

Attachment Theory in Adolescent Counselling

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Abstract

John Bowlby's (1982) attachment theory can be applied to an existing therapeutic framework to enhance the effectiveness of therapy. Using the Adult Attachment Inventory (AAI), a therapist can identify the type of attachment the client formed with his/her caregivers, and use this to navigate an authentic attachment between client and therapist. This paper focuses on the application of attachment theory in adolescent counselling, because in adolescence a person has the linguistic and psychological constructs in place to recognize the significance of attachment, and can take advantage of the brain's adaptive state before brain development reaches its adult configuration.

John Bowlby (1982) introduced attachment theory in 1969 to describe the different ways that children can attach, or fail to attach, to their parents or caregivers. Although it is a well-supported theory, it can not itself form the basis of therapy, but can be a useful framework to facilitate therapy (Ross, Hinshaw, & Murdock, 2016), and pairs well with common established therapeutic approaches. Specific attachment styles can be identified by a reliable (Lorito & Scrima, 2007) test called the Adult Attachment Interview (AAI), which is also used in a modified form to assess adolescents (Mikulincer & Shaver, 2007). The AAI can identify clusters of mental health challenges that are associated with each attachment style. Adolescence is a time when people exhibit behaviours and experience feelings that lead to therapy, and these feelings and behaviours are connected to the level of attachment that the person experienced as an infant. Adolescence is an effective time for an intervention based on attachment theory, because parental attachment is still evolving but adolescents have the cognitive structures in place to engage in metacognitive analyses of their own attachment relationships (Allen, 2008).

Bowlby (1982) developed attachment theory in order to describe the different ways, both secure and insecure, that children attach to parents or caregivers. A secure attachment is what makes for a healthy parent-child relationship. There are three kinds of insecure attachment: avoidant, anxious, and disorganized (Cassidy, 2008). A child who is insecurely attached in an anxious style (Ross et al., 2016) is emotionally sensitive, highly dependent on caregivers (marked by an inability to process negative emotions without help from others), and preoccupied with feelings of being unloved and unaccepted. Children who are insecurely attached in an avoidant style (Ross et al., 2016) have a self-image that hinges upon comparing themselves to others: avoidant children can see themselves in a positive light only by evaluating comparative others negatively. Avoidants tend to be preoccupied with personal power, have suppressed feelings of failure and worthlessness, and deal with negative situations by avoiding them through social isolation. They are also more likely to find ways of numbing the emotions that they are experiencing through substances such as alcohol or drugs.

The most extreme form of insecure attachment is the disorganized style. Children who exhibit the disorganized style of insecure attachment (Holmes, 2004) are theorized to do so because of the unpredictability of their primary caregiver: approaching the caregiver for nurture sometimes led to rejection or even injury, if not simply disinterest. As the disorganized child matures to adolescence and early adulthood, typical characteristics begin to manifest: an urge to control others, an attitude of aggressiveness, an inability to work through negative emotions (e.g. anger management issues), a tendency toward dissociation, and an inability to escape from harmful relationships. This style was not part of Bowlby's (1982) original theory, but was developed by Mary Main (Mikulincer & Shaver, 2007, p. 25). The disorganized style often seems to be dismissed outright in papers and studies that connect attachment style to

counselling approaches, “because it is characteristic of severe levels of psychopathology” (Ross et al., 2016, p. 401). The reason for the dismissal seems to be, at least on the surface, that clients presenting with the disorganized style usually require “intensive psychotherapy” (Blakely & Dziadosz, 2015, p. 287), and therefore the therapeutic path required is too complex for an overview in an article or study that also explores the other forms of attachment.

As with all of the attachment types, they are often given slightly different names over time and across different researchers; for the purpose of clarity, a terminology was chosen and translated from the different terminologies used in different articles and studies, and this is the accepted method in attachment theory. There is one additional clarification of note regarding disorganized attachment: the term “disorganized” is also a point of contention between researchers, in a sense. Beyond semantics, there are at least two schools of thought: (1) that a disorganized child grows into a disorganized adult with characteristics that can be extrapolated from infant to adult, and (2) the disorganized child develops into the fearful avoidant adult, which is kind of like an extreme form of both avoidant and anxious styles combined (Mikulincer & Shaver, 2007). The second example implies that the disorganized style is more a product of both extreme neglect and extreme fear from the caregiver during infancy and not something that is completely different from the anxious and avoidant styles. Intuitively, the *fearful avoidant* seems a more apt label with slightly different implications, because “disorganized infants are characterized by simultaneous or rapidly vacillating displays of approach and avoidance behavior toward an attachment figure” and “fearful avoidance in adolescence or adulthood probably has to be extreme before it parallels disorganization in infancy . . . but when a person scores quite high on both the anxiety and avoidance scales¹ . . . he or she may qualify as disorganized” (Mikulincer & Shaver, 2007, p. 43). It is perhaps why most studies seem to dodge the whole category, but for very practical reasons: attachment could be looked at as being secure or insecure, and the insecure attachment can be either anxious, avoidant, or both, and following this there is no real “disorganized” type. If attachment is considered in this light, then the studies and articles that seem to omit the disorganized type are actually addressing its components (the anxious component and the avoidant component).

Although attachment theory can be a valuable therapeutic tool, there is evidence that it should not be the singular guiding principle of a therapeutic intervention. Burke, Danquah, and Berry (2015) interviewed 12 therapists who had a “stated interest” in attachment theory (p. 144), and concluded that attachment theory can not be the sole template used for a therapeutic model, but is indispensable as an “informing paradigm” (p. 146). Burke et al. found that attachment theory was being successfully paired with the classic psychoanalytic model, the psychodynamic model, and with cognitive-behavioural approaches in practice. The study also revealed specific applications of attachment theory for understanding the development of mental health issues, as an alternative to the diagnostic model but also for explanations to the client and other clinicians. The study also revealed that different attachment styles affected therapy, including the interaction of the client’s attachment and the therapist’s. Further, Burke et al. found that therapists using attachment theory to complement their therapy style found it useful to analyze each therapeutic relationship as an attachment relationship. Though this study was aimed at therapists of adult clients, its conclusions are encouraging for clinicians who help adolescents.

In a study of nursing students in Israel (Moked & Drach-Zahavy, 2016), the researchers sought to find a connection between attachment style and support-seeking behaviour. The students in the study were between the ages of 22 and 50, but the average age was 25.44. The study concluded that the attachment style of the supervisor was much more a factor in whether students seeking support actually received support, and that supervisors with non-secure attachments, meaning avoidant and anxious, were not very helpful. The study also found that

¹ Mikulincer and Shaver (2007) seem to be referring to scores on the AAI, a test they introduce in the preceding chapter, but they do not refer to it specifically, but rather to scoring high on “a measure of adult attachment” (p. 40).

securely attached students did not seek out support from supervisors as much as students identified as having avoidant and anxious attachments. These findings are significant and relevant to clinical interventions with adolescents. The modern view of adolescence is that it ends at a later age than 18, the entry into adulthood perhaps better set around age 25 (Arnett, 2007, p. 68). Arnett (2007) argued that Erikson's developmental theories are still valid but require a slight tuning for the 21st century: it made sense that 18 was the end of adolescence in the mid-20th century, when most people were married and stably employed by age 20, but now marriage happens on average much later and securing stable employment remains an ongoing challenge for many, a marked contrast to the stability of the mid-20th century society.

One reason that adolescence is a good time for therapeutic intervention is because, according to Allen (2008), adolescents develop the ability to "de-idealize" (p. 420) their parental figures; that is, adolescents are able to evaluate more objectively the performance of their parents, and can even engage in a metacognitive way to unpack and mentally reorganize their attachment experiences. The adolescent brain is developed to the point where individuals can fully engage in "mentalization": the ability of a person to empathize with others in order to discern the intentions of others (Shemmings & Shemmings, 2011, p. 129); in a child, it refers to being able to see from the perspective of the caregiver and guess at his/her motivations, and in the caregiver it refers to attributing child behaviour to motivations. Mentalization also enables individuals to use the insights gained in order to predict the behaviour of others. Shemmings and Shemmings (2011) drew a brief connection to Rogerian therapy when describing the emotional facet of mentalization: the mentalizer can mislabel one's own feelings; to be a good mentalizer, like an effective Rogerian therapist, one needs to accurately identify one's own feelings and the feelings of others.

Identifying the attachment issues of an adolescent and having the adolescent share in the analysis enables the adolescent to begin to develop new insights based on these staked territories. In this way, individuals may continue the journey into adulthood with a clearer insight into their own behaviours, with less baggage, and with a new lens through which to view their behaviours, thoughts, and emotions in reaction to life's challenges, and also with a gauge to evaluate their own new attachments as new relationships begin to develop.

One tool that facilitates the pairing of attachment theory with therapy frameworks is the AAI, a keystone for facilitating adolescent therapy. In a recent test of the content validity of the AAI, it was found to accurately categorize people into the attachment type (Lorito & Scrima, 2007). When attachment theory is incorporated into an existing therapy framework, the AAI enables the therapist and the adolescent to verify which style of attachment is prevalent in the adolescent. Granted, the test does end up labeling the client, but given that the different styles of attachment seem to be connected to particular clusters of mental health challenges, it can be useful for assisting in diagnosis; however, the therapist must be careful to use it more as a system of verification and validation for analysis rather than as a replacement for analysis.

The secure attachment is protective, in that secure individuals are less likely to develop psychological dysfunction, which has been proven statistically in many cases, including for posttraumatic stress disorder (Dieperink, Leskela, Thuras, & Engdahl, 2001). For the insecure attachment types, research has linked attachment styles to certain kinds of psychological dysfunctions. Anxious attachment is associated with dependent, histrionic, and borderline disorders, whereas avoidant attachment is associated with schizoid and avoidant disorders (Mikulincer & Shaver, 2007). Crawford et al. (2007) found that attachment anxiety is associated with personality disorders that are connected to irregularities in emotional regulation, which includes identity confusion, anxiety, spontaneous emotional outbursts, cognitive distortions, submissiveness, an irrational and pronounced opposition to authority, self-harm, narcissism, and suspiciousness. The anxious style of insecure attachment has been found to be significantly correlated to "dependent, histrionic, and borderline disorders" (Mikulincer & Shaver, 2007, p. 372), while the avoidant style of insecure attachment was significantly correlated to

“schizoid, avoidant” disorders. As compared to secure attachment and disorganized attachment, the anxious style and avoidant style together are associated with depression, clinically significant anxiety, post-traumatic stress disorder “suicidal tendencies, and eating disorders. Borderline personality disorder was significantly correlated with types connected to anxiety (anxious and disorganized) but not to avoidant (Mikulincer & Shaver, 2007).

Thus, the AAI can help the therapist look for these clusters of possible afflictions, but it can also work backwards and see a manifestation of these afflictions as having a specific attachment root. Used in this way, the AAI becomes like a GPS for sussing out potential diagnoses, but just like a GPS it can send one down the wrong avenue if one is not careful (or even if one is careful). That said, continuing with the GPS analogy, one can usually find the right neighborhood eventually even if one has been wrongly directed into a couple of cul-de-sacs along the way. This analogy is apt in the sense that the GPS is not meant to replace a therapist’s instincts and common sense: no one drives into a river just because the GPS says so, and, in the same spirit, a therapist should not accept the AAI or the clusters associated with its selection if the information does not mesh with what is being observed and assimilated by the therapist (a caution encapsulated by the Russian proverb, “trust, but verify”).

Bowlby’s (1982) attachment theory has been supplemented by other researchers, including Mary Main’s addition of the disorganized style of attachment (Mikulincer & Shaver, 2007). Attachment theory is a therapy tool that can not itself form the basis of therapy, but can supplement established therapeutic approaches effectively (Ross et al., 2016), and the AAI is a linchpin to this therapeutic pairing. The AAI is a reliable test that can identify an adult’s specific attachment style (Lorito & Scrima, 2007), and has been successfully modified to assess adolescents (Mikulincer & Shaver, 2007). When a child reaches adolescence, the child’s core attachment relationships are still evolving, making it an effective time for therapeutic intervention because the child is newly able to engage in mentalization and metacognition (Allen, 2008; Shemmings & Shemmings, 2001). Adolescents are uniquely positioned to shift perspectives between the children they once were and the adults they will soon become, thereby enabling them to process childhood experiences and incorporate insights facilitated by therapy toward the construction of a resilient adult persona.

References

- Allen, J. P. (2008). The attachment system in adolescence. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 419-435). New York, NY: Guilford Press.
- Arnett, J. J. (2007). Emerging adulthood: What is it, and what is it good for? *Child Development Perspectives*, 1(2), 68-73. doi:10.1037/0003-066X.55.5.469 Retrieved from http://jeffreymarrett.com/ARNETT_2007_Emerging_Adulthood_What_is_it_and_What.pdf
- Blakely, T. J., & Dziadosz, G. M. (2015). Application of attachment theory in clinical social work. *Health & Social Work*, 40(4), 283-289. doi:10.1093/hsw/hlv059 Retrieved from Psychology and Behavioral Sciences Collection database.
- Bowlby, J. (1982). *Attachment* (2nd ed., Vol. 1). New York, NY: Basic Books.
- Burke, E., Danquah, A., & Berry, K. (2015). A qualitative exploration of the use of attachment theory in adult psychological therapy. *Clinical Psychology & Psychotherapy*, 23(2), 142-154. doi:10.1002/cpp.1943 Retrieved from PsycINFO database.
- Cassidy, J. (2008). The nature of the child’s ties. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (pp. 3-22). New York, NY: Guilford Press.
- Crawford, T. N., Livesley, W. J., Jang, K. L., Shaver, P. R., Cohen, P., & Ganiban, J. (2007). Insecure attachment and personality disorder: A twin study of adults. *European Journal of Personality*, 21(2), 191-208. doi:10.1002/per.602 Retrieved from <http://onlinelibrary.wiley.com/doi/10.1002/per.602/pdf>

- Dieperink, M., Leskela, J., Thuras, P., & Engdahl, B. (2001). Attachment style classification and posttraumatic stress disorder in former prisoners of war. *American Journal of Orthopsychiatry*, 71(3), 374-378 doi:10.1037/0002-9432.71.3.374 Retrieved from PsycARTICLES database.
- Holmes, J. (2004). Disorganized attachment and borderline personality disorder: A clinical perspective. *Attachment & Human Development*, 6(2), 181-190. doi:10.1080/14616730410001688202 Retrieved from Academic Search Premier database.
- Lorito, L., & Scrima, F. (2011). The content validity of the Adult Attachment Interview: an empirical investigation using text analysis. *Testing, Psychometrics, Methodology in Applied Psychology*, 18(4), 243–255. Retrieved from <http://www.tpmmap.org/wp-content/uploads/2014/11/18.4.4.pdf>
- Mikulincer, M., & Shaver, P. R. (2007). *Attachment in adulthood: Structure, dynamics, and change*. New York, NY: Guilford Press.
- Moked, Z., & Drach-Zahavy, A. (2016). Clinical supervision and nursing students' professional competence: Support-seeking behaviour and the attachment styles of students and mentors. *Journal of Advanced Nursing*, 72(2), 316-327. doi:10.1111/jan.12838
- Ross, A. S., Hinshaw, A. B., & Murdock, N. L. (2016). Integrating the relational matrix: Attachment style, differentiation of self, triangulation, and experiential avoidance. *Contemporary Family Therapy*, 38(4), 400-411. doi:10.1007/s10591-016-9395-5
- Shemmings, D., & Shemmings, Y. (2011). *Understanding disorganized attachment: Theory and practice for working with children and adults*. London, England: Jessica Kingsley.

About the Author

Riel Langlois is a teacher working toward his Master of Education with a specialization in guidance and counselling. He is interested in the role that attachment plays in human development, and in how attachment theory can help teachers and school counsellors guide students toward self-actualization.