The clinical matching:
interactions between patient's and therapist's attachment strategies in a DMM perspective.

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Attachment, Working Alliance and therapeutic relationship: What makes a psychotherapy work?

Franco Baldoni & Alessandro Campailla (2017)

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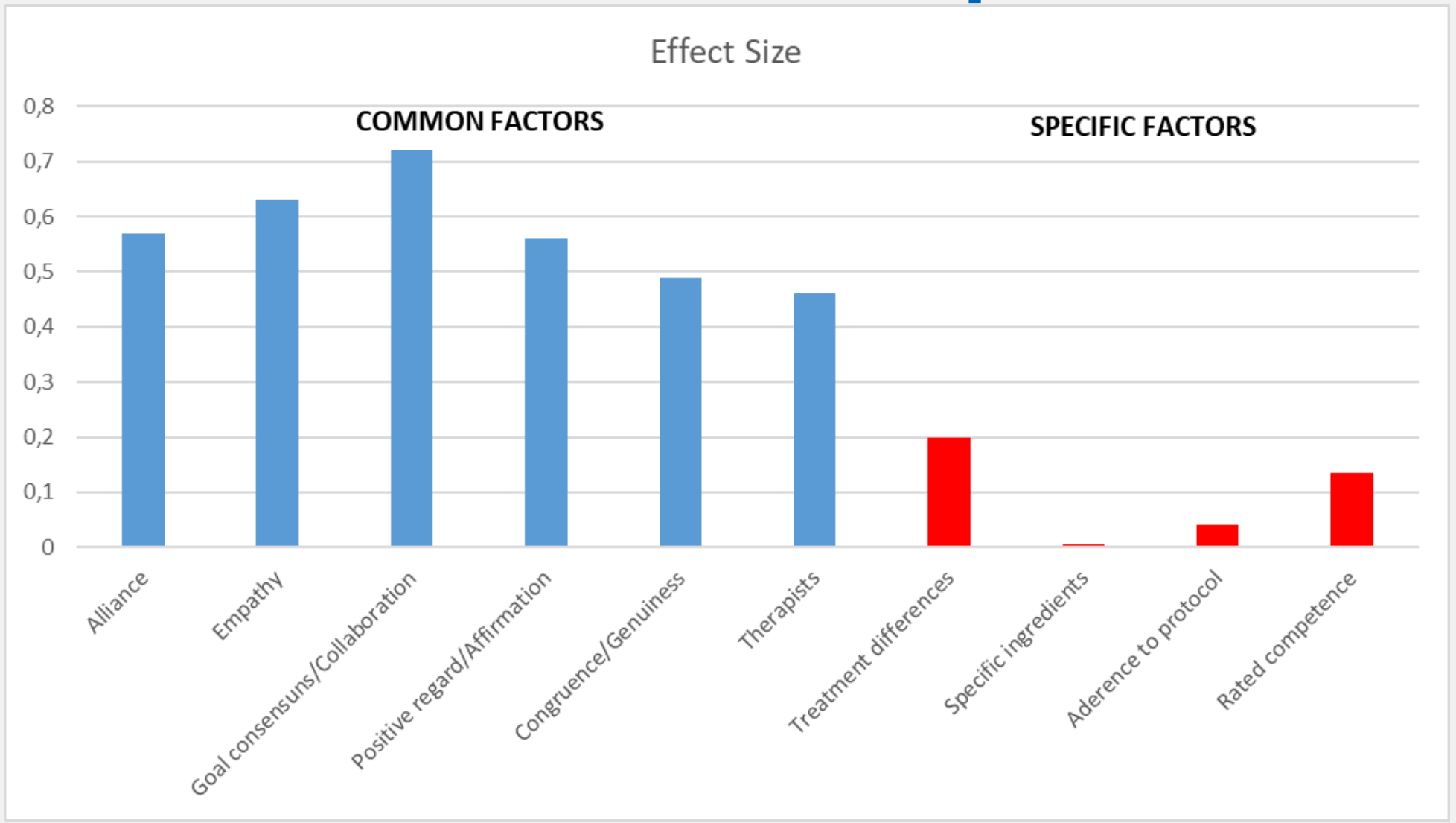
- Despite methodological limitations and some conflicting results, research has evidenced that attachment patterns of the patient and the therapist significantly influence the therapeutic process and the outcome of the treatment.
- Meta-analyses
  - Patient safety and treatment effectiveness are related to the development of a valid working alliance (Dozier et al. 1994; Diener, Hilsenroth & Weinberger, 2009; Monroe & Diener, 2011).
  - The characteristics of the therapist explain 5-7% of the therapeutic variance (effect of 5-8 times higher than the type of treatment)(Baldwin & Imel 2013)
  - The matching between the attachment patterns of the patient and the therapist influences the working alliance, the therapeutic process and its outcome (Mohr, Gelso e Hill, 2004; Romano, Janzen e Fitzpatrick, 2009; Baldoni, 2008, 2013; Hill, 2015).

Factors that influence therapeutic efficacy



(Wampold, 2014, courtesy of the author; Baldoni & Campailla, 2017)

How the DMM works (in psychotherapy)

- The DMM pays attention to the attachment patterns of the patient and the therapist and considers their matching
- The therapist may organize the most appropriate relational and therapeutic interventions by considering the patient's (and his family) specific ability to process cognitive and affective information
- The therapist
  - needs to be B in the clinical relationship (whatever his attachment pattern is)
  - becoming a transitional attachment figure and offering a secure base that supports the exploration of mental processes and encourages new experiences (Hill, 2015)

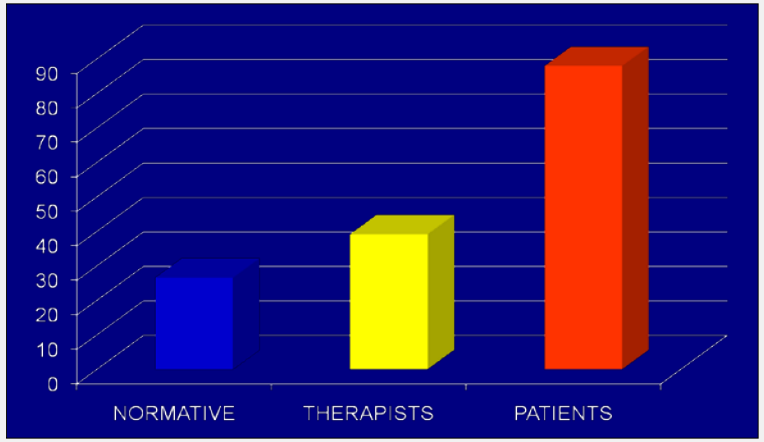
Therapists' Attachment patterns

Tend to differ from those of the general population, with more frequent expression of A+ and C+ patterns and, in particular, **unresolved trauma or losses** (such as illness or death of a family member) that may be the basis of their motivation to choose a helping profession

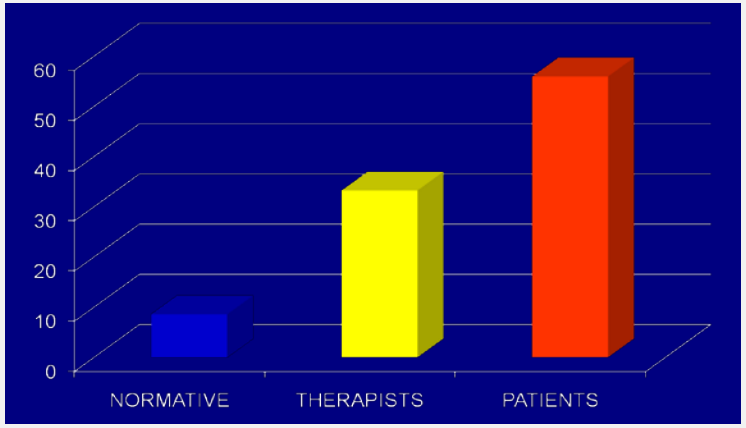
(Dozier, Cue & Barnett, 1994; Wilkinson, 2003; Lambruschi, 2008; Dinger et al., 2009; Holmes, 2009; Wilkinson 2003, 2008; Baldoni, 2010; Baldoni & Campailla, 2017).

			ABCAC				
			Type A	Type B	Type C	Type A/C	Total
3 major groups	NORMATIVE	Count	38	38	37	15	128
		% within 3 major groups	29.7%	29.7%	28.9%	11.7%	100.0%
	THERAPISTS	Count	17	13	11	10	51
		% within 3 major groups	33.3%	25.5%	21.6%	19.6%	100.0%
	PATIENTS	Count	34	0	29	37	100
		% within 3 major groups	34.0%	.0%	29.0%	37.0%	100.0%
Total		Count	89	51	77	62	279
		% within 3 major groups	31.9%	18.3%	27.6%	22.2%	100.0%

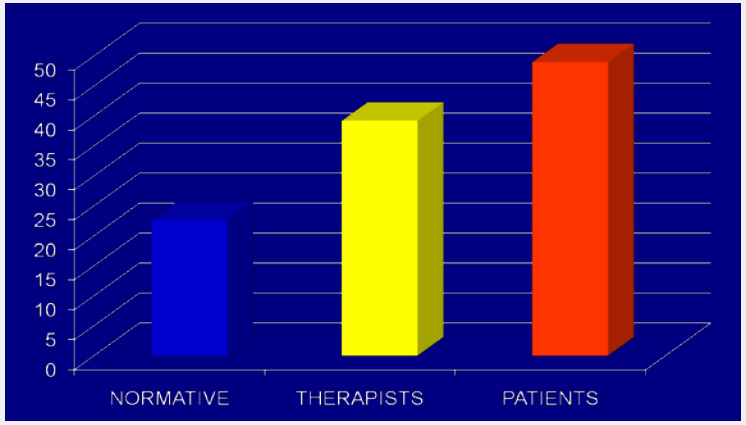
DMM-AAI - Italian sample, N: 279



Extreme Attachment Patterns



Unresolved Traumas



Unresolved Losses

(Lambruschi, 2008; Lambruschi et al., unpulished)

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The clinical matching

(Baldoni, 2008, 2013)

Clinician		Patient	Results
A Possible U/tr or U/l	⟺	A	Rigid technical-cognitive approach Unexplored and avoided areas Dismissing negative emotions false affects, intr. of neg. affects
C Possible U/tr or U/l	⟺	C	Emotional emphasis Excessive expectations Extended consultations Relationship conflicts
A Possible U/tr or U/l	⟺	C	Partial compensation Difficulty in understanding Therapy interruption
C	⟺	A	
B	⟺	A, B, C	Mentalization, affect regulation Affective and cognitive integration Tailored to patient strategies

In A+ and C+ the results could be very complex

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A Therapist vs A Patient

- Their attachment strategies will probably collude
- More directive interventions focused on rational aspects (rigid technical-cognitive approach, cognitive-behavioral prescriptions, intellectual explanations of disorders, focusing on the somatic dimension)
- Avoidance of problematic areas that remain poorly explored (relational problems, depression, fantasies of death or suicidality, unresolved losses or traumas)
- Systematic dismissing of negative emotions with the tendency for both to express false positive affects (such as smiling or joking when facing painful or scary topics)

(Baldoni, 2008, 2010; Romano, Janzen & Fitzpatrick, 2009; Baldoni & Campailla, 2017).

C Therapist vs C Patient

- Tendency for both to emphasize the emotions and foster excessive and unrealistic expectations of treatment.
- It will be difficult to maintain relationships within proper limits, with the tendency to extend the consultations after a correct time.
- At the beginning they could have the impression of being on the same wavelength (as if they were friends), but, over time, intense transference neurosis will tend to manifest (due to the disappointment of mutual expectations), with controversy, quarrels, relational conflicts and possible interruption of therapy

(Baldoni, 2008, 2010; Romano, Janzen & Fitzpatrick, 2009; Baldoni & Campailla, 2017).

A Therapist vs C Patient (or C vs A)

- A partial compensation can occur. Studies have shown, in fact, that this condition is often related to a satisfactory therapeutic relationship, especially if the therapist is dismissing (Meyer & Pilkonis 2001; Bruck et al. 2006).
- Countertransference enactments may also occur, along with omissions and misunderstandings concerning the neglected or problematic areas of mutual attachment patterns (such as affectivity for dismissing subjects and cognition for preoccupied), with the consequence that difficulty arises in understanding and sharing of the results (Mohr, Gelso & Hill 2005).
- Consequences may be poor therapeutic compliance or even the abrupt withdrawal of treatment.

(Baldoni, 2008, 2010; Romano, Janzen & Fitzpatrick, 2009; Baldoni & Campailla, 2017).

B Therapist vs A or C or B Patient

- Integration of mentalization, cognitive information, affects and communicative skills with a good ability to analyze problems
- The therapist will address the clinical relationship in a more conscious way and will work to adapt better to the patient's strategy and its specific characteristics and requirements (Tailored treatment)
- This is particularly true with earned B therapists

(Dozier, Cue & Barnett 1994; Shorey & Snyder 2005; Romano, Fitzpatrick & Janzen 2008; Baldoni, 2008, 2010; Baldoni & Campailla, 2017)

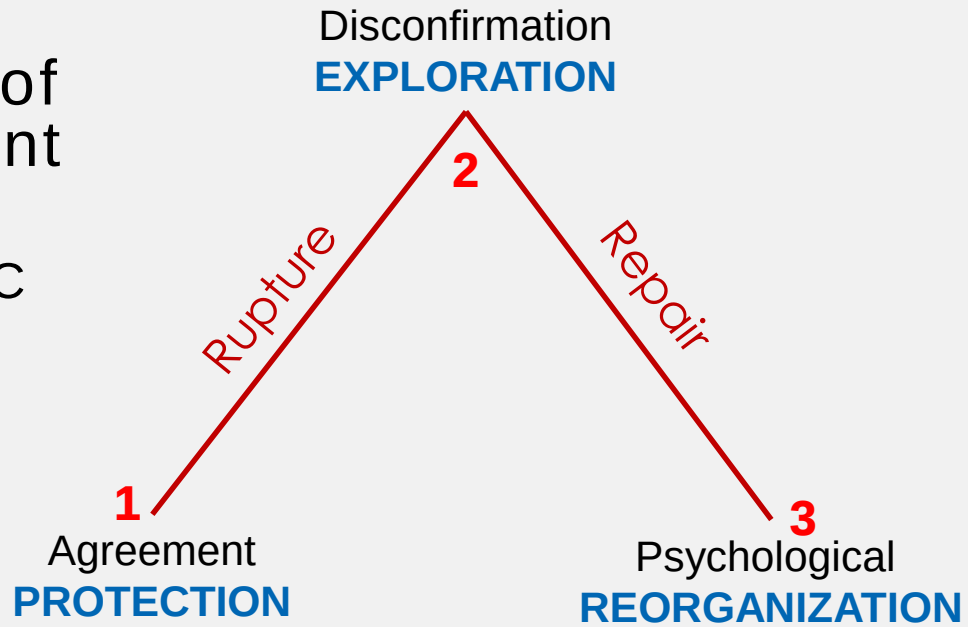
A taylored attitude

- **Dismissing patients (A)** need to receive clear information and organize thoughts in a relatively rational way, but also be helped in the expression of emotions, especially negative ones.
- **Preoccupied patients (C)** the therapist needs to be more careful not to collude with his mental state and acts more firmly maintaining a constant psychological containment attitude to improve the regulation of emotions (Meyer et al., 2001; Purnell, 2010; Baldoni, 2008, 2010).
- At the beginning, the therapist proposes himself as a transitional attachment figure, his relational attitude is organized in a relatively **complementary style**, by avoiding exposing the patient too early to excessively anxious or overly confusing conditions.
- Subsequently, the patient's maladaptive expectations needs to be gradually disconfirmed (**symmetrical style**) “Sure, but not too sure” (Bromberg, 2006).
- Treatment produces changes through reorganization after moments of crisis (**Rupture and Repair**) (Winnicott, 1956 ; De Bernart & Landini, 2015 **-Bumps in the Road to Change**)

(Millinckrodt, Porter & Kivlighan 2005; Holmes, 2009; Baldoni & Campailla, 2017)

A "dynamic" attachment relationship (three phases) (Millinckrodt, Porter & Kivlighan 2005; Holmes 2009)

1. Agreement: (Protection) therapist as a transitional attachment figure, acceptance of the role unconsciously assigned by the patient
   - More rational and intellectual attitude with A patients
   - Greater gratification and emotional participation with C (slight violations of the setting, extra sessions, phone messages)
2. Rupture: patient's maladaptive expectations needs to be gradually disconfirmed (Exploration)
3. Repair: Psychological Reorganization



Transitional Attachment Relationship

The positive outcome of a therapy is associated with positive resolutions of the ruptures of the alliance
(Safran et al 1990; Horvath et al 1991; Safran & Muran 1996, 2000; Eubanks et al., 2010; Ardito & Rabellino 2011; Miller-Bottome et al 2017; Baldoni & Campailla 2017)

Conclusions (for the clinicians)

- Work on yourself as a patient
- Be aware of your attachment startegies (including their somatic expressions) and possible U/Tr or U/I
- Be B with patients (whatever your attachment pattern is) and change attitude considering their needs
- Be imperfect and learn about crisis and discrepacies

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