SPRINGER PUBLISHING COMPANY

THIRD EDITION

THEORETICAL PERSPECTIVES FOR DIRECT SOCIAL WORK PRACTICE

A GENERALIST-ECLECTIC APPROACH

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PART III

Mid-Level Theories for Direct Social Work Practice

SECTION A

Psychodynamic Theories

SEVEN

Attachment Theory

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John Bowlby (1907–1990) is widely recognized as the originator of attachment theory. He was a British child psychiatrist and psychoanalyst who spent much of his career working with and observing troubled children. Unlike his psychoanalytic peers who privileged fantasy over reality, Bowlby paid attention to the real-life experiences of children, particularly the dire effects of separations from and losses of caregivers (Holmes, 1993b). He came to view attachment not only as a primary social need for human connections but also as essential evolutionary survival behavior. A strong influence on Bowlby was the work of social worker James Robertson, who made the 1952 documentary film *A Two-Year-Old Goes to Hospital*, demonstrating the painful effects of separation on children in hospitals. As a result of Bowlby's and Robertson's work, a virtual revolution was observed throughout the world in hospital visiting policies; hospital provision for children's play, educational, and social needs; and the use of residential nurseries. Over time, orphanages were abandoned in favor of foster care or family-style homes in most developed countries (Rutter, 2008). Six decades later, expanding from early attachment to human relationships across the life span, attachment theory has attracted much interest with very important implications for various disciplines, including social work (Bennett & Nelson, 2010; Sable, 2010; Schore & Schore, 2008).

AN OVERVIEW OF THE THEORY

Understanding of Human Problems

Attachment theory holds that many mental health problems derive from failures of caregiving relationships in the early years to optimally meet the child's need for emotional security, comfort, and protection. Interactions with inconsistent, unreliable, insensitive, or abusive attachment figures interfere with the development of a secure and positive internal representation of self and others, reduce resilience in coping with stressful life events, and predispose a person to break down psychologically in

times of crisis (Hartling, 2008). Attachment insecurity is therefore viewed as a general vulnerability to mental health challenges, with particular symptoms depending on genetic, developmental, cultural, and environmental factors.

One of the least recognized aspects of attachment theory is the importance of fear in the development of mental health problems (Slade, 2008). A core concept is that the attachment behavioral system is "hard-wired" in humans as a means of survival. Therefore,

> because a child is biologically programmed to seek care from those to whom he or she is attached, the child's recourse in the face of fear is to do whatever is necessary to maintain the relationship with an attachment figure, even if the attachment figure is the source of fear. (Slade, 2008, p. 775)

In contrast to Freud's psychoanalytic theory, which suggests that maladaptive behavior is rooted in frustration and anger, attachment theory implies that the therapeutic task is to help clients change the ways of thinking and feeling that were once essential to survival. Such an understanding is more likely to lead to a sympathetic and compassionate stance toward clients than one that suggests the need to confront clients about thoughts and feelings about which they feel shame and guilt.

Recent research in neuroscience suggests that many of the basic functions of the human brain may rely on social co-regulation of emotions and physiological states, especially in early childhood (Coan, 2008; Schore & Schore, 2008). These findings support attachment theory because they suggest that, rather than conceptualizing human beings as separate biological entities with brains that develop automatically and in isolation, we should consider social relatedness and its mental correlates as the normal and necessary condition. These empirical findings also help us to see why experiences of separation, isolation, rejection, abuse, and neglect are so psychologically painful, and why dysfunctional relationships are often the causes or amplifiers of mental health problems.

Conception of Therapeutic Intervention

Attachment theory supplies an overarching framework for understanding the need to intervene early in family relationships that seem to be failing to provide a secure base for children; it also provides a conceptualization of therapy with individuals and families as a way to support revision of maladaptive internal working models (view of self and others). Attachment theory has led to research demonstrating that individuals employ different strategies for regulating attachment distress. This knowledge can inform therapeutic interventions, allowing the therapist to identify when clients may be using strategies that contribute to problems in relationships and to mental health issues.

According to attachment theory, the therapist becomes an attachment figure and the therapeutic relationship becomes an opportunity to experience a significant relationship differently and thereby revise internal models of self and others. Therapy can also provide an opportunity to better understand how experiences in previous relationships may be affecting the client's current perceptions of self and others in a way that does not necessarily correspond with reality. The primary goal of attachment-informed therapy is to enhance the client's capacity to establish and

maintain increasingly secure attachment relationships. The research evidence leads to optimism about the utility of clinical interventions that increase clients' sense of attachment security.

HISTORICAL DEVELOPMENT

Although Bowlby was the creative force behind the original formulation of attachment theory, it was Mary Ainsworth who gave this theory its scientific rigor and academic reputation. Although initially rejected by classical psychoanalysis, developmental and social psychologists embraced Bowlby's theory, apparently because of its inclusion of concepts from biology, ethology, and cognitive psychology. Over several decades, numerous researchers have contributed to the empirical support for attachment theory and have extended it beyond a focus on early attachment to adult attachment relationships. At the same time, the rift between attachment theory and psychoanalytic thinking has been closing. This rapprochement has been helped by the evolution of psychoanalytic theories to their contemporary relational and interpersonal focus, the strengthening of empirical research in psychoanalysis, and the increasing recognition of the effects of abusive and other traumatic experiences on psychological development (Holmes, 2010). Modern conceptual frameworks of attachment continue to guide a wide range of research, theory, and clinical innovations.

CENTRAL THEORETICAL CONSTRUCTS

Attachment Relationship Through Affectional Bonds

Attachment develops and takes shape in the context of a relationship, interaction by interaction, over the course of the relationship. "Bond" is used to refer to an emotional or affectional bond. Ainsworth (1989) defined an affectional bond as a "relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other" (p. 711). Further, affectional bonds are characterized by "a need to maintain proximity, distress upon inexplicable separation, pleasure or joy upon reunion, and grief at loss" (p. 711). Attachment is essential not only for infants and children to survive and thrive but also for the caregiver to provide optimal caregiving. In childhood, primary caregivers typically serve as the main attachment figures. Because of the social norms at the time that attachment theory was initially developed, mothers were seen as the most likely primary attachment figure, but more recent research (e.g., Grossmann & Grossmann, 2009) shows that the attachment figure can also be the father, both parents, or nonbiological caregivers. From adolescence onward, we normally transfer our primary attachment from our parents to our peers, and typically, to a romantic partner (Zeifman & Hazan, 2008). Just as attachment remains significant from the cradle to the grave, so does caregiving—not just in parenting but also in providing emotional comfort and security to adults.

Ainsworth (1989) observed that many relationships have affectional bonds. Attachment relationships are distinguished from other affectionate relationships in that they provide comfort and a feeling of security in times of distress. Close

friendships, and other relationships that involve emotional confiding, meet attachment needs to some extent and could be considered as secondary attachment relationships—that is, secondary to primary attachments. In adulthood, attachment theorists refer to romantic relationships as "pair-bonds" or enduring love relationships (Hazan & Shaver, 1987; Zeifman & Hazan, 2008). These relationships involve romantic love as well as sociability and affiliation, that is, companionship and friendship.

Attachment as a Behavioral System

Bowlby proposed that the attachment behavioral system becomes activated in times of threat or danger (e.g., when one is frightened, injured, distressed, fatigued, or ill), prompting a person to seek an attachment figure for support, comfort, or protection through proximity-seeking behavior. Attachment behaviors in infants and young children include clinging to caregivers when frightened, protesting caregivers' departure, and following and greeting caregivers after an absence. Thus, any behaviors that increase the probability of caregivers' proximity and availability are deemed attachment behaviors. When children's attachment behaviors are adequately responded to, their attachment system becomes far less active as they move freely away from caregivers and explore the environment. The attachment behavior system operates in balance and interdependently with the exploratory behavioral system (Bowlby, 1988; Grossmann, Grossmann, Kindler, & Zimmermann, 2008).

In adulthood, the adaptive value of attachment goes far beyond physical protection to provide emotional well-being and developmental competence. This brings together all the core aspects of attachment: proximity (comfort that comes from the close physical or psychological presence of the attachment figure), a safe haven (to seek help and support when one is distressed), and a secure base (support in pursuing personal goals), in relation to the partner as a primary attachment figure (Ainsworth, 1989; Mikulincer & Shaver, 2009). When adult attachment behavior is adequately responded to, the individual's subjective experience is one of felt security: He or she experiences a sense of worth, a belief in the helpfulness of others, and is able to explore the environment with confidence.

Patterns of Attachment and Inner Working Models

Bowlby (1969/1982) emphasized that caregiver behavior and response determines the development of predictable patterns of attachment in the child. The earliest observable patterns are behavioral, and are the first manifestations of what will become representations or internal working models of attachment, which will guide the individual's feelings, thoughts, and expectations in later relationships (Bretherton & Munholland, 2008). Bowlby postulated that these inner working models include both cognitive and affective aspects and are largely unconscious.

Internal working models determine attachment orientations—patterns of expectations, needs, and emotions one exhibits in interpersonal relationships that extend beyond the early attachment figures. These working models have two sides, namely, models of self as worthy of care (or not) and models of others as being emotionally dependable (or not). Inner working models tend toward stability and go on to influence: (a) personality development, (b) social interaction tendencies,

(c) expectations of the world and of other people, and (d) strategies for regulating emotions (Mikulincer & Shaver, 2009; Sroufe, 2005).

Bretherton and Munholland (2008) make a crucial distinction between implicit and explicit models. We employ our implicit models habitually and nonconsciously, that is, without awareness that they are shaping our experience. These implicit models are based on memories that guide our behavior, and these memories become automatic procedures for interacting (like riding a bicycle or driving a car). What we may be most aware of, however, relates to emotion. We naturally resonate emotionally to each other without having to think about it (Jacobvitz, 2008).

By comparison, explicit working models are conscious and therefore can be thought about and talked about. Ideally, this process of explication begins early in life when "parents perform a positive role in helping a child construct and revise working models through emotionally open dialogue" (Bretherton & Munholland, 2008, p. 107). Such clarification through narratives is essential for updating out-of-date working models of self and others, as clients experience in therapeutic contexts such as psychotherapy.

Bowlby called these internalized memories of attachment "working models" because they are dynamic and capable of change. Therefore, although working models may remain stable, adult outcomes are not predetermined in childhood. With access to coherent, organized information about their own attachment, adults who have experienced rejection, neglect, or trauma are able to experience security in adulthood and facilitate secure attachment in their children.

Attachment Patterns in Childhood

Four decades of empirical research have yielded both measures and classification systems for these patterns of attachment. Mary Ainsworth developed the Strange Situation Procedure (SSP; Ainsworth, Blehar, Waters, & Wall, 1978), which was designed originally to assess the effect of maternal absence on 12-month-old infant exploration. The focus of attention later shifted to the infant's reunion behaviors following brief separations from the caregiver, as these behaviors seemed to best reflect the quality of the relationship. Employing a close study of videotapes of the child's behavior in the Strange Situation, Ainsworth and her colleagues identified three patterns of attachment: secure, insecure–avoidant, and insecure–ambivalent. In further research, Mary Main and her colleagues identified a fourth pattern and classification group called disorganized (Main & Solomon, 1990). See the left-hand column of Table 7.1 for behavioral descriptions of child attachment categories.

A longitudinal study showed that children classified as secure in the Strange Situation were found several years later to be more socially competent, more empathic, and happier than children rated in one of the insecure categories. Similarly, children having avoidant and ambivalent histories have been shown to exhibit more dependent behaviors (Sroufe 2005; Sroufe, Egeland, Carlson, & Collins, 2009). Similar findings with respect to the capacity for emotion regulation are discussed later. It is important to note that the "organized" patterns of avoidant and ambivalent insecure attachment are not viewed as problematic in themselves, but as a significant indicator of early development that is a risk factor for later problems. On the other hand, classifications of early attachment disorganization are considered a strong predictor of later disturbance.

TABLE 7.1 Corresponding Child and Adult Attachment Categories

Child Attachment Category	Adult Attachment Category
Secure: ■ Has caregiver who is consistently available, meets needs of infant, and has pleasurable interaction with infant/child ■ Child trusts caregiver, turns to caregiver for comfort and safety ■ Child perceives self as lovable and has positive expectations of others	**Secure/Autonomous:** ■ In AAI, describes coherent, believable narrative about childhood experiences ■ Values relationships, turns to intimate others for comfort and security ■ Is self-reflective and accepts that others have different perceptions ■ Adaptable, open, and self-regulated ■ Positive and realistic view of self
Avoidant: ■ Has caregiver who is unavailable or indifferent, perhaps hostile at times ■ Learns to deny needs/feelings and avoid close relationships ■ Appears independent ■ Believes that he/she has to take care of himself/herself ■ Often compliant and displays positive affect with caregiver	**Dismissing:** ■ In AAI, describes early history of rejection or neglect, but denies importance of this on his/her development ■ Needs to be independent and self-sufficient ■ Prefers not to depend on others ■ Avoids feelings of closeness and focuses on activities ■ Suppresses feelings ■ Distances himself/herself from others who may reject him/her ■ Views self as superior
Ambivalent: ■ Has caregiver who is inconsistently available ■ Does not trust caregiver to be consistently available to offer comfort and security ■ Longs for closeness ■ Clingy, or impulsively angry ■ May exaggerate need to elicit caregiver's attention ■ Difficulty separating from caregiver to develop autonomy	**Preoccupied:** ■ In AAI, describes confusing childhood experiences with caregivers who were unpredictably available and unavailable ■ Tends to depend heavily on others ■ Seeks approval from others and fears being devalued ■ Exhibits high levels of emotional intensity ■ Impulsive reactions ■ Views self as unworthy ■ Views others as superior
Disorganized: ■ Has caregiver who is abusive, severely neglecting, or experiencing unresolved loss or trauma ■ Hypervigilant ■ Conflicted by drive to flee to caregiver for safety and flee from caregiver as source of fear ■ Responds with fight, flight, or freeze ■ Does not have organized strategy for attachment	**Unresolved/Disorganized:** ■ In AAI, describes confused and incoherent family history ■ Has not resolved early trauma or loss ■ Perceives relationships as dangerous ■ Easily triggered in relationships ■ May dissociate ■ Views self as victim or becomes the aggressor to avoid this feeling

AAI, Adult Attachment Interview.

Attachment Patterns in Adults

Empirical studies exploring attachment between adults have been conducted by two groups of researchers. In one line of research, Mary Main and colleagues, who are developmental and clinical psychologists, created the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1996) to operationalize Ainsworth's patterns in terms of adult attachment categories—secure/autonomous, dismissing, preoccupied, and unresolved/disorganized. While the Strange Situation focuses on

attachment behaviors, the AAI focuses on how attachment processes are revealed through language and speech patterns. It is believed to tap into unconscious cognitive and emotional processes. The interviewer asks the adult to describe childhood relationships with his or her parents, and to provide specific biographical episodes that support more general descriptions. The individual is asked about experiences of rejection; being upset, ill, and hurt; and experiences of loss, abuse, and separation; and then, to reflect on the effects of early experiences on his or her development. The authors describe the interview protocol as "surprising the unconscious" as it quickly taps into sensitive issues. Attachment categories are determined through an assessment of how organized the speaker's state of mind is regarding past attachment relationships and how coherent the speaker's narrative is when discussing this attachment history. The AAI focuses on intergenerational and longitudinal patterns that translate into categories of attachment, and it requires specialized training to code reliably. The right-hand column of Table 7.1 gives a general description of the adult attachment categories assessed by the AAI.

In a second line of research, social psychologists emphasize the dimensional or continuous nature of adult attachments in terms of attachment styles. This second group of researchers observed that Ainsworth's original patterns of child attachment behavior fell along a two-dimensional continuum of attachment avoidance (high or low) and attachment anxiety (high or low; Mikulincer & Shaver, 2007). Hazan and Shaver (1987) used these two dimensions to create the first self-report measure of adult romantic attachment styles. Adults completing this measure were classified as having either an anxious attachment style or an avoidant attachment style when they scored highly on questions related to the corresponding two dimensions. When they scored neither in the high range nor in the low range on either dimension, they were classified as having a secure attachment style. Similar to the AAI, an anxious attachment style is characterized by an expectation of separation, abandonment, or insufficient love; a preoccupation with the availability and responsiveness of others; and hyperactivation of attachment behavior. An avoidant attachment style is characterized by devaluation of the importance of close relationships, avoidance of intimacy and dependence, self-reliance, and relative deactivation of attachment behavior. Later researchers added a fourth category that they labeled "fearful attachment," thereby creating a four-box grid with high and low avoidance representing one continuum and high and low anxiety representing the other (Bartholomew & Horowitz, 1991). Self-report measures of adult attachment focus on views that individuals consciously hold about themselves and others in close relationships. These measures are relatively easy to administer and score compared to the AAI.

Different methods of assessing adult attachment emphasize different attachment phenomena. Whether it is dimensional versus categorical ways of thinking about attachment or self-report versus narrative lines of research, Mikulincer and Shaver (2007) stated, "the two lines both derive from Bowlby's and Ainsworth's writings, and both deal with secure and insecure strategies of emotion regulation and behavior in close relationships" (p. 107).

Intergenerational Transmission of Attachment

Attachment theory has been supported by empirical research, showing that parents' attachment organizations tend to correspond to their children's attachment organizations and an infant's attachment organization tends to remain stable into

young adulthood. Remarkable research has shown that a parent's state of mind with respect to attachment as revealed in the AAI, even when administered prior to the birth of the infant, predicts the infant's pattern of attachment behavior at 12 months (Main, Hesse, & Kaplan, 2005). This finding holds for fathers (Steele, Steele, & Fonagy, 1996) as well as mothers. See Table 7.1 for a comparison of child attachment categories and AAI categories of the caregivers.

Research also suggests that adult romantic relationship styles are reflections of the attachment bond adults had with their caregivers in childhood. In longitudinal research, compared with 2-year-olds who were insecurely attached, 2-year-olds who showed secure attachment to their mothers were better able, at age 20 or 21 years, to resolve and rebound from romantic relationship conflicts. In addition, the partners of securely attached 20-year-olds rebounded faster from relationship conflict regardless of their own attachment history (Simpson, Collins, & Salvatore, 2011).

How do we get from parental state of mind with respect to attachment to infant attachment behavior? According to Allen (2013), for each attachment pattern,

> (1) parents' current states of mind with respect to their attachment history relate to (2) the way parents interact with their infants which, in turn, relate to (3) the patterns of security their infants display toward them and then to (4) adjustment in childhood, adolescence, and adulthood, which includes adult attachment patterns and caregiving behavior. (p. 109)

Understanding this intergenerational process points the way toward intervention; the possibility of interrupting this intergenerational transmission process is one of the most inspired endeavors in attachment research.

Mentalization: Reflective Functioning and Affect Regulation

Sensitive responsiveness—to an infant, a partner, or oneself—requires attunement to mental states in self and others. Fonagy and his colleagues, over the last two decades, have had an enormous impact on attachment theory and clinical practice with the introduction of the construct of mentalization (Allen, 2013; Fonagy, Gergely, Jurist, & Target, 2002). This term refers to the ability to reflect upon, and to understand one's own state of mind; to have insight into what one is feeling, and why. It also involves being able to imagine and consider another's state of mind when observing the other's behavior. Fonagy and colleagues use the phrase "holding mind in mind." Allen (2013) refers to mentalizing as a form of emotional knowing. In the emerging field of interpersonal neurobiology, Siegel (2010) has coined the term *mindsight* to help explain mentalization and link science with practical applications to cultivate mindsight skills and well-being.

Mentalization is considered a precondition of effective social skills, self-soothing, empathy, and other facets of emotional intelligence and social–emotional maturity. This skill of mentalization is thought to develop through a caregiver's empathic and insightful response to a child's distress and other emotions. This means mentalization is learned through a secure attachment to the caregiver. Insecure attachments limit the development of this important skill.

Reflective functioning is the term used in research to operationalize the capacity to mentalize. Metacognitive monitoring, with a meaning similar to reflective functioning, is considered central to coherent AAI narratives (Jacobvitz, 2008).

Parental reflective functioning (Slade, 2005) is distinctive from more general mentalizing processes. It is the caregivers' abilities to hold in their own minds a representation of their child's mind. When a caregiver is able to reflect on both her own and her child's mental states, whether positive or negative, and to appropriately reflect back the reality of the child's internal experience, the child develops a representation of his or her inner self, which is internalized over time. The child learns through this process of attunement or mirroring to be aware of what he or she is feeling and how to manage those affects. This is the beginning of self-organization and self-understanding as well as an understanding that others have internal experiences (Slade, 2005). Two conditions are essential to the reflecting or mirroring process. The mirroring must be "contingent." In other words, facial expressions, sounds, or behavior must be responded to within an optimally brief window of time so that the baby learns that the response came as a result of his or her effort. This enables the child to develop a sense of agency or of being able to influence others (Fonagy et al., 2002). Mirroring must also be contingent in terms of emotional tone. For example, if the caregiver's response to a baby's signal of distress is consistently one of depressed apathy, the child may develop a sense of helplessness and may come to depend only on the self for coping with emotional regulation (Tronick, 2009).

The capacity to mentalize is also necessary for affect regulation (Fonagy, Gergely, & Target, 2008). Through secure attachments, children learn to self-soothe and self-regulate their emotions because their caregiver has modeled these comforting responses to them in a manner that is neither too distant from, nor too close to, their experiences. In contrast, insecure attachment inhibits mentalization because the child must be concerned about the mind of the parent, who may be mirroring mental states that either are not in tune with what the child is experiencing or are frightening.

Attachment With the Brain in Mind

Allan Schore (2001) is one of the authors who has been exploring the convergence of attachment theory and neuroscience and the implications for psychotherapeutic treatment; he refers to this neuroscientific development as "the modern attachment/regulation theory." One of his most significant contributions has been the exploration of right brain-to-right brain communication between caregiver and child and between therapist and client, and its significance in attachment outcomes (Brown & Sorter, 2010). The right brain is responsible for the more intuitive, implicit, nonlinear forms of communication. According to Schore (2001), the caregiver's right brain is largely responsible for the "comforting functions" of the caregiver, while the infant's right brain is geared toward attachment. He emphasizes that the growth of the right brain continues throughout the life span but that its maturation is experience-dependent.

Although some writers (e.g., Rutter, 2008) argue that claims regarding the effects of experience on the brain are speculative, Schore's research suggests that attachment-based, emotion-focused therapies that have been shown to be most effective may be altering clients' brains at neurological levels as well as healing attachment traumas. For example, Diana Fosha's (2003) accelerated experiential dynamic psychotherapy (AEDP) for individuals, Sue Johnson's (2008) emotionally focused therapy (EFT) for couples, and Dan Hughes's (2009) dyadic developmental psychotherapy (DDP) for children and families focus on attuning to nonverbal

right brain signals of facial expressions, body language, tone of voice, and eye contact. They emphasize the relationships (therapist and client, client-client in couples and families) right here, right now, in this room, in this moment. These therapies explore engagement–disengagement, closeness–distance, intimacy, and individuation, and attempt to create a new experience of relationship, leading to new internal working models and a new experience of self in relationships.

Neurobiological research also suggests that early stress and trauma in attachment relationships have enduring effects on stress reactivity and affect regulation (Allen, 2013). Such traumas, including abuse and neglect, greatly compromise the capacity to regulate one's emotional state in times of stress; the neurochemical switch tends to shut down reflective thinking (mentalizing) in favor of reflexive action—fighting, fleeting, or freezing (Mayes, 2000).

Coan's (2008) review of research regarding the neural systems supporting emotion, motivation, emotion regulation, and social behavior demonstrates that collaboration between neuroscientists and attachment researchers is leading to an "attachment neuroscience" that has much potential for future knowledge. An example is a study by Coan, Schaefer, and Davidson (2006) that provided evidence that the attachment system functions to regulate emotion in the face of threat. In a clever experiment with married couples, these researchers fastened electrodes to the ankles of the women in the couples, and exposed them to electric shocks on selected trials; anticipating shock presumably activated their attachment needs. At different points, as patterns of brain activity were assessed, the women were permitted to hold their husband's hand, an anonymous experimenter's hand, or no one's hand. Holding hands decreased activation in brain areas associated with threat responding and emotion regulation. Moreover, holding the spouse's hand was especially powerful in this regard, as measured not only by brain activity but also subjective emotional distress. Furthermore, based on prior assessments of marital satisfaction, high-quality marriages were associated with lowered activation of threat-responsive brain areas. The authors interpreted their findings as showing that holding one's spouse's hand decreases the need for vigilance and self-regulation of emotion, although this beneficial effect may not be true of insecure relationships.

Both attachment and neuroscience research are offering us new lenses with which to view our clients and our interactions with them. Understanding the possible connections between attachment theory and brain research will deepen the biopsychosocial–cultural perspective of clinical social work (Schore & Schore, 2010) and equip us with more effective relational and therapeutic skills for child and family-centered practice.

PHASES OF HELPING

It is important to recognize that a single school of psychotherapy based on attachment theory has not been universally recognized. As Slade (2008) stated, "Attachment theory does not dictate a particular form of treatment; rather, understanding the nature and dynamics of attachment and mentalization informs rather than defines intervention and clinical thinking" (p. 763).

Holmes (2001) argues that attachment theory provides a theoretical base for "the story-telling, story-listening and story-understanding that form the heart of

psychotherapy sessions" (p. 16). Attachment theorists (e.g., Allen, 2013; Holmes, 2010) also point out that the empirical support for the association of secure attachment and reflective function is an endorsement of psychotherapy, because increasing reflective function or capacity to mentalize is one of the main functions of psychotherapy.

Engagement

The task for therapists in the engagement phase is to establish themselves as a secure base from which clients can explore painful aspects of their lives and find new ways of understanding themselves and others. If therapists are not able to provide clients with some sense of security, therapy cannot even begin (Bowlby, 1988). To depend on others is seen as part of the human condition—not an immature or dysfunctional response to be ameliorated (Bowlby, 1979). The focus in therapy is on the person rather than the problem; and the therapist is concerned with the process rather than the content (Holmes, 2010). The therapist responds to the client's pain and helps the client bear that pain. In cases of extreme trauma or lack of any kind of secure attachment, experiencing the therapist as an attachment figure gives the client a glimpse of another world where others are responsive and accessible, and where safe engagement with inner experience and with others is possible.

In therapy informed by attachment theory, how clients are seen is inherently nonpathologizing. Strategies or ways of dealing with emotions that land people in trouble are seen as having originated as defensive maneuvers to maintain connections with loved ones or ward off a sense of the self as unlovable and helpless. For example, the fearful clinging and hostile defensiveness of many clients labeled as having borderline personality disorder is easier to connect with if it is seen as fearful–avoidant disorganized attachment based on experiences in which key others have been both a source of safety and a source of violation. Such a client has experienced being left in an impossible, paradoxical position and is still caught in the mode of "Come here, I need you—but go away, I can't trust you."

Allen (2013) makes the important point that professional helping is limited in the degree to which it can meet attachment needs because of the professional boundaries that are essential to effective helping. These boundaries require that sessions are scheduled in the therapist's office and involve limited therapist self-disclosure. The provision of a safe haven in therapy must rely on psychological attunement and does not usually involve physical comforting.

Assessment and Intervention

In attachment-informed treatment, assessment and intervention are not easily separated. Initial sessions are normally used to gather information about the presenting problem and the client's history, but assessment is ongoing and continually informs the therapist's interventions. Assessment tools based on attachment research have been developed. Steele and Steele (2008) proposed 10 clinical uses of the AAI, suggesting how clinicians familiar with the interview questions and attachment categories may incorporate this information into their work with clients. Such knowledge can help clinicians become attuned to the client's relational style, history of traumatic experiences and losses, and ways of defending against emotional wounds. Clinicians not certified as AAI coders may still find that the questions enrich their

work, particularly in the initial stages of therapy. This information, in combination with knowledge of attachment patterns, will guide therapists' formulations of clients' experiences and their intervention strategies.

Clients who display avoidant/dismissing forms of attachment (see Table 7.1) are seen to have rigid, inflexible stories that function to restrict emotional expression because experience has taught them such expression leads to rejection. These stories lack coherence in that events that are expected to evoke pain are minimized, or relationships are described as "good" or "fine" when the evidence is not convincing. Attachment research suggests that for dismissing clients "the goal of treatment will be to tolerate and express emotional experiences that have been denied access to consciousness" (Slade, 2008, p. 774).

Clients with ambivalent/preoccupied attachment organization seem overwhelmed by intense feelings, their discourse tends to be rambling and unstructured, and they may have difficulty coming to the point. These clients "will require more 'containing' responses from the therapist and have a greater need for organization and structure" (Slade, 2008, p. 774) as they work to revise their ways of thinking about themselves and others.

Clients who are disorganized/unresolved with respect to loss or trauma can be particularly challenging. This classification is much more highly represented in clinical samples than in nonclinical samples. Holmes (2001) stresses the importance of timing and sequencing with these clients, and the importance of first establishing a secure base and strong alliance before any form of interpretation, challenge, or confrontation.

Understanding the early nonverbal processes that are involved in developing the capacity to mentalize is valuable for understanding the interactive patterns constructed in the therapy dyad. This understanding is especially useful with "difficult-to-serve" clients who may have deficits in mentalizing and verbalizing their feelings (Fewell, 2010). According to Schore and Schore (2008), when the early development of an individual's right brain was compromised because of caregiver misattunement, abuse, or neglect, significant change is still possible in psychotherapy as the therapist's right brain engages the client's right brain in a spontaneous, implicit, and explicit meeting of minds. Ultimately, effective psychotherapeutic treatment may be able to facilitate changes in the right brain, which future research may find to be associated with alterations of the internal working model and more effective coping strategies for affect regulation. While still a hypothesis, it may be that this form of communication contributes to treatment that transforms "insecure" into "earned secure" attachments (Schore & Schore, 2008, p. 69).

Monitoring of the self-of-the-therapist is considered critical because the client's painful narrative and behavior can evoke emotional responses in therapists similar to those experienced by clients. Therapists need to have astute reflective functioning skills because this capacity to reflect on one's own and others' mental states allows the therapist to more accurately appreciate the client's dilemma and communicate with the client more empathically. For clients, it is the need for empathy—the need to be seen, understood, and reflected—that drives the intersubjective work of psychotherapy. It is not defined by what the therapist says to the client, or does for the client; rather, the key mechanism is how to "be with" the client, especially during affective stressful moments (Schore & Schore, 2010).

Termination

It is well known clinically that separations from the therapist, even temporary ones, can be painful and lead to protest or despair. Rosenzweig, Farber, and Geller (1996) observed these responses independently of whether the clients were secure or anxious/ambivalent in their attachment patterns. It appears that clients with loss as a predominant theme may experience termination both as a crisis and, when given appropriate clinical attention, an opportunity for development. In other words, therapists can support these clients in more fully experiencing and processing their reactions to ending so that these clients have a corrective termination experience.

Holmes (2010) points out a number of clinical implications for termination from an attachment-informed perspective. For example, therapists must keep in mind the client's attachment style of coping. Deactivating clients may well appear to take an ending in their stride, apparently seeing it as inevitable and presenting themselves as eager to move onto the challenges of "real life" now that their symptoms have diminished. Regret, doubt, anger, and disappointment may be noticeable by their failure to be acknowledged. Expressions of gratitude can be superficial and conventional. The therapist should direct the client's attention to these possibilities as manifest in missed appointments, seeking other forms of treatment, or in overexcitement. Premature ending can be a frequent occurrence with such clients. It is always worth pushing for at least one final goodbye session, in which disappointments and resentments can be aired, rather than simply letting an avoidant client slip away.

A common phenomenon of clinical work holds that as the end of therapy approaches, the client's symptoms, even if diminished during the course of therapy, may reappear. This is particularly likely for hyperactivating clients who may overestimate the negative impact of ending. The therapist may be tempted by this response into premature offers of further therapy or suggestions of an alternative therapist or therapy modality (such as a group).

The client's social context should also be taken into consideration early in the process when deciding whether to offer or recommend time-limited therapy or longer-term treatment. Therapy informed by attachment theory can be used in a time-limited way; however, short-term intervention is much more likely to succeed when the client has a good social and emotional network to which he or she can "return" once therapy is over. For more disturbed clients who require longer-term therapy, if treatment has not strengthened the client's capacity to generate outside attachment relationships, post-therapy relapse is likely to occur.

The experiences of the therapist during the termination phase should also be processed. A study (Ledwith, 2011) explored the links between the attachment orientations of clinical social workers and their subjective approaches to termination. Findings suggested those with secure attachment were more likely to engage in the process of termination, whereas those with less secure attachment orientation were more likely to avoid the termination process. Attachment-informed therapy suggests that increased attention to termination and to client and therapist attachment in this phase of the work will strengthen the overall psychotherapy and minimize the unfavorable effects of termination on clients and on therapists.

APPLICATION TO FAMILY AND GROUP WORK

Family Work

Attachment theory is an important lens through which the relational context of family life can be examined. Research on attachment relationships in families emphasizes that the quality of affectional ties, whether secure or insecure, within the family is a more important mediator of developmental well-being than the particular structure of the family context (Shapiro, 2010). This is particularly relevant to social work practitioners who seek to bring a strengths perspective to work with nontraditional families or parents and children in a broad range of social contexts and situations.

When children have experienced traumatic early beginnings with primary attachment relationships, multiple areas of developmental vulnerability may exist. Practitioners can offer support to parents as they work to understand the impact of the child's attachment history and to create more stable bonds of attachment within the family context. The following are some clinical applications by attachment theorists and clinicians that are aimed at working with families with infants or children who have developed or are at risk of developing less desirable, insecure attachment styles or an attachment disorder: Infant/Child–Parent Psychotherapy (Lieberman & van Horn, 2008), Dyadic Developmental Psychotherapy (also called Attachment-Focused Family Therapy; Hughes, 2009), Watch, Wait, and Wonder (Cohen, Lojkasek, & Muir, 2006), and Modified Interaction Guidance (Benoit et al., 2001).

Attachment-based family therapy (ABFT; Diamond, Diamond, & Levy, 2013) is an empirically informed family therapy model based on the belief that strong relationships within families can buffer against the risk of adolescent depression or suicide and help in the recovery process. ABFT therapists are taught to rapidly focus on core family conflicts, relational failure, vulnerable emotions, and the instinctual desire for giving and receiving attachment security. ABFT has also been adapted for use with suicidal LGBTQ adolescents (Diamond et al., 2013).

EFT for couples, a short-term empirically validated intervention, views close relationships from the perspective of attachment theory and integrates systemic and experiential interventions (Johnson & Best, 2003). Research studies find that following EFT, 70% to 75% of couples move from distress to recovery and approximately 90% show significant improvements (Johnson, 2008). The major contraindication for EFT is ongoing violence in the relationship. EFT is being used with various types of couples in private practice and with different cultural groups throughout the world. These distressed couples include partners suffering from disorders such as depression, posttraumatic stress disorders, and chronic illness (Johnson & Wittenborn, 2012).

Group Work

Applications of attachment theory to group interventions have become a vibrant area for research and practice in recent years. Group interventions addressing important social relationships and contexts of human problems can provide a uniquely potent corrective experience because they involve the protective function of a community of peers functioning as a safe haven and secure base. Page (2010) conducted an extensive review of group interventions that are explicitly based on attachment theory. He divided his findings into the categories of group processes, psychiatric

symptom relief, intimate relationship in sexual pair-bonds, and parenting. Of these categories, the literature on parenting is the largest, reflecting the strong interest in improving attachment security in children through interventions aimed at strengthening parenting capacities.

The Circle of Security (COS) program (Powell, Cooper, Hoffman, & Marvin, 2013) is a 20- to 26-week manualized group intervention for parents based on attachment theory. Treatment plans are developed through videotaping of parent–child interactions and utilizing the Preschool Strange Situation Procedure for assessment. Excerpts from the videotaping, viewed in group sessions, constitute the basis of the intervention and it is the major evaluation outcome variable. Studies have shown that following the intervention, attachment classifications of children and caregivers tend to improve in the direction of security and organization.

Mentalization-based therapy (MBT; Fonagy, Bateman, & Luyten, 2012) is a specific type of psychodynamically oriented group therapy designed to help people with borderline personality disorder. MBT is offered to clients twice a week with sessions alternating between group therapy and individual treatment. During sessions, the therapist activates the attachment system through a range of techniques that include the elaboration of current and past attachment relationships, as well as encouragement and regulation of the client's attachment bond with the therapist, and attempts to create attachment bonds between members of the therapy group. The lasting efficacy of MBT was demonstrated in an 8-year follow-up of MBT versus treatment as usual (Fonagy, Bateman, & Luyten, 2012).

Flores (2004) argues that attachment theory provides a theoretical foundation for understanding why individuals with substance abuse disorders often respond well to group treatment. He conceptualizes addiction as a kind of attachment disorder and that individuals use substances as a substitute for satisfying relationships with others. The highs provided by the substance come to compensate for the pain associated with unmet attachment needs. Flores explains that an ongoing therapy group provided at the optimal time in the treatment of addiction can help the client create the capacity for reciprocal attachment and mutually satisfying relationships, which the individual must achieve in order to give up the substances that have become his or her "secure base." The group must become an "attachment object" so that participating in the group provides a new, more positive experience of relationships with others, thereby modifying internal working models and helping the client to develop healthier forms of affect regulation. He argues that group treatment is more effective than individual treatment because the group dilutes the intensity of the shame as well as the fear of becoming too dependent or being controlled that often floods the client with addiction issues in a one-to-one setting. Here again, the response of the group leader is critical to the development of a group that can serve the secure base function. Furthermore, a therapist who can reflect on his or her own affect and manage the client's "hostility or anger without retaliation or fear is likely to have greater treatment success" (Flores, 2004, p. 286).

COMPATIBILITY WITH THE GENERALIST-ECLECTIC APPROACH

The reader will recognize that attachment theory is very compatible with the generalist-eclectic framework for direct social work practice. It shares with the generalist-eclectic framework a strong emphasis on the development and

maintenance of the worker–client relationship. Bowlby (1988) explicitly stated that the therapeutic stance he advocated was "You know, you tell me" rather than "I know, I'll tell you" (p. 151). This defines his approach as collaborative rather than expert-oriented. Holmes (2001) stresses the need for the therapist to allow the client to lead, noting that responsiveness is essential to providing a secure base.

Attachment theory is also compatible with a systemic perspective and a holistic, multilevel assessment. It was Bowlby's criticism of previous theories' rigidity, and lack of attention to environmental factors, that spurred the development of the theory. Sable (1995, 2008) has been a strong advocate of the usefulness of attachment theory in social work practice and its compatibility with the *biopsychosocial* perspective of systems thinking. Similarly, Egeland (1998), whose longitudinal studies of high-risk families have supported the tenets of attachment theory, argued for the use of a comprehensive ecological model that recognizes that poverty and other social stressors have a significant impact on parents' ability to provide a secure base for their children. Following this line of thinking, Holmes (2004) has argued that borderline personality disorder (BPD) is best viewed as a social/psychological construct related to failures of society to care for its members:

> Social configurations such as endemic racism create fear in victimized minorities, and that fear transmits itself via attachment relationships to oppressed people's children. Similarly, the salience of absent or abusive fathers in the life-histories of people diagnosed as suffering from BPD cannot, and should not, be seen merely at the level of individual psychology. The social seedbed for these negative male roles—colonialism and consequent immigration, educational disadvantage, the move from manufacturing to a service economy—needs also to be acknowledged, and ultimately, worked with in increasing reflexive function of BPD sufferers not just in their own psychology, but consciousness of choices and dilemmas faced by their progenitors in previous generations. (p. 184)

With regard to eclecticism, many clinicians have recognized that attachment theory can be integrated with concepts from other models of therapy. McMillen (1992) noted that attachment theory "can easily be integrated into several approaches to clinical (social work) practice" (p. 211), and he identified these as psychosocial therapy, self-psychology, cognitive therapy, and family therapy. Many writers (Holmes, 1993a; McMillen, 1992; Rutter, 1995) have commented on the compatibility of attachment theory with cognitive-behavioral techniques in view of the similarities in the concepts of internal working models, basic assumptions, and cognitive schemata. Other authors have pointed out how cognitive behavioral interventions promote mentalizing (Bjorgvinsson & Hart, 2006) and how dialectical behavioral therapy can increase mentalizing (Lewis, 2006).

Attachment and narrative theories can also be productively integrated (Fish, 1996; Holmes, 1993b). Holmes (1993b) conceptualized psychotherapy as a process where the therapist and client work together on a "tentative and disjointed" story brought by the client until a more "coherent and satisfying narrative emerges" (p. 158). He explained, "Out of narrative comes meaning—the 'broken line' of

insecure attachment is replaced by a sense of continuity, an inner story which enables new experience to be explored, with the confidence that it can be coped with and assimilated" (Holmes, 1993b, p. 158).

CRITIQUE

Strengths

The greatest strength of attachment theory is the strong empirical support for its tenets (Cassidy & Shaver, 2008; Shilkret & Shilkret, 2011). The idea that the ability to be an adequate parent and the ability to relate to others in satisfying ways are transmitted from one generation to another through experiences beginning in early life is no longer just a hypothesis; it has reached the status of a well-supported proposition. Furthermore, we have clearer understandings of the mechanisms for this transmission, and therefore more specific ideas about how to intervene with high-risk families.

A second strength is that attachment theory has made clearer the relationship between certain kinds of early experiences with caregivers and attachment strategies commonly seen in adult clients. This knowledge can also help our ability to understand and respond empathically to difficult clients whose behaviors are often confusing, upsetting, and distancing.

A third strength is the accessibility of attachment theory. "Ideas are expressed simply and directly, in everyday language and without traditional jargon" (Sable, 1995, p. 34). Attachment theory retains many of the strengths of other relational theories (e.g., viewing relationship as the crucial factor and recognizing the power of the unconscious and internalized ideas) without the difficult terminology. Such accessibility in language reflects the "experience-near" quality of the concepts of attachment theory, which likely contributes to workers' comfort with the theory and their ability to be responsive to the client (Sable, 1992). Other strengths of this theory referred to earlier include a focus on strengths versus pathology, an acknowledgment of the influence of environmental factors, and recognition of the prime importance of the worker–client relationship.

Weaknesses

Attachment theory has been criticized for insufficiently acknowledging the role of temperament in human development, as well as the effects of racism, poverty, social class, and other environmental conditions; it has also been argued that the theory places too much importance on the relationship between mother and child and consequently supports "mother blaming" ideologies (Birns, 1999). Other authors have argued that attachment theory and research are excessively influenced by Western perspectives and they question the universality of its basic tenets (e.g., Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000).

A review of research findings with respect to the domains of attachment theory and temperament theories has led Vaughn, Bost, and Van Ijzendoorn (2008) to conclude that the relationship between measures of temperament and the development of attachment is very complex: "Aspects of both domains contribute meaningfully

to a broad range of interpersonal and intrapersonal outcomes, both as direct effects and as products of their interaction" (p. 210). They recommend that future studies of the "consequences" of either attachment or temperament should include measures from both domains.

With respect to criticisms about neglect of the effects of environmental conditions such as racism, social class, and poverty, Bowlby repeatedly recognized societal contributions to the quality of parenting and child well-being (Holmes, 1993b), and attachment researchers have certainly acknowledged the influence of systemic factors on parenting as previously noted.

Criticism with respect to "mother blaming" results from a narrow view of attachment theory, and fails to take into account the evolution of the theory since Bowlby first articulated it. Currently, considerable research has explored the contribution of fathers to attachment security in children. German researchers (Grossmann et al., 2008) have conducted many studies of the quality of child–father attachment, and they suggest that the Strange Situation may not be the best indicator of attachment between child and father—rather that "a father's play sensitivity . . . is the best and most valid measure of the quality of a child-father relationship" (p. 861). Their review of a "wider view of attachment and exploration" concludes "mothers and fathers both contribute to the lengthy, complex developmental process of achieving psychological security or insecurity" (p. 874).

In response to Rothbaum et al.'s (2000) claims that comparisons of attachment research conducted in the United States and Japan do not support the universality of key tenets of attachment theory, Van Ijzendoorn and Sagi-Schwartz (2008) conducted a thorough review of the empirical support for the core hypotheses of attachment theory. They concluded that the evidence for the cross-cultural validity of attachment theory is strong: The evidence is particularly robust for the hypothesis that attachment is a universal phenomenon and that even in cultures where children are cared for by a network of caregivers, the "caregiver who takes responsibility for the care of the child during part of the day or night becomes the favourite target of infant attachment behaviors" (p. 897).

Populations Most Suited to Attachment Theory

Attachment theory has something to contribute to the understanding of all clients. The most obvious populations to which attachment theory can be applied are those of all ages dealing with separation, loss, and grief, as well as trauma and abuse. Interventions heavily influenced by attachment theory and research include treatment of depressed parents or traumatized mothers (Iles, Slade, & Spiby, 2011; Toth, Rogosch, & Cicchetti, 2008), treating young children with disorganized attachment (Benoit, 2001), and working with maltreated children in child protection, foster care, or adoptive placements (Barth, Crea, John, Quinton, & Thoburn, 2005; Mennen & O'Keefe, 2005). Attachment theory has also been recognized as useful in interventions with adolescents and adults with borderline personality disorder (de Zulueta & Mark, 2000) and eating disorders (Tasca, Balfour, Ritchie, & Bissada, 2007), with adults coping with childhood abuse (Muller & Rosenkranz, 2009), with issues of domestic and intimate partner violence (Lawson, Barnes, Madkins, & Francios-Lamonte, 2006; Levendosky, Lannert, & Yalch, 2012), and with concerns involving intimacy with a romantic partner (Kilmann, Urbaniak, & Parnell, 2006).

CASE EXAMPLE

The following case example illustrates how an attachment-informed family therapy can help a blended family work through the issues that each member brings to the new family. It is also an example of how the therapist allows family members to use her or him as a secure base to explore their feelings, thoughts, and attitudes, and modify ways of thinking and perceiving that are interfering with positive feelings about self and others. When done effectively, attachment-informed family therapy helps children to express their fears and concerns and discover their place within the new family unit, and parents can learn how to maintain a healthy relationship with their children while building a new and loving bond with their spouse and stepchildren.

The Spencer family consists of Jeff, his second wife, Karen (both in their early 40s), and Jeff's two children from a previous marriage, Justin (age 14) and Linda (age 18, currently away from home attending university). The family was referred by Justin's school because of his inattentive and withdrawn behavior in school, which surfaced suddenly over the previous semester. Jeff and Karen have been married for 2 years and Jeff has been divorced from Justin's mother for 6 years. In the first session with the family, the social worker heard from the parents that the transition to a blended family seemed quite smooth at first. Recently, however, Justin's sister had graduated high school and moved out, and Jeff had been working more hours, leaving Justin and Karen at home alone in the evenings. Jeff said that he had always simply trusted Karen to build the connection with his son, because she raised two children on her own (her husband died several years ago) who were now grown and not living with them. Karen stated that her parenting style was somewhat different from Jeff's, and while Karen felt that she and Justin were getting along well with each other, it was the social worker's impression that her interaction style may not have been as energetic or warm as her husband's tended to be.

Karen described how hard she had been working to fit into Jeff's family and get close to Justin and his sister. She stated she had been very conscious of not wanting to be critical or authoritarian with them and had generally taken a "hands-off" approach; she stated it was not her role to discipline. It was very important to her that she not repeat what she had experienced with her own stepfather who had come into her life as a teenager and with whom she had a contentious and hostile relationship. She expressed how much she wanted to avoid being seen as the "wicked stepmother." Jeff acknowledged the efforts his wife had made coming into the family; he also stated that he had been preoccupied with work as he had been spending long hours at two jobs in an effort to overcome the financial debt incurred during the first marriage. He reported that Justin had seemed to adjust well and had made good progress both at school and at home until now.

Justin was very quiet and kept silent for much of the conversation; although he verbally stated he was happy, his face looked sad and he turned away and avoided eye contact with everyone in the room. The worker reflected in the session that Justin seemed sad; in response, Karen recounted that Justin was a quiet boy and she felt she had learned to understand his personality and that they had become closer when she had accepted his quietness and not pushed him to talk. Justin nodded silently when asked how this was for him. Jeff then explained how his son was a "good boy" who never was in any trouble and seemed content to spend time alone in his room or on his computer playing games. Jeff talked about how much he wanted his children

to be happy and how hard he was working to try and make that happen. As he described this, a flash of sadness crossed his face; however, when asked by the social worker, he stated he was not aware of feeling sad. When asked, he said that emotions were not talked about in his family of origin and that his way of dealing with problems was to try and solve them and fix anything that was amiss. Jeff's explanation was followed by an immediate assertion by Karen that Justin was really fine and that they as a family were really doing well. She did say, however, that the family was willing to engage in any sessions the social worker thought appropriate, but she was hopeful that this would not involve a lot of expense of time or money for the family.

In assessing the emotional connection between the family members, the social worker began to identify the patterns of interaction among the family members that might be interfering with openness and engagement. The overarching pattern seemed to be the avoidance of emotional contact as each member was reluctant to move the conversation beyond superficial descriptions and constructed a rather flat narrative that seemed to be motivated by a desire, particularly by Karen and Jeff, to be viewed positively by the social worker. Emotions of sadness or frustration that were observed and reflected by the worker were rationalized or minimized. Justin was quiet, shy, and avoided eye contact with both his parents and the social worker. Karen was the most verbal member of the family, and took the lead in the discussion, providing her version of Justin that seemed shaped primarily by her own experience. The social worker's goals in the initial sessions were to establish a strong therapeutic alliance with each family member and to explore each partner's emotional experience in the family. After the family session, the couple was seen separately from Justin in order to assess their relationship, specifically their ability to respond to Justin's attachment needs for safety, security, and comfort, and how the couple's interactional dynamic and their own attachment histories might be playing into the building of family cohesion.

The session with Karen and Jeff revealed the couple's openness and receptivity to therapy, fueled primarily by their strong connection with each other. The social worker hypothesized that the primary challenge to their understanding and responsiveness to Justin was their different relationships as father and stepmother. At the end of the initial couple session, the worker suggested that she meet with the couple for more couple sessions interspersed with the family sessions and sessions including only Jeff and Justin. She wanted to help the couple better understand how their earlier life experiences might be influencing their interactions in their roles as father and stepmother, and ultimately help them to more effectively support each other in these roles and be more accessible to Justin. She also wanted to better understand the nature of the relationship between Justin and his father.

The worker assessed that it was critical to help Jeff, the biological parent, focus on his son, Justin, and to separate out the marriage relationship from the parenting relationship due to the conflicting and competing nature of the attachment needs of the two subsystems. It appeared that for Justin to feel emotionally safer and secure he needed more of his dad's undivided attention and Jeff needed the opportunity to be entirely present for his son. During a session with only Jeff and Justin, the social worker actively directed the interaction between Jeff and Justin, by coaching Justin to openly express to his father his worries about whether he was truly wanted in the new family. She then helped Jeff to directly express his genuine wish to have his son continue to live with him and his deep concern and caring for his son.

During the following family session, Justin was able to tell his father that he missed the way they had been as a family before the divorce, but that he did not want to hurt his father's and Karen's feelings. He was able to say that the new family situation had felt unbearable for him, but he also did not want to go to live with his mother who now lived in another city in a new relationship. He had, therefore, been feeling quite hopeless. In this session, he was also able to acknowledge his own need for attention and consideration; Jeff was able to hear his son and respond with openness and reassurance.

Jeff took what he had learned from the session with his son back to the couple's session to help process the information together with Karen. Since Jeff's needs had been discussed previously, he was now more able to comfort and be present with Karen's feelings of inadequacy; he was now also able to ask for Karen's support around helping him to be there for Justin. Jeff's request for Karen's assistance worked to break the isolation she was feeling in the family. Over time, Karen's increased feelings of security helped her to relax her rigid, somewhat distant, stance around Justin, and Jeff was able to adopt a more active and effective role in parenting his son. A later joint family session, with Jeff and Karen demonstrating a more open and engaging manner toward Justin, allowed Justin to open up more; he creatively used lyrics from one of his favorite songs to express his grief over the loss of his own family and his feeling of not belonging within this new family structure. This is an example of how the increased sense of safety to express painful feelings that can be developed in a family session allows family members to take risks and have a "corrective emotional experience" when the response from the worker and other family members is one of support and understanding.

The Spencers had 13 sessions in total with the social worker. Five sessions were composed of the couple, four of the father and son, and four with all three family members. These were interspersed throughout the process to optimize the therapeutic outcome. The final session was held with the family unit to track and reflect how the family was functioning currently and help to solidify and consolidate the changes. In general, the family continued to have challenges associated with common issues in blended families, but the atmosphere in the family was one of greater ease and lightness with a more open flow of conversation between all the family members. This change reflected a recovery from the withdrawn, avoidant pattern that was characteristic of the family in the beginning of treatment.

SUMMARY

Attachment theory has provided the theoretical framework for enormous amounts of research into a wide range of human experiences. This research continues to both support and amplify the basic tenets of the theory, and to grow at a phenomenal rate. The theory provides a way of understanding human relationships that is very compatible with the best of social work practice. Attachment theory can be integrated with other perspectives, and can guide the use of techniques from a variety of therapeutic models. It is applicable to individual, family, and group interventions. It also has much to offer policies and interventions that aim to prevent mental health and social problems in future generations.

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