Psychology and Psychotherapy: Theory, Research and Practice (2016), 89, 15–32

The British Psychological Society

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Attachment-informed therapy for adults: Towards a unifying perspective on practice

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Purpose. We aimed to provide an integrated overview of the key goals and strategies of an attachment-informed psychotherapy by summarizing the literature describing the clinical implications of attachment theory for psychological therapy for adults.

Method. We carried out a narrative thematic review of 58 texts from a diverse range of therapeutic schools, until we agreed that we had reached a saturation of themes.

Results. We identified six key themes: Changing internal working models; the therapeutic relationship and creating a secure base; formulating and processing relationship experiences; countertransference; separation, termination and boundary issues; and working with different attachment styles or patterns. We discuss empirical evidence in relation to each theme and highlight areas for research.

Conclusions. Attachment theory provides a useful framework to inform psychological therapy with adults, but there is a pressing need for further research to empirically demonstrate the 'added value' of an attachment perspective.

Practitioner points

- Attachment theory should be used to inform individual psychological therapy in adulthood.
- From the outset of their careers, therapists should receive training and supervision to enhance their awareness of their own and their clients' attachment experiences and how these play out during therapy.
- There is a need for greater empirical research to investigate whether the degree to which therapists formulate and meet clients' attachment needs influences outcomes.

Overview of attachment theory

Attachment theory aims to explain 'the propensity of human beings to make strong affectional bonds to particular others . . . and the many forms of emotional distress and personality disturbance . . . to which unwilling separation and loss give rise' (Bowlby, 1977a, p. 201). Attachment bonds are first formed with primary caregivers during childhood, but are of importance throughout the life cycle (Bowlby, 1977a). Bowlby (1977a) proposed that as a result of their interactions with caregivers during infancy, individuals develop mental representations of the self in relation to significant others that guide attention, interpretation and predictions about future interpersonal interactions.

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DOI:10.1111/papt.12063

Empirical support for Bowlby's theory comes from laboratory-based observations of the infant's response to two brief separations from his or her caregiver (Ainsworth, Blehar, Waters, & Wall, 1978). Different patterns of response, which are attributed to different underlying working models and methods of regulating distress, are traditionally classified as *secure* or *insecure*, with the insecure category subdivided into *resistant/ambivalent* or *avoidant* categories (Ainsworth *et al.*, 1978). The caregiver's sensitivity to distress appears to be a significant factor in determining the pattern of attachment or 'attachment style' that the infant develops (Weinfield, Sroufe, Egeland, & Carlson, 1999).

Although Bowlby (1977a) proposed that working models persist throughout the lifespan, due to their influence on new relationships, there is evidence that changes in attachment patterns can change in either a positive or a negative direction, due to life stressors and changes in key relationships (Waters, Merrick, Treboux, Crowell, & Albersheim, 2000). There are two major paradigms in adult attachment research. Main and Goldwyn (1984) developed the Adult Attachment Interview (AAI), which measures 'attachment states of mind' on the basis of the coherence of the individual's narrative in describing parental child relationships. Individuals are classified as secure autonomous, dismissing (avoidant attachment) or preoccupied (similar to ambivalent attachment). There is also an unresolved category, which is associated with reports of loss events or abuse, in addition to confusion and disorganization in discussing the topic (Hesse, 1999).

The second social psychology paradigm developed from Hazan and Shaver's (1987) conceptualization of romantic love as an attachment process. These authors translated Ainsworth *et al.*'s (1978) three categories into prototypical adult attachment styles. Multi-item continuous self-report attachment measures have been developed, and factor analysis suggests two dimensions of attachment anxiety and attachment avoidance underlie these measures (Brennan, Clark, & Shaver, 1998).

Insecure attachment styles are 'survival strategies' to adapt to suboptimal caregiving environment. However, they can have an adverse effect on adjustment in later relationships and can increase vulnerability to psychopathology (Goodwin, 2003). Bowlby (1977b) conceptualized the therapeutic relationship as an attachment relationship and argued that effective therapy can repair early attachment failures by engendering 'earned security'. Since Bowlby's seminal paper in 1977 that summarized the clinical implications of attachment theory, authors from a range of different therapeutic schools have developed these ideas further. However, to date, there have been no systematic reviews of how attachment theory can inform the practice of psychotherapy.

Aims of review

The aims of this review are to guide clinical practice by describing key goals and strategies of an attachment-informed psychotherapy. This will be achieved by carrying out a narrative thematic review of the literature describing the clinical implications of attachment theory. We will discuss the evidence base for these ideas by presenting any supporting evidence or highlighting gaps in the literature. It is anticipated that this review will guide clinical work with clients with insecure attachments and help to promote evidence-based research to evaluate attachment-informed therapy. Our review complements the recent edited book 'Attachment theory in adult mental health: A guide to clinical practice' (Danquah & Berry, 2013). The edited book draws together a number of different theoretical perspectives concerning the clinical implications of attachment theory. Here, we provide a more systematic summary of the literature covered in the book and attempt to integrate and critically appraise current thinking.

Method

We identified texts describing the clinical implications of attachment theory using MEDLINE, PsycInfo, Web of Knowledge, EMBASE and The Pep Archive databases, entering the key terms 'attachment' OR 'Bowlby' AND 'psychotherapy' OR 'therapy' OR 'treatment' OR 'clinical' OR 'intervention'. The terms were entered for searching in the titles and/or abstracts of articles. We included journal articles, books or chapters in edited books, published from 1977 onwards, which described the use of attachment theory in individual psychotherapy with adults. All texts were written in English. To generate practice implications from the literature, we only included those articles that specifically described the practice of psychotherapy. We therefore excluded papers purely focused on: how attachment theory might explain the development of mental health problems; described using attachment theory to assess clients in or for therapy; and made conceptual links between attachment theory and other theories of psychopathology or therapy. We excluded papers describing family therapy, couples therapy, group therapy and parenting interventions, given the different focus and format of these interventions. We also excluded papers that exclusively focused on the application of attachment theory to the organization of mental health services. Although papers within these excluded domains might no doubt represent the clinical implications of attachment theory, our focus was restricted to the clinical implications of attachment theory for adult psychotherapy, as we felt that the clinical implications in this domain had been relatively less well articulated and summarized. Papers that were cited in the reference lists of papers from the initial search were followed up and were incorporated if they met inclusion criteria, and we contacted well-established authors in the field to identify book chapters or 'gray literature' that was less likely to be identified by electronic searches of databases (Thomas & Harden, 2008).

The first author used data extraction forms to summarize the main themes from each paper and both authors independently coded the data. As we coded each paper, we added to our 'bank' of codes and developed new ones when necessary (Thomas & Harden, 2008). Through regular discussion, we grouped codes into themes and subthemes assisted by 'diagramming'. Where differences arose, these were discussed and agreement was reached on how to incorporate these into the analysis.

Consistent with qualitative review methodology, our aim was not only to locate all relevant papers, but to sample a range of concepts (Thomas & Harden, 2008). We therefore carried out the analysis alongside the data collection process and continued searching databases and references lists, until we agreed we had reached a saturation of themes, with no significant new information arising from the literature (Thomas & Harden, 2008). As stated above, a secondary goal of the review was to discuss the evidence base for the clinical implications derived from our thematic analysis and highlight any gaps in the literature that warrant further research. This critical appraisal was closely informed by the content of papers reviewed, but also drew on the wider literature on attachment theory and therapeutic relationships.

Overview of papers

We reviewed a total of 58 papers from a variety of different sources which are highlighted in the reference list. The majority of reviewed papers were published in journals (n = 37), although there were also book chapters from edited books about attachment theory or

psychotherapy (n = 13) and books about attachment-informed therapies (n = 8). Approximately half the papers did not make explicit references to particular schools of therapy, although a significant proportion of the authors were psychoanalytic psychotherapists. There were also 26 texts specifically describing the relevance of attachment theory for psychodynamic or psychoanalytic therapy, including mentalization-based treatments. There were only two papers on cognitive analytic therapy, one paper on interpersonally orientated therapy, one paper on emotion-focused therapy and one paper on cognitive behaviour therapy (CBT). Some of the papers or book chapters focused on specific types of clinical problems, including borderline personality disorder (n = 4), narcissism (n = 1), personality disorder generally (n = 1), trauma (n = 4), incest survivors (n = 1), medically unexplained symptoms (n = 1), depression (n = 1), agoraphobia (n = 1), grief and loss (n = 1), emotional detachment (n = 1), emotional abuse (n = 1) and dismissing attachment (n = 1).

We agreed on six key themes: Changing internal working models; the therapeutic relationship and creating a secure base; formulating and processing relationship experiences; countertransference; separation, termination and boundary issues; and working with different attachment styles or patterns. The main body of the review will describe the themes in more detail. This will be followed by a final section discussing and integrating key themes.

Key themes

Changing internal working models

According to the majority of the texts, including Bowlby's (1977b) original paper, the major goal of therapy should be to help the client move from insecure to more secure attachment working models by providing a 'corrective emotional experience'. The goals of therapy were not explicitly stated in all of the texts, because the authors focused on specific clinical problems where the primary goal was a reduction in symptoms (e.g., Maunder & Hunter, 2004) or they focused on one particular type of therapy (e.g., Jellema, 1999).

In support of the theory that therapy can lead to changes in attachment status, a growing body of research has provided evidence that attachment security increases during therapy, whereas attachment insecurity appears to decrease (Taylor, Rietzschel, Danquah, & Berry, 2015a). A smaller number of studies have also investigated the premise that changes in attachment representations predict other treatment outcomes and they suggest a significant relationship between change in attachment representations and symptom change (Mueller & Rosenkranz, 2009; Tasca, Balfour, Ritchie, & Bissada, 2007). Further research is, however, needed to identify key factors which lead to change in attachment status.

The therapeutic relationship and creating a secure base

All of the articles reviewed highlight the important role of the therapeutic relationship in promoting change in therapy and that this relationship provides a 'secure base' for the client. Following Bowlby (1977b), there was an acknowledgement in the literature that the secure base provided a corrective emotional experience for insecurely attached clients or provided a platform from which to accomplish the potentially anxiety-provoking exploratory work of therapy.

The role that the therapist plays in providing a secure base raises the question of whether or not the therapeutic relationship can truly be considered an attachment relationship. Mallinckrodt (2010) addresses this issue by outlining the key characteristics of attachment relationships and presenting empirical evidence to evaluate whether or not these criteria are met. He concludes that some clients (1) regard their therapist as stronger and wiser; (2) seek proximity through emotional connection and regular meetings; (3) rely upon their therapist as a safe haven when feeling threatened; (4) gain a sense of felt security from their therapist, who serves as a secure base for psychological exploration; and (5) experience separation anxiety when anticipating loss of their therapist. The author cautions that not all psychotherapy relationships will meet the criteria for attachment relationships, although to help the client develop more secure attachment working models, it is essential that these characteristics are present (Mallinckrodt, 2010).

All papers highlight therapist qualities that are necessary for the establishment of a secure attachment relationship. These include both verbal and nonverbal communication, which suggest that the therapist is attuned, sensitive and responsive to the client's needs. Several papers highlight the importance of the therapist being genuine in their relationships with clients and expressing the full range of their feelings, including offence, anger or confusion (Biringen, 1994; Holmes, 2001; Sherry, 2007; Wallin, 2007). Many papers also stress the importance of establishing a secure base prior to engaging in other therapeutic tasks (Bettmann, 2006; Eagle, 2003; Florsheim & McArthur, 2009; Mackie, 1981; Pearlman & Courtois, 2005; Sable, 1992, 2000; Shane & Shane, 2001; Van der Hart, Nijenhuis, & Steele, 2006). Holmes (2001) provides a good description of this process in outlining his 10-session, 'brief attachment-based intervention'. The overall strategy of therapy and within each session is to establish a secure base prior to challenging and confronting the clients.

The therapist qualities described above are similar to those highlighted as characteristics of attachment figures in infancy, which are associated with the development of secure attachment (Feeney & Van Vleet, 2010) and the core conditions that are essential for the development of a positive alliance in person-centred counselling (Rogers, 1965). However, in an attachment-informed therapy, the therapist also needs to use this secure relationship as a platform to carry out attachment-related therapeutic tasks (Bateman & Fonagy, 2004; Farber & Metzger, 2009; Wallin, 2007).

In terms of the empirical evidence, it is well established that the positive working alliance is a key factor in determining outcome in therapy (e.g., Horvath & Bedi, 2002) and some more recent evidence that secure attachment to therapists is related to both working alliance and a greater reduction in client distress over time (Taylor, Rietzschel, Danquah, & Berry, 2015b). Given well-established findings that caregivers' attachment style can influence their caregiving ability (George & Solomon, 1999) and some evidence of associations between therapists' own attachment styles and working alliance (e.g., Degnan, Seymour-Hyde, Harris, & Berry, 2015), it would also seem important to investigate the influence of therapists' own attachment styles on their ability to function as an attachment figure for clients and provide a secure therapeutic base.

Formulating and processing relationship experiences

One of the key tasks of an attachment-informed intervention is to explore perceived separation and loss experiences with attachment figures. In describing attachment-based therapies, both Holmes (2001) and Wallin (2007) suggest that this material can be elicited

using standardized attachment measures, such as the AAI (Main & Goldwyn, 1984) and transference and countertransference reactions.

Several authors argue that it is important to help the client understand how their past experiences influence their current behaviour, symptoms and relationships, including the therapeutic relationship (Biringen, 1994; Brisch, 1999; Cobb & Davila, 2009; Heard & Lake, 1997; Heard, Lake, & McCluskey, 2009; Holmes, 1994a,b; Jellema, 2002; Osofsky, 1988; Sable, 1992, 1997, 2000, 2007; Sperling & Lyons, 1994; West, Sheldon, & Reiffer, 1989). In terms of the therapeutic relationship, both Holmes (2001) and Wallin (2007) argue clients should also evaluate how their perceptions of the therapist fit with the reality, which is facilitated by the therapist disclosing how he or she feels towards the client.

In carrying out exploratory work, several authors highlight that therapists should not present formulations to clients, but should create conditions which help the client find an interpretation or decide a course of action for him or herself (Bowlby, 1977b, 1988; Heard & Lake, 1997; Holmes, 1994a; Sable, 1992, 2000, 2007). Several authors also suggest that clients with avoidant/dismissing attachment patterns in particular might be resistant to recalling negative memories and feelings and, therefore, the importance of working at the client's own pace (Alexander & Anderson, 1994; Bowlby, 1977b, 1988; Heard & Lake, 1997; Mallinckrodt, 2000; Sable, 2000). In describing an attachment-informed 'emotion-focused therapy', Johnson (2009) further highlights the benefits of asking clients to imagine a supportive attachment figure in their lives when embarking on difficult emotive work. Papers also highlight the importance of helping the client understand that his or her insecure attachment patterns or other maladaptive behaviours were functional in the context of earlier relationships although they may lead to disruptions in later relationships (Brisch, 1999; Gormley, 2004; Johnson, 2009; Mallinckrodt, 2000; Marrone, 1998; McBride & Atkinson, 2009; Sable, 2004, 2007).

In reviewing past experience, several papers highlight the importance of enabling the client to grieve for loss or express anger about attachment-related experiences (Bowlby, 1988; Holmes, 1993, 1994a; Sable, 1997; Silverman, 1998; Wallin, 2007; West & Keller, 1994; West *et al.*, 1989). However, there is recognition in the attachment literature that it is important to go beyond catharsis and also help the person develop insight into the influence of past relationships on present relationships and how they might think, feel and act differently (Cobb & Davila, 2009; Connors, 1997; Gormley, 2004; Holmes, 2001; McBride & Atkinson, 2009; Wallin, 2007).

Insecure attachments are associated with incoherent or distorted narratives of attachment-related experiences, poor reflective function and mentalizing skills (i.e., developmental capacity to interpret own and others' behaviour in terms of mental states) and difficulties in affect regulation (Bateman & Fonagy, 2004; Hesse, 1999). Holmes (1994a,b, 2010) and several other authors therefore argue that therapists should probe clients' dialogues of attachment-related experiences to help them to develop more emotionally charged and/or coherent narratives. Making interpretations that are attuned to the client's affective state are also hypothesized to strengthen the client's self-reflection and meta-cognitive functioning, leading to more coherent narratives of attachment-related experiences (Bateman & Fonagy, 2004; Bennett, 2006; Cobb & Davila, 2009; Heard & Lake, 1997; Heard *et al.*, 2009; Holmes, 1993; Wallin, 2007).

In terms of empirical evidence, there is evidence of improvement in both narrative coherence and reflective function in people with borderline personality disorder as a function of transference-focused therapy and mentalization-based therapies (MBT), which are attachment-informed treatments for people with borderline personality

disorder, incorporating many of the key processes and strategies described above (Fonagy & Bateman, 2006; Levy *et al.*, 2006). The former study did, however, find limited evidence of change in patients' unresolved/resolved status with respect to trauma and loss as a result of therapy, despite the high levels of loss and trauma in the group. The importance of reflective function to the formulation and processing of loss experiences has also not been explored for other psychiatric groups.

Countertransference

Bowlby (1977b, 1988) highlights that the client's need for a secure base may lead to high demands as the client may unknowingly exert influence on the therapist to play out the role of earlier attachment figures. This theme is discussed further in later papers, which highlight the importance of the therapist being aware of their own attachment issues, so that they are able to function as effective attachment figures for clients (Brisch, 1999; Eagle & Wolitzky, 2009; Marrone, 1998; Wallin, 2007). Marrone (1998) discusses the potential for therapists who are dismissive of their own and clients' attachment issues to be insensitive towards clients' needs and invalidate their experiences. Heard and Lake (1997) also highlight how clients' inadequate experiences of care can remind therapists of their own and if therapists are not aware of this, they can respond unempathically and be misattuned to clients. Pearlman and Courtois (2005) and Wallin (2007) discuss the potential for trauma victims with insecure attachment patterns to be re-traumatized or 'rescued' by therapists and describe the re-enactment of victim–perpetrator–rescuer–bystander dynamics in therapeutic relationships. They highlight the importance of the therapist paying particular attention to these transference and countertransference reactions.

There is some empirical evidence to suggest that securely attached psychiatric staff are less likely to be pulled into ways of behaving that maintain clients' attachment difficulties (Dozier, Cue, & Barnett, 1994). However, there is limited discussion in the literature or evidence for the ways in which therapists may learn to manage countertransference and be more effective attachment figures.

Separation, termination and boundaries

Several papers including those by Bowlby himself highlight that the sequence of therapy with breaks and endings can be important in terms of assessing clients' experiences of attachment-related losses and developing a more positive experience of these (Biringen, 1994; Bowlby, 1977b, 1988; Mallinckrodt, 2000; Sable, 1992, 2000). Several authors also highlight that it is important for the therapist to normalize feelings of anxiety about loss and endings and encourage clients to express these feelings (Brisch, 1999; Mallinckrodt, 2010; Sable, 1992, 2000).

Papers highlight that the termination of therapy can provoke anxieties for insecure clients in particular and therefore needs to be addressed and anticipated at the outset. For example, this may involve anticipating symptom relapse as termination approaches and how to deal with it, considering attachments outside the therapeutic relationship, reviewing what skills the client has learnt in therapy and ensuring that termination is gradual and clarity about the contact the client can have with the therapist after therapy (Harris, 2004; Mallinckrodt, Daly, & Wang, 2009; Maunder & Hunter, 2004; Sable, 2000). Holmes (2001) also argues that within sessions, misunderstanding or ruptures can serve similar functions to breaks and endings in therapy. He suggests that the therapist's role is

to repair ruptures and re-establish a secure base, unlike those experiences an individual may have had in childhood.

Several authors emphasize how clear boundaries in therapy are important for the development of a secure base (Heard & Lake, 1997; Holmes, 2001; Maunder & Hunter, 2004; Pearlman & Courtois, 2005; Wallin, 2007). Other papers emphasize that in an attachment-informed therapy, a therapist should take additional measures to ensure that they are available to their clients. This includes enabling the client to decide when to end therapy, seeing the client more frequently or outside of scheduled sessions if needed and even staying in contact with clients following therapy (Heard & Lake, 1997; Sable, 2000; Shane & Shane, 2001; Sherry, 2007).

Evidence from the attachment literature suggests that secure relationships with attachment figures in infancy are more likely to promote independent behaviour and exploration in childhood (Thompson, 1999). This suggests that initially meeting the client's needs for dependency helps to facilitate him or her moving on. Given the controversy in the therapy literature surrounding boundary issues, it would be helpful to carry out research to assess clients' perceptions and needs in therapy. As will be discussed below, people with different patterns of attachment may have different needs in terms of closeness to therapists, and on a practical level, it is important to allow clients to regulate this, including the frequency of sessions (Bowlby, 1988; Brisch, 1999; Wallin, 2007).

Working with different attachment styles or patterns

The majority of the articles discuss different types of attachment style or patterns and how these should inform therapy. In particular, authors make a distinction between attachment avoidance and attachment anxiety and discuss the importance of adapting the tasks and styles of therapy with these clients.

Anxious or ambivalent attachment is associated with experiences of inconsistent caregiving, a preoccupation with attachment-related events and low self-efficacy. Papers therefore highlight the importance of consistency and reliability with this group and helping the clients express strengths and needs which may have been denied through fear of abandonment. Authors also suggest the need to be clear about boundaries, power and responsibility in the therapeutic relationship and avoid the pull to be overprotective towards the client or frustrated with his or her dependency (Alexander & Anderson, 1994; Bernier & Dozier, 2002; Daly & Mallinckrodt, 2009; Farber & Metzger, 2009; Harris, 2004; Holmes, 1997, 2009, 2010; Pearlman & Courtois, 2005; Slade, 2000; Wallin, 2007). Both Holmes (2001) and Wallin (2007) suggest that the anxiously attached client may mask anxiety by too-ready acceptance of therapy, so therapists need to help them find their own investment in it, for example, by asking them to think carefully before entering therapy.

Purnell (2010) cautions against the use of exploratory therapies with anxiously attached clients as emotional exploration may intensify affect. He argues that these clients may benefit from therapies that help to develop skills in cognitive reflection. Similarly, in terms of narrative work, Holmes (2001) emphasizes that therapists need to introduce frequent 'shaping' remarks or punctuations, for example, 'we'll come back to what happened to you as a child in a minute; first lets here about what is troubling you right now'. There is a need to hold the client at a slight distance and develop a theory about their emotions (Holmes, 2001).

Avoidant attachment is associated with an apparent lack of care in attachment relationships, limited expression of affect and devaluing relationships. The papers therefore suggest that therapists must therefore not reinforce the client's self-sufficiency

and lack of emotional expression, by avoiding falling into the traps of rejecting and not protecting the client, talking about superficial or nonthreatening topics, or intellectualizing, or even prematurely discharging the client (Alexander & Anderson, 1994; Bennett, 2006; Bernier & Dozier, 2002; Daly & Mallinckrodt, 2009; Farber & Metzger, 2009; Pearlman & Courtois, 2005; Wallin, 2007). Authors also suggest the client may discredit, compete with or adopt a superior stance to the therapist, so the therapist must avoid falling into the trap of feeling incompetent, talking about the importance of therapy and giving premature interpretations (Alexander & Anderson, 1994; Harris, 2004; Holmes, 1997, 2010; Shilkret, 2005; Slade, 2000).

Holmes (2001) argues that in the case of avoidant clients, it is particularly important that therapy is at the client's own pace, even if this makes progress more gradual, for example, offering reflective comments on plans and feelings of key others in the environment, as a first step to mind-mindedness about his or her own motivations and emotions. Wallin (2007) also recommend that therapists are more proactive in disclosing their own thoughts and feelings to avoidant clients as a way of encouraging clients to show their own vulnerabilities later on in therapy and modelling skills in mentalizing.

Biringen (1994) suggests that telephone sessions may be a helpful way of engaging more avoidantly attached clients at the outset, and Connors (1997) recommends focusing on concrete problems such as aids for stress-related symptoms early in therapy to build up trust. McBride and Atkinson (2009) argue that avoidant clients may find CBT less threatening than interpersonal therapies. However, Purnell (2010) cautions about using cognitive-based approaches with clients with avoidant attachment, due to the risk of reinforcing their need for self-control rather than helping them feel difficult feelings. Consistent with this perspective, several authors argue that affectively attuned interventions, which help the client understand and feel emotions rather than control them, may be more useful for the avoidantly attached client (Cobb & Davila, 2009; Gormley, 2004; Purnell, 2010; Wallin, 2007). In terms of narrative, Holmes (2001) emphasizes that the therapist needs to search for detailed images, memories and examples that bring perfunctory stories to life, for example 'What was your mother like? Where in your body do you experience unhappiness?'

Mallinckrodt (2000, 2010) outlines the Gratification, Relief, Anxiety and Frustration Model for working with anxious and avoidant clients. This model draws on the ideas discussed above and incorporates the concept of 'therapeutic distance'. Therapeutic distance is defined as the level of transparency and disclosure in the psychotherapy relationship from both the client and the therapist, together with the immediacy, intimacy and emotional intensity of the session. Increased distance is characterized by a lack of here and now focus and a reluctance to discuss threatening material. As therapeutic distance decreases, a client's willingness to depend on the therapist increases, as does the client's vulnerability to empathetic failures. Decreased distance from the client's perspective also involves testing boundaries in the therapeutic relationship.

Mallinckrodt's (2000, 2010) model emphasizes both an engagement stage of therapy, which involves matching the client's attachment strategy, and a working phase, which involves encouraging the client towards an optimal level of therapeutic distance. Similarly, Holmes (2010) argues that successful therapy requires initial concordance on the part of the therapist, which involves partial acceptance by the therapist of the role allocated by the client's unconscious expectations and procedures, for example, allowing a degree of boundary flexibility in hyperactivating or anxiously attached clients and allowing a degree of intellectualizing with deactivating or avoidantly attached clients. However, consistent with Mallinckrodt (2000, 2010), Holmes (2001) highlights that later

in therapy, therapists need to move to a complementary more challenging role to disconfirm maladaptive client expectations.

In terms of disorganized/unresolved attachment, papers argue that early treatments should be aimed at managing personal safety, teaching skills to keep affect levels tolerable and ensuring that the therapist is consistently supportive. Direct treatment of traumatic memories should be approached only after the client has developed emotional regulation skills to avoid re-traumatization and has given informed consent to the potentially anxiety-provoking experience of remembering past events (Alexander & Anderson, 1994; Pearlman & Courtois, 2005; Van der Hart *et al.*, 2006). For example, Van der Hart *et al.* (2006) outline a phase-orientated treatment approach for the severe dissociative problems typically associated with chronic traumatization and disorganized attachment patterns. The treatment begins with an initial phase of stabilization, ego strengthening and skills building, followed by the treatment of traumatic memory, and, in the final phase, a focus on the adaptive integration of the individual's functioning across all domains. Although described as a phase-orientated approach, the authors do acknowledge that a return to earlier phases is often necessary over the course of treatment, according to the needs of the patient.

Alexander and Anderson (1994) also emphasize that a lack of interpersonal trust and difficulties in engagement is normal in this group and it may be important to help the client identify other sources of emotional support. Wallin (2007) highlights the way in which clients with disorganized attachment can behave in unpredictable ways and how this can worry, confuse or overwhelm the therapist. The author argues that it is important to remain concerned, but not be overwhelmed or frightened by affect storms and shifting symptoms. With the disorganized client, the therapist must tolerate oscillation, for example missing sessions, drop outs and still proactively try to engage him or her until he or she is ready. This may involve writing to or phoning him or her following missed appointments. With disorganized clients, therapists must also work especially hard at repairing frequent alliance ruptures (Holmes, 2001; Wallin, 2007).

Holmes (1997) focuses specifically on disorganized attachment with people with a diagnosis of borderline personality disorder. He argues that the therapist needs to provide a secure-enough frame and, within this, be able to be sensitive to the client's emptiness and misery, despite huge distractions. With these clients, the therapist also has to resist attempts for the client to reverse roles and to try to look after them, without diminishing the client or the importance of this defence. Holmes (2001) highlights that trauma victims may be initially avoidant of, but then later trapped by their stories. Turning trauma into narrative in therapy requires a sequential process, starting with overcoming of avoidance by imagery and later moving to a more objective distanced position. Similarly, both Wallin (2007) and Van der Hart *et al.* (2006) argue that the goal of therapy with traumatized clients with disorganized attachment should be to help them integrate traumatic experiences and disassociated affects with other parts of personality. For example, in working with earlier trauma, Van der Hart *et al.* (2006) suggest that the therapist must empathically explore all the client's conflicted feelings and beliefs related to perpetrators.

Also describing optimal approaches for those with borderline personality disorder, Liotti, Cortina, and Farina (2008) highlight the benefits of the participation and close collaboration of at least two therapists (e.g., an individual therapist and a group therapist) working together to prevent or correct the consequences of disorganized attachment emerging in therapeutic relationships. The authors describe how both dialectical behavioural therapy (Linehan, 1993) and MBT (Bateman & Fonagy, 2004), which have been used successfully with people with borderline personality disorder, utilize two

therapists in two separate but integrated settings. For example, when the consequences of the client's disorganized attachment manifest with therapist A (e.g., collapses in metacognitive abilities, surfacing of poorly explicable fear in an until then positive interaction, blank spells and other dissociative symptoms, attempts at re-establishing control over the interaction through punitive strategies), they may then be better explored and coped with during the clinical exchanges with therapist B.

There is evidence that some individuals with psychiatric problems do have secure attachment styles (Mickelson, Kessler, & Shaver, 1997) and that individuals with secure attachments are more likely to develop positive relationships with therapists and benefit from therapy (Smith, Msetfi, & Golding, 2010). Alexander and Anderson (1994) argue that secure clients are more able to recognize and tolerate distress and therefore benefit from therapy. However, the majority of papers do not discuss working with secure clients.

Integration and discussion

The above review incorporates articles from a number of different authors, draws on different therapeutic schools and focuses on different types of presenting problems. Consistent themes were, however, evident across this relatively diverse literature, which permits us to infer a model of how attachment theory can inform psychotherapy. A key goal of an attachment-informed therapy should be helping the insecure client develop more secure attachment working models. There may also be other important outcomes, such as symptom reduction or improved functioning, which may occur in addition to or following changes in attachment status. In support of this aspect of the model, there is evidence of change in attachment status as a result of therapy and some evidence that changes in attachment status are associated with changes in symptoms.

According to our model, certain therapist characteristics and strategies are likely to create a 'secure base' in therapy. These include being attuned, sensitive and responsive to the client's needs and demonstrating empathy, acceptance, understanding and unconditional positive regard in relation to distressing thoughts and feelings. These characteristics are associated with a positive therapeutic alliance, and in support of this aspect of our model, there is evidence that secure attachment to the therapist is associated with positive therapeutic alliance and improved outcomes.

Our model proposes that it is important to establish a secure base before moving to more exploratory work. In carrying out such work, therapists need to monitor clients' distress levels and strike a balance between meeting dependency needs and encouraging independent exploration. Key themes for exploratory work in attachment-informed therapy are separation and loss experiences with attachment figures, and helping clients understand how their past experiences influence their current behaviour, symptoms and relationships, including the therapeutic relationship. In support of this aspect of our model, there is evidence that coherence of narrative and reflective function improves as a result of attachment-informed therapies for people with borderline personality disorder and that these changes are linked to changes in symptoms.

Within our attachment-informed model, the therapeutic relationship is pivotal to change in attachment-informed therapy. Therapists therefore need to be aware of the potential to be drawn into re-enacting the client's previous attachment experiences and the influence that their own attachment style can have on the relationship. If managed well, the therapeutic relationship and in particular boundaries, separations

and endings can be used to directly challenge the client's previous expectations of attachment relationships and ways of relating to others. The degree to which therapists should be involved in clients' lives outside of and following therapy and the flexibility of boundaries within therapy should be determined by the individual therapist's styles or formulations of clients' needs. It is likely that different types of clients will have different types of needs in relation to boundaries. The importance of monitoring the client's distress levels is crucial in working with people with different types of attachment patterns. Therapists need to assess the client's attachment pattern, develop relationships by initially matching the client's habitual patterns of relating and, later once distress is more manageable for the client, challenge typical ways of relating or dealing with emotions.

We believe that attachment theory can contribute to all types of psychotherapy although the degree to which therapists draw on the theory is likely to be influenced by the degree to which clients demonstrate insecure attachment styles, clients' experiences of attachment-related loss and clients' therapy goals. For example, therapists may find themselves drawing more heavily on attachment theory when clients have avoidant, anxious or disorganized attachment patterns, and these are played out in the therapy relationship or the client's key relationships outside of therapy sessions. Similarly, attachment theory may be particularly helpful if clients have experienced loss in the context of attachment relationships and the consequences of loss continue to intrude on the client's thinking, feelings or behaviour. Importantly, the degree to which therapists draw on attachment theory is equally likely to be influenced by the client's own goals for therapy, for example, the degree to which the client want to focus on improving relationships or processing past losses. The therapist's own access to training supervision on attachment-related countertransference will also influence how well and safely therapists are able to practice an attachment-informed therapy. Finally, service constraints in terms of the setting of boundaries and length of therapies are likely to influence the degree to which the therapist is able to modify key parameters of therapy in assessing the clients' attachment style and provide a 'corrective emotional experience'. Nonetheless, we would argue that a good therapeutic alliance is a prerequisite for all forms of therapy and that establishing a good quality alliance goes a long way to laying the foundations for a 'secure base' from which more detailed exploration of the internal and external world can take place.

Although the above themes were consistent across a number of independent papers, there is a paucity of empirical work supporting the ideas and, in fact, the absence of empirical literature impeded a review of the clinical implications of attachment theory specifically focused on reviewing the results of research. Carrying out the current review has enabled us to identify priorities for future research in relation to each of the six themes derived from our analysis. First, studies are needed to identify the mechanisms which result in clients changing from an insecure to secure attachment style/pattern. It is hypothesized that attachment status changes as a result of therapy providing a 'corrective emotional experience'. As a starting point, studies could therefore assess whether the client's attachment relationship with the therapist assessed using a measure such as Mallinckrodt's Client Attachment Scale (Mallinckrodt, Coble, & Gantt, 1995) predicts change in attachment status. Second, future studies should identify what therapist characteristics predict their capacity to act as a secure base and facilitate client change in attachment status. Existing evidence suggests the therapist's own attachment style is associated with alliance and outcomes, but it would also be important to assess whether therapist attachment style is similarly associated with the security of the client's

attachment to the therapist and any subsequent change in the client's attachment status. Third, research should determine the extent to which changes in narrative coherence and reflective function are related to therapy outcomes for patients with not only borderline personality disorders, but also other psychiatric presentations. Fourth, future studies should use qualitative methods to explore the ways in which therapists learn to manage countertransference reactions in response to attachment-related dynamics and to function as effective attachment figures for their clients. Fifth, further exploratory work is needed to identify clients' perceptions of therapists' use of boundaries within therapy and in particular both clients' and therapists' views on how and when client contact with the therapist should be predetermined or purely client-led. Semi-structured interviews or focus groups with both therapists and clients who represent different experiences of boundary setting may be most suited to answering these questions. Finally, researchers should help to shed light on the degree to which therapists adapt their responses in accordance with different clients' attachment patterns at different points in the therapy. Ideally, this would require detailed process research using actual session material.

This review is a theoretical overview of how attachment-informed psychotherapy might be conceptualized, rather than a synthesis of actual outcome data. It is important to note that the process of thematic analysis is reflexive and subjective in nature and will be biased by the authors' own influences. Both authors are clinical psychologists who have clinical and research interests in applying attachment theory to clinical practice. As such, our literature search and interpretations of the papers reviewed may be biased by our existing knowledge and theoretical orientations. Where possible, our critical appraisal of the themes identified was informed by the content of papers reviewed. However, in the interests of providing a more comprehensive appraisal, our discussion was supplemented by our own broader knowledge of the attachment and psychotherapy literature. Although between us we believe that we have extensive knowledge of these literatures, our appraisal is inevitably influenced by the breath and source of our knowledge.

We believe that attachment theory can potentially inform understanding and treatment across a range of presenting problems in psychotherapy. However, just as attachment difficulties are not always associated with psychopathology, using attachment theory to inform psychotherapy will not necessarily be the only mechanism by which to improve outcomes, and in some cases, it might not be necessary to directly involve attachment theory into psychotherapy. Research demonstrates that a number of different therapies are effective in bringing about change even when therapists have limited or no awareness of attachment theory. So-called common factors across therapeutic modalities have often been implicated in this general effectiveness of psychological therapy (rather than specialized, modality-specific techniques), often cited as chief of which is the therapeutic relationship. Recent research has shown the importance of the client's attachment to the therapist in outcomes even within the task (as opposed to relationally)-focused CBT framework (Taylor *et al.*, 2015b). Disrupted attachment is certainly not the whole story where psychological distress is concerned, but it may be that attachment theory offers the most well-established and theoretically coherent way to investigate empirically the main medium of therapy (the relationship) in ways readily operationalizable across therapeutic models and trainings.

Caveats aside, this review is an important contribution to the literature as it is the first to provide a narrative thematic analysis of the adult attachment literature with specific

reference to the practice of adult psychotherapy. As such, we anticipate that it provides a useful guide to clinical practice and also highlights specific theoretical implications that need to be tested through further empirical research.

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Received 14 January 2015; revised version received 26 March 2015