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CHAPTER 14

Implications of Attachment Theory and Research for Counseling and Psychotherapy

As we explained in Chapter 1, John Bowlby was a psychoanalyst whose ideas began to take shape before he was formally trained in psychology or psychiatry. They were rooted in observations he made while working in a residential school for troubled children. All through his later professional life, he worked as a clinician at the Tavistock Clinic in London—work that followed his postgraduate education and a 7-year training analysis with a Kleinian psychoanalyst, Joan Riviere. He was not, therefore, an ivory tower, university-based researcher or theorist whose ideas might or might not be stretched to apply to psychotherapy. Although he was very interested in research and made excellent use of it, his main concern, ultimately, was to prevent psychopathology and human suffering—in advance, through education and prevention if possible, or effectively, through appropriate psychotherapy, if prevention was too late.

Bowlby's main collaborator, especially in his later years, Mary Ainsworth, was trained more explicitly for a career in

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research and university teaching, but she focused from the beginning on what has since come to be called developmental psychopathology. She also coauthored a book about the Rorschach Inkblot Test (a well-known, if controversial, clinical assessment tool) and mentored many clinical psychology graduate students over the years. Following a painful divorce after several years of marriage, she underwent a long and fruitful psychoanalysis, which she valued highly (as indicated in her personal correspondence; Isaacson, 2006).

Both originators of attachment theory therefore had firmly in mind a variety of clinical phenomena, their own experiences in psychotherapy, the societal need for preventive education, and the importance of clinical applications of psychological research. Still, they did not write much about such applications, preferring to discover how attachment works before telling clinicians how to treat its dysfunctional forms. Only in 1988, near
the end of his life, did Bowlby summarize his ideas about applying attachment theory clinically. In this chapter we begin with his 1988 book, *A Secure Base* (which he named after Ainsworth's main theoretical construct), and present his theoretical perspective on therapeutic change, the therapeutic relationship, and the therapist's role in emotional healing. We then review empirical evidence regarding changes in working models during therapy and the beneficial effects of a therapist's provision of a safe haven and secure base. Next we focus on attachment-related individual differences and consider the influence of clients' and therapists' attachment orientations on various aspects of therapy—forming and maintaining a working alliance, managing the transference, and dealing with countertransference—including therapy outcomes. Finally, we provide an attachment-theoretical

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analysis of the therapy supervision process and show how attachment theory and research can help us understand the supervisee–supervisor relationship and ways to supervise effectively.

AN ATTACHMENT THEORETICAL MODEL OF THERAPEUTIC CHANGE

In *A Secure Base*, Bowlby (1988) proposed a model of therapeutic change based on helping a client understand his or her accumulated, and often forgotten or misunderstood, attachment experiences, identify and revise insecure working models by transforming them into more secure models, and learn about ways to achieve both comfortable intimacy and flexible autonomy. Because of the central role played by insecure working models in the genesis of emotional and relational difficulties (as we explained in Chapter 13), Bowlby believed that favorable therapeutic outcomes depend on the extent to which pathogenic mental representations are identified, clarified, questioned, revised, and transformed into more adaptive models.

Bowlby called his book *A Secure Base* partly to acknowledge Ainsworth's important contribution to attachment theory, and partly to indicate that a good therapist's role—providing a secure base for exploration—is similar to the role of a security-providing parent. In the case of a parent, providing a secure base creates the emotional bedrock on which a child can develop knowledge about self and world, and acquire important life skills. In the case of a therapist, providing a

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secure base allows a client to muster the courage for self-exploration—to delve deeply into partially occluded memories and distorted wishes and feelings, and to develop greater self-understanding, revise working models of self and others, and get back on the path to personal growth. The process of exploration in psychotherapy is bound to be difficult and painful, because the client must confront issues, remember long-forgotten experiences, encounter strong emotions, and explore perplexities that he or she has not been able to face, manage, or understand alone. Only through this difficult process, supported by a skillful and caring therapist, can the client uncover and understand deep-seated fears, well-practiced defenses, and distorted perceptions that interfere with revising working models and create the conditions for a more satisfying and productive life.

Bowlby (1988) discussed five therapeutic tasks that contribute to the revision of insecure working models and the achievement of positive therapeutic outcomes. The first is to provide clients with a safe haven and secure base from which they can begin to explore painful memories and emotions, characteristic but destructive defenses, and maladaptive beliefs and behaviors. This precondition for the entire therapeutic process is based on the
concept of attachment–exploration balance proposed by Bowlby (1973) and Ainsworth (1991), and validated by subsequent attachment research on information search and cognitive openness (see Chapter 8, this volume). In the attachment–exploration dynamic, the provision of a secure base by a sensitive and responsive therapist (like a good parent in the lives of young children) allows clients to devote attention and energy to exploration, to take the risks involved in reflecting on painful experiences, and to accept revisions in

working models suggested by the therapist. Without such a secure base, clients are likely to be afraid to explore and to disclose thoughts and feelings, instead remaining closed, inauthentic, distrustful, or ambivalent about the therapist's intentions and interpretations. Moreover, a therapist who is unable to provide the client with a sense of security will not be able to create a relationship that the client experiences as refreshingly and therapeutically different from previous relationships, which were likely characterized by criticism, disapproval, disinterest, unpredictability, or abandonment.

The second task is to explore and to understand how the client currently relates to other people, based on particular goals, perceptions, expectations, and fears. The therapist needs to encourage and to assist the client in learning about maladaptive consequences of his or her major pattern of relating to others, whether it be avoidant, anxious, or disorganized; the way the client cognitively construes interpersonal relationships; and the cognitive biases that distort the client's interpretations and memories of interpersonal experiences and relationship partners' actions. As Cobb and Davila (in press) noted, because these cognitive biases are largely unconscious, clients need the help of a therapist's sensitive interventions (e.g., mirroring, interpreting) if they are to become aware of previously unrecognized biases and failed relational strategies. Clients also need a therapist to provide reality-testing tools that reveal the dysfunctional nature and destructive consequences of misguided working models. In most cases, the client will have had a long history of self-destructively misinterpreting his or her own goals, generating the opposite of the emotional outcomes intended, and hurting other people with whom he or she hoped to have mutually rewarding relationships.

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The third task is to examine the client's particular relationship with the therapist, which is an example of the client's self-destructive modes of relating to close partners, and one that inevitably includes the transference and projection of established working models onto the therapist and the therapeutic relationship. This task is similar to the core psychoanalytic task of "working through a client's transference" and is based on Bowlby's (1973) notion that working models are automatically projected onto new relationship partners, including the therapist. Bowlby (1988) suggested that clients' examination of their attitudes and feelings toward the therapist, and their patterns of relating to him or her, provides an opportunity to understand how working models are expressed in a particular relationship and how they typically distort the course and experience of that relationship. To some extent, this requires the therapist to avoid falling into the complementary roles required by the client's habitual dramas. Clients' new knowledge about the patterns they repeat and induce in relationship partners, combined with their recognition and reevaluation of personal goals, cognitive appraisals, and emotional reactions as they occur during therapy, can open the door to new and corrective emotional experiences and experimentation, with more secure patterns of relating to the therapist.

The fourth therapeutic task is for clients to reflect on how their working models of self and others are rooted in childhood experiences with primary attachment figures. Accomplishing this difficult and sometimes painful task depends on the therapist's empathic sensitivity and responsiveness while helping and encouraging the client to allow into consciousness, then work through, memories of frustrating and humiliating experiences

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with inconsistent, rejecting, neglectful, or abusive attachment figures. Clients often need to understand how these experiences shaped their maladaptive beliefs and behaviors before they can revise and update them in beneficial ways.

This exploration of the developmental roots of insecure working models leads to the fifth therapeutic task: helping clients recognize that although their working models may once have been adaptive, or at least may have seemed better than the alternatives when interacting with nonoptimal attachment figures, they are no longer functional. The therapist helps the client to understand how current maladaptive feelings, thoughts, and behaviors relate to early working models of negative attachment experiences and to consider ways in which these beliefs can be revised and updated to fit better with current relational experiences and relationship partners. Through this process, clients can improve their reality-testing skills and create more realistic working models of self and others in the context of current relationships.

Dozier and Tyrrell (1998) summarized these therapeutic tasks in a helpful diagram (Figure 14.1), which includes three processes that contribute to the revision of insecure working models of self and others: (1) the therapist's provision of corrective attachment-related experiences based on the therapist becoming a safe haven and secure base for the client during therapy; (2) the client's exploration of and reflection on current relationships, including the relationship with the therapist; and (3) the client's exploration and reflection on earlier relationships with attachment figures. The two kinds of exploratory ventures—into past relationship experiences and into current experiences, including those with the

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therapist—affect each other. Exploration of past attachment experiences helps clients become more aware of how they construe and distort current relationships, and exploration of current relationships helps them reflect on earlier attachment experiences. Present distortions inevitably point back to special features of earlier troubled relationships, and past attachment injuries color expectations and strategies in current relationships. Both kinds of therapeutic exploration encourage constructive overhaul of working models, and initiate and sustain a broaden-and-build cycle of attachment security that facilitates therapeutic change and continued personal growth.

Following Bowlby's (1988) principles of therapeutic change, several treatment interventions have been specifically designed to target attachment issues in couples (e.g., S. M. Johnson's [1996, 2003] *emotionally focused couple therapy*) and families (e.g., T. M. Levy & Orlans's [1998] *corrective attachment therapy* and G. S. Diamond & Stern's [2003] *attachment-based family therapy*). These interventions explicitly recognize the trauma induced by rejection, separation, and loss, and the impact these experiences have on couple and family functioning; the self-fulfilling nature of working models; and the likely therapeutic effects of interventions that focus on developing secure emotional connections within a couple or family. Moreover, they underscore the importance of the therapist as a provider of a safe haven and secure base for the exploration and revision of maladaptive working models and dysfunctional patterns of thinking, feeling, emotion regulation techniques, and behavior within a couple or a family.

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S. M. Johnson (2003) sees the updating and revision of attachment-related beliefs and behaviors as the primary focus of couple therapy. In her view, couple therapy should produce "an explicit shaping of pivotal attachment responses that redefine a relationship and an addressing of injuries that block relationship repair" (p. 110). Importantly, research indicates that this attachment-based approach to couple therapy is more effective than cognitive-behavioral approaches in reducing relationship distress, even in very troubled, high-risk couples (e.g., Clothier, Manion, Gordon-Walker, & Johnson, 2002; S. M. Johnson & Greenberg, 1985; S. M. Johnson, Hunsley, Greenberg, & Schindler, 1999).

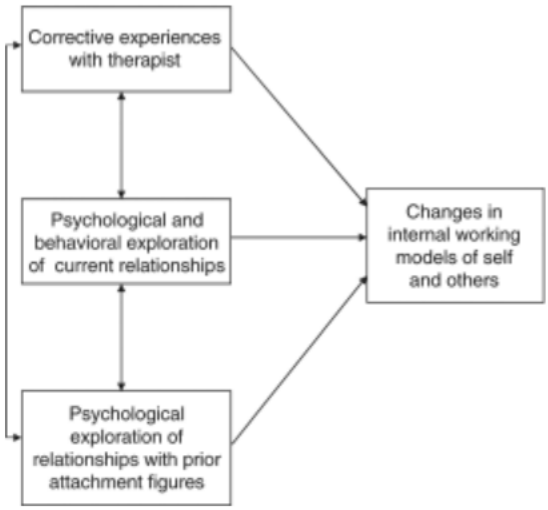


FIGURE 14.1. Dozier and Tyrrell's (1998) figure presenting a schematic representation of Bowlby's (1998) model of therapeutic change. From Dozier and Tyrrell (1998). Copyright 1998 by The Guilford Press. Reprinted by permission of the publisher and authors.

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When considering the validity of Bowlby's (1988) model of therapeutic change, one needs to answer three important questions:

1. Can insecure working models of self and others be revised during adulthood?

2. Can these models be challenged effectively in therapy and transformed into more secure ones?

3. Are changes in working models really an important part of achieving beneficial therapeutic outcomes?

With positive answers to these questions we can proceed to ask whether each of Bowlby's five therapeutic tasks actually contributes to the revision of insecure working models, how these tasks are interrelated, and which specific interventions contribute to accomplishing these tasks.

With regard to the possibility of revising and updating working models of self and others during adulthood, the answer is clearly affirmative. As we summarized in Chapter 5, there is good evidence that working models are malleable during adulthood and that corrective emotional experiences with new relationship partners, as well as reflecting on these experiences, can produce beneficial revisions of working models. There is also supportive, although scarce, evidence that therapy can move clients away from insecure and toward secure working models, and that this movement is a good indication of effective treatment. In two independent studies, Blatt, Stayner, Auerbach, and Behrends (1996) and Harpaz-Rotem and Blatt (2005) assessed the severity of psychopathology of seriously disturbed, hospitalized

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adolescents at the beginning and end of long-term intensive therapy. In addition, Blatt et al. (1996) assessed changes in the structure of descriptions of
mother, father, self, and therapist across the course of therapy, and Harpaz-Rotem and Blatt (2005) assessed changes in the description of a significant other whom each patient elected to describe at the beginning and end of treatment. In both studies, improvement over the course of treatment (reduction in severity of psychiatric symptoms) was associated with increases in the coherence of attachment-related representations. Conceptually similar findings were reported by Travis, Bliwise, Binder, and Horne-Moyer (2001), who found significant associations between increases in self-reports of secure attachment (on the Relationship Questionnaire [RQ]) and decreases in the severity of psychiatric symptoms across the course of time-limited dynamic psychotherapy.

Although these preliminary findings are encouraging, we need to be cautious in interpreting them as support for Bowlby's (1988) model of therapeutic change. We do not have good, controlled research that compares the degree of change in working models achieved in therapy with the change that occurs in a wait-list control group. It is therefore too early to conclude that because working models change during therapy, therapy itself brings about the change. More research is also needed on the nature, strength, and temporal course of revisions in insecure working models during therapy and on how particular features of revised models contribute to therapy outcomes in the case of different kinds of emotional and behavioral disorders. Researchers should try to determine whether change in working models is necessary for lasting psychotherapeutic changes in emotional experience

and social behavior, and whether therapy can still be effective without change in working models.

So far, there is no published study of the effects of Bowlby's five therapeutic tasks on the revision of insecure working models. Such research would require careful analysis of therapeutic interventions and clients' exploration of and reflection on current and past attachment-related experiences. It would also require recording therapeutic sessions, after first assessing clients' working models and attachment orientations when they entered therapy, and repeatedly reassessing working models and attachment styles across the course of therapy. Luborsky and Crits-Christoph (1998) provided a model of this kind of research, using what they call a "core conflictual relationship theme" (CCRT) approach to coding therapy sessions. They found that it was possible to determine a person's core dysfunctional relational schema and link the therapist's illumination of this schema in particular sessions to the client's increased insight and progress in therapy.

THE ROLE OF THE THERAPIST AS A SECURE BASE

Bowlby (1988) drew an analogy between a psychotherapist and a mother: Just as a sensitive and responsive mother (the kind that Winnicott [1965] called a "good enough mother") induces a sense of attachment security in her child and facilitates the child's exploration of the world by making it clear that support will be available if needed, a "good enough" therapist serves as a safe haven and a secure base from which clients can explore and reflect on painful

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memories and experiences. Therapists should provide safety, comfort, and unconditional positive regard, and help the client manage the distress associated with exploring and articulating painful memories, thoughts, and feelings. They should also affirm the client's ability to handle distress and problematic life situations, not interfering with exploration by providing inappropriate interpretations, and admiring and applauding the client's efforts and achievements in therapy. In other words, like a good parent, a good therapist ensures the client that the therapist can be relied upon for safety and support, while the client becomes increasingly capable of dealing with distress
autonomously. In Bowlby's (1988) words, "The therapist strives to be reliable, attentive, and sympathetically responsive to his patient's exploration, and so far as he can, to see and feel the world through his patients eyes, namely to be empathic" (p. 152).

When the therapeutic relationship develops as intended by the therapist, he or she becomes a genuine attachment figure for the client (i.e., a reliable and relied-upon provider of security and support). Clients typically enter therapy in a state of frustration, anxiety, or demoralization that naturally activates their attachment system and causes them to yearn for support and relief. Attachment needs are easy to direct toward therapists, because therapists, at least when a client believes in their healing powers, are perceived as "stronger and wiser" caregivers, possessing the hallmarks of good attachment figures. Therapists are expected to know better than their clients how to deal with the clients' problems, and they occupy the dominant and caregiving role in the relationship. Therefore, the therapist can easily become a target of the

client's proximity seeking and projection of unmet needs for a safe haven and secure base.

Of course, clients' subjective construal of the therapeutic relationship as involving an attachment bond and of the therapist as an attachment figure can also cause the therapist to serve as a target for attachment-related worries, defenses, and hostile projections. These projections sometimes disrupt therapeutic work, but they also provide an opportunity for a therapist to make useful observations and interpretations, and for the client to have corrective emotional experiences and understand him- or herself better.

Borelli and David (2004) noted an additional parallel between therapists and other attachment figures. Like a security-enhancing caregiver who reflects on a young child's experiences and enhances the child's ability to "mentalize" his or her own and other people's experiences (Fonagy, Steele, Steele, Moran, et al., 1991), a therapist reflects on a client's internal states and articulates interpretations in ways the client can understand and model.

At the same time that the therapist provides the client with a haven during distress and a safe base from which to explore oneself, the therapist should also begin to question why the client may respond in a suboptimally receptive manner within the therapy. For instance, the therapist should work to understand why Client A may be critical or aloof, and why Client B may voice strong veneration and unconditional compliance during the treatment. The therapist should then use this knowledge to guide the client toward self-understanding. (Borelli & David, 2004, p. 267)

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There are, however, some important differences between the client–therapist and the child–mother relationship. For example, Farber, Lippert, and Nevas (1995) noted that the client–therapist relationship is more objective and less emotionally involving than the child–mother relationship, and is defined by unique temporal, financial, logistical, and ethical boundaries. Although Farber et al. do not say so, it probably makes a huge difference that parents are usually genetically invested in their children, and that each of their children plays an enormous role in their own sense of significance and self-worth. For a therapist, although each client clearly does and should matter to the therapist's sense of significance and well-being, the investment in any particular client is not likely to be as intense or prolonged as a parent's investment in a child. This difference is likely to be important in allowing the therapist to maintain an objective, therapeutic perspective.

A therapist cannot always be present when needed or wanted by the client—not nearly as often as a good parent can be available during a child's first years of life. Dozier and Tyrrell (1998) also noted that the client–therapist relationship is more difficult than
the usual child–mother relationship, because therapists have to compensate for a history of painful attachment experiences, and clients tend to project attachment-related worries and defenses onto their therapist. Clients then tend to react even to a sensitive therapist as if he or she is unavailable or rejecting. Moreover, the exploration process needs to begin almost from the outset of therapy even before a firm secure base has been established (Dozier & Tyrrell, 1998).

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In subsequent sections we review evidence concerning the attachment-theoretical perspective on therapy, tackling two major questions: (1) Is it reasonable to conceptualize the client–therapist relationship as an attachment relationship? and (2) Does a therapist's provision of a secure base facilitate therapeutic progress? Beyond examining these issues in the context of counseling and individual psychotherapy, we consider residential treatment and examine the role of client–staff relationships in bringing about therapeutic change. This is an appropriate topic for a chapter based on Bowlby's ideas, because he was working in a residential treatment context (a school for troubled children) when he first began to formulate his theoretical ideas.

The Therapeutic Relationship as Involving an Attachment Bond

Though scarce, and limited by exclusive reliance on self-report methods and cross-sectional designs, there is preliminary evidence that clients tend to use the therapist as a safe haven in times of stress and to react to the therapist's absence with separation protest—two definitional criteria for an attachment bond. (Needless to say, these are classic issues in psychoanalytic psychotherapy more generally.) For example, Geller and Farber (1993) found that clients tend to think about their therapists mainly when painful feelings arise, and Rosenzweig, Farber, and Geller (1996) found that such thoughts produce feelings of comfort, safety, and acceptance. As reviewed in Chapter 3, this volume, these thoughts and feelings are often directed to an attachment figure, but not often to other relationship partners; that is, only mental representations of special people who accomplish

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attachment functions tend to be activated in times of need and have the effect of increasing security and comfort (Mikulincer, Gillath, & Shaver, 2002). On the basis of these findings, it seems reasonable to conclude that mental representations of a therapist function similarly to mental representations of other attachment figures.

In a study of the "August phenomenon" (i.e., separations that occur because of the usual monthlong summer break in therapy when therapists take vacations), Barchat (1989) observed that such separations are likely to evoke feelings of longing for the therapist, together with anger, sadness, and fear. These responses resemble the mixture of anxiety, anger, and hope for reunion that Bowlby (1969/1982) observed when infants were separated from their primary attachment figures. (As explained in Chapter 1, this volume, he labeled this reaction "protest.") Moreover, Barchat (1989) also found that the intensity of a client's anger and fear were associated with greater difficulties in resuming therapy, which mirrors the strong separation protest reactions displayed by anxious infants in Ainsworth's Strange Situation, when they were reunited with their mother following an unwanted separation. Whether clients in Barchat's study were securely or anxiously attached to their therapist, they reacted with strong emotion during their therapist's absence. (In the Strange Situation, both secure and anxious infants cry and protest when their mothers leave the room, but the secure ones more quickly reestablish a positive mood and return to curious and creative play following reunion.)

In a study of 105 adults who had been involved in therapy for at least 6 months, Parish and Eagle (2003) assessed the extent to which clients construed the therapeutic relationship

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in line with the definitional criteria for a secure attachment bond. Specifically, clients completed a 45-item self-report scale, Components of Attachment Questionnaire (CAQ), tapping the extent to which they sought proximity to their therapist; felt strong emotions toward the therapist and distress upon separation from him or her; viewed the therapist as a safe haven, a secure base, a stronger and wiser person, an available and sensitive figure, and a unique relationship partner who could not easily be replaced; and relied on mental representations of the therapist for comfort and guidance outside the therapeutic setting. Clients also completed the CAQ with regard to the relationship partner to whom they felt closest (in most cases, a primary attachment figure). In addition, they completed the RQ measure of attachment style.

Although most of the CAQ scores were higher for the primary attachment figure than for the therapist, all of the therapists' scores were above the scale midpoint. Moreover, the therapist was rated higher on the stronger/wiser and availability/ sensitivity aspects of attachment than was the primary attachment figure, and the difference between the two figures' scores on the secure base component was statistically insignificant. These findings suggest that clients, at least the ones in Parish and Eagle's (2003) study, view the therapist as a security provider and believe that he or she is even stronger, wiser, and more available and sensitive than their primary attachment figures.

The study also indicated that appraisal of the therapist as a security-enhancing attachment figure was positively associated with duration and frequency of therapy, and the quality of the therapeutic relationship. In addition, higher self-ratings on avoidant attachment were associated with

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lower ratings of the therapist as a security provider, which is similar to findings reviewed in Chapter 10, this volume, showing that avoidant attachment is associated with partner derogation and relationship dissatisfaction (typical manifestations of negative models of others). In other words, avoidant attachment seems to play a part in psychotherapy and interfere with the formation of a secure attachment relationship, just as it interferes with the formation of strong emotional bonds in other attachment relationships.

Security Provision and Therapeutic Change

Having concluded that the therapist can generally be viewed as a source of security and comfort, we can move to the question of whether good performance by the therapist as a security-providing attachment figure has beneficial effects on therapy outcome. Only three studies have dealt with this important question. In one, Goodwin, Holmes, Cochrane, and Mason (2003) asked clients of mental health services in the United Kingdom to complete a 25-item self-report scale, the Service Attachment Questionnaire (SAQ), tapping (1) feelings of being attended and listened to during therapy, (2) confidence in the continuity and consistency of the therapeutic relationship, (3) confidence in the provision of social support even after discharge, (4) perceptions of therapy as a safe haven rather than a restricting and suffocating environment, (5) feelings of being unconditionally accepted by the staff, and (6) feelings of being valued by the staff.

Goodwin et al. (2003) found that all six subscales loaded highly on a single factor, and that higher SAQ scores were positively associated with clients' reports of mental health

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improvement and therapy helpfulness; that is, clients who perceived mental health services as a secure base were more satisfied with the outcome of therapy. Although this is compatible with an attachment-theoretical analysis of therapy, it is still fairly weak evidence because of the possibility of cross-measure halo effects. (Satisfied clients may have been satisfied with everything, causing all forms of satisfaction to load on a single factor.)
A prospective study with repeated measures is needed to see how the different forms of satisfaction emerge over time, if in fact they do emerge over time, rather than being a product of other personality factors (e.g., agreeableness, optimism).

In a three-session career counseling study, Litman-Ovadia (2004) asked counselees after the second counseling session to complete a 25-item scale assessing the extent to which their counselor functioned as a secure base (the extent to which he or she was an available, sensitive, supportive, and accepting figure and provided safety and comfort during the counseling process). In addition, counselees completed the ECR attachment style scales before they entered counseling and a scale measuring career exploration (both before and after counseling).

The results replicated Parish and Eagle's (2003) finding that avoidant counselees were less likely to perceive their counselor as a security-enhancing attachment figure. More important, counselees' appraisal of their counselors as security-enhancing attachment figures was a significant predictor of heightened career exploration following counseling (compared to baseline career exploration), even after controlling for counselees' attachment orientations. This appraisal of the therapist as a security-enhancing attachment

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figure also mitigated the detrimental effects of attachment anxiety and avoidance on career exploration; that is, even insecurely attached counselees who appraised their counselor as a secure base showed an increase in career exploration, and in fact their postcounseling exploration did not differ from that of more secure counselees. Overall, the study provides encouraging evidence for the beneficial effects on counseling outcome of a counselor's provision of a secure base for exploration.

In a study based on data from the multi-site National Institute of Mental Health (NIMH) Treatment for Depression Collaborative Research Program (TDCRP), Zuroff and Blatt (2006) examined the impact on treatment outcome of patients' perceptions of the quality of their relationship with their therapists. One hundred sixty-two seriously depressed outpatients were randomly assigned to one of four 16-week treatments: interpersonal therapy, cognitive-behavioral therapy, imipramine plus clinical management, and placebo plus clinical management. Perceived quality of the therapeutic relationship was measured early in therapy with a self-report scale assessing the therapist's accurate empathy, unconditional positive regard, and genuineness (or congruence). Sample items ask whether the therapist "nearly always knows what I mean" (empathy), "feels a true liking for me" (regard), and "is comfortable and at ease in our relationship" (congruence). Scores on this measure significantly predicted relief from depression and maintenance of therapeutic benefits during an 18-month follow-up period, regardless of the type of therapy administered, and the results were not attributable to patient characteristics or severity of depression. In discussing possible reasons for these effects, Zuroff and Blatt concluded

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that the experience of a positive therapeutic relationship has a transforming effect on patients' mental representations of the self and others, a conclusion compatible with attachment theory.

Security Provision in a Residential Treatment Setting

An attachment perspective on therapeutic change is important for understanding effective residential treatment of high-risk, difficult adolescents (e.g., H. W. Maier, 1987; Moore, Moretti, & Holland, 1998; Schuengel & van IJzendoorn, 2001). According to H. W. Maier (1987), residential treatment involves corrective emotional experiences based on staff members becoming safe havens and secure bases for emotionally deprived, neglected, or abused adolescents. Under these conditions, adolescents can establish, for the first time in most cases, a secure attachment bond, which allows them to reassess and rebuild their working models and to practice more adaptive patterns of relating to others. The quality of relationships established with staff members is, according to this approach, indicative of adolescents' future personal and social adjustment.

According to H. W. Maier (1987), the most important attachment figure in residential treatment centers is the child care worker (CCW), who is usually a person with no specialized therapeutic training who accompanies adolescents during their daily routine. Moore et al. (1998) also consider CCWs to be the primary therapeutic agents, because, in contrast to other professionals, they are able to integrate the various aspects of an adolescent's life. Like "good enough"

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parents, CCWs are almost always available when an adolescent needs them, and they serve as models of functional adult behavior. In their daily work, CCWs combine parental functions, therapeutic functions, and social functions, and allow adolescents to participate in a secure attachment relationship (Moore et al., 1998). Interestingly, Schuengel and van IJzendoorn (2001) claimed that institutionalized adolescents' attachment needs are so strong that when CCWs fail to meet them, the adolescents seek alternative security providers, such as maintenance staff or cooks, who do not have a formal therapeutic role but can nevertheless function as available, sensitive, and supportive figures. In any case, security provision by any member of the staff can have beneficial therapeutic consequences. (This is, once again, reminiscent of Bowlby's early role as a care provider for delinquent boys, a role for which he had no formal training.)

Attachment theory is highly relevant to residential treatment, because the vast majority of institutionalized adolescents have a history of negative and frustrating attachment experiences with parents and other adult figures, and they arrive at residential treatment centers with extremely insecure working models (Maier, 1987). Moreover, research has shown that most of them have experienced parental loss, neglect, or abuse and have a variety of attachment-related emotional problems, such as depression, anxiety, and emotional detachment (e.g., J. P. Allen et al., 1996; Bowlby, 1944). Tolmacz (2001) claims that such adolescents have huge attachment injuries, and many suspect there will never be reliable help and support available to them. For such adolescents, forming a relationship with a security-enhancing staff member and developing a secure attachment bond during residential treatment can be an important corrective emotional

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experience and a "second chance" for building adaptive working models.

Focusing on attachment issues also provides a valuable perspective on the problems that bring adolescents to residential treatment centers. Crittenden (1992), for example, suggests that institutionalized adolescents' hostile and aggressive behaviors are distorted and maladaptive expressions of a desire for proximity and acceptance (see Chapter 13, this volume, for a similar approach to conduct disorders). According to Crittenden, institutionalized adolescents attempt to relate to others in ways that are consistent with their working models and past attachment experiences. Because these experiences have often included inconsistent or ambivalent care, neglect, abuse, or abandonment, aggression and violence can be construed as means of coercing attention and care from unavailable attachment figures (Crittenden, 1992). If CCWs can view these aggressive behaviors as proximity-seeking efforts, they can react in a more empathic and sensitive manner and provide corrective emotional experiences that make the use of aggression and violence as attachment behaviors less necessary (Moore et al., 1998).

Of course, being a staff member who tries to provide a safe haven and secure base for an institutionalized adolescent is difficult; it can be frustrating and exhausting when one is working with an adolescent who seems incapable of forming a stable, secure
attachment bond. Adolescents who were extremely neglected or abused by their primary attachment figures are likely to resist forming an attachment bond with staff members, because they cannot allow themselves to trust anyone (B.

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James, 1994). Moreover, Schuengel and van IJzendoorn (2001), who emphasized the therapeutic importance of establishing secure attachment bonds during residential treatment, claim that not all adolescents who are removed from their homes seek alternative attachment figures, even if staff members offer a safe haven and secure base. Hopes for support from their own parents, feelings of sorrow and anger about being separated from parents, and overwhelming and paralyzing distress can interfere with the formation of a secure attachment bond during residential treatment.

Part of the problem in these cases may be physiological. In a recent study of severely neglected Romanian orphans who were rescued from their orphanages and adopted by loving and economically comfortable parents, Wismer Fries, Ziegler, Kurian, Jacoris, and Pollak (2005) found that despite many improvements in their condition, on average, the orphans continued to have lower levels of vasopressin in their bloodstreams at baseline (compared with normally reared children), and lower levels of oxytocin after having loving interactions with their adoptive parents. Both vasopressin and oxytocin are known to play a role in emotional bonding in mammalian species. Thus, early experiences of neglect and abuse may change a person physiologically, not just psychologically, in ways that make it more difficult to become fully and normally attached. (See C. S. Carter [2005] for a discussion of the role of oxytocin and vasopressin in emotional bonding, and Zeanah, Smyke, Koga, & Carlson [2005] for a description of the attachment behavior of Romanian orphans.) These kinds of physiological barriers to secure attachment should make us cautious, although still hopeful, about how well an attachment approach to institutionalized adolescents can succeed. This kind of

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therapeutic work is, and always has been, difficult and complicated, and there is no guarantee of success.

Despite the difficulties, there is growing evidence for beneficial effects of forming and maintaining a secure attachment bond with residential staff members. For example, Born, Chevalier, and Humblet (1997), Fritsch and Goodrich (1990), and Shealy (1995) found that institutionalized adolescents who formed more secure relationships with staff members showed better adjustment following residential treatment. Moretti, Holland, and Peterson (1994) evaluated the effectiveness of the "Response Program," which emphasizes secure attachment bonds as the main therapeutic agent in residential treatment of high-risk adolescents, and found that parents and staff members noted a significant decrease in adolescents' conduct disorders during treatment. Adolescents themselves did not report, in the initial stage, any decrease in conduct disorder and even reported an increase in anxiety-related symptoms, but later on, after 12 months of treatment, they also reported a significant decrease in symptoms.

In an effort to provide more systematic evidence on the therapeutic effects of using staff members as a secure base, Gur (2006) conducted a prospective study examining the course of emotional and behavioral problems of 131 Israeli high-risk adolescents during their first year in residential treatment centers. Four meetings were held with each participant, 1 week after beginning treatment and 3, 6, and 12 months later. At Time 1, participants completed the ECR scale and measures of emotional and behavioral adjustment. In the three subsequent waves of measurement, participants completed the adjustment scales and rated the extent to which

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targeted staff members functioned as a secure base (the extent to which staff members were available, sensitive, responsive, and supportive). The targeted staff members also rated participants' adjustment and their own functioning as a secure base in the second, third, and fourth waves of measurement. In the fourth wave of measurement, adolescents again completed the ECR.

The study replicated the well-established association between attachment insecurities (assessed by the ECR) and adjustment problems at the beginning of residential treatment. However, attachment insecurities did not necessarily interfere with the subsequent perception of staff members as security providers. More important, the study demonstrated that staff members serving as a secure base contributed to positive changes in emotional and behavioral adjustment across the four waves of measurement and notably weakened the detrimental impact of baseline attachment insecurities. These findings were obtained whether the functioning of staff members as a secure base and adjustment was assessed via adolescents' self-reports or staff members' reports. Adolescents who formed more secure attachment bonds with staff members had lower rates of anger, depression, and behavioral problems, as well as higher rates of positive feelings across the study period. The functioning of staff members as a secure base was also associated with positive changes in the adolescents' attachment representations. Adolescents who formed more secure attachment bonds with staff members had lower scores on the ECR insecurity scales after their first year of residential treatment.

Overall, findings to date support the theoretical notion that attachment security can have healing effects even in fairly

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extreme cases of youngsters who enter residential treatment with insecure attachment representations. Moreover, the findings suggest that security provision should be given top priority in residential treatment, and that such treatment might benefit from the explicit adoption of an attachment approach.

ATTACHMENT AND THERAPEUTIC PROCESSES

Beyond providing a model of therapeutic change and conceptualizing the role of the therapist as a secure base, Bowlby (1988) argued that working models of self and others, by being automatically projected onto new relationships, can affect the client–therapist relationship and help to explain why this relationship at times produces positive therapy outcomes and at other times ends in therapeutic failure. In the same way that attachment orientations shape other kinds of relationships (see Chapters 9–12, this volume), the attachment styles of both clients and therapists can affect the quality of the client–therapist relationship, determine clients' reactions to therapists' interventions and therapists' reactions to clients' disclosures, thereby biasing the therapeutic process. In this section, we focus on three components of the therapeutic process: (1) the working alliance between client and therapist, (2) the client's transference of prior schemas and feelings onto the therapist, and (3) the therapist's countertransference onto the client. We also consider the effects of attachment orientations on therapy outcome.

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The Working Alliance

One important aspect of therapy that has been discussed many times and from many different theoretical perspectives is the formation of an alliance between client and therapist (the so-called "working alliance" or therapeutic alliance). The formation of an alliance enables therapist and client to work together collaboratively to reach therapeutic goals (Gelso & Carter, 1985; Greenson, 1967). Every psychotherapist from Freud to the present has probably noticed what Freud called "resistance" to treatment, if not outright rebellion against the therapist's interpretations and influence. According to Bordin (1979) and Gelso and Carter (1985), a working alliance reflects an emotional alignment of client and therapist based on trust, respect, and mutual regard, as well as agreement about the tasks and goals of therapy. This alliance engages the rational, self-observing aspects of the
client and the working, therapeutic qualities of the therapist (Bordin, 1979; Horvath & Luborski, 1993). Horvath and Greenberg (1989) constructed a 36-item self-report scale, the Working Alliance Inventory (WAI) to assess clients' and therapists' appraisals of the extent to which they feel they have formed an emotional bond based on trust and mutual regard, and can agree about therapeutic goals and tasks. Research has consistently shown that higher WAI scores early in therapy are good predictors of successful therapeutic outcomes (e.g., Horvath & Greenberg, 1994; Horvath & Symonds, 1991).

Although a good working alliance can be formed in the first phase of therapy and is predictive of therapeutic progress thereafter (Horvath & Greenberg, 1994), the success of

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therapy also depends on clients' and therapists' abilities to maintain a stable alliance throughout the entire course of therapy and to manage effectively potential or actual ruptures in the alliance (Safran, 1993; Safran & Muran, 1996). Safran and Muran defined these ruptures as negative shifts in the quality of the working alliance due to miscommunications between clients and therapists; clients' feelings of being misunderstood, unloved, rejected, or criticized by their therapists; or clients' angry or distancing reactions to lack of immediate gratification of needs, wishes, or fantasies within therapy. From an attachment perspective, these ruptures are likely to be due to the activation of a client's insecure working models within the therapy setting and the projection of these models onto the therapist. According to Safran (1993), resolution of these ruptures and restoration of a "good enough" working alliance provide the client with corrective emotional experiences, enable the exploration and management of the client's negative feelings, and are crucial for achieving favorable treatment outcomes.

The establishment of a "good enough" working alliance can be viewed as a result of the client's appraisal of the therapist as a security-enhancing attachment figure. The "emotional bond" aspect of the alliance involves the client's feelings of being valued, cared for, and loved by the therapist, as well as his or her sense of trust in the therapist's availability and sensitivity (Horvath & Greenberg, 1994). According to attachment theory (e.g., Bowlby, 1988), all of these feelings emerge whenever a relationship partner, including a therapist, is viewed as an available, sensitive, and supportive attachment figure. Agreement about therapeutic tasks and goals can be greatly facilitated by a client's appraisal of the therapist as a wise caregiver who knows what needs to be

done to reduce afflictive emotions and heal damaged relationships. Appraising the therapist as a trustworthy attachment figure help clients to recognize that therapists' interventions and insights are based on good intentions and true concern for clients' welfare. Indeed, two of the studies we reviewed earlier in this chapter (Litman-Ovadia, 2004; Parish & Eagle, 2003) assessed both clients' appraisals of their therapist as a secure base and their ratings of the working alliance (in the WAI), and consistently found a positive association between the two constructs.

Clients' Attachment Styles and the Working Alliance

The attachment perspective on the working alliance also implies that the attachment orientations clients bring with them to therapy are likely to affect the formation and maintenance of an alliance. Secure clients generally find it easy to form a good working alliance. Their positive models of others, core sense of trust in others' availability and good intentions, and propensities to form interdependent, intimate relationships (see Chapters 6 and 9, this volume) all should facilitate the formation of strong emotional bonds with a therapist. Moreover, their reliance on constructive strategies of conflict resolution (see Chapter 9, this volume) should contribute to effective management of ruptures in the alliance. In
contrast, insecure people's negative models of others and exaggerated expression of unmet attachment needs or defensive denial of these needs are major impediments to the formation of a working alliance. Insecure clients' propensity to doubt their therapists' regard for them, and their worries

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and defenses against dependency and intimacy may be present from the first therapy session.

Although anxious clients' desire for merger and consensus may cause them to agree readily with their therapists about the goals and tasks of therapy, their ambivalence toward relationship partners may interfere with forming a strong working alliance in the initial phase of therapy. Moreover, their hunger for attention, care, and love; misinterpretation of others' responses as signs of disapproval, rejection, or criticism; and uncontrollable outbursts of anger (see Chapters 6 and 7, this volume) can increase the frequency and intensity of ruptures in the alliance throughout therapy. As in other close relationships, an anxious client's bond with the therapist can be so emotionally turbulent that it repeatedly interferes with therapeutic work.

The working alliance can also be hindered by avoidant clients' distrust of others, dismissal of attachment needs, and reluctance to engage in interdependent, intimate exchanges (see Chapters 6 and 9, this volume). Avoidant people's desire for self-reliance and uniqueness can also work against accepting a therapist's suggestions about therapeutic goals and tasks, while their reluctance to experience conflict may prevent constructive discussions about client–therapist disagreements and resolution of ruptures in the alliance. Avoidant clients may attempt to maintain emotional distance from the therapist and remain emotionally uninvolved during therapy, which obviously makes it difficult to form a productive alliance.

Studies of the characteristics of clients who find it difficult to form a strong working alliance at the beginning of therapy

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provide indirect evidence concerning the adverse effects of attachment insecurities. For example, clients who develop weak alliances have been found to feel unsupported and unloved by others, to have poor quality "object relations," problems with the dominance–submission dimension of the interpersonal circumplex, lack of cognitive and affective flexibility, and poor reflective functioning (e.g., Mallinckrodt, 1991; Muran, Segal, Samstag, & Crawford, 1994; E. R. Ryan & Cicchetti, 1985). As we have shown throughout this book, all of these psychological deficits are characteristic of insecurely attached people.

Research has also shown that clients' problems in current relationships with family members—a common interpersonal problem of insecurely attached people (see Chapter 9, this volume)—are significant predictors of problematic therapeutic alliances (Kokotovic & Tracey, 1990; Moras & Strupp, 1982; but see Gaston, Marmar, Thompson, & Gallagher, 1988, who failed to replicate this finding). More important, there is growing evidence that clients' negative mental representations of parental figures (assessed with the Parental Bonding Inventory [PBI]) have adverse effects on their capacity to create a productive working alliance with a therapist, as reported by both clients and therapists (Mallinckrodt; 1991; Mallinckrodt, Coble, & Gantt, 1995).

Assessments of clients' attachment styles have consistently corroborated the hypothesized link between attachment insecurities and problems in the formation of a good working alliance. For example, Dolan, Arnkoff, and Glass (1993) found that therapists of more avoidant clients reported less client–therapist agreement about the goals of therapy (assessed with the WAI) by the third therapeutic session. In

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contrast, therapists of more secure clients reported more client–therapist agreement about goals and tasks. Similar findings have been obtained when clients themselves complete the WAI and provide their own perspective on the working alliance. Satterfield and Lyddon (1995, 1998), Kivlighan, Patton, and Foote (1998), and Parish and Eagle (2003) found that more avoidant clients (as assessed with self-report scales) tended to report weaker alliances and more problems in establishing an emotional bond with their therapist during the initial therapy sessions. Moreover, Mallinckrodt, Coble, et al. (1995) found that more anxiously attached clients (as assessed with the Adult Attachment Scale [AAS]) scored lower on self-reports of a good working alliance. However, S. Reis and Grenyer (2004) found no significant association between attachment orientations (based on the RQ) and ratings of working alliance in a sample of clients with major depression.

In an attempt to probe attachment style differences in the way clients relate to their therapists, Mallinckrodt, Gantt, and Coble (1995) constructed a self-report scale (Client Attachment to Therapist Scale, CATS) tapping (1) secure attachment to therapist (perception of the therapist as responsive and consistently emotionally available), (2) fearful avoidant attachment to therapist (distrust of therapist, feeling unsafe or patronized, strong reluctance to self-disclose or become more intimate in therapy), and (3) preoccupied attachment to therapist (longing to be at one with the therapist and worrying about his or her love and approval). In a validation study with 129 outpatients, the secure attachment factor was positively correlated with the bond, task, and goals scores of the WAI. In fact, these correlations (around .80) suggest that secure attachment to the therapist shares a

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common core with the working alliance (Robbins, 1995). In contrast, fearful avoidant attachment to the therapist was associated with a weaker alliance. Interestingly, no significant association was found between preoccupied attachment and ratings of the working alliance. B. Meyer and Pilkonis (2001) interpreted this result as implying that desires for merger with one's therapist do not guarantee a good alliance or a successful therapy outcome. As they explain, "In their frenetic attempts to avoid rejection, patients with preoccupied attachment may try to submissively please and appease their therapist without engaging in the more risky task of identifying and openly discussing difficult personal problems" (p. 468).

Following this line of research, Mallinckrodt, King, and Coble (1998) found that a client's dysfunctional experiences with parents and difficulties in reflecting on feelings and thoughts interfere with a client's secure attachment to a therapist. Specifically, clients' reports of fear of separation from parents during childhood and their scores on an alexithymia scale (see our discussion of alexithymia in Chapter 7, this volume) were associated with lower levels of secure attachment to a therapist and higher levels of preoccupied and avoidant attachment. In a more recent study, Mallinckrodt, Porter, and Kivlighan (2005) assessed global attachment orientations (with the ECR), attachment to one's therapist (CATS), strength of the working alliance (WAI), and clients' reports of session depth and smoothness. The study participants were 38 clients in time-limited therapy. The investigators found that global ratings of attachment insecurities were associated with less secure attachment to one's therapist, and both kinds of attachment insecurity interfered with the working alliance. Interestingly, less secure

attachment to one's therapist was also associated with inhibited exploration of inner experiences during sessions and perception of the therapeutic sessions as less smooth and deep. This association was still significant after controlling for ratings of the working alliance.

Research has also documented the effects of clients' attachment orientations on fluctuations in the working alliance throughout therapy. For example, Eames and Roth (2000) assessed clients' self-reports of attachment style after the first session of cognitive-behavioral therapy, and asked both clients and therapists to complete the WAI after the second, third, fourth, and fifth session. Whereas attachment security was associated with a stronger working alliance from the start and a stably positive alliance across the four assessed sessions (as reported by both clients and therapists), fearful avoidant clients and their therapists reported weaker alliances and more alliance ruptures across the four sessions. Interestingly, although more anxious and avoidant clients showed weaker alliances during initial sessions, they showed a significant improvement in the strength of the alliance over time, as reported by both clients and therapists. According to Eames and Roth, insecure clients' initial worries about a therapist's availability and dependability might have diminished over time due to the therapist's ability to instill a sense of attachment security, which in turn facilitated the formation of a good working alliance as therapy progressed. Thus, the formation of a good working alliance depends on not only clients' attachment style but also therapists' ability to become security providers and calm insecure clients' worries and soften their defenses.

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In a related study, Kanninen, Salo, and Punamaki (2000) assessed attachment patterns (in an interview based on the AAI) and working alliance (using the WAI) at the beginning, middle, and end of therapy among 36 Palestinian political ex-prisoners. Whereas securely attached clients formed relatively stable alliances throughout treatment, anxiously attached clients reported a poor alliance in the middle stages but a very strong alliance in later stages of therapy. By contrast, avoidant clients reported a deteriorating alliance toward the end of therapy. According to Kanninen et al., anxious clients' yearning for care and attention might have led them to persist in attempting to establish a close alliance with the therapist even at the end of therapy. This finding is compatible with Eames and Roth's (2000) conclusion that effective therapy can facilitate anxious people's formation of a working alliance in the late stages of therapy. In contrast, avoidant clients may defensively deny problems in the alliance or establish only a superficial relationship with a therapist, while remaining reluctant to connect emotionally. Ruptures and strains in the alliance can appear even near the end of therapy, when issues of separation come to the fore. As reviewed in Chapter 7, this volume, these kinds of problems seem to reactivate memories of attachment-related pain and elicit deactivating defenses.

Overall, there is considerable evidence concerning the obstacles that attachment insecurities place in the way of developing a strong and stable working alliance. The findings also show, however, that skilled therapists can work around these barriers and create a satisfactory alliance with many insecure clients.

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Effects of the Therapist's Attachment Style on the Working Alliance

As in other dyadic relationships, the quality of the therapeutic relationship is shaped by both partners' interpersonal dispositions and skills (C. E. Hill, 1992). From an attachment perspective, creating a good working alliance depends on not only the client's willingness and ability to trust the therapist, and view him or her as a "stronger and wiser caregiver," but also the therapist's ability and willingness to occupy the role of security provider. In other words, although the client's working model is important to the formation of a good working alliance, the therapist's effectiveness as a caregiver, which means sensitively providing a safe haven and secure base for the client, is equally important. Moreover, because sensitive caregiving depends on one's sense of attachment security (Chapter 11, this volume), it seems likely that the therapist's contributions to a good working alliance can be disrupted by his or her own attachment insecurities. Whereas a secure therapist should find it easy to occupy the role of security provider and create a good working alliance even with a difficult client, an insecure therapist is likely to complicate the process of alliance formation.

A secure therapist is likely to focus on clients' problems, remain open to new information,
and maintain compassion and empathy rather than be overwhelmed by personal distress (Chapter 11, this volume, provides a review of the literature on attachment style and reactions to other people's needs). Being secure allows a therapist to acquire and apply a variety of skills—both simple ones, such as maintaining appropriate eye contact and

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following a client's personal narrative, and more complex skills such as gradually transforming a professional acquaintanceship into an intimate therapeutic relationship (Mallinckrodt, 2000, 2001). Moreover, habitual reliance on constructive strategies of conflict resolution (see Chapter 9, this volume) can allow therapists with a secure attachment style to handle alliance ruptures more effectively and restore the quality of alliances more easily. In contrast, an insecure therapist is less likely to empathize accurately, to keep personal distress and defenses from interfering with compassion, and to mobilize constructive strategies for managing ruptures in the alliance. In line with research on attachment insecurities and caregiving (see Chapter 11, this volume), avoidant therapists may lack the skills needed to provide sensitive care and promote emotional bonds with clients. Anxiously attached therapists may experience intense distress, a desire to merge or lose boundaries with clients, and difficulty regulating emotions, which can obviously interfere with both objectivity and accurate observation, and empathic sensitivity and responsiveness to a client's needs.

Several studies of therapists' personality traits and mental representations have provided indirect evidence for the beneficial effects of secure attachment on alliance formation and maintenance. For example, W. P. Henry, Schacht, and Strupp (1990) and W. P. Henry and Strupp (1994) found that therapists who have more positive mental representations of close relationships (a core component of attachment security) were more likely to form a strong working alliance. Similarly, Dunkle (1996) found a positive association between therapists' comfort with closeness and clients' ratings of the quality of the working alliance. In an extensive review of therapist factors that affect the working alliance, Ackerman

and Hilsenroth (2003) concluded that core traits associated with secure attachment, such as therapist warmth, trustworthiness, and openness, contribute to an effective working alliance.

After directly assessing therapists' attachment orientations, Sauer, Lopez, and Gormley (2003) found that although therapists' attachment anxiety was associated with clients' reports of a better working alliance after the first therapeutic session, this association was gradually reversed by the fourth and seventh sessions; that is, in the long run, anxiously attached therapists had adverse effects on clients' feelings about the working alliance. In a study of 491 psychotherapists with different therapeutic orientations, S. Black, Hardy, Turpin, and Parry (2005) found that securely attached therapists were more likely to report stronger alliances, whereas anxiously attached therapists reported weaker alliances and more therapy-related problems (e.g., "unable to comprehend the essence of my client's problem," "lacking confidence that I have a beneficial effect on the client"). Importantly, these associations were found even after controlling for general personality traits (extraversion, neuroticism) and therapeutic orientation. Similar findings were reported by Rozov (2002), who found that attachment-anxious therapists created poorer alliances in general, and especially poor ones with secure clients. However, Ligiero and Gelso (2002) found no significant association between therapists' attachment styles and quality of working alliances (as rated by therapists and their supervisors), suggesting that sample and other methodological factors remain to be identified.

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Tyrrell, Dozier, Teague, and Fallot (1999) examined the joint contribution of clients' and therapists' attachment orientations to the quality of the working alliance and clients' quality of functioning. For this purpose, 54 clients with severe mental disorders and their
21 case managers completed the AAI, clients reported on the alliance (using the WAI), and case managers rated clients' functioning. However, when the AAIs were scored using the typical tripartite classification system, 90% of the case managers were classified as secure and 83% of the clients as insecure. Therefore, due to lack of variability in attachment security, Tyrrell et al. used Kobak's (1993) *Q*-set system for scoring secondary attachment strategies (deactivation vs. hyperactivation). There were significant interactions between therapists' and clients' reliance on secondary attachment strategies. Therapists who relied on deactivating strategies formed stronger alliances with clients who relied on hyperactivating strategies; therapists who relied on hyperactivating strategies had stronger alliances with clients who relied on deactivating strategies. In addition, the formation of stronger alliances was significantly associated with better client functioning. These findings imply that client–therapist dissimilarity in reliance on secondary attachment strategies, at least when most of the therapists are securely attached, is associated with stronger alliances and more therapeutic gains.

According to Mallinckrodt (2000), Tyrrell et al.'s (1999) findings are an illustration of "countercomplementary attachment proximity strategies," by which a therapist reacts to clients' attitudes toward proximity in ways that collide with their demands and disconfirm their expectations and maladaptive patterns of relatedness. This collision provides an

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opportunity for corrective emotional experiences that seem to be beneficial for both alliance strength and client functioning. For avoidant clients, who prefer interpersonal distance and tend to elicit emotional detachment from others, corrective emotional experiences can be provided mainly when therapists rely on hyperactivating strategies, tend to increase proximity, and insist on deepening clients' disclosures. For anxiously attached clients, who prefer to remain in an infantile, dependent position, compulsively seek the "savior" who will love and care for them, and tend to elicit compassion and rescue fantasies from others, corrective emotional experiences can be provided mainly when therapists adopt deactivating strategies, maintain optimal distance from clients, and encourage clients to take an autonomous role in dealing with their problems. From this perspective, Tyrrell et al.'s findings imply that these corrective experiences, though provoking uneasiness and anxiety, can heighten clients' trust in the strength and caregiving wisdom of the therapist, because he or she prevents them from reproducing the ineffective and painful patterns of relatedness within therapy.

However, it is important to acknowledge that the vast majority (90%) of the case managers in Tyrrell et al.'s (1999) study were securely attached. Dozier and Tyrrell (1998) argued that when therapists' secondary strategies are accompanied by an insecure state of mind, the beneficial effects of "countercomplementary attachment proximity strategies" no longer hold. They asserted that the clinician must have the strong sense of attachment security necessary to respond to the client in a countercomplementary manner, even if it is uncomfortable for the clinician to do so. Mallinckrodt (2000) suggested that this countercomplementary approach requires considerable

interpersonal sensitivity and responsiveness in trying to understand what the client wants to recreate in the therapeutic relationship, and how to break maladaptive patterns without overwhelming the client with anxiety. These skills are rare among insecurely attached people (see Chapter 11, this volume). Mallinckrodt used a creative analogy of control rods in a nuclear reactor to symbolize the extreme sensitivity needed for effective countercomplementary interventions. "If the rods are inserted too far, the energy source (client anxiety) is over-controlled, all the reactions cease, and the reactor core cools. If the rods are withdrawn too far the energy source becomes uncontained and a 'melt down' ensues" (p. 251).

Dozier and Tyrrell (1998) and Mallinckrodt (2000) concluded that although secure
therapists are prone to form strong alliances with every client due to their interpersonal flexibility and caregiving sensitivity, they can form these alliances more easily and rapidly with clients who differ from them in regard to deactivation–hyperactivation. In contrast, insecure therapists are likely to have difficulty forming strong alliances and providing effective therapeutic interventions, even when clients differ from them in secondary attachment strategies. In fact, an insecure therapist might react in a complementary manner to clients' demands, while confirming once again clients' maladaptive patterns and preventing therapeutic change (see relevant findings in the section of this chapter dealing with countertransference).

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Transference Reactions

From a psychodynamic perspective, the therapeutic relationship includes not only the working alliance between client and therapist but also less rational and more fantasy-based disruptive processes. One of these processes is the client's transference reactions to the therapist. In his initial writings about transference neurosis, Freud (1905/1953) suggested that unconscious relational representations established during repeated experiences in early relationships with parental figures tend to be reactivated during therapy. Hence, feelings, perceptions, and attitudes that belonged to a past relationship are transferred to the therapist. Freud's initial ideas referred to the transference of Oedipal fantasies to the therapist, but later he extended his ideas to any misperception or misinterpretation of the therapist's traits, intentions, or behaviors derived from clients' earlier experiences with significant others (Luborsky & Crits-Christoph, 1998). Based on this broader conception, Greenson (1967) defined *transference* as "experiencing of feelings, drives, attitudes, fantasies and defenses toward a person in the present which are inappropriate to that person and are a repetition, a displacement of reactions originating in regard to significant people of early childhood" (p. 156). Transference reactions can easily be recognized by a misfit between a therapist's interventions and a client's responses (e.g., the strength of the reaction may seem inappropriate, capricious, or unusually tenacious).

From an attachment perspective, the client's transference reactions reflect the reactivation of conflictual attachment working models during therapy and their projection onto the

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therapist. Bowlby (1973, p. 206) characterized transference reactions as "forecasts" that clients make about a therapist's traits, intentions, and behaviors based on working models they developed during early attachment experiences. The problem is that in the context of the relationship with the therapist, these "forecasts" are no longer valid and appropriate; they can disrupt the working alliance and prevent therapeutic change, if the therapist fails to identify and deal effectively with them. Therefore, the identification of clients' attachment working models is an important step in understanding their transference reactions and can help therapists foresee the particular kinds of irrational and inappropriate demands and responses that can emerge during therapy.

We believe that attachment patterns can shape the feelings, wishes, and fantasies that clients transfer to a therapist, as well as the intensity, tenacity, and pervasiveness of transference reactions. The sense of attachment security fosters a positive transference that facilitates rather than disrupts the formation of a strong working alliance. Secure clients can transfer to the therapist their positive models of others, which, if not disconfirmed by the therapist's behavior, can strengthen the client–therapist emotional bond and enhance their collaborative work.

However, this positive transference can be moderated by other definitional characteristics
of secure attachment. Secure people's cognitive openness and positive attitude toward exploration of new information (see Chapter 9, this volume) can act against automatic, intensive, and pervasive transference of their inner world to the therapist. (We discussed this kind of inhibition of projection

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of self-traits onto others in Chapter 6.) This kind of transference is likely to be accompanied by a reality-based analysis of information about the therapist and the therapeutic relationship. That is, secure clients may project onto a therapist their positive models of others but still process and reflect on the therapist's reactions, and alter their appraisals and expectations, if their therapist disconfirms their working models.

In contrast, insecure people are likely to transfer to a therapist their negative models of others, to imbue their therapist with the negative traits and intentions that characterized earlier frustrating and rejecting attachment figures, and to re-create earlier conflict-ridden interactions within therapy. Moreover, their cognitive rigidity and defensive impermeability, as well as deficits in their ability to understand and reflect on inner experiences, may amplify the negative effects of transference and prevent a rational, reality-based perspective on the actual therapist and the therapeutic relationship.

Anxiously attached people are likely to transfer their ambivalent working models of others onto their therapists, that is, they are likely to project their longing for love and care onto the therapist, together with their fears of rejection and abandonment, worries about unlovability, and angry reactions to perceived unavailability or lack of responsiveness. According to Woodhouse, Schlosser, Crook, Ligiero, and Gelso (2003), "They tend to vacillate between a desire to cope with a lowered sense of self-worth by wishing to merge with the other (who is perceived as being unrealistically good) and feelings of anger at the other for not being available or understanding enough" (p. 398). As a result, anxious clients' transferences are likely to be

characterized by unrealistic hopes, frustration, rage, and perceptions of the therapist as not adequately supportive (Slade, 1999). Avoidant people also possess negative models of others, but their transference is likely to be characterized more by devaluation of the therapist and rejection of his or her interventions. Moreover, their tendency to block open expression of negative feelings and expectations toward a therapist can prevent the analysis of transference reactions and the exploration of dysfunctional working models.

Unfortunately, the likely links between clients' attachment patterns and forms of transference have not received enough empirical attention. Indirect evidence is provided by Honig, Farber, and Geller (1997), who studied how clients' mental representations of parental figures were associated with thoughts about their therapists. Clients were asked to write a short paragraph describing their mothers after the first session of therapy, then 8–12 weeks later write descriptions of the therapist and their feelings toward him or her. Clients with more complex representations of their mothers, which is a well-documented characteristic of securely attached people (Chapter 6, this volume), described their therapists in more differentiated terms, displayed less overlap between parent and therapist representations, and were less likely to include sexual and aggressive content in their mental representations of their therapists. This suggests that secure clients may be able to differentiate between their parents and their therapist. In contrast, insecure clients were more likely to project working models of parents onto the therapist and recreate with him or her unresolved conflicts involving sex and aggression.

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The study by Woodhouse et al. (2003) is the single published study providing direct evidence about clients' attachment styles and transference reactions. Following at least five therapy sessions, clients reported their attachment orientation toward their therapists (using the CATS), and therapists completed measures describing clients' positive and negative transference reactions during recent sessions. As expected, more anxiously attached clients were rated as displaying greater transference in general, and higher levels of negative transference (suspiciousness, annoyance) in particular. There was no significant association between avoidant attachment and transference, probably because of avoidant clients' lack of emotional involvement in therapy. Unexpectedly, secure attachment to the therapist was also associated with negative transference reactions. Woodhouse et al. proposed that because secure clients can view the therapist as a secure base, they explore deeper, more negative childhood memories that in turn at times cause a negative reaction to the therapist. According to these authors, negative transference accompanied by secure attachment to a therapist allow clients to gain insight into conflictual patterns of relating and lead to a better therapy outcome. However, this speculative interpretation of unexpected findings is based on a single study. Further research is needed to assess the replicability of the findings and to discover how secure clients make use of negative transference reactions, if in fact they do.

Countertransference

Another irrational process that can damage a therapeutic relationship is counter-transference on the part of a therapist toward a client. Countertransference involves a therapist's

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misinterpretation of a client's needs, or the enactment of behaviors stemming from the therapist's own unresolved conflicts and mental representations of others. Freud (1910/1959) viewed the unconscious reactivation of a therapist's unmet needs and dysfunctional fantasies during therapy as a hindrance to therapeutic work, because the therapist's interventions are determined by his or her inner world rather than a realistic analysis of the client's needs and problems. However, Freud also noted that counter-transference can be a joint creation of the client and the therapist, and it sometimes reflects a therapist's unconscious reactions to a client's transference (Gabbard, 2001). As such, countertransference, if accurately detected and acknowledged by a therapist, can be a window on a client's unconscious needs and conflicts, in which case it can provide a lever for therapeutic change. Noticing and handling the transference is obviously a tricky business, however, because the therapist simultaneously has to notice that his or her reactions are irrational or inappropriate and have the strength to do something constructive about them.

The complexity of countertransference is acknowledged in recent psychoanalytic writings (e.g., Gabbard, 2001; Kiesler, 2001). For example, Kiesler differentiated between subjective and objective kinds of countertransference. In the subjective kind, therapists' countertransference reactions result from their own conflicts, anxieties, and defenses, and can be harmful to the therapeutic relationship if they remain undetected. In the objective kind of countertransference, therapists' reactions are triggered by clients' transference of their own conflicts and anxieties, and it can be helpful to therapy if therapists recognize their countertransference feelings, reject clients' unconscious demands or coercive

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behavioral strategies, analyze these demands and strategies, and provide corrective emotional experiences.

From an attachment perspective, the therapist's sense of attachment security can mitigate countertransference reactions and allow the use of these reactions to understand and respond to a client's unconscious material. As noted throughout this book, secure attachment is associated with emotional and cognitive openness, reflection on inner states, and constructive management of impulses, feelings, and behaviors that tend to interfere with goal pursuit. As a result, securely attached therapists can more easily process what is happening in the "real relationship" with clients, recognize their own countertransference feelings, and prevent the automatic expression of these feelings when expressing them would interfere with effective therapy. In addition, as reviewed earlier in this chapter, secure therapists' interpersonal sensitivity and responsiveness can sometimes facilitate their detection of clients' transference demands and allow them to use countercomplementary strategies (Mallinckrodt, 2000). Rather than playing into and reinforcing the client's dysfunctional transference, a secure therapist may be able to break the transference–countertransference cycle, while still maintaining a good working alliance.

In contrast, attachment insecurities may render therapists more vulnerable to reactivation of their own attachment-related worries and defenses during therapy. Insecure therapists may lack the skills needed to regulate their own distress, to remain fairly accurate in their social perceptions, and to keep their goal-corrected behaviors and interventions on a healthy track (see Chapters 8 and 9, this

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volume, for examples of these difficulties in nontherapists). This could obviously leave them poorly equipped to detect and manage their countertransference reactions. As a result, their therapeutic interventions are likely at times to be misguided by their own worries, fantasies, and defensive maneuvers, which may cause them to act in a complementary rather than a controlled, countercomplementary way to clients' transference demands. When therapy goes astray in this way, it obviously interferes with a constructive working alliance and may even result in a therapist's unprofessional anger toward or withholding of support for a client, and it can sometimes lead to highly damaging and defensively rationalized sexual relations with a client (Pope, 1994).

In the last decade, attachment research has begun to examine associations between therapists' attachment patterns and countertransference. Ligiero and Gelso (2002) assessed therapists' attachment styles using the RQ, along with supervisors' ratings of the therapists' countertransference reactions in clinical cases they had discussed during supervision. The supervisors completed the Inventory of Countertransference Behavior, which measures both positive countertransference behaviors (e.g., trying to befriend the client, engaging in too much self-disclosure, agreeing too often with the client) and negative countertransference behaviors (e.g., being excessively critical, punitive, or rejecting). There were no significant associations between therapists' attachment orientation and supervisors' ratings of *positive* countertransference behaviors. As expected, however, supervisors rated more securely attached therapists as less likely to engage in negative countertransference behaviors.

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Another manifestation of attachment-related processes in countertransference was documented in a study by Marmarosh et al. (2006), in which group therapists completed E. R. Smith et al.'s (1999) measure of group attachment (see Chapter 15, this volume) and reported on their expectations concerning their clients' attitudes about group therapy. More anxiously attached therapists were more likely to expect that patients would hold negative stereotypes and misconceptions about group treatment. In other words, attachment anxiety seemed to bias perceptions of others in ways compatible with the usual worries of attachment-anxious people.

Research has also shown that insecure therapists' countertransference depends on their clients' attachment orientations. For example, Rubino, Barker, Roth, and Fearon (2000) presented to clinical psychology students a variety of videotaped vignettes depicting simulated alliance ruptures with secure, avoidant, or anxious clients. The clinical trainees were asked to respond as if they were interacting with actual clients, and independent raters judged their empathic responses to the vignettes. The results revealed that more anxious therapists (based on the RSQ) responded less empathically to clients' narratives, and this was especially true when clients had secure or avoidant attachment styles. According to Rubino et al., "More anxious therapists might interpret ruptures as an indication of their patients' intention to leave therapy, and their own sensitivity toward abandonment might diminish their ability to be empathic" (p. 416).

In a study of therapists' countertransference reactions during the first therapy session (as rated by the therapists' supervisors), Mohr, Gelso, and Hill (2005) found that

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supervisors rated avoidant therapists (based on the ECR) as exhibiting more hostile countertransference behaviors (e.g., "therapist was critical of the client during the session"). However, this effect was moderated by clients' attachment patterns: More avoidant therapists exhibited more hostile countertransference behaviors mainly toward anxiously attached clients. Interestingly, more anxiously attached therapists also tended to show heightened hostility only when clients were avoidant; that is, incompatibility of attachment strategies (hyperactivation vs. deactivation) between clients and therapists tended to elicit more hostile countertransference behaviors from the therapists. Possibly this kind of incompatibility works against insecure therapists' attachment strategies, frustrates them, and elicits hostile responses toward frustrating clients. Whereas an anxiously attached client can frustrate an avoidant therapist's attempt to maintain distance, an avoidant, detached client can frustrate an anxious therapist's wish for intimacy and approval. In line with this interpretation, Connors (1997) suggested that anxious therapists are likely to be alarmed by avoidant clients' detachment; hence, they intrude upon these clients with "overly intense efforts to evoke a deeper and more affective relationship" (p. 489). These findings suggest how difficult it may be to maintain the appropriate degree of countercomplementary attachment behavior thought by Dozier and Tyrrell (1998), Mallinckrodt (2000), and Tyrrell et al. (1999) to contribute to good therapeutic outcomes.

Lyddon and Satterfield (1994) also examined the possibility that clients' insecurities and transference demands elicit particular countertransference behavior from therapists. Anxiously attached clients are likely to express excessive distress, vulnerability, and helplessness even during an initial

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therapy session, and this can cause therapists to become prematurely pulled into excessive emotional involvement and compassion, and an overly intense focus on clients' negative views of self. In contrast, avoidant clients are likely to maintain an emotionally detached position and reject therapeutic interventions that require emotional expression and disclosure of vulnerabilities, thereby causing therapists to use more rational and cognitive techniques that may not get to heart of clients' problems. A therapist who is not sufficiently cognizant of these deactivating strategies may use task-based interventions that do not challenge client defenses but instead reinforce maladaptive relational patterns.

In support of these theoretical possibilities, Lyddon and Satterfield (1994) found that therapists with more anxiously attached clients (as measured by the AAS) were more likely to rate clients' problems as pervasive and due to developmental deficits, and to view the goal of therapy as exploration of core pathological beliefs. It seems that clients' attachment anxiety biased therapists' interventions toward what Guidano (1987) labeled "second-order changes"—interventions that challenge clients' core assumptions about the self and world, and involve intensely painful emotional experiences that must be hashed out during therapy. This sort of distress intensification fits well with anxious people's preferences for emotional drama and hyperactivating attachment strategies.

There is also evidence that therapists use more affective and relationship-oriented interventions with anxiously attached clients, and more cognitive therapeutic methods
with avoidant clients. For example, Hardy et al. (1999) content-analyzed transcripts of significant therapy sessions

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and found that whereas therapists tended to respond to anxiously attached clients by reflecting their emotions and concerns, they reacted to avoidant clients by offering cognitive interpretations. Conceptually similar findings were reported by Rubino et al. (2000), who found therapists to be more deeply involved with anxiously attached clients and to react more empathically to them than to less anxious clients.

There is also important evidence, however, that these countertransference reactions are moderated by therapists' attachment orientations. Dozier et al. (1994) administered the AAI to clients with severe mental disorders and to their therapists. The therapists were interviewed regarding their therapeutic interventions. Whereas secure therapists did not use different interventions for anxious and avoidant clients, insecure clinicians attended more to dependency needs and made more in-depth interpretations when treating clients with an "anxious state of mind with respect to attachment" than when treating avoidant clients. These findings suggest that insecure therapists respond in a complementary way to clients' dysfunctional needs and perhaps perpetuate and reinforce clients' maladaptive attachment strategies. In contrast, secure therapists are less likely to react in a complementary manner, thereby providing a relational context that differs from the relationships that clients probably maintain with other partners and helping clients to reformulate their models and create therapeutic change.

Therapy Outcome

The effects of clients' and therapists' attachment orientations on aspects of the therapy process should be reflected in

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therapeutic outcomes. Whereas clients' and therapists' attachment security should contribute to good outcomes, attachment insecurities can be expected to impair therapeutic work by interfering with the creation of a good working alliance, distorting the analysis of clients' problematic cognitions and behaviors, and preventing the provision of security and corrective emotional experiences. In fact, negative therapeutic outcomes have been observed even at the level of a single session. Mohr et al. (2005) assessed clients' attachment orientations (using the ECR) and ratings of the smoothness and value of the first therapy session. Insecure clients were less likely to view the first treatment session as smooth and valuable. Moreover, therapists working with insecure clients were also less likely to rate the first session as smooth and comfortable.

Attachment styles may also affect people's willingness or reluctance to seek help from therapists in the first place (see Chapter 7, this volume, for general examples of people's attachment-related attitudes toward help seeking). Lopez et al. (1998) found that undergraduates with an avoidant attachment style, either dismissing or fearful, were less willing than secure undergraduates to seek therapy and had more negative attitudes toward therapy. Along similar lines, Riggs, Jacobvitz, and Hazen (2002), who assessed people's exposure to psychotherapy in a sample of middle-class women, found that women with an avoidant state of mind with respect to attachment (assessed with the AAI) were less likely than secure women ever to have been in therapy.

Insecure people's poor regulation of goal-oriented behavior (difficulties in maintaining a task-oriented focus, persisting with challenging tasks, and inhibiting disrupting thoughts and

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action tendencies) may also interfere with therapeutic success. These difficulties, which have been shown to interfere with insecure people's compliance with medical treatment regimens (see Chapter 8, this volume), can also contribute to poor compliance in psychotherapy (Cortina, 1999). Dozier (1990) found that an avoidant state of mind (assessed with the AAI) in clients with severe mental disorders was associated with
more rejection of treatment providers, less self-disclosure, and poorer use of treatment. In an intervention program for low-SES, high-risk mothers, Korfmacher, Adam, Ogawa, and Egeland (1997) found that mothers classified as insecure on the AAI were less involved in the intervention and accepted fewer treatment suggestions than those who were securely attached. Whereas women with an "unresolved attachment" status seemed to be disoriented during the intervention, avoidant women remained emotionally unin-volved. These findings are compatible with Tasca et al.'s (2006) discovery that self-reported avoidant attachment was associated with dropping out of cognitive-behavioral therapy for eating disorders.

Research has also yielded evidence of an association between clients' attachment styles and therapy outcomes. Cyranowski et al. (2002) assessed clients' attachment orientations prior to therapy and measured the effectiveness of interpersonal psychotherapy in women with recurrent major depression. Although attachment anxiety and avoidance did not distinguish between clients who did and did not show improvement in their mental status by the end of therapy, attachment insecurities were associated with a longer time to relieve depressive symptoms. In related studies, S. Reis and Grenyer (2004) found that self-rated attachment anxiety and

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avoidance, assessed prior to therapy, predicted more severe depressive symptoms (compared to baseline depression) after six and 16 therapy sessions, and Hardy et al. (2001) found that avoidant clients were less responsive to time-limited cognitive therapy.

In a sample of clients with severe personality disorders, B. Meyer, Pilkonis, Proietti, Heape, and Egan (2001) found that insecure attachment (assessed shortly after clients entered therapy) was associated with a less favorable pattern of anxiety symptoms over 6 months of treatment. Similar findings were reported by Mosheim et al. (2000), who used a prototype methodology to sort clients diagnosed with eating disorders, mood disorders, or anxiety disorders into attachment categories. Insecure attachment was a significant predictor of problems in attaining therapy goals: Patients rated as less comfortable and confident in past and present relationships tended to benefit less from a 7-week course of intensive therapy.

In contrast, Fonagy et al. (1996) found that although secure clients (assessed with the AAI) tended to function better than insecure clients at both admission into and discharge from individual or group psychoanalytic therapy (lasting more than 9 months), avoidant clients exhibited the greatest amount of improvement over the course of treatment. According to B. Meyer and Pilkonis (2001), this finding may be attributable to the special benefits of long-term therapy for avoidant clients: "Those with dismissing attachment may require concentrated or targeted interventions, helping them overcome their characteristic detachment. Once they do connect emotionally with a therapist, however, improvement might be all the more dramatic" (p. 467).

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THE SUPERVISION PROCESS AND THERAPISTS' NEED FOR A SECURE BASE

Therapists obviously experience a great deal of stress while conducting therapy with emotionally demanding clients. Like anyone else under stress, they need a safe haven and secure base (outside of their consulting room) in relationships with supervisors, consulting therapists, marital partners, friends, and spiritual advisors (e.g., Hess, 1987; Hollo-way, 1994). Needless to say, it would be dangerous and destructive for a therapist to
reverse roles and attempt to meet his or her attachment needs by relying on clients for comfort, safety, and support—a process that attachment researchers have identified as dysfunctional when it occurs in disturbed parent–child attachment relationships. Recently, Kurtz (2005) provided an extensive review of the needs of therapists who work with severely disordered patients and identified the importance of supervisors' provision of a safe haven and a secure base for clinician supervisees. Using a "chain of security" metaphor, Kurtz argued that therapists benefit from feeling supported, comforted, and empowered by their supervisor, while the therapists themselves attempt to provide security and support to their clients (analogous to the ways in which spousal support helps a parent provide a safe haven and secure base for his or her children [Cohn et al., 1992]).

Attachment theory is also useful for conceptualizing the effects on the therapy supervision process of therapists' and supervisors' attachment orientations. According to Pistole and

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Watkins (1995), therapists' insecure working models can be reactivated during the supervision process, because supervision entails self-disclosure, reliance on a "stronger and wiser" other, reflection on inner experiences, and discussion of issues related to autonomy and dependency. An avoidant therapist may be reluctant to seek support and assistance from a supervisor; may adopt a defiant, resentful, or disparaging attitude toward the supervisor; and may maintain emotional and cognitive distance from him or her. An anxiously attached therapist is likely to form a clingy, overly dependent relationship with a supervisor, to feel that he or she cannot succeed as a therapist without a great deal of help from the supervisor, and to worry about the supervisor's disapproval or criticism. In either case, the reactivation of insecure working models is likely to impair the supervision process (Neswald-McCalip, 2001). Of course, the supervisor's sense of attachment security and his or her ability to provide a safe have and secure base for supervisees can moderate the detrimental effects of supervisees' insecure attachment. A secure foundation provides a supervisee with sufficient safety so that he or she can feel confident in the supervisor's availability, sensitivity, and responsiveness.

In their work with counseling supervisees, Pistole and Watkins (1995) found that a secure supervisory alliance "serves to ground or hold the supervisee in a secure fashion" (p. 469). The relationship provides supervisees with security or safety by letting them know that "(a) they are not alone in their counseling efforts, (2) their work will be monitored and reviewed across clients, and (3) they have a ready resource or beacon—the supervisor—who will be available in times of need" (p. 469). At present, attachment-oriented research on therapists' relationships with supervisors is scarce. This

would be a fruitful area in which to test theory-based supervisory strategies and their effects on both supervisees and clients.

Psychotherapists who work with special populations, such as victims of terrorism, abused children, disaster survivors, dying clients, and severely disturbed patients, sometimes neglect their own needs for care while focusing on the pressing needs of their clients (Figley, 2002). This kind of work can easily result in emotional depletion and professional burnout (Skovholt, Grier, & Hanson, 2001), which is sometimes called "compassion fatigue." This unpleasant and destructive condition is marked by withdrawal and isolation from others, inappropriate emotionality, depersonalization, loss of pleasure in work and perhaps in life more generally, loss of boundaries with patients, and a sense of being overwhelmed (Rainer, 2000). Such emotional deficits are particularly common in attachment-anxious therapists, who have problems regulating their distress while providing care to others. Indeed, Racanelli (2005) found that attachment anxiety was predictive of compassion fatigue among American and Israeli therapists working with victims of terrorism. This finding implies that anxiously attached therapists may be especially in need
of good supervision. Paradoxically, however, their attachment insecurities may interfere with the supervision process.

CONCLUDING REMARKS

Attachment theory originated in Bowlby's ideas about the causes of mental disorders and the need for a more scientifically sound approach to psychotherapy. Now that

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attachment theory has been extended into the adult realm and many measures of attachment-related constructs have been devised and validated, it is possible to explore the realm of psychotherapy itself from an attachment perspective. Bowlby's (1988) own wisdom about therapy, based on both theory and extensive clinical experience, provides a good starting point for anyone wishing to conceptualize psychotherapy and residential treatment from an attachment perspective. Many valuable studies have already been conducted, as indicated in this chapter. But research on the topic (i.e., research on the therapy process, the attachment issues involved in transference and countertransference, and the importance of attachment issues in therapist training and supervision) is relatively new, and many questions need further study. There is some uncertainty about how countercomplementary attachment behaviors can and should be used in therapeutic settings. Almost nothing is known about how to match therapists' and clients' attachment orientations in productive ways, nor is much known about how to help therapists achieve a greater sense of felt security, along with mature social perception and effective social behavior in the therapy setting. Almost every issue discussed in this chapter would benefit from more sophisticated research.

At a conceptual level, it is unclear how differences in the two major lines of adult attachment research (see Chapter 4, this volume)—one based on self-report measures of attachment patterns and the one based on the AAI—can be applied in therapeutic settings. The self-report research tradition leans investigators toward the issues of working models, relational behaviors, and emotion regulation. The AAI tradition leans investigators toward the role of discourse coherence and

"mentalizing" in therapy settings. We still know little about how insights from these two research traditions can be combined to optimize psychotherapy. Both basic theory and clinical applications would benefit greatly from examination of both kinds of issues in the same studies of psychotherapy processes and outcomes. It would also be worthwhile to consider how attachment constructs do or do not meld well with specific therapeutic techniques, such as emotion-focused therapy, cognitive-behavioral therapy, and interpersonal therapy. Obegi and Berant's (in press) book on this topic is a valuable place to begin.

Attachment theory arose in a clinical context, took some time to be studied by basic researchers (because of the difficulty of creating good measures, and using them in laboratory experiments and prospective longitudinal studies), and is now ready to be reintegrated into the therapeutic process and clinical research. The reintegration process presents many exciting challenges to clinical researchers.

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