitates the client's confidence in his or her own abilities and in the capacity to have fulfilling relational experiences (Sable, 2007). Therapists' empathetic presence combined with the mastery they project embeds a base that a patient feels comfortable using to venture into difficult territories (Holmes, 2000).

By reflecting on past life experiences and early attachment relationships with the help and support of therapists, patients can give meaning to past experiences and explore the influence they had and/or have on their distress and functioning (Sable, 2007). The availability of the therapist during exploration facilitates the change needed for the client to explore and make modifications to his or her current cogni-

tions, feelings, and behaviors (Eagle et al., 2009; Mahoney, 1990, paraphrased from Leger, 1998; Sable, 2007). This transformation towards a stable, coherent self-representation is not possible in psychotherapy without the therapist's fundamental role as a "secure base" (Bowlby, 1980; Eagle et al., 2009; Farber et al., 1995). The empathy of the therapist, the security of the client-therapist relationship, and the safe intimate space are needed for the patient to obtain the freedom to think and feel without the fear that his or her unstable or fragile self will be threatened or attacked.

In addition to the therapist's function as a secure base within the therapeutic setting, the patient can utilize the representations of the therapist developed through attachment, even after the termination of therapy, during times of stress in order to gain that sense of comfort and competence that allowed for problem solving during treatment, as well as to explore new opportunities and relationships (Farber et al., 1995). The evocation of the therapist's internal working model (discussed above during emotional and/or interpersonal strain can even help the individual regulate affect and change the way he or she approaches the stressful situation (Eagle et al., 2009; Obegi, 2008). The new strategies for dealing with stress and relationships reflect a positive transformation in the client's internal working models and attachment security (Eagle et al., 2009). The client's increased capacity for reflective functioning permits the construction of a more coherent narrative, which is less ambiguous and conflicting (Eagle et al., 2009). Lipton and Fosha (2011) propose, "through meta-therapeutic processing, or metaprocessing for short, the secure attachment relationship between patient and therapist becomes the vehicle through which a patient's right-brain experiencing of psychotherapy is integrated with her left-brain, conscious, verbal knowing that a therapeutic experience has just occurred" (p. 271). The resulting clarity in one's narrative and the improvement of reflective functioning foster a sense of security and stability in the view of not only oneself, but also in the view of others.

The Alliance As A Predictor of Therapeutic Outcome

Research has indicated that the quality of the

early working alliance and the nature of the therapist as a secure base is crucial to the therapeutic outcome (Diener et al., 2011; Harris, 2004; Horvath et al., 1991; Meyer et al., 2001; Mikulincer et al., 2007; Sauer et al., 2010; Schauenburg et al., 2010; Smith et al., 2009). Byrd et al. (2010) studied the impact of the working alliance on the patient's attachment style during treatment, as well as the impact of the attachment style on the psychotherapeutic process. Results showed that two attachment dimensions (Comfort with Closeness and Comfort Depending on Others) were positively related to the alliance and treatment outcome. Additionally, the alliance influenced the dimension Comfort with Closeness, which, in turn, promoted more successful therapeutic outcome.

It has also been proposed that therapists' perceptions of the therapeutic alliance depend on the attachment style of the client, while the client's perception of the therapeutic alliance was not related to attachment style (Dolan et al., 1993; Horvath et al., 1986). Therapists reported a stronger therapeutic alliance with secure patients and a weaker alliance with patients that had a more avoidant attachment (Dolan et al., 1993). A meta-analytic review investigated past research exploring the relationship between client attachment and the therapeutic alliance, which consist of two categories of client attachment, clients' global attachment patterns and clients' specific attachment pattern to their therapist (Smith et al., 2009). The theoretical literature indicates that with regard to patients' global attachment, clients' secure attachment yields a stronger therapeutic alliance (Diener et al., 2011; Mikulincer et al., 2007; Smith et al., 2009). Similarly, those who perceive themselves as securely attached to their therapist develop stronger therapeutic alliances (Smith et al., 2009). On the other hand, clients with an avoidant-fearful attachment pattern experience a less positive therapeutic alliance (Smith et al., 2009). Comparing the two categories, evidence supports that the client's attachment to therapist has a greater impact on the therapeutic alliance than the client's global attachment (Smith et al., 2009). Perhaps measuring clients' specific attachment may be more valuable than measuring clients' global attachment when interested in predicting the quality of the therapeutic alliance (Smith et al.,

2009). Dolan et al. (1993) also propose that perhaps more research should be done on whether therapists' modify their interpersonal stance and intervention strategies based on the client's attachment style and how the therapist perceives the therapeutic alliance.

Studies investigating the working alliance relationship have primarily focused on clients' individual pretreatment characteristics, such as motivation and sociability (Horvath et al., 1986; Smith et al., 2009). Clients' internal working models determine their perceptions of the therapist and the client-therapist relationship (Bowlby, 1980; Dozier et al., 2004; Eames et al., 2000; Smith et al., 2009; Zilcha et al., 2011). Especially when working with insecurely attached patients, knowledge of patients' attachment histories can provide the therapist with insight that can help them predict potential ruptures in the alliance; therefore, they can be proactive in their methods for intervening (Diener et al., 2011; Shorey et al., 2006). Recognizing the significance of attachment experiences in the therapeutic relationship, Mallinckrodt, Gantt, and Coble (1995) created the Client Attachment to Therapist Scale (CATS) (Sauer et al., 2010). The measure contains three subscales similar to attachment style classifications: Secure, Avoidant-Fearful, and Preoccupied-Merger (Sauer et al., 2010). A study investigating the relationship between attachment and the early therapeutic alliance reported that preoccupied attachment in patients predicted more frequency in ruptures, whereas dismissing attachment was associated with fewer ruptures (Eames et al., 2000). Attachment theory can facilitate the building and maintenance of the therapeutic alliance that endows a client with a perception of safety and a motivation for deep exploration, and, thus, the possibility for a positive therapeutic outcome and a reduction in symptomology (Mallinckrodt et al., 2005).

The Patient's Attachment Style

The Secure Patient

During the AAI, adults with secure attachments convey coherent narratives that integrate past experiences in a relatively balanced manner (Mallinckrodt et al., 2005). These individuals most likely do not have picture-perfect childhoods, yet they can understand

and reflect on past early attachment relationships, whether they were positive or negative (Sable, 2007). Lipton and Fosha (2011) suggest, “Several decades of research on the moment-to-moment (and even millisecond-to-millisecond) interactions between mothers and their babies tells us that reiterative, ongoing cycles of attunement, disruption and repair in the context of emotional experiencing are the essential building blocks of secure attachment” (p. 258; Beebe et al., 2002). This type of security in attachment is necessary for the self-reflective mentalization that supports introspection and metacognition (Mallinckrodt et al., 2005). With the ability to examine current and past experiences in a constructive fashion, an adult can develop a more balanced approach and appraisal of relationships, as well as better strategies for resolving thoughts, memories, and feelings that are related to distress (Sable, 2007). Thus, attachment security strongly influences functioning in interpersonal relations, the capacity for affect regulation, and psychopathology in adulthood (Atkinson et al., 2004; Obegi, 2008). A person assessed as having a secure attachment will be more willing to self-disclose information about him- or herself in psychotherapy (Atkinson et al., 2004; Mikulincer et al., 2007). Therefore, the formation of an emotional bond between therapist and patient would most likely be an easier and quicker process than with those patients lacking a secure attachment (Bordin, 1979; Smith et al., 2009).

The Preoccupied Patient

Among those assessed to have an attachment style that is not defined by a sense of security, there is greater likelihood for psychopathology, dysfunction, and distress. For preoccupied individuals, intense anxiety, hyperactivation, and defense mechanisms are maintained in order to combat feelings of insecurity and psychological distress that has resulted from insecurity in early attachment experiences (Bachelor et al., 2010; Smith et al., 2009). Most likely, as children their caregivers were unpredictable leading them to develop neuroceptions of potential danger, as well as create contradictory internal representations of the caregiver (Badenoch, 2008). The disintegration characterizing their childhood experiences results in disruptions in the brain’s neural networks, bringing

about emotional dysregulation and an overwhelming energy that blinds the individual from forming reasonable and objective perceptions (Badenoch, 2008). Badenoch (2008) terms the preoccupied individual’s internal world an “emotional jungle” (p. 70). With regards to relating with others, the mental models guiding them lead them to expect they will have jagged and unreliable relationships (Badenoch, 2008).

They exaggerate their personal distress and have an overwhelming need for the support and closeness of others (Bernier et al., 2002; Dozier et al., 1995; Main et al., 1998). Their state of mind typically consists of enmeshment in past and current relationships, as well as confused feelings, possibly anger or fear, toward relationships (Atkinson et al., 2004; Badenoch, 2008; Bernier et al., 2002). An AAI narrative would consist of continuous interchanges of past and present experiences that are tangled together in a confusing disintegrated web, representing a poor sense of self (Badenoch, 2008). Their narratives may be extremely lengthy, with the clients becoming so caught up in their memories that it seems as if they are reliving past experiences (Atkinson et al., 2004).

At the onset of therapy, preoccupied clients are more likely to have high anxiety and distress, and they often ruminate about what the therapist and others may have said (Atkinson et al., 2004; Mikulincer et al., 2007; Shilkret, 2005; Smith et al., 2009). They are often concerned with the availability of the therapist and want to be emotionally and physically close (Mikulincer et al., 2007; Smith et al., 2009). The chaotic swapping, lack of coherency, and anxiety the patient brings to therapy can even make the clinician a bit anxious (Badenoch, 2008). In this case, it is important that the therapist be mindful and remain calm, as simply the presence of the therapist’s calmness can promote the patterning of emotion regulation (Badenoch, 2008).

The Dismissing Patient

Dismissing individuals, by contrast, tend to minimize the significance of early attachments and believe relationships are relatively unimportant (Atkinson et al., 2004; Badenoch, 2008; Bernier et al., 2002; Mikulincer et al., 2007; Muller, 2009; Zilcha et al., 2011). These patients have difficulty engaging in discussion regarding the inadequacy of their early at-

tachment relationships, and, thus deny their feelings about these issues (Atkinson et al., 2004; Mikulincer et al., 2007; Muller, 2009; Zilcha et al., 2011). Even traumatic events will be minimized into an occurrence that is more socially accepted (Muller, 2009). Applying the role of imagination proposed by Bonovitz (2012), these individuals may overly use fantasy to avoid facing reality, resulting in rigidity in life and trouble in interpersonal relations (Bonovitz, 2012). Due to their insistence on self-reliance and separateness, they have difficulty forming bonds and they reject or deny attachment needs (Bernier et al., 2002; Dozier, 2004; Eagle, 2006; Main et al., 1998; Mikulincer et al., 2007; Muller, 2009, 2007; Shorey et al., 2006; Smith et al., 2009; Zilcha et al., 2011).

The discourse of dismissing patients' narratives may be fluent, yet seems to be very superficial and lack details (Badenoch, 2008; Bernier et al., 2002; Dozier et al., 2004). There is either dissociation or absence of many aspects of early attachment experiences and emotional numbness as well (Bernier et al., 2002; Muller, 2009). Badenoch (2008) describes the mental model of a dismissing patient as an "emotional desert" (p. 68). The patient may describe their parents as "nice" or the relationship as "good" (Badenoch, 2008). When listening to these narratives, clinicians may struggle to grasp the internal model and community directing the patient's mind (Badenoch, 2008). Patients may convey cues that the therapist should not probe discussion on a certain topic or intrude in areas of their life that they insist are not troubling (Dozier et al., 2004). When treating a dismissing patient, there may be a challenge in creating an interpersonal connection, especially since dismissing individuals often lack the ability to read others' signals (Badenoch, 2008). A particular obstacle to a therapist's relationship with a dismissing client is "mutual avoidance" (Muller, 2009). The patient's ambiguous feelings toward a trauma or attachment relationship lead the therapist to question how to react; therefore, the therapist surrenders to the patient's pull to avoid the topic (Bernier et al., 2002; Muller, 2009). Muller (2009) suggests, "The challenge in treatment, then, is in helping such patients find a way to tell a story too painful to speak, but too compelling to ignore" (pp.79).

The Unresolved Patient

Similarly, those with unresolved attachment styles often lack recollections of important experiences relating to attachment in childhood (Dozier et al., 2004). They are so overwhelmed by the loss or trauma they experienced that they may have a lapse in reasoning (e.g., refusing to believe a person is dead), discourse, and behavior (Dozier et al., 2004). These individuals are even more disorganized in their cognitions and behaviors due to the inability to resolve early traumas in attachment (Bernier et al., 2002). Their inner worlds are fragmented, consisting of both chaos and rigidity (Badenoch, 2008). The disorganization that characterizes the unresolved pattern of attachment is demonstrated when these patients discuss early attachment experiences and current relationships (Shilkret, 2005). Not surprisingly, individuals with unresolved attachments are more likely than others to be found in a psychiatric setting (Dozier et al., 2004).

While relaying their narratives, unresolved-attached patients' speech may appear disorganized in, for example, the use of incorrect tenses (e.g., using the present tense when speaking about the past), long pauses, and inability to find one's words (Badenoch, 2008). During the course of therapy, they may present as one of the other attachment styles at different times, as they sporadically vary in the symptoms they are suffering from and their affective states (Shilkret, 2005). Lamagna (in press) describes this common manifestation as "come close/stay away" messages (p.8). The patient's lack of coherency in discourse and behavior can cause a therapist to feel unstable and confused (Badenoch, 2008). Therapy with patients characterized by the unresolved attachment style is filled with confusion; therefore, the therapist must strive to maintain calmness and clarity (Shilkret, 2005). Additionally, it is important to mention that these patients often come to therapy feeling ashamed about hurting those they loved with their unmanageable behaviors (Badenoch, 2008). For this reason, the beginning of therapy must consist of the ther-

¹Some theorists hold that those with unresolved attachments always can be diagnosed with an additional attachment pattern simultaneously (Main & Solomon, 1986; Badenoch, 2008). For example, a patient may have a secure attachment to his father, while having an unresolved attachment with his mother (Badenoch, 2008).

apist making a purposeful effort to provide patients with a sense of empathy, as well as emphasize the patients' ability to change the dissociated mental models that led to regretful actions (Badenoch, 2008).

The Therapist's Attachment Style

Of tantamount importance to the therapeutic endeavor is the therapist's attachment style (Meyer et al., 2001). Just like any other individual, the therapist possesses his or her own internal working models and attachment patterns (Bennett, 2008). In order for treatment to be efficacious, the therapist must be aware of his or her attachment style due to its large impact on one's interpersonal competencies and disposition, and, thus, the client's experience of the therapist and vice versa (Atkinson et al., 2004; Bennett, 2008; Wallin, 2007). The internal working models of therapists affect their patterns of self-protection, their ability to be self-reflective, their capacity for caregiving (empathy), their proclivity for empathic understanding and their range of affect regulation (Bennett, 2008).

Cortina and Marrone (2003) suggest four important factors influencing the quality of the therapist's empathetic understanding, which include: his/her own early attachment history, his/her own experiences as an analysand (client), his/her own experiences in clinical supervision, and his/her theoretical framework or biases. As a clinician, one needs to mentalize during sessions with patients in order to separate his or her feelings and experiences from those of the patient, while simultaneously recognizing the mental states of the patient (Bateman et al., 2003). When interactions provoke unconscious conflicts and wishes in the therapist, it is possible for defense mechanisms to become mobilized and uncomfortable countertransference to occur (Bateman et al., 2003). The phenomenon of countertransference involves the changes in the therapist's state of mind and automatic verbal/nonverbal behaviors that the patient picks up, causing either the exacerbation or alleviation of anxiety and other symptoms (Pally, 2001). Countertransference may occur due to the therapist's need to be guarded from the patient's transference, resulting in a distancing in the relationship; or there can be an activation of automatic internal responses in the ther-

apist, causing him or her to involuntarily react without thinking (Pally, 2001). All of these occurrences can hinder the therapist's capacity to be empathetic, the quality of his/her technical skills, and the capacity for affect attunement (Mallinckrodt, 2010). These elements have an influence on the treatment conditions and outcome, as well as the therapeutic relationship (Meyer et al., 2001; Pally, 2001; Sable, 2007).

Securely- Attached Therapists

Therapists who are securely attached typically exhibit behaviors consistent with this attachment style, such as warmth and trustworthiness, which are beneficial for developing relationships (Obegi, 2008). These secure attachment representations provide the therapist with greater flexibility, stability, and autonomy when in difficult interpersonal situations, such as an uncomfortable fight with a patient and the inevitable ruptures in the therapeutic relationship (Lopez & Brennan, 2000; Meyer, 2001). Instead of acting on one's own attachment related fears and needs, the therapist can adapt his or her behaviors to suit the needs of the patient involved in the interpersonal difficulty, affording better care for the patient (Cortina et al., 2003; Schauenburg et al., 2010). The study by Schauenburg et al (2010) focused on the influence of therapists' attachment representations on the alliance and confirmed the beneficial effect of therapists' attachment security on the working alliance with interpersonally distressed patients.

Insecurely- Attached Therapists

Conversely, therapists with an insecure attachment style, such as dismissing or preoccupied, may have difficulty when it comes to working through and dealing with ruptures given the anxiety and fear of rejection that constitute these attachment styles (Meyer et al., 2001). Their insecure attachment needs may also lead to substandard intervention strategies and an inability to be self-reflective (Bennett, 2008). Due to the lack of reflection in insecurely attached therapists, they may struggle with the regulation of their own affect; therefore, they lack the ability to facilitate affect regulation in the patient, a critical healing element in the therapeutic process (Bennett, 2008). Given that therapist attachment style predicts aspects

of countertransference, therapists with dismissive attachment may be more distant with difficult patients and situations, as well as have more antagonistic countertransference reactions to patients (Bennett, 2008). Those with preoccupied attachment style might fear they are inadequate and struggle to separate their own anxieties and emotions from those of the patient (Bateman et al., 2003; Bennett, 2008). These findings suggest that the therapist's attachment style interacts with the client's attachment style to determine transference and countertransferences, the interpersonal experience, and, most importantly, the building and strength of therapeutic relationship (Bennett, 2008).

Interaction Of Therapist and Client Attachment Styles

Taking into account the importance of the attachment style of both clinicians and patients, it is not surprising that the interaction between the two styles weighs heavily on the therapeutic process. Some research has indicated the advantageous effect of similarities between the therapist and client regarding attitudes, personal beliefs and values, expectations toward counseling, and self-concept (Bernier et al., 2002). This would lead one to think that similarity in attachment styles would be optimal for psychotherapy (Bernier et al., 2002). However, interpersonal researchers and theorists suggest the presence of both complementary and non-complementary exchanges is superior to the employment of simply complementary or non-complementary stance (Bernier et al., 2002). Although interpersonal theorists believe in the need for complementary exchanges, they are in agreement with attachment theorists and studies proposing the importance of dissimilarities in the interpersonal facets of client and therapist, and the notion that noncomplementary attachment styles are optimal for treatment (Bernier et al., 2002). If the therapist reinforces the client's rigid expectations and/or replicates the aspects of the client's poor early attachment experiences in therapy, it can possibly re-traumatize the patient (Cortina et al., 2003).

Bowlby (1980) suggests that the therapist flexibly adopt a contrasting stance that will challenge the client's beliefs and rigid expectations about relationships (Bernier et al., 2002). Dismissing patients

are prone to using defensive deactivation (active inhibition of attachment-related material). Therapists need to challenge the client's defensive strategy because this coping mechanism will only save the patient from distress for a short time and will eventually fail (Muller, 2009). According to Cortina & Marrone (2003), disconfirming the internal working models of dismissing (avoidant) patients' is easier than doing the same for preoccupied patients. Whereas avoidant individuals' primary attachment figures were unresponsive, preoccupied individuals experienced inconsistency in their primary attachments (Cortina et al., 2003; Smith et al., 2009). As discussed before, the capacity of the therapist to carry out this adaptation depends on his or her attachment style, with securely-attached therapists being the most adaptable (Bernier et al., 2002). The therapist's resistance to naturally respond to the patient's attachment tendencies in a conforming manner can facilitate emotional change and growth within the patient (a corrective experience) (Bernier et al., 2002; Bowlby, 1980).

For example, a dismissive client may avoid specific topics containing deep emotional content. Instead of courteously following the patient's attempt to focus on nonthreatening issues, the therapist needs to carefully challenge the client's strategies and promote the gradual exploration of the more intimate issues the client tries to shroud with superficial conversation (Bernier et al., 2002; Dozier et al., 1998). On the other hand, excessively emotional or preoccupied patients may require interventions encouraging the control of emotions and autonomy (Bernier et al., 2002; Meyer et al., 2001). Hence, corrective experiences are facilitated by matching therapist with patient based on dissimilar deactivating (avoidance) versus hyperactivating (clinging) dimensions of attachment (Bernier et al., 2002; Tyrell et al., 1999). One study reported by Tyrell et al (1999) found that preoccupied therapists formed the strongest alliance with dismissing patients and vice versa (Bernier et al., 2002). Undoubtedly, the interaction of attachment styles in psychotherapy is impactful on the transformation of patient's maladaptive thoughts and behaviors and the formation of the therapeutic alliance.

In addition to the impact of the therapist's attachment style, the style of interpretation a therapist

uses also has implications in psychotherapy (Cortina et al., 2003). Even in the context of a strong therapeutic relationship, certain types of interpretations can have a negative influence, such as decontextualization and double binding (Cortina et al., 2003). Decontextualization refers to placing too much emphasis on the patients' unconscious feelings and internal mechanisms (Cortina et al., 2003). Consequently, the therapist undervalues the patients' subjective feelings and the effects of the external world (Cortina et al., 2003). The other counterproductive interpretation, double binding, for example occurs when the therapist unintentionally instigates a feeling in the patient (e.g., makes the patient feel guilty) and then interprets that the patient possesses a guilt-ridden internal world (Cortina et al., 2003). Using attachment theory as a guide, the issues of decontextualization and double binding are less likely to occur in the psychotherapeutic process given the theory's strong emphasis on the external world's role in development (Cortina et al., 2003). By taking into account the internal and external worlds of patients, the patient is less likely to feel he or she is being blamed, which would impair progress in psychotherapy.

Conclusion and Summary

Attachment theory describes the instinctive style of individuals seeking proximity or protection when feeling threatened. Further, it suggests ways in which attachment behavior is affected by environmental factors (Bowlby, 1980; Sable, 2007). Research in attachment theory following John Bowlby has given clinicians a compelling reason to explore the actual events and relationships in a patient's early development, as well as the patient's distinct interpretations and representations of experiences (Eagle et al., 2009). Early adverse experiences with attachment internalized by the receptive infant can impede the development of psychological structures that favor resilience; therefore, the infant's vulnerability to the emergence of psychopathology is heightened (Sable, 2007). It is suggested that, although an individual's attachment style in infancy may be different from that of adulthood, a child's internal working model strongly influences subsequent behavior, affects the way

others treat them, and, thus, affects their likelihood to suffer from psychopathology (Carlson, 1998 paraphrased from Snyder & Shorey, 2006; Harris, 2004).

Undoubtedly, it is the internalization of these negative early experiences that generate negative internal working models (Harris, 2004; Levy, 2000; Wallin, 2007). With their strong impact on how one carries out his or her life, internal working models may give the impression of being irreversible and resolute (Wallin, 2007). Although they have a strong influence on personality and interpersonal interactions, internal working models and one's attachment state of mind are open to modifications by means of new experiences and relationships, with psychotherapy being a useful modality for positive transformation (Bernier et al., 2002; Wallin, 2007). Individuals with maladaptive attachment styles may have impairments in critical psychological processes; such as intersubjective relatedness, affect regulation, and mentalization (Bateman et al., 2003). Such dysfunctions can expose an individual to psychological, physical, and/or social distress. Key goals of psychotherapeutic treatment using attachment theory involve aiding the patient in: identifying unresolved emotions and appropriately expressing affect, developing stable internal representations of self and others, constructing a secure and coherent sense of self, and acquiring interpersonal characteristics that promote the potential for positive relationships (Bateman et al., 2003; Holmes, 1995). Internal working models can be revised as dysfunctional representations are challenged, reflected on, and transformed (McCluskey, 1999; Zilcha et al., 2011). Bowlby (1980) asserted that clients must comprehend how their working models cause their unhealthy thoughts and behaviors in order for these models to be revised (Zilcha et al., 2011). The reorganization of these inflexible internal working models and the therapeutic relationship allows for psychological processes, like affect-regulation, to be established, as well as new realistic views of oneself and others to be formed (Eagle et al., 2009; McCluskey et al., 1999).

Attachment-informed psychotherapy has its advantages since it not only focuses on the history of early attachment experiences that led to the maladaptive attachment behaviors of the patient in treatment, but also gives the therapist guidance in what approach

to employ for a particular patient, illuminating an optimal trajectory of treatment (Dolan et al., 1993; Harris, 2004). With knowledge of a patient's attachment style, the therapist can be sensitive and adaptive to the patient's needs, increasing and accelerating the chance for exploration and beneficial change to occur (Eagle et al., 2009). The therapist's consistent understanding from the start can enhance the experience of the therapist as a secure base and strengthen the bond between the therapist and client, allowing the client to increase his or her exploration, and resolve the issues involved (Eagle et al., 2009). In addition to the therapist's support in confronting negative feelings and forming new models, the patient's experience of a trustworthy and reliable other (the therapist) is a healing element in itself (Eagle et al., 2009; Obegi, 2008). There is accumulating agreement that the quality of the therapeutic alliance is one of the strongest predictors of psychotherapeutic outcome (Harris, 2004; Horvath et al., 1991; Cortina & Marrone, 2003).

Some have argued that attachment theory isn't applicable to the practice of psychotherapy (Farber et al., 1995). Hamilton (1987) believed attachment is a "background concept," and "is all too palpable; we are surrounded by it; we can observe it; and yet, from a clinical point of view, we cannot use it directly." (p. 69). The relationship between attachment theory and psychotherapy may not now boast enough empirical research for an explicit "attachment therapy" for adults, yet there continues to be growing evidence and innovative interventions supporting the benefits of applying attachment theory and research to the psychotherapeutic process (Eagle et al., 2009). As more studies are undertaken, the importance of attachment theory and its applicability to practice becomes better understood. Evidence suggests that attachment theory can enhance both the therapist's and the adult patient's awareness of their roles in the psychotherapeutic process and therapeutic alliance. Additionally, attachment style it is a strong predictor of outcome for psychotherapy. Taken together, the strengths of attachment theory suggest promising new directions for psychotherapy with adults.

References

- Ainsworth, M.D. (1985). Patterns of attachment. *Clinical Psychologist*, 38(2), 27–29.
- Ainsworth, M.D., Blehar, M.C., Waters, E. & Wall, S. (1978). *Patterns of attachment: A psychological study of the Strange Situation*. Oxford, England: Lawrence Erlbaum. xviii 391 pp.
- Anderson, P. & Perris, C. (2000), Attachment styles and dysfunctional assumptions in adults. *Clinical Psychology & Psychotherapy*, 7, 47–53.
- Atkinson, L., & Goldberg, S., (2004). *Attachment issues in psychopathology and intervention*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc., Publishers.
- Bachelor, A; Meunier, G; Laverdiér, O. & Mache, D. (2010). Client attachment to therapist: Relation to client personality and symptomatology, and their contributions to the therapeutic alliance. *Psychotherapy Theory, Research, Practice, Training*, 47(4), 454–468.
- Badenoch, B. (2008). *Being a Brain-Wise Therapist: A Practical Guide to Interpersonal Neurobiology*. New York, NY: W.W. Norton & Company.
- Bateman, A., & Fonagy, P. (2003). The development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic*, 67(3), 187–211.
- Beebe, B. & Lachmann, F. M. (2002). *Infant research and adult treatment: Co-constructing interactions*. Hillsdale, NJ: Analytic Press.
- Bennett, S.C. (2008). The interface of attachment, transference, and countertransference: Implications for the clinical supervisory relationship. *Smith College Studies in Social Work*, 78(2-3).
- Bernier, A., & Dozier, M. (2002). The client-counselor match and the corrective emotional experience: Evidence from interpersonal and attachment research. *Psychotherapy: Theory, Research, Practice, Training*, 39(1), 32–43.
- Bonovitz, C. (2012). Disorganized attachment and the use of fantasy: An interpersonal/developmental perspective. *Psychoanalytic Psychology*.
- Bordin, E. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research, and Practice*, 16, 252

- 260.
- Bowlby, J. (1980). *Loss*. New York: Basic.
- Bretherton I. (1992). The origins of attachment theory: John Bowlby and Mary Ainsworth. *Developmental Psychology*, 28(5), 759–775.
- Byrd, K; Patterson, C. & Turchik, J. (2010). Working alliance as a mediator of client attachment dimensions and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training*, 47(4), 631-636.
- Cortina, M. & Marrone, M. (2003). Reclaiming Bowlby's Contribution to Psychoanalysis. *International Forum of Psychoanalysis*, 13, 133-146.
- Daly, K. & Mallinckrodt, B. (2009). Experienced therapists' approach to psychotherapy for adults with attachment avoidance or attachment anxiety. *Journal of Counseling Psychology*, 56(4), 549-563.
- Diener, M. & Monroe, J. (2011). The relationship between adult attachment style and therapeutic alliance in individual psychotherapy: A meta-analytic review. *Psychotherapy*, 48(3), 237-248.
- Dolan, R; Arnkoff, D. & Glass, C. (1993). Client attachment style and the psychotherapist's interpersonal stance. *Psychotherapy: Theory, Research, Practice, Training*, 30(3), 408-412.
- Dozier, M. & Bates, B. C. (2004). Attachment state of mind and the treatment relationship. In L. Atkinson & S. Goldberg (Eds.), *Attachment issues in psychopathology and intervention* (pp. 167-180). Mahwah, NJ: Lawrence Erlbaum.
- Eagle, M. (2006). Attachment, Psychotherapy, and Assessment : A Commentary. *Journal of Consulting and Clinical Psychology*, 4(6), 1086-1097.
- Eagle, M., & Wolitzky, D. (2009). Adult psychotherapy from the perspectives of attachment theory and psychoanalysis. *Attachment theory and research in clinical work with adults*. Attachment theory and research in clinical work with adults. (pp. 351-378). New York, NY, US: Guilford Press. Obegi, Joseph H. (Ed); Berant, Ety (Ed), (2009). xii, 529 pp.
- Eames, V. & Roth, A. (2000). Patient attachment orientation and the early working alliance-A study of patient and therapist reports of alliance quality and ruptures. *Psychotherapy Research*, 10(4).
- Farber, B.A.; Lippert, R.A. & Nevas, D.B. (1995). The therapist as attachment figure. *Psychotherapy: Theory, Research, Practice, Training*, 32(2), 204-212.
- Gergely, G. & Watson, J. S. (1996). The social bio-feedback theory of parental affect-mirroring: The development of emotional self-awareness and self-control in infancy. *International Journal of Psychoanalysis*, 77, 1181-1212.
- Goodman, G. (2010). *Therapeutic attachment relationships: interaction structures and the processes of therapeutic change*. Lanham, MD. Rowman & Littlefield Publishers, Inc.
- Greenson, R. R. (1967). *The technique and practice of psychoanalysis* (Vol. 1). Madison, CT: International Universities Press.
- Hamilton, V. (1987). Some problems in the clinical application of attachment theory. *Psychoanalytic Psychotherapy*, 3(1), 67-83..
- Harris, T.O. (2004). Discussion of the Special Issue: Chef or chemist? Practicing psychotherapy within the attachment paradigm. *Attachment & Human Development*, 6(2),
- Hietanen, O. & Punamäki, R.L; (2006). Attachment and early working alliance in adult psychiatric inpatients. *Journal of Mental Health*. 15(4), 423-435.
- Holmes, J. (1995). "Something there is that doesn't love a wall": John Bowlby, attachment theory, and psychoanalysis. *Attachment theory: Social, developmental, and clinical perspectives*. (pp.19-43). Hillsdale, NJ: Analytic Press, Inc. Goldberg, S. (Ed); Muir, R. (Ed); Kerr, J. (Ed). xiii, 515 pp.
- Holmes, J. (2000). Attachment theory and psychoanalysis: A rapprochement. *British Journal of Psychotherapy*, 17, 157–172.
- Horvath, A., & Greenberg, L. (1986). The development of the Working Alliance Inventory. In L. S. Greenberg & W. M. Pinsof (Eds.), *The psychotherapeutic process: A research handbook* (pp. 529-556). New York: Guilford.
- Horvath, A. & Symonds, D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*, 38(2), 139-149.
- Lamagna, J. (In press). *Of the Self, by the Self and*

ATTACHMENT IN PSYCHOTHERAPY

- for the Self: Internal Attachment, Attunement and Psychological change. *Journal of Psychotherapy Integration*.
- Leger, F., & De Piano, F. (1998). *Beyond the Therapeutic Relationship: Behavioral, Biological, and Cognitive Foundations of Psychotherapy*. Binghamton, New York. The Haworth Press, Inc.
- Levy, K.N. (2005). The implications of attachment theory and research for understanding borderline personality disorder. *Development and Psychopathology*, 17(4), 959-986.
- Lipton, B. & Fosha, D. (2011). Attachment as a transformative process in AEDP: Operationalizing the intersection of attachment theory and affective neuroscience. *Journal of Psychotherapy Integration*, 21 (3), pp 253-279.
- Main, M. & Goldwyn, R. (1998). Adult attachment classification system. In M. Main (Ed.), *Behavior and the development of representational models of attachment: Five methods of assessment*. Cambridge. Cambridge University Press.
- Main, M. & Solomon, J. (1986) Discovery of a new, insecure-disorganized/disoriented attachment pattern. In T. B. Brazelton & M. Yogman (Eds), *Affective development in infancy*, pp. 95-124. Norwood, New Jersey. Ablex..
- Mallinckrodt, B., Gantt, D. & Coble, H. (1995). Attachment patterns in the psychotherapy relationship: development of the client attachment to therapist scale. *Journal of Counseling Psychology*, 42(3), 307 – 319.
- Mallinckrodt, B., Porter, M., & Kivlighan Jr., D. M (2005). Client Attachment to Therapist, Depth of In-Session Exploration, and Object Relations in Brief Psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 42(1), 85-100.
- McCluskey, U., Hooper, C., & Miller, L. (1999). Goal-corrected empathic attunement: Developing and rating the concept within an attachment perspective. *Psychotherapy: Theory, Research, Practice, Training*, 36(1), 80-90.
- Meyer, B. & Pilkonis, P. (2001). Attachment style. *Psychotherapy: Theory, Research, Practice, Training*, 38(4), 466-472.
- Mikulincer, M. & Shaver, P. (2007). Attachment in adulthood: Structure, dynamics, and change. New York: The Guilford Press.
- Muller, Robert T. (2009). Trauma and dismissing (avoidant) attachment: Intervention strategies in individual psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, 46(1), 68-81.
- Obegi, J.H. (2008). The development of the client-therapist bond through the lens of attachment theory. *Psychotherapy: Theory, Research, Practice, Training*, 45(4), 431-446.
- Pally, R. (2001): A Primary Role for Nonverbal Communication in Psychoanalysis, *Psychoanalytic Inquiry: A Topical Journal for Mental Health Professionals*, 21(1), 71-93.
- Sable, P. (2007). What is Adult Attachment? *Clinical Social Work Journal*. 36, 21–30.
- Sauer, E.M; Anderson, M.A; Gormley, B; Richmond, C.J. & Preacco, L. (2010): Client attachment orientations, working alliances, and responses to therapy: A psychology training clinic study. *Psychotherapy Research*, 20(6), 702-711.
- Schauenburg, H; Buchheim, A; Beckh, K; Nolte, T; Brenk-Franz, K; Leichsenring, F...Dinger, U. (2010): The influence of psychodynamically oriented therapists' attachment representations on outcome and alliance in inpatient psychotherapy, *Psychotherapy Research*, 20(2), 193-202.
- Shapiro, D; Hardy, G; Aldridge, J; Davidson, C; Rowe, C. & Reilly, S. (1999). Therapist Responsiveness to Client Attachment Styles and Issues Observed in Client-Identified Significant Events in Psychodynamic-Interpersonal Psychotherapy. *Psychotherapy Research*, 9(1), 36-53.
- Shilkret, C.J. (2005). Some Clinical Applications of Attachment Theory in Adult Psychotherapy. *Clinical Social Work Journal*, 33(1).
- Shorey, H. & Snyder, C. (2006). The role of adult attachment styles in psychopathology and psychotherapy outcomes. *Review of General Psychology*, 10(1), 1-20.
- Simpson, J.A., Rholes, W.S. & Neligan, J.S. (1992). Support seeking and support giving within couples in an anxiety-provoking situation: The role of attachment styles. *Journal of Personality and Social Psychology*, 62, 434-446.
- Smith, A., Msetfi, R., & Golding, L. (2009). Client self rated adult attachment patterns and the ther-

- apeutic alliance: A systematic review. *Clinical Psychology Review*, 30(3), 326-337.
- Steele, H. & Steele, M. (2008). *Clinical applications of the adult attachment interview*. New York, NY: Guilford Press. 501 pp.
- Wallin, D.J. (2007). *Attachment in Psychotherapy*. New York, NY, US: Guilford Press.
- Zilcha-Mano, S; Mikulincer, M. & Shaver, P.R. (2011). Pet in the therapy room: An attachment perspective on Animal-Assisted Therapy. *Attachment & Human Development*, 13(6), 541-561.