

An Attachment Perspective on Therapeutic Processes and Outcomes

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Abstract

Over the past decade, there has been an explosion of interest in clinical applications of attachment theory. In the present article, we briefly describe John Bowlby's model of therapeutic change, the therapeutic relationship, and the therapist's role in emotional healing. We then review empirical evidence for three key propositions in Bowlby's model. First, a client's sense of security during therapy is crucial for facilitating therapeutic work. Second, a therapist's own sense of security contributes to positive therapeutic outcomes. Third, attachment insecurities can be effectively reduced in therapy, and movement toward greater attachment security is central to achieving favorable therapeutic outcomes. In sum, research evidence confirms the importance of establishing what Bowlby called a safe haven and a secure base within a therapeutic relationship.

One of the most influential theoretical frameworks in contemporary developmental, personality, social, and clinical psychology is John Bowlby and Mary Ainsworth's attachment theory. In the early years of the theory's creation and empirical validation, most of the effort was devoted to basic research. But as the theory became operationalized by researchers and tested in many different subfields, its potential for beneficial therapeutic and community interventions drew more attention from both practitioners and researchers (e.g., Daniel, 2006; Muller, 2010; Wallin, 2007). In the present article, we briefly explain some of the theory's fundamental implications for psychotherapy and then go on to review research relevant to these implications.

ATTACHMENT THEORY: BASIC CONCEPTS

In his seminal books on attachment theory, Bowlby (1973, 1980, 1982) proposed that human infants are born with a repertoire of attachment behaviors (e.g., vigilance, crying, clinging) "designed" by evolution to ensure proximity to supportive others (i.e., attachment figures) in times of need. These psychological and behavioral responses increase the chances of being protected from physical and psychological threats, and they encourage the development of coping skills related to emotion regulation and healthy exploration of the physical and social environment. Although the attachment system is most essential to survival and well-being early in life, Bowlby (1988) claimed that it is active throughout life and is manifested in thoughts, emotions, and behaviors related to support seeking (e.g., Mikulincer, Gillath, & Shaver, 2002).

Although all human beings are born with the capacity to seek proximity, support, and comfort from protective others in times of need, important individual differences arise in the context of relationships from birth on. Ideally, positive exchanges with available, sensitive, and responsive attachment figures in times of need promote 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). However, if one's key attachment figures have not been reliably available and supportive, this sense of security is not attained, doubts about one's lovability and worries about others' motives and intentions are raised, and affect-regulation strategies other than healthy proximity seeking are formed (i.e., secondary attachment strategies characterized by anxiety and avoidance).

In sociopsychological studies of adolescents and adults, tests of attachment theory have focused on a person's attachment orientation, or style—a systematic pattern of relational expectations, emotions, and behaviors conceptualized as the psychological residue of each person's unique attachment history (Fraley & Shaver, 2000). Beginning with Ainsworth, Blehar, Waters, and Wall's (1978) studies of infant attachment, and followed up in hundreds of adult attachment studies, researchers have found that attachment orientations can be measured along two orthogonal dimensions: attachment-related anxiety and avoidance (Brennan, Clark, & Shaver,

1998). Attachment-related anxiety is based on self-doubt and worries that relationship partners will not be available in times of need. Attachment-related avoidance is rooted in a person's distrust of relationship partners' goodwill, which causes him or her to maintain behavioral and emotional independence and distance from others. People who score low on these two dimensions are said to be secure with respect to attachment or to have a secure attachment style. The two dimensions can be measured with reliable and valid self-report scales (e.g., Brennan et al., 1998) and are associated in theoretically predictable ways with relationship quality, affect-regulation strategies, psychological well-being, and physical and mental health (see Mikulincer & Shaver, 2007, for a comprehensive review of hundreds of studies).

We (Mikulincer & Shaver, 2007) proposed that a person's location along the anxiety and avoidance dimensions reflects both his or her sense of attachment security and the ways in which he or she deals with threats and stressors. People who score low on these two dimensions are generally secure, hold positive mental representations of self and others, and tend to employ constructive and effective affect-regulation strategies. Those who score high on either attachment anxiety or avoidance, or both (a condition called fearful avoidance, based on a seminal article by Bartholomew and Horowitz, 1991), suffer from attachment insecurities, self-related worries, and distrust of others' goodwill and responsiveness in times of need. Moreover, such insecure people tend to use secondary attachment strategies that we, following Cassidy and Kobak (1988), conceptualize as attachment-system "hyperactivating" or "deactivating" to cope with threats, frustrations, rejections, and losses.

People who score high on attachment anxiety rely on hyperactivating strategies—energetic attempts to achieve support and love combined with a lack of confidence that these resources will be provided and with feelings of anger and despair when they are not provided (Cassidy & Kobak, 1988). The main goal of these strategies is to get an attachment figure, viewed as unreliable or insufficiently available and responsive, to pay attention and provide protection and love. In contrast, people who score high on attachment-related avoidance tend to use deactivating strategies: trying not to seek proximity to others when threatened, denying vulnerability and needs for other people, and avoiding closeness and interdependence in relationships. The primary goal of deactivating strategies is to keep the attachment system down-regulated to avoid the distress caused by attachment figure unavailability or rejection.

Attachment orientations are initially formed in interactions with primary caregivers during early childhood, as a large body of research has shown (Cassidy & Shaver, 2008), but Bowlby (1988) claimed that the quality of relationships with subsequent attachment figures, at any age, can alter a person's sense of security and move him or her along the attachment anxiety or avoidance dimensions. In fact, a wide variety of relationship partners can serve as attachment figures during adolescence

and adulthood, including siblings, other relatives, familiar coworkers, teachers or coaches, close friends, and romantic partners. They form what Bowlby (1982) called a person's "hierarchy of attachment figures." There may also be context-specific attachment figures—real or potential sources of comfort and support in specific milieus, such as teachers in schools or leaders in organizational settings. In our studies, we have found, for example, that the actual presence of a supportive relationship partner in different kinds of relationships (romantic, leader-follower, intragroup) has long-term influences on a person's attachment security and mental health (see Shaver & Mikulincer, 2008, for a review).

According to attachment theory, any relationship partner can serve as an attachment figure if he or she becomes a reliable source of protection and support. Bowlby (1982) specified three provisions that a relationship partner should supply, or the functions this person should serve, if he or she is to become an attachment figure (see also Hazan & Zeifman, 1994). First, attachment figures are targets of proximity maintenance. Humans of all ages tend to seek and enjoy proximity to their attachment figures in times of need and to experience distress upon separation from them. Second, attachment figures provide a physical and emotional safe haven; they facilitate distress alleviation and are a source of support and comfort. Third, attachment figures provide a secure base from which people can explore and learn about the world and develop their own capacities and personality. From this perspective, the client-therapist relationship can be conceptualized as involving an attachment bond; the therapist can become a safe haven and secure base for the client, thereby heightening the client's sense of attachment security, which in turn can facilitate healthy emotion regulation and exploration of new possibilities, which contribute to mental health.

AN ATTACHMENT-THEORETICAL MODEL OF PSYCHOTHERAPY

According to Bowlby (1988), a therapist can fulfill the three definitional criteria for an attachment figure. Just as a sensitive and responsive mother induces a sense of attachment security in her child, hence facilitating the child's exploration of the world by making it clear that support will be available if needed, a therapist can serve as a safe haven and a secure base from which clients can explore and reflect on painful memories and experiences. Therapists should provide safety, comfort, encouragement, and unconditional positive regard, making it possible for clients to manage the anxiety and distress associated with articulating and exploring painful memories, conflicts, and sources of doubt and confusion. Therapists can affirm clients' positive qualities and potential, offer new perspectives on problems and possibilities for change, and help clients understand their feelings and actions, and also understand other people's reactions to these actions. In other words, like other good attachment figures, a therapist assures the

client that the therapist can be relied upon for safety and support while the client becomes increasingly capable of dealing with emotions and social relationships more effectively and, eventually, autonomously. In Bowlby's (1988) words, "The therapist strives to be reliable, attentive, and sympathetically responsive to his patient's exploration, and so far as he can, to see and feel the world through his patient's eyes, namely to be empathic" (p. 152).

Of course, not every psychotherapy relationship involves an attachment bond, and this bond may gradually evolve during treatment. That is, the extent to which a therapist-client relationship fulfills the definitional criteria for an attachment bond after 6 months of therapeutic sessions might be very different than at the initial phases of treatment. According to Mallinckrodt (2010), many therapist-client dyads who finish their work and meet the definitional criteria of an attachment bond do not start out meeting all of them. Indeed, much of the effort of therapy can be considered the struggle to mold a weak bond into a strong attachment bond that conveys felt security and serves as a safe haven for exploration (Mallinckrodt, 2010).

In this context, it is important to differentiate between the therapist's role as a secure base and his or her role as a safe container (Winnicott, 1969) that might allow for the expression of negative emotion and even the working through of an angry negative transference. For example, a client with borderline tendencies would minimize or disparage any sense of connection to a therapist during a period of frustration or disappointment. Yet at the same time, the client's willingness to return to sessions, despite intense anger or frustration, is a sign that the container is in place and eventual therapeutic progress may be reached. That is, there might be instances during psychotherapy that the experience of a safe container would be maintained despite anger and frustration targeted toward a disappointing therapist.

With these background considerations in mind, Bowlby (1988) proposed a model of therapeutic change focused on helping a client understand his or her accumulated, and often forgotten or misunderstood, attachment experiences, identify and revise insecure working models of self and relationships by transforming them into more secure models, and learn about ways to achieve both comfortable intimacy and confident autonomy. Because of the central role played by attachment insecurities in the genesis of emotional and relational difficulties, Bowlby (1988) believed that favorable therapeutic outcomes depend on the extent to which these insecurities are identified, clarified, questioned, revised, and transformed into more secure representations of attachments.

Bowlby (1988) discussed five therapeutic tasks that contribute to the revision of insecure mental representations and to the achievement of positive therapeutic outcomes. The first is to provide clients with a safe haven and secure base from which they can begin to explore painful memories and emotions, characteristic but destructive defenses, and maladaptive beliefs and behaviors. This is a precondition for the entire therapeutic process. The second and third tasks are to encourage clients to

consider how beliefs and expectations about themselves and others influence how they think, feel, and act in relationships, including in the therapeutic relationship itself. The fourth task is to help clients assess how current thoughts, feelings, and behaviors may have originated in childhood relationships with parents or other caregivers, and with subsequent relationship partners. The fifth task is to help clients to understand that previous ways of thinking and behaving may not be well adapted to their current lives and to imagine and practice alternative, healthier ways of coping and relating.

According to Dozier and Tyrrell (1998), a client's movement toward a more secure attachment orientation during therapy depends on three processes: (a) the therapist's provision of corrective attachment-related experiences, based on the therapist becoming a safe haven and secure base for the client during therapy; (b) the client's exploration of and reflection on current relationships, including the relationship with the therapist; and (c) the client's exploration and reflection on earlier relationships with attachment figures. The two kinds of exploratory ventures—into past relationship experiences and into current experiences, including with the therapist—affect each other. Exploration of past attachment experiences helps clients become more aware of how they construe and distort current relationships, and exploration of current relationships helps them reflect on earlier attachment experiences. Present distortions inevitably point back to special features of earlier troubled relationships, and past attachment injuries color expectations and strategies in current relationships, including the one with the therapist. Both kinds of therapeutic exploration encourage constructive overhaul of insecure mental representations and initiate and sustain a broaden-and-build cycle of attachment security (Mikulincer & Shaver, 2007), which results in beneficial therapeutic change and improvements in mental health.

During the last decade, creative research has been conducted to examine the validity of Bowlby's (1988) model of psychotherapy. This research has focused mainly on three core propositions of this model. First, a client's sense of security in close relationships and in the relationship with the therapist will facilitate therapeutic processes (e.g., forming a stronger working alliance with the therapist, fostering deeper self-disclosures and more thorough exploration of painful experiences) and enhance therapeutic outcomes. In this context, a client's attachment insecurities may be reactivated during therapy sessions and elicit negative emotional and cognitive reactions toward the therapist—what both Freudian theories and social cognitive studies call transference (e.g., Greenson, 1967; Miranda & Andersen, 2010). Second, a therapist's own sense of security will facilitate his or her provision of a safe haven and secure base to the client, which will contribute to positive therapeutic processes and outcomes. Third, attachment insecurities can be effectively challenged in therapy, resulting in a stronger sense of security, which will help to bring about good outcomes. In the following sections, we review some of the evidence for these propositions.

CLIENTS' ATTACHMENT ORIENTATIONS IN RELATION TO THERAPEUTIC PROCESSES AND OUTCOMES

When examining Bowlby's (1988) proposal that a client's sense of security affects therapeutic processes and outcomes, researchers have focused on two kinds of attachment-related mental representations: (a) the client's global attachment orientation in close relationships, as he or she conveys it during therapy, and (b) the client's specific attachment orientation to his or her therapist. Both kinds of attachment orientations (global and therapist-specific) should affect therapeutic processes and outcomes. However, considering Bowlby's (1988) model of psychotherapy, a therapist-specific sense of security, derived from the therapist's provision of a safe haven and secure base, is likely to be especially important in facilitating the client-therapist working alliance and the client's exploration of painful experiences and insecure working models, which will allow the extension or generalization of the newly formed sense of security to other close relationships. Moreover, the emerging sense of global security should support further therapeutic changes and improve therapy outcomes.

The Client's Attachment Security and the Working Alliance

One component of beneficial therapy is the working alliance between client and therapist, which enables them to work together collaboratively to reach therapeutic goals (Safran, Muran, & Rothman, 2006). According to Bordin (1979), a working alliance reflects an emotional alignment of client and therapist based on trust, respect, and mutual regard as well as agreement about the tasks and goals of therapy. This alliance engages the rational, self-observing aspects of the client and the working, therapeutic qualities of the therapist (Safran et al., 2006). Research has consistently shown that a stronger working alliance early in therapy, as reported either by the client or by the therapist, is a good predictor of successful therapeutic outcomes (e.g., Horvath, Del Re, Flückiger, & Symonds, 2011).

Research assessing clients' global attachment orientations during therapy have shown that attachment insecurities tend to disrupt the client-therapist working alliance, and that a more secure orientation can contribute to the formation of a more stable and stronger working alliance. For example, Dolan, Arnkoff, and Glass (1993) found that therapists of more secure clients (compared with therapists of more avoidant clients) reported greater client-therapist agreement about the tasks and goals of therapy by the third therapeutic session. Similar findings have been obtained when clients themselves have provided their own perspective on the strength of the working alliance (e.g., Byrd, Patterson, & Turchik, 2010; Goldman & Anderson, 2007; Kivlighan, Patton, & Foote, 1998; Satterfield

& Lyddon, 1995). Mallinckrodt, Coble, and Gantt (1995) found that more anxiously attached clients also tended to score lower on self-reports of a good working alliance.

However, a meta-analysis of 12 studies that assessed the association between global attachment orientations in close relationships and clients' reports of their working alliance in individual psychotherapy (Diener, Hilsenroth, & Weinberger, 2009) revealed an effect size of only .17, raising doubts about the strength and validity of the association. Diener and Monroe (2011) conducted another meta-analysis with 17 independent samples (total $N = 886$, average $n = 52$) and found similar results: More attachment security in close relationships was associated with a stronger therapeutic alliance, with an overall weighted effect size of $r = .17$. These findings suggest that, although clients' global attachment orientations may contribute somewhat to the formation of a client-therapist working alliance, they do not seem to be a crucial factor. This raises the question of whether the attachment pattern a client forms with the therapist might be more important, although the two kinds of attachment orientation might be somewhat, but not perfectly, related. In fact, research has consistently yielded only low to moderate correlations between clients' attachments to their therapists and measures of global attachment style (e.g., Mallinckrodt, Gantt, & Coble, 1995; Mallinckrodt, Porter, & Kivlighan, 2005) or attachment history (e.g., Mallinckrodt, King, & Coble, 1998; Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). The modest size of the associations suggests that therapist-specific attachment is distinguishable from attachment orientations in other close relationships.

In an attempt to assess clients' therapist-specific attachment orientations, Mallinckrodt, Gantt, and Coble (1995) constructed a self-report scale (Client Attachment to Therapist [CATS]) and found that secure attachment to the therapist was positively and strongly associated with clients' reports of the strength of their working alliance with that therapist. In fact, the strong correlations (around .80) suggest that secure attachment to the therapist shares a common core with the working alliance. These findings have been replicated in subsequent studies (e.g., Bachelor, Meunier, Laverdière, & Gamache, 2010; Goldman & Anderson, 2007; Mallinckrodt et al., 1998; Mallinckrodt et al., 2005). Marmarosh, Gelso, et al. (2009) added to this line of research by assessing the quality of the actual client-therapist relationship and working alliance at the third session of therapy at a university counseling center. They found that a client's avoidant attachment to the therapist was negatively associated with the client's report of both relationship satisfaction and quality of the working alliance. Fuertes et al. (2007) also found that clients' secure attachment to their therapist was positively associated with clients' perceptions of the working alliance and the therapist's empathy, and with the clients' ratings of progress in treatment. In addition, Moore and Gelso (2011) found that clients who were more securely attached to their therapist were more likely to have positive recollections of the therapeutic relationship after five sessions of therapy. Overall, research consistently suggests that devel-

oping a secure attachment to one's therapist is a crucial factor in helping a client work collaboratively with a therapist in achieving therapeutic change.

The Client's Attachment Security and Other Therapeutic Processes

There is also evidence that a client's attachment security in therapy is associated with more positive attitudes toward therapy and more constructive therapeutic behavior, such as deeper self-disclosure and more complete inner exploration. For example, Marmarosh, Whipple, et al. (2009) found that avoidant attachment in close relationships was related to greater fear of shame and humiliation in group therapy. Other group therapy studies have found that group members' attachment security in close relationships was related to more self-disclosure in group therapy (Shechtman & Rybko, 2004) and more positive attitudes toward other group members (e.g., Shechtman & Dvir, 2006).

In a recent study, Saypol and Farber (2010) assessed clients' attachment orientations to their therapists and found a positive association between attachment security and the overall level of self-disclosure during therapeutic sessions. Moreover, whereas attachment security was associated with less unpleasant feelings following in-session self-disclosure, clients' anxious attachment to the therapist was associated with more unpleasant feelings experienced both before and after self-disclosure. These findings indicate that developing a secure attachment to a therapist may be important for encouraging a patient to deeply explore distressing issues.

This conclusion was corroborated in a study of 38 clients in time-limited therapy by Mallinckrodt et al. (2005). The researchers assessed associations between global attachment orientation, attachment to one's therapist, strength of the working alliance, and clients' reports of session depth and smoothness. Although both kinds of attachment security contributed to the working alliance, only more secure attachment to the therapist was associated with more exploration of inner experiences during sessions and with perceiving the therapeutic sessions as smooth and deep. Notably, this last association could not be explained by ratings of the working alliance and seemed to be a unique reflection of the sense of security clients experienced during therapy. Similar positive associations between clients' attachment security and greater self-exploration in psychotherapy have been found in subsequent studies (e.g., Janzen, Fitzpatrick, & Drapeau, 2008; Romano, Fitzpatrick, & Janzen, 2008).

From a psychodynamic perspective, the therapeutic relationship includes not only the working alliance between client and therapist but also less rational and more fantasy-based processes. One of these processes is the client's transference reactions to the therapist—"experiencing of feelings, drives, attitudes, fantasies and defenses toward a person in the present which are inappropriate to that person and are a repetition, a

displacement of reactions originating in regard to significant people of early childhood" (Greenson, 1967, p. 156). Woodhouse et al. (2003) provided initial evidence that the attachment orientation a client adopts toward his or her therapist contributes to the quality of these transference reactions. Following at least five therapy sessions, clients reported their attachment orientation toward their therapist, and the therapist completed measures describing the client's positive and negative transference reactions during recent sessions. More anxiously attached clients were rated as displaying greater transference in general and higher levels of negative transference (e.g., suspiciousness, annoyance) in particular. There was no significant association between avoidant attachment and transference, probably because of avoidant clients' lack of emotional involvement in therapy. Unexpectedly, secure attachment to the therapist was also associated with negative transference reactions.

Woodhouse et al. (2003) proposed that secure clients can view their therapist as a secure base and therefore explore deeper, more negative childhood memories, which in turn cause, at times, a negative reaction to the therapist. According to these authors, negative transference accompanied by secure attachment to a therapist can allow a client to gain insight into conflictual patterns of relating and lead to a better therapy outcome. However, this speculative interpretation of unexpected findings is based on a single study. Further research is needed to assess how secure clients make use of negative transference reactions, if in fact they do.

The Client's Attachment Security and Therapy Outcome

Studies examining the contribution of a client's attachment orientation to therapy outcome have consistently found that attachment insecurities in close relationship can interfere with positive therapeutic change. For example, Horowitz, Rosenberg, and Bartholomew (1993) found that avoidant outpatients showed less clinical improvement than secure or anxious outpatients following individual therapy. Byrd et al. (2010) used archival data from 66 psychotherapy clients treated at a university graduate program training clinic and also found that avoidant attachment was inversely related to psychotherapy outcome and that problems in the working alliance were a partial mediator of the avoidance-outcome association. In addition, Tasca, Taylor, Bissada, Ritchie, and Balfour (2004) found that avoidant attachment was related to dropping out of group psychotherapy in a sample of clients diagnosed with eating disorders. Levy, Ellison, Scott, and Bernecker (2011) conducted a meta-analysis examining the association between attachment orientations in close relationships and psychotherapy outcome (14 studies, $N = 1,467$). Findings indicated that whereas attachment insecurities were inversely related to therapy outcome, attachment security showed a significant positive association with outcome (effect size of .37).

In a recent study, Sauer, Anderson, Gormley, Richmond, and Preacco (2010) examined the associations between attachment orientations in close relationships, client attachment to the therapist, working alliance, and progress in therapy. Clients completed measures of attachment to the therapist (graduate students in clinical training) and working alliance at the third therapy session. A standardized measure of progress in therapy was administered at intake, the third session, and termination. Findings indicated that a stronger working alliance and more secure attachment to the therapist were significantly associated with greater reductions in client distress over time. In addition, clients who were more anxiously attached in close relationships were more likely to show increases in psychological distress at therapy termination. Overall, the findings indicate that the sense of attachment security during therapy facilitates beneficial therapeutic change and contributes to positive therapy outcomes.

THE THERAPIST'S ATTACHMENT ORIENTATION AND THERAPEUTIC PROCESSES

As in other attachment relationships, a client's sense of attachment security depends on the therapist's ability and willingness to occupy the role of security provider. In other words, the therapist's effectiveness as a caregiver, providing a safe haven and secure base, is important for the client's formation of a secure attachment bond to the therapist. Moreover, because sensitive and effective caregiving depends on one's own sense of attachment security (Mikulincer & Shaver, 2007), it seems likely that the therapist's contributions to the client's security, and the consequent cascade of positive therapeutic processes (e.g., the formation of a good working alliance, the client's exploration of memories and feelings), can be disrupted by his or her own attachment insecurities. Whereas a secure therapist should find it easy to occupy the role of security provider and create a good working alliance even with a difficult client, an insecure therapist is likely to complicate these therapeutic processes.

A secure therapist is likely to focus on clients' problems, remain open to new information, and maintain compassion and empathy rather than be overwhelmed by personal distress (see Mikulincer & Shaver, 2007, for a review of studies on attachment orientations and reactions to other people's needs). Moreover, their habitual reliance on constructive strategies of affect regulation and conflict resolution (Mikulincer & Shaver, 2007) can allow therapists with a secure attachment style to handle their clients' distress and resistances more effectively. In contrast, an insecure therapist is less likely to empathize accurately and keep personal distress and defenses from interfering with compassion. In line with research on attachment insecurities and caregiving (Mikulincer & Shaver, 2007), avoidant therapists may lack the skills needed to provide sensitive care to clients. Anxiously attached therapists may expe-

rience intense distress, a desire to merge or lose boundaries with clients, and difficulty regulating emotions, which can obviously interfere with empathic sensitivity and responsiveness to a client's needs. According to this reasoning, a more secure therapist should be more likely to facilitate a client's attachment security and the consequent formation of a strong working alliance and an ability to do constructive therapeutic work.

Sauer, Lopez, and Gormley (2003) assessed attachment orientations of graduate students in clinical training and found that their attachment anxiety was associated with clients' reports of a worse working alliance after the fourth and seventh therapy sessions. Similarly, Black, Hardy, Turpin, and Parry (2005) found that more securely attached therapists were more likely to report stronger alliances, and Rozov (2002) found that more anxiously attached therapists were more likely to create poorer alliances in general and especially poor ones with secure clients. Berry et al. (2008) also found that therapists' attachment security was positively associated with ratings of the quality of their therapeutic relationships. In addition, therapists' avoidant attachment was associated with greater therapist-client discrepancies in ratings of clients' interpersonal problems and with therapists' poorer theory-of-mind abilities (i.e., the ability to reflect on one's own and others' mental states).

Dinger, Strack, Sachse, and Schauenburg (2009) assessed therapists' attachment orientations (with the Adult Attachment Interview) and obtained weekly ratings by clients of their working alliance with their therapist. These researchers found that therapists' higher attachment anxiety was associated with lower ratings of the working alliance over the entire study period. In addition, clients of anxiously attached therapists were more likely to report a decline of alliance quality over the course of therapy. Schauenburg et al. (2010) also used the Adult Attachment Interview and found that higher attachment security on the part of therapists was associated with both better working alliances and better therapy outcomes, only in a subsample of severely impaired clients.

There is also some evidence that therapists' attachment orientations interact with clients' orientations in shaping therapeutic processes. For example, Romano, Janzen, and Fitzpatrick (2009) assessed attachment orientations of graduate students in clinical training and found that their orientations interacted with clients' attachment orientations in shaping therapist interventions in early sessions of psychotherapy. Specifically, more avoidant therapists were more likely to intervene with directive interventions when clients were also relatively high on avoidance. In a more recent study, Petrowski, Nowacki, Pokorny, and Buchheim (2011) found that anxiously attached clients evaluated the relationship with a more avoidant therapist as more helpful. This finding echoed Tyrrell, Dozier, Teague, and Fallot's (1999) finding that whereas more avoidant therapists tend to form stronger alliances with anxiously attached clients, more anxious therapists had stronger alliances with avoidant clients.

According to Mallinckrodt (2000, p. 257), these findings emphasized the positive effects of “counter-complementary attachment proximity strategies,” by which a therapist reacts to clients’ attitudes toward proximity in ways that collide with their demands and disconfirm their expectations and maladaptive patterns of relating. For avoidant clients, who prefer interpersonal distance, corrective emotional experiences can be provided mainly when therapists tend to increase proximity and insist on deepening clients’ disclosures. For anxiously attached clients, who prefer to remain in an infantile, dependent position and tend to elicit compassion from others, corrective emotional experiences can be provided mainly when therapists maintain optimal distance from clients and encourage them to take a more autonomous stance.

However, Mallinckrodt (2000) also noted that therapists must have a strong sense of attachment security in order to respond to the client in a counter-complementary manner. He suggested that this counter-complementary approach requires considerable interpersonal sensitivity and responsiveness in trying to understand what the client tries, perhaps unconsciously, to re-create in the therapeutic relationship and how to break maladaptive patterns without overwhelming the client with anxiety. These skills are rare among insecurely attached people (Mikulincer & Shaver, 2007). Mallinckrodt (2000) concluded that, although secure therapists are prone to forming strong alliances with every client due to their interpersonal flexibility and caregiving sensitivity, they can form these alliances more easily and rapidly with clients who differ from them in regard to regulation of proximity and distance. In contrast, insecure therapists are likely to have difficulty forming strong alliances and providing effective therapeutic interventions even when clients differ from them in attachment strategies. In fact, an insecure therapist might react in a complementary manner to clients’ demands while confirming once again clients’ maladaptive patterns and preventing therapeutic change.

This conclusion has been supported in studies examining therapists’ negative countertransference reactions (e.g., being excessively critical, punitive, or rejecting) as a function of therapists’ and clients’ attachment orientations. Generally, these negative reactions toward clients have been related to therapists’ attachment insecurities (e.g., Ligiero & Gelso, 2002; Marmarosh et al., 2006; Mohr, Gelso, & Hill, 2005). However, both Mohr et al. (2005) and Rubino, Barker, Roth, and Fearon (2000) found that these countertransference reactions were more marked when an insecure therapist met an insecure client who challenged his or her characteristic way of regulating proximity and distance. Specifically, more avoidant therapists exhibited more hostile countertransference behaviors mainly toward anxiously attached clients, whereas more anxiously attached therapists tended to show heightened hostility mainly when the client was avoidant. That is, incompatibility of attachment insecurities (anxiety vs. avoidance) between clients and therapists tended to elicit more hostile countertransference behaviors from the therapists. These find-

ings highlight how difficult it may be for an insecure therapist to maintain the appropriate degree of counter-complementary attachment behavior thought by Mallinckrodt (2000) to contribute to good therapeutic outcomes.

Therapists may also adjust treatment (e.g., rapport building, interpretation) in light of a client’s avoidant versus anxious attachment pattern. For example, anxiously attached clients are likely to express excessive distress, vulnerability, and helplessness during initial sessions, and this can cause a therapist to become prematurely pulled into excessive emotional involvement and compassion, and an overly intense focus on the client’s inner world. Indeed, Lyddon and Satterfield (1994) found that therapists with more anxiously attached clients were more likely to rate the clients’ problems as pervasive and due to developmental deficits and to view the goal of therapy as exploration of core pathological beliefs. In contrast, avoidant clients are likely to reject therapeutic interventions that require emotional expression and disclosure of vulnerabilities, thereby causing a therapist to use more rational and cognitive techniques that do not challenge clients’ defenses. In support of this view, Hardy et al. (2001) content-analyzed transcripts of significant therapy sessions and found that therapists reacted to avoidant clients by offering cognitive interpretations.

However, there is also important evidence that these countertransference reactions are moderated by therapists’ attachment orientations. Dozier, Cue, and Barnett (1994) found that whereas secure therapists did not use different interventions for anxious and avoidant clients, insecure clinicians attended more to dependency needs and made more in-depth interpretations when treating anxiously attached clients than when treating avoidant clients. These findings suggest that insecure therapists respond in a complementary way to clients’ dysfunctional needs and perhaps perpetuate and reinforce clients’ maladaptive attachment patterns. In contrast, secure therapists are less likely to react in a complementary manner, thereby providing a relational context that helps clients reformulate their core pathological beliefs.

Overall, the findings to date support the hypothesis that a therapist’s attachment security is an important factor for facilitating the initiation and maintenance of a broaden-and-build cycle of attachment security for the client and the subsequent cascade of positive therapeutic processes leading to a good outcome. The findings also indicate that, as in other attachment relationships, the quality of the therapeutic relationship depends on both the therapists’ and the clients’ attachment orientations.

CHANGES IN ATTACHMENT REPRESENTATIONS AND THERAPY OUTCOMES

Although attachment orientations are viewed as relatively stable patterns of relating across the life span, there is good evidence that new experiences with sensitive and supportive

relationship partners can move an insecure person toward a more secure pattern of relating (see Shaver & Mikulincer, 2008, for a review). There is also supportive evidence that therapy, viewed as a corrective attachment experience, can move clients away from insecure and toward secure orientations, and that this movement is a good indication of effective treatment. In two independent studies, Blatt, Stayner, Auerbach, and Behrends (1996) and Harpaz-Rotem and Blatt (2005) assessed the severity of psychopathology of seriously disturbed, hospitalized adolescents at the beginning and end of long-term intensive therapy. In addition, Blatt et al. (1996) assessed changes in the structure of the adolescents' descriptions of mother, father, self, and therapist across the course of therapy, whereas Harpaz-Rotem and Blatt (2005) assessed changes in the description of a significant other whom each patient elected to describe at the beginning and end of treatment. In both studies, findings indicated increases in the coherence of attachment-related representations over the course of therapy and showed that such increases were associated with a reduction in severity of psychiatric symptoms.

Some studies have directly assessed changes in attachment orientations over the course of psychotherapy. For example, Fonagy et al. (1996) reported that a significant proportion of inpatient psychiatric patients receiving psychodynamically oriented psychotherapy changed to a secure attachment style (as measured by the Adult Attachment Interview) over the course of treatment. Similarly, Travis, Bliwise, Binder, and Horne-Moyer (2001) found an increase in clients' reports of secure attachment across the course of time-limited dynamic psychotherapy, and this increase was associated with decreases in the severity of psychiatric symptoms. Similar findings were reported by Levy et al. (2006) and Diamond, Stovall-McClough, Clarkin, and Levy (2003) in studies of clients receiving transference-focused psychotherapy for borderline personality disorder. And Tasca, Balfour, Ritchie, and Bissada (2007) obtained similar findings in a study of women receiving group psychodynamic-interpersonal psychotherapy for eating disorders. However, Strauss, Mestel, and Kirchmann (2011) found that attachment orientations did not change dramatically during a time-limited psychological treatment for personality disorder. They obtained only a decrease in features of anxious attachment after 7 weeks of therapy, which was associated with a more positive therapy outcome.

Muller and Rosenkranz (2009) assessed changes in attachment orientation after treatment in an inpatient program for adults with posttraumatic stress disorder. They found that secure attachment increased significantly over the course of treatment in comparison to a wait-list group, and this change was maintained over 6 months after discharge. Furthermore, positive changes in secure attachment were associated with symptom reduction during treatment and with maintenance of these reductions after discharge. Positive changes were also noted in the underlying attachment dimensions of anxiety and avoidance. Furthermore, positive changes in attachment were associated with symptom reduction during treatment and

maintenance of these reductions after discharge. Similar findings were reported by Lawson, Barnes, Madkins, and Francois-Lamonte (2006) in a study of domestically violent men who received 17 weeks of integrated cognitive-behavioral/psychodynamic group treatment. The results showed that the number of men reporting a secure attachment in close relationships increased from pre- to posttreatment and that men who became more secure reported lower anxiety, depression, and partner violence than still-insecure men at posttreatment.

A study that examined the effectiveness of residential treatment of high-risk adolescents (Gur, 2006) provided another kind of evidence for the importance of a therapist's functioning as a secure base in promoting increases in attachment security and facilitating good therapeutic outcomes. Gur assessed the course of emotional and behavioral problems of 131 Israeli high-risk adolescents during their first year in residential treatment centers (1 week after beginning treatment and 3, 6, and 12 months later). At Time 1, participants reported on their attachment orientations in close relationships and completed measures of emotional and behavioral adjustment. In the three subsequent waves of measurement, participants completed the adjustment scales and rated the extent to which targeted staff members functioned as a secure base for them. The targeted staff members also rated participants' adjustment and their own functioning as a secure base in the second, third, and fourth waves of measurement. In the fourth wave of measurement, adolescents again completed the self-report attachment measure in order to examine possible changes in their attachment orientations.

The findings indicated that staff members serving as a secure base contributed to positive changes in emotional and behavioral adjustment across the four waves of measurement, and these secure-base provisions weakened the detrimental effects of baseline attachment insecurities. Adolescents who formed more secure attachment bonds with staff members had lower rates of anger, depression, and behavioral problems as well as higher rates of positive feelings across the study period. Moreover, the functioning of staff members as a secure base was also associated with positive changes in the adolescents' attachment orientations. Adolescents who formed more secure attachment bonds with staff members had lower scores on attachment anxiety and avoidance after their first year of residential treatment. Overall, the findings support the theoretical proposition that attachment security has healing effects even in the case of abnormally insecure, institutionalized youngsters.

Although these findings are encouraging, we need more controlled research that examines the long-term effects of security-enhancing therapeutic figures on clients' attachment orientations, and the extent to which changes in these representations are associated with therapy outcomes. More research is also needed on the temporal course of revisions in attachment orientations during therapy and on the way particular features of therapist-client relations contribute to these revisions in the case of different kinds of emotional disorders.

CONCLUDING REMARKS

This further research is highly warranted because the empirical findings generated so far, within a relatively short time period, suggest that Bowlby (1988) was on the right track when he extended basic research on attachment into therapeutic settings. His confidence in making this extension was based partly on his own extensive experience as a child and family psychoanalyst working in London's deservedly famous Tavistock Clinic. Bowlby's roots in the object relations tradition within psychoanalysis and his open-minded outreach to all kinds of relevant basic research in ethology, cognitive and developmental psychology, and community psychiatry allowed him to retain both the depth of psychoanalysis and the specificity of careful empirical studies, resulting in a broad and deep theoretical perspective that is still inspiring new research on many fronts as well as fruitful therapeutic applications and community interventions.

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