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RUNNING HEAD: Framework

A Framework for Attachment-Based Psychotherapy with Adults

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Over the past decade there has been an explosion of interest in the clinical applications of attachment theory. Indeed, a number of authors have described *attachment-related therapies*, a term we use to describe any clinical approach that invokes attachment concepts and relies on attachment research to facilitate clinical work. With varying degrees of completeness, authors have described therapies for couples, families, infant-parent dyads, children, and adults. Among these therapies, two broad types can be discerned: attachment-based psychotherapy and attachment-informed psychotherapy (Obegi & Berant, 2009). By *attachment-based psychotherapy* we mean therapy that relies extensively on attachment theory to conceptualize problems, assess personality, and define clinical interventions. In many cases, the efficacy of this kind of therapy has been, or is being, actively researched. In contrast, we use the term *attachment-informed psychotherapy* to refer to therapy in which attachment theory and research are used to inform and supplement clinical practice based on some other established clinical approach (e.g., cognitive-behavioral therapy).

Although we imagine that Bowlby, a psychoanalyst and the founder of attachment theory, would find the proliferation of clinical applications of his theory encouraging, at this point the precise nature of an emerging attachment-related therapy is unclear. Bowlby (1988) himself offered only a brief sketch of how he thought attachment-related concepts and insights could be put to clinical use. Since Bowlby (1973, 1980, 1982) published his landmark trilogy on attachment theory, subsequent theorists have refined his ideas, and many researchers have provided supportive and theory-extending findings. Given this rich but very complicated research context, it is necessary to consider what the central components of an attachment-based psychotherapy should be. We hope that engaging with us in this exercise will orient clinicians to ideas and research that can enhance their clinical work as well as ground the growing number of

attachment-related therapies in a common framework. Of course, our discussion of these issues reflects our personal clinical and research experience; it is only a beginning, a work in progress that remains open to dialogue, further theoretical refinements, new empirical research, and practice-based insights into using attachment theory and research in clinical settings. Our discussion is organized around themes thought to be useful in analyzing any form of psychotherapy (Gurman & Messner, 2003). For the sake of brevity, we present our framework primarily in theoretical terms and refer readers to representative studies and authoritative literature reviews.

Historical Background

As a British psychoanalyst, Bowlby was intimately familiar with psychoanalytic theories, and he was dissatisfied with them, particularly Freud's and Klein's. He viewed them as (a) based too heavily on reconstructions of the past rather than direct observations of early family interactions, (b) increasingly out of step with recent advances in other psychological and biological disciplines, and (c) inconsistent with his clinical experience with patients and their families (Bowlby, 1988). As a result, Bowlby sought to update psychoanalytic theory based on his own observations and research findings from primate ethology, cognitive and developmental psychology, control systems theory, and psychopathology.

In his early clinical work with children and families, Bowlby (1944, 1969) was struck by the degree to which actual experiences in early childhood, particularly early loss of a parent, separation from mother, and troubled interactions with parents, were related to later psychological disturbance. His views were starkly different from those of some of his fellow psychoanalysts, who maintained that universal psychic conflicts and libidinal fantasies, not experience, were the roots of maladjustment. In his extensive review of the effects of maternal

deprivation on homeless children in post-World War II Europe, Bowlby (1951) concluded that “maternal care in infancy and early childhood is essential for mental health” (p. 59). He also remarked that there was no available theory capable of explaining the necessity of adequate and ongoing maternal care.

Motivated by this theoretical gap, Bowlby (1969, revised in 1982) drew on various research fields to create attachment theory. He proposed that *attachment*, an enduring emotional tie with a specific other (or small set of others), is central to psychological development and ensures an infant’s survival by eliciting care and protection from stronger, wiser figures. He viewed the formation of attachments as a crucible in which personality development, healthy or unhealthy, takes place. Attachment relationships are important because repeated interactions with primary caregivers instill in infants and young children strategies for emotion regulation as well as beliefs and feelings related to security, self-efficacy, and self-worth. Ideally, the emotional tone and quality of early exchanges promotes a steady sense of *attachment security* —“a sense that one can rely on close relationship partners for protection and support, can safely and effectively explore the environment, and can engage effectively with other people” (Mikulincer & Shaver, 2004, p. 159).

Bowlby proposed (1982) that interactions between children and caregivers are governed by an innate *attachment-behavioral system*; later theorists emphasized that the same system shapes behavior in close relationships throughout the lifespan (Fraley & Shaver, 2000). Here we discuss our theoretical refinement and conceptual analysis of this system as it pertains to adults (see Figure 1, based on Mikulincer & Shaver, 2007a). In the first module of the flowchart in Figure 1, threats to physical and psychological safety are monitored, and when one is detected the attachment system is activated and deploys attachment behaviors (e.g., moving closer,

calling, conjuring up relevant memories and expectations) intended to bring a person into closer physical or psychological proximity to a preferred, protective figure (an *attachment figure*).

When experiences support the primary attachment strategy, which is to seek proximity to a caregiver with the expectation of receiving protection and support, distress is soothed, confidence is recharged, and what we (Mikulincer & Shaver, 2007a) call a *broaden-and-build cycle of attachment security* is triggered (the second module in Figure 1). As we discuss later, this cycle increases psychological resilience and expands perspectives and coping capacities.

On the other hand, when bids for increased proximity are overlooked, rebuffed, or even punished, the resulting helplessness amplifies distress. Given the resulting emotional strain, both children and adults are likely to turn to defensive *secondary attachment strategies* to elicit care. These can be roughly classified as *hyperactivating* strategies (which are anxious, strident, and demanding) or *deactivating* strategies (which involve withdrawal and avoidance). Adolescents and adults tend to use the strategy that has proven most effective with prior caregivers and is therefore the most practiced and automatic. Theoretically, these strategies are rooted in chronically accessible cognitive-affective schemas or *internal working models* (Bowlby, 1982; Bretherton & Munholland, 2008), which adults can quickly tap to predict the behavior of their relational partners and inform interactions with them (Mikulincer, Shaver, Sapir-Lavid, & Avihou-Kanza, in press).

Historically, critics of attachment theory have charged that Bowlby merely swung the pendulum from an overemphasis on internal representations and conflicts to an overemphasis on real experience. Closer to the truth, we believe, is that Bowlby made room for a dynamic exchange between lived experienced and subjective perceptions of it. As he noted, "...it is just as necessary for analysts to study the way a child is really treated by his parents as it is to study the

internal representations he has of them, indeed...the principal focus of our studies should be the *interaction* [emphasis added] of the one with the other, of the internal with the external” (Bowlby, 1988, p. 44).

Although he wrote little about it, Bowlby did consider how his theoretical ideas might be applied in clinical work (Bowlby, 1977, 1988). Just as good parents provide the conditions that allow infants to securely and curiously explore their world, so, Bowlby thought, effective clinicians create conditions in which patients feel comfortable enough to examine and then reassess internal working models of themselves and their relationship partners. This process involves five main tasks. First, clinicians need to function as attachment figures; they must provide a secure base from which patients can discuss their current problems and past experiences, without fear of recrimination or invalidation. Second, clinicians need to encourage patients to consider how beliefs about themselves and expectations of others influence how they think, feel, and act in relationships, including in the therapeutic relationship itself (the third task). The fourth task involves helping patients assess how current thoughts, feelings, and behaviors may have originated in childhood experiences or in their relationships with parents or other caregivers and subsequent relationship partners. Finally, clinicians need (a) to help patients consider that historical ways of thinking and behaving may not be well-adapted to their current lives and (b) to imagine and practice alternative, healthier ways of coping and interacting.

Beyond providing this outline, Bowlby (1988) also took a stand on some technical aspects of treatment, including the validity of early experience and the desired stance of the therapist. Although he appreciated the role of childhood experiences in shaping personality, his view of these experiences in the context of psychotherapy was multifaceted. On the one hand, he strongly recommended that clinicians elicit and accept accounts of early experience as

“reasonable approximations to the truth” (p. 149), because to do otherwise would undermine the therapeutic relationship. However, he also recommended eliciting detailed accounts as a means to support (or challenge) any sweeping characterizations patients might make of their parents’ behavior. Discrepancies are likely to reveal the kinds of misperceptions patients have of their current relationship partners and of the therapist. Bowlby also warned that patients’ perceptions of therapists are shaped not only by internal working models (i.e., by transference) but by the way their therapists actually treat them.

For the most part, Bowlby (1988) thought that treatment should focus on interactions in present-day relationships as well as here-and-now interactions with the clinician, exploring the past “only for the light it throws on [the patient’s] current ways of feeling and dealing with life” (p. 141). Bowlby also recommended approaching patients as knowledgeable partners, trusting them to focus on the salient issues and engage in the work necessary for change.

Attachment-Related Differences in Defensive Processes

Attachment theory has a well-articulated and empirically supported view of individual differences in defensive processes. (For an in-depth discussion of attachment-related defensive processes, see Mikulincer, Shaver, Cassidy, & Berant, 2009.) Although early research focused on types or styles of attachment (e.g., secure, anxious, and avoidant styles), recent work suggests that two dimensions of insecurity (Brennan, Clark, & Shaver, 1998)—attachment-related anxiety and attachment-related avoidance—best capture differences in attachment orientations.

People high in anxiety rely on hyperactivating strategies. Despite their best efforts to enlist others’ help, anxious adults have frequently experienced severe distress in the absence of reliable and sufficient support. As a result, they tend to view themselves as inept, helpless, and unloved and view relationship partners as likely to be unreliable or insufficiently attentive. These

negative attributions urgently motivate anxiously attached adults to avoid being alone or without readily available support, and they accomplish this with little regard for the cost of their tactics to their own self-confidence or the strain they place on relationship partners.

Anxious adults rely on three defensive maneuvers: distress amplification, self-devaluation, and reduction of self-other differentiation. Because they feel that their needs have been overlooked, anxious adults habitually “turn up the volume” of their distress in hopes of rousing relationship partners’ attention and aid. They may unintentionally exaggerate their feelings, react strongly and negatively when they perceive a sluggish or inadequate response, and engage in rumination on reasons for feeling angry or jealous. At other times, self-deprecation may be more effective than up-regulating distress. For example, overtly belittling oneself tends to elicit sympathy and reassurance, although it also reinforces others’ views of one as overly needy or childish. A third way anxious adults try to keep attachment figures near is to make an extreme effort to be liked or appreciated. To this end, they may sacrifice their own preferences, imagine more twinship (Banai, Mikulincer, & Shaver, 2005, based on Kohut, 1971) than actually exists, and generally placate and over-attend to their partners’ wishes. Although the overall strategy behind these tactics is to keep attachment figures attentive and responsive, they can leave relationship partners feeling so drained and coerced that they are inclined, over time, either to withdraw or to respond angrily or impatiently, thereby producing the very responses that the anxious people fear.

People high in attachment-related avoidance have also experienced inadequate responses from attachment figures to their needs and signals of distress but more often in the form of outright rejection or punishment. As a result, in times of distress they are motivated to avoid being humiliated or let down by attachment figures. They tend to rely on deactivating strategies

to achieve these ends: distancing themselves from feelings of vulnerability or distress and outwardly projecting a composed, independent demeanor. Their first line of defense against experiencing distress is simply to suppress, either consciously or automatically, any attachment-related thoughts, feelings, or memories. This decreases the likelihood of feeling vulnerable or being tempted to call on supportive others for support. Another way avoidant adults try to minimize attachment needs is by devaluing both their own dependency needs and the people capable of meeting them. Avoidant adults strive to be independent and self-sufficient, are inclined to project unwanted qualities onto others, and exaggerate the dissimilarities between themselves and others. They further diminish the possibility of feeling vulnerable by inflating their sense of their own value. They may see themselves as especially capable and decline offers of assistance even when their need for it is obvious. Taken together, these tactics give the impression of aloofness and emotional inaccessibility. As a result, potentially supportive figures overestimate avoidant adults' confidence and self-sufficiency, leading them to overlook subtle hints that the avoidant person could use help, raise their expectations for independent coping, and become less accessible.

Psychological Health and Pathology

In our view, psychological health is closely tied to the history of interactions with caregivers and later relationship partners during times of need. When positive, such interactions have a variety of salutary effects, both immediate and long-term, which are a consequence of what we referred to earlier as the broaden-and-build cycle of attachment security. These effects constitute a resilience resource that lowers susceptibility to mental health problems by maximizing personal adjustment and decreasing reliance on defensive processes (Mikulincer & Shaver, 2007a).

The most immediate effect of rewarding interactions with attachment figures in times of need is a sense of safety and security. Beyond obtaining relief from physiological and psychological distress, well-supported individuals receive a boost of felt security that enhances self-efficacy and reduces negativistic thinking that could interfere with effective coping. Repeated experiences of unconditional support create an additional and durable resource: an internalized representation of the self as lovable and capable that can be called upon during stressful times. Along with assuaging suffering and boosting self-worth, interactions with a responsive attachment figure increase peoples' willingness to turn to partners again in the future and increase their confidence that relief and renewal will follow. These kinds of expectations make intimacy safer and more desirable, and ultimately, deepen bonds of affection and trust. With personal and social resources readily available, people experiencing responsive care are more likely to take on challenges, reflect on private but painful thoughts and feelings, and become more compassionate and altruistic. In this sense, attachment security is the foundation of mental health.

In contrast, interacting with unreliable, critical, or rejecting caregivers initiates a downward and potentially destabilizing cycle of insecurity that increases the likelihood of psychopathology. Anxiously attached adults are especially vulnerable. Without assistance, they may become increasingly distressed, devoid of coping resources, cognitively disorganized, and overwhelmed by a stream of pessimistic and self-critical thoughts. If this happens very frequently, it erodes what little self-confidence anxious adults may have and reinforces representations of the self as vulnerable and unworthy. In the long run, insecure mental representations of self and others exacerbate problems in emotion-regulation and self-control and damage close relationships.

Deactivating strategies make avoidant adults less susceptible to the immediate effects of caregiver unavailability; they quickly distance themselves from the source of distress by minimizing if not ignoring their own negative feelings and distract themselves by blaming and escaping. Unfortunately, these tactics may not suffice in protracted periods of stress and may lead to precipitous drops in well-being and increased psychopathology.

Most research on the associations between attachment insecurities and adjustment do not indicate that particular forms of insecurity are connected with specific psychological disorders, although they may predict different forms of personality disorders (Brennan & Shaver, 1998; Crawford et al., 2006). Rather, attachment insecurities appear generally to be non-specific vulnerabilities which, in the presence of other factors, can result in specific psychological problems. Dispositional attachment security, in contrast, buffers people from the effects of daily strain and adversity, although it obviously does not completely immunize them from stress symptoms.

The Process of Clinical Assessment

A good clinical assessment ends with a dynamic formulation that (a) suggests why a particular patient is experiencing particular problems at the present time, (b) describes how the problems are being maintained, (c) predicts treatment obstacles, and (d) identifies useful targets for change. Attachment theory and research can make practical contributions to each of these components.

A central goal of an attachment-informed assessment is to understand how patients uniquely experience and respond to threats to attachment security. Therefore, attachment-informed clinicians assess a patient's attachment-system functioning at the intrapsychic level (e.g., perceptions, affective experiences and capacities, representations of self and others,

defenses, and mentalizing skills), the interpersonal level (e.g., style of relating, quality of relationships), and contextual level (e.g., chronic stressors, availability and quality of support systems). Key components of assessment include taking an attachment history, attending to narrative style, and collecting data on attachment-related mental representations. The goal is not to definitively determine attachment style (e.g., secure, anxious, or avoidant)—the style may change over the course of therapy and may be different with different attachment figures—but to develop hypotheses about the idiosyncratic workings of a patient’s attachment system, his or her reliance on specific attachment-related strategies, and the developmental origins of these strategies (Slade, 2004).

Attachment History

An attachment history is an account of relationships and events, both past and present, that have shaped patients’ understanding of themselves and their interpersonal relationships. Taking a history requires eliciting narratives about childhood relationships with parents or other significant figures in childhood, past intimate adult relationships, and relationships with current attachment figures (e.g., romantic partners). Attachment-informed clinicians use a semi-structured approach that takes cues from the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996; for an overview of research based on the AAI see Hesse, 2008). Answers to questions from this interview draw the clinician’s attention to the availability, responsiveness, and stability of attachment figures, significant separations or losses, and attachment injuries (e.g., gross betrayals of trust such as abuse in childhood or infidelity in romantic relationships; Johnson, Makinen, & Millikin, 2001).

Narrative Style

Researchers have discovered that how a person delivers a narrative about his or her attachment history is often more important than the content of the narrative. That is, attachment strategies are so intertwined with defenses and cognitive processes that they influence the structure of one's oral language (Hesse, 2008). To give a coherent narrative, patients must generally maintain a collaborative stance (i.e., present their story without losing track of the interviewer's questions or the purpose of the history taking), give information that is relevant and comprehensive but reasonably succinct, be clear and well-organized, and support any general descriptions with evidence. Insecurely attached people tend to violate these rules of adult conversation in systematic ways. For example, avoidant adults, consistent with their goal of minimizing felt distress and defensively preserving self-esteem, tend to give terse accounts and are either unable to support idealized descriptions of parents or partners with specific episodic memories or unknowingly offer memories that contradict them (e.g., describing a relationship with one's mother as loving but then giving an example in which the mother placed the child's safety at risk). This is a narrative style that Holmes (2001) calls "clinging to rigid stories" (p. 88). Anxiously attached adults, given their chronic difficulties with emotion regulation, tend to produce rambling narratives punctuated with anger and nonsense words ("...and then da-de-da") or vague descriptions ("I was there and he was there and there it was"), a form of narrative that Holmes calls "being overwhelmed by unstoried experience" (p. 88).

Attachment-informed clinicians are interested in the degree of coherence in attachment narratives because it reveals (a) how well patients can mentalize and articulate feelings and (b) deficits in mentalizing that may be related to attachment insecurities. For example, the terseness of avoidant narratives suggests a disinterest in one's own or others' mental states, or at least a reluctance to reflect on them, particularly mental states suggestive of vulnerability such as

sadness, fear, or shame. One of Obegi's patients, when asked about how he felt when his partner did not respect his wishes, predictably replied, "I dunno...weird." He was also unable to imagine why he felt compelled to engage in anonymous sex after experiencing a frustrating interaction with his primary partner.

Attachment-Related Mental Representations

Attachment-related cognitive-affective representations are composed of thoughts, beliefs, emotions, and behavioral tendencies. Attachment-informed clinicians collect information on each of these components to create detailed portraits of their patients. They are particularly interested in how these representations manifest themselves in response to stressors such as hurt feelings, illnesses, anxieties, or losses. They are interested in questions such as: How do patients respond cognitively, affectively, and behaviorally to threats? Do they confidently turn to attachment figures or withdraw? In times of need, how do they perceive themselves and relationship partners' responses? How do they feel about intimacy and closeness? What are they likely to do during interpersonal conflicts?

Data on these attachment-related representations are also gathered from observations of patients' in-session behavior. Pursuing and participating in therapy is a microcosm of attachment system functioning. First, patients seek treatment because they are experiencing psychological distress. Second, they direct attachment behaviors (calling prospective therapists, engaging in weekly sessions) toward someone they hope will be a responsive and knowledgeable provider of support and guidance. Third, they monitor their moment-to-moment sense of security and, based on their therapists' verbal and nonverbal behavior, judge whether it is safe to continue exploring or necessary to avert shame and discomfort. During this process, patients reveal their feelings about dependence and intimacy, and show how they elicit and accept support and comfort. (Of

course, clinicians reveal as much about their own attachment and caregiving strategies as they *become* an attachment figure.)

A third source of insight into patients' attachment dynamics is paper-and-pencil measures. Abundant research indicates that peoples' reports of conscious beliefs, attitudes, and behaviors in intimate relationships are a valid means of assessing attachment security. Results from measures such as the Experiences in Close Relationships questionnaire (ECR; Brennan et al., 1998) can give clinicians a rough idea of how anxious or avoidant their patients are. (Of course, it must be remembered that such reports are susceptible to distortions caused by limited insight or defensive responding; see Gjerde, Onishi, & Carlson, 2004.) Analogous measures of attachment security in the therapeutic relationship also exist (e.g., Mallinckrodt, Gantt, & Coble, 1995), and Westen, Nakash, Thomas, and Bradley (2006) have devised a promising clinician-rated questionnaire that assesses both narrative and interpersonal indicators of attachment security.

Salient Attachment Issues

Data collected on attachment history, narrative style, and attachment-related representations will usually yield one attachment-related issue that is the most salient and relevant to treatment (Hardy et al., 2004). Exposure to this issue would predictably evoke the maladaptive attachment strategies that have made a patient vulnerable to current problems and that play a contributing role in perpetuating these problems. Stated differently, the goal of case formulation is to delineate the circumstances and factors that block the broaden-and-build cycle that would normally flow from attachment security. Once these blocks are identified, a dynamic formulation can be created, usually comprising four components: (1) the precipitating attachment-related events; (2) the typical cognitive-affective meanings ascribed to these events;

and (3) the strategies patients use to cope with these events and their subjective meanings, strategies that leave patients susceptible to (4) the socio-emotional problems that prompted treatment.

The Practice of Therapy

Because attachment insecurities are maintained by poor self-esteem, problematic belief systems, and deficits in emotional regulation and interpersonal skills, targeting any of these areas is likely to stimulate change (Cobb & Davila, 2009). There is little in attachment theory that elevates the importance of one of these areas above the others or that privileges one set of therapeutic techniques over another. Rather, attachment-related psychotherapies aim to construct or fortify a broaden-and-build cycle of attachment security by (a) creating a climate of security that at least partially relieves stress and promotes positive affect so that emotional resources can be directed to effective problem solving, and (b) encouraging exploration, learning, and independent coping. There is a diverse array of clinical attitudes and techniques, culled from various therapeutic approaches, which can be marshaled to initiate or restore and then perpetuate the broaden-and-build cycle. Thus, the following discussion is less about specific techniques than about how an attachment-informed approach organizes and focuses what we already know about the practice of psychotherapy.

Creating a Climate of Security

Above all, attachment-informed clinicians endeavor to create a *climate of security*, without which the broaden-and-build cycle cannot begin. Such a climate requires certain therapeutic attitudes and practices, many of which overlap with those described by Rogers (1961). In our terms these are defining features of security-enhancing attachment figures. Thus, adopting an attachment-informed approach means endeavoring to be consistently trustworthy

and dependable in-session, having therapy practices that transparently communicate what can and cannot be done within a practice (e.g., hours of availability, limits of confidentiality, and other aspects of informed consent), and giving advance notice of upcoming changes in availability. It also means creating a permissive and sufficiently accepting setting where patients can disclose as freely as they are able. They should be able to feel confident that they will not be shamed or invalidated as they disclose their problems and concerns. Creating a security-enhancing climate requires assuaging patients' distress, at least to some degree. This may come in the form of acceptance, nonjudgmental listening, instilling hope, reframing, or an active focus early in treatment on symptom reduction. These and other practices communicate to patients that a wise, kind, reliable, and committed person is at their side. Over time this should engender patients' inner confidence that help is nearby, that emotional equanimity can be restored, and that crises can be weathered between sessions with their security-enhancing attachment figure.

Customizing Treatment Based on Attachment Security

A further step in creating a security-enhancing climate involves customizing aspects of treatment based on a patient's unique pattern of attachment-system functioning. For example, early in treatment anxious and avoidant patients differ in what feels safe and secure and what constitutes a comfortable therapeutic distance (Mallinckrodt, Daly, & Wang, 2009). As a result, the levels of validation and reassurance desired by anxious patients will be perceived as noxious to avoidant patients and perhaps lead them to drop out before treatment makes much progress. In a qualitative study, Mallinckrodt et al. (2009) found that attachment-informed clinicians endeavored to provide treatment that was initially, though not totally, congruent with patients' preferred level of intimacy. Then, when sufficient rapport (i.e., attachment security) was established, they consciously and gradually shifted toward a more optimal therapeutic distance.

Differences in patients' attachment orientations may also be relevant in determining the effectiveness of specific types of intervention. McBride, Atkinson, Quilty, and Bagby (2006), for example, found that avoidant adults diagnosed with depression fared better in a cognitive-behavioral treatment (CBT) than in an interpersonal treatment, perhaps because CBT interventions are consistent with avoidant people's goals of maintaining emotional control and self-sufficiency.

Attachment-informed clinicians also choose interventions according to the specific deficits inherent in the attachment strategies used by insecure patients. Numerous interventions can address one or more of these deficits. To name just a few: cognitive techniques can challenge distorted ways of thinking that perpetuate attachment insecurities; emotion-focused techniques can promote better emotion regulation and communication of relationship needs; behavioral experiments can undermine long-held beliefs; narrative techniques can loose the grip of rigid personal accounts that artificially narrow response alternatives; and psychoeducation can redress skill deficits. (For a discussion of how different therapeutic approaches can be supplemented by attachment concepts, see Obegi & Berant, 2009.)

Lastly, we wish to mention one promising technique that may be worth adding to an attachment-informed toolbox: visualization of a security-enhancing figure. This guided imagery technique, first discussed clinically by Johnson (2009), is intended to jump-start the broaden-and-build cycle by invoking a mental representation of an actual or symbolic figure that patients regard as responsive and encouraging. A substantial amount of research suggests that cognitively exposing people to security-enhancing images, via conscious effort or subliminally, increases curiosity, flexible learning, positive expectations of partners, and altruistic tendencies (for a review see Mikulincer & Shaver, 2007b).

The Therapeutic Relationship

Psychotherapy provides an important opportunity for patients to build a secure attachment to a therapist: Due to their level of distress, patients seek out stronger, wiser figures, meet regularly with them, and find the contact to be soothing and revitalizing. With repetition, this sequence solidifies therapists' place in patients' emotional lives. In fact, what is typically understood as the therapeutic bond in the clinical literature on the "therapeutic alliance" is arguably better understood as the unfolding of an increasingly secure attachment to a therapist (for an in-depth discussion see Obegi, 2009). Moreover, the positive therapeutic lessons that occur in this deepening and increasingly influential relationship become the brick and mortar of the patient's increasing psychological resilience.

Over time, patients can build positive mental representations of self and others based on their interactions with the therapist. Insofar as therapeutic sessions have been comforting and supportive, patients construct a mental representation of their therapists' sensitive and dependable responsiveness, thereby laying a foundation for *security-based self-representations* (Mikulincer & Shaver, 2007a). With repeated experiences of acceptance, nurturance, and safety, patients gradually begin to see themselves as worthwhile, capable people, and they incorporate or internalize the skillful ways in which their therapists have cared for and soothed them. As a result, patients can draw on self-models to independently withstand strain and alleviate their own distress. Consistent with this view, researchers have found that patients can report a deeply felt, multi-sensorial representation of their therapists (Knox, Goldberg, Woodhouse, & Hill, 1999), and this representation reflects their perceptions of therapists' care (Quintana & Meara, 1990). Patients deliberately call upon these representations when they need to self-soothe (Knox et al., 1999); do so more often as treatment continues (Geller & Farber, 1993); and, over time, view

themselves in a more benevolent and accepting light (Arnold, Farber, & Geller, 2000). Because mental representations of self and therapist are constructed during interpersonal exchanges that occur in the context of psychological suffering, they become strongly associated with one another and more available under stressful conditions.

These positive representations of therapist and self promote therapeutic change. Findings from clinical psychotherapy research and social-cognitive laboratory research support this view. Among the most reliable findings in psychotherapy research is that a strong therapeutic alliance, indicative of secure attachment, is strongly and positively associated with psychotherapy outcome (Martin, Garske, & Davis, 2000)—more so, in fact, than allegiance to a particular theory or technique (Wampold, 2001). In social-cognitive research, attachment security is consistently associated with fewer psychological problems or symptoms (Mikulincer & Shaver, 2007a) and, in the laboratory, priming secure attachment representations promotes a positive mood (e.g., Mikulincer et al., 2001), boosts self-esteem (Kumashiro & Sedikides, 2005), and mitigates, for example, symptoms of post-traumatic stress (Mikulincer, Shaver, & Horesh, 2006).

The extent to which patients see themselves as worthy and effective is, of course, dependent on therapists' own sense of security. Theoretically, insecure therapists are less well equipped to tolerate their own distress, let alone that of their patients. This leaves them vulnerable to activation of their own attachment-related concerns and maladaptive ways of coping. As result, they may be less able to remain open to their patients' needs, less able to provide attuned, well-timed interventions, and more susceptible to the negative countertransferences that insecure patients frequently evoke. Research findings to date are consistent with this view. Insecure therapists tend to be less empathic (Rubino, Barker, Roth, & Fearon, 2000), to develop weaker therapeutic alliances (e.g., Black, Hardy, Turpin, & Parry,

2005), and to be critical and rejecting when paired with especially insecure patients (Mohr, Gelso, & Hill, 2005).

Therapeutic Change and Therapeutic Factors

Attachment theory offers a specific view of what changes in psychotherapy, a view that is compatible with the common factors view of psychotherapy (e.g., Weinberger, 1995).

Attachment theory also acknowledges that change can be facilitated in a variety of ways (i.e., multiple routes of therapeutic action; Gabbard & Westen, 2003).

Therapeutic Change

As implied throughout this article, fortifying the broaden-and-build cycle of attachment security is a central means to achieve therapeutic change. The crux of the cycle is representations of caregiver availability and sensitivity that are stored in the form of declarative and procedural knowledge. Collectively, the representations have a script-like organization (Mikulincer et al., in press; Waters & Waters, 2006) consisting of a series of if-then contingencies. The “secure base script” goes something like this: “If I become distressed, others will gladly support me; I am capable of eliciting support and expect it to be effective; I expect to feel reassured and regulated, so much so that I can resume my activities.” The neural networks that encode this script are deeply intertwined with other networks, such that triggering the secure-base script sets off a cascade of related coping scripts.

Psychological problems are more likely to appear when the secure-base script is not as accessible, detailed, and practiced as more insecure scripts. An important goal of psychotherapy is to reinforce components of the secure-base script (or in some cases, first build and then reinforce it) sufficiently so that the secure-base script is activated by default when distress

occurs. A key factor in this process is engaging in a relationship with a security-enhancing attachment figure.

Four additional kinds of declarative and procedural knowledge help to perpetuate the broaden-and-build cycle's positive effects on well-being and psychological functioning: optimistic life appraisals, positive cognitive models of others, authentic self-esteem, and constructive coping strategies (Mikulincer & Shaver, 2008). When warm, soothing caregivers are reliably available, people develop optimistic beliefs about coping with distress. Distress is generally understood to be temporary, tolerable, and manageable. And although distress cannot always be avoided, there is sense that obstacles can be overcome and a faith that at least some control can be exerted over the outcomes. Optimistic appraisals insulate people from excessive catastrophic thinking, despair, and helplessness. Interactions with available and sensitively responsive attachment figures lead to a view of others as well-intentioned and supportive. The experience of caring and love contributes to a complementary sense of oneself as worthwhile and competent, and this, in turn, buffers a person's self-esteem from the inevitable rejections and failures that punctuate normal living. Security-enhancing experiences also build an authentic self that need not rely on defensive maneuvers to preserve self-confidence. Finally, receiving soothing care not only alleviates distress but imparts lessons about how to regulate intense emotions, solve problems effectively, mobilize support, and reframe stressful situations to make them less overwhelming.

Therapeutic Factors

In psychotherapy, fortifying the broaden-and-build cycle of attachment security requires two broad, therapeutic factors that we have already discussed: a secure climate in which an attachment to a clinician can develop and active techniques aimed at enhancing personal

adjustment. A secure climate increases trust and collaboration, dampens defenses, inspires hope, and provides the support necessary to entertain the sometimes frightening prospect of abandoning familiar defenses in order to permit constructive change. This kind of movement toward change often depends on a deepening relationship with a particular person who is reliably available and responsive. An intimate therapeutic relationship provides a fresh opportunity to examine internal working models that inhibit psychological growth and well-being, to revise beliefs and understandings, and to practice and internalize new ways of relating to oneself and others. These change processes are facilitated not only by the way clinicians treat their patients but by the active and tailored methods they use to teach patients new skills and broaden their perspectives.

Conclusion

Although Bowlby designed his theory in a clinical context and for the benefit of clinicians, developmental, personality, and social psychologists did much of the work of subjecting his ideas to empirical tests. Nevertheless, over the past two decades attachment theory has found its ways into various approaches to psychotherapy—at first by playing a supporting role and then increasingly by providing a central framework for new psychotherapies. These therapies leverage attachment theory's ability to connect early experiences to emotion-regulation strategies, to conceptually integrate diverse methods of promoting change, to value actual interpersonal relationships as well as the intrapsychic domain, and to make sense of supportive, therapeutic relationships. Considerable work is still needed to explore and validate attachment theory's implications for psychotherapy. However, Bowlby's eclectic approach to theory construction, his theory's insights into intimate relationships, and attachment researchers' diligence in testing his ideas promise an exciting future for attachment-related psychotherapies.

Recommended Readings

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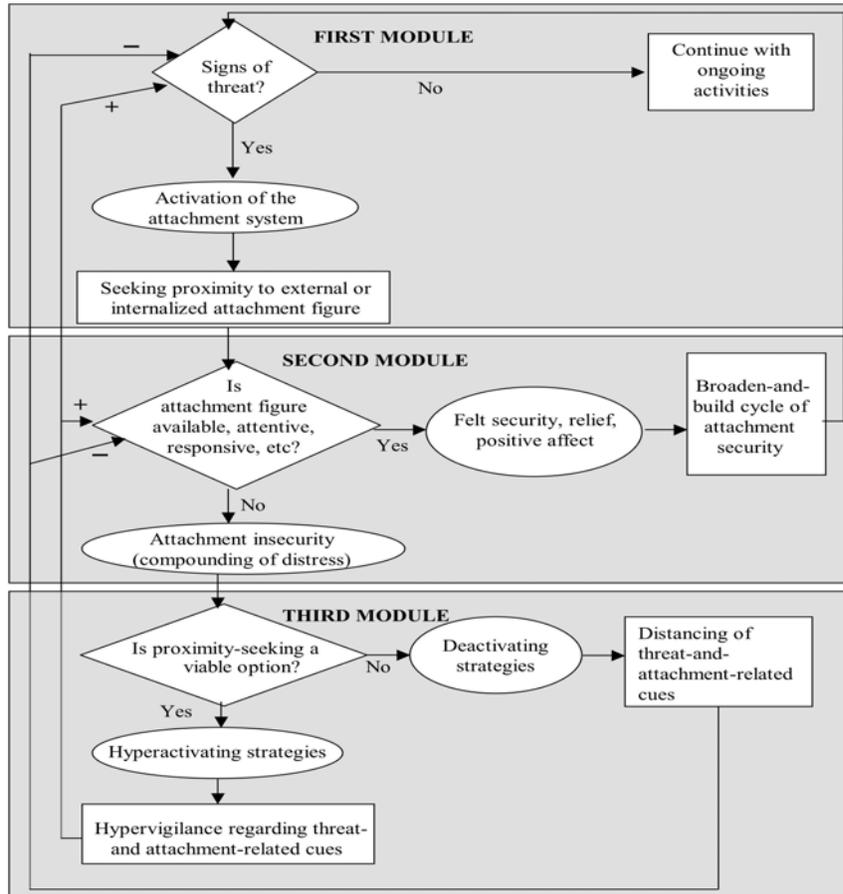


Figure 1. Mikulincer and Shaver's (2007a) integrative model of the activation and dynamics of the attachment system in adulthood