

## **USING ATTACHMENT THEORY TO UNDERSTAND THE TREATMENT OF ADULT DEPRESSION**

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*ABSTRACT:* John Bowlby developed attachment theory to explain connections between infant and caregiver behavior and how these impacted children's behavior. Extended and researched heavily in a variety of contexts, attachment theory has advanced clinical thinking over time. Its core ideas regarding infant and caregiver connections are very useful to mental health practitioners today and have particular ramifications for clinical work with adults. This paper discusses the application of Bowlby's attachment theory to the clinical treatment of adult depression and explores a relevant case example.

*KEY WORDS:* attachment; adult psychotherapy; depression.

### **INTRODUCTION**

Attachment theory has significant ramifications for clinical social work with adults. These days, the understanding of attachment in mental health settings is complex and ever-evolving (Rutter, 1995). However, a solid understanding of a client's attachments drives treatment in more productive ways. For example, a clinician who understands the attachment style of the client he or she is working with, as well as the resiliency and risks of that attachment style, is better prepared to provide sensitive, appropriate treatment. In this article,

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I will explore how the tenets of attachment theory apply usefully to the treatment of depressed adults.

## ORIGINS OF ATTACHMENT THEORY

John Bowlby is generally regarded as the founder of attachment theory (Karen, 1994). Trained in England as a psychoanalyst and scientist, Bowlby developed ideas which challenged Freud's long-held notions of humans as compelled by their drives. Bowlby saw humans as compelled by relationships and particularly by their need in infancy to attach to a primary caregiver. In his early papers and later books (1940, 1944, 1958, 1969/1982, 1973, 1980), Bowlby developed a new theory. He hypothesized that children are born with a predisposition to be attached to caregivers and that children will organize their behavior and thinking in order to maintain those relationships. Bowlby believed that caregiver relationships are crucial to children's psychological and physical survival. Further, attachment theory asserts that children often maintain caregiver relationships at significant cost to their own functioning and that distortions in children's feeling and thinking occur typically in response to parents' inability to meet children's needs for comfort, security, and emotional reassurance (Slade, 1999). Attachment theory asserts that one internalizes the experience of one's earliest caregivers, believing that others in life will act similarly to those early providers.

Bowlby conceived attachment theory as having important ramifications for the treatment of infants and children, but more recently attachment theory has been applied to adults (Dozier, Stovall, & Albus, 1999; George, Kaplan, & Main, 1985/1995; Main & Hesse, 1990). There is now strong empirical support for Bowlby's conviction that early family experience is related to later personality functioning and relationships (Amini et al., 1996, as cited in Sable, 2000). Moreover, current theorists posit that adults have attachment needs similar to those of children, needs which are met through adult attachment relationships with romantic partners, peers, and family members (Feeny, 1999).

Recent application of attachment theory to adulthood has considered how childhood patterns of attachment present as relational and sometimes pathological patterns in adulthood (Dozier et al., 1999; Holmes, 2001; Slade, 1999). Sable (2000) asserts that in childhood, environmental deficits like inconsistent or rejecting caregiving, negatively impact healthy development and "...introduce corresponding distortions and lack of coherence in working models that continue to

affect the person as an adult. Symptoms of anxiety, depression, or anger, therefore, are responses to disruptions of personal bonds..." (p. 56).

Sable's statement is significant for clinical work as it allows us to reconceptualize adult symptomatology in attachment terms. Adult symptoms of depression may be indicative of problematic internal working models, rather than just biochemical imbalances as suggested by scientific press. Symptoms of depression or anxiety may be expressions of adult relational isolation created by difficult early relationships.

Reconceptualizing treatment in attachment terms suggests a rethinking of the goals of adult psychotherapy. Holmes (2001) suggests, "the overall goals of therapy can be summarized as the search for intimacy and autonomy and that the capacity for intimacy arises out of attunement, while a sense of autonomy comes from the successful expression of healthy protest, and, where loss is irretrievable, grieving" (p. 49). Holmes conceives of therapy as replaying early processes of intimacy and autonomy and thus healing adults' early experiences with caregivers. He continues, "The aims of therapy are to provide an environment that fosters attunement, is secure enough to cope with relevant protest and therefore, where new meanings...can arise" (p. 49). Sable (2000) states, "The working model of the therapeutic relationship eventually exerts dominance over hurtful experiences and models of the past, countering the patient's image of himself as unlovable and unworthy of secure affectional ties" (p. 333). Both authors conceptualize therapy as healing adults' pain through attuned, empathic connection between therapist and client. Both authors also see this connection as providing reparative relational experiences for clients, experiences which will eventually reduce clients' distress.

Attachment theory thus provides a framework in which to view adult therapy in a new way. However, a case best illustrates this application of attachment theory to adult psychotherapy. I focus my case example on the attachment relationships of my client, the functions of those relationships and how those impacted the clinical work and its goals. An attachment-oriented approach to adult psychotherapy is useful even in relatively brief treatment, as seen in the case example described below.

## CASE EXAMPLE

### *Background and History*

Nate was a 29-year-old Caucasian man, who referred himself to the counseling center at the major state university he attended. He presented to the

center requesting individual outpatient treatment because of his concerns about his depression. He stated at intake that his depression, currently treated by an anti-depressant medication, had been on-going for several years and included symptoms of sleeplessness, feeling of hopelessness, anhedonia, and frequent thoughts of suicide. He noted that he experienced some symptoms of depression beginning in junior high, but was unable to recall specific details. Nate reported that he had one serious suicide attempt less than a year ago, when he took an overdose of sleeping pills, subsequently called a friend, and recuperated in a hospital for one day.

When Nate began treatment, he displayed symptoms of psychomotor retardation. He spoke slowly with long pauses between phrases and walked at a snail's pace to the treatment room every week. Vocabulary and intelligence suggested below average intelligence, which was surprising given that Nate was in his first semester of a graduate medical degree at a competitive university.

Nate had graduated several months earlier from an undergraduate program in the same state. He was living in a city some 40 min from his undergraduate school and reported that he was lonely, most of his friends having left the state following their graduation. He described that he had three close friends, but noted that these relationships were more important to him than they were to his friends. Nate described his relationships with others as tenuous, stating that he always wanted more than others could give. He described himself as "needy" and worried that others would not like him if he was not amusing.

He reported significant symptoms of social phobia and stated that he found it difficult to make friends. At the start of treatment, about 2 months into his new school program, Nate reported that he had made no friends since school's start. He noted that he was an active member of his church, but felt disconnected from people in his church group.

Nate was single and reported that he was heterosexual and never married. He expressed a strong desire to get married, stressing his religion's encouragement of church members to marry. Nate had two older brothers, both married and with children of their own. Nate was particularly close with one of his brothers who lived an hour away, while the rest of his family resided in a nearby state and visited infrequently.

Nate described his upbringing as "regular, except for my mom." He grew up in a home with his biological, married parents and brothers. His father, an engineer, was often away at work, while his mother, a homemaker, was around the home but difficult to be around. Nate described his father as "the ideal guy, a provider for the family, a man who knows what he wants and how to get it, an important man at work." Nate described his mother as "hard to be with; she's crazy; we all just try to steer clear when we can."

He described a long history of his mother's apparent mental illness, although he was unaware of any formal psychological help his mother might have received or any diagnoses given. He detailed that his mother typically became overwhelmed by daily life and retreated into her closet where she would stay for days without coming out. Sometimes, he described, she "ran away" for several days, driving in her car hours from home, staying in a motel, and calling home infrequently. He described her personality as "selfish" and stated that he and his brothers were angry at her because "everything always has to be about what Mom wants."

*Assessment of Nate*

My assessment of Nate at the beginning of treatment was that he appeared suffer from both major depressive disorder and social phobia. His religious affiliation was crucially important to him, but provided little apparent comfort or social support. Similarly, his family provided some financial support, but little apparent emotional support. Nate appeared to be lonely, isolated young man, seeking solace and support with little hope of actually getting it.

From an attachment perspective, Nate appeared to have qualities of both preoccupied and dismissing attachment styles. Preoccupied attachment is characterized by preoccupation with previous attachment relationships. A client with this attachment style is likely to appear angry, passive, or fearful when talking about important childhood relationships and to speak in long, entangled, or excessively vague sentences. Dismissive attachment is typified by an emotional dismissal of important relationships. A client with dismissive attachment is likely to idealize parents, but be unable to provide memories which support the idealization (George et al., 1985/1995; Main, Kaplan, & Cassidy, 1985; Main & Goldwyn, 1984, 1998). Adult clients' narratives in therapy often reveal their attachment styles (Fish, 1996; Fish & Dudas, 1999; Gubman, 2004).

In sessions, Nate's narratives showed symptoms of preoccupied attachment in regard to his mother. Angry at his mother, Nate often described her in thin and vague narratives. Details in these narratives were difficult to find and Nate often ended his vague sentences about her by drifting off into long silences. However, he seemed to idealize his father without being able to give concrete examples of his father's warm behavior towards him.

Nate often communicated in session a significant ambivalence about expressing his distress, typical of dismissing attachment style. He refused to discuss substantively his negative views of himself and expressed little hope for the possibility of achieving support through treatment. He expressed his difficulty in hoping for more from his relationships in this process excerpt from a session midpoint in treatment:

N: Sometimes I worry that, I don't know if I want to call it a lack of faith or, maybe it is just a lack of faith, that things could (pause) work out as well and as wonderfully as I could dream of. Maybe if I say that that's so unrealistic (pause) you know, you could hope for it, but could you really anticipate that happening, if I say no, then maybe the likelihood of it happening just keeps going down, like I make it less and less likely that my dreams will come true if I don't think that they will, (pause) so, (pause) And then, but a part of me also says, even if (pause) maybe if, I think that my goal is to get married. (small embarrassed laugh) But, I mean, I want to have a happy life and a happy family, so, I want that to be a source of (pause) I know that it will be a source of both joy and disappointment and trials, but I want the positives to outweigh the negatives. I don't want it to be, I don't want the most miserable, I don't want more misery in my marriage than (pause) um, (pause) I'd rather be single and like (pause) I'd rather be single and longing for that than married and miserable with just a terrible situation.

T: Do those seem like the most likely options at the moment?

N: Yeah (pause) I don't know, I just (pause) guess the thing that I'd like to change the most is, just this apprehension of even trying. Because that's really, that's what scares me a lot, just even (pause) I mean, it's not rational. I could, I could sit down and pretend to try to say, "look, what's the worst thing that could happen." I've done all "the what's the worst things that could happen" arguments, and although (pause) logically and reasonably, I could go down the list and say, I could convince myself, you know, reasonably, that I should at least try. But emotionally, that's too hard. It's (pause) I don't know, it's almost a risk I'm unwilling to take.

T: It scares you too much.

N: (nods)

Typical of preoccupied attachment style, Nate sought close relationships but worried that these relationships would not work out and he would end up devastated and alone. His worries about the availability and dependability of others provide clear messages as to the quality of his early relationships.

Looking again at attachment theory, we see that the theory posits "the primary purpose of many of the infant's and young child's instinctual responses, in man as in other animals, is to ensure proximity to the adult, which is necessary to survival. Sucking, clinging, following, crying, and smiling...are all instinctual responses that eventually coalesce to form the broad mosaic of attachment behavior." (Karen, 1994, p. 96) Attachment theory founder Bowlby asserted that crying and smiling do not serve to attach the child to the parent, but rather serve to attach the parent to the child. Crying and smiling indicate to the mother that the child is hungry, thirsty, wet, scared, or emotionally needy.

If, as Bowlby proposes, the purpose of these infant behaviors is to draw the parent to the child, what might Nate's experiences have been with his clearly impaired mother? Is it likely that his crying was gratified by his mother picking him up, attentive to his needs and wants? Given Nate's socially constricted and depressive behaviors as an adult, it seems doubtful that he enjoyed a warm, engaged, and connected relationship with his mother when he was an infant. Indeed, it seems more likely that Nate the infant and young child was often left to soothe himself. It seems likely too that he was often unsuccessful at this. As a young adult, Nate had developed few self-soothing behaviors. His attempts at self-soothing behaviors, such as looking at pictures of loved ones or reading letters from them, failed because he still felt lonely and alone. Reminders of his important relationships did not provide Nate with comfort or support, a clear indication of an insecure attachment classification.

Moreover, Nate seemed to have little expectation that others would be able to help him, to comfort him, and to be there for him reliably. Bowlby asserted that human infants cry in order to ensure proximity to a caregiver. But when Nate cried, he did not seem to expect that others would be there attentively. He seemed to have learned from his impaired mother and absent father that his crying did not draw caregivers closer and that his distress needed to be handled on his own. Nate appeared to have carried such expectations with him from childhood to adulthood.

Nate the adult seemed to feel that his emotional needs were unreasonable. He learned as a child that it was best not to seek fulfillment of his needs from his mother or others. His father, often busy at work, failed to provide the kind of attentive, empathic connection which Nate clearly needed as a child. Nate the adult had difficulty in hoping that someone would be there this time when he cried. He had trouble trusting and hoping, because he had not experienced this reliability and attentive emotionality before. These low expectations contributed to his overwhelming feelings of depression.

Bowlby wrote, "In most forms of depressive disorder,...the principal issue about which a person feels helpless is his ability to make and maintain affectional relationships. The feeling of being helpless...can be attributed, I believe, to the experiences he has had in his family of origin" (1980, p. 247). From this perspective, Nate's current depression was linked to his early family relationships, which left him feeling helpless to connect with others. Still, Nate resisted the idea of seeing himself as a victim of relationships. The following process excerpt illustrates this stance:

T: It sounds like you're trying to understand why what's happening is happening to you.

N: I don't want to feel, I don't want to make myself, I don't (pause) the way you say it there, I feel like I'm somehow a victim, I don't want to make myself out to be like some kind of victim, I don't feel like I'm being victimized anyway. I just feel like it's the reality. So, (pause) I think that if I felt like, if I felt like I was being victimized, I could be angry at someone. Someone would have wronged me. But I don't feel like anyone has wronged me.

It is clear that Nate did not want to see himself as helpless, a victim of relationships. Nate resisted seeing himself as a child who had been hurt and needed soothing. We can infer that he learned that it was not safe with his mother to be the wronged party, the infant who needed changing. Instead, it was his mother who argued that her own diaper was wet. Retreating into the closet, Nate's mother sent the message to her son that her own needs were primary and Nate needed to care for himself.

Infant researchers, Beebe, Lachmann, and Jaffe (1997) argue that, between the infant and the caregiver, "early interaction structures provide an important basis for emerging self and object representations" (p. 134). They define "interaction structures" as "characteristic patterns of the ways mother and infant influence each other, patterns of the ways the interaction unfolds" (p. 135). Beebe et al. describe that, as these patterns recur, "they become generalized structures and begin to organize the infant's experience" (p. 135).

Nate and his mother developed early interaction structures which reinforced the message that Nate's mother was unable to be there for him, that Nate had to cry alone. Nate's depressive feelings including feelings of hopelessness, his view that relationships with others were tenuous, his resistance to seeing others as able to comfort him: all these adult feelings support the notion that Nate the infant learned he would always have to adapt to his mother. He learned that she could not be relied upon for attuned emotional presence.

### *Course of Treatment*

In initially treating Nate, I focused on the relief of his serious depression using a combination of relational and ego-supportive interventions in individual psychotherapy, along with adjunctive psychiatric support and group therapy to support work on his social phobia and interpersonal issues. In the first three months of treatment, Nate became stable on a regimen of psychiatric medications. His suicidal ideation, nearly daily at the start of treatment, became absent by the end of the third month of regular psychiatric and individual treatment. Psychomotor retardation lessened and vocabulary improved. Nate's IQ actually seemed to rise.

It is notable that Nate attended every one of our 28 psychotherapy appointments on time and followed up on both referrals that this therapist made for him, to psychiatric help and group therapy. Moreover, Nate never called to say he was sick or to reschedule if he had a test. In his constant attendance, this therapist saw his dim, but not extinguished, hope that someone finally would be attentive and hear him cry.

### *The Therapeutic Relationship*

Nate's transference was complex, and seemed to shift at times. Sometimes it seemed clear that this therapist was the stand-in for Nate's mother; at other times, his transference was idealizing of the therapist. At certain points in sessions, Nate seemed eager to please the therapist. When my interpretations did not seem to fit with his internal experiences, he still did not disagree with me. He clearly did not want risk alienating himself from me by disagreeing.

Later in treatment, Nate did seem angry at me, the stand-in for his mother, although he had difficulty communicating this directly. Instead, he laughed uncomfortably, wanting to disagree with me but unwilling to do this directly. However, as treatment progressed, Nate improved in his ability to express feelings towards me. I encouraged his open expression of emotion in the moment, but he still struggled to feel that it was safe enough in the relationship to do so. Here the goal of treatment in attachment terms was "to provide an environment that fosters attunement, [and] is secure enough to cope with relevant protest" (Holmes, p. 49). The therapeutic goals were (1) to provide a space where Nate felt understood and heard, and (2) to provide a relationship in which Nate's appropriate and "relevant protests" could be voiced. In the context of such conditions, Nate's attachment strategies could become more secure and his internal working model might begin to shift.

Often, Nate played down the importance of the therapeutic relationship. This minimization of important relationships is characteristic of dismissive attachment style. We see this minimizing in the following process excerpt, when I affirmed his relational growth:

T: I think you're being pretty brave.

N: By? (small embarrassed laugh)

T: By coming here, opening up, going to group...

N: I think the context of group, and like individual therapy is much safer. (pause) In group and coming here, and granted my tuition probably subsidizes the, a lot of, like it's a paid-for service and you're, you

have a professional obligation not to like, go away. (embarrassed laugh)

T: Oh I see, because you're paying me.

N: Uh huh, whereas in a real life setting, no one has any obligation to pay attention to me. Do you know what I mean?

T: Yes I do.

N: I think, there, you could say that that's good and that's a step, but I don't see them as anything close to an equivalent in terms of, like, the amount of, I don't know, it sounds lame, but like, the amount of risk I incur. It's less risky to come here.

T: Because it's not real life.

N: Yeah.

It was safer for Nate to convince himself that the therapist did not truly care for him; then, if he lost her, it might not mean so much. Such thinking is typical of dismissive attachment, where children have learned that important relationships cannot be relied upon for emotional support.

This therapist's countertransference was complex. At times early in treatment, I found it difficult to sit with Nate's depression and psychomotor retardation. He spoke slowly, with long pauses between words and long silences between statements. Often in early and mid-treatment, I felt unsure what progress was being made in session as Nate's narratives were vague and his affect flat. I often felt impatient early in treatment but stayed quiet as a general rule, asking clarifying questions or making supportive statements.

As treatment progressed and Nate's depression lessened, he became somewhat more animated and engaged. I found this exciting to witness. The therapeutic relationship in treatment, difficult to see emerging, became clearly solid which made me feel engaged and involved. At the midpoint of treatment, 4 months into the 8-month treatment course, Nate began to recognize and express his own anger, something which was unavailable to him at the beginning of treatment. In the concluding months of work, Nate began to express directly his feelings regarding the therapeutic relationship. He was also able to state, albeit in somewhat vague terms, that he trusted this therapist. Such trust is typical in secure attachment relationships, but had been unfamiliar to Nate in previous relationships. His expression of this burgeoning trust in the therapeutic relationship was an indication to me that he was beginning to utilize more secure attachment strategies.

Sable (2000) asserts, "The working model of therapeutic relationship eventually exerts dominance over hurtful experiences and models of the past, countering the patient's image of himself as unlovable and unworthy of secure affectional ties" (p. 333). Nate began treatment deeply depressed, with long-held beliefs about his unworthiness as a person and his unlovability. Throughout treatment, his preoccupied and dismissive strategies slowly gave way to more secure attachment strategies, which included accessing and expressing a range of positive and negative affects to the therapist. This simple expression of feelings showed Nate's progress in believing that an adult finally would be attentive and listen to his pain. Given his history with caregivers, such relational progress was gratifying to see and was likely contributory towards his decreasing depressive symptoms.

### *Termination*

Bowlby (1980) wrote, "Loss of a loved person is one of the most intensely painful experiences any human being can suffer" (p. 7). It seems likely that Nate experienced therapeutic termination as a significant loss. The loss of his therapist may have represented the loss of the only attentive caregiver he has known. Such a loss triggered regression in session, bringing up Nate's earliest feelings of being the infant whose mother was not there to comfort him. Nate and I spent significant time processing this loss in session and attending to his feelings of loss. It was my therapeutic goal that an introject of the therapist as an attentive and connected caregiver was a part of Nate's internal world following treatment.

### CONCLUSION

The case of Nate illustrates the application of John Bowlby's attachment theory to clinical work with adults. At the start of treatment, Nate was a young man experiencing serious loneliness, isolation and suicidal depression. Suffering from symptoms of both major depression and social phobia, he had a highly constricted world into which few people entered. In Nate's world, neither family nor friends could be relied upon to be there when he needed them and all relationships were tenuous and subject to change without explanation. Using the lens of attachment theory, we see that Nate's internal working model was formed from his relationships with earliest caregivers. Nate experienced his father as often absent and emotionally unsupportive, although he continued to idealize his father's qualities. Nate's mother, a person with significant deficits, sent the message to Nate that he could not depend on her emotionally. He learned early that her needs came before his and that she could not be relied upon to help soothe his upsets.

Nate's learned strategies for connecting with others, including pre-occupied and dismissing strategies, served him poorly as an adult and contributed to his social isolation and depressive symptoms. As an adult, Nate attempted to soothe himself with little success. He even attempted to use the church as an adjunct parent, as an authority on which he could rely, but he seemed to find little comfort there. From an attachment theory perspective, his depressive symptoms resulted from this relational isolation and loneliness.

Nate sought treatment as he might, as an infant, seek the breast for comfort and feeding. The treatment then was focused on forming a reparative attachment relationship (Sable, 2000) with Nate in which he could begin to experience and rely upon an attentive, caring, and attuned other. During the course of treatment, Nate learned to rely upon the therapist as an available other and learned to trust in the

relationship to provide some emotional needs. Nate's corrective emotional experience in treatment likely served to embolden him to hope for and to seek connected relationships with others in which his needs could be met.

Nate's case illustrates how adult attachment strategies appear in psychotherapy relationships. The case also draws a clear link between the attachment theory and depression, showing how relational isolation and despair contributes to adult depressive symptomatology. The lens of attachment theory allows us to consider the clinical treatment of adult depression in a new way. My discussion of clinical work with Nate, using the lens of attachment theory to understand our work together, clearly illustrates the strengths of this theory in applied clinical social work.

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