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Attachment and Psychotherapy: Implications From Empirical Research

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Abstract

In this paper, we provide an overview of Bowlby's theory of attachment, its revisions, and related constructs, and describe how attachment may underlie many of the processes of psychotherapy. Modern psychotherapy research, plagued by the omnipresent "dodo bird" that has consistently determined that most psychotherapy modalities appear to have similar levels of effectiveness, has moved towards attempting to understand mechanisms of change underlying treatment outcomes. Delineating the ways in which attachment theory may form the foundation for psychotherapy processes may help answer the call for change mechanisms and common therapeutic factors. In this paper, we outline attachment theory as it applies to both children and adults, focusing specifically on its relevance for psychotherapy, followed by a review of the current empirical findings regarding the connection between attachment and psychotherapy. Finally, we highlight a series of existing psychotherapeutic modalities and techniques that are relevant for understanding the relationship between these domains and extend these examples to other forms of psychotherapy and psychotherapy process more broadly. Attachment provides a comprehensive yet parsimonious foundation for psychotherapy research and practice, with implications for enhancing treatments, personalizing care, and explaining the process of psychotherapeutic change.

Keywords: adult attachment interview; childhood; development; intervention; psychopathology

Attachment and Psychotherapy: Implications From Empirical Research

John Bowlby and Mary Ainsworth's attachment theory and the subsequent research generated from it has resulted in attachment theory becoming one of the most influential frameworks in developmental psychology (Dixon, 2003). However, from its inception, Bowlby, a psychiatrist and psychoanalyst, conceptualized attachment theory as a clinical theory with relevance for guiding clinical practice. In this paper, we outline attachment theory as it applies to both children and adults, focusing specifically on its relevance for psychotherapy, followed by a review of the current empirical findings regarding the connection between attachment and psychotherapy. Finally, we highlight a series of existing psychotherapeutic modalities and techniques that are relevant for understanding the relationship between these domains and extend these examples to other forms of psychotherapy and psychotherapy process more broadly.

A Brief History and Overview of Attachment Theory

John Bowlby's attachment theory (1969) is one of the most influential perspectives on lifespan development with implications for not only understanding psychopathology but also psychotherapy processes and principles (Dixon, 2002). Although Bowlby was a psychiatrist, psychoanalyst, and psychotherapist, much of the research on attachment theory has been carried out by developmental and social psychologists and has focused on normative aspects of attachment. However, Bowlby, as a developmental psychopathologist, conceptualized attachment theory as relevant not only to normal development but also psychopathology and more importantly for psychotherapy in particular.

Attachment theory emerged from Bowlby's clinical observations in his classic study of forty-four delinquent children, in which he noted the pervasiveness of interpersonal loss in these

children's lives. Attachment theory was further elaborated in his work with institutionalized children during World War II. His findings suggested pervasive disruptive consequences of caregiver deprivation in children temporarily separated from their primary caregivers. His observations further indicated that: "the young child's hunger for his mother's presence is as great as his hunger for food," and that her absence inevitably generates "a powerful sense of loss and anger," (Bowlby, 1969, p.xiii). Bowlby described the emotional attachment of an infant to his or her primary caregiver¹ and conceptualized this attachment and its associated separation anxiety as biologically functional within an evolutionary framework. He theorized this affectional bond serves the evolutionary function of maintaining the infant's proximity to its caregiver in the face of occasional separations. Infants who stay close to their caregivers are more likely to be safe from predators and to be better fed and cared for than infants who do not stay close to their mothers.

These clinical observations were elaborated and evolved out of Bowlby's interest in diverse scientific disciplines, including psychoanalysis, ethology, evolution, and cognitive and developmental psychology. He integrated principles from each of these areas to explain affectional bonding between infants and their caregivers and the long-term effects of early attachment experiences on personality development, interpersonal functioning, and psychopathology. Bowlby postulated that the attachment system was operative throughout the life-span—"from the cradle to the grave"—and across a wide variety of relationships, including the therapeutic relationship.

Early interactions between child and caregiver are at the core of attachment theory. The affectional bond that develops between caregiver and infant is the developmental nucleus of identity formation, intrapersonal regulation, and interpersonal attitudes, or "internal working

models” of self and other (Bowlby, 1977). The attachment bond, according to Bowlby, is a complex, behavioural system that has functioned throughout human evolution to protect the infant from danger by seeking security from a caregiver guardian, thus enhancing the infant’s likelihood of survival and eventual reproduction. At the same time, this bond promotes comfort during stressful periods, reducing negative affect and allowing the infant to develop a healthy, realistic, and coherent sense of self (Fonagy, 1999).

Although this adaptive form of attachment is perhaps ideal, Bowlby suggested that other modes of attachment exist. He hypothesized that security of attachment derives from a caregiver’s reliable and sensitive provision of love and comfort, as well as food and warmth. Infants with a caregiver who meets their biological and psychological needs turn to their caregiver when experiencing distress, fear, or other needs (safe haven), while otherwise exploring their surroundings with a sense that the caregiver is looking out for them (secure base). However, if the infant’s needs are not met by a caregiver, then adaptive attachment is disrupted. These infants are unable to garner support from their caregiver when distressed or are limited in their ability to explore during stress-free times. Thus, differences in styles of behaviour surrounding the caregiver as safe haven and secure base reveal underlying disparities in the formation of the infant-caregiver bond.

Bowlby believed that attachment insecurity, although originally an adaptive set of strategies designed to manage distress, increases vulnerability to psychopathology and could be linked to specific types of difficulties that arise. Bowlby suggested that the disruption of healthy and adaptive attachment bonds might lead to “the many forms of emotional distress and personality disturbance, including anxiety, anger, depression, and emotional detachment” (Bowlby, 1977, p. 127). Several meta-analyses and systematic reviews of the extensive

attachment literature have confirmed Bowlby's hypotheses, finding insecure attachment styles to be implicated in a wide range of child and adult psychopathology and clinical disorders (Fearon et al., 2010; Levy, Ellison, Scott, & Bernecker, 2011; Madigan, Atkinson, Laurin, & Benoit, 2013; Mikulincer & Shaver, 2007).

Attachment in Adulthood

Based on Bowlby's (1977) contention that the attachment system remains active throughout the lifespan, various investigators in the mid-1980's (e.g., Hazan & Shaver, 1987; Kobak & Sceery, 1988; West & Sheldon, 1988) independently began to apply the tenets of attachment theory to the study of adult behaviour and personality. Mary Main and her colleagues (George, Kaplan, & Main, 1985), from the developmental tradition of Ainsworth, developed the Adult Attachment Interview (AAI), a one-hour attachment-history interview, noting that features in interviews with parents of infants reliably predicted the Strange Situation behaviour of their children. The interview enquires into early relationships and attachment related events with one's parents as well as for the adult's sense of the way these relationships and events had affected adult personality, "by probing for both specific corroborative and contradictory memories of parents and the relationship with parents" (Main et al., 1985 p. 98). Three major patterns of adult attachment were initially identified: secure, dismissing and enmeshed/preoccupied; and later two additional categories were identified: unresolved and "cannot classify". The first three categories parallel the attachment classifications originally identified in childhood (Ainsworth, Blehar, Waters, & Wall, 1978), and the unresolved classification parallels a pattern Main later described in infants (Main & Weston, 1981). A number of studies found that AAI classifications, based on reports of interactions with their own parents could predict their children's Strange Situation classifications (see van IJzendoorn, Juffer, & Duyvesteyn, 1995, for a review). Additionally, a

growing body of research (Lewis, Feiring, & Rosenthal, 2000; Waters, Hamilton, & Weinfield, 2000) examining attachment continuity suggests that patterns of attachment are both relatively stable over long periods of time *and* subject to change, influenced by a variety of factors including ongoing relationships with family members, new romantic relationships, traumatic life events, and possibly psychotherapy (Fraley, 2002; Waters et al., 2000).

In contrast to Main's focus on relationships with parents, Hazan and Shaver (1987), from a social psychological perspective, extrapolated the childhood attachment paradigm to study attachment in adulthood by conceptualizing romantic love as an attachment process. They translated Ainsworth's secure, avoidant, and anxious-ambivalent attachment patterns into a paper-and-pencil measure of adult attachment styles, allowing easy study of attachment with much larger samples. Based on Bartholomew's (1990) conceptual framework of positive models of self and other, and using the advantage of large amounts of data, Brennan, Clark, and Shaver (1998) summarized factor analytic data from 1,086 participants suggesting that positive models of self and other indicate secure attachment styles, whereas increasingly negative models of self suggest increased attachment anxiety and increasingly negative models of others suggest increased attachment avoidance. Although attachment categories show poor consistency between the AAI and self-report measures (Crowell, Fraley, & Shaver, 2008), attachment anxiety and avoidance correlate well across measures (Shaver, Belsky, & Brennan, 2000). In a host of studies since 1987, the attachment dimensions of anxiety and avoidance have significantly predicted relationship outcomes (e.g., satisfaction, breakups, commitment), patterns of coping with stress, couple communication, general well-being, and even phenomena such as religious experiences and patterns of career development (see Mikulincer & Shaver, 2007, for a review).

Some have posited that fearful attachment—the confluence of both high attachment anxiety and high attachment avoidance—may confer the greatest risk for maladaptive functioning (Dutton, Saunders, Starzomski, & Bartholomew, 1994). However, empirical evidence has indicated that at least some adults high in fearful attachment may in fact be well-adjusted and have integrated and individuated internal working models, although they may have experienced early attachment ruptures (e.g., Levy, Blatt, & Shaver, 1998). As Levy and colleagues' (1998) write, these individuals “have had a difficult time with their parents but have achieved structural sophistication in their parental representations” (p. 416), akin to previous conceptualizations of the “earned secure” individual. This may indicate the importance of evaluating attachment anxiety and avoidance as independent domains in terms of their associations with psychotherapy, which we attempt below. To promote the comprehensiveness of our review, we include research utilizing both categorical and dimensional assessments of attachment from both the developmental and social psychological traditions.

It is worth noting that individuals do not always display the same attachment attitudes towards all significant others in their life, suggesting a multiplicity of attachment tendencies for a given individual. However, evidence has also indicated consistency in attachment patterns across individuals in one's environment, suggesting the presence of a *general* attachment style one recruits in the interpersonal context (e.g., Markiewicz, Lawford, Doyle, & Haggart, 2006), which may prove an important focus of intervention and therapy implications.

Attachment and Psychotherapy

Given the importance of close others in the development and maintenance or alteration of attachment styles throughout the lifespan, Bowlby believed that attachment theory had particular relevance for psychotherapy. The chief role of the therapist, according to Bowlby, is “to provide

the patient with a temporary attachment figure” (Bowlby, 1975, p. 191) through which the patient might gain access to “a secure base from which to explore both himself and also his relations with all those with whom he has made or might make, an affectional bond” (Bowlby, 1977; p. 421). Furthermore, he outlined six key goals of psychotherapy related to the theory of attachment: 1) Establishing a secure base, which involves providing patients with a secure base from which they can explore the painful aspects of their life in a supportive and caring environment; 2) Exploring past attachments, which involves helping patients explore past and present relationships, including their expectations, feelings, and behaviours; 3) Exploring the therapeutic relationship, which involves helping the patient examine the relationship with the therapist and how it may relate to relationships or experiences outside of therapy; 4) Linking past experiences to present ones, which involves encouraging awareness of how current relationship experiences may be related to past ones; 5) Revising internal working models, which involves helping patients to feel, think, and act in new ways that are unlike past relationships. Patients may present with multiple contradictory internal working models, and the therapist, through the interpersonal dynamics that arise in therapy, may help the patient to foster the most adaptive models of behaviour; and 6) Providing a safe haven during times of distress. Although this safe haven initially exists only concretely in the therapy room itself, it may eventually become representational, internalized by the patient such that he or she can utilize it at will to reduce distress even when the therapist is not present.

There are a number of ways that attachment and psychotherapy intersect (see Levy, 2013). Attachment theory has formed the foundation of several interventions for psychological disorders, and principles of attachment theory have been incorporated into other indirectly related forms of psychotherapy. Patients’ attachment style and reflective functioning has been

examined as both a predictor and indicator of treatment outcome, and some literature has examined the different roles attachment styles play in various treatment orientations. Attachment processes have also been examined during psychotherapy sessions as a measure of psychotherapy process and mechanisms of change. Although many have provided extensive theoretical and clinical expositions of the intersection of attachment theory and psychotherapy (Borelli & David, 2004; Costello, 2013; Daniel, 2006; Eagle, 2013; Fonagy, 2001; Holmes, 2014; Lieberman & Zeanah, 1999; Obegi & Berant, 2009; Slade, 2000; Wallin, 2007; see also Levy, 2013), we aim to augment such work with a review focused specifically on the existing empirical treatment literature relevant to the confluence of attachment and psychotherapy and the clinical implications of this literature.

There are a range of psychotherapy modalities that have been developed based on attachment theory. These treatments are predominantly designed for children, given the strong developmental emphasis of attachment theory and the especial relevance of attachment attitudes and behaviour to caregiver-child interactions. However, several treatments for adults, both explicitly and implicitly derived from attachment theory, have likewise been developed and empirically tested. These have generally been utilized in the treatment of disorders with a strong relational component, such as personality disorders, a debilitating and long-standing form of psychopathology that tends to involve insecure attachment (Levy, Johnson, Clouthier, Scala, & Temes, 2015). For this reason, many of the treatments (specifically those for adults) that we discuss below are designed for individuals with personality or related pathology.

Attachment-Based Child Interventions

In the 1980s and 90s, a series of parent-child interventions and psychotherapies were developed (Table S1) that generally derive from psychodynamic theory, although often with the

incorporation of other intervention components such as direct modifications of the home environment or explicit focus on parent and/or child strengths. These and later intervention programs tend to be quite integrative and influenced by developmental theory and family and community systems models. These interventions tend to focus on 1) improving caregiver sensitivity, empathy, and responsiveness, 2) fostering child self-efficacy and autonomy, and 3) increasing the reciprocity and emotional engagement between child and caregiver. Although not all of these interventions have received empirical support for their efficacy, several have shown improvements in primary attachment-related outcomes, reductions in maltreatment, and other gains in caregiver-child relationship quality and family well-being (e.g., Lieberman & Zeanah, 1999).

The majority of more recent attachment-based interventions for caregivers (generally mothers) and their children tend to focus on the real-life attachment behaviour that plays out in the caregiver-child dyad (Table S1). Such behaviour—displayed in communication, play, and other parent-child interactions—becomes the content of assessment of dysfunctional patterns between parent and child, the target of modification and improvement, and often the tool by which such improvement is made. Several forms of attachment-based child intervention utilize video recordings of child-parent interactions, along with psychoeducation and discussion of recorded interactions, to facilitate this process. The “Circle of Security” intervention (Hoffman, Marvin, Cooper, & Powell, 2006) incorporates tape review, group discussion, didactics, and psychoeducation about positive and sensitive caregiving and has a series of studies providing at least some support for its efficacy. Van Zeijl and colleagues’ (2006) have also developed a video-feedback intervention for parents that focuses on therapists and parents reviewing and discussing recorded interactions between parents and their children, with an emphasis on

pointing out and reinforcing sensitive behaviours already being engaged in by caregivers, and has been shown to be helpful (compared to a non-intervention control) in increasing sensitive behaviours and discipline by mothers and decreasing externalizing behaviours on the part of 1- to 3-year-old children.

Focusing directly on dyadic interactions in real-time (i.e., not recorded), Cohen and colleagues' (1999) "Watch, Wait, and Wonder" intervention, a psychodynamically informed mother-infant therapy, utilizes infant-led play to enhance infants sense of autonomy and security of attachment, as well as improve mother's reciprocity in interactions. This intervention has also been shown to improve infants' level of cognitive and emotional functioning (e.g., improvements on Bayley Scales) and mothers' sense of competence with their children over and above standard mother-infant psychotherapy, which does not focus on the attachment relationship or infant-led interactions. Similarly, the attachment/object-relations focused toddler-parent psychotherapy of Cicchetti, Toth, and Rogosch (1999) aims to increase positivity and mentalizing during interactions between mothers and their children. This intervention utilizes in-the-moment modeling of introspection and taking the mind of another by the therapist to enhance mother's ability to mentalize and increase their own sensitivity, responsivity, and attunement to their children. This intervention has also proved efficacious, including for children's cognitive capabilities, although maternal psychopathology (specifically depression) did not improve.

Reviews and a meta-analysis of the attachment intervention literature find consistent support for interventions that focus on behavioural patterns, either in person or via video recordings, and that include psychoeducation regarding healthy parent-child interactions and effective parenting (Bakermans-Kranenburg, van IJzendoorn, & Juffer, 2003; Olds, Sadler, & Kitzman, 2007). These also suggest that home visits by trained nurses and specific short-term

behaviour-focused interventions may be especially beneficial. Olds and colleagues' (2007) review further suggests the importance of taking into account and promoting the *physical* well-being of the child in intervention work. Furthermore, high-risk groups (e.g., maternal psychopathology, low socioeconomic status) may benefit most from attachment-focused parent-child interventions in terms of the outcomes described before and that treatments targeting these populations, rather than broad-band treatments for all parents, may be most cost-effective.

Attachment-Based Adult Interventions

Despite the overwhelming prevalence of child-oriented attachment-based therapies, at least three treatments for adults deriving explicitly from attachment theory have received empirical support for a range of psychological concerns (Table S2). Perhaps the most explicitly based on attachment theory is Interpersonal Psychotherapy (IPT; Klerman, Weissman, Rounsaville, & Chevron, 1984). IPT originates from interpersonally oriented psychodynamic Neo-Freudian theory, most notably from the work of Karen Horney, Harry Stack Sullivan, Erich Fromm, Clara Thomason, and Frieda Fromm-Reichmann. The origin of interpersonal psychotherapy can also be seen in Franz Alexander and Thomas French's concept of therapy as a corrective emotional experience between the therapist and the patient. IPT was originally conceptualized as deriving from psychodynamic psychotherapy, and particularly the writings of Sullivan and Bowlby, although it also resembles cognitive-behavioural therapy (CBT) in that it is a structured, manualized, and time-limited approach that involves formal assessments and psychoeducation and employs homework assignments. Building on the importance of a secure base and safe haven for fostering attachment security, in IPT the therapist is active, collaborative, and empathic. The therapist tends to present in a warm, compassionate manner. In being active, the therapist tries to balance not being too directive or dependence promoting.

IPT garnered significant attention through the National Institute of Mental Health's Treatment of Depression Collaborative Research Program, which suggested that IPT is equally as effective as cognitive-behavioural therapy (often considered the "gold standard" depression treatment) for major depressive disorder (MDD). IPT has since been expanded/modified to address other problems, such as eating disorders and addiction (e.g., Carroll, Rounsaville, & Gawin, 2009). It is worth noting that Attachment-Based Family Therapy (ABMT), a highly similar treatment to IPT for adolescents, has found improvements in depression, suicidality, hopelessness, anxiety, internalizing and externalizing behaviours, and family conflict (Diamond et al., 2010), further indicating the utility of this attachment-based therapy.

A second treatment that explicitly draws on attachment theory is emotion focused therapy (EFT) for couples. The Attachment Injury Resolution Model was developed within the EFT framework to enhance communication and closeness within couples (Makinen & Johnson, 2006). This trauma-informed model addresses "attachment injuries," moments of a breach of trust or acts that impinge on relationship quality as the focus of resolution and repair in relationships. Therapy conducted in this model unfolds via three steps: First, the therapist assists the couple to identify and contextualize difficult emotions in an attachment framework (e.g., discussing fears of closeness or loss). Second, communication regarding needs and related interpersonal risk-taking is encouraged, promoting an attachment bond between the members of the couple, consistent with evidence suggesting positive relationship-building interactions may foster attachment security (Mikulincer & Shaver, 2007). Third, as attachment security increases, other more logistical or secondary relationship concerns (e.g., drinking problems) can be addressed and resolved in the context of a strong attachment.

Although the evidence is preliminary and based largely on an uncontrolled clinical trial, empirical research on the Attachment Injury Resolution Model in EFT has focused on the *process* of change as delineated by this model. Specifically, evidence suggests that the processes of emotional exploration of attachment injuries, as well as the attachment-informed resolution of such injuries, predicted outcome (e.g., relationship quality, forgiveness) among patients in EFT compared to those couples who did not successfully navigate such resolutions (Makinen & Johnson, 2006). Furthermore, such gains appeared stable over a 3-year follow-up period (Halchuk, Makinen, & Johnson, 2010), providing further support for the benefit of this intervention.

A third treatment built explicitly on the foundation of attachment theory, and which has received considerable empirical and theoretical attention (primarily for the treatment of borderline personality disorder [BPD]), is Bateman and Fonagy's (1999) mentalization based treatment (MBT). MBT is based on the developmental theory of mentalizing (Fonagy et al., 1995), which integrates philosophy (theory of mind), ego psychology, Kleinian theory, and attachment theory, and of which reflective function is a core aspect. Fonagy and Bateman (2006) posit that the mechanism of change in MBT involves the social-cognitive-affective capacity for mentalization—the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Mentalizing involves both 1) implicit or *unconscious* mental processes that are activated along with the attachment system in affectively charged interpersonal situations and 2) coherent integrated representations of mental states of self and others.

Bateman and Fonagy have conducted two large-scale randomized controlled trials (RCTs) of MBT supporting its use for BPD (Bateman & Fonagy, 1999; 2009). Both trials found 18 months of MBT (both a day hospital program and outpatient treatment) to outperform

treatment-as-usual (TAU) in improvements in depressive symptoms and social and interpersonal functioning, as well as significant decreases in suicidal and parasuicidal behaviour and psychiatric resources utilized. Follow-up assessment also showed maintained gains and increased remittance in the MBT condition compared to TAU, further supporting the effectiveness of this treatment for personality pathology.

Beyond the treatments above which are explicitly derived from attachment theory, many forms of therapy implicitly or indirectly use principles and techniques that are based on attachment constructs. Primary areas for this integration of attachment include the establishment of a therapeutic alliance and the exploration of past and present relational experiences, in order to update maladaptive views of self and other.

Two examples of such treatments are supportive psychodynamic psychotherapy (SPT) and transference focused psychotherapy (TFP), both studied treatments for BPD (Table S2). SPT, an object-relational and psychoanalytically-based treatment for BPD developed by Ann Appelbaum (2005), places primary emphasis on development of a collaborative engagement with the patient to foster identity development. Rather than focusing on transference interpretation, SPT aims to strengthen adaptive defenses, foster a positive alliance, and provide reassurance and advice, indirectly placing the therapist in the role of a supportive attachment figure. SPT may recruit aspects of caregiving that have been identified as important developmentally to foster healthy mentalizing and secure attachment, specifically *contingency* (accurately matching or reflective another's affective state) and *markedness* (clearly indicating that one is expressing the feelings of the other and their own). However, although SPT has been shown efficacious as a treatment for personality pathology (e.g., Clarkin, Levy, Lenzenweger, & Kernberg, 2007), these

putative attachment-based mechanisms of change have yet to receive process-based research support indicating their centrality to SPT's efficacy.

TFP also integrates attachment-relevant constructs (specifically focusing on “reflective function,” an attachment construct relating to how one reflects on one's own and others' behaviour) indirectly into its techniques and proximal goals. TFP is a modified psychoanalytic psychotherapy specifically for BPD (although it has been extended to other problems such as narcissistic PD; Diamond et al., 2013) originating in the theoretical writings of Kernberg in the 1960s and 70s (e.g., Kernberg, 1968) and manualized in 2006 by Clarkin, Yeomans, and Kernberg. The focus of TFP is on the development of integrated representations of self and others, the modification of primitive defensive operations, and the resolution of identity diffusion that perpetuates the fragmentation of the patient's internal representational world. Identifying and explicating the recapitulation of dominant, often unconscious interpersonal patterns, as they are experienced and expressed in the here-and-now relationship with the therapist (which is conceptualized as a transference relationship) is the primary vehicle for the transformation of undifferentiated and unintegrated (e.g., split, polarized) to advanced (e.g., complex, differentiated, and integrated) and benign mental representations of self and others. In this treatment, a triad of *clarifications*, *confrontations*, and *interpretations* are used to both help the therapist understand the internal world of the patient and then to help the patient understand and come to terms with the conflicts involved in this world. TFP has received supporting evidence as a treatment for PDs (Clarkin et al., 2007; Diamond et al., 2013) equivalent to other empirically supported treatments (e.g., dialectical behaviour therapy [DBT]) and more effective for certain conditions (e.g., narcissism).

Targeting and improving patients' level of reflective function (RF) has been posited as a mechanism of change in TFP, due to fostering self-reflection and a coherent sense of self, as well as the ability to accurately, yet tentatively, consider the mental states of the therapist and others in patients' lives (Levy, Clarkin, et al., 2006). RF, an important component of attachment, is the social, cognitive, and affective process of interpreting or making sense of behaviour engaged in by oneself or others in terms of intentional mental states, such as desires, feelings, and beliefs (Fonagy & Bateman, 2006). RF consists of four levels of capacity. 1) Awareness of the nature of mental states, indicated by an ability to attribute one's own or others' behaviours to internal psychological processes or states of mind; 2) Explicit efforts to tease out mental states underlying behaviour, especially when such behaviours are inconsistent or otherwise unpredictable; 3) Recognizing developmental aspects of mental states, shown as an ability to note change in one's own and others' mental states over the lifespan and potential reasons for such change; and 4) Recognition of mental states in relation to the interviewer. The ability to incorporate all four of the aforementioned components of RF indicates fully developed mental reflective capacity. As is highlighted below, RF may play a role both in effecting change in psychotherapy.

Finally, attachment theory has been incorporated into adult group therapy, with a body of literature showing the efficacy of group psychodynamic interpersonal therapy (GPIP) for women with binge eating disorder (Tasca, Mikail, & Hewitt, 2002; Tasca et al., 2006). GPIP is based on the idea that "cyclical relational patterns" or CRPs underlie maladaptive behaviours such as engagement in binge eating. CRPs are modified in the course of group interactions via the therapist's assessment and elucidation of these patterns to group members using interactions among the members themselves (Tasca et al., 2002). However, given a paucity of broader

research, less is known about attachment-theory-based group therapy in the context of other disorders besides binge eating disorder, although GPIP has been shown to reduce secondary symptoms such as depression (e.g., Tasca et al., 2002).

Attachment as a Moderator of Psychotherapy Efficacy

Meta-analytic findings suggest that specific attachment dimensions may predict treatment response (Levy et al., 2011). Specifically, findings suggest that attachment anxiety tends to predict worse treatment outcome, while attachment security predicts better outcome. Avoidant attachment appears less related to treatment success (e.g., Fonagy et al., 1996). It is possible that high levels of a patients' dependency needs in therapy may confound the goals of most therapies of enhancing agency, self-reliance, and healthy individuation, leading to poorer outcome. Relatedly, it is possible that this effect is especially salient among emerging adults, perhaps due to the increased importance of identity development at this age, as Constantino and colleagues (2013) found that young fearfully attached patients were less likely to remit in an IPT treatment for depression than patients over the age of 25.

Contextualizing research above on attachment style differences in treatment response, further research has examined whether or not individuals with certain attachment styles respond better to certain treatment orientations. Such findings have the potential for substantial practice implications in terms of optimizing treatment referral, improving treatment effectiveness, and decreasing costs. McBride, Atkinson, Quilty, and Bagby (2006) found in an RCT of CBT and IPT for MDD ($N = 56$) that avoidantly attached patients appeared to show greater reductions in depression in the CBT versus IPT arm, whereas anxious attachment did not predict different outcomes with the two treatments. However, in a later attempt to replicate this finding, Bernecker and colleagues (2016) found no interaction between attachment dimension and

treatment condition (CBT vs IPT) in change in depression. Tasca and colleagues (2006) found that higher baseline attachment anxiety predicted decreased binge eating episodes in GPIP, while *lower* attachment anxiety predicted improvement in group CBT. However, attachment avoidance was unrelated to symptom change, although attachment avoidance predicted increased dropout in the CBT group. Clearly the results of these studies are mixed but suggest the potential for patients' pre-treatment attachment styles to aid determination of the optimal treatment type. Of note, these studies utilized different self-report attachment measures (i.e., the ECR-R, Relationship Scales Questionnaire, and Attachment Styles Questionnaire, respectively), potentially contributing to the mixed findings. It is also unclear how attachment as assessed in line with the developmental tradition (e.g., with the AAI) might relate to similar symptom changes.

Certain treatments may also be better equipped to prevent dropout with patients with attachment difficulties. In a randomized controlled trial (Clarkin et al., 2007), found that BPD patients with impaired levels of RF were less likely to drop out of TFP or SPT—both of which treatments, as suggested above, may implicitly incorporate attachment themes into their repertoire of techniques—compared to DBT. The three treatments had equivalent levels of attrition with patients with normal reflective function. These results have important clinical implications, suggesting that PD patients presenting with low RF may be better served by a psychodynamically informed treatment that incorporates attachment principles than a more directive cognitive-behavioural treatment.

Matching patients with therapists based on patients and therapists' own attachment styles may also prove beneficial. Some evidence suggests that, although securely attached clinicians tend to challenge patients existing interpersonal strategies and insecure clinicians tend to instead

mirror their patients' styles of interacting, assigning patients to a therapist with a *complementary* (rather than concordant) attachment style may improve treatment effects (Diamond, Stovall-McClough, Clarkin, & Levy, 2003).

Dismissing attachment specifically may lead individuals to be hesitant to self-disclose in treatment or even present to treatment at all. In a sample of 120 women, Riggs, Jacobovitz, and Hazen (2002) found that those with dismissing attachment styles were least likely to have a history of engaging in psychotherapy, while unresolved women reported greater individual psychotherapy history, and securely attached women reported greater couples therapy experience. Securely attached patients tend also to be more cooperative with treatment recommendations (Mikulincer & Shaver, 2007). Increased support, psychoeducation, or flexibility in psychotherapy format may be beneficial in order to increase the likelihood that distressed dismissing women seek individual therapy and insecurely attached women seek couples therapy.

Attachment as a Mechanism of Change in Psychotherapy

Not only does a body of evidence suggest attachment may *moderate* treatment efficacy, but there is some evidence to indicate attachment or its facets may *mediate* or be a primary target of change in psychotherapy as well. For instance, recent evidence of the effect of EFT on relationship satisfaction indicates not only that the ability of critical, blaming relationship partners to move to a position of vulnerability and emotional expressivity with their partner facilitates such improvements, but also that such a shift is accompanied by an initial *increase* (followed by a rapid decrease) in attachment anxiety, suggesting that exploring fear of abandonment in an attachment context may itself lead to improved relationship quality (Moser Johnson, Dalgleish, Wiebe, & Tasca, 2017). Furthermore, evidence has found that decreases in

attachment insecurity 12 months after completion of a year-long GPIP treatment was associated with interpersonal relationships, and decreased attachment anxiety was associated with decreased depressive symptoms (Maxwell, Tasca, Ritchie, Balfour, & Bissada, 2014). However, given the contemporaneous nature of these associations, whether attachment changes *caused* improvements in these other outcomes is unclear and further longitudinal research is needed in this respect.

A related body of research pointing to attachment as an ingredient of therapeutic change has focused not on general attachment styles but on more granular attachment-relevant interpersonal processes or mental states that may fluctuate on a shorter time-scale and be more accessible to direct intervention. One construct that has received focus in the intervention literature (specifically in adults) is *reflective function*. RF is the social, cognitive, and affective process of interpreting or making sense of behaviour engaged in by oneself or others in terms of intentional mental states, such as desires, feelings, and beliefs. RF consists of four levels of capacity. 1) Awareness of the nature of mental states, indicated by an ability to attribute one's own or others' behaviours to internal psychological processes or states of mind; 2) Explicit efforts to tease out mental states underlying behaviour, especially when such behaviours are inconsistent or otherwise unpredictable; 3) Recognizing developmental aspects of mental states, shown as an ability to note change in one's own and others' mental states over the lifespan and potential reasons for such change; and 4) Recognition of mental states in relation to the interviewer. The ability to incorporate all four of the aforementioned components of RF indicates fully developed mental reflective capacity.

RF has been found to go above and beyond simple categorical determinations of adult attachment patterns in predicting of important interpersonal factors. For example, Fonagy and

colleagues (1995) found that RF mediated the relationship between parental attachment security and infant attachment security in the strange situation paradigm. Insecurely attached parents with high RF were more likely to have securely attached babies than insecurely attached parents with low RF. One of the reasons for this finding may be that high RF protects against socially and interpersonally transmitted intergenerational risk for insecure attachment. In support of this hypothesis, Grienberger, Kelly, and Slade (2005) found that mothers' RF mediated the relationship between atypical maternal behaviours (e.g., affective communication errors, role/boundary confusion, intrusiveness) and attachment security in their infants. These findings corroborate the importance of RF as a potential intervening variable in psychotherapy, fostering improvements in attachment and other outcomes, and evidence suggests that it is amenable to change via treatment (e.g., Levy, Meehan et al., 2006).

A recent secondary analysis of RCT data found that within-session observer-rated patient RF after therapist interventions that call for reflection may predict decreased emotional arousal in session (Kivity, Levy, & Clarkin, 2018). Given the importance of modulating affect during session for maximizing the tolerability and efficacy of interventions (Schoore, 2014), the results of Kivity and colleagues' study provide further evidence that RF may serve as an important catalyst of moments in therapy that may be optimal for therapeutic change. This finding adds to a body of transtheoretical research examining *within-session* attachment behaviours and aspects of patient narrative related to attachment (e.g., coherence, duration of talk turns) (e.g., Daniel, 2011). For instance, Talia and colleagues (2014) have utilized an observer-rated psychotherapy coding system (the Patient Attachment Coding System) to assess several aspects of in-session attachment behaviour (e.g., patient proximity seeking toward the therapist), finding theoretically consistent patterns of patient behaviour in relation to the therapist (e.g., preoccupied patients

although seeking closeness displayed more resistance to help, and dismissing patients avoided emotional connection more).

Shifts in Attachment as an Outcome of Psychotherapy

A body of experimental literature has attempted to produce subtle, short-term changes in attachment-relevant attitudes (usually self-reported; see Gillath & Karantzas, 2019, for a recent review) with some success. However, facilitating stable and deep improvements in attachment security may necessitate more intensive interventions such as those reviewed above. Parent-child attachment-based interventions have been helpful in improving children's attachment security (Cicchetti et al., 1999; Cohen et al., 1999; Diamond et al., 2010), although to a lesser extent maternal security. These studies also seem to reveal that proximal improvements in maternal sensitivity and responsiveness via these interventions may be mediator of down-stream changes in their children's attachment security, although this question has not yet received clear and direct empirical support.

Adult psychotherapy has also been helpful for improvements in attachment (Fonagy et al., 1995; Levy, Meehan, et al., 2006; Moser et al., 2015). These studies have consistently found both qualitative improvements in attachment security (i.e., shifts from an insecure to a secure style of attachment; Buchheim et al., 2017), as well as more dimensional changes in attachment and its components. Levy and colleagues (Levy, Meehan et al., 2006) found improvements in both RF and coherence (a related but distinct attachment construct) through a course of TFP, a change not reflected in DBT or SPT. Although research on attachment-based interventions has been most interested in attachment change as an outcome of these treatments, other non-attachment-based interventions have also found improvements in attachment security (e.g., exposure therapy, Stovall-McClough & Cloitre, 2003).

Discussion and Implications

Attachment as a Unifying Theory for Psychotherapy

Attachment theory provides a cogent and empirically based model for understanding psychotherapy that has both parsimony and breadth. The research on attachment theory is long-standing and extensive and has focused both on refining the theory itself but also on further connecting attachment styles and dimensions to myriad other processes, outcomes, and ways of functioning. A range of psychological concerns have been successfully addressed with attachment-based therapy models, including risk for maltreatment, family well-being, relationship satisfaction, depression, eating disorders, personality disorders, and attachment problems themselves, and may have implications for alleviating many other less-studied conditions. Attachment theory is consistent with research from a breadth of scientific domains, including ethology, evolutionary biology, cognitive, developmental, and social psychology, and neuroscience (Levy et al., 2015). Despite some early disagreements within the realm of clinical psychology, attachment constructs have increasingly been viewed as having important theoretical implications for the cognitive (McBride & Atkinson, 2009), behavioural (Sterkenburg, Janssen, & Schuengel, 2008), cognitive-behavioural (Leahy, 2008), interpersonal (Klerman et al., 1984), emotion-focused (Makinen & Johnson, 2006), and psychodynamic and/or psychoanalytic (Slade, 2000) treatments.

Moreover, attachment theory provides a framework for thinking integratively across these different clinical orientations. Along these lines, Eagle (2006) has suggested that most schools of psychotherapy stress the role of attachment-related difficulties in the development of a wide variety of psychological problems and consequently they focus therapeutic attention on these difficulties. As highlighted previously, attachment theory is consistent with interpersonal

theory and various forms of interpersonal-based psychotherapy (Levy et al., 2015). Interpersonal psychoanalytic approaches, such as brief relational therapy (Safran & Muran, 2000), have also integrated significant aspects from attachment theory. The ruptures and repair cycles discussed by Safran and Muran are conceptually similar to separation and reunion episodes in Ainsworth's Strange Situation Paradigm. At its heart a theory of behaviour (and associated mental representations), attachment theory likewise reconceptualizes behaviourist models of patterns of behaviour, formation of the self, and responses to stress in the context of formative interactions between caregiver and child that either do or do not dependably foster safety from danger and promote learning of increasingly adaptive behavioural patterns. Furthermore, Bowlby's explication of internal working models of self and other, which underlie attachment behaviours such as secure base and safe haven behaviours, provide a conceptual foundation for later description of "cognitive schemas" (deep-seated, often rigid, and usually self-referential ways of thinking) in cognitive-behavioural formulations, especially schemas involving conditional assumptions of others (e.g., "I must be with my partner as much as possible or they will leave me"). In sum, attachment theory not only provides a universal language of behaviours, mental representations, and interpersonal attitudes, but also offers a parsimonious, developmentally informed, and evidence-based conceptual framework for understanding these aspects of psychotherapy across treatment orientations.

The existing attachment-based treatments outlined above also provide both conceptual and empirical support for the use of attachment and attachment-relevant constructs, such as RF, as tools for building or enhancing non-attachment-based therapy regimens. For example, DBT, mentioned above, is a popular and effective treatment primarily for BPD, but which has not displayed the same ability as the attachment-influenced treatment TFP to facilitate changes in

attachment styles. Given the similarities of components of DBT to other attachment-theory-informed BPD treatments (e.g., mindfulness in DBT emphasizes balance between emotions and thoughts, resembling the goal of healthy mentalizing in MBT or integrated representations of self and other in TFP), it may be feasible to incorporate attachment-based principles directly into DBT, such as bringing into mindfulness exercises the patient's explicit thoughts and feelings about the therapist or the therapist as a model of other important figures in the patient's life. With such additions, DBT might be enhanced to foster growth in patients' level of RF and attachment security. Similarly, the body of literature on attachment-informed child interventions suggests that incorporating attachment principles to foster caregiver sensitivity and responsiveness may be an important augmentation to standard treatments (e.g., in CBT, including cognitive restructuring of distorted views of children's motivations and caregivers' schema of themselves as parents). It is likely that a similar process of integrating attachment concepts into other existing empirically supported treatments may also be beneficial.

Attachment theory may also extend existing psychotherapies that focus on specific age cohorts, such as treatments specifically for adults, due to its foundation in the developmental tradition and its incorporation of dyadic and family systems principles. Kazdin (1995) has argued that conceptualizations of psychotherapy should be based on models of the developmental psychopathology of the conditions it seeks to treat. Given its developmental focus, attachment theory provides an ideal backdrop against which psychotherapy process and psychopathology can be jointly understood. Some attempts have already been made to explain certain broad domains of psychopathology (e.g., personality disorders, Levy et al., 2015), including the development, maintenance, and treatment of these conditions, through the lens of attachment theory. Furthermore, attachment theory was proposed as a model of behaviour across the lifespan

(Bowlby, 1969) and has been researched across all ages and developmental periods, including in older age (Bradley & Cafferty, 2010). Thus, it also provides a model of psychopathology and its treatment that cuts across and unifies child, adolescent, adult, and geriatric interventions (e.g., ABFT and IPT are similar attachment-based therapies for depressed adolescents and adults, respectively). The lifespan model of attachment aligns well with a recent push in the arena of psychological nosology towards jettisoning arbitrary age-based cutoffs in terms of the applicability of diagnoses (e.g., attention-deficit/hyperactivity disorder; personality disorders).

Finally, despite its ability to change via psychotherapy and even short-term manipulations, attachment security/insecurity has been found to be likely to be passed down through generations. Van IJzendoorn and Bakermans-Kranenburg (1997) have elucidated a model of parental attachment style contributing to parent caregiving behaviour, which in turn molds their children's attachment schema. Incorporating attachment theory into psychotherapy may have the important benefit of allowing access to and modification of the intergenerational transmission of attachment insecurity, as highlighted by some of the child intervention literature reviewed above. Given the liability to later psychopathology and relationship difficulties conferred by insecure attachment (Mikulincer & Shaver, 2007), early prevention of this risk is of great value and may be facilitated by incorporation of attachment principles into child and adult treatments alike.

Recommendations for Clinical Treatment and Research

The preceding review and our specific mention of the moderating and mediating effects of attachment styles on treatment outcome provide several important clinical implications and recommendations for practicing clinicians. First, special attention to dismissing individuals who may be in distress or experiencing functioning difficulties but who do not present to treatment is

warranted. These individuals may present for other forms of care (e.g., psychiatric, primary care, ER visits) and may require careful and sensitive encouragement to pursue psychotherapy in these contexts. Second, a recognition that preoccupied or anxiously attached patients may experience less benefit from psychotherapy than their dismissing or securely attached counterparts is important, both for accurate prognosis as well as recruitment of effective attachment-based strategies from or referral to treatments that have shown improvement of attachment security (outlined above), which may be an important first step in longer-term care for these patients. Third, risk of dropout may be elevated in patients with low reflective function (particularly those with a personality disorder) or with avoidant attachment, also meriting an attachment-informed treatment. Each of these cases indicate the importance of assessing patients' attachment style, ideally through direct observation of behaviours of children or adults, although brief and easily administered self-report measures such as the ECR-R may also be useful—in order to optimize treatment selection, tailor the goals of therapy, and preempt treatment failure. Fourth, clinicians may benefit from an assessment of their own attachment style in order to avoid enactments with insecurely attached patients and pursue complementary interpersonal patterns with these patients (e.g., refraining from reinforcing anxiously attached patients' wishes for contact outside of therapy sessions; modeling emotional vulnerability and empathy with dismissing patients) to enhance treatment gains. Patients' characteristic maladaptive relational patterns (e.g., frequently participating in relationships that end in abandonment) are often enacted with the therapist, pulling the therapist to engage in iatrogenic behaviours that actually recapitulate these feared outcomes (e.g., excessive requests for personal disclosure from the therapist that erodes the therapist's ability to empathize with the patient) (Diamond et al., 2003). Understanding patients'

attachment schema prior to or early on in treatment can help to alleviate such concerns and allow these dysfunctional patterns to be an explicit target of treatment (Levy et al., 2011).

Furthermore, several implications of the literature on attachment as a mechanism of psychotherapeutic change are evident. First, directly facilitating improved attachment attitudes through therapy may garner increased treatment response and potentially even lasting treatment gains after the conclusion of therapy. Specifically, a focus on increasing patients' reflective function, narrative coherence, and attachment behaviours toward the therapist, via techniques that have been designed with this goal in mind (e.g., clarification or confrontation interventions, [Clarkin et al., 2006]; explicit demands for the patient to reflect on their own or others' mental states [Fonagy & Bateman, 2006]), may foster the development of more secure attachment schemas, catalyzing symptom change and improved relationship functioning. Relatedly, maladaptive interactions between parents and their children may be targeted both at the level of behaviour in live play and child-parent interaction, or indirectly via parents' attachment schemas, which may have downstream effects not only on parents' own behaviour, but on the internal working models of their children through improved and parental sensitivity and caregiving behaviour. Second, a recognition that a sudden increase in attachment anxiety in the middle phase of treatment may itself be a harbinger of subsequent improvements in attachment attitudes and other outcomes, as long as this period of vulnerability is carefully facilitated and structured by a therapist with the goal of working through difficult emotions and fears of interpersonal loss from the "secure base" of therapy.

Conclusion

Given its breadth and parsimony, as well as its strong empirical foundation, attachment theory provides an ideal integrative framework for conceptualizing both normative and

disordered development as well as the treatment of psychopathology. Attachment styles provide nuanced predictions of engagement in and response to treatment. Therapies founded on attachment principles have been shown to enhance security of attachment, which may lead to a wealth of positive intrapsychic and interpersonal outcomes. Parent-child attachment interventions also are effective at increasing caregiver sensitivity and responsiveness, which may have downstream benefits for their children's attachment styles. Although many areas still require much further research, such as the in-session effects of intervention strategies on attachment constructs (e.g., Kivity et al., 2018; Talia et al., 2014), attachment theory is a promising approach for clinicians and researchers alike.

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