Utilizing Attachment Theory in Clinical Practice

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Mary Ainsworth and John Bowlby described attachment as "a deep and enduring emotional bond that connects one person to another across time and space."[1] Evidence-based psychotherapies employing constructs from attachment theory have gained traction in early childhood mental health, though attachment is not often consciously considered when it comes to formulating clinical impressions during appointments. This is not to imply that providers are not meeting the attachment needs for families they serve, but rather that increased awareness of attachment processes offer insight into what makes relationships work and how to make the therapeutic alliance stronger. For example, the reassurance a provider gives that allows a patient to explore their relationships and feelings is promotive of the attachment relationship.[2] Often this leads to a reduction in anxiety and improvement in functioning.[2] Sometimes by telling the anxious patient that they can find help in therapy and medications, that there is a reason and treatment for their pain and worries, and that they are not "stuck forever" can make a huge difference. To that end, this article seeks to provide basic information on attachment theory and how it can be used therapeutically during clinical appointments.

History of Attachment Theory

The work of John Bowlby and Mary Ainsworth propelled attachment theory and research.[3] John Bowlby (1907-1990), a child psychiatrist and psychoanalyst, postulated that an infant's attachment system serves to keep an infant close to the mother when under threat, thus improving the child's chances of survival.[3] Bowlby believed early attachment experiences with an attachment figure heavily influenced how individuals perceive themselves and relationships long-term.[3] Briefly put, "When a child develops a secure attachment, they see themselves as good and loveable and the other as responsive, available and loving…if they develop a model of the self as unworthy of love… or worthless and the other as unavailable or threatening, then the child develops an insecure attachment style."[2] He worked in tandem with developmental psychologist Mary Ainsworth (1913-1999). She expanded on attachment theory and one of her contributions was the idea of patterns of attachment: secure, insecure avoidant, and insecure ambivalent/resistant.[3] Infants with an insecure avoidant pattern learn that their best strategy for keeping their caregiver close in stressful situations is to minimize outward distress and to display interest in exploring the environment.[3] In contrast, infants with an insecure ambivalent/resistant pattern learn their best strategy for keeping their caregiver close in stressful situations is to minimize exploration and to increase outward distress (despite attempts to comfort and soothe).[3] Ainsworth described how interactions in infancy formed these patterns, which led to her design of the brief separation-reunion procedure called the Strange Situation. A fourth attachment classification, disorganized, was later conceptualized.[4] Disorganized attachment is characterized by a lack of a coherent, organized strategy to keep the caregiver engaged. In some ways, disorganized attachment is the lack of a pattern of attachment. While secure and insecure attachments are more common in society than disorganized attachments, there is a disproportionally large number of children with disorganized attachments seen in psychiatry. Often there is a high correlation between trauma and disorganized attachment.[4]

Mental Health Providers as Attachment Figures

Clinical providers often become attachment figures for patients and their parents.[5] Attachment-informed practice does not mean conducting a specific type of psychotherapy, but rather having perpetual curiosity about attachment and what role it plays in relationships.

To promote secure internal working models of attachment, providers can consciously work to maintain a stance that is regulating, non-threatening, sensitive, synchronous, mentalizing, and radically accepting.[5] These are approaches that many providers are already utilizing, though we argue that clinical practice can be bolstered with increased awareness and intentionality. In order to provide a secure base to patients, providers must not only be curious about others' attachment states, but their own as well. In reflecting on their own histories and relational state of mind, providers increase their own and patients' mentalizing capacity too.[5] Providers willing to understand their own attachment history can provide a more stable base for their patients because they are more aware of how their own relational needs impact the provider-patient relationship.

Intersubjective Relatedness and Mentalizing States

Intersubjective relatedness or intersubjectivity can be understood as sharing intentions and feeling states.[6] Mentalizing is viewed as a manifestation of intersubjectivity and is a process that allows people to understand and make meaningful sense of their experience and that of others. Intersubjectivity is driven by the need to know and be known by others whereas attachment is driven by the need for security. Attachment and intersubjectivity complement each other—attachment facilitates security, intersubjectivity for belonging.

Further, intersubjectivity allows us to understand others by joining in, being with, or sharing the subjective experience of another person with no attempt to change it. It requires mutual regulation and recognition; allowing for two distinct, independent personal experiences while maintaining the ability to recognize and be recognized by the other.[6] Within this, there are two broad experiences—intersubjective and intrapsychic.[6] For the intersubjective experience ("I-Thou"), the other is outside one's mental field as a separate subject, while for the intrapsychic ("I-it"), mutuality is absent and the other exists within one's mental field as a product of the person's preexisting categories of people.[6] Recognition of these two processes within the therapeutic working relationship allows a more regulated exchange between practitioner and patient—asserting one's own reality and accepting the (potentially) opposing reality of another.[6] This lifelong process increases flexibility and willingness to experience the world from another's perspective while continuously being aware of one's own attachment and interactional style.[6] When practitioners mentalize, they can more consciously and intentionally respond to others as individuals with specific and unique needs.[6]

Tying Together in a Case Study

Ashley, a 14-year-old female with the complaint, "I think I have schizophrenia" presented for psychiatric evaluation of somatic symptom disorder. Hyperfocused on perceived limitations, Ashley pushed others away confirming to herself that she was broken. Feeling misunderstood, she pushed providers away. Like Ashley, insecurely attached (ambivalent/resistant) individuals increase outward distress in response to immense internal struggle.

Attachment informed therapy guided Ashley's care drawing connection between her insecure attachment and symptom perseveration. Through this process, mentalization improved and rigid defenses softened. A general attitude of curiosity was the foundation, such as, "I wonder why you think that," or, "I wonder what this was like for you." Instead of meeting resistance, she was praised for showing resilience. In turn, treatment engagement led to more focus on developmentally appropriate discussions about her life, and improved school and relationship outcomes. By approaching her in a regulating way, her pathological symptoms decreased, and she had improved functioning.

Points to Keep in Mind

Learning about attachment theory and reflecting upon one's personal attachment history can evoke uncomfortable feelings for providers. Use of attachment theory in clinical practice requires vulnerability from the provider to examine their own relational style and attachment

experiences. The following are some aspects to keep in mind when thinking about attachment theory.

First, the information in this article should be considered an introduction and brief summary. What is known about attachment and its clinical utility is rich and continues to evolve as investigators test and refine this theory. With that in mind, the most useful step to immediately take may be to simply start thinking about it as part of clinical practice. Just as providers consistently consider the biopsychosocial aspects of a case, they can also recognize attachment, including their role in promoting attachment security.

Next, to paraphrase Winnicott, it is important to remember there is no such thing as being a perfect parent. Neither is there a perfect doctor, a perfect teacher, a perfect partner, etc. It is important to pause judgment and demonstrate grace, while approaching relationships with curiosity so as not to diminish the capacity to mentalize.

Finally, secure relationships can be restorative for individuals classified as insecure or disorganized. Ongoing experiences in close relationships influence internal working models. Mental health providers have the chance to provide restorative experiences to patients, coworkers, trainees, and others by observing how they interact with others. It is amazing that by exploring and being curious about how we individually connect to others, we can ultimately help others build better relationships.

Take Home Summary

The application of attachment theory to clinical medicine is a meaningful and relevant method for conceptualizing cases. While many clinicians instinctually apply attachment principles when working with patients, providers' intentional use of attachment theory can improve patient care by both understanding their own attachment style and being able to identify that of their patients. Conscious awareness and use of attachment processes, such as mentalization, intersubjective relatedness, and attachments to mental health providers can allow clinicians to connect with patients more effectively, efficiently, and meaningfully across a variety of contexts.

References

1. Salcuni S. New frontiers and applications of attachment theory. *Front Psychol.* 2015;6:273. https://doi.org/10.3389/fpsyg.2015.00273
2. Gerretsen P, Myers J. The physician: a secure base. *J Clin Oncol.* 2008;10;26(32):5294-6. https://doi.org/10.1200/JCO.2008.17.5588
3. Bowlby, John. A Secure Base, Parent-child attachment and Healthy Human Development. London: Routledge;1998
4. Main M, Solomon J. Procedures for identifying infants as disorganized/disoriented during the Ainsworth Strange Situation. In: Attachment in the Preschool Years: Theory, Research, and Intervention. The John D. and Catherine T. MacArthur Foundation series on mental health and development. University of Chicago Press; 1990:121-160.
5. Holmes J, Slade A. Attachment in Therapeutic Practice. Sage Publications, Inc; 2018.
6. Wallin, David J. Attachment in Psychotherapy. New York: The Guilford Press; 2007.

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