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A Review of Attachment and Its Relationship to the Working Alliance
Analyse de l'attachement et de son lien avec l'alliance de travail

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ABSTRACT

Attachment theorists propose that attachment styles affect the development of relationships inside and outside of therapy. By integrating attachment theory into their work with clients, therapists may strengthen the working alliance and lower the risk of clients prematurely ending therapy. Attachment theory is reviewed, and methods of integrating it into counselling practice are discussed. Daly and Mallinckrodt's (2009) model of adapting therapeutic distance to establish safety in the therapy relationship is presented. Also reviewed is how therapists can integrate client culture into the adjustment of therapeutic distance.

RÉSUMÉ

Les théoriciens de l'attachement avancent que les styles d'attachement influencent le développement de relations à l'intérieur et à l'extérieur de la thérapie. En intégrant la théorie de l'attachement dans leur travail auprès des clients, les thérapeutes peuvent renforcer l'alliance de travail et réduire les risques que le client n'interrompe prématurément la thérapie. On passe en revue la théorie de l'attachement, tout en discutant des méthodes permettant de l'intégrer dans la pratique de counseling. On présente le modèle de Daly et Mallinckrodt (2009) d'adaptation de la distance thérapeutique pour sécuriser la relation de thérapie. On examine également la façon dont les thérapeutes peuvent intégrer la culture du client au réglage de la distance thérapeutique.

A strong working relationship contributes to positive therapy outcomes (Bohart & Tallman, 2010; Norcross, 2010; Wampold, 2010), and therapists' contributions to the working relationship predict alliance strength (Baldwin, Wampold, & Imel, 2007). Daly and Mallinckrodt (2009) suggested using attachment theory (AT) to adapt the working alliance to meet clients' needs. In this article, AT is presented as a construct that can be applied in the development of a positive working alliance across different models of counselling.

First, AT and the importance of the working alliance are discussed, and evidence for the importance of attachment in the relationship is outlined. Next, Daly and Mallinckrodt's (2009) model of therapeutic distance is reviewed, and methods to integrate client culture into this model are identified. Finally, recommendations for integrating client attachment needs into the development of the working alliance are provided. Attending to clients' attachment patterns can assist therapists

working within different theoretical paradigms in developing a positive working alliance.

AN OVERVIEW OF ATTACHMENT THEORY

Bowlby (1969, 1973, 1988) pioneered AT, but he has not been the only contributor to its development. Several other researchers have built upon Bowlby's initial hypotheses to expand AT across cultures. In this section, the development of AT is discussed, cross-cultural applications are examined, and the importance of self-awareness of therapist attachment is emphasized.

The Development of Attachment Theory

Bowlby (1969) developed AT to explain relational patterns. According to Bowlby, attachment to others is a cross-cultural survival mechanism that is favoured by evolution. He hypothesized that although individual attachment patterns may change through the lifespan, they usually do not. Attachment is defined by the ways that people engage with others in times of stress (Bowlby, 1969). Through interaction with caregivers, infants develop internal working models that inform how they interact with caregivers and others throughout their lifetime (Bowlby, 1988). Bowlby (1973) emphasized the importance of caregiver responsiveness in the development of attachment. AT "assumes that proximity seeking and activation of the attachment system are basic to intra- and interpersonal functioning" (L'Abate, 2009, p. 782).

Ainsworth, Bell, and Stayton (1971) built on Bowlby's (1969, 1973, 1988) theory of attachment, proposing that children form one of three patterns of attachment: secure, anxious resistant, and anxious avoidant. The first pattern, secure attachment, develops when infants are confident that their caregivers will be available and responsive (Ainsworth, Blehar, Waters, & Wall, 1978). Securely attached infants use the caregiver as a secure base from which to explore, confident that the caregiver will be available if needed (Pearce & Pezzot-Pearce, 2007).

Ainsworth et al. (1971) described two insecure patterns of attachment: anxious resistant and anxious avoidant. Anxious resistant infants are uncertain whether the caregiver will be available to them in times of need. They are prone to clinging behaviour. Ainsworth et al. proposed that some infants develop this pattern of attachment because their caregivers are inconsistently available—sometimes responsive and helpful, other times distant and unhelpful. Anxious resistant infants learn to over-express their feelings to increase the likelihood that the caregiver will respond (Pearce & Pezzot-Pearce, 2007).

Anxious avoidant attachment, in contrast, involves an infant's lack of confidence that the caregiver will ever respond helpfully (Ainsworth et al., 1971). Infants with anxious avoidant attachment patterns attempt emotional self-sufficiency. They avoid intimacy with the caregiver (Pearce & Pezzot-Pearce, 2007).

The three patterns of attachment described by Ainsworth et al. (1971) involve organized and predictable attachment styles. Main and Solomon (1986) proposed

a fourth pattern, disorganized-disoriented attachment, to identify infants whose behaviour does not represent an organized strategy for maintaining closeness to the caregiver. Infants displaying disorganized-disoriented attachment demonstrate fear and confusion about the caregiver (Pearce & Pezzot-Pearce, 2007).

Hazan and Shaver (1987) expanded AT into research with adults, outlining the similarities and differences between adult and childhood attachments. In adulthood, attachment relationships are usually reciprocal, with both partners giving and receiving support (Hazan & Shaver, 1987). In addition, adult attachment figures are commonly peers and sexual partners rather than caregivers. Like childhood attachment relationships, adult relationships are satisfying to the extent that an individual's basic needs are met, but they often persist when basic needs are not met. Hazan and Shaver (1994) described the persistence of Ainsworth et al.'s (1971) attachment patterns and classifications (secure, anxious ambivalent, and anxious avoidant) in adulthood.

Based on Ainsworth et al.'s (1971) classification system, Bartholomew and Horowitz (1991) proposed a four-category model of attachment involving an internal working model (IWM) of the self and an IWM of others. Secure individuals have a positive IWM of themselves and others, while preoccupied individuals view themselves negatively and others positively. Dismissing individuals have a positive IWM of themselves and a negative IWM of others, and fearful individuals view both themselves and others negatively. Bartholomew and Horowitz's description of a secure attachment style remained consistent with Ainsworth et al.'s (1971) description, and the preoccupied group corresponded with an anxious ambivalent attachment style. Bartholomew and Horowitz broke the avoidant attachment style into two categories: individuals who avoid intimacy due to fear of rejection (fearful), and individuals who avoid intimacy because they do not value connection with others (dismissing).

Relational Cultural Theory builds further on AT, suggesting that all individuals need connection throughout the lifespan. Individuals flourish through building connections with others (Jordan, 2008). According to Jordan (2008), attachment to others is not only an important facet of relationships; it is a driving force of development and well-being.

Currently, researchers agree that adult attachment patterns cannot be identical to patterns formed in infancy (Broderick & Blewitt, 2010). Welch and Houser (2010) found that relationship satisfaction, hope, and self-disclosure are all relevant predictors of attachment in adults. According to Bowlby (1988), although the attachment patterns that individuals form in infancy tend to persist in adulthood, they may change. Sroufe, Egeland, Carlson, and Collins (2005) supported Bowlby's hypothesis, finding that adults with insecure attachment patterns could develop a secure attachment style when they experienced supportive adult relationships. Therefore, therapists have an opportunity to facilitate change through establishing stable and supportive relationships with their clients.

Attachment and Culture: Expanding Applicability

Attachment researchers have focused primarily on research with White North American and European populations (Metzger, Erdman, & Ng, 2010), which has some researchers questioning the cross-cultural validity of the model. Cultural contexts shape human behaviour (Allwood & Berry, 2006; Wang & Song, 2010), so an inclusive theoretical model should recognize the importance of context. Several authors have expanded the research base of attachment to increase its cross-cultural validity. Evidence supports the hypothesis that basic concepts of attachment are universal, although culture plays an important role in how individuals develop and express attachment (Metzger et al., 2010; Wang & Mallinckrodt, 2006).

Wang and Song (2010) examined AT within the context of Chinese culture. They asserted that in order to understand attachment in Chinese clients, therapists must consider factors such as fatalistic beliefs, social structure, interpersonal norms, behavioural guidelines, and relational status. Wang and Song contended that in contrast to Western ideals for self-appraisal, the fulfillment of social role responsibilities determines personal self-worth in Chinese culture. Although labels may differentiate attachment styles for Chinese adults, in order to get a complete picture, therapists must consider how attachment develops.

Like Wang and Song (2010), Imamoğlu and Imamoğlu (2010) asserted that in order to understand attachment, therapists should consider cultural and individual drives to individuation and relatedness. They discussed the importance of investigating family contexts in the development of attachment in order to understand the impact of culture. Behrens (2010) agreed, noting that the importance Japanese culture places on closeness between mother and infant has contributed to a relatively high number of Japanese children categorized as anxious-resistant (Mizuta, Zahn-Waxler, Cole, & Hiruma, 1996; Rothbaum, Kakinuma, Nagaoka, & Azuma, 2007). According to Bowlby (1988), infants' interactions with caregivers are the basis for the development of IWMs, which inform behaviour. Rothbaum, Weisz, Pott, Miyake, and Morelli (2000) discussed differences in what Japanese and American culture consider sensitive parenting. In the United States, sensitive parenting involved responding to infants' needs to individuate; in Japan, sensitive parenting involved a response to infants' needs for social contact (Rothbaum et al., 2000). Culturally informed definitions of sensitivity may play a role in the differences between Japanese and American infants' IWMs.

Yalçinkaya, Rapoza, and Malley-Morrison (2010) examined the cross-cultural research on attachment and found patterns of adult attachment security and insecurity across cultures. However, the distribution of individuals displaying each attachment pattern varied cross-culturally. Similarly, Fiori, Consedine, and Magai (2008) drew attention to differences in adult attachment distributions among seven American ethnic groups. Yalçinkaya et al. (2010) asserted that AT provides a useful construct for understanding behaviour, but these differences in frequency indicate a need to reconsider the labelling of attachment patterns. Attachment patterns, such as self-expression, that are labelled as secure are not

necessarily desirable in many cultures: collectivist cultures may favour patterns associated with social inhibition, which is related to insecure attachment. Rothbaum et al. (2000) noted that in Japan, social inhibition is favoured; children are encouraged to keep their feelings to themselves to maintain social harmony. Attachment is a useful construct for understanding behaviour, but in order to appropriately apply AT, therapists should consider the ways in which attachment manifests across cultures.

Therapist Attachment

Meyer and Pilkonis (2001) emphasized that although client attachment patterns are important factors in therapy, therapists should also consider their own attachment styles. They suggested that therapists with secure attachment styles may handle ruptures in the relationship more easily than therapists with preoccupied attachment styles. Several researchers have examined this hypothesis.

Rubino, Barker, Roth, and Fearon (2000) found that therapists' attachment styles may influence their ability to empathize with clients. Specifically, preoccupied therapists tended to respond to clients less empathically. Similarly, Mohr, Gelso, and Hill (2005) found high rates of countertransference in the therapy relationship when counsellor trainees had a fearful or dismissing attachment pattern and clients had a preoccupied pattern. Romano, Fitzpatrick, and Janzen (2008) found that secure attachment in therapists contributed to session depth.

There is not much research on the impact of therapist attachment on the working alliance and therapy outcomes. However, awareness of personal attachment may help therapists identify their own triggers and determine whether they naturally meet or challenge specific clients' attachment needs. After all, "The person of the therapist is a fundamental part of the alliance … Clients react to therapists as therapists but also as people" (Sprenkle, Davis, & Lebow, 2009, p. 92). By increasing awareness of their own attachment patterns, therapists may avoid personal reactions that set off clients and potentially lead to premature termination of counselling. In the next section, the importance of the working alliance is examined.

THE WORKING ALLIANCE: A REVIEW

Bordin (1979) hypothesized that therapists could conceptualize the working alliance in terms of three features: an agreement on the goals of therapy, an agreement on the tasks involved in attaining those goals, and an affective bond between client and therapist. He asserted that while some level of trust is present in all therapy relationships, deeper bonds between the therapist and client may strengthen the alliance, especially when clients discuss aspects of themselves that may be difficult to share. Across theoretical orientations, therapists agree that a positive working alliance is important. In this section, the working alliance is discussed as an empirically supported key ingredient of change, followed by some methods for managing the alliance.

As part of a task force commissioned by the American Psychological Association, Ackerman et al. (2001) outlined support for empirically supported relationships in therapy. They asserted that therapists can enhance therapy outcomes by adapting the relationship to meet client needs. In line with this idea, Common Factors Theory (CFT) acknowledges the importance of the therapy relationship. According to CFT, all reputable forms of therapy are equally effective when delivered competently to a motivated client (Wampold, 2010). The four common factors of change described by Hubble, Duncan, Miller, and Wampold (2010) include client and external factors, models and techniques, therapist factors, and the working alliance. In order to work most effectively with clients, therapists should consider all four factors of change.

Hubble et al. (2010) suggested that the working alliance is an important contributor to therapy outcome. Similarly, Norcross (2010) asserted that establishing a positive working alliance should be a primary aim of therapy. Goldfried and Davila (2005) asserted that "[s]trong, positive, trusting relationships can provide therapists with the power that is necessary to allow clients to tolerate … feedback and to have feedback make an impact on them" (p. 428). Because the working alliance is an important factor in therapeutic success, therapists establishing stronger alliances experience more positive outcomes in therapy (Goldfried & Davila, 2005; Hubble et al., 2010; Wampold, 2010). The important role a strong working alliance plays in therapy is virtually undisputed.

What We Know: Managing the Working Alliance

Rogers (1957) began a movement toward focusing on the working alliance in therapy. He suggested that a positive therapy relationship presents both necessary and sufficient conditions for change. By being present with clients and conveying empathy, genuineness, and unconditional positive regard, therapists establish a positive working relationship with clients. Building on the therapeutic relationship, clients improve their views of themselves and general well-being (Cain, 2010).

While many theorists agree that conveying empathy, genuineness, and positive regard are important for building a positive working alliance, few believe that these conditions are sufficient. Prochaska and DiClemente (1984) proposed a transtheoretical model for tailoring the working alliance to match client readiness for change. The model involves a progression through four stages: precontemplation, contemplation, action, and maintenance. Matching the therapeutic relationship and tasks of therapy to the client's stage of change enhance therapy outcomes (Prochaska & DiClemente, 1984).

Another factor in establishing a positive working alliance is the integration of motivational interviewing techniques (Miller & Rollnick, 2002). Miller and Rollnick (2002) contended that all clients are motivated in therapy; one responsibility of therapists is to find and activate that motivation. Rollnick, Miller, and Butler (2008) suggested that therapists can help clients tap into their motivation through resisting the urge to quickly fix problems, instead focusing on listening to and understanding clients.

Another suggestion for building a strong alliance comes from Siegel's (2010) work on mindfulness and therapy. Siegel suggested that to create bonds with clients and facilitate change, therapists must be mindful. Therapists can practice mindfulness in therapy through being fully present with clients and by being intentional in their engagement; mindfulness involves a state of awareness that fosters flexibility and receptiveness (Siegel, 2010). Siegel's work ties into Bergum and Dossetor's (2005) principles of relational ethics. Bergum and Dossetor suggested that a therapist's way of being can enhance the therapy alliance. Through self-reflection, focusing on connecting with clients, sharing power, and attending actively in session, therapists promote a form of ethics that embodies respect for and genuine interest in clients.

making connections: attachment and the working alliance

Researchers agree that attachment affects the ways in which people interact (Yalçinkaya et al., 2010), and also that interactions between clients and therapists affect therapy outcomes (Baldwin et al., 2007; Goldfried & Davila, 2005; Norcross, 2010). In this section, reasons and strategies for integrating AT into practice are discussed. Daly and Mallinckrodt's (2009) ideas about adjusting therapeutic distance are introduced. Finally, ways to integrate client culture into the use of therapeutic distance are identified. Therapists across theoretical orientations can adjust therapeutic distance with their clients in the development of a strong working alliance.

Why Integrate Attachment?

Research suggests that therapists should engage with clients in ways that foster a positive working alliance. Several researchers have studied the impact of client attachment style on the working alliance and found client attachment to be a predictor of both working alliance and therapy outcome (Bachelor, Meunier, Laverdière, & Gamache, 2010; Byrd, Patterson, & Turchik, 2010; Eames & Roth, 2000; Marmarosh et al., 2009; Meyer & Pilkonis, 2001). In order to effectively tailor the working alliance to client needs and form an empirically supported relationship (Ackerman et al., 2001), therapists must consider client attachment in the development of the working alliance. This section describes the relationship between client attachment and the working alliance.

Clients who have secure attachment styles tend to form better alliances with their therapists. Bachelor et al. (2010) looked at how client attachment impacts the working alliance. They found that clients with secure attachment were more in agreement with their therapists regarding goals and tasks, had greater bonds with therapists, and engaged more actively in therapy. Similarly, Romano et al. (2008) observed that client attachment security correlated positively with session depth. Byrd et al. (2010) found that securely attached clients were more comfortable with closeness in therapy and formed stronger alliances with therapists.

While clients demonstrating secure attachment patterns tend to form stronger working alliances with therapists, clients with dismissing attachment patterns form weaker bonds (Marmarosh et al., 2009). Bachelor et al. (2010) found that clients with dismissing attachment patterns consistently had poor therapeutic outcomes. Clients demonstrating dismissing attachment patterns may require targeted interventions to solidify a therapy bond (Meyer & Pilkonis, 2001). Like clients demonstrating dismissing attachment patterns, clients with preoccupied attachment styles give lower ratings to the working alliance (Eames & Roth, 2000; Mohr et al., 2005). Woodhouse, Schlosser, Crook, Ligiéro, and Gelso (2003) found that clients with preoccupied attachment also had higher rates of negative transference in therapy sessions.

Sprenkle et al. (2009) asserted that "[t]herapists must always remain well aware of who their clients truly are in order to establish alliance … The therapist must remain true to self and yet adapt to the clients seen" (p. 91). Clients are all different, and what works to establish a relationship with one client is different from what works with another (Ackerman et al., 2001; Bohart & Tallman, 2010; Sprenkle et al., 2009). The consideration of, and adaptation to, client attachment style is one variable that will assist therapists in facilitating a positive working alliance.

Applying Attachment Theory: Emotion-Focused Therapy

Client attachment styles impact the working alliance and therapy outcomes, and the recognition of the role attachment plays in therapy is not new. In Emotion-Focused Therapy (EFT), therapists focus on client emotion as a way of organizing views of the self and others in close relationships (Karakurt & Keiley, 2009). Emotion drives attachment responses (Karakurt & Keiley, 2009), and attachment style impacts emotional reactions (Crawley & Grant, 2005). Emotion-focused therapists focus on feelings of closeness and trust that are related to client attachment, helping clients recognize and gain control of their patterns of emotional responding (Greenberg, 2002).

In an interview with Young (2008), Johnson asserted that AT provides an understanding of what does and does not work in relationships. Johnson stated that the basic goal of couples' therapy from an EFT perspective is to "help people step out of negative cycles that increase their attachment insecurity … and help them step into a place where they can dance together in a more accessible and responsive manner" (p. 266). In order to affect a lasting change with clients, Johnson suggested that therapists must engage them at a level in which they are accessible and responding emotionally.

Emotion-focused therapists use several interventions in their attachment-based work with clients (Johnson, 2009). First, therapists engage and bond with clients through tracking and reflecting on clients' experiences, emphasizing emotions associated with attachment figures. Next, therapists validate clients' emotional experiences, using AT to explain client emotions and behaviours. Therapists then evoke deeper engagement with clients, actively tracking and reflecting client-therapist engagement. Finally, therapists help clients reframe emotions in ways that

lead to positive outcomes, providing opportunities to practice secure engagement (Johnson, 2009). Using AT as a guideline, therapists using EFT help clients gain awareness of relationship patterns and work with clients to change patterns that are not working for them.

Beyond Emotion-Focused Therapy: Other Model-Specific Uses of Attachment Theory

Although emotion-focused therapists are well known for their use of AT in sessions, therapists practicing within different theoretical orientations can apply AT in establishing a working alliance and a plan for therapy. Several authors from a diverse range of theoretical paradigms have provided frameworks for the integration of client attachment into their work (Dallos & Vetere, 2009; Eagle & Wolitzky, 2009; Florsheim & McArthur, 2009; McBride & Atkinson, 2009).

AT has several implications in the application of Psychoanalytic Theory. Eagle and Wolitzky (2009) contended that AT's greatest application in Psychoanalytic Theory concerns the therapist's function as a secure base: as a secure base, the therapist can assist the client in making the inner structural changes that occur in successful psychoanalysis. From a psychoanalytic perspective, client struggles occur as the result of inner conflicts. AT can shed light on these conflicts, as client attachment styles represent adaptive strategies to have basic needs met (Eagle & Wolitzky, 2009). The client's inner conflict lies in the free expression of emotion amidst expectations that the attachment figure may not provide comfort (Eagle & Wolitzky, 2009).

Florsheim and McArthur (2009) proposed that AT has important applications within the context of Interpersonal Therapy (IPT). From the perspective of AT, goals of therapy often involve enhancing attachment security. While AT may clarify the goals of therapy, IPT provides a framework for how to proceed with therapy. Interpersonal therapists address attachment insecurity by focusing on current relationships and supporting the client in trying different strategies to build security (Florsheim & McArthur, 2009).

AT can also be integrated into Cognitive-Behavioural Therapy (CBT; McBride & Atkinson, 2009). Therapists practicing from a CBT perspective often focus on client schemas, which relate to the IWMs proposed by AT. As with schemas, either internal or external stimuli can activate IWMs (McBride & Atkinson, 2009). AT can inform CBT by providing insight into client schemas. Through recognizing these schemas, therapists can apply interventions that are an appropriate fit for their clients (McBride & Atkinson, 2009).

There are several other points of convergence between AT and CBT. Both theories recognize the importance of the therapy relationship and the idea that therapists may provide a safe place (or secure base) from which to work toward client goals (McBride & Atkinson, 2009). According to AT, therapists should explore patterns in relationships; in CBT, therapists explore patterns through the concept of schemas. Both CBT and AT acknowledge that the therapy relationship provides information regarding an individual's relational style that can highlight underlying schemas/IWMs. Finally, in CBT, therapists encourage clients to rec-

ognize and adapt maladaptive models of the self; AT provides a framework for understanding clients' IWMs and the adaptive functions they serve (McBride & Atkinson, 2009).

From a postmodern perspective, therapists view clients as capable rather than pathological. Each client's experience is unique and based on his or her political, social, familial, and cultural experiences (Guterman, 2006; Payne, 2006). AT fits into postmodern beliefs by providing a framework to explain the patterns that clients develop. Attachment theorists view attachment styles as adaptive behaviours rather than individual deficiencies (Pearce & Pezzot-Pearce, 2007). While these behaviours have adaptive origins, they do not necessarily benefit the client. Through understanding the development of attachment patterns, therapists working within postmodern frameworks can understand clients' relational patterns.

Dallos and Vetere (2009) suggested that narrative therapists can integrate attachment into their work. One of the key premises of narrative therapy is the idea that individuals create stories based on past experiences, and these stories guide current and future thoughts, feelings, and behaviours. AT provides insight into the creation of individual narratives, including memories and beliefs about how significant others have reacted and will react in times of stress (Dallos & Vetere, 2009). Therapists working from a narrative perspective can work with clients to review their stories within the context of attachment, considering alternatives for present and future relationships.

Therapeutic Distance

The previous sections discussed model-specific ways to integrate attachment into therapy. This section presents Daly and Mallinckrodt's (2009) concept of therapeutic distance and discusses how therapists can adjust therapeutic distance based on client attachment patterns.

Shaver and Mikulincer (2009) described the strategies individuals employ when others do not meet their needs for security as deactivation and hyperactivation. People use hyperactivating strategies when the attachment figure is inconsistently available in times of stress. These strategies include exaggerating danger and distress, and intensifying demands for attention and support. Hyperactivation is associated with adults who have a preoccupied attachment style. Conversely, individuals employ deactivating strategies when the attachment figure is consistently unavailable. The purposes of deactivation are escape, avoidance, and minimizing pain. Deactivation is associated with dismissing and fearful adult attachment styles.

One way to attend to the different needs of hyperactivating and deactivating clients is through adapting therapeutic distance (Daly & Mallinckrodt, 2009). Mallinckrodt (2010) described therapeutic distance as "the level of transparency and disclosure in the psychotherapy relationship from both client and therapist, together with the immediacy, intimacy, and emotional intensity of a session" (p. 266). Simply put, therapeutic distance refers to the emotional closeness or distance

between client and therapist. Through adapting therapeutic distance to client attachment style and stage of therapy, therapists can maintain a strong alliance with clients while meeting therapy goals and promoting secure attachment.

Mallinckrodt (2010) proposed that therapists and clients can gain an optimal level of therapeutic distance by adjusting it through the course of therapy. However, to establish a strong alliance in the initial stages of therapy and reduce the risk of clients dropping out of therapy, therapists should engage with clients in ways that match clients' needs regarding therapeutic distance (Mallinckrodt, Daly, & Wang, 2009).

In the engagement phase of therapy, Mallinckrodt et al. (2009) suggested meeting the needs of hyperactivating clients by providing reassurance and evidence of positive regard. As clients reveal more about themselves in the initial stages, therapists should focus on expressing warmth and acceptance. In addition, hyperactivating clients may feel more connected to and supported by therapists who set less strict boundaries in the early stages of therapy (Mallinckrodt et al., 2009).

Therapists can initiate strong alliances with deactivating clients early in therapy by allowing time for a close relationship to establish (Mallinckrodt et al., 2009). Engaging deactivating clients too quickly may trigger defensiveness and cause withdrawal from or within therapy. To promote safety in the initial stages of therapy with deactivating clients, therapists can give clients control of the therapy sessions, perhaps remaining at an intellectual level and avoiding pressure to disclose (Mallinckrodt et al., 2009).

As therapy progresses and strong alliances are forged, Mallinckrodt et al. (2009) suggested watching for transition markers signalling that the client is ready to transition to the working stages of therapy. Transition markers include client commitment to change, reports of extratherapeutic behaviour changes, tolerance for intense emotions in sessions, and demonstration of readiness to do therapeutic work. The use of transition markers as indications of readiness to progress in therapy reflects Prochaska and DiClemente's (1984) model of client stages of change, bringing together two methods for strengthening the working alliance.

In the working phase of therapy, Mallinckrodt et al. (2009) proposed that the goal should be to work gradually toward establishing a closer relationship with deactivating clients and a more distant relationship with hyperactivating clients. To do this, therapists should monitor the therapeutic distance sought by the client, recognize the optimal distance for the relationship, and work carefully to bring the distance to its optimal level. Progress toward optimal therapeutic distance is not linear, and often therapists will need to backtrack to retain clients' feelings of safety in the alliance (Mallinckrodt et al., 2009).

During the working phase of therapy, hyperactivating clients continue to seek comfort and support, but the therapist should not always gratify this need (Mallinckrodt, 2010). A hyperactivating client may become frustrated when the therapist does not satisfy her/his needs for comfort. However, because the working alliance is strong, the client and therapist can discuss the client's feelings and perceptions, developing client autonomy and affect regulation.

While in the working phase with deactivating clients, therapists should strive to achieve a closer relationship (Mallinckrodt, 2010). Clients may feel some anxiety at the reduction of distance, but the safety of the relationship can help moderate these feelings. Eventually, clients may become more comfortable with intimacy in the therapy relationship and develop a greater capacity to seek support from others.

Applying Therapeutic Distance

Clients with different attachment patterns may have different levels of risk for prematurely ending therapy (Levy & Kelly, 2009) and may benefit from different therapy approaches. Meyer and Pilkonis (2001) suggested that clients may require different interventions based on their attachment orientations; dismissive clients may require interventions that facilitate emotional expression, while preoccupied clients may require support in overcoming intense emotions. Similarly, Levy and Kelly (2009) suggested that in work with preoccupied clients, it may be important to maintain structure and predictability; in work with dismissing clients, therapists should proceed slowly to avoid provoking clients to withdraw. Through attending to how clients tell their stories, therapists can gain insight into how they relate to others, what feelings they tolerate, and what they need from the therapist in order to feel safe in therapy (Bachelor et al., 2010). Mallinckrodt's (2010) model integrates these ideas by proposing that therapists initially match their clients' needs for closeness or distance in therapy. By adjusting the ways in which therapists engage clients with different attachment styles, they can increase the likelihood of positive therapy outcomes for clients with both secure and insecure attachment styles.

Daly and Mallinckrodt's (2009) proposal to adjust therapeutic distance does not adhere to any specific theoretical orientation. Like Rogers (1957), Prochaska and DiClemente (1984), and Miller and Rollnick (2002), Daly and Mallinckrodt's ideas are model-general. Daly and Mallinckrodt (2009) do not discuss specific techniques for adjusting therapeutic distance, so therapeutic distance can be adapted to various frameworks.

Therapists working from a variety of theoretical perspectives integrate Rogerian values (Rogers, 1957), stages of change (Prochaska & DiClemente, 1984), and motivational interviewing (Miller & Rollnick, 2002) into their practice. Like these concepts, therapeutic distance focuses on enhancing the working alliance. Also like these concepts, a goal of adjusting therapeutic distance is to meet client needs. Adjusting therapeutic distance is one more way for therapists to accommodate their clients.

Most therapists recognize the importance of establishing a strong working alliance with clients. Daly and Mallinckrodt (2009) outlined client factors and therapy pacing as useful for therapists regardless of theoretical orientation. Their model for working with clients demonstrating insecure attachment patterns serves several purposes. First, a focus on client attachment may help therapists to initially proceed with clients in ways in which the clients are comfortable, thereby reducing the risk of early drop-out from therapy. Second, therapists can build a strong working alliance with clients to enhance the probability of positive outcomes. Finally,

through slowly and gently challenging client attachment patterns, therapists can help clients develop styles of engaging with others in ways that will lower their levels of distress. The next section discusses how therapists can consider client culture in helping clients adjust their relational patterns.

Client Culture and Therapeutic Distance

Several theorists have criticized AT for being culturally insensitive (Metzger et al., 2010; Rothbaum et al., 2007). Attachment classifications are based on Western values of what is desirable. Behaviours that match Western values of independence are classified as secure attachment, while behaviours that demonstrate interdependence and a greater desire for closeness are classified as insecure (Rothbaum et al., 2007). However, despite a culturally insensitive labelling system for attachment patterns, AT provides a useful framework for understanding how clients interact with others. This section proposes that therapeutic distance can be applied with cultural sensitivity based on what clients hope to achieve in their relationships with others.

Mallinckrodt et al. (2009) discussed the optimal level of therapeutic distance between client and therapist, acknowledging that the optimal level will be different for each client. They proposed that the level of therapeutic distance that the client initially seeks to establish may be different from what the therapist views as optimal. Therapists operating from a Western worldview may have beliefs about optimal levels of therapeutic distance that differ from the cultural worldviews of their clients. Without understanding client culture, therapists may impose their own values of an optimal level of therapeutic distance. For example, working toward a greater therapeutic distance with a client who has cultural values of interdependence and closeness fails to address the client's cultural context.

Clients often come to therapy because of difficulties in relationships with others. Through examining what is not working and discussing client hopes for improving relationships, therapists can learn about the levels of relational closeness that the client desires. Considering client relational goals can assist therapists in determining an optimal level of therapeutic distance, which may or may not coincide with secure attachment patterns. Through integrating client culture, therapists can honour the relational goals of clients and avoid imposing their own perspectives of what client attachment should be.

RECOMMENDATIONS

Several authors have indicated the importance of a strong working alliance in therapy (Ackerman et al., 2001; Hubble et al., 2010; Norcross, 2010), and that attachment patterns play a role in these relationships (Bachelor et al., 2010; Byrd et al., 2010). Daly and Mallinckrodt (2009) furthered this idea by developing a guideline for integrating client attachment into the working alliance, but their description does not emphasize the importance of respecting client culture in determining what is optimal in attachment.

The following recommendations are based upon the importance of the alliance, the importance of cultural integration, and Daly and Mallinckrodt's (2009) method for considering client attachment in the development of the working alliance. Therapists are advised to

1. Consider client attachment when developing a working alliance, regardless of the theoretical paradigm from which they are working. Therapists across theoretical paradigms integrate strategies to enhance the working alliance. By including client attachment as a consideration, therapists can add one more dimension that may enhance the working alliance. This recommendation is supported by Ackerman et al. (2001), who asserted that a stronger alliance improves therapy outcomes.
2. Initially match therapeutic distance to client needs for safety in the relationship. Mallinckrodt (2010) suggested that initially meeting client attachment needs may reduce client anxiety and decrease the risk of premature termination of counselling.
3. Discuss client cultural values with clients, including factors such as closeness versus distance in relationships and independence versus interdependence. Through gaining a clear picture of client values regarding these factors, therapists avoid making assumptions and imposing their own perspectives on what is optimal attachment.
4. Determine what relational goals a client has during and outside of therapy. By discussing relational goals with clients, therapists determine whether relationships and attachment style are a source of distress for the client. With this knowledge, therapist and client may discuss whether working on client attachment patterns is an appropriate goal. Therapists may then adjust therapeutic distance to initially meet and subsequently challenge client attachment needs as appropriate for each client.
5. Determine an optimal level of therapeutic distance in therapy relationships based on client attachment style, culture, and therapy goals. This optimal distance may or may not fall into a secure attachment classification. By integrating each client's culture into the assessment of attachment, therapists respect that their clients' perspectives of what is an appropriate level of therapeutic distance may be different from what the therapist believes is appropriate distance in relationships.
6. Gradually adjust therapeutic distance toward the optimal level for each client. Through working gradually on attachment, rather than challenging client attachment patterns outright or ignoring them altogether, therapists can help clients develop relational patterns that lower their distress and help them meet their relational goals outside of therapy.
7. Develop and maintain awareness of their own attachment patterns. By recognizing their own attachment styles and triggers, therapists may be more present in their sessions and avoid reactions that may in turn trigger their clients. If clients feel safe in therapy, they may be less prone to anxiety regarding therapy and premature termination of therapy.

DIRECTIONS FOR FUTURE RESEARCH

AT has been criticized for a lack of cross-cultural validity. Cultural research on AT is primarily focused on client ethnicity. Arthur and Collins (2010) discussed an expanded definition of culture, which includes socioeconomic status, age, ethnicity, gender, ability, religion, and sexual orientation. To gain a clear picture of the impact of culture on attachment, future researchers must look beyond ethnicity to include other aspects of culture. While examining different aspects of culture, researchers may establish a way to differentiate attachment style without culturally insensitive labelling.

In this article, AT was presented as a construct with clinical utility across theoretical orientations. However, Mallinckrodt et al.'s (2009) suggestions for the applications of AT to the working alliance require research to confirm clinical effectiveness. In order to integrate attachment more confidently into the working alliance, practitioners will need evidence that adapting therapeutic distance positively impacts the working alliance, drop-out rates, and therapy outcomes.

Therapists present their own attachment patterns in the therapy relationship (Meyer & Pilkonis, 2001; Rubino et al., 2000). As such, one potential focus for future research lies in an examination of therapist ability to adapt relational style and strategies within personal attachment patterns. Another potential area for future research may lie in examining the extent to which self-awareness of personal attachment mediates how a therapist's attachment affects therapy.

A final direction for research concerns the interplay between client and therapist attachment, and the concept of attachment matching. Tyrrell, Dozier, Teague, and Fallot (1999) examined how client and therapist attachment styles affected the working alliance. These researchers found that deactivating clients formed stronger alliances with therapists who were not deactivating, whereas clients who did not use deactivation formed stronger alliances with therapists who had deactivating patterns. Although this study suggests a positive alliance is more likely to form between clients and therapists who have differing attachment styles, more research may reveal the specific therapist factors that appeal to clients with particular attachment styles.

SUMMARY

Researchers and therapists recognize that the working alliance is a significant predictor of therapy outcome. A strong working alliance is also related to lower rates of premature termination of therapy. In this article, AT was presented as a relationship-strengthening tool across theoretical orientations. Through awareness of client and therapist attachment patterns, integration of client cultural values, and modifications of therapeutic distance, therapists can meet the relational needs of clients. By establishing a secure relationship with clients, therapists can also help them engage in more satisfying relationships outside of therapy. If the goals of therapy are to strengthen clients' ability to cope with problems, it is the therapist's responsibility to integrate every known means to develop a relationship that will

encourage client growth. Integrating an awareness of client attachment styles can help therapists do just that.

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