# SECTION III

# Attachment-Based Psychotherapy



## DEFINITION AND DELIMITATION

This section of the book was titled "Attachment Therapy" in the first edition. Here, it has been changed to "Attachment-Based Psychotherapy," a difference that will be explained in detail below. It is based on John Bowlby's attachment theory and uses the results of basic research to treat and develop preventive attachment-based interventions for parents and children, adolescents, and adults.

Attachment-based psychotherapy differs completely from a form of intervention that, unfortunately, increasingly calls itself "attachment therapy." This term was not yet widespread at the time of the first edition of this book and was chosen because it awakened no erroneous associations. However, the new edition makes it clear that these are completely different concepts, even though *attachment-based psychotherapy* and *attachment therapy* are frequently confused on the Internet and elsewhere.

Although so-called attachment therapy claims to be based on attachment theory, the descriptions and practical applications of this therapeutic approach stand in diametrical opposition to attachment theory. In earlier days, such "attachment therapy" was often called "holding therapy." In this approach, children of all ages—particularly traumatized foster children and adopted children (and sometimes even adults)—who for various reasons resisted physical contact and emotional attachment to adults would be forcibly held against their will and in spite of massive resistance until, exhausted from screaming, raging, fighting, and even injury, they gave in to physical contact.

This procedure fundamentally violates the concepts of attachment theory, especially the concepts of sensitivity and close attention to a child's signals, which are necessary to build a fear-free secure attachment with his caregivers. The child is forced (at least externally) to give up his resistance to physical contact because he must yield to the physical and social superiority of adults if he is to survive. Internally, however, he will remain fearful and resistant, which means that this method can actually induce and encourage attachment disorders.

This therapeutic approach is irreconcilable with attachment theory. Several deaths of children have been reported in the United States as a result of violent interventions aimed at encouraging attachment. In 2006, the American Professional Society on the Abuse of Children (APSAC), a working group within the American Psychological Association (APA), grappled with this approach and its advertising strategies and criticized it as unethical and unscientific. APSAC rejected it as irreconcilable with attachment theory, calling it a form of child abuse (Chaffin et al., 2006). I agree completely with this judgment, and I believe it is necessary at this point to begin an in-depth discussion about "attachment therapy," which has recently made inroads in the German-speaking countries as well.

## THERAPEUTIC THEORY

Bowlby's theoretical ideas were an outgrowth of his practical experiences and observations. In the foreword to A Secure Base: Clinical Implications of Attachment Theory (Bowlby, 1988), he expressed regret that the theory he had developed for clinicians involved in the diagnosis and treatment of disturbed patients and families had been so little used in practice. In his opinion, use of the theory in practice was needed to extend our insight into the development of personality and psychopathology (Strauss, 2008). Until then, his theory had mostly served to advance research in developmental psychology. Bowlby explained this disappointing reception of his theory by clinicians and their failure to apply it in practice by pointing out that the empirical, observationally based research on which he drew to formulate his theory struck some

as too "behavioristic." Furthermore, he said, clinicians are busy people hesitant for that reason to commit time to try working with a new theory without first having concrete evidence that its translation into practice can further clinical understanding and therapeutic technique.

Psychoanalytic theory developed in the context of a treatment conceived as "one-person therapy" that is primarily centered on the patient. Even though Freud himself was relationally oriented and certainly worked interactionally, his vision of the psychoanalyst as a patient's "mirror" led his students and later psychoanalysts to emphasize a rather one-sided treatment relationship focused on the contributions of the patient rather than those of the analyst. Interactional reciprocity between patient and analyst was denied, at least theoretically. It took extensive discussion within the field of psychoanalysis before the ideas of object relations theoreticians, who called attention to the dyadic, interactive, and reciprocal processes between patient and therapist, gained greater prominence in treatment and in the training of candidates. To date, the disagreements within psychoanalysis regarding treatment focus have not been settled. Nevertheless, those who advocate an interactive approach have received much support from infant research. An infant is primed from the outset for interaction with a primary attachment figure, and nature has supplied the infant with an abundance of early capacities for perception and action. This is why we can say today that the relationship between mother and infant is reciprocal from the very beginning (Dornes, 1993, 1997). We must ascribe to infants an active capacity to contribute to the relationship. Bowlby was certainly one of the advocates of object relations theory who assumed an interactive relationship between mother and infant. For this reason, it seemed obvious to him that the therapeutic process and the therapeutic relationship should also be interactive and mutually established by the patient and the therapist. The idea that a psychoanalyst would limit himself to the role of mirror and abstain from active engagement in the relationship had no place in his conception (Köhler, 1995, 1998).

Comprehensive research on psychotherapeutic technique (Orlinsky, Grawe, & Parks, 1994) concluded that, of the wide array of variables that can influence the results of therapy, the therapeutic bond[1] between patient and therapist is of decisive predictive value. Research in psychotherapy shows a consistent connection between the quality of

the therapeutic bond and the success of therapy. The "unspoken affective harmony" between patient and therapist and the "affective climate" are very important triggering factors in the creation and maintenance of therapeutic bonding. A good therapeutic bond affects the patient's readiness to open up and to break down defensive processes and resistance. The bond is deemed to have a primarily supportive quality. Establishing this bond is seen as a fundamental condition for the effective use of therapeutic techniques and the analysis of relational experiences. Especially when working with patients who have personality disorders and correspondingly severe psychopathology, the ability to establish and maintain a good therapeutic bond over the long term is a basic precondition for effective longer term therapy. An open, consistent, and respectful attitude on the part of the therapist is particularly important for the creation of a therapeutic bond. These factors are very reminiscent of the basic therapeutic capacities and attitudes called for by client-centered therapy (Finke, 1994; Rogers, 1973).

These consistent findings of research on psychotherapy (Rudolf, Grande, & Porsch, 1988) show similarities to attachment theory, in which the creation of a bond between patient and therapist is fundamental (Bowlby, 1988).

The attachment that grows between mother and child during early development, as well as the need for exploration and the behavior linked to it, can be transferred to the therapeutic situation. It is important to be clear, however, that what takes place in the therapeutic situation is never an exact reenactment of what was experienced in the original situation. Rather, we are dealing with early experiences that are already altered by the experience of later events.

I assume that the patient's self- and object representations mature within the therapeutic relationship as a result of changes in affect, cognition, and behavior. According to Bowlby, the child's inner working model of self and attachment figure and the adult's attachment representation or attachment strategy may change as a result of new attachment relationships (Bowlby, 1969, 1973, 1980). A working model, as conceptualized by Bowlby, is based on the actual experiences of the self in interaction with attachment figures. Research has shown that children can develop different working models for mother and father (see also Buchheim et al., 1998; Köhler, 1998). Furthermore, under some circumstances, a child may develop two contradictory working models of

the same relationship. In this case, Bowlby (1980) proposes, one working model is accessible to consciousness, while the other is defensively excluded from awareness. The latter situation arises, for example, when parents ridicule a child's attachment behavior, but tell the child that their rejecting behavior is motivated by love.

In my clinical experience, an emphasis on attachment-related issues facilitates work with emotional disorders. Such a thematic focus could include issues related to attachment, separation, loss, and exploration. The concept of attachment can be viewed as a basic factor that affects all therapeutic methods and thus represents a basic precondition for psychotherapeutic work. Proceeding from the notion of the therapist as "secure base" (Bowlby, 1988), other seemingly unrelated aspects of emotional problems, such as disorders of drive dynamics or behavior, can be worked through either successively or in parallel.

Without a secure base—in other words, without a secure therapeutic attachment—it is difficult to work through affectively laden conflicts involving drive dynamics. Therapeutic work on drive conflicts can trigger considerable anxiety in the patient, who seeks a secure attachment figure in the therapist so that he can use that attachment to tolerate his anxiety. When the therapist as secure base is prepared to absorb this anxiety, conflicts may be processed. Without a secure base, the patient may be unable to endure the anxiety and fall back on resistance and defense. However, he will unconsciously continue to desire the establishment of a secure base with the therapist so that he can find the relational support that allows him to cope with his anxiety.



## TREATMENT TECHNIQUE

Bowlby dealt with the therapeutic application of attachment theory in various articles now collected in A Secure Base: Clinical Implications of Attachment Theory (Bowlby, 1988).

### General Considerations for Adult Psychotherapy

A patient seeking a therapist is generally anxious and fearful, and the therapist must expect, for this reason, that the patient's attachment sys-

tem is activated to some extent. The patient will try to find someone to take the role of attachment figure by any means at his disposal, including means that have been distorted by his disorder. He focuses this search upon the therapist.

My experience with adult psychotherapy leads me to believe that the therapist must take the following points into consideration:

- In his caregiving behavior, the therapist must allow the help-seeking patient to speak to him via his activated attachment system, and make himself emotionally available to the patient. This includes budgeting sufficient time and space.
- The therapist must function as a reliable secure base from which the patient can safely work through his problems.[2]
- Taking the various attachment patterns into consideration, the therapist must be flexible in the way he handles closeness and distance with the patient, both in their interactions and in the establishment of the therapeutic setting.
- The therapist should encourage the patient to think about what attachment strategies he is presently using in his interactions with his important attachment figures.
- The therapist must urge the patient to examine the therapeutic relationship in detail. The therapist himself must do so, as well, because this is where all the perceptions of relationship conditioned by one's representations of one's parents and oneself are reflected.
- The patient should be cautiously encouraged to compare his current perceptions and feelings with those experienced in childhood.
- It should be made clear to the patient that his painful experiences with attachment and relationship, and the distorted representations of self and object that arose from these experiences, are probably inappropriate for dealing with current important relationships: in other words, that they are outdated.[3]
- In his careful dissolution of the therapeutic bond, the therapist serves as a model for dealing with separation. Separation is left to the patient's initiative, as a forced separation initiated by the therapist could be experienced as rejection. The patient should be

encouraged to verbalize his separation anxieties and his questions about being on his own without the therapist—perhaps even to do some experimenting. Physical separation is not the same as loss of the "secure base." Should the patient need help at a later date, he would still be able to rely on the therapist.

- A therapist who offers more closeness than the patient can handle (and which is therefore experienced as a threat) may trigger a premature desire for separation and/or more distance in the therapeutic relationship in patients with an avoidant pattern of attachment.

These aspects of therapeutic technique, grounded in interactional understanding, are based on the belief that early childhood interactions between attachment figures and child carry over to therapy. This ascribes to attachment processes a fundamental role in the creation of a therapeutic relationship, and is thus the central variable in the therapeutic process. Because patients with disordered social relationships generally do not bring a secure–autonomous strategy vis-à-vis attachment into their relationship with the therapist, it is the therapist's central task to become a secure base for the patient. This demands great sensitivity and empathy as the therapist adjusts to or feels his way into the patient's distorted attachment needs and the often bizarre interactional behaviors that arise from them. In this respect, child, adolescent, and adult therapies do not differ. The qualities Ainsworth called for—sensitivity in perceiving the patient's signals and the capacity to interpret them correctly and react to them appropriately and promptly—are just as necessary in the therapeutic situation and are just as helpful there as they are in the creation of attachment between mother and child.

Even when the patient's chief complaint, such as a sleep disturbance, appears not to be linked to relationship issues, constellations of relationships will quickly become associated with the symptom, and the therapist will recognize these as significant triggers or sustaining factors.

The discussion with patients of both current and childhood forms of important attachment relationships, which Bowlby recommended, will probably not just happen spontaneously in therapy. Although the patient comes to therapy with the more or less conscious intention of discuss-

ing problems and difficulties in interactional relationships, unconscious processes interfere with this desire because of anxiety-provoking themes and conflicts. This is precisely why the therapist's way of structuring the therapeutic relationship is so crucial.

Bowlby proceeded from the assumption that early childhood representations of self and parents with their corresponding attachment and exploratory strategies are reactivated in the transference. Through a consideration of relationship experiences—particularly attachment relationship experiences—in therapy, the patient's earlier self and object representations can be analyzed and understood. In this sense, Bowlby is wholly a psychoanalyst and adherent of object relations theory. Even insensitive behaviors on the part of the therapist may at times have a healing effect if the patient responds to them and if the therapist takes them seriously as actual perceptions of the patient and does not fall prey to a defensive transference interpretation (cf. also Thomä & Kächele, 1985, pp. 64–82). In the latter case, the therapist denies the patient's perceptions that his (the therapist's) behaviors were insensitive by associating them instead with the patient's early childhood ways of experiencing. An opportunity is therefore missed to analyze the actual experience of attachment that resulted from the therapeutic interaction. Interpretations in which the patient's actual perception of an experienced injury is repudiated by the therapist's current behavior only serve to defend the therapist, whose self-esteem may be threatened by the patient's criticism. There is no doubt that such occurrences represent a great injury to the patient and probably weaken the therapeutic bond. They may even contribute to the termination of therapy because the patient's primary need for attachment has been rejected. In such a situation the patient may actually experience a repetition of his adverse early childhood attachment interactions.

Eventually treatment allows the patient to gain access to his painful attachment and relationship experiences, depending on the extent to which he can perceive his own affects, such as rage and grief. He experiences how these early childhood experiences promoted the development of rigid representations of self and object that to this day condition his relationships to other people through perceptual distortions, and the destructive interactions that result. In early childhood, Bowlby noted, such aggression develops when the child's needs for attachment

or exploration are not adequately satisfied. This view is completely in accord with Parens's theory of aggression. On the one hand, Parens defines a beneficial, healthy aggression or assertiveness that aims at understanding the world and acting in it, an idea very close to a concept of exploration. On the other hand, he also defines a destructive aggression, which he considers to be caused by early childhood experiences of massive frustration (Parens, 1993b).

## General Considerations for Child and Adolescent Psychotherapy

Bowlby's guidelines must be modified for child psychotherapy as follows:

- The child therapist must function as a reliable emotional and physical base in his caring behavior so that a secure attachment relationship can develop in spite of the child's attachment disorder.
- The therapist facilitates play that promotes, both through direct interaction and observation of symbolic play, the depiction of material that relates to the child's experienced relationships with his attachment figures.
- The therapist interprets attachment-related interactions between himself and the child either verbally or by participating in symbolic play interactions.
- The therapist fosters emotional expression related to attachment issues that emerge in the transference and links them to past attachment experiences.
- The therapist promotes, through new security-providing attachment experiences, an environment in which the child can free himself from earlier destructive and insecure attachments and can develop a secure attachment in the context of therapy.
- The therapist must dissolve the therapeutic bond carefully so that it will serve as a model for handling separations. Separation should be initiated by the patient and/or his parents; this makes it much less likely that the child will experience it as a rejection on the part of the therapist. Physical separation is not the same as

loss of the "secure base"; should the child or parents need help at a later date, they can still rely on the therapist.

In child psychotherapy it seems especially obvious that the therapist must establish a secure base for the child patient because the child is so much closer in time to the early childhood process. The younger the child, the more he relies on an actual attachment figure. The therapist must function even more compellingly as a secure base than for an adult. This pertains even to his physical presence. Here, too, sensitivity is of fundamental importance. Children are considerably more honest and direct than adults, who can enter into mostly cognitive pro forma relationships. If children's need for attachment is not responded to in therapy, however, and appropriately taken into consideration from the outset, therapy becomes impossible, or is terminated after only a few hours.

In child therapy the child's play behavior is focused on material relating to attachment, separation, and exploration. Depending on the age of the child and the therapist's therapeutic orientation, attachment-related play interactions between child and therapist can be addressed either by direct verbal communication or interpretively in the course of participatory play, and the child can to some extent be confronted with that material. The extent of the confrontation, or of direct verbal uncovering of attachment themes, depends on the age of the child and his cognitive capacities. In general, children can themselves address attachment experiences, in regard both to transference and to actually experienced past attachments. If these experiences are too charged with anxiety and aggression, however, one must in my opinion proceed very cautiously. A therapeutic bond that is not yet secure can be overburdened if the child is flooded by the affects connected with these experiences, and if these are interpreted and explained too early.

The attachment system is activated when a session ends, over weekends, and during vacations and illnesses. In child therapy children can take home toys from the therapeutic space during separations, and I consider these helpful as transitional objects (after Winnicott, 1958) that can stand in symbolically for the therapist and the therapeutic relationship. Some children ask to have postcards sent, as proof that the therapist as attachment figure has not been lost as a result of the separation.

Concurrent psychotherapy of parents or attachment figures plays an important role in the treatment of children. Because the child can only realize the advances he makes in therapy to the extent that the parents are able to understand and accept them, the therapist must inform the parents about the basic theory of psychotherapy, the therapeutic process, and any insights that arise as work progresses, as well as the specific treatment plan undertaken and the changes that they may expect to see in their child. More intensive individual or couples psychotherapy may also be undertaken with the parents, depending on their own psychopathology. In such cases, the same aspects of attachment must be considered as in adult therapy.

Therefore, the child therapist must enter into a positive therapeutic attachment (i.e., become a secure base) not only for the child but also for the parents. If the parents are disconcerted by the therapist's relationship to the child or changes in the child's symptoms, or if they feel that the therapist rejects them or they themselves reject him, treatment will eventually fail because the parents, out of fear, will incline toward termination of therapy. The therapist must also establish a secure emotional base for the parents, demonstrating great sensitivity for their attachment needs (which may well be very different for mother and father) so that they will be able to discuss their own traumas, injuries, and experiences of loss and separation during their concurrent therapeutic work. Moreover, the parents' attachment and exploratory needs within their own relationship will generally be of considerable importance. If these needs are not well integrated in their partnership, the desires and needs for attachment of the partners may be transferred to the child, who may then be forced into the role of ersatz partner. Similar transference desires may be projected onto the therapist.



## Special Considerations

In patients with attachment disorders, it is very important to acknowledge actual but defensively excluded needs for attachment, and not to interpret the patient's defensive behavior merely in terms of regression and resistance (Köhler, 1992). This means that therapists must understand the entire spectrum of attachment patterns. Only in this way will they be able to recognize relevant disordered attachment behaviors. In

this connection, the therapist must pay special attention to the significance of real experiences of separation and loss.

Changes in attachment figures during the first years of life, as well as inconsistent and ambivalent caregiving on the part of the attachment figure, must also be considered, as they will have influenced the current attachment patterns of the patient.

An avoidant attachment disorder places great demands on therapists. They must deal with the attachment needs against which patients are defending and carefully interpret them, while at the same time paying heed to the need for distance conditioned by the patient's disorder. Satisfaction of defensively excluded attachment needs may therefore be bound up with an emotional closeness that is too much for the patient. This represents a potential threat to the therapeutic relationship and can lead to termination of therapy.

In treating patients with ambivalent attachment disorders, the therapist must pay attention not only to the reliability and predictability of his emotional presence, but also to the clarity and contextualizing structure of the therapeutic setting. The therapist must not activate the patient's attachment system unnecessarily, by changing the therapeutic arrangements (postponement or cancellation of therapy sessions, for example) or by starting therapy sessions late.

In general, patients expect that their need for attachment will not be satisfied in therapy either, and that sooner or later they will experience the disappointment of their desire for attachment. Offering only as much caregiving and emotional closeness as the patient himself can regulate has been shown to be effective; allowing the patient to negotiate the frequency of sessions with the therapist is one way of doing this.

Special attention must also be paid to situations relating to separation. These include the beginnings and ends of sessions as well as breaks in treatment for weekends, vacations, or illnesses. Termination of treatment, or its recommencement, are also significant. These are precisely the situations in which a patient's need for receiving care is activated and the affects that are triggered become accessible to processing.

In addition to the focus on attachment-related experiences, a second focus on the exploration side of the equation is necessary. A child's need to explore can be inhibited—even extremely distorted or disordered—by interaction with his mother and other important attachment figures

during early childhood. One of the reasons for a disorder in exploratory behavior is a mother's insecure attachment strategy or "state of mind." A parent may "cling" to the child as a result of his or her own psychopathology. Parental anxieties may thus completely deny the child the possibility to explore.

The need to explore will also sooner or later be activated in the psychotherapeutic interaction. Therapists who do not recognize this need may well interpret the patient's exploratory behavior as resistance to working through issues—as acting out against, or as avoidance of, the transference relationship. Therapists who understand the connection between attachment and exploration will consider whether the patient's enjoyment of exploration might not be indicating the development of a secure-base relationship. He can then be supportive of this enjoyment in his patient and not interpret his behavior as a form of resistance or defense.

The spectrum of conceivable forms of exploration is great not only in children but also in adolescents and adults. It may include attending growth-promoting programs, whether individual, group, or a combination. However, trips, vacations, and breaks in therapy initiated by the patient for his own exploratory purposes may also be seen in this light. Arguing that these represent resistance to analysis, many therapists and schools of therapy demand that patients adjust their vacations to those of the therapist. Any deviation is interpreted as a form of resistance and is treated accordingly. While this may be so in individual cases, this approach sometimes overlooks the healthy aspect of the exploring patient. An attitude that allows the patient a certain amount of choice in structuring the therapeutic setting—changes in session frequency, breaks for vacations, and the like—may offer more potential for the analysis of the reciprocal relationship between attachment and exploration than a therapeutic setting that rigidly sets session frequency and rules. This way of proceeding has proved itself especially valuable in the treatment of adolescents, because their need for autonomous exploration, sometimes at the cost of the denial of attachment needs, is central in their therapy.

It is still unclear to me whether what is activated in therapy is a dominant working model of approaching attachment relations with other people, or whether what is activated in therapy is a specific work-

ing model of mother or father in childhood. Köhler (1998) assumes that a hierarchy of working models (from specific to general) is formed. However, I regard it as an open question whether, apart from the "dominant" working model, there might not also be a "recessive" one that reappears later in life. The possibility that a "healthier" attachment pattern might exist that had been pushed into the background is an important one for therapy, but has not been proposed by attachment theorists. If present, such relationship strategies could then be reactivated in therapy and would not have to be newly constructed within therapy (L. Köhler, personal communication). Other problems may occur when patients have constructed two contradictory working models of the same relationship,[4] only one of which is accessible to consciousness, as described by Bowlby (1980) and elaborated by Bretherton (1995, 1998) with regard to children who were subjected to highly rejecting or traumatizing interactions. From the point of view of attachment theory, it makes little sense to probe these patients' free associations before the inconsistencies of their thought processes and the causes thereof are worked through (cf. also Köhler, 1998).

The secure base offered by therapy makes possible an affective "new beginning" (Balint, 1968), or a "corrective emotional experience" (Alexander & French, 1946). It is a fundamental prerequisite for the processing of old maladaptive attachment patterns.

It is still an open question to what extent a change toward a more secure attachment representation is effected through the therapeutic techniques. There have been very few studies examining whether or not an insecure or disorganized attachment strategy, assessed with the AAI, may be converted into a secure strategy—in other words, whether a secure "state of mind" with respect to attachment can be achieved later, possibly as a result of new corrective attachment experiences in the course of psychotherapy (cf. also Main's [1995] "earned secure") treatment reports of therapies during which changes in the AAI were found seem to speak in favor of this, as do the treatment cases that follow (cf. also Fonagy et al., 1996a; Levy et al., 2006; Wesselmann & Potter, 2009; Steele, Steele, & Murphy, 2009).





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