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HOW DOES ATTACHMENT THEORY IMPROVE OUR CLINICAL PRACTICE? A TIME FOR SUMMING UP

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La Teoría del Apego ha hecho contribuciones muy útiles para la intervención psicológica, y exponemos las más relevantes. Partiendo de que la psicoterapia conlleva inevitablemente la activación del sistema de apego, abordamos sus distintas presentaciones en función del estilo de apego, y planteamos algunas recomendaciones para su manejo (responder a necesidades subyacentes, desplegar actitud terapéutica en dos fases, considerar trabajo metacomunicacional, y ser cautos al activar el apego). Exponemos la influencia del apego en la capacidad para relacionarse con las experiencias internas (como fuente de amenaza o como vivencias no accesibles). Consideramos los tres tipos de seguridad buscada tras la activación del apego (física, emocional y cognitiva) y las distintas demandas que imponen en la relación terapéutica. Abordamos las implicaciones de la Teoría del Apego en los procesos de auto-regulación. Finalmente, revisamos brevemente algunas contribuciones adicionales a nivel conceptual, de evaluación y de tratamiento.
Palabras Clave: *Apego, Psicoterapia, Psicología Clínica*

Attachment theory has provided us with very useful resources for psychological intervention. The most relevant of these resources are presented here. Considering that psychotherapy inevitably involves the activation of the attachment system, some advice is provided in managing this (addressing underlying needs, deploying a two-stage therapeutic stance, including meta-communication dialogues, and being cautious when activating attachment). The influence of attachment on the ability to relate to inner experience (either as a threat or an experience that is difficult to reach) is presented. Three kinds of security related to attachment (physical, emotional, and cognitive) are taken into account, as well as their different demands on therapeutic relationships. Implications of attachment theory on self-regulation processes are presented. Finally, some additional contributions about conceptualization, assessment, and treatment are reviewed.
Key Words: *Attachment, Psychotherapy, Clinical Psychology.*

Attachment theory could be the most influential evolutionary perspective in current psychology. Initiated by a research-minded clinician (John Bowlby, 1907-1990), it was adopted by academics and researchers who endowed it with strong conceptual and empirical support. Numerous study curricula, research projects, and publications are unequivocal manifestations of its success. While this academic development was taking place, the clinical aspects took a back seat, which is somewhat paradoxical in a theory initially developed to help clinicians diagnose and treat individuals and families (Bowlby, 1989). However, in recent years attempts have been made to recover the clinical dimension that inspired Bowlby, and now we can take stock of what attachment theory brings us. Thus, we find efforts to compile and systematize these clinical and therapeutic referrals, with monographs in journals such as the Infant Mental Health Journal (Vol 25, No. 4), Child & Adolescent Social Work Journal (Vol 26, No. 4), and Psychoanalytic Inquiry (Vol 23 , No. 1; Vol 37, No. 5), or

collective works that explicitly seek to fill the gap between research and practice (Bennett & Nelson, 2010; Bettman & Friedman, 2013; Oppenheim & Goldsmith, 2007).

We cannot ignore the limitations of these clinical contributions (see Galán, 2019): a) an absence of therapies with specific techniques and interventions directly linked to or prescribed by attachment theory (Eagle, 2017); b) a lack of accepted proposals for attachment dysfunctions (Allen, 2016); and c) the existence of proposals that use attachment as an attractive label for interventions already formulated based on other models (Allen, 2011). But along with these limitations, valuable contributions stand out that illuminate many aspects of our clinical practice. Attachment is considered to be *a behavioral system designed to activate when feeling vulnerable, needing protection, and requiring the help of a more capable fellow human being*, and we will review the specifically clinical contributions linked to this fundamental evolutionary dimension.

MANAGING THE INEVITABLE

Attachment is unavoidable in the therapeutic relationship, to the extent that feeling vulnerable, needing protection, and requiring help from a more capable fellow human being, define the patient who attends the clinic. The theory argues

that the relationship of early attachment promotes a way of dealing with vulnerability, transferred to the therapeutic relationship (Bowlby, 1989). The "ideal" patient recognizes their distress and their inability to solve it, placing the therapist in the position of a helper. But patients come to consultancy with what they are, not what we would like. Communicational disagreements, rejection of the indications, or therapeutic abandonments, reflect the patient-professional mismatch. From the study of the encounter between a vulnerable person (stimulated by a behavioral system that drives them to seek help) and a protective figure who attempts to take care of them, attachment theory offers a fundamental frame of reference to handle these encounters and disagreements. We consider then the inevitability of attachment in any therapeutic relationship (regardless of the theoretical model that supports it). This logical conclusion based on the theory has found empirical support, for example with the Patient Attachment Coding System (PACS), an evaluation instrument that allows us to evaluate the deployment of the attachment relationship to the therapist within the session, regardless of the specific type of psychotherapy (Talia, Miller-Bottome, & Daniel, 2017).

The basic typology of attachment offers a map for understanding and managing difficulties:

✔ We perceive the patient with a secure attachment as "easy", because he or she can risk establishing a different relationship with the professional and with him- or herself, as well as recognizing the help received.

✔ In ambivalent ("anxious" or "preoccupied") attachment, someone driven to seek security and protection at all costs will exaggerate their vulnerability (which the therapist could inadvertently reinforce); they will enter into an insatiable escalation of demanding help (which may suffocate the professional) or use coercive strategies (such as threats of abandonment or suicide) to guarantee the care experienced as uncertain, with the risk of drifting into tangled and confusing relationships. The clinician should strive to deactivate these strategies, establishing functional limits (clear rules on when and how to attend in consultation, rules on how to act in case of autolytic threats, etc.), reinforcing the patient's abilities (reducing the experience of vulnerability that over-stimulates the attachment), or emphasizing its presence and availability (thus making the excessive demand for help unnecessary).

✔ Dismissive (or "dismissive-avoidant") attachment involves a dilemma: needing help that at the same time creates distrust, after a life journey in which the individual has learned to trust their own resources and value self-sufficiency. The attitude to the therapist is suspicious, ungrateful, and lacking in emotional involvement; they may ask for an intervention that involves little emotional commitment ("to receive guidelines" or learn a technique, etc., from which he/she can show recognition to the professional. The risks for the therapist will be feeling questioned, responding with the same distance with which he or she is treated, or producing a pseudotherapy dominated by a lack of mutual involvement, etc. It will be necessary to fine tune the relational distance carefully (being physically and emotionally present, but not so much that it arouses their anguish), and to practice self-validation as a professional from within (because it will not come from the patient).

✔ Disorganized (or "unresolved") attachment may appear as moments of relational confusion, triggered at times when the activation of the attachment is experienced as extremely dangerous or catastrophic; in times of collapse of the relationship management strategies the individual will not be able to turn to a reliable source of help and will immerse themselves in confusion or inappropriate strategies in which he or she only counts on him- or herself (such as self-mutilation or substance use) (Holmes, 2017a). Relationship formats described by the researchers may also appear. Thus, children who in their first two years develop disorganized attachment styles, from 3-4 years tend to inhibit their dependence, replacing it with controlling behaviors, through coercive or caring attitudes (parentalization); and later, a sexualization of the relationship (Liotti, 2011; Lyons-Ruth & Spielman, 2004). Where vulnerability should produce a seeking for care, here it leads to coercive control, provision of adultiform help, or inappropriate sexualization of the relationship. In summary, when the therapy activates this (disorganized) attachment, it should be immediately disconnected and replaced by responses that require specific management.

These therapeutic relationship patterns lead us to five clinical considerations:

A. The psychologist should not expect frank recognition of vulnerability, but instead look for it behind relational strategies designed to manage it. As a warning to the therapist, we would say: seek to respond to the underlying needs of the patient and not to the erroneous clues (described in attachment styles) that the patient uses to defend him- or herself from his or her vulnerability (Goodman, 2009).

B. It is useful to think of the therapeutic attitude in two phases (Goodman, 2009). The first is a stage of acceptance of the patients' own (perhaps dysfunctional) management of vulnerability, since it is one that the patient can allow him- or herself. It involves assuming the leitmotiv "the patient comes to the consultation with what he or she is". A second moment of questioning follows, promoting (through the therapeutic relationship and reflexive analysis of the relationship) the exploration of new ways of managing the need for help. We could say that the factor of change is in the mismatch and in the challenge to expectations (Holmes, 2017b).

C. It may be valuable to include in the intervention an approach to the therapeutic relationship itself, a metacognitive or metacommunicative work (a "conversation about conversation"), a proposal already noted by Bowlby, and

which found its best representation in mentalization theory (an interesting derivation of attachment theory). Thus, it points to the core of metacognitive work: developing the capacity to think about one's own and other people's internal world. There will be talk of "mentalizing the relationship", focusing on the therapeutic relationship itself and the ups and downs of the mentalization within it. Repeatedly therapist and patient will embark on a joint effort to understand what happened in one individual when the other said or did something. Certain interviewing skills favor these processes (Bateman & Fonagy, 2013), so these authors propose the therapist should:

✔ be curious and maintain an investigative position of "not-knowing".

✔ be committed, using self-revelations when appropriate.

✔ have an inquisitive attitude but not excessively so ("I wonder why you never ask me for help", "I am struck by the fact that you have many doubts about this matter, but you have never asked me what I think or if I can help you out; why might that be?"), focusing on the professional's responsibility ("maybe because before I was not able to realize what was happening to you, now you don't feel you can trust me", "maybe I haven't yet earned the right for you to put that trust in me; it doesn't matter, we must take our time") and respecting the patient's attitude ("I guess it has always been helpful for you not to trust people right away, and that you have avoided disappointments").

✔ focus his or her intervention more on the processes than on the mental contents; it is not so much an insight of the difficulties that is sought, as a different way of relating to one's mental functioning, whereby we notice connections with third generation behavioral therapies, such as acceptance and commitment therapy (Wilson & Luciano, 2014).

D. It is important to consider the dangers of activating attachment. Faced with a certain naive image (underscoring the benefit of the warmth of the attachment relationship), we know that its activation can be experienced as very dangerous, especially with a disorganized attachment pattern. It is dramatically evident in people that have been diagnosed with borderline personality disorder, where the alternation of hyperactivation-hypoactivation of attachment leads to extremely conflicting, confused, or broken therapist-patient relationships. This also occurs in patients with traumatic experiences in attachment relationships (intrafamilial sexual abuse, severe child abuse, etc.). The warning here would be "don't activate what you can't contain". Hence the usefulness in some cases of cautious and cold approaches, appealing more to a work of mutual inquiry than of emotional commitment, maintaining the attachment system at a "warm" level of functioning. Thus, the intervention could be considered in terms of an egalitarian attitude of cooperation ("I am an expert in psychology and you are the expert in your problem; let's see if by joining the two experts we can find a solution"), rather than of great asymmetry and emotional involvement (Liotti, 2017). Only if (or when) a sufficiently containing relationship framework has been created could the risk be run of activating the attachment decidedly.

E. A central concept in attachment theory is the internal working model (IWM), which is the cognitive map, representation, or scheme that the individual has of himself and others in relation to attachment (Marrone, 2001). It is what that person uses to predict whether and how the other will protect him. Inquiring about IWMs is essential to understand how the patient relates to their environment and the therapist. But we must go one step further. In addition to the cognitive schemes relatively accessible to the patient him- or herself through reflexive inquiry (accompanied by the therapist or not), there are pre-verbal schemes, linked to procedural rather than semantic learning. There are many theoretical proposals that have described these pre-verbal schemes that strongly influence the relationships marked by attachment ("implicit relational knowledge"). Due to its solid foundation in child development research, we highlight among these proposals the concept of "models of being-with" (Stern, 1997). At the clinical level the implication would be: beyond the verbal, the patient will interact with you with interactional schemes forged from pre-verbal and pre-reflexive schemes that, rather than being spoken, will be acted upon in the relationship; and as a corollary: those will be modified from the (therapeutically) protective relationship that you establish with the patient, where nonverbal aspects (physical presence, tone and cadence of voice, etc.) will be fundamental.

EXPLORE THE EXTERIOR, EXPLORE THE INTERIOR

Attachment and exploration seem antagonistic: attachment drives the child closer to the caregiver, whereas exploration encourages them to move away. Therefore, activating one implies deactivating the other. But in evolutionary terms it is a complementary relationship: the attachment relationship offers the child the necessary security to explore the environment (with the caregiver as a secure base) and a place to which to return in order to seek protection (the caregiver as a safe haven). In humans, this provision of security to explore the external world may be complemented by security to address internal processes (sensory, affective, and cognitive experiences) (Eagle, 2017). This implies that the ability to attend to our private experiences will be powerfully influenced by the personal trajectory of attachment (Miller-Bottome, Talia, Eubanks, Safran, & Muran, 2019; Wallin, 2007). As clinicians, we ask: what support did the caregivers give to the patient when in her childhood she turned her gaze to internal experiences (affections, cognitions, body sensations)? Did they accompany her in a healthy way in this exploration, or

did they leave her alone when faced with experiences they could not recognize, or even "disorient" her on this journey? What does she anticipate from me, in this therapeutic space, when attending to her private experiences?

The child or adult with secure attachment will dare to explore his inner world, question his thinking, and connect with his emotional experiences. Those who have a preference to work based on avoidance strategies, confronted with such disappointment (care needs not validated or frustrated) could avoid being aware or expressing certain experiences, including their attachment needs. Just as he has difficulty connecting with the other, it will be difficult for him to be genuinely intimate with himself. He will do so in a precarious and strongly biased way, excluding the affective arena, certain basic needs, and relevant experiences. Therefore, psychotherapeutic questions about his inner world can generate anguish ("they want to control me", "they will reject me at some point") or can be perceived as exotic and incomprehensible language. The mismatch is inevitable.

In the ambivalent (preoccupied) style, early experience with unpredictable attachment figures has taught that ensuring the attention and support of others requires making one's own distress too large to be ignored. Therefore, the patient will tend to be too aware of the thoughts, feelings, and bodily sensations related to the threat and vulnerability, and will be very willing to exaggerate their meaning. Since each attachment style entails a specific level of access to internal information (cognitive versus affective) (Crittenden, 2006; Crittenden & Dallos, 2009; Wallin, 2007), here emotional processing will be prioritized over cognitive processing.

Finally, the individual with elements of disorganization will often have gone through overwhelming and unprocessed emotional experiences and will have her inner world full of past experiences ready to reactivate (and lead to pain and disorganization). Access to them will be avoided, and if this is not possible, anguish and disorganization will arise. Words, which constitute a privileged instrument in psychotherapy to calm the patient, could be experienced here as a threat, because they activate deeply painful memories (Holmes, 2004).

We finish by taking up again the proposal of the double effort of accommodation and challenge. At the same time that the therapist validates and respects the strategies that the patient feels are so necessary to protect himself, she will exercise a constant counterweight that allows access to these avoided dimensions: focus on the affective and bodily aspects that the avoidant disregards, reinforce the intellectual and cognitive analysis in the ambivalent patient, and impose order in the internal confusion of the disorganized.

WHAT SECURITY DO I LOOK FOR, WHAT ANSWER DO I NEED?

The attachment system, automatically activated in the psychologist-patient relationship, involves three basic demands possibly linked to phylogenetic development.

The first thing: not to be devoured, not to be abandoned

The attachment system has its evolutionary origin in the need for protection against predators or loneliness; for this reason, it impels us to look for physical protection, requiring the caretaker to vanquish dangers to our integrity (facing the threat or helping us to escape). What is needed from the attachment figure is "to show up". Sometimes this will be activated in therapy: the patient will somehow require protective gestures beyond verbal messages. From here we will reconsider the value that it may have for a patient if the therapist makes an effort to find space in the agenda, phones him at a time of special difficulty, or anticipates a problem that may arise. At other times, "showing up" means something more committed, for which some models are not prepared. Although sometimes an atmosphere of security and tranquility is enough (with regular and committed meetings) for the demands of attachment to be satisfied, in certain patients (such as borderline personality disorders), or some psychosocial intervention contexts (disorganized families, children in marginal environments), protecting effectively requires going beyond verbal exchange, and intervening in the patient's life: clearly speaking out when facing life decisions (instead of maintaining neutrality), helping in life organization actions, contacting other people or institutions, forcing hospital admissions, doing procedures outside of the consultancy, etc. While some psychotherapy models consider these elements to be incompatible with psychotherapeutic work, others consider them inevitable and try to include them in the therapeutic project. In attachment theory the latter would be the most appropriate option, because it responds to a need that demands a response.

The second thing: to be emotionally welcomed

On top of this basic need for physical security, we humans experience an additional one, and we have resorted to the attachment system to satisfy it. Not only do we feel danger from a predator, but our own internal experiences are lived as a danger; unpleasant sensations (hunger, pain), emotions (fear, grief, anger), thoughts, etc. are felt as dangers. The experience of anxiety itself is received as a threat ("fear of fear" in anxiety conditions). For these dangers we do not need a physically strong figure to face the predator, but someone emotionally receptive, sensitive to the inner world, who is in tune with their patients' emotions and validates their experiences. On the other hand, and although we are obviously concerned with survival and physical well-being, we are a species that is distinguished by an unusual concern for emotional well-being (Watchel, 2017), and we have recruited the attachment system to guarantee it. In the same line of

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"evolutionary sophistication", humans need the experience of being recognized (being understood and feeling ourselves in the mind of another person) (Seligman, 2017). In relation to all these needs covered in the attachment system, we see that here it is not so much about the search for security in proximity, as it is about security and pleasure in intimacy.

How to attend to these needs in psychological intervention? We can add little in this text because one of the great assets of psychotherapy lies precisely in the concepts and techniques that allow the establishing of an interpersonal relationship that satisfies these needs. Thus, from classic proposals such as those of Rogers (1978) to recent research on the vicissitudes of this fine emotional therapist-patient connection (Safran & Muran, 2005), psychology has not ceased to offer tools for the patient to feel safe emotionally, and for this experience to be constructive and therapeutic.

Third: allow yourself to learn

The last great contribution of attachment theory, proposed by Peter Fonagy, underlines the importance of communicative exchange in our species. The creation of a natural "highway" for the transmission of knowledge among humans is a process that is subject to many ups and downs, and in which attachment takes part. Thus, in the attachment relationship we learn a fundamental capacity for social survival: opening our minds to communication when it is good for us ("epistemic trust") and maintaining "epistemic vigilance" when it involves risks (Fonagy & Allison, 2014; Fonagy, Luyten, & Allison, 2015). The key element for this is to determine if our interlocutor is teaching us things that are relevant, useful, accurate, and good for us. The participation of attachment and the capacity for mentalization in this learning means that its activation implies a fundamental question in any communication process (including the therapeutic one): can I open my inner world to the messages of my interlocutor? This concept contributes to attachment theory something that was previously absent and that has ballasted it as a psychotherapeutic theory: a theory of change (Fonagy & Campbell, 2017). But, in addition, it sensitizes us to the error of assuming that therapists are validated a priori, and that the patient will consider our messages relevant, useful, accurate, and well-intentioned. Each patient comes with what they are. Their life trajectory may have generated epistemic distrust, which should become the first objective (or requirement) of the intervention. Making an effort to become a secure base (regularity, perseverance, commitment), being in tune with the patient (adjustment), and establishing communication that favors mentalization, are basic strategies to achieve what we have wrongly taken for granted.

The existence of three dimensions of attachment leads to questioning whether they are manifestations of a single system, or different manifestations of a single global concept labeled as "attachment" (Watchel, 2017). Beyond this theoretical disquisition, this systematization helps us to respond more precisely to the diversity of demands that are packed into the therapeutic relationship.

WHAT YOU LEARN IN PAIRS

An ambitious and fascinating study within attachment theory is the longitudinal investigation that L. Alan Sroufe and Byron Egeland have been leading since the 1970s. Although its implications seem to be aimed at evolutionary psychology rather than clinical psychology, its implications for the latter are fundamental.

The Minnesota Longitudinal Study of Parents and Children (Sroufe, 2005; Vaughn, 2005) used attachment as the construct that provided organization to the affective, cognitive, and behavioral changes that define the child's development. Sustaining children's attachment is one of several important functions of parents, but it occupies a central place in the hierarchy of development due to its primacy: the attachment relationship is the core around which other experiences are structured. Attachment allows the child to not be eaten by predators, but it also provides the framework in which to learn to self-regulate emotionally, connect emotionally, discover corporeality, develop language, and so on. It becomes the "relational niche" where other facets of personal growth will develop, a complex evolution marked by non-linear effects (Cortina, 2013). This ability to overlap with other variables will be evident when we try to predict what will happen to the child in the future. These predictions (how she will do in school, adapt socially or at work, or how her mental health will be) will inevitably need an assessment of the current attachment, but they will be really accurate when we combine this with other predictors; this means those things that parents do at the same time as they provide a secure base for exploration, a safe haven, and a source of reassurance for the distressed child (the seals of attachment).

Another relevant aspect of the Minnesota study from which we will draw clinical implications is the importance of attachment in the development of self-regulation, also noted in other places within this theory (Fonagy & Target, 2002). Attachment is considered "the dyadic regulation of emotion" (the child cannot self-regulate and is regulated in an interpersonal relationship). It happens as in other basic functions that are learned in pairs and finally internalized (interpersonal processes become intrapersonal mechanisms). Thus, what was a dialogue with a caregiver ("Son, think carefully about what you have to do now") becomes an internal dialogue ("I'm going to stop for a moment to think before acting"); an external control process ("Don't do that, child!") goes to moral conscience ("I shouldn't do this"). This idea, which has a long history in clinical thinking, has found support in neuroscience, as it understands the brain as an organ open to the outside, to the interpersonal relationship, which is built internally based on relationships with the outside

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(Siegel, 2013). After all, the attachment system emerged to regulate the physical distance from the attachment figure; but humans (unlike other mammals and birds) take a long time to gain the physical mobility to separate ourselves from our caregiver, and it could be that attachment has ended up focusing more on the regulation of emotional distance; and thus, attachment in humans is more a matter of regulation of emotions and trust, than of physical safety.

What are the clinical implications? In short, attachment theory:

✔ supports proposals for the understanding of psychopathology as problems of self-regulation. In the search for transdiagnostic dimensions, including these deficits in the translation of hetero-regulatory processes to mechanisms of self-regulation (of emotions, thoughts, and behaviors) helps us to understand the pathology and the therapeutic process. This is conceived as a new attempt to create a dyadic relationship that allows the co-regulation of processes, and finally the internalization (and autonomization) of that capacity.

✔ reveals the fundamental role of ruptures and repairs in these close communicative exchanges. In investigations close to this theory (for example, Stern, 1997), it is argued that the determining element of the quality of the attachment relationship is not the maintenance of the connection in the dyad (since adjustment failures are frequent) but the caregiver's ability to repair these frequent connection ruptures (notice the rupture and resume the connection). This has therapeutic implications: knowing that the most important thing is not accommodating to the patient, but rather re-accommodating after a disagreement, impels one to direct a constant scrutiny to the evolution of the contact, detect ruptures quickly, and implement techniques to repair them, because a fundamental therapeutic element resides in this. This is explored fruitfully by researchers of the therapeutic process inspired by attachment, including Jeremy D. Safran (see for example Miller-Bottome et al., 2019).

✔ as the Minnesota study shows (Suess & Sroufe, 2005):
  • the importance of how children are treated by their parents begins in the early moments of life; therefore, we must start early with the interventions, and support the caregiver-child relationship.
  • complex interventions are required, which address: 1) the influence of the cumulative history of care and adaptation in the past; and 2) experiences and support in the present. The best predictor of development is the entire history of care, so interventions must be complex, not isolated. Since the relationships between the adults who care for the child are important, elements of couples therapy must be added to the early intervention programs. And since, as the child grows up, he influences his environment more, reinforcing the type of relationship that has been imposed on him, we must consider the self-maintenance circles of dysfunctional relationships.

FORMALIZED RESOURCES FOR ASSESSMENT AND INTERVENTION

We have reviewed the great contributions of attachment theory to clinical practice and, in this section, we will offer a brief illustrative sketch of the evaluation and treatment resources.

In the field of assessment, beyond the usual questionnaires, there are also innovative and enriching proposals. Although many suffer from being excessively oriented to research and are not very transferable to the clinical environment, they contain interesting contributions for the psychotherapist. For example, there is the Adult Attachment Interview (AAI), difficult and laborious in application, but nevertheless a fascinating proposal: since linguistic patterns are outlined by attachment (Holmes, 2017b), the *way* we talk about our relationship patterns is more revealing than the *content* of our message about these patterns, which forces us to change the focus of attention to the patient's speech. Also noteworthy is the evaluation of children's narratives through the joint construction of stories, with tests such as The MacArthur Story Stem Battery or the Attachment Completion Story Test; using these tools, the beginning of a family story in which the attachment system is activated is staged with small dolls, and the child will complete it with a narrative that possibly reflects his internal attachment schemes (Emde, Wolf & Oppenheim, 2014; Galán, 2018). A third illustrative example is found in the Strange Situation Procedure, a laboratory observation design that enabled the defining of the basic patterns of attachment. We can be inspired by it to generate adaptations closer to the healthcare reality, such as the one proposed in the "Practice Parameters" of the American Academy of Child and Adolescent Psychiatry (Boris & Zeanah, 2005). Clinicians willing to make adaptations tailored to their professional practice can obtain undoubted benefits with these tools.

In this brief review we end with treatment formats. Although one can hardly speak of an "attachment therapy" (as proposals directly and exclusively based on this theory), its presence in some therapeutic formats is undeniable:

✔ It has provided very suggestive and useful concepts and metaphors in the therapeutic process, such as "safe haven" and "secure base". It is possibly the theory that has best combined a scientific reading with a poetic approach (suggestive, "tender", evocative) in addressing that intimate coupling between a vulnerable person and the person who is trying to help them.

✔ It has been recruited by therapy schools where there was a lack of additional input provided by attachment theory, even in models initially far removed from it, such as the systemic model (Crittenden & Dallos, 2009). It has also found fit in specific areas, such as (in very recent proposals) the treatment of trauma in close relationships (Allen, 2013) or borderline personality disorder (Serván, 2018). This theory invokes basic evolutionary processes, and a specific factor involved in any therapeutic process (Goodman, 2009),

which makes its presence inevitable, regardless of the model used. In this sense, attachment refers to what Holmes (2017b) calls "meta-competencies".

✔ It has inspired therapeutic proposals with attachment theory as a central pillar, such as mentalization-based therapy (Allen, Fonagy & Bateman, 2008), especially recognized in the treatment of borderline personality disorders (Bateman & Fonagy, 2013, 2016), but also in programs aimed at improving parenting (Slade, 2006). It is probably in the field of childhood where we find the most innovative and creative proposals, such as the Attachment Biobehavioral Catch-up (ABC) by Mary Dozier (see Grube & Liming, 2018) and the Circle of Security Project (Marvin, Cooper, Hoffman, & Powell, 2002); or the use of recordings of caregiver-child interactions, a strategy incorporated in several programs and whose origin can be found in research projects around the mother-baby communicational adjustment (Beebe, 2014).

We conclude by emphasizing how attachment theory has promoted a specific way of relating to the patient, whereby proximity, availability, and committed emotional care are fundamental elements. Although this type of therapeutic relationship is not exclusive to attachment theory, it is probably the theory that has defended it in the most firm and scientifically-established way.

CONCLUSIONS

Beyond the inspiring and suggestive aspects of attachment theory, it offers the clinician extremely valuable tools. It helps identify crucial aspects of the difficulties in managing vulnerability (giving key elements for handling fundamental issues of the therapeutic relationship) and it offers useful maps of the patient's functioning (management of her internal world, management of the interpersonal relationship) that allow us to better conceptualize and handle the intervention. In addition, it provides evaluation and treatment tools, and offers a scientifically supported proposal concerning the central element of the therapeutic process: the relationship.

Whilst it offers these resources, it illuminates relevant human realities in the clinical-therapeutic field, such as the value of early experiences (both of good care, and traumatic ones), and the importance of a protective figure for personal development (emotional regulation, displaying of intimacy, development of the ability to establish intersubjective contact, etc.). This may explain why, without being an exclusively clinical theory or developing as a specific psychotherapeutic practice, it exerts an enormous influence on psychotherapy, fundamentally permeating our psychotherapeutic culture.

In short, we are faced with a very suggestive and valuable theory. But it may die of success if we lose the conceptual rigor or stay in attractive generic formulations. Thus, it has practical implications that we have pointed out throughout the article, and that have led us to the conviction that they will enrich the practice of any clinician who decides to implement them.

CONFLICT OF INTERESTS

There is no conflict of interest.

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