

Outline

- Does attachment matter?
- Attachment theory—the basics
- Clinical application

• The reflections from the workshop have been added at the end of the slides.

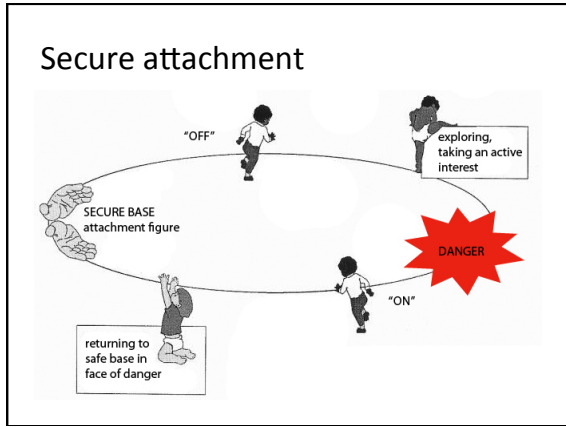
Attachment theory – basics

Attachment (John Bowlby; 1969, 1972, 1980)

- is an affectional bond formed with a specific person (attachment figure).
- persistent and emotionally significant, associated with a desire for close proximity. Involuntary separation from the attachment figure results in distress.
- the attachment figure provides a “secure base”, enabling the infant to explore, develop and gain independence.
- the attachment system is triggered by environmental threats, distress, illness or fatigue, causing the infant to seek contact with the attachment figure for safety.
- the attachment system is designed to facilitate proximity seeking, protection and care, and emotional validation.

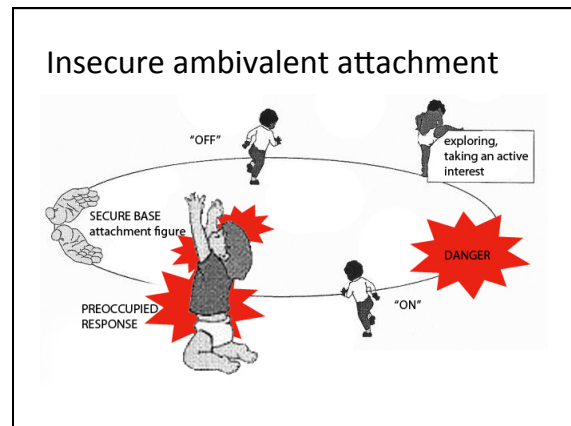
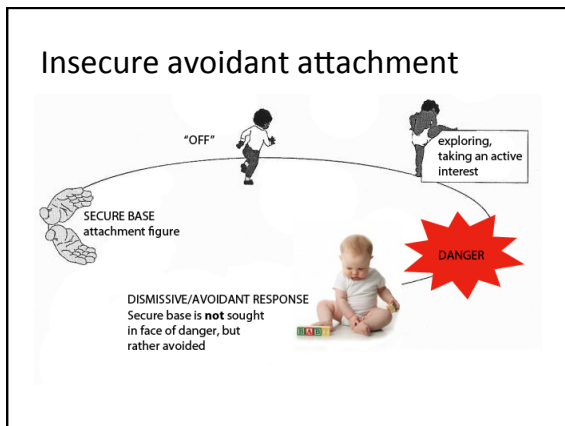
Attachment theory – basics

- The attachment figure provides a “secure base”, enabling the infant to explore, develop and gain independence.
- The attachment system is *activated when needed* (switches on/off). Triggers are environmental threats, distress, illness or fatigue.



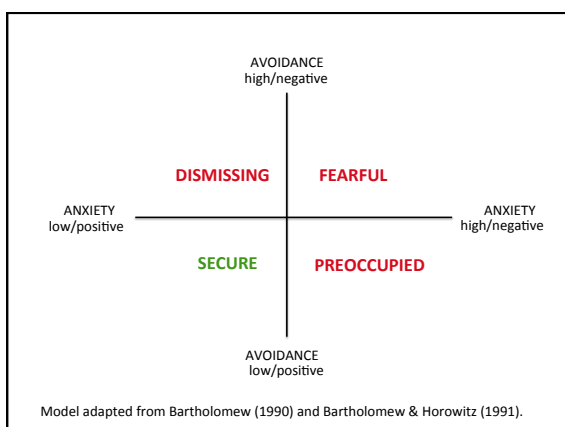
Attachment theory – basics

- The attachment system is reciprocal; the caregiver’s attachment system is also switched on/off.
- Each infant’s attachment needs are responded to in different ways by the environment.
- The primary response of infants is to seek security from a caregiver. If this proves ineffective, the infant will employ secondary strategies.



- ### Attachment theory – basics
- Attachment is an instinct aimed at protection of the physical as well as the psychological self, including emotional self-regulation.
 - Attachment theory is a *regulatory* theory focusing on how our primary need for felt security establishes patterns of emotion regulation and proximity seeking.

- ### Attachment theory – basics
- While we typically classify attachment in one of several categorical organisations, it might be useful to think of attachment style as a location on a map where the coordinates are *anxiety of intimacy* and *avoidance of intimacy*.
 - Our expectations of the usefulness (or harmfulness) of attachment is shaped by previous experiences.
 - Our "location" on the map is dependant on the levels of anxiety and avoidance attachment elicits in us.



MODEL OF SELF (ANXIETY)

		Positive (low)	Negative (high)
MODEL OF OTHER (AVOIDANCE)	Positive (low)	SECURE High self-worth, believes that others are responsive. Comfortable with autonomy and in forming close relationships with others.	PREOCCUPIED¹ Preoccupied with relationships. A sense of self-worth that is dependent on gaining the approval and acceptance of others.
	Negative (high)	DISMISSING² Overt positive self-view. Denies feelings of subjective distress and dismisses the importance of close relationships/intimacy.	FEARFUL³ Negative self-view. Lack of trust in others, subsequent apprehension about close relationships and high levels of distress. Socially avoidant.

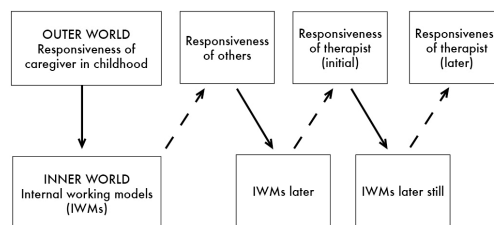
¹ Main's preoccupied category; Hazan & Shaver's anxious-ambivalent category
² Main's dismissive category
³ Main's unresolved category; Hazan & Shaver's avoidant category

Model adapted from Bartholomew (1990) and Bartholomew & Horowitz (1991).

From infants to adults: Internal Working Models

- During childhood, experiences of interactions with attachment figures become internalised and are carried into adulthood as internal working models (IWMs; or core relational schemata).
- IWM produce
 - internal representations (and expectations) about the self
 - internal representations (and expectations) about others
- These internal working models come to regulate responses in subsequent interpersonal interactions, and are theorised to form the prototype for interpersonal relationships throughout life.

Inner and outer world interaction



Dotted lines denote impact of inner world on outer world; continuous lines denote impact of outer world on inner world.

Model adapted from Harris (2004). Chef or chemist? Practicing psychotherapy within the attachment paradigm. *Attachment and Human Development*, 6, 191–207.

Reflection I

What does attachment mean to you?

- When you were upset as a child, what would you do?
- Choose three adjectives or words that reflect your relationship with your main caregiver starting from as far back as you can remember in early childhood.

Reflection II

As an adult, what do you do when you are upset?

How would you react in the face of ...

- separation from significant people in your life?
- loss of grandparents, parents, siblings, friends?
- loss of work, social status, health?

Measures of attachment

There are several self-report measures of attachment available.

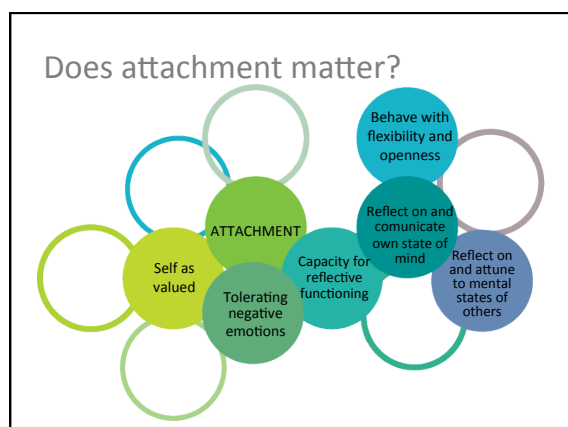
If you are curious about where on the map you might find yourself, you could try this online, free version, which is part of a research project on new self-report measures on attachment ...

<http://www.web-research-design.net/cgi-bin/crq/crq.pl>

Does attachment matter in psychosis?

- Attachment security impacts positively on
 - cognitive competence
 - emotion regulation
 - communications style
 - interpersonal and social functioning

E.g. Fonagy et al (1998), Fonagy et al (2000).



Does attachment matter?

Research consistently finds that psychiatric patients in general have a higher prevalence of insecure attachment styles, including

- depression (Muller, Lemieux & Sicoli, 2001; van Buuren & Cooley, 2002)
- anxiety (Muller et al, 2001; van Buren & Cooley, 2002)
- eating disorders (Brennan & Shaver, 1995)
- borderline personality disorders (Fonagy et al., 1996)
- psychosis (e.g. Dozier, 1990; Mickelson, Kessler & Shaver, 1997)

Does attachment matter?

- Attachment style is linked to
 - help-seeking behaviours
 - self-report of symptoms
 - use of treatment, including disclosure
 - adherence to treatment (or reasons to leave)
 - recovery style and outcome

Dozier (1990), Dozier & Lee (1995), Tait et al (2004)

Attachment styles in psychosis

Dozier (1990) and Dozier, Stevenson, Lee & Velligan (1991)

- N = 42: 12 schizophrenia; 25 manic-de; 3 MDE; 2 atypical psychosis.
- N = 40: 21 schizophrenia; 19 affective disorders
- Found significantly higher levels of attachment insecurity in the psychiatric group in total. Schizophrenia diagnosis was related to higher levels of insecurity than other diagnoses.

Attachment styles in psychosis

Mickelson, Kessler & Shaver (1997)

- Nationally representative sample in the USA, including app. 800 individuals with a diagnosis of schizophrenia.
- Hazan and Shaver's (1987) three-category attachment measure.
- Found a particularly high prevalence of avoidant attachment among individuals with schizophrenia.

Tyrell et al (1999)

- N = 54: 40 schizophrenia spectrum, 14 affective disorders; 48% additional substance abuse disorder
- Found that 89% of individuals with schizophrenia were classified as dismissing when unresolved not included.
- When unresolved was included, 44% classified as this category.

Attachment styles in psychosis

MacBeth et al (2011)

N=34 patients, FEP, used AAI

	3-way	4-way
Secure/freely autonomous	26,5 %	11,8 %
Insecure/Dismissing	61,8%	50,0 %
Insecure/Preoccupied	11,8 %	8,8 %
Unresolved/Disorganised	n/a	29,4 %

- Greater degree of heterogeneity in attachment organisation than suggested in previous literature.
- No of secure classifications indicated that AAI coding is in fact not compromised by psychosis symptoms as warned by Dozier et al 1991.

Attachment styles in psychosis

Berry, K., Wearden, Al., & Barrowclough, C. (2007)

N = 96, PAM

- General attachment style v attachment style in specific relations (family and/or key worker).
- No of attachment relations reduced compared to normal (4 v 2)
- General attachment style predicted specific attachment relations, but
 - reported significantly less anxiety in keyworker relations
 - significantly less avoidance in parental relationships

“The foundations are not regarded as deterministic of future behaviour. However they are considered to initiate developmental trends that make the achievement of later optimal functioning more or less difficult; in this way early attachment patterns are viewed as either developmental assets or developmental liabilities which interact with later life circumstances in complex but coherent ways.”

Harwood, R. L., Miller, J. G., & Irizarry, N. L. (1995), p. 10, in *Culture and attachment: perceptions of the child in context*. New York: Guilford.

Attachment theory – basics

- Secure attachment is most strongly predicted by the caregiver’s sensitivity towards the infant’s intentional and emotional states (e.g. Slade et al, 1999).
- Attachment patterns are relatively stable
 - 77 per cent of secure representations in childhood go on to remain securely attached as adults (Waters et al, 2000).
 - 94 per cent of insecure representations in childhood predicted insecure attachment style in adulthood when associated with subsequent negative life events (Weinfeld et al, 2000).

Attachment theory – basics

- Life events influence changes in attachment style (Hamilton, 2000)
 - loss or formation of key relationships
 - interpersonal trauma (sexual and/or physical abuse)
- We are capable of having multiple attachments as adults, and levels of anxiety and avoidance can differ.

Insecure attachment

- Children: A lack of confidence that the attachment figure will be able to provide security.
 - Avoidant will avoid caregiver.
 - Ambivalent children hyper-activate their attachment system to harness the caregiver’s attention, but will refuse to be reassured and comforted.
- Adults: A lack of capacity to reflect upon one’s own experiences and emotions and provide the self with reassurance, warmth, security and self-soothing.
 - Dismissive adults minimise and avoid attachment-related experiences. Reduced ability to reflect on own affects as well as attune to minds/ mental states/intentions of others.
 - Preoccupied adults value attachment but feel insecure, ruminate about attachment experiences and are concerned with being abandoned or rejected.

Attachment theory and CBT

- Although originally developed within a psychodynamic framework, attachment theory differs from analytical tradition in several ways that are more in tune with a typical CBT approach to therapy.
- Importantly, the main tenet that personal development depends on a collaborative process hallmarked by dialogue and reflection rather than an expert showing the way. Furthermore, the basic underlying understanding of how early experiences come to shape our understanding of and expectations to the world, ourselves and others greatly overlaps with the notion of schema.

Attachment theory and CBT

- At the same time, there are also important differences between CBT and attachment theory: Bowlby postulates that our need for attachment and safety is an innate instinct. An individual's need for attachment can be met in various ways and develop more or less optimally—but some kind of attachment style will inevitably develop; we cannot be non-attached. This calls for an even greater focus on the effect of early experiences in later difficulties, opening for a more contextual or narrative integration of the here-and-now.

Potential benefits

- Attachment style provides important insight into patients' likely previous relational experiences.
- Provides a model of how the inner and the outer world both influence development and further use and reworking of internal working models of close/important relationships.
- Offers a framework to understand the working alliance and generate predictions about how to successfully tailor interventions to client attachment style.
- Conceptualises aggression as key emotion that "moves" us, much like fear, and gives specific input on how to meet patients' hostility and aggression.

CLINICAL APPLICATION

Acknowledgements:

While the compilation and adaptation is my own, a major part of this section builds on Andrew Gumley and Matthias Schwannauer's thoughts published in their book *Staying Well After Psychosis: A Cognitive Interpersonal Approach to Recovery and Relapse Prevention*.

"... the therapist's role is analogous to that of a mother who provides her child with a secure base from which to explore the world."

John Bowlby (1988, p. 140)

Therapeutic stance

Five basic elements in fostering a secure attachment (Siegel, 1999)

1. Collaboration
2. Reflective dialogue
3. Repair
4. Coherent narratives
5. Emotional communication

1. Collaboration

- Already an inherent principle in CBTp secure relationships are based on collaborative and carefully attuned communication.
- Collaboration is developed through
 - careful negotiation of a client's problem list and goals within therapy
 - the therapist's encouragement of the client to develop an active, enquiring and explorative approach to understanding and resolving emotional distress

2. Reflective dialogue

- Focus on the client's internal experiences. The therapist aims to make sense of client narratives and communicate their understanding in such a way that the client can create new meanings and perspectives on their own emotions, perceptions, thoughts, intentions, memories, beliefs and attitudes. In particular, reflection on the construction of meaning in relation to sense of agency and self is encouraged.
- The focus of such a reflective dialogue can be thoughts or schema, as in traditional CBT, but also feelings, images, here-and-now-experiences in the relationship between therapist and client, etc.

3. Repair

- When attuned communication is disrupted, there is a focus on collaborative repair, allowing the client to reflect upon misunderstandings and disconnections in their interpersonal experiences.
- Disagreements on tasks and goals versus problems associated with the relational bond.

4. Coherent narratives

- Helping the client to connect past, present and future is essential in developing her autobiographical self-awareness.
- Developing coherent narratives within therapy is aimed at help fostering the flexible capacity to integrate internal as well as external experiences.
- What help patients need with this different ways depending on attachment style.

5. Emotional communication

- The therapist needs to maintain close awareness of the client's emotional communication in the narrative, as well as the actual content.
- Focusing on negative or painful emotions within sessions should aim to communicate and encourage self-reflection, understanding, acceptance and soothing.

“First, make them come back;
then make them stay.”

ENGAGEMENT AND FORMULATION

Two central therapeutic processes:

Emotional validation—“stands as the fulcrum between *empathy* (where we recognise the feeling that another person has) and *compassion* (whereby we feel with and for another person and care about the suffering of that person)” (Leahy, 2005).

Formulation—“is an open, collaboratively developed working model of the person's adaptation to, and recovery from, the distressing experiences of a psychotic episode.” (Gumley & Schwannauer, 2006).

Emotional validation

Client's beliefs about emotional validation matter! (Leahy, 2002; 2005)

- Emotions (positive and negative) as comprehensible, meaningful and valid, or problematic, negative and unacceptable.
- Alternative ways of managing emotions are often
 - sealing over and minimising difficulties; alcohol and substance abuse; dissociation (avoidant style)
 - worrying, rumination (preoccupied)
- Leahy (2005): A social-cognitive model of validation incorporating therapeutic alliance in the context of a client's attachment style.

Validation, attachment and working alliance

ATTACHMENT ORGANISATION	SECURE	PREOCCUPIED	DISMISSING
BELIEFS ABOUT VALIDATION	Available Useful to self-reflect Valuing	Not available unless I try very hard Conditional	Not available Not useful or helpful
INTERPERSONAL STRATEGIES	Expressive Self-reflective Sharing Listening Integrating	Perseverative Ruminative Angry Mixed integrating/ sealing over	Rationalise Minimise Distrusting Sealing over

Model adapted from Leahy (2005). A social-cognitive model of validation. In Gilbert, P. (ed.), *Compassion, conceptualisations, research and use in psychotherapy*. London: Routledge, pp. 195-217.

Formulation

- Open, collaboratively developed working model and/or narrative.
- Agree on goals and tasks for therapy; revisit goals/tasks.
- Dynamic, changes as new information emerges and is incorporated.
- A comprehensive formulation helps make sense of an individual's difficulties at the levels of symptoms and emotional experiences; functioning; and problematic interpersonal strategies.
- Focus on development and attachment aspects.
- Make use of emotional information in narrative in addition to content information.

... formulation

- Used to underpin the therapeutic bond, alliance and engagement
1. Statement of the client's problems and their associated goals.
 2. Validation of the client's distress.
 3. The therapist's hypothesis about the underlying psychological mechanisms.
 4. Valuing the alliance
 5. A statement of tasks

... formulation

- Focus of formulation needs to be attuned to the client's
 - recovery style
 - attachment style
 - ability to regulate affect
 - previous experiences of recovery, therapy and change
- How?
 - Use client's own words whenever possible.
 - Sealing over gives less room for dwelling than integrations.
 - Dismissive attachment gives less room than a preoccupied style.
 - Experiences of failure or help, hopelessness or hope need to be acknowledged alike.

... formulation

Key questions in starting a formulation

- Can you tell me a bit about what was going on in your life before you came to <services>?
- What is happening in your life now?
- You have told me that you struggle with What bothers you the most?
- How have you tried to manage <problems> so far? How has this worked for you?
- Have you had any previous experience with services? What were they like?

Engagement and formulation

- Formulation can be developed by the use of a model or a narrative.
- Model formulation is typical of CBTp
 - develops a more coherent understanding of the immediate problems, and is often an “easy way in”
 - helps gain agreement on goals and tasks
- Narrative formulation allows for
 - a more coherent understanding of antecedents, precipitating factors
 - can help develop integration of psychotic difficulties
 - can be written as a letter in addition to the collaborative conversation in therapy

Engagement and formulation

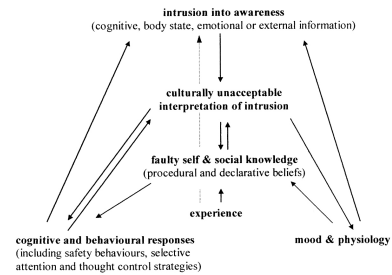
- The following formulations are for the same client.
- In this case, a more narrative/interpersonal approach was the wish of the client after her first session, and so the initial formulation was narrative.
- The formulation was developed over the first few sessions with the client, and presented as a more coherent “story” in a session.
- You might also consider sharing the formulation in writing with the client, as the letter in the example.
- A model formulation if described for the same case.

EXAMPLE OF AN INITIAL CASE FORMULATION — LETTER

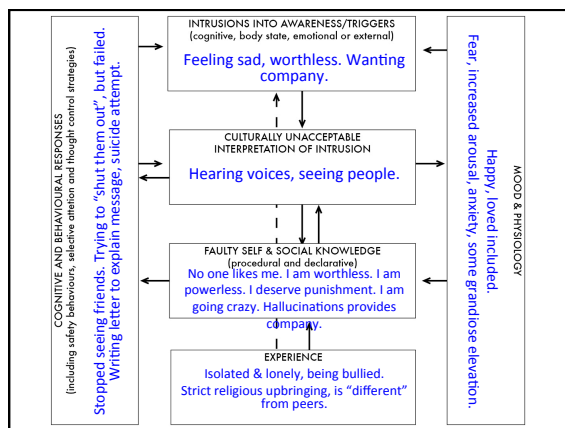
Dear Hanna,

Recently we have talked more about what happened before you became ill. You have described spending much of your time alone as your peers seemed not to understand or appreciate you for who you were and teased you. Still, you enjoyed friendships very much and in this period of life you found some comfort in an imaginary world. After a while this seemed to take on a life of its own, which you found increasingly unpleasant. When we talk about your experiences of becoming ill, you often feel overwhelmed and “fade out”, going blank, especially when you think about how you got into hospital. You are particularly wondering “what really happened?” You have also expressed that you find it difficult to communicate clearly with others about how you feel, and that you sometimes fall out with your family because they don’t understand your need for space. It seems to me that we have been able to talk a little bit about some of your experiences, and the difficulties you experience when trying to explore what really happened. I wonder whether an important task for us is to continue to help you find a way of understanding some of the things that went on, and how you can share this with the people who are important to you.

EXAMPLE OF A CASE FORMULATION — STANDARD MODEL FOR HALLUCINATIONS



Model adapted from Morrison (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy*, 29, 257-276.



Case example

Diagnoses PTSD; schizoaffective disorder, depressive type

Background Previous history of some physical abuse in early childhood and multiple sexual assaults in late teens. Had recently rejected contact with services over a minor issue. A typical “revolving door” patient!

Session 1

“I do not need you, you cannot help me, no one can help me, stop bothering me, give me up and let me kill myself in peace.”

How do we handle such a first meeting?

A few tips ...

- Dismissive/fearful clients—"defended against affect"
 - Need to be consistently there
 - These patients have affect phobia: Keep in mind equal difficulties with positive feelings as well as negative feelings!
 - Need quieter, more steady disconfirmation of previous consistent unresponsiveness.
- Preoccupied/enmeshed clients—"defended against cognition"
 - Consistency in therapist's response.
 - Take care to convey that imposing reasonable boundaries on relationship is not rejection.
 - Acknowledge worry, but don't get sucked into it.

What happened in session 1?

Session 1—5

- Negotiated space and time (literally!) – 5 sessions.
- Mapped out main symptoms/difficulties, *as defined by patient.*
- Explored patient's interpretation/understanding of own problems and situation, as well as "evidence" underlying such theories, especially previous experiences of self in relation to important others.
- Listened to narrative style/fluency to determine level of emotion that could be handled.
- Attuned to attachment style = "*I can handle your rejection.*"

Mid-stages

- Formulation is used to
 - highlight important therapeutic tasks
 - identify relationships between historical events and current problems
- Working with topics central to reorganising the self in recovery
 - humiliation
 - entrapment
 - loss

Mid-stages

"If the task with avoidant patients is to break open the semi-clichéd narratives they bring to therapy, with ambivalent patients it is necessary to introduce punctuation and shape into their stories — a *making* rather than a *breaking* function"

(Holmes, 2000, p. 169).

End phase and closure

- Formulation is used to
 - identify links between historical events and upcoming break in close relationship.
 - establish a more coherent narrative of client's illness, recovery and future.
 - work out a wellness and recovery plan that includes a focus on using newly developed attachment behaviours to stay well.
- Focus on helping the client establish alternative attachment bonds outside of therapy.
 - relatives, friends, etc.
 - support groups
 - community workers, teams, etc.

Some concluding remarks

- AT would pose that therapist's attachment style is of equal importance as that of the client.
- There is some research showing that secure attachment does facilitate more open, flexible interventions, tailored to meet client's underlying needs, whereas ...
- Insecure attachment styles appears to affect both how ill patients are perceived, what "level" of patient communication is perceived and targeted in interventions, and what types of interventions are delivered, at what level of intensity.
- The studies have mostly focused on community treatment settings and in-patient units, and no-one has dared look at clinical psychologists or psychiatrists...

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Feedback is welcome!

If you have any questions or additional comments, please feel free to contact me at

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