Chapter 11

What are the Implications of Attachment Processes for Psychopathology and Therapy?

Bowlby developed attachment theory as a way of understanding how problems or disruptions in infant–mother attachment relationships shape personality development in childhood and beyond. Although Bowlby's early work was inspired by children who had been separated from their primary caregivers, he believed that attachment was important throughout the lifespan. In particular, he suggested that disruptions in childhood, resulting in the development of insecure attachment, can forecast adjustment issues and mental health problems well into adulthood (Bowlby, 1988). According to attachment researchers, attachment insecurity can act as a stressor that heightens psychological distress by compromising emotion regulation and heightening interpersonal difficulties (eg, Crawford et al., 2006). As such, attachment theory provides a useful framework for understanding the underpinnings, development, and sequelae of psychopathology and mental health, and in guiding therapy. Although our focus in the chapter is on adult mental health, we should note that much work has been done on related issues in the infant–parent literature. Interested readers should consult Bakermans-Kranenburg, van IJzendoorn, and Juffer (2003), Berlin, Ziv, Amaya-Jackson, and Greenberg (2005), and Groh, Roisman, van IJzendoorn, Bakermans-Kranenburg, and Fearon (2012) for examples.

In this chapter we provide an overview of the research examining the associations between adult attachment and mental health problems. In particular we review whether attachment insecurity functions as a risk factor for mental health concerns, and whether attachment security functions to buffer mental health problems. This is followed by a discussion of the pathways most widely cited as linking attachment insecurities to mental health problems. We then turn our attention to understanding the implications of attachment theory for therapy and practice. In doing so, we outline some of the broad therapeutic strategies advocated by therapists working in the area of adult attachment. We examine studies investigating the efficacy of therapy in bringing about change in adult attachment and review two evidence-based attachment therapies (Attachment-Focused Group Therapy and Emotionally Focused Therapy) for working with adults.

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IS ATTACHMENT INSECURITY A RISK FACTOR FOR MENTAL HEALTH PROBLEMS?

The short answer to this question is yes. There are hundreds of studies investigating associations between adult attachment styles and numerous mental health problems and psychopathologies, including substance abuse, conduct disorders, suicidality, and pathological grief. Nonetheless, there are four particular categories of mental health problems that have received considerable attention in the attachment literature, largely because these mental health issues involve problems with distress regulation and interpersonal functioning. These categories of mental health problems include: (1) affective disorders, (2) posttraumatic stress disorder (PTSD), (3) eating disorders, and (4) personality disorders.

Affective Disorders

When it comes to affective disorders, the most widely researched disorders are depression and anxiety (eg, Selcuk & Gillath, 2009). To date there are over 100 studies in adult attachment that have investigated depression and anxiety using either community or clinical samples (eg, Eng, Heimberg, Hart, Schneier, & Liebowitz, 2001; Feeney, Alexander, Noller, & Hohaus, 2003; Wei, Vogel, Ku, & Zakalik, 2005). Bowlby noted either separation from a parent due to death or an inability to form a secure attachment with one's primary caregiver early in life, promotes the development of pessimistic and hopeless attitudes and beliefs of the self and the world. Bowlby (1973) also suggested that attachment insecurity could contribute to experiencing general anxiety because inconsistent or rejecting attachment figures hinder people's ability to achieve felt security. Thus, people are left experiencing chronic distress and uncertainty regarding how safe it is to explore their social worlds.

Research into the associations between adult attachment and depression and anxiety suggests that attachment anxiety (including preoccupied attachment) demonstrates very consistent associations with these affective disorders. Studies find that the higher an individual's attachment anxiety [measured using either self-report or interview assessments (eg, adult attachment interview, AAI)], the higher their symptoms for depression and anxiety (eg, Bifulco et al., 2004; Cassidy, Lichtenstein-Phelps, Sibrava, Thomas, & Borkovec, 2009; Gamble & Roberts, 2005; Oliver & Whiffen, 2003).

Attachment avoidance on the other hand may not necessarily be associated with affective disorders. While some debate exists regarding this assumption, various attachment scholars have proposed that attachment avoidance may be unrelated to negative mental health outcomes (eg, Fraley & Bonanno, 2004; Fraley & Shaver, 1999) such as depression and anxiety. It may be that avoidant individuals' excessive self-reliance and use of cognitive and behavioral deactivating strategies inoculate them from experiencing psychopathology. Thus, speculation that attachment avoidance is associated with mental health problems may actually reflect an assumption about fearful avoidance (individuals

high on attachment avoidance and anxiety). That is, attachment anxiety rather than attachment avoidance is the driver behind the associations between fearful avoidance and mental health outcomes.

In support of this notion, the associations between attachment avoidance are far less consistent. Some studies find a positive association between attachment avoidance and depression and anxiety, while other studies find either negative associations or no associations between attachment avoidance and these disorders. And in line with the argument summarized earlier, the picture becomes clearer when examining associations in studies where attachment avoidance is separated into fearful-avoidance and dismissing-avoidance. In these studies, fearful-avoidance is more consistently associated with depression and anxiety compared with dismissing-avoidance (eg, Irons, Gilbert, Baldwin, Baccus, & Palmer, 2006; Murphy & Bates, 1997; Reis & Grenyer, 2004). Thus, it may well be the anxiety dimension of attachment insecurity that is more central to the experience of these affective disorders.

However, the inconsistencies found between attachment avoidance and depression and anxiety may not only be explained by decoupling dismissive-avoidance from fearful-avoidance, but by separating out the different symptoms of depression and anxiety. As a case in point, some studies that have unpacked depressive symptomology have found that attachment avoidance is positively associated with depression, but only with depressive symptoms related to achievement (self-criticism, self-punishment, and perfectionism, eg, Batgos & Leadbeater, 1994; Davila, 2001; Murphy & Bates, 1997; Zuroff & Fitzpatrick, 1995) and depressive symptoms associated with bipolar or schizoaffective depressive disorders (eg, Fonagy et al., 1996). In contrast, attachment avoidance appears not to be as consistently associated with depressive symptoms pertaining to agency and relatedness (lack of autonomy, overdependence, neediness, eg, Fonagy et al., 1996). Rather, these depressive symptoms are associated with attachment anxiety (Crawford et al., 2006; Fonagy et al., 1996).

Research has also been conducted with a focus on specific forms of depression and anxiety that are contextually bound, such as depression and anxiety experienced after the birth of a child. In these studies, a diathesis-stress approach has been adopted in which attachment insecurity is framed as a vulnerability factor (ie, diathesis) that when coupled with a challenging, negative, or stressful environment (ie, stress) may yield psychological difficulties (eg, Simpson, Rholes, Campbell, & Wilson, 2003). Across these studies, attachment anxiety in women has been shown to be positively associated with postnatal depression (and anxiety) anywhere between 3 months and 2 years postpartum (eg, Behringer, Reiner, & Spangler, 2011; Condon, Corkindale, Boyce & Gamble, 2013; Feeney et al., 2003; Simpson et al., 2003a,b).

Furthermore, in a number of studies investigating the transition to parenthood, the association between attachment anxiety and depression is moderated by such factors as perceptions of partner support and the experience of anger (eg, Simpson et al., 2003a,b). For instance, anxiously attached mothers that perceive

adequate support from their partners report less postnatal depressive symptomatology than anxiously attached mothers that perceive partner support as inadequate (eg, Simpson et al., 2003a,b; Simpson, Rholes, & Shallcross, 2012). Other studies have found that the association between attachment anxiety and generalized anxiety is heightened during the transition to parenthood as a function of paternal work-life spillage and difficulties with childcare arrangements (eg, Trillingsgaard, Elklit, Shevlin, & Maimburg, 2011). When it comes to attachment avoidance however, other than Besser, Priel, and Wiznitzer (2002), hardly any studies have found links between this dimension of insecurity and postnatal depression and anxiety. That is, attachment avoidance appears to have little to do with the experience of postnatal depression and general anxiety.

There is also some research to suggest that people who are high on both attachment anxiety and avoidance [ie, fearful-avoidance in Bartholomew & Horowitz's (1991) terms] experience quite severe depression and anxiety symptoms (Carnelley, Pietromonaco, & Jaffe, 1994, Study 2; DiFilippo & Overholser, 2002; Marganska, Gallagher, & Miranda, 2013; Reis & Grenyer, 2004, Study 1). That is, scoring high on both insecurity dimensions appears to exacerbate the symptoms of depression and anxiety.

In relation to attachment security (ie, people scoring low on dimensions of attachment anxiety/avoidance, or rating as secure using typological self-report or interview assessments) findings generally suggest that attachment security is negatively associated with depression and anxiety across community and clinical samples (eg, Kenny, Lomax, Brabeck, & Fife, 1998; Wautier & Blume, 2004). That is, attachment security appears to act as a buffer against experiencing affective disorders such as depression and anxiety.

Trauma Symptoms and Posttraumatic Stress Disorder

There are close to 150 studies examining the association between attachment in adults and PTSD or trauma symptoms more broadly. Research into this area has exploded in recent times, with approximately 40% of studies published in the last 5 years (eg, Fowler, Allen, Oldham, & Frueh, 2013; Sandberg, 2010). The majority of these studies are cross-sectional in nature (ie, attachment style and trauma symptoms are assessed contemporaneously). However, some longitudinal studies do exist and speak to the directionality of the association between adult attachment and trauma (eg, Fraley, Fazzari, Bonanno, & Dekel, 2006; Mikulincer, Ein-Dor, Solomon, & Shaver, 2011; Solomon, Dekel, & Mikulincer, 2008). The interest in investigating the associations between adult attachment and trauma reflects widely held assumptions regarding the interplay between the experiences of trauma and attachment system dynamics. That is, traumatic events by their very nature compromise a person's felt security, and thus, traumatic events can activate the attachment behavioral system.

Given the theoretical link between attachment behavioral system activation and the experience of trauma, Mikulincer and colleagues (Mikulincer &

Shaver, 2007a,b; Mikulincer, Shaver, & Solomon, 2015) suggest that individual differences in attachment system functioning are likely to yield consistent associations with trauma symptoms, and in particular, PTSD. In fact, Mikulincer and colleagues provided some of the first evidence linking attachment to PTSD symptoms (eg, Mikulincer, Florian, & Weller, 1993; Mikulincer, Horesh, Eilati, & Kotler, 1999). In studies focusing on war time and related contexts (ie, the Gulf War, Iraq–US war, and war captivity) Mikulincer and colleagues found cross-sectional and longitudinal evidence that attachment insecurity is positively associated with symptoms of PTSD (eg, Mikulincer et al., 2011; Mikulincer et al., 1999; Mikulincer, Solomon, Shaver, & Ein-Dor, 2014). By and large, this research has found that attachment anxiety is positively associated with the two broad types of trauma symptoms that characterize PTSD: *intrusion* (the experience of unwanted and uncontrollable thoughts, images, emotions, and nightmares related to the traumatic event); and *avoidance* (numbing, denial of the significance and consequences of the traumatic event, and behavioral inhibition). Attachment avoidance tends to be positively associated with the experience of severe avoidance trauma symptoms, although no consistent relationships are found with intrusion symptoms.

Studies of trauma in other contexts and samples, such as interpersonal violence, sexual abuse, and terrorist attacks (eg, Alexander et al., 1998; Muller & Lemieux, 2000; Muller, Sicoli, & Lemieux, 2000; Roche, Runtz, & Hunter, 1999; Sandberg, 2010), recruits in military training (Neria et al., 2001), prisoners of war (eg, Zakin, Solomon, & Neria, 2003), war veterans (eg, Ghafoori, Hierholzer, Howsepian, & Boardman, 2008), Holocaust survivors (Cohen, Dekel, & Solomon, 2002), survivors of terrorist attacks (eg, Besser, Neria, & Haynes, 2009; Fraley et al., 2006), and victims of interpersonal violence (eg, Scott & Babcock, 2010), find similar associations.

However, there are a handful of studies that have found no association between attachment insecurity and PTSD. Interestingly the studies that have found associations have primarily used self-report measures of attachment, while studies that find no associations appear to have primarily used interview assessments such as the AAI (eg, Kanninen, Punamaki, & Qouta, 2003; Nye et al., 2008). These inconsistencies may thus reflect methodological and measurement differences between the types of individual differences in attachment captured by self-report and interview assessments. The self-report measures largely tap into conscious cognitive-affective and behavioral responses, whereas the interview assessments (such as the AAI) focus on the coherence of discourse concerning early attachment experiences. Given that PTSD symptoms reflect cognitive-affective and behavioral responses to traumatic events, it may be that assessments of attachment that target individual differences along the same lines (ie, cognitions, emotions, and behaviors) more directly map onto the experience of trauma symptoms.

In contrast to attachment insecurity, studies focusing on attachment security (whether it be via dimensional or categorical assessments of attachment style)

generally find negative associations with posttraumatic symptoms (eg, Dekel, Solomon, Ginzburg, & Neria, 2004; Mikulincer et al., 1999; Zakin et al., 2003). However, the association between attachment security and posttraumatic symptoms appears to be less consistent in trauma situations that are of a highly interpersonal nature. For instance, Palestinian political prisoners classified as securely attached exposed to physical torture demonstrated significantly less severe PTSD symptomatology compared to prisoners classified as insecurely attached (Kanninen et al., 2003). However, no differences in trauma symptoms were found between securely and insecurely attached prisoners when the torture involved interpersonal cruelty. A study of college students found that for those that experienced interpersonal trauma in the form of child sexual abuse, attachment security demonstrated inconsistent findings with trauma symptoms. Specifically, attachment security was found to attenuate symptoms of agitation, but not symptoms of dysphoria (Aspelmeier, Elliott, & Smith, 2007). Mikulincer and Shaver (2007) suggest that while attachment security may buffer against the experience of trauma symptoms in noninterpersonal events, traumatic interpersonal events may compromise the positive working model of securely attached individuals to the extent that it weakens the protective properties of this attachment style.

Based on the existing longitudinal research the links between adult attachment and trauma seem reciprocal. In some studies, attachment style is found to predict the subsequent experience of trauma symptoms at a later time point, while in other studies, trauma symptoms, such as those associated with PTSD, seem to predict changes in a person's experience of attachment insecurity (eg, Mikulincer et al., 2011). For example, Fraley et al. (2006) found that for survivors of the World Trade Center terrorist attacks, attachment anxiety and avoidance were positively associated with the experience of trauma symptoms and depression 11 months after reporting on their adult attachment. In a diary study of Israeli citizens' psychological reactions to the US–Iraq 2003 war, Mikulincer, Shaver, and Horesh (2006) found that over a 21- day period, attachment insecurity (assessed prior to the commencement of the war) predicted the day-to-day experience of trauma symptoms during the war.

In a study demonstrating the inverse association, Solomon et al. (2008) found that compared to a control group of non-POW war veterans, POW war veterans experienced increases in attachment insecurity. While the non-POW veterans demonstrated some reductions in levels of attachment anxiety and avoidance over a 12- year period, ex-POWs demonstrated increases in both attachment anxiety and avoidance. In particular, ex-POWs showed an increase in attachment avoidance was three times the rate of attachment anxiety. Moreover, PTSD severity was a better predictor of increases in attachment insecurity over time than ex-POWs' baseline assessments of attachment insecurity. In a follow-up study of this sample, Mikulincer et al. (2011) found similar associations when controls and ex-POWs were assessed 5 years later. In this subsequent study, the severity of PTSD symptoms was again associated with increases in attachment insecurity. Thus it appears, at least within the context of a traumatic

event such as war captivity, that enduring trauma symptoms or PTSD either increase attachment insecurity or wear away at attachment security.

Experimental studies however suggest that contextual manipulations of attachment security in the form of security priming appear to yield shifts in people's experience of trauma symptoms. For instance, in the same diary study that found dispositional attachment insecurity to increase day-to-day trauma symptoms, Mikulincer et al. (2006) found that priming security in individuals on a given day was negatively associated with severity of intrusion and avoidance trauma symptoms reported the following day. Further, security priming moderated the link between dispositional attachment anxiety and trauma symptoms, such that this association was attenuated, especially for the experience of intrusion symptoms. However, no moderation effects were found between attachment avoidance and avoidance trauma symptoms. Similarly, in another study Mikulincer et al. (2006) found that security priming reduced Israeli civilians' cognitive accessibility of trauma-related thoughts and again moderated the link between attachment anxiety and people's reaction time towards trauma-related thoughts. However, security priming was found not to moderate the association between cognitive accessibility of trauma thoughts and attachment avoidance. Mikulincer and Shaver (2007) explained these findings by suggesting that avoidant individuals' deactivating strategies do not respond to security priming of actual or symbolic supportive attachment figures. That is, when it comes to people's implicit trauma-related vulnerabilities, attachment avoidance may short-circuit the effects of security priming, such that these vulnerabilities remain active even when comforting attachment representations are available.

Eating Disorders

Over 100 studies have investigated the links between adult attachment and eating disorders across clinical and community samples. Some of these studies have focused exclusively on eating disorders while others have investigated symptoms of disordered eating more broadly (eg, Cole-Detke & Kobak, 1996; Dakanalis et al., 2014; Suldo & Sandberg, 2000). Across all the studies conducted in the area of eating disorders and symptoms (largely with female samples), the focus has ranged from anorexia nervosa (AN) and bulimia nervosa (BN) (eg, Cole-Detke & Kobak, 1996; Evans & Wertheim, 2005; Orzolek-Kronner, 2002), to binge eating (both symptoms and binge eating disorder), emotional eating (eg, Taube-Schiff et al., 2015), and body dissatisfaction more generally (eg, Cash, Theriault, & Annis, 2004; Troisi et al., 2006).

Within clinical samples, research on attachment style and eating disorders has consistently demonstrated that women who experience disordered eating report more attachment insecurities than women who do not experience eating pathology (Gutzwiller, Oliver, & Katz, 2003; Kenny & Hart, 1992; Orzolek-Kronner, 2002). For example, Chassler (1997) compared women who were diagnosed with either AN or BN to a nonmatched control group of women without

an eating disorder. Findings revealed that women with AN or BN scored higher on insecure attachment (either attachment anxiety or avoidance) and lower on secure attachment compared to the control group—a finding consistent with those reported by Kenny and Hart (1992) and Orzolek-Kronner (2002). A more recent study by Illing, Tasca, Balfour, and Bissada (2010) found that women seeking treatment for an eating disorder scored significantly higher on attachment insecurity (ie, attachment anxiety and/or avoidance) compared to a comparison group of noneating disordered women. Similar findings emerge in studies using community samples. Generally, attachment insecurity has been found to be positively associated with the severity of eating disorder symptoms and increased concern about body shape and weight (eg, Brennan & Shaver, 1995; Evans & Wertheim, 1998, 2005; Tasca et al., 2006a,b).

Whilst a consistent link seems to exist between attachment insecurity and eating pathology, it is not entirely clear whether eating pathology is differentially associated with anxiety and avoidance. Some researchers (eg, Cole-Detke & Kobak, 1996) argue that disordered eating behaviors represent deactivating strategies used by avoidantly attached individuals, which serve to suppress and divert attention from real or imagined attachment-related distress (ie, feeling rejected). Individuals exert control over food consumption and body weight to compensate for the helplessness and vulnerability they feel pertaining to interpersonal relationships.

Other researchers (eg, Orzolek-Kronner, 2002) argue that disordered eating behaviors represent hyperactivating strategies used by anxiously attached individuals, to either gain or maintain attention, love, and approval from attachment-figures. More specifically, Orzolek-Kronner suggests that for anxiously attached individuals, eating disorders may manifest as means to perpetuate a thin, child-like body to delay the onset of adulthood and, therefore, maintain a dependency on attachment figures (see also Bruch, 1973; Masterson, 1977; Palazzoli, 1978).

In light of these views, Mikulincer and Shaver (2007) conclude that both avoidant and anxious attachment-related behaviors and cognitions may contribute to eating disorders depending on a person's preexisting tendencies to deactivate or hyperactive the attachment system. Therefore, individuals high on attachment anxiety or attachment avoidance may both develop disordered eating behavior; however, the pathways that lead to disordered eating may differ as a function of individuals' attachment style.

Given that attachment theory can be framed as a broad theory of distress and emotion regulation, recent research has attempted to delineate the pathways that link attachment style to disordered eating through various coping and affect regulation strategies. For instance, Tasca et al. (2009), in a sample of women seeking treatment for an eating disorder, found that attachment had direct effects on disordered eating, as well as indirect effects through affect regulation strategies. Specifically, Tasca et al. found that attachment avoidance was found to be associated with disordered eating symptoms indirectly through emotional deactivation—an affect regulation strategy that aligns with the deactivation tendencies

of avoidant individuals. In contrast, attachment anxiety was indirectly associated with disordered eating symptoms through emotional reactivity—a strategy consisting of emotional flooding, emotional lability, and hypersensitivity.

Studies have also examined the association between attachment and dietary restraint as another factor that may impact on eating disorders and associated symptomatology. The research conducted in this area suggests that dietary restraint is more likely to be associated with attachment avoidance (Candelori & Ciocca, 1998; Turner, Bryant-Waugh, & Peveler, 2009). According to Mikulincer and Shaver (2007), these findings may represent the "suppressive, need-denying nature of deactivating strategies" (p. 394) that underpin attachment avoidance. Furthermore, dietary restraint may be used as a deactivating strategy by avoidant individuals such that it maintains their evaluation of the self in terms of personal achievements and accomplishments rather than in terms of their relationships with others (Feeney et al., 1994). Researchers (Fitzgibbon, Sánchez-Johnsen, & Martinovich., 2003; Heatherton & Baumeister, 1991) propose that, by focusing attention on body shape and one's ability to control dietary intake, an individual may also avoid focusing on aversive emotions, such as those associated with current and past relationships that consistently fail to meet one's attachment needs. It may be argued that dietary restraint is used by avoidant individuals as a means of suppressing or minimizing the experience of negative emotions related to past hurtful relationship experiences.

There are also a handful of studies that have investigated the links between adult attachment and binge eating (eg, Pace, Cacioppo, & Schimmenti, 2012; Tasca et al., 2006a,b). Across these studies attachment insecurity is again found to be positively associated with binge eating (eg, Pace et al., 2012). However, studies seem to more readily find associations between attachment anxiety and binge eating than attachment avoidance (eg, Pace et al., 2012; Suldo & Sandberg, 2000). Research has attempted to uncover the factors that may explain the associations between attachment insecurity and binge eating. These studies have found that issues of body disturbance, negative affectivity, perfectionistic tendencies, and difficulties in regulating emotions, mediate the associations between attachment anxiety and attachment avoidance and binge eating (Boone, 2013; Han & Pistole, 2014; Shakory et al., 2015).

Finally, recent research by Karantzas, Karantzas, and McCormack (2015c) has investigated the extent that food is perceived to fulfill attachment functions for people that experience symptoms of binge eating. The premise behind this research is that for people who binge eat, their preoccupation with, and consumption of, food may be a consequence of turning to food to fulfill needs for comfort and security that may not be effectively fulfilled by significant others. To this end, common expressions, such as "comfort eating" (Roth, 1992), may have strong ties to attachment processes. Karantzas and colleagues found that 46% of people who reported moderate to severe binge eating symptomatology ranked food in the top two of their attachment hierarchy for the attachment function of safe haven, 31% for the attachment function of secure base, and

20% for proximity seeking. In contrast, only 18% of participants reporting no to low binge eating symptoms ranked food in the top two rankings of their attachment hierarchy for both safe haven and secure base. Only 9% reported food in the top two rankings for the attachment function of proximity seeking.

Karantzas and colleagues also found that people reporting moderate to severe binge eating symptoms reported significantly higher attachment anxiety and avoidance compared to people classified as reflecting no to low binge eating symptoms. The findings suggest that binge eating may not only be associated with individual differences in attachment insecurity, but binging may reflect attempts to use food to fulfill attachment needs that may be inadequately addressed by significant others.

Personality Disorders

There are over 200 studies examining the links between attachment insecurity and various personality disorders. A common characteristic of most personality disorders is an unremitting difficulty with social relationships (Widiger & Frances, 1985). Lyddon and Sherry (2001) noted that difficulties in interpersonal behavior contributed 45% of the variance in personality diagnoses. Therefore, the application of attachment theory has been deemed a useful framework to understand personality disorders. From an attachment theory perspective, personality disorders can be framed in terms of the cognitive, affective, and behavioral problems associated with attachment insecurity (Bartholomew, Kwong, & Hart, 2001; Lyddon & Sherry, 2001; Meyer & Pilkonis, 2005). Specifically, attachment insecurity is associated with difficulties in regulating emotions, developing a positive and stable sense of self, effectively navigating key developmental tasks, and difficulties in establishing meaningful relationships. The personal and interpersonal problems associated with attachment insecurity are suggested by Mikulincer and Shaver (2007) to either reflect characteristics of personality disorders or heighten the risk for personality disorders.

Findings to date generally support the notion that attachment insecurity is positively associated with personality disorders (eg, Agrawal, Gunderson, Holmes, & Lyons-Ruth, 2004; Fossati et al., 2003a,b; van IJzendoorn et al., 1997). However, as has been the case with many of the other mental health issues reviewed in the chapter, the associations between attachment insecurity and personality disorders are somewhat varied when examined in terms of attachment anxiety and avoidance and the classes of symptoms associated with various personality disorders (Bartholomew et al., 2001; Brennan, Clark, & Shaver, 1998; Meyer & Pilkonis, 2005).

Specifically, attachment anxiety is associated with dependent personality disorder, which includes symptoms such as worries and concerns about being alone or being independent, self-deprecation, and excessive reliance on others (Bornstein, 1992; Brennan et al., 1998; Fossati et al., 2003b; Hardy & Barkham, 1994). Attachment anxiety is also positively associated with

histrionic personality disorder that entails symptoms such as a desperate desire for attention, approval, and reassurance and excessive emotionality (Bartholomew et al., 2001; Brennan et al., 1998; Fossati et al., 2003b; Hardy & Barkham, 1994). Finally, attachment anxiety is related to borderline personality disorder (BPD) for which key symptoms include self-defeatist thoughts and behaviors and fluctuating emotions (Bartholomew et al., 2001) as well as other features of BPD, including experiences of emptiness, loneliness, low self-worth, intense and volatile relationships, an unstable sense of self, and outbursts characterized by rage and anger (American Psychiatric Association, 2013).

Studies utilizing both self-report and interviews to assess attachment generally find positive links between attachment anxiety and BPD in both clinical and community samples (eg, Barone, 2003; Fonagy et al., 1996; Rosenstein & Horowitz, 1996). In studies that have investigated the prevalence of attachment insecurity in BPD, it was shown that between 44% and 100% of BPD patients are classified as anxiously attached [or reflect a preoccupied state of mind (classified using the AAI), eg, Fonagy et al., 1996]. Other studies have shown BPD patients to be classified as high on attachment anxiety, but this is often coupled with attachment avoidance, and they are thus regarded as fearfully attached in self-report measures, or classified as unresolved (according to studies using the AAI, eg, Barone, 2003; Fonagy et al., 1996; Sack, Sperling, Fagen, & Foelsch, 1996). These studies underscore the association between attachment anxiety and BPD.

Both attachment anxiety and avoidance appear to be positively associated with the manifestations of avoidant personality disorder too (Brennan et al., 1998; Fossati et al., 2003b; Hardy & Barkham, 1994; Meyer, Pilkonis, & Beevers, 2004; Sheldon & West, 1990; West, Rose, & Sheldon-Keller, 1994). This makes theoretical sense given that individuals that experience this disorder can be characterized as longing for emotional closeness and intimacy coupled with fears of being rejected (Millon & Davis, 1996). However, an important point made by Bartholomew et al. (2001) is that avoidant personality disorder is manifested across many and varied social situations whereas fearful avoidance is essentially expressed in the context of close relationships. The point being that avoidant personality disorder and fearful avoidance should not be conceived as one-and-the-same.

While attachment anxiety seems to be an important dimension (either independent of, or coupled with, attachment avoidance) in predicting personality disorders, attachment avoidance appears to be uniquely associated with schizoid personality disorder (Brennan et al., 1998; West et al., 1994). According to Bartholomew et al. (2001), this disorder reflects an extreme case of attachment system deactivation, characteristic of highly dismissive people. Thus, the behavioral characteristics of dismissive avoidance align closely with the symptoms associated with schizoid personality disorder, namely, little interest in social relationships and sexual experiences with another person, an indifference to praise or criticism, emotional coldness, or flattened affect (American Psychiatric Association, 2013).

Summary

In reviewing some of the most widely studied mental health issues that have been researched within the context of adult attachment, it becomes clear that attachment insecurity is a vulnerability factor for a broad array of mental health problems. What is also apparent is that the two attachment dimensions have different associations with different disorders. Attachment anxiety is more consistently associated with affective disorders and particular personality disorders (eg, histrionic personality disorders, dependent personality disorder). In contrast, attachment avoidance is more commonly associated with schizoid personality disorder. Disorders that are more difficult to treat seem to be associated with both attachment dimensions (eg, borderline personality disorder and avoidant personality disorder). Thus, the attachment dynamics associated with these hard-to-treat disorders reflects a disorganized pattern involving both behavioral system hyperactivation and deactivation.

WHAT ARE THE FACTORS LINKING ADULT ATTACHMENT TO MENTAL HEALTH PROBLEMS?

According to attachment theory, the linkage between attachment insecurities and mental health problems is mediated by several important factors (Mikulincer & Shaver, 2012). These factors can be distilled into three broad categories: self-representations, emotion regulation, and problems in interpersonal relations. Fundamental to attachment insecurity and mental health issues are negative cognitions that individuals hold about themselves. Therefore, self-representations can be regarded as a key explanatory mechanism of the association between adult attachment and mental health problems.

Emotion regulation reflects another mechanism that plays a central role in both adult attachment and mental health problems. As a theory of distress regulation, attachment theory provides insights into the way individuals use security-based strategies or strategies associated with attachment insecurity such as hyperactivation and deactivation to modulate the experience of affect. Difficulties in the regulation of emotions are a common issue associated with many mental problems, the most obvious being affective disorders.

Finally, problems with interpersonal relations are fundamental to the experience of attachment insecurity and many mental health issues. In terms of attachment, individuals characterized by attachment insecurity report many and varied difficulties in developing and sustaining positive interpersonal relationships. Likewise, a number of mental health problems such as BPD or avoidant personality disorder include difficulties in relating to others and forming close, loving, and satisfying relationships. Therefore, problems with interpersonal relations may help in developing an understanding of how attachment insecurities feed into mental health issues. In the sections that follow, we provide a brief review of the research associated with each of these factors.

Self-Representations

Insecurely attached and securely attached individuals tend to differ on two dimensions with regard to their self-representations, and these differences play an important role in explaining their divergent experience with regards to mental health problems. The two dimensions are the valence of the representations and their coherence (a clear and connected understanding of oneself). First, as described in chapter: What Are Attachment Working Models?, insecure individuals hold negative self-perceptions (eg, Corcoran & Mallinckrodt, 2000; Mikulincer, 1995; Pietromonaco & Carnelley, 1994; Pietromonaco & Barrett, 1997; Strodl & Noller, 2003). It is these negative self-representations, manifested in beliefs, attitudes, and feelings of hopelessness, neediness, incompetence, and self-criticism, which contribute to mental health problems—especially affective disorders, eating disorders, and trauma symptomatology (eg, Batgos & Leadbeater, 1994; Davila, 2001; Mikulincer et al., 1993; Orzolek-Kronner, 2002). That is, these negative evaluations of the self give rise to cognitive distortions about one's competence, worthiness for love and attention, concerns regarding safety, and ability to relate to other people. These distortions can be so pervasive and chronic that they manifest as clinical or subclinical symptoms, and thus, mental health problems ensue.

Second, insecurely attached individuals' self-representations appear to be more labile and lack cohesion compared to those of securely attached individuals (eg, Davila & Cobb, 2003; Stalker & Davies, 1998; Steiner-Pappalardo & Gurung, 2002). Lack of coherence compromises one's ability to make sense of life stressors and challenges, appropriately manage stressors and life events, and understand one's reasons for dealing with matters in a given way (Antonovsky, 1987). Therefore, this lack of coherence in self-representation is likely to contribute to the experience of various personality disorders and severe psychological outcomes of trauma such as PTSD (eg, Fonagy et al., 1996; Mikulincer et al., 2015).

Emotion Regulation

Emotion regulation is linked with the functioning of the attachment system. In fact, some regard attachment theory as a theory of distress regulation and regard the attachment behavioral system as a distress regulatory system calibrated for regulating threats and punishment in close relationships (eg, Karantzas, Kamboroupoulos, & Ure, 2015b). Once the system is activated, individuals seek security and comfort from their attachment figures. The provision of sensitive and responsive caregiving by attachment figures helps an individual regulate his or her emotions and foster their abilities and competencies in a manner that develops their constructive coping strategies to regulate distress (Cassidy, 1994; Karantzas et al., 2015a; Mikulincer & Shaver, 2007a,b). Conversely, inept, inconsistent, or neglectful caregiving during times of distress is thought to result in emotion-focused coping strategies that either intensify emotional

responses (ie, hyperactivation, as in the case of attachment anxiety) or suppress emotional responses (ie, deactivation, as in the case of attachment avoidance, Cassidy, 1994; Karantzas et al., 2015a; Mikulincer & Shaver, 2007a,b).

People high in attachment anxiety engage in regulation and coping strategies such as venting and rumination that intensify the experience of negative affect. In turn, these affective experiences and emotion regulation strategies have been found to be associated with affective disorder symptomatology as well as eating disorders, both of which relate to difficulties in regulating emotions (eg, Tasca et al., 2009; Wei et al., 2005). In contrast, people high in attachment avoidance tend to experience shallow affect (eg, Mikulincer, 1998b; Mikulincer & Orbach, 1995). Their shallow affective experience is thought to be the result of their tendency to either suppress the experience of affect (especially negative affect) or to short-circuit the processing of uncomfortable emotions (Mikulincer & Shaver, 2007a,b). Research to date supports these assumptions, with attachment avoidance found to be positively associated with emotion regulation strategies geared towards the suppression of negative affect (eg, Bartholomew et al., 2001; Wei et al., 2005). However, under conditions of high cognitive or emotional strain, the attempts to suppress emotions appear to break down for people high on attachment avoidance (eg, Mikulincer, Gillath, & Shaver, 2002; Mikulincer et al., 2004). The result of this faltering in defensive regulation strategies is the experience of heightened negative affect. These findings speak to the fragility of the affect regulation strategies of individuals who experience attachment avoidance. The findings across the studies reviewed suggest that different emotion regulation pathways contribute to secure and insecure individuals' experience of mental health issues.

Problems in Interpersonal Relations

In chapter: What Are the Effects of Context on Attachment?, we reviewed a number of interpersonal problems associated with attachment insecurity. In short, attachment anxiety is associated with excessive support seeking from relationship partners, a dissatisfaction with support received, excessive self-disclosure, the use of destructive conflict strategies, vigilance to violations of trust, heightened concerns regarding partner commitment, and lower relationship satisfaction (eg, Gillath & Shaver, 2007; Holland, Fraley, & Roisman, 2012; Karantzas et al., 2014; Simpson, Rholes, & Phillips, 1996). Attachment avoidance has been negatively associated with perceptions of partner trust and support, the desire for relationship intimacy, and relationship satisfaction (eg, Karantzas et al, 2014; Simpson et al., 1996).

Thus, attachment insecurity represents an aspect of individual differences that reduces people's abilities to develop and sustain high-functioning and rewarding interpersonal relationships. The difficulties experienced as part of relationships can act as a stressor that heightens psychological distress and threatens a person's emotional well-being (eg, Pincus & Ansell, 2003). Rather than relationships

functioning to soothe the distress and worries associated with the pressures of the external world, interpersonal difficulties short-circuit the protective function of relationships. That is, the relationships themselves become another stressor that feeds into the mental health problems experienced by an individual.

For people who experience mental health problems such as personality disorders, interpersonal difficulties reflect variations in people's tendencies regarding dominance within relationships and a desire for affiliation (eg, Pincus & Ansell, 2003; Pincus & Wiggins, 1990). The dominance dimension ranges from dominance through to submissiveness, while the affiliation dimension ranges from cold and detached through to self-sacrificing (eg, Pincus & Ansell, 2003; Pincus & Wiggins, 1990). Both dimensions of interpersonal functioning are thought to tie in with the primary dimensions of attachment insecurity, such that individual differences in attachment insecurity yield different linear combinations of interpersonal functioning (eg, Haggerty, Hilsenroth, & Vala-Stewart, 2009; Horowitz, Rosenberg, & Bartholomew, 1993; Kobak & Sceery, 1988). For instance, research suggests that individuals high on attachment avoidance demonstrate a highly dominant and hostile approach to interpersonal functioning, while individuals high in attachment anxiety demonstrate interpersonal functioning that is more reflective of a submissive orientation that can be of a hostile or nonhostile nature (eg, Haggerty et al., 2009; Horowitz et al., 1993; Kobak & Sceery, 1988). Thus, difficulties with interpersonal functioning can be thought of as a manifestation of attachment insecurities. When these interpersonal issues are highly problematic or chronic, they contribute to the experience of personality disorders.

CAN KNOWLEDGE ABOUT ATTACHMENT INSECURITY AND MENTAL HEALTH BE USED TO FACILITATE THERAPY?

Approaching therapy from an attachment theory perspective can provide practitioners with important insights in helping clients work through attachment issues and mental health problems. First, understanding the attachment style of a client can inform both the therapist and the client about how therapy should be tailored to meet the socio-emotional needs of the client (eg, Clulow, 2001; Obegi & Berant, 2009; Wallin, 2007). Second, the attachment functions of secure base and safe haven provide practitioners with a "therapeutic blueprint" on how to balance the provision of encouragement, support, and comfort towards clients when exploring challenging and uncomfortable issues during therapy. That is, creating a therapeutic environment in which people feel safe and are acknowledged for their strengths and capabilities empowers the client to tackle difficult issues in a more open and confident manner. Third, understanding the characteristics of secure attachment can help therapists model security-enhancing relationships with clients. Security-enhancing interactions between a client and therapist can then help clients revise their working models of attachment in a manner that can reduce attachment insecurity.

According to Bowlby (1969/1982, 1988), therapeutic work requires the therapist to develop an understanding of the life experiences and pathways that have influenced the development of a person's attachment style. This understanding can help the therapist shape the work undertaken with the client to revise insecure mental representations, and thus bring about change in a person's attachment style. While chapter: How Stable Are Attachment Styles in Adulthood? reviews and discusses some of the theory and research relating to change in attachment styles, we expand on this discussion here to specifically focus on the ways in which therapeutic interventions may lead to changes in attachment organization.

Davila and Cobb (Cobb & Davila, 2009; Davila & Cobb, 2004) discuss various theoretical models of attachment style change that emphasize the role of working models as a mechanism for bringing about change. Two models that are relevant to our discussion are the life-stress model and the social-cognitive model. Each model sheds light on different aspects of therapeutic work.

The life-stress model posits that stressful life events disrupt people's socioemotional worlds, and with it, relationships with significant others. Davila et al. suggest that at the heart of therapeutic work is unpacking and reframing of the cognitive and emotional experiences of clients. To this end, treatment is often targeted at assisting individuals to either develop new meanings or new insights regarding the life stress experienced. These new insights and interpretations can be used to augment or reframe aspects of people's internal working models of attachment. However, it is important for therapists to keep in mind that, for insecurely attached individuals, entering therapy may itself be deemed a stressful life event (Davila & Cobb, 2004). Thus, not only must the therapist work on the cognitive and affective reframing of past or recurrent stressful life events, but they must also cultivate a therapeutic relationship (ie, working alliance, Horvath & Greenberg, 1989) that is appraised by the client as nonstressful. Such an environment provides a safe and encouraging context to deal with issues of attachment insecurity.

According to the social-cognitive model, individuals may hold multiple attachment representations of different attachment relationships in addition to more global/general mental representations (see also chapter: What Are Attachment Working Models?). Davila and Cobb (2004) claim that this affords the opportunity in treatment to explore clients' more secure working models to guide behavior and interpretations as a way of strengthening those models or making them more salient and frequently activated. Frequent activation of these secure models may induce more lasting change by making the secure models more chronically salient. As a related point, security priming (covered in chapter: What Can Social Cognition and Priming Tell Us About Attachment?) is geared towards this goal, to make secure models more salient in the minds of individuals (eg, Carnelley, Otway, & Rowe, 2015).

Like Davila and Cobb, Bowlby (1988) placed a strong emphasis on the importance of attending to working models in therapy as a way to modify a person's

insecure attachment mental representations. Specifically, Bowlby (1988) discussed five therapeutic tasks that contribute to the revision of insecure working models and the achievement of positive therapeutic outcomes: (1) the therapist provides a secure base and safe haven for the client to engage with challenging and difficult issues; (2) the therapist helps the client explore and understand how they relate to other people as a function of their attachment goals, perceptions, expectations, and fears; (3) an examination of the client–therapist relationship as the client is likely to project and transfer their self-destructive modes of relating to close others onto the therapeutic relationship; (4) the therapist helps the client to reflect on how their working models are rooted in childhood experiences with primary attachment figures; and (5) the therapist assists the client to recognize that although their working models may have been adaptive in the past, they are no longer functional.

While Bowlby's five therapeutic tasks provide a detailed and programmatic framework for how to approach psychotherapy related to attachment issues, there is little research that has investigated the efficacy of Bowlby's therapeutic model. For instance, Parish and Eagle (2003) found that clients viewed their therapist as a security-providing figure and perceived their therapist as being stronger, wiser, and more available and sensitive than their primary attachment figures. Furthermore, Parish and Eagle found positive associations between clients' reports of the therapist as security-enhancing and the extent and frequency of therapy as well as the quality of the therapist–client relationship. However, clients' attachment avoidance was negatively associated with reports of the therapist as a security-enhancing figure. In other studies investigating the therapist's security-promoting characteristics and therapeutic outcomes, similar results are found, such that those clients who perceived their therapist as a security-enhancing figure reported greater exploration of personal issues during counseling (eg, Goodwin, Holmes, Cochrane, & Mason, 2003; Litman-Ovadia, 2004).

HOW CAN ATTACHMENT THEORY INFORM US ABOUT THE KIND OF DIFFICULTIES INSECURE PEOPLE MAY HAVE IN RELATION TO THERAPY?

Attachment theory has been applied to a wide variety of existing therapeutic approaches, such as psychodynamic, cognitive-behavioral, and dialectic-behavioral therapies. As mentioned previously, one insight that attachment theory has to offer to the therapist is a priori knowledge about the kinds of difficulties clients may possess in relation to therapeutic work. Cobb and Davila (2009) note that insecurely attached individuals hold relatively rigid views of themselves and others and engage in cognitions and behaviors to confirm their existing attitudes, beliefs, expectations, and behavioral strategies. These rigid views help insecure individuals defend or uphold their self-image. Coupled with their behavioral tendencies, insecure individuals perpetuate self-fulfilling prophecies

regarding interpersonal relationships that further feed into their inflexibility regarding cognitions and behavior.

Cobb and Davila (2009) further note that an inherent difficulty in targeting cognition in therapy is that internal working models often operate on an unconscious and automatic level. Thus, it is difficult for clients to reflect and appraise the content of their thoughts and attitudes, let alone make considered judgments about the adaptiveness or maladaptiveness of these working models in different contexts. If therapy is perceived by insecurely attached individuals as a stressful or threatening context, then it is likely that clients' cognitive and behavioral reactions to therapy will reflect the hyperactivating and deactivating strategies characteristic of attachment anxiety and attachment avoidance respectively. Thus, therapists need to be aware that an insecurely attached client's presentation during therapy may well reflect the manifestation of attachment system dysregulation.

Finally, Cobb and Davila (2009) point out that while the ultimate goal of therapy may be to shift clients from harboring an insecure attachment style to a secure attachment style, the reality of therapeutic work may be such that the best a therapist can do with some clients is to help them become less insecure. This final point is an important and sobering consideration for therapists working with insecurely attached clients, especially those who demonstrate very high attachment anxiety and/or attachment avoidance. This does not mean that change via therapy is impossible. Rather, therapists should consider what attachment theory provides in the form of strategies to overcome these difficulties (eg, Berant, 2009; Wallin, 2007).

HOW CAN ATTACHMENT THEORY INFORM US ABOUT DEALING WITH AVOIDANTLY ATTACHED CLIENTS?

According to Berant (2009), therapists need to be mindful that challenging avoidant individuals or having them confront their vulnerabilities can activate defensive reactions that are in line with their attachment deactivation strategies. From a cognitive standpoint, a therapeutic approach that challenges avoidant individuals threatens their self-perceptions regarding excessive self-reliance and exaggerated views of being capable and independent. Berant suggests that in the early stages of therapy it may be worthwhile to sidestep issues that highlight inadequacies or issues that require deep reflection. This approach is likely to reduce resistance and can assist with establishing rapport in the early stages of therapy. However, this does not mean that avoidant individuals should not be challenged in therapy; rather it is more about using one's therapeutic expertise and observational skills to know when is an opportune time to challenge an avoidant person or ask them to engage in deep reflection.

On the one hand, creating a security-enhancing environment in therapy is likely to reduce avoidant individuals' tendencies to engage in defensive reactions against the therapist. As already reviewed, there exists some evidence to

suggest that if a therapist is viewed as a security-enhancing figure, then clients are more likely to engage in exploration during therapy. However, attempts to make an avoidant client more secure, or to make the client see the therapist as a security-providing figure are less likely to succeed with avoidant clients (Levy, Ellison, Scott, & Bernecker, 2011; Taylor, Rietzschel, Danquah, & Berry, 2015). To date, some studies suggest that avoidant clients are less likely to seek out help and are inclined to reject a practitioner's attempts at providing comfort and support during therapy (eg, Dozier, 1990; Korfmacher, Adam, Ogawa, & Egeland, 1997).

So where does that leave therapists working with avoidantly attached clients? Research shows that when avoidant individuals become cognitively overloaded or stressed, their defensive strategies become compromised (eg, Mikulincer, Dolev, & Shaver, 2004). In these instances, the cognitive responses of avoidant individuals resemble those of anxiously attached individuals. This research suggests that avoidant individuals have the same underlying attachment concerns as anxiously attached people but have developed defense mechanisms to minimize dealing with these worries. Accordingly, Berant (2009) suggests that the best time to engage in some reflective work with clients or to challenge the client is when therapists sense that an avoidant person's defenses are lowered (eg, when they appear less resistant or when they open up slightly during therapy).

Wallin (2007) points out that some degree of confrontation may be in order when working with avoidant individuals. From a therapeutic perspective, the confrontation is viewed as functional in that its purpose is to give the avoidant individual insight into the subjective experience of the therapist. That is, the avoidant individual is provided with an explicit account of an interaction between the client and therapist from the therapist's perspective that challenges the avoidant individual's response or behavior towards the therapist. By engaging in such confrontation the avoidant individual can also be exposed to how the therapist was feeling during or post the interaction. The purpose of this approach is to alert the avoidant individual to their behavior and how it impacts the therapist. Such explicit confrontation may be required given that avoidant individuals tend to experience shallow affect (eg, Mikulincer, 1998b; Mikulincer & Florian, 1998) and have a poor ability to perspective-take (eg, Corcoran & Mallinckrodt, 2000). According to Wallin (2007), avoidant individuals are likely to be surprised in learning that they are behaving in a manner that makes the therapist feel uncomfortable, inadequate, or hurt.

While confrontation may be one approach that can be used with avoidantly attached clients on occasions, Wallin (2007) also suggests that framing therapeutic activities in terms of empowering the individual—giving them tools to deal with things themselves—may be a way to get "buy-in" from avoidant clients. This type of approach may well be a path of least resistance in therapy as it aligns with avoidant individuals' views of the self as independent and self-reliant. However, therapists need to temper the extent to which the approach they undertake feeds into avoidant individuals' perceptions of self-reliance, as

this is one of the characteristics that make avoidant individuals devalue relationships and minimize disclosure.

Irrespective of the strategies used in working with avoidantly attached individuals, Berant (2009) and Wallin (2007) highlight that therapists need to be prepared to be devalued by the clients or that the client is dismissive of therapy. These reactions by avoidantly attached individuals may be strategies to bolster their sense of self-reliance and minimize investment in the therapeutic relationship—strategies that Berant and Wallin suggest are reflective of avoidant individuals' worries regarding the ending of the therapeutic relationship in the future.

HOW CAN ATTACHMENT THEORY INFORM US ABOUT DEALING WITH ANXIOUSLY ATTACHED CLIENTS?

Berant (2009) suggests that therapists should target the anxiously attached client's sense of self-competence and value as an individual. To this end, therapy should center on the reassurance of a client's worth, and on encouraging anxiously attached individuals to deal with relational issues in a more independent, agentic, and constructive way. Another emphasis should be on enhancing a client's coping and emotion regulation strategies. For this to happen effectively, Berant notes that the therapist needs to "provide adequate scaffolding and suggestions to help the anxious client find new strengths and better methods of handling thoughts and feelings" (p. 186). However, Berant notes that therapy with anxiously attached clients can be "slow going" (p. 186) due to their excessive need for approval and validation. Nevertheless, this type of therapeutic approach is designed to assist revision of a client's model of self and to reduce his or her reliance on attachment hyperactivation strategies.

Wallin (2007) suggests that the therapeutic relationship should provide emotional availability and unconditional acceptance. The idea behind creating such a therapeutic relationship is to diminish the notion that a response can only be obtained if an anxious person amplifies affect and a sense of helplessness, thus rendering the hyperactivating strategy increasingly unnecessary. As a way of dampening the hyperactivating tendencies of anxiously attached individuals, Wallin also suggests that integrating mindfulness and meditation-based strategies can help to reduce physical arousal and quiet the mind. Furthermore, the implementation of these therapeutic strategies can help an anxious client to notice sensations and emotions as well as to connect with uncomfortable internal states—capacities and skills that are generally not part of the default repertoire associated with hyperactivation strategies. As such, it can be useful to begin sessions with a brief meditation or relaxation.

Wallin (2007) also highlights that early on in therapy, anxious people can appear eager for change and prepared to commit to therapeutic work. However, this eagerness may be an attempt to gain the approval of the therapist rather than a genuine commitment to change. Accordingly, what appears like a client

ready for change, may quickly turn into one who presents a sense of helplessness, need for validation, and resistance to empowerment. Therapists need to be mindful that, for anxiously attached individuals, working on attachment insecurities runs the risk of not having to rely on people as much, including the therapist. This possible reality can be very confronting for anxiously attached individuals, especially if it becomes clear that getting better involves terminating the therapeutic relationship. Given the intense neediness of individuals high on attachment anxiety, Wallin (2007) recommends that it is important that therapists set clear boundaries with such clients to protect both parties from becoming too enmeshed and to guard against negative countertransference—an outcome of the therapeutic relationship that would make it difficult for the therapist to provide empathy.

CAN THERAPY HELP INSECURE CLIENTS?

Despite the theoretical writings and strategies that have been advocated for use in therapy when working with people who experience attachment insecurity (eg, Berant, 2009; Wallin, 2007), there is relatively little rigorous scientific research on the ability of therapy to bring about change in adult attachment. The research that has been conducted to date suggests that therapy can have an impact on enhancing clients' attachment security and reducing attachment anxiety. However, it appears that attachment avoidance is far more resistant to change initiated through therapy.

In a randomized controlled trial investigating the effects of integrative couple behavior therapy and cognitive behavior therapy on changes in attachment style, Benson, Sevier, and Christensen (2013) found that therapy yielded no direct changes to couple members' attachment style over time. However, an indirect effect was found such that increases in marital satisfaction as a function of therapy were associated with increases in attachment security and decreases in attachment anxiety. Again, no changes were found in relation to attachment avoidance.

In reviewing group therapy work amongst people experiencing binge eating symptomatology, Marmarosh and Tasca (2013) suggest that group interpersonal therapy yields significant reductions in both attachment anxiety and group avoidance from pretreatment to 12 weeks posttreatment. A study by Maxwell, Tasca, Ritchie, Balfour, and Bissada (2014) demonstrated a similar finding, but this time effects were found for up to 1 year posttreatment.

In a metaanalytic study also involving 14 studies, Levy et al. (2011) found that across various therapeutic contexts and therapeutic approaches, attachment anxiety showed a reduction posttherapy ($d = -0.46$) while attachment security demonstrated an increase ($d = 0.37$). Levy and colleagues found no significant association between therapy and posttherapy changes in attachment avoidance. Likewise, a recent systematic review by Taylor et al. (2015) located 14 published studies that specifically investigated changes in adult attachment style (measured using self-report measures or interview assessments) as a result of

therapy. The systematic review suggested that therapy was associated with increases in attachment security, decreases in attachment anxiety, but little change in attachment avoidance. These findings seem to be consistent irrespective of the patient group, therapeutic approach, therapy setting, and research methodology employed as part of each study. While the consistency of the effects is impressive, many of these studies were characterized by small sample sizes, while a number of the studies suffered from confounds and possible selection bias of study participants. All in all about 79% of the studies reviewed were deemed to be of weak methodological quality using standardized indicators of quality assessment (such as The Effective Public Health Practice Project tool; Thomas, Ciliska, Dobbins, & Micucci, 2004).

These findings make it clear that far more clinically based research is required to develop greater confidence regarding the efficacy of therapy in bringing about change in people's attachment styles. This needs to be a key area of focus for future applied research into attachment theory.

HOW CAN ATTACHMENT THEORY INFORM THE DEVELOPMENT OF THERAPEUTIC INTERVENTIONS?

Numerous publications have been written on "attachment-based psychotherapy" or "attachment psychotherapy" (eg, Berry & Danquah, 2015; Clulow, 2001; Brisch, 2012). Whereas many of these publications discuss how attachment can inform therapy, only a few propose a therapeutic model or therapeutic protocol that can be regarded as an "attachment therapy" per se. Some attachment therapies target children or adolescents and their parents (the most common being: Parent–Child Interaction Therapy, McNeil & Hembree-Kigin, 2010; The Circle of Security, Hoffman, Marvin, Cooper, & Powell, 2006; Attachment-Based Family Therapy, Diamond et al., 2010; and Attachment Narrative Therapy, Dallos, 2006; Dallos & Vetere, 2009, 2010). While not the focus of this volume, many parent–child-focused therapies target enhancing the sensitivity and responsiveness of parents. By and large, therapies that address parenting behavior generally yield improvements in child behavior (eg, reductions in externalizing problems) and some yield changes in the attachment styles of children as well as parents (for a review see Bakermans-Kranenburg et al., 2003).

In contrast to therapies used with parents and their children, there exists little by way of evidence-based therapeutic protocols that target adults. Therefore, our review of this literature is limited to two therapeutic approaches: Attachment-Focused Group Therapy (Kilmann, 1996) and Emotionally Focused Therapy (Johnson, 2004).

Attachment-Focused Group Therapy

Kilmann (1996) developed a manualized attachment-focused (AF) group intervention that attempts to foster greater awareness of attachment issues in clients, thereby providing a platform to engage in therapeutic work within a group

context to promote positive and satisfying current or future romantic relationships. Given the focus on attachment, AF has an extensive focus on identifying and resolving the attachment issues of each group member coupled with segments on developing healthy beliefs and skills for navigating relationships. AF includes three sequential segments: (1) dysfunctional relationship beliefs and expectations, (2) attachment issues influencing partner choices and relationship styles, and (3) relationship strategies.

The relationship beliefs segment includes an introduction into the rationale for the program to enhance participant motivation and involvement. Participants and group facilitators share background about themselves including information about families and dating experiences. Participants are then supported in developing a rational belief system about romantic relationships. The participants then form small groups and work through material related to commonly held unrealistic relationship beliefs regarding relationships. Using Socratic reasoning, the group facilitators challenge any unrealistic beliefs held by the participants. The "attachment issues" segment is focused on familial factors that may contribute to the development of a person's attachment style and their decision-making and choices regarding romantic partners. During this segment of the group therapy, group facilitators use cognitive restructuring methods to help group members identify and express disappointments and emotions such as anger and they are encouraged to resolve their negative affect as they relate to their relationship experiences. Group members also discuss their dating successes and failures along with the attachment-related emotions associated with these successes and failures. Participants are encouraged to resolve these feelings and related experiences. The relationship strategies segment provides participants with helpful guidelines and strategies to navigate relationships more successfully. Two published studies by Kilmann and colleagues have investigated the efficacy of this therapy. Kilmann et al., 1999 tested the AF group intervention on 13 women with attachment avoidance and compared this group against a nonintervention control group. At 6-month follow-up, AF participants reported improved and more positive interpersonal styles, enhanced satisfaction with family relationships, and a reduction in adherence to dysfunctional relationship beliefs compared to the control group. Furthermore, participants reported reduced fearful attachment and increased attachment security and reported more positive relationship experiences than the control group. However, as noted by Brennan (1999), given the small sample size of this study, the study was likely to be significantly underpowered.

In another study, Kilmann, Urbaniak, and Parnell (2006) randomly assigned college students with insecure adult attachment patterns into either an AF group intervention, a manualized relationship skills (RS) intervention group, or a no-intervention control group. At 6 months postintervention, the AF and RS groups reported reduced adherence to dysfunctional relationship beliefs and an increased ability to control anger compared to the control group. The AF intervention group also demonstrated higher self-esteem, decreased angry reaction, and increased control of anger. At 15–18 months postintervention, participants

in the AF and RS group interventions reported enhanced self-awareness and positive relationship expectations and experiences, while participants in the control group demonstrated no changes over time.

Emotionally Focused Therapy

Emotionally Focused Couple Therapy (EFT, Johnson, 2004) is largely underpinned by an attachment theory framework and is aimed at addressing people's needs for safety and security. Attending to these fundamental attachment needs as part of therapy creates a more secure attachment relationship between romantic partners. EFT focuses on the regulation and processing of affect, gearing therapeutic work towards healing attachment injuries (emotional hurts that have compromised the attachment bond between relationship partners).

In dealing with attachment injuries in session, the therapist's role parallels that of a security-promoting figure (Johnson, 2009). The therapist acts as a secure base and safe haven thereby supporting couples to explore painful issues that have compromised the couple's attachment relationship in the past. As part of EFT, experiential, intrapsychic, and systemic factors that shape harmful and recursive interaction patterns in couples are targeted and addressed (Johnson, 2004). The therapist uses techniques such as constant validation, empathic reflection, and evocative questioning to elicit an understanding of the role that these factors play in their relationship.

Therapeutic work within EFT involves nine steps separated into three stages.

Stage one is an assessment of the couple's destructive interaction pattern (eg, demand-withdrawal communication), and therapeutic work is aimed at de-escalating this destructive behavior. The therapist works on helping the couple to step out of their destructive patterns and view these patterns as the couple's joint enemy. In stage two, the therapist works on restructuring the couple's bond to yield positive interaction patterns. These patterns involve mutual emotional accessibility and responsiveness in which withdrawn partners become emotionally reengaged and criticism and blame are softened. According to Johnson and Rheem (2012) this restructuring of the relationship allows both partners to have their attachment needs met, while also assuaging their partners' distress, fears, worries, concerns, or vulnerabilities. Johnson and Rheem suggest that this alternative relationship environment (brought about as a function of therapy) constitutes what Bowlby (1969/1982) termed effective dependency, where each partner can offer the other a safe haven and a secure base.

In stage three, the therapist helps the couple work on consolidating their revised perceptions of their relationships. The couple generates a coherent narrative of their descent into distress and their ascent into a relationship characterized by love, comfort, and safety. As the couple develops their narrative, the therapist encourages them to acknowledge that problems that were once deemed threatening and distressing (and likely activated the attachment system) are now perceived as manageable and solvable, and hence can and should be addressed.

During therapy, the therapist uses empathic reflection, constant validation, and evocative questioning to help increase relationship partners' awareness and clarity about given problems or issues. The therapist also heightens the clients' experience through the use of images and replays, and subtle reinterpretations of language.

The therapist also reflects patterns of interaction between relationship partners and reframes interactions and responses in terms of attachment theory; for example, framing withdrawal as a response to rejection rather than as a response of indifference or apathy towards the complaining partner.

Currently there are about 30 empirical studies investigating various outcomes, including the effectiveness of EFT (eg, Dalgleish et al., 2015; Dalton, Greenman, Classen, & Johnson, 2013). Regardless of study design or the sample size of studies (some are randomized controlled trials and some are single case studies), the outcomes of EFT are largely consistent. Couples who go through EFT generally report enhanced relationship functioning, reductions in relationship-related depression and anxiety, resolution of attachment injuries, improved adjustment to chronic illness, and reduced trauma symptomatology (eg, Dalgleish et al., 2014; Dessaulles, Johnson, & Denton, 2003; Halchuk, Makinen, & Johnson, 2010). For instance, Halchuk, Makinen, and Johnson found that couples that sought EFT for marital distress reported improvements in trust, forgiveness, and couple adjustment, and reductions in the severity of attachment injuries. These improvements were sustained 3 years postintervention. In another study, Soltani, Shairi, Roshan, and Rahimi (2014) found that infertile couples demonstrated reductions in depression, anxiety, and stress symptoms once they were administered EFT.

Summary

Many therapists use attachment theory to inform their therapeutic practice in working with people experiencing mental health problems or attachment insecurities. Despite this, there is little by way of evidence-based manualized therapeutic approaches for working with adults that are based on attachment theory. In fact, only two therapeutic interventions explicitly target adults, "Attachment-Focused Group Therapy" (Kilmann, 1996) and "EFT" (Johnson, 2004). While both therapeutic interventions have received empirical support, the evidence for Kilmann's approach is limited to three studies. Thus, significantly more work is required to determine the efficacy of this therapeutic approach. EFT on the other hand has been evaluated as part of a large number of studies, and shows promising results in terms of mental health outcomes and in helping couples strengthen their romantic relationships.

CHAPTER SUMMARY

Attachment insecurities appear to be a risk factor for a wide variety of mental health problems. In the chapter we reviewed four of the most widely studied mental health problems that have been linked to adult attachment: affective

disorders, posttraumatic stress disorder and trauma symptoms, eating disorders, and personality disorders. Our overview suggests that attachment insecurity heightens people's tendencies to experience mental health problems. It also suggests that there are three major factors explaining the link between attachment insecurity and mental health problems. Importantly, these factors provide avenues for mental health professionals to undertake therapeutic work with insecurely attached clients. The pathways highlight that intervention strategies may be most effective if they target cognitive and affective aspects of attachment insecurities while also attending to the interpersonal difficulties that people may have in relating to others.

In the chapter, we also provided an overview of the associations between attachment theory and therapeutic strategies and interventions. Interestingly, there exists little by way of research investigating the extent to which therapy can assist with shifting people's attachment style. This is clearly an area in need of further research if we are to develop therapeutic models that attenuate attachment insecurity, and for that matter, foster attachment security. We outlined two therapies that are heavily grounded in attachment theory for working with adults. In particular, EFT seems to be an effective therapeutic approach that is supported by numerous empirical studies. Irrespective of whether a therapeutic approach reflects a systematized protocol or a more nuanced method, what is clear is that attachment theory is a framework of wide appeal for therapists and is likely to provide further therapeutic insights in the future.