10

An Attachment Approach to Adult Psychotherapy

Brent Mallinckrodt
Katherine Daly
Chia-Chih D. C. Wang

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

Our assignment in this chapter was to explain how an attachment-oriented therapist might approach the tasks involved in psychotherapy, basing the approach whenever possible on the research literature generated by attachment theory. In reviewing this literature from a clinical perspective, we encountered a fundamental tension between science and practice. Empirical research is incremental, and those who seek to further a scientific understanding of psychotherapy are cautious about interpreting the findings of any particular study. This stance is in keeping with the scientific tradition of null hypothesis testing, in which a group difference or the effect of a variable is presumed not to exist unless there is quite convincing evidence to the contrary. Because of the considerable negative consequences of concluding that an effect exists when in fact it does not, researchers impose a high standard of proof when interpreting their results. Setting a .05 or .01 level for a Type I error is comparable to the legal standard of proof "beyond a reasonable doubt" used in criminal cases, where the negative consequences of convicting an innocent defendant are considered far more serious than those of exonerating a defendant who has committed a crime.

A review of adult attachment research (Meyer & Pilkonis, 2001) led the American Psychological Association's Division 29 (Psychotherapy) Task Force on Psychotherapy Relationships to conclude that evidence is "insufficient to make a clear judgment" about specific recommendations regarding psychotherapy relationships based on clients' attachment style (Ackerman et al., 2001, p. 496). From a "beyond a reasonable doubt" standpoint, this

conclusion is probably still warranted today and probably reflects the fact that research on attachment and adult psychotherapy is still nascent.

However, appropriate scientific caution does not release therapists from their obligation to make tough decisions. Although we ourselves (the authors of this chapter) are researchers, we are also practitioners who work with adult outpatients suffering considerable emotional distress resulting from interpersonal problems. Like any practitioner reading this chapter, we have been faced with on the spot demands in a session to make a clinical decision. Often such decisions take the form of either–or dilemmas that are not amenable to the .05 level of certainty. For example, when a client we have been seeing weekly asks for a second session later the same week, the request must either be granted or denied. When a client's disclosure prompts our own feeling of deep empathic sadness, we must decide to make a self-disclosure of this feeling or to let the moment pass. In making these choices, we are especially mindful of the ethical imperative to "above all, do no harm," but we are still faced with the question of whether granting the request for an extra session or making the self-disclosure is likely to be helpful or harmful.

This chapter is written for practitioners whose work with adult outpatients requires them to make choices like these. For them the standard of proof is not "beyond a reasonable doubt," but rather "based on the evidence, which course of action is the best?" To continue with the legal analogy, in civil cases the standard of proof is the "preponderance of the evidence"; that is, given competing versions of events, which among these is the most likely explanation for the observed facts? Often some doubt remains about the chosen version, but after careful consideration, one interpretation is judged to be more plausible than any other. Because therapists make clinical decisions based on the most reasonable interpretation of the evidence, even though they are not certain beyond a doubt, we have also adopted a "preponderance of the evidence" standard in reviewing literature for this chapter. After considering the available evidence, we draw conclusions that, from our perspective, are the most reasonable interpretations of the data. We hope that therapists reading this chapter will find our recommendations helpful, but it is important to remember that there are alternative interpretations of the literature.

A few other caveats are in order. Although the literature on attachment is large, we focus on empirical studies of relatively high-functioning adult clients and, for studies of nonclient samples, on the laboratory and correlational studies that are most directly relevant for psychotherapy processes. We use the term *client* in preference to *patient*, and focus on psychotherapy with relatively high-functioning adult outpatients whose presenting problems include maladaptive patterns of behavior in interpersonal relationships. These patterns need not be the primary presenting problem—indeed, some clients may not list improving their interpersonal relationships among their goals for therapy—but key features of the problem suggest that (1)

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

maladaptive interpersonal patterns significantly contribute to a client's predicament, and (2) adult attachment theory offers a useful framework for case conceptualization and treatment of these maladaptive patterns. Excellent resources have recently become available for readers interested in the applications of attachment theory to clients with pervasive and more debilitating personality disorders than the populations we consider in this chapter (Bateman & Fonagy, 2003; Clarkin & Posner, 2005; Holmes, 2005).

Finally, as we prepared this chapter, two of us were engaged in a qualitative study, informed by the methodology of grounded theory (Charmaz, 2006; Glasser & Strauss, 1967), of how expert therapists use attachment theory in their work with the kinds of clients on whom we focus here. To supplement our review of the quantitative empirical literature, we summarize some of the results of this qualitative study (Daly & Mallinckrodt, 2008). A few words about the methodology are in order.

We began by preparing two case descriptions based on the items from the Avoidance and Anxiety subscales of the Experiences in Close Relationships inventory (Brennan, Clark, & Shaver, 1998). A narrative describing each client was presented in terms reflecting how an intake interviewer might describe a client with a high self-report score on the Avoidance subscale (client "R") or a high score on the Anxiety subscale (client "J"): for example, "R is very uncomfortable opening up to others on a deep personal level, and finds it equally uncomfortable when others begin to get too close.... " or "J has always feared abandonment in relationships and usually experiences a lot of anxiety even at the slightest sign of rejection or loss.... " To avoid adding an extra layer of complexity and length to the interviews, therapists were not asked how they might work with a client scoring high on both Avoidance and Anxiety. Neither vignette made reference to the gender of the client, thus freeing the therapists to "adapt the scenario to the circumstances you experience most frequently in your practice."

Therapists were presented with written copies of both case descriptions and informed they should assume that neither client had experienced sexual or physical abuse, that neither had any organic neurological problems, and that neither had any history or current pattern of substance abuse. They were further told to assume that couple therapy was not an option, that the romantic partners of each clients had been persons of the opposite sex of the clients, and that the clients would finance their own therapy up to a limit of 20 sessions. No preauthorization from an insurance provider would be necessary.

Therapists known to one of us (Brent Mallinckrodt) were contacted in three communities: a large city on the East Coast, and two midsized cities each containing a large university, one in the Midwest and one on the West Coast. The therapists contacted in each community were asked to nominate colleagues whom they considered experts in working with adult outpatients who have problems in close personal relationships. Interviews were then conducted with those therapists who had been nominated as experts by two

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

or more of their colleagues. At the conclusion of the interview, each expert was also asked to nominate colleagues, using the same criteria by which they had been nominated. A total of 12 interviews were completed, transcribed, and analyzed by our qualitative research team.

The clinically rich and informative accounts provided by these expert therapists have been enormously helpful—not only as sources of data in themselves about how they conceptualize cases and work with adult clients who manifest problems with either anxious or avoidant attachment, but also in helping us organize the other literature we reviewed. The interviews generated a total of 96 themes that were classified into eight higher-order categories: (1) conceptualization, (2) client defenses, (3) managing therapeutic boundaries, (4) markers of progress, (5) transference and therapist nontransference reactions, (6) individual interventions, (7) corrective relational patterns, and (8) internal representations and models.

Our interviews suggest that expert therapists think in terms of an initial *engagement* phase of therapy in which they simultaneously gather data and conceptualize a client, while at the same time systematically tailoring the psychotherapy relationship to engage this particular client in therapy. Ideally, this initial phase leads to a *working* phase after certain *transition markers* become evident. The working phase must be followed with careful attention to the dynamics of *termination*. Many readers will recognize similarities in overall sequence of these stages to psychodynamic models of therapy process (e.g., Goldman & Milman, 1978; Weiner, 1998), even though the content differs. In the remainder of this chapter, we use the process model suggested by our interviews—conceptualization, engagement, transition markers, working phase, and termination—to organize our research review and present some of the preliminary findings of our own qualitative study.

CONCEPTUALIZATION

One of the most helpful schemes for conceptualizing relatively high-functioning adults with interpersonal problems is the model of attachment system activation and associated affect regulation strategies proposed by Mikulincer, Shaver, and Pereg (2003; for an overview, see Shaver & Mikulincer, Chapter 2, this volume). According to the model, when adults perceive a sufficiently great threat, their attachment system is activated in much the same way as in infancy. However, adults have a longer history of developmental experiences that influence the next stage of the process—namely, a determination of whether an attachment figure is available and likely to be responsive. If the answer to these questions is "yes," adults will use *security-based* strategies to seek comfort and emotional proximity with an attachment figure. However, adults who appraise their social environment as lacking in available and responsive attachment figures experience a heightened

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

sense of distress and will engage in one of two possible secondary strategies. Those who anticipate that proximity seeking, if exaggerated, may result in at least some measure of felt security are likely to engage in a *hyperactivating* secondary attachment strategy, whereas those who believe that proximity seeking is at best useless and at worst likely to lead to further emotional injury engage in a *deactivating* secondary attachment strategy.

Although these three reactions may be specific, to some degree, to a particular caregiver or situation (especially early in development), Mikulincer et al. (2003) describe a range of mechanisms that tend to ingrain these patterns by early adulthood as habitual, trait-like dispositions. For example, processes of selective attention and increasingly inflexible working models of self and others serve to harden attachment activation patterns that had greater plasticity early in development. In concrete terms, this means that therapists can expect clients to predominantly employ one of these strategies or a mix of the secondary strategies, corresponding to four broadly different types of adult attachment styles, each with a different ingrained pattern of attachment, affect regulation style, and potential vulnerability to a different set of interpersonal problems. (For an in-depth review of each style, see Lopez, Chapter 5, this volume.)

Most important, each attachment strategy requires a different engagement approach in order to lay the foundation for a working alliance that will eventually lead to therapeutic change. Clients who rely predominantly on security-based strategies generally present the fewest challenges for therapists, because they have developed relatively optimistic expectations of self-efficacy and others' responsiveness in the face of distress, and they come to therapy with considerable capacity for affect regulation and for self-reflection that bodes well for therapeutic change (Fonagy, Gergely, Jurist, & Target, 2002). We do not discuss these clients in great detail, because they have developed a capacity for secure attachment to others and to a therapist that presents relatively fewer challenges than the two types of clients on whom we focus.

Clients who rely on hyperactivating strategies present formidable challenges. In Mikulincer et al.'s (2003) model, these individuals have negative beliefs about their ability to cope with distress and expect that others will be inconsistently responsive and available. They tend to score relatively high on self-report measures of anxious attachment. Anxious attachment is associated with rumination and exaggerated appraisal of perceived threat, intense reactions to stressful events, and pervasive fears of abandonment (Mikulincer & Florian, 1998). Experimental research suggests that persons with high attachment anxiety are unable to suppress painful thoughts of separation, even when explicitly instructed to do so, and instead become more alert to their self-perceived weaknesses (Mikulincer, Dolev, & Shaver, 2004). Studies of undergraduates report that the positive association between anxious attachment and self-reported symptoms of distress is mediated by a

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

low capacity for self-reinforcement and a high need for reassurance from others (Wei, Mallinckrodt, Larson, & Zakalik, 2005), emotional reactivity (Wei, Vogel, Ku, & Zakalik, 2005), alexithymia (i.e., low emotional awareness), and the perception of low self-efficacy in social relationships (Mallinckrodt & Wei, 2005).

Clients who rely on deactivating strategies present equally formidable challenges, but of a different nature. Mikulincer et al. (2003) describe these individuals as tending to inflate their self-esteem defensively in the face of attachment threats and to avoid interactions that might involve intimacy or dependency. Under conditions of perceived threat, their secondary strategy involves both conscious and unconscious efforts to suppress attachment-related thoughts and feelings in an effort to avoid heightened distress. These individuals have relatively high scores on self-report measures of avoidant attachment. Studies based on self-reports of undergraduates have found that the association between attachment-related avoidance and self-reported symptoms of distress is mediated by the tendency to suppress emotional experience (Wei, Vogel, et al., 2005).

Experimental studies suggest that persons with high attachment avoidance do not initially encode into memory attachment-related material as well as others, although their rate of forgetting material once it is encoded is no higher than that for nonavoidant persons (Fraley, Garner, & Shaver, 2000). Experimental research also suggests that avoidant individuals are actually able to reduce physiological arousal when they suppress thoughts of attachment, rather than merely masking distress or denying it in self-reports (Fraley & Shaver, 1997). However, more recent experimental research suggests that the capacity to suppress thoughts about a previous painful separation tends to break down when cognitive resources are otherwise taxed, resulting in a rebound of suppressed thoughts about separation and heightened access to negative self-evaluations (Mikulincer et al., 2004). Avoidant individuals also have a tendency to project unwanted self-traits onto others (Mikulincer & Horesh, 1999). Similar to the self-reports of persons scoring high on attachment-related anxiety, avoidant individuals' self-reports of distress tend to be mediated by alexithymia (i.e., low emotional awareness) and the perception of low self-efficacy in social relationships (Mallinckrodt & Wei, 2005).

Although there is now a considerable body of experimental and correlational research to differentiate the three variations in attachment activation described by Mikulincer et al. (2003) in the general population, much less is known about how clients might exhibit these strategies in the initial sessions of psychotherapy. However, some indication may be found in the factor analysis that Mallinckrodt, Gantt, and Coble (1995) used to develop the 36-item Client Attachment to Therapist Scale (CATS). In this study of over 130 clients, three factors emerged that appear to parallel the security-based, hyperactivating, and deactivating strategies described in research with

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

nonclients. The highest-loading five items from each subscale are shown in Table 10.1.

The first factor comprises perceptions of the therapist as supportive, responsive, and dependable, and as providing a secure base for exploration. The second CATS factor taps clients' reluctance to self-disclose; perceptions of the therapist as disapproving and easily rejecting; and negative "self-conscious" feelings about therapy, including shame and humiliation (Lewis & Wolan Sullivan, 2005). These client characteristics are consistent with the research literature on individuals who rely on deactivating attachment strategies. The third CATS factor involves clients' wishes for boundary-crossing merger or constant contact with the therapist, which seem quite compatible with the strong dependency needs of clients who rely on hyperactivating attachment strategies.

Studies of clients have shown that the CATS subscales are significantly associated with the working alliance and with clients' self-reports of their object relations capacity (Mallinckrodt et al., 1995; Mallinckrodt, Porter, & Kivlighan, 2005). A study using the CATS with 51 client–therapist dyads reported that clients' memories of fathers as inconsistent were positively associated with scores on the Preoccupied/Merger subscale, whereas memories of mothers as cold were positively associated with scores on the Avoidant-Fearful subscale. Therapists' perceptions of negative client transference were positively associated with scores on both the Secure and the Preoccupied/Merger CATS subscales (Woodhouse, Schlosser, Crook, Ligiero, & Gelso, 2003). The authors interpreted the somewhat surprising find-

TABLE 10.1. Selected Items of the Client Attachment to Therapist Scale (CATS)

Factor 1: Secure
1. I don't get enough emotional support from my counselor.*
2. My counselor is sensitive to my needs.
3. My counselor is dependable.
4. I feel that somehow things will work out OK for me when I am with my counselor.
5. My counselor isn't giving me enough attention.*

Factor 2: Avoidant-Fearful
6. I think my counselor disapproves of me.
7. Talking over my problems with my counselor makes me feel ashamed or foolish.
8. I know I could tell my counselor anything and s/he would not reject me.*
9. I don't like to share my feelings with my counselor.
10. I feel humiliated in my counseling sessions.

Factor 3: Preoccupied/Merger
11. I yearn to be "at one" with my counselor.
12. I wish my counselor could be with me on a daily basis.
13. I would like my counselor to feel closer to me.
14. I'd like to know more about my counselor as a person.
15. I think about calling my counselor at home.

Note. Adapted from Mallinckrodt, Gantt, and Coble (1995). Copyright 1995 by the American Psychological Association. Adapted by permission. * indicates a reverse-keyed item.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

ing of a connection between the Secure subscale and negative transference as perhaps indicating that a certain degree of attachment security may be necessary for clients to express their negative feelings of transference.

Whether or not the expert therapists we interviewed (Daly & Mallinckrodt, 2008) explicitly used terms derived from the CATS, most conceptualized clients' initial presentations with regard to hyperactivation or deactivation of their attachment systems. Another concept discussed explicitly by most of these therapists (and implied by the others) was the concept of engagement and alliance formation as a corrective emotional experience. They described their primary goals for the engagement phase of therapy as beginning the process of helping a client form a secure attachment that he or she had rarely, if ever, known previously. This secure attachment could then become the basis for a transformative experience of psychotherapeutic change. These experts described their work in terms of continually monitoring and managing what we term *therapeutic distance* in their unfolding relationship with a client. Although not all of the 12 clinicians used this phrase, each described some variation of the concept. Some described it with such terms as *level of intimacy*, *self-disclosure*, *gratification of needs*, *boundaries*, or *depth* of the work.

Embodied in the concept of decreasing therapeutic distance is the notion of increasing transparency and disclosure—from both client and therapist—and strengthening the bond aspect of the working alliance. Clients who seek very low levels of therapeutic distance tend to have high dependency needs, a limited capacity to function autonomously, and a tendency to push limits and cross appropriate boundaries in the relationship. Thus it is apparent that the construct of therapeutic distance, as described by the expert therapists interviewed in the Daly and Mallinckrodt (2008) study, is composed of a mixture of component strands with positive and negative valence. More importantly, for each client there is an optimal therapeutic distance that characterizes healthy functioning in the psychotherapy relationship, as well as a level of therapeutic distance that the client initially seeks to establish in the early sessions but is typically not the level the therapist views as ultimately optimal.

For clients who employ security-based strategies, the levels of initial and optimal therapeutic distance are not far apart. Generally, therapists and clients in these dyads are able to enter a mutual partnership indicative of a secure attachment and are able to close the gap between initial and ideal distance relatively quickly. However, clients who employ hyperactivating strategies begin therapy with a desire for much less therapeutic distance than is optimal, whereas clients who employ deactivating strategies seek to maintain far more therapeutic distance than is ideal. For both kinds of clients, the gap between the initial level of therapeutic distance and the optimal level is very wide indeed. Furthermore, because a secure client–therapist attachment is difficult to establish, the process of closing this gap is often long and difficult.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

Thus the process of change described by the experts we interviewed (Daly & Mallinckrodt, 2008) requires that therapists (1) continually monitor the therapeutic distance sought by a given client; (2) recognize the optimal distance in the psychotherapy relationship that would represent a corrective emotional experience for this client; and, finally, (3) engage in an active and carefully planned effort to manage the psychotherapy relationship so as to close the gap between 1 and 2. At each stage, this process is informed by attachment theory, especially by an understanding of the dynamics of attachment hyperactivation and deactivation. In Figure 10.1 we have summarized our view of this process, gleaned from a review of the empirical literature and from the Daly and Mallinckrodt (2008) interviews with expert therapists.

Clients with high attachment-related anxiety have a strong tendency to hyperactivate their attachment systems. In the initial sessions, they seek to shrink therapeutic distance to a degree that is much closer than optimal. The tendency of some of these clients to push boundaries in the engagement phase of therapy is represented in the upper left-hand portion of Figure 10.1 by placing the "C" symbol for these clients immediately adjacent (or even intruding across) the vertical line indicating the midpoint of optimal therapeutic distance. In these circumstances, if a therapist insists on maintaining his or her share of the optimal therapeutic distance, indicated by the "X" on the continuum, few hyperactivating clients are able to tolerate the resulting frustration. Instead, an expert therapist takes deliberate steps to reduce ther-

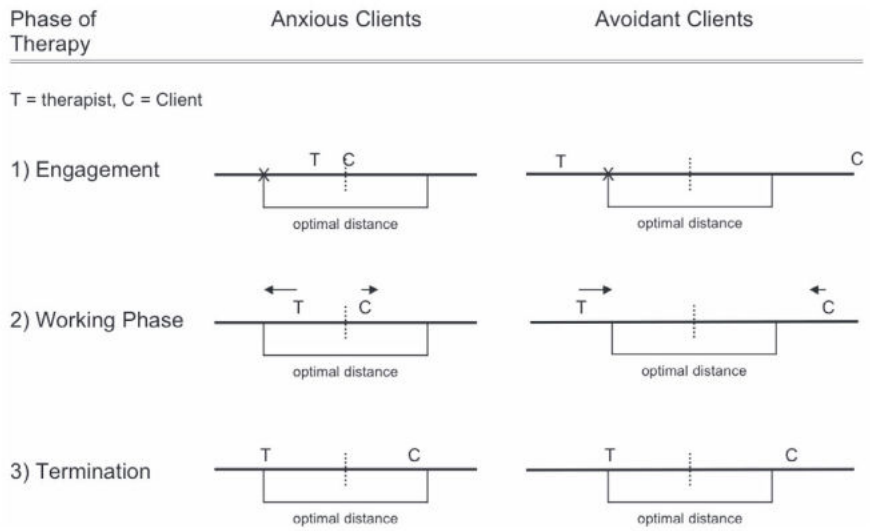


FIGURE 10.1. The process of change in therapy from an attachment-theoretical perspective.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

apeutic distance in the early work, symbolized by the right-pointing arrow. The "T" indicates the therapist's initial stance, which involves gratifying some client needs in the early sessions and establishing a closeness that the therapist knows would not be optimal in the long term but is necessary at the outset to engage an anxiously attached client.

Once these clients have been sufficiently engaged, the beginnings of an increasingly secure psychotherapeutic attachment emerge. Transitional markers make their appearance, signaling that therapists can begin the working phase by gradually increasing their portion of the therapeutic distance (left-pointing arrow). Ideally, clients respond with a reciprocal—though usually somewhat lesser—increase in their own contribution to the therapeutic distance (smaller right-pointing arrow). Rarely is the work as smooth as the middle section of Figure 10.1 implies. Anxious clients, fearing abandonment, often make bids to close therapeutic distance. New stresses in their lives precipitate setbacks. Therapists may need to reverse course temporarily. However, when things go well, the process of change generally follows the pattern of gradually increasing therapeutic distance as shown in Figure 10.1. The prospect of termination presents a fresh set of challenges, but ideally when the work is finished, the therapist can consistently maintain an optimal level of therapeutic distance. The "C" for anxious clients is shown slightly inboard of the optimal distance at termination, to represent an acknowledgment that these clients may always retain some tendency toward hyperactivation and anxious attachment.

For clients with a highly avoidant attachment style, who have a strong tendency to deactivate their attachment systems, the right-hand column of Figure 10.1 depicts the usual process. Initially, these clients seek to maintain a much greater therapeutic distance than would be optimal. A therapist who insists on maintaining an optimal distance ("X" on the continuum) early in treatment will create considerable discomfort in these clients. (Note the paradox: The optimal therapeutic distance tends to produce tension and discomfort in avoidant clients, whereas it tends to produce frustration for anxious clients.) To engage clients who tend to deactivate their attachment systems, a therapist must take an initial stance that is more distant than will ultimately be best (left-pointing arrow). After these clients are sufficiently engaged and transitional markers appear, the working phase involves a gradual approach by the therapist that narrows the therapeutic distance. Ideally, the clients reciprocate, although their approach is not likely to match the therapist's in magnitude. Again, the process is by no means a smooth one and may contain a number of approaches and retreats. Ultimately, at termination, the therapist has narrowed the gap so that his or her contribution to the relationship is optimal, although these clients may always function at a distance slightly outside the optimal range, indicating a tendency toward avoidance and deactivation that is never entirely relinquished.

Research investigating the match of client and therapist attachment style provides some support for the model shown in Figure 10.1. A study that

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

categorized 27 outpatients with fairly severe psychopathology and their 18 case managers along dimensions of secure–insecure strategies and preoccupied–dismissing (i.e., hyperactivating–deactivating) strategies also coded the case managers' interventions in terms of depth and responsiveness to clients' dependency needs (Dozier, Cue, & Barnett, 1994). Case managers' insecurity interacted with client attachment strategy, such that insecure, but not secure, managers tended to react with greater depth of intervention as client hyperactivation increased. However, the generalizability of these results is limited because these case managers included seven with only bachelor's-level training, seven who had earned a master's degree in social work or a related field, and four who were working toward a master's degree. It is also not clear whether inferences to other types of psychotherapy can be drawn from the case management interventions examined in this study.

A second study of 21 somewhat more experienced case managers and similar outpatient clients assessed participants on similar dimensions (Tyrrell, Dozier, Teague, & Fallott, 1999). Results suggested that client and case manager deactivation interacted, such that less deactivating case managers formed stronger working alliances with more deactivating clients.

These findings have been interpreted as suggesting that therapists whose own attachment style is noncomplementary to that of their clients have a natural inclination toward providing the type of corrective emotional experience that is best for clients with either attachment-related anxiety or avoidance. Writers have speculated about the benefits of matching clients to therapists on the basis of dissimilar attachment styles (Bernier & Dozier, 2002). We suspect that practical difficulties will prevent this suggestion from ever being widely implemented; more importantly, however, the model we have described suggests that different types of relationships are needed to facilitate change at different points in therapy. For example, even though clients with high attachment-related anxiety may ultimately benefit from interacting with a therapist who resists their bids to become enmeshed, in the initial sessions it will be necessary to gratify some of these needs for proximity. Matching this client with a therapist whose own attachment-related avoidance makes establishing distance easier may not be the best way to facilitate initial engagement.

Instead, our reading of the empirical literature and our synthesis of the Daly and Mallinckrodt (2008) interviews suggests that expert therapists—whatever their own attachment tendencies—have an especially high capacity for flexibility in the relationship conditions they offer to clients. They are able to adjust the "thermostat" of therapeutic distance through a wide range, as the needs of a particular client dictate. Whether attempting to foster more or less distance, they are able to maintain a consistently high level of genuineness through a flexible range of relationships—a quality Lazarus (1993) has termed "being an authentic chameleon (p. 404)." This allows them to work effectively with both hyperactivating and deactivating clients,

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

although, interestingly, many of the expert therapists expressed a preference for working with one type over the other.

We are aware that thus far, our discussion of client conceptualization and the presentation of our theoretical model have remained at a highly abstract level. In the next sections, we discuss concretely what therapists do to increase or decrease therapeutic distance as they engage, enter the working phase, and terminate therapy with clients who have strong tendencies toward either attachment system hyperactivation or deactivation. Fortunately, the therapists we interviewed shared a great deal of their hard-won clinical wisdom.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

ENGAGEMENT

The expert therapists in the Daly and Mallinckrodt (2008) interviews emphasized the importance of initially engaging clients with high attachment-related anxiety by "giving more" than they might with other clients. Hyperactivating clients require reassurance and repeated evidence of the therapist's positive regard. Clients' anxiety may be alleviated by therapists' disclosing about their experience of a session and feelings toward the clients. As clients begin to divulge more aspects of themselves that are shameful or unacceptable, it becomes especially important for therapists to reassure them that these disclosures strengthen rather than weaken the developing relationship. Several therapists revealed that they typically set less strict boundaries—but boundaries nonetheless—in the initial sessions with these clients. The therapists sense that these clients are less able to tolerate a level of withholding that would be appropriate for other clients, and at a point later in therapy will be more appropriate for these clients as well.

Therapists were quick to add that any decision to gratify these clients' needs must be carefully considered and may well represent the beginnings of a "slippery slope" that will need to be halted with stricter limit setting later in the work. Therapists acknowledged that in these early sessions, they may well be colluding in clients' maladaptive patterns of managing anxiety. However, some degree of collusion is necessary until such clients develop alternative, more adaptive ways of regulating affect and meeting their own needs. The expert therapists spoke in terms of building a "temporary bridge," and of "intentionally" rather than impulsively deciding to grant the implicit request of these clients for a decrease in therapeutic distance.

Expert clinicians emphasized that the initial engagement phase of therapy is crucial precisely because the diminished capacity for secure attachment (i.e., having access to and using security-based strategies) in both hyperactivating and deactivating clients is fundamental to their interpersonal problems, and at the same time presents considerable obstacles to forming a productive working alliance. Many of our expert informants spoke of how they monitored the initial sessions for signs of how clients

might be projecting onto the relationship expectations developed from their earlier interactions with attachment figures. Some therapists believed that this tendency requires early and frequent discussions about the relationship as a way to promote engagement, especially with clients who manifest high attachment-related anxiety.

Discussions of how these clients feel toward the therapist and about the relationship serve to engage clients, particularly if they are also invited to reveal any disappointments about the therapist or fears of rejection in these early sessions. Several therapists mentioned that anxious clients tend to be relatively easier to engage in the beginning, but may pose greater challenges later, when their idealization of the therapist is inevitably shattered. Discussing negative feelings toward the therapist in the early sessions tends to blunt idealization and sets the stage for a crucial task that is to follow—namely, working through feelings of frustration and disappointment with the therapist as well as other attachment figures. Many anxious clients find consistency and some level of structure in a session reassuring; for example, a therapist could begin each session with a similar opening question, as well as ending each session in a consistent way (perhaps taking a few minutes to ask clients about their experience of the previous hour).

Many expert therapists believe that one of the most powerful tools for engaging clients with high attachment-related anxiety is for a therapist to directly solicit any negative feelings a client harbors toward the therapist or about something that has happened in a session. Because of their developmental history, hyperactivating clients fear that any criticism of an attachment figure risks the dissolution of the relationship. Thus therapists who solicit criticism and respond nondefensively in ways that validate such clients' feelings can create a powerful corrective experience. Clients learn more adaptive and direct ways of handling relationship setbacks and conflict. They also develop a stronger sense that the psychotherapy relationship is not as fragile as they feared. In other words, open dialogues are opportunities for clients to experiment with a security-based strategy for dealing with negative feelings. However, many clients with high attachment-related anxiety will require considerable encouragement and coaching to express any negative feelings toward a therapist. Thus therapists need to be especially vigilant for nonverbal as well as verbal indications that a client is displeased with the ongoing process.

These moments can be acknowledged with a process comment, or a statement of curiosity from the therapist about what the observed behavior may signify. For example, one therapist discussed how he approaches this issue:

> "It needs to be discussed much more openly with a client like J, compared to others—because [clients like J] will say they forgive, but they will hold onto it. It might be okay at the moment, but it almost inevitably, with patients as vulnerable as J, leads to them thinking that I don't

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

> care about them and occasional thoughts of quitting therapy. It surprised me that it was not in your vignette that J has had many therapists because no one is quite good enough. This is just like her relationships; she always needs a therapist, but no work is ever going to be good enough. So we need to constantly be talking about how we are doing. I'm encouraging her to tell me when she thinks I've screwed up, when she thinks I haven't been sensitive enough. We need to continually talk about how things are going between us."

Many of the therapists felt that overt client resistance, such as canceling an appointment or arriving late for a session, provides an invitation for open dialogue regarding the client's reaction to the therapist. A gentle, nonblaming exploration of the meaning of this behavior promotes engagement and makes it less likely that the pattern will be repeated. The following excerpt illustrates what this might look like:

> "I think if R and I had a really deep session and [in the next session] R no-showed, I would call … and say, 'I noticed you didn't come in. What's up?' I would process that with [R] and try and make [R] feel safe enough to come back in. But I would [also] try to prevent that in the session by being connected when the client is feeling vulnerable."

Therapists reported using such interventions to encourage engagement with clients who were high in either attachment-related anxiety or avoidance, although they reported implementing them at different paces, depending on the clients' attachment styles. A tactic for promoting safety and engagement that may be particularly useful for avoidant clients is to allow them considerable control of the topics discussed in early sessions; this may serve to protect them from feeling overwhelmed or pressured to disclose to an extent that might otherwise risk premature termination. Some therapists expressed reticence about proceeding too quickly with initiating open dialogue about the therapeutic relationship with clients high in avoidance. The following excerpt underscores some of the concerns most frequently expressed:

> "I guess I would be concerned about not invading him [R]. It would be easy to invade his space, but it is also a delicate balance because you don't want to be avoidant yourself, because then you just have an avoidant pair. So I would want to be trying to move in, but be empathically aware of when I'm going too far."

Establishing rapport and promoting engagement must be a gradual process for avoidant clients, because a distinguishing feature of their attachment style is discomfort with closeness and with the intimacy that effective therapy requires. Another therapist commented:

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

> "They're uncomfortable opening up and unable to depend on someone. In a sense, their very issue is what's going to happen in therapy—if therapy goes right. They're going to open up to me; they're going to feel deeply connected; at some stage in therapy they're going to feel dependent. And so the tricky thing is to not push that too fast, I think, because that could scare them away."

Avoidant clients may find talking about emotions and relationship issues a rather aversive experience. Therapists described increasing engagement with avoidant clients by continually monitoring signs of anxiety or discomfort, and by being sensitive to indications that a client was reaching the limits of her or his tolerance for decreased therapeutic distance. When this limit is approached, therapists spoke of "slowing the pace." In early sessions therapists often permitted the dialogue to remain superficial or intellectualized, thus allowing clients to retain a sense of safety. Consider this example:

> "I can think of clients I've worked with who are avoidant, and their avoidance is manifested partly through intellectualization as a defense. These are people who live in their heads. . . . one of the ways of engaging them is to do a little bit of that. Maybe talk about things that are intellectual. If they're talking about philosophy, rather than move away from this because you're being too intellectualized, maybe doing a little bit of that. I think this creates a rapport that you are in a 'similar enough tribe,' if you will. It's sort of sidling up to the patient to an extent, and that could be engaging. Now, if you go too far, then you've lost the game, I think."

Another example of a tactic that therapists endorsed for engaging both hyperactivating and deactivating clients—but one that required more gradual pacing for deactivating clients—was the practice of involving them in a spirit of mutual curiosity about the clients' history, feelings, and sources of motivation. Here is an example:

> "I try to engage them in being curious about themselves. Then we can start to connect around the curiosity about him, my curiosity and interest and his, in a way that can begin to allow him to absorb himself."

Other therapists spoke about developing a mutual collaboration with the client to join forces to work at defeating the client's pain. One therapist explained:

> "For me, the metaphor is sort of like the suicidal client. If clients tell you they're suicidal, then there's a small piece of them that wants you to stop them, and so [I focus on connecting] to that part. [For a cli-

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

> ent with attachment problems,] there's a huge part … that wants to depend on someone, that wants a relationship, that wants to feel safe in a relationship—or else [the client] would not be coming into therapy about this. So I would really work hard to access that part of what has been painful for the person in this pattern, and really try to talk to and reach the part that wants things to be different."

Presenting a client with the metaphor of fighting as allies against his or her pain can be useful, because the client is invited to become an active collaborator in the change process. In addition, this collaboration early in the work establishes a pattern quite different from anything the client may have known. Adults with either anxious or avoidant attachment patterns often have a history with caregivers who were unavailable, inconsistent, or hurtful in some way. Thus, if a therapist is perceived as a person who is genuinely concerned about a client's well-being, allying and empathizing with the client can be a healing experience. Another way of looking at the "fighting as allies" metaphor is that the client is invited to connect with a painful past experience but—unlike in the past—to use more security-based strategies to process the experience and regulate affect.

Instillation of hope is another intervention used to promote engagement by the therapists we interviewed (Daly & Mallinckrodt, 2008). Helping clients envision what they would like to see change and how relationships could potentially look different following therapy is a powerful incentive that can increase engagement. This may enable a therapist to connect with the part of a client that is in pain and wants to experience closeness with others or wants to feel comfortable alone. Some therapists reported using more tangible means of expressing their belief that change is possible—for instance, drawing a continuum on a 3 □ 5 note card that depicts a beginning with the client's current issues and an endpoint of what he or she would like to achieve. This emphasis in the early sessions on eventual outcomes is another way that therapists can engage clients by showing a high level of interest and an eagerness to help clients achieve desired goals. Emphasizing final goals may be especially important for avoidant clients, because this concrete conversation in the beginning of therapy paves the way for subsequent discussions of the more abstract (and frightening) session-level tasks that will be necessary to achieve these goals.

Finally, a crucial aspect of the engagement process (and subsequent phases of therapy), according to the experts interviewed in the Daly and Mallinckrodt (2008) study, is a therapist's capacity to manage the strong affective reactions that hyperactivating or deactivating clients can engender, together with the strong "pulls" these clients exert to replicate dysfunctional interpersonal patterns. Slade (1999) has speculated that avoidant clients deny the therapist a meaningful personal connection, just as they were once denied closeness and intimacy in their own childhood. The "impermeability" of the narratives that avoidant clients tell about their relationships,

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

their rigid inflexibility, their interpersonal aloofness, and their rejection of bids for empathic connection leave the therapist "caught in the same barren landscape" as the clients, and left feeling much as the clients once felt as children: "angry, unacknowledged, silly, and inept" (p. 588). In contrast, hyperactivating clients can focus tremendous energy on efforts to have the therapist take care of them and ease their sense of emotional confusion. Because a true mutual collaboration is all but impossible in the early sessions with these clients, their overwhelming dependency leaves the therapist feeling much the way the clients felt as children: swamped, angry, helpless, confused, and dysregulated" (p. 588).

Not surprisingly, then, expert therapists reported intense countertransference to clients high in either attachment-related anxiety or avoidance. Frustration and boredom emerged as examples of fairly frequent reactions to avoidant clients. As one therapist explained:

> "I have to watch out for feeling really frustrated and becoming disengaged from the work. You know, chatting and abstract disclosures are difficult to engage with—they are too far away. And his presentation may keep me away from the interesting stuff, so I may even experience boredom."

On the other hand, many therapists asserted that it was relatively easy for them to empathize and connect with avoidant clients, because they conceptualized the avoidant clients they work with as more closely resembling the fearful attachment style (high in both attachment-related anxiety and avoidance) than the dismissing style (high in avoidance but low in anxiety). Thus therapists were able to concentrate on the part of avoidant clients that deeply yearns for a real connection, despite the fear of rejection or hurt typical of previous relationships. The following excerpt captures this kind of reaction:

> "My countertransference is very maternal. This is a very wonderful client for me to work with, because it is very clean and clear to understand what the person needs. There is a lot of tenderness in my work with this kind of client."

Frustration was a common response that emerged in therapists' work with clients high in attachment-related anxiety. One therapist noted:

> "It frustrates me, but I understand that this is the nature of the work. They are not frustrating me out of any sense of meanness. They have been terribly hurt early in life and are always testing the world to see who else is going to hurt them."

Unlike reactions to clients high in avoidance, where the relationship evolves at a slower pace that can produce boredom, therapists said they often felt

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

the need to brace themselves for the intensity of relationships with clients high in anxiety. Many therapists underscored the importance of knowing themselves and their boundaries so that they did not react with anger to the incessant demands of anxious clients. One therapist explained how she responds to the intensity of an anxious client:

> "I think J would come to really be intense with me and have our relationship be really, really, really important, and I would have to not be afraid of that. I would have to be able to engage and really connect, but not merge and keep my own boundaries. And let them know I really do care. I really would have to be one of the people who fill their hole. I mean, we talk about 're-parenting' sometimes in therapy. I think there may be a stage where J wants me to fill his hole, and I'd have to not run away from that. I'd have to really stay okay with that. And know that it was part of the process and not be freaked out by it."

TRANSITION MARKERS

Engagement involves the gradual development of a sufficiently firm therapeutic alliance to allow the difficult work of change to begin. As the engagement phase comes to a close, the avoidant/deactivating client's fears of intimacy and vulnerability in the therapeutic relationship, and the anxious/hyperactivating client's fears of the therapist's abandonment and rejection, have been sufficiently contained for a new phase of the therapy to begin. The expert therapists we interviewed (Daly & Mallinckrodt, 2008) described beginning the process depicted in the middle row of Figure 10.1—namely, developing a closer relationship with avoidant clients, or introducing more distance and insisting on a more autonomous relationship with anxious clients. But how do therapists know when to safely begin this new phase of the work? In our interviews, the expert therapists described the emergence of signals that indicated when each type of client was now ready for this more intensive phase of therapy. We term these signals *transition markers*.

Therapists stressed the idiosyncratic nature of transition markers, but nevertheless four general themes cut across the interviews: (1) The client makes a commitment to change; (2) the client reports some behavioral change outside sessions; (3) the client develops tolerance for deeper and more intense affect in sessions; and (4) the client evinces a capacity to "do the work of therapy." With regard to the first theme, from a stages-of-change standpoint (Prochaska & DiClemente, 1983), the client has moved from the stage of *precontemplation* or *contemplation* to the *preparation* stage, which features a firm commitment to change; also, although there is as yet little movement toward achieving the primary goals, some of the component changes required for these larger goals have begun to occur. From the standpoint of the working alliance, the bond has been reasonably estab-

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

lished, and there is initial agreement about the goals and tasks of therapy (Gelso & Carter, 1994).

With regard to changes outside of therapy, clients high in attachment-related anxiety report an increase in their ability to regulate affect independently of the therapist, an increasing repertoire of self-soothing skills, and at least some increase in autonomous coping ability. One therapist explained:

> "You're feeling a good bond with the person, a good alliance, a real relationship. And the person is at work—not that he has good feelings towards everything or you, but he's working on understanding and invested in understanding. So it's two things: the person doing the work of therapy, which from my vantage point concerns the patient's understanding, and outside of treatment it involves changing behavior and feeling better."

Among the in-session transition markers mentioned by therapists is an increase in clients' ability to experience and effectively process more intense affect in the session. For avoidant clients, this may take the form of a willingness to approach feelings and allow an experience of affect instead of only an intellectualized examination. Conversely, for anxious clients, the intense experience of affect is coupled with a decreased fear of being overwhelmed and an increased capacity for insight and introspection.

Another sign of progress that many therapists mentioned is evidence that a client is emotionally affected by a therapist—for example, a negative reaction, such as feeling rejected or angered by the therapist's absence. Evidence of positive influence includes reports of feeling comforted between sessions or recalling an in-session experience or something the therapist has said. Of course, a client's disclosures of a therapist's influence present new opportunities to discuss the therapy relationship, how it is evolving, and what it has come to mean for both client and therapist.

Examples of demonstrating an ability to do the work of therapy include an avoidant client's capacity to engage in a sustained discussion about the ongoing therapy relationship—even occasionally initiating such a discussion, or speculating about the possibility that patterns occurring with significant others might also be influencing the relationship with the therapist. Such discussions may come more naturally to clients high in attachment-related anxiety, because they are preoccupied by their relationship to the therapist. However, therapists observed that the capacity to engage in more productive introspection develops for both anxious and avoidant clients only after they have developed more effective affect regulation skills. Fonagy et al. (2002) have described a cluster of skills they term the capacity to *mentalize* (see Jurist & Meehan, Chapter 4, this volume). At the core of these skills is a self-reflective capacity to understand one's own behavior and the behavior of others in terms of changing mental states. This capacity allows clients to understand the sources of their own motives in interpersonal transactions

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

and to reliably predict others' reactions. Mentalizing is developed through secure attachment early in life and is a key to effective affect regulation (Fonagy et al., 2002). Clients who demonstrate some capacity for mentalizing signal that they may be ready to enter a more difficult phase of therapy.

Some of our expert therapists spoke of testing clients to assess their capacity for doing the work of therapy. For example, because anxious clients frequently externalize and are so focused on having their needs met by others, they tend to overlook their own role in maintaining painful interactions. Therapists may redirect the focus of these clients' stories back to themselves, to assess their willingness to self-reflect and accept some responsibility for the pattern. Similarly, therapists can test the willingness of avoidant clients to work with affect by assessing their reaction to an empathic reflection of feeling or asking the clients to imagine the feelings that motivate the behavior of important others in their lives. If, rather than immediately dismissing the redirection, a client tentatively accepts the reflection and elaborates on it, this could be taken as a signal that more in-depth affective work may be possible.

Taken together, these transition markers can be considered indicators that a secure therapeutic attachment is in the making. Bowlby (1988, p. 71) placed particular emphasis on the therapist's serving as a secure base as a requisite for successful therapy. He stressed that perceived threat is incompatible with exploration for both infants and adults. However, when a sufficiently secure therapeutic attachment has been formed, an adult client is able to use the presence of the therapist and the comparative safety of the session to quell perceptions of threat. Bowlby believed that under these conditions clients can examine and eventually integrate previously warded-off experiences, which include unresolved past traumatic events, but also feelings in the here and now about the therapist. Although few of the experts interviewed by Daly and Mallinckrodt (2008) explicitly mentioned the term *secure base*, it is clear that the transition markers they described are evidence, in attachment-theoretical terms, that the client has begun to use the therapist as (1) a valued target for proximity seeking, (2) a safe haven when threats are perceived, and (3) a secure base for exploration. (See also Farber & Metzger, Chapter 3, this volume.)

At least 4 of the 14 items of the CATS Secure subscale tap the secure-base aspect of the relationship: "I feel that somehow things will work out OK for me when I am with my counselor," "My counselor helps me to look closely at the frightening or troubling things that have happened to me," "My counselor is a comforting presence to me when I am upset," and "I know my counselor will understand the things that bother me" (Mallinckrodt et al., 1995, p. 317). Client scores on the secure subscale between the 4th and 8th sessions of 12-session time-limited therapy were strongly and positively associated with depth of exploration in a session (Mallinckrodt et al., 2005), providing support for Bowlby's conclusions about the value of the therapist as a secure base for clients' exploration. Perhaps scores on

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

the CATS Secure subscale above a minimum threshold, or simply clients' general agreement with the four items that assess secure-base perceptions of the therapist, could be taken as an additional indicator that the working phase of the therapy can begin.

WORKING PHASE

In her seminal chapter on attachment and psychotherapy, Slade (1999) wrote that attachment theory "*informs* rather than *defines* intervention and clinical thinking" (p. 577; emphasis in original) and that a manualized attachment-based therapy for individual psychotherapy with adults does not yet exist. We interpret this comment as suggesting that a "cookbook" list of techniques and proscriptive directives is not likely to emerge from the application of attachment theory to psychotherapy. However, instead of a definitive series of linked statements (e.g., "If the client does X, the therapist should respond with Y"), attachment theory can provide a rich description of a range of options that are likely to be effective. In this sense the guidance offered by attachment theory to therapists is more like a jazz chord progression than a musical score for a chamber quartet.

Thus it is perhaps not surprising that the remarkable agreement we (Daly & Mallinckrodt, 2008) observed in expert therapists' descriptions of conceptualization and engagement disappeared in these clinicians' idiosyncratic descriptions of treatment interventions and specific techniques. Indeed, although the therapists described in detail how concepts from attachment theory guide the formation of their relationships with clients, many of the 12 experts interviewed were reluctant to describe any specific techniques they use in the working phase. Some of them felt that the individual circumstances of each client render meaningless any discussion of techniques that should be used with a hypothetical "typical" client with an anxious or avoidant attachment style. Therefore, readers seeking a guide for "what to do when with whom" may be disappointed in this section.

However, a clear theme that emerged throughout the interviews was the idea that at least a minimal level of security in the client–therapist attachment is a necessary precursor for implementing techniques at this stage. Furthermore, work to deepen and broaden the quality of therapeutic attachment was viewed by many experts as a core component of facilitating change. Therapists described how in the working phase they gradually withdraw the considerable amount of direct support they have been providing to anxious clients in the engagement phase.

For example, whereas a therapist may have initially responded to clients in emotional crisis with a very problem-focused, highly directive intervention, in the working phase the same therapist may begin by asking clients in crisis to first generate their own possibilities for a solution. For clients high in attachment-related anxiety, careful monitoring of their fears of

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

abandonment and tolerance for frustration is necessary. Like withdrawing control rods from a nuclear reactor, a precipitous movement could result in "meltdown," whereas gradual increments of withdrawal lead to clients' steadily growing confidence in their ability to function more autonomously. In contrast to this process of slowly fostering more self-reliance for anxious clients, therapists described the working phase with clients who exhibit high attachment-related avoidance as involving gradual insistence on reducing therapeutic distance—that is, insisting on less superficiality and less intellectualization, together with more in-session emotional experience and discussion of affect. Careful monitoring of these clients' tolerance for vulnerability and fears of intimacy is required. Gradual increments of emotional connection with the therapist lead to the clients' steadily growing capacity for mutually satisfying relationships with others.

In essence, an important goal for the working phase for both types of clients—and the chief goal for some therapists we (Daly & Mallinckrodt, 2008) interviewed—is to develop a secure attachment in which clients are able to meet their needs consistently through security-based strategies of attachment, rather than relying on either hyperactivating or deactivating strategies to regulate affect or meet their interpersonal needs (Mikulincer et al., 2003). This is the core feature of the corrective emotional experience. Students who are first exposed to these concepts often question how a corrective emotional experience in only one relatively temporary relationship, even when this relationship is the most secure possible attachment to a therapist, can overcome hundreds of negative interactions with others and decades of time that have solidified maladaptive patterns in a client. When teaching beginning practicum students, one of us (Brent Mallinckrodt) uses the following allegory to illustrate:

> "Once there was a starving peasant who passed a large gnarled tree on her way to work in the fields each day. One evening on her way home, in hunger and desperation, she reached up and thrust her hand deep into a hollow high up in this tree. The recess was so high and so deep that she could not see what lay inside, but she had caught a whiff of something sweet, and so great was her hunger that her need overcame her fear. To her great dismay, as she reached inside, her hand was stabbed with painful splinters. The next evening, still driven by hunger, she again desperately groped in the hollow recess for anything that might sustain her. This time her hand was pierced by thorns. On the next occasion she was stung by bees. After dozens of similar painful and disappointing encounters, what impression would the peasant form about this tree? About all hollow trees? If this were her only experience, it would certainly be understandable if she concluded that such trees are dangerous and should be always be avoided.
>
> "But consider how the outcome would be different if, on what she vowed would be her last attempt, she reached into the hollow this

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

> time slowly and carefully, and on this occasion she discovered the bees' honey and was neither stung nor injured in any way. Wouldn't just this one countervailing experience completely change her thinking about the tree and about the possibilities of trying yet again? Even if she were stung or occasionally injured on subsequent tries, her *conception* of the tree would be changed forever. She might even learn the patience to consistently reach inside slowly. She might teach herself how to avoid bees by using a ladder and a torch to see more clearly inside and dislodge them with smoke. In time, she might even seek out other hollow trees, trusting in her ability to cope with the dangers in order to reap the rewards."

Such is the power of the corrective experience of secure attachment with a therapist to provide a single countervailing example that begins to break up clients' monolithic negative thinking about attachment and rigid patterns of interacting with others.

The interviewed therapists emphasized that the process of building a secure therapeutic relationship is not linear. Many described the unavoidable rough patches of alliance breaches and repairs in the struggle to form a secure attachment with these clients as an essential part of the process of change itself. Research suggests that strains in the relationship are inevitably brought about when therapists initially fail to respond as clients had hoped, but that these alliance ruptures can be repaired by validating clients' feelings of hurt and disappointment, and by responding nondefensively and effectively to these secondary reactions. Such repairs may even leave the relationship stronger, or in attachment terms "more secure," than before (Safran & Muran, 1996; Safran, Muran, Samstag, & Stevens, 2001).

In addition to establishing a secure attachment and healing inevitable alliance ruptures, more recent research suggests other possible goals for the working phase of therapy, based on a study of variables that mediate the relationship between attachment anxiety or avoidance and psychological distress. It must be stressed that this relatively new area of research has only examined *statistical mediation*—that is, circumstances in which a significant proportion of the association between an attachment variable *X* and an indicator of symptoms or distress *Y* can be accounted for by an intervening mediating variable *M* that is associated with both *X* and *Y*. In theory, *X* causes *M*, and *M* in turn causes *Y*; in practice, because most of these studies collect data at only one time point, these strong causal inferences cannot be fully supported. However, findings of statistical mediation suggest at least potential targets for intervention.

Among the mediators identified so far, this correlational research suggests that persons with high attachment-related anxiety may be helped by interventions that reduce their need for reassurance from others (Wei, Mallinckrodt, et al., 2005) and their tendency toward high emotional reactivity (Wei, Vogel, et al., 2005). This research also suggests that avoidant persons

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

may be helped by interventions that reduce their tendency to cut off emotional experience (Wei, Vogel, et al., 2005). Finally, these studies suggest that both avoidant and anxious individuals may be helped by interventions that reduce maladaptive perfectionism (Wei, Heppner, Russell, & Young, 2006; Wei, Mallinckrodt, Russell, & Abraham, 2004), increase the capacity for self-reinforcement (Wei, Mallinckrodt, et al., 2005), increase emotional self-awareness and a sense of self-efficacy in close relationships (Mallinckrodt & Wei, 2005), and enhance the ability to cope with distress (Wei, Heppner, & Mallinckrodt, 2003).

Some of the pioneering research on attachment and psychotherapy investigated the connection between attachment styles and responses to treatment. Horowitz, Rosenberg, and Bartholomew (1993) used the interpersonal circumplex, formed by the two orthogonal dimensions of dominance versus submissiveness and hostility versus affiliation, to characterize presenting problems of outpatients in brief therapy. An analysis of these interpersonal problems suggested that clients in the dominant/hostile quadrant of the circumplex were the least likely to show improvement in 20-session time-limited treatment. Furthermore, outpatients classified as dismissing in attachment style tended to report interpersonal problems centered in this portion of the circumplex. However, Fonagy et al. (1996) reported that in a sample of inpatients with fairly severe personality disorders, those with a dismissing attachment style tended to respond best to treatment that averaged over 9 months of inpatient hospitalization. A post hoc analysis of archival videotapes used observers to classify the attachment styles of 29 clients who received up to 25 sessions of outpatient therapy (Travis, Binder, Bliwise, & Horne-Moyer, 2001). Results suggested a significant shift from insecure to secure attachment style over the course of therapy. Attachment security did not predict better therapeutic outcomes as measured by the Symptom Checklist 90, although improvement in scores on the Global Assessment Scale did differ by attachment type. In a study of interpersonal psychotherapy Cyranowski et al. (2002) found that clients with secure attachment tended to recover from a depressive episode more quickly than clients with a fearful style did. Unfortunately, this small number of studies is as yet insufficient to guide therapists in confidently determining which specific variables may be productive targets of intervention to reduce clients' attachment-related anxiety or avoidance.

TERMINATION

From an attachment perspective, the nature of terminating a therapeutic relationship represents the loss of and separation from an attachment figure (the therapist). The client may perceive this as the end of a stable, safe, and nurturing relationship that he or she has come to rely upon for proximity, comfort, and security. The anticipated loss of a therapeutic relationship is

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

likely to result in feelings of grief and anxiety. In addition, clients anticipate that after termination they will need to face challenges and difficulties on their own, and this may be an additional source of considerable anxiety (Webb, 1985). For most clients, especially those who have experienced losses of significant others or unresolved issues connected with previous relationship endings, the grief, anxiety, and vulnerability they experience when ending work with their therapists are likely to activate some of their previous maladaptive patterns (Bembry & Ericson, 1999).

Paradoxically, the more secure a client's attachment to a therapist has been, the more grief and overwhelming affect he or she may experience as termination nears. This may especially be the case for clients who experience the therapist as their first truly secure adult attachment figure. Under the best of circumstances, even when the work has been quite successful, therapists should anticipate the reemergence of some vestige of the clients' previous hyperactivating or deactivating secondary strategy. Clearly, termination must be approached with great care and skill. However, like all crises, termination holds the potential for considerable client growth as well as potential setbacks.

Because there is always a foreseeable ending for every therapeutic relationship, we believe that, conceptually, all of the work throughout the process should be viewed in terms of preparation for a successful termination. The general task for the termination is to create a more effective, more positive ending experience than the problematic endings the client has experienced in the past. Several of the interviewed therapists emphasized that clients must be prepared for termination from the very beginning of therapy. The following excerpt captures this idea:

> "Even in the beginning, I'm talking about the end. Sometimes my first assignment is to have clients imagine that they have just successfully completed therapy, and then I have them make a list of the ways they are different. I ask them to be specific. I think it works great, because it gives people hope and lets clients know that I believe they can change."

The highly intimate and temporary nature of the therapeutic relationship poses the risk of recapitulating painful experiences of abandonment for clients high in attachment-related anxiety, and risks confirming the belief of clients high in attachment-related avoidance that close attachments are not worth the risk. Such a damaging ending might unravel much of the gains of the previous therapeutic work.

Although some aspects of termination may be applied more generally, therapists can anticipate that reactions to termination will differ substantially between anxious and avoidant clients, just as individuals with these patterns form attachments differently. The therapists we interviewed (Daly & Mallinckrodt, 2008) connected early interactions with caregivers to the

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

strategies children adopted, whether hyperactivating or deactivating, and subsequently related these strategies to relationship functioning in adulthood. Therapists should be keenly aware of any reemergence of the behaviors associated with hyperactivating and deactivating strategies when termination is approaching. After all, these are the coping mechanisms clients developed early in life to help them deal with separation and unmet needs, and they may resurface as the clients are faced with the challenge of the end of the therapeutic relationship.

According to our interviewees, avoidant clients may display a wide array of behaviors as termination nears, such as pulling away from the therapist, minimizing the importance of the relationship, acting critical toward the therapist, and responding negatively to gestures of warmth or empathy. It may be useful to encourage avoidant clients to revisit how they developed these strategies. For instance, a common antecedent may be a parent who was harsh and punitive in response to the expression of emotion. Some therapists find it helpful to reiterate that this relationship is different from the earlier relationship(s), and that expressions of sadness, grief, and anger are appropriate reactions to the loss of an important relationship. Therapists may model such reactions by disclosing their sadness over losing a meaningful relationship with the clients. Reflecting on the clients' growth in terms of their increased receptiveness to connection with others may be comforting, because it instills hope and reaffirms that meaningful connections are worthwhile despite the risk, investment, and sometimes pain inherent in close relationships.

When therapists are preparing anxiously attached clients for termination, a different set of reactions can be expected. These clients have learned to exaggerate their responses in order to increase the likelihood of a desired response, so they may become demanding, unstable, or angry in response to termination. Therapists will want to distinguish the relationship termination from previous endings that were probably traumatic for the clients. In addition, a therapist may want to highlight how a client has changed since the earlier losses. Adopting an empowering and affirming stance that the client has the resilience to continue making positive changes without the assistance of the therapist may help an anxious client to feel more stable. Reframing termination as a change in the relationship, but not an end to the care the therapist feels for the client, may be needed for such a client. Some interviewed therapists reported that they offer a more gradual termination, leaving the possibility of returning to therapy open for their clients. For clients high in attachment-related anxiety, who have often experienced abandonment by attachment figures, this might be yet another way to demonstrate how the therapeutic relationship is different and that endings need not be abrupt or devastating, but can gradually wane over time as the clients develop the skills necessary to function autonomously. The following excerpt illustrates this point:

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

> "When I terminate, it usually starts with meeting once every 2 weeks, then once a month, but I suggest, 'Come back in 2 months and tell me how you're doing.' It's totally what they want, but it's nice to be able to say that if it doesn't feel better, [they can] come back. 'I'm here in town, so if it starts acting up again, come back in.' So it's more of that family doc kind of model. 'This is just a resource in your life now, and I won't ever turn you away.'"

Given the histories of abandonment and mistrust experienced by anxious clients, it is important to prepare them for the end of therapy from the earliest sessions. Talking about the eventual ending provides clients with information and opportunities to process their concerns with their therapist. This also opens a dialogue that is germane to a client's core issues, increasing the possibility for the client to improve in this area and learn to cope with his or her reaction to loss and the absence of important figures. One therapist explained:

> "At some point as we get closer and have worries about losing our relationship and having serious feelings, we would talk about that. That's okay if they have concerns about that. I won't try to do things to make that not happen, because that's a growth opportunity for us to find out what their underlying needs are and what's driving it, and this is how we're going to help them get what they need."

For avoidant clients, this discussion should probably be postponed until they show evidence of more comfort in talking about the therapy relationship. However, once these discussions have begun, it is important not to delay introducing the topic of the relationship ending. As clients begin to recognize maladaptive patterns in their relationships, they can be helped to anticipate their own strong reactions as termination nears.

For example, after anxious clients have recognized how their pattern of hyperactivation is manifested with others, the therapist might ask, "How do you suppose your pattern might show up as our work together nears an end?" Similarly, after avoidant clients recognize their deactivating patterns, a therapist might ask them to speculate about how they might be tempted to pull back in the last weeks of working together. Anticipating these patterns makes it less likely that they will be manifested in an unmanageable way during the actual termination phase.

Assuming that a client has been carefully prepared for termination throughout treatment, once the therapist assesses that the client is ready for the work to end (or external events mandate the termination), it is critical to allow the client adequate time to resolve the conflict of separation/individuation associated with the termination. There are no clear guidelines for how many sessions will be sufficient, because of the idiosyncratic attachment needs of each client. However, inexperienced therapists often underestimate

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

how much time will be needed. Thus the halfway point of the work may not be too early for a discussion of termination. It is important to recognize that discussions of the relationship ending need not occupy an entire session. As the termination date nears, these discussions can become more frequent and may occupy a proportionately larger part of the session.

When the therapist and the client agree upon a specific date for the final session, this helps provide needed structure and a clear timeline for a successful termination (Teyber, 2006). Other techniques, such as counting down the number of sessions left for counseling and repeatedly initiating a "check-in" for the client to express any feelings or emotions associated with the upcoming ending, may also be helpful. Forced termination may result in clients' regression and should be handled with extra caution and care (Anthony & Pagano, 1998; Teyber, 2006; Ward, 1984). If the therapist needs to terminate because of external constraints, time limits, or other extratherapeutic reasons, it is important to acknowledge the reasons and the unfinished counseling work, and to invite clients to talk about their emotions and reactions in response to this abrupt ending.

Clients who perceive the termination as a loss or threat are likely to feel angry and abandoned, and to use denial or other defense mechanisms to cope with the anticipated anxiety (Siebold, 1991). It is critical for the therapist to communicate acceptance and validation of clients' feelings in a nondefensive manner. One of our interviewed therapists stated:

> "I would prepare them for termination, and want to walk through that with them, so they don't experience me as abandoning them. There are memories and internal thoughts that I hope to leave them with, so that they don't feel so alone."

Clients are more likely to perceive the termination as a positive transition if the therapist empowers them by allowing adequate time to process their feelings and giving them maximal control and choices during the termination process (Baum, 2005). Therapists can facilitate the process by guiding clients to directly express the emotions aroused by the upcoming termination, and by encouraging them to explore their previous experience of ending relationships, together with the meanings they attach to such endings (Shefler, 2000). Many clients with insecure attachment styles may hold a false expectation that the therapist will not end the treatment if he or she "really cares about me" (Youngren, Alonso, & Nahum, 2000). This belief is likely to be manifested during the termination process. It is important to help clients to understand and accept that termination of a relationship is an inevitable part of life, and that learning to simultaneously separate from and remain connected to significant others is a lifelong task (Teyber, 2006).

Therapists can help to reframe the termination as an opportunity for growth, and as yet another corrective emotional experience that helps to increase clients' confidence and self-efficacy in managing other losses and

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

relationship endings in the future (Baum, 2005; Teyber, 2006). Termination can be described to clients as an opportunity to integrate and consolidate their learning from the previous weeks of therapy, as well as serving as a safe environment to practice the new interpersonal patterns they have developed (Anthony & Pagano, 1998). In addition, the therapist may discuss the meaning and feelings associated with the completion of a meaningful life-enhancing task, what it means to become more independent and autonomous after the termination, and possible ways to celebrate this accomplishment. The goals of a successful termination can be defined as part of a meaningful relationship with a therapist that comes to an end with more closure and resolution than clients have typically experienced. In the terms of the model proposed by Mikulincer et al. (2003), security-based strategies predominate in a successful therapeutic termination, and neither hyperactivation nor deactivation is much in evidence as a secondary strategy. Although clients will feel grief and loss with regard to this ending, and perhaps considerable anger toward the therapist as well, the differences from what happened following previous endings are that clients have ideally developed newfound skills to cope with this affect, and are given an opportunity to process and integrate their reactions. As a result, they leave therapy free to enter new attachment relationships relatively unencumbered by unresolved feelings from a previous ending, and perhaps with greater confidence in their ability to experience closure. For many clients, this will be a new experience of freedom.

Therapists can bring about this type of termination in the last sessions by inviting clients to review and revisit significant topics discussed previously, and to synthesize what they have learned about themselves and about relationships to form a hopeful perspective for the future. A therapist may invite clients to describe a few "critical moments" that occurred during the counseling process—moments at which the clients felt inspired, gained a new insight, or experienced unusual emotional arousal (Ward, 1984). It may be useful to ask clients to examine past endings and to extract the common features of the "best and worst good-byes." With these insights, clients can be encouraged to actively bring about the best features and avoid the worst features of other endings, thereby taking more control of this ending. Clients can be encouraged to identify what they liked best about their relationship with the therapist, and then develop strategies to cultivate these features in other existing relationships, or to seek out new connections in which these relationship qualities can be developed. For many clients, interpersonal group therapy (with a different therapist as facilitator) may provide an ideal opportunity to consolidate skills and continue growth.

Finally, therapists' continued transparency and genuineness through the termination process can be very beneficial to clients. Therapists can share their genuine joy and pleasure at the clients' progress and improvement, as well as their feelings of sadness and loss at the ending of this relationship. Clients should not leave their final session without a clear understanding of whether a therapist will be available to work with them in the future, and/

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

or what types of future contact with the therapist (or other therapists at the agency) will be possible.

CONCLUSIONS

We have reviewed studies from a broad range of disciplines (including counseling, clinical, social, and developmental psychology) that represent the growing body of research using attachment theory to gain a better understanding of how adult clients change in psychotherapy. A theme that has emerged from these diverse lines of research is the importance of the psychotherapy relationship as a primary catalyst for change. We now have a fairly detailed understanding from laboratory and correlational research of the maladaptive patterns of interaction and affect regulation difficulties experienced by adults with attachment-related avoidance and/or anxiety. This research has identified a growing number of variables that appear to mediate the associations between anxious or avoidant attachment styles and symptoms of distress in nonclinical samples. Relatively less is known about how these patterns manifest themselves in psychotherapy, but a coherent picture is beginning to emerge.

This research suggests that skillful therapists are able to build a psychotherapy relationship that provides a secure base and safe haven for clients. Secure attachment to a therapist provides a corrective emotional experience through which a client eventually comes to rely more on security-based strategies to regulate affect, and develops more effective social competencies to form satisfying attachments with others (Mallinckrodt, 2001). A crucial element of this corrective experience appears to be the therapist's deliberate regulation of emotional distance in the psychotherapy relationship, so that clients' initial needs (for close involvement in the case of anxious clients, and for distance in the case of avoidant clients) are met sufficiently to engage the clients in therapy. At the close of this initial engagement phase, transitional markers appear, signaling that the working alliance is sufficiently strong and the therapeutic attachment is sufficiently secure to permit more intensive work to commence. Some of the most important of these transition markers may be the first appearance of a client's capacity for productive introspection about relationships, the arousal of intense affect, and the capacity to reflect in the therapy hour about the client–therapist relationship.

In the working phase, the therapist gradually begins to insist on more intimacy from avoidant clients and more independence from anxious ones. This regulation of therapeutic distance fosters a new kind of corrective experience, in which clients eventually develop more reliable capacities for affect regulation and secure attachment to people outside therapy. Therapists nominated by their peers as experts in working with adult interpersonal problems report that this working phase of therapy poses significant challenges and requires continual monitoring of a client's level of engagement,

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

anxiety, and frustration, as the relationship is gradually shifted from the level of distance a client prefers to the level of distance a therapist believes is optimal (Daly & Mallinckrodt, 2008). Even when (and perhaps *especially* when) the engagement and working phases have been successful, termination of the psychotherapy relationship poses fresh challenges—not least because it represents the ending, or mental reorganization and internalization, of a very significant attachment for many clients.

Although it is encouraging to see the growing number of studies of clients in therapy that extend what has been learned from experimental and correlational studies with nonclinical samples, we still need to know much more about the session-by-session interactions between client and therapist that serve to build a secure base in psychotherapy (Bowlby, 1988). We also need to know more about how this base of attachment security facilitates lasting change in adult clients with interpersonal problems. This may be the greatest challenge for the next generation of attachment and psychotherapy researchers.

RECOMMENDATIONS FOR FURTHER READING

Bowlby, J. (1990). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books.—This book is a collection of Bowlby's lectures and some previously published papers covering a diverse range of topics. It provides an excellent summary of his thinking about attachment theory in the last years of his life. Ch. 8, "Attachment, Communication and the Therapeutic Process," is of particular interest to psychotherapists.

Cassidy, J., & Shaver, P. R. (Eds.). (2008). *Handbook of attachment: Theory, research, and clinical applications* (2nd ed.). New York: Guilford Press.—A comprehensive resource, and one of the best single general references about research and applications of attachment theory.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.—This book places special emphasis on the role of childhood attachment in the development of capacities necessary for healthy adult emotional functioning.

Mallinckrodt, B. (2001). Interpersonal processes, attachment, and development of social competencies in individual and group psychotherapy. In B. R. Sarason & S. Duck (Eds.), *Personal relationships: Implications for clinical and community psychology* (pp. 89–117). New York: Wiley.—This chapter reviews empirical research supporting a theoretical model of how insecure forms of attachment in childhood lead to deficits in critical adult social competencies, which in turn create vulnerabilities to the kinds of interpersonal problems clients typically present in psychotherapy. The struggle to form a productive working alliance helps clients to develop these social competencies. The model is also applied to the change process in interpersonal group therapy.

Meyer, B., & Pilkonis, P. A. (2001). Attachment style. *Psychotherapy: Theory, Research, Practice, Training, 38*, 466–472.—A review of attachment research that has special relevance for the psychotherapy relationship.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York: Guilford Press.—A comprehensive review of the latest research applying attachment theory to the understanding of adult close relationships. It contains chapters on psychopathology and psychotherapy.

REFERENCES

Ackerman, S. J., Benjamin, L. S., Beutler, L. E., Gelso, C. J., Goldfried, M. R., Hill, C., et al. (2001). Empirically supported therapy relationships: Conclusions and recommendations of the Division 29 Task Force. *Psychotherapy, Theory, Research, Practice, Training, 38*, 495–497.

Anthony, S., & Pagano, G. (1998). The therapeutic potential for growth during the termination process. *Clinical Social Work Journal, 26*, 281–296.

Bateman, A. W., & Fonagy, P. (2003). Development of an attachment-based treatment program for borderline personality disorder. *Bulletin of the Menninger Clinic, 67*, 187–211.

Baum, N. (2005). Correlates of clients' emotional and behavioral responses to treatment termination. *Clinical Social Work Journal, 33*, 309–326.

Bembry, J. X., & Ericson, C. (1999). Therapeutic termination with the early adolescent who has experienced multiple losses. *Child and Adolescent Social Work Journal, 16*, 177–189.

Bernier, A., & Dozier, M. (2002). The client–counselor match and the corrective emotional experience: Evidence from interpersonal and attachment research. *Psychotherapy: Theory, Research, Practice, Training, 39*, 32–43.

Brennan, K. A., Clark, C. L., & Shaver, P. R. (1998). Self-report measurement of adult attachment: An integrative overview. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 46–76). New York: Guilford Press.

Bowlby, J. (1988). *A secure base: Parent–child attachment and healthy human development*. New York: Basic Books.

Charmaz, K. (2006). Constructing grounded theory: A practical guide through qualitative analysis. Thousand Oaks, CA: Sage.

Clarkin, J. F., & Posner, M. (2005). Defining the mechanisms of borderline personality disorder. *Psychopathology, 38*, 56–63.

Cyranowski, J. M., Bookwala, J., Feske, U., Houck, P., Pilkonis, P., Kostelnik, B., et al. (2002). Adult attachment profiles, interpersonal difficulties, and response to interpersonal psychotherapy in women with recurrent major depression. *Journal of Social and Clinical Psychology, 21*, 191–217.

Daly, K. D., & Mallinckrodt, B. (2008). *Experienced therapists' approaches to psychotherapy for adults with attachment avoidance or attachment anxiety*. Manuscript submitted for publication.

Dozier, M., Cue, K. L., & Barnett, L. (1994). Clinicians as caregivers: Role of attachment organization in treatment. *Journal of Consulting and Clinical Psychology, 62*, 793–800.

Fonagy, P., Gergely, G., Jurist, E. L., & Target, M. (2002). *Affect regulation, mentalization, and the development of the self*. New York: Other Press.

Fonagy, P., Leigh, T., Steele, J., Steele, H., Kennedy, R., Mattoon, G., et al. (1996).

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

The relation of attachment status, psychiatric classification, and response to psychotherapy. *Journal of Consulting and Clinical Psychology, 64*, 22–31.

Fraley, R. C., Garner, J. P., & Shaver, P. R. (2000). Adult attachment and the defensive regulation of attention and memory: Examining the role of preemptive and postemptive defensive processes. *Journal of Personality and Social Psychology, 79*, 816–826.

Fraley, R. C., & Shaver, P. R. (1997). Adult attachment and the suppression of unwanted thoughts. *Journal of Personality and Social Psychology, 73*, 1080–1091.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 296–306.

Glasser, B., & Strauss A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Goldman, G. D., & Milman, D. S. (Eds.). (1978). *Psychoanalytic psychotherapy.* Reading, MA: Addison-Wesley.

Holmes, J. (2005). Disorganized attachment and borderline personality disorder: A clinical perspective. *Archives of Psychiatry and Psychotherapy, 7*, 51–61.

Horowitz, L. M., Rosenberg, S. E., & Bartholomew, K. (1993). Interpersonal problems, attachment styles, and outcome in brief dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 549–560.

Lazarus, A. A. (1993). Tailoring the therapeutic relationship or being an authentic chameleon. *Psychotherapy, 30*, 404–416.

Lewis, M., & Wolan Sullivan, M. (2005). The development of self-conscious emotions. In A. J. Elliot & C. S. Dweck (Eds.), *Handbook of competence and motivation* (pp. 185–201). New York: Guilford Press.

Mallinckrodt, B. (2001). Interpersonal processes, attachment, and development of social competencies in individual and group psychotherapy. In B. R. Sarason & S. Duck (Eds.), *Personal relationships: Implications for clinical and community psychology* (pp. 89–117). New York: Wiley.

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology, 42*, 307–317.

Mallinckrodt, B., Porter, M. J., & Kivlighan, D. M. Jr. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 42*, 85–100.

Mallinckrodt, B., & Wei, M. (2005). Attachment, social competencies, social support and psychological distress. *Journal of Counseling Psychology, 42*, 358–367.

Meyer, B., & Pilkonis, P. A. (2001). Attachment style. *Psychotherapy: Theory, Research, Practice, Training, 38*, 466–472.

Mikulincer, M., Dolev, T., & Shaver, P. R. (2004). Attachment-related strategies during thought suppression: Ironic rebounds and vulnerable self-representations. *Journal of Personality and Social Psychology, 87*, 940–956.

Mikulincer, M., & Florian, V. (1998). The relationship between adult attachment styles and emotional and cognitive reactions to stressful events. In J. A. Simpson & W. S. Rholes (Eds.), *Attachment theory and close relationships* (pp. 143–165). New York: Guilford Press.

Mikulincer, M., & Horesh, N. (1999). Adult attachment style and the perception of

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

others: The role of projective mechanisms. *Journal of Personality and Social Psychology, 76,* 1022–1034.

Mikulincer, M., Shaver, P. R., & Pereg, D. (2003). Attachment theory and affect regulation: The dynamics, development, and cognitive consequences of attachment-related strategies. *Motivation and Emotion, 27,* 77–102.

Prochaska, J. O., & DiClemente, C. C. (1983). Stages and processes of self-change in smoking: Toward an integrative model of change. *Journal of Consulting and Clinical Psychology, 51,* 390–395.

Safran, J. D., & Muran, J. C. (1996). The resolution of ruptures in the therapeutic alliance. *Journal of Consulting and Clinical Psychology, 64,* 447–458.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C. (2001). Repairing alliance ruptures. *Psychotherapy, 38,* 406–412.

Shefler, G. (2000). Time-limited psychotherapy with adolescents. *Journal of Psychotherapy Practice and Research, 9,* 88–99.

Siebold, C. (1991). Termination: When the therapist leaves. *Clinical Social Work Journal, 19,* 191–204.

Slade, A. (1999). Attachment theory and research: Implications for the theory and practice of individual psychotherapy with adults. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 575–594). New York: Guilford Press.

Travis, L. A., Binder, J. L., Bliwise, N. G., & Horne-Moyer, H. L. (2001). Changes in clients' attachment styles over the course of time-limited dynamic psychotherapy. *Psychotherapy, Theory, Research, Practice, Training, 38,* 149–159.

Teyber, E. (2006). *Interpersonal process in therapy: An integrative model* (5th ed.). Belmont, CA: Thomson Brooks/Cole.

Tyrrell, C. L., Dozier, M., Teague, G. B., & Fallott, R. D. (1999). Effective treatment relationships for persons with serious psychiatric disorders: The importance of attachment states of mind. *Journal of Consulting and Clinical Psychology, 67,* 725–733.

Ward, D. E. (1984). Termination of individual counseling: Concepts and strategies. *Journal of Counseling and Development, 63,* 21–25.

Webb, N. B. (1985). A crisis intervention perspective on the termination process. *Clinical Social Work Journal, 13,* 329–340.

Wei, M., Heppner, P. P., & Mallinckrodt, B. (2003). Perceived coping as a mediator between attachment and psychological distress: A structural equation modeling approach. *Journal of Counseling Psychology, 50,* 438–447.

Wei, M., Heppner, P. P., Russell, D. W., & Young, S. K. (2006). Maladaptive perfectionism and ineffective coping as mediators between attachment and future depression: A prospective analysis. *Journal of Counseling Psychology, 53,* 67–79.

Wei, M., Mallinckrodt, B., Larson, L. M., & Zakalik, R. A. (2005). Adult attachment, depressive symptoms, and validation from self versus others. *Journal of Counseling Psychology, 52,* 368–377.

Wei, M., Mallinckrodt, B., Russell, D. W., & Abraham, T. (2004). Maladaptive perfectionism as a mediator and moderator of attachment and depressive mood. *Journal of Counseling Psychology, 51,* 201–212.

Wei, M., Vogel, D. L., Ku, T.-Y., & Zakalik, R. A. (2005). Adult attachment, affect regulation, negative mood, and interpersonal problems: The mediating roles of

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817

emotional reactivity and emotional cutoff. *Journal of Counseling Psychology, 52*, 14–24.

Weiner, I. B. (1998). *Principles of psychotherapy*. New York: Wiley.

Woodhouse, S., Schlosser, L. Z., Crook, R. E., Ligiero, D. P., & Gelso, C. J. (2003). Client attachment to therapist: Relations to transference and client recollections of parental caregiving. *Journal of Counseling Psychology, 50*, 395–408.

Youngren, V. R., Alonso, A., & Nahum, J. P. (2000). When goodbye precedes hello: A premature termination. *Harvard Review of Psychiatry, 8*, 25–35.

© Obegi, Joseph H.; Berant, Ety, Dec 10, 2008, Attachment Theory and Research in Clinical Work with Adults
Guilford Publications, New York, ISBN: 9781606230817