

**Insecure attachment and the therapeutic relationship: Relational
dynamics between therapists and addicts in psychotherapy**

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Attestation of Authorship

“I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning”.

Signed

Date

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ABSTRACT

Using attachment theory as a framework to understand relationships and the dynamics of addiction, this dissertation addresses the difficulties encountered in the therapeutic relationship when both the therapist and client have an insecure attachment style. This study uses a modified systematic literature review with the use of hypothetical vignettes to demonstrate the problematic dynamics that are likely to be encountered in psychotherapy. Qualitative and quantitative research that addresses attachment styles of therapists and addicts in a therapeutic relationship will be reviewed. Attachment dynamics between therapists and addicts are conceptualised based on Bartholomew and Horowitz's internal working models of self and other. Results highlight that insecure attachment is prominent among clients with addiction issues and in particular addicts with fearful and dismissing attachment styles are more difficult to engage in therapy. Findings indicate that insecure attachment in therapists leads to difficulties in managing negative countertransference reactions, which interferes with their ability to provide a secure base. Potential problems that may arise out of the match or mismatch between therapists and addicts insecure attachment are highlighted with particular emphasis on the development of the alliance and transference and countertransference issues. Recommendations for research highlight methodological problems and the lack of research exploring how therapist's attachment styles may contribute to the difficulties of working with addicts.

INTRODUCTION

Addiction adversely impacts all aspects of an individual's life and the damage that substance abuse causes is felt not only by the addict but also by family members and society. Concerning are the high rates of relapse among addicts as they seem to be stuck in a cycle of self-destruction. Addicts can be difficult to hold in psychotherapy and of concern is the high rate of drop out early in treatment. Attachment theory sheds light on how adult attachment style relate to interpersonal and emotional functioning. Having an understanding of adult attachment styles may help therapists retain addicts in therapy and improve treatment outcomes.

Attachment theory

Attachment is defined as an affectional bond to another person and healthy human beings continue to rely on attachment relationships in times of danger, vulnerability or illness (Bowlby, 1988). What differentiates attachment relationships from other close relationships is the need to maintain proximity in times of distress, the use of the attachment figure as a "secure base" from which to explore the world and as a "safe haven" to flee to for comfort and reassurance (Bowlby, 1988). The attachment system is organized and regulated based on caregiver responsiveness and sensitivity to distress signals and the infant learns what to expect and modifies their behaviour accordingly (Hazan and Shaver, 1994; Levy and Blatt, 1999). Experiences of distress may become associated with negative outcome if the parent is rejecting or inconsistently available. These expectations form the basis of "internal working models" of self and others (Bowlby, 1988).

Adult attachment style refers to "particular working models or schemas of self and other that are related to both interpersonal and emotional functioning" (Doumas, Blasey and Mitchell, 2006, p. 42). Individual differences related to attachment systems are thought to reflect the

degree to which a person has come to expect warm, responsive, and reliable care giving in times of need (Main, Kaplan, Cassidy, 1985). Adult attachment patterns are thought to be relatively stable because new experiences are assimilated into the existing working model and these patterns give rise to self-perpetuating interactional behaviours (Levy and Blatt, 1999; Slade, 1999).

According to Bartholomew and Horowitz (1991), confidence that an attachment figure will be accessible and responsive, can be seen to be based on

- whether the attachment figure is judged to be the sort of person who generally responds to calls for support and protection (*model of other*)
- whether the self is judged to be the sort of person towards whom the attachment figure is likely to respond to in a helpful way (*model of self*)

Four different attachment styles were conceptualised based on model of self and other (Bartholomew and Horowitz, 1991, p. 227).

	Positive Other	Negative Other
Positive Self	SECURE	DISMISSING
Negative Self	PREOCCUPIED	FEARFUL

More recently Brennan, Clark and Shaver (1998, cited in Daniel, 2006, p. 971) conceptualised adult attachment in terms of anxiety and avoidance. Anxiety has been interpreted as the degree to which individuals are sensitive to cues of potential abandonment and rejection by attachment figures. Avoidance relates to the degree to which individuals are

uncomfortable relying on their attachment figures for support in times of need.

		AVOIDANCE	
		High	Low
ANXIETY	High	FEARFUL	PREOCCUPIED
	Low	DISMISSING	SECURE

These two models have been used interchangeably in the literature addressing adult attachment styles and will be referred to in this dissertation. Cyranowski et al. (2002, p. 192) defines adult attachment styles the following way:

- Preoccupied individuals view the self as unworthy or unlovable but hold a positive evaluation of others. They tend to be preoccupied with attempts to gain the love, acceptance and emotional closeness of others, are anxious about possible abandonment, and are often viewed by others as clingy or demanding.
- Dismissing individuals view the self as worthy, yet view others as unreliable or rejecting. They find it difficult to trust or be close to others and are often seen as defensively independent, taking a dismissing or detached attitude toward attachment relationships.
- Fearful individuals hold negative views of both the self and others. They see the self as unworthy and others as rejecting or unreliable. Although fearful individuals desire close relationships they find it difficult to trust and become close to others, fear interpersonal rejection and abandonment and may be seen as socially avoidant.
- Secure individuals have a model of others as warm, reliable, and available in time of need and a model of oneself as lovable and worthy of care.

There are two main approaches of measuring attachment style in adults. The first is through interviews, which assesses states of mind with respect to attachment. This is based on the idea that the manner in which adults speak about past and present relationships provides clues about their internal working models (Meyer & Pilkonis, 2001; Daniel, 2006). For example, dismissing adults tend to give incomplete and incoherent accounts of their experiences and tend to present attachment figures in positive terms without being able to give concrete examples whereas preoccupied individuals tend to narrate their experience in an excessive and non-objective way (Bucheim & Kachele, 2003). The second approach is through the use of self report measures.

Therapeutic relationship

Greenson (1967) defined the therapeutic relationship as consisting of transference, the real relationship and the working alliance (cited in Rozov, 2001, p. 1). Similarities between the concept of attachment and transference have been highlighted as both refer to a strong emotional connection to another person in which one repeats patterns of relating that are rooted in early childhood (Sack, 1996; Parish and Eagle, 2003). Attachment theory can be used to understand the practice of therapy as the therapeutic alliance is seen as a situation where the therapist functions as an attachment figure and the transference relationship becomes one in which maladaptive aspects of the client's relationship (insecure attachment) with the therapist can be identified and worked through (Reading, 2002).

Increasingly there is recognition that the nature of the relationship between the therapist and client is an important variable in the process of psychotherapy. Research on adult attachment recognises that interpersonal functioning has an impact on the quality of relationship between therapist and client. Conditions under which the infant develops a secure attachment are similar to the conditions for effective therapy (Osofsky, 1988). While there is a lot of literature looking at how adult

attachment styles influences psychotherapeutic processes, relatively little considers the interaction of therapist and client attachment and none directly considers how this impacts on psychotherapy with addicts. This is an important area for research given literature highlights that addicts tend to be insecurely attached and have poor rates of retention in therapy that often leads to relapse.

The first part of this dissertation discusses the method used to investigate the research question. The rationale for this method is discussed within an evidence based practice tradition. The relevance of this approach to psychotherapy along with its limitations will be explored. Lastly, the databases used to find articles relevant to the topic and the search results are displayed.

The first chapter looks at the therapeutic relationship as an attachment relationship and considers how a therapist's attachment history shapes their ability to be a caregiver and provide a secure base for clients. Quality of the working alliance has been described as an important predictor of treatment outcome. How insecure attachment in a therapist influences the therapeutic relationship and a therapist's ability to foster an alliance will be considered. Countertransference is an important variable to consider in understanding a therapeutic relationship. Whether insecurely attached therapists are more likely to experience negative countertransference and how countertransference is managed in the therapeutic relationship will be explored.

In the second chapter addiction is understood from an attachment perspective. This chapter looks at how a history of neglect, parental misattunement and dysfunctional family systems leads to the development of insecure attachment and later addiction. High rates of alexithymia and somatic disorders have been noted in addicts and these are described as a product of insecure attachment. Lastly, addicts' attachment style and how this influences their ability to form a

relationship in therapy and factors that lead to poor retention and outcome will be considered.

The last chapter considers how insecure attachment in therapists and addicts interacts and the problems this causes in the therapeutic relationship. The problems that are likely to be encountered in the process of alliance formation and possible countertransference reactions within the different insecure attachment dyads will be explored. Finally some thought will be given to how therapists could enable addicts to form an attachment in therapy and use the therapist as a secure base.

METHOD

The method used in this dissertation is a modified systematic literature review. Systematic reviews are literature reviews that adhere closely to a set of scientific methods that explicitly aim to limit systematic error by identifying, appraising and synthesizing all relevant studies to answer a particular question (Petticrew & Roberts, 2006, p. 9). They are a method of making sense of large bodies of information and of mapping out areas of uncertainty and identifying where little or no relevant research has been done (Petticrew & Roberts, 2006).

Rationale for systematic reviews in medicine is firmly embedded in the positivist paradigm (Mulrow, 1994, cited in Torgerson, 2003). Positivist approaches to knowing emphasises the importance of objectivity, systematic and detailed observation, testing hypotheses through experimentation and verification (Grant & Giddings, 2002). Within a positivist paradigm, knowledge is to be discovered so people can explain, predict or control events (Grant & Giddings, 2002, p. 14). Randomized controlled trials has been labelled the gold standard in the hierarchy of evidence however it does not account for individual experience and the evolving and continuing construction of meaning that takes place in psychotherapy (Milton, 2006).

Traditional researchers maintain that the scientific method is the sole guarantor of truth and the attainment of reliable evidence (Rubaie, 2006). However it is difficult to apply experimental method to study psychotherapy because people are complex and it is difficult to device deep experiments. Psychotherapy falls into the interpretive paradigm that seeks to understand what it means to be human and what meanings people attach to the events in their lives (Grant & Giddings, 2002). Psychotherapy aims at helping clients gain sense of “being their own expert” by enabling clients to author their own narratives based upon their experiences, thoughts and feelings rather than upon definitions of

normality or abnormality dictated by external agency (Rubaie, 2006, p. 36).

Evidence based practice is a paradigm that was originally developed in medicine and has been described as a new paradigm within health and social care as practitioners began to question their practice and to search for a scientific rationale for the care they delivered which previously might have been given according to tradition and experience (Aveyard, 2007, p. 6). Sackett, Richardson, Rosenberg and Haynes (1997) define evidence-based practice as “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individuals” (cited in Glick, 2005, p. 6). Growth of interest in evidence based practice has increased pressure for practitioners to demonstrate that their existing work and their new practices are based on the best available research evidence (Petticrew & Roberts, 2006). For practitioners in social care, interest in evidence based practice is also driven by issues of accountability and decisions about policy and practice based on research evidence as well as on values, professional knowledge and experience (Macdonald, 1999 cited in Petticrew & Roberts, 2006, p. 13).

Evidence based practice guidelines are based on systematic reviews of the literature (Cook, Mulrow, Haynes, 1998). Systematic reviews provide a key source of evidence based information to support and develop practice by identifying new and emerging developments and gaps in knowledge (Petticrew & Roberts, 2006). Petticrew and Roberts (2006, p. 27) identifies 7 steps in a systematic review.

1. defining a research question
2. determining types of studies that need to be located to answer the question
3. literature search to locate those studies
4. selection of studies for inclusion
5. critical appraisal of included studies

6. synthesis of studies
7. dissemination of review findings

There are also limitations to a systematic review. Petticrew and Roberts (2006) named difficulties in locating and synthesizing appropriate contextual information and in incorporating results of qualitative research. The results of the review are often provisional and indicative rather than definitive.

Historically science and practice have largely occupied different worlds with the scientist seen as 'too positivist' and clinicians seen as 'unscientific' (Lebow, 2006, p. 4). Criticisms have been made about evidence based approach in health care disciplines due to limited definition of evidence used in scientific research. Context helps to shape evidence and researchers need to be aware of how evidence is collected and interpreted. Practice based evidence is a complementary paradigm to evidence based practice offering potential for a combined knowledge base. Barkham and Margison (2007) define practice based evidence as the "conscientious, explicit, and judicious use of current evidence drawn from practice settings in making decisions about care of patients" (p. 446). This approach provides foundation for generating research questions based on clinical work, which are more relevant to psychotherapists.

This dissertation has been modified in two ways. Firstly the use of qualitative research and secondly hypothetical vignettes will be used for purpose of illustration. The question I wish to explore in this study is how insecure attachment style in therapists and addicts impacts on their ability to work together in psychotherapy. As one of the intentions of this dissertation is to encourage those who work with addicts therapeutically to think about their attachment patterns, studies that have talked about therapists, counsellors and psychologists have also been included.

Search results

PEP

Search terms	Number of articles	Relevant to topic
addiction and attachment	37	9
addiction and insecure attachment	9	5
addiction and alliance	9	5
insecure attachment and alliance	32	18
Attachment style and psychotherapy	56	25
therapist attachment style	14	7

PROQUEST 5000

Search terms	Number of articles	Relevant to topic
addict* and attachment	165	40
addict* and "attachment style"	22	15
Addiction, attachment, psychotherapy	39	18
Addiction, alliance, psychotherapy	14	9
"therapist attachment style"	6	5
"attachment style" and alliance	35	20
therapist and "attachment style"	52	22

PSYCHINFO

Number	Search Terms	Number of articles	Relevant to topic
1	addict*.mp/ or exp drug addiction/ or exp alcohol abuse/ or exp drug abuse.	77614	
2	exp individual psychotherapy/ or exp interpersonal psychotherapy/ or exp supportive psychotherapy/ or exp psychodynamic psychotherapy.	4554	
3	"therapist attachment style*".mp./ or exp emotional security/ or exp attachment behavior/ or exp therapist characteristics.	19783	
4	1 and 2 and 3	4	3
5	2 and 3	182	31
6	alliance.mp./ exp therapeutic alliance	6593	
7	5 and 6	21	7
8	exp attachment disorders/ or exp attachment behavior/ or exp attachment theory	11604	
9	"attachment style*".mp/ exp interpersonal interaction/ or exp attachment behavior/ or exp parent child relations	240123	
10	"insecure attachment".mp/ exp mother child relations/ or exp attachment behavior/ or exp emotional security.	25502	
11	(therapist or counsel*or).mp.	59550	

	[mp=title, abstract, heading word, table of contents, key concepts]		
12	1 and 6	258	32
13	1 and 8	236	43
14	6 and 10	162	28
15	1 and 6 and 9	36	18
16	1 and 6 and 11	91	22
17	2 and 6 and 10	6	4
18	1 and 3 and 6	15	7
19	6 and 10 and 11	84	26
20	"therapist attachment style*".mp. [mp=title, abstract, heading word, table of contents, key concepts]	6	5

In addition to the above searches, I also explored the reference list of articles and books used in the study from the searches. Relevant articles and books passed on by my colleagues and supervisor have also been included.

Exclusion criteria

All studies that were not written in English and studies that were not relevant to my question were excluded. Also any studies about children, adolescents, family or groups were excluded, as my focus was on attachment patterns of adults in individual psychotherapy.

Ethics approval was not required, as no clinical material are used and the vignettes included are hypothetical examples of attachment dynamics in therapy.

CHAPTER 1: THERAPIST'S ATTACHMENT PATTERNS

The nature of the relationship between client and therapist is a significant factor in promoting therapeutic change. Just as client variables impact on the nature of the therapeutic relationship, therapist variables would also play into the dynamics of this relationship. This would be consistent with the view of two-person psychology which emphasizes the therapist as an active participant in the therapeutic relationship rather than an observer who neither affects nor is affected by the client's experience (Gelso & Hayes, 1998, cited in Mohr, Gelso & Hill, 2005, p. 298). This chapter considers how a therapist's attachment pattern impacts on the therapeutic relationship. The idea of a therapist as an attachment figure will be explored and factors that may determine a therapist's ability to function as a secure base are described. Furthermore, difficulties that could arise in the therapeutic relationship when a therapist has an insecure attachment style will be considered.

Therapist as an attachment figure

Many authors have described the therapist-client relationship as an attachment relationship (Bowlby, 1988; Pistole, 1989; Epstein, 1995; Parish, 1999; Parish & Eagle, 2003; Daniel, 2006; Collins, 2007). The therapeutic relationship is said to contain many features which activate an adult client's ingrained attachment expectations and behaviours (Bowlby, 1988). Similar to the attachment behaviours initiated by infants in times of stress, people tend to seek therapy when faced with difficult situations that they feel they cannot handle on their own. Therapists tend to fulfil the primary function of attachment that is providing comfort, security and safety therefore the therapeutic relationship can be understood as the therapist serving as an attachment figure, a "secure base" that enables exploration (Bowlby, 1988). Bowlby (1988) writes that "in providing his patient with a secure base from which to explore and express his thoughts and feelings 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” (p. 140). Just as a secure base allows a child to actively explore his external and internal worlds, a secure base in the therapist would enable clients to safely explore in therapy.

The idea of a therapist being an attachment figure have been explored by several authors (Mackie, 1981; Mallinckrodt, Gantt & Coble, 1995; Farber, Lippert & Nevas, 1995; Parish, 1999; Collins, 2007) and this has particular significance for working with addicts as part of the goal of therapy is one where the therapist needs to become a new object of attachment in order to help addicts shift from being attached to substances to getting their needs met in relationships (Walant, 1995; Flores, 2004). Attachment is a tie that develops over time and stronger attachment to the therapist was found with increased duration of therapy and frequency of sessions (Parish, 1999). In fact, Parish and Eagle (2003) showed that “clients in long term psychotherapy sought proximity to their therapist, turned to them in times of distress, evoked a mental representation of them in their absence and relied on them as a secure base” (p. 280). While duration of therapy indicates stronger attachment to therapists, factors in the therapist that promotes client retention needs to be explored.

Therapist attachment pattern and care giving

More attention is being drawn to therapist’s personal characteristics that contribute to their ability to form and maintain relationships (Mackie, 1981; Grosenick & Hatmaker, 2000; Lessard, 2002). Studies show that there is a link between care-giving and attachment behaviour (Bowlby, 1988; Grossman & Grossman, 1991; Slade, 1999). An individual’s ability to be a caregiver is thought to be determined by their initial experience of being cared. A caregiver’s retrospective recollection of childhood attachment was found to influence their ability to provide a secure base (Osofsky, 1988). Therefore a therapists’ ability to care for and function as a secure base would depend on the therapist’s own history of receiving care. For example, a therapist who had a neglectful or rejecting parent

would have a different set of expectations in relationships to a therapist who had an available and loving parent. Individuals who showed high attachment related avoidance were found to be less responsive and more controlling caregivers whereas those who have high anxiety are more compulsive caregivers (Feeney & Collins, 2004). Interestingly, parents who were dismissive of attachment were noted to have children who showed avoidant attachment (Main et al., 1985) and mothers who were securely attached had children who showed secure attachment (Slade, 1999; Stapleton, 2004). If this is the case then insecure attachment in the therapist may influence their ability to foster secure attachment in their clients.

What appears to be increasingly clear is that it is not what the therapist does but how the therapist creates the emotional climate of the relationship that promotes the client's engagement in therapy (Mackie, 1981; Flores, 2004; Daniel, 2006). Grossman and Grossman (1991) suggested if a parent lacks the experience and model of an attachment figure able to integrate negative feelings into emotional empathy but has instead experienced more often rejection or unsupportiveness during distress, the mother seems to turn from infant distress management to the management of her own emotional conflict (p. 107). Similarly, a therapist who has an insecure attachment style is likely to find it more difficult to create feelings of security within the therapeutic relationship. Clients are likely to respond to the therapist in ways that are consistent with their lifelong patterns of defense, affect regulation and security operations (Slade, 1999). As Brisch (1999) points out working with client's conflicts can produce considerable anxiety and without a secure base in the therapist, clients may be unable to tolerate their anxiety and fall back on defensive processes and resistance (p.76). A therapist who is sensitive to cues of rejection may struggle with their own emotional process when working with a rejecting or hurtful client and may not be able to hold the client's experience. In order to hold the client's experience, therapists need to understand their own patterns of defense related to attachment to withstand what is likely to be a turbulent

relationship with clients who present to therapy with attachment difficulties.

Just as problems in the early years of a client's development brings clients to therapy, a therapist's childhood experiences also seem to lead to a career in the helping profession. Fussell and Bonney (1990) found that psychotherapists reported higher incidence of childhood trauma, emotional deprivation and experienced more parent-child role inversion. Mar (2000) suggested that rejection in the maternal relationship may serve to predispose women to consider working in the helping profession. Care taking stance was seen as an attempt to avoid or treat one's own feelings of failing to be close to a depressed mother. While these factors may have drawn them to the helping profession, it was suggested that these factors might also hinder the development of a good therapeutic relationship by encouraging avoidance of the client's pain, by care taking and over identification or enmeshment with the client. While problems in the early years of development can lead to insecure attachment, research shows that adult attachment patterns can be changed through the process of therapy or through a secondary attachment relationship that allow individuals to re-work their internal working models (Lewis, 1994; Hopkins, 2006; Steckley, 2006). These findings further highlight the importance of those who work in the helping profession to have undertaken personal therapy and have awareness of their own attachment patterns and unresolved issues so that they could better foster secure attachment with clients.

Therapist's attachment style

Despite recognising that therapist factors shapes the therapeutic relationship, relatively few studies have directly considered attachment patterns of therapists. Leiper and Casares (2000) found 69.9% of psychologists have a secure attachment style whereas Ligiero and Gelso (2002) found 90% of therapist to be securely attached. Insecure psychologists experienced more difficulty in practice, experienced more

early loss and unempathic parental responses. Results of these studies indicate a higher proportion of secure attachment among clinicians in comparison to the clinical population. Both studies utilised self report measures and the first study had a survey return rate of only 40% and the second study looked at attachment style of therapists in training which may highlight certain biases. Psychologists who chose not to return the survey and therapists in training may not want to be viewed as being insecurely attached. Also due to the nature of self report measures we need to be mindful of what dimensions of attachment is being considered. Griffin and Bartholomew (1994) pointed out that results based on self report ratings of attachment patterns should be validated with interview. This is significant because there could be discrepancies between how someone views their own pattern of attachment to how someone else views them. In contrast to the above studies, a German study by Nord, Hoger and Eckert, 2000 (cited in Strauss, 2000) found only 20% of therapists were securely attached. It is unclear how these results were obtained but does highlight a possible cultural influence on attachment in different samples and would be worth further investigation.

While research looking at therapist's attachment style are lacking what is clear is that a therapist's early experiences shape their current attachment style and insecure attachment leads to relational difficulties (Pistole, 1989; Collins & Read, 1990; Daniel, 2006). For example, Mahoney (2007) found that the more secure the therapist feels in the relationship, the greater the likelihood of the client returning to therapy and Porter (2002) found that clients who were securely attached to their therapist participated in deeper psychological exploration. This is especially significant when working with a clinical population such as addicts who are difficult to retain in therapy. Flores (2004) describes addictive driven behaviours as a 'compensatorily determined substitute for a person's inability to derive satisfaction from relationships' (p. 241). As addicts have learnt to derive pleasure and regulate emotions through substances, engaging them in relationship can be difficult. Hence a

therapist's ability to engage and form a relationship with addicts in treatment is crucial.

Therapeutic alliance

Research has consistently shown that a good therapeutic alliance is related to positive outcomes in psychotherapy. Originally the alliance was believed to be positive transference from the client toward the therapist (Freud, 1958) but this perception developed into a more conscious and active collaboration between the client and therapist (cited in Hilsenroth, Peters and Ackerman, 2004). The alliance is seen as comprising of three features, "an agreement on goals, an assignment of a task or a series of tasks and the development of bonds" (Bordin, 1979, p. 253). The bond refers to the emotional attachment between the therapist and client. The process of establishing an alliance is thought to be analogous to the process by which the infant develops attachment to its primary caregiver (Grotstein, 1990). The attachment between therapist and client has been described as a fundamental aspect of the alliance and as the basic framework of trust from which change will emerge (Dunkle & Friedlander, 1996; Brisch, 1999; Meissner, 2007; Rubino, Barker, Roth & Fearon, 2000; Ligiero & Gelso, 2002; Diamond et al., 2003; Sauer, Lopez & Gormley, 2003).

Therapist factors in alliance formation

Building an alliance has been described as an interpersonal process (Henry & Strupp, 1994; Horvath & Greenberg, 1994; Rozov, 2001; Pantaloni, Chawarski, Falcioni, Pakes, & Schottenfeld, 2004). Interpersonal process variables such as therapist empathy and positive responses to client resistance have been positively associated with achievement of abstinence and treatment retention (Pantaloni et al., 2004) whereas attributes such as being rigid, aloof, distant and self focussed have been found to negatively impact on the alliance (Ackerman & Hilsenroth, 2001).

Literature highlights that a therapist's ability to form an alliance is related to their early relationship with significant others (Henry, Schacht and Strupp, 1990; Piper et al., 1991; Hovarth & Greenberg, 1994; Dunkle and Friedlander, 1996; Rozov, 2001; Mallinckrodt, Porter & Kivlighan, 2005; Goldman & Anderson, 2007). Object relations theory posits that early relationships are internalized or introjected and these introjected relationships influence how the individual will experience subsequent relationships (Goldman & Anderson, 2007, p. 111). Therapists' own introject was related to their interpersonal process in therapy, in particular therapist with disaffiliative (self-hating) introjects tended to engage in a much higher level of problematic interpersonal processes that have been associated with poorer outcome (Henry et al., 1990). Piper et al. (1991) found therapists with hostile introjects behaved in a more critical and neglectful manner towards the clients whereas therapists with more affiliative (self-loving) introjects and secure styles report better in process measures and their clients showed greater improvements in therapy (Bruck, Winston, Aderholt & Muran, 2006).

Therapist attachment style and alliance

Research exploring the relationship between therapist attachment and alliance has produced mixed results. Some research findings indicate that therapists who are comfortable with intimacy and able to trust and rely on others without overwhelming fear of rejection are more able to form stronger alliances (Dunkle & Friedlander, 1996; Black, Hardy, Turpin & Parry, 2005; Goldman & Anderson, 2007). As would be expected Sack (1996) found therapists who reported a more hostile style of attachment, received lower alliance ratings from their clients. Surprisingly Sauer (1999) found that therapists with insecure attachment received higher ratings of alliance early in the session which was confirmed by a subsequent study by Sauer et al. (2003) that therapist attachment anxiety was positively related to client-rated alliance in early therapy. However securely attached therapists appear to be able to

establish a better working relationship as therapy progresses (Sauer, 1999). It was suggested that this could be due to anxious therapist working harder to make the client feel good about the relationship. However, anxious attachment in therapists was found to have a negative effect on client-rated alliance over time. Interestingly Ligiero and Gelso (2002) found no relationship between therapist attachment style and perception of alliance as rated by either the therapist or their supervisor. Measures of alliance in this study were self-rated reports and 90% of therapists reported being securely attached. The therapists were students in training and perhaps the lack of experience could have influenced these results. Results of this study are questionable due to the unusually high rate of secure attachment among therapists. Perhaps therapists in training rate themselves in more positive terms to be perceived as more competent. These results are worth replicating through the use of interviews. Overall the results suggest that securely attached therapists tend to form better alliances.

Assessment of working alliance within a therapeutic relationship has typically been rated by either the client, the therapist or by an independent observer. Studies have shown that clients' evaluation of alliance was the best predictor of outcome and therapists' evaluation was the worst predictor (Horvath & Symonds, 1991; Bachelor, 1991). This may possibly highlight the fact that clients and therapists may be focussing on different aspects of the alliance and may have different views on what makes the relationship work. For example clients may be rating the alliance based on whether they perceive the therapist to be warm, empathic and emotionally available which emphasises the bond aspect of the alliance whereas therapist may perceive client's resistance as a lack of collaboration and therefore view the alliance as poor.

Research indicates a relationship between attachment style and alliance ratings (Eames & Roth, 2000; Rozov, 2001). Higher staff avoidance was associated with more discrepancies between client and staff perception of alliance (Berry et al., 2008). Rozov (2001) suggested therapists who

generally view others in a positive way would view the alliance in positive terms whereas therapists with a dismissive and fearful attachment, who maintain cold or hostile orientations toward other people, will view alliance negatively. Fearful attachment was associated with lower alliance ratings whereas secure attachment styles predicted more favourable alliances. However Rozov (2001) found the opposite where preoccupied therapists had a negative perception of alliance with secure and fearful clients and dismissing therapists showed a predisposition to think of alliance positively with dismissing clients. These results are not entirely surprising given individuals with preoccupied attachment have high levels of anxiety which may “interfere with their natural predisposition towards affiliation” (Rozov, 2001, p. 93). Dismissing individuals have also been described to give incomplete and incoherent accounts of their relationship (Bucheim & Kachele, 2003). Rozov (2001) suggested that insecurely attached therapists are more likely to be influenced by emotional biases, for example some therapists may be more predisposed to hostile emotions which could influence their capacity to remain emotionally resonant when attempting to develop alliance with difficult clients. In contrast, Britton (2005) found that therapist attachment was not related to alliance. It could be because more experienced therapist may be better at forming alliances irrespective of their attachment style. This study assessed attachment based on therapists’ recollection of attachment figures. Worth wondering is if an individual is more likely to be honest and forthcoming in an interview as opposed to anonymously filling out a questionnaire. Also a therapist who has done some work in therapy are likely to be less blaming and therefore recollect the past in a different way but how much this could change someone’s attachment pattern is worth wondering. Lack of relationship between attachment style and alliance ratings was related to the small sample size used in this study. Given different measures are used to rate alliance, this could also influence the results by possibly capturing different dimensions of alliance.

Attachment style and ruptures in therapy

Ruptures in therapy are worthy of attention, as they are inevitable and can have a negative impact on the relationship if not addressed. Eames and Roth (2000) viewed ruptures as moments in which client's schemas or working models are acted out in the therapeutic context representing a vital part in the change process (p. 422). The study showed that frequency of rupture reported varied with different attachment orientations. Individuals with preoccupied attachment reported more ruptures whereas those with dismissing attachment reported fewer ruptures. These findings are interesting as preoccupied clients have high anxiety and may be more sensitive to comments whereas dismissing individuals tend to be highly avoidant and dismissive hence reporting fewer ruptures. Andrew (2003) found that dismissing therapists were less likely to use the defensive strategy of denial during termination which is consistent with the suggestion that dismissing individuals tend to be dismissive in relationships. Rubino et al. (2000) found therapists who scored higher on the anxious attachment dimension tended to respond less empathically to ruptures in the alliance especially with clients with a secure or dismissing attachment. It was concluded that "anxious therapists might interpret ruptures as an indication of their clients' intention to leave therapy and their own sensitivity toward abandonment might diminish their ability to be empathic" (p. 416).

Countertransference

Gabbard (2001) stated that clients will inevitably try to transform the therapist into a transference object and countertransference is a joint creation between therapist and client. Subjective countertransference is the therapist's reactions to the client originating from the therapist's own unresolved conflicts whereas objective countertransference are the therapist's reactions to the client evoked by the client's maladaptive behaviour (Ligiero & Gelso, 2002, p. 4). Regardless of the degree to

which a therapist has come to terms with his or her own early experience, different patients will engage the therapist's attachment dramas in different ways (Hovarth & Greenberg, 1994; Slade, 1999; Daniel, 2006). Strupp (1980) found that even well trained therapist show surprising vulnerability to countertransference reactions with hostile, resistant clients (cited in Hovarth & Greenberg, 1994, p. 79).

Therapist attachment style and countertransference

Given that a therapists' attachment style influences their perception of the alliance it is worth wondering if therapists' countertransference impacts the relationship. Some studies have directly explored the link between therapist attachment style and countertransference. Securely attached therapists are said to be more likely to make use of their countertransference by reflecting on what the client elicits and providing appropriate feedback instead of acting out on their countertransference (Dozier, Cue & Barnett, 1994; Slade, 1999). Literature shows that insecure attachment in therapists is related to varying levels of countertransferential behaviour originating both from therapist's own unresolved issues as well as responses evoked by clients. Therapist level of comfort with negative emotions appeared to dictate the delivery of interventions particularly in response to client distress (Lessard, 2002). Therapist attachment representations were found to influence therapist responsiveness and attunement. Therapists who had a stronger negative reaction towards clients were perceived as being less empathic and received lower alliance ratings from clients (Wolff, 2006). Therapists with fearful and dismissing attachment styles were found to intervene in less depth and perceived less dependency needs in clients whereas preoccupied therapists tended to intervene in greater depth and perceived greater dependency needs in clients (Dozier et al., 1994). Given that fearful and dismissing attachment have a negative model of other, they are more likely to dismiss or struggle with their own dependency needs and hence not address them with their clients. Ligiero and Gelso (2002) found therapists who are securely attached

engaged in less negative countertransference behaviours but no relationship was found between insecure attachment and countertransference behaviour. However negative countertransference was associated with poorer working alliances. Therapists engaging in negative countertransference were found to interfere with establishment of a strong working alliance, as clients are less likely to form a strong emotional bond with the therapist. These results were explained by suggesting that a therapist's attachment style may not have been activated in the session, as therapists do not view clients as attachment figures. Perhaps these results could also be explained by considering the therapist's role which is to provide a corrective emotional experience and could mean that the therapist's attachment patterns does not get played out in therapy to the same extent as the client's attachment patterns.

Therapist attachment and helping style

Differing attachment organization has been shown to pull for different types of interventions from therapists. Therapists tended to use relationship-oriented interventions dealing with affect, resistance and transference with preoccupied clients and more cognitive interventions with avoidant clients (Hardy, Stiles, Barkham & Startup, 1998; Hardy et al., 1999). According to Hardy et al. (1998) these results were as expected as preoccupied clients tend to display greater emotional needs and be more demanding of therapists and avoidant clients are likely to show more resistance and pull for cognitive interventions.

Therapist attachment style was also found to determine how a therapist chooses to work with clients. Ostrowski (2000) found that therapists who reported greater comfort with closeness in personal relationships preferred to use a more directive helping style as opposed to a reflective helping style. In context of working with addicts especially in early stages of treatment, structure and direction are required which calls for a directive helping style. Therapists who are uncomfortable with closeness may find it difficult to be directive and if this is the case they may have

difficulty providing a secure base for addicts in therapy. While a directive helping style could highlight confidence in a therapist it could also be argued that it arises from a therapist's anxiety. A therapist's anxiety could interfere with their ability to foster a secure attachment but it could also be argued that anxious therapists may work harder in forming a relationship. Another factor worth considering is how a therapist's training influences their helping style. For example psychotherapists are more likely to use a reflective helping style whereas drug and alcohol counsellors may be more likely to use a directive helping style.

Understanding countertransference with addicts

Addicts can be a challenging client group to work with. Conceptualising addiction from an attachment perspective has been useful in understanding the relationship that addicts have formed to substances and the drama that gets played out with the therapist as this bond is threatened. Inevitably a crucial part of the work in therapy is working through the relationship which has already been established between the client and their drug of choice. As Flores (2004) states, in order for addicts to form an attachment to therapy they must first detach from the substances that they have used to comfort and regulate their emotions. This view is consistent with the abstinence-based models of treatment.

Reading (2002) proposes that the relationship between the drug users and the drug may be associated with experiences of security and satisfaction of needs similar to an infant experiencing mother as both providing safety and pleasurable gratification (p. 15). As attachment behaviour is activated under conditions of threat, behavioural patterns designed to maintain proximity to the drug will naturally become activated when additional bond is threatened in therapy. Clients are likely to have ambivalent feelings towards the therapist who is likely to be experienced as both the 'helper and the depriver' (Reading, 2002, p. 27). Clients may express their opposition of the threat to this bond through

resistance, use of maladaptive defenses, and cancellations. Therapist will swing between feeling like the most important object in their client's world to feeling useless, valueless and written off as the drug or the need for it is mediating the relationship (Read, 2002, p. 96). This in turn is likely to create negative countertransferential feelings in the therapist such as anger, hopelessness and a pull to retaliate and be punishing. The following vignette is an example of what may happen in therapy.

A female client who had recently completed treatment for opiate addiction presented to therapy with a cold demeanour and was difficult to warm to. She seemed guarded and suspicious of others. During the sessions she would make little eye contact and often dissociated by looking out the window. Attempts to connect with her seemed to hit brick walls and she increasingly gave the impression that she did not want to be there. She missed her second appointment and told the therapist that she did not realise that she agreed to meet at the same time on a weekly basis. The therapist felt pushed around by the client and increasingly felt frustrated and anxious due to the lack of progress. The client missed her 5th session and in a conversation over the phone with the therapist the client was hostile and stated that she assumed the sessions were over as she had decided to move overseas.

A therapist who has a secure attachment style is more likely to be able to respond to provocation of this kind by offering empathic understanding of its meaning within the client's struggle to reconcile the conflicting demands for change and a familiar sense of security. A therapist who is insecurely attached may find it difficult to hold the client's inner experience. It is not uncommon to experience hostility from a dismissing client following a session where the therapist feels connected to the client. As Coen (2003) points out client acting out is a defense against attachment to the therapist. Being able to destroy what was good in the relationship protects the client from feeling anxious and vulnerable. Therapist will swing between feeling the most important object in their client's world and feeling useless, valueless and written off. The drug or the need for it is mediating the relationship (Read, 2002, p. 96).

The literature highlighted that therapists working with clients with addiction showed an unconscious conflict of attitudes. Rice (2006) found that therapists who were empathic and knowledgeable about addiction also implied that the client's problems were due to a lack of effort. There seemed to be a dislike of working with this client group because the therapists perceive them as not being psychologically minded. Therapists in this study named difficulty managing their emotional reactions such as anger, guilt, frustration and helplessness and owned struggling to act out on these feelings by rescuing or confronting the client's behaviour. Psychotherapists and therapists practicing supportive expressive therapy consistently showed more negative feelings towards addicts than 12 steps drug and alcohol counsellors. Subsequent study by Najavits (2001) confirmed that therapist's countertransference negatively impacts treatment. Given that there are many drug and alcohol counsellors who are in recovery, it is possible that they may be more empathic and less judgmental.

SUMMARY

Insecure attachment seems to be a product of deficits in the early attachment relationship. A therapist's ability to be a good caregiver seems to be influenced by their history of receiving care with secure therapists more able to foster secure attachment in clients. Insecure attachments in therapists highlighted greater object relation deficits which highlighted difficulty in alliance formation. Secure attachment in therapists seems to be more favourable in the development of alliance and insecure attachment was found to be associated with more negative countertransference, which consequently also meant a poorer alliance.

CHAPTER 2: ADDICT'S ATTACHMENT PATTERNS

Attachment theory defines the problem of addiction as both a “consequence of and solution to an individual’s incapacity to establish healthy emotional regulatory relationships” (Flores, 2004, p. 246). Literature consistently highlights the link between problems in early years of life and the development of addiction. This chapter looks at addiction as an attachment disorder and how this contributes to problems in the therapeutic relationship.

Addiction as an attachment disorder

Review of the literature on addiction supports the view that difficulties in early attachment experiences appear to be a central component in the development of later addiction (Firestone, 1993; Adams & Robinson, 2001; Sachs, 2003). According to Schwartz and Southern (1999), early attachment difficulty with caregivers leads to overwhelming experiences the child is unable to assimilate causing affect dysregulation and impaired self-development. Research that looks at the history of addicted persons highlights deprivation of developmental needs, early trauma, neglect, lack of physical and emotional closeness and problems in the family system (Woolcott, 1981; Firestone, 1993; Walant, 1995; Bell, Montoya & Atkinson, 1997; Sicher, 1998; Gold, 1999; Golden & Stermac, 2000; Grosenick & Hatmaker, 2000; Gaiton, 2004; DaVania, 2006; De Rick & Vanheule, 2007). Chafetz (1959) found that addicts grew up with a lack of a warm, giving, meaningful relationship with a mother figure during early years of development (cited in Silber, 1970, p. 430) and experienced significant amounts of rejection (Hofler & Kooyman, 1996; Andersson & Eisemann, 2003). Disrupted emotional bonding and inconsistent parental responsiveness does not allow for provision of a secure base, which leaves these individuals seeking comfort and security through substance use. For individuals who have experienced little sense or comfort or security the effects of drugs and alcohol may be far more gratifying than any attachment experiences they may have had.

Clients with alcoholism consistently reported being dominated by the core affect of shame related to narcissistic conflict and attachment ambivalence (Carolan, 1995). Parental misattunement is said to lead to shame experiences by creating an experience of the “mother as a stranger and the child as deficient” (Spiegel, Severino & Morrison, 2000, p. 26). The self is thought to be simultaneously experienced as deficient, helpless, confused, exposed, and passive while experiencing the shaming other as if inside the self. States of shame resulting from experiences of misattunement are said to be the origin of learned patterns of interpersonal connection based on fear where the individual tends to fear abandonment, punishment, rejection and loss of approval (Spiegel et al., 2000, p. 26). Substance use is thought to represent a way for addicts to defend against internalised shame and seeking selfobject experiences in adult relationships. Early traumatic frustrations and non empathic parental interactions are said to result in ruptures in the course of development leading to self destructive attempts at self-repair (Flores, 2004; Brook, 2006).

Individuals with addiction have been characterised as having a negative self-concept, an inability to maintain stable interpersonal relationships and a fear of intimacy (Kooyman, 1993, cited in Hofler & Kooyman, 1996). Cook (1991) points to the roots of addiction in “early dysfunctional family experiences where representations of self and others come to be internalised and lead the child to develop a sense of self as unworthy, unwanted and inferior” (p. 405). It was suggested that a lack of emotional bonding and closeness in their childhood lead them to view themselves negatively in relation to others. Addicts reported experiencing more separation from their primary caregivers, threats of separation and inaccessibility of caretakers due to relationship separation, emotional problems, and substance abuse (Mottola, 1984). According to attachment theory, threats of separation can lead to anxious attachment to caretakers (Jones, 1983; Mottola, 1984). When caregivers are neglectful children will modify their behaviour to get whatever approximation to attachment that is possible. Addicts have learnt to use

substances to deactivate the attachment feeling and to modulate the negative affects associated with activated attachment needs (Cook, 1991). While the roots of addiction can be found in early attachment dynamics, the substance use itself is thought to be an attempt to minimise or eliminate the need for attachment.

Alexithymia and somatisation

Alexithymia refers to an inability to name, recognise or use one's feelings (Kraemer & Loader, 1995; Gold, 1999). High rates of alexithymia have been observed among clients with substance use disorders where they tend to use oral and somatic styles of affect regulation such as bingeing on food or developing somatic symptoms (Taylor, 1995; De Rick & Vanheule, 2007). In particular, individuals with avoidant and preoccupied attachment styles showed higher rates of alexithymia (De Rick and Vanheule, 2006; Schaffer, 1993, cited in Taylor, 1995). Individuals with alexithymia are said to be raised by parents who were unable to identify and respond appropriately to the child's affective states leading to the development of insecure attachment where the child is unprotected from unmanageable intensities of emotion (Kraemer and Loader, 1995, p. 938). It is viewed as an adaptive response where the child cuts off feeling aspects of emotion leaving physiological components to manifest as bodily sensations (Kraemer & Loader, 1995; Flores, 2004).

Somatizing behaviour is described as a form of interpersonal communication driven by insecure attachment (Baumeister & Leary, 1995; Solano, Toriello, Barnaba, Ara & Taylor, 2000; Stuart & Noyes, 2006). When early attunement experiences are consistently deficient, or regulatory processes are insufficiently internalized, the child may become somatically ill (Schore, 1994, cited in Solano et al., 2000). Insecure attachment influences the ability to cope with stress and subsequently drives care seeking behaviour (Maunder & Hunter, 2001; Stuart & Noyes, 2006). Consistent with literature describing adult attachment patterns, individuals with preoccupied attachment style were

reported to be constantly seeking care whereas those with fearful attachment do not believe they are worthy of care and those with dismissing attachment were quick to disregard others as unable to provide care (Diamond et al., 2003). Ciechanowski et al. (2002) found that preoccupied and fearful clients reported more physical symptoms than clients with secure or dismissing attachment (cited in Stuart & Noyes, 2006). Clients with dismissing attachment were also more likely to ignore physical symptoms and were less compliant and less likely to form collaborative relationship with care providers.

Addiction and insecure attachment

Research on adult attachment shows that individuals with a secure attachment style tend to seek social support to cope with emotional stress whereas individuals with an insecure attachment style tend to seek other means such as use of alcohol or drugs as a coping mechanism for emotional self-regulation (Flores, 2004; Thorberg & Lyvers, 2006). Research has consistently reported that addicts often display insecure patterns of attachment (Mottola, 1984; Ball & Legow, 1996; Sicher, 1998; Frank, 2001; Short, 2001; Markus, 2003; McNally, Palfai, Levine & Moore, 2003; Kohn, 2004; Molnar, 2004; Stapleton, 2004, Flores, 2004; Lapidus, 2005; Doumas et al., 2006; Thorberg & Lyvers, 2006; Zapf, 2007; Berman, Kallmen, Barradel & Lindqvist, 2008). People with insecure attachment tend to experience higher levels of anxiety and have greater difficulty regulating their emotions than those with secure attachment (Doumas et al., 2006; Flores, 2004). Insecure attachment styles interfere with the ability to derive satisfaction from interpersonal relationships (Connors, 1997; Williams, 1998; Wildmon-White, 2002) hence addicts are more likely to self medicate and regulate their emotions through the use of substances (Southwick & Satel, 1990; Orford, 2001; Johnson, 2003).

Insecure attachments can be seen as defensive strategies designed to maintain contact with rejecting or inconsistent caregivers (Flores, 2004).

Less attachment anxiety was found among addicts who had consistent and warm care giving from their father whereas addicts who perceived their mother as being intrusive showed high anxiety and avoidance (Newell, 2005). Insecurely attached children are more likely to sacrifice exploration for the sake of security (Flores, 2004) and this is noticeable with addicts in therapy who are more likely to perceive treatment as unhelpful and opting to leave instead of trying to make sense of their internal process and building capacity for self awareness (Berman, 2008).

Doumas et al. (2006) found that fearful and preoccupied attachment styles were overrepresented in the drug and alcohol dependent sample. Fearful and preoccupied clients in this study reported more interpersonal problems and higher levels of anxiety and depression than clients with a secure or dismissing attachment style did. These findings are consistent with McNally et al. (2003) who found that clients with a negative view of self have more difficulty regulating affect in relationships and tend to use substances as a coping strategy. In contrast some studies reported higher prevalence of avoidant attachment among chemically dependent individuals (Gardner, 1995; Frank, 2001). While all three insecure attachment styles were found to be prevalent among addicts, fearful attachment has been consistently identified in all the studies exploring attachment styles of addicts. This is understandable given their negative working model of self and other which makes it more difficult to derive satisfaction from relationships and consequently more likely to turn to objects for comfort.

Research suggests attachment styles are associated with addiction severity (McNally et al., 2003; Brummett, 2007). Fonagy et al. (1996) stated that “one’s level of anxiety indicates the extent to which past traumatic experiences are felt to be in the present” (p. 28). If this is the case, clients with higher attachment related anxiety would have more severe addiction problems. Results indicated that fearful attachment was associated with addiction severity but only for participants who indicated

having relationship and drug and alcohol problems (Brummett, 2007). Interestingly avoidant attachment was unrelated to addiction severity in this study. In another study, higher rates of illicit drug use were found among dismissing and preoccupied individuals (Caspers, Cadoret, Langbehn, Yucuis & Troutman, 2005). It seems that all three forms of insecure attachment were related to addiction severity however preoccupied clients demonstrated fewer relapses and greater continuation and compliance with treatment (Lotter, 2000) whereas dismissing clients were less cooperative in treatment (Stuart & Noyes, 2006). These results make sense as preoccupied clients are more likely to be compliant to ensure their attachment needs are met whereas dismissing clients would prefer to be self reliant and more likely to resist help from others.

Forming alliance with addicts

Addicts often present to treatment with relational difficulties. There appears to be a general consensus that addicts must learn to replace addiction with human relationships if they are to maintain sobriety (Berke, 1991; Flores, 2004). Concerning are the high rate of dropout in drug and alcohol rehabilitation (Splete, 2001; Cournoyer, Brochu, Landry & Bergeron, 2007) and the difficulties therapists face in retaining and engaging addicts in psychotherapy (Meier, Barrowclough and Donmall, 2005). The development of alliance with addicts is a dynamic non-linear relationship that develops over time and forms in stages (Scott & Moore, 1990; Berke, 1991). Research provided support that clients who form weaker alliances are more likely to leave treatment prematurely (Meier, Donmall, McElduff, Barrowclough & Heller, 2006) and stronger alliances predicts positive outcomes in psychotherapy with addicts (Connors, Carroll, DiClemente, Longabaugh & Donovan, 1997; Barber et al., 2001; Moos, 2003; Gaiton, 2004; Liszka-Chaloner, 2004; Pantaloni et al., 2004). However forming an alliance in therapy with addicts is a challenging task as the following vignette demonstrates.

A female client sought psychotherapy after her third relapse. Recently she completed an inpatient treatment program and relapsed 2 weeks following treatment. She is the oldest child of 8 siblings who grew up with alcoholic parents who were often physically and emotionally absent. She described a strained relationship with her adult daughter who had recently moved out following her relapse. She identified her father, a heavy drinker as her only source of support. The client described a pattern of staying sober for 5 days then binge drinking and isolating. Though she was physically present in therapy she was difficult to engage in a conversation and resistant to making any changes in her life that may help her sobriety. She turned up to three sessions then did not show up for her next appointment.

The above vignette demonstrates an example of a client who has an avoidant attachment style. Increasing number of studies suggest attachment style influences both process and outcome in psychotherapy (Cyranowski et al., 2002; Fonagy et al., 1996; Meyer & Pilkonis, 2001). Research shows that clients who tend to have high levels of anxiety and avoidance showed greater severity of problems related to addiction (Molnar, 2004; Brummett, 2007) and did not do as well in treatment (Justitz, 2002). Clients with dismissing states of mind were associated with less help seeking, less self disclosure and poorer treatment use (Dozier, 1990).

Client attachment patterns were found to be related to the development of alliance in therapy (Mallinckrodt, 1991; Mallinckrodt, Coble & Gantt, 1995; Satterfield & Lyddon, 1995, 1998; Kivilighan, Patton & Foote, 1998; Eames & Roth, 2000). Addicts with insecure patterns of attachment were found to form poorer alliances (Liszka-Chaloner, 2004). Factors that helped addicts form alliance in treatment were the personal qualities of the case manager, having control over goal setting and treatment that focussed on the client's strengths and abilities (Redko, Rapp, Elms, Snyder & Carlson, 2007).

In order to form an alliance, addicts must be willing to experience dependency however addicts are often in conflict with their own dependency needs (Berke, 1991). The number of times clients have attempted to change their drug-using behaviour on their own was positively associated with retention (Brocato & Wagner, 2008). Clients with dismissing and fearful attachment style are more likely to remain in treatment if they have had unsuccessful attempts to stop on their own. An addict may be dependent on a therapist to fulfil a function but not necessarily attached. For example someone may be dependent on their employer for income so that their bills can be paid but they have not formed an attachment. Similarly an addict may be dependent on the therapist to help him stop using drugs without forming an emotional attachment. Someone who has an insecure attachment style would probably stay in treatment for long enough to feel confident they can stop using but not necessarily engage in a relationship or use the therapist as a secure base. The therapist is seen as an object that fulfils a function similar to the drug.

Alliance and treatment retention

Bair (2007) found attachment security provided the strongest individual predictor of working alliance. Clients with more successful relationship histories, secure attachment style and better social support find it easier to establish a successful alliance with their therapists (Logan, 2000; Freeman, 2001; Meier, Donmall, Barrowclough, McElduff & Heller, 2005) and showed greater improvements in symptoms (Miller, 1995; Meyer, Pilkonis, Proietti, Heape & Egan, 2001). However several findings suggest that a strong alliance may not necessarily predict client retention in treatment. Studies show that secure attachment style and better coping strategies predicted shorter retention (De-Weert-Van Oene, Schippers, De Jong & Schrijvers, 2001; Meier et al., 2006). Securely attached clients tended to report positive working alliances, good object relations capacity, and a relatively strong sense of self-efficacy (Mallinckrodt, Gantt and Coble, 1995; Brummett, 2007). Clients who

have more confidence in their own abilities to cope with their substance use and those who have good support networks tend to leave treatment early but it is unclear whether they continue to remain sober or able to manage their use post treatment.

Literature on addiction suggests that if a strong alliance is established early in treatment the more likely clients are to engage and remain in treatment (Connors et al., 1997; Barber et al., 2001; De Weert-Van Oene et al., 2001). Assessment of alliance early in treatment appears to be predictive of treatment retention but if alliance was assessed later in treatment there was no relationship found between alliance and retention (Tunis, Delucchi, Schwartz, Banyas & Sees, 1995; Belding, Iguchi, Morral & McLellan, 1997). If alliance ratings are taken later in treatment then it is possible that clients who had lower ratings of alliance early in treatment may have already left.

While early alliance has been shown to predict retention, some studies have also considered its relationship with post treatment outcomes. Review by Meier et al. (2005) found that alliance measured early in treatment is an inconsistent predictor of post treatment outcomes. Client rated alliance early in treatment was not predictive of outcome (Barber et al., 2001) however alliance ratings later in treatment by client and therapist predicted reduction in drug use (Belding et al., 1997). Connors et al. (1997) measured alliance later in treatment and found whether rated by client or therapist consistently predicted treatment participation and positive outcomes among alcoholic clients. Interesting to note is that findings in the general psychotherapy field found therapist rated alliance to be less predictive of outcome however within the addiction literature therapist rated alliance was found to be better predictor of outcome (Horvath and Symonds, 1991). The longer duration of time spent in therapy was also associated with better treatment outcomes (Freeman, 2001; Moos & Moos, 2004).

While early ratings of alliance is predictive of retention it is also interesting that clients tend to rate alliance higher in the early stages of treatment (Barber et al., 2001) but the early stages of treatment is also a period of highest drop out (De Leon, 2001). Also lower alliance rating and fewer treatment sessions were predictive of relapse (Ilgen & Moos, 2005). Due to their attachment to substances addicts are more likely to come into treatment as a last resort. Without the use of substances in treatment clients start to become aware of their emotions and the desire to use to numb painful feelings are likely to increase which would mean they are more likely to act out in treatment. This would suggest that in working with addicts, a good alliance alone may not be enough to retain clients in treatment.

Motivation and retention

Surprisingly, the highest retention rates were found among clients from the criminal justice system referrals (McDuff & Beuger, 1997). Motivation to change and client readiness was identified as a significant predictor of alliance development (De Leon, 2001; Brocato & Wagner, 2008) however Brocato and Wagner (2008) found clients who were in treatment as an alternative to prison programs were under engaged 1 month into treatment in comparison to clients from the general population. While it would seem that one of the factors that motivates clients to stay in treatment is negative consequences this may not mean that they are motivated to give up substance use. Brocato and Wagner (2008) also found that a client's drug of choice predicts the likelihood of retention in treatment. Clients who reported marijuana as their primary drug left treatment early and clients who reported cocaine as their primary drug were more likely to remain in treatment. This may be due to the ease of availability of the drug, the easier it is to obtain the greater the temptation to drop out and fall back into old behaviours. Connors et al. (1997) found that the greater the severity of use prior to treatment the less the likelihood of abstinence during and after treatment. Doing an

initial assessment of the clients' history of drug use may help therapists identify clients who may require more support.

It has also been shown that therapists are able to identify clients who will have difficulty committing and who will present a higher risk of dropout (Cournoyer et al., 2007). However therapist characteristics such as experience and time spent with client may influence clinical judgment. It could also be true that once a therapist perceives a client to have low motivation, the therapist may lose interest in working with the client and this could also influence the client's motivation to stay in treatment. In fact it was shown that positive perception by clients and therapists of their therapeutic relationship was associated with favourable behaviour changes (Logan, 2000; Ilgen, McKellar, Moos & Finney, 2006). Being perceived by others as capable and worthy enhances self-confidence (Booth, Russell, Soucek & Laughlin, 1992). Often addicts come into treatment having strained many relationships and having someone who has not given up on them is likely to be the encouragement they need to focus on their recovery.

Having highlighted reasons why addicts may struggle to form and alliance and remain in treatment, it is also important to identify factors that may help addicts engage in treatment. Barber et al. (2001) found that the use of cognitive therapy was better in engaging and retaining clients who reported weaker alliances. Whereas clients who reported stronger alliances were more successfully retained in time-limited psychodynamic therapy and individual drug counselling based on the 12-step disease model. Clients who reported weaker alliance may have less motivation to change or an avoidant attachment style. Furthermore therapy based on the 12 steps demands abstinence and psychodynamic treatment emphasises relationships which addicts would find challenging whereas cognitive therapy may focus on "acquisition of skills and cognitive change" (Bryant, 1992) which may be less confronting. Using cognitive therapy may help addicts gradually warm to therapy before deeper work can begin.

SUMMARY

This review confirms that there is higher prevalence of insecure attachment, alexithymia and somatic problems among addicts. While all the forms of insecure attachment were represented in the addiction literature, fearful attachment consistently emerged in all the studies as being vulnerable to addiction. Clients with a dismissing attachment style were found to be the least compliant in treatment. Consistent with their attachment style, addicts who have a negative view of others showed less care seeking behaviour. Therapists ratings of alliance were found to be more predictive of outcome and it was highlighted that alliance alone might not be sufficient in retaining addicts in treatment. Use of cognitive strategies was emphasised to help clients engage in treatment. The next chapter will consider how both client and therapist attachment style impacts on their ability to work together.

CHAPTER 3: INTERACTION OF THERAPIST AND CLIENT ATTACHMENT STYLES

Dynamics in the therapeutic relationship emerge partly from the attachment histories of client and therapist. This chapter considers how different insecure attachment patterns in the therapist and client can lead to specific dynamics and pose problems in the therapeutic relationship.

Attachment dynamics and therapeutic process

Studies provide support that attachment related dynamics are present even in the first therapeutic encounter and that these dynamics are a function of client attachment, counsellor attachment and the unique combination of client and counsellor attachment patterns (Hardy et al., 1999; Borsanyi, 2001; Meyer & Pilkonis, 2001; Flores, 2004; Biscoglio, 2005; Mohr et al., 2005; Daniel, 2006). Therapists' and clients' internal working models of attachment affect a number of aspects of the therapeutic process including the nature of the client's symptom reporting, capacity to make use of treatment, quality of alliance, treatment outcome (Dozier et al., 1994; Fonagy et al., 1996; Tyrrell, Dozier, Teague & Falloot, 1999; Stuart & Noyes, 2006) and countertransference and transference (Diamond et al., 2003). Certain insecure attachment dynamics are proposed to be more problematic due to the internal working models of attachment which gives rise to particular transference and countertransference reactions in the therapeutic dyad. These dynamics are predicted to cause problems in the formation of an alliance and the use of the therapist as a secure base.

Studies that explored the interaction between client and therapist attachment styles highlighted problematic dynamics that influences the therapeutic process. Rubino et al. (2000) found that anxious therapists tend to be particularly unempathic with fearful and secure clients. Perhaps the high level of anxiety interferes with the therapist's ability to

be emotionally attuned and responsive to the client. On the other hand when therapist and client attachment style complemented each other, dismissing counsellors were found to be inappropriately hostile, critical and rejecting with preoccupied clients whereas preoccupied counsellors displayed this type of countertransference behaviour with dismissing clients (Mohr et al., 2005). Dismissing therapists may be drawn to punish needy parts of the clients that they do not allow in themselves. Whereas preoccupied therapists may perceive the lack of connection with dismissing clients as their own inadequacies or failures and project their frustrations on their clients. Preoccupied clients appeared to elicit inappropriate distancing behaviour for counsellors high in avoidance. This dynamic is expected given preoccupied individuals tend to be needy in relationships whereas avoidant individuals prefer to be self reliant and struggle with closeness.

The highest levels of distancing and hostile countertransference behaviour were found in dyads with a preoccupied client and an avoidant counsellor (Mohr et al., 2005). Results also showed that dismissing counsellors were more likely than others to engage in hostile countertransference behaviour. This finding is consistent with research suggesting that dismissing attachment is associated with a cold and rejecting interpersonal stance (Bartholomew and Horowitz, 1991). These results show that negative countertransference dynamics were more prevalent in dyads in which the client has a relational style that challenges the counsellors' own emotion regulation strategies. For example, an avoidant counsellor who would be expected to seek a sense of security by minimizing emotional intensity and dependency in relationships might be more likely than preoccupied or secure therapists to feel overwhelmed by the exaggerated affect expected in preoccupied clients (Mohr et al., 2005).

By taking a closer look at these dynamics, different client attachment orientations were found to elicit different types of interventions from therapists. Hardy et al. (1999) found that therapists were more likely to

respond with interpretation to dismissing attachment styles and with reflection of feelings to preoccupied attachment styles. This confirmed findings from other studies that showed therapists tended to react with more cognitive interventions to an under-involved client interpersonal stance (Hardy et al., 1999; Lessard, 2002) and with more affective interventions to an over-involved client interpersonal stance (Hardy et al., 1998). Dozier et al. (1994) also found that insecure case managers intervened in greater depth and perceived greater dependency needs with preoccupied clients. Perhaps an explanation for this could be that therapists may feel pulled to use cognitive interventions sensing the guardedness of an under-involved client as an attempt to connect with the client whereas a preoccupied client with exaggerated affect may naturally draw therapists to be a holding container.

Given that insecure attachment shapes countertransference reactions it would be reasonable to suspect that this also influences the ability of the therapist and client to form a therapeutic relationship. Both the therapist and the client's attachment styles were found to contribute to the development of the alliance (Strauss, 2000; Flores, 2004) however Fehling (2005) and Sauer (1999) did not find that client and therapist attachment style influenced alliance. The use of different measures and ratings of alliance at different points in treatment makes direct comparison of these results difficult. Tyrrell et al. (1999) found that less deactivating case managers formed stronger alliances with more deactivating clients. Similarity between therapist and client attachment organization was associated with lower client rated alliance especially when both were compulsively self reliant or avoidant (Stuart et al., 1991, cited in Ammaniti, 1999; Borsanyi, 2001; Fuertes et al., 2007). This is not surprising because it would be difficult to form an emotional bond that will lead to deepening of therapeutic work when both therapists and clients are avoidant or self-reliant. According to Wallin (2007) "a therapist and patient whose predominantly dismissing styles mirror each other may collude to steer clear of strong feelings" (cited in Collins, 2007, p. 123). Stuart et al. (1991) reported higher rates of early termination when both

clients and therapists are insecurely attached (cited in Ammaniti, 1999). Clients who perceived themselves as dominant also tend to perceive their therapists as dominant and the more dominant the therapist is perceived the less co-operative the relationship (De Weert-Van Oene, Jorg and De Jong, 2006). Surprisingly Biscoglio (2005) found that secure attachment in clients and therapists was related to poor outcome and dismissing and fearful attachment in clients was related to better outcomes. As individuals with a dismissing attachment style are more likely to be dismissive of relationships and less likely to see their relational patterns as being problematic it would be better to assess their attachment style through an interview. It is unclear why secure attachment in therapists and clients were found related to poor outcomes. The author attributed the findings to a small sample size. Another issue that is worth considering is how well the use of self report measures captures the complexities of human emotions and behaviour.

These dynamics draw attention to complementarity of clients and therapists attachment in treatment. Tyrell et al. (1999) found dissimilar therapist-client attachment match in an in patient treatment for severe psychiatric patients increased likelihood of strong alliance and better client satisfaction. Dozier et al. (1994) found the more insecure the therapists were, the more likely they were to give in to what the clients elicit. However, secure therapists seemed to respond in a way that corrected for the insecure attachment pattern of the clients (Bernier and Dozier, 2002). Findings so far seem to indicate that complementarity between therapists and clients is more favourable in the formation of an alliance however therapists need to be aware of negative countertransference reactions. There is also evidence to suggest that similarity between therapists and clients attachment is problematic and probably would not provide clients with a reparative experience.

While research on adult attachment style suggest complementarity in attachment as the best combination in the formation of alliance and providing a reparative experience this dissertation suggests that this is

likely to be problematic in working with addicts given high rates of drop out is reported in early stages of therapy. Countertransference issues are more likely to shape the clients and therapists ability to relate to each other and form an alliance. The following vignette demonstrates an example of the type of problem that is likely to be encountered between a preoccupied therapist and an addict with a dismissing attachment style.

A female client presented to psychotherapy with relationship problems. She gave away little information about herself and obsessively focussed on her new relationship. She described a history of having many casual relationships with men but could not name any significant relationship with a female apart from her younger sister. In her past relationships, she reports leaving when her partners get clingy. She alluded to having fears around commitment and this played out in the sessions by her showing-up late, cancelling appointments and complaining that she feels depressed and isolating between our sessions. The highly anxious therapist was concerned about the client leaving treatment and felt increasingly incompetent as she complained of no improvements with her psychological functioning. During the sessions the conversation increasingly focussed on helping the client find answers, exploring transference issues and the therapist making interpretations. She turned up to her fifth session stating she could not remember why she decided to come to therapy and do not feel that she needs to be in therapy anymore. The therapist responded by reflecting back the issues they had explored together, concerns the therapist had around the client's mental health and reasons why the therapist felt she needed to be in therapy. The client appeared to go along with the suggestion but did not show up for her next appointment and could not be contacted.

An addict with an avoidant attachment cannot be expected to give up their primary defenses that deny need for attachment and bond with a therapist who appears to be available. Addicts carry projections of their childhood relationships and memories of neglect, rejection and abandonment are projected into adult relationships (Stapleton, 2004, p. 89). A therapist who is clingy poses a threat to a client who has learnt to keep themselves safe by not needing anyone. Client's perception of


themselves and their therapist contributes to the way they view the therapeutic relationship (De Weert-Van Oene et al., 2006).

Attachment is a bond that develops over time and therapists need to be mindful of their client's attachment style so that they don't come across as smothering with a client who avoids closeness. Often with addicts the window of opportunity to build trust and facilitate engagement is small due to the high rates of termination early in treatment. The table that follows highlight the potential dynamics between therapist and client that may facilitate or cause problems in the crucial early phases of alliance development.



INSECURE ATTACHMENT DYNAMICS


DISMISSING THERAPIST (positive self, negative other)

<p>DISMISSING CLIENT (positive self, negative other)</p> <div style="text-align: center; margin: 10px 0;"> <p>← → Therapist Client</p> </div>	<ul style="list-style-type: none"> • Because both client and therapist mirror each other, healthy dependency may be discouraged and client's affect regulation strategies may not be challenged. • Therapist may not facilitate client to use the therapist as a secure base for exploration and emotional connection may not be possible. However in working with addicts this may help in the initial phase of treatment as their defenses are not confronted too soon hence the client is likely to feel safer in this relationship. • This dynamic reinforces client's negative working model of other - therapist may not be nurturing or responsive hence as therapy progresses client is more likely to be resistant. • May be difficult to maintain the alliance and work collaboratively as therapy progresses due to their self reliance and characteristic hostility in interpersonal relationships.
<p>PREOCCUPIED CLIENT (negative self, positive other)</p> <div style="text-align: center; margin: 10px 0;"> <p>← ← Therapist Client</p> </div>	<ul style="list-style-type: none"> • Client may initially remain in therapy because they are likely to see the therapist in positive terms and view self as inadequate. • Therapist would struggle with client's neediness and may be drawn to punish parts of the client that challenges the therapist's own emotional regulation strategies. • This dynamic would complement the client's attachment style, encouraging less dependency and improving cognitive functions.



	<ul style="list-style-type: none"> • This dynamic may also reinforce client's negative model of self where being pushed away confirms that the self is not worthy or deserving of care. In the initial phases of treatment this may lead clients to look for comfort somewhere else.
<p>FEARFUL CLIENT (negative self, negative other)</p>  <p style="text-align: center;"> ← ↪ Therapist Client </p>	<ul style="list-style-type: none"> • This dynamic would be problematic in developing an alliance. As fearful clients are sensitive to cues of rejection, the dismissing therapist may reinforce the client's fears by being dismissive of closeness in relationship. • Client may be resistant in therapy as they may not feel safe in the relationship. • As both client and therapist are avoidant of attachment needs, the therapist may not be able to provide a secure base for clients to explore. • Client may be well defended in the relationship and not likely to stay in treatment as this dynamic reinforces their negative internal working model.

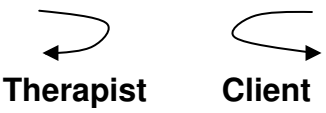
PREOCCUPIED THERAPIST (negative self, positive other)

<p>DISMISSING CLIENT (positive self, negative other)</p> <p style="text-align: center;">  </p>	<ul style="list-style-type: none"> • This dynamic is problematic for development of alliance with addicts as the client may be overwhelmed and struggle with the closeness pulled for by the therapist. • Client may experience therapist as intrusive and become resistant to the therapeutic process. • Therapist may struggle with the hostility shown by the client and find it difficult to manage their countertransference reactions hence be drawn to be punishing or forceful with the client. • Therapist may look for acknowledgement from the client and possibly feel rejected. Therapist may find themselves working harder in the relationship than the client.
<p>PREOCCUPIED CLIENT (negative self, positive other)</p> <p style="text-align: center;">  </p>	<ul style="list-style-type: none"> • Client may remain in therapy but form unhealthy dependence to the therapist. This may be a co-dependent relationship. • An alliance would be formed where the therapist would feel needed and the client feel responded to but the client's emotional regulation strategies may not be challenged. • Therapist may discourage autonomy and client may not learn to have healthy boundaries. • Therapist may work hard to meet emotional demands of client but client may not learn to solve their own problems and improve their cognitive abilities.
<p>FEARFUL CLIENT (negative self, negative other)</p>	<ul style="list-style-type: none"> • Therapist may be trying hard to get it right for the client and this may either be reparative where the client feels responded to and cared for or the

 <p>The diagram consists of two labels, "Therapist" and "Client", positioned horizontally. Above "Therapist" is a straight arrow pointing to the right towards "Client". Above "Client" is a curved arrow that starts pointing right, then loops back up and left to point towards "Therapist".</p>	<p>closeness may be too much for the client who is expecting to be let down.</p> <ul style="list-style-type: none">• This dynamic may help addicts form an alliance early in treatment as the therapist appears to be emotionally available.• Difficulties in this dynamic could be the therapists' focus on emotional experience which may be difficult for a client who uses avoidant strategies.• Client may struggle with therapist's expectations and experience therapist as demanding and self as faulty.
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FEARFUL THERAPIST (negative self, negative other)

<p>DISMISSING CLIENT (positive self, negative other)</p>  <p>Therapist Client</p>	<ul style="list-style-type: none"> • Therapist may be trying too hard to form an alliance which may push the client further away. • Due to anxiety therapist may struggle to manage own emotional process and find it difficult to be attuned to the client's needs. • Client would not be able to use the therapist as a secure base as the therapist is not attuned to the client's needs. • Client may be overwhelmed with intensity of the sessions and may perceive therapist as demanding hence show more resistance. • Therapist may struggle to make use of negative countertransference reactions which may get acted out by being punishing or forceful with client.
<p>PREOCCUPIED CLIENT (negative self, positive other)</p>  <p>Therapist Client</p>	<ul style="list-style-type: none"> • Fearful therapists may successfully engage preoccupied clients in therapy as the client tend to be needy and the therapist is less likely to feel rejected. • Therapist may struggle with client's neediness and be drawn to punish client's dependency. • Interventions may be more intellectual rather than exploring client's emotions. • Clients may pull to be rescued or looked after by the therapist who may struggle to tolerate client's dependency when they can't tolerate their own needs.
<p>FEARFUL CLIENT (negative self, negative other)</p>	<ul style="list-style-type: none"> • Both therapist and client may be guarded and this relationship may not foster alliance. • Client may not perceive therapist as being emotionally available or able to

 <p style="text-align: center;">Therapist Client</p>	<p>tolerate negative affect hence the client may struggle to use therapist as secure base but would instead tune into possible cues of being disappointed, criticized and rejected.</p> <ul style="list-style-type: none"> • Though therapist may be able to feel empathy for the client, they may struggle with parts of themselves that gets mirrored to each other. • Therapist may get frustrated and be punishing and client may be withholding.
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The table above highlights how insecure attachment in the therapeutic relationship can negatively impact on the therapeutic process. The ideal match between therapist and client may be different in the early stages of therapy when creation of an alliance is the essential task from the degree of complementarity required in the later stages of treatment (Dolan, Arnkoff & Glass, 1993). From the table above the best combination that would help in the engagement and development of alliance early in treatment are dismissing therapist-dismissing client, preoccupied therapist-fearful client and fearful therapist-preoccupied client.

Therapists with a negative view of others are more likely to be drawn to punish client's attachment strategies that challenge their own. Difference however between dismissing and fearful therapists is that fearful therapists are more likely to be aware of their faults whereas dismissing therapists are more likely to view the behaviour of the other as problematic. Fearful therapists may work best with preoccupied clients but may be drawn to punish client's neediness as they struggle with their own needs. Coon (2007) suggested that fearful therapists are likely to have trust issues, poor self esteem and lack confidence hence may overcompensate for their fears of not being a good enough. In contrast dismissing therapists may struggle with the intensity of emotion

displayed by preoccupied clients and likely to encourage avoidance of emotional connection which is likely to have a negative impact with addicts who already prefer to use substances for affect regulation. Dismissing therapists may be more effective when working with clients who display low emotional intentness and expression (Coon, 2007). Positive model of self supports a denial of the need for close relationships (Coon, 2007).

Therapists with a positive view of others are more likely to perceive inadequacies in themselves and work harder to establish a good relationship. Preoccupied therapists may doubt their ability to bond with clients and tend to report lower alliance (Coon, 2007). As preoccupied therapists tend to work harder to establish a relationship, they may be better able to engage with fearful addicts who are sensitive to cues of rejection. Therapists with a negative view of self are more likely to struggle to manage their own emotional responses due to their sensitivity towards abandonment and rejection and be poorly attuned to their client's needs especially those who display intense negative affects.

Given the high rates of dropout in the early phases of treatment with addicts, it is important for therapists to consider factors that impede and foster attachment. This requires therapists to be one step ahead and by having an awareness of their own attachment dynamics it is hoped that therapists will be able to help addicts engage and form better alliances in therapy. Clients tend to come into therapy with little awareness of their feelings and how these contribute to problems in their relationships. This is one of the reasons why therapists need to be aware of their own attachment patterns and understand their countertransference so that clients may have a reparative experience and learn healthy ways of regulating their emotions.

Understanding insecure attachment in addicts

Dismissing clients tend to lock their therapist out as they themselves were locked out by their attachment figures and the therapist is left feeling what the client once felt as a child, angry, unacknowledged and inept (Slade, 1999, p. 588). Minimising the importance of attachment is a defense against the surfacing of painful memories (Bucheim, 2003). Dismissing clients can be hostile, rejecting, hurtful and difficult to retain in therapy and as Dozier (1990) pointed out these patients often do succeed in driving therapists away, and lose the help they need. Due to a history full of disappointments dismissing individuals are distrustful of others, avoid intimate contact and refuse to relinquish control to other people (Horowitz, Rosenberg & Bartholomew, 1993). Vail (2003) found that dismissing clients were more likely to dropout of treatment. They tend to minimise the importance of relationships and minimise expression of emotions (Bernardi, 1998; Lessard, 2002; Profis, 2005). As Holmes (2001) points out “the avoidant person is all container and no feelings” (p. 40). Their tendency to dissociate in sessions can be frustrating and a possible countertransference reaction is to force them to acknowledge disturbing feelings. This reaction like withdrawal stems from the frustration of being utterly shut out as well as from the projection of the patient’s unmetabolized feelings onto the therapist (Slade, 1999, p. 588). It is important for therapists to understand their countertransference instead of acting out on it and in the process confirming the client’s problematic internal working models.

In contrast preoccupied clients tend to be needy and hungry for attention. They are unable to tolerate the emptiness within and constantly look externally to fill what’s missing internally. These clients lack the ability to reflect on their emotions and tend to be highly anxious in relationships. Preoccupied clients have an inherent need to be viewed in positive terms and may use defensive strategies where the reality of the situation is distorted to accommodate their dependency needs and efforts to maintain security with the other (Profis, 2005). Therapists are likely to

find themselves in situations where they are problem solving for these clients due to their needy and helpless presentation which can be seen as efforts to keep the attachment figure close by. Preoccupied clients are likely to draw punishment from therapists who are also in conflict with their own dependency issues. Progress in work with preoccupied clients seems to follow from the therapist's long term emotional availability and tolerance for fragmentation and chaos (Slade, 1999, p. 588).

Clients who have developed a fearful pattern of attachment expected to be rejected, criticized or humiliated and have striven to be emotionally self contained and insulated against intimate contact with others (Bowlby, 1988, p. 143). These clients tend to keep therapists at a distance. Fearful attachment has been shown to be related to more negative outcomes in treatment (Reis & Grenyer, 2004). Avoidance of intimacy for fear of rejection appears to impede successful therapy. Unlike dismissing clients, fearful clients desire close relationships but fear rejection. Cyranski (2002) found that individuals with fearful attachment style show lower levels of self esteem, greater interpersonal difficulties and are prone to depression. As fearful individuals view themselves as unlovable and unworthy and others as unreliable and rejecting they may take longer to develop a trusting relationship in therapy.

Developing capacity for attachment with addicts

Masterton (1993) stated that "clients with disorders of the self come to therapy not to get better but to feel better" (cited in Sachs, 2003, p. 81). The aim of therapy is to provide a secure base, an environment that is responsive, emotionally attuned and secure enough to cope with protest to allow new meanings and secure-autonomous narratives to arise (Jones, 1983; Sable, 1992; Holmes, 1996; Holmes, 1998; Williams, 1998). To successfully engage addicts in therapy, therapists must understand how the client's and their own attachment patterns contribute to the difficulties in the therapeutic relationship (Szajnberg & Crittenden,

1997). Therapists can use their countertransference as a tool in understanding the client's attachment dynamics. Countertransference with attachment disordered populations often represents anxieties about the bond and level of connection or trust established in the relationship (Mills, 2004). Harris (2004) suggested that during the initial assessment therapists' listen for a history of caregiver responsiveness, insensitivity and parental loss and how this may have shaped the client's current attachment patterns.

Changes in attachment pattern are thought to be related to events that bear on the caregiver's availability and responsiveness such as having a parent who is an addict, death of a parent, parental separation and foster care (Waters, Hamilton, Weinfield, 2000). Individuals who have had these experiences are more likely to change attachment patterns because they have developed unclear models of self and other therefore their internal working models of attachment are likely to be multiple, contradictory and unintegrated (Diamond et al. 2003; Davila & Cobb, 2004). While there is usually one dominant attachment state of mind, others can be activated by specific circumstances such as separation, marriage and therapy (Diamond et al. 2003; Davila & Cobb, 2004). Research supports that over the course of therapy a client's insecure attachment can change to a more secure attachment style (Shane & Shane, 2001; Travis, Binder, Bliwise & Horne-Moyer, 2001; Bucheim, 2003; Diamond et al., 2003; Diamond, Stovall-McClough, Clarkin & Levy, 2003; Hopkins, 2006). Ammaniti (1999) states that even clients with insecure states of mind have had some experience of attachment security with a secondary attachment figure. Focussing on positive memories around attachment in therapy can help individuals with attachment difficulties form a relationship with therapists (Sandler, 2007, cited in Carter, 2007).

However therapists' attempts to provide safety so that they can be experienced as a secure base could pose a threat to individuals whose only sense of security resides in the stability of their defense systems

(Hamilton, 1987, cited in Hopkins, 2006, p. 98). Drawing on work with children in foster care, it was found that to enable attachment children need to externalize their feelings with someone who can safely tolerate being hated, humiliated and helpless without retaliating or collapsing (Hopkins, 2006, p. 99). Willingness to risk further attachment lies in the therapist's capacity to contain negative emotions (Hopkins, 2006, p. 105).

Clients tend to elicit responses that confirm their internal working models. Meyer and Pilkonis (2001) stated that being responsive to the client's needs means giving in to these pulls but also countering them by complementary therapeutic action. For example preoccupied clients pull for emotional-experiential interventions but they may benefit as well from cognitive-behavioural strategies that help modulate overwhelming feelings (Meyer and Pilkonis, 2001, p. 470). Similarly avoidant clients pull for rational-cognitive interventions may also benefit from strategies that facilitate emotional engagement and connection (Meyer and Pilkonis, 2001).

Addicts have poor coping mechanisms and an inadequate ability to cope with stress and anxiety (Berke, 1991; Flores, 2004). Capacity to soothe anxiety internally develops from primary attachment experiences (Berke, 1991; Johnson, 1999). Lack of a soothing internal object would make it difficult for addicts to stay in therapy during painful moments. Kohut (1977) believes that alcoholics suffer from self-deficits, and self-objects are valued for the internal function and emotional stability they provide (cited in Banai, Mikulincer, Shaver, 2005). Lack of an empathic or available object to merge with in early development is thought to lead to merger with drugs and alcohol (Stapleton, 2004). It is important for therapists to replace the function of the drugs and be the new object of merger.

Attachment difficulties were found to be related to a clients' pattern of constructing inter-session representations (Bender, 1996). Improvements

were related to the client's ability to continue the therapeutic dialogue between sessions. Walant (1995) encourages the use of "immersion aids" such as the therapist's phone number, a picture or an object from the office so that the client can evoke the therapeutic relationship when feeling alienated.

In order for addicts to form an attachment and use therapists as a secure base, the clients must feel safe in the relationship and understood by the therapists. Therapists' empathy has been shown to help foster alliance and lead to structural changes in client's internal working models (Steckley, 2006). Clients who felt understood and accepted by their therapists reported less avoidance and anxiety in their relationships.

As addicts are a vulnerable client group to work with, it is important that therapists bear in mind the client's ability to cope. Supervision can be a useful resource for therapists in highlighting attachment dynamics in the therapeutic relationship and the supervisor's experience and expertise could shed light on ways to foster a more secure relationship with addicts. Literature highlights an active, directive, supportive and educative therapeutic approach that deemphasizes exploratory work in early recovery helps clients achieve abstinence and develop a sense of security and attachment with the therapist (Ball and Legow, 1996, p. 533). Use of supportive strategies is suggested to help clients who struggle to engage (Gaston, 1990) and cognitive interventions have been shown to improve depressive symptoms and better outcome among clients who show an avoidant attachment (McBride, Atkinson, Quilty & Bagby, 2006). Confronting clients' defenses at the beginning of a difficult therapeutic relationship has been shown to hinder development of collaborative relationship (Liotti, 2002; Karno & Longabaugh, 2005). Use of transference interpretations have also been advised to be used as a last resort to maintain the therapeutic working compact (Silber, 1970).

SUMMARY

Literature shows that therapists' and clients' attachment dynamics can impact negatively on the therapeutic relationship. Negative countertransference behaviour resulted when the therapist was challenged by the client's emotional regulation strategies and similarity in attachment resulted in lower alliance. The best attachment combination to help addicts engage in therapy was outlined. Therapy can help shift clients who are insecurely attached to a more secure attachment with therapists being able to hold negative emotions facilitating this process.

CONCLUSION

While there are research to support that a therapist's ability to provide care was determined by their own history of receiving care there are also findings that suggest that through a secondary attachment relationship internal working models can be re-worked which could improve the therapist's ability to foster secure attachment. Findings also highlighted that there was a higher proportion of secure attachment among therapists in comparison to the general population. However these findings were a result of self report measures and it would have been interesting to have these results confirmed through an interview or rated by an independent observer such as the therapist's supervisor to see if there are any discrepancies between therapists' perception and how others viewed them. Furthermore the study in question had a low response rate and looked at attachment style of psychologists and therapists in training. Given that psychotherapists are required to have done some work in therapy as part of their training and psychologists are not, this raises the question of how aware psychologists may be of their own attachment patterns. Study by Nord, Hoger and Eckert (2000, cited in Strauss, 2000) raises another question around the possible cultural influences of attachment style. As this dissertation only looked at articles written in English, it would be interesting to explore whether there are higher proportion of therapists across cultures that rate themselves securely attached in comparison to the general population. Also interesting was the lack of research directly considering a therapist's attachment style. It should be stressed that the results cited are based on 3 studies with one study contradicting the other two which makes it difficult to draw conclusions.

Therapist attachment patterns influenced their ability to relate to clients and their tendency to engage in negative countertransference. Clients rated better alliances with securely attached therapists and poorer alliances with dismissing therapists. Surprisingly, preoccupied attachment in the therapist was also positively associated with alliance

but anxiety in the therapist was found to have negative effect on the alliance over time. Therapists who rated highly on the anxiety dimension of attachment were less emphatic to ruptures in therapy. This could indicate that therapists who fear rejection or abandonment may struggle to manage their own anxiety and be less sensitive to client's underlying process.

Literature on addiction suggests therapist's ratings of alliance were more predictive of outcome whereas in the general psychotherapy literature client ratings of alliance were more predictive of outcome. This could be because addicts tend to use avoidant strategies and therapists may be able to better identify issues or situations in the client's life that would lead to relapse. Findings highlights the importance of building a strong alliance with addicts early in treatment and alliance with addicts needs to be maintained week by week.

Addicts who had a negative view of self and other had greater difficulty regulating their affect in relationships and more likely to use substances as a coping strategy. Fearful attachment was consistently prevalent among addicts and those with dismissing attachment were more difficult to engage and retain in therapy.

There were no studies found that specifically investigated the interaction between addicts' and therapists' attachment patterns. This review found that therapists' and clients' attachment patterns do influence important aspects of the therapeutic process in general psychotherapy. Highest levels of negative countertransference were found in dyads between preoccupied clients and dismissing therapists. Complementarity between therapist and client attachment seemed to be more favourable in fostering alliance however the degree of complementarity required varies with phases of treatment.

In working with addicts however, pairings between a preoccupied therapist and a fearful client may foster better alliance in the initial stages

of treatment as the therapist appears emotionally available. Therapists paired with preoccupied clients should be able to form an alliance readily as preoccupied clients tend to be needy and dependent. However a preoccupied client paired with a preoccupied therapist may form a co-dependent relationship over time. The dyad where a dismissing client is paired with a fearful or preoccupied therapist or where both therapist and client have a fearful attachment may be the most challenging in terms of fostering attachment. Highest level of negative countertransference would be expected with dismissing therapists especially with preoccupied clients. A dismissing therapist may be able to work well in forming an alliance with a client who also has a dismissing attachment as they are less likely to smother the client. But over time the client may not experience healthy dependency in this relationship.

Limitation of study and areas for future research

Studies that were included in this review largely focussed on addiction to drugs and or alcohol. There were not many articles found on other forms of addiction such as gambling, sex addiction or addiction to food. So it is unclear whether these attachment dynamics can be generalised to other forms of addiction. The quantitative research found largely used self report measures to determine attachment styles and alliance. Also interesting was that the measures given to therapist to rate the alliance focussed on the therapist's perception of how the client viewed the alliance instead of directly assessing how the therapists felt about the relationship. Whether such measures can adequately capture the complexities of human behaviour is questionable. This however highlighted the difficulties of studying psychotherapy processes due to the sensitive and private nature of the therapeutic relationship. This dissertation was a modified systematic literature review which could only draw conclusions based on evidence that is already available. Use of exploratory research could have given a better picture of how match or mismatch in attachment between therapist and client influences process in therapy. Given that there are many drug and alcohol counsellors who

are in recovery future research could explore if their attachment styles were significantly different to therapist who are not in recovery. Also it is unclear whether insecure attachment is more prevalent among less experienced therapists compared to more experienced therapists.

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