Chapter 24
Attachment Theory and Research: Implications for Psychodynamic Psychotherapy

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Keywords Attachment theory • Attachment-based interventions • Process and outcome • Psychoanalysis • Psychodynamic psychotherapy • Psychotherapy research • Therapeutic alliance

Though attachment research today is best conceptualized as integrationist and multidisciplinary, it is important to remember that attachment theory was born out of clinical process. Bowlby [1–3] was first and foremost a psychoanalyst, and he drew from clinical experiences with children and adults to conceptualize his theory. Many of his ideas developed in response to dissatisfaction with the prevailing perspectives of the time. Though Melanie Klein, his supervisor at the time, was quite influential in his thinking about object relations, her conceptualization of development focused almost exclusively on internal conflict rather than external events in the child's family and environment [4, 5]. Contrary to Klein's perspective, during the analysis of a 3-year-old boy, Bowlby observed direct links between disturbances in the mother and pathology in the child. Such experiences in analytic treatment formed the basis for his assertion that early attachment difficulties increase vulnerability to later psychopathology.

Bowlby [2] contended that internal working models of attachment help to explain "the many forms of emotional distress and personality disturbances, including anxiety, anger, depression, and emotional detachment, to which unwilling separations and loss give rise" (p. 201). He held that childhood attachment underlies the "later capacity to make affectional bonds as well as a whole range of adult dysfunctions" including "marital problems and trouble with children, as well as … neurotic symptoms and personality disorders" (p. 206). Thus, Bowlby [1, 3] postulated that early attachment experiences have long-lasting effects that tend to persist across the lifespan, are among the major determinants of personality organization, and have specific clinical relevance. Despite their shared

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R.A. Levy et al. (eds.), *Psychodynamic Psychotherapy Research: Evidence-Based Practice and Practice-Based Evidence*, Current Clinical Psychiatry, DOI 10.1007/978-1-60761-792-1_24,

history, for many years, attachment theory and psychoanalysis developed in parallel. Consistent with Bowlby's integrationist perspective, attachment theory incorporated concepts and research paradigms from a breadth of traditions such as ethology, behaviorism, and cognitive and affective psychology (and more recently developmental neuroscience). Based on Bowlby's attachment theory, Ainsworth et al. developed an observational research paradigm called the Strange Situation for assessing attachment security [6]. Ainsworth identified three major behavioral patterns of attachment in infancy—secure, avoidant, and anxious-ambivalent—and traced these attachment patterns to caregivers' parenting behavior. Babies that approached their mother for comfort, soothing, and emotional refueling were deemed securely attached. Infants who avoided, ignored, or were difficult to console following a 3-min separation from their mother were coded as insecurely attached.

Subsequent investigators replicated and extended Ainsworth et al.'s [6] initial findings, both in the United States and within other countries (see reviews by [4, 7, 8]). Longitudinal studies investigating the predictability of later functioning and adaptation from infant attachment styles have found considerable, although variable, stability of attachment classification from infancy to adulthood [9–11], although the degree of stability is dependent on intervening experiences in relationships (see [9, 12–14] for a review).

Despite the richness of this body of research, psychoanalysts experienced these behaviorally derived findings as distant from the internal experiences of their patients, and thus the influence of this work on psychoanalytic practice was minimal. However, a major shift occurred with the introduction of the work of Main [15, 16], who focused on adults' "state of mind with respect to attachment" as a predictor of the adults' infants' attachment classification in the Strange Situation. In so doing, she moved the assessment of attachment from the behavioral level to, what she and her colleagues (e.g. [17]) called, "the level of representation" as reflected in the Adult Attachment Interview (AAI). Research using the AAI has demonstrated that mental representations with respect to attachment can be assessed with empirical rigor and that parental representations have significant implications for the social-emotional development of their children.

These findings have had significant implications for not only theory and research, but also psychotherapy technique [18]. This influence is not limited to psychodynamic psychotherapy, but also has provided a framework useful for those of various orientations/perspectives (e.g., developmentalists, behaviorists, cognitive-behaviorists). While there is no form of psychotherapy that could be said to derive wholly from attachment theory, a number of psychodynamic treatments have come to conceptualize change in terms of attachment (e.g., Transference-Focused Psychotherapy (TFP)), while others specifically target the attachment system (e.g., Mentalization-Based Therapy (MBT)).

In the present chapter, we will review the empirical literature on attachment theory, with a focus on how findings have altered psychotherapy technique. We discuss the empirical literature on adult attachment classifications, including issues surrounding the measurement of the construct of attachment and how these issues have been addressed. We also discuss attachment in psychotherapy research, including its role as a moderator of process and indicator of outcome in treatment. Lastly, we will demonstrate the clinical utility of attachment theory for technique in psychodynamic psychotherapy.

Measurement of Attachment

From the seminal work of Bowlby, attachment theory and research has evolved into two traditions, each with its own methodology for assessing attachment patterns (e.g., self-report and interview). Main and her colleagues developed the AAI [19], which inquires about early attachment relationships. The interview evaluates the subject's sense of how these experiences have affected adult personality by probing for specific memories that both corroborate and contradict the sense of attachment history the interviewee presents. Noting the discourse features in the interviews, Main and

colleagues identified three major patterns of adult attachment: secure/autonomous (F), dismissing (D), and enmeshed/preoccupied (E); and more recently, two additional categories have been identified: unresolved/disorganized (U/d) and cannot classify (CC). The first three categories parallel the attachment classifications originally identified in childhood [6], and the disorganized classification parallels a pattern later described in infants [15, 16]. These attachment patterns in adults reliably predicted the Strange Situation behavior of their children.

Security on the AAI is characterized by a well-organized, undefended discourse style in which emotions are freely expressed and by a high degree of coherence exhibited in the discussion of attachment relationships, regardless of how positively or negatively these experiences are portrayed. These individuals maintain a balanced and realistic-seeming view of early relationships, value attachment relationships, and view attachment-related experiences as influential to their development. In contrast, dismissing individuals devalue the importance of attachment relationships or portray them in an idealized fashion with few corroborating concrete examples. They have difficulty recalling specific events and usually describe an early history of rejection. These individuals are judged to have low "coherence of mind" because of the vagueness and the sparseness of their descriptions as well as the inconsistency between the vaguely positive generalizations and "leaked" evidence to the contrary.

Preoccupied individuals have little difficulty talking about attachment and expressing attachment-related feelings. However, these individuals tend to display confusion about past experiences, and are unable to gain insight into early events. They describe early relationships with parents as overinvolved or as guilt inducing. Descriptions of their current relationship with parents are often characterized by pervasive anger, passivity, and attempts to please parents, even when they describe the relationship as positive. Perhaps, most importantly, preoccupied individuals have a tendency toward incoherence in their descriptions. Specifically, their interviews are often excessively long and are characterized by the use of long, grammatically entangled sentences, jargon and nonsense words, reversion to childlike speech, and confusion regarding past and present relationships.

The u/D classification is assigned when an individual displays lapses in the monitoring of reasoning or discourse when discussing experiences of loss and abuse. These lapses include highly implausible statements regarding the causes and consequences of traumatic attachment-related events, loss of memory for attachment-related traumas, and confusion and silence around discussion of trauma or loss. CC is assigned when an individual displays a combination of contradictory or incompatible attachment patterns, or when no single state of mind with respect to attachment is predominant. This occurs when the subject shifts attachment patterns in mid-interview, when the subject demonstrates different attachment patterns with different attachment figures, or when the subject shows a mixture of different attachment patterns within the same transcript or passage.

In contrast to Main's focus on relationships with parents, Hazan and Shaver [20] and colleagues [21], using a social psychological perspective, applied the childhood attachment paradigm to study adulthood by conceptualizing romantic love as an attachment process. This work is important because it translates the childhood paradigm into terms directly relevant for adolescent and adult relationships. They translated Ainsworth's descriptions of the three infant attachment types into a single-item, vignette-based measure in which subjects characterized themselves as secure, avoidant, or anxious-ambivalent in romantic relationships. In subsequent research, Bartholomew [22, 23] and Bartholomew and Horowitz [24] developed a four-category classification of adult attachment that corresponds to a two-dimensional model of anxiety and avoidance. This classification system includes secure (low anxiety/low avoidance) and preoccupied (high anxiety/low avoidance) categories, but divides the avoidant category into both dismissing (low anxiety/high avoidance) and fearful-avoidant (high anxiety/high avoidance) attachment classifications.

Although categorical comparisons between the AAI and self-report measures have typically failed to correspond with each other (see [25, 26] for reviews), studies that have related the dimensional coding scales from the AAI to the self-report measures have found that they are significantly related, even if the two categorical typologies were not significantly related [27].

Attachment and Psychotherapy

From its inception, Bowlby believed that attachment theory was central to both normative and psychopathological development, and he believed that attachment theory had particular relevance for psychotherapy. This shift to an attachment perspective was accompanied by a move toward a view of the therapist as functioning to "provide the patient with 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" ([2, p. 421]). The role of the therapist "to provide the patient with a temporary attachment figure" serves many functions in the treatment process ([1, p. 191]). In this role, the therapist helps the patient to explore past and present attachments, including their expectations, feelings, and behaviors. The therapist accomplishes this goal by helping the patient examine the relationship with the therapist and how it may relate to relationships or experiences outside of therapy. The therapist creates links between past experiences to present ones, which involves encouraging awareness of how current relationship experiences may be related to past ones. In doing so, the patient has the opportunity to revise internal working models. Transference and countertransference dynamics provide the opportunity to negotiate multiple contradictory internal working models, which involves helping patients to feel, think, and act in new ways that are unlike past relationships. The internalization of the affectional bond with the therapist then itself becomes a representational safe haven to which the patient can turn internally in times of distress.

Following from Bowlby's theory, there are a number of ways in which attachment and psychotherapy may intersect, and many of these connections have been examined empirically. First, attachment theory has provided a guiding framework for many interventions, and many existing treatments employ attachment theory principles either implicitly or explicitly. Secondly, client attachment organization has been shown to act as moderator or prognostic indicator of both psychotherapy outcome and psychotherapy process. This body of research, particularly comparisons of findings between treatments and patient groups, has also provided evidence regarding how attachment organization may act as a prescriptive indicator. Third, changes in attachment representations have been conceptualized as outcomes, with several studies finding evidence for shifts in client attachment organization over the course of psychotherapy. Finally, attachment and related constructs may be thought of as psychotherapy process that can be examined through client–therapist in-session behaviors. Findings from this body of research indicate the clinical importance of accounting for patients' attachment styles as well as the potential fruitfulness of addressing issues around attachment, both in terms of current relationships and internal working models, within treatment. In particular, this work suggests that patient attachment status may be extremely relevant to the course and outcome of psychotherapy and may also change as a result of psychotherapy interventions.

Attachment Theory-Based Interventions

As noted previously, most existing psychotherapies implicitly employ techniques and principles that are congruous with attachment theory, particularly those concerning the importance of a healthy therapeutic relationship as well as the exploration and updating of mental representations of significant relationships and the self. Until recently, few psychotherapies have been based directly on the principles of attachment theory; however, in recent years, a number of explicitly attachment-based interventions have been developed for both child and adult populations. Trials of these interventions have yielded promising evidence with regard to their efficacy.

Consistent with the developmental framework from which attachment theory stems, a number of attachment-based treatments are aimed at preventing or alleviating symptoms and fostering secure

attachment organization in child populations. Many of these treatments actively engage other family members, particularly maternal caregivers, and some also include visits to the home. These interventions, which target a range of child ages, include prenatal treatments for high-risk pregnant women [28], a baby carrier intervention [29], toddler–parent psychotherapy [30, 31], parent–child psychotherapy [32, 33], prenatal and postnatal home visits [34, 35], and other structured treatments including the Watch, Wait, and Wonder program [36] and the Circle of Security [37, 38].

In addition to these various child-directed interventions, a few efficacious adult interventions have also been based on attachment theory principles. Interpersonal psychotherapy (IPT [39]) is a time-limited, widely used, and efficacious treatment for several disorders, most notably depression. IPT is explicitly based on the work of Bowlby, Adolf Meyer, and Harry Stack Sullivan and is focused on addressing interpersonal issues and disruptions in interpersonal relationships above and beyond any other clinical foci. This strictly interpersonal focus is consistent with Bowlby's theory that disordered attachment relationships are at the root of the development of pathology. The Attachment Injury Resolution Model for Couples [40, 41] is another currently used treatment that is based directly on attachment theory. This intervention is based within emotion-focused therapy (EFT) and is designed for couples who have experienced an "attachment injury" (i.e., a perceived abandonment during a time of need that threatens the perceived safety/security of the entire relationship). This treatment, which has the explicit goal of resolving attachment injuries and rebuilding the attachment relationship between partners, has shown efficacy over long-term follow-up periods with regard to increases in dyadic adjustment, trust, and forgiveness. A final attachment-based adult intervention is MBT [42–44], which was designed as a long-term, psychoanalytically oriented, partial hospitalization treatment for borderline personality disorder. This treatment model is based on the idea that patients were not able to develop the capacity of mentalization (i.e., the social-cognitive and affective process through which one makes sense of intentional behavior in the self and others by reflecting on mental states) within the context of an early attachment relationship, and that fostering the development of this capacity in turn leads to more stability in terms of the self (e.g., emotional and behavioral regulation) and relationships with others. This goal of MBT also rests on developing a safe attachment relationship between client and therapist to provide a context in which these mental states can be explored. MBT has been demonstrated to be effective over long-term follow-up with regard to reduction of depressive symptoms, suicidality, parasuicidality, and length of inpatient stays as well as improvement in social functioning [45].

Attachment as a Moderator of Psychotherapy Outcome

Several studies have examined how attachment styles, as measured prior to treatment, may relate to psychotherapy outcome. Many of these studies have focused on psychodynamic treatments, although there is also evidence of this moderating relationship within treatments of other orientations. In an early study in this area, Fonagy et al. [46] found evidence that attachment classification (as assessed by the AAI) at intake was associated with clinical change by the end of treatment in a nonpsychotic inpatient sample. Half of their sample had shown clinically reliable improvement on the GAF by the end of intensive psychodynamic inpatient treatment. In analyses examining the proportion of patients within different attachment classifications that had shown this improvement, almost 93% of those in the dismissive group improved, whereas 41% of the preoccupied group and 33% of the free-automous group improved. Subsequent analyses also found that attachment status was a significant predictor of final GAF score (controlling for GAF at intake). Interestingly, the authors found that attachment status was the only one of the psychometric measures used (including unresolved status, Axis I and Axis II comorbidity, and other measures of initial symptomotology) that significantly predicted improvement on the GAF, suggesting that attachment status may have a robust effect on

treatment progress. Fonagy and colleagues proposed two main explanations for the particular pattern of findings they observed (1) dismissive individuals may represent such an extreme interpersonal state that the observed change may just be due to regression to the mean and (2) these findings indicate how difficult it is for preoccupied individuals to do well in psychotherapy.

Reis and Grenyer [47] examined how attachment, as measured by Bartholomew and Horowitz's Relationship Questionnaire (RQ) at intake, related to process (specifically the alliance) and outcome in short-term supportive–expressive psychodynamic psychotherapy for clients diagnosed with major depressive disorder. They found that 39% of their sample of 58 clients was classified as fearful avoidant with regard to attachment; additionally, they found that fearful avoidance at intake was associated with more negative outcomes in terms of non-remittance of depressive symptomatology, particularly over the first 6 weeks of treatment. They also found that 21% of their sample was preoccupied with respect to attachment; this style was predictive of relatively poorer outcomes later in treatment. The authors also found that attachment style was not related to the alliance and that the alliance was unrelated to treatment outcome, suggesting that the negative impact of attachment on treatment response was unrelated to impacts on the alliance. According to the authors, these findings suggest that the early phase of treatment may be particularly difficult for individuals with a fearful-avoidant attachment status, as psychotherapy involves a level of interaction and disclosure with which they may be typically uncomfortable. For preoccupied individuals, the later stage of treatment may prove more difficult, as it may activate fears of separation from the treating clinician and feelings of abandonment prior to time of termination.

Similar findings relating attachment status to outcome have been observed in subsequent studies. Strauss et al. [48] also found that preoccupied clients showed the least improvement among clients with a variety of psychiatric diagnoses who were receiving inpatient treatment (principally psychodynamic-interpersonal group therapy). In this sample, securely attached clients were the most likely to show improvement. Similarly, higher levels of feared loss of attachment figure, a subscale of the Reciprocal Attachment Questionnaire related to insecure attachment styles, were found to be associated with poorer outcomes at both treatment termination and follow-up in a sample of patients participating in an inpatient, psychodynamic treatment program for traumatic stress [49]. In this study, attachment remained a predictor independent of demographic variables, symptom severity, and degree of trauma exposure.

Tasca et al. [50] suggested that attachment may differentially predict treatment outcome depending on the type of treatment. Their study examined attachment as it related to outcome within two treatments—group cognitive-behavioral psychotherapy and group psychodynamic-interpersonal psychotherapy—for binge eating disorder. In this study, the authors assessed attachment using the Attachment Styles Questionnaire, a self-report measure of attachment that yields five scale scores related to different attachment patterns. In this study, higher scores on the Need for Approval subscale (associated with anxious attachment patterns) were related to greater improvement in the group psychodynamic-interpersonal treatment (as assessed by fewer days binged) but relatively poorer outcomes in group cognitive-behavioral psychotherapy. Additionally, higher scores on the Relationship as Secondary subscale (associated with avoidant attachment patterns) were related to greater attrition within group cognitive-behavioral psychotherapy.

Investigations of treatments other than psychodynamic psychotherapies have also found evidence for a relationship between attachment status and outcome. Meyer and Pilkonis [51] found that secure attachment status, assessed by the Pilkonis [52] Attachment Prototype Rating System, predicted improvement in patient symptom severity (on the Hamilton Rating Scale for Anxiety) and GAF in a diagnostically diverse sample of patients who received 1 year of outpatient or inpatient treatment. In a study of interpersonal therapy for women with recurrent major depression [53], remitted patients identified as having a fearful-avoidant attachment style on the RQ were found to reach clinical stabilization more slowly when compared with other patients whose depression had

remitted with treatment. In this study, attachment style did not predict whether or not patients reached clinical remission following treatment. In a study of integrative treatment for male perpetrators of intimate partner violence, attachment anxiety, as assessed by the Adult Attachment Scale, predicted higher levels of posttreatment mild abuse and psychological abuse; additionally, attachment avoidance predicted higher total violence severity scores posttreatment [54]. In this sample, a decrease in attachment avoidance over the course of treatment was related to less violence posttreatment. Additionally, McBride et al. [55] examined dimensional attachment anxiety and avoidance, as measured by Griffin and Bartholemew's Relationship Scales Questionnaire (RSQ), as moderators of treatment outcome in interpersonal and cognitive-behavioral psychotherapy for major depression. In this study, clients who displayed higher levels of attachment avoidance were less likely to reach clinical remission of symptoms when treated with interpersonal therapy as compared to patients in cognitive-behavioral therapy, who were more likely to reach clinical remission. Attachment anxiety did not predict treatment outcome in this study.

Taken together, this literature suggests that attachment classification may significantly influence the trajectory of change in psychotherapy. While generalizing from findings is to some degree hampered by differences in methods for assessing attachment status, a number of patterns seem to be consistent across samples. First, a number of studies indicated that secure attachment was related to better treatment outcomes across psychotherapies for a range of disorders (e.g. [48, 51]). Second, there is evidence that higher attachment anxiety may be predictive of poorer treatment outcomes, among both preoccupied (e.g. [46, 48]) and fearful-avoidant clients (e.g. [53]). Finally, findings from studies that examined attachment status in relation to outcome in more than one psychotherapy suggest that attachment may be differentially predictive of outcome depending on type of treatment (e.g. [50, 55]).

Attachment as a Moderator of Psychotherapy Process

Researchers have also explored how attachment relates to psychotherapy process, with emphasis on the therapeutic alliance, treatment engagement, and treatment compliance. Patients with more secure attachment styles generally tend to have stronger alliances with their therapists across a variety of treatments [56–60]. In general, attachment avoidance—particularly fearful avoidance—is related to a poorer alliance across a variety of clinical groups [56, 57, 60, 61]. Attachment avoidance has also been found to be related to a fearful-avoidant attachment between client and therapist (as assessed by the Client Attachment to Therapist Scale), which may explain some of the impact on the alliance [61].

Other studies have examined how patients' attachment patterns may impact treatment use and engagement. In terms of treatment use, these studies utilizing the AAI and the ECR have found that dismissive individuals are less likely to report having been in treatment than secure, preoccupied, or unresolved individuals [62, 63]. Furthermore, one study examining the relationship between attachment status and reported psychotherapy use in a large sample of young adults found that individuals classified as fearful or preoccupied with regard to attachment were approximately twice as likely to report past psychotherapy use as securely attached individuals [62]. There is some indication that preoccupied individuals may also be more frequent users of medical services other than psychotherapy, as well; for example, preoccupied individuals with Cluster B personality disorders report longer medical hospitalizations than do matched individuals of other attachment classifications [64]. Related to treatment use, attachment anxiety is related to more acknowledgement or perception of distress as well as more help-seeking behaviors, while dismissing attachment is more associated with less acknowledgement of distress and help-seeking [65].

In general, findings have suggested that securely attached patients in a variety of treatments tend to be particularly collaborative, compliant, and are able to fully utilize treatment. These patients are typically able to trust their therapists and use interventions in an effective way. By contrast, dismissive individuals tend to be more resistant to treatment and less engaged. Interestingly, preoccupied individuals may seem needy and disclosive in treatment yet may not be more compliant [28, 63, 66]. Dozier [66] examined this question in a sample of 40 young adults who were receiving inpatient treatment for a variety of serious psychological disorders, including schizophrenia and bipolar disorder. In this study, client attachment was assessed using the Assessment Interview Q-set [67]. In addition, clinicians rated their clients' degree of compliance with treatment, help-seeking or help-rejecting behaviors, self-disclosure, and overall use of treatment. As suggested earlier, more secure strategies were found to be associated with more compliance (e.g., these clients were more likely to come to appointments and/or take medications as prescribed), as compared with more avoidant strategies. Similarly, avoidant individuals were found to be less likely to seek out help (and more likely to reject it) and were rated overall as poorer users of treatment as compared to preoccupied individuals. More preoccupied strategies were associated with higher levels of disclosure than were more avoidant strategies.

Interestingly, findings from other medical disciplines have also indicated that dismissing individuals may be less compliant with treatment recommendations. For instance, patients with Type I and II diabetes have been shown to exhibit poorer glucose control than preoccupied or secure patients [68]. In this sample, dismissing patients who also rated communication with their treatment provider as poor displayed higher glycosylated hemoglobin levels and were less likely to adhere to taking oral hypoglycemic medications and regularly monitoring glucose.

Subsequent studies have found that dismissive patients often become more distressed and confused when confronted with difficult issues in treatment, which may impact their subsequent engagement [69]. In general, these findings may suggest that dismissive patients are at a greater risk for treatment drop-out, given the lack of initial engagement and compliance. However, while these findings suggest that avoidant clients may seem less engaged than their preoccupied counterparts, it should be noted that they do seem to fare better in terms of outcome. As noted earlier, Fonagy et al. [46] found that dismissive patients were most likely to show improvement during treatment, as compared to patients exhibiting other attachment styles (including preoccupied clients). These findings suggest that while avoidant (particularly dismissing) clients may seem detached, they may be able to effectively utilize treatment; conversely, while preoccupied individuals may seem particularly engaged, they may not be able to use interventions in a helpful way. Interestingly, it also appears that dismissing clients may pull for more active interventions from therapists (i.e., interpretations) whereas preoccupied clients may elicit more reflective comments from therapists [70].

These ideas are echoed in relevant clinical writings, which have focused on how the findings of the process and outcome literature may play out in everyday practice. Diamond et al. [71] described two patients with borderline personality disorder who changed from insecure to secure attachment after 1 year of TFP with the same therapist. One of these patients was initially classified as preoccupied on the AAI, whereas the other was initially classified as dismissing; the therapist experienced interactions with each of these patients as very different. The patient who was initially classified as preoccupied engaged the therapist, and the therapist felt more active in the treatment; however, the therapist felt less engaged and even excluded by the patient initially classified as dismissive. By the therapist's estimation, a weaker therapeutic bond was forged with the dismissive patient, as well. These observations are congruent with the findings on preoccupied versus dismissive attachment styles as they relate to treatment use and engagement (e.g. [72]). Other clinical writings, particularly those of Slade [73–75], describe how preoccupied patients may be more difficult to treat despite seeming more engaged and engaging. These patients' representations of self and other may be vivid and rich (and therefore intriguing to the therapist) but also very chaotic, which may prove to be confusing and difficult material for the therapist to work with.

Therapist Attachment as a Moderator of Psychotherapy Process and Outcome

A number of studies have also examined how therapist attachment style may impact the course and outcome of psychotherapy. One prevailing finding is that securely attached clinicians (as assessed by the AAI and the RSQ) tended to have clients who had relatively better outcomes than clinicians with other attachment classifications [72, 76]. There is some evidence that secure attachment in clinicians is particularly related to better outcomes and alliance in more severely symptomatic patients [77]. Securely attached clinicians have also been shown to appear more "psychologically available" to patients over time, as compared to insecurely attached clinicians [78]. Clinicians classified on the secure/autonomous dimension also tended to challenge their clients' interpersonal styles, particularly as opposed to those clinicians classified on the insecure dimensions, who tended to compliment clients' interpersonal styles [72, 79]. Furthermore, clinicians with an anxious attachment style tended to respond with less empathy than those with a secure attachment style [72, 79–83] and also have weaker therapeutic alliances [84].

Additionally, findings suggest that the match between therapist and client attachment styles may be an important predictor of psychotherapy process and outcome [72, 76, 79]. In particular, aside from having a securely attached therapist, clients who have a therapist opposite to them on the preoccupied to dismissing dimension of attachment on the AAI tended to have better outcomes and stronger therapeutic alliances than patient–therapist dyads who were not matched in this way. For example, a particularly advantageous pairing in terms of alliance and outcome would be a clinician rated at the dismissing end of the autonomous dimension and a preoccupied client. This pattern of findings, along with prior research on client–clinician match, suggests that a mismatch of interpersonal style between clinician and client may be beneficial in terms of crafting an intervention that is particularly effective for a given client with regard to developing a more adaptive interpersonal style. That is, more emotional or preoccupied patients may need more detached interventions whereas more dismissing patients may benefit more from interventions directed at emotional expression and affiliation with others [70, 85].

Attachment as Outcome

Several studies have used change in attachment representations as a means of assessing clinical outcome within psychodynamic psychotherapies across diverse patient populations. Many of these investigations have compared pre- and posttreatment assessments of client attachment styles to evaluate changes in these patients' attachment classifications that occur during the course of psychotherapy.

Fonagy et al. [46] found evidence of a shift in attachment status following 1 year of intensive psychodynamic psychotherapy in 35 nonpsychotic inpatients. In their sample, all 35 patients were classified as insecure based on pre-treatment AAIs, yet 40% ($n = 14$) showed a shift to secure attachment status by discharge. This study was among the first to examine changes in attachment status from pre- to posttreatment and was integral in suggesting that psychotherapy can alter clients' attachment patterns and lead them to progress to a secure attachment status. However, neither the type of psychopathology nor the treatment used in this study was well specified. Subsequent studies aimed to examine these changes in the context of specific diagnoses and/or more structured treatments.

Travis et al. [86] examined changes in attachment styles in clients enrolled in the Vanderbilt II Study who were treated with time-limited dynamic psychotherapy. These patients exhibited a range of psychological difficulties but had to carry at least one Axis I or Axis II diagnosis to be included in the study. Client attachment styles were rated at intake and termination using the Bartholomew Attachment Rating Scale [24], which allowed attachment patterns to be rated both dimensionally

and categorically. The researchers found significant changes from insecure to secure attachment styles from intake to termination on both dimensional and categorical ratings of attachment. Additionally, the researchers found significant relationships between attachment styles, posttreatment Global Assessment Scale scores, and posttreatment symptom severity. They interpreted these findings as suggesting that secure attachment status may endow a person with more adaptive interpersonal coping strategies, which would then serve to mitigate symptom severity.

In another group of studies, Levy and colleagues [87–89] examined changes in attachment status as assessed by the AAI in patients diagnosed with borderline personality disorder. In a pilot study [89], the researchers assessed change in attachment following a year-long course of TFP, a structured psychodynamic treatment, in a group of ten patients and found that of the nine patients who were initially classified as insecure, an additional two patients became secure after treatment, resulting in a third of the patients being classified as secure posttreatment. Additionally, of the six patients initially classified as unresolved with respect to trauma and/or loss, four lost their unresolved status by the end of treatment (leaving only 40% of the sample unresolved). In a randomized controlled trial [89], the researchers examined changes in attachment in 90 patients with borderline personality disorder who were randomized to receive one of three treatments: TFP, dialectical behavior therapy (DBT), or a modified psychodynamic supportive psychotherapy (SPT). After a year of treatment, the researchers observed a significant increase in the number of patients classified as secure who were in the TFP condition; this change was not observed within the other two treatment groups. Within the TFP group, 7 of 22 (31.8%) patients changed from an insecure to secure attachment classification.

There is also evidence that change in attachment status may also be related to changes in symptomatology. Similar to the findings of the previously discussed studies, patients within an inpatient treatment for posttraumatic stress disorder showed significant increases in secure attachment over the course of treatment, which was sustained over follow-up [90]. Interestingly, these positive changes in attachment styles were also significantly related to symptom reduction.

Attachment as Process

Some preliminary work has indicated that attachment-related constructs may also be used as a lens through which to examine psychotherapy process. Samstag et al. [91] used the narrative coherence coding system from the AAI to examine psychotherapy process as a predictor of treatment outcome within 48 client–therapist dyads. This sample included clients with mixed diagnoses (primarily Cluster C personality disorders with comorbid depression and/or anxiety) who were randomly assigned to be treated with a 30-session protocol of one of the following: short-term psychodynamic psychotherapy, brief adaptive (dynamic) psychotherapy, cognitive-behavioral psychotherapy, SPT, or relational psychotherapy (see [91] for details about these treatments). Patients were divided into three groups (with 16 patients in each group) based on outcome (1) drop-out (termination within first third of treatment), (2) good outcome (high reliable change), and (3) poor outcome (low reliable change). Coherence was rated for a portion of sessions that were randomly selected from the first third of treatment. Coherence ratings were significantly higher for the good outcome group, as compared with the drop-out and poor outcome groups. These findings suggest that more highly coherent narratives occurring within the context of psychotherapy may be an indication of a particularly fruitful collaboration within the client–therapist dyad. Furthermore, it is possible that patient-level factors, including attachment, may influence the level of narrative coherency, which may in turn influence the course of psychotherapy.

Clinical Implications of Attachment Research

Taken together, these findings have prescriptive implications for working with patients of various attachment classifications. The two patient classifications with the most research suggestive of clinical application, preoccupied and dismissive, will be highlighted.

Preoccupied patients are often likely to seek treatment. Because such individuals often have a negative model of themselves but a positive model of others [22], they are likely to look for the therapist to meet needs that they feel unable to address within themselves. Such individuals are likely to disclose a great deal of information to the therapist, with evocative descriptions of themselves and others that engage the therapist's attention; however, their discourse often lacks the narrative coherence that would allow for others to fully join with their experience. In fact, such individuals are likely to assume that the therapist has more knowledge about the patient than can be realistically expected. At best, the therapist often may feel that she is working hard to make links within her own mind between disparate pieces of information, since the patient has not provided such narrative bridges. At worst, the therapist may feel lost in a chaotic, entangled narrative that leaves the therapist feeling confused and frustrated. Thus, even though the preoccupied patient may appear to be working very hard in treatment, such work may not translate into a productive dialog that allows for shifts in the patients representations of self and others.

The work of Dozier et al. [69] suggests a seemingly contradictory stance on the part of the therapist; to remain securely present with the patient while simultaneously maintaining sufficient distance from becoming entangled in the patient's production. This secure detachment allows the therapist sufficient distance to clarify and confront breaks and omissions in the patient's discourse [92]. Slade suggests that progress is slow moving with preoccupied patients, and that it is gained through the therapist's "emotional availability and tolerance for fragmentation and chaos" as they aid the patient in forming less distorted and/or chaotic representations of self and others ([73, p. 588]).

In contrast, dismissive patients are less likely to seek treatment [62]. Because such individuals often have a positive model of themselves and a negative model of others [22], they are unlikely to expect that help from and dependency on others will lead to change. Such individuals are likely in the early stages of treatment to maintain a distance from the therapist, disclose little, and express skepticism about the treatment. Though they may appear compliant in relaying personal information, their discourse will often lack the details needed to create vivid, complex, and multifaceted images of self and others in the mind of the therapist. At best, the therapist often may feel that she is going through the motions of a treatment with a distant and superficially complaint patient. At worst, the therapist may repeatedly feel she has to answer to the criticisms of an individual who continually has "one foot out the door."

Therefore, the early phases of treatment with dismissive patients often focus on the high threat of drop-out. As with preoccupied patients, this challenges the therapist to balance two seemingly contradictory demands. On one hand, as previously discussed, dismissive patients often become more distressed and confused when confronted with difficult issues in treatment [69]. At the same time, to not directly confront threats to the treatment creates an increased risk for drop-out [92]. The capacity of the therapist to emotionally engage herself in a narrative that may not be engaging to begin with, and to bring direct emotional expression to a narrative that often omits complex affects, may provide an optimal space for intervening with such patients. Despite these challenges in engaging and retaining dismissive patients in treatment, as previously discussed, when they follow through with treatment they do seem to fare better in terms of outcome.

Conclusions

Bowlby's attachment theory, coupled with the large body of research his theory has generated, has come to occupy a central place in current psychodynamic theory and treatment. Whereas classical drive theory once dominated psychodynamic thought, Bowlby's contention of a drive toward object-seeking has come to be a commonly accepted tenant among many schools of psychoanalysis [93].

Initially, psychoanalysis was relatively uninterested in attachment theory and research, in part because of its behavioral emphasis but also because of its focus on actual relationships, the view of representations as relatively accurate, and the de-emphasis on sex and aggression. However, attachment theory and research has proven to provide a powerful and valuable heuristic framework for conducting psychoanalytic research, testing psychoanalytic hypotheses, and enriching the perspective of psychoanalytic clinicians and investigators.

Attachment research has provided evidence for many of the basic tenets of psychoanalysis. The landmark research by Ainsworth et al. [6] on the relationship of maternal sensitivity to attachment patterns and the subsequent research by Sroufe, Hamilton, and Waters [9–11] on the continuity of infant attachment into adolescence and young adulthood have provided strong empirical evidence for two basic psychoanalytic tenets (1) the importance of early childhood relationships in shaping adult relationships; and (2) the importance of meaning systems. Additionally, the seminal work of Mary Main and her colleagues in developing the AAI and relating mothers' and fathers' attachment representations to their children's attachment patterns as well as Fonagy and Target's creative research on mentalizing provide fertile ground for the future growth of psychoanalysis and its scientific evolution.

Following from Bowlby's theory, there are a number of conclusions that can be drawn from the data reviewed regarding research at the intersection of attachment and psychotherapy. Specifically, we have learned that:

1. Attachment theory has provided a guiding framework for many child-directed interventions, and these interventions have demonstrated promising outcomes [29–38]. The success of such interventions is also notable because, in contrast to skills-based interventions that target manifest behaviors, these programs demonstrate the importance of addressing the underlying attachment organization in order to effect long-term change.
2. Attachment theory has provided a guiding framework for many types of psychotherapy, thus bringing psychodynamically oriented principles into broader non-dynamic treatments (e.g., IPT and EFT). Though such treatments may not typically be conceptualized as rooted in dynamic principles, these treatments employ attachment theory principles either implicitly or explicitly [39–41].
3. Attachment theory has also led to the modification of psychodynamic treatments for specific populations and disorders (e.g., MBT). The impact of attachment theory evidences itself not only in the conceptualization of clinical phenomenon (such as BPD), but also in terms of the implementation of interventions (such as monitoring the level of activation of the patient's attachment system; [45]).
4. Attachment organization has been shown to act as moderator of both psychotherapy process and outcome, thus influencing the trajectory of therapy within a given session and over the entire course of the treatment [71, 87]. This set of findings suggests that attachment constructs have prognostic implications for treatment. While attachment avoidance may be related to poorer alliance and compliance in therapy [56, 57, 61], individuals high in attachment avoidance often benefit from therapy if they stay in treatment [46]. On the other hand, those high in attachment anxiety, while more likely to seek help, may evidence poorer treatment outcomes [46, 48, 53].
5. Research comparing findings between treatments and patient groups has also provided evidence regarding how attachment organization may act as a prescriptive indicator [50, 55]. The fact that

attachment status is differentially predictive of outcome depending on type of treatment suggests the importance of clinicians attending to attachment organization during treatment planning.

6. Attachment-related constructs such as narrative coherence may be thought in terms of psychotherapy process through examination of client–therapist in-session behaviors [91]. This suggests that attachment constructs have implications for the quality of relatedness between patient and therapist, which may in turn influence the course of psychotherapy [66].
7. Further, the therapist's own attachment organization, and its correspondence to the patient's organization, may significantly impact the process and outcome of treatment [72, 76, 79]. Though it is no surprise that securely attached therapists have the best outcomes, research has shown that clients who have a therapist discordant to them on the preoccupied to dismissing dimension tended to have better outcomes and stronger therapeutic alliances than concordant dyads.
8. Research has demonstrated evidence for shifts in client attachment organization over the course of psychotherapy [88]. This suggests that attachment constructs such as narrative coherence and reflective functioning may be important outcomes in their own right.

The last point is worth highlighting because it speaks to the powerful role attachment theory and research has played in validating what may be a unique aspect of psychodynamic therapy: the capacity to change internal psychological structures. This body of research demonstrates that patients can change relationship patterns and can revise internal working models, and this shift allows them to feel, think, and act in new ways that are unlike past relationships.

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